

**First Regular Session
Seventy-third General Assembly
STATE OF COLORADO**

PREAMENDED

*This Unofficial Version Includes Committee
Amendments Not Yet Adopted on Second Reading*

LLS NO. 21-0050.02 Kristen Forrestal x4217

HOUSE BILL 21-1232

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A BILL FOR AN ACT

101 **CONCERNING THE ESTABLISHMENT OF A STANDARDIZED HEALTH**
102 **BENEFIT PLAN TO BE OFFERED IN COLORADO, AND, IN**
103 **CONNECTION THEREWITH, MAKING AN APPROPRIATION.**

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://leg.colorado.gov>.)

The bill requires the commissioner of insurance (commissioner) in the department of regulatory agencies to establish a standardized health benefit plan (standardized plan) by rule to be offered by health insurance carriers (carriers) in the individual and small group markets. The standardized plan must:

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters or bold & italic numbers indicate new material to be added to existing statute.
Dashes through the words indicate deletions from existing statute.

- Offer health-care coverage at the bronze, silver, and gold levels;
- Be offered through the Colorado health benefit exchange;
- Be a standardized benefit design created through a stakeholder engagement process;
- Provide first-dollar, predictable coverage for certain high value services; and
- Comply with state and federal law.

Beginning January 1, 2023, and each year thereafter, the bill encourages carriers that offer:

- An individual health benefit plan in Colorado to offer the standardized plan in the individual market; and
- A small group health benefit plan in Colorado to offer the standardized plan in the small group market.

For 2023, each carrier shall set a goal of offering a standardized plan premium that is at least 10% less than the premium rate for health benefit plans offered by that carrier in the 2021 calendar year in the individual and small group market. For 2024, each carrier shall set a goal of offering a standardized plan premium that is at least 20% less than the premium rate for health benefit plans offered by that carrier in the 2021 calendar year in the individual and small group market. For 2025 and each year thereafter, carriers are encouraged to limit annual premium rate increases for the standardized plan to no more than the consumer price index plus one percent, relative to the previous year.

The Colorado option authority (authority) is created for the purpose of operating as a carrier to offer the standardized plan as the Colorado option if the carriers do not meet the established premium rate goals. The authority shall operate as a nonprofit, unincorporated public entity. The authority is required to implement a provider fee schedule as established by the commissioner in consultation with the executive director of the department of health care policy and financing. Health-care providers and health facilities are required to accept consumers who are enrolled in any health benefit plan offered by the authority.

The bill creates an advisory committee to make recommendations to the authority concerning the development, implementation, and operation of the authority.

The commissioner is required to apply to the secretary of the United States department of health and human services for a waiver and include a request for a pass-through of federal funding to capture savings as a result of the implementation of the standardized plan. The commissioner is required to disapprove of a rate filing submitted by a carrier if the rate filing reflects a cost shift between the standardized plan and the health benefit plan for which rate approval is being sought.

The bill makes the failure to accept consumers who are covered

through the Colorado option or the balance billing of a patient in violation of this bill grounds for discipline under specified practice acts.

The bill repeals the authority and its functions if the United States congress establishes a national public option program that meets or exceeds the premium rate goals set forth in and health-care coverage pursuant to this bill.

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

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

PART 13

COLORADO STANDARDIZED HEALTH BENEFIT PLAN

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

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

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

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

(c) ALTHOUGH GREAT STRIDES HAVE BEEN MADE IN INCREASING ACCESS TO HEALTH-CARE COVERAGE THROUGH FEDERAL AND STATE LEGISLATION, NOT ENOUGH HAS BEEN ACCOMPLISHED TO ADDRESS THE AFFORDABILITY OF HEALTH INSURANCE IN COLORADO, PARTICULARLY IN

1 THE STATE'S RURAL AREAS AND FOR COLORADANS WHO HAVE
2 HISTORICALLY AND SYSTEMICALLY FACED BARRIERS TO HEALTH,
3 INCLUDING PEOPLE OF COLOR, IMMIGRANTS, AND COLORADANS WITH LOW
4 INCOMES;

5 (d) THE HEALTH-CARE SYSTEM IS A COMPLEX SYSTEM WHEREIN
6 CONSUMERS RELY ON HEALTH INSURANCE CARRIERS TO NEGOTIATE THE
7 RATES PAID TO HEALTH-CARE PROVIDERS, PHARMACEUTICAL COMPANIES,
8 AND HOSPITALS FOR SERVICES PROVIDED AND EXPECT THAT THE
9 NEGOTIATED RATES ARE CLOSELY TIED TO THE AMOUNT OF THE HEALTH
10 INSURANCE PREMIUMS PAID;

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

15 (f) IN ORDER TO ENSURE THAT HEALTH INSURANCE IS AFFORDABLE
16 FOR COLORADANS, IT IS CRITICAL THAT THE STATE ESTABLISH A
17 STANDARDIZED PLAN FOR CARRIERS TO OFFER IN THE STATE AND SET
18 PREMIUM REDUCTION TARGETS FOR CARRIERS TO ACHIEVE.

19 **10-16-1303. Definitions.** AS USED IN THIS PART 13, UNLESS THE
20 CONTEXT OTHERWISE REQUIRES:

21 (1) "ADVISORY BOARD" MEANS THE BOARD ESTABLISHED IN
22 SECTION 10-16-1307.

23 (2) "CRITICAL ACCESS HOSPITAL" MEANS A HOSPITAL THAT IS
24 FEDERALLY CERTIFIED OR UNDERGOING FEDERAL CERTIFICATION AS A
25 CRITICAL ACCESS HOSPITAL PURSUANT TO 42 CFR 485, SUBPART F.

26 (3) "ESSENTIAL ACCESS HOSPITAL" MEANS A CRITICAL ACCESS
27 HOSPITAL OR GENERAL HOSPITAL LOCATED IN A RURAL AREA WITH

1 TWENTY-FIVE OR FEWER LICENSED BEDS.

2 (4) "ESSENTIAL COMMUNITY PROVIDER" HAS THE SAME MEANING
3 AS SET FORTH IN SECTION 25.5-8-103 (6).

4 (5) "GENERAL HOSPITAL" MEANS A HOSPITAL LICENSED AS A
5 GENERAL HOSPITAL BY THE COLORADO DEPARTMENT OF PUBLIC HEALTH
6 AND ENVIRONMENT.

7 (6) "HEALTH-CARE COVERAGE COOPERATIVE" HAS THE SAME
8 MEANING AS SET FORTH IN SECTION 10-16-1002 (2).

9 (7) "HEALTH-CARE PROVIDER" MEANS A HEALTH-CARE
10 PROFESSIONAL REGISTERED, CERTIFIED, OR LICENSED PURSUANT TO TITLE
11 12 OR A HEALTH FACILITY LICENSED OR CERTIFIED PURSUANT TO SECTION
12 25-1.5-103.

13 (8) "HEALTH SYSTEM" MEANS A CORPORATION OR OTHER
14 ORGANIZATION THAT OWNS, CONTAINS, OR OPERATES THREE OR MORE
15 HOSPITALS.

16 (9) "MEDICAL INFLATION" MEANS THE ANNUAL PERCENTAGE
17 CHANGE IN THE MEDICAL CARE INDEX COMPONENT OF THE UNITED STATES
18 DEPARTMENT OF LABOR'S BUREAU OF LABOR STATISTICS CONSUMER PRICE
19 INDEX FOR MEDICAL CARE SERVICES AND MEDICAL CARE COMMODITIES,
20 OR ITS APPLICABLE PREDECESSOR OR SUCCESSOR INDEX, BASED ON THE
21 AVERAGE CHANGE IN THE MEDICAL CARE INDEX OVER THE PREVIOUS TEN
22 YEARS.

23 (10) (a) "MEDICARE REIMBURSEMENT RATE" MEANS THE
24 FACILITY-SPECIFIC REIMBURSEMENT RATE FOR A PARTICULAR
25 HEALTH-CARE SERVICE PROVIDED UNDER THE "HEALTH INSURANCE FOR
26 THE AGED ACT", TITLE XVIII OF THE FEDERAL "SOCIAL SECURITY ACT",
27 42 U.S.C. SEC. 1395 ET SEQ., AS AMENDED.

1 (b) FOR A HOSPITAL THAT IS REIMBURSED THROUGH THE MEDICARE
2 PROSPECTIVE PAYMENTS SYSTEMS RATE FOR A CRITICAL ACCESS HOSPITAL,
3 "MEDICARE REIMBURSEMENT RATE" MEANS THE RATE BASED ON
4 ALLOWABLE COSTS AS REPORTED IN MEDICARE COST REPORTS AND THE
5 HISTORICAL COST-TO-CHARGE RATIOS FOR THE SPECIFIC HOSPITAL.

6 (11) "PUBLIC BENEFIT CORPORATION" MEANS A PUBLIC BENEFIT
7 CORPORATION FORMED PURSUANT TO PART 5 OF ARTICLE 101 OF TITLE 7
8 THAT MAY BE ORGANIZED AND OPERATED BY THE EXCHANGE PURSUANT
9 TO SECTION 10-22-106 (3).

10 (12) "SMALL GROUP MARKET" MEANS THE MARKET FOR SMALL
11 GROUP SICKNESS AND ACCIDENT INSURANCE.

12 (13) "STANDARDIZED PLAN" MEANS THE STANDARDIZED HEALTH
13 BENEFIT PLAN DESIGNED BY RULE OF THE COMMISSIONER PURSUANT TO
14 SECTION 10-16-1304.

15 **10-16-1304. Standardized health benefit plan - established -**
16 **components - rules - independent analysis - repeal.** (1) ON OR BEFORE
17 JANUARY 1, 2022, THE COMMISSIONER SHALL ESTABLISH, BY RULE, A
18 STANDARDIZED HEALTH BENEFIT PLAN TO BE OFFERED BY CARRIERS IN
19 THIS STATE IN THE INDIVIDUAL AND SMALL GROUP MARKETS. THE
20 STANDARDIZED PLAN MUST:

21 (a) OFFER HEALTH-CARE COVERAGE AT THE BRONZE, SILVER, AND
22 GOLD LEVELS OF COVERAGE AS DESCRIBED IN SECTION 10-16-103.4;

23 (b) INCLUDE, AT A MINIMUM, PEDIATRIC AND OTHER ESSENTIAL
24 HEALTH BENEFITS;

25 (c) BE OFFERED THROUGH THE EXCHANGE AND IN THE INDIVIDUAL
26 MARKET THROUGH THE PUBLIC BENEFIT CORPORATION;

27 (d) BE A STANDARDIZED BENEFIT DESIGN THAT:

1 (I) IS CREATED THROUGH A STAKEHOLDER ENGAGEMENT PROCESS
2 THAT INCLUDES PHYSICIANS, HEALTH-CARE INDUSTRY AND CONSUMER
3 REPRESENTATIVES, INDIVIDUALS WHO REPRESENT HEALTH-CARE WORKERS
4 OR WHO WORK IN HEALTH CARE, AND INDIVIDUALS WORKING IN OR
5 REPRESENTING COMMUNITIES THAT ARE DIVERSE WITH REGARD TO RACE,
6 ETHNICITY, IMMIGRATION STATUS, AGE, ABILITY, SEXUAL ORIENTATION,
7 GENDER IDENTITY, OR GEOGRAPHIC REGIONS OF THE STATE AND THAT ARE
8 AFFECTED BY HIGHER RATES OF HEALTH DISPARITIES AND INEQUITIES;

9 (II) HAS A DEFINED BENEFIT DESIGN AND COST-SHARING THAT
10 IMPROVES ACCESS AND AFFORDABILITY; AND

11 (III) IS DESIGNED TO IMPROVE RACIAL HEALTH EQUITY AND
12 DECREASE RACIAL HEALTH DISPARITIES THROUGH A VARIETY OF MEANS,
13 WHICH ARE IDENTIFIED COLLABORATIVELY WITH CONSUMER
14 STAKEHOLDERS, INCLUDING:

15 (A) IMPROVING PERINATAL HEALTH-CARE COVERAGE; AND

16 (B) PROVIDING FIRST-DOLLAR, PREDEDUCTIBLE COVERAGE FOR
17 CERTAIN HIGH-VALUE SERVICES, SUCH AS PRIMARY AND BEHAVIORAL
18 HEALTH CARE;

19 (e) BE ACTUARIALLY SOUND AND ALLOW A CARRIER TO CONTINUE
20 TO MEET THE FINANCIAL REQUIREMENTS IN ARTICLE 3 OF THIS TITLE 10;

21 (f) COMPLY WITH THE FEDERAL ACT, INCLUDING THE RISK
22 ADJUSTMENT REQUIREMENTS UNDER 45 CFR 153, AND THIS ARTICLE 16;
23 AND

24 (g) HAVE A NETWORK THAT IS:

25 (I) CULTURALLY RESPONSIVE AND, TO THE GREATEST EXTENT
26 POSSIBLE, REFLECTS THE DIVERSITY OF ITS ENROLLEES IN TERMS OF RACE,
27 ETHNICITY, GENDER IDENTITY, AND SEXUAL ORIENTATION IN THE AREA

1 THAT THE NETWORK EXISTS; AND

2 (II) NO MORE NARROW THAN THE MOST RESTRICTIVE NETWORK

3 THE CARRIER IS OFFERING FOR NONSTANDARDIZED PLANS IN THE

4 INDIVIDUAL MARKET FOR THE METAL TIER FOR THAT RATING AREA.

5 (2) (a) IN DEVELOPING THE NETWORK FOR THE STANDARDIZED

6 PLAN PURSUANT TO SUBSECTION (1)(g) OF THIS SECTION, EACH CARRIER

7 SHALL:

8 (I) INCLUDE AS PART OF ITS NETWORK ACCESS PLAN A DESCRIPTION

9 OF THE CARRIER'S EFFORTS TO CONSTRUCT DIVERSE, CULTURALLY

10 RESPONSIVE NETWORKS THAT ARE WELL-POSITIONED TO ADDRESS HEALTH

11 EQUITY AND REDUCE HEALTH DISPARITIES; AND

12 (II) INCLUDE A MAJORITY OF THE ESSENTIAL COMMUNITY

13 PROVIDERS IN THE SERVICE AREA IN ITS NETWORK.

14 (b) IF A CARRIER IS UNABLE TO ACHIEVE THE NETWORK ADEQUACY

15 REQUIREMENTS IN SUBSECTION (1)(g) OF THIS SECTION, THE CARRIER

16 SHALL FILE AN ACTION PLAN WITH THE DIVISION THAT DESCRIBES THE

17 CARRIER'S EFFORTS TO ACHIEVE THE REQUIREMENTS IN SUBSECTION (1)(g)

18 OF THIS SECTION.

19 (c) THE COMMISSIONER SHALL PROMULGATE RULES REGARDING

20 THE NETWORK ADEQUACY REQUIREMENTS IN SUBSECTION (1)(g) OF THIS

21 SECTION AND THE ACTION PLAN IN SUBSECTION (2)(b) OF THIS SECTION.

22 (3) THE STANDARDIZED PLAN MUST BE OFFERED IN A MANNER

23 THAT ALLOWS CONSUMERS TO EASILY COMPARE THE STANDARDIZED

24 PLANS OFFERED BY EACH CARRIER.

25 (4) THE COMMISSIONER MAY UPDATE THE STANDARDIZED PLAN

26 ANNUALLY BY RULE THROUGH THE STAKEHOLDER PROCESS DESCRIBED IN

27 SUBSECTION (1)(d)(I) OF THIS SECTION.

1 (5) THE COMMISSIONER SHALL CONTRACT WITH AN INDEPENDENT
2 THIRD PARTY TO CONDUCT AN ANALYSIS OF THE IMPACT OF THIS SECTION
3 ON HEALTH PLAN ENROLLMENT, HEALTH INSURANCE AFFORDABILITY, AND
4 HEALTH EQUITY. TO THE EXTENT AVAILABLE, THE ANALYSIS MUST
5 INCLUDE DISAGGREGATED DATA BY RACE, ETHNICITY, IMMIGRATION
6 STATUS, SEXUAL ORIENTATION, GENDER IDENTITY, AGE, AND ABILITY. IF
7 THE DATA IS NOT AVAILABLE, THE ANALYSIS MUST NOTE SUCH
8 UNAVAILABILITY. THE ANALYSIS MUST INCLUDE INFORMATION
9 CONCERNING TOTAL OUT-OF-POCKET HEALTH-CARE SPENDING. THE
10 ANALYSIS MUST BE COMPLETED ON OR BEFORE JANUARY 1, 2026.

11 (6) (a) THE COMMISSIONER SHALL COLLABORATE WITH THE
12 EXCHANGE CONCERNING THE SURVEY REQUIRED IN SECTION 10-22-114,
13 WHICH SURVEY ADDRESSES CONSUMERS' EXPERIENCE.

14 (b) THIS SUBSECTION (6) IS REPEALED, EFFECTIVE JULY 1, 2026.

15 (7) THE COMMISSIONER IS NOT REQUIRED TO COMPLY WITH THE
16 "PROCUREMENT CODE", ARTICLES 101 TO 112 OF TITLE 24, FOR THE
17 PURPOSES OF THIS SECTION.

18 **10-16-1305. Standardized health benefit plan - carriers**
19 **required to offer - premium rates - rules.** (1) BEGINNING JANUARY 1,
20 2023, A CARRIER THAT OFFERS:

21 (a) AN INDIVIDUAL HEALTH BENEFIT PLAN IN COLORADO IS
22 REQUIRED TO OFFER THE STANDARDIZED PLAN IN THE INDIVIDUAL MARKET
23 IN EACH COUNTY WHERE THE CARRIER OFFERS AN INDIVIDUAL HEALTH
24 BENEFIT PLAN AND SHALL OFFER THE STANDARDIZED PLAN THROUGHOUT
25 THE ENTIRE COUNTY; AND

26 (b) A SMALL GROUP HEALTH BENEFIT PLAN IN COLORADO IS
27 REQUIRED TO OFFER THE STANDARDIZED PLAN IN THE SMALL GROUP

1 MARKET IN EACH COUNTY WHERE THE CARRIER OFFERS A SMALL GROUP
2 HEALTH BENEFIT PLAN AND SHALL OFFER THE STANDARDIZED PLAN
3 THROUGHOUT THE ENTIRE COUNTY.

4 (2) (a) (I) IN THE INDIVIDUAL MARKET, FOR THE PLAN YEAR
5 BEGINNING JANUARY 1, 2023, AND IN THE SMALL GROUP MARKET,
6 BEGINNING JANUARY 1, 2023, EACH CARRIER SHALL OFFER THE
7 STANDARDIZED PLAN AT A PREMIUM RATE THAT IS AT LEAST SIX PERCENT
8 LESS THAN THE PREMIUM RATE FOR HEALTH BENEFIT PLANS THAT THE
9 CARRIER OFFERED IN THE 2021 CALENDAR YEAR, AS ADJUSTED FOR
10 MEDICAL INFLATION, IN THE INDIVIDUAL AND SMALL GROUP MARKETS.
11 THE COMMISSIONER SHALL CALCULATE THE PREMIUM RATE REDUCTION
12 BASED ON THE RATES CHARGED IN THE SAME COUNTY IN WHICH THE
13 CARRIER OFFERED HEALTH BENEFIT PLANS IN THE INDIVIDUAL AND SMALL
14 GROUP MARKETS IN 2021 PRIOR TO THE APPLICATION OF THE COLORADO
15 REINSURANCE PROGRAM PURSUANT TO PART 11 OF THIS ARTICLE 16.

16 (II) FOR CARRIERS OFFERING THE STANDARDIZED PLAN IN THE
17 2023 PLAN YEAR IN A COUNTY IN WHICH THE CARRIER DID NOT OFFER A
18 HEALTH BENEFIT PLAN IN THE INDIVIDUAL OR SMALL GROUP MARKET IN
19 THE 2021 CALENDAR YEAR, EACH CARRIER THAT OFFERS THE
20 STANDARDIZED PLAN SHALL OFFER THE STANDARDIZED PLAN:

21 (A) IN THE INDIVIDUAL MARKET AT A PREMIUM RATE THAT IS AT
22 LEAST SIX PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR
23 INDIVIDUAL HEALTH BENEFIT PLANS OFFERED IN THAT COUNTY IN 2021,
24 CALCULATED BASED ON THE AVERAGE PREMIUM RATE FOR INDIVIDUAL
25 HEALTH BENEFIT PLANS OFFERED IN THAT COUNTY, AS ADJUSTED FOR
26 MEDICAL INFLATION, PRIOR TO THE APPLICATION OF THE COLORADO
27 REINSURANCE PROGRAM PURSUANT TO PART 11 OF THIS ARTICLE 16; AND

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

5 (b) (I) IN THE INDIVIDUAL MARKET, FOR THE PLAN YEAR
6 BEGINNING JANUARY 1, 2024, AND IN THE SMALL GROUP MARKET,
7 BEGINNING JANUARY 1, 2024, EACH CARRIER SHALL OFFER THE
8 STANDARDIZED PLAN AT A PREMIUM RATE THAT IS AT LEAST TWELVE
9 PERCENT LESS THAN THE PREMIUM RATE FOR HEALTH BENEFIT PLANS THAT
10 THE CARRIER OFFERED IN THE 2021 CALENDAR YEAR, AS ADJUSTED FOR
11 MEDICAL INFLATION, IN THE INDIVIDUAL AND SMALL GROUP MARKETS.
12 THE COMMISSIONER SHALL CALCULATE THE PREMIUM RATE REDUCTION
13 BASED ON THE RATES CHARGED IN THE SAME COUNTY IN WHICH THE
14 CARRIER OFFERED HEALTH BENEFIT PLANS IN THE INDIVIDUAL AND SMALL
15 GROUP MARKETS IN 2021 PRIOR TO THE APPLICATION OF THE COLORADO
16 REINSURANCE PROGRAM PURSUANT TO PART 11 OF THIS ARTICLE 16.

17 (II) FOR CARRIERS OFFERING THE STANDARDIZED PLAN IN THE
18 2024 PLAN YEAR IN A COUNTY IN WHICH THE CARRIER DID NOT OFFER A
19 HEALTH BENEFIT PLAN IN THE INDIVIDUAL OR SMALL GROUP MARKET IN
20 THE 2021 CALENDAR YEAR, EACH CARRIER THAT OFFERS THE
21 STANDARDIZED PLAN SHALL OFFER THE STANDARDIZED PLAN:

22 (A) IN THE INDIVIDUAL MARKET AT A PREMIUM RATE THAT IS AT
23 LEAST TWELVE PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR
24 INDIVIDUAL PLANS OFFERED IN THAT COUNTY IN 2021, CALCULATED
25 BASED ON THE AVERAGE PREMIUM RATE FOR INDIVIDUAL PLANS OFFERED
26 IN THAT COUNTY, AS ADJUSTED FOR MEDICAL INFLATION, PRIOR TO THE
27 APPLICATION OF THE COLORADO REINSURANCE PROGRAM PURSUANT TO

1 PART 11 OF THIS ARTICLE 16; AND

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

6 (c) (I) IN THE INDIVIDUAL MARKET, FOR THE PLAN YEAR
7 BEGINNING JANUARY 1, 2025, AND IN THE SMALL GROUP MARKET,
8 BEGINNING JANUARY 1, 2025, EACH CARRIER SHALL OFFER THE
9 STANDARDIZED PLAN AT A PREMIUM RATE THAT IS AT LEAST EIGHTEEN
10 PERCENT LESS THAN THE PREMIUM RATE FOR HEALTH BENEFIT PLANS THAT
11 THE CARRIER OFFERED IN THE 2021 CALENDAR YEAR, AS ADJUSTED FOR
12 MEDICAL INFLATION, IN THE INDIVIDUAL AND SMALL GROUP MARKETS.
13 THE COMMISSIONER SHALL CALCULATE THE PREMIUM RATE REDUCTION
14 BASED ON THE RATES CHARGED IN THE SAME COUNTY IN WHICH THE
15 CARRIER OFFERED HEALTH BENEFIT PLANS IN THE INDIVIDUAL AND SMALL
16 GROUP MARKETS IN 2021 PRIOR TO THE APPLICATION OF THE COLORADO
17 REINSURANCE PROGRAM PURSUANT TO PART 11 OF THIS ARTICLE 16.

18 (II) FOR CARRIERS OFFERING THE STANDARDIZED PLAN IN THE
19 2025 PLAN YEAR IN A COUNTY IN WHICH THE CARRIER DID NOT OFFER A
20 HEALTH BENEFIT PLAN IN THE INDIVIDUAL OR SMALL GROUP MARKET IN
21 THE 2021 CALENDAR YEAR, EACH CARRIER THAT OFFERS THE
22 STANDARDIZED PLAN SHALL OFFER THE STANDARDIZED PLAN:

23 (A) IN THE INDIVIDUAL MARKET AT A PREMIUM RATE THAT IS AT
24 LEAST EIGHTEEN PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR
25 INDIVIDUAL PLANS OFFERED IN THAT COUNTY IN 2021, CALCULATED
26 BASED ON THE AVERAGE PREMIUM RATE FOR INDIVIDUAL PLANS OFFERED
27 IN THAT COUNTY, AS ADJUSTED FOR MEDICAL INFLATION, PRIOR TO THE

1 APPLICATION OF THE COLORADO REINSURANCE PROGRAM PURSUANT TO
2 PART 11 OF THIS ARTICLE 16; AND

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

7 (d) FOR THE PLAN YEAR BEGINNING ON OR AFTER JANUARY 1,
8 2026, AND EACH YEAR THEREAFTER, EACH CARRIER AND HEALTH-CARE
9 COVERAGE COOPERATIVE SHALL LIMIT ANY ANNUAL PERCENTAGE
10 INCREASE IN THE PREMIUM RATE FOR THE STANDARDIZED PLAN IN BOTH
11 THE INDIVIDUAL AND SMALL GROUP MARKETS TO A RATE THAT IS NO MORE
12 THAN MEDICAL INFLATION, RELATIVE TO THE PREVIOUS YEAR.

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

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

23 **10-16-1306. Rate filings - failure to meet premium**
24 **requirements - notice - public hearing.** (1) (a) IN THE RATE FILINGS
25 REQUIRED PURSUANT TO SECTION 10-16-107, EACH CARRIER MUST FILE
26 RATES FOR THE STANDARDIZED PLAN AT THE PREMIUM RATES REQUIRED
27 IN SECTION 10-16-1305 (2).

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

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

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

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

22 (3) (a) IF, ON OR AFTER JANUARY 1, 2023, AND PURSUANT TO
23 SUBSECTION (2) OF THIS SECTION, A CARRIER NOTIFIES THE COMMISSIONER
24 THAT THE CARRIER IS UNABLE TO OFFER THE STANDARDIZED PLAN AT THE
25 PREMIUM RATE REQUIRED IN SECTION 10-16-1305 (2) OR THE
26 COMMISSIONER OTHERWISE DETERMINES, WITH SUPPORT FROM AN
27 INDEPENDENT ACTUARY AND BASED ON A REVIEW OF THE RATE AND FORM

1 FILINGS, THAT A CARRIER HAS NOT MET THE PREMIUM RATE
2 REQUIREMENTS IN SECTION 10-16-1305 (2) OR THE NETWORK ADEQUACY
3 REQUIREMENTS, THE DIVISION SHALL HOLD A PUBLIC HEARING PRIOR TO
4 THE APPROVAL OF THE CARRIER'S FINAL RATES; EXCEPT THAT, FOR THE
5 PURPOSES OF HOLDING A PUBLIC HEARING, IF A CARRIER DOES NOT MEET
6 THE NETWORK ADEQUACY REQUIREMENTS IN SECTION 10-16-1304 (1)(g),
7 THE COMMISSIONER SHALL CONSIDER A CARRIER TO HAVE MET NETWORK
8 ADEQUACY REQUIREMENTS IF THE CARRIER FILES THE ACTION PLAN
9 REQUIRED IN SECTION 10-16-1304 (2)(b).

10 (b) INFORMATION SUBMITTED BY A PARTY FOR PURPOSES OF A
11 PUBLIC HEARING HELD PURSUANT TO SUBSECTION (3)(a) OF THIS SECTION
12 IS SUBJECT TO THE "COLORADO OPEN RECORDS ACT", PART 2 OF ARTICLE
13 72 OF TITLE 24.

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

26 (d) THE OFFICE OF THE INSURANCE OMBUDSMAN ESTABLISHED IN
27 SECTION 25.5-1-131 SHALL PARTICIPATE IN THE PUBLIC HEARINGS AND

1 REPRESENT THE INTERESTS OF CONSUMERS.

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

5 (a) (I) ESTABLISH CARRIER REIMBURSEMENT RATES UNDER THE
6 STANDARDIZED PLAN FOR HOSPITAL SERVICES, IF NECESSARY, TO MEET
7 NETWORK ADEQUACY REQUIREMENTS OR THE PREMIUM RATE
8 REQUIREMENTS IN SECTION 10-16-1305.

9 (II) THE BASE REIMBURSEMENT RATE FOR HOSPITAL SERVICES
10 SHALL NOT BE LESS THAN ONE HUNDRED FIFTY-FIVE PERCENT OF THE
11 HOSPITAL'S MEDICARE REIMBURSEMENT RATE OR EQUIVALENT RATE.

12 (III) A HOSPITAL THAT IS AN ESSENTIAL ACCESS HOSPITAL OR THAT
13 IS INDEPENDENT AND NOT PART OF A HEALTH SYSTEM MUST RECEIVE A
14 TWENTY-PERCENTAGE-POINT INCREASE IN THE BASE REIMBURSEMENT
15 RATE.

16 (IV) A HOSPITAL THAT IS AN ESSENTIAL ACCESS HOSPITAL THAT IS
17 NOT PART OF A HEALTH SYSTEM MUST RECEIVE A
18 FORTY-PERCENTAGE-POINT INCREASE IN THE BASE REIMBURSEMENT RATE.

19 (V) A HOSPITAL WITH A COMBINED PERCENTAGE OF PATIENTS WHO
20 RECEIVE SERVICES THROUGH PROGRAMS ESTABLISHED THROUGH THE
21 "COLORADO MEDICAL ASSISTANCE ACT", ARTICLES 4 TO 6 OF TITLE 25.5,
22 OR MEDICARE, TITLE XVIII OF THE FEDERAL "SOCIAL SECURITY ACT", AS
23 AMENDED, THAT EXCEEDS THE STATEWIDE AVERAGE MUST RECEIVE UP TO
24 A THIRTY-PERCENTAGE-POINT INCREASE IN ITS BASE REIMBURSEMENT
25 RATE, WITH THE ACTUAL INCREASE TO BE DETERMINED BASED ON THE
26 HOSPITAL'S PERCENTAGE SHARE OF SUCH PATIENTS.

27 (VI) A HOSPITAL THAT IS EFFICIENT IN MANAGING THE

1 UNDERLYING COST OF CARE AS DETERMINED BY THE HOSPITAL'S TOTAL
2 MARGINS, OPERATING COSTS, AND NET PATIENT REVENUE MUST RECEIVE
3 UP TO A FORTY-PERCENTAGE-POINT INCREASE IN ITS BASE
4 REIMBURSEMENT RATE.

5 (VII) NOTWITHSTANDING SUBSECTIONS (4)(a)(III) TO (4)(a)(VI)
6 OF THIS SECTION, IN DETERMINING THE REIMBURSEMENT RATES FOR
7 HOSPITALS, THE COMMISSIONER MAY CONSULT WITH EMPLOYEE
8 MEMBERSHIP ORGANIZATIONS REPRESENTING HEALTH-CARE PROVIDERS'
9 EMPLOYEES IN COLORADO AND WITH HOSPITAL-BASED HEALTH-CARE
10 PROVIDERS IN COLORADO, AND SHALL TAKE INTO ACCOUNT THE COST OF
11 ADEQUATE WAGES, BENEFITS, STAFFING, AND TRAINING FOR HEALTH-CARE
12 EMPLOYEES TO PROVIDE CONTINUOUS QUALITY CARE.

13 (b) ESTABLISH REIMBURSEMENT RATES UNDER THE STANDARDIZED
14 PLAN, IF NECESSARY, FOR HEALTH-CARE PROVIDERS FOR CATEGORIES OF
15 SERVICES WITHIN THE GEOGRAPHIC SERVICE AREA FOR THE STANDARDIZED
16 PLAN TO MEET NETWORK ADEQUACY REQUIREMENTS OR THE PREMIUM
17 RATE REQUIREMENTS IN SECTION 10-16-1305 (2), WHICH RATES MAY NOT
18 BE LESS THAN ONE HUNDRED THIRTY-FIVE PERCENT OF THE MEDICARE
19 REIMBURSEMENT RATES WITHIN THE APPLICABLE GEOGRAPHIC REGION FOR
20 THE SAME SERVICES;

21 (c) REQUIRE HOSPITALS THAT ARE LICENSED PURSUANT TO
22 SECTION 25-1.5-103 TO ACCEPT THE REIMBURSEMENT RATES ESTABLISHED
23 PURSUANT TO SUBSECTION (4)(a) OF THIS SECTION IF NECESSARY TO
24 ENSURE THE STANDARDIZED PLAN MEETS THE PREMIUM RATE
25 REQUIREMENTS AND THE NETWORK ADEQUACY REQUIREMENTS;

26 (d) (I) REQUIRE HEALTH-CARE PROVIDERS TO ACCEPT THE
27 REIMBURSEMENT RATES ESTABLISHED PURSUANT TO SUBSECTION (4)(b)

1 OF THIS SECTION, IF NECESSARY, TO ENSURE THE STANDARDIZED PLAN
2 MEETS THE PREMIUM RATE REQUIREMENTS AND THE NETWORK ADEQUACY
3 REQUIREMENTS.

4 (II) THE COMMISSIONER SHALL NOT REQUIRE A HEALTH-CARE
5 PROVIDER, OTHER THAN A HOSPITAL THAT PROVIDES A MAJORITY OF
6 COVERED PROFESSIONAL SERVICES THROUGH A SINGLE, CONTRACTED
7 MEDICAL GROUP FOR A NONPROFIT, NONGOVERNMENTAL HEALTH
8 MAINTENANCE ORGANIZATION, TO CONTRACT WITH ANY OTHER CARRIER;
9 AND

10 (e) REQUIRE THE CARRIER TO OFFER THE STANDARDIZED PLAN IN
11 SPECIFIC COUNTIES WHERE NO CARRIER IS OFFERING THE STANDARDIZED
12 PLAN IN THAT PLAN YEAR IN EITHER THE INDIVIDUAL OR SMALL GROUP
13 MARKET. IN DETERMINING WHETHER THE CARRIER IS REQUIRED TO OFFER
14 THE STANDARDIZED PLAN IN A SPECIFIC COUNTY, THE COMMISSIONER
15 SHALL CONSIDER:

16 (I) THE CARRIER'S STRUCTURE, THE NUMBER OF COVERED LIVES
17 THE CARRIER HAS IN ALL LINES OF BUSINESS IN EACH COUNTY, AND THE
18 CARRIER'S EXISTING SERVICE AREAS; AND

19 (II) ALTERNATIVE HEALTH-CARE COVERAGE AVAILABLE IN EACH
20 COUNTY, INCLUDING HEALTH-CARE COVERAGE COOPERATIVES.

21 (5) A CARRIER OR HEALTH-CARE PROVIDER MAY APPEAL A
22 DECISION BY THE COMMISSIONER MADE PURSUANT TO SUBSECTION (4) OF
23 THIS SECTION TO THE DISTRICT COURT IN THE APPLICABLE JURISDICTION.
24 THE DECISION OF THE COMMISSIONER IS A FINAL AGENCY ACTION SUBJECT
25 TO JUDICIAL REVIEW PURSUANT TO SECTION 24-4-106 (6).

26 (6) NOTWITHSTANDING SUBSECTION (4) OF THIS SECTION, THE
27 COMMISSIONER SHALL NOT SET THE REIMBURSEMENT RATES FOR:

1 (a) A HOSPITAL AT LESS THAN ONE HUNDRED SIXTY-FIVE PERCENT
2 OF THE MEDICARE REIMBURSEMENT RATE OR THE EQUIVALENT RATE; AND

3 (b) ANY HOSPITAL FOR ANY PLAN YEAR AT AN AMOUNT THAT IS
4 MORE THAN TWENTY PERCENT LOWER THAN THE RATE NEGOTIATED
5 BETWEEN THE CARRIER AND THE HOSPITAL FOR THE PREVIOUS PLAN YEAR.

6 (7) NOTWITHSTANDING SUBSECTIONS (4) AND (6) OF THIS SECTION,
7 FOR A HOSPITAL WITH A NEGOTIATED REIMBURSEMENT RATE THAT IS
8 LOWER THAN TEN PERCENT OF THE STATEWIDE HOSPITAL MEDIAN
9 REIMBURSEMENT RATE MEASURED AS A PERCENTAGE OF MEDICARE FOR
10 THE 2021 PLAN YEAR USING DATA FROM THE COLORADO ALL-PAYER
11 CLAIMS DATABASE DESCRIBED IN SECTION 25.5-1-204, THE COMMISSIONER
12 SHALL SET THE REIMBURSEMENT RATE FOR THAT HOSPITAL AT NO LESS
13 THAN THE GREATER OF:

14 (a) THE HOSPITAL'S COMMERCIAL REIMBURSEMENT RATE AS A
15 PERCENTAGE OF MEDICARE MINUS ONE-THIRD OF THE DIFFERENCE
16 BETWEEN THE HOSPITAL'S 2021 COMMERCIAL REIMBURSEMENT RATE AS
17 A PERCENTAGE OF MEDICARE AND THE RATE ESTABLISHED BY SUBSECTION
18 (4) OF THIS SECTION;

19 (b) ONE HUNDRED SIXTY-FIVE PERCENT OF THE HOSPITAL'S
20 MEDICARE REIMBURSEMENT RATE OR EQUIVALENT RATE; OR

21 (c) THE RATE ESTABLISHED BY SUBSECTION (4) OF THIS SECTION.

22 (8) FOR THE PURPOSE OF MAKING THE DETERMINATION IN
23 SUBSECTION (3) OF THIS SECTION:

24 (a) A HEALTH-CARE COVERAGE COOPERATIVE, AND A CARRIER
25 OFFERING HEALTH BENEFIT PLANS UNDER AGREEMENT WITH THE
26 HEALTH-CARE COVERAGE COOPERATIVE, THAT HAS OFFERED ONE OR MORE
27 HEALTH BENEFIT PLANS TO PURCHASERS IN THE INDIVIDUAL AND SMALL

1 GROUP MARKETS THAT PREVIOUSLY ACHIEVED AND MAINTAINED AT LEAST
2 AN EIGHTEEN PERCENT REDUCTION IN PREMIUM RATES, REGARDLESS OF
3 THE FIRST YEAR THE HEALTH BENEFIT PLANS WERE OFFERED, SHALL BE
4 DEEMED BY THE COMMISSIONER AS HAVING MET THE REQUIREMENTS FOR
5 CARRIERS IN SECTIONS 10-16-1304 AND 10-16-1305 WITH RESPECT TO THE
6 COUNTIES IN WHICH THE INDIVIDUAL AND SMALL GROUP PLANS ARE BEING
7 OFFERED BY THE HEALTH-CARE COVERAGE COOPERATIVE.

8 (b) THE COMMISSIONER SHALL TAKE INTO ACCOUNT:

9 (I) ANY ACTUARIAL DIFFERENCES BETWEEN THE STANDARDIZED
10 PLAN AND THE HEALTH BENEFIT PLANS THE CARRIER OFFERED IN THE 2021
11 CALENDAR YEAR;

12 (II) ANY CHANGES TO THE STANDARDIZED PLAN; AND

13 (III) STATE OR FEDERAL HEALTH BENEFIT COVERAGE MANDATES
14 IMPLEMENTED AFTER THE 2021 PLAN YEAR.

15 (9) IF THE 1332 WAIVER APPLIED FOR PURSUANT TO SECTION
16 10-16-1308 IS DENIED, SUSPENDED, OR OTHERWISE RESCINDED, THE
17 COMMISSIONER IS REQUIRED TO SET THE PREMIUM RATE REQUIREMENTS
18 TO MAXIMIZE SUBSIDIES FOR COLORADANS.

19 (10) A HOSPITAL OR A HEALTH-CARE PROVIDER IN COLORADO
20 SHALL NOT BALANCE BILL CONSUMERS ENROLLED IN THE STANDARDIZED
21 PLAN AND SHALL ACCEPT THE REIMBURSEMENT RATES ESTABLISHED BY
22 THE COMMISSIONER PURSUANT TO SUBSECTION (4) OF THIS SECTION, IF
23 APPLICABLE, FOR THE SERVICE PROVIDED TO THE CONSUMER.

24 (11) (a) THE COMMISSIONER SHALL ONLY SET REIMBURSEMENT
25 RATES PURSUANT TO THIS SECTION FOR HOSPITALS OR HEALTH-CARE
26 PROVIDERS THAT:

27 (I) PREVENTED A CARRIER FROM MEETING THE PREMIUM RATE

1 REQUIREMENTS FOR A STANDARDIZED PLAN BEING OFFERED IN A SPECIFIC
2 COUNTY; OR

3 (II) CAUSED THE CARRIER TO FAIL TO MEET NETWORK ADEQUACY
4 REQUIREMENTS.

5 (b) THE CARRIER SHALL PROVIDE THE COMMISSIONER WITH
6 REASONABLE INFORMATION NECESSARY TO IDENTIFY WHICH HOSPITALS OR
7 HEALTH-CARE PROVIDERS WERE THE CAUSE OF THE CARRIER'S FAILURE TO
8 MEET THE PREMIUM RATE REQUIREMENTS OR TO MEET NETWORK
9 ADEQUACY REQUIREMENTS.

10 (12) THE COMMISSIONER SHALL NOT USE THE FAILURE OF A
11 CARRIER TO MEET THE PREMIUM RATE REQUIREMENTS FOR THE
12 STANDARDIZED PLAN IN A COUNTY AS A REASON TO DENY PREMIUM RATES
13 FOR A NONSTANDARDIZED PLAN OF A CARRIER IN THAT COUNTY.

14 **10-16-1307. Advisory board - members - rules.** (1) (a) THE
15 COMMISSIONER SHALL CONSULT WITH AN ADVISORY BOARD TO IMPLEMENT
16 THIS PART 13. THE GOVERNOR SHALL APPOINT THE MEMBERS OF THE
17 ADVISORY BOARD ON OR BEFORE JULY 1, 2022, AND SHALL ENSURE THAT
18 THE MEMBERSHIP OF THE ADVISORY BOARD HAS DEMONSTRATED
19 EXPERIENCE AND EXPERTISE IN MOST OF THE AREAS LISTED IN SUBSECTION
20 (2) OF THIS SECTION.

21 (b) TO THE EXTENT POSSIBLE, THE GOVERNOR SHALL APPOINT
22 ADVISORY BOARD MEMBERS WHO ARE DIVERSE WITH REGARD TO RACE,
23 ETHNICITY, IMMIGRATION STATUS, AGE, ABILITY, SEXUAL ORIENTATION,
24 GENDER IDENTITY, AND GEOGRAPHY. IN CONSIDERING THE RACIAL AND
25 ETHNIC DIVERSITY OF THE ADVISORY BOARD, THE GOVERNOR SHALL
26 ATTEMPT TO ENSURE THAT AT LEAST ONE-THIRD OF THE MEMBERS ARE
27 PEOPLE OF COLOR. IN CONSIDERING THE GEOGRAPHIC DIVERSITY OF THE

1 ADVISORY BOARD, THE GOVERNOR SHALL ATTEMPT TO APPOINT MEMBERS
2 FROM BOTH RURAL AND URBAN AREAS OF THE STATE.

3 (2) THE GOVERNOR MAY APPOINT UP TO ELEVEN MEMBERS TO THE
4 ADVISORY BOARD AND, TO THE EXTENT PRACTICABLE, SHALL INCLUDE
5 INDIVIDUALS WHO:

6 (a) HAVE FACED BARRIERS TO HEALTH ACCESS, INCLUDING PEOPLE
7 OF COLOR, IMMIGRANTS, AND COLORADANS WITH LOW INCOMES;

8 (b) HAVE EXPERIENCE PURCHASING THE STANDARDIZED PLAN;

9 (c) REPRESENT CONSUMER ADVOCACY ORGANIZATIONS;

10 (d) HAVE EXPERTISE IN HEALTH EQUITY;

11 (e) HAVE EXPERTISE IN HEALTH BENEFITS FOR SMALL BUSINESSES;

12 (f) REPRESENT CARRIERS OR WHO HAVE EXPERIENCE WITH
13 DESIGNING A HEALTH INSURANCE PLAN AND SETTING RATES;

14 (g) REPRESENT HOSPITALS OR WHO HAVE EXPERIENCE WITH
15 CONTRACTS BETWEEN HOSPITALS AND CARRIERS;

16 (h) REPRESENT HEALTH-CARE PROVIDERS OR WHO HAVE
17 EXPERIENCE WITH CONTRACTS BETWEEN HEALTH-CARE PROVIDERS AND
18 CARRIERS; OR

19 (i) REPRESENT AN EMPLOYEE ORGANIZATION THAT REPRESENTS
20 EMPLOYEES IN THE HEALTH-CARE INDUSTRY.

21 (3) THE MEMBERS SERVE AT THE PLEASURE OF THE GOVERNOR.

22 (4) IN ADDITION TO CONSULTING WITH THE COMMISSIONER
23 PURSUANT TO SUBSECTION (1)(a) OF THIS SECTION, THE ADVISORY BOARD
24 MAY:

25 (a) CONSIDER RECOMMENDATIONS TO STREAMLINE PRIOR
26 AUTHORIZATION AND UTILIZATION MANAGEMENT PROCESSES FOR THE
27 STANDARDIZED PLAN;

1 (b) RECOMMEND WAYS TO KEEP HEALTH-CARE SERVICES IN THE
2 COMMUNITIES WHERE PATIENTS LIVE; AND

3 (c) CONSIDER WHETHER ALTERNATIVE PAYMENT MODELS MAY BE
4 APPROPRIATE FOR PARTICULAR SERVICES, TAKING INTO CONSIDERATION
5 THE IMPACTS OF SUCH MODELS ON HEALTH OUTCOMES FOR PEOPLE OF
6 COLOR.

7 (5) THE DIVISION SHALL PROVIDE TECHNICAL AND
8 ADMINISTRATIVE SUPPORT TO ASSIST THE ADVISORY BOARD.

9 **10-16-1308. Federal waiver - commissioner application - use**
10 **of money.** (1) ON OR AFTER THE EFFECTIVE DATE OF THIS SECTION, THE
11 COMMISSIONER MAY APPLY TO THE SECRETARY OF THE UNITED STATES
12 DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR A STATE INNOVATION
13 WAIVER TO WAIVE ONE OR MORE REQUIREMENTS OF THE FEDERAL ACT AS
14 AUTHORIZED BY SECTION 1332 OF THE FEDERAL ACT TO CAPTURE ALL
15 APPLICABLE SAVINGS TO THE FEDERAL GOVERNMENT AS A RESULT OF THE
16 IMPLEMENTATION OF THIS PART 13.

17 (2) (a) UPON APPROVAL OF THE 1332 WAIVER APPLICATION, THE
18 COMMISSIONER MAY USE ANY FEDERAL MONEY RECEIVED THROUGH THE
19 WAIVER FOR THE IMPLEMENTATION OF THIS PART 13 OR FOR THE
20 COLORADO HEALTH INSURANCE AFFORDABILITY ENTERPRISE CREATED IN
21 SECTION 10-16-1204. THE COMMISSIONER MAY ALLOCATE FEDERAL
22 MONEY TO THE HEALTH INSURANCE AFFORDABILITY CASH FUND CREATED
23 IN SECTION 10-16-1206 FOR USE BY THE COLORADO HEALTH INSURANCE
24 AFFORDABILITY ENTERPRISE TO INCREASE THE VALUE, AFFORDABILITY,
25 QUALITY, AND EQUITY OF HEALTH-CARE COVERAGE FOR ALL
26 COLORADANS, WITH A FOCUS ON INCREASING THE VALUE, AFFORDABILITY,
27 QUALITY, AND EQUITY OF HEALTH-CARE COVERAGE FOR COLORADANS

1 HISTORICALLY AND SYSTEMICALLY DISADVANTAGED BY HEALTH AND
2 ECONOMIC SYSTEMS.

3 (b) THE IMPLEMENTATION AND OPERATION OF SECTION 10-16-1305
4 (2) IS CONTINGENT ON THE APPROVAL OF THE 1332 WAIVER APPLICATION
5 AND THE RECEIPT OF FEDERAL FUNDS.

6 **10-16-1309. Standardized plan - cost shift.** (1) IF THE
7 ADMINISTRATOR OF A SELF-FUNDED HEALTH INSURANCE PLAN
8 VOLUNTARILY PROVIDES TO THE COMMISSIONER ITS CONTRACTED RATES
9 AND ANY OTHER INFORMATION DEEMED NECESSARY AND AGREED UPON BY
10 THE ADMINISTRATOR AND THE COMMISSIONER, THE COMMISSIONER MAY
11 EVALUATE WHETHER THE RATES OF THE SELF-FUNDED HEALTH INSURANCE
12 PLAN REFLECT A COST SHIFT BETWEEN THE SELF-FUNDED PLAN AND THE
13 STANDARDIZED PLAN OFFERED BY A CARRIER PURSUANT TO SECTION
14 10-16-1305.

15 (2) IF THE COMMISSIONER DETERMINES THERE IS A COST SHIFT, THE
16 COMMISSIONER SHALL, TO THE EXTENT PRACTICABLE, PROVIDE A
17 DESCRIPTION OF WHICH CATEGORIES OF SERVICES HAVE EXPERIENCED THE
18 GREATEST COST SHIFT TO THE ADMINISTRATOR OF THE SELF-FUNDED
19 HEALTH INSURANCE PLAN.

20 **10-16-1310. Reports required - repeal.** (1) THE COMMISSIONER
21 SHALL CONTRACT WITH AN INDEPENDENT THIRD-PARTY ORGANIZATION TO
22 PREPARE THREE SEPARATE REPORTS AS SPECIFIED IN SUBSECTION (4) OF
23 THIS SECTION, TO THE EXTENT THAT INFORMATION IS AVAILABLE
24 REGARDING THE IMPLEMENTATION OF THIS PART 13 AS IT RELATES TO THE
25 STAFFING, WAGES, BENEFITS, TRAINING, AND WORKING CONDITIONS OF
26 HOSPITAL WORKERS.

27 (2) IN CHOOSING AN INDEPENDENT THIRD-PARTY CONTRACTOR,

1 THE COMMISSIONER SHALL CONSIDER ORGANIZATIONS WITH EXPERIENCE
2 CONDUCTING IN-PERSON INTERVIEWS WITH HEALTH-CARE EMPLOYERS AND
3 EMPLOYEES IN COLORADO.

4 (3) THE INDEPENDENT THIRD-PARTY CONTRACTOR MAY MAKE
5 POLICY RECOMMENDATIONS RELATED TO INFORMATION IN THE REPORTS
6 AND MAY INCLUDE DATA COLLECTED FROM EMPLOYERS, EMPLOYEES, AND
7 OTHER THIRD-PARTY SOURCES.

8 (4) THE INDEPENDENT THIRD-PARTY CONTRACTOR SHALL DELIVER
9 THE REPORTS TO THE COMMISSIONER AS FOLLOWS:

10 (a) THE FIRST REPORT BY JULY 1, 2023;

11 (b) THE SECOND REPORT BY JULY 1, 2024; AND

12 (c) THE THIRD REPORT BY JULY 1, 2025.

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

14 **10-16-1311. State measurement for accountable, responsive,**
15 **and transparent (SMART) government act report.** (1) THE
16 COMMISSIONER SHALL REPORT DURING THE HEARINGS CONDUCTED
17 PURSUANT TO THE "STATE MEASUREMENT FOR ACCOUNTABLE,
18 RESPONSIVE, AND TRANSPARENT (SMART) GOVERNMENT ACT", PART 2
19 OF ARTICLE 7 OF TITLE 2:

20 (a) BEGINNING IN JANUARY 2022 AND EACH YEAR THEREAFTER,
21 ON THE PROGRESS OF THE IMPLEMENTATION AND OPERATION OF THIS PART
22 13;

23 (b) BEGINNING IN JANUARY 2024, AND EACH YEAR THEREAFTER,
24 ON THE CARRIERS' EFFORTS TO DEVELOP NETWORKS THAT ARE DIVERSE
25 AND CULTURALLY RESPONSIVE PURSUANT TO SECTION 10-16-1304 (1)(g)
26 AND THE CARRIERS' EFFORTS REQUIRED BY SECTION 10-16-1304 (2); AND

27 (c) IN JANUARY 2024, JANUARY 2025, AND JANUARY 2026, ON THE

1 RESULTS OF THE REPORTS REQUIRED IN SECTION 10-16-1310.

2 **10-16-1312. Rules.** THE COMMISSIONER MAY PROMULGATE RULES
3 AS NECESSARY TO DEVELOP, IMPLEMENT, AND OPERATE THIS PART 13.

4 **10-16-1313. Severability.** IF ANY PROVISION OF THIS PART 13 OR
5 APPLICATION THEREOF TO ANY PERSON OR CIRCUMSTANCES IS JUDGED
6 INVALID, THE INVALIDITY DOES NOT AFFECT PROVISIONS OR APPLICATIONS
7 OF THIS PART 13 THAT CAN BE GIVEN EFFECT WITHOUT THE INVALID
8 PROVISION OR APPLICATION, AND TO THIS END THE PROVISIONS OF THIS
9 PART 13 ARE DECLARED SEVERABLE.

10 **SECTION 2.** In Colorado Revised Statutes, 10-16-107, **amend**
11 (3)(a)(V); and **add** (3)(a)(VII) as follows:

12 **10-16-107. Rate filing regulation - benefits ratio - rules.**

13 (3) (a) The commissioner shall disapprove the requested rate increase if
14 any of the following apply:

15 (V) The rate filing is incomplete; ~~or~~

16 (VII) THE RATE FILING REFLECTS A COST SHIFT BETWEEN THE
17 STANDARDIZED PLAN, AS DEFINED IN SECTION 10-16-1303 (13), OFFERED
18 BY THE CARRIER AND THE HEALTH BENEFIT PLAN FOR WHICH RATE
19 APPROVAL IS BEING SOUGHT. THE COMMISSIONER MAY CONSIDER THE
20 TOTAL COST OF HEALTH CARE IN MAKING THIS DETERMINATION.

21 **SECTION 3.** In Colorado Revised Statutes, 10-16-1206, **amend**
22 (1)(d) and (1)(e); and **add** (1)(f) as follows:

23 **10-16-1206. Health insurance affordability cash fund -**
24 **creation.** (1) There is hereby created in the state treasury the health
25 insurance affordability cash fund. The fund consists of:

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

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

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

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

8 **10-22-114. Standardized plan survey - repeal.** (1) THE
9 EXCHANGE SHALL CONDUCT A SURVEY IN COLLABORATION WITH THE
10 DIVISION THAT ADDRESSES THE EXPERIENCE OF CONSUMERS WHO
11 PURCHASED THE STANDARDIZED HEALTH BENEFIT PLAN ESTABLISHED
12 PURSUANT TO SECTION 10-16-1304. THE SURVEY MUST BE COMPLETED ON
13 OR BEFORE JANUARY 1, 2026.

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

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

17 **12-30-116. Acceptance of patients enrolled in standardized**
18 **plan - acceptance of reimbursement rate requirements - warning -**
19 **fine.** (1) THE COMMISSIONER OF INSURANCE MAY REQUIRE A
20 HEALTH-CARE PROVIDER, AFTER A HEARING PURSUANT TO SECTION
21 10-16-1306, TO PARTICIPATE IN A STANDARDIZED PLAN, AS DEFINED IN
22 SECTION 10-16-1303 (13), AND ACCEPT THE REIMBURSEMENT RATE
23 DESCRIBED IN SECTION 10-16-1306.

24 (2) IF THE DIRECTOR RECEIVES NOTICE FROM THE COMMISSIONER
25 OF INSURANCE THAT AN APPLICANT, LICENSEE, CERTIFICATE HOLDER, OR
26 REGISTRANT REFUSES TO PARTICIPATE IN THE STANDARDIZED PLAN OR
27 ACCEPT THE REIMBURSEMENT RATE AS MAY BE REQUIRED IN SUBSECTION

1 (1) OF THIS SECTION, THE DIRECTOR SHALL ISSUE A WARNING TO THE
2 APPLICANT, LICENSEE, CERTIFICATE HOLDER, OR REGISTRANT.

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

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

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

14 **25-1.5-116. Hospitals - standardized health benefit plan -**
15 **participation - penalties.** (1) THE COMMISSIONER OF INSURANCE MAY
16 REQUIRE A HOSPITAL LICENSED PURSUANT TO SECTION 25-1.5-103, AFTER
17 A HEARING PURSUANT TO SECTION 10-16-1306 (3) CONCERNING THE
18 PREMIUM RATE REQUIREMENTS AND NETWORK ADEQUACY, TO
19 PARTICIPATE IN A STANDARDIZED HEALTH BENEFIT PLAN DESCRIBED IN
20 SECTION 10-16-1304.

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

27 (I) SHALL FINE THE HOSPITAL UP TO TEN THOUSAND DOLLARS PER

1 DAY FOR THE FIRST THIRTY DAYS THAT THE HOSPITAL REFUSES TO
2 PARTICIPATE AND UP TO FORTY THOUSAND DOLLARS PER DAY FOR EACH
3 DAY OVER THIRTY DAYS THAT THE HOSPITAL REFUSES TO PARTICIPATE;
4 AND

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

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

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

14 **25.5-1-131. Insurance ombudsman - consumer advocate -**
15 **duties.** (1) THERE IS HEREBY CREATED IN THE STATE DEPARTMENT THE
16 OFFICE OF THE INSURANCE OMBUDSMAN TO ACT AS THE ADVOCATE FOR
17 CONSUMER INTERESTS IN MATTERS RELATED TO ACCESS TO AND THE
18 AFFORDABILITY OF THE STANDARDIZED HEALTH BENEFIT PLAN CREATED
19 PURSUANT TO SECTION 10-16-1304. THE OMBUDSMAN SHALL:

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

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

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

27 (2) IN THE PERFORMANCE OF THE OMBUDSMAN'S DUTIES, THE

1 OMBUDSMAN SHALL ACT INDEPENDENTLY OF THE STATE DEPARTMENT.
2 ANY RECOMMENDATIONS MADE OR POSITIONS TAKEN BY THE OMBUDSMAN
3 DO NOT REFLECT THOSE OF THE STATE DEPARTMENT.

4 **SECTION 8. Appropriation.** (1) For the 2021-22 state fiscal
5 year, \$1,199,637 is appropriated to the department of regulatory agencies.
6 This appropriation is from the division of insurance cash fund created in
7 section 10-1-103 (3), C.R.S. To implement this act, the department may
8 use this appropriation as follows:

9 (a) \$948,667 for use by the division of insurance for personal
10 services, which is based on an assumption that the division will require
11 an additional 5.4 FTE;

12 (b) \$38,290 for use by the division of insurance for operating
13 expenses; and

14 (c) \$212,680 for use by the executive director's office and
15 administrative services for the purchase of legal services.

16 (2) For the 2021-22 state fiscal year, \$212,680 is appropriated to
17 the department of law. This appropriation is from reappropriated funds
18 received from the department of regulatory agencies under subsection
19 (1)(c) of this section and is based on an assumption that the department
20 of law will require an additional 1.1 FTE. To implement this act, the
21 department of law may use this appropriation to provide legal services for
22 the department of regulatory agencies.

23 (3) For the 2021-22 state fiscal year, \$78,993 is appropriated to
24 the department of health care policy and financing for use by the
25 executive director's office. This appropriation is from the general fund.
26 To implement this act, the office may use this appropriation as follows:

27 (a) \$65,243 for personal services, which amount is based on an

1 assumption that the office will require an additional 0.8 FTE; and

2 (b) \$13,750 for operating expenses.

3 **SECTION 9. Safety clause.** The general assembly hereby finds,
4 determines, and declares that this act is necessary for the immediate
5 preservation of the public peace, health, or safety.