

First Regular Session
Seventy-fifth General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 25-0421.02 Nicole Myers x4326 & Kristen Forrestal x4217 **HOUSE BILL 25-1174**

HOUSE SPONSORSHIP

Brown and Sirota,

SENATE SPONSORSHIP

Bridges and Jodeh,

House Committees
Health & Human Services

Senate Committees

A BILL FOR AN ACT

101 **CONCERNING LIMITS ON THE AMOUNTS THAT CERTAIN HEALTH**
102 **INSURERS MAY REIMBURSE FOR THE PROVISION OF CERTAIN**
103 **HEALTH-CARE SERVICES, AND, IN CONNECTION THEREWITH,**
104 **CREATING THE "SUPPORT COLORADO'S HEALTH-CARE SAFETY**
105 **NET ACT OF 2025".**

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 sets the reimbursement rates that a health insurance carrier (carrier) may reimburse a health-care provider (provider) for covered

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

services for the state employee group benefit plans (state group benefit plans) and for small employer group benefit plans (small group plans).

The bill prohibits a provider that is subject to the reimbursement limitations from billing or collecting payment from a person covered under a state group benefit plan or small group plan for any outstanding balance for covered services that is not reimbursed by the carrier, except for the applicable in-network coinsurance, copayment, or deductible amounts.

The bill requires a carrier to provide cost and quality of care information to the commissioner of insurance (commissioner) in the case of small group plans and to the director of the department of personnel (director) in the case of state group benefit plans, at the request of the commissioner or director, as applicable, and prohibits a carrier from entering into an agreement with a provider or third party that would restrict the carrier from providing the information.

By September 1, 2027, and by September 1 each year thereafter, the director is required to provide a report to the governor's office, the state treasurer's office, and the joint budget committee that states the amount of calculated savings in general fund expenditures (calculated savings), if any, for health plan reimbursement for the prior fiscal year as a result of the reimbursement limits for state group benefit plans. The director is also required to include in the report the cost to the department in determining the calculated savings. By September 15, 2027, and by September 15 each year thereafter, of the money from the calculated savings, the state treasurer is required to transfer an amount equal to the department's costs in determining the calculated savings to the group benefit plans expenditure savings cash fund (expenditure savings cash fund), which is created in the bill, and specified percentages of the calculated savings from the general fund to the primary care fund and to the expenditure savings cash fund.

The bill also requires the executive director of the department of health care policy and financing (state department) to conduct a study, in collaboration with specified state agencies, to determine the feasibility of establishing a similar reimbursement limit for group benefit plans offered to school district, higher education, and local government employees. The executive director is required to complete the study and report the findings to the general assembly on or before January 1, 2028. The bill allocates \$500,000 from the calculated savings to a health care reimbursement feasibility study cash fund created in the bill and authorizes the state department to use the money to conduct the study.

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

2 **SECTION 1.** In Colorado Revised Statutes, **add** 10-16-711 as

1 follows:

2 **10-16-711. Group health benefit plans - small employer**
3 **carriers - reimbursement to providers and facilities - limitations -**
4 **required participation in small group market - penalties - definitions.**

5 (1) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE
6 REQUIRES:

7 (a) "AFFILIATED HEALTH FACILITY" MEANS A HEALTH FACILITY
8 THAT IS AFFILIATED WITH A HOSPITAL OR HEALTH SYSTEM UNDER A
9 PROFESSIONAL SERVICES AGREEMENT, FACULTY AGREEMENT, OR
10 MANAGEMENT AGREEMENT THAT PERMITS THE HOSPITAL OR HEALTH
11 SYSTEM TO BILL ON BEHALF OF THE HEALTH FACILITY.

12 (b) (I) "EQUIVALENT RATE" MEANS THE PAYMENT OR
13 REIMBURSEMENT RATE DETERMINED BY RULE OF THE COMMISSIONER
14 FOR A HOSPITAL THAT IS PART OF A PEDIATRIC SPECIALTY HOSPITAL
15 SYSTEM WHERE OVER NINETY PERCENT OF THE HOSPITAL SYSTEM'S
16 POPULATION SERVED IS UNDER EIGHTEEN YEARS OF AGE AND THAT HAS A
17 LEVEL I PEDIATRIC TRAUMA CENTER.

18 (II) THE "EQUIVALENT RATE" IS:

19 (A) CALCULATED BY MULTIPLYING THE MEDICAID FEE SCHEDULE
20 FOR THE HOSPITAL BY A CONVERSION FACTOR EQUAL TO THE RATIO OF THE
21 STATEWIDE PAYMENT-TO-COST RATIO FOR MEDICARE TO THE HOSPITAL'S
22 SPECIFIC PAYMENT-TO-COST RATIO, WHICH IS 1.52; AND

23 (B) ADJUSTED ANNUALLY FOR CUMULATIVE INFLATION BY A
24 FACTOR EQUAL TO THE AVERAGE PERCENTAGE INCREASE IN THE MEDICARE
25 INPATIENT AND OUTPATIENT PROSPECTIVE PAYMENT SYSTEMS OVER THE
26 PREVIOUS THREE YEARS.

27 (c) "ESSENTIAL ACCESS HOSPITAL" MEANS A CRITICAL ACCESS

1 HOSPITAL OR A GENERAL HOSPITAL THAT IS LOCATED IN A RURAL AREA
2 AND THAT HAS TWENTY-FIVE OR FEWER LICENSED BEDS.

3 (d) "HEALTH FACILITY" MEANS A FACILITY LICENSED OR CERTIFIED
4 PURSUANT TO SECTION 25-1.5-103 OR ESTABLISHED PURSUANT TO PART
5 5 OF ARTICLE 21 OF TITLE 23 OR ARTICLE 29 OF TITLE 25.

6 (e) "HEALTH SYSTEM" MEANS A CORPORATION OR OTHER
7 ORGANIZATION THAT OWNS, CONTAINS, OR OPERATES THREE OR MORE
8 HOSPITALS.

9 (f) (I) "HOSPITAL" MEANS A HOSPITAL THAT IS LICENSED OR
10 CERTIFIED BY THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT
11 PURSUANT TO THE DEPARTMENT'S AUTHORITY UNDER SECTION 25-1.5-103
12 (1)(a) OR THAT IS ESTABLISHED PURSUANT TO PART 5 OF ARTICLE 21 OF
13 TITLE 23 OR ARTICLE 29 OF TITLE 25.

14 (II) "HOSPITAL" DOES NOT INCLUDE A HOSPITAL OR OTHER
15 MEDICAL FACILITY CREATED BY AND OPERATED UNDER THE AUTHORITY
16 OF SECTION 25-29-101.

17 (g) "MEDICARE REIMBURSEMENT RATE" MEANS THE
18 FACILITY-SPECIFIC REIMBURSEMENT RATE FOR A PARTICULAR
19 HEALTH-CARE SERVICE PROVIDED UNDER THE "HEALTH INSURANCE FOR
20 THE AGED ACT", TITLE XVIII OF THE FEDERAL "SOCIAL SECURITY ACT",
21 42 U.S.C. SEC. 1395 ET SEQ. FOR HOSPITALS THAT MEDICARE REIMBURSES
22 UNDER THE HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM AND THE
23 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM, THE "MEDICARE
24 REIMBURSEMENT RATE" MEANS THE RATE BASED ON THE APPLICABLE
25 PROSPECTIVE PAYMENT SYSTEM FEE SCHEDULE THAT IS EFFECTIVE AS OF
26 THE QUARTER IN WHICH THE CARRIER WILL FILE RATES PURSUANT TO
27 SECTION 10-16-107.

1 (h) "OUTPATIENT BEHAVIORAL HEALTH SERVICES" MEANS
2 SERVICES PROVIDED TO AN INDIVIDUAL REGARDING THEIR BEHAVIORAL
3 HEALTH, AS DEFINED IN SECTION 27-50-101, IN ACCORDANCE WITH THE
4 INDIVIDUAL'S SERVICE PLAN, ON A REGULAR BASIS, AND IN A
5 NON-OVERNIGHT SETTING. "OUTPATIENT BEHAVIORAL HEALTH SERVICES"
6 MAY INCLUDE INDIVIDUAL, GROUP, OR FAMILY COUNSELING; PEER
7 SUPPORT PROFESSIONAL SERVICES; CASE MANAGEMENT; OR MEDICATION
8 MANAGEMENT.

9 (i) "PRIMARY CARE PROVIDER" HAS THE SAME MEANING AS SET
10 FORTH IN SECTION 10-16-157 (2)(e).

11 (j) "PRIMARY CARE SERVICES" HAS THE SAME MEANING AS SET
12 FORTH IN SECTION 10-16-157 (2)(c).

13 (k) "SMALL GROUP MARKET" MEANS THE MARKET FOR SMALL
14 GROUP HEALTH BENEFIT PLANS.

15 (l) "SMALL GROUP HEALTH BENEFIT PLAN" MEANS A HEALTH
16 BENEFIT PLAN OFFERED OR ISSUED TO A SMALL EMPLOYER.

17 (2) (a) EXCEPT AS OTHERWISE PROVIDED IN SUBSECTION (2)(b) OF
18 THIS SECTION, BEGINNING JANUARY 1, 2027, EACH CARRIER OFFERING
19 COVERAGE IN THE SMALL GROUP MARKET SHALL REIMBURSE PROVIDERS
20 IN ACCORDANCE WITH THE FOLLOWING REQUIREMENTS:

21 (I) (A) FOR INPATIENT AND OUTPATIENT SERVICES RECEIVED AT
22 AN IN-NETWORK HOSPITAL OR AT AN IN-NETWORK AFFILIATED HEALTH
23 FACILITY, THE REIMBURSEMENT MUST NOT EXCEED, AND THE HOSPITAL OR
24 AFFILIATED HEALTH FACILITY SHALL NOT CHARGE MORE THAN, THE
25 LESSER OF: THE CARRIER'S CONTRACTED RATE FOR THE SERVICE IN THE
26 2024 PLAN YEAR; OR ONE HUNDRED SIXTY-FIVE PERCENT OF THE
27 MEDICARE REIMBURSEMENT RATE OR ONE HUNDRED SIXTY-FIVE PERCENT

1 OF THE EQUIVALENT RATE, WHICHEVER IS APPLICABLE, FOR THE SAME OR
2 SIMILAR SERVICES;

3 (B) FOR INPATIENT AND OUTPATIENT SERVICES RECEIVED AT AN
4 OUT-OF-NETWORK HOSPITAL OR AT AN OUT-OF-NETWORK AFFILIATED
5 HEALTH FACILITY, THE REIMBURSEMENT MUST NOT EXCEED, AND THE
6 HOSPITAL OR AFFILIATED HEALTH FACILITY SHALL NOT CHARGE MORE
7 THAN, ONE HUNDRED FIFTY PERCENT OF THE MEDICARE REIMBURSEMENT
8 RATE OR ONE HUNDRED FIFTY PERCENT OF THE EQUIVALENT RATE,
9 WHICHEVER IS APPLICABLE, FOR THE SAME OR SIMILAR SERVICES;

10 (II) FOR PRIMARY CARE SERVICES PROVIDED BY AN IN-NETWORK
11 PRIMARY CARE PROVIDER, THE REIMBURSEMENT MUST NOT BE LESS THAN
12 ONE HUNDRED THIRTY-FIVE PERCENT OF THE MEDICARE REIMBURSEMENT
13 RATE FOR THE SAME OR SIMILAR SERVICES; AND

14 (III) FOR OUTPATIENT BEHAVIORAL HEALTH SERVICES, THE
15 REIMBURSEMENT MUST NOT BE LESS THAN ONE HUNDRED THIRTY-FIVE
16 PERCENT OF THE MEDICARE REIMBURSEMENT RATE FOR THE SAME OR
17 SIMILAR SERVICES.

18 (b) SUBSECTION (2)(a) OF THIS SECTION DOES NOT APPLY TO AN
19 ESSENTIAL ACCESS HOSPITAL.

20 (3) THIS SECTION DOES NOT PROHIBIT A CARRIER OFFERING
21 COVERAGE IN THE SMALL GROUP MARKET FROM REIMBURSING A HOSPITAL
22 OR AN AFFILIATED HEALTH FACILITY THROUGH AN ALTERNATIVE
23 PAYMENT MODEL THAT IS NOT PAID ON A FEE-FOR-SERVICES OR PER-CLAIM
24 BASIS SO LONG AS THE PAYMENTS INCENTIVIZE THE HOSPITAL OR
25 AFFILIATED HEALTH FACILITY TO ACHIEVE HIGHER QUALITY OR IMPROVED
26 HEALTH OUTCOMES AND THE CARRIER CONTINUES TO COMPLY WITH THE
27 REIMBURSEMENT REQUIREMENTS OF THIS SECTION.

1 (4) A HOSPITAL OR AN AFFILIATED HEALTH FACILITY THAT IS
2 REIMBURSED IN ACCORDANCE WITH SUBSECTION (2)(a)(I) OF THIS SECTION
3 SHALL NOT BILL OR COLLECT PAYMENT FROM A COVERED PERSON FOR ANY
4 OUTSTANDING BALANCE FOR COVERED SERVICES NOT PAID BY THE
5 CARRIER, EXCEPT FOR THE APPLICABLE IN-NETWORK COINSURANCE,
6 DEDUCTIBLE, OR COPAYMENT AMOUNT REQUIRED, PURSUANT TO THE
7 SMALL GROUP HEALTH BENEFIT PLAN, TO BE PAID BY THE COVERED
8 PERSON.

9 (5) AT THE REQUEST OF THE COMMISSIONER, A CARRIER OFFERING
10 COVERAGE IN THE SMALL GROUP MARKET SHALL PROVIDE COST AND
11 QUALITY OF CARE INFORMATION TO THE COMMISSIONER, INCLUDING
12 NEGOTIATED REIMBURSEMENT RATE DATA. A CARRIER SHALL NOT ENTER
13 INTO AN AGREEMENT WITH A HOSPITAL, HEALTH FACILITY, PROVIDER, OR
14 THIRD PARTY THAT WOULD RESTRICT THE CARRIER FROM PROVIDING COST
15 AND QUALITY OF CARE INFORMATION TO THE COMMISSIONER.

16 (6) (a) IN ESTABLISHING AND FILING RATES FOR SMALL GROUP
17 PLANS PURSUANT TO SECTION 10-16-107, A CARRIER MUST TAKE INTO
18 ACCOUNT ANY ANTICIPATED REDUCTION IN THE COST OF SERVICES
19 PROVIDED AT A HOSPITAL OR AFFILIATED HEALTH FACILITY THAT MAY
20 RESULT FROM THE APPLICATION OF THIS SECTION.

21 (b) (I) THE COMMISSIONER MAY REQUIRE A HOSPITAL OR
22 AFFILIATED HEALTH FACILITY TO PARTICIPATE IN A SMALL GROUP HEALTH
23 BENEFIT PLAN OFFERED IN THE SMALL GROUP MARKET AND TO ACCEPT THE
24 REIMBURSEMENT RATE SPECIFIED IN THIS SECTION. IF THE COMMISSIONER
25 REQUIRES A HOSPITAL OR AFFILIATED HEALTH FACILITY TO PARTICIPATE
26 IN A SMALL GROUP HEALTH BENEFIT PLAN AND TO ACCEPT THE
27 REIMBURSEMENT RATE SPECIFIED IN THIS SECTION AND RECEIVES NOTICE

1 THAT A HOSPITAL OR AFFILIATED HEALTH FACILITY REFUSES TO
2 PARTICIPATE IN A SMALL GROUP MARKET HEALTH BENEFIT PLAN AND
3 ACCEPT THE REIMBURSEMENT RATE SPECIFIED IN THIS SECTION, THE
4 COMMISSIONER SHALL ISSUE A WARNING TO THE HOSPITAL OR AFFILIATED
5 HEALTH FACILITY. IF THE HOSPITAL OR AFFILIATED HEALTH FACILITY
6 REFUSES TO PARTICIPATE IN A SMALL GROUP MARKET HEALTH BENEFIT
7 PLAN AND ACCEPT THE REIMBURSEMENT RATE SPECIFIED IN THIS SECTION
8 AFTER RECEIPT OF THE WARNING, THE COMMISSIONER SHALL FINE THE
9 HOSPITAL OR AFFILIATED HEALTH FACILITY UP TO TEN THOUSAND
10 DOLLARS PER DAY FOR THE FIRST THIRTY DAYS THAT THE HOSPITAL OR
11 AFFILIATED HEALTH FACILITY REFUSES TO PARTICIPATE AND ACCEPT THE
12 REIMBURSEMENT RATE SPECIFIED IN THIS SECTION AND UP TO FORTY
13 THOUSAND DOLLARS PER DAY FOR EACH DAY BEYOND THE FIRST THIRTY
14 DAYS THAT THE HOSPITAL OR AFFILIATED HEALTH FACILITY REFUSES TO
15 PARTICIPATE AND ACCEPT THE REIMBURSEMENT RATE SPECIFIED IN THIS
16 SECTION.

17 (II) IN DETERMINING THE APPROPRIATE FINE PURSUANT TO
18 SUBSECTION (6)(b)(I) OF THIS SECTION, THE COMMISSIONER SHALL
19 CONSIDER ANY RECOMMENDATIONS FROM THE DEPARTMENT OF PUBLIC
20 HEALTH AND ENVIRONMENT, THE HOSPITAL'S FINANCIAL CIRCUMSTANCES,
21 AND OTHER CIRCUMSTANCES THE COMMISSIONER DEEMS RELEVANT.

22 (7) THE COMMISSIONER MAY ADOPT RULES IN ACCORDANCE WITH
23 ARTICLE 4 OF TITLE 24 TO IMPLEMENT THIS SECTION.

24 **SECTION 2.** In Colorado Revised Statutes, 10-16-704, **amend**
25 (5.5)(b)(I) introductory portion; and **add** (5.5)(b)(IV) as follows:

26 **10-16-704. Network adequacy - required disclosures - balance**
27 **billing - rules - legislative declaration - definitions.** (5.5) (b) (I) If a

1 covered person receives emergency services at an out-of-network facility,
2 other than any out-of-network facility operated by the Denver health and
3 hospital authority pursuant to article 29 of title 25, ~~the~~ EXCEPT AS
4 PROVIDED IN SUBSECTION (5.5)(b)(IV) OF THIS SECTION, A carrier shall
5 reimburse the out-of-network provider in accordance with subsection
6 (3)(d)(II) of this section and reimburse the out-of-network facility directly
7 in accordance with section 10-16-106.5 the greater of:

8 (IV) FOR A COVERED PERSON ENROLLED IN A SMALL GROUP PLAN
9 WHO RECEIVES EMERGENCY SERVICES AT AN OUT-OF-NETWORK FACILITY
10 OTHER THAN AN ESSENTIAL ACCESS HOSPITAL, AS DEFINED IN SECTION
11 10-16-711 (1)(c), THE CARRIER SHALL REIMBURSE THE OUT-OF-NETWORK
12 FACILITY DIRECTLY IN ACCORDANCE WITH SECTIONS 10-16-106.5 AND
13 10-16-711 (2)(a)(II).

14 **SECTION 3.** In Colorado Revised Statutes, 25-3-122, **amend**
15 (3)(a) as follows:

16 **25-3-122. Out-of-network facilities - emergency medical**
17 **services - billing - payment - deceptive trade practice.** (3) (a) (I) An
18 out-of-network facility, other than any out-of-network facility operated
19 by the Denver health and hospital authority pursuant to article 29 of title
20 25, must send a claim for emergency services to the carrier within one
21 hundred eighty days after the receipt of insurance information in order to
22 receive reimbursement as specified in this subsection (3)(a).

23 (II) EXCEPT AS PROVIDED IN SUBSECTION (3)(a)(III) OF THIS
24 SECTION, the reimbursement rate is the greater of:

25 (A) One hundred five percent of the carrier's median in-network
26 rate of reimbursement for that service provided in a similar facility or
27 setting in the same geographic area; or

1 (B) The median in-network rate of reimbursement for the same
2 service provided in a similar facility or setting in the same geographic
3 area for the prior year based on claims data from the all-payer health
4 claims database created in section 25.5-1-204.

5 (III) FOR EMERGENCY SERVICES PROVIDED BY AN
6 OUT-OF-NETWORK FACILITY, OTHER THAN AN ESSENTIAL ACCESS
7 HOSPITAL, AS DEFINED IN SECTION 10-16-711 (1)(c), TO A COVERED
8 PERSON ENROLLED IN A SMALL GROUP PLAN, AS DEFINED IN SECTION
9 10-16-102 (63), THE REIMBURSEMENT RATE IS DETERMINED IN
10 ACCORDANCE WITH SECTION 10-16-711 (2)(a)(II).

11 **SECTION 4.** In Colorado Revised Statutes, 24-50-605, **add**
12 (1)(g) as follows:

13 **24-50-605. Group benefit plans - specifications - contracts.**

14 (1) (g) THE SPECIFICATIONS DRAWN BY THE DIRECTOR FOR ANY GROUP
15 BENEFIT PLANS SHALL INCLUDE THE PARAMETERS FOR PROVIDER
16 REIMBURSEMENTS SPECIFIED IN SECTION 24-50-621.

17 **SECTION 5.** In Colorado Revised Statutes, **add** 24-50-621 as
18 follows:

19 **24-50-621. Group benefit plans - reimbursement limits for**
20 **health plans - hospital services - health plan expenditure savings**
21 **distribution - group benefit plans expenditure savings cash fund -**
22 **report - short title - rules - definitions.** (1) THE SHORT TITLE OF THIS
23 SECTION IS THE "SUPPORT COLORADO'S HEALTH-CARE SAFETY NET ACT
24 OF 2025".

25 (2) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE
26 REQUIRES:

27 (a) "AFFILIATED HEALTH FACILITY" MEANS A HEALTH FACILITY

1 THAT IS AFFILIATED WITH A HOSPITAL OR HEALTH SYSTEM UNDER A
2 PROFESSIONAL SERVICES AGREEMENT, FACULTY AGREEMENT, OR
3 MANAGEMENT AGREEMENT THAT PERMITS THE HOSPITAL OR HEALTH
4 SYSTEM TO BILL ON BEHALF OF THE HEALTH FACILITY.

5 (b) (I) "EQUIVALENT RATE" MEANS THE PAYMENT OR
6 REIMBURSEMENT RATE DETERMINED BY RULE OF THE COMMISSIONER OF
7 INSURANCE FOR A HOSPITAL THAT IS PART OF A PEDIATRIC SPECIALTY
8 HOSPITAL SYSTEM WHERE OVER NINETY PERCENT OF THE HOSPITAL
9 SYSTEM'S POPULATION SERVED IS UNDER EIGHTEEN YEARS OF AGE AND
10 THAT HAS A LEVEL I PEDIATRIC TRAUMA CENTER.

11 (II) THE "EQUIVALENT RATE" IS:

12 (A) CALCULATED BY MULTIPLYING THE MEDICAID FEE SCHEDULE
13 FOR THE HOSPITAL BY A CONVERSION FACTOR EQUAL TO THE RATIO OF THE
14 STATEWIDE PAYMENT-TO-COST RATIO FOR MEDICARE TO THE HOSPITAL'S
15 SPECIFIC PAYMENT-TO-COST RATIO, WHICH IS 1.52; AND

16 (B) ADJUSTED ANNUALLY FOR CUMULATIVE INFLATION BY A
17 FACTOR EQUAL TO THE AVERAGE PERCENTAGE INCREASE IN THE MEDICARE
18 INPATIENT AND OUTPATIENT PROSPECTIVE PAYMENT SYSTEMS OVER THE
19 PREVIOUS THREE YEARS.

20 (c) "ESSENTIAL ACCESS HOSPITAL" MEANS A CRITICAL ACCESS
21 HOSPITAL OR A GENERAL HOSPITAL THAT IS LOCATED IN A RURAL AREA
22 AND THAT HAS TWENTY-FIVE OR FEWER LICENSED BEDS.

23 (d) "HEALTH FACILITY" MEANS A FACILITY LICENSED OR CERTIFIED
24 PURSUANT TO SECTION 25-1.5-103 OR ESTABLISHED PURSUANT TO PART
25 5 OF ARTICLE 21 OF TITLE 23 OR ARTICLE 29 OF TITLE 25.

26 (e) "HEALTH SYSTEM" MEANS A CORPORATION OR OTHER
27 ORGANIZATION THAT OWNS, CONTAINS, OR OPERATES THREE OR MORE

1 HOSPITALS.

2 (f) "HOSPITAL" MEANS A HOSPITAL THAT IS LICENSED OR
3 CERTIFIED BY THE DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT
4 PURSUANT TO THE DEPARTMENT'S AUTHORITY UNDER SECTION 25-1.5-103
5 (1)(a) OR THAT IS ESTABLISHED PURSUANT TO PART 5 OF ARTICLE 21 OF
6 TITLE 23 OR ARTICLE 29 OF TITLE 25.

7 (g) "MEDICARE REIMBURSEMENT RATE" MEANS THE
8 FACILITY-SPECIFIC REIMBURSEMENT RATE FOR A PARTICULAR
9 HEALTH-CARE SERVICE PROVIDED UNDER THE "HEALTH INSURANCE FOR
10 THE AGED ACT", TITLE XVIII OF THE FEDERAL "SOCIAL SECURITY ACT",
11 42 U.S.C., SEC. 1395 ET SEQ. FOR HOSPITALS THAT MEDICARE REIMBURSES
12 UNDER THE HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM AND THE
13 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM, THE "MEDICARE
14 REIMBURSEMENT RATE" MEANS THE RATE BASED ON THE APPLICABLE
15 PROSPECTIVE PAYMENT SYSTEM FEE SCHEDULE THAT IS EFFECTIVE AS OF
16 EACH JANUARY OF THE APPLICABLE PLAN YEAR.

17 (h) "OUTPATIENT BEHAVIORAL HEALTH SERVICES" MEANS
18 SERVICES PROVIDED TO AN INDIVIDUAL REGARDING THEIR BEHAVIORAL
19 HEALTH, AS DEFINED IN SECTION 27-50-101, IN ACCORDANCE WITH THE
20 INDIVIDUAL'S SERVICE PLAN, ON A REGULAR BASIS, AND IN A
21 NON-OVERNIGHT SETTING. "OUTPATIENT BEHAVIORAL HEALTH SERVICES"
22 MAY INCLUDE INDIVIDUAL, GROUP, OR FAMILY COUNSELING; PEER
23 SUPPORT PROFESSIONAL SERVICES; CASE MANAGEMENT; OR MEDICATION
24 MANAGEMENT.

25 (i) "PRIMARY CARE PROVIDER" HAS THE SAME MEANING AS SET
26 FORTH IN SECTION 10-16-157 (2)(e).

27 (j) "PRIMARY CARE SERVICES" HAS THE SAME MEANING AS SET

1 FORTH IN SECTION 10-16-157 (2)(c).

2 (3) (a) EXCEPT AS OTHERWISE PROVIDED IN SUBSECTION (3)(b) OF
3 THIS SECTION, BEGINNING JULY 1, 2026, EACH CARRIER THAT PROVIDES OR
4 ADMINISTERS A GROUP BENEFIT PLAN PURSUANT TO THIS PART 6 SHALL
5 REIMBURSE PROVIDERS IN ACCORDANCE WITH THE FOLLOWING
6 REQUIREMENTS FOR THE FOLLOWING SERVICES PROVIDED TO AN
7 EMPLOYEE OR DEPENDENT ENROLLED IN THE GROUP BENEFIT PLAN:

8 (I) (A) FOR INPATIENT AND OUTPATIENT SERVICES RECEIVED AT
9 AN IN-NETWORK HOSPITAL OR AT AN IN-NETWORK AFFILIATED HEALTH
10 FACILITY, THE REIMBURSEMENT MUST NOT EXCEED, AND THE HOSPITAL OR
11 AFFILIATED HEALTH FACILITY SHALL NOT CHARGE MORE THAN, THE
12 LESSER OF: THE CARRIER'S CONTRACTED RATE FOR THE SERVICE IN THE
13 ANNUAL GROUP BENEFIT PLAN YEAR THAT COMMENCES IN THE 2024-25
14 STATE FISCAL YEAR; OR ONE HUNDRED SIXTY-FIVE PERCENT OF THE
15 MEDICARE REIMBURSEMENT RATE OR ONE HUNDRED SIXTY-FIVE PERCENT
16 OF THE EQUIVALENT RATE, WHICHEVER IS APPLICABLE, FOR THE SAME OR
17 SIMILAR SERVICES; AND

18 (B) FOR INPATIENT AND OUTPATIENT SERVICES RECEIVED AT AN
19 OUT-OF-NETWORK HOSPITAL OR AT AN OUT-OF-NETWORK AFFILIATED
20 HEALTH FACILITY, THE REIMBURSEMENT MUST NOT EXCEED, AND THE
21 HOSPITAL OR AFFILIATED HEALTH FACILITY SHALL NOT CHARGE MORE
22 THAN, ONE HUNDRED FIFTY PERCENT OF THE MEDICARE REIMBURSEMENT
23 RATE OR ONE HUNDRED FIFTY PERCENT OF THE EQUIVALENT RATE,
24 WHICHEVER IS APPLICABLE, FOR THE SAME OR SIMILAR SERVICES.

25 (II) FOR PRIMARY CARE SERVICES PROVIDED BY A PRIMARY CARE
26 PROVIDER, THE REIMBURSEMENT MUST NOT BE LESS THAN ONE HUNDRED
27 THIRTY-FIVE PERCENT OF THE MEDICARE REIMBURSEMENT RATE FOR THE

1 SAME OR SIMILAR SERVICES; AND

2 (III) FOR OUTPATIENT BEHAVIORAL HEALTH SERVICES, THE
3 REIMBURSEMENT MUST NOT BE LESS THAN ONE HUNDRED THIRTY-FIVE
4 PERCENT OF THE MEDICARE REIMBURSEMENT RATE FOR THE SAME OR
5 SIMILAR SERVICES.

6 (b) SUBSECTION (3)(a) OF THIS SECTION DOES NOT APPLY TO AN
7 ESSENTIAL ACCESS HOSPITAL.

8 (4) THIS SECTION DOES NOT PROHIBIT A CARRIER FROM
9 REIMBURSING A HOSPITAL OR AFFILIATED HEALTH FACILITY THROUGH AN
10 ALTERNATIVE PAYMENT MODEL THAT IS NOT PAID ON A FEE-FOR-SERVICES
11 OR PER-CLAIM BASIS SO LONG AS THE PAYMENTS INCENTIVIZE THE
12 HOSPITAL OR AFFILIATED HEALTH FACILITY TO ACHIEVE HIGHER QUALITY
13 OR IMPROVED HEALTH OUTCOMES AND THE CARRIER CONTINUES TO
14 COMPLY WITH THE REIMBURSEMENT REQUIREMENTS OF THIS SECTION.

15 (5) A HOSPITAL OR AN AFFILIATED HEALTH FACILITY THAT IS
16 REIMBURSED IN ACCORDANCE WITH SUBSECTION (3)(a)(I) OF THIS SECTION
17 SHALL NOT BILL OR COLLECT PAYMENT FROM A PLAN ENROLLEE FOR ANY
18 OUTSTANDING BALANCE FOR COVERED SERVICES NOT PAID BY THE
19 CARRIER, EXCEPT FOR THE APPLICABLE IN-NETWORK COINSURANCE,
20 DEDUCTIBLE, OR COPAYMENT AMOUNT REQUIRED, PURSUANT TO THE
21 GROUP BENEFIT PLAN, TO BE PAID BY THE PLAN ENROLLEE.

22 (6) AT THE REQUEST OF THE DIRECTOR, A CARRIER SHALL PROVIDE
23 COST AND QUALITY OF CARE INFORMATION TO THE DIRECTOR, INCLUDING
24 NEGOTIATED REIMBURSEMENT RATE DATA. A CARRIER SHALL NOT ENTER
25 INTO AN AGREEMENT WITH A HOSPITAL, HEALTH FACILITY, PROVIDER, OR
26 THIRD PARTY THAT WOULD RESTRICT THE CARRIER FROM PROVIDING COST
27 AND QUALITY OF CARE INFORMATION TO THE DIRECTOR.

1 (7) (a) BY SEPTEMBER 1, 2027, AND BY SEPTEMBER 1 EACH YEAR
2 THEREAFTER, THE DIRECTOR SHALL PROVIDE A REPORT TO THE
3 GOVERNOR'S OFFICE, THE OFFICE OF THE STATE TREASURER, AND THE
4 JOINT BUDGET COMMITTEE OF THE GENERAL ASSEMBLY THAT SPECIFIES
5 THE CALCULATED SAVINGS, IF ANY, IN GENERAL FUND EXPENDITURES
6 THAT RESULT FROM REDUCED PROVIDER REIMBURSEMENTS UNDER GROUP
7 BENEFIT PLANS IN THE IMMEDIATELY PRECEDING FISCAL YEAR PURSUANT
8 TO THIS SECTION. THE DIRECTOR SHALL INCLUDE IN THE REPORT THE COST
9 TO THE DEPARTMENT TO DETERMINE THE CALCULATED SAVINGS, IF ANY,
10 IN GENERAL FUND EXPENDITURES THAT RESULT FROM REDUCED PROVIDER
11 REIMBURSEMENTS UNDER GROUP BENEFIT PLANS IN THE IMMEDIATELY
12 PRECEDING STATE FISCAL YEAR AS PURSUANT TO THIS SECTION, AS
13 REPORTED PURSUANT TO THIS SUBSECTION (7)(a).

14 (b) BY SEPTEMBER 15, 2027, OF THE CALCULATED GENERAL FUND
15 EXPENDITURE SAVINGS IDENTIFIED IN THE REPORT REQUIRED BY
16 SUBSECTION (7)(a) OF THIS SECTION, THE STATE TREASURER SHALL
17 TRANSFER FROM THE GENERAL FUND:

18 (I) TO THE GROUP BENEFIT PLANS EXPENDITURE SAVINGS CASH
19 FUND CREATED IN SUBSECTION (8) OF THIS SECTION, AN AMOUNT, AS
20 SPECIFIED IN THE REPORT REQUIRED BY SUBSECTION (7)(a) OF THIS
21 SECTION, EQUAL TO THE DEPARTMENT'S COST TO CALCULATE AND REPORT
22 GENERAL FUND EXPENDITURE SAVINGS AS REQUIRED BY SUBSECTION
23 (7)(a) OF THIS SECTION, WHICH AMOUNT IS TO BE USED BY THE
24 DEPARTMENT IN ACCORDANCE WITH SUBSECTION (8)(c)(I) OF THIS
25 SECTION;

26 (II) FIVE HUNDRED THOUSAND DOLLARS TO THE HEALTH CARE
27 REIMBURSEMENT FEASIBILITY STUDY CASH FUND, CREATED IN SECTION

1 25.5-1-135 (5), TO BE USED BY THE DEPARTMENT OF HEALTH CARE POLICY
2 AND FINANCING FOR THE FEASIBILITY STUDY REQUIRED IN SECTION
3 25.5-1-135; AND

4 (III) OF THE AMOUNT SPECIFIED IN THE REPORT SUBMITTED FOR
5 THE 2026-27 STATE FISCAL YEAR PURSUANT TO SUBSECTION (7)(a) OF THIS
6 SECTION THAT IS REMAINING AFTER THE STATE TREASURER TRANSFERS
7 THE AMOUNTS REQUIRED BY SUBSECTIONS (7)(b)(I) AND (7)(b)(II) OF THIS
8 SECTION:

9 (A) AN AMOUNT EQUAL TO TWENTY PERCENT OF THE REMAINING
10 AMOUNT TO THE GROUP BENEFIT PLANS EXPENDITURE SAVINGS CASH FUND
11 CREATED IN SUBSECTION (8) OF THIS SECTION TO BE USED BY THE
12 DEPARTMENT AS SPECIFIED IN SUBSECTION (8)(c)(II) OF THIS SECTION; AND

13 (B) AN AMOUNT EQUAL TO EIGHTY PERCENT OF THE REMAINING
14 AMOUNT TO THE PRIMARY CARE FUND CREATED IN SECTION 24-22-117
15 (2)(b) TO BE USED BY THE DEPARTMENT OF HEALTH CARE POLICY AND
16 FINANCING FOR THE PURPOSES SPECIFIED IN THAT SECTION.

17 (c) BY SEPTEMBER 15, 2028, AND BY SEPTEMBER 10 EACH YEAR
18 THEREAFTER, OF THE CALCULATED GENERAL FUND EXPENDITURE SAVINGS
19 IDENTIFIED IN THE REPORT REQUIRED BY SUBSECTION (7)(a) OF THIS
20 SECTION, THE STATE TREASURER SHALL TRANSFER FROM THE GENERAL
21 FUND:

22 (I) TO THE GROUP BENEFIT PLANS EXPENDITURE SAVINGS CASH
23 FUND CREATED IN SUBSECTION (8) OF THIS SECTION, AN AMOUNT, AS
24 SPECIFIED IN THE REPORT REQUIRED BY SUBSECTION (7)(a) OF THIS
25 SECTION, EQUAL TO THE DEPARTMENT'S COST TO CALCULATE AND REPORT
26 GENERAL FUND EXPENDITURE SAVINGS AS REQUIRED BY SUBSECTION
27 (7)(a) OF THIS SECTION, WHICH AMOUNT IS TO BE USED BY THE

1 DEPARTMENT IN ACCORDANCE WITH SUBSECTION (8)(c)(I) OF THIS
2 SECTION; AND

3 (II) OF THE AMOUNT SPECIFIED IN THE REPORT SUBMITTED FOR THE
4 APPLICABLE STATE FISCAL YEAR PURSUANT TO SUBSECTION (7)(a) OF THIS
5 SECTION THAT IS REMAINING AFTER THE STATE TREASURER TRANSFERS
6 THE AMOUNT REQUIRED BY SUBSECTION (7)(c)(I) OF THIS SECTION:

7 (A) AN AMOUNT EQUAL TO TWENTY PERCENT OF THE REMAINING
8 AMOUNT TO THE GROUP BENEFIT PLANS EXPENDITURE SAVINGS CASH FUND
9 CREATED IN SUBSECTION (8) OF THIS SECTION TO BE USED BY THE
10 DEPARTMENT AS SPECIFIED IN SUBSECTION (8)(c)(III) OF THIS SECTION;
11 AND

12 (B) AN AMOUNT EQUAL TO EIGHTY PERCENT OF THE REMAINING
13 AMOUNT TO THE PRIMARY CARE FUND CREATED IN SECTION 24-22-117
14 (2)(b) TO BE USED BY THE DEPARTMENT OF HEALTH CARE POLICY AND
15 FINANCING FOR THE PURPOSES SPECIFIED IN THAT SECTION.

16 (8) (a) THE GROUP BENEFIT PLANS EXPENDITURE SAVINGS CASH
17 FUND IS CREATED IN THE STATE TREASURY. THE FUND CONSISTS OF MONEY
18 TRANSFERRED TO THE FUND PURSUANT TO SUBSECTIONS (7)(b)(I),
19 (7)(b)(III)(A), (7)(c)(I), AND (7)(c)(II)(A) OF THIS SECTION AND ANY
20 OTHER MONEY THAT THE GENERAL ASSEMBLY MAY APPROPRIATE OR
21 TRANSFER TO THE FUND.

22 (b) THE STATE TREASURER SHALL CREDIT ALL INTEREST AND
23 INCOME DERIVED FROM THE DEPOSIT AND INVESTMENT OF MONEY IN THE
24 GROUP BENEFIT PLANS EXPENDITURE SAVINGS CASH FUND TO THE FUND.

25 (c) THE MONEY IN THE FUND IS CONTINUOUSLY APPROPRIATED TO
26 THE DEPARTMENT TO BE USED AS FOLLOWS:

27 (I) FOR THE 2027-28 STATE FISCAL YEAR AND EACH STATE FISCAL

1 YEAR THEREAFTER, FIRST TO REIMBURSE THE DEPARTMENT FOR ITS COSTS
2 IN DETERMINING THE CALCULATED SAVINGS, IF ANY, IN GENERAL FUND
3 EXPENDITURES THAT RESULT FROM REDUCED PROVIDER REIMBURSEMENTS
4 UNDER GROUP BENEFIT PLANS IN THE IMMEDIATELY PRECEDING STATE
5 FISCAL YEAR PURSUANT TO THIS SECTION, AND THEN FOR THE PURPOSES
6 SPECIFIED IN SUBSECTIONS (8)(c)(II) AND (8)(c)(III) OF THIS SECTION;

7 (II) FOR THE 2027-28 STATE FISCAL YEAR, OF THE AMOUNT
8 REMAINING AFTER THE REQUIREMENTS OF SUBSECTION (8)(c)(I) OF THIS
9 SECTION HAVE BEEN SATISFIED, TO REDUCE GROUP BENEFIT PLAN PREMIUM
10 COSTS FOR STATE EMPLOYEES FOR THE REMAINDER OF THAT STATE FISCAL
11 YEAR; AND

12 (III) FOR THE 2028-29 STATE FISCAL YEAR AND EACH STATE
13 FISCAL YEAR THEREAFTER, OF THE AMOUNT REMAINING AFTER THE
14 REQUIREMENTS OF SUBSECTION (8)(c)(I) OF THIS SECTION HAVE BEEN
15 SATISFIED, FOR THE BENEFIT OF STATE EMPLOYEES AS NEGOTIATED IN THE
16 PARTNERSHIP AGREEMENT BETWEEN THE STATE AND COLORADO
17 WORKERS FOR INNOVATIVE AND NEW SOLUTIONS PURSUANT TO THE
18 "COLORADO PARTNERSHIP FOR QUALITY JOBS AND SERVICES ACT", PART
19 11 OF THIS ARTICLE 50.

20 (9) THE DIRECTOR MAY ADOPT RULES IN ACCORDANCE WITH
21 ARTICLE 4 OF THIS TITLE 24 TO IMPLEMENT THIS SECTION, INCLUDING
22 RULES FOR LEVYING FINES AND TAKING OTHER CONTRACT ACTIONS
23 DEEMED NECESSARY TO ENFORCE COMPLIANCE WITH THIS SECTION.

24 **SECTION 6.** In Colorado Revised Statutes, **add 25.5-1-135** as
25 follows:

26 **25.5-1-135. Feasibility study - requirements for health plan**
27 **reimbursement for public employee group benefit plans - school**

1 **districts - higher education institutions - local governments - health**
2 **plan reimbursement feasibility study cash fund - repeal. (1) THE**

3 EXECUTIVE DIRECTOR SHALL CONDUCT A STUDY TO DETERMINE THE
4 FEASIBILITY OF ESTABLISHING SPECIFICATIONS FOR HEALTH PLAN
5 REIMBURSEMENTS, SIMILAR TO THE REQUIREMENTS ESTABLISHED FOR
6 STATE EMPLOYEE GROUP BENEFIT PLANS PURSUANT TO SECTION
7 24-50-621, IN COLLABORATION WITH THE FOLLOWING STATE AGENCIES
8 FOR BENEFIT PLANS OFFERED TO THE FOLLOWING PUBLIC EMPLOYEES:

9 (a) IN COLLABORATION WITH THE DEPARTMENT OF EDUCATION,
10 FOR EMPLOYEES OF SCHOOL DISTRICTS;

11 (b) IN COLLABORATION WITH THE COLORADO COMMISSION ON
12 HIGHER EDUCATION, FOR EMPLOYEES OF INSTITUTIONS OF HIGHER
13 EDUCATION; AND

14 (c) IN COLLABORATION WITH THE DEPARTMENT OF LOCAL AFFAIRS,
15 FOR EMPLOYEES OF LOCAL GOVERNMENTS.

16 (2) SCHOOL DISTRICTS, INSTITUTIONS OF HIGHER EDUCATION, AND
17 LOCAL GOVERNMENTS SHALL SUBMIT THE DATA AND INFORMATION
18 REQUESTED OF THEM BY THE EXECUTIVE DIRECTOR, IN THE FORMAT AND
19 TIMELINE REQUESTED, AS NECESSARY TO COMPLETE THE FEASIBILITY
20 STUDY.

21 (3) THE EXECUTIVE DIRECTOR SHALL COMPLETE THE STUDY
22 REQUIRED BY SUBSECTION (1) OF THIS SECTION AND SUBMIT THE REPORT
23 TO THE GENERAL ASSEMBLY ON OR BEFORE JANUARY 1, 2028.

24 (4) THE STATE DEPARTMENT SHALL USE THE MONEY IN THE
25 HEALTH CARE REIMBURSEMENT FEASIBILITY STUDY CASH FUND, CREATED
26 IN SUBSECTION (5) OF THIS SECTION, TO CONDUCT THE STUDY AND
27 PREPARE THE REPORT REQUIRED IN THIS SECTION.

1 (5) (a) THE HEALTH CARE REIMBURSEMENT FEASIBILITY STUDY
2 CASH FUND IS CREATED IN THE STATE TREASURY. THE FUND CONSISTS OF
3 MONEY TRANSFERRED TO THE FUND PURSUANT TO SECTION 24-51-621
4 (7)(b)(II) AND ANY OTHER MONEY THAT THE GENERAL ASSEMBLY MAY
5 APPROPRIATE OR TRANSFER TO THE FUND.

6 (b) THE STATE TREASURER SHALL CREDIT ALL INTEREST AND
7 INCOME DERIVED FROM THE DEPOSIT AND INVESTMENT OF MONEY IN THE
8 HEALTH CARE REIMBURSEMENT FEASIBILITY STUDY CASH FUND TO THE
9 FUND.

10 (c) THE MONEY IN THE HEALTH CARE REIMBURSEMENT FEASIBILITY
11 STUDY CASH FUND IS CONTINUOUSLY APPROPRIATED TO THE STATE
12 DEPARTMENT TO BE USED TO CONDUCT THE STUDY AND PREPARE THE
13 REPORT REQUIRED IN THIS SECTION.

14 (d) THE STATE TREASURER SHALL TRANSFER ALL UNEXPENDED
15 AND UNENCUMBERED MONEY IN THE HEALTH CARE REIMBURSEMENT
16 FEASIBILITY STUDY CASH FUND ON JUNE 30, 2027, TO THE GENERAL FUND.

17 (6) THIS SECTION IS REPEALED, EFFECTIVE JULY 1, 2027.

18 **SECTION 7.** In Colorado Revised Statutes, 24-22-117, **amend**
19 (2)(b)(I) as follows:

20 **24-22-117. Tobacco tax cash fund - accounts - creation -**
21 **legislative declaration.** (2) There are hereby created in the state treasury
22 the following funds:

23 (b) (I) The primary care fund to be administered by the department
24 of health care policy and financing. The state treasurer and the controller
25 shall transfer an amount equal to nineteen percent of the ~~moneys~~ MONEY
26 deposited into the cash fund, plus nineteen percent of the interest and
27 income earned on the deposit and investment of ~~those moneys~~ THAT

1 MONEY, to the primary care fund; except that, for the 2008-09, 2009-10,
2 2010-11, and 2011-12 fiscal years, the state treasurer and the controller
3 shall transfer to the primary care fund only an amount equal to nineteen
4 percent of the ~~moneys~~ MONEY deposited into the cash fund. BEGINNING
5 IN THE 2027-28 STATE FISCAL YEAR, THE PRIMARY CARE FUND ALSO
6 CONSISTS OF MONEY TRANSFERRED TO THE PRIMARY CARE FUND
7 PURSUANT TO SECTION 24-50-621 (6)(b)(I) AND (6)(c). All interest and
8 income derived from the deposit and investment of ~~moneys~~ MONEY in the
9 primary care fund shall be credited to the primary care fund; except that
10 all interest and income derived from the deposit and investment of
11 ~~moneys~~ MONEY in the primary care fund during the 2008-09, 2009-10,
12 2010-11, and 2011-12 fiscal years shall be credited to the general fund.
13 Any unexpended and unencumbered ~~moneys~~ MONEY remaining in the
14 primary care fund at the end of a fiscal year ~~shall remain~~ REMAINS in the
15 fund and shall not be credited or transferred to the general fund or any
16 other fund.

17 **SECTION 8. Safety clause.** The general assembly finds,
18 determines, and declares that this act is necessary for the immediate
19 preservation of the public peace, health, or safety or for appropriations for
20 the support and maintenance of the departments of the state and state
21 institutions.