0543 Interim Committee on Health Insurance

Colorado Legislative Council

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Interim Committee on
Health Insurance

Report to the
COLORADO
GENERAL ASSEMBLY

Colorado Legislative Council
Research Publication No. 543
December 2005
RECOMMENDATIONS FOR 2006

INTERIM COMMITTEE ON HEALTH INSURANCE

Report to the
Colorado General Assembly

Research Publication No. 543
December 2005
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To Members of the Sixty-fifth General Assembly:

Submitted herewith is the final report of the Interim Committee on Health Insurance. This committee was created pursuant to Senate Joint Resolution 05-036. The purpose of the committee is to review health insurance issues that face the citizens of Colorado.

At its meeting on November 15, 2005, the Legislative Council reviewed the report of this committee. A motion to forward this report and the bills therein for consideration in the 2006 session was approved.

Respectfully submitted

/s/ Senator Joan Fitz-Gerald
Chairman
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>LETTER OF TRANSMITTAL</td>
<td>iii</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>v</td>
</tr>
<tr>
<td>RECOMMENDED BILLS AND FISCAL NOTES</td>
<td>vii</td>
</tr>
<tr>
<td>MEMBERS OF THE COMMITTEE</td>
<td>ix</td>
</tr>
<tr>
<td>EXECUTIVE SUMMARY</td>
<td>xi</td>
</tr>
<tr>
<td>Committee Charge</td>
<td>xi</td>
</tr>
<tr>
<td>Committee Activities</td>
<td>xi</td>
</tr>
<tr>
<td>Committee Recommendations</td>
<td>xii</td>
</tr>
<tr>
<td>STATUTORY AUTHORITY AND RESPONSIBILITIES</td>
<td>1</td>
</tr>
<tr>
<td>COMMITTEE ACTIVITIES</td>
<td>3</td>
</tr>
<tr>
<td>Uninsured</td>
<td>3</td>
</tr>
<tr>
<td>Reinsurance</td>
<td>3</td>
</tr>
<tr>
<td>Small Group Market Regulation</td>
<td>5</td>
</tr>
<tr>
<td>Promoting Local Initiatives</td>
<td>6</td>
</tr>
<tr>
<td>Health Savings Accounts</td>
<td>7</td>
</tr>
<tr>
<td>Primary and Preventative Care Networks</td>
<td>8</td>
</tr>
<tr>
<td>Health Information Technology</td>
<td>9</td>
</tr>
<tr>
<td>Dental Insurance</td>
<td>10</td>
</tr>
<tr>
<td>SUMMARY OF RECOMMENDATIONS</td>
<td>11</td>
</tr>
<tr>
<td>Bill A — Expansion of the Availability of Affordable Health Care Coverage for Coloradans, and, in Connection Therewith, Creating the Healthy Business Healthy People Program and Making an Appropriation Therefor</td>
<td>11</td>
</tr>
<tr>
<td>Bill B — Provision of Health Care Services by Local Governmental Entities, and, in Connection Therewith, Allowing Such Districts to be Created in any Part of the State, Authorizing Such Districts to Levy a Sales Tax, and Authorizing Counties to Impose a Sales Tax for the Purpose of Providing Health Care Services</td>
<td>11</td>
</tr>
<tr>
<td>Bill C — Provision of Health Care Services to Specified Low-Income Adults</td>
<td>12</td>
</tr>
<tr>
<td>Bill D — A Study to Analyze Factors that Drive the Cost of Health Care within Pueblo County</td>
<td>12</td>
</tr>
<tr>
<td>Bill E — Types of Health Benefit Plans Required to be Offered by Small Employer Carriers to Small Employers in the State</td>
<td>12</td>
</tr>
<tr>
<td>Bill F — Creation of a Program to Provide Premium Subsidies</td>
<td></td>
</tr>
</tbody>
</table>
# RECOMMENDED BILLS AND FISCAL NOTES

<table>
<thead>
<tr>
<th>Bill</th>
<th>Title</th>
<th>Fiscal Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Concerning the Expansion of the Availability of Affordable Health Care Coverage for Coloradans, and, in Connection Therewith, Creating the Healthy Business Healthy People Program and Making an Appropriation Therefor</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Fiscal Note</td>
<td>41</td>
</tr>
<tr>
<td>B</td>
<td>Concerning the Provision of Health Care Services by Local Governmental Entities, and, in Connection Therewith, Allowing Such Districts to be Created in any Part of the State, Authorizing Such Districts to Levy a Sales Tax, and Authorizing Counties to Impose a Sales Tax for the Purpose of Providing Health Care Services</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>Fiscal Note</td>
<td>65</td>
</tr>
<tr>
<td>C</td>
<td>Concerning the Provision of Health Care Services to Specified Low-Income Adults</td>
<td>69</td>
</tr>
<tr>
<td></td>
<td>Fiscal Note</td>
<td>not available</td>
</tr>
<tr>
<td>D</td>
<td>Concerning a Study to Analyze Factors that Drive the Cost of Health Care within Pueblo County</td>
<td>77</td>
</tr>
<tr>
<td></td>
<td>Fiscal Note</td>
<td>83</td>
</tr>
<tr>
<td>E</td>
<td>Concerning the Types of Health Benefit Plans Required to be Offered by Small Employer Carriers to Small Employers in the State</td>
<td>87</td>
</tr>
<tr>
<td></td>
<td>Fiscal Note</td>
<td>103</td>
</tr>
<tr>
<td>F</td>
<td>Concerning the Creation of a Program to Provide Premium Subsidies to Certain Individuals Enrolled in a Qualifying Health Benefit Plan</td>
<td>105</td>
</tr>
<tr>
<td></td>
<td>Fiscal Note</td>
<td>121</td>
</tr>
</tbody>
</table>

The fiscal note for Bill C was not available on the date of printing and will be posted on the committee's website when it is completed.
INTERIM COMMITTEE ON
HEALTH INSURANCE

Members of the Committee

Senator Bob Hagedorn, Chair
Senator Steve Johnson
Representative Betty Boyd, Vice-Chair
Senator Maryanne Keller
Representative Gwyn Green
Senator Andy McElhany
Representative Bob McCluskey
Senator Brandon Shaffer
Representative Josh Penry

Legislative Council Staff

Elizabeth Burger
Research Associate
Jeanette Chapman
Research Associate
Jessika Shipley
Research Assistant
Amy Larsen
Senior Fiscal Analyst

Office of Legislative Legal Services

Christy Chase
Senior Staff Attorney
Kristen Forrestal
Senior Staff Attorney
Committee Charge

Pursuant to Senate Joint Resolution 05-036, the Interim Committee on Health Insurance was charged with reviewing health insurance issues that affect the citizens of Colorado. The committee was required to study issues including, but not limited to, the following:

- issues surrounding network adequacy, including practice by both participating and nonparticipating providers at in-network facilities; workforce training; certificates of need; and provider quality;
- the use of credit scoring for insurance underwriting purposes;
- issues surrounding dental insurance;
- rate-setting processes for health care services by third-party carriers, including the use of federal Medicare rates as a benchmark, establishment of rates through negotiations between providers and carriers, the extent to which legal or regulatory standards affect marketplace negotiations, and any other underwriting or accounting practices that might be utilized;
- processes utilized by third-party carriers for determination of covered benefits; preauthorization for services, including medical necessity; retrospective approval or denial of claims; and claims payment practices;
- the feasibility of direct contracting between providers and employers; and
- a comparison of regulatory requirements between state-regulated health insurance plans and those under the jurisdiction of the federal Department of Labor through the federal "Employee Retirement Income Security Act of 1974."

Committee Activities

The committee held six meetings over the course of the 2005 interim. At each meeting, the committee received testimony from working groups that were formed by the committee chairman to comment on the topics to be considered by the committee. The working groups consisted of representatives of health care providers, health insurance carriers, consumer advocacy groups, and small and large employers. The committee heard a variety of presentations from the Colorado Health Institute, the National Conference of State Legislatures, the state Division of Insurance, and various provider, insurance, employer, and consumer groups.

Uninsured. The committee began its study of health insurance issues by receiving information on the number of uninsured persons in the state. According to the U.S. Census Bureau, over 760,000 Coloradans did not have health insurance in 2004. This is
approximately 17 percent of the state's population. Presenters explained that many uninsured Coloradans are employed, but simply cannot afford the high cost of health insurance. As a result, the committee considered various proposals that focused on reducing the cost of health insurance for employed individuals. Among the proposals recommended by the committee was the creation of a program to subsidize a portion of insurance premiums for low-income, working individuals. The committee also recommended a proposal to allow local entities to form health assurance districts, a special district with taxing authority, to provide health care services to residents of the district.

Small group market. The committee also received information concerning the small group health insurance market in Colorado. Colorado's small group market consists of employers with 2-50 employees and business groups of 1 (sole proprietors). Much of the committee's discussion revolved around the current level of participation in the market and the impact of legislative changes on the market over the past ten years. Some presenters concluded that participation in the small group market is declining because of high insurance costs, and, as the market continues to decline, costs grow even higher. The committee considered a variety of proposals to increase participation and lower costs in the small group market. Among the proposals were two separate state reinsurance programs to fund a portion of small employers' health insurance claims. One of the programs, the Healthy Business Healthy People Program, was recommended by the committee. The committee also considered, but did not recommend, a proposal that would change small group insurers' provider network requirements.

Additional topics. Additional topics related to health insurance were explored by the committee. The committee heard from dentists and dental insurers regarding direct dental reimbursement, a new method of paying for dental care. The committee considered possible methods of expanding access to health care for of low-income persons through the creation of a primary and preventative care network. In response, the committee recommended legislation to create a primary care program for adults who are ineligible for Medicaid, and to fund services for Medicaid-eligible adults whose incomes are above 60 percent of the federal poverty level. In addition, the committee was given information regarding health information technology initiatives at the state and federal level.

The committee considered eight proposals based upon the information received over the course of the meetings. The six proposals recommended by the committee are described below.

**Committee Recommendations**

**Bill A — Expansion of the Availability of Affordable Health Care Coverage for Coloradans.** Bill A creates the Healthy Business Healthy People Program. Under the program, a five-year pilot, small group insurance carriers will receive state-funded reinsurance payments for 90 percent of total claims between $5,000 and $75,000 paid on behalf of an individual insured under a health insurance plan sponsored by a qualifying employer. Qualifying employers include employers with five or fewer employees, at least
two of whom earn less than $28,000 annually, or a business group of one. In addition, under the program, certain individuals who meet income and eligibility requirements will receive a subsidy to purchase insurance through CoverColorado. The reinsurance and subsidy payments will be funded from the newly created Healthy Business Healthy People Fund, which will contain $15 million from the General Fund Exempt Account. The General Fund Exempt Account is funded with dollars made available through the passage of Referendum C at the 2005 election.

**Bill B — Health Care Services Provided by Local Governmental Entities.** Currently, health assurance districts can only be formed in rural areas of the state. Bill B allows health assurance districts to be formed in any area of the state for the purpose of providing and funding health care services for residents of the district. Health assurance districts are permitted to seek voter approval to levy a sales tax, property tax, or a combination of sales and property taxes in order to fund health care services. Bill B also permits counties to seek voter approval to levy a sales tax to provide health care services in the county.

**Bill C — Primary Care Services Provided to Specified Low-income Adults.** Bill C establishes the Colorado Primary Care Program through which uninsured, low-income adults who have a condition that requires frequent medical treatment can receive primary health care services at a community health clinic. The bill further allocates $7.5 million to fund Medicaid services for adults with incomes above 60 percent of the federal poverty level. The funding for the bill is from the newly created Colorado Health Care Services Fund which will consist of $15 million from the General Fund Exempt Account. The General Fund Exempt Account is funded with dollars made available through the passage of Referendum C at the 2005 election.

**Bill D — A Study to Analyze Factors that Drive the Cost of Health Care within Pueblo County.** Bill D requires the state Division of Insurance to conduct a study to identify the factors that drive health insurance costs in Pueblo county, and specifies that the division may contract with a nonprofit entity to analyze the data collected through the study.

**Bill E — Types of Health Benefit Plans Required to be Offered by Small Employer Carriers to Small Employers in the State.** Bill E eliminates the requirement that small group health insurers offer a standard health benefit plan to small employers. In addition, the bill adds an additional design to the basic health benefit plan health insurers are required to offer to small employers, allowing carriers to offer a basic health benefit plan that is similar to the managed care plan in which Medicaid clients are enrolled. The standard plan design approximates the average level of coverage offered in the small group market and the basic health benefit plan design approximates the lowest level of coverage offered in the small group market. Small group health insurers are currently required to offer a standard plan and one of three basic health benefit plan designs to small employers.
Bill F — Premium Subsidies Provided to Certain Individuals Enrolled in a Qualifying Health Benefit Plan. Bill F creates the Colorado Premium Subsidy Program, a five-year pilot, through which uninsured persons with a household income of no more than 200 percent of the Federal poverty level are eligible for state-funded subsidies to purchase a qualifying health plan. Qualifying health plans include a high deductible health plan that is coupled with a health savings account and a managed care plan similar to the managed care plan in which Medicaid enrollees are enrolled. The subsidy is set at 50 percent of the monthly premium for the plan, or no more than $100 a month. The program is funded by the newly created Colorado Premium Subsidy Program Fund, which will contain $15 million from the General Fund Exempt Account. The General Fund Exempt Account is funded with dollars made available through the passage of Referendum C at the 2005 election.
Senate Joint Resolution 05-036 established the Interim Committee on Health Insurance in order to study issues facing the citizens of Colorado regarding health insurance. The resolution mandated that the committee consist of ten members of the General Assembly: five members of the Senate and five members of the House of Representatives. The committee was required to meet at least four times between July 1, 2005, and October 15, 2005.

The committee was charged with studying the following:

- issues surrounding network adequacy, including practice by both participating and nonparticipating providers at in-network facilities; workforce training and adequacy; the encouragement of provider competition based on quality; and certificates of need, alignment of needs, and resources in communities;
- the use of credit scoring for insurance underwriting purposes;
- dental insurance issues;
- rate-setting processes for health care services by third-party carriers, including the use of federal Medicare rates as a benchmark, establishment of rates through negotiations between providers and carriers, the extent to which legal or regulatory standards affect marketplace negotiations, and any other underwriting or accounting practices that might be utilized;
- processes utilized by third-party carriers for determination of covered benefits; preauthorization for services, including medical necessity; retrospective approval or denial of claims; and claims payment processes;
- the feasibility of direct contracting between providers and employers; and
- a comparison of regulatory requirements between state-regulated health insurance plans and those under the jurisdiction of the federal "Employment Retirement Income Security Act of 1974" (ERISA).
Uninsured

The committee began its study of health insurance issues in Colorado by discussing the number of uninsured persons in the state. In Colorado, over 17 percent of the state's population was without health insurance in 2004, according to the U.S. Census Bureau. In some rural counties of the state, the rate of the uninsured was as high as 29 percent of the county's population in 2000.

The committee received data showing that almost two-thirds of the state's 760,000 uninsured persons are employed. Many working uninsured persons either cannot afford the health insurance plans offered by their employers or work in jobs that do not offer health insurance. As a result, many presenters urged the committee to focus on initiatives that provide access to health insurance for low-income working individuals and lower the high cost of health care.

Presenters also noted that as the number of uninsured persons increases, the costs for insured persons, in turn, increase. Health care providers often attempt to recover the cost of uncompensated care provided to the uninsured by charging increased prices to persons with health insurance. This practice increases the cost of health insurance, which may cause some insured persons to drop their coverage. Committee members were urged to consider policies which address cost-shifting in health care and which broadly promote health care coverage.

Recommendation. The committee recommended a number of proposals designed to promote health insurance coverage. The proposals recommended by the committee are discussed in detail under the following topics.

Reinsurance

Overview. The committee discussed the issue of reinsurance in great detail. It was examined as a possible solution to the high cost of health insurance for small businesses. Reinsurance is a type of insurance for insurance companies in which the state assumes some or all of the responsibility for high-cost claims incurred by small businesses in order to make health insurance premiums more affordable. Reinsurance is not activated until a set deductible is met, and there is an upper limit on reinsurable expenses. There is a layer between the deductible and the upper limit and reinsurance covers the expenses within that layer. Reinsurance limits the liability on specific risks and helps to protect insurance companies against unforeseen or extraordinary losses. Employers, the state, and insurance companies share the liability, which encourages coverage among small groups and individuals, as well as lowering premiums.
There are two types of reinsurance—aggregate stop-loss and excess-of-loss. Aggregate stop-loss reinsurance protects against total annual losses of an insurer up to a certain level, which is typically set based on group experience. Excess-of-loss reinsurance refers to protection against annual losses per insured individual that exceed some set level.

**Reinsurance in practice.** The committee heard presentations about two active state-sponsored reinsurance programs. The first, Healthy New York, is an excess-of-loss program that was implemented in January 2001. It was funded with tobacco settlement money. Healthy New York restricts eligibility to uninsured small employers and individuals. All health maintenance organizations in New York are required to participate in the program. Administrators of the program report that premiums are 15-30 percent lower than comparable small group products.

The other state-sponsored program discussed by the committee is the Healthcare Group of Arizona, an aggregate stop-loss reinsurance program. It began in 1985 as a small group coverage program and became a reinsurance program in 2000. Arizona state funds subsidize collective losses incurred by participating health plans. Eligible participants are uninsured small employers or uninsured self-employed individuals. Arizona uses an "aggressive medical management" plan to drastically reduce costs, thereby reducing premiums.

**Committee recommendation.** The committee recommended a bill that utilizes the reinsurance concept. Bill A creates the Healthy Business Healthy People Program, which would expand the availability of health care coverage to eligible small employers and individuals. The bill sets forth criteria for the eligibility of small employers and creates a reinsurance arrangement under which eligible small employer plans would receive reimbursement for certain amounts of claims paid. Small employers must have no more than five employees, at least two of whom earn $28,000 or less per year. Business groups of one, with a net annual income from the business that is $28,000 or less per year, are also eligible. A qualifying plan under the Healthy Business Healthy People Program refers to a basic or standard health benefit plan that provides coverage through a health maintenance organization or preferred provider organization. The employer must pay at least 50 percent of the premiums for employees and the employee contribution must be the same dollar amount for every employee.

For individuals, the bill creates a subsidy plan to pay part of the premiums charged for plans offered by CoverColorado. CoverColorado is a non-profit entity created by the legislature to provide insurance coverage to eligible Colorado residents who, due to pre-existing conditions, are unable to obtain medical insurance from traditional sources.

The reinsurance and subsidy payments will be funded from the newly created Healthy Business Healthy People Fund, which will contain $15 million from the General Fund Exempt Account. The General Fund Exempt Account is funded with dollars made available through the passage of Referendum C at the 2005 November election.
Small Group Market Regulation

Colorado's small group market consists of employers with 2 to 50 employees and business groups of 1 (sole proprietors) who do not self-fund their health insurance programs. The committee heard presentations on the history of the state's regulation of the small group market, and possible methods of increasing enrollment and reducing costs for small employers in the market. The committee's activities with regard to the regulation of the small group market focused on two areas: the requirement that small group health insurers offer a basic and standard plan and network adequacy requirements.

**Basic and standard plans.** In Colorado, health insurers are required to offer two health benefit plans to small employers: the basic and standard plans. In addition to the basic and standard plans, health insurers may offer other plan designs to small businesses, although health insurers are not required to issue other plan designs to business groups of one. The standard plan approximates the average level of coverage offered in the small group market and the basic plan approximates the lowest level of coverage offered in the small group market. All small group health insurers are required to offer small groups the same standard plan design, but only one of three basic plan designs. The requirement that health insurers offer a standard and basic health benefit plan to small employers is set to repeal on July 1, 2006.

In Colorado, health insurers are permitted to offer a basic plan that does not cover certain mandated benefits, such as mammography and mental health treatment. Eliminating coverage for these mandated benefits is thought to lower the premiums for the plan. In 2004, enrollment in the basic plan was limited to only 6.9 percent of small employers. More small employers, 9.1 percent, were enrolled in the standard plan, which offers increased benefits and allows small employers to compare the cost of coverage across insurers. This comparison is not always possible with the basic plan as health insurers may currently choose one of three basic plan designs to offer. Most small employers in Colorado, however, are not enrolled in either a basic or standard plan, but in different plans offered by their health insurer.

**Committee recommendation.** The committee recommended Bill E, which eliminates the requirement that health insurers offer a standard plan to small employers and adds an additional design to the basic plan. The new basic plan design allows health insurers to offer a plan with the same or similar design to the managed care plan currently available to Medicaid clients.

**Network adequacy.** Small group health insurers are required under state law to maintain an adequate network of providers. Health insurers create incentives for an insured individual to see in-network providers by charging the individual more to see an out-of-network provider. In this way, the insurer can maximize the number of people who receive care from providers that accept the insurer's rates, reducing costs for the insurer.

In some circumstances, an insured patient may be treated at in an in-network facility by a provider working at the facility who has not contracted with the patient's...
insurance company. In these instances, Colorado law requires the benefit level for all covered services and treatment received through the facility to be the in-network benefit. The Division of Insurance has interpreted this provision of Colorado law to mean that the patient cannot be charged for the difference between the health insurer's rate and the rate charged by the out-of-network provider. The Division of Insurance has further found that health insurers must pay the out-of-network provider's charges for the service in order to avoid "balance billing" the patient. A patient is "balance billed" if he or she is charged the difference between the insurance company's rate and the provider's charge.

Health insurers testified that current law creates a disincentive for physicians to contract with health plans because, under the current law, some physicians may charge their own, possibly higher, rate for providing health care services instead of accepting the rate the paid by the insurance company. Health insurers maintained that this practice increases costs for the health insurance companies which, in turn, increases health insurance premiums. Consumer advocates testified that the current law protect consumers from being "balance billed" by physicians. The consumer groups maintained that a patient who has complied with the terms of his or her health insurance plan by seeking treatment in an in-network facility should not be "balance billed" and that health insurers have a responsibility to maintain an adequate network of providers within each facility covered under the health plan.

No committee recommendation. The committee considered, but did not recommend, a bill that would have required consumers receiving non-emergency care at an in-network facility to be responsible for the difference between an out-of-network provider's billed charges and the health insurer's in-network rate.

Promoting Local Initiatives

The committee was encouraged to consider legislation that supported the efforts of local initiatives to increase health care coverage. Three local initiatives in the Roaring Fork Valley, El Paso County, and Northern Larimer County are utilizing innovative approaches and partnerships to promote quality health care and decrease the number of uninsured persons in the communities. For instance, in Northern Larimer County, a health district originally formed to support the construction of a hospital has started to research the possibility of levying property or sales taxes to provide health services to residents of the district. In general, the local initiatives focus on collaborative processes between government, health care providers, and community activists to develop innovative health programs.

Committee recommendations. The committee recommended Bill B, which allows health assurance districts to be formed in all areas of the state for the purpose of providing and funding health care services for residents of the districts. Previously, the formation of health assurance districts was limited to only rural areas of the state. Health assurance districts are permitted to seek voter approval to levy a sales tax, property tax, or a combination of sales and property taxes in order to fund health care services. Bill B also
permits counties to seek voter approval to levy a sales tax to provide health care services in the county.

The committee also recommended Bill D. Bill D requires the state Division of Insurance to conduct a study to identify the factors that drive health insurance costs in Pueblo county, and specifies that the division may contract with a nonprofit entity to analyze the data collected through the study.

**Health Savings Accounts**

*Overview.* Health savings accounts (HSAs) are a growing trend in the effort to combat rising health care costs. HSAs were mentioned in several presentations to the committee. They are similar to medical savings accounts (MSAs), in that they can be used to pay for health care costs, but they are more flexible than MSAs. HSAs are paired with a high-deductible health benefit plan and participants contribute tax-deferred money to the HSA. Individuals use the money in their HSAs to pay for eligible health care costs that are not covered by the high-deductible plan. Both employers and employees may contribute to the HSA, but the money in the account is owned in full by the employee and is portable. Employees can move the HSA with them from one job to the next and unused dollars can be rolled over from year to year.

*Benefits of HSAs.* The presentations to the committee focused mainly on the positive aspects of HSAs. They give consumers the flexibility to use any health care provider they choose. An HSA belongs to an employee, so the employer is not responsible for the maintenance of the HSA. This reduces administrative costs for the employer, which may act as an incentive to offer health insurance benefits. The HSA is funded by pre-tax salary contributions and that translates to savings for employees.

*Possible negative aspects.* While most of the presentations about HSAs concentrated on the positive aspects, most mentioned the downsides, as well. First, most health care providers negotiate with health insurance companies to offer services at a discounted price. Individuals with HSAs must pay for services out-of-pocket until their deductible is met. For those services, they do not have the benefit of the negotiation process and would likely pay much higher prices for the same services. Second, testimony was given to the committee that there is currently a lack of high-quality, high-deductible health plans in the market. Finally, unless the consumer's health insurance premium is significantly reduced, either through a premium subsidy program or a tax credit, the consumer may not have enough money to initially fund the HSA.

*Committee recommendation.* The committee recommended Bill F, which establishes a premium subsidy program that would provide monetary assistance to eligible individuals enrolled in qualifying health benefit plans. It is essentially another form of reinsurance, with the state paying part of a health insurance premium in an effort to extend health benefits to low-income individuals. An eligible individual, according to the bill, is one:
who has been uninsured for the previous 12 months;
• who has not been offered health insurance by his or her employer in the
  previous 12 months, or whose employer has offered health insurance, but is
  unable to pay the employee portion of the premium;
• who resides in a household having a net income of less than 200 percent of the
  federal poverty level;
• who, if enrolled in a high deductible plan that qualifies for a health savings
  account, has established a health savings; and
• who applies for reduced-price coverage under the program on or after

A qualifying health benefit plan is one that has a total premium that does not exceed
$200 per month. It must be a high deductible plan that qualifies for a health savings
account or a managed care plan with the same or a similar benefit design as that of a
managed care plan in which Medicaid clients are enrolled.

The premium subsidy program provides 50 percent of the premium paid for
coverage in a qualifying plan. The bill caps the monthly subsidy per individual at $100. If
the individual has an HSA, the bill requires that premium subsidies be paid directly into
that account. The premium subsidy program is funded through the newly-created Colorado
Premium Subsidy Program Fund, which is established using $15 million that will be
available due to the passage of Referendum C at the 2005 statewide election.

Primary and Preventative Care Networks

One of the options for expanding health care coverage described to the committee
was the creation of a primary and preventative care network for low-income adults who are
currently not eligible for Medicaid. Typically, these networks provide limited primary care
services to a large group of uninsured individuals, but do not cover hospitalizations or
long-term care. By providing uninsured individuals with access to preventative health care,
it is hoped that high-cost emergency room visits and hospitalizations can be averted.

The committee received information on primary and preventative care networks
that have been implemented in other states. In Maryland, the PrimaryCare program
provides a medical home for persons with a chronic illness and incomes of up to 116
percent of the federal poverty level. Under the program, individuals receive an annual
physical exam, treatment for chronic and acute conditions, and prescription drugs for the
treatment of the individual's chronic disease. No premiums or co-payments are charged
to program participants. The program is funded with $7.5 million in state funds and
enrollment is capped at 8,000 participants per year.

In 2002, Utah implemented a program through a Medicaid waiver that provides
limited primary and preventative care services to low-income adults. Individuals 19 to 64
years of age with incomes below 150 percent of the federal poverty level who are
uninsured and do not have access to health insurance are eligible for the program. The
program covers primary care physician visits, some emergency room costs, and up to four prescriptions per month. Participants must pay an enrollment fee ranging from $15 to $50 a year and co-payments for emergency room visits and prescription drugs.

Committee recommendation. The committee recommended Bill C, which creates the Colorado Primary Care Program. Under the program, eligible individuals who have a chronic health condition may receive coverage of office visits for acute and chronic health conditions, health care screenings, lab tests and x-rays, outpatient drug and alcohol treatment, four prescriptions per month, and any other primary care service authorized by the state Medical Services Board. Eligible individuals are residents of Colorado who are between 19 and 64 years of age and who have incomes at or below 100 percent of the federal poverty level. Eligible individuals must be uninsured and cannot be eligible for Medicaid or veteran's medical benefits. The program is funded with $7.5 million from the newly created Colorado Health Care Services Fund, which will be funded with moneys available from the passage of Referendum C at the 2005 statewide election.

Bill C also authorizes $7.5 million from the Colorado Health Care Services Fund to be allocated to increase the Medicaid eligibility level for parents of children enrolled in Medicaid or the Children's Basic Health Plan. Currently, the Medicaid eligibility level for parents is set at 60 percent of the federal poverty level; the bill specifies that the appropriated moneys must be used to pay for services for individuals with incomes above 60 percent of the federal poverty level.

Health Information Technology

Background. Health information technology (HIT) includes things like electronic medical records, billing and payroll software programs, clinical diagnosis systems, and other technology resources that help to streamline health care services. The committee heard a presentation from the Colorado Health Institute on the trends in HIT and the potential cost savings that may be realized through the use of HIT.

There was also some attention given to the federal agenda regarding HIT, which is heavily focused on the establishment of a National Health Information Network (NHIN). The proposed NHIN will use the Internet to link health care professionals and allow them to share information. A key component of the NHIN is a framework of common standards and practices across the nation that will make this type of information sharing feasible.

Colorado is in the process of developing its own health information network. The Colorado Health Information Exchange (COHIE) Initiative is a statewide coalition of interested individuals, health care providers, agencies, organizations, and community leaders working to establish a process whereby health care professionals and patients gain and share access to health care information when it is needed. The COHIE Initiative is funded by a $5 million grant from the Agency for Healthcare Research and Quality. Colorado is one of five states that have received such a grant.
Dental Insurance

The committee was required to study the feasibility of direct contracting between providers and employers as well as issues surrounding dental insurance. The committee heard presentations from representatives of the Colorado Dental Association, employers, and dental insurers regarding a method of paying for dental care: dental direct reimbursement.

Dental direct reimbursement is defined as a dental benefit plan under which patients pay for their dental care at the time of service and are later reimbursed by their employer for the cost of the care up to an annual limit that is set by the employer. Representatives of the Colorado Dental Association testified that such arrangements are becoming more common. They stated that employers who have implemented a direct reimbursement arrangement are satisfied with the care that patients receive under the system, and that employers are dropping traditional dental insurance plans in order to offer direct reimbursement arrangements.

Representatives from Delta Dental, Colorado's largest dental insurer, testified that the cost savings associated with direct reimbursement plans occur because individuals utilize their dental benefits less than when they have dental insurance. As a result, individuals may avoid receiving proper preventative dental care, which could lead to costly problems in the future. Representatives from Delta Dental also testified that dental networks provide important consumer protections because they only allow licensed dentists to join the network. Under a direct reimbursement plan, receiving care from unqualified or unlicensed dentists may be more common.

No committee recommendation. The committee did not make any recommendations based on this testimony.
SUMMARY OF RECOMMENDATIONS

As a result of the committee’s activities, the following bills are recommended to the Colorado General Assembly.

**Bill A — Concerning the Expansion of the Availability of Affordable Health Care Coverage for Coloradans, and, in Connection Therewith, Creating the Healthy Business Healthy People Program and Making an Appropriation Therefor**

Bill A creates the Healthy Business Healthy People Program to expand the availability of small group and individual insurance coverage to qualified individuals. For small employer group plans, the bill establishes a reinsurance arrangement under which the plans are eligible to receive reimbursement for a portion of claims paid. Reimbursement will be made for 90 percent of claims paid between $5,000 and $75,000. For individuals, the bill creates a premium subsidy program to offset a portion of the premiums charged for plans offered by CoverColorado. A qualified individual's portion shall be no more than 80 percent of the normal premium charged by CoverColorado. The Healthy Business Healthy People Program is established as a five-year pilot program that will terminate in 2011 unless it is extended or made permanent by the General Assembly.

The reinsurance and subsidy payments will be funded from the newly created Healthy Business Healthy People Fund, which will contain $15 million from the General Fund Exempt Account. The General Fund Exempt Account is funded with dollars made available through the passage of Referendum C at the 2005 statewide election.

**Bill B — Concerning the Provision of Health Care Services by Local Governmental Entities, and, in Connection Therewith, Allowing such Districts to be Created in any Part of the State, Authorizing Such Districts to Levy a Sales Tax, and Authorizing Counties to Impose a Sales Tax for the Purpose of Providing Health Care Services**

In 2001, the legislature created special health assurance districts in response to the increasing problem of limited access to health care in rural areas of the state. These districts were created to establish, fund, manage, and promote health care services for residents of the district. Bill B expands the health assurance district provision to any area of the state rather than only rural areas. It authorizes the districts to ask voter approval to levy a sales tax, a property tax, or a combination of the two in order to fund the health care services. Counties are also authorized to seek voter approval to levy a sales tax, which is exempt from the total cap on county sales tax, for the purpose of providing health care services to residents of that county.
Bill C — Concerning the Provision of Health Care Services to Specified Low-income Adults

Bill C creates the Colorado Primary Care Program, which will provide primary care services to low-income, uninsured adults who have a qualifying medical condition. Primary care services include office visits for acute and chronic health care conditions; age and gender appropriate health care screenings; laboratory tests for baseline studies, as well as tests needed to diagnose or treat medical conditions; basic X-rays; outpatient drug and alcohol treatment, as prescribed by the participating medical care provider; diabetic care, including medical supplies; four prescriptions per month that are written by an authorized provider; and any other primary care service that is medically necessary for the eligible individual to receive. The primary care services would be provided through contracts with federally qualified health centers. The bill also requires the Department of Health Care Policy and Financing to report to the Joint Health and Human Services Committee on or before July 1, 2007, options for incorporating the Colorado Primary Care Program into the state's Medicaid program.

The program will be funded from the newly created Colorado Health Care Services Fund which will contain $15 million from the General Fund Exempt Account. The General Fund Exempt Account is funded with dollars made available through the passage of Referendum C at the 2005 statewide election.

Bill D — Concerning a Study to Analyze Factors that Drive the Cost of Health Care within Pueblo County

Bill D requires the state Division of Insurance to conduct an independent study to investigate the factors that drive health insurance costs for residents of Pueblo county, the availability of health insurance within the county, and other factors relating to the pricing and availability of health insurance within the county. Bill D permits the Division of Insurance to contract with a nonprofit entity to analyze the collected data and to prepare a report of the analysis. No later than June 15, 2006, the Commissioner of Insurance must convene a meeting of all interested persons involved in the study to discuss the data to be collected, the method and time frames for collecting the data, and the objectives and standards for analysis of the data. The Commissioner of Insurance is required to submit the findings of the study to the General Assembly no later than January 15, 2008.

Bill E — Concerning the Types of Health Benefit Plans Required to be Offered by Small Employer Carriers to Small Employers in the State

Currently, Colorado law requires small group health insurers to offer a basic and standard plan to small employers. The basic plan design approximates the lowest level of coverage available in the small group market, and the standard plan design approximates the average level of coverage available in the market. Bill E eliminates the requirement
that health insurers in the state offer a standard plan to small employers. Further, Bill E permits small group health insurers to offer a basic plan design that is the same or similar to the managed care plan available to Medicaid clients. Currently, health insurers may offer one of three different basic plan designs to small employers.

**Bill F — Concerning the Creation of a Program to Provide Premium Subsidies to Certain Individuals Enrolled in a Qualifying Health Benefit Plan**

Bill F creates the Colorado Premium Subsidy Program, a five-year pilot, through which qualifying individuals may receive state-funded health insurance premium subsidy payments. In order to qualify for the program, an individual must:

- have been uninsured for the past 12 months;
- work for an employer who has not provided group health insurance for the past 12 months or work for an employer who does provide group health insurance when the individual cannot afford the employee portion of the health insurance premium;
- reside in a household having a net household income of no higher than 200 percent of the federal poverty level;
- establish a health savings account if the individual enrolls in a high deductible plan that qualifies for a health savings account; and
- apply for reduced-priced coverage under the Colorado Premium Subsidy Program on or after January 1, 2007.

An individual who qualifies for the program is eligible for a premium subsidy of 50 percent of the individual's health insurance premium per month, or $100 per month, whichever is less. The premium subsidy must be paid directly into the qualifying individual's health savings account, if the individual is enrolled in a high deductible plan that qualifies for a health savings account.

The subsidy payments will be funded from the newly created Premium Subsidy Program Fund, which is funded with $15 million from the General Fund Exempt Account. The General Fund Exempt Account is funded with dollars made available through the passage of Referendum C at the 2005 statewide election.
RESOURCE MATERIALS

The resource materials listed below were provided to the committee or developed by Legislative Council Staff during the course of the meetings. The summaries of meetings and attachments are available at the Division of Archives, 1313 Sherman Street, Denver, (303-866-2055). The meeting summaries and materials developed by Legislative Council Staff are also available on our web site at:

www.state.co.us/gov_dir/leg_dir/lcsstaff/2005/05interim.htm

<table>
<thead>
<tr>
<th>Meeting Summaries</th>
<th>Topics Discussed</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 28, 2005</td>
<td>The number of uninsured persons in Colorado; health care access options; local initiatives to promote health insurance coverage; the history and current status of small group health insurance regulation in Colorado; credit scoring and health insurance; direct dental reimbursement.</td>
</tr>
<tr>
<td>August 10, 2005</td>
<td>Reinsurance programs in other states; types of reinsurance programs; Senate Bill 05-237 - Healthy Business Healthy People Program; reinsurance and CoverColorado.</td>
</tr>
<tr>
<td>August 22, 2005</td>
<td>Health savings accounts; network adequacy; participating and nonparticipating providers; Senate Bill 05-227; expanding the state employees' health insurance program.</td>
</tr>
<tr>
<td>September 7, 2005</td>
<td>Primary and preventative care networks; sunsetting the basic and standard plans; health savings accounts; health reimbursement arrangements; expanding the Colorado Medicaid program; individual and employer health insurance mandates.</td>
</tr>
<tr>
<td>September 22, 2005</td>
<td>Health information technology in Colorado; expanding the Colorado Medicaid program; discussion of proposed legislation.</td>
</tr>
<tr>
<td>October 6, 2005</td>
<td>Finalization of proposed legislation.</td>
</tr>
</tbody>
</table>

Memoranda and Reports

*Overview of the Interim Committee to Study Health Insurance*; Memorandum prepared by Legislative Council Staff, July 25, 2005.
A BILL FOR AN ACT

Concerning the expansion of the availability of affordable health care coverage for Coloradans, and, in connection therewith, creating the Healthy Business Healthy People program and making an appropriation therefor.

Bill Summary

(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently adopted.)

Interim Committee on Health Insurance. Creates the healthy
business healthy people program ("program") to expand the availability of health care coverage to qualifying Colorado small employers and individuals. Specifies that the program will be administered by the board of directors of CoverColorado ("board of directors") and an expanded board consisting of 6 members, 2 of whom will be appointed by the governor, subject to senate confirmation, and 4 of whom will be appointed by the president of the senate and speaker of the house of representatives. Specifies that the expanded board shall have all powers necessary to implement the reinsurance portion of the program, and the board of directors shall have all powers necessary to implement the premium subsidy portion of the program.

Establishes criteria for the small employers and individuals to be eligible for coverage under the program. For small employer group plans, creates a reinsurance arrangement under which eligible small employer plans would be eligible to receive reimbursement for certain amounts of claims paid for eligible insureds. For eligible individuals, creates a premium subsidy plan to pay part of the premiums normally charged for plans offered by CoverColorado.

Creates the healthy business healthy people fund ("fund") in the state treasury to provide moneys for reinsurance reimbursements and premium subsidies for the program.

Requires small employer health insurance entities to issue qualifying small employer plans to qualifying small employers. In addition, requires small employer carriers to apply a rating factor to health benefit plans to account for reinsurance reimbursement payments through the program.

Appropriates $15 million from the general fund exempt account to establish the healthy business healthy people fund. Makes appropriations from the fund to the division of insurance for the implementation of this act.

Extends the requirement that small employer carriers issue a standard and basic plan until July 1, 2007.

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

SECTION 1. Article 8 of title 10, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PART to read:

PART 7

HEALTHY BUSINESS HEALTHY PEOPLE PROGRAM

10-8-701. Short title. This PART 7 SHALL BE KNOWN AND MAY BE CITED AS THE "HEALTHY BUSINESS HEALTHY PEOPLE PROGRAM ACT".
10-8-702. Legislative declaration. (1) The General Assembly hereby finds, determines, and declares that:

(a) All Colorado citizens deserve to have access to affordable, comprehensive health insurance and quality health care;

(b) Individuals, families, and small businesses deserve to have predictable, stable costs for health care from one year to the next;

(c) Small businesses are the backbone of our economy and must not be asked to disproportionately bear the burden of providing health insurance;

(d) Between 1996 and 2002, small business health insurance premiums increased more than eighty percent, both nationally and in Colorado;

(e) Less than fifty percent of Colorado small businesses offer health insurance;

(f) Most low-income working Coloradans who are not offered health insurance at the workplace and who have preexisting conditions cannot obtain coverage in the private market and cannot afford the high cost of coverage made available to uninsurable individuals through the CoverColorado program;

(g) Reinsurance policies have been proven to lower the cost of insurance for small employers by providing additional coverage for those at highest risk;

(h) The purpose of this Part 7 is to make standardized, low-cost health insurance contracts available to qualifying small employers and qualifying individuals as defined in this Part 7.
PART 7. THIS PART 7 IS DESIGNED TO ENCOURAGE SMALL EMPLOYERS TO OFFER HEALTH INSURANCE COVERAGE TO THEIR EMPLOYEES AND ALSO TO MAKE AFFORDABLE COVERAGE AVAILABLE TO UNINSURED INDIVIDUALS WHOSE EMPLOYERS DO NOT PROVIDE GROUP HEALTH INSURANCE.

10-8-703. Definitions. As used in this Part 7, unless the context otherwise requires:

(1) "Administering carrier" means the carrier or third-party administrator designated in this Part 7.

(2) "Basic health benefit plan" means the basic health benefit plan promulgated by rule of the Commissioner pursuant to Section 10-16-105 (7.2), as such rule was effective on December 1, 2004.

(3) "Board" means the board of directors for CoverColorado, created in section 10-8-505.

(4) "Business group of one" shall have the same meaning as set forth in section 10-16-102 (6).

(5) "Carrier" shall have the same meaning as set forth in section 10-16-102 (8).

(6) "Commissioner" means the Commissioner of Insurance or the Commissioner's designee.

(7) "CoverColorado" means the program established in Part 5 of this Article.

(8) "Expanded board" means the expanded board constituted pursuant to section 10-8-705.

(9) "Group health plan" shall have the same meaning as set forth in section 10-16-105.5 (1) (a).

(10) "Health benefit plan" shall have the same meaning as set forth in section 10-16-102 (21).
(11) "Program" or "Healthy Business Healthy People"
means the Healthy Business Healthy People program, including
the administration and implementation of reinsurance and
premium subsidies for the health benefit plans permitted under
this Part 7.

(12) (a) "Qualifying Individual" means a person:
(I) who meets the definition of an "Eligible Individual"
for the CoverColorado program, as defined in section 10-8-503
(5);
(II) who does not have and has not had health insurance
with benefits on an expense-reimbursed or prepaid basis during
the twelve-month period immediately preceding the individual's
application for reduced-price CoverColorado coverages under
the program established by this Part 7;
(III) whose employer does not provide group health
insurance and has not provided group health insurance with
benefits on an expense-reimbursed or prepaid basis covering
employees during the twelve-month period immediately
preceding the individual's application for reduced-price
CoverColorado coverage under the program established by this
Part 7;
(IV) who resides in a household having a net household
income that is no higher than an amount set by the expanded
board; except that such amount shall not exceed three hundred
fifty percent of the non-farm federal poverty level, as defined
and updated by the United States Department of Health and
Human Services, or the gross equivalent of such net income; and
(V) who applies for reduced-price CoverColorado
COVERAGE UNDER THE PROGRAM ESTABLISHED BY THIS PART 7 ON OR AFTER JANUARY 1, 2007.

(b) The requirements set forth in subparagraphs (II) and (III) of paragraph (a) of this subsection (12) shall not apply to an individual who had health insurance coverage during the immediately preceding twelve months if such coverage was terminated for any reason other than the voluntary termination of such coverage by the individual.

(13) (a) "Qualifying small employer" means a small employer that has no more than five employees, at least two of whom earn annual wages of twenty-eight thousand dollars or less, or a business group of one whose net annual income from the business is twenty-eight thousand dollars or less, and that meets all of the following criteria:

(I) At least one of the employees receiving annual wages of twenty-eight thousand dollars or less is eligible for and is offered qualifying plan coverage.

(II) At least one of the employees described in subparagraph (I) of this paragraph (a) accepts the qualifying plan coverage offered to them.

(III) The employer pays at least fifty percent of the premiums for employees covered under a qualifying plan.

(IV) The employee contribution, in dollars, is the same for all covered employees.

(b) The expanded board shall adjust the twenty-eight-thousand-dollar figure referred to in paragraph (a) of this subsection (13) periodically, but no more than once each year, to reflect increases or declines in the average wage.
(14) "Qualifying small employer plan" or "qualifying plan" means a basic health benefit plan or a standard health benefit plan that provides coverage through a health maintenance organization or preferred provider organization.

(15) "Small employer" shall have the same meaning as set forth in section 10-16-102 (40).

(16) "Small employer carrier" shall have the same meaning as set forth in section 10-16-102 (41).

(17) "Standard health benefit plan" means the basic health benefit plan promulgated by rule of the commissioner pursuant to section 10-16-105 (7.2), as such rule was effective on December 1, 2004.

10-8-704. Healthy business healthy people program - creation - pilot program. (1) There is hereby created the healthy business healthy people program, which shall operate a pilot reinsurance program to lower the cost of health insurance for qualifying small businesses and a premium subsidy program for qualifying individuals.

(2) The board and the expanded board shall operate the program. The program is an instrumentality of the state; except that the debts and liabilities of the program shall not constitute debts and liabilities of the state, and the program, the board, and the expanded board shall not be agencies of state government.

(3) Funding for the program shall come from the healthy business healthy people fund, created in section 10-8-710.

(4) The program shall operate as a five-year pilot
PROGRAM THAT SHALL TERMINATE ON DECEMBER 31, 2011, UNLESS
EXTENDED OR MADE PERMANENT BY THE GENERAL ASSEMBLY.

(5) THE PROGRAM IS NOT AN ENTITLEMENT PROGRAM. THE
TOTAL NUMBER OF INDIVIDUALS, SMALL EMPLOYERS, AND HEALTH
BENEFIT PLANS COVERED BY THE PROGRAM SHALL NOT EXCEED THE
FUNDING CAPACITY OF THE MONEYS AVAILABLE.

10-8-705. Expanded board - powers and duties -
recommendations from legislative interim committee created in
Senate Joint Resolution 05-036. (1) (a) THE EXPANDED BOARD SHALL
CONSIST OF SIX MEMBERS WHO HAVE BOOKKEEPING, ACCOUNTING, OR
ACTUARIAL EXPERIENCE. OF SUCH SIX MEMBERS, ONE SHALL BE A
REPRESENTATIVE OF SMALL EMPLOYER CARRIERS, TWO SHALL BE
REPRESENTATIVES OF SMALL EMPLOYERS WITH NO MORE THAN FIVE
EMPLOYEES, TWO SHALL BE EMPLOYEES OF A SMALL EMPLOYER WITH FIVE
OR FEWER EMPLOYEES WHO IS NOT A BUSINESS GROUP OF ONE, AND ONE
SHALL BE AN INSURANCE BROKER WHO SELLS BOTH INDIVIDUAL AND
SMALL GROUP HEALTH BENEFIT PLANS IN COLORADO.

(b) THE SMALL EMPLOYER CARRIER MEMBER AND INSURANCE
BROKER MEMBER SHALL BE APPOINTED BY THE GOVERNOR WITH THE
CONSENT OF THE SENATE. THESE TWO MEMBERS SHALL SERVE FOR TERMS
OF FOUR YEARS; EXCEPT THAT, OF THOSE MEMBERS INITIALLY APPOINTED,
ONE SHALL SERVE FOR A TERM OF TWO YEARS. THE GOVERNOR SHALL
APPOINT A QUALIFIED PERSON TO FILL EITHER POSITION, SHOULD IT
BECOME VACANT, FOR THE REMAINDER OF ANY UNEXPIRED TERM.

(c) THE SMALL EMPLOYER MEMBERS SHALL BE APPOINTED BY THE
PRESIDENT OF THE SENATE, AND THE EMPLOYEE MEMBERS SHALL BE
APPOINTED BY THE SPEAKER OF THE HOUSE OF REPRESENTATIVES. THESE
FOUR MEMBERS SHALL SERVE FOR TERMS OF FOUR YEARS; EXCEPT THAT,
OF THOSE MEMBERS INITIALLY APPOINTED, THE EMPLOYEE MEMBERS
SHALL SERVE FOR A TERM OF THREE YEARS.

(2) THE BOARD AND THE EXPANDED BOARD SHALL BE THE
GOVERNING BODIES OF THE PROGRAM. THE EXPANDED BOARD SHALL
HAVE ALL POWERS NECESSARY TO IMPLEMENT THE REINSURANCE PORTION
OF THE PROGRAM TO LOWER THE COST OF HEALTH INSURANCE FOR
QUALIFYING SMALL BUSINESSES. THE BOARD SHALL HAVE ALL THE
POWERS NECESSARY TO IMPLEMENT THE PREMIUM SUBSIDY PORTION OF
THE PROGRAM FOR QUALIFYING INDIVIDUALS. IN ADDITION, THE BOARD
AND THE EXPANDED BOARD SHALL HAVE THE SPECIFIC AUTHORITY FOR
THE PORTIONS OF THE PROGRAM FOR WHICH THEY HAVE AUTHORITY TO:

(a) Enter into such contracts as are necessary or proper
to carry out the provisions and purposes of this Part 7,
including, without limitation, the authority to enter into
contracts with appropriate administrative staff, consultants,
and legal counsel and to select and contract with the
administering carrier in accordance with section 10-8-706. In
addition, the expanded board shall have the authority, with the
approval of the commissioner, to enter into contracts with
other states with similar plans for the joint performance of
common administrative functions or with persons or other
organizations for the performance of administrative functions.
No contract entered into pursuant to this paragraph (a) shall
be subject to article 103 of title 24, C.R.S.

(b) Sue or be sued, including taking any legal action as
necessary or proper on behalf of the program;

(c) Take such legal action as necessary to avoid the
payment of improper claims against the program or to defend the
COVERAGE PROVIDED BY OR THROUGH THE PROGRAM;

(d) Establish appropriate rates for qualifying individuals who are eligible for a premium subsidy pursuant to Section 10-8-709 and undertake any other actuarial functions appropriate to the operation of the program;

(e) Establish such procedures and standards for the reinsurance of qualifying plans covering qualifying small employers, and of plans issued by CoverColorado that cover qualifying individuals, as may be appropriate to accomplish the purposes of this Part 7. For the purposes of administering the reinsurance under the program, the expanded board may request the submittal of such reasonable documentation by qualifying plans concerning qualifying small employers and by qualifying individuals as it deems necessary.

(f) Oversee the issuance of policies of insurance covering qualifying individuals and certificates or evidences of coverage in accordance with the requirements of this Part 7;

(g) Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the program, policy development, and other contract design and in any other function within the authority of the program;

(h) Borrow money to effect the purposes of this Part 7;

(i) Establish conditions and procedures for reinsuring risks under this Part 7;

(j) Establish procedures for the reasonable advance notice to interested parties of the agenda for meetings of the expanded board;
(k) Accept and expend gifts, grants, and donations for operation of the program. Moneys from such gifts, grants, and donations shall be transmitted to the state treasurer, who shall credit the same to the Healthy Business Healthy People fund created in section 10-8-710.

(l) Develop procedures for handling and accounting for the funds and other assets of the program, including records of all financial transactions and an annual fiscal report to the commissioner;

(m) Develop procedures for selection of an administering carrier as provided in section 10-8-706;

(n) Develop procedures to establish and maintain public awareness of the program, including its eligibility requirements and enrollment procedures;

(o) Develop procedures to ensure public knowledge concerning availability of the program;

(p) Establish regular times and places for meetings of the board;

(q) Develop procedures under which applicants and participants can report grievances to the board, which grievances shall be fairly and impartially considered, and administrative remedies for such grievances; and

(r) Establish any other provisions necessary to implement the purposes of this part 7.

(3) All applicants and participants reporting any grievance pursuant to paragraph (q) of subsection (2) of this section shall exhaust all administrative remedies as set forth by the expanded board before any such grievance may be the
BASIS FOR LEGAL ACTION. THE VENUE FOR ANY LEGAL ACTION INVOLVING
THE PROGRAM SHALL BE THE CITY AND COUNTY OF DENVER. NOTHING IN
THIS SUBSECTION (3) SHALL PROHIBIT THE EXPANDED BOARD FROM
REQUIRE BINDING ARBITRATION FOR THE FINAL ADJUDICATION OF ANY
GRIEVANCE.

(4) FOR ANY ACT PERFORMED WITHIN THE COURSE AND SCOPE OF
AUTHORITY UNDER THIS PART 7, THE BOARD AND THE EXPANDED BOARD,
THE INDIVIDUAL MEMBERS OF THE EXPANDED BOARD, AND THE
EMPLOYEES AND AGENTS OF THE BOARD AND THE EXPANDED BOARD
SHALL BE ENTITLED TO THE IMMUNITY GRANTED PURSUANT TO SECTION
24-10-106, C.R.S., UNLESS SUCH ACT OR OMISSION CONSTITUTES WILLFUL
AND WANTON MISCONDUCT.

(5) EXCEPT AS SPECIFICALLY PROVIDED IN THIS PART 7, THE
EXPANDED BOARD SHALL OPERATE ACCORDING TO THE SAME RULES AND
PROCEDURES AS THE BOARD.

10-8-706. Administering carrier. (1) THE ADMINISTERING
CARRIER SHALL PERFORM ALL ADMINISTRATIVE, ELIGIBILITY, AND CLAIMS
PAYMENT FUNCTIONS RELATING TO THE PROGRAM, INCLUDING:

(a) ASSURING TIMELY PAYMENT OF REIMBURSEMENTS OF
COVERAGE TO SMALL EMPLOYER CARRIERS AND REIMBURSEMENTS OF
COVERAGE TO COVERCOLORADO FOR QUALIFYING INDIVIDUALS
PURSUANT TO SECTION 10-8-708, INCLUDING:

(I) MAKING AVAILABLE INFORMATION RELATING TO THE PROPER
MANNER OF SUBMITTING CLAIMS FOR REIMBURSEMENT OF COVERAGE;

(II) EVALUATING THE ELIGIBILITY OF EACH CLAIM FOR
REIMBURSEMENT OF COVERAGE PURSUANT TO GUIDELINES ESTABLISHED
BY THE BOARD AND THE EXPANDED BOARD;

(b) SUBMITTING REGULAR REPORTS TO THE EXPANDED BOARD
regarding the operation of the program. The frequency, content, and form of the reports shall be as determined by the board after consultation with the expanded board.

(c) Determining the expense of administration and the paid and incurred losses for each year and reporting such information to the expanded board and the commissioner in a form and manner prescribed by the commissioner.

(2) The board, in consultation with the expanded board, shall establish its own competitive bidding process to select a carrier or third-party administrator to serve as the administering carrier and to select one or more vendors to provide services that may be necessary to administer the program. The board, in consultation with the expanded board, shall evaluate bids submitted based on the criteria it establishes and shall not be subject to the provisions of article 103 of title 24, C.R.S., in making such selections.

(3) The administering carrier shall serve for a period of three years, subject to removal for cause. At least one year prior to the expiration of the three-year period of service, the board shall invite all interested parties, including the current administering carrier, to submit bids to serve as the administering carrier for the ensuing two years of the pilot program. Selection of the administering carrier for the ensuing period shall be made at least six months prior to the end of the current three-year period.

(4) The administering carrier shall be paid as provided for by the board and the expanded board.

10-8-707. Program - examination - financial report. (1) Not
LATER THAN MARCH 1, 2007, AND BY MARCH 1 OF EACH SUCCEEDING YEAR, THE BOARD AND THE EXPANDED BOARD SHALL SUBMIT AN AUDITED FINANCIAL REPORT FOR THE PROGRAM FOR THE PRECEDING CALENDAR YEAR TO THE COMMISSIONER IN A FORM PROVIDED OR PRESCRIBED BY THE COMMISSIONER.

(2) The financial status of the program shall be subject to examination by the commissioner or the commissioner's designee. Such examinations shall be conducted at least once every five years.

(3) The board and the expanded board shall establish a competitive bidding process to select a third party to collect data on an ongoing basis and to use such data to evaluate the program. The evaluation of the program shall be submitted to the committees of the house of representatives and the senate that oversee business affairs and labor issues on or before March 1, 2011. The evaluation shall include data and analysis as determined by the board and the expanded board prior to the bidding process, but shall include an evaluation of the program's outcomes, including but not limited to program costs, the benefits to the recipients and the state, and any net fiscal savings. Payment for the cost of the program shall not exceed one hundred thousand dollars from the five percent of the healthy business healthy people fund allocated for administrative costs pursuant to section 10-8-710 (2) (a).

10-8-708. Healthy business healthy people reinsurance coverage - eligibility for reimbursement payments. (1) Health benefit plans eligible for reinsurance reimbursement payments under this part 7 shall be qualifying plans issued by small
EMPLOYER CARRIERS AUTHORIZED TO ISSUE HEALTH BENEFIT PLANS UNDER ARTICLE 16 OF THIS TITLE. EACH SMALL EMPLOYER CARRIER SHALL OFFER QUALIFYING PLANS TO QUALIFIED SMALL EMPLOYERS FOR THE DURATION OF THE PROGRAM.

(2) (a) Reinsurance reimbursement to carriers shall be made from the Healthy Business Healthy People Fund moneys earmarked for reinsurance for qualifying plans, pursuant to section 10-8-710. Such reimbursements shall be made, to the extent of funds available therefor, for claims paid by such carriers under qualifying plans.

(b) Commencing on January 1, 2007, small employer carriers shall be eligible to receive reinsurance reimbursement for ninety percent of total claims paid between the amount of five thousand dollars, or such greater amount as shall be set by the expanded board before implementation of the program, and seventy-five thousand dollars in a calendar year for any insured covered under a qualifying plan. Reinsurance reimbursement payments shall only be available for coverage provided under managed care plans by network providers, except for emergency care. The five-thousand-dollar and seventy-five-thousand-dollar figures in this paragraph (b) shall be adjusted by the expanded board periodically, but no more than once each year, to reflect the inflation in medical care costs paid by carriers.

(c) Claims shall be reported and reinsurance reimbursements shall be distributed on a quarterly basis. Claims shall be eligible for reimbursement only for the calendar year in which the claims are paid. Once claims paid on
BEHALF OF A COVERED INSURED EQUAL OR EXCEED SEVENTY-FIVE THOUSAND DOLLARS IN A GIVEN CALENDAR YEAR, NO FURTHER CLAIMS PAID ON BEHALF OF SUCH INSURED IN THAT CALENDAR YEAR SHALL BE ELIGIBLE FOR REIMBURSEMENT.

(d) EACH CARRIER SHALL SUBMIT A REQUEST FOR REINSURANCE REIMBURSEMENT FROM THE PROGRAM ON FORMS PRESCRIBED BY THE EXPANDED BOARD. THE EXPANDED BOARD MAY REQUIRE CARRIERS TO SUBMIT SUCH CLAIMS DATA IN CONNECTION WITH THE REIMBURSEMENT REQUESTS AS IT DEEMS NECESSARY TO ENABLE THE EXPANDED BOARD TO DISTRIBUTE MONEYS AND OVERSEE THE OPERATION OF THE PROGRAM.

(e) (I) THE EXPANDED BOARD SHALL DETERMINE THE TOTAL CLAIMS REIMBURSEMENT AMOUNT FOR ALL CARRIERS FOR THE CALENDAR YEAR FOR WHICH CLAIMS ARE BEING REPORTED.

(II) IF THE FUNDS AVAILABLE FOR DISTRIBUTION FOR CLAIMS PAID BY ALL CARRIERS DURING A CALENDAR YEAR EXCEED THE TOTAL AMOUNT REQUESTED FOR REIMBURSEMENT BY ALL CARRIERS DURING THAT SAME CALENDAR YEAR, ANY EXCESS FUNDS SHALL BE CARRIED FORWARD AND MADE AVAILABLE FOR DISTRIBUTION IN THE NEXT CALENDAR YEAR.

(III) EACH CARRIER SHALL PROVIDE THE EXPANDED BOARD WITH MONTHLY REPORTS OF THE TOTAL ENROLLMENT UNDER QUALIFYING PLANS. THE REPORTS SHALL BE IN A FORM PRESCRIBED BY THE EXPANDED BOARD.

(IV) THE EXPANDED BOARD SHALL SEPARATELY ESTIMATE THE PER-INSURED ANNUAL COST OF TOTAL CLAIMS REIMBURSEMENT FOR QUALIFYING PLANS BASED UPON AVAILABLE DATA AND APPROPRIATE ACTUARIAL ASSUMPTIONS. UPON REQUEST, EACH CARRIER SHALL FURNISH CLAIMS EXPERIENCE DATA TO THE EXPANDED BOARD FOR USE IN SUCH ESTIMATIONS.
(V) The expanded board shall determine total eligible enrollment under qualifying plans. The total eligible enrollment shall be determined by dividing the total moneys available for distribution from the healthy business healthy people fund by the estimated per-insured annual cost of total claims reimbursement from the fund.

(VI) The expanded board shall suspend the enrollment of new insureds if it determines that the total enrollment reported by all carriers exceeds the total eligible enrollment, thereby resulting in anticipated annual expenditures from the healthy business healthy people fund in excess of the total amount available for distribution.

(VII) The expanded board shall provide carriers with notification of any enrollment suspensions as soon as practicable after receipt of all enrollment data.

(VIII) If, at any point during a suspension of enrollment, the expanded board determines that funds are sufficient to provide for the addition of new enrollments, the expanded board may reactivate new enrollments and notify all carriers that enrollments may again commence.

(IX) The suspension of enrollments shall not preclude the addition of new employees of an employer already covered, or new dependents of employees already covered, under qualifying plans.

10-8-709. Healthy business healthy people premium subsidy program - eligibility for subsidy payments. (1) The board shall establish a premium subsidy program for qualified individuals who apply for coverage on or after January 1, 2007, under a
CoverColorado benefit plan designated by the board.

(2) The premium subsidy may be set on an income-based, sliding fee scale; except that in no event shall a qualified individual pay more than eighty percent of the premium normally charged by CoverColorado.

(3) Premium subsidies shall be paid from healthy business healthy people fund moneys earmarked for subsidies for qualifying individuals. In the event that an assessment on carriers is triggered under Section 10-8-530(1.5), carriers shall not be assessed for any claims costs for qualifying individuals. Instead, such costs shall be paid for out of healthy business healthy people fund moneys earmarked for subsidies for qualifying individuals.

(4) Before implementing the premium subsidy program, the board shall develop a table of proposed premium subsidies and shall hold a public hearing and take comments on the proposed table of subsidies.

(5) (a) The board shall determine the total premium subsidies for the calendar year for which subsidies are paid.

(b) If the funds available for distribution for premium subsidies paid during a calendar year exceed the total amount of subsidies during that same calendar year, any excess funds shall be carried forward and made available for distribution in the next calendar year.

(c) The board shall separately estimate the per-insured annual cost of all subsidies for designated CoverColorado plans based upon available data and appropriate actuarial assumptions.
(d) The board shall determine the total eligible enrollment under designated CoverColorado plans. The total eligible enrollment shall be determined by dividing the amount of moneys available for distribution from the Healthy Business Healthy People fund for premium subsidies by the estimated per-insured annual cost of all premium subsidies from the fund.

(e) The board shall suspend the enrollment of new insureds in designated CoverColorado plans if it determines that the total enrollment reported by CoverColorado exceeds the total eligible enrollment, thereby resulting in anticipated annual expenditures from the Healthy Business Healthy People fund in excess of the moneys available for distribution.

(f) If, at any point during a suspension of enrollment, the board determines that funds are sufficient to provide for the addition of new enrollments, the board may again accept new enrollments.

(g) The suspension of enrollment in designated CoverColorado plans shall not preclude the addition of new dependents of individuals already covered under such plans.

10-8-710. Healthy business healthy people fund - creation.

(1) (a) There is hereby created in the state treasury the Healthy Business Healthy People fund, also referred to in this section as the "fund". The fund shall consist of moneys credited thereto pursuant to this part 7.

(b) In fiscal year 2006-07, and each of the four fiscal years thereafter, if the most recent legislative council staff economic and revenue forecast estimates that the General Fund Exempt Account, created in section 24-77-103.6 (2), C.R.S., will
RECEIVE MORE THAN ONE HUNDRED FIFTEEN MILLION DOLLARS, FIFTEEN MILLION DOLLARS OF THE MONEYS IN SUCH GENERAL FUND EXEMPT ACCOUNT SHALL BE APPROPRIATED TO THE HEALTHY BUSINESS HEALTHY PEOPLE FUND CREATED IN THIS SUBSECTION (1).

(c) ALL MONEYS APPROPRIATED TO THE HEALTHY BUSINESS HEALTHY PEOPLE FUND SHALL BE USED AS PROVIDED IN THIS PART 7 AND SHALL NOT BE DEPOSITED IN OR TRANSFERRED TO THE GENERAL FUND OF THIS STATE OR TO ANY OTHER FUND. NOTWITHSTANDING ANY PROVISION OF SECTION 24-36-114, C.R.S., TO THE CONTRARY, ALL INTEREST DERIVED FROM THE DEPOSIT AND INVESTMENT OF MONEYS IN THE FUND SHALL BE CREDITED TO THE FUND.

(2) (a) OF THE MONEYS IN THE FUND, NO MORE THAN FIVE PERCENT SHALL BE USED FOR PROGRAM ADMINISTRATIVE COSTS, INCLUDING ADMINISTRATIVE COSTS OF THE DIVISION OF INSURANCE.

(b) (I) OF THE MONEYS REMAINING IN THE FUND AFTER THE PAYMENT OF PROGRAM ADMINISTRATIVE COSTS, TWO-THIRDS SHALL BE USED FOR REINSURANCE PAYMENTS UNDER SECTION 10-8-708 AND ONE-THIRD SHALL BE USED FOR COVERCOLORADO PREMIUM SUBSIDIES UNDER SECTION 10-8-709.

(II) THE STATE TREASURER SHALL TRANSMIT TO COVERCOLORADO, FOR USE AS SPECIFIED BY THE BOARD AND THE EXPANDED BOARD PURSUANT TO THIS PART 7, SUCH AMOUNTS AS APPROPRIATED TO THE HEALTHY BUSINESS HEALTHY PEOPLE FUND.

SECTION 2. 10-8-503 (17.3), Colorado Revised Statutes, is amended to read:

10-8-503. Definitions. As used in this part 5, unless the context otherwise requires:

(17.3) "Program" or "CoverColorado" means CoverColorado and
its administration and implementation of the health benefit plans permitted under this part 5 and part 7 of this article.

SECTION 3. 10-8-530 (1), Colorado Revised Statutes, is amended by the addition of a new paragraph to read:

10-8-530. Funding of program - repeal. (1) The program shall be funded by the following:

(f) Money transmitted pursuant to section 10-8-710 (2).

SECTION 4. 10-16-105, Colorado Revised Statutes, is amended by the addition of a new subsection to read:

10-16-105. Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic and standard health benefit plans - rules - definitions. (16) (a) As used in this subsection:

(1) "Qualifying small employer" shall have the same meaning as set forth in section 10-8-703 (13).

(II) "Qualifying small employer plan" shall have the same meaning as set forth in section 10-8-703 (14).

(b) On and after January 1, 2007, each small employer carrier shall issue qualifying small employer plans to qualifying small employers who apply for coverage pursuant to part 7 of article 8 of this title.

(c) On and after January 1, 2007, in addition to any other rating factor allowed under this section, small employer carriers shall apply a rating factor for health benefit plans issued to qualifying small employers under the healthy business healthy people program pursuant to part 7 of article 8 of this title.

(d) On and after January 1, 2007, the premiums for
QUALIFYING SMALL EMPLOYER PLANS SHALL FACTOR IN THE AVAILABILITY OF REIMBURSEMENT FROM THE HEALTHY BUSINESS HEALTHY PEOPLE PROGRAM.

(e) The determination of whether a small employer is a qualifying small employer shall be made at the time a small employer applies for coverage, and shall be redetermined annually at renewal. A small employer that no longer qualifies as a qualifying small employer at renewal may continue on the same coverage, but such coverage shall not be eligible for reinsurance, and the small employer carrier shall adjust the small employer's renewal rate accordingly. The commissioner shall promulgate rules setting forth the process, including any necessary forms, that small employer carriers shall use to determine whether a small employer applying for coverage under a qualifying small employer plan meets the definition of a qualifying small employer under Section 10-8-703 (13).

(f) On and after January 1, 2007, the commissioner shall annually publish sample rates for qualifying small employer plans offered pursuant to Part 7 of Article 8 of this title.

SECTION 5. 10-16-107, Colorado Revised Statutes, is amended by the addition of a new subsection to read:

10-16-107. Rate regulation - approval of policy forms - benefit certificates - evidences of coverage - loss ratio guarantees - disclosures on treatment of intractable pain - definitions. (1.9) (a) As part of its review of small employer health benefit plan rate filings, the division shall ensure that savings for small employer carriers from the availability of reinsurance through...
THE HEALTHY BUSINESS HEALTHY PEOPLE PROGRAM FOR QUALIFYING SMALL EMPLOYER PLANS UNDER PART 7 OF ARTICLE 8 OF THIS TITLE IS PASSED ALONG TO QUALIFYING SMALL EMPLOYERS IN THE FORM OF LOWER RATES.

(b) AS USED IN THIS SUBSECTION (1.9):

(I) "QUALIFYING SMALL EMPLOYER" SHALL HAVE THE SAME MEANING AS SET FORTH IN SECTION 10-8-703 (13).

(II) "QUALIFYING SMALL EMPLOYER PLAN" SHALL HAVE THE SAME MEANING AS SET FORTH IN SECTION 10-8-703 (14).

SECTION 6. Appropriation. (1) In addition to any other appropriation, there is hereby appropriated, out of any moneys in the general fund exempt account created in section 24-77-103.6 (2), Colorado Revised Statutes, not otherwise appropriated, to the healthy business healthy people cash fund created in section 10-8-710 (1) (a), Colorado Revised Statutes, for the fiscal year beginning July 1, 2006, the sum of fifteen million dollars ($15,000,000).

(2) In addition to any other appropriation, there is hereby appropriated, out of any moneys in the healthy business healthy people fund created in section 10-8-710, Colorado Revised Statutes, not otherwise appropriated, to the department of regulatory agencies, for allocation to the division of insurance, for the fiscal year beginning July 1, 2006, the sum of ten thousand six hundred forty-four dollars ($10,644), or so much thereof as may be necessary, for the implementation of this act.

SECTION 7. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.
CONCERNING THE EXPANSION OF THE AVAILABILITY OF AFFORDABLE HEALTH CARE COVERAGE FOR COLORADANS, AND, IN CONNECTION THEREWITH, CREATING THE HEALTHY BUSINESS HEALTHY PEOPLE PROGRAM AND MAKING AN APPROPRIATION THEREFOR.

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<td><strong>State Revenues</strong></td>
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<td>Cash Funds Exempt - Transfer to Healthy Business Healthy People Fund</td>
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| FTE Position Change | 0.0 FTE | 0.0 FTE |

Effective Date: Upon signature of the Governor.

Appropriation Summary for FY 2006/2007:
- Healthy Business Healthy People Cash Fund: $15,000,000 GFE
- Department of Regulatory Agencies: $10,444 CFE*

Local Government Impact: None.

*These amounts are included in the $15 million appropriation to the Healthy Business Healthy People Fund

Summary of Legislation

This Interim Committee on Health Insurance bill creates the Healthy Business Healthy People (HBHP) five-year pilot program with the purpose of making standardized, low-cost health insurance available to qualifying small employers and individuals. It is funded through annual transfers of $15 million to the Healthy Business Healthy People Fund. The total number of individuals and plans covered by the program cannot exceed the funding capacity of the monies available. Thus, this is not an entitlement program and enrollment may be suspended if determined necessary. The pilot program ends on December 31, 2011.
Starting January 1, 2007, small employer group health insurance carriers are eligible for reinsurance reimbursement payments for qualified employer plans. The bill designates two-thirds of the fund balance, $9.5 million the first year, for reinsurance to reduce the cost of health insurance premiums for qualified employer plans. To qualify for the program, employers must meet the following requirements:

- the business has 5 or fewer employees, or be a business group of one;
- at least two of the employees earn less than $28,000 per year;
- at least one of those employees is offered and accepts the coverage;
- the employer pays at least 50 percent of the premiums for covered employees; and
- the employee contribution is the same for all covered employees.

Starting January 1, 2007, qualified individuals can receive a premium subsidy of at least 20 percent of the normal premium for health insurance coverage through CoverColorado. The bill designates one-third of the fund balance, $4.7 million the first year, for subsidizing qualified individual health insurance. To qualify for the program, individuals must meet the following requirements:

- meet the current requirements for the CoverColorado program;
- have been uninsured for at least 12 months;
- not be offered health insurance through an employer;
- have a net household income no higher than 350 percent of the federal poverty level or the amount set by the expanded CoverColorado Board; and
- apply for the program.

This bill creates an expanded CoverColorado Board consisting of six members. The original 7-member CoverColorado board and the expanded board together act as the governing body of the HBHP Program and have broad powers including the ability to enter contracts, take legal action and establish procedures to implement the program. The boards must submit an annual audited financial report of the program to the Insurance Commissioner. In addition, the program is subject to examination by the Insurance Commissioner at least once every five years. The bill limits administrative costs to 5 percent of the HBHP Fund, or $750,000 the first year, for both CoverColorado and the Division of Insurance.

State Revenues

For FY 2006-07, and each year through FY 2010-11, the bill requires a transfer of $15 million from the General Fund Exempt account to the HBHP Fund if the most recent Legislative Council Staff Forecast estimates that the General Fund Exempt account will receive more than $115 million. The December 2005 forecast shows sufficient funds in the General Fund Exempt account to fund the program through FY 2010-11.
In addition, interest earned from the deposit and investment of moneys in the HBHP Fund shall be credited to the fund. At this time, the fiscal note does not estimate interest revenue because expenditures from the fund resulting from program enrollment are unknown. However, the interest rate for funds held by the State Treasurer is estimated to be 3.75 percent for FY 2006-07, and the fund could expect interest additional revenue of up to $534,375 ($14,250,000 X 3.75%).

State Expenditures

**Administrative expenses.** In FY 2006-07, expenses of $580,444 are anticipated. Of the total, $570,000 cash fund exempt is for CoverColorado and $10,444 cash funds exempt is for the Department of Regulatory Agencies. The bill limits administrative expense to 5 percent of the HBHP fund balance or $750,000 in FY 2006-07. Following is a description of anticipated expenses:

- **CoverColorado.** CoverColorado requires an estimated $570,000 in FY 2006-07 and $560,000 in FY 2007-08 for administrative costs. Expenditures are necessary for actuarial work, reinsurance administration, marketing, legal assistance, expanded board support and general administration.

- **Department of Regulatory Agencies, Division of Insurance.** The division requires an estimated $10,444 in FY 2006-07 and $8,271 in FY 2007-08. Expenditures are anticipated for approving contracts, reviewing small group carrier rates and annual reports, revising regulations, performing a financial exam, and publishing sample rates. This work is expected to be spread among numerous employees without the need for new FTE.

**Insurance Premium Subsidies for Individuals.** Starting January 1, 2007, qualifying individuals are eligible for health insurance premium subsidies through CoverColorado. The CoverColorado Board must determine premiums and subsidy levels, and up to $4.7 million is designated for premium subsidies in FY 2006-07. If individual subsidies do not reach the limit, excess moneys remain in the HBHP Fund.

**Reinsurance for Small Employers.** Starting January 1, 2007, small employer health insurance carriers are eligible to receive reinsurance reimbursement for 90 percent of total claims paid between the amounts of $5,000 and $75,000, in a calendar year, for any insured covered under a qualifying plan. For calendar year 2007, reinsurance payments are limited to $9.5 million which would be paid quarterly once reports and analysis are completed. If reinsurance payments do not reach the limit, excess funds remain in the HBHP fund.

State Appropriations

For FY 2006-07, Section 6 of the bill directs $15 million General Fund Exempt be appropriated to the HBHP Fund and, out of those funds, directs $10,644 cash funds exempt to the
Department of Regulatory Agencies. The fiscal note indicates that the department should receive $10,444 instead of $10,644.

Departments Contacted

CoverColorado  Regulatory Agencies  Treasury
A BILL FOR AN ACT

CONCERNING THE PROVISION OF HEALTH CARE SERVICES BY LOCAL
GOVERNMENTAL ENTITIES, AND, IN CONNECTION THEREWITH,
ALLOWING SUCH DISTRICTS TO BE CREATED IN ANY PART OF
THE STATE, AUTHORIZING SUCH DISTRICTS TO LEVY A SALES
TAX, AND AUTHORIZING COUNTIES TO IMPOSE A SALES TAX FOR
THE PURPOSE OF PROVIDING HEALTH CARE SERVICES.

Bill Summary

(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently
Interim Committee on Health Insurance. Allows a health assurance district to be formed in any area of the state rather than only in rural areas. Authorizes a district to seek voter approval to levy a sales tax in the district to generate revenues to provide health care services. Maintains the authority for a district to be organized in accordance with the "Special District Act" and to levy a property tax in the district to generate revenues to provide health care services. For any district that has the authority to levy a property tax or a sales tax, allows the district to seek voter approval to levy both a property tax and a sales tax.

For purposes of a health assurance district that will levy a sales tax, exempts the district from certain requirements of the "Special District Act" and allows all eligible electors in the proposed district, rather than the property owners, to vote on the organization of the district and any related ballot issues.

Authorizes any health assurance district to contract with or work in cooperation and in conjunction with a health service district or any other existing health care provider or service in order to provide health care services to residents of such districts.

Upon voter approval, allows any county in the state to impose an additional sales tax for the purpose of providing health care services in the county. Exempts such additional sales tax from the total cap on total county sales tax imposed by law.

Makes legislative findings and declarations. Defines terms.

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

SECTION 1. 32-1-103, Colorado Revised Statutes, is amended by the addition of a new subsection to read:

32-1-103. Definitions. As used in this article, unless the context otherwise requires:

(8.5) "HEALTH ASSURANCE DISTRICT" MEANS A SPECIAL DISTRICT THAT IS CREATED TO ORGANIZE, OPERATE, CONTROL, DIRECT, MANAGE, CONTRACT FOR, FURNISH, OR PROVIDE, DIRECTLY OR INDIRECTLY, HEALTH CARE SERVICES TO RESIDENTS OF THE DISTRICT WHO ARE IN NEED OF SUCH SERVICES AND TO FAMILY MEMBERS OF SUCH RESIDENTS.

SECTION 2. 32-1-202 (2), Colorado Revised Statutes, is
amended BY THE ADDITION OF A NEW PARAGRAPH to read:

32-1-202. Filing of service plan required - report of filing - contents - fee. (2) The service plan shall contain the following:

(k) FOR A HEALTH ASSURANCE DISTRICT, ANY ADDITIONAL INFORMATION REQUIRED BY SECTION 32-18-106 (2) THAT IS NOT OTHERWISE REQUIRED BY PARAGRAPHS (a) TO (i) OF THIS SUBSECTION (2).

SECTION 3. 32-1-301 (2) (a), Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SUBPARAGRAPH to read:

32-1-301. Petition for organization. (2) The petition shall set forth:

(a) The type of service to be provided by the proposed special district and the name of the proposed special district, consisting of a chosen name preceding one of the following phrases:

(X) HEALTH ASSURANCE DISTRICT;

SECTION 4. 32-1-1003.5 (1), (2) (a), and (4), Colorado Revised Statutes, are amended, and the said 32-1-1003.5 (2) is further amended BY THE ADDITION OF THE FOLLOWING NEW PARAGRAPHS, to read:

32-1-1003.5. Health assurance districts - additional powers - legislative declaration. (1) The general assembly hereby finds, determines, and declares that access to health care services in rural areas is an increasing problem in Colorado AND THAT some rural Coloradans do not have access to a primary care provider in their town and are forced to travel. It is the intent of the general assembly to ease the strain on rural Coloradan's health care needs by allowing a special district to be created to directly contract with a physician, a nurse practitioner, or a physician's assistant to provide health care services to rural areas. It is the intention of the general assembly to review the success of such efforts as
authorized by subsection (2) of this section to determine the effectiveness
of the program.

(2) In addition to the powers specified in section 32-1-1001, the
board of any health assurance district has any or all of the following
powers for and on behalf of such district:

(a) To organize, operate, control, direct, manage, contract for, or
furnish, health care services from a physician, nurse practitioner, or
physician's assistant licensed in this state and such health care provider
shall be known as a "community-contracted health care provider" or
provide, directly or indirectly, health care services to
residents of the health assurance district who are in need of
such services and to the family members of such residents;

(c) To contract with or work cooperatively and in
conjunction with a health service district or other existing
health care provider or service to provide health care services
to the residents of such districts; and

(d) To seek approval from the eligible electors in the
health assurance district to collect, retain, and spend all
revenue generated by any tax approved by such eligible
electors in excess of the limitation provided in section 20 of
article X of the state constitution.

(4) This section is repealed, effective July 1, 2008.

SECTION 5. 32-1-1003.5, Colorado Revised Statutes, is
amended BY THE ADDITION OF A NEW SUBSECTION to read:

32-1-1003.5. Health assurance districts - additional powers
- legislative declaration. (5) Any health assurance district that
is created pursuant to this article shall have the power, upon
approval by the eligible electors of the district, to levy and
COLLECT A UNIFORM SALES TAX THROUGHOUT THE ENTIRE GEOGRAPHIC AREA OF THE DISTRICT UPON EVERY TRANSACTION OR OTHER INCIDENT WITH RESPECT TO WHICH A SALES TAX IS LEVIED BY THE STATE PURSUANT TO THE PROVISIONS OF ARTICLE 26 OF TITLE 39, C.R.S., SUBJECT TO THE FOLLOWING PROVISIONS:

(a) FOR PURPOSES OF THIS SUBSECTION (5), "ELIGIBLE ELECTOR" SHALL HAVE THE SAME MEANING AS SET FORTH IN SECTION 32-18-102 (2).

(b) FOR PURPOSES OF COMPLYING WITH THE PROVISIONS OF SECTION 32-1-301 (2) (d.1), THE PETITION FOR ORGANIZATION SHALL SET FORTH THE ESTIMATED SALES TAX REVENUES FOR THE DISTRICT'S FIRST BUDGET YEAR IF THE DISTRICT WILL SEEK APPROVAL FROM THE ELIGIBLE ELECTORS OF THE DISTRICT TO LEVY A SALES TAX IN ITS FIRST BUDGET YEAR.

(c) ANY SALES TAX AUTHORIZED PURSUANT TO THIS SUBSECTION (5) SHALL BE LEVIED AND COLLECTED AS PROVIDED IN SECTION 32-18-112.

SECTION 6. Title 32, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW ARTICLE to read:

ARTICLE 18

Health Assurance Districts

32-18-101. Legislative declaration. THE GENERAL ASSEMBLY HEREBY FINDS, DETERMINES, AND DECLARES THAT ACCESS TO HEALTH CARE SERVICES IS AN INCREASING PROBLEM IN COLORADO AND THAT SOME COLORADANS DO NOT HAVE ACCESS TO A PRIMARY CARE PROVIDER.

IT IS THE INTENT OF THE GENERAL ASSEMBLY TO EASE THE STRAIN ON COLORADAN'S HEALTH CARE NEEDS BY ALLOWING A SPECIAL DISTRICT TO BE CREATED TO PROVIDE HEALTH CARE SERVICES.

32-18-102. Definitions. AS USED IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRE:
(1) "DISTRICT" MEANS A HEALTH ASSURANCE DISTRICT CREATED PERSUANT TO THIS ARTICLE TO ORGANIZE, OPERATE, CONTROL, DIRECT, MANAGE, CONTRACT FOR, FURNISH, OR PROVIDE, DIRECTLY OR INDIRECTLY, HEALTH CARE SERVICES TO RESIDENTS OF THE DISTRICT WHO ARE IN NEED OF SUCH SERVICES AND TO FAMILY MEMBERS OF SUCH RESIDENTS.

(2) "ELIGIBLE ELECTOR" MEANS A PERSON WHO, AT THE DESIGNATED TIME OR EVENT, IS REGISTERED TO VOTE PERSUANT TO THE "UNIFORM ELECTION CODE OF 1992", ARTICLES 1 TO 13 OF TITLE 1, C.R.S.

(3) "INTERESTED PARTY" MEANS A RESIDENT OR ELIGIBLE ELECTOR OF THE DISTRICT OR A MUNICIPALITY LOCATED IN THE DISTRICT.

32-18-103. Applicability of "Special District Act".

(1) Except as provided in this article, a district created pursuant to this article shall be governed by the applicable provisions of the "Special District Act", article 1 of this title, including, but not limited to:

(a) Part 1 of article 1 of this title containing general provisions;

(b) Parts 2 and 3 of article 1 of this title concerning the organization of a special district;

(c) Part 6 of article 1 of this title concerning the consolidation of special districts;

(d) Part 7 of article 1 of this title concerning the dissolution of special districts;

(e) Part 8 of article 1 of this title concerning elections;

(f) Parts 9, 10, and 11 of article 1 of this title concerning the board of directors for a special district and the board's general and financial powers; and
(g) Parts 13 and 14 of Article 1 of this title concerning refunding of bonds and special district indebtedness.

(2) The following provisions shall not apply to a district created pursuant to this article:

(a) Parts 4 and 5 of Article 1 of this title concerning the inclusion and exclusion of territory in a special district;

(b) Part 12 of Article 1 of this title concerning the levy and collection of ad valorem taxes; and

(c) Part 16 of Article 1 of this title concerning certification and notice of special district taxes for general obligation indebtedness.

32-18-104. Special districts file - notice of organization or dissolution. (1) For purposes of complying with section 32-1-104 (2), a district created pursuant to this article shall provide the required notice to the department of revenue instead of the county assessor.

(2) For purposes of complying with section 32-1-105, the county clerk and recorder shall file a certified copy of the decree or order confirming the organization or dissolution of a district created pursuant to this article with the department of revenue instead of notifying the county assessor of the action.

32-18-105. Service area of district - governmental immunity.

(1) A district may include all of the territory of one or more municipalities or counties, as may be proposed. The district shall be a body corporate and politic and a political subdivision of the state.

(2) Each of the directors, officers, and employees of the
DISTRICT SHALL BE A PUBLIC EMPLOYEE FOR PURPOSES OF THE "COLORADO GOVERNMENTAL IMMUNITY ACT", ARTICLE 10 OF TITLE 24, C.R.S.


(1) Persons proposing the organization of a district, except for a district that is contained entirely within the boundaries of a municipality and subject to the provisions of section 32-18-107, shall submit a service plan in accordance with the requirements of section 32-1-202 (1) and shall pay any fee required pursuant to section 32-1-202 (3).

(2) Notwithstanding the provisions of section 32-1-202 (2), the service plan for the district shall contain the following information:

(a) A description of the proposed health services to be provided and the persons who will be eligible to receive those services;

(b) A description of the proposed health services to be provided in conjunction with a health service district, if any, as defined in section 32-1-103 (9);

(c) Quality assurance measures;

(d) A financial plan showing how the proposed services are to be financed, including the proposed operating revenue derived from sales taxes for the first budget year of the district, which shall not be materially exceeded except as authorized pursuant to section 32-1-207. All proposed indebtedness for the district shall be displayed together with a schedule indicating the year or years in which the debt is scheduled to be issued. The board of directors of the district
SHALL NOTIFY THE BOARD OF COUNTY COMMISSIONERS OR THE GOVERNING BODY OF THE MUNICIPALITY, WHICHEVER IS APPLICABLE, OF ANY ALTERATION OR REVISION OF THE PROPOSED SCHEDULE OF DEBT ISSUANCE SET FORTH IN THE FINANCIAL PLAN.

(e) A MAP OF THE PROPOSED DISTRICT BOUNDARIES;

(f) IF THE DISTRICT PLANS TO CONSTRUCT FACILITIES, A GENERAL DESCRIPTION OF THE FACILITIES TO BE CONSTRUCTED AND THE STANDARDS OF SUCH CONSTRUCTION, INCLUDING A STATEMENT OF HOW THE FACILITY AND SERVICE STANDARDS OF THE PROPOSED DISTRICT ARE COMPATIBLE WITH FACILITY AND SERVICE STANDARDS OF ANY COUNTY OR MUNICIPALITY WITHIN WHICH ALL OR ANY PORTION OF THE PROPOSED DISTRICT IS TO BE LOCATED;

(g) IF APPLICABLE, A GENERAL DESCRIPTION OF THE ESTIMATED COST OF ACQUIRING OR LEASING LAND OR FACILITIES, ACQUIRING ENGINEERING, LEGAL, AND ADMINISTRATIVE SERVICES, INITIAL PROPOSED INDEBTEDNESS AND ESTIMATED PROPOSED MAXIMUM INTEREST RATES AND DISCOUNTS, AND OTHER MAJOR EXPENSES RELATED TO THE ORGANIZATION AND INITIAL OPERATION OF THE DISTRICT;

(h) A DESCRIPTION OF ANY ARRANGEMENT OR PROPOSED AGREEMENT WITH ANY POLITICAL SUBDIVISION FOR THE PERFORMANCE OF ANY SERVICES BETWEEN THE PROPOSED DISTRICT AND SUCH OTHER POLITICAL SUBDIVISION, INCLUDING THE FORM CONTRACT TO BE USED, IF AVAILABLE;

(i) INFORMATION, ALONG WITH OTHER EVIDENCE PRESENTED AT THE HEARING PURSUANT TO SECTION 32-1-204, SATISFACTORY TO ESTABLISH THAT EACH OF THE CRITERIA SET FORTH IN SECTION 32-1-203, IF APPLICABLE, IS MET; AND

(j) SUCH ADDITIONAL INFORMATION AS THE BOARD OF COUNTY
COMMISSIONERS OR THE GOVERNING BODY OF THE MUNICIPALITY, WHICHEVER IS APPLICABLE, MAY REQUIRE ON WHICH TO BASE ITS FINDINGS PURSUANT TO SECTION 32-1-203.

(3) Except as provided in section 32-18-107, the board of county commissioners of each county that has territory included within the proposed district shall constitute the approving authority for the proposed district and shall review any service plan filed by the petitioners of a proposed district in accordance with the provisions of section 32-1-203. The provisions of section 32-1-203 (3.5) shall not apply to a district proposed pursuant to this article.

32-18-107. Approval by municipality. If the boundaries of a district proposed pursuant to this article are wholly contained within the boundaries of a municipality, the persons proposing the organization of the district shall comply with the provisions of section 32-1-204.5; except that the service plan submitted to each governing body shall contain the information required by section 32-18-106 (2). The governing body of each municipality shall have the authority set forth in section 32-1-204.5 with regard to the review of the service plan.

32-18-108. Public hearing on service plan - procedures - decision - judicial review - modifications - enforcement. (1) For purposes of section 32-1-204 (1) and (1.5), the board of county commissioners or the governing body of the municipality, whichever is applicable, shall be deemed to have complied with the provisions of such sections if the board or governing body provides written notice of the date, time, and location of the hearing to the petitioners and, at least twenty days prior to the
HEARING DATE, PUBLISHES NOTICE OF THE DATE, TIME, LOCATION, AND PURPOSE OF THE HEARING. THE PUBLISHED NOTICE SHALL CONSTITUTE CONSTRUCTIVE NOTICE TO THE INTERESTED PARTIES IN THE PROPOSED DISTRICT.

(2) THE PROVISIONS OF SECTION 32-1-204 (2) SHALL NOT APPLY TO A DISTRICT PROPOSED PURSUANT TO THIS ARTICLE.


(4) UPON FINAL APPROVAL BY THE COURT FOR THE ORGANIZATION OF A DISTRICT, THE DISTRICT SHALL CONFORM AS MUCH AS POSSIBLE TO THE APPROVED SERVICE PLAN, AND ANY MATERIAL MODIFICATIONS TO THE PLAN SHALL BE APPROVED IN ACCORDANCE WITH SECTION 32-1-207 (2). ANY MATERIAL DEPARTURE FROM THE APPROVED SERVICE PLAN MAY BE ENJOINED IN ACCORDANCE WITH SECTION 32-1-207 (3); EXCEPT THAT, FOR PURPOSES OF ENFORCEMENT OF THE PLAN, "INTERESTED PARTY" SHALL HAVE THE SAME MEANING AS SET FORTH IN SECTION 32-18-102 (3).

32-18-109. Organization. (1) EXCEPT AS PROVIDED IN THIS SECTION, THE ORGANIZATION OF A DISTRICT PURSUANT TO THIS ARTICLE SHALL BE GOVERNED BY THE PROVISIONS OF PART 3 OF ARTICLE 1 OF THIS TITLE.
(2) FOR PURPOSES OF COMPLYING WITH THE PROVISIONS OF SECTION 32-1-301 (1), A PETITION FOR THE ORGANIZATION OF A DISTRICT PROPOSED PURSUANT TO THIS ARTICLE SHALL BE SIGNED BY NOT LESS THAN THIRTY PERCENT OR TWO HUNDRED ELIGIBLE ELECTORS OF THE PROPOSED DISTRICT, WHICHEVER NUMBER IS SMALLER.

(3) FOR PURPOSES OF COMPLYING WITH THE PROVISIONS OF SECTION 32-1-301 (2) (d.1), THE PETITION FOR ORGANIZATION SHALL SET FORTH THE ESTIMATED SALES TAX REVENUES FOR THE DISTRICT'S FIRST BUDGET YEAR.

(4) FOR PURPOSES OF COMPLYING WITH THE PROVISIONS OF SECTION 32-1-304, WHEN THE COURT WITH WHOM A PETITION FOR ORGANIZATION OF A DISTRICT HAS BEEN FILED SETS A HEARING DATE, THE CLERK OF COURT SHALL PUBLISH NOTICE OF THE HEARING AND MAIL THE REQUIRED NOTICE TO THE APPROPRIATE BOARD OF COUNTY COMMISSIONERS OR GOVERNING BODY OF THE MUNICIPALITY, BUT THE CLERK OF COURT SHALL NOT BE REQUIRED TO MAIL NOTICE OF THE HEARING TO ALL INTERESTED PARTIES.

(5) FOR PURPOSES OF COMPLYING WITH THE PROVISIONS OF SECTION 32-1-305 (1), THE COURT SHALL DETERMINE WHETHER THE REQUIRED NUMBER OF ELIGIBLE ELECTORS OF THE PROPOSED DISTRICT HAVE SIGNED THE PETITION.


32-18-110. Persons entitled to vote at health assurance district elections. NOTWITHSTANDING THE PROVISIONS OF SECTION
32-1-806, any person who is an eligible elector as defined in
section 32-18-102 (2) shall be eligible to vote in an
organizational election or any election conducted by the board
of directors for a district.

32-18-111. Financial powers. Any health assurance
district created pursuant to this article shall have all of the
financial powers described in section 32-1-1101; except that the
levy and collection of ad valorem taxes shall be subject to the
provisions of section 32-18-115. The district shall also have the
power, upon voter approval, to levy and collect a uniform sales
tax throughout the entire geographical area of the district
upon every transaction or other incident with respect to which
a sales tax is levied by the state pursuant to the provisions of
article 26 of title 39, C.R.S. Any sales tax authorized pursuant
to this section shall be levied and collected as provided in
section 32-18-112.

32-18-112. Sales tax imposed - collection - administration of
tax. (1) (a) Upon the approval of the eligible electors in the
district at an election held in accordance with section 20 of
article X of the state constitution and part 8 of article 1 of this
title, the district shall have the power to levy a uniform sales
tax throughout the entire geographical area of the district
upon every transaction or other incident with respect to which
a sales tax is levied by the state pursuant to the provisions of
article 26 of title 39, C.R.S.

(b) The sales tax imposed pursuant to paragraph (a) of
this subsection (1) shall also be levied on the following sales
and purchases:
(I) PURCHASES OF MACHINERY OR MACHINE TOOLS THAT ARE OTHERWISE EXEMPT PURSUANT TO SECTION 39-26-709(1), C.R.S., TO THE EXTENT THAT SUCH SALES AND PURCHASES ARE SUBJECT TO THE SALES TAX LEVIED BY THE REGIONAL TRANSPORTATION DISTRICT PURSUANT TO SECTION 29-2-105 (1) (d), C.R.S.;

(II) SALES OF LOW-EMITTING MOTOR VEHICLES, POWER SOURCES, OR PARTS USED FOR CONVERTING SUCH POWER SOURCES AS SPECIFIED IN SECTION 39-26-719 (1), C.R.S.; AND

(III) VENDING MACHINE SALES OF FOOD THAT ARE OTHERWISE EXEMPT PURSUANT TO SECTION 39-26-714 (2), C.R.S.

(c) The sales tax imposed pursuant to paragraph (a) of this subsection (1) shall not be levied on:

(I) The sale of tangible personal property delivered by a retailer or a retailer's agent or to a common carrier for delivery to a destination outside the district; or

(II) The sale of tangible personal property on which a specific ownership tax has been paid or is payable when such sale meets the following conditions:

(A) The purchaser does not reside in the district, or the purchaser's principal place of business is outside the district.

(B) The personal property is registered or required to be registered outside the geographical boundaries of the district under the laws of this state.

(d) The sales tax imposed pursuant to paragraph (a) of this subsection (1) is in addition to any other sales or use tax imposed pursuant to law and is exempt from the limitation imposed by section 29-2-108 (1), C.R.S.

(2) (a) The collection, administration, and enforcement
OF THE SALES TAX SHALL BE PERFORMED BY THE EXECUTIVE DIRECTOR OF
THE DEPARTMENT OF REVENUE IN THE SAME MANNER AS THAT FOR THE
COLLECTION, ADMINISTRATION, AND ENFORCEMENT OF THE STATE SALES
TAX IMPOSED PURSUANT TO ARTICLE 26 OF TITLE 39, C.R.S., INCLUDING,
WITHOUT LIMITATION, THE RETENTION BY A VENDOR OF THE PERCENTAGE
OF THE AMOUNT REMITTED TO COVER THE VENDOR'S EXPENSE IN THE
COLLECTION AND REMITTANCE OF THE SALES TAX AS PROVIDED IN SECTION
39-26-105, C.R.S. THE EXECUTIVE DIRECTOR SHALL MAKE MONTHLY
DISTRIBUTIONS OF SALES TAX COLLECTIONS TO THE DISTRICT. THE
DISTRICT SHALL PAY THE NET INCREMENTAL COST INCURRED BY THE
DEPARTMENT OF REVENUE IN THE ADMINISTRATION AND COLLECTION OF
THE SALES TAX.

(b) (I) A QUALIFIED PURCHASER MAY PROVIDE A DIRECT
PAYMENT PERMIT NUMBER ISSUED PURSUANT TO SECTION 39-26-103.5,
C.R.S., TO A VENDOR OR RETAILER THAT IS LIABLE AND RESPONSIBLE FOR
COLLECTING AND REMITTING ANY SALES TAX LEVIED ON A SALE MADE TO
THE QUALIFIED PURCHASER PURSUANT TO THE PROVISIONS OF THIS
ARTICLE. A VENDOR OR RETAILER THAT HAS RECEIVED A DIRECT
PAYMENT PERMIT NUMBER IN GOOD FAITH FROM A QUALIFIED PURCHASER
SHALL NOT BE LIABLE OR RESPONSIBLE FOR COLLECTION AND REMITTANCE
OF A SALES TAX IMPOSED ON A SALE THAT IS PAID FOR DIRECTLY FROM THE
QUALIFIED PURCHASER'S FUNDS AND NOT THE PERSONAL FUNDS OF AN
INDIVIDUAL.

(II) A QUALIFIED PURCHASER THAT PROVIDES A DIRECT PAYMENT
PERMIT NUMBER TO A VENDOR OR RETAILER SHALL BE LIABLE AND
RESPONSIBLE FOR THE AMOUNT OF SALES TAX LEVIED ON A SALE MADE TO
THE QUALIFIED PURCHASER PURSUANT TO THE PROVISIONS OF THIS
ARTICLE IN THE SAME MANNER AS LIABILITY WOULD BE IMPOSED ON A
32-18-113. District revenues. Any revenues raised or generated by the district shall be in addition to and shall not be used to replace any funding the counties in the district would otherwise be entitled to receive from the state or federal government.

32-18-114. Cooperation with health service district or other existing providers permitted. A district shall have the authority to contract with or work cooperatively and in conjunction with a health service district or any existing health care providers or services to provide health care services to the residents of such districts.

32-18-115. Levy and collection of ad valorem taxes. (1) Any health assurance district that is created pursuant to this article shall have the power, upon approval by the eligible electors of the district, to levy and collect ad valorem taxes on and against all taxable property within the district subject to the following provisions:

   (a) For purposes of this section, "eligible elector" shall have the same meaning as set forth in section 32-1-103 (5).

   (b) The levy and collection of ad valorem taxes shall be subject to the applicable provisions of the "Special District Act", Article 1 of this title.

SECTION 7. Article 2 of title 29, Colorado Revised Statutes, is amended by the addition of a new section to read:

29-2-103.8. Sales tax for health care services. (1) In addition to any sales tax imposed pursuant to section 29-2-103, each
COUNTY IN THE STATE IS AUTHORIZED TO LEVY A COUNTY SALES TAX FOR
THE PURPOSE OF PROVIDING, DIRECTLY OR INDIRECTLY, HEALTH CARE
SERVICES TO RESIDENTS OF THE COUNTY WHO ARE IN NEED OF HEALTH
CARE SERVICES AND TO FAMILY MEMBERS OF SUCH RESIDENTS.

(2) (a) Any county in which health care services are
provided may enter into intergovernmental agreements with
any municipality or other county or may enter into contractual
agreements with any private provider or health service district,
as defined in section 32-1-103 (9), C.R.S., for the purpose of
providing health care services within the county.

(b) Any county that uses sales tax revenues imposed
pursuant to this section for the provision of health care
services shall establish standards for such services.

(3) (a) No sales tax shall be levied pursuant to the
provisions of subsection (1) of this section until the proposal has
been referred to and approved by the eligible electors of the
county in accordance with the provisions of this article. The
ballot question for any proposal for a sales tax increase
pursuant to this section shall clearly state that the approval
of the sales tax may result in a sales tax rate in excess of the
current limitation imposed by section 29-2-108.

(b) Any proposal for the levy of a sales tax in
accordance with paragraph (a) of this subsection (3) shall only
be submitted to the eligible electors of the county on the first
Tuesday after the first Monday in November of each year, and
any election on the proposal shall be conducted by the county
clerk and recorder in accordance with the "Uniform Election
Code of 1992", articles 1 to 13 of title 1, C.R.S.
(4) All revenues collected from a county sales tax imposed pursuant to this section shall be credited to a special fund in the county treasury known as the county health care services fund. The fund shall be used only for the purpose of providing mental health care services in accordance with this section.

SECTION 8. 29-2-108 (3), Colorado Revised Statutes, is amended to read:

29-2-108. Limitation on amount. (3) A tax imposed pursuant to section 24-90-110.7 (3) (f), 29-1-204.5 (3) (f.1), 29-2-103.7, 29-2-103.9, 30-11-107.5, 30-11-107.7, or 37-50-110, C.R.S. section 24-90-110.7 (3) (f), 29-1-204.5 (3) (f.1), 29-2-103.7, 29-2-103.8, 29-2-103.9, 30-11-107.5, 30-11-107.7, or 37-50-110, C.R.S., and the additional tax authorized by section 30-20-604.5, C.R.S., if imposed, shall be exempt from the six and ninety one-hundredths percent limitation imposed by subsection (1) of this section.

SECTION 9. 24-34-104 (39) (b) (XIV), Colorado Revised Statutes, is amended to read:

24-34-104. General assembly review of regulatory agencies and functions for termination, continuation, or reestablishment. (39) (b) The following agencies, functions, or both, shall terminate on July 1, 2008:

(XIV) Review of the use of community contracted health care providers pursuant to section 31-15-302 (1), C.R.S., and 32-1-1003.5, C.R.S., by the department of public health and environment in cooperation with the department of regulatory agencies;

SECTION 10. Safety clause. The general assembly hereby
finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.
CONCERNING THE PROVISION OF HEALTH CARE SERVICES BY LOCAL GOVERNMENTAL ENTITIES, AND, IN CONNECTION THEREWITH, ALLOWING SUCH DISTRICTS TO BE CREATED IN ANY PART OF THE STATE AUTHORIZING SUCH DISTRICTS TO LEVY A SALES TAX AND AUTHORIZING COUNTIES TO IMPOSE A SALES TAX FOR THE PURPOSE OF PROVIDING HEALTH CARE SERVICES.

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Effective Date: Upon signature of the Governor.

Appropriation Summary for FY 2006/2007: None Required (see State Appropriations section)

Local Government Impact: Counties and health assurance districts may impose a new sales tax to fund health care services, with voter approval.

Summary of Legislation

Recommended by the Interim Committee on Health Insurance, this bill allows for the establishment of sales-tax-funded health assurance districts, with voter approval. Such districts are already authorized to impose a property tax to fund services, if approved by voters. The bill also allows a county to impose an additional sales tax to fund health care services, with voter approval, and exempts the new tax from the existing 6.91 percent limitation on county sales taxes.
State Revenues

The bill requires that districts reimburse the Department of Revenue for costs incurred in administering and collecting a sales tax. However, this impact will only occur if voters approve a new sales tax. Thus, the bill is assessed as having a conditional fiscal impact. The earliest that voters could be presented with a proposed sales tax would be at the November 2006 general election, most likely for a sales tax that would begin January 1, 2007. Thus, the department could incur costs, and seek reimbursement for those costs, as early as FY 2006-07. The expenses incurred by the department are described in the State Expenditures section below. Reimbursement revenue from the district will be credited to either the Highway Users Trust Fund (HUTF) or the General Fund, depending on the type of expenditure incurred.

State Expenditures

If voters approve a new sales tax for a health assurance district under the provisions of the bill, the Department of Revenue would be responsible for implementing, administering, and collecting the tax. This responsibility would require the department to reprogram the existing sales tax systems, both for vehicles and for all other taxable items. Overall, the cost for implementing a new sales tax district is expected to be at least $66,322 in FY 2006-07, as described below.

**Vehicles.** Sales taxes on vehicles are collected through the Colorado State Titling and Registration System (CSTARS), the computer code for which is currently being rewritten under contract. Any changes that occur before the expiration of the contract would have to be paid at the contractor's rate of $191 per hour. Establishing a new health assurance district is expected to require 320 hours of computer programming at a cost of $61,120 in FY 2006-07. These costs would be paid from the CSTARS special purpose account in the HUTF.

**All Other Taxable Items.** Programming a new non-vehicle-related sales tax is expected to cost $5,202 in FY 2006-07 for 150 hours of computer programming. The rate for in-house computer programming is $34.68 per hour. These costs would be paid from the General Fund.

In addition to the computer programming costs identified above, the department would have to notify affected businesses of the imposition of a new sales tax. The cost of notification would depend on the number of affected businesses.

It should be noted that the computer programming resources identified in this fiscal note may also be included in the FY 2006-07 Long Bill appropriation for the Department of Revenue. If these resources are provided in the Long Bill, no further appropriation for computer programming will be necessary to implement the bill.
Local Government Impact

The bill allows health assurance districts and counties to impose additional sales taxes, with voter approval, to fund health care services. Any costs associated with establishing a district or imposing a new sales tax would likely be paid for out proceeds collected from the tax.

State Appropriations

No state appropriations are required for FY 2006-07 to implement the bill, unless voters approve a new local sales tax. If such a tax is approved, the Department of Revenue could be expected to request the following amounts through a supplemental appropriation:

- $5,202 from the General Fund, and
- $61,120 from the CSTARS Special Purpose Account of the HUTF.

Departments Contacted

Local Affairs    Revenue
A BILL FOR AN ACT

CONCERNING THE PROVISION OF HEALTH CARE SERVICES TO SPECIFIED LOW-INCOME ADULTS.

Bill Summary

(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently adopted.)

Interim Committee on Health Insurance. Establishes the Colorado primary care program ("program") for the purpose of providing primary care services to specified low-income, uninsured adults who have a qualifying medical condition. Defines who is eligible for the program.
Specifies the primary care services that may be provided to an eligible person, subject to available appropriations. Requires the department of health care policy and financing ("department") to contract with federally qualified health centers for the provision of all primary care services to eligible persons enrolled in the program.

Requires the department to propose rules for approval by the medical services board to implement financial management of the program. Requires the general assembly to annually establish maximum enrollment figures for eligible persons in the program. Authorizes the department to establish a waiting list for the program when enrollment in the program must be limited.

Establishes the Colorado health care services fund ("fund"), which shall annually consist of $15 million of the moneys in the general fund exempt account. For fiscal years 2006-07 to 2010-11, specifies that $7.5 million of the moneys in the fund shall be appropriated for the program and $7.5 million of the moneys in the fund shall be appropriated to pay for services provided to specified medicaid eligible adults who are above 60% of the federal poverty level.

Contains a reporting requirement.

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

SECTION 1. Title 25.5, Colorado Revised Statutes, is amended by the addition of a new article to read:

ARTICLE 4

Colorado Primary Care

25.5-4-101. Short title. This article shall be known and may be cited as the "Colorado Primary Care Act".

25.5-4-102. Definitions. As used in this article, unless the context otherwise requires:

(1) "Eligible person" means a person who is:

(a) A resident of Colorado and who is a citizen of the United States or a qualified alien as defined in section 26-2-703 (17.7), C.R.S.;

(b) At least nineteen years of age and less than sixty-four years of age;
(c) At or below one hundred percent of the federal poverty level;

(d) Not eligible for medical assistance pursuant to Article 4 of Title 26, C.R.S., or the Children's Basic Health Plan pursuant to Article 19 of Title 26, C.R.S., or enrolled in health insurance coverage from any other third-party payor; and

(e) Not eligible for Veteran's Administration Medical benefits or the treatment of the qualifying medical condition through workers' compensation coverage.

(2) "Primary care" means the basic, entry-level health care provided by health care practitioners or non-physician health care practitioners that is generally provided in an outpatient setting.

(3) "Program" means the Colorado Primary Care Program.

(4) "Qualifying medical condition" means a condition that requires a plan of care and at least four visits annually to a medical care provider.

25.5-4-103. Colorado primary care - benefits - providers.

(1) There is hereby created the Colorado Primary Care Program for the purpose of providing primary care services to low-income, uninsured adults who have a qualifying medical condition. The State Department shall administer and implement the program consistent with the provisions of this article.

(2) Subject to available appropriations, an eligible person may receive the following primary care services when enrolled in the program:

(a) Office visits for acute and chronic health care conditions;
(b) AGE AND GENDER APPROPRIATE HEALTH CARE SCREENINGS;
(c) LABORATORY TESTS FOR BASELINE STUDIES AS WELL AS TESTS NEEDED TO DIAGNOSE OR TREAT MEDICAL CONDITIONS;
(d) BASIC X-RAYS;
(e) OUTPATIENT DRUG AND ALCOHOL TREATMENT AS PRESCRIBED BY THE PARTICIPATING MEDICAL CARE PROVIDER;
(f) DIABETIC CARE, INCLUDING MEDICAL SUPPLIES;
(g) FOUR PRESCRIPTIONS PER MONTH THAT ARE WRITTEN BY AN AUTHORIZED PROVIDER; AND
(h) ANY OTHER PRIMARY CARE SERVICE THE STATE BOARD AUTHORIZES BY RULE THAT IS MEDICALLY NECESSARY FOR THE ELIGIBLE PERSON TO RECEIVE AND THAT IS WITHIN THE PROGRAM'S ANNUAL APPROPRIATION.

(3) THE STATE DEPARTMENT SHALL CONTRACT WITH FEDERALLY QUALIFIED HEALTH CENTERS FOR THE PROVISION OF ALL PRIMARY CARE SERVICES TO ELIGIBLE PERSONS ENROLLED IN THE PROGRAM.

25.5-4-104. Financial management - rules. (1) THE STATE DEPARTMENT SHALL PROPOSE RULES FOR APPROVAL BY THE STATE BOARD TO IMPLEMENT FINANCIAL MANAGEMENT OF THE PROGRAM. PURSUANT TO SUCH RULES, THE STATE DEPARTMENT SHALL ADJUST BENEFIT LEVELS AND PROVIDER REIMBURSEMENT TO ENSURE THAT SUFFICIENT FUNDS ARE PRESENT TO IMPLEMENT THE PROVISIONS OF THIS ARTICLE. THE DEPARTMENT SHALL DEVELOP AND USE QUALITY ASSURANCE MEASURES TO ENSURE THAT APPROPRIATE HEALTH CARE OUTCOMES ARE MET.

(2) (a) NOTHING IN THIS ARTICLE OR ANY RULES PROMULGATED PURSUANT TO THIS ARTICLE SHALL BE INTERPRETED TO CREATE A LEGAL ENTITLEMENT IN ANY PERSON TO COVERAGE UNDER THE PROGRAM.

ENROLLMENT IN THE PROGRAM SHALL BE LIMITED BASED UPON ANNUAL
APPROPRIATIONS MADE BY THE GENERAL ASSEMBLY AND ANY GIFTS, 
grants, and donations received by the state department. The 
general assembly shall annually establish maximum 
enrollment figures for eligible persons in the program. The 
enrollment caps shall not be exceeded by the state department 
regardless of whether the funding comes from annual 
appropriations or gifts, grants, and donations. When 
enrollment in the program must be limited pursuant to this 
subsection (2), the state department shall establish a waiting 
list for the program.

(b) The department shall report quarterly to the joint 
budget committee on any enrollment caps that have been 
instituted for the program and the number of eligible persons 
who are on the waiting list.

(3) The state board shall promulgate rules necessary to 
implement and administer this article that shall include, but 
not be limited to, an appeal process for the program, quality 
assurance measures for providers participating in the program, 
and financial management of the program.

25.5-4-105. Report. On or before July 1, 2007, the state 
department shall report to the joint health and human services 
committees of the senate and the house of representatives on 
the use of the moneys in the health care services fund 
established in section 25.5-1-114 and the implementation and 
operation of the Colorado primary care program.

SECTION 2. Part 1 of article 1 of title 25.5, Colorado Revised 
Statutes, is amended by the addition of a new section to 
read:
25.5-1-114. Health care services fund - creation.

(1) (a) There is hereby created in the state treasury the Colorado health care services fund, also referred to in this section as the "fund". The fund shall consist of moneys credited thereto pursuant to this section.

(b) In fiscal year 2005-06, and each of the four fiscal years thereafter, if the most recent legislative council staff economic and revenue forecast estimates that the general fund exempt account, created in section 24-77-103.6 (2), C.R.S., will receive more than one hundred fifteen million dollars, fifteen million dollars of the moneys in the general fund exempt account shall be appropriated to the Colorado health care services fund created in this subsection (1).

(c) All moneys appropriated to the fund shall be used as provided in this section and shall not be deposited in or transferred to the general fund of this state or to any other fund. Notwithstanding any provision of section 24-36-114, C.R.S., to the contrary, all interest derived from the deposit and investment of moneys in the fund shall be credited to the fund.

(2) In fiscal year 2006-07, and each of the four fiscal years thereafter, of the moneys deposited into the fund:

(a) Seven million five hundred thousand dollars shall be appropriated for the Colorado primary care program established in article 4 of this title; and

(b) (I) Seven million five hundred thousand dollars shall be appropriated to increase eligibility in the medical assistance program pursuant to section 26-4-301 (1) (u), C.R.S.

(II) The moneys specified in this paragraph (b) shall be
USED ONLY TO PAY FOR SERVICES PROVIDED TO PERSONS IN THE
ELIGIBILITY CATEGORY SPECIFIED IN SECTION 26-4-301 (1) (u), C.R.S.,
WHO ARE ABOVE SIXTY PERCENT OF THE FEDERAL POVERTY LEVEL.

SECTION 3. Effective date. This act shall take effect July 1,
2006.

SECTION 4. Safety clause. The general assembly hereby finds,
determines, and declares that this act is necessary for the immediate
preservation of the public peace, health, and safety.
A BILL FOR AN ACT

CONCERNING A STUDY TO ANALYZE FACTORS THAT DRIVE THE COST OF HEALTH CARE WITHIN PUEBLO COUNTY.

Bill Summary

(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently adopted.)

Interim Committee on Health Insurance. Instructs the division of insurance to conduct a study of the factors that drive health insurance in the Pueblo area. Defines the parameters of the study and the data to be
gathered and analyzed. Requires the commissioner of insurance to convene a meeting of all interested persons related to the study no later than June 15, 2006. Authorizes the division of insurance to contract with a nonprofit entity to analyze data collected by the division and prepare a report of the analysis of such data.

Instructs the director of the division of registrations to conduct a survey of each health care professional concerning the charges billed in Pueblo county to health insurers. Instructs the department of public health and environment to survey all licensed health facilities in Pueblo county for charges billed to health insurers and consumers. Requires both sets of survey results to be forwarded to the division of insurance.

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

SECTION 1. Part 1 of article 16 of title 10, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

10-16-131. Study of health insurance premiums charged in Pueblo county - repeal. (1) (a) The division shall conduct an independent and objective study pursuant to subsection (2) of this section to gather and analyze data to identify:

(I) The factors that drive health insurance costs for individuals and groups in Pueblo county;

(II) The statistical interaction, relationships, and dependencies of the factors;

(III) The demographic, health services, and other cost components of health insurance premiums for individuals and groups in Pueblo county;

(IV) The role of modified community rating for Pueblo county; and

(V) Whether health coverage for individuals and groups in Pueblo county is reasonably available.
(b) The division may contract with a nonprofit entity to analyze data collected by the division and prepare a report of the analysis of such data.

(2) (a) The commissioner shall convene a meeting of all interested persons related to the study no later than June 15, 2006. Interested persons include, but are not limited to, providers and consumers of health insurance, the chairs of the board of medical examiners and any other type 1 board that regulates a health care profession, the director of the division of registrations, and the executive director of the department of public health and environment. The meeting shall include a discussion of the exact data to be gathered, if any, in addition to the data specified in subsection (3) of this section, the method and time frames for collection of the data, and the objectives and standards for the analysis thereof.

(b) Upon completion of the analysis, the division shall present a draft of the report to the commissioner for approval and transmission to the general assembly pursuant to paragraph (c) of this subsection (2).

(c) The commissioner shall submit a report of the study containing conclusions and an analysis of the factors that drive the cost of health care, the cost of health insurance coverage on an individual and group basis, and the impact of modified community rating on Pueblo County to the president of the Senate, majority leader of the Senate, minority leader of the Senate, speaker of the House of Representatives, majority leader of the House of Representatives, minority leader of the House of Representatives, and chairs of the Health and Human Services

(d) The commissioner shall aggregate data collected from the Division of Registrations within the Department of Regulatory Agencies and the Department of Public Health and Environment pursuant to Sections 24-34-102 (15) and 25-1.5-103 (5), C.R.S. If the commissioner contracts with a nonprofit entity to analyze data collected pursuant to this section, such aggregated data may be transmitted to such nonprofit entity for analysis.

(e) Nothing in this section shall waive any claim to privileged or confidential information pursuant to federal or state law.

(3) The data to be collected shall include the amount of claims paid by health insurers in Pueblo County for the period beginning ______ and ending ______; the rates charged for health insurance during this period; the charges billed by licensed, certified, or registered health care providers during this same period; the charges billed by all licensed health care facilities during this period; the number of licensed, certified, or registered health care providers in Pueblo County during this period; the number of health insurers conducting business in Pueblo County during this period; whether the practice patterns of health care providers in the Pueblo community differ from accepted standards and guidelines; whether the health status of the Pueblo community drives health insurance costs; and any other information determined necessary by the commissioner.

(4) This section is repealed, effective January 15, 2008.
SECTION 2. 24-34-102, Colorado Revised Statutes, is amended by the addition of a new subsection to read:

24-34-102. Division of registrations - creation - duties of division and department heads - definitions - license, registration, or certification renewal and reinstatement - repeal.

(15) (a) Notwithstanding any type 1 transfer, as such transfer is defined by section 24-1-105, the director of the division of registrations shall conduct a survey of each licensed, certified, or registered health care professional concerning the charges billed to health insurers and consumers in Pueblo county for the period beginning ______ and ending _______. The director shall forward the survey results to the division of insurance pursuant to section 10-16-131, C.R.S., by ____ 200_. The director shall create the survey questionnaire after consultation with the insurance commissioner.

(b) This subsection (15) is repealed, effective January 15, 2008.

SECTION 3. 25-1.5-103, Colorado Revised Statutes, is amended by the addition of a new subsection to read:

25-1.5-103. Hospitals and community mental health centers - powers and duties of the department - limitations on rules promulgated by the department - repeal. (5) (a) The executive director of the department shall survey all licensed health facilities in Pueblo county for charges billed to health insurers and consumers for the period beginning ______ and ending _______. The executive director shall forward the survey results to the division of insurance pursuant to section 10-16-131, C.R.S., by ____ 200_. The executive director shall
CREATE THE SURVEY QUESTIONNAIRE ON CONSULTATION WITH THE
INSURANCE COMMISSIONER.

(b) This subsection (5) is repealed, effective January 15, 2008.

SECTION 4. Safety clause. The general assembly hereby finds,
determines, and declares that this act is necessary for the immediate
preservation of the public peace, health, and safety.
CONCERNING A STUDY TO ANALYZE FACTORS THAT DRIVE THE COST OF HEALTH CARE WITHIN PUEBLO COUNTY.

Fiscal Impact Summary

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<tr>
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<tbody>
<tr>
<td>State Revenues</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>General Fund</td>
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<tr>
<td>Cash Fund - Division of Registrations</td>
<td>($6,757)</td>
<td>($20,904)</td>
<td>$81,984</td>
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<td>State Expenditures</td>
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<td></td>
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<tr>
<td>General Fund</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cash Fund - Division of Insurance</td>
<td>$6,757</td>
<td>20,904</td>
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<tr>
<td>Cash Fund - Division of Registrations</td>
<td>101,740</td>
<td>0.0 FTE</td>
<td>0.0 FTE</td>
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<tr>
<td>FTE Position Change</td>
<td></td>
<td></td>
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Effective Date: Upon signature of the Governor.

Appropriation Summary for FY 2005/2006:
Department of Regulatory Agencies: $6,757 CF

Appropriation Summary for FY 2006/2007:
Department of Public Health and Environment: $58,708 GF
Department of Regulatory Agencies: $122,644 CF

Local Government Impact: None.

Summary of Legislation

This Interim Committee on Health Insurance bill requires the Department of Regulatory Agencies, Division of Insurance, to conduct a study of the factors that drive health insurance costs for individuals and groups in Pueblo County. The Insurance Commissioner must submit a report to numerous members of the General Assembly no later than January 15, 2008.

In addition, the bill directs the Division of Registrations to survey all health care professionals serving consumers in Pueblo County and directs the Department of Public Health and Environment to survey all health facilities in the county. The Division of Insurance may contract with a nonprofit organization to analyze the data collected by the Department of Public Health and
Bill D

Environment, the Division of Registrations, and the Division of Insurance and prepare a report of the analysis.

Note: While the bill directs the Division of Insurance to conduct a study of factors that drive health insurance costs in Pueblo County, it also directs the Division of Registrations to survey all licensed health care professionals who provide services to consumers in the county. Since a resident of Pueblo may receive health care services in another county, the fiscal note anticipates a statewide survey to reach all potential health care professionals.

State Revenues

General Fund revenue is anticipated to decrease $6,757 in the current fiscal year. In FY 2006-07, state revenues are expected to decrease by a net of $408. Of the total, $20,904 is a General Fund decrease and $20,496 is a cash fund increase. Following is a description of these changes.

The bill is estimated to require a one-time increase in fee revenue to the Division of Registrations Cash Fund of $20,496 in FY 2006-07 and $81,984 in FY 2007-08 to offset the costs associated with surveying an estimated 122,000 licensed health professions across the state. Pursuant to Section 2-2-322, C.R.S., which requires legislative service agency review of legislative measures which include the creation or increase of any fee collected by a state agency, the following analysis is provided.

<table>
<thead>
<tr>
<th>Type of Fee</th>
<th>Current Fee</th>
<th>Proposed Fee</th>
<th>Fee Change</th>
<th># of Affected Individuals</th>
<th>Total Fee Impact</th>
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</thead>
<tbody>
<tr>
<td>License fees for various health professionals</td>
<td>$34 - $38</td>
<td></td>
<td>$0.85</td>
<td>24,400</td>
<td>$20,496</td>
</tr>
<tr>
<td>20% in FY 2006-07</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>License fees for various health professionals</td>
<td>$34 - $38</td>
<td></td>
<td>$0.85</td>
<td>97,600</td>
<td>$81,984</td>
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<tr>
<td>80% in FY 2007-08</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$102,480</td>
</tr>
</tbody>
</table>

The bill also increases one-time costs in the Department of Regulatory Agencies, Division of Insurance, which are funded from a diversion of premium tax revenue that would otherwise be credited to the General Fund. As a result, state General Fund revenues are anticipated to decrease $6,757 in FY 2005-06 and $20,904 in FY 2006-07. These moneys will instead be credited to the Division of Insurance Cash Fund.

State Expenditures
In the current fiscal year, the bill is estimated to increase state expenditures by $6,757. These costs will be paid from the Division of Insurance Cash Fund. In FY 2006-07, state expenditures are expected to increase $181,352. Of the FY 2006-07 total, $20,904 is Division of Insurance Cash Fund, $101,740 is Division of Registrations Cash Fund, and $58,708 is General Fund for the Department of Public Health and Environment. Following is a description of these expenditures.

<table>
<thead>
<tr>
<th>Table 2. Expenditure Detail</th>
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</thead>
<tbody>
<tr>
<td>Division of Insurance - Personal Services</td>
</tr>
<tr>
<td>Division of Registrations - Mailing Expenses</td>
</tr>
<tr>
<td>Subtotal Department of Regulatory Agencies</td>
</tr>
<tr>
<td>Department of Public Health and Environment - Personal Services &amp; Operating</td>
</tr>
<tr>
<td>Total Expenses</td>
</tr>
</tbody>
</table>

**Department of Regulatory Agencies, Division of Insurance.** The bill requires the Insurance Commissioner to convene a meeting of all interested parties by June, 15, 2006. At the meeting, the commissioner must be prepared to discuss the data to be collected, the method and time frames for collection and the objectives and standards for analysis. These requirements are expected to require 190 hours of staff time spread across numerous employees resulting in personal services expenses of $6,757 in FY 2005-06.

The bulk of the work related to this bill is anticipated in FY 2006-07. The division expects to identify sources to access required data, to determine how to collect the data, to create an online survey tool to collect required data from insurance carriers, to oversee data collection, and to review and cleanse the data. These one-time activities are expected to take 750 hours of staff time spread across numerous employees resulting in personal services expense of $20,904.

The fiscal note assumes that a nonprofit organization will analyze the data and prepare a report for the commissioner as allowed in the bill. If a nonprofit is not identified to complete this work, additional expenses would be expected.

**Department of Regulatory Agencies, Division of Registrations.** The bill directs the division to survey each licensed health care professional concerning charges billed to insurers and consumers in Pueblo County. Since a provider outside of Pueblo County may have patients in the county, the fiscal note assumes that all health professionals statewide (122,000) will be surveyed. An initial survey mailing and follow-up postcard are expected to cost $93,940 (122,000 x $0.77). A 16 percent return is anticipated, or 20,000 responses, resulting in additional postage costs of $7,800 (20,000 x $0.39). The total cost of mailing the survey to health professionals is estimated at $101,740 in FY 2006-07.
Department of Public Health and Environment. The bill directs the department to survey all licensed health facilities in Pueblo County for charges billed to health insurers and consumers. The fiscal note anticipates that the department will hire contractors to design the survey (80 hours) and to review and cleanse returned data (400 hours) at a cost of $54,400 due to the high level of skill and knowledge in data quality, statistics and medical billing practices required. In addition, 170 hours of administrative assistant time is expected to coordinate the survey mailing, respond to facility questions, collect survey responses, and contact facilities to assure survey completion. Additional expenses include project oversight (60 hours = $4,274) and mailing to 68 facilities ($34). Total one-time costs for the department of $58,708 in FY 2006-07 are anticipated.

State Appropriations

For FY 2005-06, the fiscal note indicates that the Department of Regulatory Agencies, Division of Insurance, should receive an appropriation of $6,757 cash funds from the Division of Insurance Cash Fund.

For FY 2006-07, the fiscal note indicates that the following appropriations are appropriate:

- Department of Regulatory Agencies - $20,904 cash funds from the Division of Insurance Cash Fund;
- Department of Regulatory Agencies - $101,740 cash funds from the Division of Registrations Cash Fund; and
- Department of Public Health and Environment - $58,708 General Fund.

Departments Contacted

Public Health and Environment  Regulatory Agencies
A BILL FOR AN ACT

CONCERNING THE TYPES OF HEALTH BENEFIT PLANS REQUIRED TO BE OFFERED BY SMALL EMPLOYER CARRIERS TO SMALL EMPLOYERS IN THE STATE.

Bill Summary

(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently adopted.)

Interim Committee on Health Insurance. Eliminates the requirement that small employer carriers offer a standard health benefit
plan to small employers in the state. Adds an additional benefit design option to the basic health benefit plan required to be offered by small employer carriers, allowing carriers to offer a basic health benefit plan with the same or similar benefit design as is available to a medical assistance recipient enrolled with a managed care organization under the statewide managed care system. Makes conforming amendments.

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

SECTION 1. 10-16-105 (5) (g), (7.2), (7.3) (a), (7.3) (c) (I), (7.3) (f), and (7.3) (g), the introductory portion to 10-16-105 (7.3) (i), and 10-16-105 (7.5) (b) and (11), Colorado Revised Statutes, are amended to read:

10-16-105. Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic health benefit plans - rules. (5) Each small group sickness and accident insurer or other entity shall make reasonable disclosure in solicitation and sales materials provided to small employers the following information in a form and manner prescribed by the commissioner and upon request of any such small employer shall provide such information in detail:

(g) (I) That the small employer purchasing any health benefit plan other than a basic plan pursuant to SUBPARAGRAPH (I) OR (III) OF paragraph (b) of subsection (7.2) of this section, must pay for all of the mandated benefits pursuant to section 10-16-104 and that these mandates include mandatory, nonwaivable coverages for newborn, maternity, pregnancy, childbirth, complications from pregnancy and childbirth, therapies for congenital defects and birth abnormalities, low-dose mammography, mental illness, biologically-based mental illness, the availability of alcoholism treatment, the availability of hospice care, prostate cancer screening, child health supervision, hospitalization and general anesthesia for dental procedures for dependent children, diabetes,
and prosthetic devices.

(II) That a small employer purchasing a basic health benefit plan as described in subparagraph (I) or (III) of paragraph (b) of subsection (7.2) of this section is waiving coverage for low-dose mammography screening, mental illness, prostate screening, hospitalization and general anesthesia for dental procedures for children, the availability of treatment for alcoholism, and the availability of hospice care.

(7.2) The commissioner shall promulgate rules to implement a basic health benefit plan and a standard health benefit plan to be offered by each small employer carrier as a condition of transacting business in this state. The commissioner shall survey small group carriers to determine the range of health benefit plans available annually. The commissioner shall implement a basic plan that approximates the lowest level of coverage offered in small group health benefit plans and shall implement a standard plan that approximates the average level of coverage offered in small group health benefit plans. In determining such levels of coverage, the commissioner shall consider such factors such as coinsurance, copayments, deductibles, out-of-pocket maximums, and covered benefits. The commissioner shall amend the rules to implement the basic and standard plans health benefit plans no more frequently than once every two years. Such the rules shall be in conformity with the provisions of article 4 of title 24, C.R.S., and shall incorporate the following basic health benefit plan designs:

(a) The standard health benefit plan shall reflect the benefit design of common plan offerings in the small group market and may reflect a plan design that has a deductible amount of two thousand five hundred dollars for which the covered person is responsible after the first
one thousand dollars of coverage has been provided by an employer in a manner similar to a personal care account; and

(b) (I) A basic health benefit plan may reflect a basic health benefit plan that does not include coverage pursuant to the mandatory coverage provisions of section 10-16-104 (4), (5), (8), (9), (10), and (12);

(II) A basic health benefit plan may reflect a health benefit plan that is a high deductible HEALTH plan that would qualify for a health savings account pursuant to 26 U.S.C. sec. 223; except that a carrier may apply deductible amounts for mandatory health benefits for mammography, prostate screening, child supervision services, or prosthetic devices pursuant to section 10-16-104 (4), (10), (11), and (14) if such mandatory benefits are not considered by the federal department of treasury to be preventive or to have an acceptable deductible amount; or

(III) A basic health benefit plan may reflect a basic health benefit plan that does not include coverage pursuant to the mandatory coverage provisions of section 10-16-104 (4), (5), (8), (9), (10), and (12) and is a high deductible plan that would qualify for a health savings account pursuant to 26 U.S.C. sec. 223; except that a carrier may apply deductible amounts for mandatory health benefits for mammography, prostate screening, child supervision services, or prosthetic devices pursuant to section 10-16-104 (4), (10), (11), and (14) if such mandatory benefits are not considered by the federal department of treasury to be preventive or to have an acceptable deductible amount; OR

(IV) A basic health benefit plan with the same or similar benefit design as is available to a medical assistance recipient enrolled with a managed care organization under the statewide managed care system in subpart 2 of part 1 of article 4 of title
(c) Notwithstanding any provision of law to the contrary, a small employer carrier may offer and a small employer may accept or reject coverage for employees' domestic partners and their dependents under a standard or basic health benefit plan.

(7.3) (a) Except as otherwise provided in this subsection (7.3), effective January 1, 1995 January 1, 2007, every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to such small employers the choice of a basic health benefit plan or a standard health benefit plan. Effective July 1, 1997 January 1, 2007, every small employer carrier shall also offer to small employers a choice of all the other small group plans the carrier markets in Colorado; except that this requirement shall not apply to a health benefit plan offered by a carrier if such plan is made available in the small group market only through one or more bona fide association plans and except as provided in paragraph (i) of this subsection (7.3).

(c) (i) A small employer carrier shall issue a basic health benefit plan, or a standard health benefit plan, except as provided in paragraph (i) of this subsection (7.3), to any eligible small employer that applies for such health benefit plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan that are consistent with this article. A small employer carrier shall also issue any of its other small employer plans to any small employer that applies for such a plan; except that this requirement shall not apply to a business group of one where the business group of one does not meet the carrier's normal and actuarially based underwriting criteria. The requirements of this paragraph (c) shall not apply to a health benefit plan offered by a carrier if such plan is made available in the small group...
market only through one or more bona fide association plans.

(f) Basic and standard health benefit plans offered by a small employer carrier shall be subject to the certification requirements of section 10-16-107.2.

(g) The commissioner may, at any time after providing notice and an opportunity for a hearing to a small employer carrier, disapprove the continued use by the small employer carrier of the basic health benefit plan and the standard health benefit plan on the grounds that such plans do not meet the requirements of this article.

(i) In lieu of accepting applications from and guarantee issuing the basic and standard plans HEALTH BENEFIT PLAN to business groups of one year round, small employer carriers may limit their issuance of coverage as provided in this paragraph (i). A small employer carrier may establish open enrollment periods for guarantee issued basic or standard HEALTH BENEFIT plan applications from business groups of one for a period of thirty-one days following the birth date of the person qualifying as a business group of one. A small employer carrier may establish annual open enrollment periods for business groups of one for thirty-one days following the birth date of the applicant and may limit issuance of a basic health benefit plan and a standard health benefit plan to such thirty-one-day period. Carrier marketing and sales materials for business groups of one shall clearly disclose the open enrollment period. If a person qualifying as a business group of one applies for coverage under a plan other than the basic or standard HEALTH BENEFIT plan, and if the business group of one is denied coverage as provided by law, then the small employer carrier shall offer the business group of one a choice of coverage under the basic or standard HEALTH BENEFIT plan during the applicant's appropriate open enrollment period. A small employer carrier
shall accept applications from business groups of one for a basic or standard HEALTH BENEFIT plan through the thirty-first day after the birth date of the person qualifying as a business group of one. The date upon receipt of the signed application and the applicant's birth date shall be used in determining whether the thirty-one day open enrollment applies to a particular person qualifying as a business group of one. Eligible dependents of such person may also be covered at the same time as the applicant. Small employer carriers that use open enrollment periods shall also accept applications from business groups of one and issue a basic or standard HEALTH BENEFIT plan as provided by law if such applications are submitted within thirty-one days of any one of the following events:

(7.5) (b) A small employer carrier shall not modify a basic health benefit plan or a standard health benefit plan with respect to a small employer or any eligible employee or dependent through a rider, endorsement, or otherwise, if the effect of such modification is to restrict or exclude coverage for certain diseases or medical conditions that are otherwise covered by such plan.

(11) The requirements contained in this section for small employer carriers to issue basic and standard health benefit plans shall terminate July 1, 2006, unless the general assembly acts by bill to extend such requirements beyond said date after conducting the review required in section 10-16-120:

SECTION 2. 10-3-1104 (1) (v), Colorado Revised Statutes, is amended to read:

10-3-1104. Unfair methods of competition and unfair or deceptive acts or practices. (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
(v) Failure to comply with all provisions of section 10-16-108.5 concerning fair marketing of basic and standard health benefit plans, and section 10-16-105 concerning guaranteed issue of basic and standard health benefit plans;

SECTION 3. 10-16-102 (7) and (43), Colorado Revised Statutes, are amended to read:

10-16-102. Definitions. As used in this article, unless the context otherwise requires:

(7) "Capped employees" means the number of employees and dependents with health problems at the time the plan of which such employees are a part was issued who are in small groups covered by the carrier where the small employer group would have failed the carrier's normal and actuarially based small group underwriting criteria specifically because of the health status of those employees with health problems at the time the plan was issued, but who were issued basic or standard health benefit plan coverage as required under section 10-16-105 (7.3) (c) regardless of the health status of the group. "Capped employees" only includes employees and dependents covered by a small employer group health benefit plan of a carrier at the time the carrier proposes to suspend its duty to issue basic or standard health benefit plan coverage as required under section 10-16-105 (7.3) (c).

(43) "Standard health benefit plan" means a health benefit plan developed pursuant to section 10-16-105 (7.2);

SECTION 4. 10-16-104 (11) (a) and (15), Colorado Revised Statutes, are amended to read:

10-16-104. Mandatory coverage provisions. (11) Child health supervision services. (a) For purposes of this subsection (11), unless the context otherwise requires, "child health supervision services"
means those preventive services and immunizations required to be
provided in a basic and standard health benefit plan pursuant to
section 10-16-105 (7.2), to dependent children up to age thirteen. Such
services shall be provided by a physician or pursuant to a physician's
supervision or by a primary health care provider who is a physician's
assistant or registered nurse who has additional training in child health
assessment and who is working in collaboration with a physician.

(15) Notwithstanding any provision to the contrary, a small
employer may purchase health benefit coverage that does not include the
coverage for benefits pursuant to subsections (4), (5), (8), (9), (10), and
(12) of this section through a basic health benefit plan pursuant to section
10-16-105 (7.2) (b) (I) AND (7.2) (b) (III).

SECTION 5. 10-16-105.2 (1) (c) (I) (D), Colorado Revised
Statutes, is amended to read:

10-16-105.2. Small employer health insurance availability
program. (1) (c) (I) The provisions of this article concerning small
employer carriers and small group plans shall not apply to an individual
health benefit plan newly issued to a business group of one that includes
only a self-employed person who has no employees, or a sole proprietor
who is not offering or sponsoring health care coverage to his or her
employees, together with the dependents of such a self-employed person
or sole proprietor if, pursuant to rules adopted by the commissioner, all
of the following conditions are met:

(D) As part of its application form, an individual carrier requires
a business group of one self-employed person purchasing an individual
health benefit plan pursuant to this subparagraph (I) to read and sign a
disclosure form stating that, by purchasing an individual policy instead of
a small group policy, such person gives up what would otherwise be his
or her right to purchase a business group of one standard, basic or other
health benefit plan from a small employer carrier for a period of three
years after the date the individual health benefit plan is purchased, unless
a small employer carrier voluntarily permits such person to purchase a
business group of one policy within such three-year period. The
disclosure form shall also briefly describe the factors used to set rates for
the individual policy being purchased in comparison with the factors used
to set rates for a business group of one small group policy. The
individual carrier shall provide to the business group of one
self-employed applicant a copy of the health benefit plan description form
for the Colorado standard health benefit plan in addition to the description
form for the individual plan being marketed. The disclosure form may be
included within any other certification form that the carrier uses for the
plan. The division of insurance shall make available a standard plan
description form to individual carriers upon request.

SECTION 6. 10-16-108 (1) (d) (1), (4) (a), and (4) (b) and the
introductory portion to 10-16-108 (4) (c), Colorado Revised Statutes, are
amended to read:

10-16-108. Conversion and continuation privileges.
(1) Group sickness and accident insurance - conversion privileges.
(d) (1) A converted policy issued upon the exercise of the conversion
privilege of paragraph (c) of this subsection (1) shall offer a choice of a
basic or standard health benefit plan.

(4) Special provisions for small group health benefit plans.
(a) Effective January 1, 1995, each small employer carrier shall, upon
termination of a group policy by the carrier or employer for reasons other
than replacement with another group policy or fraud and abuse in
procuring and utilizing coverage, offer to any individual the choice of a
basic or standard health benefit plan, except as provided in paragraph (b) of this subsection (4). Reasons for termination include, but are not limited to, the group no longer meeting participation requirements, cancellation due to nonpayment of premiums, or the policyholder exercising the right to cancel.

(b) If the group's original plan had benefits which were significantly less generous in most respects than the standard plan as determined by the commissioner, the carrier is only required to offer the basic health benefit plan to such group or individual. If an individual is eligible for continuation coverage or conversion coverage pursuant to this section 10-16-108 or is eligible for continuation coverage under federal law, then the provisions of paragraph (a) of this subsection (4) and this paragraph (b) shall not apply to such an individual.

(c) Each small employer carrier shall offer the choice of a basic or standard health benefit plan to any individual who loses nexus to existing small group coverage; except that:

SECTION 7. 10-16-108.5 (1) and (4), Colorado Revised Statutes, are amended to read:

10-16-108.5. Fair marketing standards. (1) Each small employer carrier shall actively market health benefit plan coverage, including the basic health benefit plan, and the standard health benefit plan, to eligible small employers in the state. If a small employer carrier denies coverage to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents, the carrier shall offer the small employer the opportunity to purchase a basic health benefit plan or a standard health benefit plan.

(4) A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the small
employer health reinsurance program, to a producer, if any, for the sale
of a basic or standard health benefit plan.

SECTION 8. Repeal. 10-16-120, Colorado Revised Statutes, is repealed as follows:

10-16-120. Legislative review of requirements for guaranteed
issue of basic and standard health benefit plans. (1) During the
regular session of the general assembly in the year 2001, the legislative
council of the general assembly shall conduct a review of the operation
of requirements contained in section 10-16-105 for small employer
carriers to issue basic and standard health benefit plans. Such review
shall consider, but not be limited to, the effect of such requirement on the
availability and affordability of health care coverage to residents of
Colorado. As a result of the review required by this subsection (1), the
legislative council may recommend to the general assembly any
legislation determined to be necessary based on such review:

(2) The requirements contained in section 10-16-105 for small
employer carriers to issue basic and standard health benefit plans shall
terminate July 1, 2006, unless the general assembly acts by bill to extend
said requirements beyond July 1, 2006:

SECTION 9. 10-16-902 (1) (c), Colorado Revised Statutes, is
amended to read:

10-16-902. Authority to self-fund - pilot program - rules - fees
- cash fund. (1) (c) A MEWA shall offer standard and a basic health
benefit plans PLAN AS defined in section 10-16-105 (7.2).

SECTION 10. 10-16-1002 (6) (b), Colorado Revised Statutes,
is amended to read:

10-16-1002. Definitions. As used in this part 10, unless the
context otherwise requires:
(6) (b) If, pursuant to section 10-16-1009 (3) (I), a cooperative provides coverage to individuals and allows individuals to join the cooperative, "member" may also include an individual and any dependent of such individual who is covered by a plan purchased through a cooperative, is eighteen years of age or older, and is not:

(I) Eligible for other coverage with benefits substantially similar to those included in the basic and standard health benefit plans PLAN; and

(II) A dependent of an individual who is eligible for other coverage with benefits substantially similar to those included in the basic and standard health benefit plans PLAN that covers that individual.

SECTION 11. 10-16-1011 (1) (e), Colorado Revised Statutes, is amended to read:

10-16-1011. Requirements for waiver of health care coverage cooperatives - rules. (1) The commissioner shall promulgate rules setting forth the application procedure for cooperatives seeking a waiver under this section that:

(e) Require the cooperative to offer, at a minimum, the basic and standard health benefit plans PLAN for employers with fifty or fewer employees that all participating carriers must offer. Other benefit plans and benefit packages may be established and offered by some or all carriers that contract with the cooperative, and such plans or packages may include a range of cost-sharing levels. Benefit packages may also include some variations for differences in delivery systems, such as health maintenance organizations, point-of-service plans, preferred provider plans, and fee-for-service plans.

SECTION 12. 10-16-1014 (1) (b), Colorado Revised Statutes, is amended to read:

10-16-1014. Technical assistance to authorized cooperatives
from the division of insurance. (1) Subject to available appropriations, the commissioner may provide technical assistance to any cooperative that:

(b) Requires that employer members not self-insure for any benefits included in the cooperative's basic health benefit plans PLAN;

SECTION 13. 26-19-107 (1) (a) (I), Colorado Revised Statutes, is amended to read:

26-19-107. Duties of the department - schedule of services - premiums - copayments - subsidies. (1) In addition to any other duties pursuant to this article, the department shall have the following duties:

(a) (I) To design, on or after April 21, 1998, and from time to time revise, a schedule of health care services included in the plan and to propose said schedule to the medical services board for approval or modification. The schedule of health care services as proposed by the department and approved by the medical services board shall include, but shall not be limited to, preventive care, physician services, prenatal care and postpartum care, inpatient and outpatient hospital services, prescription drugs and medications, and other services that may be medically necessary for the health of enrollees. The department shall design and revise this schedule of health care services included in the plan to be based upon the basic health benefit plans PLAN defined in section 10-16-102 (4), and (42), C.R.S.; except that the department may modify the basic health benefit plans PLAN to meet specific federal requirements or to accommodate those changes necessary for a program designed specifically for children.

SECTION 14. Effective date - applicability. (1) Except as provided in subsection (2) of this section, this act shall take effect January
1, 2007, and shall apply to basic health benefit plans offered on or after said date.

(2) Section 10-16-105 (11), Colorado Revised Statutes, as amended in section 1 of this act, and section 8 of this act shall take effect July 1, 2006, and shall apply to health benefit plans issued by small employer carriers on or after said date.

SECTION 15. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.
TITLE: CONCERNING THE TYPES OF HEALTH BENEFIT PLANS REQUIRED TO BE OFFERED BY SMALL EMPLOYER CARRIERS TO SMALL EMPLOYERS IN THE STATE.

Summary of Assessment

Under current law, the requirement for small group carriers to offer basic and standard health benefit plans terminates July 1, 2006. This Interim Committee on Health Insurance bill extends the requirement that small group sickness and accident insurance carriers offer a basic health benefit plan indefinitely. Effective January 1, 2007, the bill also adds a benefit design option allowing carriers to offer a plan with the same or similar benefits as is available to a Medicaid recipient enrolled with a managed care organization. The bill removes the current requirement for carriers to offer a standard health benefit plan.

The Department of Regulatory Agencies, Division of Insurance, anticipates a minimal amount of rule promulgation, but this is considered to be part of the division's ongoing workload. This bill is assessed as having no fiscal impact, and it is effective January 1, 2007, except the provision terminating the requirement for carriers to offer basic and standard health benefit plans which is repealed effective July 1, 2006.

Departments Contacted

Regulatory Agencies
A BILL FOR AN ACT

Concerning the creation of a program to provide premium subsidies to certain individuals enrolled in a qualifying health benefit plan.

Bill Summary

(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently adopted.)

Interim Committee on Health Insurance. Establishes the Colorado premium subsidy program (program) to provide premium...
subsidy payments to qualifying individuals enrolled in qualifying health benefit plans. Limits the scope of the program to counties with specified populations and the duration of the program to 5 years. Defines "qualifying individual" as a person:

- Who has been uninsured for the past 12 months;
- Whose employer has not provided group health insurance during the prior 12 months or whose employer provides group health insurance but who is unable to pay the employee portion of the premium associated with the employer-sponsored plan;
- Who resides in a household having a net household income no higher than 200% of the federal poverty level;
- Who, if enrolled in a high deductible plan that qualifies for a health savings account, has established a health savings account upon enrollment in a qualifying plan; and
- Who applies for reduced-price coverage under the program on or after January 1, 2007.

Defines "qualifying health benefit plan" as a health benefit plan that has a total premium that does not exceed $200 per month and is:

- A high deductible plan that would qualify for a health savings account; or
- A managed care plan with the same or similar benefit design as is available to a medical assistance recipient enrolled with a managed care organization under the statewide managed care system.

Requires the board of directors for the program, in cooperation with the commissioner of insurance, to further define the specifications of a qualifying plan.

Establishes a board of directors (board) to administer and operate the program. Authorizes the board to contract with an administrative carrier or 3rd-party administrator to perform the administrative functions of the program. Requires the board to submit to the commissioner of insurance an annual audited financial report of the program for the preceding calendar year.

Allows qualifying individuals to obtain a premium subsidy of 50% of the premium paid for coverage in a qualifying plan in which the individual enrolled on or after January 1, 2007. Caps the monthly premium subsidy per qualifying individual at $100. Requires premium subsidies to be paid directly to the qualifying individual's health savings account if the individual is enrolled in a high deductible plan that qualifies for a health savings account.

Establishes a procedure for the board to determine the total premium subsidies for a calendar year and to suspend new enrollment if funds are insufficient to meet the anticipated premium subsidy amount needed for the calendar year.

Establishes the Colorado premium subsidy program fund (fund),
consisting of a portion of moneys in the general fund exempt account. Allows up to 5% of the moneys in the fund to be used for program administrative costs, with the remaining moneys available for premium subsidies under the program.

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

**SECTION 1.** Article 16 of title 10, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PART to read:

**PART 11**

COLORADO PREMIUM SUBSIDY PROGRAM

**10-16-1101. Short title.** This PART 11 SHALL BE KNOWN AND MAY BE CITED AS THE "COLORADO PREMIUM SUBSIDY PROGRAM ACT".

**10-16-1102. Definitions.** As used in this PART 11, UNLESS THE CONTEXT OTHERWISE REQUIRES:

1. "ADMINISTERING CARRIER" MEANS THE CARRIER OR THIRD-PARTY ADMINISTRATOR DESIGNATED BY THE BOARD IN ACCORDANCE WITH SECTION 10-16-1106.

2. "BOARD" OR "PREMIUM SUBSIDY PROGRAM BOARD" MEANS THE BOARD OF DIRECTORS CREATED BY SECTION 10-16-1104.

3. "FUND" OR "PROGRAM FUND" MEANS THE COLORADO PREMIUM SUBSIDY PROGRAM FUND CREATED IN SECTION 10-16-1109.

4. "PROGRAM" OR "COLORADO PREMIUM SUBSIDY PROGRAM" MEANS THE PREMIUM SUBSIDY PROGRAM CREATED IN THIS PART 11, INCLUDING THE ADMINISTRATION AND IMPLEMENTATION OF PREMIUM SUBSIDIES FOR THE HEALTH BENEFIT PLANS AUTHORIZED BY THIS PART 11.

5. (a) "QUALIFYING HEALTH BENEFIT PLAN" OR "QUALIFYING PLAN" MEANS A HEALTH BENEFIT PLAN THAT HAS A TOTAL PREMIUM THAT DOES NOT EXCEED TWO HUNDRED DOLLARS PER MONTH AND IS:

1. A HIGH DEDUCTIBLE PLAN THAT WOULD QUALIFY FOR A
HEALTH SAVINGS ACCOUNT PURSUANT TO 26 U.S.C. SEC. 223; OR

(II) A MANAGED CARE PLAN WITH THE SAME OR SIMILAR BENEFIT DESIGN AS IS AVAILABLE TO A MEDICAL ASSISTANCE RECIPIENT ENROLLED WITH A MANAGED CARE ORGANIZATION UNDER THE STATEWIDE MANAGED CARE SYSTEM IN SUBPART 2 OF PART 1 OF ARTICLE 4 OF TITLE 26, C.R.S.

(b) The board, in cooperation with the commissioner, shall further define the specifications of a qualifying plan for purposes of this part 11.

(6) (a) "QUALIFYING INDIVIDUAL" MEANS A PERSON:

(I) WHO DOES NOT HAVE AND HAS NOT HAD HEALTH INSURANCE WITH BENEFITS ON AN EXPENSE-REIMBURSED OR PREPAID BASIS DURING THE TWELVE-MONTH PERIOD IMMEDIATELY PRECEDING THE INDIVIDUAL'S APPLICATION FOR REDUCED-PRICE COVERAGES UNDER THE PROGRAM ESTABLISHED BY THIS PART 11;

(II) (A) WHOSE EMPLOYER DOES NOT PROVIDE GROUP HEALTH INSURANCE AND HAS NOT PROVIDED GROUP HEALTH INSURANCE WITH BENEFITS ON AN EXPENSE-REIMBURSED OR PREPAID BASIS COVERING EMPLOYEES DURING THE TWELVE-MONTH PERIOD IMMEDIATELY PRECEDING THE INDIVIDUAL'S APPLICATION FOR REDUCED-PRICE COVERAGE UNDER THE PROGRAM ESTABLISHED BY THIS PART 11; OR

(B) WHOSE EMPLOYER PROVIDES GROUP HEALTH INSURANCE AS DESCRIBED IN SUB-SUBPARAGRAPH (A) OF THIS SUBPARAGRAPH (II), BUT WHO IS UNABLE TO PAY THE EMPLOYEE PORTION OF THE PREMIUM ASSOCIATED WITH THE EMPLOYER-SPONSORED PLAN;

(III) WHO RESIDES IN A HOUSEHOLD HAVING A NET HOUSEHOLD INCOME THAT IS NO HIGHER THAN TWO HUNDRED PERCENT OF THE FEDERAL POVERTY LEVEL, AS DEFINED AND UPDATED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, OR THE GROSS
EQUIVALENT OF SUCH NET INCOME LEVEL;

(IV) WHO, IF ENROLLED IN A QUALIFYING PLAN AS DESCRIBED IN
SUBPARAGRAPH (I) OF PARAGRAPH (a) OF SUBSECTION (5) OF THIS
SECTION, ESTABLISHES A HEALTH SAVINGS ACCOUNT UPON ENROLLMENT
IN THE QUALIFYING PLAN; AND

(V) WHO APPLIES FOR REDUCED-PRICE COVERAGE UNDER THE
PROGRAM ESTABLISHED BY THIS PART 11 ON OR AFTER JANUARY 1, 2007.

(b) A QUALIFYING INDIVIDUAL MAY ONLY RECEIVE COVERAGE
UNDER THE PROVISIONS OF THIS PART 11 FOR A MAXIMUM PERIOD OF FIVE
YEARS.

(c) THE REQUIREMENTS SET FORTH IN SUBPARAGRAPHS (II) AND
(III) OF PARAGRAPH (a) OF THIS SUBSECTION (6) SHALL NOT APPLY TO AN
INDIVIDUAL WHO HAD HEALTH INSURANCE COVERAGE DURING THE
IMMEDIATELY PRECEDING TWELVE MONTHS IF SUCH COVERAGE WAS
TERMINATED FOR ANY REASON OTHER THAN THE VOLUNTARY
TERMINATION OF SUCH COVERAGE BY THE INDIVIDUAL.

10-16-1103. Colorado premium subsidy program - creation.

(1) THERE IS HEREBY CREATED THE COLORADO PREMIUM SUBSIDY
PROGRAM, WHICH SHALL OPERATE AS A PILOT PROGRAM TO MAKE HEALTH
INSURANCE MORE AFFORDABLE FOR QUALIFYING INDIVIDUALS. THE PILOT
PROGRAM SHALL OPERATE IN ANY COUNTY IN THE STATE THAT HAS A
POPULATION, BASED ON THE 2000 FEDERAL CENSUS, OF:

(a) BETWEEN FORTY-THREE THOUSAND NINE HUNDRED AND
FORTY-FOUR THOUSAND PEOPLE; AND

(b) BETWEEN ONE HUNDRED SIXTEEN THOUSAND AND ONE
HUNDRED SIXTEEN THOUSAND FIVE HUNDRED PEOPLE.

(2) THE BOARD SHALL OPERATE THE COLORADO PREMIUM
SUBSIDY PROGRAM. THE PROGRAM SHALL BE AN INSTRUMENTALITY OF
THE STATE; EXCEPT THAT THE DEBTS AND LIABILITIES OF THE PROGRAM
SHALL NOT CONSTITUTE DEBTS AND LIABILITIES OF THE STATE, AND
NEITHER THE PROGRAM NOR THE BOARD SHALL BE AN AGENCY OF STATE
GOVERNMENT.

(3) FUNDING FOR THE COLORADO PREMIUM SUBSIDY PROGRAM
SHALL COME FROM THE COLORADO PREMIUM SUBSIDY PROGRAM FUND
CREATED IN SECTION 10-11-1109.

(4) THE COLORADO PREMIUM SUBSIDY PROGRAM SHALL OPERATE
AS A FIVE-YEAR PILOT PROGRAM THAT SHALL TERMINATE ON DECEMBER
31, 2011, UNLESS EXTENDED OR MADE PERMANENT BY THE GENERAL
ASSEMBLY.

(5) THE COLORADO PREMIUM SUBSIDY PROGRAM SHALL NOT BE
CONSTRUED TO BE AN ENTITLEMENT PROGRAM. THE TOTAL NUMBER OF
INDIVIDUALS AND HEALTH BENEFIT PLANS COVERED BY THE PROGRAM
SHALL NOT EXCEED THE FUNDING CAPACITY OF THE MONEYS AVAILABLE.

10-16-1104. Board of directors. (1) THERE IS HEREBY
CREATED THE BOARD OF DIRECTORS OF THE COLORADO PREMIUM SUBSIDY
PROGRAM, CONSISTING OF SEVEN MEMBERS APPOINTED BY THE GOVERNOR
WITH THE CONSENT OF THE SENATE. THE MEMBERS SHALL SERVE FOR
TERMS OF FOUR YEARS; EXCEPT THAT, OF THOSE MEMBERS INITIALLY
APPOINTED, THREE SHALL SERVE FOR TERMS OF TWO YEARS, TWO SHALL
SERVE FOR TERMS OF THREE YEARS, AND TWO SHALL SERVE FOR TERMS OF
FOUR YEARS. THE GOVERNOR SHALL APPOINT A QUALIFIED PERSON TO
FILL ANY VACANCY ON THE BOARD FOR THE REMAINDER OF ANY
UNEXPIRED TERM.

(2) THE BOARD MEMBERS SHALL BE APPOINTED AS FOLLOWS:

(a) FOUR SHALL BE REPRESENTATIVES OF CARRIERS, ONE OF
WHICH REPRESENTATIVES SHALL REPRESENT A HEALTH MAINTENANCE
ORGANIZATION, ONE OF WHICH SHALL REPRESENT A SICKNESS AND
ACCIDENT INSURANCE CARRIER, AND ONE OF WHICH SHALL REPRESENT A
STOP-LOSS OR EXCESS LOSS INSURANCE CARRIER;

(b) ONE SHALL BE A MEDICAL PROFESSIONAL;

(c) ONE SHALL BE AN INDIVIDUAL WHO IS NOT ASSOCIATED WITH
THE MEDICAL PROFESSION, ANY HOSPITAL, OR ANY CARRIER; AND

(d) ONE SHALL BE AN INSURANCE BROKER WHO SELLS BOTH
INDIVIDUAL AND SMALL GROUP HEALTH BENEFIT PLANS IN COLORADO.

(3) The commissioner or his or her designee and a member
of the general assembly shall serve as ex officio nonvoting
members of the board. The initial appointee of the general
assembly shall be a member of the senate appointed by the
president of the senate, the next appointee shall be a member of
the house of representatives appointed by the speaker of the
house of representatives, and thereafter such appointment
shall rotate in like manner between the senate and the house of
representatives.

(4) The board shall elect one of its members to serve as
chair.

(5) Any four members of the board shall constitute a
quorum for the purpose of transacting business and carrying
out the provisions of this part 11.

(6) Any member of the board may be removed by the
appointing authority for misconduct, incompetency, or neglect
of duty.

(7) A member of the board serving a four-year term shall
not serve for more than two consecutive terms.

(8) Members of the board shall serve without
COMPENSATION; EXCEPT THAT THEY SHALL BE REIMBURSED FOR ANY
ACTUAL AND NECESSARY EXPENSES INCURRED IN THE PERFORMANCE OF
THEIR DUTIES UNDER THIS PART 11, WITH MILEAGE RATES NOT TO EXCEED
THOSE AUTHORIZED FOR THE DIVISION OF INSURANCE.

10-16-1105. Board - powers and duties. (1) The board shall
be the governing body of the Colorado premium subsidy program
and shall have all powers necessary to implement this Part 11
and shall have the following specific authority to:

(a) Enter into such contracts as are necessary or proper
to carry out the provisions and purposes of this Part 11,
including the authority to enter into contracts with
appropriate administrative staff, consultants, and legal
counsel and to select and contract with the administering
carrier in accordance with Section 10-16-106. In addition, the
board shall have the authority, with the approval of the
commissioner, to enter into contracts with other states with
similar plans for the joint performance of common
administrative functions or with other persons or organizations
for the performance of administrative functions. No contract
entered into pursuant to this paragraph (a) shall be subject to
Article 103 of Title 24, C.R.S.

(b) Sue or be sued, including taking any legal action as
necessary or proper on behalf of the Colorado premium subsidy
program;

(c) Take such legal action as necessary to avoid the
payment of improper claims against the Colorado premium
subsidy program or to defend the coverage provided by or
through the program;
(d) ESTABLISH APPROPRIATE RATES FOR QUALIFYING INDIVIDUALS WHO ARE ELIGIBLE FOR A PREMIUM SUBSIDY PURSUANT TO SECTION 10-16-1108, AND ANY OTHER ACTUARIAL FUNCTIONS APPROPRIATE TO THE OPERATION OF THE COLORADO PREMIUM SUBSIDY PROGRAM;

(e) ESTABLISH PROCEDURES AND STANDARDS FOR PREMIUM SUBSIDIES TO QUALIFYING INDIVIDUALS COVERED UNDER QUALIFYING PLANS THE BOARD DEEMS APPROPRIATE TO ACCOMPLISH THE PURPOSES OF THIS PART 11. FOR THE PURPOSES OF ADMINISTERING THE PREMIUM SUBSIDIES UNDER THE COLORADO PREMIUM SUBSIDY PROGRAM, THE BOARD MAY REQUEST THE SUBMITTAL OF SUCH REASONABLE DOCUMENTATION BY QUALIFYING PLANS CONCERNING QUALIFYING INDIVIDUALS AND BY QUALIFYING INDIVIDUALS AS IT DEEMS NECESSARY.

(f) OVERSEE THE ISSUANCE OF POLICIES OF INSURANCE COVERING QUALIFYING INDIVIDUALS AND CERTIFICATES OR EVIDENCES OF COVERAGE IN ACCORDANCE WITH THE REQUIREMENTS OF THIS PART 11;

(g) APPOINT APPROPRIATE LEGAL, ACTUARIAL, AND OTHER COMMITTEES AS NECESSARY TO PROVIDE TECHNICAL ASSISTANCE IN THE OPERATION OF THE COLORADO PREMIUM SUBSIDY PROGRAM, POLICY DEVELOPMENT, AND OTHER CONTRACT DESIGN AND IN ANY OTHER FUNCTION WITHIN THE AUTHORITY OF THE PROGRAM;

(h) BORROW MONEY TO EFFECT THE PURPOSES OF THIS PART 11;

(i) ESTABLISH PROCEDURES FOR THE REASONABLE ADVANCE NOTICE TO INTERESTED PARTIES OF THE AGENDA FOR MEETINGS OF THE BOARD;

(j) ACCEPT AND EXPEND GIFTS, GRANTS, AND DONATIONS FOR OPERATION OF THE COLORADO PREMIUM SUBSIDY PROGRAM. MONEYS FROM SUCH GIFTS, GRANTS, AND DONATIONS SHALL BE TRANSMITTED TO THE STATE TREASURER AND CREDITED TO THE COLORADO PREMIUM
(k) Develop procedures for handling and accounting for the funds and other assets of the Colorado Premium Subsidy Program, including records of all financial transactions and an annual fiscal report to the Commissioner;

(l) Develop procedures for selection of an administering carrier as provided in Section 10-16-1106;

(m) Develop procedures to establish and maintain public awareness of the Colorado Premium Subsidy Program, including its eligibility requirements and enrollment procedures;

(n) Develop procedures to ensure public knowledge concerning availability of the Colorado Premium Subsidy Program;

(o) Establish regular times and places for meetings of the Board;

(p) Develop procedures under which applicants and participants can report grievances to the Board, which grievances shall be fairly and impartially considered, and administrative remedies for such grievances; and

(q) Establish any other provisions necessary to implement this Part 11.

(2) An applicant or participant reporting a grievance pursuant to paragraph (p) of subsection (1) of this section shall exhaust all administrative remedies as set forth by the Board before the grievance may be the basis for legal action. The venue for any legal action involving the Colorado Premium Subsidy Program shall be the City and County of Denver. Nothing in this subsection (2) shall prohibit the Board from
REQUIRING BINDING ARBITRATION FOR THE FINAL ADJUDICATION OF ANY
GRIEVANCE.

(3) FOR ANY ACT PERFORMED WITHIN THE COURSE AND SCOPE OF
AUTHORITY UNDER THIS PART II, THE BOARD, THE INDIVIDUAL MEMBERS
OF THE BOARD, AND THE EMPLOYEES AND AGENTS OF THE BOARD SHALL
BE ENTITLED TO THE IMMUNITY GRANTED PURSUANT TO SECTION
24-10-106, C.R.S., UNLESS SUCH ACT OR OMISSION CONSTITUTES WILLFUL
AND WANTON MISCONDUCT.

10-16-1106. Administering carrier. (1) The administering
carrier shall perform all administrative, eligibility, and claims
payment functions relating to the Colorado premium subsidy
program, including:

(a) Assuring timely payment of premium subsidies to
qualifying individuals, including:

(I) Making available information relating to the proper
manner of submitting claims for premium subsidies; and

(II) Evaluating the eligibility of each claim for premium
subsidy pursuant to guidelines established by the board;

(b) Submitting regular reports to the board regarding
the operation of the program. The frequency, content, and form
of the reports shall be as determined by the board.

(c) Determining the expense of administration and the
paid and incurred losses for each year and reporting such
information to the board and the commissioner in a form and
manner prescribed by the commissioner.

(2) The board shall establish its own competitive bidding
process to select a carrier or third-party administrator to
serve as the administering carrier and to select one or more
VENDORS TO PROVIDE SERVICES THAT MAY BE NECESSARY TO ADMINISTER
THE COLORADO PREMIUM SUBSIDY PROGRAM. THE BOARD SHALL
EVALUATE BIDS SUBMITTED BASED ON THE CRITERIA IT ESTABLISHES AND
SHALL NOT BE SUBJECT TO THE PROVISIONS OF ARTICLE 103 OF TITLE 24,
C.R.S., IN MAKING SUCH SELECTIONS.

(3) THE ADMINISTERING CARRIER SHALL SERVE FOR A PERIOD OF
THREE YEARS, SUBJECT TO REMOVAL FOR CAUSE. AT LEAST ONE YEAR
PRIOR TO THE EXPIRATION OF THE THREE-YEAR PERIOD OF SERVICE, THE
BOARD SHALL INVITE ALL INTERESTED PARTIES, INCLUDING THE CURRENT
ADMINISTERING CARRIER, TO SUBMIT BIDS TO SERVE AS THE
ADMINISTERING CARRIER FOR THE REMAINING TWO YEARS OF THE
PROGRAM. SELECTION OF THE ADMINISTERING CARRIER FOR THE
REMAINING TWO YEARS SHALL BE MADE AT LEAST SIX MONTHS PRIOR TO
THE END OF THE INITIAL THREE-YEAR PERIOD.

(4) THE ADMINISTERING CARRIER SHALL BE PAID AS PROVIDED
FOR BY THE BOARD.


(1) Not later than March 1, 2008, and by March 1 of each
succeeding year, the board shall submit an audited financial
report for the Colorado premium subsidy program for the
preceding calendar year to the commissioner in a form provided
or prescribed by the commissioner.

(2) The financial status of the Colorado premium subsidy
program shall be subject to examination by the commissioner or
the commissioner’s designee. Such examinations shall be
conducted at least once every five years.

10-16-1108. Colorado premium subsidy program - eligibility
for subsidy payments. (1) The board shall establish a program
FOR ADMINISTERING PREMIUM SUBSIDIES FOR QUALIFIED INDIVIDUALS WHO APPLY FOR COVERAGE ON OR AFTER JANUARY 1, 2007, UNDER A QUALIFYING PLAN.

(2) The premium subsidy shall be fifty percent of the premium for the qualifying plan, not to exceed one hundred dollars per month per qualifying individual.

(3) Premium subsidies shall be paid from the Colorado premium subsidy program fund to the carrier providing a qualifying plan to the qualifying individual. If the qualifying individual is enrolled in a qualifying plan as described in section 10-16-1102 (5) (a) (I), the qualifying individual shall pay the entire premium to the carrier, and the premium subsidy shall be paid directly to the qualifying individual's health savings account.

(4) (a) The board shall determine the total premium subsidies for the calendar year for which subsidies are paid.

(b) If the funds available for distribution for premium subsidies paid during a calendar year exceed the total amount of subsidies during that same calendar year, any excess funds shall be carried forward and made available for distribution in the next calendar year.

(c) Upon the request of the board, the qualifying plan carrier shall be required to furnish data the board deems necessary to oversee the operation of the Colorado premium subsidy program. The data shall be furnished in a form prescribed by the board. The carrier shall provide the board with monthly reports of the total enrollment in the qualifying plan. The reports shall be in a form prescribed by the board.
(d) The board shall separately estimate the per-insured annual cost of all subsidies for qualifying plans based upon available data and appropriate actuarial assumptions.

(e) The board shall determine the total eligible enrollment under qualifying plans. The total eligible enrollment shall be determined by dividing the amount of moneys available for distribution from the Colorado premium subsidy program fund for premium subsidies by the estimated per-insured annual cost of all premium subsidies from the program fund.

(f) The board shall suspend the enrollment of new insureds in qualifying plans if it determines that the total enrollment reported by carriers exceeds the total eligible enrollment, thereby resulting in anticipated annual expenditures from the Colorado premium subsidy program fund in excess of the moneys available for distribution.

(g) If, at any point during a suspension of enrollment, the board determines that funds are sufficient to provide for the addition of new enrollments, the board may again accept new enrollments.

(h) The suspension of enrollment in qualifying plans shall not preclude the addition of new dependents of individuals already covered under such plans.

10-16-1109. Colorado premium subsidy program fund - creation. (1) (a) There is hereby created in the state treasury the Colorado premium subsidy program fund. The fund shall consist of moneys credited thereto pursuant to this part 11.

(b) In fiscal year 2005-06, and each of the four fiscal
YEARS THEREAFTER, IF THE MOST RECENT LEGISLATIVE COUNCIL STAFF ECONOMIC AND REVENUE FORECAST ESTIMATES THAT THE GENERAL FUND EXEMPT ACCOUNT, CREATED IN SECTION 24-77-103.6 (2), C.R.S., WILL RECEIVE MORE THAN ONE HUNDRED FIFTEEN MILLION DOLLARS, FIFTEEN MILLION DOLLARS OF THE MONEYS IN THE GENERAL FUND EXEMPT ACCOUNT SHALL BE APPROPRIATED TO THE COLORADO PREMIUM SUBSIDY PROGRAM FUND CREATED IN THIS SUBSECTION (1).

(c) All moneys appropriated to the Colorado premium subsidy program fund shall be used as provided in this part 11 and shall not be deposited in or transferred to the general fund of this state or to any other fund. Notwithstanding any provision of section 24-36-114, C.R.S., to the contrary, all interest derived from the deposit and investment of moneys in the program fund shall be credited to the program fund.

(2) (a) Of the moneys in the Colorado premium subsidy program fund, no more than five percent shall be used for program administrative costs, including administrative costs of the division of insurance.

(b) The moneys remaining in the Colorado premium subsidy program fund after the payment of program administrative costs shall be used for premium subsidy payments under section 10-16-1108.

SECTION 2. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.
**Fiscal Impact**

<table>
<thead>
<tr>
<th>Fiscal Impact Summary</th>
<th>FY 2005-06</th>
<th>FY 2006-07</th>
<th>FY 2007-08</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Revenues</td>
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<td>Cash Funds Exempt - Colorado Premium Subsidy Program Fund</td>
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<td>15,000,000</td>
<td>15,000,000</td>
</tr>
<tr>
<td>Cash Funds Exempt - Dept. of Regulatory Agencies*</td>
<td>9,721</td>
<td>7,616</td>
<td></td>
</tr>
<tr>
<td>FTE Position Change</td>
<td>0.0 FTE</td>
<td>0.0 FTE</td>
<td>0.0 FTE</td>
</tr>
</tbody>
</table>

**Effective Date:** Upon Signature of the Governor

**Appropriation Summary for FY 2005/2006:**
Colorado Premium Subsidy Program Cash Fund: $15,000,000 GFE

**Appropriation Summary for FY 2006/2007:**
Colorado Premium Subsidy Program Cash Fund: $15,000,000 GFE
Department of Regulatory Agencies: $9,721 CFE*

**Local Government Impact:** None

*These amounts are included in the $15 million transfer to the Colorado Premium Subsidy Program Fund.

**Summary of Legislation**

This Interim Committee on Health Insurance bill creates the Colorado Premium Subsidy five-year pilot program (program) with the purpose of making health insurance more affordable for qualifying individuals. The program shall operate in La Plata and Mesa counties only, and it is funded through five annual appropriations of $15 million General Fund Exempt to the Colorado Premium Subsidy Program Fund starting in the current fiscal year. Interest earned from the deposit and investment of these moneys is credited to the fund. The total number of individuals and plans covered by the program shall not exceed the funding of the program. Thus, this is not an entitlement.
program, and enrollment may be suspended if necessary. The pilot program ends on December 31, 2011.

Starting January 1, 2007, qualified individuals can receive a subsidy toward a qualifying health benefit plan of 50 percent of the premium, up to $100 per month, per person. To qualify for the program for up to five years, individuals must meet the following requirements:

- been uninsured during the prior 12 months;
- be unable to pay the employee portion of an employer sponsored plan or not be offered an employer sponsored plan;
- have household income less than 200 percent of the federal poverty level; and
- establish a health savings account if enrolled in a high deductible plan.

The bill creates a seven-member board of directors to be the governing body of the program. The board has broad powers including the ability to enter contracts, take legal action, and establish procedures to implement the program. The board must submit an annual audited financial report of the program to the Insurance Commissioner, and the program is subject to examination by the commissioner at least once every five years. The bill limits administrative costs to 5 percent of the Colorado Premium Subsidy Program Fund, or $750,000 the first year.

**State Revenues**

For FY 2005-06, and each year through FY 2009-10, the bill requires an appropriation of $15 million from the General Fund Exempt account to the Colorado Premium Subsidy Program fund if the most recent Legislative Council Staff Forecast estimates that the General Fund Exempt account will receive more than $115 million for that year. The December 2005 LCS forecast shows sufficient funds in the General Fund Exempt account to fund the program through FY 2010-11.

**State Expenditures**

For FY 2005-06, no expenditures are anticipated. In FY 2006-07 and future years, expenses are anticipated for insurance premium subsidies and administrative costs as described below.

**Administrative costs.** In FY 2006-07, expenses of $504,721 are anticipated. Of the total, $495,000 cash fund exempt is for program expenses and $9,721 cash fund exempt is for the Department of Regulatory Agencies. The bill limits administrative expense to five percent of the program fund balance or $750,000 in FY 2006-07. Following is a description of anticipated expenses:

- **Program Board.** The board requires an estimated $495,000 in FY 2006-07 and $520,000 in FY 2007-08 for administrative costs. Expenditures are necessary for actuarial work, contracting with an administering carrier, marketing, legal assistance, board support and general administration.
• **Department of Regulatory Agencies, Division of Insurance.** The division requires an estimated $9,721 in FY 2006-07 and $7,616 in FY 2007-08. Expenditures are anticipated for rule promulgation, reviewing annual reports, responding to consumer complaints, and performing a financial exam. This work is expected to be spread among numerous employees without the need for new FTE.

**Insurance Premium Subsidies.** Starting January 1, 2007, qualifying individuals are eligible for health insurance premium subsidies. The board must determine total premium subsidies each year, and up to $14.2 million is designated for premium subsidies in FY 2006-07. If premium subsidies do not reach the limit, excess funds remain in the program fund.

**State Appropriations**

For FY 2005-06, the bill directs $15 million General Fund Exempt be appropriated to the Colorado Premium Subsidy Program Fund.

For FY 2006-07, the bill directs $15 million General Fund Exempt be appropriated to the Colorado Premium Subsidy Program Fund. Out of those funds, the Department of Regulatory Agencies should receive an appropriation of $9,721 cash funds exempt.

**Departments Contacted**

Regulatory Agencies       Treasury