A BILL FOR AN ACT

CONCERNING THE ESTABLISHMENT OF A STANDARDIZED HEALTH BENEFIT PLAN TO BE OFFERED IN COLORADO.

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:

- 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 OPTION HEALTH BENEFIT PLAN
10-16-1301. Short title. The short title of this part 13 is the "COLORADO OPTION HEALTH BENEFIT PLAN ACT".

10-16-1302. Legislative declaration - intent. (1) The general assembly, through the exercise of its police 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 the state's rural areas and for groups historically and
SYSTEMATICALLY DISINVESTED IN PUBLIC POLICY INCLUDING PEOPLE OF
COLOR AND UNDOCUMENTED COLORADANS;

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

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

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

(g) IF CARRIERS CANNOT OFFER THE STANDARDIZED PLAN AT THE
PREMIUM TARGETS SET FORTH IN THIS PART 13, A QUASI-GOVERNMENTAL
ENTITY IS NEEDED TO OFFER THE COLORADO OPTION, AN AFFORDABLE
HEALTH-CARE OPTION, FOR THE PURPOSE OF INCREASING EQUITABLE
ACCESS TO AND AVAILABILITY OF STATEWIDE AFFORDABLE, QUALITY
HEALTH INSURANCE IN THE SMALL GROUP MARKET AND TO ANY RESIDENT
SEEKING COVERAGE IN THE INDIVIDUAL MARKET.

10-16-1303. Definitions. As used in this Part 13, unless the
context otherwise requires:

(1) "Advisory Committee" means the Colorado option
advisory committee established in section 10-16-1308.
(2) "Authority" means the Colorado Option Authority described in section 10-16-1306.

(3) "Board" means the Colorado Option Authority Board described in section 10-16-1306.

(4) "Colorado option" means a standardized plan offered by the authority.

(5) "Health-care coverage cooperative" has the same meaning as set forth in section 10-16-1002 (2).

(6) "Health-care provider" means a health-care professional registered, certified, or licensed pursuant to Title 12 or a health facility licensed pursuant to section 25-1.5-103.

(7) "Public benefit corporation" means a public benefit corporation formed pursuant to part 5 of article 101 of title 7 that may be organized and operated by the exchange pursuant to section 10-22-106 (3).

(8) "Small group market" means the market for small group sickness and accident insurance.

(9) "Standardized plan" means the standardized health benefit plan designed by rule of the commissioner pursuant to section 10-16-1304.

10-16-1304. Standardized health benefit plan - established - rules. (1) On or before January 1, 2022, the commissioner shall establish, by rule, a standardized health benefit plan to be offered by carriers in this state in the individual and small group markets. The standardized plan must:

(a) Offer health-care coverage at the bronze, silver, and gold levels of coverage as described in section 10-16-103.4;
(b) Include, at a minimum, all essential health benefits;
(c) Be offered through the exchange and through the public benefit corporation, if any;
(d) Be a standardized benefit design that:
   (I) is created through a stakeholder engagement process that includes health-care industry and consumer representatives and individuals working in or representing communities that are diverse with regard to race, ethnicity, immigration status, age, ability, sexual orientation, gender identity, or geographic regions of the state or are affected by higher rates of health disparities and inequities;
   (II) has a defined benefit design and cost-sharing; and
   (III) is designed to improve racial health equity and decrease racial health disparities, through a variety of means, including the improvement of perinatal health-care coverage;
(e) Provide first-dollar, pre-deductible coverage for certain high-value services identified collaboratively with consumer stakeholders that reduce racial disparities in health outcomes, such as primary health care and behavioral health care; and
(f) Comply with the federal act and this article 16.

(2) The standardized plan must be offered in a manner that allows consumers to easily compare the standardized plans offered by each carrier.

(3) The commissioner may update the standardized plan annually by rule through the stakeholder process set forth in subsection (1)(d)(I) of this section.
10-16-1305. Standardized health benefit plan - carriers
required to offer - required components - commissioner - rules.

(1) BEGINNING JANUARY 1, 2023, AND EACH YEAR THEREAFTER, A
CARRIER THAT OFFERS:

(a) AN INDIVIDUAL HEALTH BENEFIT PLAN IN COLORADO IS
ENCOURAGED TO OFFER THE STANDARDIZED PLAN IN THE INDIVIDUAL
MARKET IN EACH ZIP CODE WHERE THE CARRIER OFFERS AN INDIVIDUAL
HEALTH BENEFIT PLAN; AND

(b) A SMALL GROUP HEALTH BENEFIT PLAN IN COLORADO IS
ENCOURAGED TO OFFER THE STANDARDIZED PLAN IN THE SMALL GROUP
MARKET IN EACH ZIP CODE WHERE THE CARRIER OFFERS A SMALL GROUP
HEALTH BENEFIT PLAN.

(2) (a) (I) IN THE INDIVIDUAL MARKET, FOR THE PLAN YEAR
BEGINNING JANUARY 1, 2023, AND IN THE SMALL GROUP MARKET,
BEGINNING JANUARY 1, 2023, EACH CARRIER THAT OFFERS THE
STANDARDIZED PLAN SHALL SET A GOAL OF OFFERING THE STANDARDIZED
PLAN AT A PREMIUM RATE THAT IS AT LEAST TEN PERCENT LESS THAN THE
PREMIUM RATE FOR HEALTH BENEFIT PLANS THAT THE CARRIER OFFERED
IN THE 2021 CALENDAR YEAR IN THE INDIVIDUAL AND SMALL GROUP
MARKETS. THE COMMISSIONER MUST CALCULATE THE PREMIUM RATE
REDUCTION BASED ON THE RATES CHARGED IN THE SAME COUNTY IN
WHICH THE CARRIER OFFERED HEALTH BENEFIT PLANS IN THE INDIVIDUAL
AND SMALL GROUP MARKETS IN 2021 PRIOR TO THE APPLICATION OF THE
COLORADO REINSURANCE PROGRAM PURSUANT TO PART 11 OF THIS
ARTICLE 16.

(II) FOR CARRIERS OFFERING THE STANDARDIZED PLAN IN A
COUNTY IN WHICH THE CARRIER DID NOT OFFER A HEALTH BENEFIT PLAN
IN THE INDIVIDUAL OR SMALL GROUP MARKET IN 2021, EACH CARRIER THAT OFFERS THE STANDARDIZED PLAN SHALL SET A GOAL OF OFFERING THE STANDARDIZED PLAN:

(A) IN THE INDIVIDUAL MARKET AT A PREMIUM RATE THAT IS AT LEAST TEN PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR INDIVIDUAL PLANS OFFERED IN THAT COUNTY IN 2021, CALCULATED BASED ON THE AVERAGE PREMIUM RATE FOR INDIVIDUAL HEALTH BENEFIT PLANS OFFERED IN THAT COUNTY PRIOR TO THE APPLICATION OF THE COLORADO REINSURANCE PROGRAM PURSUANT TO PART 11 OF THIS ARTICLE 16; AND

(B) IN THE SMALL GROUP MARKET AT A PREMIUM RATE THAT IS AT LEAST TEN PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR SMALL GROUP PLANS OFFERED IN THAT COUNTY IN 2021, CALCULATED BASED ON THE AVERAGE PREMIUM RATE FOR SMALL GROUP PLANS OFFERED IN THAT COUNTY PRIOR TO THE APPLICATION OF THE COLORADO REINSURANCE PROGRAM PURSUANT TO Part 11 OF THIS ARTICLE 16.

(b) (I) IN THE INDIVIDUAL MARKET, FOR THE PLAN YEAR BEGINNING JANUARY 1, 2024, AND IN THE SMALL GROUP MARKET, BEGINNING JANUARY 1, 2024, EACH CARRIER THAT OFFERS THE STANDARDIZED PLAN SHALL SET A GOAL OF OFFERING THE STANDARDIZED PLAN AT A PREMIUM RATE THAT IS AT LEAST TWENTY PERCENT LESS THAN THE PREMIUM RATE FOR HEALTH BENEFIT PLANS THAT THE CARRIER OFFERED IN THE 2021 CALENDAR YEAR IN THE INDIVIDUAL AND SMALL GROUP MARKETS. THE COMMISSIONER MUST CALCULATE THE PREMIUM RATE REDUCTION BASED ON THE RATES CHARGED IN THE SAME COUNTY IN WHICH THE CARRIER OFFERED HEALTH BENEFIT PLANS IN THE INDIVIDUAL AND SMALL GROUP MARKETS IN 2021 PRIOR TO THE APPLICATION OF THE
COLORADO REINSURANCE PROGRAM PURSUANT TO PART 11 OF THIS
ARTICLE 16.

(II) FOR CARRIERS OFFERING THE STANDARDIZED PLAN IN A
COUNTY IN WHICH THE CARRIER DID NOT OFFER A HEALTH BENEFIT PLAN
IN THE INDIVIDUAL OR SMALL GROUP MARKET IN 2021, EACH CARRIER
THAT OFFERS THE STANDARDIZED PLAN SHALL SET A GOAL OF OFFERING
THE STANDARDIZED PLAN:

(A) IN THE INDIVIDUAL MARKET AT A PREMIUM RATE THAT IS AT
LEAST TWENTY PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR
INDIVIDUAL PLANS OFFERED IN THAT COUNTY IN 2021, CALCULATED
BASED ON THE AVERAGE PREMIUM RATE FOR INDIVIDUAL PLANS OFFERED
IN THAT COUNTY PRIOR TO THE APPLICATION OF THE COLORADO
REINSURANCE PROGRAM PURSUANT TO PART 11 OF THIS ARTICLE 16; AND

(B) IN THE SMALL GROUP MARKET AT A PREMIUM RATE THAT IS AT
LEAST TWENTY PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR
SMALL GROUP PLANS OFFERED IN THAT COUNTY IN 2021, CALCULATED
BASED ON THE AVERAGE PREMIUM RATE FOR SMALL GROUP PLANS
OFFERED IN THAT COUNTY PRIOR TO THE APPLICATION OF THE COLORADO
REINSURANCE PROGRAM PURSUANT TO PART 11 OF THIS ARTICLE 16.

(c) FOR THE PLAN YEAR BEGINNING JANUARY 1, 2025, AND EACH
YEAR THEREAFTER, EACH CARRIER AND HEALTH-CARE COOPERATIVE IS ENCOURAGED TO LIMIT ANNUAL PREMIUM RATE
INCREASES FOR THE STANDARDIZED PLAN IN BOTH THE INDIVIDUAL AND
SMALL GROUP MARKETS BY A RATE THAT IS NO MORE THAN THE MAXIMUM
OF THE CONSUMER PRICE INDEX FOR ALL URBAN CONSUMERS PLUS ONE
PERCENT, RELATIVE TO THE PREVIOUS YEAR.

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


(b) (I) THE PURPOSE OF THE AUTHORITY IS TO OPERATE AS A CARRIER IN THIS STATE AND OFFER THE COLORADO OPTION TO INDIVIDUALS AND SMALL EMPLOYERS STATEWIDE IF AN INDEPENDENT, ACTUARIAL ANALYSIS DEMONSTRATES THAT ALL CARRIERS FAILED TO MEET THE PREMIUM RATE GOALS SPECIFIED IN SECTION 10-16-1305 FOR 2023 AND 2024 AS ADJUSTED FOR CHANGES TO THE STANDARDIZED PLAN BASED ON CHANGES IN PLAN COVERAGE REQUIREMENTS IMPOSED UNDER STATE OR FEDERAL LAW. THE ACTUARIAL ANALYSIS MUST TAKE INTO ACCOUNT ANY CHANGES TO THE STANDARDIZED PLAN OFFERED IN 2023 AND 2024 AND STATE OR FEDERAL HEALTH BENEFIT COVERAGE MANDATES IMPLEMENTED IN 2023 OR 2024. THE COMMISSIONER SHALL ESTABLISH, BY RULE, THE REQUIREMENTS FOR THE METHODOLOGY TO CALCULATE PREMIUM RATE REDUCTIONS.

(II) IF THE COMMISSIONER DETERMINES THAT ALL CARRIERS FAILED TO MEET THE PREMIUM GOALS SPECIFIED IN SECTION 10-16-1305,
THE COMMISSIONER SHALL NOTIFY THE GOVERNOR AND THE BOARD THAT
THE AUTHORITY IS REQUIRED TO OFFER THE COLORADO OPTION PURSUANT
TO THIS PART 13.

(c) THE AUTHORITY IS AN INSTRUMENTALITY OF THE STATE;
EXCEPT THAT THE DEBTS AND LIABILITIES OF THE AUTHORITY DO NOT
CONSTITUTE THE DEBTS AND LIABILITIES OF THE STATE, AND THE
AUTHORITY IS NOT AN AGENCY OF THE STATE. THE AUTHORITY IS NOT A
DISTRICT FOR PURPOSES OF SECTION 20 OF ARTICLE X OF THE STATE
CONSTITUTION. THE AUTHORITY IS NOT AUTHORIZED TO PROMULGATE
RULES PURSUANT TO THE "STATE ADMINISTRATIVE PROCEDURE ACT",
ARTICLE 4 OF TITLE 24.

(d) THE AUTHORITY SHALL IMPLEMENT THE PROVIDER
REIMBURSEMENT FEE SCHEDULE ESTABLISHED IN SECTION 10-16-1307 FOR
SERVICES COVERED BY THE COLORADO OPTION.

(2) (a) THE COLORADO OPTION AUTHORITY BOARD IS HEREBY
CREATED. THE BOARD CONSISTS OF NINE MEMBERS APPOINTED BY THE
GOVERNOR AND CONFIRMED BY THE SENATE. THE BOARD IS THE
GOVERNING BODY OF THE AUTHORITY AND SHALL DETERMINE THE
DEVELOPMENT, GOVERNANCE, AND OPERATION OF THE AUTHORITY. THE
BOARD IS NOT AN AGENCY OF THE STATE.

(b) (I) IN MAKING APPOINTMENTS TO THE BOARD, THE GOVERNOR
SHALL APPOINT INDIVIDUALS WHO HAVE EXPERIENCE OR EXPERTISE IN AT
LEAST TWO OF THE FOLLOWING AREAS:
(A) INDIVIDUAL HEALTH INSURANCE COVERAGE;
(B) VALUE-BASED PURCHASING AND PLAN DESIGN;
(C) HEALTH-CARE CONSUMER NAVIGATION AND ASSISTANCE IN
ACCESSING HEALTH CARE;
(D) Health-care finance;
(E) The provision of health-care services in rural areas;
(F) The provision of health-care services to uninsured and
low-income populations;
(G) Health-care actuarial analysis;
(H) As a member of an employee organization that
represents employees in the health-care industry;
(I) Health-care delivery systems;
(J) Representing consumers in the development of
health-care policy;
(K) Hospital administration;
(L) Insurance brokerage; and
(M) Improving health equity for communities of color and
decreasing racial disparities in health care.

(II) The governor must ensure that the membership of the
board, as a whole, has demonstrated experience and expertise in
most areas outlined in subsection (2)(b)(I) of this section.

(III) At least five members of the board must be
consumers, representatives of consumers, and small business
owners. One member must be a representative of hospitals. One
member must be a representative of providers.

(IV) To the extent possible, the governor shall appoint
board members who reflect the diversity of the state with
regard to race, ethnicity, immigration status, income, wealth,
ability, and geography. In considering geographic diversity, the
governor shall attempt to appoint members from both rural and
urban areas of the state.
(V) A person who is employed by a carrier or a managed care organization is not eligible for appointment to the board.

(c) The governor shall appoint five members to an initial term of four years and four members to an initial term of two years. Thereafter, the term of office of all members is four years. Each member may serve no more than two full four-year terms. Members who serve an initial two-year term may serve up to two additional four-year terms after serving the initial term.

(d) Members of the board serve at the pleasure of the governor. The governor may appoint new members to fill any vacancies on the board in accordance with subsections (2)(b) and (2)(c) of this section.

(e) The members must publicly disclose whether they have any financial interest in the implementation of the Colorado option.

(f) Members of the board may receive a per diem for their service on the board and may be reimbursed for actual and necessary expenses, including any required dependent care and dependent or attendant travel, food, and lodging, while engaged in the performance of official duties of the board.

(g) The governor shall convene the board and provide technical and administrative support to assist with the board's organizational duties. The board shall elect a chair and vice-chair from among the appointed members. The board shall meet as often as necessary to carry out its duties pursuant to this section.
(h) THE BOARD AND ITS MEMBERS:

(I) ARE SUBJECT TO PART 4 OF ARTICLE 6 OF TITLE 24 AND PART 2 OF ARTICLE 72 OF TITLE 24; EXCEPT THAT MEMBERS OF THE BOARD MAY CONVENE IN GROUPS OF NO MORE THAN THREE MEMBERS TO ORGANIZE AND PLAN FOR THE BUSINESS OF THE AUTHORITY AS LONG AS NO FORMAL ACTION IS TAKEN THAT CONCERNS THE BUSINESS OF THE AUTHORITY;

(II) ARE NOT REQUIRED TO COMPLY WITH THE "PROCUREMENT CODE", ARTICLES 101 TO 112 OF TITLE 24; AND

(III) ARE NOT SUBJECT TO OR PART OF THE STATE PERSONNEL SYSTEM, ARTICLE 50 OF TITLE 24.

(3) THE BOARD SHALL:

(a) HIRE AN EXECUTIVE DIRECTOR OF THE AUTHORITY;

(b) SEEK AND MAINTAIN, ON BEHALF OF THE AUTHORITY, A CERTIFICATE OF AUTHORITY TO DO BUSINESS PURSUANT TO SECTION 10-3-105 TO ENABLE THE AUTHORITY TO OPERATE AS A CARRIER IN THIS STATE;

(c) CONSULT WITH AND CONSIDER RECOMMENDATIONS OF THE ADVISORY COMMITTEE CREATED IN SECTION 10-16-1308; AND

(d) NOT DUPLICATE OR REPLACE THE POWERS AND DUTIES OF THE COMMISSIONER PURSUANT TO THIS ARTICLE 16.

(4) THE BOARD, ON BEHALF OF THE AUTHORITY, MAY CONTRACT WITH STATE AGENCIES IN ORDER TO IMPLEMENT THE COLORADO OPTION.

**10-16-1307. Provider fee schedule - duty of commissioner - health-care providers - rules.** (1) (a) THE COMMISSIONER SHALL PROMULGATE RULES TO ESTABLISH A REASONABLE REIMBURSEMENT FEE SCHEDULE FOR HEALTH-CARE SERVICES THAT ARE COVERED BY THE COLORADO OPTION. THE COMMISSIONER SHALL CONSULT WITH THE
EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING TO INFORM HEALTH-CARE PROVIDERS CONCERNING THE PROPOSED FEE SCHEDULE. THE COMMISSIONER SHALL MAKE THE FEE SCHEDULE AVAILABLE TO THE AUTHORITY TO ENABLE THE AUTHORITY TO SET PREMIUM RATES FOR THE COLORADO OPTION. THE PREMIUM RATES ARE SUBJECT TO REVIEW AND APPROVAL PURSUANT TO SECTION 10-16-107.

(b) IN ESTABLISHING THE REIMBURSEMENT FEE SCHEDULE, THE COMMISSIONER MAY TAKE INTO ACCOUNT THE CIRCUMSTANCES OF CRITICAL ACCESS HOSPITALS, RURAL AND INDEPENDENT HEALTH-CARE PROVIDERS, AND THOSE HEALTH-CARE PROVIDERS THAT SERVE A PERCENTAGE OF UNINSURED PATIENTS AND PATIENTS WHO RECEIVE MEDICAL SERVICES THROUGH THE "COLORADO MEDICAL ASSISTANCE ACT", ARTICLES 4 TO 6 OF TITLE 25.5, THAT EXCEEDS THE STATEWIDE AVERAGE AND MAY CONSIDER THE COST OF ADEQUATE WAGES, BENEFITS, STAFFING, AND TRAINING FOR HEALTH-CARE PROVIDERS' EMPLOYEES TO PROVIDE ADEQUATE CARE.

(c) THE FEE SCHEDULE ESTABLISHED PURSUANT TO THIS SUBSECTION (1) MUST:

(I) APPLY TO HOSPITALS, HEALTH-CARE PROVIDERS, PHARMACIES, AND ALL OTHER PROVIDERS DELIVERING HEALTH-CARE SERVICES IN COLORADO THAT ARE COVERED BY THE COLORADO OPTION;

(II) SET THE REIMBURSEMENT FEES FOR 2025 TO ACHIEVE AT LEAST A TWENTY-PERCENT PREMIUM REDUCTION WHEN COMPARED TO THE RATES FOR HEALTH BENEFIT PLANS OFFERED BY CARRIERS IN THE INDIVIDUAL AND SMALL GROUP MARKETS IN 2021;

(III) SET REIMBURSEMENT FEES FOR 2026 AND EACH YEAR
THEREAFTER AT RATES THAT ENSURE THAT THE COLORADO OPTION
PREMIUMS DO NOT INCREASE BY MORE THAN THE CONSUMER PRICE INDEX
FOR ALL URBAN CONSUMERS PLUS ONE PERCENT, RELATIVE TO THE
PREVIOUS YEAR; AND

(IV) BE AVAILABLE TO OTHER HEALTH PLANS AS DETERMINED BY
THE COMMISSIONER, INCLUDING HEALTH-CARE COVERAGE COOPERATIVES
IF MEMBERS OF THE COOPERATIVE OPT TO BE SUBJECT TO THE
REGULATORY AUTHORITY OF THE COMMISSIONER.

(2) EACH HEALTH-CARE PROVIDER SHALL ACCEPT PATIENTS WHO
ARE ENROLLED IN ANY COLORADO OPTION PLAN OFFERED BY THE
AUTHORITY; EXCEPT THAT THE COMMISSIONER MAY, IN CONSULTATION
WITH THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING AND THE
BOARD, EXEMPT A PARTICULAR HEALTH-CARE PROVIDER, HOSPITAL, OR
PHARMACY FROM THE FEE SCHEDULE OR CHANGE THE FEE SCHEDULE FOR
THAT ENTITY UPON A DEMONSTRATION THAT THE FEE SCHEDULE WILL
REDUCE THE ENTITY'S ABILITY TO ACCEPT OR PROVIDE HEALTH-CARE
SERVICES TO PATIENTS WHO ARE UNINSURED OR ENROLLED IN A PROGRAM
OF MEDICAL ASSISTANCE ESTABLISHED PURSUANT TO SECTION 25.5-4-104
OR THE CHILDREN'S BASIC HEALTH PLAN ESTABLISHED PURSUANT TO
ARTICLE 8 OF TITLE 25.5.

(3) A HEALTH-CARE PROVIDER IN COLORADO SHALL NOT BALANCE
BILL CONSUMERS ENROLLED IN THE COLORADO OPTION AND SHALL
ACCEPT THE FEE SPECIFIED IN THE FEE SCHEDULE ESTABLISHED BY THE
COMMISSIONER PURSUANT TO SUBSECTION (1) OF THIS SECTION FOR THE
SERVICE PROVIDED TO THE CONSUMER.

(4) WHEN IMPLEMENTING THE HOSPITAL REIMBURSEMENT RATE
FORMULA PURSUANT TO THIS SECTION, THE COMMISSIONER SHALL, IN
COLLABORATION WITH THE BOARD, CONSULT WITH EMPLOYEE MEMBERSHIP ORGANIZATIONS REPRESENTING HEALTH-CARE PROVIDERS' EMPLOYEES IN COLORADO AND WITH HOSPITAL-BASED HEALTH-CARE PROVIDERS IN COLORADO AND, BASED ON THE CONSULTATIONS, MAY MAKE CHANGES, BY RULE, TO THE HOSPITAL REIMBURSEMENT RATE FORMULA AS APPROPRIATE SO THAT REIMBURSEMENT RATES REFLECT THE COST OF ADEQUATE WAGES, BENEFITS, STAFFING, AND TRAINING FOR THESE EMPLOYEES TO PROVIDE QUALITY CARE.

10-16-1308. Advisory committee - creation - purpose. (1) The board shall appoint an advisory committee to make recommendations to the board and the authority concerning the development, implementation, and operation of the authority and the Colorado option. In making recommendations to the authority and the board, the advisory committee shall give special consideration to Coloradans with low income and to communities of color.

(2) The board shall determine the terms for the advisory committee members and shall ensure that the advisory committee represents the diversity of the state. The advisory committee must include members who intend to enroll in the Colorado option.

10-16-1309. Commissioner - waiver. (1) On or after the effective date of this section, the commissioner may apply to the secretary of the United States department of health and human services for a state innovation waiver to waive one or more requirements of the federal act as authorized by section 1332 of the federal act to capture all applicable savings to the federal act.

(2) UPON APPROVAL OF THE 1332 WAIVER APPLICATION, THE
COMMISSIONER MAY USE ANY FEDERAL MONEY RECEIVED THROUGH THE
WAIVER:

(a) FOR THE ESTABLISHMENT OF THE AUTHORITY FOR THE PURPOSE
OF OFFERING THE COLORADO OPTION; AND

(b) FOR THE COLORADO HEALTH INSURANCE AFFORDABILITY
ENTERPRISE CREATED IN SECTION 10-16-1204 TO INCREASE THE VALUE,
AFFORDABILITY, QUALITY, AND EQUITY OF HEALTH-CARE COVERAGE FOR
ALL COLORADANS, WITH A FOCUS ON INCREASING THE VALUE,
AFFORDABILITY, QUALITY, AND EQUITY OF HEALTH-CARE COVERAGE FOR
COLORADANS HISTORICALLY AND SYSTEMATICALLY DISADVANTAGED BY
HEALTH AND ECONOMIC SYSTEMS.

(3) THE IMPLEMENTATION AND OPERATION OF THE AUTHORITY IS
CONTINGENT UPON APPROVAL OF THE 1332 WAIVER APPLICATION AND THE
RECEIPT OF ANY FEDERAL FUNDS.

10-16-1310. Rules. The commissioner may promulgate rules
as necessary to develop, implement, and operate this Part 13.

10-16-1311. Severability. If any provision of this Part 13 or
application thereof to any person or circumstance is judged
invalid, the invalidity does not affect provisions or applications
of this Part 13 that can be given effect without the invalid
provision or application, and to this end the provisions of this
Part 13 are declared severable.

10-16-1312. Repeal if national public option program enacted.
The provisions of this Part 13, except for sections 10-16-1303 (8)
and (9), 10-16-1304, and 10-16-1305 (1), will be repealed if, after
THE EFFECTIVE DATE OF THIS PART 13, THE UNITED STATES CONGRESS
ENACTS, AND THE PRESIDENT SIGNS, A NATIONAL PUBLIC OPTION PROGRAM
THAT MEETS OR EXCEEDS THE PREMIUM REDUCTION GOALS SET FORTH IN
SECTION 10-16-1305 (2) AND COVERS THE POPULATION THAT WILL
RECEIVE COVERAGE UNDER THIS PART 13. THE COMMISSIONER SHALL
NOTIFY THE REVISOR OF STATUTES IN WRITING OF THE DATE ON WHICH THE
CONDITION SPECIFIED IN THIS SECTION HAS OCCURRED BY E-MAILING THE
NOTICE TO REVISOROFSTATUTES.GA@STATE.CO.US. THE PROVISIONS OF
THIS PART 13, EXCEPT FOR SECTIONS 10-16-1303 (8) AND (9), 10-16-1304,
AND 10-16-1305 (1), ARE REPEALED, EFFECTIVE UPON THE DATE
IDENTIFIED IN THE NOTICE THAT THE CONDITION SPECIFIED IN THIS
SECTION HAS OCCURRED OR, IF THE NOTICE DOES NOT SPECIFY THAT DATE,
UPON THE DATE OF THE NOTICE TO THE REVISOR OF STATUTES.

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

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

(V) The rate filing is incomplete; or

(VII) THE RATE FILING REFLECTS A COST SHIFT BETWEEN THE
STANDARDIZED PLAN, AS DEFINED IN SECTION 10-16-1303 (9), OFFERED BY
THE CARRIER AND THE HEALTH BENEFIT PLAN FOR WHICH RATE APPROVAL
IS BEING SOUGHT. THE COMMISSIONER MAY CONSIDER THE TOTAL COST OF
HEALTH CARE IN MAKING THIS DETERMINATION.

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

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

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

e) All interest and income derived from the deposit and
investment of money in the fund MONEY ALLOCATED TO THE FUND
Pursuant to section 10-16-1309; AND

(f) All interest and income derived from the deposit and
investment of money in the fund.

SECTION 4. In Colorado Revised Statutes, 10-22-106, amend
(1) introductory portion, (1)(j), and (1)(k); and add (1)(l) as follows:

10-22-106. Powers and duties of the board. (1) The board is the
governing body of the exchange and has all the powers and duties
necessary to implement this article ARTICLE 22. The board shall:

(j) Consider the affordability and cost in the context of quality
care and increased access to purchasing health insurance; and

(k) Investigate requirements, develop options, and determine
waivers, if appropriate, to ensure that the best interests of Coloradans are
protected; AND

(l) CONDUCT A SURVEY, THROUGH THE EXCHANGE, OF CONSUMERS
WHO PURCHASED THE STANDARDIZED HEALTH BENEFIT PLAN DEVELOPED
Pursuant to Section 10-16-1305, Which Survey Addresses The
Consumers' Purchasing Experience, Generally, And Whether The
Standardized Plan Addresses Health Equity And Health Disparity
Issues.

SECTION 5. In Colorado Revised Statutes, 12-200-109, amend
(1)(n) and (1)(o); and add (p) as follows:
12-200-109. **Grounds for disciplinary action.** (1) The director may deny licensure to or take disciplinary action against an acupuncturist pursuant to sections 12-20-403, 12-20-404, and 24-4-105 if the director finds that the acupuncturist has committed any of the following acts:

(n) Committed and been convicted of a felony or entered a plea of guilty or nolo contendere to a felony; and

(o) Published or circulated, directly or indirectly, any fraudulent, false, deceitful, or misleading claims or statements relating to acupuncture or to the acupuncturist's practice, capabilities, services, methods, or qualifications; AND

(p) FAILED TO COMPLY WITH SECTION 10-16-1307 (2) OR (3).

**SECTION 6.** In Colorado Revised Statutes, 12-215-115, **add**

(1)(ff) as follows:

12-215-115. **Discipline of licensees - suspension, revocation, denial, and probation - grounds - definitions.** (1) Upon any of the following grounds, the board may take disciplinary or other action as specified in section 12-20-404 or impose conditions on a licensee's license:

(ff) FAILING TO COMPLY WITH SECTION 10-16-1307 (2) OR (3).

**SECTION 7.** In Colorado Revised Statutes, 12-225-109, **add**

(3)(o) as follows:

12-225-109. **Disciplinary action authorized - grounds for discipline - injunctions - rules.** (3) The director may take disciplinary action as authorized by section 12-20-404 (1)(a), (1)(b), or (1)(d) for any of the following acts or omissions:

(o) FAILING TO COMPLY WITH SECTION 10-16-1307 (2) OR (3).

**SECTION 8.** In Colorado Revised Statutes, 12-235-111, **amend**
(1)(p); and add (1)(r) as follows:

**12-235-111. Grounds for discipline - definitions.** (1) The director is authorized to take disciplinary action pursuant to section 12-235-112 against any person who has:

(p) Used fraudulent, coercive, or dishonest practices, or demonstrated incompetence or untrustworthiness, in this state or elsewhere; or

(r) FAILED TO COMPLY WITH SECTION 10-16-1307 (2) OR (3).

**SECTION 9.** In Colorado Revised Statutes, 12-240-121, add (1)(hh) as follows:

**12-240-121. Unprofessional conduct - definitions.**

(1) "Unprofessional conduct" as used in this article 240 means:

(hh) FAILING TO COMPLY WITH SECTION 10-16-1307 (2) OR (3).

**SECTION 10.** In Colorado Revised Statutes, 12-245-224, amend (1)(w) and (1)(x); and add (1)(y) as follows:

**12-245-224. Prohibited activities - related provisions - definition.** (1) A person licensed, registered, or certified under this article 245 violates this article 245 if the person:

(w) Has sold or fraudulently obtained or furnished a license, registration, or certification to practice as a psychologist, social worker, marriage and family therapist, licensed professional counselor, psychotherapist, or addiction counselor or has aided or abetted in those activities; or

(x) Has failed to respond, in the manner required by the board, to a complaint filed with or by the board against the licensee, registrant, or certificate holder; or

(y) HAS FAILED TO COMPLY WITH SECTION 10-16-1307 (2) OR (3).
SECTION 11. In Colorado Revised Statutes, 12-255-120, **amend**
(1)(gg); and **add** (1)(ii) as follows:

12-255-120. **Grounds for discipline - definitions.** (1) "Grounds
for discipline", as used in this part 1, means any action by any person
who:

(gg) Is diverting or has diverted a controlled substance, as defined
in section 18-18-102 (5), or any other drug having similar effects from the
person's place of employment; or

(ii) FAILS TO COMPLY WITH SECTION 10-16-1307 (2) OR (3).

SECTION 12. In Colorado Revised Statutes, 12-270-114, **amend
as enacted by Senate Bill 21-003** (2)(o) and (2)(p); and **add** (2)(q) as
follows:

12-270-114. **Grounds for discipline - disciplinary proceedings
- definitions - judicial review.** (2) The director may take disciplinary or
other action as authorized in section 12-20-404 against, or issue a
cease-and-desist order under the circumstances and in accordance with
the procedures specified in section 12-20-405 to, a licensee in accordance
with this section, upon proof that the licensee:

(o) Has committed a fraudulent insurance act, as described in
section 10-1-128; or

(p) Has otherwise violated this article 270 or any lawful order or
rule of the director; OR

(q) HAS FAILED TO COMPLY WITH SECTION 10-16-1307 (2) OR (3).

SECTION 13. In Colorado Revised Statutes, 12-275-120, **add
(1)(ii) as follows:**

12-275-120. **Unprofessional conduct - definitions.** (1) The term
"unprofessional conduct", as used in this article 275, means:
(ii) FAILING TO COMPLY WITH SECTION 10-16-1307 (2) OR (3).

(1)(aa) as follows:

(1) The board may take disciplinary action in accordance with sections
12-20-404 and 12-285-122 against a person who has:
(aa) FAILED TO COMPLY WITH SECTION 10-16-1307 (2) OR (3).

SECTION 15. In Colorado Revised Statutes, 12-290-108, add
(3)(z) as follows:

12-290-108. Issuance, revocation, or suspension of license -
probation - unprofessional conduct - definitions - immunity in
professional review. (3) "Unprofessional conduct" as used in this article
290 means:
(z) FAILING TO COMPLY WITH SECTION 10-16-1307 (2) OR (3).

SECTION 16. In Colorado Revised Statutes, add 25-3-126 as
follows:

25-3-126. Health facilities - Colorado option - covered persons
- services - balance billing prohibited. (1) A HEALTH FACILITY
LICENSED OR CERTIFIED BY THE DEPARTMENT PURSUANT TO SECTION
25-1.5-103 (1), THAT PROVIDES SERVICES COVERED UNDER THE
COLORADO OPTION, AS DEFINED IN SECTION 10-16-1303 (4), SHALL:
(a) ACCEPT CONSUMERS WHO ARE ENROLLED IN THE COLORADO
OPTION OFFERED BY THE COLORADO OPTION AUTHORITY DESCRIBED IN
SECTION 10-16-1306;
(b) NOT BALANCE BILL CONSUMERS ENROLLED IN A HEALTH
BENEFIT PLAN OFFERED BY THE COLORADO OPTION AUTHORITY; AND
(c) ACCEPT THE FEE SPECIFIED IN THE FEE SCHEDULE ESTABLISHED
PURSUANT TO SECTION 10-16-1307 (1) FOR SERVICES PROVIDED TO A CONSUMER ENROLLED IN THE COLORADO OPTION.

(2) THE DEPARTMENT MAY SUSPEND, REVOKE, OR IMPOSE CONDITIONS ON A HEALTH FACILITY'S LICENSE OR CERTIFICATE OF AUTHORITY FOR NONCOMPLIANCE WITH THIS SECTION.

SECTION 17. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, or safety.