A BILL FOR AN ACT

CONCERNING MEASURES TO ADDRESS THE HIGH COSTS OF HEALTH INSURANCE IN THE STATE, AND, IN CONNECTION THEREWITH, AUTHORIZING THE STATE PERSONNEL DIRECTOR TO IMPLEMENT A PILOT PROGRAM TO ALLOW RESIDENTS OF A SPECIFIED REGION TO PARTICIPATE IN STATE EMPLOYEE MEDICAL BENEFIT PLANS AND MODIFYING THE HEALTH CARE COVERAGE COOPERATIVES LAWS TO INCLUDE CONSUMER PROTECTIONS AND ALLOW CONSUMERS TO COLLECTIVELY NEGOTIATE RATES DIRECTLY WITH PROVIDERS.

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...
Sections 1 and 2 of the bill authorize the state personnel director to explore the feasibility of offering and, if feasible, to develop and implement a one-year pilot program in a limited geographic region of the state affected by high health insurance premiums to provide access to individuals in that region to participate in the group medical benefit plans offered to state employees. The pilot program would be available:

- In the portions of Eagle and Garfield counties that are within the service area of the state group benefit plans;
- To a limited number of individuals whose household income is more than 400% but not more than 500% of the federal poverty line; and
- In the 2019-20 benefit plan year.

Section 2 outlines the factors for the state personnel director to consider in determining the feasibility of the pilot program.

Sections 3 through 15 modernize laws authorizing health care cooperatives in the state to incorporate consumer protections such as coverage for preexisting conditions and to encourage consumers to help control health care costs by negotiating rates on a collective basis directly with providers.

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

SECTION 1. In Colorado Revised Statutes, 24-50-604, add (1)(n) as follows:

24-50-604. Powers and duties of the director. (1) The director shall administer and manage the state employees group benefit plans and, subject to the provisions of this part 6, has the following powers and duties:

(n) The authority to develop and implement a pilot program pursuant to section 24-50-620.

SECTION 2. In Colorado Revised Statutes, add 24-50-620 as follows:

24-50-620. Pilot program - participation in group medical benefit plans - individuals in high-cost areas - legislative declaration...
- definitions - repeal. (1) The General Assembly hereby finds and
declares that:

(a) Currently, premiums for health insurance across the
nine health insurance geographic rating regions in Colorado, as
well as the number of insurance carriers available and the
number and variety of plans offered in the different regions,
vary significantly;

(b) Premiums in rural areas, especially in the eastern
plains and the western slope areas of the state, are
considerably higher than premiums in metropolitan areas, and
the number of carriers and the diversity of plans they offer are
very limited in those areas. In fact, only one carrier is
currently offering plans on the health benefit exchange in some
rural areas of the state.

(c) Many Coloradans in rural areas whose incomes fall
between four hundred percent and five hundred percent of the
federal poverty line are cost-burdened in that they spend more
than twenty percent of their household income on premiums for
health insurance but earn too much to qualify for subsidies
available under federal law;

(d) Because of the financial burden high-cost health
insurance places on individuals in rural areas of the state, a
considerable number of these cost-burdened individuals may not
purchase health insurance in 2019, exacerbating the problems of
few carriers, few plan options, and high costs of health
insurance in rural regions of the state as well as increasing the
number of uninsured individuals in those areas;
(e) It is therefore important to explore the feasibility of offering and, if feasible, to develop and implement a pilot program in a limited geographic region of the state affected by high health insurance premiums to provide access to individuals in that region to participate in the group medical benefit plans offered to state employees.

(2) As used in this section:

(a) "Federal poverty line" has the same meaning as "poverty line", as defined in 42 U.S.C. sec. 9902 (2).

(b) "Group medical benefit plan" means a group benefit plan that provides medical benefits.

(3) If feasible, the director shall develop and implement a one-year pilot program to allow eligible individuals to enroll in and receive medical benefits through the group medical benefit plans. If the director is able to develop and implement the pilot program, the director shall allow eligible individuals to enroll in group medical benefit plans for the 2019-20 plan year.

(4) (a) In determining whether the pilot program is feasible, the director shall consider:

(I) Whether and how the state can enroll individuals who are not state employees, and manage their participation, in a group medical benefit plan; whether the state can contract with a third party for either or both of those services; and the cost to the state to perform or contract with a third party to perform those services;

(II) Actuarial information about the effects of enrolling...
ELIGIBLE INDIVIDUALS ON THE SOLVENCY AND VIABILITY OF A
SELF-FUNDED GROUP MEDICAL BENEFIT PLAN;

(III) WHETHER, IN THE CASE OF A FULLY FUNDED GROUP MEDICAL
BENEFIT PLAN, THE CARRIER IS WILLING TO ENROLL ELIGIBLE INDIVIDUALS
IN THE PLAN AND WHETHER AND THE EXTENT TO WHICH THEIR
ENROLLMENT WOULD AFFECT PREMIUMS FOR THE PLAN;

(IV) WHETHER TO LIMIT PARTICIPATION BY ELIGIBLE INDIVIDUALS
TO EITHER SELF-FUNDED OR FULLY FUNDED GROUP MEDICAL BENEFIT
PLANS;

(V) WHETHER ENROLLMENT IN A GROUP MEDICAL BENEFIT PLAN
WILL REDUCE PREMIUM COSTS FOR ELIGIBLE INDIVIDUALS IN COMPARISON
TO THE PREMIUM COSTS FOR AN INDIVIDUAL HEALTH BENEFIT PLAN
AVAILABLE TO ELIGIBLE INDIVIDUALS IN THE PRIVATE MARKET, INCLUDING
THROUGH THE COLORADO HEALTH BENEFIT EXCHANGE CREATED
PURSUANT TO ARTICLE 22 OF TITLE 10, AND WHETHER THE STATE WOULD
NEED TO CONTRIBUTE A PORTION OF THE PREMIUM AMOUNT TO
EFFECTUATE REDUCED PREMIUMS FOR ELIGIBLE INDIVIDUALS; AND

(VI) ANY OTHER INFORMATION RELEVANT TO DETERMINING
WHETHER THE PILOT PROGRAM IS FEASIBLE.

(b) UPON MAKING A FEASIBILITY DETERMINATION, THE DIRECTOR
SHALL NOTIFY THE JOINT BUDGET COMMITTEE AND THE MEMBERS OF THE
SENATE AND HOUSE OF REPRESENTATIVES FROM THE SENATE AND HOUSE
DISTRICTS THAT INCLUDE GARFIELD AND EAGLE COUNTIES OF THE
determination. If the director determines that a pilot program
is feasible, the director shall include in the notice required by
this subsection (4)(b) information about how and when the
director will implement the pilot program.
(a) To be eligible to participate in the pilot program, an individual must:

(I) reside in the portions of Garfield or Eagle counties that are within the service area of the group medical benefit plans that are offered through the pilot program; and

(II) have a household income of more than four hundred percent, but no more than five hundred percent, of the federal poverty line.

(b) The director may determine the method by which an individual demonstrates eligibility to participate in the pilot program.

(6) The director shall limit participation in the pilot program to the first one hundred individuals who apply to and demonstrate eligibility to participate in the pilot program. An eligible individual authorized to participate in the pilot program may enroll the individual’s dependents in the pilot program.

(7) This section is repealed, effective December 31, 2020.

SECTION 3. In Colorado Revised Statutes, 10-16-1001, amend (2)(a), (3)(a), (3)(e), (3)(f), (4)(a), and (4)(e); and add (3)(g) as follows:

10-16-1001. Legislative declaration. (2) The general assembly hereby finds that:

(a) Under the current health care system in this state, individuals risk losing their health care coverage when they move, when they lose or change jobs when they become seriously ill, or when coverage becomes unaffordable;

(3) The general assembly hereby determines that:

(a) Comprehensive health care benefits that meet the full range of
health needs, including primary, preventive, and specialized care, as mandated by Colorado and federal law, should be readily available to citizens of this state;

(e) All individuals should have a responsibility to pay their fair share of the costs of health care coverage; and

(f) Colorado's health care system should build on the strength of the employment-based coverage arrangements that now exist in this state;

AND

(g) In order to help control health care costs, consumers should be empowered to organize to directly negotiate health care prices with providers.

(4) The general assembly, therefore, declares that the purposes of this part 10 are to:

(a) Promote control of the cost of health care for employers, employees, and others individuals who pay for health care coverage by pooling purchasing power among consumers and organizing providers so that health care services are delivered in the most efficient manner;

(e) Encourage all individuals to take responsibility for their health care coverage by building on existing employment-based arrangements for health care benefits.

SECTION 4. In Colorado Revised Statutes, 10-16-1002, amend (5) and (6)(b); repeal (1) and (11); and add (6.5) as follows:

10-16-1002. Definitions. As used in this part 10, unless the context otherwise requires:

(1) "Class of business" means all or a distinct grouping of small
employers as shown on the records of a small carrier. Each class shall reflect substantial differences in administrative costs related to the use of health care cooperatives for the marketing and sale of health benefit plans to small employers.

(5) "Managed care" means systems or techniques generally used by third-party payors or their agents to affect access to, and to control, payment for health care services. For example, and not for the purpose of limitation, managed care techniques most often include one or more of the following: Prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or of the site at which services are provided; contracts with selected health care providers; financial incentives or disincentives related to the use of specific providers, services, or service sites; controlled access to and coordination of services by a case manager; and payor efforts to identify treatment alternatives and modify benefit restrictions for high-cost patient care. "Managed care" also includes but is not limited to health maintenance organizations HAS THE SAME MEANING AS "MANAGED CARE PLAN", AS DEFINED IN SECTION 10-16-102 (43).

(6) (b) If, pursuant to section 10-16-1009 (3)(l), a cooperative provides coverage to individuals and allows individuals to join the cooperative, "member" may also include an individual and any dependent of such individual who is covered by a plan purchased through a cooperative is eighteen years of age or older, and is not: AND ANY DEPENDENT OF THE INDIVIDUAL, INCLUDING A DEPENDENT CHILD WHO IS UNDER TWENTY-SIX YEARS OF AGE.

(i) Eligible for other coverage with benefits substantially similar to those included in the basic and standard health benefit plans; and
(II) A dependent of an individual who is eligible for other
coverage with benefits substantially similar to those included in the basic
and standard health benefit plans that cover that individual:

(6.5) "MEMBER CLASS" MEANS THE CLASS OF MEMBER BASED ON
WHETHER THE MEMBER WOULD QUALIFY FOR COVERAGE IN THE
INDIVIDUAL MARKET, THE SMALL EMPLOYER MARKET, OR THE LARGE
EMPLOYER MARKET.

(11) "Waivered health care coverage cooperative" means a
cooperative that has been approved to receive a waiver from the
commissioner pursuant to section 10-16-1011.

SECTION 5. In Colorado Revised Statutes, 10-16-1003, amend
(1) as follows:

10-16-1003. Privacy of health information. (1) The privacy of
Individually identifiable health information collected for or by a
cooperative shall be protected. Disclosure of such information is
prohibited except for: IS SUBJECT TO HIPAA.

(a) Disclosures by an individual identified in the information or
whose identity can be associated with the information;
(b) Disclosures explicitly authorized through written informed
consent procedures by an individual;
(c) Disclosures to federal, state, or local law enforcement agencies
for lawful purposes;
(d) Subject to rules promulgated by the commissioner, disclosures
for bona fide research projects:

SECTION 6. In Colorado Revised Statutes, 10-16-1004, repeal
(5) as follows:

10-16-1004. Health care coverage cooperatives - establishment
- fees. (5) Except as allowed by section 10-16-1014, the division of
insurance shall not participate in the formation or administration of a
health care coverage cooperative created pursuant to this part 10.

SECTION 7. In Colorado Revised Statutes, 10-16-1009, amend
(2), (3)(f), (3)(l), and (4)(a); repeal (1)(d), (3)(a), (3)(c), (3)(d), and
(3)(k); and add (1)(o) and (1)(p) as follows:

10-16-1009. Powers, duties, and responsibilities of
cooperatives. (1) Each cooperative organized pursuant to this part 10
shall:

(d) Except for groups over fifty, offer to all members and their
eligible employees the standard and basic health benefit plans;

(o) Consider all individuals in all individual health
benefit plans offered through the cooperative, including those
individuals who do not enroll in the plans through the
exchange, to be members of a single risk pool;

(p) Consider all covered persons in small employer health
benefit plans offered through the cooperative, including those
covered persons who do not enroll in plans through the
exchange, to be members of a single risk pool.

(2) Members that are not self-insured may only be offered plans
or services offered by licensed provider networks, licensed individual
providers, and other carriers. For purposes of this part 10, "self-insured"
means not insured under a plan underwritten by a carrier. or licensed
provider network. A self-insured employer or individual may join a
cooperative in order to have access to the discounted provider rates
(excluding capitated agreements) that the cooperative may negotiate on
behalf of its self-insured members.
(3) Each cooperative organized pursuant to this part 10 may:

(a) Determine, from time to time, the need to establish classes of membership;

(c) Offer any and all health benefit packages permitted under law in addition to the standard and basic health benefit plans;

(d) Require, as a condition of membership, that all employers include all their employees or a minimum percentage of employees in coverage purchased through the cooperative. The cooperative may establish minimum percentages that differ according to the benefit plan or carrier offered. The cooperative may require an employer making membership application to a cooperative that would entail entering fewer than one hundred percent of such employer's eligible employees or dependents to demonstrate, under standards consistent with paragraph (g) of subsection (4) of this section, that such membership is not likely to result in an adverse selection group being brought into the cooperative and would not otherwise act as a form of risk selection or risk avoidance.

(f) Reject, or allow a carrier to reject, an employer from membership or drop, or allow a carrier to drop, an employer from membership if the employer or any of its employee members fails to pay premiums or engages in fraud or material misrepresentation in connection with a plan purchased through the cooperative. If an employer or employee is dropped from membership DUE TO THE EMPLOYER'S FAILURE TO PAY PREMIUMS OR ENGAGEMENT IN FRAUD OR MATERIAL MISREPRESENTATION, the employee shall be entitled to continuation and conversion coverage as provided under applicable state or federal continuation laws and the state conversion law COOPERATIVE MAY OFFER A SPECIAL ENROLLMENT PERIOD IN ACCORDANCE WITH SECTION
10-16-105.7 (3) TO ALLOW THE EMPLOYEE TO ENROLL IN THE INDIVIDUAL
MEMBER CLASS, IF AVAILABLE.

(k) Require that members and their eligible employees continue
to pay administrative fees that are part of the contract with the
cooperative if a member or eligible employee cancels prior to completion
of a contract period;

(l) Offer coverage for individuals who are members; If coverage
is offered to individuals as members, the cooperative may require that
individuals include all dependents under such coverage.

(4) No cooperative organized pursuant to this part 10 may:

(a) Exclude from membership in the cooperative any small
employer or eligible employee or dependent of a small employer
PROSPECTIVE MEMBERS, OR DEPENDENTS OF PROSPECTIVE MEMBERS, who
agrees AGREE to pay fees for membership and any premium for coverage
through the cooperative and who abides ABIDE by the bylaws and rules of
the cooperative and satisfies SATISFY the requirements of the benefit plan
selected;

SECTION 8. In Colorado Revised Statutes, repeal 10-16-1011
as follows:

10-16-1011. Requirements for waived health care coverage
cooperatives - rules. (1) The commissioner shall promulgate rules
setting forth the application procedure for cooperatives seeking a waiver
under this section that:

(a) Establish fair, effective, and timely procedures for addressing
consumer, contractor, and health plan grievances. Such rules shall
include, without limitation, a requirement that health plans provide the
cooperative written notification of all grievances filed with the health
plans and at least a quarterly summary of such grievances: This paragraph (a) shall not be construed to exempt participating carriers from any requirements of this title concerning grievance procedures.

(b) Require the cooperative to demonstrate that it provides coverage in every geographic area in which its participating carriers are authorized to do business by the division of insurance;

c) Establish that small employers that purchase fully insured products through the cooperative are not permitted to offer their employees comparable fully insured or self-insured products through any means other than the cooperative;

d) Ensure that the cooperative will at all times comply with the provisions of section 10-16-1009 (4)(g);

e) Require the cooperative to offer, at a minimum, the basic and standard benefit plans for employers with fifty or fewer employees that all participating carriers must offer. Other benefit plans and benefit packages may be established and offered by some or all carriers that contract with the cooperative, and such plans or packages may include a range of cost-sharing levels. Benefit packages may also include some variations for differences in delivery systems, such as health maintenance organizations, point-of-service plans, preferred provider plans, and fee-for-service plans.

(2) A waiver shall be in effect for a period of not less than ten years after the date of issue, unless the commissioner determines that the waivered cooperative is in violation of subsection (1) of this section. In such a case, the waiver may be phased out over a period of three years by the commissioner in a manner that is consistent with the market viability of the cooperative:
(3) The commissioner may grant a permanent waiver effective upon expiration of a ten-year period. If at any time the commissioner determines that a waivered cooperative operating under a permanent waiver is in violation of subsection (1) of this section, the permanent waiver may be phased out by the commissioner over a period of three years in a manner that is consistent with the market viability of the cooperative.

(4) The commissioner shall promulgate rules for annual reporting requirements for waivered cooperatives. Reporting requirements shall be based only on the requirements for obtaining a waiver as outlined under subsection (1) of this section. Such reporting requirements shall be integrated with other reporting requirements for cooperatives operating under this part 10.

(5) (a) (I) Any carrier doing business with a waivered cooperative shall comply with all rules regarding underwriting, claims handling, sales, solicitation, and other applicable requirements specified pursuant to this title:

(II) Notwithstanding the provisions of subparagraph (I) of this paragraph (a), if a waivered cooperative requires its participating small employer carriers to offer a standardized health benefit plan that such carriers do not offer outside of the waivered cooperative, such carriers shall not be required to market that standardized plan either inside or outside the waivered cooperative in those areas of the state that are not part of the waivered cooperative's geographic service area.

(b) (I) Any carrier doing business with a waivered cooperative shall comply with all applicable rules regarding rating specified pursuant to this title:
(II) (A) Notwithstanding subparagraph (I) of this paragraph (b) and subject to the provisions of subparagraph (B) of this subparagraph (II), a waivered cooperative and a participating carrier may negotiate a percentage discount off of what would otherwise be allowable rates under sections 10-16-107 (6)(a) and 10-16-1012 for a particular plan. That percentage discount shall be applied uniformly to all small employer members of the cooperative. Pursuant to section 10-16-1012, a carrier may apply rating factors differently for its business with a waivered cooperative than for the carrier's other business. Participating carriers shall notify the division of insurance of a negotiated cooperative discount at least thirty days prior to use.

(B) A waivered cooperative may negotiate the non-health-care expense component of the premium rates charged with participating health care coverage plans. As used in this sub-subparagraph (B), "non-health-care expense" includes but is not limited to marketing expenses, acquisition expenses, cost of paying claims, commissions, maintenance expenses, other administration costs, profits, and other contingency margins. "Non-health-care expense" does not include fees paid to health care providers for health care services regardless of the methodology of reimbursement or payment.

(C) Participating health care coverage plans, including those plans that are under consideration for participation, shall, upon request, disclose to waivered cooperatives a list and description of all relevant public information regarding all expenses of the health plans, including but not limited to: The plan's recent filings and previously required filings with the Colorado division of insurance; filings with the national association of insurance commissioners (NAIC); health employer data information.
set (HEDIS) reports regarding provider compensation; and federal health
care financing administration and federal office of personnel management
filings relevant to provider compensation. Public information shall be
provided upon request to a cooperative within fifteen days after such
request:

(D) All health care plans participating in a cooperative shall sign
an affidavit declaring that all coinsurance paid by the insured participants
of the employer members of a waived cooperative shall be based on the
health plan's contracted rate within the health plan's provider network.

(6) If the commissioner does not act on an application for a waiver
under this section within sixty days after submission of the application,
the cooperative may request a formal hearing with the commissioner:

SECTION 9. In Colorado Revised Statutes, repeal 10-16-1012
as follows:

10-16-1012. Application of rating factors inside a waived
cooperative. With the prior approval of the commissioner, a waived
cooperative may require all participating carriers to apply allowable rate
adjustment factors and case characteristic factors to all of that waived
cooperative's business in a consistent fashion, as determined by the
cooperative. If a waived cooperative has received such approval, a
participating carrier within that cooperative shall not be required to apply
allowable rate adjustment factors and case characteristic factors in the
same way for its waived cooperative business as for its other business:

SECTION 10. In Colorado Revised Statutes, 10-16-1013, amend
(3) as follows:

10-16-1013. Violations of article by persons involved with
operations of cooperatives - enforcement - penalties. (3) Any person
adversely affected by an order issued pursuant to this section may, within twenty days after the date of the order, request judicial review under section 24-4-106 (11). C.R.S. An action for judicial review shall not operate to stay or vacate a decision or order; except that the court may issue a stay pending review. The commissioner may recover reasonable attorney fees incurred to enforce the order.

SECTION 11. In Colorado Revised Statutes, 10-16-1014, amend (1)(h); and repeal (1)(a), (1)(b), (1)(c), and (1)(e) as follows:

10-16-1014. Technical assistance to authorized cooperatives from division of insurance. (1) Subject to available appropriations, the commissioner may provide technical assistance to any cooperative that:

(a) Makes coverage available to employer members and covered individuals statewide to the extent possible;

(b) Requires that employer members not self-insure for any benefits included in the cooperative's basic or standard health benefit plans;

(c) Sets maximum employer member contributions to any plan for a covered individual at an amount not to exceed one hundred percent of the cost of the lowest-priced coverage for that employee's family composition for any particular plan package, with employee members paying the difference between the premium of the selected plan and the employer contribution;

(e) Contracts with as many carriers as is allowed by the market and the cooperative's quality, access, and information reporting requirements;

(h) Gives each covered individual the opportunity to choose among carriers that contract with the cooperative.
SECTION 12. In Colorado Revised Statutes, amend 10-16-1015 as follows:

10-16-1015. Health care cooperatives - rule-making authority.
The commissioner may promulgate rules consistent with this part 10 for purposes of carrying out the commissioner's duties under this part 10. The commissioner may promulgate rules to carry out the commissioner's duties under section 10-16-1005, so long as such rules impose no additional requirements beyond those specifically enumerated in section 10-16-1005.

SECTION 13. In Colorado Revised Statutes, add 10-16-1016 as follows:

10-16-1016. State innovation waiver - authority to apply. As necessary to implement this part 10, the commissioner may apply to the secretary of the United States department of health and human services for a five-year state innovation waiver in accordance with section 1332 of the federal act, codified at 42 U.S.C. sec. 18052, and 45 CFR 155.1300. The commissioner shall ensure that a waiver application submitted pursuant to this section complies with the requirements specified in section 1332 of the federal act, codified at 42 U.S.C. sec. 18052, and 45 CFR 155.1308.

SECTION 14. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.