MEMORANDUM

TO: Joint Budget Committee

FROM: Eric Kurtz, JBC Staff (303-866-4952)

SUBJECT: Comebacks, Health Care Policy and Financing Figure Setting
- End of primary care rate bump
- Hospital Provider Fee restriction

DATE: March 22, 2016

1. **End of primary care rate bump** – The JBC did not vote on the end of the primary care rate bump. The previous policy of the JBC had the primary care rate bump expiring at the end of FY 2015-16. During figure setting the JBC did not take action to add any money to extend the primary care rate bump. Absent action by the JBC, the assumption is that the primary care rate bump will end in FY 2016-17. At the end of this memo is an excerpt from the JBC staff figure setting recommendations that discusses the issue.

2. **Hospital Provider Fee restriction –** The JBC did not vote on the Governor's proposed legislation to restrict the revenue from the Hospital Provider Fee in order to reduce the General Fund obligation for a TABOR refund. At the end of this memo is an excerpt from the JBC staff figure setting recommendations that discusses the issue. However, the available options have changed somewhat based on the March revenue forecasts from Legislative Council Staff (LCS) and the Office of State Planning and Budgeting (OSPB).

   a. The maximum General Fund benefit in FY 2016-17 from restricting the Hospital Provider Fee revenue is $59.3 million under the LCS forecast and $168.9 million under the OSPB forecast. These are the projected TABOR refunds under each forecast.
   b. To achieve the maximum General Fund benefit requires a restriction on the Hospital Provider Fee revenue of $39.7 million under the LCS forecast and $149.3 million under the OSPB forecast. These are the projected TABOR surplus revenues under each forecast. The remaining $19.6 million of the TABOR refund is a carry forward of a refund obligation from FY 2014-15 that must be paid in the next year a TABOR refund is due.
   c. Restricting the Hospital Provider Fee revenue will have no effect on the estimated transfers to the Highway Users Tax Fund (HUTF) and Capital Construction Fund (CCF) under the LCS forecast, but a restriction of more than $62.9 million would double the projected transfers under the OSPB forecast.

   Regarding bullet b, in both the LCS and OSPB forecast only part of the projected TABOR refund is attributable to a TABOR surplus in FY 2016-17 and the rest is money that should have been refunded in FY 2014-15. Of the total projected TABOR refund, $19.6 million is related to money transferred from the Unclaimed Property Trust Fund to the Adult Dental Fund that should have been counted as TABOR revenue and refunded in FY 2014-15. Based on statute, when an error in the refund is discovered it is corrected in the next year a TABOR refund is due. If the JBC restricts the Hospital Provider Fee by an amount sufficient to

eliminate the TABOR surplus, then all of the TABOR refund would be eliminated, but $19.6 million would be carried forward as a TABOR refund obligation for the next year when a TABOR refund is due.

Hospital Provider Fee Restriction Scenarios (in millions)	LCS Forecast	OSPB Forecast
TABOR Surplus in FY 16-17	$39.7	$149.3
Adult dental refund owed from FY 14-15	$19.6	$19.6
Total TABOR refund obligation in FY 16-17	$59.3	$168.9
If the JBC restricts the HPF by:	$39.7	$149.3
The GF savings from a lower TABOR refund would be:	$59.3	$168.9

If the JBC restricts the Hospital Provider Fee revenue by an amount that does not entirely eliminate the TABOR surplus, then the $19.6 million does not get shifted to a future year. Also, if the JBC budgets based on eliminating the TABOR surplus and then actual revenues are higher than the forecast, then the $19.6 million refund obligation could shift back into FY 2016-17.

Regarding bullet c, restricting revenue from the Hospital Provider Fee could affect transfers to the HUTF and CCF under the OSPB forecast. There would be no effect on the transfers to the HUTF and CCF under the LCS forecast. The formula in S.B. 09-228 calls for a transfer of 2 percent of General Fund revenues to the HUTF and 0.5 percent of revenues to the CCF, but these transfers can be reduced based on the size of the TABOR refund as follows:

- TABOR refund ≤ 1% of General Fund revenue = Full Transfer
- TABOR refund >1%, but ≤ 3% of General Fund revenue = Half Transfer
- TABOR refund > 3% of General Fund revenue = No Transfer

The table below shows the size of a TABOR refund where a change in the transfers would occur. If the JBC balances to the OSPB forecast and a restriction on the Hospital Provider Fee revenue causes the TABOR refund to drop below $106 million, then the expected transfers to the HUTF and CCF would increase by a total of $132.4 million combined, by virtue of going from a half transfer to a full transfer.[1]

[1] The actual transfers will be based on the Legislative Council Staff forecast and actual revenue.

S.B. 09-228 Transfers (in millions)	LCS Forecast	OSPB Forecast
GF Revenue Projection	$10,535.8	$10,595.6
S.B. 09-228 Triggers		
No transfer if TABOR refund is above 3% of GF or:	$316.1	$317.9
Half transfer if TABOR refund is above 1% of GF or:	$105.4	$106.0
Projected TABOR Refund	$59.3	$168.9
Transfer Required	Full	Half
Projected Transfers*	$263.4	$132.4
HUTF	$210.7	$106.0
CCF	$52.7	$26.5

** A full transfer is 2.0% of GF to the HUTF and 0.5% of GF to the CCF.*

➔ Annualize Primary Care Rate Bump

Request: The Governor's request does not extend an increase in primary care rates that was originally put in place January 2013 and is scheduled to expire June 2016. The Department estimates this saves $145.1 million total funds, including $49.5 million General Fund.

Recommendation: Staff recommends the Governor's request. The funding for the primary care rate bump, as it is called, was tied by both the Governor and the legislature to a temporary increase in the federal match rate for Colorado Medicaid that is no longer available. Also, a third-party analysis commissioned by the Department does not show a correlation between the primary care rate bump and provider participation in Medicaid. After the analysis section there is a discussion of options the JBC could consider if the Committee wants to continue funding for primary care rates at a reduced level.

Analysis: The primary care rate bump was originally implemented to comply with Section 1202 of the Affordable Care Act that required states to increase Medicaid rates for certain primary care services and immunizations performed by primary care providers to at least match the equivalent Medicare Part B rates. The ACA provided a 100 percent federal match for the primary care rate bump from January 2013 through the end of calendar year 2014. The purpose of the federally-mandated primary care rate bump was to ensure there would be a sufficient pool of primary care providers willing to see people newly eligible for Medicaid as a result of the expansion.

During the state FY 2014-15 budget cycle, the General Assembly decided to extend the primary care rate bump with some modifications. Colorado was one of 15 states to fully or partially extend the rate bump. The decision to extend the rate bump was made following unexpected news that the federal match rate, called the federal medical assistance percentage (FMAP), was going to increase for Colorado in federal fiscal year 2014-15 from 50.00 percent to 51.01 percent. The Governor submitted a budget amendment connecting the enhanced primary care rates to the General Fund savings from the increase in the FMAP rate. The Governor proposed

that the elevated primary care rates continue an additional 18 months from January 2015 through June 2016.

Part of the rationale for a time-limited extension was that the source of funding financing the extension was expected to have a short-duration. The increase in the FMAP was due to Colorado's per capita personal income falling relative to other states during the economic downturn. As the economy improved, the Department anticipated the FMAP would approach the federal minimum of 50% that Colorado had received each year for at least the preceding decade. The FMAP has decreased as predicted. The FMAP for federal fiscal year 2016-17 will be 50.02 percent and the Department projects it will drop to 50 percent for federal fiscal year 2017-18.

The second reason for the time-limited extension was that the Department had only anecdotal evidence about whether the change in primary care rates was effective in improving client access to services. As part of the extension of the enhanced primary care rates the Department requested and received funding to study the effect of the rates on access. The Department indicated that the extension would allow time to collect data to inform a decision about whether to request continued funding in future years.

The state extension of the rate bump made some modifications intended to improve the effectiveness of the policy as an incentive for access. First, the state extension removed a requirement that providers self-attest that they meet the federal eligibility qualifications or operate under the personal supervision of a provider meeting the eligibility qualifications. Instead, the state extension paid based on the type of service provided. The Department indicated the self-attestation requirement was administratively burdensome for providers, potentially causing them to not claim the enhanced rate. The change also allowed some new providers to benefit from the enhanced rates, such as independent advanced practice nurses, school based health clinics, nephrologists, or HIV doctors, who often act as the medical home for clients. Second, the Department began paying the enhanced rate on a per claim basis, rather than quarterly as a supplemental payment. This made the enhanced rates more transparent to providers and got the money in the hands of the providers more quickly. The changes also made the payments significantly easier for the Department to administer.

The effect of the rate bump on payments varied widely by code from a 1.1 percent to 69.4 percent increase, so it is hard to say the exact percentage reduction that will be caused by the end of the rate bump. The effect by provider will vary based on the codes most frequently used by the provider. According to HCPF, more than half of the rate increases from the rate bump were between 10% and 30%. Overall expenditures for eligible codes increased 23.2% due to the rate bump.

The Department contracted for a study of the effect of the primary care rate bump on access. An initial report with analysis of data through June 2014 was shared with the JBC during the briefing. A final report that includes analysis of data through June 2015 is in editing and will be published in March, but the Department was able to share a draft with the JBC staff. The final report includes analysis of the effect of the Colorado modifications to the primary care rate

bump, including removing the attestation requirement. The draft of the final report indicates there were no major differences in the key findings from the initial report. As indicators of access the study looked at client outcomes and at provider behavior, using claims data.

If the rate bump increased access, then the report expected client outcomes to improve. The client outcomes measured were:

- The number of emergency department visits for ambulatory care sensitive conditions per 10,000 adult Medicaid clients. Ambulatory care sensitive conditions are those that are potentially preventable with good primary care, such as visits for diabetes, as opposed to visits for accidents such as a broken arm.
- The percentage of adults having at least one primary care visit in the prior 12 months
- The percentage of children having at least one primary care visit in the prior 12 months
- The percentage of bump-eligible visits with usual care providers, which measures continuity of care

If the rate bump increased access, then the report expected the following provider behaviors to increase:

- Number of providers with bump-eligible visits
- Number of bump-eligible visits in a month

The report had three main findings:

- During a period of significant enrollment growth, client-based access to care measures remained stable and the number of providers of primary care services to Medicaid clients increased with enrollment.
- Graphical and time-series regression analysis of the claims data suggest that the rate bump did not significantly alter the time trends of the client outcomes and provider behaviors measured.
- Statistical modeling suggests providers delivered an additional two to five bump-eligible visits per month to Medicaid clients in months when the provider was attested. The modeling of the Colorado extension of the primary care rate bump, which removed the attestation requirement, does not show an impact on the number of bump-eligible visits.

Options: Some JBC members have expressed an interest in trying to maintain a portion of the primary care rate bump at a reduced funding level.

One way to reduce costs would be to prioritize certain rates over others. The Department broke the codes out into some categories and identified two areas of concern. First, when Colorado extended the primary care rate bump and switched from a supplemental payment to a per claim payment, some of the rate increases ended up getting applied to evaluation and management codes used for emergency room visits. Funding evaluation and management in an emergency room setting may not be what legislators had in mind when trying to increase resources for primary care services. Second, the Department noted that some of the largest gaps between Medicaid and Medicare reimbursement for primary care are related to immunization administration, and so this might be an area to prioritize for funding.

Primary Care Rate Bump by Code Group				
Code Group	Total Funds	General Fund	Cash Funds	Federal Funds
Counseling and Health Risk Assessments	$198,744	$55,319	$2,666	$140,758
Critical Care Visit	4,763,812	1,703,417	60,399	2,999,995
Emergency Department Visit	29,462,705	8,995,271	338,657	20,128,777
Home Visit	165,138	75,545	1,411	88,182
Immunization Administration	6,247,766	2,817,432	13,285	3,417,048
Inpatient/facility Visit	20,323,467	6,779,537	296,333	13,247,597
Newborn	1,702,933	823,858	2,533	876,542
Office Visit	70,139,341	23,366,191	871,058	45,902,092
Preventive Medicine visits	11,722,786	4,772,177	51,621	6,898,987
Prolonged visits	348,204	130,389	4,090	213,725
Standby, Warfarin, Interdisciplinary conference	739	264	5	470
Total	$145,075,634	$49,519,402	$1,642,057	$93,914,175

Another way to reduce costs would be to target some minimum percentage of Medicare rates that the JBC doesn't want to fall below. In this scenario primary care rates would be reduced to the greater of their pre-primary care rate bump level or a specified percentage of the equivalent Medicare rate. The table below summarizes the cost of bringing the primary care rates to a few different percentages of the Medicare rates. This particular table excludes emergency department visits, but the same could be done including emergency department visits, if the JBC wants.

Primary Care to a Minimum Percent of Medicare (Excluding Emergency Department Visits)				
	Total Funds	General Fund	Cash Funds	Federal Funds
90% of Medicare	$76,368,277	$26,926,222	$841,709	$48,600,347
85% of Medicare	$56,761,514	$20,134,517	$610,874	$36,016,123
80% of Medicare	$37,214,463	$13,365,381	$380,652	$23,468,431
75% of Medicare	$18,507,594	$6,904,060	$160,101	$11,443,434
70% of Medicare	$5,622,569	$2,361,125	$22,195	$3,239,249

➔ R1 Restrict Hospital Provider Fee revenue

Description: The Department requests legislation to restrict hospital provider fee revenue for FY 2016-17 and FY 2017-18. This was originally described by the executive branch as a $100 million restriction, but in the February 2016 forecast the Department lowered the projected maximum revenue that could be collected from the Hospital Provider Fee without lowering the requested total revenue from the Hospital Provider Fee with the Governor's restriction, so it is now better described as an approximately $73.1 million restriction on the Hospital Provider Fee revenue. The Department explains that the Governor's budget was balanced to a specific total revenue from the Hospital Provider Fee, rather than a specific restriction on the revenue.

	Governor's Request	February 2016 Forecast
Maximum HPF under federal limits	$756,254,120	$729,403,848
Requested HPF	$656,254,120	$656,254,120
Required restriction on HPF	($100,000,000)	($73,149,728)

In the Governor's request, restricting the revenue from the Hospital Provider Fee would save General Fund that would otherwise be needed for a TABOR refund. This strategy for saving General Fund only works if there is a TABOR refund that can be reduced that is at least as large as the Hospital Provider Fee restriction. If the March revenue forecast shows that there is not a large enough TABOR refund that can be reduced, or if the General Assembly takes some other action to reduce TABOR revenues (such as designating the Hospital Provider Fee as an enterprise), then this strategy may not produce General Fund savings.

In the Governor's request, the reduction in Hospital Provider Fee revenues would result in lower booster payments paid from the Medical Services Premiums line item. The other major purpose of the Hospital Provider Fee is to pay for Medicaid expansion populations and the Governor is NOT requesting any reduction to Medicaid eligibility or benefits as a result of the restriction on Hospital Provider Fee revenues.

The Governor proposed that the restriction on the Hospital Provider Fee revenue be accomplished through a statutory change. The JBC received an opinion from Legislative Legal Services, dated December 7, 2015, that reducing Hospital Provider Fee revenues without reducing Medicaid eligibility or benefits would require legislation, due to the way the statutes prioritize expenditures from the Hospital Provider Fee when revenues are insufficient.

The Department provided an estimate of the change in net payments by hospital as a result of the proposed restriction. The estimate can be found in Appendix B at the end of this document.

Recommendation: Staff recommends that the JBC sponsor legislation to restrict Hospital Provider Fee revenues by $100 million for FY 2016-17 and FY 2017-18. This is a greater restriction than currently requested by the Department. As described previously, the Department originally proposed a $100 million restriction on revenue, but with the revised February 2016 forecast, the effective restriction in the Governor's request is approximately $73.1 million.

The staff recommendation assumes that the March revenue forecast will show at least a $100 million General Fund obligation for a TABOR refund. If the March revenue forecast shows less than a $100 million General Fund obligation for a TABOR refund, or if the General Assembly takes some other action to reduce TABOR revenues (such as designating the Hospital Provider Fee as an enterprise), then the JBC staff does not believe a $100 million reduction in Hospital Provider Fee revenues would be beneficial to the budget and would not recommend the restriction.

The Hospital Provider Fee booster payments can be thought of as filling a gap between Medicaid rates and hospital costs and the JBC staff recommendation is to maintain expectations about how much of the gap will remain unfilled. The booster payments raise hospital reimbursement to the

federal Upper Payment Limit (UPL), and the UPL is based on what Medicare would have paid for equivalent services, and Medicare rates are nominally based on cost, and so the Hospital Provider Fee is closing a gap between Medicaid rates and hospital costs. It could be argued whether the UPL formula accurately describes what Medicare would have paid, and whether Medicare rates accurately reflect costs, but these are the policy objectives that guide the calculations. The booster payments do not fully fill the gap between Medicaid rates and cost, because half the money to make the booster payments comes from the hospitals themselves. The Governor's request established an expectation of how much of the gap would go unfilled. Based on the February 2016 forecast, the size of the gap is smaller than originally assumed, so the same total revenue from the Hospital Provider Fee could fill more of the gap. However, the staff recommendation is to maintain expectations about how much of the gap will go unfilled. Relative to the most recent information about actual hospital costs for Medicaid clients, the JBC staff recommends the same shortfall in funding as originally proposed by the Governor.

Both the JBC staff recommendation and the Governor's request would reduce the TABOR refund due to taxpayers. The loss of TABOR refunds is one objection sometimes raised to designating the Hospital Provider Fee as an enterprise, and so the JBC staff wants to make sure that legislators understand that this staff recommendation would have a similar effect on TABOR refunds, although the magnitude might be different.

Adopting the JBC staff recommendation could affect statutory transfers to the Highway Users Tax Fund and Capital Construction, including whether the transfers are made and the size of the transfers. The purpose of the staff recommendation is to provide budget relief and not to direct a specific allocation of that relief to another budget priority. The JBC staff recommendation assumes the JBC will explore any potential transfers from the General Fund and the size of those transfers as a separate issue.

The staff recommendation is for a temporary reduction in Hospital Provider Fee revenue for FY 2016-17 and FY 2017-18, consistent with the temporary restriction proposed by the Governor.

Alternative – Replace hospital booster payments with a provider rate increase

If legislators want to mitigate the effect on hospitals of the staff recommendation or the Governor's request, a possible alternative would be to replace hospital booster payments with a provider rate increase. When the Hospital Provider Fee booster payments were created, they allowed the state to increase reimbursements to hospitals with no cost to the General Fund. Hospitals paid the state a dollar to get two dollars in return, or a net benefit of $1. However, in a TABOR refund environment, booster payments are an inefficient way to deliver increased funding to hospitals. This is because the revenue from the Hospital Provider Fee increases the General Fund obligation for a TABOR refund. To give the hospitals a net benefit of $1 costs the General Fund $1 in increased TABOR refunds. It is as if the General Assembly made a direct General Fund payment to the hospitals with no matching federal funds. If the same net benefit of $1 was provided through a rate increase for the hospitals, it would only cost the General Fund $0.50 at the standard federal match rate. However, because some of the populations and treatments provided by the hospitals are eligible for enhanced federal matching funds, the cost to the General Fund would be even less. Based on the mix of populations and treatments that the

Department projects hospitals will provide in FY 2016-17, the average General Fund match rate for fee-for-service payments to hospitals is expected to be 28.4 percent.

If the JBC wanted to replace $10 million from the Hospital Provider Fee with a rate increase, it would cost $2.9 million General Fund to hold the hospitals harmless in aggregate, and the General Fund would pay $10 million less in TABOR refunds, resulting in a net savings to the General Fund of $7.1. This example, summarized n the table below, is scalable, so if the JBC wanted to replace the entire $100 million reduction to the Hospital Provider Fee that is recommended by the JBC staff with a rate increase to hold hospitals harmless, the net savings to the General Fund would be $71 million. This is less than the $100 million savings to the General Fund under the JBC staff recommendation, but it is still a considerable savings. If the JBC wanted to achieve the same $100 million of General Fund savings recommended by the JBC staff, it could do so by replacing $140.2 million from the Hospital Provider Fee with a provider rate increase.

Restrict Hospital Provider Fee (HPF) revenue	($10,000,000)
Effect on hospitals	
Net loss in HPF booster payments	($10,080,321)
Provider rate increase	$10,080,321
Net benefit/(loss) to hospitals	$0
Effect on the General Fund	
TABOR Refund (not appropriated)	($10,000,000)
GF cost of rate increase	$2,867,207
Net benefit to General Fund	($7,132,793)

There are a some limits on how much General Fund savings the JBC could achieve by replacing Hospital Provider Fee booster payments with a provider rate increase. First, the cut to the Hospital Provider Fee cannot exceed the booster payments. The FY 2016-17 projected Hospital Provider Fee expenditure from the Medical Services Premiums line item for hospital booster payments is $409.8 million. Potentially, the General Assembly could also replace booster payments from the Safety Net Provider Payments line item with rate increases, but this would require a reimagining of the Colorado Indigent Care Program. Second, the cut to the Hospital Provider Fee cannot exceed the TABOR refund, because the General Fund savings from this strategy is dependent on reducing the General Fund obligation for a TABOR refund. The March revenue forecast will provide a new estimate of the TABOR refund. The actual TABOR refund will be dependent on actual revenues.

While replacing Hospital Provider Fee revenues with a rate increase could hold hospitals harmless in aggregate, it would most likely result in a reallocation of resources between hospitals. The larger the change in financing the greater the distortion will be from the status quo distribution by hospital. The Department could potentially make adjustments to the distribution formula for any remaining Hospital Provider Fee booster payments to minimize the change in funding by hospital, if this was a policy goal, but it is unlikely that a new distribution formula plus a rate increase could exactly duplicate the current allocation of funds by hospital.

Reducing Hospital Provider Fee revenues and increasing provider rates would require federal approval from the Centers for Medicare and Medicaid Services (CMS). The size of the change in financing might influence the level of CMS scrutiny and the time required to receive approval. The Department has accounted for the time required to get CMS approval for a change in the Hospital Provider Fee revenues in the request. A reduction in revenues may not be evenly distributed through the state fiscal year, but the Department believes a reduction in revenues to a specific dollar amount identified by the General Assembly is achievable within the fiscal year. Similarly, a rate increase might not be approved by CMS by July 1, but upon CMS approval it could be implemented retroactively to July 1.

If Hospital Provider Fee revenues were replaced with a provider rate increase, it might reduce the potential for a challenge by CMS based on the new federal regulation regarding assuring access (see the discussion of *BA6 Fed reg for assuring access* for more background on this regulation).

The JBC staff is not recommending this alternative in part because it may have unintended consequences. As noted above, replacing the Hospital Provider Fee with a rate increase will likely change the distribution of funding among hospitals and that could have negative consequences for the delivery system, but it is unknown whether and how the Department might change the distribution formula for the remaining booster payments and what the final result would be by hospital. One factor in the distribution of the Hospital Provider Fee is quality of care, but that is not a consideration in the current fee-for-service rates. Also, if hospital provider rates are increased, then the effect on the budget of future changes in the utilization of hospital services is magnified.

Another consideration is that both the Governor's request and the JBC staff recommendation are for temporary reductions to the Hospital Provider Fee, while a provider rate increase for the hospitals would be perceived as permanent. The JBC staff is uncomfortable recommending a rate increase for the hospitals, particularly if it is a large increase, before the S.B. 15-228 rate review process has had a chance to do even one review cycle. It could be that increasing rates for a different provider turns out to be more important for the delivery system than backfilling lost revenue to the hospitals from the Hospital Provider Fee. While it may be unrealistic to assume that the budget environment will be significantly better in two years such that restoring the Hospital Provider Fee will be easy, there might be more clarity in two years about where Medicaid provider rates are causing the most issues with access and where backfilling lost revenue from the Hospital Provider Fee falls among the Department's priorities.

Another consideration is that the net benefit to hospitals from the Hospital Provider Fee has been significantly greater than originally expected. When the Hospital Provider Fee was created it was not expected that the expansion populations would receive an enhanced federal match pursuant to the ACA. That match for FY 201617 is 97.5 percent. The enhanced federal match reduces the amount of Hospital Provider Fee revenue that goes to providers other than hospitals for services to expansion populations and increases the proportion of the Hospital Provider Fee that directly benefits the hospitals. Also, when the Hospital Provider Fee was created the effect

of the Medicaid expansion on increasing the federal limits on the Hospital Provider Fee was not fully understood.

The booster payments have not always been in place and during their existence there have been frequent variations in funding levels, including large diversions from the booster payments to offset the need for General Fund as follows:

- $46.3 million in FY 2009-10
- $53.5 million in FY 2010-11
- $50.0 million in FY 2011-12
- $25.0 million in FY 2012-13

Alternative – Designate the Hospital Provider Fee as an enterprise

Last year the Governor proposed that rather than limiting the Hospital Provider Fee revenue, the General Assembly designate the Hospital Provider Fee as part of an enterprise, which would make the revenue exempt from TABOR. He then went one step further and argued that doing so would not require an adjustment to the TABOR base. House Bill 15-1389 (Hullinghorst & Court / Steadman) was introduced to implement the idea, but it was postponed indefinitely in the Senate's State, Veterans, and Military Affairs Committee. If something similar to H.B. 15-1389 was implemented in FY 2016-17, it would remove approximately $730 million in projected revenue attributable to the Hospital Provider Fee from the calculation of whether a TABOR refund is due. This does not mean that there would be $730 million more General Fund available for the budget. The amount of General Fund savings would be dependent on the size of the TABOR refund absent a change in policy.

In addition to saving General Fund that would otherwise be needed for a TABOR refund, designating the Hospital Provider Fee as an enterprise would remove the budget balancing reason to implement the Governor's proposed restriction on Hospital Provider Fee revenues.

There would be some secondary effects from designating the Hospital Provider Fee as an enterprise. First, the conservation easement tax credit would remain non-refundable. Pursuant to Section 39-22-522 (5) (b), C.R.S., a portion of the tax credit becomes refundable if a TABOR surplus is due. In November the Legislative Council Staff estimated that this would increase General Fund revenue projections by approximately $5.2 million in FY 2016-17 and $10.5 million in FY 2017-18. These figures might need to be updated after the March revenue forecast. Second, the General Assembly would be allowed to eliminate tax expenditures without prior voter approval in FY 2016-17, if it wanted, which could increase General Fund revenues. The conclusion that limiting tax expenditures without prior voter approval is allowable when it doesn't cause a TABOR refund is based on the Colorado Supreme Court's decision in Mesa County Bd. of County Comm'rs v. State.

The two main downsides to designating the Hospital Provider Fee as an enterprise are that: (1) it may not be constitutional; and (2) it eliminates projected TABOR refunds taxpayers could otherwise expect to receive. There could be legal costs if a designation of the Hospital Provider Fee as an enterprise is challenged. If it is found unconstitutional, the state would owe a refund

for money retained illegally through the policy for up to four full fiscal years prior to the date a suit is filed, plus 10 percent annual simple interest.

The dollar risk of designating the Hospital Provider Fee as an enterprise and subsequently receiving a court determination that it is unconstitutional is dependent on when a law suit is filed and resolved and on how much revenue is retained. It is important to note that the Governor's budget, including budget amendments, was balanced in January assuming $100 million in savings from restricting Hospital Provider Fee revenues. So, when looking at what designating the Hospital Provider Fee as an enterprise would save compared to the Governor's request, the total savings from the enterprise designation needs to be reduced by the $100 million that the Governor was already counting on achieving through a different policy action.