

**First Regular Session  
Seventy-fifth General Assembly  
STATE OF COLORADO  
CORRECTED INTRODUCED**

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

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**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".**

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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 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.

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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** 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.