Second Regular Session
Sixty-seventh General Assembly
STATE OF COLORADO

ENGROSSED
This Version Includes All Amendments Adopted on Second Reading in the House of Introduction

LLS NO. 10-0388.01 Jerry Barry **SENATE BILL 10-002**

SENATE SPONSORSHIP

Steadman and Keller,

HOUSE SPONSORSHIP

Looper and Primavera, Acree, Todd

Senate Committees
Health and Human Services
Appropriations

House Committees

A BILL FOR AN ACT

CONCERNING THE DENIAL OF BENEFITS BY HEALTH COVERAGE PLANS, AND, IN CONNECTION THEREWITH, INCREASING RECOVERIES TO THE MEDICAID PROGRAM, PROVIDING ADDITIONAL ASSISTANCE TO FAMILIES ELIGIBLE FOR CERTAIN BENEFITS, AND MAKING AN APPROPRIATION IN CONNECTION THEREWITH.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at http://www.leg.state.co.us/billsummaries.)

Interim Committee on the Developmental Disability Waiting

SENATE
Amended 2nd Reading
April 26, 2010

List. Section 1 makes legislative findings.

Sections 2 and 3 require a health insurance company to notify any known covered person's designated representative of any denial of a benefit and of the right to appeal the denial. The designated representative could exercise certain rights during the appeal processes.

Section 4 directs the department of health care policy and financing (department) to provide recipients of public medical benefits with information concerning the recipient's right to appeal denials of benefits by third parties.

Section 5 provides that, by signing the application for medicaid, the applicant is designating the department as the applicant's designated representative for purposes of appealing any denial of benefits by a health insurance company paid for by medicaid.

Section 6 requires the department or its independent contractor to notify an insurance carrier that the department is the designated representative of a medicaid recipient. The department or the department's independent contractor, if necessary, shall appeal an adverse insurance coverage decision at any level.

Any agreement with an independent contractor to review and appeal adverse coverage decisions by an insurance carrier shall require the contractor to report specified information to the department. The department will report annually the information from the independent contractor to specified committees of the general assembly, which reporting requirement is repealed July 1, 2017.

The bill expresses the intent of the general assembly that additional recoveries from third parties pursuant to the bill should be used to pay the expenses of a long-term care ombudsman office and to reduce the waiting list of persons with a developmental disability.

Section 7 directs the department to establish a long-term care ombudsman office to assist long-term care recipients.

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

SECTION 1. Legislative declaration. (1) The general assembly hereby finds and declares that:

(a) There is a long waiting list for home- and community-based services for children;

(b) Many families receiving services under the home- and community-based services for children waivers have third-party insurance coverage, but some families have difficulty:

(I) Navigating through the waiver application process;

(II) Understanding the scope and role of any private insurance coverage they may have; and

(III) Filing an appeal when a third-party insurance carrier denies a claim for benefits;

(c) More successful appeals of denials of claims would result in increased reimbursements to the medicaid program and the state;

(d) The costs of providing assistance to families seeking home- and community-based services waivers for children and providing assistance to those families in filing appeals of denials from third-party insurance carriers could be covered by increased reimbursements from third-party insurance carriers; and

(e) The increased reimbursements and recovered moneys from third-party insurance carriers should be used to reduce the waiting list for home- and community-based services for children.

SECTION 2. 10-16-113 (2), (3) (a) (III) (B), (3) (b) (IV), and (3) (b) (VI) (B), Colorado Revised Statutes, are amended to read:

10-16-113. Procedure for denial of benefits - internal review - rules. (2) Following a denial of a request for benefits by the health coverage plan, ~~such~~ THE plan shall notify the covered person AND ANY DESIGNATED REPRESENTATIVE OF THE COVERED PERSON KNOWN TO THE HEALTH COVERAGE PLAN in writing. The content of ~~such~~ THE notification and the deadlines for making ~~such~~ THE notification shall be made pursuant to ~~regulations~~ RULES promulgated by the commissioner.

(3) (a) (III) In the event of an adverse benefit determination by a health coverage plan concerning a request involving urgent care, a carrier:

(B) May communicate the other information required pursuant to

subparagraph (I) of this paragraph (a) to the covered person orally within the time frame outlined in 29 CFR 2560.503-1 (f) (2) (i) so long as a written or electronic copy of such information is furnished to the covered person AND THE COVERED PERSON'S DESIGNATED REPRESENTATIVE no later than three days after the oral notification.

(b) (IV) The carrier shall notify the covered person AND THE COVERED PERSON'S DESIGNATED REPRESENTATIVE of his or her right to appeal a denial of benefits through a two-level internal review process and that the second level of internal review may be utilized at the option of the covered person.

(VI) (B) The health coverage plan shall allow the covered person OR THE COVERED PERSON'S DESIGNATED REPRESENTATIVE to be present for the second-level internal review, either in person or by telephone conference. The covered person OR THE COVERED PERSON'S DESIGNATED REPRESENTATIVE shall have the opportunity to bring counsel, advocates, and health care professionals to the review, to prepare in advance for the review, and to present materials to the health care professional prior to the review and at the time of the review. The health coverage plan and the covered person OR THE COVERED PERSON'S DESIGNATED REPRESENTATIVE shall, upon request, provide a copy of the materials it presents at the review to the other party at least five days prior to the review. If new information is developed after the five-day deadline, such material may be presented when practicable. The health coverage plan shall notify the covered person OR THE COVERED PERSON'S DESIGNATED REPRESENTATIVE that the plan shall make an audio or video recording of the review unless neither the covered person NOR THE COVERED PERSON'S DESIGNATED REPRESENTATIVE nor the health coverage plan wants the recording made.

The health coverage plan shall make such recording available to the covered person OR THE COVERED PERSON'S DESIGNATED REPRESENTATIVE. If there is an external review, the audio or video recording shall, at the request of either party, be included in the material provided by the carrier to the reviewing entity.

SECTION 3. 10-16-113.5 (2) (a) (II), Colorado Revised Statutes, is amended to read:

10-16-113.5. Independent external review of benefit denials - legislative declaration - definitions. (2) As used in this section, unless the context otherwise requires:

(a) (II) The term "covered individual requesting an independent external review" shall also include the designated representative of a covered individual requesting an independent external review, INCLUDING BUT NOT LIMITED TO THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING, IF DESIGNATED, PURSUANT TO SECTION 25.5-4-205 (4) (b), C.R.S.

SECTION 4. Part 1 of article 1 of title 25.5, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

25.5-1-126. Third-party benefit denials information. THE STATE DEPARTMENT SHALL PROVIDE INFORMATION TO RECIPIENTS OF BENEFITS UNDER THIS TITLE CONCERNING THEIR RIGHT TO APPEAL A DENIAL OF BENEFITS BY A THIRD PARTY AND SHALL POST INFORMATION ON THE STATE DEPARTMENT'S WEB SITE CONCERNING RECIPIENTS' ABILITIES TO APPEAL A THIRD PARTY'S DENIAL OF BENEFITS, INCLUDING BUT NOT LIMITED TO PROVIDING A LINK TO INFORMATION ON THE INSURANCE COMMISSIONER'S WEB SITE REGARDING SUCH APPEALS.

SECTION 5. 25.5-4-205 (4), Colorado Revised Statutes, is amended to read:

25.5-4-205. Application - verification of eligibility - demonstration project - rules - repeal. (4) (a) By signing an application for medical assistance, a person assigns to the state department, by operation of law, all rights the applicant may have to medical support or payments for medical expenses from any other person on ~~his~~ THE APPLICANT'S own behalf or on behalf of any other member of ~~his~~ THE APPLICANT'S family for whom application is made. For purposes of this subsection (4), an assignment takes effect upon the determination that the applicant is eligible for medical assistance and up to three months prior to the date of application if the applicant meets the requirements of subsection (3) of this section and shall remain in effect so long as an individual is eligible for and receives medical assistance benefits. The application shall contain a statement explaining this assignment.

(b) (I) BY SIGNING AN APPLICATION FOR MEDICAL ASSISTANCE, A PERSON DESIGNATES THE STATE DEPARTMENT AS THE PERSON'S DESIGNATED REPRESENTATIVE FOR PURPOSES OF APPEALING A DENIAL OF BENEFITS BY A HEALTH COVERAGE PLAN FOR A MEDICAL TREATMENT PAID FOR BY THE MEDICAL ASSISTANCE PROGRAM PURSUANT TO SECTION 10-16-113 OR 10-16-113.5, C.R.S. NOTHING IN THIS PARAGRAPH (b) SHALL BE INTERPRETED TO REQUIRE THE STATE DEPARTMENT OR THE INDEPENDENT CONTRACT RETAINED PURSUANT TO SECTION 25.5-4-209 (3) (b) TO APPEAL EVERY DENIAL OF BENEFITS.

(II) THE STATE DEPARTMENT MAY CONTRACT WITH AN INDEPENDENT CONTRACTOR TO ACT AS THE DESIGNATED REPRESENTATIVE OF A PERSON WHO APPLIES FOR MEDICAL ASSISTANCE.

(c) AN APPLICANT FOR MEDICAL BENEFITS UPON INITIAL APPLICATION AND EACH REDETERMINATION SHALL DISCLOSE ANY THIRD PARTY WHO MAY BE RESPONSIBLE FOR THE PAYMENT OF MEDICAL EXPENSES ON BEHALF OF THE APPLICANT OR ANY OTHER MEMBER OF THE APPLICANT'S FAMILY FOR WHOM APPLICATION IS MADE. AS PART OF ITS MEDICAID ELIGIBILITY MODERNIZATION, THE STATE DEPARTMENT SHALL REQUIRE THE COUNTY DEPARTMENT OR OTHER ENTITY DESIGNATED TO ACCEPT APPLICATIONS FOR MEDICAL BENEFITS TO ENTER THE THIRD-PARTY INFORMATION INTO THE AUTOMATED SYSTEM DEVELOPED PURSUANT TO SECTION 25.5-4-204.

SECTION 6. 25.5-4-209 (3) (a), Colorado Revised Statutes, is amended, and the said 25.5-4-209 (3) is further amended BY THE ADDITION OF THE FOLLOWING NEW PARAGRAPHS, to read:

25.5-4-209. Payments by third parties - copayments by recipients - review - appeal - repeal. (3) (a) The rights assigned by a recipient of medical assistance to the state department pursuant to section 25.5-4-205 (4) shall include the right to appeal an adverse coverage decision by a third party for which the medical assistance program may be responsible for payment, including but not limited to the internal and external reviews provided for in sections 10-16-113 and 10-16-113.5, C.R.S., and a third party's reasonable appeal procedure under state and federal law. The state department or the independent contractor retained pursuant to paragraph (b) of this subsection (3) shall:

(I) NOTIFY THE THIRD PARTY THAT THE STATE DEPARTMENT IS THE DESIGNATED REPRESENTATIVE OF THE RECIPIENT PURSUANT TO SECTION 25.5-4-205 (4) (b); AND

(II) Review and, if necessary, appeal AT ANY LEVEL an adverse

coverage decision, except an adverse coverage decision relating to medicare, Title XVIII of the federal "Social Security Act", as amended.

(e) AFTER THE EFFECTIVE DATE OF THIS PARAGRAPH (e) AND PRIOR TO THE STATE DEPARTMENT ENTERING INTO A NEW AGREEMENT OR RENEWING AN AGREEMENT PURSUANT TO PARAGRAPH (b) OF THIS SUBSECTION (3), THE STATE DEPARTMENT SHALL EXAMINE THE FEASIBILITY OF REQUIRING THE INDEPENDENT CONTRACTOR TO DEVELOP AN ADDITIONAL PROCESS TO IDENTIFY REASONS FOR DENIALS FOR WHICH AN APPEAL SHOULD BE CONSIDERED AND TO PRIORITIZE APPEALS OF DENIALS BASED UPON THE REASONS FOR THE DENIAL TO INCREASE AND SPEED RECOVERIES FROM THIRD PARTIES. IF THE STATE DEPARTMENT DETERMINES THAT IT IS IN THE STATE'S BEST INTEREST, THE STATE DEPARTMENT IS AUTHORIZED TO ADD THIS PROCESS TO THE REQUIREMENTS FOR AN AGREEMENT PURSUANT TO PARAGRAPH (b) OF THIS SUBSECTION (3). IF THE STATE DEPARTMENT ADDS THIS PROCESS, THE LIMIT ON COMPENSATION PAID TO THE CONTRACTING AGENT PURSUANT TO SECTION 25.5-4-301 (3) (b) (I) FOR AGREEMENTS INCLUDING THIS PROCESS SHALL BE INCREASED TO TWENTY-FIVE PERCENT.

(f) IT IS THE INTENT OF THE GENERAL ASSEMBLY THAT MONEYS RECEIVED AS INCREASED RECOVERIES UNDER THIS SUBSECTION (3) DUE TO THE DESIGNATION OF THE STATE DEPARTMENT AS THE DESIGNATED REPRESENTATIVE PURSUANT TO SECTION 25.5-4-205 (4) (b) AND THE ADDITIONAL ASSISTANCE PROVIDED TO FAMILIES PURSUANT TO SECTION 25.5-6-113 BE USED FIRST TO PAY THE COSTS ASSOCIATED WITH THE ADDITIONAL ASSISTANCE PROVIDED TO FAMILIES AND THEN TO REDUCE THE WAITING LIST FOR HOME- AND COMMUNITY-BASED SERVICES FOR

CHILDREN.

SECTION 7. Part 1 of article 6 of title 25.5, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

25.5-6-113. Home- and community-based services for children - additional assistance to families. THE STATE DEPARTMENT IS ENCOURAGED AND AUTHORIZED TO CONTRACT WITH AN INDEPENDENT AGENCY _____ TO ASSIST FAMILIES ELIGIBLE FOR HOME- AND COMMUNITY-BASED SERVICES FOR CHILDREN UNDER THIS ARTICLE IN APPLYING FOR BENEFITS AND ASSISTING IN THE APPEALS OF DENIALS OF BENEFITS BY THIRD PARTIES.

SECTION 8. Appropriation. (1) In addition to any other appropriation, there is hereby appropriated, to the department of health care policy and financing, for allocation to the executive director's office, for the fiscal year beginning July 1, 2010, the sum of one hundred eighty-four thousand seventy-two dollars ($184,072), or so much thereof as may be necessary, for the implementation of this act. Of said sum, ninety-two thousand thirty-six dollars ($92,036) shall be from the general fund, and ninety-two thousand thirty-six dollars ($92,036) shall be from federal funds.

(2) It is the intent of the general assembly that the general fund appropriation in subsection (1) of this section shall be derived from savings generated from the implementation of the provisions of Senate Bill 10-167, as enacted during the Second Regular Session of the Sixty-seventh General Assembly.

SECTION 9. Effective date. (1) Except as otherwise provided in subsection (2) of this section, this act shall take effect upon passage.

(2) Sections 2 through 8 of this act shall take effect September 1, 2010, only if:

(a) The final fiscal estimate for Senate Bill 10-167, as determined from the appropriations enacted in said bill, shows a net reduction in the amount of general fund revenues appropriated for state fiscal year 2010-11, that is equal to or greater than the amount of the general fund appropriation made for the implementation of this act for state fiscal year 2010-11, ___ as reflected in section 8 of this act;

(b) Senate Bill 10-167 is enacted and becomes law; and

(c) The staff director of the joint budget committee files written notice with the revisor of statutes no later than July 15, 2010, that the requirement set forth in paragraph (a) of this subsection (2) has been met.

SECTION 10. 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.