

CHAPTER 311

INSURANCE

HOUSE BILL 02-1003

BY REPRESENTATIVE(S) Spradley, Clapp, Williams T., Alexander, Boyd, Cadman, Cloer, Crane, Daniel, Dean, Decker, Fairbank, Fritz, Harvey, Hefley, Hoppe, Jahn, Johnson, Kester, King, Lawrence, Lee, Miller, Mitchell, Paschall, Rhodes, Rippy, Romanoff, Sanchez, Schultheis, Scott, Snook, Spence, Stafford, Stengel, Webster, White, Williams S., and Young ; also SENATOR(S) Hagedorn, Owen, Epps, Hernandez, Isgar, and Taylor.

AN ACT**CONCERNING EXPANDED ACCESS TO HEALTH INSURANCE.**

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. 10-16-102 (10) (b) (II) and (40), Colorado Revised Statutes, are amended to read:

10-16-102. Definitions. As used in this article, unless the context otherwise requires:

(10) (b) "Case characteristics" are limited to the following demographic characteristics:

(II) Geographic location of the policyholder ~~including the following location categories only, unless the commissioner determines that, based on differences in medical costs for certain counties described in sub-subparagraphs (B) or (C), or both, of this subparagraph (II), certain counties should be included in one or more separate geographic location categories that the commissioner may establish:~~

~~(A) Counties in Colorado that are part of a primary metropolitan statistical area or a metropolitan statistical area, except that different primary metropolitan statistical areas and metropolitan statistical areas may have different rates;~~

~~(B) Counties in Colorado with a population of twenty thousand or fewer residents;~~
~~and~~

~~(C) All other counties in Colorado;~~ AS DETERMINED BY RULE OF THE

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

COMMISSIONER PURSUANT TO SECTION 10-16-104.7;

(40) (a) "Small employer" means any person, firm, corporation, partnership, or association that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed no more than fifty eligible employees, the majority of whom were employed within this state and that was not formed primarily for the purpose of purchasing insurance. ~~On and after January 1, 1996,~~ "Small employer" includes a business group of one. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation, shall be considered one employer.

(b) IN ORDER TO BE CLASSIFIED AS A SMALL EMPLOYER WITH MORE THAN ONE EMPLOYEE WHEN ONLY ONE EMPLOYEE ENROLLS IN THE SMALL EMPLOYER'S HEALTH BENEFIT PLAN, THE SMALL EMPLOYER SHALL SUBMIT TO THE SMALL EMPLOYER CARRIER THE TWO MOST RECENT QUARTERLY EMPLOYMENT AND TAX STATEMENTS SUBSTANTIATING THAT THE EMPLOYER HAD TWO OR MORE ELIGIBLE EMPLOYEES. SUCH SMALL EMPLOYER GROUP SHALL ALSO MEET THE PARTICIPATION REQUIREMENTS OF THE SMALL EMPLOYER CARRIER.

SECTION 2. 10-16-102 (6), Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

10-16-102. Definitions. As used in this article, unless the context otherwise requires:

(6) (d) FOR PURPOSES OF DETERMINING WHETHER AN APPLICANT MEETS THE REQUIREMENTS OF TWENTY-FOUR HOURS OR MORE PER WEEK ON A PERMANENT BASIS AS SET FORTH IN THIS SUBSECTION (6), THE COMMISSIONER SHALL PROMULGATE A RULE, WITHIN EXISTING RESOURCES, TO DEFINE WHAT TYPES OF DOCUMENTATION MAY BE REQUESTED BY A CARRIER TO SUBSTANTIATE THIS REQUIREMENT.

SECTION 3. 10-16-105 (7.2), (7.4) (c), (7.6) (a) (I), and (8) (f) (II), Colorado Revised Statutes, are amended to read:

10-16-105. Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic and standard health benefit plans. (7.2) The commissioner shall promulgate rules to implement a basic health benefit plan and a standard health benefit plan to be offered by each small employer carrier as a condition of transacting business in this state. Such rules shall be ~~effective January 1, 1995,~~ and in conformity with the provisions of article 4 of title 24, C.R.S., AND SHALL INCORPORATE THE FOLLOWING:

(a) THE STANDARD HEALTH BENEFIT PLAN SHALL REFLECT THE BENEFIT DESIGN OF COMMON PLAN OFFERINGS IN THE SMALL GROUP MARKET; AND

(b) THE BASIC HEALTH BENEFIT PLAN SHALL REFLECT ONE OF THE FOLLOWING BENEFIT DESIGNS:

(I) COVERAGE THAT MEETS THE REQUIREMENTS FOR A HIGH DEDUCTIBLE HEALTH PLAN FOR THE PURPOSES OF QUALIFYING FOR A FEDERAL MEDICAL SAVINGS ACCOUNT;

EXCEPT THAT HEALTH MAINTENANCE ORGANIZATION BASIC HEALTH BENEFIT PLANS SHALL REFLECT A SHARING OF HIGHER CONSUMER COSTS THROUGH HIGHER COPAYMENTS INSTEAD OF DEDUCTIBLE AMOUNTS. SUCH HEALTH INSURANCE SHALL BE OFFERED IN CONJUNCTION WITH A MEDICAL SAVINGS ACCOUNT, AS DEFINED IN SECTION 39-22-504.7, C.R.S., OR AN ACCOUNT OR OTHER MECHANISM AS DEFINED IN FEDERAL LAW THAT IS COMPARABLE TO A MEDICAL SAVINGS ACCOUNT, WHICH ACCOUNT OR MECHANISM SHALL REFLECT AN EMPLOYER CONTRIBUTION OF NOT LESS THAN ONE HUNDRED PERCENT OF THE AMOUNT OF THE PREMIUM PAID BY THE EMPLOYER FOR EACH INDIVIDUAL EMPLOYEE UP TO SEVENTY-FIVE PERCENT OF THE AMOUNT OF THE DEDUCTIBLE; EXCEPT THAT A BUSINESS GROUP OF ONE MAY NOT CONTRIBUTE MORE THAN THE BUSINESS GROUP OF ONE'S NET INCOME TO A MEDICAL SAVINGS ACCOUNT OR MORE THAN SIXTY-FIVE PERCENT OF THE DEDUCTIBLE AMOUNT OF THE PLAN. A MEDICAL SAVINGS ACCOUNT MAY BE ACCESSED THROUGH A DEBIT CARD SYSTEM.

(II) COVERAGE THAT MEETS THE REQUIREMENTS FOR A HIGH DEDUCTIBLE HEALTH PLAN FOR THE PURPOSES OF QUALIFYING FOR A FEDERAL MEDICAL SAVINGS ACCOUNT; EXCEPT THAT A HEALTH MAINTENANCE ORGANIZATION MAY REFLECT A SHARING OF HIGHER CONSUMER COSTS THROUGH HIGHER COPAYMENTS INSTEAD OF DEDUCTIBLE AMOUNTS. SUCH HIGH DEDUCTIBLE HEALTH PLAN SHALL INCLUDE ALL OF THE MANDATED BENEFITS REQUIRED PURSUANT TO SECTION 10-16-104 AND MAY BE OFFERED IN CONJUNCTION WITH A MEDICAL SAVINGS ACCOUNT OR OTHER MECHANISM AS DEFINED IN FEDERAL LAW THAT IS COMPARABLE TO A MEDICAL SAVINGS ACCOUNT.

(III) A HEALTH BENEFIT PLAN THAT HAS A DEDUCTIBLE AMOUNT OF TWO THOUSAND FIVE HUNDRED DOLLARS IN WHICH THE COVERED PERSON IS RESPONSIBLE AFTER THE FIRST ONE THOUSAND DOLLARS OF COVERAGE HAS BEEN PROVIDED BY AN EMPLOYER IN A MANNER SIMILAR TO A PERSONAL CARE ACCOUNT; OR

(IV) A BASIC HEALTH BENEFIT PLAN AS DETERMINED BY RULE BY THE COMMISSIONER.

(7.4) (c) In applying minimum participation requirements with respect to an employer, a small employer carrier shall not consider employees or dependents who have creditable group coverage OR INDIVIDUAL COVERAGE THAT HAS BEEN CONSISTENTLY MAINTAINED AND THAT WAS IN FORCE PRIOR TO THE INDIVIDUAL'S ELIGIBILITY FOR GROUP COVERAGE UNDER AN EXISTING GROUP PLAN when determining whether the applicable percentage of participation is met. However, a small employer carrier may consider employees or dependents of such employer who have coverage under another health benefit plan that is sponsored by such small employer.

(7.6) (a) No small employer carrier is required to accept applications from or offer coverage pursuant to paragraph (a) of subsection (7.3) of this section:

(I) To a small employer, where the employer is not physically located in the small employer carrier's established geographic service area, EXCEPT AS PROVIDED IN SECTION 10-16-704 (a);

(8) (f) The commissioner may establish ~~regulations~~ RULES to implement the provisions of this subsection (8) and to assure that rating practices used by small

employer carriers are consistent with the purposes of this subsection (8), including ~~regulations~~ RULES that:

(II) Prescribe the manner in which case characteristics THAT ARE CONSISTENT WITH SECTION 10-16-104.7 may be used by small employer carriers.

SECTION 4. 10-16-116, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

10-16-116. Catastrophic health insurance - coverage. (3) INSURERS SHALL PROVIDE A WRITTEN DISCLOSURE TO A COVERED PERSON THAT INDICATES THE MANDATED BENEFITS OF SECTION 10-16-104 (1), (1.7), (4), (5), (5.5), (8), (9), (10), (11), (12), (13), AND (14) ARE COVERED BENEFITS OF THE HIGH DEDUCTIBLE HEALTH PLAN OFFERED PURSUANT TO SECTION 10-16-105 (7.2) (b) (I) OR (7.2) (b) (II).

SECTION 5. 10-16-118 (1) (a) (I), Colorado Revised Statutes, is amended to read:

10-16-118. Limitations on preexisting condition limitations. (1) A health coverage plan that covers residents of this state:

(a) (I) If it is a group health benefit plan, shall not deny, exclude, or limit benefits for a covered individual because of a preexisting condition for losses incurred more than six months following the date of enrollment of the individual in such plan or, if earlier, the first day of the waiting period for such enrollment; EXCEPT THAT, FOR BUSINESS GROUPS OF ONE, A HEALTH BENEFIT PLAN SHALL NOT DENY, EXCLUDE, OR LIMIT BENEFITS FOR A COVERED INDIVIDUAL BECAUSE OF A PREEXISTING CONDITION FOR LOSSES INCURRED MORE THAN TWELVE MONTHS FOLLOWING THE DATE OF ENROLLMENT OF THE INDIVIDUAL IN SUCH PLAN. A group health benefit plan may impose a preexisting condition exclusion or limitation only if such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within six months immediately preceding the date of enrollment of the individual in such plan or, if earlier, the first day of the waiting period for such enrollment; except that a group health benefit plan shall not impose any preexisting condition exclusion in the case of a child that is adopted or placed for adoption before attaining eighteen years of age, or relating to pregnancy.

SECTION 6. 10-16-119 (2) (c), Colorado Revised Statutes, is amended to read:

10-16-119. Requirements for excess loss insurance used in conjunction with self-insured employer benefit plans under the federal "Employee Retirement Income Security Act". (2) All excess loss insurance shall be issued to cover the employer's liability under the employer's self-insured obligation. Excess loss insurance shall meet the following requirements:

(c) ~~(d)~~ ~~Effective~~ COMMENCING WITH POLICIES ISSUED OR RENEWED ON AND AFTER January 1, ~~1995~~ 2003, the minimum retention to the employer shall be no less than ~~ten~~ FIFTEEN thousand dollars per person per plan year with a minimum one hundred twenty percent of expected claims aggregate. ~~except as provided in subparagraph (II) of this paragraph (c).~~

~~(H) For excess loss policies issued and in force prior to January 1, 1995, the minimum retention to the employer shall be no less than five thousand dollars per person per plan year through December 31, 1995, with a minimum one hundred twenty percent of expected claims aggregate. Effective on policy anniversary dates occurring on and after January 1, 1996, such policies shall comply with the provisions of subparagraph (I) of this paragraph (c).~~

SECTION 7. Part 1 of article 16 of title 10, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

10-16-104.7. Geographic areas for small employers. (1) THE COMMISSIONER SHALL PROMULGATE A RULE CONCERNING GEOGRAPHIC CASE CHARACTERISTICS, WHICH MAY INCLUDE METROPOLITAN STATISTICAL AREAS FOR SMALL EMPLOYERS. IN PROMULGATING SUCH RULE, THE COMMISSIONER SHALL TAKE TESTIMONY FROM ALL INTERESTED PARTIES, INCLUDING, BUT NOT LIMITED TO, CONSUMER ADVOCATES AND CONSUMERS, INSURERS, HEALTH CARE PROVIDERS, THE STATE DEMOGRAPHER, AND PRODUCERS. THE RULE SHALL INCLUDE, WITHOUT LIMITATION, THE FOLLOWING FEATURES:

(a) IF THE RULE ESTABLISHES SEPARATE GEOGRAPHIC AREAS, IN RATE FILINGS TO THE COMMISSIONER, A CARRIER SHALL BE REQUIRED TO SHOW THAT RATES REFLECT A RELATIVITY TO RATES FOR OTHER AREAS IN THE STATE AND THAT RATES AND RELATIVITIES ARE NOT EXCESSIVE, INADEQUATE, OR UNFAIRLY DISCRIMINATORY IN SUCH GEOGRAPHIC AREAS;

(b) THE RULE SHALL CONTAIN A DETERMINATION OF THE APPROPRIATE POPULATION BASE FOR STATISTICAL RELIABILITY IN DETERMINING GEOGRAPHIC AREAS OR METROPOLITAN STATISTICAL AREAS;

(c) (I) THE RULE SHALL PROVIDE JUSTIFICATIONS OF WHY ANY SEPARATE GEOGRAPHIC AREAS, WHICH MAY INCLUDE METROPOLITAN STATISTICAL AREAS, SERVE THE PUBLIC INTEREST IN REGARD TO ENSURING THAT PREMIUM RATES FOR DIFFERENT GEOGRAPHIC AREAS OF THE STATE ARE NOT EXCESSIVE, MANDATORY, OR UNFAIRLY DISCRIMINATORY;

(II) IF THE COMMISSIONER DETERMINES THAT METROPOLITAN STATISTICAL AREAS ARE NO LONGER THE BEST METHOD FOR ADDRESSING GEOGRAPHIC CASE CHARACTERISTICS, THE COMMISSIONER SHALL PROVIDE DETAILED JUSTIFICATIONS CONCERNING THE SEPARATE GEOGRAPHIC AREAS, IN CONNECTION WITH WHICH THE COMMISSIONER SHALL MAKE PUBLIC THE IMPACT THE GEOGRAPHIC CASE CHARACTERISTICS MAY HAVE ON INSURANCE PREMIUMS FOR THE SEPARATE GEOGRAPHIC AREAS; AND

(d) IN ADOPTING SUCH RULE, THE COMMISSIONER MAY CONSIDER THE COST OF HEALTH CARE IN A GEOGRAPHIC AREA, EXPERIENCE OF HEALTH CARE OF ANY SEPARATE GEOGRAPHIC AREA, AND INFORMATION INCLUDING ACTUARIAL OPINIONS OR CERTIFICATIONS AND SET LOSS RATIOS FOR LOSS RATIO GUARANTEES SUBMITTED BY SMALL EMPLOYER CARRIERS PURSUANT TO SECTION 10-16-107 (1). THE COST OF HEALTH CARE AND EXPERIENCE AND THE POPULATION THAT MAY BE SERVED MAY BE A CONSIDERATION WHEN DETERMINING WHETHER SEPARATE GEOGRAPHIC CASE CHARACTERISTICS ARE NECESSARY, BUT SHALL NOT BE THE SOLE FACTORS OF

SEPARATE GEOGRAPHIC CASE CHARACTERISTICS, NOR SHALL IT COMPROMISE THE PUBLIC INTEREST OF INSUREDS AND POTENTIAL INSUREDS OF THIS STATE.

SECTION 8. Part 1 of article 16 of title 10, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

10-16-124. Reimbursement to nurses. IN COUNTIES OF THE STATE THAT ARE NEITHER PART OF A METROPOLITAN STATISTICAL AREA NOR A PRIMARY STATISTICAL AREA, A CARRIER OFFERING A HEALTH BENEFIT PLAN SHALL NOT DISCRIMINATE BETWEEN A PHYSICIAN AND AN ADVANCE PRACTICE NURSE NOT PRACTICING UNDER THE DIRECTION OF A PHYSICIAN WHEN ESTABLISHING REIMBURSEMENT RATES FOR COVERED SERVICES THAT COULD BE PROVIDED BY AN ADVANCE PRACTICE NURSE OR A PHYSICIAN.

SECTION 9. 10-16-201.5 (1) (d), Colorado Revised Statutes, is amended to read:

10-16-201.5. Renewability of health benefit plans - modification of health benefit plans. (1) A carrier providing coverage under a health benefit plan shall not discontinue coverage or refuse to renew such plan except for the following reasons:

(d) (I) The carrier elects to discontinue offering and nonrenew all of its individual, small group, or large group health benefit plans delivered or issued for delivery in this state. In such case the carrier shall provide notice of the decision to discontinue or not to renew coverage to all policyholders and covered persons and to the insurance commissioner in each state in which an affected individual is known to reside at least one hundred eighty days prior to the discontinuance or nonrenewal of the health benefit plan by the carrier. The carrier shall also discontinue and nonrenew all of its individual or small or large group health benefit plans in Colorado. Notice to the insurance commissioner under this paragraph (d) shall be provided at least three working days prior to the notice to the affected individuals.

(II) IF A CARRIER DISCONTINUES COVERAGE COMPLETELY FROM A MARKET SEGMENT AND OTHERWISE REMAINS IN THE MARKET, THE CARRIER SHALL CONTINUE TO PROVIDE COVERAGE THROUGH THE FIRST RENEWAL PERIOD NOT TO EXCEED TWELVE MONTHS AFTER THE NOTICE PROVIDED PURSUANT TO SUBPARAGRAPH (I) OF THIS PARAGRAPH (d) HAS EXPIRED.

SECTION 10. 10-16-407 (2), Colorado Revised Statutes, is amended to read:

10-16-407. Information to enrollees. (2) Every health maintenance organization shall clearly state in its brochures, contracts, policy manuals, and printed materials distributed to enrollees that such enrollees shall have the option of calling the local prehospital emergency medical service system by dialing the emergency telephone access number 9-1-1 or its local equivalent whenever an enrollee is confronted with a life or limb threatening emergency. For the purposes of this section, a "life or limb threatening emergency" means any event ~~which the enrollee believes~~ THAT A PRUDENT LAY PERSON WOULD BELIEVE threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health. No enrollee shall in any way be discouraged from using the local prehospital emergency medical service system, the 9-1-1 telephone number, or the local equivalent, or be denied coverage for medical and

transportation expenses incurred as a result of such use in a life or limb threatening emergency.

SECTION 11. 10-16-402 (2) (c), Colorado Revised Statutes, is amended to read:

10-16-402. Issuance of certificate of authority - denial. (2) The commissioner shall issue or deny a certificate of authority to any person filing an application pursuant to section 10-16-401 within thirty days of receipt of the certification from the executive director. Issuance of a certificate of authority shall be granted upon payment of the application fee prescribed in section 10-16-110 (2) if the commissioner is satisfied that the following conditions are met:

(c) The health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments, DEDUCTIBLES, AND PAYMENTS FOR OUT-OF-NETWORK SERVICES RECEIVED PURSUANT TO SECTION 10-16-704 (2);

SECTION 12. 10-16-704 (1) (c), (9) (a.7), and (9) (b) (II), Colorado Revised Statutes, are amended to read:

10-16-704. Network adequacy. (1) A carrier providing a managed care plan shall maintain a network that is sufficient in numbers and types of providers to assure that all covered benefits to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access to health care services twenty-four hours per day, seven days per week. Sufficiency shall be determined in accordance with the requirements of this section and may be established by reference to any reasonable criteria used by the carrier, including but not limited to:

(c) Geographic accessibility, WHICH IN SOME CIRCUMSTANCES MAY REQUIRE THE CROSSING OF COUNTY OR STATE LINES;

(9) Beginning January 1, 1998, a carrier shall maintain and make available upon request of the commissioner, the executive director of the department of public health and environment, or the executive director of the department of health care policy and financing, in a manner and form that reflects the requirements specified in paragraphs (a) to (k) of this subsection (9), an access plan for each managed care network that the carrier offers in this state. The carrier shall make the access plans, absent confidential information as specified in section 24-72-204 (3), C.R.S., available on its business premises and shall provide them to any interested party upon request. In addition, all health benefit plans and marketing materials shall clearly disclose the existence and availability of the access plan. All rights and responsibilities of the covered person under the health benefit plan, however, shall be included in the contract provisions, regardless of whether or not such provisions are also specified in the access plan. The carrier shall prepare an access plan prior to offering a new managed care network and shall update an existing access plan whenever the carrier makes any material change to an existing managed care network, but not less than annually. The access plan of a carrier offering a managed care plan shall demonstrate the following:

(a.7) Geographic accessibility, which in some circumstances may require the crossing of county OR STATE lines; and

(b) A carrier offering a managed care plan shall maintain procedures for making referrals within and outside its network that, at a minimum, must include the following:

(II) (A) A provision that referral options cannot be restricted to less than all providers in the network that are qualified to provide covered specialty services; EXCEPT THAT A HEALTH MAINTENANCE ORGANIZATION MAY OFFER VARIABLE DEDUCTIBLES AND COPAYMENTS TO ENCOURAGE THE SELECTION OF CERTAIN PROVIDERS.

(B) A HEALTH MAINTENANCE ORGANIZATION THAT OFFERS VARIABLE DEDUCTIBLES AND COPAYMENTS SHALL PROVIDE ADEQUATE AND CLEAR DISCLOSURE, AS REQUIRED BY LAW, OF VARIABLE DEDUCTIBLES AND COPAYMENTS TO ENROLLEES, AND THE AMOUNT OF ANY DEDUCTIBLE OR COPAYMENT SHALL BE REFLECTED ON THE BENEFIT CARD PROVIDED TO THE ENROLLEES.

SECTION 13. 10-16-704 (2), Colorado Revised Statutes, is amended BY THE ADDITION OF THE FOLLOWING NEW PARAGRAPHS to read:

10-16-704. Network adequacy. (2) (g) A HEALTH MAINTENANCE ORGANIZATION OFFERING HEALTH BENEFITS IN THIS STATE MAY:

(I) OFFER HEALTH BENEFIT COVERAGE IN ACCORDANCE WITH PARAGRAPH (i) OF THIS SUBSECTION (2) TO A SMALL EMPLOYER THAT IS NOT LOCATED, OR WHOSE EMPLOYEES DO NOT WORK OR RESIDE, WITHIN THE HEALTH MAINTENANCE ORGANIZATION'S GEOGRAPHIC SERVICE AREA.

(II) OFFER HEALTH BENEFIT COVERAGE IN ACCORDANCE WITH PARAGRAPH (i) OF THIS SUBSECTION (2) IN A GEOGRAPHIC AREA WITHIN THE CARRIER'S SERVICE AREA IN WHICH A HEALTH MAINTENANCE ORGANIZATION IS UNABLE TO MAINTAIN AN ADEQUATE NETWORK AND IS ABLE TO DEMONSTRATE TO THE COMMISSIONER UPON REQUEST THAT THE CARRIER HAS MADE UNSUCCESSFUL GOOD FAITH EFFORTS TO CONTRACT WITH LOCAL PROVIDERS ON REASONABLE TERMS; OR

(III) A HEALTH MAINTENANCE ORGANIZATION THAT ELECTS TO OFFER COVERAGE PURSUANT TO PARAGRAPH (g) OF THIS SUBSECTION (2) SHALL OFFER SUCH COVERAGE WITHIN A GEOGRAPHIC AREA CONSISTENT WITH THE REQUIREMENTS OF SUBSECTION (7.3) OF SECTION 10-16-105.

(h) THE HEALTH MAINTENANCE ORGANIZATION SHALL PROVIDE A DISCLOSURE TO A SMALL EMPLOYER AND ITS EMPLOYEES WHO PURCHASE HEALTH INSURANCE COVERAGE UNDER THE CIRCUMSTANCE DESCRIBED IN THIS PARAGRAPH (h). SUCH DISCLOSURE SHALL ALSO BE GIVEN IN WRITING TO ALL INTERESTED POLICYHOLDERS AND CERTIFICATE HOLDERS AS PART OF THE SALES AND MARKETING MATERIALS BEFORE THE INSURER OR ENTITY APPROVES AN APPLICATION FOR INSURANCE FROM AN INSURED. THE DISCLOSURE SHALL CONTAIN THE FOLLOWING STATEMENT: "INTERESTED POLICYHOLDERS, CERTIFICATE HOLDERS, AND ENROLLEES ARE HEREBY GIVEN NOTICE THAT THIS SMALL GROUP POLICY REQUIRES THAT AN INSURED TRAVEL

OUTSIDE OF THE GEOGRAPHIC AREA TO RECEIVE COVERED HEALTH BENEFITS. THE CARRIER SHALL, IN A CONSPICUOUS LOCATION ON THE POLICY CONTRACT MATERIALS, CERTIFICATES OF COVERAGE FOR A POLICYHOLDER, AND MARKETING MATERIALS, PROVIDE THE DISCLOSURE REQUIRED BY THIS PARAGRAPH IN BOLD-FACED, TWELVE-POINT TYPE AND ALL CAPITAL LETTERS.

(i) (I) A HEALTH MAINTENANCE ORGANIZATION THAT OFFERS COVERAGE PURSUANT TO THIS SECTION MAY REQUIRE THAT A COVERED PERSON TRAVEL A REASONABLE DISTANCE BEYOND THE AREA SPECIFIED UNDER SECTION 10-16-704 (6) IN ORDER TO RECEIVE SERVICES FROM A PARTICIPATING PROVIDER. EXCEPT FOR EMERGENCY SERVICES AND BENEFITS AVAILABLE FOR OUT-OF-NETWORK SERVICES, IN SUCH CASES WHERE THE COVERED PERSON IS REQUIRED TO TRAVEL A REASONABLE DISTANCE TO RECEIVE SERVICES FROM A PARTICIPATING PROVIDER AND KNOWINGLY SEEKS SERVICES FROM A NONPARTICIPATING PROVIDER, THE HEALTH MAINTENANCE ORGANIZATION SHALL BE RESPONSIBLE TO PAY FOR THE LESSER OF:

(A) THE PROVIDER'S BILLED CHARGES;

(B) A NEGOTIATED RATE; OR

(C) IN THE ABSENCE OF A NEGOTIATED RATE, THE GREATER OF THE HEALTH MAINTENANCE ORGANIZATION'S AVERAGE IN-NETWORK RATE FOR THE RELEVANT GEOGRAPHIC AREA OR THE USUAL, CUSTOMARY, AND REASONABLE RATE FOR SUCH GEOGRAPHIC AREA.

(II) UPON REQUEST, THE HEALTH MAINTENANCE ORGANIZATION SHALL DISCLOSE TO THE COVERED PERSON OR THE NONPARTICIPATING PROVIDER WHETHER THE AMOUNT REIMBURSED TO THE NONPARTICIPATING PROVIDER WAS THE NONPARTICIPATING PROVIDER'S BILLED CHARGES, A NEGOTIATED RATE, OR THE GREATER OF THE CARRIER'S AVERAGE IN-NETWORK RATE FOR THE RELEVANT GEOGRAPHIC AREA OR THE USUAL, CUSTOMARY, AND REASONABLE RATE FOR SUCH GEOGRAPHIC AREA.

(j) NOTHING IN PARAGRAPH (i) OF THIS SUBSECTION (2) SHALL REQUIRE EITHER A CARRIER OR A NONPARTICIPATING PROVIDER TO ATTEMPT TO NEGOTIATE A REIMBURSEMENT RATE.

(k) A NONPARTICIPATING PROVIDER MAY BALANCE BILL THE COVERED PERSON IN THE EVENT THAT THE REIMBURSEMENT RATE DESCRIBED IN PARAGRAPH (i) OF THIS SUBSECTION (2) IS NOT EQUAL TO THE PROVIDER'S BILLED CHARGES.

(l) THE PROVISIONS OF PARAGRAPH (i) OF THIS SUBSECTION (2) SHALL NOT APPLY TO CASES IN WHICH THE COVERED PERSON IS SO SEVERELY ILL OR IMPAIRED THAT SUCH PERSON IS UNABLE TO MOVE FROM PLACE TO PLACE WITHOUT THE AID OF A MECHANICAL DEVICE; HAS A PHYSICAL OR MENTAL CONDITION, VERIFIED BY A PHYSICIAN LICENSED TO PRACTICE MEDICINE IN THIS STATE OR PRACTICING MEDICINE PURSUANT TO SECTION 12-36-106 (3) (i), C.R.S., THAT SUBSTANTIALLY LIMITS THE PERSON'S ABILITY TO MOVE FROM PLACE TO PLACE; OR SUFFERS FROM A PHYSICAL HARDSHIP SUCH THAT TRAVEL WOULD THREATEN THE SAFETY OR WELFARE OF THE COVERED PERSON AS VERIFIED BY THE COVERED PERSON'S IN-NETWORK TREATING PHYSICIAN. DECISIONS IN WHICH A CARRIER CONTESTS THE COVERED PERSON'S

ABILITY TO TRAVEL MAY BE APPEALED PURSUANT TO SECTION 10-16-113 OR 10-16-113.5.

SECTION 14. 10-16-705, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

10-16-705. Requirements for carriers and participating providers. (16) A PROVIDER WHO IS NOT LICENSED TO FURNISH HEALTH CARE SERVICES IN THIS STATE AND WHO PARTICIPATES IN A NETWORK SHALL BE LICENSED IN THE STATE IN WHICH THE PROVIDER PRACTICES AND SHALL MEET MINIMUM STATUTORY AND REGULATORY STANDARDS FOR THAT PROFESSIONAL PRACTICE APPLICABLE IN THIS STATE.

SECTION 15. 10-16-707, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

10-16-707. Enforcement. (3) FAILURE OF A PROVIDER TO COMPLY WITH THE REQUIREMENTS OF SECTION 10-16-705 (16) SHALL PRECLUDE A CARRIER FROM CONTRACTING WITH A PROVIDER.

SECTION 16. 10-8-601.5 (1) (c), Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SUBPARAGRAPH to read:

10-8-601.5. Applicability and scope. (1) (c) (III) FOR THE PURPOSES OF THIS PARAGRAPH (c), AN INDIVIDUAL HEALTH BENEFIT POLICY SHALL NOT INCLUDE ONE OR MORE SHORT-TERM LIMITED DURATION HEALTH INSURANCE POLICIES ISSUED WITHIN SIX MONTHS BEFORE THE DATE OF APPLICATION FOR GROUP COVERAGE.

SECTION 17. 10-8-601.5 (3), Colorado Revised Statutes, is amended to read:

10-8-601.5. Applicability and scope. (3) Effective ~~October 1, 1997~~ JANUARY 1, 2003, pursuant to rules adopted by the commissioner, a small employer carrier may reject for coverage under a small group plan a business group of one self-employed person if, at the time of application for group coverage, the self-employed person has in place or, within the immediately preceding thirty days, has had in place an individual health benefit plan that meets the requirements of subparagraph (I) of paragraph (c) of subsection (1) of this section and has been in place for less than three years. AN INDIVIDUAL HEALTH BENEFIT POLICY SHALL NOT INCLUDE ONE OR MORE SHORT-TERM LIMITED DURATION HEALTH INSURANCE POLICIES ISSUED WITHIN SIX MONTHS BEFORE THE DATE OF APPLICATION FOR GROUP COVERAGE.

SECTION 18. 10-16-105.2 (1) (c), Colorado Revised Statutes, as enacted by House Bill 02-1136, enacted at the Second Regular Session of the Sixty-third General Assembly, is amended BY THE ADDITION OF A NEW SUBPARAGRAPH to read:

10-16-105.2. Applicability and scope. (1) (c) (III) FOR THE PURPOSES OF THIS PARAGRAPH (c), AN INDIVIDUAL HEALTH BENEFIT POLICY SHALL NOT INCLUDE ONE OR MORE SHORT-TERM LIMITED DURATION HEALTH INSURANCE POLICIES ISSUED WITHIN SIX MONTHS BEFORE THE DATE OF APPLICATION FOR GROUP COVERAGE.

SECTION 19. 10-16-105.2 (3), Colorado Revised Statutes, as enacted by House

Bill 02-1136, enacted at the Second Regular Session of the Sixty-third General Assembly, is amended to read:

10-16-105.2. Applicability and scope. (3) Pursuant to rules adopted by the commissioner, a small employer carrier may reject for coverage under a small group plan a business group of one self-employed person if, at the time of application for group coverage, the self-employed person has in place or, within the immediately preceding thirty days, has had in place an individual health benefit plan that meets the requirements of subparagraph (I) of paragraph (c) of subsection (1) of this section and that has been in place for less than three years. AN INDIVIDUAL HEALTH BENEFIT POLICY SHALL NOT INCLUDE ONE OR MORE SHORT-TERM LIMITED DURATION HEALTH INSURANCE POLICIES ISSUED WITHIN SIX MONTHS BEFORE THE DATE OF APPLICATION FOR GROUP COVERAGE.

SECTION 20. Part 1 of article 4 of title 26, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

26-4-127. Direct contracting with providers - legislative declaration. (1) THE GENERAL ASSEMBLY HEREBY FINDS, DETERMINES, AND DECLARES THAT COSTS ASSOCIATED WITH PROVIDING MEDICAL ASSISTANCE TO RECIPIENTS HAVE INCREASED SUBSTANTIALLY DUE IN PART TO INCREASED COSTS OF HEALTH CARE SERVICES AND HIGHER UTILIZATION RATES. THESE COST PRESSURES HAVE BEEN MOST DRAMATICALLY DEMONSTRATED IN THE SOUTHERN AREA OF THE STATE. THEREFORE, THE GENERAL ASSEMBLY FINDS, DETERMINES, AND DECLARES THAT A PILOT PROGRAM SHOULD BE CREATED TO EVALUATE WHETHER A PROVIDER MAY CONTRACT DIRECTLY WITH THE STATE DEPARTMENT FOR THE PROVISION OF SERVICES TO RECIPIENTS.

(2) (a) THE STATE DEPARTMENT IS AUTHORIZED TO CONTRACT DIRECTLY WITH ANY PROVIDER WHO IS ABLE TO DEMONSTRATE COMPLIANCE WITH STATE LAWS AND REGULATIONS PERTAINING TO RISK-BEARING ENTITIES TO PROVIDE A CAPITATED-RISK PROGRAM ON A PER MEMBER PER MONTH BASIS. THE PROVIDER SHALL NOT SERVE MORE THAN TWO THOUSAND FIVE HUNDRED RECIPIENTS. THE PROVIDER SHALL ACCEPT FULL RISK FOR EACH PARTICIPANT, EXCEPT FOR TRANSPLANTS OR OUT-OF-AREA SERVICES.

(b) IF THE STATE DEPARTMENT IMPLEMENTS DIRECT CONTRACTING WITH A PROVIDER PURSUANT TO THIS SECTION, THE PROVIDER AND THE STATE DEPARTMENT SHALL REPORT TO THE HEALTH, ENVIRONMENT, WELFARE, AND INSTITUTIONS COMMITTEE OF THE HOUSE OF REPRESENTATIVES AND THE HEALTH, ENVIRONMENT, CHILDREN AND FAMILIES COMMITTEE OF THE SENATE NO LATER THAN JULY 1, 2003, ON THE STATUS OF DIRECT CONTRACTING. THE REPORT SHALL INCLUDE AN ANALYSIS OF THE EFFECTIVENESS OF DIRECT CONTRACTING AND WHETHER THE DIRECT CONTRACTING SHOULD BE CONTINUED TO THE SAME OR LARGER NUMBERS OF RECIPIENTS.

(3) **Selection of the provider.** THE STATE DEPARTMENT SHALL SELECT ANY PROVIDER WHO:

(a) IS ABLE TO PROVIDE EVIDENCE OF A SUCCESSFUL HISTORY OF RISK MANAGEMENT FOR RECIPIENTS;

(b) INITIATES DIRECT CONTRACTING WITH THE STATE DEPARTMENT; AND

(c) IS ABLE TO DEMONSTRATE COMPLIANCE WITH STATE LAWS AND REGULATIONS PERTAINING TO RISK-BEARING ENTITIES.

SECTION 21. Part 4 of article 4 of title 26, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

26-4-408.5. Legislative declaration - state department - disease management programs authorization - report. (1) THE GENERAL ASSEMBLY FINDS THAT, BECAUSE COLORADO IS FACED WITH RISING HEALTH CARE COSTS AND LIMITED RESOURCES, IT IS NECESSARY TO SEEK NEW WAYS TO ENSURE THE AVAILABILITY OF HIGH-QUALITY, COST-EFFICIENT CARE FOR MEDICAID RECIPIENTS. THE GENERAL ASSEMBLY FURTHER FINDS THAT DISEASE MANAGEMENT IS A PATIENT-FOCUSED, INTEGRATED APPROACH TO PROVIDING ALL COMPONENTS OF CARE WITH ATTENTION TO BOTH QUALITY OF CARE AND TOTAL COST. IN ADDITION, THE GENERAL ASSEMBLY FINDS THAT THIS APPROACH MAY INCLUDE COORDINATION OF PHYSICIAN CARE WITH PHARMACEUTICAL AND INSTITUTIONAL CARE. THE GENERAL ASSEMBLY FURTHER FINDS THAT DISEASE MANAGEMENT ALSO ADDRESSES THE VARIOUS ASPECTS OF A DISEASE STATE, INCLUDING MEETING THE NEEDS OF PERSONS WHO HAVE MULTIPLE CHRONIC ILLNESSES. THE GENERAL ASSEMBLY DECLARES THAT THE IMPROVED COORDINATION IN DISEASE MANAGEMENT HELPS TO PROVIDE CHRONICALLY ILL PATIENTS WITH ACCESS TO THE LATEST ADVANCES IN TREATMENT AND TEACHES THEM HOW TO BE ACTIVE PARTICIPANTS IN THEIR HEALTH CARE THROUGH HEALTH EDUCATION, THUS REDUCING TOTAL HEALTH CARE COSTS.

(2) THE STATE DEPARTMENT IS AUTHORIZED TO DEVELOP AND IMPLEMENT DISEASE MANAGEMENT PROGRAMS, FOR FEE-FOR-SERVICE AND PRIMARY CARE PHYSICIAN PROGRAM RECIPIENTS, THAT ARE DESIGNED TO ADDRESS OVER- OR UNDER-UTILIZATION OR THE INAPPROPRIATE USE OF SERVICES OR PRESCRIPTION DRUGS AND THAT MAY AFFECT THE TOTAL COST OF HEALTH CARE UTILIZATION BY A PARTICULAR MEDICAID RECIPIENT WITH A PARTICULAR DISEASE OR COMBINATION OF DISEASES. THE DISEASE MANAGEMENT PROGRAMS SHALL TARGET MEDICAID RECIPIENTS WHO ARE RECEIVING PRESCRIPTION DRUGS OR SERVICES IN AN AMOUNT THAT EXCEEDS GUIDELINES OUTLINED BY THE STATE DEPARTMENT. THE STATE DEPARTMENT SHALL NOT RESTRICT A MEDICAID RECIPIENT'S ACCESS TO THE MOST COST-EFFECTIVE AND MEDICALLY APPROPRIATE PRESCRIPTION DRUGS OR SERVICES. THE STATE DEPARTMENT MAY CONTRACT ON A CONTINGENCY BASIS FOR THE DEVELOPMENT OR IMPLEMENTATION OF THE DISEASE MANAGEMENT PROGRAMS AUTHORIZED IN THIS SUBSECTION (2).

(3) IF THE STATE DEPARTMENT IMPLEMENTS ANY DISEASE MANAGEMENT PROGRAMS AUTHORIZED IN SUBSECTION (2) OF THIS SECTION, THE STATE DEPARTMENT SHALL REPORT TO THE JOINT BUDGET COMMITTEE OF THE GENERAL ASSEMBLY AN ESTIMATE OF THE FISCAL IMPLICATIONS GENERATED BY THE IMPLEMENTATION OF THE DISEASE MANAGEMENT PROGRAMS. SUCH REPORT SHALL BE MADE ON OR BEFORE FEBRUARY 1 OF THE YEAR FOLLOWING THE IMPLEMENTATION OF A DISEASE MANAGEMENT PROGRAM AND ON OR BEFORE EACH FEBRUARY 1 THEREAFTER IN WHICH SUCH PROGRAM IS IN PLACE.

SECTION 22. Part 2 of article 71 of title 8, Colorado Revised Statutes, is

amended BY THE ADDITION OF A NEW SECTION to read:

8-71-218.7. Encouragement of nursing education programs - legislative declaration. (1) THE CONSORTIUM WORK FORCE INVESTMENT BOARD SHALL ENCOURAGE WORK FORCE INVESTMENT PROGRAMS AND WORK FORCE INVESTMENT AREAS TO ENROLL INDIVIDUALS IN EDUCATIONAL PROGRAMS RELATED TO PRACTICAL NURSING.

(2) THE GENERAL ASSEMBLY FINDS, DETERMINES, AND DECLARES THAT EDUCATING INDIVIDUALS ELIGIBLE TO RECEIVE MONEYS FROM WELFARE-TO-WORK OR TEMPORARY ASSISTANCE TO NEEDY FAMILIES WILL BENEFIT SUCH INDIVIDUALS. IN ADDITION, THE GENERAL ASSEMBLY FINDS, DETERMINES, AND DECLARES THAT COLORADO IS FACING A SHORTAGE OF LICENSED PRACTICAL NURSES AND THAT ENCOURAGING INDIVIDUALS TO FOLLOW SUCH A CAREER PATH FURTHER BENEFITS COLORADO AND ITS RESIDENTS.

SECTION 23. 8-71-223, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

8-71-223. Colorado department of labor and employment - functions. (3) THE DEPARTMENT SHALL ENCOURAGE WORK FORCE INVESTMENT AREAS TO INFORM INDIVIDUALS OF THE CAREER POSSIBILITIES IN THE FIELD OF NURSING AND THE AVAILABILITY OF PRACTICAL NURSING EDUCATION PROGRAMS.

SECTION 24. Article 38 of title 12, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PART to read:

PART 2
THE NURSING SHORTAGE ALLEVIATION ACT OF 2002

12-38-201. Legislative declaration. (1) THE GENERAL ASSEMBLY HEREBY FINDS, DETERMINES, AND DECLARES THAT COLORADO IS FACING A SHORTAGE OF NURSES. SUCH SHORTAGE CHALLENGES COLORADO COMMUNITIES TO OBTAIN ADEQUATE NURSING PERSONNEL TO PROVIDE CARE IN MULTIPLE SETTINGS INCLUDING EMERGENCY, ACUTE, LONG-TERM, HOME, AND HOSPICE CARE. THEREFORE, THE GENERAL ASSEMBLY FINDS, DETERMINES, AND DECLARES IN THE INTERESTS OF THE RESIDENTS OF COLORADO THAT:

(a) COLLABORATION BY THE STATE, PRIVATE ENTITIES, AND THE PUBLIC AND PRIVATE SECTORS WITHIN REGIONS OF THE STATE IS NECESSARY TO IMPROVE RETENTION AND RECRUITMENT OF NURSES;

(b) PUBLIC AND PRIVATE PARTNERSHIPS SHOULD BE CREATED TO SUBSIDIZE AND IMPROVE SALARIES FOR NURSES; AND

(c) A CLEARINGHOUSE OF DATA CONCERNING EMPLOYMENT OPPORTUNITIES FOR REGISTERED NURSES, NURSE PRACTITIONERS, ADVANCED PRACTICE NURSES, CERTIFIED NURSE AIDES, AND OTHER NURSING PROFESSIONALS SHOULD BE CREATED TO PROVIDE INTERESTED PERSONS WITH A CONSOLIDATED OPPORTUNITY TO INVESTIGATE NURSING EMPLOYMENT POSITIONS.

12-38-202. Public and private partnership for education and information concerning the nursing shortage - fund. (1) THE BOARD, IN COOPERATION WITH THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT, MAY COLLABORATE WITH PUBLIC AND PRIVATE PERSONS TO IDENTIFY AND ENCOURAGE REMEDIES TO THE SHORTAGE OF NURSES IN COLORADO. SUCH COLLABORATION MAY INCLUDE, BUT NOT BE LIMITED TO, COLLABORATION WITH REPRESENTATIVES FROM HOSPITALS, LONG-TERM CARE FACILITIES, OTHER EMPLOYERS OF NURSES, CONSUMERS, NURSES, ALL INSTITUTIONS OF HIGHER EDUCATION THAT OFFER NURSING EDUCATION PROGRAMS, AND OTHER NONPROFIT ENTITIES THAT HAVE AS A MAJOR PURPOSE THE PROMOTION OF AN ADEQUATE HEALTH CARE WORKFORCE. IT IS THE GENERAL ASSEMBLY'S INTENT THAT SUCH COLLABORATION ENCOURAGE AND SUPPORT PROGRAMS AND INITIATIVES TO ENCOURAGE INDIVIDUALS TO ENTER THE NURSING PROFESSION AND CREATE SHORT-TERM INTERVENTIONS AS WELL AS LONG-TERM STRUCTURES TO MEET THE ESCALATING DEMAND FOR HEALTH CARE ACTIVITIES AND DEAL WITH THE INCREASING COMPLEXITY OF NURSING CARE.

(2) (a) THE BOARD, IN CONSULTATION WITH THE REPRESENTATIVES DESCRIBED IN SUBSECTION (1) OF THIS SECTION, MAY RECOMMEND LEGISLATIVE CHANGES NECESSARY TO ACCOMPLISH THE PURPOSES SET FORTH IN SAID SUBSECTION (1).

(b) THE BOARD IS ENCOURAGED TO IMPLEMENT A PUBLIC EDUCATION-AWARENESS PROGRAM BASED ON RECOMMENDATIONS FROM THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT, THE DEPARTMENT OF HIGHER EDUCATION, THE STATE BOARD FOR COMMUNITY COLLEGES AND OCCUPATIONAL EDUCATION, ALL INSTITUTIONS OF HIGHER EDUCATION THAT OFFER NURSING EDUCATION PROGRAMS, AND REPRESENTATIVES DESCRIBED IN SUBSECTION (1) OF THIS SECTION.

(3) THE BOARD IS AUTHORIZED TO SEEK AND ACCEPT FUNDS, GIFTS, GRANTS, OR DONATIONS FROM ANY PRIVATE ENTITY FOR IMPLEMENTING THE PUBLIC EDUCATION-AWARENESS PROGRAM OR TO SUPPORT OR IMPLEMENT THE COLLABORATIVE EFFORTS DESCRIBED IN SUBSECTION (1) OF THIS SECTION. ANY SUCH FUNDS COLLECTED SHALL BE TRANSMITTED TO THE STATE TREASURER, WHO SHALL CREDIT THE SAME TO THE NURSING SHORTAGE FUND, WHICH FUND IS HEREBY CREATED. THE MONEYS IN THE FUND SHALL BE SUBJECT TO ANNUAL APPROPRIATION BY THE GENERAL ASSEMBLY FOR THE SOLE PURPOSE OF PUBLIC EDUCATION-AWARENESS TRAINING PROGRAMS AND SEMINARS. THE MONEYS IN THE FUND SHALL BE CONTINUOUSLY AVAILABLE FOR THE PURPOSES OF THIS SECTION AND SHALL NOT BE TRANSFERRED TO OR REVERT TO THE GENERAL FUND AT THE END OF ANY FISCAL YEAR.

(4) THE PURPOSES AND GOALS OF THE COLLABORATIVE EFFORTS PURSUANT TO SUBSECTION (1) OF THIS SECTION ARE TO PROMOTE AND ENCOURAGE:

(a) COLLABORATION TO ENHANCE THE PUBLIC HEALTH AND SAFETY BY:

(I) ENHANCING CLINICAL COMPETENCY OF NURSES THROUGH SHARED EDUCATION AND TRAINING;

(II) OFFERING A COMMON ASSESSMENT AND INTERVENTION PROGRAM; AND

(III) CREATING A CLEARINGHOUSE OF INFORMATION AND RESOURCES;

(b) ENHANCED TRAINING AND ASSESSMENT EFFORTS BY:

(I) SHARING DEVELOPMENT COURSES;

(II) DEVELOPING A REENTRY PROGRAM FOR NURSES CURRENTLY NOT PRACTICING;

(III) EXPANDING THE ENROLLMENT OF SPECIALTY DEVELOPMENT COURSES;

(IV) EXPANDING THE ENROLLMENT OF ANNUALLY REQUIRED COMPETENCY AND SKILL DEVELOPMENT TRAINING COURSES; AND

(V) UTILIZING A VARIETY OF METHODOLOGIES INCLUDING, BUT NOT LIMITED TO, DISTANCE LEARNING TECHNOLOGY, MENTORING, PRECEPTORS, INTERNSHIPS, RESIDENCIES, HOSPITAL-BASED TRAINING, AND HIGHER EDUCATION;

(c) IDENTIFICATION OF THE NEEDS OF NURSES RELATED TO LICENSE RENEWAL, SKILL BUILDING, AND COMPETENCY DEVELOPMENT BY:

(I) DEVELOPING EDUCATIONAL OBJECTIVES BASED ON ASSESSMENT FINDINGS;

(II) DESIGNING FOCUSED AND PERSONALIZED EDUCATION PROGRAMS FOR NURSES;

(III) UPGRADING SKILLS AND KNOWLEDGE; AND

(IV) EVALUATING AND DOCUMENTING FULFILLMENT OF EDUCATIONAL AND PERSONAL OBJECTIVES;

(d) DEVELOPMENT OF A NURSING CAREER MODEL FOR COLORADO THAT INCLUDES, BUT IS NOT LIMITED TO, THE FOLLOWING:

(I) A COLORADO PUBLIC IMAGE AND MESSAGE THAT POSITIVELY IMPACTS THE NURSING PROFESSION;

(II) DEVELOPMENT AND RETENTION STRATEGIES IN ORDER TO ASSEMBLE A COLLECTION OF BEST PRACTICES OF HIRING AND RETAINING NURSES;

(III) REGIONAL COLLABORATIVE PLANS FOR RECRUITMENT TO THE NURSING PROFESSION OF INDIVIDUALS IN SECONDARY SCHOOLS AND INDIVIDUALS WHO ARE NONTRADITIONAL STUDENTS;

(IV) CAREER APTITUDE AND SELF-EVALUATION TOOLS FOR POTENTIAL NURSING STUDENTS;

(V) NURSE ASSESSMENT, CAREER DIRECTION, AND SELF-EVALUATION TOOLS;

(VI) NURSE PROFESSIONAL PORTFOLIO DEVELOPMENT TOOLS, WORKSHOPS, AND COACHING;

(VII) A METHOD TO DEVELOP AND COORDINATE VOLUNTEER NURSES TO SUPPORT MENTORING AND PRECEPTORSHIP; AND

(VIII) CORE, TRANSITIONAL, OR RETOOLING COMPETENCY DEVELOPMENT COURSES FOR NURSES;

(e) NURSING WORK FORCE RESEARCH, INCLUDING, BUT NOT LIMITED TO, THE FOLLOWING:

(I) BEST PRACTICES;

(II) TYPES OF NURSES NEEDED FOR SAFE AND QUALITY CARE;

(III) WORKPLACE FACTORS THAT IMPACT THE QUALITY OF CARE AND JOB SATISFACTION OF NURSES;

(IV) LEARNING MODELS; AND

(V) INDIVIDUAL AND PROGRAM EVALUATIONS AND OUTCOMES;

(f) A CLEARINGHOUSE FOR A SINGLE POINT OF CONTACT TO ACCESS THE SHARED RESOURCES AND INFORMATION ABOUT ACADEMIC, COMMUNITY, PROFESSIONAL, AND STUDENT RESOURCES AND SUPPORT INFORMATION, INCLUDING, BUT NOT LIMITED TO, THE FOLLOWING:

(I) DATA COLLECTED ON NURSES AND OTHER NURSING PERSONNEL, INCLUDING DEMOGRAPHICS, AREAS OF PRACTICE, SUPPLY, DEMAND, AND MIGRATION. TO THE EXTENT POSSIBLE, DATA SHALL BE COLLECTED:

(A) FROM EXISTING SOURCES, BUT STEPS MAY BE TAKEN TO COLLECT ADDITIONAL DATA, INCLUDING CONDUCTING SURVEYS; AND

(B) ON A COUNTY OR OTHER APPROPRIATE REGIONAL BASIS.

(II) DATA ON NURSING PERSONNEL ANALYZED TO IDENTIFY TRENDS RELATING TO NUMBERS AND GEOGRAPHICAL DISTRIBUTION, PRACTICE SETTING, AND AREA OF PRACTICE, AND, TO THE EXTENT POSSIBLE, A COMPARISON OF THOSE TRENDS WITH CORRESPONDING NATIONAL TRENDS;

(III) PREDICTIONS OF SUPPLY AND DEMAND FOR NURSING PERSONNEL IN COLORADO, INCLUDING THE DEVELOPMENT OF A SUPPLY AND DEMAND MODEL APPROPRIATE FOR COLORADO.

(5) **Confidentiality.** REPORTS, RECORDS, AND INFORMATION OBTAINED UNDER PARAGRAPH (f) OF SUBSECTION (4) OF THIS SECTION ARE CONFIDENTIAL, ARE NOT PUBLIC RECORDS, AND SHALL NOT BE SUBJECT TO DISCLOSURE UNDER PARTS 2 AND 3 OF ARTICLE 72 OF TITLE 24, C.R.S.

(6) **Reports.** (a) THE BOARD, THROUGH ITS COLLABORATIVE RELATIONSHIPS, SHALL ENCOURAGE THE COLLECTION AND ANALYSIS OF DATA PURSUANT TO PARAGRAPH (f) OF SUBSECTION (4) OF THIS SECTION AND THE PUBLICATION OF REPORTS REGARDING:

(I) THE EDUCATIONAL AND EMPLOYMENT TRENDS FOR NURSING PERSONNEL;

(II) THE SUPPLY AND DEMAND FOR NURSING PERSONNEL; AND

(III) ANY OTHER ISSUE AS NECESSARY CONCERNING NURSING IN THE STATE.

(b) REPORTS, RECORDS, AND INFORMATION SHALL BE RELEASED IN AN AGGREGATE FORM AND SHALL NOT CONTAIN EMPLOYER-SPECIFIC INFORMATION.

(7) **No advisory committee.** THE BOARD SHALL NOT CREATE AN ADVISORY COMMITTEE TO IMPLEMENT ANY PROVISION OF THIS SECTION.

(8) **Grants.** THE BOARD MAY AUTHORIZE A NONPROFIT ENTITY TO ACT ON ITS BEHALF TO ACCEPT AND ADMINISTER ANY PRIVATE OR FEDERAL GRANTS, GIFTS, OR DONATIONS.

(9) **Rules.** THE BOARD MAY PROMULGATE RULES AS NECESSARY FOR THE IMPLEMENTATION OF THIS SECTION.

(10) **Fees.** THE BOARD MAY ESTABLISH AND CHARGE A REASONABLE FEE FOR NURSING WORKFORCE DATA, REPORTS PRODUCED, AND STATISTICAL INFORMATION. SUCH FEES SHALL BE CREDITED TO THE NURSING SHORTAGE FUND CREATED PURSUANT TO SUBSECTION (3) OF THIS SECTION.

SECTION 25. Article 1 of title 23, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

23-1-126. Commission directive - nursing programs. (1) THE GENERAL ASSEMBLY FINDS THAT COLORADO IS FACING A SHORTAGE OF NURSES. IT IS DETERMINED BY THE GENERAL ASSEMBLY THAT BECAUSE NURSES ARE CRUCIAL AND INTEGRAL TO THE HEALTH AND WELFARE OF THE PEOPLE OF COLORADO, IT IS THEREFORE IN THE PUBLIC INTEREST TO ENHANCE EDUCATIONAL OPPORTUNITIES FOR INDIVIDUALS PURSUING A CAREER IN NURSING.

(2) THE COMMISSION SHALL EVALUATE AND IMPLEMENT TWO-YEAR EDUCATIONAL PROGRAMS FOR PROFESSIONAL REGISTERED NURSING. THE COMMISSION SHALL ADOPT ANY NECESSARY POLICIES AND RULES FOR THE IMPLEMENTATION OF A TWO-YEAR PROGRAM FOR PROFESSIONAL REGISTERED NURSING.

SECTION 26. Article 2 of title 2, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PART to read:

PART 10
LEGISLATIVE INTERIM COMMITTEE ON
HEALTH CARE SYSTEMS

2-2-1001. Health care systems interim committee - creation - duties - repeal.

(1) THERE IS HEREBY CREATED THE HEALTH CARE SYSTEMS INTERIM COMMITTEE, REFERRED TO IN THIS SECTION AS THE "COMMITTEE". THE COMMITTEE SHALL MEET IN THE INTERIM AFTER THE CONCLUSION OF THE 2002 REGULAR SESSION OF THE SIXTY-THIRD GENERAL ASSEMBLY. THE COMMITTEE SHALL CONSIST OF TEN MEMBERS OF THE GENERAL ASSEMBLY. FIVE MEMBERS OF THE COMMITTEE SHALL BE FROM THE SENATE, THREE OF WHOM SHALL BE APPOINTED BY THE PRESIDENT OF THE SENATE

AND TWO OF WHOM SHALL BE APPOINTED BY THE MINORITY LEADER OF THE SENATE. FIVE MEMBERS OF THE COMMITTEE SHALL BE FROM THE HOUSE OF REPRESENTATIVES AND SHALL BE APPOINTED BY THE SPEAKER OF THE HOUSE OF REPRESENTATIVES. NO MORE THAN THREE OF THE FIVE MEMBERS FROM THE HOUSE OF REPRESENTATIVES SHALL BE FROM THE SAME POLITICAL PARTY. THE PRESIDENT OF THE SENATE AND THE SPEAKER OF THE HOUSE OF REPRESENTATIVES SHALL APPOINT COCHAIRPERSONS OF THE COMMITTEE, WHO SHALL SHARE THE RESPONSIBILITIES OF CHAIRING THE COMMITTEE.

(2) THE COMMITTEE SHALL STUDY, BUT NEED NOT LIMIT ITS CONSIDERATION TO, THE FOLLOWING:

(a) WHICH, IF ANY, CURRENT STATE HEALTH PLANS OR PROGRAMS SHOULD BE COMBINED TO CREATE MORE EFFICIENT ADMINISTRATION, EXPANDED COVERAGE, AND COST SAVINGS TO THE STATE. THE COMMITTEE SHALL CONSIDER, BUT NEED NOT LIMIT ITS CONSIDERATION TO, THE "COLORADO MEDICAL ASSISTANCE ACT", ARTICLE 4 OF TITLE 26, C.R.S., THE "CHILDREN'S BASIC HEALTH PLAN ACT", ARTICLE 19 OF TITLE 26, C.R.S., AND COVER COLORADO, CREATED PURSUANT TO PART 5 OF ARTICLE 8 OF TITLE 10, C.R.S.

(b) HOW PREVIOUS ATTEMPTS TO INCREASE PARTICIPATION IN THE CHILDREN'S BASIC HEALTH PLAN HAVE FALLEN SHORT AND OF WHAT ADDITIONAL MEASURES CAN BE IMPLEMENTED TO IMPROVE ENROLLMENT IN THE CHILDREN'S BASIC HEALTH PLAN;

(c) AN ANALYSIS OF CURRENT HEALTH CARE STATUTES, HEALTH INSURANCE STATUTES, ANY OTHER POSSIBLE BARRIERS TO THE IMPLEMENTATION OF A STATE HEALTH PLAN, AND IDENTIFICATION OF WHAT SERVICES ARE NECESSARY, INCLUDING MENTAL HEALTH SERVICES THAT ARE CURRENTLY COVERED;

(d) THE ISSUE OF PALLIATIVE CARE AND WHETHER SUCH CARE IS SUFFICIENTLY AVAILABLE TO COLORADANS WHO NEED AND DESIRE SUCH CARE AND THE PRESENCE OF ANY BARRIERS TO PALLIATIVE CARE THAT CAN BE ADDRESSED BY THE GENERAL ASSEMBLY;

(e) THE EXTENT TO WHICH PROVIDER NETWORKS CAN BE COORDINATED THROUGH HIGH DEDUCTIBLE HEALTH BENEFITS PLANS, SUPPLEMENTAL POLICIES, OR HOSPITAL CONFINEMENT INDEMNITY PLANS; AND

(f) THE EXTENT TO WHICH PROVIDERS ARE ABLE TO OFFER DISCOUNTS RELATED TO FEE-FOR-SERVICE PAYMENT ARRANGEMENTS.

(3) THE COMMITTEE SHALL MEET SIX TIMES DURING THE 2002 INTERIM.

(4) (a) EXPENDITURES INCURRED IN CONDUCTING THE STUDY DESCRIBED IN THIS SECTION SHALL BE APPROVED BY THE CHAIRPERSON OF THE LEGISLATIVE COUNCIL AND PAID BY VOUCHERS AND WARRANTS DRAWN AS PROVIDED BY LAW FROM MONEYS ALLOCATED TO THE LEGISLATIVE COUNCIL FROM APPROPRIATIONS MADE BY THE GENERAL ASSEMBLY.

(b) THE LEGISLATIVE COUNCIL STAFF AND THE OFFICE OF LEGISLATIVE LEGAL SERVICES SHALL BE AVAILABLE TO ASSIST THE COMMITTEE IN CARRYING OUT ITS

DUTIES.

(5) THE LEGISLATIVE MEMBERS OF THE COMMITTEE SHALL BE COMPENSATED AS PROVIDED IN SECTION 2-2-307 FOR ATTENDANCE AT MEETINGS OF THE COMMITTEE.

(6) THE COMMITTEE SHALL MAKE A REPORT TO THE GENERAL ASSEMBLY IN ACCORDANCE WITH THE JOINT RULES OF THE SENATE AND THE HOUSE OF REPRESENTATIVES. SUCH REPORT MAY INCLUDE RECOMMENDATIONS FOR LEGISLATION, INCLUDING BUT NOT LIMITED TO LEGISLATION CONTINUING THE COMMITTEE. LEGISLATION RECOMMENDED BY THE COMMITTEE SHALL BE TREATED AS LEGISLATION RECOMMENDED BY ANY OTHER INTERIM COMMITTEE FOR PURPOSES OF ANY INTRODUCTION DEADLINES OR BILL LIMITATIONS IMPOSED BY THE JOINT RULES OF THE SENATE AND HOUSE OF REPRESENTATIVES.

(7) THIS PART 10 IS REPEALED, EFFECTIVE JANUARY 1, 2003.

SECTION 27. Part 1 of article 1 of title 25.5, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

25.5-1-110. Waiver applications - authorization. THE STATE DEPARTMENT IS AUTHORIZED TO APPLY FOR HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY WAIVERS THAT WILL ENABLE THE STATE TO ADD MORE FLEXIBILITY TO COLORADO'S MEDICAID PROGRAM AND THAT WILL RESULT IN A COST-EFFECTIVE METHOD OF PROVIDING HEALTH CARE SERVICES TO COLORADANS.

SECTION 28. Part 6 of article 50 of title 24, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

24-50-617. Group benefit plans statewide pilot program - director's duties - audit - repeal. (1) FOR PURPOSES OF FACILITATING A REDESIGN OF MEDICAL BENEFITS OFFERED TO EMPLOYEES AS PART OF THE STATE EMPLOYEES GROUP BENEFIT PLANS ADMINISTERED PURSUANT TO THIS PART 6, THE DIRECTOR MAY CONDUCT A GROUP BENEFIT PLANS STATEWIDE PILOT PROGRAM FOR ALL EMPLOYEES. THE PURPOSE OF THE STATEWIDE PILOT PROGRAM SHALL BE TO OFFER AT LEAST ONE LOW-COST CATASTROPHIC MEDICAL BENEFIT PLAN TO ALL EMPLOYEES AND OTHER MEDICAL BENEFIT PLANS WITH DIFFERING COSTS THAT ALLOW EMPLOYEES TO MAKE CHOICES TO MEET THEIR INDIVIDUAL NEEDS.

(2) THE DIRECTOR SHALL HAVE ALL OF THE POWERS AND DUTIES SPECIFIED IN SECTION 24-50-604 FOR PURPOSES OF DEVELOPING AND IMPLEMENTING THE STATEWIDE PILOT PROGRAM AND SHALL HAVE THE FOLLOWING ADDITIONAL POWERS AND DUTIES WITH REGARD TO THE PROGRAM:

(a) THE AUTHORITY TO DEVELOP A REQUEST FOR PROPOSALS AND PREPARE CONTRACT SPECIFICATIONS IN ORDER TO CONTRACT WITH ANY APPROPRIATE ENTITY TO PROVIDE OR ADMINISTER MEDICAL BENEFITS TO ALL EMPLOYEES PURSUANT TO THIS SECTION;

(b) THE AUTHORITY TO ALLOW AN EXCEPTION TO SECTION 24-50-606 (1) AND (2) AND SECTION 24-50-605 (1) (f) UPON A DETERMINATION BY THE DIRECTOR THAT THE REQUIREMENTS OF THOSE SECTIONS WOULD INHIBIT THE STATE'S ABILITY TO

EFFECTIVELY SECURE THE BEST POSSIBLE COMBINATION OF APPROPRIATE BENEFITS AND REASONABLE PRICING FOR THE MEDICAL BENEFITS OFFERED PURSUANT TO THIS SECTION;

(c) THE AUTHORITY TO ALLOCATE THE STATE CONTRIBUTION FOR GROUP BENEFITS, INCLUDING MEDICAL, LIFE, AND DENTAL BENEFITS, THAT ARE COMPONENTS OF THE STATEWIDE PILOT PROGRAM IN A MANNER DIFFERENT FROM THE MANNER IN WHICH THE STATE CONTRIBUTION IS ALLOCATED FOR GROUP BENEFITS, INCLUDING MEDICAL, LIFE, AND DENTAL BENEFITS, THAT ARE NOT OFFERED TO EMPLOYEES PURSUANT TO THE STATEWIDE PILOT PROGRAM AS LONG AS:

(I) THE THREE-TIERED CONTRIBUTION STRUCTURE AND THE TOTAL STATE CONTRIBUTION SPECIFIED IN SECTION 24-50-609 ARE NOT ALTERED; AND

(II) THE TOTAL APPROPRIATION FOR THE GROUP BENEFIT PLANS OFFERED TO EMPLOYEES PURSUANT TO THE PROGRAM DOES NOT EXCEED THE TOTAL APPROPRIATIONS THAT WOULD OTHERWISE BE PROVIDED FOR GROUP BENEFIT PLANS OFFERED PURSUANT TO THIS PART 6;

(d) THE AUTHORITY TO ALLOW AN EXCEPTION TO SECTION 24-50-104 IN ORDER TO OFFER ALTERNATIVE MEDICAL BENEFIT PLANS THAT ARE NOT DIRECTLY COMPARABLE TO PREVAILING PRACTICES IN APPROPRIATE MARKETS OF PUBLIC AND PRIVATE EMPLOYMENT; AND

(e) THE AUTHORITY TO TERMINATE THE GROUP BENEFIT PLANS STATEWIDE PILOT PROGRAM AT ANY TIME PRIOR TO THE DATE SPECIFIED IN SUBSECTION (4) OF THIS SECTION.

(3) THE STATE AUDITOR SHALL CONDUCT A PERFORMANCE REVIEW OF THE PILOT PROGRAM DEVELOPED PURSUANT TO THIS SECTION ON OR AFTER JULY 1, 2006, BUT BEFORE JANUARY 1, 2007, AND PRESENT SUCH REVIEW TO THE LEGISLATIVE AUDIT COMMITTEE ON OR BEFORE FEBRUARY 1, 2007.

(4) THE GROUP BENEFIT PLANS STATEWIDE PILOT PROGRAM AUTHORIZED PURSUANT TO THIS SECTION SHALL TERMINATE ON DECEMBER 31, 2007, UNLESS TERMINATED ON AN EARLIER DATE BY THE DIRECTOR.

(5) THIS SECTION IS REPEALED, EFFECTIVE JANUARY 1, 2008.

SECTION 29. No appropriation. The general assembly has determined that section 28 of this act can be implemented within existing appropriations, and therefore no separate appropriation of state moneys is necessary to carry out the purposes of section 28 of this act.

SECTION 30. Effective date - applicability. (1) Sections 7 to 9 and 20 through 30 of this act shall take effect upon passage and shall apply to health benefit plans issued by small employer carriers on or after said date.

(2) Sections 16 and 17 of this act shall not take effect if House Bill 02-1136 is enacted at the Second Regular Session of the Sixty-third General Assembly and becomes law; and sections 18 and 19 of this act shall take effect only if House Bill

02-1136 is enacted at the Second Regular Session of the Sixty-third General Assembly and becomes law.

(3) The remaining sections of this act shall take effect January 1, 2003, and shall apply to health benefit plans issued or renewed on or after said date.

SECTION 31. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Approved: June 7, 2002