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,

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Bridges and Jodeh,

House Committees
Health & Human Services

Senate Committees

A BILL FOR AN ACT

CONCERNING LIMITS ON THE AMOUNTS THAT CERTAIN HEALTH INSURERS MAY REIMBURSE FOR THE PROVISION OF CERTAIN HEALTH-CARE SERVICES, AND, IN CONNECTION THEREWITH, CREATING THE "SUPPORT COLORADO'S HEALTH-CARE SAFETY 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

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.

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

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

follows:

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

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

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

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

(II) THE "EQUIVALENT RATE" IS:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

THAT A HOSPITAL OR AFFILIATED HEALTH FACILITY REFUSES TO PARTICIPATE IN A SMALL GROUP MARKET HEALTH BENEFIT PLAN AND ACCEPT THE REIMBURSEMENT RATE SPECIFIED IN THIS SECTION, THE COMMISSIONER SHALL ISSUE A WARNING TO THE HOSPITAL OR AFFILIATED HEALTH FACILITY. IF THE HOSPITAL OR AFFILIATED HEALTH FACILITY REFUSES TO PARTICIPATE IN A SMALL GROUP MARKET HEALTH BENEFIT PLAN AND ACCEPT THE REIMBURSEMENT RATE SPECIFIED IN THIS SECTION AFTER RECEIPT OF THE WARNING, THE COMMISSIONER SHALL FINE THE HOSPITAL OR AFFILIATED HEALTH FACILITY UP TO TEN THOUSAND DOLLARS PER DAY FOR THE FIRST THIRTY DAYS THAT THE HOSPITAL OR AFFILIATED HEALTH FACILITY REFUSES TO PARTICIPATE AND ACCEPT THE REIMBURSEMENT RATE SPECIFIED IN THIS SECTION AND UP TO FORTY THOUSAND DOLLARS PER DAY FOR EACH DAY BEYOND THE FIRST THIRTY DAYS THAT THE HOSPITAL OR AFFILIATED HEALTH FACILITY REFUSES TO PARTICIPATE AND ACCEPT THE REIMBURSEMENT RATE SPECIFIED IN THIS SECTION.

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

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

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

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

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

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

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

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

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

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

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

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

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

24-50-605. Group benefit plans - specifications - contracts. (1) (g) THE SPECIFICATIONS DRAWN BY THE DIRECTOR FOR ANY GROUP BENEFIT PLANS SHALL INCLUDE THE PARAMETERS FOR PROVIDER REIMBURSEMENTS SPECIFIED IN SECTION 24-50-621.

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

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

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

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

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

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

(II) THE "EQUIVALENT RATE" IS:

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

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

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

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

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

HOSPITALS.

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

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

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

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

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

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

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

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

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

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

SAME OR SIMILAR SERVICES; AND

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

districts - higher education institutions - local governments - health plan reimbursement feasibility study cash fund - repeal. (1) THE EXECUTIVE DIRECTOR SHALL CONDUCT A STUDY TO DETERMINE THE FEASIBILITY OF ESTABLISHING SPECIFICATIONS FOR HEALTH PLAN REIMBURSEMENTS, SIMILAR TO THE REQUIREMENTS ESTABLISHED FOR STATE EMPLOYEE GROUP BENEFIT PLANS PURSUANT TO SECTION 24-50-621, IN COLLABORATION WITH THE FOLLOWING STATE AGENCIES FOR BENEFIT PLANS OFFERED TO THE FOLLOWING PUBLIC EMPLOYEES:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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