

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

**REENGROSSED**

*This Version Includes All Amendments  
Adopted in the House of Introduction*

LLS NO. 21-0050.02 Kristen Forrestal x4217

**HOUSE BILL 21-1232**

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**A BILL FOR AN ACT**

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

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**Bill Summary**

*(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at <http://leg.colorado.gov>.)*

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

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

HOUSE  
3rd Reading Unamended  
May 10, 2021

HOUSE  
Amended 2nd Reading  
May 7, 2021

- 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.

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

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

4 **PART 13**

5 **COLORADO STANDARDIZED HEALTH BENEFIT PLAN**

6 **10-16-1301. Short title.** THE SHORT TITLE OF THIS PART 13 IS THE  
7 "COLORADO STANDARDIZED HEALTH BENEFIT PLAN ACT".

8 **10-16-1302. Legislative declaration - intent.** (1) THE GENERAL  
9 ASSEMBLY, THROUGH THE EXERCISE OF ITS POWERS TO PROTECT THE  
10 HEALTH, PEACE, SAFETY, AND GENERAL WELFARE OF THE PEOPLE OF  
11 COLORADO, HEREBY FINDS THAT:

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

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

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

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

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

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

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

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

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

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

26 (3) (a) "EQUIVALENT RATE" MEANS, FOR A HOSPITAL THAT IS A  
27 PEDIATRIC SPECIALTY HOSPITAL WITH A LEVEL ONE TRAUMA CENTER, THE

1 PAYMENT RATE DETERMINED BY THE MEDICAID FEE SCHEDULE FOR THE  
2 HOSPITAL FROM THE MOST RECENT YEAR FOR WHICH A COMPLETE SET OF  
3 HOSPITAL FINANCIAL DATA IS PUBLICLY AVAILABLE UPON THE EFFECTIVE  
4 DATE OF THIS PART 13, MULTIPLIED BY A CONVERSION FACTOR EQUAL TO  
5 THE RATIO OF THE STATEWIDE PAYMENT TO COST RATIO FOR MEDICARE TO  
6 THE HOSPITAL'S SPECIFIC PAYMENT COST RATIO FOR THE MOST RECENT SET  
7 OF PUBLICLY AVAILABLE HOSPITAL FINANCIAL DATA UPON THE EFFECTIVE  
8 DATE OF THIS PART 13, WHICH IS 1.52.

9 (b) IN ANY GIVEN YEAR, THE RATE IN SUBSECTION (3)(a) OF THIS  
10 SECTION MUST BE ADJUSTED ANNUALLY FOR CUMULATIVE INFLATION BY  
11 A FACTOR EQUAL TO THE AVERAGE PERCENTAGE INCREASE IN THE  
12 MEDICARE INPATIENT AND OUTPATIENT PROSPECTIVE PAYMENT SYSTEMS  
13 OVER THE PREVIOUS THREE YEARS.

14 (4) "ESSENTIAL ACCESS HOSPITAL" MEANS A CRITICAL ACCESS  
15 HOSPITAL OR GENERAL HOSPITAL LOCATED IN A RURAL AREA WITH  
16 TWENTY-FIVE OR FEWER LICENSED BEDS.

17 (5) "ESSENTIAL COMMUNITY PROVIDER" HAS THE SAME MEANING  
18 AS SET FORTH IN SECTION 25.5-8-103 (6).

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

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

24 (8) "HEALTH-CARE PROVIDER" MEANS A HEALTH-CARE  
25 PROFESSIONAL REGISTERED, CERTIFIED, OR LICENSED PURSUANT TO TITLE  
26 12 OR A HEALTH FACILITY LICENSED OR CERTIFIED PURSUANT TO SECTION  
27 25-1.5-103.

1 (9) "HEALTH SYSTEM" MEANS A CORPORATION OR OTHER  
2 ORGANIZATION THAT OWNS, CONTAINS, OR OPERATES THREE OR MORE  
3 HOSPITALS.

4 (10) "MEDICAL INFLATION" MEANS THE ANNUAL PERCENTAGE  
5 CHANGE IN THE MEDICAL CARE INDEX COMPONENT OF THE UNITED STATES  
6 DEPARTMENT OF LABOR'S BUREAU OF LABOR STATISTICS CONSUMER PRICE  
7 INDEX FOR MEDICAL CARE SERVICES AND MEDICAL CARE COMMODITIES,  
8 OR ITS APPLICABLE PREDECESSOR OR SUCCESSOR INDEX, BASED ON THE  
9 AVERAGE CHANGE IN THE MEDICAL CARE INDEX OVER THE PREVIOUS TEN  
10 YEARS.

11 (11) (a) "MEDICARE REIMBURSEMENT RATE" MEANS THE  
12 FACILITY-SPECIFIC REIMBURSEMENT RATE FOR A PARTICULAR  
13 HEALTH-CARE SERVICE PROVIDED UNDER THE "HEALTH INSURANCE FOR  
14 THE AGED ACT", TITLE XVIII OF THE FEDERAL "SOCIAL SECURITY ACT",  
15 42 U.S.C. SEC. 1395 ET SEQ., AS AMENDED.

16 (b) FOR A HOSPITAL THAT IS REIMBURSED THROUGH THE MEDICARE  
17 PROSPECTIVE PAYMENTS SYSTEMS RATE FOR A CRITICAL ACCESS HOSPITAL,  
18 "MEDICARE REIMBURSEMENT RATE" MEANS THE RATE BASED ON  
19 ALLOWABLE COSTS AS REPORTED IN MEDICARE COST REPORTS AND THE  
20 HISTORICAL COST-TO-CHARGE RATIOS FOR THE SPECIFIC HOSPITAL.

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

25 (13) "SMALL GROUP MARKET" MEANS THE MARKET FOR SMALL  
26 GROUP SICKNESS AND ACCIDENT INSURANCE.

27 (14) "STANDARDIZED PLAN" MEANS THE STANDARDIZED HEALTH

1 BENEFIT PLAN DESIGNED BY RULE OF THE COMMISSIONER PURSUANT TO  
2 SECTION 10-16-1304.

3 **10-16-1304. Standardized health benefit plan - established -**  
4 **components - rules - independent analysis - repeal.** (1) ON OR BEFORE  
5 JANUARY 1, 2022, THE COMMISSIONER SHALL ESTABLISH, BY RULE, A  
6 STANDARDIZED HEALTH BENEFIT PLAN TO BE OFFERED BY CARRIERS IN  
7 THIS STATE IN THE INDIVIDUAL AND SMALL GROUP MARKETS. THE  
8 STANDARDIZED PLAN MUST:

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

11 (b) INCLUDE, AT A MINIMUM, PEDIATRIC AND OTHER ESSENTIAL  
12 HEALTH BENEFITS;

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

15 (d) BE A STANDARDIZED BENEFIT DESIGN THAT:

16 (I) IS CREATED THROUGH A STAKEHOLDER ENGAGEMENT PROCESS  
17 THAT INCLUDES PHYSICIANS, HEALTH-CARE INDUSTRY AND CONSUMER  
18 REPRESENTATIVES, INDIVIDUALS WHO REPRESENT HEALTH-CARE WORKERS  
19 OR WHO WORK IN HEALTH CARE, AND INDIVIDUALS WORKING IN OR  
20 REPRESENTING COMMUNITIES THAT ARE DIVERSE WITH REGARD TO RACE,  
21 ETHNICITY, IMMIGRATION STATUS, AGE, ABILITY, SEXUAL ORIENTATION,  
22 GENDER IDENTITY, OR GEOGRAPHIC REGIONS OF THE STATE AND THAT ARE  
23 AFFECTED BY HIGHER RATES OF HEALTH DISPARITIES AND INEQUITIES;

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

26 (III) IS DESIGNED TO IMPROVE RACIAL HEALTH EQUITY AND  
27 DECREASE RACIAL HEALTH DISPARITIES THROUGH A VARIETY OF MEANS,

1 WHICH ARE IDENTIFIED COLLABORATIVELY WITH CONSUMER  
2 STAKEHOLDERS, INCLUDING:

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

4 (B) PROVIDING FIRST-DOLLAR, PREDEDUCTIBLE COVERAGE FOR  
5 CERTAIN HIGH-VALUE SERVICES, SUCH AS PRIMARY AND BEHAVIORAL  
6 HEALTH CARE;

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

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

11 AND

12 (g) HAVE A NETWORK THAT IS:

13 (I) CULTURALLY RESPONSIVE AND, TO THE GREATEST EXTENT  
14 POSSIBLE, REFLECTS THE DIVERSITY OF ITS ENROLLEES IN TERMS OF RACE,  
15 ETHNICITY, GENDER IDENTITY, AND SEXUAL ORIENTATION IN THE AREA  
16 THAT THE NETWORK EXISTS; AND

17 (II) NO MORE NARROW THAN THE MOST RESTRICTIVE NETWORK  
18 THE CARRIER IS OFFERING FOR NONSTANDARDIZED PLANS IN THE  
19 INDIVIDUAL MARKET FOR THE METAL TIER FOR THAT RATING AREA.

20 (2) (a) IN DEVELOPING THE NETWORK FOR THE STANDARDIZED  
21 PLAN PURSUANT TO SUBSECTION (1)(g) OF THIS SECTION, EACH CARRIER  
22 SHALL:

23 (I) INCLUDE AS PART OF ITS NETWORK ACCESS PLAN A DESCRIPTION  
24 OF THE CARRIER'S EFFORTS TO CONSTRUCT DIVERSE, CULTURALLY  
25 RESPONSIVE NETWORKS THAT ARE WELL-POSITIONED TO ADDRESS HEALTH  
26 EQUITY AND REDUCE HEALTH DISPARITIES; AND

27 (II) INCLUDE A MAJORITY OF THE ESSENTIAL COMMUNITY



1 PROVIDERS IN THE SERVICE AREA IN ITS NETWORK.

2 (b) IF A CARRIER IS UNABLE TO ACHIEVE THE NETWORK ADEQUACY  
3 REQUIREMENTS IN SUBSECTION (1)(g) OF THIS SECTION, THE CARRIER  
4 SHALL FILE AN ACTION PLAN WITH THE DIVISION THAT DESCRIBES THE  
5 CARRIER'S EFFORTS TO ACHIEVE THE REQUIREMENTS IN SUBSECTION (1)(g)  
6 OF THIS SECTION.

7 (c) THE COMMISSIONER SHALL PROMULGATE RULES REGARDING  
8 THE NETWORK ADEQUACY REQUIREMENTS IN SUBSECTION (1)(g) OF THIS  
9 SECTION AND THE ACTION PLAN IN SUBSECTION (2)(b) OF THIS SECTION.

10 (3) THE STANDARDIZED PLAN MUST BE OFFERED IN A MANNER  
11 THAT ALLOWS CONSUMERS TO EASILY COMPARE THE STANDARDIZED  
12 PLANS OFFERED BY EACH CARRIER.

13 (4) THE COMMISSIONER MAY UPDATE THE STANDARDIZED PLAN  
14 ANNUALLY BY RULE THROUGH THE STAKEHOLDER PROCESS DESCRIBED IN  
15 SUBSECTION (1)(d)(I) OF THIS SECTION.

16 (5) THE COMMISSIONER SHALL CONTRACT WITH AN INDEPENDENT  
17 THIRD PARTY TO CONDUCT AN ANALYSIS OF THE IMPACT OF THIS SECTION  
18 ON HEALTH PLAN ENROLLMENT, HEALTH INSURANCE AFFORDABILITY, AND  
19 HEALTH EQUITY. TO THE EXTENT AVAILABLE, THE ANALYSIS MUST  
20 INCLUDE DISAGGREGATED DATA BY RACE, ETHNICITY, IMMIGRATION  
21 STATUS, SEXUAL ORIENTATION, GENDER IDENTITY, AGE, AND ABILITY. IF  
22 THE DATA IS NOT AVAILABLE, THE ANALYSIS MUST NOTE SUCH  
23 UNAVAILABILITY. THE ANALYSIS MUST INCLUDE INFORMATION  
24 CONCERNING TOTAL OUT-OF-POCKET HEALTH-CARE SPENDING. THE  
25 ANALYSIS MUST BE COMPLETED ON OR BEFORE JANUARY 1, 2026.

26 (6) (a) THE COMMISSIONER SHALL COLLABORATE WITH THE  
27 EXCHANGE CONCERNING THE SURVEY REQUIRED IN SECTION 10-22-114,

1 WHICH SURVEY ADDRESSES CONSUMERS' EXPERIENCE.

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

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

6 **10-16-1305. Standardized health benefit plan - carriers**  
7 **required to offer - premium rates - rules.** (1) BEGINNING JANUARY 1,  
8 2023, A CARRIER THAT OFFERS:

9 (a) AN INDIVIDUAL HEALTH BENEFIT PLAN IN COLORADO IS  
10 REQUIRED TO OFFER THE STANDARDIZED PLAN IN THE INDIVIDUAL MARKET  
11 IN EACH COUNTY WHERE THE CARRIER OFFERS AN INDIVIDUAL HEALTH  
12 BENEFIT PLAN AND SHALL OFFER THE STANDARDIZED PLAN THROUGHOUT  
13 THE ENTIRE COUNTY; AND

14 (b) A SMALL GROUP HEALTH BENEFIT PLAN IN COLORADO IS  
15 REQUIRED TO OFFER THE STANDARDIZED PLAN IN THE SMALL GROUP  
16 MARKET IN EACH COUNTY WHERE THE CARRIER OFFERS A SMALL GROUP  
17 HEALTH BENEFIT PLAN AND SHALL OFFER THE STANDARDIZED PLAN  
18 THROUGHOUT THE ENTIRE COUNTY.

19 (2) (a) (I) IN THE INDIVIDUAL MARKET, FOR THE PLAN YEAR  
20 BEGINNING JANUARY 1, 2023, AND IN THE SMALL GROUP MARKET,  
21 BEGINNING JANUARY 1, 2023, EACH CARRIER SHALL OFFER THE  
22 STANDARDIZED PLAN AT A PREMIUM RATE THAT IS AT LEAST SIX PERCENT  
23 LESS THAN THE PREMIUM RATE FOR HEALTH BENEFIT PLANS THAT THE  
24 CARRIER OFFERED IN THE 2021 CALENDAR YEAR, AS ADJUSTED FOR  
25 MEDICAL INFLATION, IN THE INDIVIDUAL AND SMALL GROUP MARKETS.  
26 THE COMMISSIONER SHALL CALCULATE THE PREMIUM RATE REDUCTION  
27 BASED ON THE RATES CHARGED IN THE SAME COUNTY IN WHICH THE

1 CARRIER OFFERED HEALTH BENEFIT PLANS IN THE INDIVIDUAL AND SMALL  
2 GROUP MARKETS IN 2021 PRIOR TO THE APPLICATION OF THE COLORADO  
3 REINSURANCE PROGRAM PURSUANT TO PART 11 OF THIS ARTICLE 16.

4 (II) FOR CARRIERS OFFERING THE STANDARDIZED PLAN IN THE  
5 2023 PLAN YEAR IN A COUNTY IN WHICH THE CARRIER DID NOT OFFER A  
6 HEALTH BENEFIT PLAN IN THE INDIVIDUAL OR SMALL GROUP MARKET IN  
7 THE 2021 CALENDAR YEAR, EACH CARRIER THAT OFFERS THE  
8 STANDARDIZED PLAN SHALL OFFER THE STANDARDIZED PLAN:

9 (A) IN THE INDIVIDUAL MARKET AT A PREMIUM RATE THAT IS AT  
10 LEAST SIX PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR  
11 INDIVIDUAL HEALTH BENEFIT PLANS OFFERED IN THAT COUNTY IN 2021,  
12 CALCULATED BASED ON THE AVERAGE PREMIUM RATE FOR INDIVIDUAL  
13 HEALTH BENEFIT PLANS OFFERED IN THAT COUNTY, AS ADJUSTED FOR  
14 MEDICAL INFLATION, PRIOR TO THE APPLICATION OF THE COLORADO  
15 REINSURANCE PROGRAM PURSUANT TO PART 11 OF THIS ARTICLE 16; AND

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

20 (b) (I) IN THE INDIVIDUAL MARKET, FOR THE PLAN YEAR  
21 BEGINNING JANUARY 1, 2024, AND IN THE SMALL GROUP MARKET,  
22 BEGINNING JANUARY 1, 2024, EACH CARRIER SHALL OFFER THE  
23 STANDARDIZED PLAN AT A PREMIUM RATE THAT IS AT LEAST TWELVE  
24 PERCENT LESS THAN THE PREMIUM RATE FOR HEALTH BENEFIT PLANS THAT  
25 THE CARRIER OFFERED IN THE 2021 CALENDAR YEAR, AS ADJUSTED FOR  
26 MEDICAL INFLATION, IN THE INDIVIDUAL AND SMALL GROUP MARKETS.  
27 THE COMMISSIONER SHALL CALCULATE THE PREMIUM RATE REDUCTION

1     BASED ON THE RATES CHARGED IN THE SAME COUNTY IN WHICH THE  
2     CARRIER OFFERED HEALTH BENEFIT PLANS IN THE INDIVIDUAL AND SMALL  
3     GROUP MARKETS IN 2021 PRIOR TO THE APPLICATION OF THE COLORADO  
4     REINSURANCE PROGRAM PURSUANT TO PART 11 OF THIS ARTICLE 16.

5             (II) FOR CARRIERS OFFERING THE STANDARDIZED PLAN IN THE  
6     2024 PLAN YEAR IN A COUNTY IN WHICH THE CARRIER DID NOT OFFER A  
7     HEALTH BENEFIT PLAN IN THE INDIVIDUAL OR SMALL GROUP MARKET IN  
8     THE 2021 CALENDAR YEAR, EACH CARRIER THAT OFFERS THE  
9     STANDARDIZED PLAN SHALL OFFER THE STANDARDIZED PLAN:

10            (A) IN THE INDIVIDUAL MARKET AT A PREMIUM RATE THAT IS AT  
11     LEAST TWELVE PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR  
12     INDIVIDUAL PLANS OFFERED IN THAT COUNTY IN 2021, CALCULATED  
13     BASED ON THE AVERAGE PREMIUM RATE FOR INDIVIDUAL PLANS OFFERED  
14     IN THAT COUNTY, AS ADJUSTED FOR MEDICAL INFLATION, PRIOR TO THE  
15     APPLICATION OF THE COLORADO REINSURANCE PROGRAM PURSUANT TO  
16     PART 11 OF THIS ARTICLE 16; AND

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

21            (c) (I) IN THE INDIVIDUAL MARKET, FOR THE PLAN YEAR  
22     BEGINNING JANUARY 1, 2025, AND IN THE SMALL GROUP MARKET,  
23     BEGINNING JANUARY 1, 2025, EACH CARRIER SHALL OFFER THE  
24     STANDARDIZED PLAN AT A PREMIUM RATE THAT IS AT LEAST EIGHTEEN  
25     PERCENT LESS THAN THE PREMIUM RATE FOR HEALTH BENEFIT PLANS THAT  
26     THE CARRIER OFFERED IN THE 2021 CALENDAR YEAR, AS ADJUSTED FOR  
27     MEDICAL INFLATION, IN THE INDIVIDUAL AND SMALL GROUP MARKETS.

1 THE COMMISSIONER SHALL CALCULATE THE PREMIUM RATE REDUCTION  
2 BASED ON THE RATES CHARGED IN THE SAME COUNTY IN WHICH THE  
3 CARRIER OFFERED HEALTH BENEFIT PLANS IN THE INDIVIDUAL AND SMALL  
4 GROUP MARKETS IN 2021 PRIOR TO THE APPLICATION OF THE COLORADO  
5 REINSURANCE PROGRAM PURSUANT TO PART 11 OF THIS ARTICLE 16.

6 (II) FOR CARRIERS OFFERING THE STANDARDIZED PLAN IN THE  
7 2025 PLAN YEAR IN A COUNTY IN WHICH THE CARRIER DID NOT OFFER A  
8 HEALTH BENEFIT PLAN IN THE INDIVIDUAL OR SMALL GROUP MARKET IN  
9 THE 2021 CALENDAR YEAR, EACH CARRIER THAT OFFERS THE  
10 STANDARDIZED PLAN SHALL OFFER THE STANDARDIZED PLAN:

11 (A) IN THE INDIVIDUAL MARKET AT A PREMIUM RATE THAT IS AT  
12 LEAST EIGHTEEN PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR  
13 INDIVIDUAL PLANS OFFERED IN THAT COUNTY IN 2021, CALCULATED  
14 BASED ON THE AVERAGE PREMIUM RATE FOR INDIVIDUAL PLANS OFFERED  
15 IN THAT COUNTY, AS ADJUSTED FOR MEDICAL INFLATION, PRIOR TO THE  
16 APPLICATION OF THE COLORADO REINSURANCE PROGRAM PURSUANT TO  
17 PART 11 OF THIS ARTICLE 16; AND

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

22 (d) FOR THE PLAN YEAR BEGINNING ON OR AFTER JANUARY 1,  
23 2026, AND EACH YEAR THEREAFTER, EACH CARRIER AND HEALTH-CARE  
24 COVERAGE COOPERATIVE SHALL LIMIT ANY ANNUAL PERCENTAGE  
25 INCREASE IN THE PREMIUM RATE FOR THE STANDARDIZED PLAN IN BOTH  
26 THE INDIVIDUAL AND SMALL GROUP MARKETS TO A RATE THAT IS NO MORE  
27 THAN MEDICAL INFLATION, RELATIVE TO THE PREVIOUS YEAR.

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

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

11 **10-16-1306. Rate filings - failure to meet premium**  
12 **requirements - notice - public hearing - rules.** (1) (a) IN THE RATE  
13 FILINGS REQUIRED PURSUANT TO SECTION 10-16-107, EACH CARRIER MUST  
14 FILE RATES FOR THE STANDARDIZED PLAN AT THE PREMIUM RATES  
15 REQUIRED IN SECTION 10-16-1305 (2).

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

27 (2) IF A CARRIER IS UNABLE TO OFFER THE STANDARDIZED PLAN AS

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

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

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

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

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

1 72 OF TITLE 24.

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

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

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

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

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

27 (III) A HOSPITAL THAT IS AN ESSENTIAL ACCESS HOSPITAL OR THAT



1 IS INDEPENDENT AND NOT PART OF A HEALTH SYSTEM MUST RECEIVE A  
2 TWENTY-PERCENTAGE-POINT INCREASE IN THE BASE REIMBURSEMENT  
3 RATE.

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

7 (V) A HOSPITAL THAT IS A PEDIATRIC SPECIALTY HOSPITAL WITH  
8 A LEVEL ONE PEDIATRIC TRAUMA CENTER MUST RECEIVE A  
9 FIFTY-FIVE-PERCENTAGE-POINT INCREASE IN THE BASE REIMBURSEMENT  
10 RATE, AND IS NOT ELIGIBLE FOR ADDITIONAL FACTORS UNDER THIS  
11 SUBSECTION (4).

12 (VI) A HOSPITAL WITH A COMBINED PERCENTAGE OF PATIENTS  
13 WHO RECEIVE SERVICES THROUGH PROGRAMS ESTABLISHED THROUGH THE  
14 "COLORADO MEDICAL ASSISTANCE ACT", ARTICLES 4 TO 6 OF TITLE 25.5,  
15 OR MEDICARE, TITLE XVIII OF THE FEDERAL "SOCIAL SECURITY ACT", AS  
16 AMENDED, THAT EXCEEDS THE STATEWIDE AVERAGE MUST RECEIVE UP TO  
17 A THIRTY-PERCENTAGE-POINT INCREASE IN ITS BASE REIMBURSEMENT  
18 RATE, WITH THE ACTUAL INCREASE TO BE DETERMINED BASED ON THE  
19 HOSPITAL'S PERCENTAGE SHARE OF SUCH PATIENTS.

20 (VII) A HOSPITAL THAT IS EFFICIENT IN MANAGING THE  
21 UNDERLYING COST OF CARE AS DETERMINED BY THE HOSPITAL'S TOTAL  
22 MARGINS, OPERATING COSTS, AND NET PATIENT REVENUE MUST RECEIVE  
23 UP TO A FORTY-PERCENTAGE-POINT INCREASE IN ITS BASE  
24 REIMBURSEMENT RATE.

25 (VIII) NOTWITHSTANDING SUBSECTIONS (4)(a)(III) TO (4)(a)(VII)  
26 OF THIS SECTION, IN DETERMINING THE REIMBURSEMENT RATES FOR  
27 HOSPITALS, THE COMMISSIONER MAY CONSULT WITH EMPLOYEE

1 MEMBERSHIP ORGANIZATIONS REPRESENTING HEALTH-CARE PROVIDERS'  
2 EMPLOYEES IN COLORADO AND WITH HOSPITAL-BASED HEALTH-CARE  
3 PROVIDERS IN COLORADO, AND SHALL TAKE INTO ACCOUNT THE COST OF  
4 ADEQUATE WAGES, BENEFITS, STAFFING, AND TRAINING FOR HEALTH-CARE  
5 EMPLOYEES TO PROVIDE CONTINUOUS QUALITY CARE.

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

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

19 (d) (I) REQUIRE HEALTH-CARE PROVIDERS TO ACCEPT THE  
20 REIMBURSEMENT RATES ESTABLISHED PURSUANT TO SUBSECTION (4)(b)  
21 OF THIS SECTION, IF NECESSARY, TO ENSURE THE STANDARDIZED PLAN  
22 MEETS THE PREMIUM RATE REQUIREMENTS AND THE NETWORK ADEQUACY  
23 REQUIREMENTS.

24 (II) THE COMMISSIONER SHALL NOT REQUIRE A HEALTH-CARE  
25 PROVIDER, OTHER THAN A HOSPITAL THAT PROVIDES A MAJORITY OF  
26 COVERED PROFESSIONAL SERVICES THROUGH A SINGLE, CONTRACTED  
27 MEDICAL GROUP FOR A NONPROFIT, NONGOVERNMENTAL HEALTH

1 MAINTENANCE ORGANIZATION, TO CONTRACT WITH ANY OTHER CARRIER;  
2 AND

3 (e) REQUIRE THE CARRIER TO OFFER THE STANDARDIZED PLAN IN  
4 SPECIFIC COUNTIES WHERE NO CARRIER IS OFFERING THE STANDARDIZED  
5 PLAN IN THAT PLAN YEAR IN EITHER THE INDIVIDUAL OR SMALL GROUP  
6 MARKET. IN DETERMINING WHETHER THE CARRIER IS REQUIRED TO OFFER  
7 THE STANDARDIZED PLAN IN A SPECIFIC COUNTY, THE COMMISSIONER  
8 SHALL CONSIDER:

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

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

14 (5) NOTWITHSTANDING SUBSECTION (4) OF THIS SECTION, THE  
15 COMMISSIONER SHALL NOT SET THE REIMBURSEMENT RATES FOR:

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

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

21 (6) (a) THE COMMISSIONER SHALL PROMULGATE RULES TO ENSURE  
22 THAT THERE IS NOT AN UNFAIR COMPETITIVE ADVANTAGE FOR A CARRIER  
23 THAT INTENDS TO OFFER THE STANDARDIZED PLAN IN THE INDIVIDUAL OR  
24 SMALL GROUP MARKET IN A COUNTY WHERE IT HAS NOT PREVIOUSLY  
25 OFFERED HEALTH BENEFIT PLANS IN THAT MARKET OR WITH A HOSPITAL  
26 WITH WHICH THE CARRIER HAS NOT PREVIOUSLY HAD A CONTRACT.

27 (b) THE RULES PROMULGATED PURSUANT TO THIS SUBSECTION (7)

1 MUST ALIGN WITH THE HOSPITAL REIMBURSEMENT METHODOLOGIES  
2 DESCRIBED IN SUBSECTIONS (4), (5), AND (6) OF THIS SECTION.

3 (7) NOTWITHSTANDING SUBSECTIONS (4) AND (5) OF THIS SECTION,  
4 FOR A HOSPITAL WITH A NEGOTIATED REIMBURSEMENT RATE THAT IS  
5 LOWER THAN TEN PERCENT OF THE STATEWIDE HOSPITAL MEDIAN  
6 REIMBURSEMENT RATE MEASURED AS A PERCENTAGE OF MEDICARE FOR  
7 THE 2021 PLAN YEAR USING DATA FROM THE COLORADO ALL-PAYER  
8 CLAIMS DATABASE DESCRIBED IN SECTION 25.5-1-204, THE COMMISSIONER  
9 SHALL SET THE REIMBURSEMENT RATE FOR THAT HOSPITAL AT NO LESS  
10 THAN THE GREATER OF:

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

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

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

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

24 (9) FOR THE PURPOSE OF MAKING THE DETERMINATION IN  
25 SUBSECTION (3) OF THIS SECTION:

26 (a) A HEALTH-CARE COVERAGE COOPERATIVE, AND A CARRIER  
27 OFFERING HEALTH BENEFIT PLANS UNDER AGREEMENT WITH THE

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

10 (b) THE COMMISSIONER SHALL TAKE INTO ACCOUNT:

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

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

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

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

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

27 (12) (a) THE COMMISSIONER SHALL ONLY SET REIMBURSEMENT

1 RATES PURSUANT TO THIS SECTION FOR HOSPITALS OR HEALTH-CARE  
2 PROVIDERS THAT:

3 (I) PREVENTED A CARRIER FROM MEETING THE PREMIUM RATE  
4 REQUIREMENTS FOR A STANDARDIZED PLAN BEING OFFERED IN A SPECIFIC  
5 COUNTY; OR

6 (II) CAUSED THE CARRIER TO FAIL TO MEET NETWORK ADEQUACY  
7 REQUIREMENTS.

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

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

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

24 (b) TO THE EXTENT POSSIBLE, THE GOVERNOR SHALL APPOINT  
25 ADVISORY BOARD MEMBERS WHO ARE DIVERSE WITH REGARD TO RACE,  
26 ETHNICITY, IMMIGRATION STATUS, AGE, ABILITY, SEXUAL ORIENTATION,  
27 GENDER IDENTITY, AND GEOGRAPHY. IN CONSIDERING THE RACIAL AND

1 ETHNIC DIVERSITY OF THE ADVISORY BOARD, THE GOVERNOR SHALL  
2 ATTEMPT TO ENSURE THAT AT LEAST ONE-THIRD OF THE MEMBERS ARE  
3 PEOPLE OF COLOR. IN CONSIDERING THE GEOGRAPHIC DIVERSITY OF THE  
4 ADVISORY BOARD, THE GOVERNOR SHALL ATTEMPT TO APPOINT MEMBERS  
5 FROM BOTH RURAL AND URBAN AREAS OF THE STATE.

6 (2) THE GOVERNOR MAY APPOINT UP TO ELEVEN MEMBERS TO THE  
7 ADVISORY BOARD AND, TO THE EXTENT PRACTICABLE, SHALL INCLUDE  
8 INDIVIDUALS WHO:

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

11 (b) HAVE EXPERIENCE PURCHASING THE STANDARDIZED PLAN;

12 (c) REPRESENT CONSUMER ADVOCACY ORGANIZATIONS;

13 (d) HAVE EXPERTISE IN HEALTH EQUITY;

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

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

17 (g) REPRESENT HOSPITALS OR WHO HAVE EXPERIENCE WITH  
18 CONTRACTS BETWEEN HOSPITALS AND CARRIERS;

19 (h) REPRESENT HEALTH-CARE PROVIDERS OR WHO HAVE  
20 EXPERIENCE WITH CONTRACTS BETWEEN HEALTH-CARE PROVIDERS AND  
21 CARRIERS;

22 (i) REPRESENT AN EMPLOYEE ORGANIZATION THAT REPRESENTS  
23 EMPLOYEES IN THE HEALTH-CARE INDUSTRY; OR

24 (j) ARE LICENSED OR RETIRED PHYSICIANS PRACTICING OR WHO  
25 PRACTICED IN THIS STATE.

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

27 (4) IN ADDITION TO CONSULTING WITH THE COMMISSIONER

1 PURSUANT TO SUBSECTION (1)(a) OF THIS SECTION, THE ADVISORY BOARD  
2 MAY:

3 (a) CONSIDER RECOMMENDATIONS TO STREAMLINE PRIOR  
4 AUTHORIZATION AND UTILIZATION MANAGEMENT PROCESSES FOR THE  
5 STANDARDIZED PLAN;

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

8 (c) CONSIDER WHETHER ALTERNATIVE PAYMENT MODELS MAY BE  
9 APPROPRIATE FOR PARTICULAR SERVICES, TAKING INTO CONSIDERATION  
10 THE IMPACTS OF SUCH MODELS ON HEALTH OUTCOMES FOR PEOPLE OF  
11 COLOR.

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

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

22 (2) (a) UPON APPROVAL OF THE 1332 WAIVER APPLICATION, THE  
23 COMMISSIONER MAY USE ANY FEDERAL MONEY RECEIVED THROUGH THE  
24 WAIVER FOR THE IMPLEMENTATION OF THIS PART 13 OR FOR THE  
25 COLORADO HEALTH INSURANCE AFFORDABILITY ENTERPRISE CREATED IN  
26 SECTION 10-16-1204. THE COMMISSIONER MAY ALLOCATE FEDERAL  
27 MONEY TO THE HEALTH INSURANCE AFFORDABILITY CASH FUND CREATED



1 IN SECTION 10-16-1206 FOR THE PURPOSES DESCRIBED IN SECTION  
2 10-16-1205 (1)(b) FOR USE BY THE COLORADO HEALTH INSURANCE  
3 AFFORDABILITY ENTERPRISE TO INCREASE THE VALUE, AFFORDABILITY,  
4 QUALITY, AND EQUITY OF HEALTH-CARE COVERAGE FOR ALL  
5 COLORADANS, WITH A FOCUS ON INCREASING THE VALUE, AFFORDABILITY,  
6 QUALITY, AND EQUITY OF HEALTH-CARE COVERAGE FOR COLORADANS  
7 HISTORICALLY AND SYSTEMICALLY DISADVANTAGED BY HEALTH AND  
8 ECONOMIC SYSTEMS.

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

12 **10-16-1309. Standardized plan - cost shift.** (1) IF THE  
13 ADMINISTRATOR OF A SELF-FUNDED HEALTH INSURANCE PLAN  
14 VOLUNTARILY PROVIDES TO THE COMMISSIONER ITS CONTRACTED RATES  
15 AND ANY OTHER INFORMATION DEEMED NECESSARY AND AGREED UPON BY  
16 THE ADMINISTRATOR AND THE COMMISSIONER, THE COMMISSIONER MAY  
17 EVALUATE WHETHER THE RATES OF THE SELF-FUNDED HEALTH INSURANCE  
18 PLAN REFLECT A COST SHIFT BETWEEN THE SELF-FUNDED PLAN AND THE  
19 STANDARDIZED PLAN OFFERED BY A CARRIER PURSUANT TO SECTION  
20 10-16-1305.

21 (2) IF THE COMMISSIONER DETERMINES THERE IS A COST SHIFT, THE  
22 COMMISSIONER SHALL, TO THE EXTENT PRACTICABLE, PROVIDE A  
23 DESCRIPTION OF WHICH CATEGORIES OF SERVICES HAVE EXPERIENCED THE  
24 GREATEST COST SHIFT TO THE ADMINISTRATOR OF THE SELF-FUNDED  
25 HEALTH INSURANCE PLAN.

26 **10-16-1310. Reports required - repeal.** (1) THE COMMISSIONER  
27 SHALL CONTRACT WITH AN INDEPENDENT THIRD-PARTY ORGANIZATION TO

1 PREPARE THREE SEPARATE REPORTS AS SPECIFIED IN SUBSECTION (4) OF  
2 THIS SECTION, TO THE EXTENT THAT INFORMATION IS AVAILABLE  
3 REGARDING THE IMPLEMENTATION OF THIS PART 13 AS IT RELATES TO THE  
4 STAFFING, WAGES, BENEFITS, TRAINING, AND WORKING CONDITIONS OF  
5 HOSPITAL WORKERS AND AS IT RELATES TO PROVIDER WORKLOAD,  
6 INCLUDING ANY IMPACT ON THE SIZE OF THE PROVIDER PANELS, IF  
7 AVAILABLE.

8 (2) IN CHOOSING AN INDEPENDENT THIRD-PARTY CONTRACTOR,  
9 THE COMMISSIONER SHALL CONSIDER ORGANIZATIONS WITH EXPERIENCE  
10 CONDUCTING IN-PERSON INTERVIEWS WITH HEALTH-CARE EMPLOYERS AND  
11 EMPLOYEES IN COLORADO.

12 (3) THE INDEPENDENT THIRD-PARTY CONTRACTOR MAY MAKE  
13 POLICY RECOMMENDATIONS RELATED TO INFORMATION IN THE REPORTS  
14 AND MAY INCLUDE DATA COLLECTED FROM EMPLOYERS, EMPLOYEES, AND  
15 OTHER THIRD-PARTY SOURCES.

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

- 18 (a) THE FIRST REPORT BY JULY 1, 2023;
- 19 (b) THE SECOND REPORT BY JULY 1, 2024; AND
- 20 (c) THE THIRD REPORT BY JULY 1, 2025.

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

22 **10-16-1311. State measurement for accountable, responsive,**  
23 **and transparent (SMART) government act report.** (1) THE  
24 COMMISSIONER SHALL REPORT DURING THE HEARINGS CONDUCTED  
25 PURSUANT TO THE "STATE MEASUREMENT FOR ACCOUNTABLE,  
26 RESPONSIVE, AND TRANSPARENT (SMART) GOVERNMENT ACT", PART 2  
27 OF ARTICLE 7 OF TITLE 2:

1 (a) BEGINNING IN JANUARY 2022 AND EACH YEAR THEREAFTER,  
2 ON THE PROGRESS OF THE IMPLEMENTATION AND OPERATION OF THIS PART  
3 13;

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

8 (c) IN JANUARY 2024, JANUARY 2025, AND JANUARY 2026, ON THE  
9 RESULTS OF THE REPORTS REQUIRED IN SECTION 10-16-1310.

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

12 **10-16-1313. Severability.** IF ANY PROVISION OF THIS PART 13 OR  
13 APPLICATION THEREOF TO ANY PERSON OR CIRCUMSTANCES IS JUDGED  
14 INVALID, THE INVALIDITY DOES NOT AFFECT PROVISIONS OR APPLICATIONS  
15 OF THIS PART 13 THAT CAN BE GIVEN EFFECT WITHOUT THE INVALID  
16 PROVISION OR APPLICATION, AND TO THIS END THE PROVISIONS OF THIS  
17 PART 13 ARE DECLARED SEVERABLE.

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

20 **10-16-107. Rate filing regulation - benefits ratio - rules.**

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

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

24 (VII) THE RATE FILING REFLECTS A COST SHIFT BETWEEN THE  
25 STANDARDIZED PLAN, AS DEFINED IN SECTION 10-16-1303 (14), OFFERED  
26 BY THE CARRIER AND THE HEALTH BENEFIT PLAN FOR WHICH RATE  
27 APPROVAL IS BEING SOUGHT. THE COMMISSIONER MAY CONSIDER THE

1 TOTAL COST OF HEALTH CARE IN MAKING THIS DETERMINATION.

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

4 **10-16-1206. Health insurance affordability cash fund -**  
5 **creation.** (1) There is hereby created in the state treasury the health  
6 insurance affordability cash fund. The fund consists of:

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

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

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

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

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

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

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

25 **12-30-116. Acceptance of patients enrolled in standardized**  
26 **plan - acceptance of reimbursement rate requirements - warning -**  
27 **fine.** (1) THE COMMISSIONER OF INSURANCE MAY REQUIRE A

1 HEALTH-CARE PROVIDER, AFTER A HEARING PURSUANT TO SECTION  
2 10-16-1306, TO PARTICIPATE IN A STANDARDIZED PLAN, AS DEFINED IN  
3 SECTION 10-16-1303 (14), AND ACCEPT THE REIMBURSEMENT RATE  
4 DESCRIBED IN SECTION 10-16-1306.

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

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

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

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

22 **25-1.5-116. Hospitals - standardized health benefit plan -**  
23 **participation - penalties.** (1) THE COMMISSIONER OF INSURANCE MAY  
24 REQUIRE A HOSPITAL LICENSED PURSUANT TO SECTION 25-1.5-103, AFTER  
25 A HEARING PURSUANT TO SECTION 10-16-1306 (3) CONCERNING THE  
26 PREMIUM RATE REQUIREMENTS AND NETWORK ADEQUACY, TO  
27 PARTICIPATE IN A STANDARDIZED HEALTH BENEFIT PLAN DESCRIBED IN

1 SECTION 10-16-1304.

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

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

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

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

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

22 25.5-1-131. Insurance ombudsman - consumer advocate -  
23 duties. (1) THERE IS HEREBY CREATED IN THE STATE DEPARTMENT THE  
24 OFFICE OF THE INSURANCE OMBUDSMAN TO ACT AS THE ADVOCATE FOR  
25 CONSUMER INTERESTS IN MATTERS RELATED TO ACCESS TO AND THE  
26 AFFORDABILITY OF THE STANDARDIZED HEALTH BENEFIT PLAN CREATED  
27 PURSUANT TO SECTION 10-16-1304. THE OMBUDSMAN SHALL:

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

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

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

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

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

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

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

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

24 (2) For the 2021-22 state fiscal year, \$212,680 is appropriated to  
25 the department of law. This appropriation is from reappropriated funds  
26 received from the department of regulatory agencies under subsection  
27 (1)(c) of this section and is based on an assumption that the department

1 of law will require an additional 1.1 FTE. To implement this act, the  
2 department of law may use this appropriation to provide legal services for  
3 the department of regulatory agencies.

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

8 (a) \$65,243 for personal services, which amount is based on an  
9 assumption that the office will require an additional 0.8 FTE; and

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

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