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HB1232_L.046

HOUSE COMMITTEE OF REFERENCE AMENDMENT

Committee on Health & Insurance.

HB21-1232 be amended as follows:

1 Amend printed bill, strike everything below the enacting clause and
2 substitute:

3 "**SECTION 1.** In Colorado Revised Statutes, **add** part 13 to
4 article 16 of title 10 as follows:

5 PART 13

6 COLORADO STANDARDIZED HEALTH BENEFIT PLAN

7 **10-16-1301. Short title.** THE SHORT TITLE OF THIS PART 13 IS THE
8 "COLORADO STANDARDIZED HEALTH BENEFIT PLAN ACT".

9 **10-16-1302. Legislative declaration - intent.** (1) THE GENERAL
10 ASSEMBLY, THROUGH THE EXERCISE OF ITS POWERS TO PROTECT THE
11 HEALTH, PEACE, SAFETY, AND GENERAL WELFARE OF THE PEOPLE OF
12 COLORADO, HEREBY FINDS THAT:

13 (a) HEALTH INSURANCE COVERAGE HAS BEEN DEMONSTRATED TO
14 HAVE A POSITIVE IMPACT ON PEOPLE'S HEALTH OUTCOMES AS WELL AS
15 THEIR FINANCIAL SECURITY AND WELL-BEING;

16 (b) ENSURING THAT ALL PEOPLE HAVE ACCESS TO AFFORDABLE,
17 QUALITY, CONTINUOUS, AND EQUITABLE HEALTH CARE IS A CHALLENGE
18 THAT PUBLIC OFFICIALS AND POLICY EXPERTS HAVE FACED FOR DECADES
19 DESPITE SEEMINGLY CONSTANT EFFORTS TO ADDRESS THE ISSUE;

20 (c) ALTHOUGH GREAT STRIDES HAVE BEEN MADE IN INCREASING
21 ACCESS TO HEALTH-CARE COVERAGE THROUGH FEDERAL AND STATE
22 LEGISLATION, NOT ENOUGH HAS BEEN ACCOMPLISHED TO ADDRESS THE
23 AFFORDABILITY OF HEALTH INSURANCE IN COLORADO, PARTICULARLY IN
24 THE STATE'S RURAL AREAS AND FOR COLORADANS WHO HAVE
25 HISTORICALLY AND SYSTEMICALLY FACED BARRIERS TO HEALTH,
26 INCLUDING PEOPLE OF COLOR, IMMIGRANTS, AND COLORADANS WITH LOW
27 INCOMES;

28 (d) THE HEALTH-CARE SYSTEM IS A COMPLEX SYSTEM WHEREIN
29 CONSUMERS RELY ON HEALTH INSURANCE CARRIERS TO NEGOTIATE THE
30 RATES PAID TO HEALTH-CARE PROVIDERS, PHARMACEUTICAL COMPANIES,
31 AND HOSPITALS FOR SERVICES PROVIDED AND EXPECT THAT THE
32 NEGOTIATED RATES ARE CLOSELY TIED TO THE AMOUNT OF THE HEALTH
33 INSURANCE PREMIUMS PAID;

34 (e) DESPITE EFFORTS TO ADDRESS ACCESS TO AND AFFORDABILITY
35 OF HEALTH CARE, UNDERLYING HEALTH-CARE COSTS CONTINUE TO RISE,
36 THUS DRIVING UP THE COSTS OF HEALTH INSURANCE PREMIUMS, OFTEN AT
37 DISPROPORTIONATE RATES IN RURAL AREAS OF THE STATE; AND

38 (f) IN ORDER TO ENSURE THAT HEALTH INSURANCE IS AFFORDABLE
39 FOR COLORADANS, IT IS CRITICAL THAT THE STATE ESTABLISH A

1 STANDARDIZED PLAN FOR CARRIERS TO OFFER IN THE STATE AND SET
2 PREMIUM REDUCTION TARGETS FOR CARRIERS TO ACHIEVE.
3 **10-16-1303. Definitions.** AS USED IN THIS PART 13, UNLESS THE
4 CONTEXT OTHERWISE REQUIRES:
5 (1) "ADVISORY BOARD" MEANS THE BOARD ESTABLISHED IN
6 SECTION 10-16-1307.
7 (2) "CRITICAL ACCESS HOSPITAL" MEANS A HOSPITAL THAT IS
8 FEDERALLY CERTIFIED OR UNDERGOING FEDERAL CERTIFICATION AS A
9 CRITICAL ACCESS HOSPITAL PURSUANT TO 42 CFR 485, SUBPART F.
10 (3) "ESSENTIAL ACCESS HOSPITAL" MEANS A CRITICAL ACCESS
11 HOSPITAL OR GENERAL HOSPITAL LOCATED IN A RURAL AREA WITH
12 TWENTY-FIVE OR FEWER LICENSED BEDS.
13 (4) "ESSENTIAL COMMUNITY PROVIDER" HAS THE SAME MEANING
14 AS SET FORTH IN SECTION 25.5-8-103 (6).
15 (5) "GENERAL HOSPITAL" MEANS A HOSPITAL LICENSED AS A
16 GENERAL HOSPITAL BY THE COLORADO DEPARTMENT OF PUBLIC HEALTH
17 AND ENVIRONMENT.
18 (6) "HEALTH-CARE COVERAGE COOPERATIVE" HAS THE SAME
19 MEANING AS SET FORTH IN SECTION 10-16-1002 (2).
20 (7) "HEALTH-CARE PROVIDER" MEANS A HEALTH-CARE
21 PROFESSIONAL REGISTERED, CERTIFIED, OR LICENSED PURSUANT TO TITLE
22 12 OR A HEALTH FACILITY LICENSED OR CERTIFIED PURSUANT TO SECTION
23 25-1.5-103.
24 (8) "HEALTH SYSTEM" MEANS A CORPORATION OR OTHER
25 ORGANIZATION THAT OWNS, CONTAINS, OR OPERATES THREE OR MORE
26 HOSPITALS.
27 (9) "MEDICAL INFLATION" MEANS THE ANNUAL PERCENTAGE
28 CHANGE IN THE MEDICAL CARE INDEX COMPONENT OF THE UNITED STATES
29 DEPARTMENT OF LABOR'S BUREAU OF LABOR STATISTICS CONSUMER PRICE
30 INDEX FOR MEDICAL CARE SERVICES AND MEDICAL CARE COMMODITIES,
31 OR ITS APPLICABLE PREDECESSOR OR SUCCESSOR INDEX, BASED ON THE
32 AVERAGE CHANGE IN THE MEDICAL CARE INDEX OVER THE PREVIOUS TEN
33 YEARS.
34 (10) (a) "MEDICARE REIMBURSEMENT RATE" MEANS THE
35 FACILITY-SPECIFIC REIMBURSEMENT RATE FOR A PARTICULAR
36 HEALTH-CARE SERVICE PROVIDED UNDER THE "HEALTH INSURANCE FOR
37 THE AGED ACT", TITLE XVIII OF THE FEDERAL "SOCIAL SECURITY ACT",
38 42 U.S.C. SEC. 1395 ET SEQ., AS AMENDED.
39 (b) FOR A HOSPITAL THAT IS REIMBURSED THROUGH THE MEDICARE
40 PROSPECTIVE PAYMENTS SYSTEMS RATE FOR A CRITICAL ACCESS HOSPITAL,
41 "MEDICARE REIMBURSEMENT RATE" MEANS THE RATE BASED ON
42 ALLOWABLE COSTS AS REPORTED IN MEDICARE COST REPORTS AND THE
43 HISTORICAL COST-TO-CHARGE RATIOS FOR THE SPECIFIC HOSPITAL.
44 (11) "PUBLIC BENEFIT CORPORATION" MEANS A PUBLIC BENEFIT
45 CORPORATION FORMED PURSUANT TO PART 5 OF ARTICLE 101 OF TITLE 7

1 THAT MAY BE ORGANIZED AND OPERATED BY THE EXCHANGE PURSUANT
2 TO SECTION 10-22-106 (3).
3 (12) "SMALL GROUP MARKET" MEANS THE MARKET FOR SMALL
4 GROUP SICKNESS AND ACCIDENT INSURANCE.
5 (13) "STANDARDIZED PLAN" MEANS THE STANDARDIZED HEALTH
6 BENEFIT PLAN DESIGNED BY RULE OF THE COMMISSIONER PURSUANT TO
7 SECTION 10-16-1304.
8 **10-16-1304. Standardized health benefit plan - established -**
9 **components - rules - independent analysis - repeal.** (1) ON OR BEFORE
10 JANUARY 1, 2022, THE COMMISSIONER SHALL ESTABLISH, BY RULE, A
11 STANDARDIZED HEALTH BENEFIT PLAN TO BE OFFERED BY CARRIERS IN
12 THIS STATE IN THE INDIVIDUAL AND SMALL GROUP MARKETS. THE
13 STANDARDIZED PLAN MUST:
14 (a) OFFER HEALTH-CARE COVERAGE AT THE BRONZE, SILVER, AND
15 GOLD LEVELS OF COVERAGE AS DESCRIBED IN SECTION 10-16-103.4;
16 (b) INCLUDE, AT A MINIMUM, PEDIATRIC AND OTHER ESSENTIAL
17 HEALTH BENEFITS;
18 (c) BE OFFERED THROUGH THE EXCHANGE AND IN THE INDIVIDUAL
19 MARKET THROUGH THE PUBLIC BENEFIT CORPORATION;
20 (d) BE A STANDARDIZED BENEFIT DESIGN THAT:
21 (I) IS CREATED THROUGH A STAKEHOLDER ENGAGEMENT PROCESS
22 THAT INCLUDES PHYSICIANS, HEALTH-CARE INDUSTRY AND CONSUMER
23 REPRESENTATIVES, INDIVIDUALS WHO REPRESENT HEALTH-CARE WORKERS
24 OR WHO WORK IN HEALTH CARE, AND INDIVIDUALS WORKING IN OR
25 REPRESENTING COMMUNITIES THAT ARE DIVERSE WITH REGARD TO RACE,
26 ETHNICITY, IMMIGRATION STATUS, AGE, ABILITY, SEXUAL ORIENTATION,
27 GENDER IDENTITY, OR GEOGRAPHIC REGIONS OF THE STATE AND THAT ARE
28 AFFECTED BY HIGHER RATES OF HEALTH DISPARITIES AND INEQUITIES;
29 (II) HAS A DEFINED BENEFIT DESIGN AND COST-SHARING THAT
30 IMPROVES ACCESS AND AFFORDABILITY; AND
31 (III) IS DESIGNED TO IMPROVE RACIAL HEALTH EQUITY AND
32 DECREASE RACIAL HEALTH DISPARITIES THROUGH A VARIETY OF MEANS,
33 WHICH ARE IDENTIFIED COLLABORATIVELY WITH CONSUMER
34 STAKEHOLDERS, INCLUDING:
35 (A) IMPROVING PERINATAL HEALTH-CARE COVERAGE; AND
36 (B) PROVIDING FIRST-DOLLAR, PREDEDUCTIBLE COVERAGE FOR
37 CERTAIN HIGH-VALUE SERVICES, SUCH AS PRIMARY AND BEHAVIORAL
38 HEALTH CARE;
39 (e) BE ACTUARIALLY SOUND AND ALLOW A CARRIER TO CONTINUE
40 TO MEET THE FINANCIAL REQUIREMENTS IN ARTICLE 3 OF THIS TITLE 10;
41 (f) COMPLY WITH THE FEDERAL ACT, INCLUDING THE RISK
42 ADJUSTMENT REQUIREMENTS UNDER 45 CFR 153, AND THIS ARTICLE 16;
43 AND
44 (g) HAVE A NETWORK THAT IS:
45 (I) CULTURALLY RESPONSIVE AND, TO THE GREATEST EXTENT

1 POSSIBLE, REFLECTS THE DIVERSITY OF ITS ENROLLEES IN TERMS OF RACE,
2 ETHNICITY, GENDER IDENTITY, AND SEXUAL ORIENTATION IN THE AREA
3 THAT THE NETWORK EXISTS; AND
4 (II) NO MORE NARROW THAN THE MOST RESTRICTIVE NETWORK
5 THE CARRIER IS OFFERING FOR NONSTANDARDIZED PLANS IN THE
6 INDIVIDUAL MARKET FOR THE METAL TIER FOR THAT RATING AREA.
7 (2) (a) IN DEVELOPING THE NETWORK FOR THE STANDARDIZED
8 PLAN PURSUANT TO SUBSECTION (1)(g) OF THIS SECTION, EACH CARRIER
9 SHALL:
10 (I) INCLUDE AS PART OF ITS NETWORK ACCESS PLAN A DESCRIPTION
11 OF THE CARRIER'S EFFORTS TO CONSTRUCT DIVERSE, CULTURALLY
12 RESPONSIVE NETWORKS THAT ARE WELL-POSITIONED TO ADDRESS HEALTH
13 EQUITY AND REDUCE HEALTH DISPARITIES; AND
14 (II) INCLUDE A MAJORITY OF THE ESSENTIAL COMMUNITY
15 PROVIDERS IN THE SERVICE AREA IN ITS NETWORK.
16 (b) IF A CARRIER IS UNABLE TO ACHIEVE THE NETWORK ADEQUACY
17 REQUIREMENTS IN SUBSECTION (1)(g) OF THIS SECTION, THE CARRIER
18 SHALL FILE AN ACTION PLAN WITH THE DIVISION THAT DESCRIBES THE
19 CARRIER'S EFFORTS TO ACHIEVE THE REQUIREMENTS IN SUBSECTION (1)(g)
20 OF THIS SECTION.
21 (c) THE COMMISSIONER SHALL PROMULGATE RULES REGARDING
22 THE NETWORK ADEQUACY REQUIREMENTS IN SUBSECTION (1)(g) OF THIS
23 SECTION AND THE ACTION PLAN IN SUBSECTION (2)(b) OF THIS SECTION.
24 (3) THE STANDARDIZED PLAN MUST BE OFFERED IN A MANNER
25 THAT ALLOWS CONSUMERS TO EASILY COMPARE THE STANDARDIZED
26 PLANS OFFERED BY EACH CARRIER.
27 (4) THE COMMISSIONER MAY UPDATE THE STANDARDIZED PLAN
28 ANNUALLY BY RULE THROUGH THE STAKEHOLDER PROCESS DESCRIBED IN
29 SUBSECTION (1)(d)(I) OF THIS SECTION.
30 (5) THE COMMISSIONER SHALL CONTRACT WITH AN INDEPENDENT
31 THIRD PARTY TO CONDUCT AN ANALYSIS OF THE IMPACT OF THIS SECTION
32 ON HEALTH PLAN ENROLLMENT, HEALTH INSURANCE AFFORDABILITY, AND
33 HEALTH EQUITY. TO THE EXTENT AVAILABLE, THE ANALYSIS MUST
34 INCLUDE DISAGGREGATED DATA BY RACE, ETHNICITY, IMMIGRATION
35 STATUS, SEXUAL ORIENTATION, GENDER IDENTITY, AGE, AND ABILITY. IF
36 THE DATA IS NOT AVAILABLE, THE ANALYSIS MUST NOTE SUCH
37 UNAVAILABILITY. THE ANALYSIS MUST INCLUDE INFORMATION
38 CONCERNING TOTAL OUT-OF-POCKET HEALTH-CARE SPENDING. THE
39 ANALYSIS MUST BE COMPLETED ON OR BEFORE JANUARY 1, 2026.
40 (6) (a) THE COMMISSIONER SHALL COLLABORATE WITH THE
41 EXCHANGE CONCERNING THE SURVEY REQUIRED IN SECTION 10-22-114,
42 WHICH SURVEY ADDRESSES CONSUMERS' EXPERIENCE.
43 (b) THIS SUBSECTION (6) IS REPEALED, EFFECTIVE JULY 1, 2026.
44 (7) THE COMMISSIONER IS NOT REQUIRED TO COMPLY WITH THE
45 "PROCUREMENT CODE", ARTICLES 101 TO 112 OF TITLE 24, FOR THE

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1 PURPOSES OF THIS SECTION.
2 **10-16-1305. Standardized health benefit plan - carriers**
3 **required to offer - premium rates - rules.** (1) BEGINNING JANUARY 1,
4 2023, A CARRIER THAT OFFERS:
5 (a) AN INDIVIDUAL HEALTH BENEFIT PLAN IN COLORADO IS
6 REQUIRED TO OFFER THE STANDARDIZED PLAN IN THE INDIVIDUAL MARKET
7 IN EACH COUNTY WHERE THE CARRIER OFFERS AN INDIVIDUAL HEALTH
8 BENEFIT PLAN AND SHALL OFFER THE STANDARDIZED PLAN THROUGHOUT
9 THE ENTIRE COUNTY; AND
10 (b) A SMALL GROUP HEALTH BENEFIT PLAN IN COLORADO IS
11 REQUIRED TO OFFER THE STANDARDIZED PLAN IN THE SMALL GROUP
12 MARKET IN EACH COUNTY WHERE THE CARRIER OFFERS A SMALL GROUP
13 HEALTH BENEFIT PLAN AND SHALL OFFER THE STANDARDIZED PLAN
14 THROUGHOUT THE ENTIRE COUNTY.
15 (2) (a) (I) IN THE INDIVIDUAL MARKET, FOR THE PLAN YEAR
16 BEGINNING JANUARY 1, 2023, AND IN THE SMALL GROUP MARKET,
17 BEGINNING JANUARY 1, 2023, EACH CARRIER SHALL OFFER THE
18 STANDARDIZED PLAN AT A PREMIUM RATE THAT IS AT LEAST SIX PERCENT
19 LESS THAN THE PREMIUM RATE FOR HEALTH BENEFIT PLANS THAT THE
20 CARRIER OFFERED IN THE 2021 CALENDAR YEAR, AS ADJUSTED FOR
21 MEDICAL INFLATION, IN THE INDIVIDUAL AND SMALL GROUP MARKETS.
22 THE COMMISSIONER SHALL CALCULATE THE PREMIUM RATE REDUCTION
23 BASED ON THE RATES CHARGED IN THE SAME COUNTY IN WHICH THE
24 CARRIER OFFERED HEALTH BENEFIT PLANS IN THE INDIVIDUAL AND SMALL
25 GROUP MARKETS IN 2021 PRIOR TO THE APPLICATION OF THE COLORADO
26 REINSURANCE PROGRAM PURSUANT TO PART 11 OF THIS ARTICLE 16.
27 (II) FOR CARRIERS OFFERING THE STANDARDIZED PLAN IN THE
28 2023 PLAN YEAR IN A COUNTY IN WHICH THE CARRIER DID NOT OFFER A
29 HEALTH BENEFIT PLAN IN THE INDIVIDUAL OR SMALL GROUP MARKET IN
30 THE 2021 CALENDAR YEAR, EACH CARRIER THAT OFFERS THE
31 STANDARDIZED PLAN SHALL OFFER THE STANDARDIZED PLAN:
32 (A) IN THE INDIVIDUAL MARKET AT A PREMIUM RATE THAT IS AT
33 LEAST SIX PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR
34 INDIVIDUAL HEALTH BENEFIT PLANS OFFERED IN THAT COUNTY IN 2021,
35 CALCULATED BASED ON THE AVERAGE PREMIUM RATE FOR INDIVIDUAL
36 HEALTH BENEFIT PLANS OFFERED IN THAT COUNTY, AS ADJUSTED FOR
37 MEDICAL INFLATION, PRIOR TO THE APPLICATION OF THE COLORADO
38 REINSURANCE PROGRAM PURSUANT TO PART 11 OF THIS ARTICLE 16; AND
39 (B) IN THE SMALL GROUP MARKET AT A PREMIUM RATE THAT IS AT
40 LEAST SIX PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR SMALL
41 GROUP PLANS OFFERED IN THAT COUNTY IN 2021, AS ADJUSTED FOR
42 MEDICAL INFLATION.
43 (b) (I) IN THE INDIVIDUAL MARKET, FOR THE PLAN YEAR
44 BEGINNING JANUARY 1, 2024, AND IN THE SMALL GROUP MARKET,
45 BEGINNING JANUARY 1, 2024, EACH CARRIER SHALL OFFER THE

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1 STANDARDIZED PLAN AT A PREMIUM RATE THAT IS AT LEAST TWELVE
2 PERCENT LESS THAN THE PREMIUM RATE FOR HEALTH BENEFIT PLANS THAT
3 THE CARRIER OFFERED IN THE 2021 CALENDAR YEAR, AS ADJUSTED FOR
4 MEDICAL INFLATION, IN THE INDIVIDUAL AND SMALL GROUP MARKETS.
5 THE COMMISSIONER SHALL CALCULATE THE PREMIUM RATE REDUCTION
6 BASED ON THE RATES CHARGED IN THE SAME COUNTY IN WHICH THE
7 CARRIER OFFERED HEALTH BENEFIT PLANS IN THE INDIVIDUAL AND SMALL
8 GROUP MARKETS IN 2021 PRIOR TO THE APPLICATION OF THE COLORADO
9 REINSURANCE PROGRAM PURSUANT TO PART 11 OF THIS ARTICLE 16.
10 (II) FOR CARRIERS OFFERING THE STANDARDIZED PLAN IN THE
11 2024 PLAN YEAR IN A COUNTY IN WHICH THE CARRIER DID NOT OFFER A
12 HEALTH BENEFIT PLAN IN THE INDIVIDUAL OR SMALL GROUP MARKET IN
13 THE 2021 CALENDAR YEAR, EACH CARRIER THAT OFFERS THE
14 STANDARDIZED PLAN SHALL OFFER THE STANDARDIZED PLAN:
15 (A) IN THE INDIVIDUAL MARKET AT A PREMIUM RATE THAT IS AT
16 LEAST TWELVE PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR
17 INDIVIDUAL PLANS OFFERED IN THAT COUNTY IN 2021, CALCULATED
18 BASED ON THE AVERAGE PREMIUM RATE FOR INDIVIDUAL PLANS OFFERED
19 IN THAT COUNTY, AS ADJUSTED FOR MEDICAL INFLATION, PRIOR TO THE
20 APPLICATION OF THE COLORADO REINSURANCE PROGRAM PURSUANT TO
21 PART 11 OF THIS ARTICLE 16; AND
22 (B) IN THE SMALL GROUP MARKET AT A PREMIUM RATE THAT IS AT
23 LEAST TWELVE PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR
24 SMALL GROUP PLANS OFFERED IN THAT COUNTY IN 2021, AS ADJUSTED FOR
25 MEDICAL INFLATION.
26 (c) (I) IN THE INDIVIDUAL MARKET, FOR THE PLAN YEAR
27 BEGINNING JANUARY 1, 2025, AND IN THE SMALL GROUP MARKET,
28 BEGINNING JANUARY 1, 2025, EACH CARRIER SHALL OFFER THE
29 STANDARDIZED PLAN AT A PREMIUM RATE THAT IS AT LEAST EIGHTEEN
30 PERCENT LESS THAN THE PREMIUM RATE FOR HEALTH BENEFIT PLANS THAT
31 THE CARRIER OFFERED IN THE 2021 CALENDAR YEAR, AS ADJUSTED FOR
32 MEDICAL INFLATION, IN THE INDIVIDUAL AND SMALL GROUP MARKETS.
33 THE COMMISSIONER SHALL CALCULATE THE PREMIUM RATE REDUCTION
34 BASED ON THE RATES CHARGED IN THE SAME COUNTY IN WHICH THE
35 CARRIER OFFERED HEALTH BENEFIT PLANS IN THE INDIVIDUAL AND SMALL
36 GROUP MARKETS IN 2021 PRIOR TO THE APPLICATION OF THE COLORADO
37 REINSURANCE PROGRAM PURSUANT TO PART 11 OF THIS ARTICLE 16.
38 (II) FOR CARRIERS OFFERING THE STANDARDIZED PLAN IN THE
39 2025 PLAN YEAR IN A COUNTY IN WHICH THE CARRIER DID NOT OFFER A
40 HEALTH BENEFIT PLAN IN THE INDIVIDUAL OR SMALL GROUP MARKET IN
41 THE 2021 CALENDAR YEAR, EACH CARRIER THAT OFFERS THE
42 STANDARDIZED PLAN SHALL OFFER THE STANDARDIZED PLAN:
43 (A) IN THE INDIVIDUAL MARKET AT A PREMIUM RATE THAT IS AT
44 LEAST EIGHTEEN PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR
45 INDIVIDUAL PLANS OFFERED IN THAT COUNTY IN 2021, CALCULATED

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BASED ON THE AVERAGE PREMIUM RATE FOR INDIVIDUAL PLANS OFFERED IN THAT COUNTY, AS ADJUSTED FOR MEDICAL INFLATION, PRIOR TO THE APPLICATION OF THE COLORADO REINSURANCE PROGRAM PURSUANT TO PART 11 OF THIS ARTICLE 16; AND

(B) IN THE SMALL GROUP MARKET AT A PREMIUM RATE THAT IS AT LEAST EIGHTEEN PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR SMALL GROUP PLANS OFFERED IN THAT COUNTY IN 2021, AS ADJUSTED FOR MEDICAL INFLATION.

(d) FOR THE PLAN YEAR BEGINNING ON OR AFTER JANUARY 1, 2026, AND EACH YEAR THEREAFTER, EACH CARRIER AND HEALTH-CARE COVERAGE COOPERATIVE SHALL LIMIT ANY ANNUAL PERCENTAGE INCREASE IN THE PREMIUM RATE FOR THE STANDARDIZED PLAN IN BOTH THE INDIVIDUAL AND SMALL GROUP MARKETS TO A RATE THAT IS NO MORE THAN MEDICAL INFLATION, RELATIVE TO THE PREVIOUS YEAR.

(3) THE PREMIUM RATE REQUIREMENTS IN SUBSECTIONS (2)(a), (2)(b), AND (2)(c) OF THIS SECTION FOR THE STANDARDIZED PLAN OFFERED IN THE INDIVIDUAL AND SMALL GROUP MARKETS MUST ACCOUNT FOR POLICY ADJUSTMENTS DEEMED NECESSARY TO PREVENT PEOPLE WITH LOW AND MODERATE INCOMES FROM EXPERIENCING NET INCREASES IN PREMIUM COSTS.

(4) THE COMMISSIONS PAID TO INSURANCE PRODUCERS FOR THE SALE OF THE STANDARDIZED PLAN MUST BE COMPARABLE TO THE AVERAGE COMMISSIONS PAID FOR THE SALE OF OTHER PLANS OFFERED IN THE INDIVIDUAL AND SMALL GROUP MARKETS.

10-16-1306. Rate filings - failure to meet premium requirements - notice - public hearing. (1) (a) IN THE RATE FILINGS REQUIRED PURSUANT TO SECTION 10-16-107, EACH CARRIER MUST FILE RATES FOR THE STANDARDIZED PLAN AT THE PREMIUM RATES REQUIRED IN SECTION 10-16-1305 (2).

(b) IF A CARRIER OR HEALTH-CARE PROVIDER ANTICIPATES THAT THE CARRIER WILL BE UNABLE TO MEET NETWORK ADEQUACY STANDARDS OR THE PREMIUM RATE REQUIREMENTS IN SECTION 10-16-1305 DUE TO A REIMBURSEMENT RATE DISPUTE FOR THE STANDARDIZED PLAN, THE CARRIER OR HEALTH-CARE PROVIDER MAY INITIATE NONBINDING ARBITRATION PRIOR TO FILING RATES FOR THE STANDARDIZED PLAN. THE RATE FILING DEADLINE ISSUED BY THE COMMISSIONER PURSUANT TO SECTION 10-16-107 MUST STILL BE MET AND MAY NOT BE DELAYED DUE TO ARBITRATION. THE COMMISSIONER SHALL NOT BE REQUIRED TO PARTICIPATE OR OTHERWISE MANAGE ANY NONBINDING ARBITRATION IMPLEMENTED UNDER THIS SECTION.

(2) IF A CARRIER IS UNABLE TO OFFER THE STANDARDIZED PLAN AS REQUIRED BY SECTION 10-16-1305 (1) AT THE PREMIUM RATE REQUIRED IN SECTION 10-16-1305 (2) IN ANY YEAR, THE CARRIER SHALL NOTIFY THE COMMISSIONER OF THE REASONS WHY THE CARRIER IS UNABLE TO MEET THE REQUIREMENTS AS FOLLOWS:

(a) FOR PREMIUM RATES APPLICABLE IN 2023, BY MAY 1, 2022; AND

(b) FOR PREMIUM RATES APPLICABLE IN 2024 OR ANY SUBSEQUENT YEAR, BY MARCH 1 OF THE YEAR PRECEDING THE YEAR IN WHICH THE PREMIUMS RATES GO INTO EFFECT.

(3) (a) IF, ON OR AFTER JANUARY 1, 2023, AND PURSUANT TO SUBSECTION (2) OF THIS SECTION, A CARRIER NOTIFIES THE COMMISSIONER THAT THE CARRIER IS UNABLE TO OFFER THE STANDARDIZED PLAN AT THE PREMIUM RATE REQUIRED IN SECTION 10-16-1305 (2) OR THE COMMISSIONER OTHERWISE DETERMINES, WITH SUPPORT FROM AN INDEPENDENT ACTUARY AND BASED ON A REVIEW OF THE RATE AND FORM FILINGS, THAT A CARRIER HAS NOT MET THE PREMIUM RATE REQUIREMENTS IN SECTION 10-16-1305 (2) OR THE NETWORK ADEQUACY REQUIREMENTS, THE DIVISION SHALL HOLD A PUBLIC HEARING PRIOR TO THE APPROVAL OF THE CARRIER'S FINAL RATES; EXCEPT THAT, FOR THE PURPOSES OF HOLDING A PUBLIC HEARING, IF A CARRIER DOES NOT MEET THE NETWORK ADEQUACY REQUIREMENTS IN SECTION 10-16-1304 (1)(g), THE COMMISSIONER SHALL CONSIDER A CARRIER TO HAVE MET NETWORK ADEQUACY REQUIREMENTS IF THE CARRIER FILES THE ACTION PLAN REQUIRED IN SECTION 10-16-1304 (2)(b).

(b) INFORMATION SUBMITTED BY A PARTY FOR PURPOSES OF A PUBLIC HEARING HELD PURSUANT TO SUBSECTION (3)(a) OF THIS SECTION IS SUBJECT TO THE "COLORADO OPEN RECORDS ACT", PART 2 OF ARTICLE 72 OF TITLE 24.

(c) THE COMMISSIONER SHALL PROVIDE PUBLIC NOTICE AND OPPORTUNITY TO TESTIFY AT THE PUBLIC HEARING TO ALL AFFECTED PARTIES, INCLUDING CARRIERS, HOSPITALS, HEALTH-CARE PROVIDERS, CONSUMER ADVOCACY ORGANIZATIONS, AND INDIVIDUALS. ALL AFFECTED PARTIES SHALL HAVE THE OPPORTUNITY TO PRESENT EVIDENCE REGARDING THE CARRIER'S ABILITY TO MEET THE PREMIUM RATE REQUIREMENTS AND THE NETWORK ADEQUACY REQUIREMENTS. THE COMMISSIONER SHALL LIMIT THE EVIDENCE PRESENTED AT THE HEARING TO INFORMATION THAT IS RELATED TO THE REASON THE CARRIER FAILED TO MEET THE NETWORK ADEQUACY REQUIREMENTS OR THE PREMIUM RATE REQUIREMENTS IN SECTION 10-16-1305 FOR THE STANDARDIZED PLAN IN ANY SINGLE COUNTY.

(d) THE OFFICE OF THE INSURANCE OMBUDSMAN ESTABLISHED IN SECTION 25.5-1-131 SHALL PARTICIPATE IN THE PUBLIC HEARINGS AND REPRESENT THE INTERESTS OF CONSUMERS.

(4) BASED ON EVIDENCE PRESENTED AT A HEARING HELD PURSUANT TO SUBSECTION (3) OF THIS SECTION AND OTHER AVAILABLE DATA AND ACTUARIAL ANALYSIS, THE COMMISSIONER MAY:

(a) (I) ESTABLISH CARRIER REIMBURSEMENT RATES UNDER THE STANDARDIZED PLAN FOR HOSPITAL SERVICES, IF NECESSARY, TO MEET NETWORK ADEQUACY REQUIREMENTS OR THE PREMIUM RATE

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1 REQUIREMENTS IN SECTION 10-16-1305.
2 (II) THE BASE REIMBURSEMENT RATE FOR HOSPITAL SERVICES
3 SHALL NOT BE LESS THAN ONE HUNDRED FIFTY-FIVE PERCENT OF THE
4 HOSPITAL'S MEDICARE REIMBURSEMENT RATE OR EQUIVALENT RATE.
5 (III) A HOSPITAL THAT IS AN ESSENTIAL ACCESS HOSPITAL OR THAT
6 IS INDEPENDENT AND NOT PART OF A HEALTH SYSTEM MUST RECEIVE A
7 TWENTY-PERCENTAGE-POINT INCREASE IN THE BASE REIMBURSEMENT
8 RATE.
9 (IV) A HOSPITAL THAT IS AN ESSENTIAL ACCESS HOSPITAL THAT IS
10 NOT PART OF A HEALTH SYSTEM MUST RECEIVE A
11 FORTY-PERCENTAGE-POINT INCREASE IN THE BASE REIMBURSEMENT RATE.
12 (V) A HOSPITAL WITH A COMBINED PERCENTAGE OF PATIENTS WHO
13 RECEIVE SERVICES THROUGH PROGRAMS ESTABLISHED THROUGH THE
14 "COLORADO MEDICAL ASSISTANCE ACT", ARTICLES 4 TO 6 OF TITLE 25.5,
15 OR MEDICARE, TITLE XVIII OF THE FEDERAL "SOCIAL SECURITY ACT", AS
16 AMENDED, THAT EXCEEDS THE STATEWIDE AVERAGE MUST RECEIVE UP TO
17 A THIRTY-PERCENTAGE-POINT INCREASE IN ITS BASE REIMBURSEMENT
18 RATE, WITH THE ACTUAL INCREASE TO BE DETERMINED BASED ON THE
19 HOSPITAL'S PERCENTAGE SHARE OF SUCH PATIENTS.
20 (VI) A HOSPITAL THAT IS EFFICIENT IN MANAGING THE
21 UNDERLYING COST OF CARE AS DETERMINED BY THE HOSPITAL'S TOTAL
22 MARGINS, OPERATING COSTS, AND NET PATIENT REVENUE MUST RECEIVE
23 UP TO A FORTY-PERCENTAGE-POINT INCREASE IN ITS BASE
24 REIMBURSEMENT RATE.
25 (VII) NOTWITHSTANDING SUBSECTIONS (4)(a)(III) TO (4)(a)(VI)
26 OF THIS SECTION, IN DETERMINING THE REIMBURSEMENT RATES FOR
27 HOSPITALS, THE COMMISSIONER MAY CONSULT WITH EMPLOYEE
28 MEMBERSHIP ORGANIZATIONS REPRESENTING HEALTH-CARE PROVIDERS'
29 EMPLOYEES IN COLORADO AND WITH HOSPITAL-BASED HEALTH-CARE
30 PROVIDERS IN COLORADO, AND SHALL TAKE INTO ACCOUNT THE COST OF
31 ADEQUATE WAGES, BENEFITS, STAFFING, AND TRAINING FOR HEALTH-CARE
32 EMPLOYEES TO PROVIDE CONTINUOUS QUALITY CARE.
33 (b) ESTABLISH REIMBURSEMENT RATES UNDER THE STANDARDIZED
34 PLAN, IF NECESSARY, FOR HEALTH-CARE PROVIDERS FOR CATEGORIES OF
35 SERVICES WITHIN THE GEOGRAPHIC SERVICE AREA FOR THE STANDARDIZED
36 PLAN TO MEET NETWORK ADEQUACY REQUIREMENTS OR THE PREMIUM
37 RATE REQUIREMENTS IN SECTION 10-16-1305 (2), WHICH RATES MAY NOT
38 BE LESS THAN ONE HUNDRED THIRTY-FIVE PERCENT OF THE MEDICARE
39 REIMBURSEMENT RATES WITHIN THE APPLICABLE GEOGRAPHIC REGION FOR
40 THE SAME SERVICES;
41 (c) REQUIRE HOSPITALS THAT ARE LICENSED PURSUANT TO
42 SECTION 25-1.5-103 TO ACCEPT THE REIMBURSEMENT RATES ESTABLISHED
43 PURSUANT TO SUBSECTION (4)(a) OF THIS SECTION IF NECESSARY TO
44 ENSURE THE STANDARDIZED PLAN MEETS THE PREMIUM RATE
45 REQUIREMENTS AND THE NETWORK ADEQUACY REQUIREMENTS;

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1 (d) (I) REQUIRE HEALTH-CARE PROVIDERS TO ACCEPT THE
2 REIMBURSEMENT RATES ESTABLISHED PURSUANT TO SUBSECTION (4)(b)
3 OF THIS SECTION, IF NECESSARY, TO ENSURE THE STANDARDIZED PLAN
4 MEETS THE PREMIUM RATE REQUIREMENTS AND THE NETWORK ADEQUACY
5 REQUIREMENTS.
6 (II) THE COMMISSIONER SHALL NOT REQUIRE A HEALTH-CARE
7 PROVIDER, OTHER THAN A HOSPITAL THAT PROVIDES A MAJORITY OF
8 COVERED PROFESSIONAL SERVICES THROUGH A SINGLE, CONTRACTED
9 MEDICAL GROUP FOR A NONPROFIT, NONGOVERNMENTAL HEALTH
10 MAINTENANCE ORGANIZATION, TO CONTRACT WITH ANY OTHER CARRIER;
11 AND
12 (e) REQUIRE THE CARRIER TO OFFER THE STANDARDIZED PLAN IN
13 SPECIFIC COUNTIES WHERE NO CARRIER IS OFFERING THE STANDARDIZED
14 PLAN IN THAT PLAN YEAR IN EITHER THE INDIVIDUAL OR SMALL GROUP
15 MARKET. IN DETERMINING WHETHER THE CARRIER IS REQUIRED TO OFFER
16 THE STANDARDIZED PLAN IN A SPECIFIC COUNTY, THE COMMISSIONER
17 SHALL CONSIDER:
18 (I) THE CARRIER'S STRUCTURE, THE NUMBER OF COVERED LIVES
19 THE CARRIER HAS IN ALL LINES OF BUSINESS IN EACH COUNTY, AND THE
20 CARRIER'S EXISTING SERVICE AREAS; AND
21 (II) ALTERNATIVE HEALTH-CARE COVERAGE AVAILABLE IN EACH
22 COUNTY, INCLUDING HEALTH-CARE COVERAGE COOPERATIVES.
23 (5) A CARRIER OR HEALTH-CARE PROVIDER MAY APPEAL A
24 DECISION BY THE COMMISSIONER MADE PURSUANT TO SUBSECTION (4) OF
25 THIS SECTION TO THE DISTRICT COURT IN THE APPLICABLE JURISDICTION.
26 THE DECISION OF THE COMMISSIONER IS A FINAL AGENCY ACTION SUBJECT
27 TO JUDICIAL REVIEW PURSUANT TO SECTION 24-4-106 (6).
28 (6) NOTWITHSTANDING SUBSECTION (4) OF THIS SECTION, THE
29 COMMISSIONER SHALL NOT SET THE REIMBURSEMENT RATES FOR ANY
30 HOSPITAL FOR ANY PLAN YEAR AT AN AMOUNT THAT IS MORE THAN
31 TWENTY PERCENT LOWER THAN THE RATE NEGOTIATED BETWEEN THE
32 CARRIER AND THE HOSPITAL FOR THE PREVIOUS PLAN YEAR.
33 (7) FOR THE PURPOSE OF MAKING THE DETERMINATION IN
34 SUBSECTION (3) OF THIS SECTION:
35 (a) A HEALTH-CARE COVERAGE COOPERATIVE, AND A CARRIER
36 OFFERING HEALTH BENEFIT PLANS UNDER AGREEMENT WITH THE
37 HEALTH-CARE COVERAGE COOPERATIVE, THAT HAS OFFERED ONE OR MORE
38 HEALTH BENEFIT PLANS TO PURCHASERS IN THE INDIVIDUAL AND SMALL
39 GROUP MARKETS THAT PREVIOUSLY ACHIEVED AND MAINTAINED AT LEAST
40 AN EIGHTEEN PERCENT REDUCTION IN PREMIUM RATES, REGARDLESS OF
41 THE FIRST YEAR THE HEALTH BENEFIT PLANS WERE OFFERED, SHALL BE
42 DEEMED BY THE COMMISSIONER AS HAVING MET THE REQUIREMENTS FOR
43 CARRIERS IN SECTIONS 10-16-1304 AND 10-16-1305 WITH RESPECT TO THE
44 COUNTIES IN WHICH THE INDIVIDUAL AND SMALL GROUP PLANS ARE BEING
45 OFFERED BY THE HEALTH-CARE COVERAGE COOPERATIVE.

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1 (b) THE COMMISSIONER SHALL TAKE INTO ACCOUNT:
2 (I) ANY ACTUARIAL DIFFERENCES BETWEEN THE STANDARDIZED
3 PLAN AND THE HEALTH BENEFIT PLANS THE CARRIER OFFERED IN THE 2021
4 CALENDAR YEAR;
5 (II) ANY CHANGES TO THE STANDARDIZED PLAN; AND
6 (III) STATE OR FEDERAL HEALTH BENEFIT COVERAGE MANDATES
7 IMPLEMENTED AFTER THE 2021 PLAN YEAR.
8 (8) IF THE 1332 WAIVER APPLIED FOR PURSUANT TO SECTION
9 10-16-1308 IS DENIED, SUSPENDED, OR OTHERWISE RESCINDED, THE
10 COMMISSIONER IS REQUIRED TO SET THE PREMIUM RATE REQUIREMENTS
11 TO MAXIMIZE SUBSIDIES FOR COLORADANS.
12 (9) A HOSPITAL OR A HEALTH-CARE PROVIDER IN COLORADO
13 SHALL NOT BALANCE BILL CONSUMERS ENROLLED IN THE STANDARDIZED
14 PLAN AND SHALL ACCEPT THE REIMBURSEMENT RATES ESTABLISHED BY
15 THE COMMISSIONER PURSUANT TO SUBSECTION (4) OF THIS SECTION, IF
16 APPLICABLE, FOR THE SERVICE PROVIDED TO THE CONSUMER.
17 (10) (a) THE COMMISSIONER SHALL ONLY SET REIMBURSEMENT
18 RATES PURSUANT TO THIS SECTION FOR HOSPITALS OR HEALTH-CARE
19 PROVIDERS THAT:
20 (I) PREVENTED A CARRIER FROM MEETING THE PREMIUM RATE
21 REQUIREMENTS FOR A STANDARDIZED PLAN BEING OFFERED IN A SPECIFIC
22 COUNTY; OR
23 (II) CAUSED THE CARRIER TO FAIL TO MEET NETWORK ADEQUACY
24 REQUIREMENTS.
25 (b) THE CARRIER SHALL PROVIDE THE COMMISSIONER WITH
26 REASONABLE INFORMATION NECESSARY TO IDENTIFY WHICH HOSPITALS OR
27 HEALTH-CARE PROVIDERS WERE THE CAUSE OF THE CARRIER'S FAILURE TO
28 MEET THE PREMIUM RATE REQUIREMENTS OR TO MEET NETWORK
29 ADEQUACY REQUIREMENTS.
30 (11) THE COMMISSIONER SHALL NOT USE THE FAILURE OF A
31 CARRIER TO MEET THE PREMIUM RATE REQUIREMENTS FOR THE
32 STANDARDIZED PLAN IN A COUNTY AS A REASON TO DENY PREMIUM RATES
33 FOR A NONSTANDARDIZED PLAN OF A CARRIER IN THAT COUNTY.
34 **10-16-1307. Advisory board - members - rules.** (1) (a) THE
35 COMMISSIONER SHALL CONSULT WITH AN ADVISORY BOARD TO IMPLEMENT
36 THIS PART 13. THE GOVERNOR SHALL APPOINT THE MEMBERS OF THE
37 ADVISORY BOARD ON OR BEFORE JULY 1, 2022, AND SHALL ENSURE THAT
38 THE MEMBERSHIP OF THE ADVISORY BOARD HAS DEMONSTRATED
39 EXPERIENCE AND EXPERTISE IN MOST OF THE AREAS LISTED IN SUBSECTION
40 (2) OF THIS SECTION.
41 (b) TO THE EXTENT POSSIBLE, THE GOVERNOR SHALL APPOINT
42 ADVISORY BOARD MEMBERS WHO ARE DIVERSE WITH REGARD TO RACE,
43 ETHNICITY, IMMIGRATION STATUS, AGE, ABILITY, SEXUAL ORIENTATION,
44 GENDER IDENTITY, AND GEOGRAPHY. IN CONSIDERING THE RACIAL AND
45 ETHNIC DIVERSITY OF THE ADVISORY BOARD, THE GOVERNOR SHALL

1 ATTEMPT TO ENSURE THAT AT LEAST ONE-THIRD OF THE MEMBERS ARE
2 PEOPLE OF COLOR. IN CONSIDERING THE GEOGRAPHIC DIVERSITY OF THE
3 ADVISORY BOARD, THE GOVERNOR SHALL ATTEMPT TO APPOINT MEMBERS
4 FROM BOTH RURAL AND URBAN AREAS OF THE STATE.
5 (2) THE GOVERNOR MAY APPOINT UP TO ELEVEN MEMBERS TO THE
6 ADVISORY BOARD AND, TO THE EXTENT PRACTICABLE, SHALL INCLUDE
7 INDIVIDUALS WHO:
8 (a) HAVE FACED BARRIERS TO HEALTH ACCESS, INCLUDING PEOPLE
9 OF COLOR, IMMIGRANTS, AND COLORADANS WITH LOW INCOMES;
10 (b) HAVE EXPERIENCE PURCHASING THE STANDARDIZED PLAN;
11 (c) REPRESENT CONSUMER ADVOCACY ORGANIZATIONS;
12 (d) HAVE EXPERTISE IN HEALTH EQUITY;
13 (e) HAVE EXPERTISE IN HEALTH BENEFITS FOR SMALL BUSINESSES;
14 (f) REPRESENT CARRIERS OR WHO HAVE EXPERIENCE WITH
15 DESIGNING A HEALTH INSURANCE PLAN AND SETTING RATES;
16 (g) REPRESENT HOSPITALS OR WHO HAVE EXPERIENCE WITH
17 CONTRACTS BETWEEN HOSPITALS AND CARRIERS;
18 (h) REPRESENT HEALTH-CARE PROVIDERS OR WHO HAVE
19 EXPERIENCE WITH CONTRACTS BETWEEN HEALTH-CARE PROVIDERS AND
20 CARRIERS; OR
21 (i) REPRESENT AN EMPLOYEE ORGANIZATION THAT REPRESENTS
22 EMPLOYEES IN THE HEALTH-CARE INDUSTRY.
23 (3) THE MEMBERS SERVE AT THE PLEASURE OF THE GOVERNOR.
24 (4) IN ADDITION TO CONSULTING WITH THE COMMISSIONER
25 PURSUANT TO SUBSECTION (1)(a) OF THIS SECTION, THE ADVISORY BOARD
26 MAY:
27 (a) CONSIDER RECOMMENDATIONS TO STREAMLINE PRIOR
28 AUTHORIZATION AND UTILIZATION MANAGEMENT PROCESSES FOR THE
29 STANDARDIZED PLAN;
30 (b) RECOMMEND WAYS TO KEEP HEALTH-CARE SERVICES IN THE
31 COMMUNITIES WHERE PATIENTS LIVE; AND
32 (c) CONSIDER WHETHER ALTERNATIVE PAYMENT MODELS MAY BE
33 APPROPRIATE FOR PARTICULAR SERVICES, TAKING INTO CONSIDERATION
34 THE IMPACTS OF SUCH MODELS ON HEALTH OUTCOMES FOR PEOPLE OF
35 COLOR.
36 (5) THE DIVISION SHALL PROVIDE TECHNICAL AND
37 ADMINISTRATIVE SUPPORT TO ASSIST THE ADVISORY BOARD.
38 **10-16-1308. Federal waiver - commissioner application - use
39 of money.** (1) ON OR AFTER THE EFFECTIVE DATE OF THIS SECTION, THE
40 COMMISSIONER MAY APPLY TO THE SECRETARY OF THE UNITED STATES
41 DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR A STATE INNOVATION
42 WAIVER TO WAIVE ONE OR MORE REQUIREMENTS OF THE FEDERAL ACT AS
43 AUTHORIZED BY SECTION 1332 OF THE FEDERAL ACT TO CAPTURE ALL
44 APPLICABLE SAVINGS TO THE FEDERAL GOVERNMENT AS A RESULT OF THE
45 IMPLEMENTATION OF THIS PART 13.

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1 (2) (a) UPON APPROVAL OF THE 1332 WAIVER APPLICATION, THE
2 COMMISSIONER MAY USE ANY FEDERAL MONEY RECEIVED THROUGH THE
3 WAIVER FOR THE IMPLEMENTATION OF THIS PART 13 OR FOR THE
4 COLORADO HEALTH INSURANCE AFFORDABILITY ENTERPRISE CREATED IN
5 SECTION 10-16-1204. THE COMMISSIONER MAY ALLOCATE FEDERAL
6 MONEY TO THE HEALTH INSURANCE AFFORDABILITY CASH FUND CREATED
7 IN SECTION 10-16-1206 FOR USE BY THE COLORADO HEALTH INSURANCE
8 AFFORDABILITY ENTERPRISE TO INCREASE THE VALUE, AFFORDABILITY,
9 QUALITY, AND EQUITY OF HEALTH-CARE COVERAGE FOR ALL
10 COLORADANS, WITH A FOCUS ON INCREASING THE VALUE, AFFORDABILITY,
11 QUALITY, AND EQUITY OF HEALTH-CARE COVERAGE FOR COLORADANS
12 HISTORICALLY AND SYSTEMICALLY DISADVANTAGED BY HEALTH AND
13 ECONOMIC SYSTEMS.
14 (b) THE IMPLEMENTATION AND OPERATION OF SECTION 10-16-1305
15 (2) IS CONTINGENT ON THE APPROVAL OF THE 1332 WAIVER APPLICATION
16 AND THE RECEIPT OF FEDERAL FUNDS.
17 **10-16-1309. Standardized plan - cost shift.** (1) IF THE
18 ADMINISTRATOR OF A SELF-FUNDED HEALTH INSURANCE PLAN
19 VOLUNTARILY PROVIDES TO THE COMMISSIONER ITS CONTRACTED RATES
20 AND ANY OTHER INFORMATION DEEMED NECESSARY AND AGREED UPON BY
21 THE ADMINISTRATOR AND THE COMMISSIONER, THE COMMISSIONER MAY
22 EVALUATE WHETHER THE RATES OF THE SELF-FUNDED HEALTH INSURANCE
23 PLAN REFLECT A COST SHIFT BETWEEN THE SELF-FUNDED PLAN AND THE
24 STANDARDIZED PLAN OFFERED BY A CARRIER PURSUANT TO SECTION
25 10-16-1305.
26 (2) IF THE COMMISSIONER DETERMINES THERE IS A COST SHIFT, THE
27 COMMISSIONER SHALL, TO THE EXTENT PRACTICABLE, PROVIDE A
28 DESCRIPTION OF WHICH CATEGORIES OF SERVICES HAVE EXPERIENCED THE
29 GREATEST COST SHIFT TO THE ADMINISTRATOR OF THE SELF-FUNDED
30 HEALTH INSURANCE PLAN.
31 **10-16-1310. Reports required - repeal.** (1) THE COMMISSIONER
32 SHALL CONTRACT WITH AN INDEPENDENT THIRD-PARTY ORGANIZATION TO
33 PREPARE THREE SEPARATE REPORTS AS SPECIFIED IN SUBSECTION (4) OF
34 THIS SECTION, TO THE EXTENT THAT INFORMATION IS AVAILABLE
35 REGARDING THE IMPLEMENTATION OF THIS PART 13 AS IT RELATES TO THE
36 STAFFING, WAGES, BENEFITS, TRAINING, AND WORKING CONDITIONS OF
37 HOSPITAL WORKERS.
38 (2) IN CHOOSING AN INDEPENDENT THIRD-PARTY CONTRACTOR,
39 THE COMMISSIONER SHALL CONSIDER ORGANIZATIONS WITH EXPERIENCE
40 CONDUCTING IN-PERSON INTERVIEWS WITH HEALTH-CARE EMPLOYERS AND
41 EMPLOYEES IN COLORADO.
42 (3) THE INDEPENDENT THIRD-PARTY CONTRACTOR MAY MAKE
43 POLICY RECOMMENDATIONS RELATED TO INFORMATION IN THE REPORTS
44 AND MAY INCLUDE DATA COLLECTED FROM EMPLOYERS, EMPLOYEES, AND
45 OTHER THIRD-PARTY SOURCES.

1 (4) THE INDEPENDENT THIRD-PARTY CONTRACTOR SHALL DELIVER
2 THE REPORTS TO THE COMMISSIONER AS FOLLOWS:
3 (a) THE FIRST REPORT BY JULY 1, 2023;
4 (b) THE SECOND REPORT BY JULY 1, 2024; AND
5 (c) THE THIRD REPORT BY JULY 1, 2025.
6 (4) THIS SECTION IS REPEALED, EFFECTIVE JULY 1, 2026.
7 **10-16-1311. State measurement for accountable, responsive,**
8 **and transparent (SMART) government act report.** (1) THE
9 COMMISSIONER SHALL REPORT DURING THE HEARINGS CONDUCTED
10 PURSUANT TO THE "STATE MEASUREMENT FOR ACCOUNTABLE,
11 RESPONSIVE, AND TRANSPARENT (SMART) GOVERNMENT ACT", PART 2
12 OF ARTICLE 7 OF TITLE 2:
13 (a) BEGINNING IN JANUARY 2022 AND EACH YEAR THEREAFTER,
14 ON THE PROGRESS OF THE IMPLEMENTATION AND OPERATION OF THIS PART
15 13;
16 (b) BEGINNING IN JANUARY 2024, AND EACH YEAR THEREAFTER,
17 ON THE CARRIERS' EFFORTS TO DEVELOP NETWORKS THAT ARE DIVERSE
18 AND CULTURALLY RESPONSIVE PURSUANT TO SECTION 10-16-1304 (1)(g)
19 AND THE CARRIERS' EFFORTS REQUIRED BY SECTION 10-16-1304 (2); AND
20 (c) IN JANUARY 2024, JANUARY 2025, AND JANUARY 2026, ON THE
21 RESULTS OF THE REPORTS REQUIRED IN SECTION 10-16-1310.
22 **10-16-1312. Rules.** THE COMMISSIONER MAY PROMULGATE RULES
23 AS NECESSARY TO DEVELOP, IMPLEMENT, AND OPERATE THIS PART 13.
24 **10-16-1313. Severability.** IF ANY PROVISION OF THIS PART 13 OR
25 APPLICATION THEREOF TO ANY PERSON OR CIRCUMSTANCES IS JUDGED
26 INVALID, THE INVALIDITY DOES NOT AFFECT PROVISIONS OR APPLICATIONS
27 OF THIS PART 13 THAT CAN BE GIVEN EFFECT WITHOUT THE INVALID
28 PROVISION OR APPLICATION, AND TO THIS END THE PROVISIONS OF THIS
29 PART 13 ARE DECLARED SEVERABLE.
30 **SECTION 2.** In Colorado Revised Statutes, 10-16-107, **amend**
31 (3)(a)(V); and **add** (3)(a)(VII) as follows:
32 **10-16-107. Rate filing regulation - benefits ratio - rules.**
33 (3) (a) The commissioner shall disapprove the requested rate increase if
34 any of the following apply:
35 (V) The rate filing is incomplete; ~~or~~
36 (VII) THE RATE FILING REFLECTS A COST SHIFT BETWEEN THE
37 STANDARDIZED PLAN, AS DEFINED IN SECTION 10-16-1303 (13), OFFERED
38 BY THE CARRIER AND THE HEALTH BENEFIT PLAN FOR WHICH RATE
39 APPROVAL IS BEING SOUGHT. THE COMMISSIONER MAY CONSIDER THE
40 TOTAL COST OF HEALTH CARE IN MAKING THIS DETERMINATION.
41 **SECTION 3.** In Colorado Revised Statutes, 10-16-1206, **amend**
42 (1)(d) and (1)(e); and **add** (1)(f) as follows:
43 **10-16-1206. Health insurance affordability cash fund -**
44 **creation.** (1) There is hereby created in the state treasury the health
45 insurance affordability cash fund. The fund consists of:

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(d) The revenue collected from revenue bonds issued pursuant to section 10-16-1204 (1)(b)(II); ~~and~~

(e) ~~All interest and income derived from the deposit and investment of money in the fund.~~ MONEY THAT MAY BE ALLOCATED TO THE FUND PURSUANT TO SECTION 10-16-1308; AND

(f) ALL INTEREST AND INCOME DERIVED FROM THE DEPOSIT AND INVESTMENT OF MONEY IN THE FUND.

SECTION 4. In Colorado Revised Statutes, **add** 10-22-114 as follows:

10-22-114. Standardized plan survey - repeal. (1) THE EXCHANGE SHALL CONDUCT A SURVEY IN COLLABORATION WITH THE DIVISION THAT ADDRESSES THE EXPERIENCE OF CONSUMERS WHO PURCHASED THE STANDARDIZED HEALTH BENEFIT PLAN ESTABLISHED PURSUANT TO SECTION 10-16-1304. THE SURVEY MUST BE COMPLETED ON OR BEFORE JANUARY 1, 2026.

(2) THIS SECTION IS REPEALED, EFFECTIVE JULY 1, 2026.

SECTION 5. In Colorado Revised Statutes, **add** 12-30-116 as follows:

12-30-116. Acceptance of patients enrolled in standardized plan - acceptance of reimbursement rate requirements - warning - fine. (1) THE COMMISSIONER OF INSURANCE MAY REQUIRE A HEALTH-CARE PROVIDER, AFTER A HEARING PURSUANT TO SECTION 10-16-1306, TO PARTICIPATE IN A STANDARDIZED PLAN, AS DEFINED IN SECTION 10-16-1303 (13), AND ACCEPT THE REIMBURSEMENT RATE DESCRIBED IN SECTION 10-16-1306.

(2) IF THE DIRECTOR RECEIVES NOTICE FROM THE COMMISSIONER OF INSURANCE THAT AN APPLICANT, LICENSEE, CERTIFICATE HOLDER, OR REGISTRANT REFUSES TO PARTICIPATE IN THE STANDARDIZED PLAN OR ACCEPT THE REIMBURSEMENT RATE AS MAY BE REQUIRED IN SUBSECTION (1) OF THIS SECTION, THE DIRECTOR SHALL ISSUE A WARNING TO THE APPLICANT, LICENSEE, CERTIFICATE HOLDER, OR REGISTRANT.

(3) IF THE APPLICANT, LICENSEE, CERTIFICATE HOLDER, OR REGISTRANT REFUSES TO PARTICIPATE IN THE STANDARDIZED PLAN OR ACCEPT THE REIMBURSEMENT RATE AFTER RECEIPT OF A WARNING, THE DIRECTOR MAY IMPOSE AN ADMINISTRATIVE FINE NOT TO EXCEED FIVE THOUSAND DOLLARS AGAINST ANY APPLICANT, LICENSEE, CERTIFICATE HOLDER, OR REGISTRANT.

(4) THE IMPOSITION OF AN ADMINISTRATIVE FINE PURSUANT TO THIS SECTION DOES NOT CONSTITUTE A DISCIPLINARY ACTION PURSUANT TO THIS TITLE 12 AGAINST A HEALTH-CARE PROVIDER.

SECTION 6. In Colorado Revised Statutes, **add** 25-1.5-116 as follows:

25-1.5-116. Hospitals - standardized health benefit plan - participation - penalties. (1) THE COMMISSIONER OF INSURANCE MAY REQUIRE A HOSPITAL LICENSED PURSUANT TO SECTION 25-1.5-103, AFTER

A HEARING PURSUANT TO SECTION 10-16-1306 (3) CONCERNING THE PREMIUM RATE REQUIREMENTS AND NETWORK ADEQUACY, TO PARTICIPATE IN A STANDARDIZED HEALTH BENEFIT PLAN DESCRIBED IN SECTION 10-16-1304.

(2) (a) IF THE DEPARTMENT RECEIVES NOTICE FROM THE COMMISSIONER OF INSURANCE THAT A HOSPITAL REFUSES TO PARTICIPATE IN THE STANDARDIZED PLAN IF REQUIRED BY SUBSECTION (1) OF THIS SECTION, THE DEPARTMENT SHALL ISSUE A WARNING TO THE HOSPITAL. IF THE HOSPITAL REFUSES TO PARTICIPATE IN THE STANDARDIZED PLAN AFTER RECEIPT OF THE WARNING, THE DEPARTMENT:

(I) SHALL FINE THE HOSPITAL UP TO TEN THOUSAND DOLLARS PER DAY FOR THE FIRST THIRTY DAYS THAT THE HOSPITAL REFUSES TO PARTICIPATE AND UP TO FORTY THOUSAND DOLLARS PER DAY FOR EACH DAY OVER THIRTY DAYS THAT THE HOSPITAL REFUSES TO PARTICIPATE; AND

(II) MAY SUSPEND, REVOKE, OR IMPOSE CONDITIONS ON THE HOSPITAL'S LICENSE.

(b) IN DETERMINING THE APPROPRIATE PENALTY, THE DEPARTMENT SHALL CONSIDER ANY PENALTIES RECOMMENDED BY THE COMMISSIONER OF INSURANCE, THE HOSPITAL'S FINANCIAL CIRCUMSTANCES, AND OTHER CIRCUMSTANCES DEEMED RELEVANT BY THE DEPARTMENT.

SECTION 7. In Colorado Revised Statutes, **add** 25.5-1-131 as follows:

25.5-1-131. Insurance ombudsman - consumer advocate - duties. (1) THERE IS HEREBY CREATED IN THE STATE DEPARTMENT THE OFFICE OF THE INSURANCE OMBUDSMAN TO ACT AS THE ADVOCATE FOR CONSUMER INTERESTS IN MATTERS RELATED TO ACCESS TO AND THE AFFORDABILITY OF THE STANDARDIZED HEALTH BENEFIT PLAN CREATED PURSUANT TO SECTION 10-16-1304. THE OMBUDSMAN SHALL:

(a) INTERACT WITH CONSUMERS REGARDING THEIR ACCESS TO, THE AFFORDABILITY OF, AND COVERAGE ISSUES WITH THE STANDARDIZED PLAN;

(b) EVALUATE DATA TO ASSESS THE STANDARDIZED PLAN'S NETWORK AND AFFORDABILITY; AND

(c) REPRESENT THE INTERESTS OF CONSUMERS IN PUBLIC HEARINGS HELD PURSUANT TO SECTION 10-16-1306.

(2) IN THE PERFORMANCE OF THE OMBUDSMAN'S DUTIES, THE OMBUDSMAN SHALL ACT INDEPENDENTLY OF THE STATE DEPARTMENT. ANY RECOMMENDATIONS MADE OR POSITIONS TAKEN BY THE OMBUDSMAN DO NOT REFLECT THOSE OF THE STATE DEPARTMENT.

SECTION 8. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, or safety.".

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