

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

REVISED

*This Version Includes All Amendments Adopted
on Second Reading in the Second House*

LLS NO. 21-0050.02 Kristen Forrestal x4217

HOUSE BILL 21-1232

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A BILL FOR AN ACT

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

Bill Summary

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

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

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

SENATE
Amended 2nd Reading
May 25, 2021

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.

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-TO-COST RATIO FOR THE MOST RECENT
7 SET OF PUBLICLY AVAILABLE HOSPITAL FINANCIAL DATA UPON THE
8 EFFECTIVE 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 (c) FOR ANY HEALTH-CARE SERVICE WITHOUT AN EXISTING
15 MEDICARE REIMBURSEMENT RATE AND FOR SERVICES THAT HAVE LOW
16 VOLUME STATEWIDE RELATIVE TO OTHER MEDICARE SERVICES, INCLUDING
17 PEDIATRIC OR OBSTETRIC SERVICES, AN EQUIVALENT RATE MEANS A RATE
18 SET BY RULE OF THE COMMISSIONER AFTER CONSULTATION WITH A
19 STATEWIDE ASSOCIATION OF HOSPITALS, PHYSICIANS, OTHER PROVIDERS,
20 AND THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING. THE
21 EQUIVALENT RATE MUST UTILIZE THE RATIO OF MEDICAID PAYMENT RATES
22 TO EXISTING MEDICARE PAYMENT RATES WHENEVER POSSIBLE.

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

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

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

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

6 (8) "HEALTH-CARE PROVIDER" MEANS A HEALTH-CARE
7 PROFESSIONAL REGISTERED, CERTIFIED, OR LICENSED PURSUANT TO TITLE
8 12 OR A HEALTH FACILITY LICENSED OR CERTIFIED PURSUANT TO SECTION
9 25-1.5-103.

10 (9) "HEALTH SYSTEM" MEANS A CORPORATION OR OTHER
11 ORGANIZATION THAT OWNS, CONTAINS, OR OPERATES THREE OR MORE
12 HOSPITALS.

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

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

25 (b) FOR A HOSPITAL THAT IS REIMBURSED THROUGH THE MEDICARE
26 PROSPECTIVE PAYMENTS SYSTEMS RATE FOR A CRITICAL ACCESS HOSPITAL,
27 "MEDICARE REIMBURSEMENT RATE" MEANS THE RATE BASED ON

1 ALLOWABLE COSTS AS REPORTED IN MEDICARE COST REPORTS AND THE
2 HISTORICAL COST-TO-CHARGE RATIOS FOR THE SPECIFIC HOSPITAL.

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

7 (13) "SMALL GROUP MARKET" MEANS THE MARKET FOR SMALL
8 GROUP SICKNESS AND ACCIDENT INSURANCE.

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

12 **10-16-1304. Standardized health benefit plan - established -**
13 **components - rules - independent analysis - repeal.** (1) ON OR BEFORE
14 JANUARY 1, 2022, THE COMMISSIONER SHALL ESTABLISH, BY RULE, A
15 STANDARDIZED HEALTH BENEFIT PLAN TO BE OFFERED BY CARRIERS IN
16 THIS STATE IN THE INDIVIDUAL AND SMALL GROUP MARKETS. THE
17 STANDARDIZED PLAN MUST:

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

20 (b) INCLUDE, AT A MINIMUM, PEDIATRIC AND OTHER ESSENTIAL
21 HEALTH BENEFITS;

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

24 (d) BE A STANDARDIZED BENEFIT DESIGN THAT:

25 (I) IS CREATED THROUGH A STAKEHOLDER ENGAGEMENT PROCESS
26 THAT INCLUDES PHYSICIANS, HEALTH-CARE INDUSTRY AND CONSUMER
27 REPRESENTATIVES, INDIVIDUALS WHO REPRESENT HEALTH-CARE WORKERS

1 OR WHO WORK IN HEALTH CARE, AND INDIVIDUALS WORKING IN OR
2 REPRESENTING COMMUNITIES THAT ARE DIVERSE WITH REGARD TO RACE,
3 ETHNICITY, IMMIGRATION STATUS, AGE, ABILITY, SEXUAL ORIENTATION,
4 GENDER IDENTITY, OR GEOGRAPHIC REGIONS OF THE STATE AND THAT ARE
5 AFFECTED BY HIGHER RATES OF HEALTH DISPARITIES AND INEQUITIES;

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

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

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

13 (B) PROVIDING FIRST-DOLLAR, PREDEDUCTIBLE COVERAGE FOR
14 CERTAIN HIGH-VALUE SERVICES, SUCH AS PRIMARY AND BEHAVIORAL
15 HEALTH CARE;

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

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

20 AND

21 (g) HAVE A NETWORK THAT IS:

22 (I) CULTURALLY RESPONSIVE AND, TO THE GREATEST EXTENT
23 POSSIBLE, REFLECTS THE DIVERSITY OF ITS ENROLLEES IN TERMS OF RACE,
24 ETHNICITY, GENDER IDENTITY, AND SEXUAL ORIENTATION IN THE AREA
25 THAT THE NETWORK EXISTS; AND

26 (II) NO MORE NARROW THAN THE MOST RESTRICTIVE NETWORK
27 THE CARRIER IS OFFERING FOR NONSTANDARDIZED PLANS IN THE

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

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

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

9 (II) INCLUDE A MAJORITY OF THE ESSENTIAL COMMUNITY
10 PROVIDERS IN THE SERVICE AREA IN ITS NETWORK.

11 (b) IF A CARRIER IS UNABLE TO ACHIEVE THE NETWORK ADEQUACY
12 REQUIREMENTS IN SUBSECTION (1)(g) OF THIS SECTION, THE CARRIER
13 SHALL FILE AN ACTION PLAN WITH THE DIVISION THAT DESCRIBES THE
14 CARRIER'S EFFORTS TO ACHIEVE THE REQUIREMENTS IN SUBSECTION (1)(g)
15 OF THIS SECTION.

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

19 (3) THE STANDARDIZED PLAN MUST BE OFFERED IN A MANNER
20 THAT ALLOWS CONSUMERS TO EASILY COMPARE THE STANDARDIZED
21 PLANS OFFERED BY EACH CARRIER.

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

25 (5) THE COMMISSIONER SHALL CONTRACT WITH AN INDEPENDENT
26 THIRD PARTY TO CONDUCT AN ANALYSIS OF THE IMPACT OF THIS SECTION
27 ON HEALTH PLAN ENROLLMENT, HEALTH INSURANCE AFFORDABILITY, AND

1 HEALTH EQUITY. TO THE EXTENT AVAILABLE, THE ANALYSIS MUST
2 INCLUDE DISAGGREGATED DATA BY RACE, ETHNICITY, IMMIGRATION
3 STATUS, SEXUAL ORIENTATION, GENDER IDENTITY, AGE, AND ABILITY. IF
4 THE DATA IS NOT AVAILABLE, THE ANALYSIS MUST NOTE SUCH
5 UNAVAILABILITY. THE ANALYSIS MUST INCLUDE INFORMATION
6 CONCERNING TOTAL OUT-OF-POCKET HEALTH-CARE SPENDING. THE
7 ANALYSIS MUST BE COMPLETED ON OR BEFORE JANUARY 1, 2026.

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

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

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

15 **10-16-1305. Standardized health benefit plan - carriers**
16 **required to offer - premium rates - rules.** (1) BEGINNING JANUARY 1,
17 2023, A CARRIER THAT OFFERS:

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

23 (b) A SMALL GROUP HEALTH BENEFIT PLAN IN COLORADO IS
24 REQUIRED TO OFFER THE STANDARDIZED PLAN IN THE SMALL GROUP
25 MARKET IN EACH COUNTY WHERE THE CARRIER OFFERS A SMALL GROUP
26 HEALTH BENEFIT PLAN AND SHALL OFFER THE STANDARDIZED PLAN
27 THROUGHOUT THE ENTIRE COUNTY.

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

13 (II) FOR CARRIERS OFFERING THE STANDARDIZED PLAN IN THE
14 2023 PLAN YEAR IN A COUNTY IN WHICH THE CARRIER DID NOT OFFER A
15 HEALTH BENEFIT PLAN IN THE INDIVIDUAL OR SMALL GROUP MARKET IN
16 THE 2021 CALENDAR YEAR, EACH CARRIER THAT OFFERS THE
17 STANDARDIZED PLAN SHALL OFFER THE STANDARDIZED PLAN:

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

25 (B) IN THE SMALL GROUP MARKET AT A PREMIUM RATE THAT IS AT
26 LEAST FIVE PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR SMALL
27 GROUP PLANS OFFERED IN THAT COUNTY IN 2021, AS ADJUSTED FOR

1 MEDICAL INFLATION.

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

14 (II) FOR CARRIERS OFFERING THE STANDARDIZED PLAN IN THE
15 2024 PLAN YEAR IN A COUNTY IN WHICH THE CARRIER DID NOT OFFER A
16 HEALTH BENEFIT PLAN IN THE INDIVIDUAL OR SMALL GROUP MARKET IN
17 THE 2021 CALENDAR YEAR, EACH CARRIER THAT OFFERS THE
18 STANDARDIZED PLAN SHALL OFFER THE STANDARDIZED PLAN:

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

26 (B) IN THE SMALL GROUP MARKET AT A PREMIUM RATE THAT IS AT
27 LEAST TEN PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR SMALL

1 GROUP PLANS OFFERED IN THAT COUNTY IN 2021, AS ADJUSTED FOR
2 MEDICAL INFLATION.

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

15 (II) FOR CARRIERS OFFERING THE STANDARDIZED PLAN IN THE
16 2025 PLAN YEAR IN A COUNTY IN WHICH THE CARRIER DID NOT OFFER A
17 HEALTH BENEFIT PLAN IN THE INDIVIDUAL OR SMALL GROUP MARKET IN
18 THE 2021 CALENDAR YEAR, EACH CARRIER THAT OFFERS THE
19 STANDARDIZED PLAN SHALL OFFER THE STANDARDIZED PLAN:

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

27 (B) IN THE SMALL GROUP MARKET AT A PREMIUM RATE THAT IS AT

1 LEAST FIFTEEN PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR
2 SMALL GROUP PLANS OFFERED IN THAT COUNTY IN 2021, AS ADJUSTED FOR
3 MEDICAL INFLATION.

4 (d) FOR THE PLAN YEAR BEGINNING ON OR AFTER JANUARY 1,
5 2026, AND EACH YEAR THEREAFTER, EACH CARRIER AND HEALTH-CARE
6 COVERAGE COOPERATIVE SHALL LIMIT ANY ANNUAL PERCENTAGE
7 INCREASE IN THE PREMIUM RATE FOR THE STANDARDIZED PLAN IN BOTH
8 THE INDIVIDUAL AND SMALL GROUP MARKETS TO A RATE THAT IS NO MORE
9 THAN MEDICAL INFLATION, RELATIVE TO THE PREVIOUS YEAR.

10 (3) THE PREMIUM RATE REQUIREMENTS IN SUBSECTIONS (2)(a),
11 (2)(b), AND (2)(c) OF THIS SECTION FOR THE STANDARDIZED PLAN OFFERED
12 IN THE INDIVIDUAL AND SMALL GROUP MARKETS MUST ACCOUNT FOR
13 POLICY ADJUSTMENTS ADOPTED CONSISTENT WITH THE REQUIREMENTS IN
14 SECTION 10-16-107 (8) TO PREVENT PEOPLE WITH LOW AND MODERATE
15 INCOMES FROM EXPERIENCING NET INCREASES IN PREMIUM COSTS, SUCH
16 AS ADOPTING THE INDUCED DEMAND FACTORS UTILIZED AS PART OF THE
17 FEDERAL RISK ADJUSTMENT PROGRAM UNDER 42 U.S.C. SEC. 18063.

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

22 **10-16-1306. Rate filings - failure to meet premium**
23 **requirements - notice - public hearing - rules.** (1) (a) IN THE RATE
24 FILINGS REQUIRED PURSUANT TO SECTION 10-16-107, EACH CARRIER MUST
25 FILE RATES FOR THE STANDARDIZED PLAN AT THE PREMIUM RATES
26 REQUIRED IN SECTION 10-16-1305 (2).

27 (b) IF A CARRIER OR HEALTH-CARE PROVIDER ANTICIPATES THAT

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

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

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

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

21 (3) (a) IF, ON OR AFTER JANUARY 1, 2023, AND PURSUANT TO
22 SUBSECTION (2) OF THIS SECTION, A CARRIER NOTIFIES THE COMMISSIONER
23 THAT THE CARRIER IS UNABLE TO OFFER THE STANDARDIZED PLAN AT THE
24 PREMIUM RATE REQUIRED IN SECTION 10-16-1305 (2) OR THE
25 COMMISSIONER OTHERWISE DETERMINES, WITH SUPPORT FROM AN
26 INDEPENDENT ACTUARY AND BASED ON A REVIEW OF THE RATE AND FORM
27 FILINGS, THAT A CARRIER HAS NOT MET THE PREMIUM RATE

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

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

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

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

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

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

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

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

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

18 (V) A HOSPITAL THAT IS A PEDIATRIC SPECIALTY HOSPITAL WITH
19 A LEVEL ONE PEDIATRIC TRAUMA CENTER MUST RECEIVE A
20 FIFTY-FIVE-PERCENTAGE-POINT INCREASE IN THE BASE REIMBURSEMENT
21 RATE, AND IS NOT ELIGIBLE FOR ADDITIONAL FACTORS UNDER THIS
22 SUBSECTION (4).

23 (VI) A HOSPITAL WITH A COMBINED PERCENTAGE OF PATIENTS
24 WHO RECEIVE SERVICES THROUGH PROGRAMS ESTABLISHED THROUGH THE
25 "COLORADO MEDICAL ASSISTANCE ACT", ARTICLES 4 TO 6 OF TITLE 25.5,
26 OR MEDICARE, TITLE XVIII OF THE FEDERAL "SOCIAL SECURITY ACT", AS
27 AMENDED, THAT EXCEEDS THE STATEWIDE AVERAGE MUST RECEIVE UP TO

1 A THIRTY-PERCENTAGE-POINT INCREASE IN ITS BASE REIMBURSEMENT
2 RATE, WITH THE ACTUAL INCREASE TO BE DETERMINED BASED ON THE
3 HOSPITAL'S PERCENTAGE SHARE OF SUCH PATIENTS.

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

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

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

25 (c) REQUIRE HOSPITALS THAT ARE LICENSED PURSUANT TO
26 SECTION 25-1.5-103 TO ACCEPT THE REIMBURSEMENT RATES ESTABLISHED
27 PURSUANT TO SUBSECTION (4)(a) OF THIS SECTION IF NECESSARY TO

1 ENSURE THE STANDARDIZED PLAN MEETS THE PREMIUM RATE
2 REQUIREMENTS AND THE NETWORK ADEQUACY REQUIREMENTS;

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

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

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

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

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

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

27 (a) A HOSPITAL AT LESS THAN ONE HUNDRED SIXTY-FIVE PERCENT

1 OF THE MEDICARE REIMBURSEMENT RATE OR THE EQUIVALENT RATE; AND

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

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

11 (b) THE RULES PROMULGATED PURSUANT TO THIS SUBSECTION (7)
12 MUST ALIGN WITH THE HOSPITAL REIMBURSEMENT METHODOLOGIES
13 DESCRIBED IN SUBSECTIONS (4), (5), AND (6) OF THIS SECTION.

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

22 (a) THE HOSPITAL'S COMMERCIAL REIMBURSEMENT RATE AS A
23 PERCENTAGE OF MEDICARE MINUS ONE-THIRD OF THE DIFFERENCE
24 BETWEEN THE HOSPITAL'S 2021 COMMERCIAL REIMBURSEMENT RATE AS
25 A PERCENTAGE OF MEDICARE AND THE RATE ESTABLISHED BY SUBSECTION
26 (4) OF THIS SECTION;

27 (b) ONE HUNDRED SIXTY-FIVE PERCENT OF THE HOSPITAL'S

1 MEDICARE REIMBURSEMENT RATE OR EQUIVALENT RATE; OR

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

3 (8) A CARRIER OR HEALTH-CARE PROVIDER MAY APPEAL A

4 DECISION BY THE COMMISSIONER MADE PURSUANT TO SUBSECTION (4) OF

5 THIS SECTION TO THE DISTRICT COURT IN THE APPLICABLE JURISDICTION.

6 THE DECISION OF THE COMMISSIONER IS A FINAL AGENCY ACTION SUBJECT

7 TO JUDICIAL REVIEW PURSUANT TO SECTION 24-4-106 (6).

8 (9) FOR THE PURPOSE OF MAKING THE DETERMINATION IN

9 SUBSECTION (3) OF THIS SECTION:

10 (a) A HEALTH-CARE COVERAGE COOPERATIVE, AND A CARRIER

11 OFFERING HEALTH BENEFIT PLANS UNDER AGREEMENT WITH THE

12 HEALTH-CARE COVERAGE COOPERATIVE, THAT HAS OFFERED ONE OR MORE

13 HEALTH BENEFIT PLANS TO PURCHASERS IN THE INDIVIDUAL AND SMALL

14 GROUP MARKETS THAT PREVIOUSLY ACHIEVED AND MAINTAINED AT LEAST

15 AN FIFTEEN PERCENT REDUCTION IN PREMIUM RATES, REGARDLESS OF THE

16 FIRST YEAR THE HEALTH BENEFIT PLANS WERE OFFERED, SHALL BE

17 DEEMED BY THE COMMISSIONER AS HAVING MET THE REQUIREMENTS FOR

18 CARRIERS IN SECTIONS 10-16-1304 AND 10-16-1305 WITH RESPECT TO THE

19 COUNTIES IN WHICH THE INDIVIDUAL AND SMALL GROUP PLANS ARE BEING

20 OFFERED BY THE HEALTH-CARE COVERAGE COOPERATIVE.

21 (b) THE COMMISSIONER SHALL TAKE INTO ACCOUNT:

22 (I) ANY ACTUARIAL DIFFERENCES BETWEEN THE STANDARDIZED

23 PLAN AND THE HEALTH BENEFIT PLANS THE CARRIER OFFERED IN THE 2021

24 CALENDAR YEAR;

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

26 (III) STATE OR FEDERAL HEALTH BENEFIT COVERAGE MANDATES

27 IMPLEMENTED AFTER THE 2021 PLAN YEAR.

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

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

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

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

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

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

10-16-1307. Advisory board - members - rules. (1) (a) THE COMMISSIONER SHALL CONSULT WITH AN ADVISORY BOARD TO IMPLEMENT THIS PART 13. THE GOVERNOR SHALL APPOINT THE MEMBERS OF THE

1 ADVISORY BOARD ON OR BEFORE JULY 1, 2022, AND SHALL ENSURE THAT
2 THE MEMBERSHIP OF THE ADVISORY BOARD HAS DEMONSTRATED
3 EXPERIENCE AND EXPERTISE IN MOST OF THE AREAS LISTED IN SUBSECTION
4 (2) OF THIS SECTION.

5 (b) TO THE EXTENT POSSIBLE, THE GOVERNOR SHALL APPOINT
6 ADVISORY BOARD MEMBERS WHO ARE DIVERSE WITH REGARD TO RACE,
7 ETHNICITY, IMMIGRATION STATUS, AGE, ABILITY, SEXUAL ORIENTATION,
8 GENDER IDENTITY, AND GEOGRAPHY. IN CONSIDERING THE RACIAL AND
9 ETHNIC DIVERSITY OF THE ADVISORY BOARD, THE GOVERNOR SHALL
10 ATTEMPT TO ENSURE THAT AT LEAST ONE-THIRD OF THE MEMBERS ARE
11 PEOPLE OF COLOR. IN CONSIDERING THE GEOGRAPHIC DIVERSITY OF THE
12 ADVISORY BOARD, THE GOVERNOR SHALL ATTEMPT TO APPOINT MEMBERS
13 FROM BOTH RURAL AND URBAN AREAS OF THE STATE.

14 (2) THE GOVERNOR MAY APPOINT UP TO ELEVEN MEMBERS TO THE
15 ADVISORY BOARD AND, TO THE EXTENT PRACTICABLE, SHALL INCLUDE
16 INDIVIDUALS WHO:

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

19 (b) HAVE EXPERIENCE PURCHASING THE STANDARDIZED PLAN;

20 (c) REPRESENT CONSUMER ADVOCACY ORGANIZATIONS;

21 (d) HAVE EXPERTISE IN HEALTH EQUITY;

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

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

25 (g) REPRESENT HOSPITALS OR WHO HAVE EXPERIENCE WITH
26 CONTRACTS BETWEEN HOSPITALS AND CARRIERS;

27 (h) REPRESENT HEALTH-CARE PROVIDERS OR WHO HAVE

1 EXPERIENCE WITH CONTRACTS BETWEEN HEALTH-CARE PROVIDERS AND
2 CARRIERS;

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

5 (j) ARE LICENSED OR RETIRED PHYSICIANS PRACTICING OR WHO
6 PRACTICED IN THIS STATE.

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

8 (4) IN ADDITION TO CONSULTING WITH THE COMMISSIONER
9 PURSUANT TO SUBSECTION (1)(a) OF THIS SECTION, THE ADVISORY BOARD
10 MAY:

11 (a) CONSIDER RECOMMENDATIONS TO STREAMLINE PRIOR
12 AUTHORIZATION AND UTILIZATION MANAGEMENT PROCESSES FOR THE
13 STANDARDIZED PLAN;

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

16 (c) CONSIDER WHETHER ALTERNATIVE PAYMENT MODELS MAY BE
17 APPROPRIATE FOR PARTICULAR SERVICES, TAKING INTO CONSIDERATION
18 THE IMPACTS OF SUCH MODELS ON HEALTH OUTCOMES FOR PEOPLE OF
19 COLOR.

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

22 **10-16-1308. Federal waiver - commissioner application - use**
23 **of money.** (1) ON OR AFTER THE EFFECTIVE DATE OF THIS SECTION, THE
24 COMMISSIONER MAY APPLY TO THE SECRETARY OF THE UNITED STATES
25 DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR A STATE INNOVATION
26 WAIVER TO WAIVE ONE OR MORE REQUIREMENTS OF THE FEDERAL ACT AS
27 AUTHORIZED BY SECTION 1332 OF THE FEDERAL ACT TO CAPTURE ALL

1 APPLICABLE SAVINGS TO THE FEDERAL GOVERNMENT AS A RESULT OF THE
2 IMPLEMENTATION OF THIS PART 13.

3 (2) (a) UPON APPROVAL OF THE 1332 WAIVER APPLICATION, THE
4 COMMISSIONER MAY USE ANY FEDERAL MONEY RECEIVED THROUGH THE
5 WAIVER FOR THE IMPLEMENTATION OF THIS PART 13 OR FOR THE
6 COLORADO HEALTH INSURANCE AFFORDABILITY ENTERPRISE CREATED IN
7 SECTION 10-16-1204. THE COMMISSIONER MAY ALLOCATE FEDERAL
8 MONEY TO THE HEALTH INSURANCE AFFORDABILITY CASH FUND CREATED
9 IN SECTION 10-16-1206 FOR THE PURPOSES DESCRIBED IN SECTION
10 10-16-1205 (1)(b) FOR USE BY THE COLORADO HEALTH INSURANCE
11 AFFORDABILITY ENTERPRISE TO INCREASE THE VALUE, AFFORDABILITY,
12 QUALITY, AND EQUITY OF HEALTH-CARE COVERAGE FOR ALL
13 COLORADANS, WITH A FOCUS ON INCREASING THE VALUE, AFFORDABILITY,
14 QUALITY, AND EQUITY OF HEALTH-CARE COVERAGE FOR COLORADANS
15 HISTORICALLY AND SYSTEMICALLY DISADVANTAGED BY HEALTH AND
16 ECONOMIC SYSTEMS.

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

20 **10-16-1309. Standardized plan - cost shift.** (1) IF THE
21 ADMINISTRATOR OF A SELF-FUNDED HEALTH INSURANCE PLAN
22 VOLUNTARILY PROVIDES TO THE COMMISSIONER ITS CONTRACTED RATES
23 AND ANY OTHER INFORMATION DEEMED NECESSARY AND AGREED UPON BY
24 THE ADMINISTRATOR AND THE COMMISSIONER, THE COMMISSIONER MAY
25 EVALUATE WHETHER THE RATES OF THE SELF-FUNDED HEALTH INSURANCE
26 PLAN REFLECT A COST SHIFT BETWEEN THE SELF-FUNDED PLAN AND THE
27 STANDARDIZED PLAN OFFERED BY A CARRIER PURSUANT TO SECTION

1 10-16-1305.

2 (2) IF THE COMMISSIONER DETERMINES THERE IS A COST SHIFT, THE
3 COMMISSIONER SHALL, TO THE EXTENT PRACTICABLE, PROVIDE A
4 DESCRIPTION OF WHICH CATEGORIES OF SERVICES HAVE EXPERIENCED THE
5 GREATEST COST SHIFT TO THE ADMINISTRATOR OF THE SELF-FUNDED
6 HEALTH INSURANCE PLAN.

7 **10-16-1310. Reports required - repeal.** (1) (a) THE
8 COMMISSIONER SHALL CONTRACT WITH AN INDEPENDENT THIRD-PARTY
9 ORGANIZATION TO PREPARE THREE SEPARATE REPORTS AS SPECIFIED IN
10 SUBSECTION (4) OF THIS SECTION, TO THE EXTENT THAT INFORMATION IS
11 AVAILABLE REGARDING THE IMPLEMENTATION OF THIS PART 13 AS IT
12 RELATES TO THE STAFFING, WAGES, BENEFITS, TRAINING, AND WORKING
13 CONDITIONS OF HOSPITAL WORKERS.

14 (b) IN CHOOSING AN INDEPENDENT THIRD-PARTY CONTRACTOR,
15 THE COMMISSIONER SHALL CONSIDER ORGANIZATIONS WITH EXPERIENCE
16 CONDUCTING IN-PERSON INTERVIEWS WITH HEALTH-CARE EMPLOYERS AND
17 EMPLOYEES IN COLORADO.

18 (c) THE INDEPENDENT THIRD-PARTY CONTRACTOR MAY MAKE
19 POLICY RECOMMENDATIONS RELATED TO INFORMATION IN THE REPORTS
20 AND MAY INCLUDE DATA COLLECTED FROM EMPLOYERS, EMPLOYEES, AND
21 OTHER THIRD-PARTY SOURCES.

22 (d) THE INDEPENDENT THIRD-PARTY CONTRACTOR SHALL DELIVER
23 THE REPORTS TO THE COMMISSIONER AS FOLLOWS:

24 (I) THE FIRST REPORT BY JULY 1, 2023;

25 (II) THE SECOND REPORT BY JULY 1, 2024; AND

26 (III) THE THIRD REPORT BY JULY 1, 2025.

27 (2) THE COMMISSIONER SHALL MONITOR WHETHER THERE ARE AN

1 ADEQUATE NUMBER OF HEALTH-CARE PROVIDERS IN THE CARRIERS'
2 STANDARDIZED PLAN NETWORK AND THE PERCENTAGE OF PREMIUMS
3 ATTRIBUTABLE TO HEALTH-CARE PROVIDERS IN THE NETWORK. AS PART
4 OF THE RATE AND FORM FILING REQUIRED PURSUANT TO 10-16-107, EACH
5 CARRIER SHALL PROVIDE TO THE COMMISSIONER INFORMATION ON
6 WHETHER THERE ARE AN ADEQUATE NUMBER OF HEALTH-CARE PROVIDERS
7 IN THE CARRIER'S STANDARDIZED PLAN NETWORK AND THE REDUCTION IN
8 PREMIUMS AS A RESULT OF HEALTH-CARE PROVIDER PARTICIPATION IN THE
9 NETWORK.

10 (3) (a) THE COMMISSIONER SHALL CONTRACT WITH AN
11 INDEPENDENT THIRD-PARTY ORGANIZATION TO EVALUATE HOW TO PHASE
12 IN, TO THE EXTENT PRACTICABLE, TO A HOSPITAL'S REIMBURSEMENT RATE
13 METHODOLOGY DESCRIBED IN SECTION 10-16-1306:

- 14 (I) A QUALITY METRIC ADJUSTMENT; AND
- 15 (II) AN ACUITY ADJUSTMENT AS MEASURED BY A HOSPITAL'S
16 CASE-MIX INDEX.

17 (b) THE EVALUATION MUST BE COMPLETED BY DECEMBER 31,
18 2022.

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

20 **10-16-1311. State measurement for accountable, responsive,**
21 **and transparent (SMART) government act report. (1) THE**
22 **COMMISSIONER SHALL REPORT DURING THE HEARINGS CONDUCTED**
23 **PURSUANT TO THE "STATE MEASUREMENT FOR ACCOUNTABLE,**
24 **RESPONSIVE, AND TRANSPARENT (SMART) GOVERNMENT ACT", PART 2**
25 **OF ARTICLE 7 OF TITLE 2:**

26 (a) BEGINNING IN JANUARY 2022 AND EACH YEAR THEREAFTER,
27 ON THE PROGRESS OF THE IMPLEMENTATION AND OPERATION OF THIS PART

1 13, INCLUDING THE INFORMATION COLLECTED PURSUANT TO SECTION
2 10-16-1310 (2).

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

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

9 **10-16-1312. Rules.** THE COMMISSIONER MAY PROMULGATE RULES
10 AS NECESSARY TO DEVELOP, IMPLEMENT, AND OPERATE THIS PART 13,
11 INCLUDING RULES NECESSARY TO ALIGN STATE LAW WITH ANY FEDERAL
12 PROGRAM REQUIREMENTS AND APPLICABLE RULES.

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

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

21 **10-16-107. Rate filing regulation - benefits ratio - rules.**

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

24 (V) The rate filing is incomplete; or

25 (VII) THE RATE FILING REFLECTS A COST SHIFT BETWEEN THE
26 STANDARDIZED PLAN, AS DEFINED IN SECTION 10-16-1303 (14), OFFERED
27 BY THE CARRIER AND THE HEALTH BENEFIT PLAN FOR WHICH RATE

1 APPROVAL IS BEING SOUGHT. THE COMMISSIONER MAY CONSIDER THE
2 TOTAL COST OF HEALTH CARE IN MAKING THIS DETERMINATION.

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

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

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

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

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

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

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

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

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

26 **12-30-116. Acceptance of patients enrolled in standardized**
27 **plan - acceptance of reimbursement rate requirements. THE**

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

5

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

8 **25-1.5-116. Hospitals - standardized health benefit plan -**
9 **participation - penalties.** (1) THE COMMISSIONER OF INSURANCE MAY
10 REQUIRE A HOSPITAL LICENSED PURSUANT TO SECTION 25-1.5-103, AFTER
11 A HEARING PURSUANT TO SECTION 10-16-1306 (3) CONCERNING THE
12 PREMIUM RATE REQUIREMENTS AND NETWORK ADEQUACY, TO
13 PARTICIPATE IN A STANDARDIZED HEALTH BENEFIT PLAN DESCRIBED IN
14 SECTION 10-16-1304.

15 (2) (a) IF THE DEPARTMENT RECEIVES NOTICE FROM THE
16 COMMISSIONER OF INSURANCE THAT A HOSPITAL REFUSES TO PARTICIPATE
17 IN THE STANDARDIZED PLAN IF REQUIRED BY SUBSECTION (1) OF THIS
18 SECTION, THE DEPARTMENT SHALL ISSUE A WARNING TO THE HOSPITAL. IF
19 THE HOSPITAL REFUSES TO PARTICIPATE IN THE STANDARDIZED PLAN
20 AFTER RECEIPT OF THE WARNING, THE DEPARTMENT:

21 (I) SHALL FINE THE HOSPITAL UP TO TEN THOUSAND DOLLARS PER
22 DAY FOR THE FIRST THIRTY DAYS THAT THE HOSPITAL REFUSES TO
23 PARTICIPATE AND UP TO FORTY THOUSAND DOLLARS PER DAY FOR EACH
24 DAY OVER THIRTY DAYS THAT THE HOSPITAL REFUSES TO PARTICIPATE;
25 AND

26 (II) MAY SUSPEND OR IMPOSE CONDITIONS ON THE HOSPITAL'S
27 LICENSE.

1 (b) IN DETERMINING THE APPROPRIATE FINE OR ACTION
2 CONCERNING THE HOSPITAL'S LICENSE PURSUANT TO SUBSECTION (2)(a)
3 OF THIS SECTION, THE DEPARTMENT SHALL CONSIDER ANY
4 RECOMMENDATIONS OF THE COMMISSIONER OF INSURANCE, THE
5 HOSPITAL'S FINANCIAL CIRCUMSTANCES, AND OTHER CIRCUMSTANCES
6 DEEMED RELEVANT BY THE DEPARTMENT.

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

9 **25.5-1-131. Insurance ombudsman - consumer advocate -**
10 **duties.** (1) THERE IS HEREBY CREATED IN THE STATE DEPARTMENT THE
11 OFFICE OF THE INSURANCE OMBUDSMAN TO ACT AS THE ADVOCATE FOR
12 CONSUMER INTERESTS IN MATTERS RELATED TO ACCESS TO AND THE
13 AFFORDABILITY OF THE STANDARDIZED HEALTH BENEFIT PLAN CREATED
14 PURSUANT TO SECTION 10-16-1304. THE OMBUDSMAN SHALL:

15 (a) INTERACT WITH CONSUMERS REGARDING THEIR ACCESS TO, THE
16 AFFORDABILITY OF, AND COVERAGE ISSUES WITH THE STANDARDIZED
17 PLAN;

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

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

22 (2) IN THE PERFORMANCE OF THE OMBUDSMAN'S DUTIES, THE
23 OMBUDSMAN SHALL ACT INDEPENDENTLY OF THE STATE DEPARTMENT.
24 ANY RECOMMENDATIONS MADE OR POSITIONS TAKEN BY THE OMBUDSMAN
25 DO NOT REFLECT THOSE OF THE STATE DEPARTMENT.

26 **SECTION 8. Appropriation.** (1) For the 2021-22 state fiscal
27 year, \$1,409,637 is appropriated to the department of regulatory agencies.

1 This appropriation is from the division of insurance cash fund created in
2 section 10-1-103 (3), C.R.S. To implement this act, the department may
3 use this appropriation as follows:

4 (a) \$1,158,667 for use by the division of insurance for personal
5 services, which is based on an assumption that the division will require
6 an additional 5.4 FTE;

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

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

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

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

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

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

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