First Regular Session
Seventy-third General Assembly
STATE OF COLORADO

PREAMENDED

This Unofficial Version Includes Committee Amendments Not Yet Adopted on Second Reading

LLS NO. 21-0050.02 Kristen Forrestal x4217

HOUSE BILL 21-1232

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A BILL FOR AN ACT

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

Bill Summary

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

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

HOUSE
3rd Reading Unamended
May 10, 2021

HOUSE
Amended 2nd Reading
May 7, 2021

- Offer health-care coverage at the bronze, silver, and gold levels;
- Be offered through the Colorado health benefit exchange;
- Be a standardized benefit design created through a stakeholder engagement process;
- Provide first-dollar, predictable coverage for certain high value services; and
- Comply with state and federal law.

Beginning January 1, 2023, and each year thereafter, the bill encourages carriers that offer:

- An individual health benefit plan in Colorado to offer the standardized plan in the individual market; and
- A small group health benefit plan in Colorado to offer the standardized plan in the small group market.

For 2023, each carrier shall set a goal of offering a standardized plan premium that is at least 10% less than the premium rate for health benefit plans offered by that carrier in the 2021 calendar year in the individual and small group market. For 2024, each carrier shall set a goal of offering a standardized plan premium that is at least 20% less than the premium rate for health benefit plans offered by that carrier in the 2021 calendar year in the individual and small group market. For 2025 and each year thereafter, carriers are encouraged to limit annual premium rate increases for the standardized plan to no more than the consumer price index plus one percent, relative to the previous year.

The Colorado option authority (authority) is created for the purpose of operating as a carrier to offer the standardized plan as the Colorado option if the carriers do not meet the established premium rate goals. The authority shall operate as a nonprofit, unincorporated public entity. The authority is required to implement a provider fee schedule as established by the commissioner in consultation with the executive director of the department of health care policy and financing. Health-care providers and health facilities are required to accept consumers who are enrolled in any health benefit plan offered by the authority.

The bill creates an advisory committee to make recommendations to the authority concerning the development, implementation, and operation of the authority.

The commissioner is required to apply to the secretary of the United States department of health and human services for a waiver and include a request for a pass-through of federal funding to capture savings as a result of the implementation of the standardized plan. The commissioner is required to disapprove of a rate filing submitted by a carrier if the rate filing reflects a cost shift between the standardized plan and the health benefit plan for which rate approval is being sought.

The bill makes the failure to accept consumers who are covered

through the Colorado option or the balance billing of a patient in violation of this bill grounds for discipline under specified practice acts.

The bill repeals the authority and its functions if the United States congress establishes a national public option program that meets or exceeds the premium rate goals set forth in and health-care coverage pursuant to this bill.

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

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

PART 13

COLORADO STANDARDIZED HEALTH BENEFIT PLAN

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

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

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

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

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

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

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

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

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

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

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

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

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

PAYMENT RATE DETERMINED BY THE MEDICAID FEE SCHEDULE FOR THE HOSPITAL FROM THE MOST RECENT YEAR FOR WHICH A COMPLETE SET OF HOSPITAL FINANCIAL DATA IS PUBLICLY AVAILABLE UPON THE EFFECTIVE DATE OF THIS PART 13, MULTIPLIED 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 FOR THE MOST RECENT SET OF PUBLICLY AVAILABLE HOSPITAL FINANCIAL DATA UPON THE EFFECTIVE DATE OF THIS PART 13, WHICH IS 1.52.

(b) IN ANY GIVEN YEAR, THE RATE IN SUBSECTION (3)(a) OF THIS SECTION MUST BE 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.

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

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

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

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

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

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

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

(11) (a) "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., AS AMENDED.

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

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

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

(14) "STANDARDIZED PLAN" MEANS THE STANDARDIZED HEALTH

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

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

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

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

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

(d) BE A STANDARDIZED BENEFIT DESIGN THAT:

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

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

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

WHICH ARE IDENTIFIED COLLABORATIVELY WITH CONSUMER STAKEHOLDERS, INCLUDING:

(A) IMPROVING PERINATAL HEALTH-CARE COVERAGE; AND

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

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

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

(g) HAVE A NETWORK THAT IS:

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

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

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

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

(II) INCLUDE A MAJORITY OF THE ESSENTIAL COMMUNITY

PROVIDERS IN THE SERVICE AREA IN ITS NETWORK.

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

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

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

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

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

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

WHICH SURVEY ADDRESSES CONSUMERS' EXPERIENCE.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

72 OF TITLE 24.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MAINTENANCE ORGANIZATION, TO CONTRACT WITH ANY OTHER CARRIER; AND

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) THE COMMISSIONER SHALL TAKE INTO ACCOUNT:

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

(II) ANY CHANGES TO THE STANDARDIZED PLAN; AND

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) HAVE EXPERIENCE PURCHASING THE STANDARDIZED PLAN;

(c) REPRESENT CONSUMER ADVOCACY ORGANIZATIONS;

(d) HAVE EXPERTISE IN HEALTH EQUITY;

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

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

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

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

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

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

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

(4) IN ADDITION TO CONSULTING WITH THE COMMISSIONER

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

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

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

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

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

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

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

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

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

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

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

10-16-1310. Reports required - repeal. (1) (a) THE COMMISSIONER SHALL CONTRACT WITH AN INDEPENDENT THIRD-PARTY

ORGANIZATION TO PREPARE THREE SEPARATE REPORTS AS SPECIFIED IN SUBSECTION (4) OF THIS SECTION, TO THE EXTENT THAT INFORMATION IS AVAILABLE REGARDING THE IMPLEMENTATION OF THIS PART 13 AS IT RELATES TO THE STAFFING, WAGES, BENEFITS, TRAINING, AND WORKING CONDITIONS OF HOSPITAL WORKERS.

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

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

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

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

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

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

(2) THE COMMISSIONER SHALL CONTRACT WITH AN INDEPENDENT THIRD-PARTY ORGANIZATION TO PREPARE A REPORT REGARDING THE IMPLEMENTATION OF THIS PART 13, TO THE EXTENT INFORMATION IS AVAILABLE, AS IT RELATES TO PROVIDER WORKLOAD, INCLUDING ANY IMPACT ON THE SIZE OF THE PROVIDER PANELS, IF AVAILABLE. THE REPORT SHALL BE COMPLETED BY DECEMBER 31, 2023.

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

10-16-1311. State measurement for accountable, responsive, and transparent (SMART) government act report. (1) THE

COMMISSIONER SHALL REPORT DURING THE HEARINGS CONDUCTED PURSUANT TO THE "STATE MEASUREMENT FOR ACCOUNTABLE, RESPONSIVE, AND TRANSPARENT (SMART) GOVERNMENT ACT", PART 2 OF ARTICLE 7 OF TITLE 2:

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

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

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

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

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

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

10-16-107. Rate filing regulation - benefits ratio - rules. (3) (a) The commissioner shall disapprove the requested rate increase if any of the following apply:

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

(VII) THE RATE FILING REFLECTS A COST SHIFT BETWEEN THE STANDARDIZED PLAN, AS DEFINED IN SECTION 10-16-1303 (14), OFFERED BY THE CARRIER AND THE HEALTH BENEFIT PLAN FOR WHICH RATE APPROVAL IS BEING SOUGHT. THE COMMISSIONER MAY CONSIDER THE TOTAL COST OF HEALTH CARE IN MAKING THIS DETERMINATION.

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

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

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

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

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

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

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

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

SECTION 5. In Colorado Revised Statutes, **add** 12-30-116 as

follows:

12-30-116. Acceptance of patients enrolled in standardized plan - acceptance of reimbursement rate requirements - warning - fine. (1) THE COMMISSIONER OF INSURANCE MAY REQUIRE A HEALTH-CARE PROVIDER, AFTER A HEARING PURSUANT TO SECTION 10-16-1306, TO PARTICIPATE IN A STANDARDIZED PLAN, AS DEFINED IN SECTION 10-16-1303 (14), AND ACCEPT THE REIMBURSEMENT RATE DESCRIBED IN SECTION 10-16-1306.

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

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

(b) IN DETERMINING THE APPROPRIATE ADMINISTRATIVE FINE, THE DIRECTOR SHALL CONSIDER ANY RECOMMENDATION OF THE COMMISSIONER OF INSURANCE, THE FINANCIAL CIRCUMSTANCES OF THE PERSON ON WHOM THE FINE IS BEING IMPOSED, AND OTHER CIRCUMSTANCES DEEMED RELEVANT BY THE DIRECTOR.

(4) THE IMPOSITION OF AN ADMINISTRATIVE FINE PURSUANT TO THIS SECTION DOES NOT CONSTITUTE A DISCIPLINARY ACTION PURSUANT

TO THIS TITLE 12 AGAINST A HEALTH-CARE PROVIDER.

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

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

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

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

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

(b) IN DETERMINING THE APPROPRIATE FINE OR ACTION CONCERNING THE HOSPITAL'S LICENSE PURSUANT TO SUBSECTION (2)(a) OF THIS SECTION, THE DEPARTMENT SHALL CONSIDER ANY RECOMMENDATIONS OF THE COMMISSIONER OF INSURANCE, THE

HOSPITAL'S FINANCIAL CIRCUMSTANCES, AND OTHER CIRCUMSTANCES DEEMED RELEVANT BY THE DEPARTMENT.

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

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

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

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

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

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

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

(a) $948,667 for use by the division of insurance for personal

services, which is based on an assumption that the division will require an additional 5.4 FTE;

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

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

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

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

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

(b) $13,750 for operating expenses.

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