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0543 Interim Committee on Health Insurance



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**

COLORADO GENERAL ASSEMBLY



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December 2005

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

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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

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Chair

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Senator Maryanne Keller
Senator Andy McElhany
Senator Brandon Shaffer

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EXECUTIVE SUMMARY

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 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 s 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.

STATUTORY AUTHORITY AND RESPONSIBILITIES

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).

COMMITTEE ACTIVITIES

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 down sides, 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 January 1, 2007.

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.

No committee recommendation. The committee made no recommendations regarding HIT.

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

Meeting Summaries

Topics Discussed

July 28, 2005	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.
August 10, 2005	Reinsurance programs in other states; types of reinsurance programs; Senate Bill 05-237 - Healthy Business Healthy People Program; reinsurance and CoverColorado.
August 22, 2005	Health savings accounts; network adequacy; participating and nonparticipating providers; Senate Bill 05-227; expanding the state employees' health insurance program.
September 7, 2005	Primary and preventative care networks; sunseting the basic and standard plans; health savings accounts; health reimbursement arrangements; expanding the Colorado Medicaid program; individual and employer health insurance mandates.
September 22, 2005	Health information technology in Colorado; expanding the Colorado Medicaid program; discussion of proposed legislation.
October 6, 2005	Finalization of proposed legislation.

Memoranda and Reports

Overview of the Interim Committee to Study Health Insurance; Memorandum prepared by Legislative Council Staff, July 25, 2005.

Bill A

Second Regular Session
Sixty-fifth General Assembly
STATE OF COLORADO

DRAFT

LLS NO. 06-0140.01 Kristen Forrestal

SENATE BILL

SENATE SPONSORSHIP

Keller, and Shaffer

HOUSE SPONSORSHIP

Green, and Boyd

Senate Committees

House Committees

A BILL FOR AN ACT

101 CONCERNING THE EXPANSION OF THE AVAILABILITY OF AFFORDABLE
102 HEALTH CARE COVERAGE FOR COLORADANS, AND, IN
103 CONNECTION THEREWITH, CREATING THE HEALTHY BUSINESS
104 HEALTHY PEOPLE PROGRAM AND MAKING AN APPROPRIATION
105 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

DRAFT

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.

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

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

4 PART 7

5 **HEALTHY BUSINESS HEALTHY PEOPLE PROGRAM**

6 **10-8-701. Short title.** THIS PART 7 SHALL BE KNOWN AND MAY
7 BE CITED AS THE "HEALTHY BUSINESS HEALTHY PEOPLE PROGRAM ACT".

1 **10-8-702. Legislative declaration.** (1) THE GENERAL
2 ASSEMBLY HEREBY FINDS, DETERMINES, AND DECLARES THAT:

3 (a) ALL COLORADO CITIZENS DESERVE TO HAVE ACCESS TO
4 AFFORDABLE, COMPREHENSIVE HEALTH INSURANCE AND QUALITY HEALTH
5 CARE;

6 (b) INDIVIDUALS, FAMILIES, AND SMALL BUSINESSES DESERVE TO
7 HAVE PREDICTABLE, STABLE COSTS FOR HEALTH CARE FROM ONE YEAR TO
8 THE NEXT;

9 (c) SMALL BUSINESSES ARE THE BACKBONE OF OUR ECONOMY
10 AND MUST NOT BE ASKED TO DISPROPORTIONATELY BEAR THE BURDEN OF
11 PROVIDING HEALTH INSURANCE;

12 (d) BETWEEN 1996 AND 2002, SMALL BUSINESS HEALTH
13 INSURANCE PREMIUMS INCREASED MORE THAN EIGHTY PERCENT, BOTH
14 NATIONALLY AND IN COLORADO;

15 (e) LESS THAN FIFTY PERCENT OF COLORADO SMALL BUSINESSES
16 OFFER HEALTH INSURANCE;

17 (f) MOST LOW-INCOME WORKING COLORADANS WHO ARE NOT
18 OFFERED HEALTH INSURANCE AT THE WORKPLACE AND WHO HAVE
19 PREEXISTING CONDITIONS CANNOT OBTAIN COVERAGE IN THE PRIVATE
20 MARKET AND CANNOT AFFORD THE HIGH COST OF COVERAGE MADE
21 AVAILABLE TO UNINSURABLE INDIVIDUALS THROUGH THE
22 COVERCOLORADO PROGRAM;

23 (g) REINSURANCE POLICIES HAVE BEEN PROVEN TO LOWER THE
24 COST OF INSURANCE FOR SMALL EMPLOYERS BY PROVIDING ADDITIONAL
25 COVERAGE FOR THOSE AT HIGHEST RISK;

26 (h) THE PURPOSE OF THIS PART 7 IS TO MAKE STANDARDIZED,
27 LOW-COST HEALTH INSURANCE CONTRACTS AVAILABLE TO QUALIFYING
28 SMALL EMPLOYERS AND QUALIFYING INDIVIDUALS AS DEFINED IN THIS

1 PART 7. THIS PART 7 IS DESIGNED TO ENCOURAGE SMALL EMPLOYERS TO
2 OFFER HEALTH INSURANCE COVERAGE TO THEIR EMPLOYEES AND ALSO TO
3 MAKE AFFORDABLE COVERAGE AVAILABLE TO UNINSURED INDIVIDUALS
4 WHOSE EMPLOYERS DO NOT PROVIDE GROUP HEALTH INSURANCE.

5 **10-8-703. Definitions.** AS USED IN THIS PART 7, UNLESS THE
6 CONTEXT OTHERWISE REQUIRES:

7 (1) "ADMINISTERING CARRIER" MEANS THE CARRIER OR
8 THIRD-PARTY ADMINISTRATOR DESIGNATED IN THIS PART 7.

9 (2) "BASIC HEALTH BENEFIT PLAN" MEANS THE BASIC HEALTH
10 BENEFIT PLAN PROMULGATED BY RULE OF THE COMMISSIONER PURSUANT
11 TO SECTION 10-16-105 (7.2), AS SUCH RULE WAS EFFECTIVE ON DECEMBER
12 1, 2004.

13 (3) "BOARD" MEANS THE BOARD OF DIRECTORS FOR
14 COVERCOLORADO, CREATED IN SECTION 10-8-505.

15 (4) "BUSINESS GROUP OF ONE" SHALL HAVE THE SAME MEANING
16 AS SET FORTH IN SECTION 10-16-102 (6).

17 (5) "CARRIER" SHALL HAVE THE SAME MEANING AS SET FORTH IN
18 SECTION 10-16-102 (8).

19 (6) "COMMISSIONER" MEANS THE COMMISSIONER OF INSURANCE
20 OR THE COMMISSIONER'S DESIGNEE.

21 (7) "COVERCOLORADO" MEANS THE PROGRAM ESTABLISHED IN
22 PART 5 OF THIS ARTICLE.

23 (8) "EXPANDED BOARD" MEANS THE EXPANDED BOARD
24 CONSTITUTED PURSUANT TO SECTION 10-8-705.

25 (9) "GROUP HEALTH PLAN" SHALL HAVE THE SAME MEANING AS
26 SET FORTH IN SECTION 10-16-105.5 (1) (a).

27 (10) "HEALTH BENEFIT PLAN" SHALL HAVE THE SAME MEANING
28 AS SET FORTH IN SECTION 10-16-102 (21).

1 (11) "PROGRAM" OR "HEALTHY BUSINESS HEALTHY PEOPLE"
2 MEANS THE HEALTHY BUSINESS HEALTHY PEOPLE PROGRAM, INCLUDING
3 THE ADMINISTRATION AND IMPLEMENTATION OF REINSURANCE AND
4 PREMIUM SUBSIDIES FOR THE HEALTH BENEFIT PLANS PERMITTED UNDER
5 THIS PART 7.

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

7 (I) WHO MEETS THE DEFINITION OF AN "ELIGIBLE INDIVIDUAL"
8 FOR THE COVERCOLORADO PROGRAM, AS DEFINED IN SECTION 10-8-503
9 (5);

10 (II) WHO DOES NOT HAVE AND HAS NOT HAD HEALTH INSURANCE
11 WITH BENEFITS ON AN EXPENSE-REIMBURSED OR PREPAID BASIS DURING
12 THE TWELVE-MONTH PERIOD IMMEDIATELY PRECEDING THE INDIVIDUAL'S
13 APPLICATION FOR REDUCED-PRICE COVERCOLORADO COVERAGES UNDER
14 THE PROGRAM ESTABLISHED BY THIS PART 7;

15 (III) WHOSE EMPLOYER DOES NOT PROVIDE GROUP HEALTH
16 INSURANCE AND HAS NOT PROVIDED GROUP HEALTH INSURANCE WITH
17 BENEFITS ON AN EXPENSE-REIMBURSED OR PREPAID BASIS COVERING
18 EMPLOYEES DURING THE TWELVE-MONTH PERIOD IMMEDIATELY
19 PRECEDING THE INDIVIDUAL'S APPLICATION FOR REDUCED-PRICE
20 COVERCOLORADO COVERAGE UNDER THE PROGRAM ESTABLISHED BY THIS
21 PART 7;

22 (IV) WHO RESIDES IN A HOUSEHOLD HAVING A NET HOUSEHOLD
23 INCOME THAT IS NO HIGHER THAN AN AMOUNT SET BY THE EXPANDED
24 BOARD; EXCEPT THAT SUCH AMOUNT SHALL NOT EXCEED THREE HUNDRED
25 FIFTY PERCENT OF THE NON-FARM FEDERAL POVERTY LEVEL, AS DEFINED
26 AND UPDATED BY THE UNITED STATES DEPARTMENT OF HEALTH AND
27 HUMAN SERVICES, OR THE GROSS EQUIVALENT OF SUCH NET INCOME; AND

28 (V) WHO APPLIES FOR REDUCED-PRICE COVERCOLORADO

1 COVERAGE UNDER THE PROGRAM ESTABLISHED BY THIS PART 7 ON OR
2 AFTER JANUARY 1, 2007.

3 (b) THE REQUIREMENTS SET FORTH IN SUBPARAGRAPHS (II) AND
4 (III) OF PARAGRAPH (a) OF THIS SUBSECTION (12) SHALL NOT APPLY TO AN
5 INDIVIDUAL WHO HAD HEALTH INSURANCE COVERAGE DURING THE
6 IMMEDIATELY PRECEDING TWELVE MONTHS IF SUCH COVERAGE WAS
7 TERMINATED FOR ANY REASON OTHER THAN THE VOLUNTARY
8 TERMINATION OF SUCH COVERAGE BY THE INDIVIDUAL.

9 (13) (a) "QUALIFYING SMALL EMPLOYER" MEANS A SMALL
10 EMPLOYER THAT HAS NO MORE THAN FIVE EMPLOYEES, AT LEAST TWO OF
11 WHOM EARN ANNUAL WAGES OF TWENTY-EIGHT THOUSAND DOLLARS OR
12 LESS, OR A BUSINESS GROUP OF ONE WHOSE NET ANNUAL INCOME FROM
13 THE BUSINESS IS TWENTY-EIGHT THOUSAND DOLLARS OR LESS, AND THAT
14 MEETS ALL OF THE FOLLOWING CRITERIA:

15 (I) AT LEAST ONE OF THE EMPLOYEES RECEIVING ANNUAL WAGES
16 OF TWENTY-EIGHT THOUSAND DOLLARS OR LESS IS ELIGIBLE FOR AND IS
17 OFFERED QUALIFYING PLAN COVERAGE.

18 (II) AT LEAST ONE OF THE EMPLOYEES DESCRIBED IN
19 SUBPARAGRAPH (I) OF THIS PARAGRAPH (a) ACCEPTS THE QUALIFYING
20 PLAN COVERAGE OFFERED TO THEM.

21 (III) THE EMPLOYER PAYS AT LEAST FIFTY PERCENT OF THE
22 PREMIUMS FOR EMPLOYEES COVERED UNDER A QUALIFYING PLAN.

23 (IV) THE EMPLOYEE CONTRIBUTION, IN DOLLARS, IS THE SAME
24 FOR ALL COVERED EMPLOYEES.

25 (b) THE EXPANDED BOARD SHALL ADJUST THE
26 TWENTY-EIGHT-THOUSAND-DOLLAR FIGURE REFERRED TO IN PARAGRAPH
27 (a) OF THIS SUBSECTION (13) PERIODICALLY, BUT NO MORE THAN ONCE
28 EACH YEAR, TO REFLECT INCREASES OR DECLINES IN THE AVERAGE WAGE

1 RATE IN COLORADO.

2 (14) "QUALIFYING SMALL EMPLOYER PLAN" OR "QUALIFYING
3 PLAN" MEANS A BASIC HEALTH BENEFIT PLAN OR A STANDARD HEALTH
4 BENEFIT PLAN THAT PROVIDES COVERAGE THROUGH A HEALTH
5 MAINTENANCE ORGANIZATION OR PREFERRED PROVIDER ORGANIZATION.

6 (15) "SMALL EMPLOYER" SHALL HAVE THE SAME MEANING AS SET
7 FORTH IN SECTION 10-16-102 (40).

8 (16) "SMALL EMPLOYER CARRIER" SHALL HAVE THE SAME
9 MEANING AS SET FORTH IN SECTION 10-16-102 (41).

10 (17) "STANDARD HEALTH BENEFIT PLAN" MEANS THE BASIC
11 HEALTH BENEFIT PLAN PROMULGATED BY RULE OF THE COMMISSIONER
12 PURSUANT TO SECTION 10-16-105 (7.2), AS SUCH RULE WAS EFFECTIVE ON
13 DECEMBER 1, 2004.

14 **10-8-704. Healthy business healthy people program - creation**
15 **- pilot program.** (1) THERE IS HEREBY CREATED THE HEALTHY BUSINESS
16 HEALTHY PEOPLE PROGRAM, WHICH SHALL OPERATE A PILOT REINSURANCE
17 PROGRAM TO LOWER THE COST OF HEALTH INSURANCE FOR QUALIFYING
18 SMALL BUSINESSES AND A PREMIUM SUBSIDY PROGRAM FOR QUALIFYING
19 INDIVIDUALS.

20 (2) THE BOARD AND THE EXPANDED BOARD SHALL OPERATE THE
21 PROGRAM. THE PROGRAM IS AN INSTRUMENTALITY OF THE STATE; EXCEPT
22 THAT THE DEBTS AND LIABILITIES OF THE PROGRAM SHALL NOT
23 CONSTITUTE DEBTS AND LIABILITIES OF THE STATE, AND THE PROGRAM,
24 THE BOARD, AND THE EXPANDED BOARD SHALL NOT BE AGENCIES OF
25 STATE GOVERNMENT.

26 (3) FUNDING FOR THE PROGRAM SHALL COME FROM THE HEALTHY
27 BUSINESS HEALTHY PEOPLE FUND, CREATED IN SECTION 10-8-710.

28 (4) THE PROGRAM SHALL OPERATE AS A FIVE-YEAR PILOT

1 PROGRAM THAT SHALL TERMINATE ON DECEMBER 31, 2011, UNLESS
2 EXTENDED OR MADE PERMANENT BY THE GENERAL ASSEMBLY.

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

7 **10-8-705. Expanded board - powers and duties -**
8 **recommendations from legislative interim committee created in**
9 **Senate Joint Resolution 05-036.** (1) (a) THE EXPANDED BOARD SHALL
10 CONSIST OF SIX MEMBERS WHO HAVE BOOKKEEPING, ACCOUNTING, OR
11 ACTUARIAL EXPERIENCE. OF SUCH SIX MEMBERS, ONE SHALL BE A
12 REPRESENTATIVE OF SMALL EMPLOYER CARRIERS, TWO SHALL BE
13 REPRESENTATIVES OF SMALL EMPLOYERS WITH NO MORE THAN FIVE
14 EMPLOYEES, TWO SHALL BE EMPLOYEES OF A SMALL EMPLOYER WITH FIVE
15 OR FEWER EMPLOYEES WHO IS NOT A BUSINESS GROUP OF ONE, AND ONE
16 SHALL BE AN INSURANCE BROKER WHO SELLS BOTH INDIVIDUAL AND
17 SMALL GROUP HEALTH BENEFIT PLANS IN COLORADO.

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

25 (c) THE SMALL EMPLOYER MEMBERS SHALL BE APPOINTED BY THE
26 PRESIDENT OF THE SENATE, AND THE EMPLOYEE MEMBERS SHALL BE
27 APPOINTED BY THE SPEAKER OF THE HOUSE OF REPRESENTATIVES. THESE
28 FOUR MEMBERS SHALL SERVE FOR TERMS OF FOUR YEARS; EXCEPT THAT,

1 OF THOSE MEMBERS INITIALLY APPOINTED, THE EMPLOYEE MEMBERS
2 SHALL SERVE FOR A TERM OF THREE YEARS.

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

12 (a) ENTER INTO SUCH CONTRACTS AS ARE NECESSARY OR PROPER
13 TO CARRY OUT THE PROVISIONS AND PURPOSES OF THIS PART 7,
14 INCLUDING, WITHOUT LIMITATION, THE AUTHORITY TO ENTER INTO
15 CONTRACTS WITH APPROPRIATE ADMINISTRATIVE STAFF, CONSULTANTS,
16 AND LEGAL COUNSEL AND TO SELECT AND CONTRACT WITH THE
17 ADMINISTERING CARRIER IN ACCORDANCE WITH SECTION 10-8-706. IN
18 ADDITION, THE EXPANDED BOARD SHALL HAVE THE AUTHORITY, WITH THE
19 APPROVAL OF THE COMMISSIONER, TO ENTER INTO CONTRACTS WITH
20 OTHER STATES WITH SIMILAR PLANS FOR THE JOINT PERFORMANCE OF
21 COMMON ADMINISTRATIVE FUNCTIONS OR WITH PERSONS OR OTHER
22 ORGANIZATIONS FOR THE PERFORMANCE OF ADMINISTRATIVE FUNCTIONS.
23 NO CONTRACT ENTERED INTO PURSUANT TO THIS PARAGRAPH (a) SHALL
24 BE SUBJECT TO ARTICLE 103 OF TITLE 24, C.R.S.

25 (b) SUE OR BE SUED, INCLUDING TAKING ANY LEGAL ACTION AS
26 NECESSARY OR PROPER ON BEHALF OF THE PROGRAM;

27 (c) TAKE SUCH LEGAL ACTION AS NECESSARY TO AVOID THE
28 PAYMENT OF IMPROPER CLAIMS AGAINST THE PROGRAM OR TO DEFEND THE

1 COVERAGE PROVIDED BY OR THROUGH THE PROGRAM;

2 (d) ESTABLISH APPROPRIATE RATES FOR QUALIFYING INDIVIDUALS
3 WHO ARE ELIGIBLE FOR A PREMIUM SUBSIDY PURSUANT TO SECTION
4 10-8-709 AND UNDERTAKE ANY OTHER ACTUARIAL FUNCTIONS
5 APPROPRIATE TO THE OPERATION OF THE PROGRAM;

6 (e) ESTABLISH SUCH PROCEDURES AND STANDARDS FOR THE
7 REINSURANCE OF QUALIFYING PLANS COVERING QUALIFYING SMALL
8 EMPLOYERS, AND OF PLANS ISSUED BY COVER COLORADO THAT COVER
9 QUALIFYING INDIVIDUALS, AS MAY BE APPROPRIATE TO ACCOMPLISH THE
10 PURPOSES OF THIS PART 7. FOR THE PURPOSES OF ADMINISTERING THE
11 REINSURANCE UNDER THE PROGRAM, THE EXPANDED BOARD MAY
12 REQUEST THE SUBMITTAL OF SUCH REASONABLE DOCUMENTATION BY
13 QUALIFYING PLANS CONCERNING QUALIFYING SMALL EMPLOYERS AND BY
14 QUALIFYING INDIVIDUALS AS IT DEEMS NECESSARY.

15 (f) OVERSEE THE ISSUANCE OF POLICIES OF INSURANCE COVERING
16 QUALIFYING INDIVIDUALS AND CERTIFICATES OR EVIDENCES OF COVERAGE
17 IN ACCORDANCE WITH THE REQUIREMENTS OF THIS PART 7;

18 (g) APPOINT APPROPRIATE LEGAL, ACTUARIAL, AND OTHER
19 COMMITTEES AS NECESSARY TO PROVIDE TECHNICAL ASSISTANCE IN THE
20 OPERATION OF THE PROGRAM, POLICY DEVELOPMENT, AND OTHER
21 CONTRACT DESIGN AND IN ANY OTHER FUNCTION WITHIN THE AUTHORITY
22 OF THE PROGRAM;

23 (h) BORROW MONEY TO EFFECT THE PURPOSES OF THIS PART 7;

24 (i) ESTABLISH CONDITIONS AND PROCEDURES FOR REINSURING
25 RISKS UNDER THIS PART 7;

26 (j) ESTABLISH PROCEDURES FOR THE REASONABLE ADVANCE
27 NOTICE TO INTERESTED PARTIES OF THE AGENDA FOR MEETINGS OF THE
28 EXPANDED BOARD;

1 (k) ACCEPT AND EXPEND GIFTS, GRANTS, AND DONATIONS FOR
2 OPERATION OF THE PROGRAM. MONEYS FROM SUCH GIFTS, GRANTS, AND
3 DONATIONS SHALL BE TRANSMITTED TO THE STATE TREASURER, WHO
4 SHALL CREDIT THE SAME TO THE HEALTHY BUSINESS HEALTHY PEOPLE
5 FUND CREATED IN SECTION 10-8-710.

6 (l) DEVELOP PROCEDURES FOR HANDLING AND ACCOUNTING FOR
7 THE FUNDS AND OTHER ASSETS OF THE PROGRAM, INCLUDING RECORDS OF
8 ALL FINANCIAL TRANSACTIONS AND AN ANNUAL FISCAL REPORT TO THE
9 COMMISSIONER;

10 (m) DEVELOP PROCEDURES FOR SELECTION OF AN ADMINISTERING
11 CARRIER AS PROVIDED IN SECTION 10-8-706;

12 (n) DEVELOP PROCEDURES TO ESTABLISH AND MAINTAIN PUBLIC
13 AWARENESS OF THE PROGRAM, INCLUDING ITS ELIGIBILITY REQUIREMENTS
14 AND ENROLLMENT PROCEDURES;

15 (o) DEVELOP PROCEDURES TO ENSURE PUBLIC KNOWLEDGE
16 CONCERNING AVAILABILITY OF THE PROGRAM;

17 (p) ESTABLISH REGULAR TIMES AND PLACES FOR MEETINGS OF
18 THE BOARD;

19 (q) DEVELOP PROCEDURES UNDER WHICH APPLICANTS AND
20 PARTICIPANTS CAN REPORT GRIEVANCES TO THE BOARD, WHICH
21 GRIEVANCES SHALL BE FAIRLY AND IMPARTIALLY CONSIDERED, AND
22 ADMINISTRATIVE REMEDIES FOR SUCH GRIEVANCES; AND

23 (r) ESTABLISH ANY OTHER PROVISIONS NECESSARY TO IMPLEMENT
24 THE PURPOSES OF THIS PART 7.

25 (3) ALL APPLICANTS AND PARTICIPANTS REPORTING ANY
26 GRIEVANCE PURSUANT TO PARAGRAPH (q) OF SUBSECTION (2) OF THIS
27 SECTION SHALL EXHAUST ALL ADMINISTRATIVE REMEDIES AS SET FORTH
28 BY THE EXPANDED BOARD BEFORE ANY SUCH GRIEVANCE MAY BE THE

1 BASIS FOR LEGAL ACTION. THE VENUE FOR ANY LEGAL ACTION INVOLVING
2 THE PROGRAM SHALL BE THE CITY AND COUNTY OF DENVER. NOTHING IN
3 THIS SUBSECTION (3) SHALL PROHIBIT THE EXPANDED BOARD FROM
4 REQUIRING BINDING ARBITRATION FOR THE FINAL ADJUDICATION OF ANY
5 GRIEVANCE.

6 (4) FOR ANY ACT PERFORMED WITHIN THE COURSE AND SCOPE OF
7 AUTHORITY UNDER THIS PART 7, THE BOARD AND THE EXPANDED BOARD,
8 THE INDIVIDUAL MEMBERS OF THE EXPANDED BOARD, AND THE
9 EMPLOYEES AND AGENTS OF THE BOARD AND THE EXPANDED BOARD
10 SHALL BE ENTITLED TO THE IMMUNITY GRANTED PURSUANT TO SECTION
11 24-10-106, C.R.S., UNLESS SUCH ACT OR OMISSION CONSTITUTES WILLFUL
12 AND WANTON MISCONDUCT.

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

16 **10-8-706. Administering carrier.** (1) THE ADMINISTERING
17 CARRIER SHALL PERFORM ALL ADMINISTRATIVE, ELIGIBILITY, AND CLAIMS
18 PAYMENT FUNCTIONS RELATING TO THE PROGRAM, INCLUDING:

19 (a) ASSURING TIMELY PAYMENT OF REIMBURSEMENTS OF
20 COVERAGE TO SMALL EMPLOYER CARRIERS AND REIMBURSEMENTS OF
21 COVERAGE TO COVER COLORADO FOR QUALIFYING INDIVIDUALS
22 PURSUANT TO SECTION 10-8-708, INCLUDING:

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

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

28 (b) SUBMITTING REGULAR REPORTS TO THE EXPANDED BOARD

1 REGARDING THE OPERATION OF THE PROGRAM. THE FREQUENCY,
2 CONTENT, AND FORM OF THE REPORTS SHALL BE AS DETERMINED BY THE
3 BOARD AFTER CONSULTATION WITH THE EXPANDED BOARD.

4 (c) DETERMINING THE EXPENSE OF ADMINISTRATION AND THE
5 PAID AND INCURRED LOSSES FOR EACH YEAR AND REPORTING SUCH
6 INFORMATION TO THE EXPANDED BOARD AND THE COMMISSIONER IN A
7 FORM AND MANNER PRESCRIBED BY THE COMMISSIONER.

8 (2) THE BOARD, IN CONSULTATION WITH THE EXPANDED BOARD,
9 SHALL ESTABLISH ITS OWN COMPETITIVE BIDDING PROCESS TO SELECT A
10 CARRIER OR THIRD-PARTY ADMINISTRATOR TO SERVE AS THE
11 ADMINISTERING CARRIER AND TO SELECT ONE OR MORE VENDORS TO
12 PROVIDE SERVICES THAT MAY BE NECESSARY TO ADMINISTER THE
13 PROGRAM. THE BOARD, IN CONSULTATION WITH THE EXPANDED BOARD,
14 SHALL EVALUATE BIDS SUBMITTED BASED ON THE CRITERIA IT
15 ESTABLISHES AND SHALL NOT BE SUBJECT TO THE PROVISIONS OF ARTICLE
16 103 OF TITLE 24, C.R.S., IN MAKING SUCH SELECTIONS.

17 (3) THE ADMINISTERING CARRIER SHALL SERVE FOR A PERIOD OF
18 THREE YEARS, SUBJECT TO REMOVAL FOR CAUSE. AT LEAST ONE YEAR
19 PRIOR TO THE EXPIRATION OF THE THREE-YEAR PERIOD OF SERVICE, THE
20 BOARD SHALL INVITE ALL INTERESTED PARTIES, INCLUDING THE CURRENT
21 ADMINISTERING CARRIER, TO SUBMIT BIDS TO SERVE AS THE
22 ADMINISTERING CARRIER FOR THE ENSUING TWO YEARS OF THE PILOT
23 PROGRAM. SELECTION OF THE ADMINISTERING CARRIER FOR THE ENSUING
24 PERIOD SHALL BE MADE AT LEAST SIX MONTHS PRIOR TO THE END OF THE
25 CURRENT THREE-YEAR PERIOD.

26 (4) THE ADMINISTERING CARRIER SHALL BE PAID AS PROVIDED
27 FOR BY THE BOARD AND THE EXPANDED BOARD.

28 **10-8-707. Program - examination - financial report. (1) NOT**

1 LATER THAN MARCH 1, 2007, AND BY MARCH 1 OF EACH SUCCEEDING
2 YEAR, THE BOARD AND THE EXPANDED BOARD SHALL SUBMIT AN AUDITED
3 FINANCIAL REPORT FOR THE PROGRAM FOR THE PRECEDING CALENDAR
4 YEAR TO THE COMMISSIONER IN A FORM PROVIDED OR PRESCRIBED BY THE
5 COMMISSIONER.

6 (2) THE FINANCIAL STATUS OF THE PROGRAM SHALL BE SUBJECT
7 TO EXAMINATION BY THE COMMISSIONER OR THE COMMISSIONER'S
8 DESIGNEE. SUCH EXAMINATIONS SHALL BE CONDUCTED AT LEAST ONCE
9 EVERY FIVE YEARS.

10 (3) THE BOARD AND THE EXPANDED BOARD SHALL ESTABLISH A
11 COMPETITIVE BIDDING PROCESS TO SELECT A THIRD PARTY TO COLLECT
12 DATA ON AN ONGOING BASIS AND TO USE SUCH DATA TO EVALUATE THE
13 PROGRAM. THE EVALUATION OF THE PROGRAM SHALL BE SUBMITTED TO
14 THE COMMITTEES OF THE HOUSE OF REPRESENTATIVES AND THE SENATE
15 THAT OVERSEE BUSINESS AFFAIRS AND LABOR ISSUES ON OR BEFORE
16 MARCH 1, 2011. THE EVALUATION SHALL INCLUDE DATA AND ANALYSIS
17 AS DETERMINED BY THE BOARD AND THE EXPANDED BOARD PRIOR TO THE
18 BIDDING PROCESS, BUT SHALL INCLUDE AN EVALUATION OF THE
19 PROGRAM'S OUTCOMES, INCLUDING BUT NOT LIMITED TO PROGRAM COSTS,
20 THE BENEFITS TO THE RECIPIENTS AND THE STATE, AND ANY NET FISCAL
21 SAVINGS. PAYMENT FOR THE COST OF THE PROGRAM SHALL NOT EXCEED
22 ONE HUNDRED THOUSAND DOLLARS FROM THE FIVE PERCENT OF THE
23 HEALTHY BUSINESS HEALTHY PEOPLE FUND ALLOCATED FOR
24 ADMINISTRATIVE COSTS PURSUANT TO SECTION 10-8-710 (2) (a).

25 **10-8-708. Healthy business healthy people reinsurance**
26 **coverage - eligibility for reimbursement payments.** (1) HEALTH
27 BENEFIT PLANS ELIGIBLE FOR REINSURANCE REIMBURSEMENT PAYMENTS
28 UNDER THIS PART 7 SHALL BE QUALIFYING PLANS ISSUED BY SMALL

1 EMPLOYER CARRIERS AUTHORIZED TO ISSUE HEALTH BENEFIT PLANS
2 UNDER ARTICLE 16 OF THIS TITLE. EACH SMALL EMPLOYER CARRIER
3 SHALL OFFER QUALIFYING PLANS TO QUALIFIED SMALL EMPLOYERS FOR
4 THE DURATION OF THE PROGRAM.

5 (2) (a) REINSURANCE REIMBURSEMENT TO CARRIERS SHALL BE
6 MADE FROM THE HEALTHY BUSINESS HEALTHY PEOPLE FUND MONEYS
7 EARMARKED FOR REINSURANCE FOR QUALIFYING PLANS, PURSUANT TO
8 SECTION 10-8-710. SUCH REIMBURSEMENTS SHALL BE MADE, TO THE
9 EXTENT OF FUNDS AVAILABLE THEREFOR, FOR CLAIMS PAID BY SUCH
10 CARRIERS UNDER QUALIFYING PLANS.

11 (b) COMMENCING ON JANUARY 1, 2007, SMALL EMPLOYER
12 CARRIERS SHALL BE ELIGIBLE TO RECEIVE REINSURANCE REIMBURSEMENT
13 FOR NINETY PERCENT OF TOTAL CLAIMS PAID BETWEEN THE AMOUNT OF
14 FIVE THOUSAND DOLLARS, OR SUCH GREATER AMOUNT AS SHALL BE SET
15 BY THE EXPANDED BOARD BEFORE IMPLEMENTATION OF THE PROGRAM,
16 AND SEVENTY-FIVE THOUSAND DOLLARS IN A CALENDAR YEAR FOR ANY
17 INSURED COVERED UNDER A QUALIFYING PLAN. REINSURANCE
18 REIMBURSEMENT PAYMENTS SHALL ONLY BE AVAILABLE FOR COVERAGE
19 PROVIDED UNDER MANAGED CARE PLANS BY NETWORK PROVIDERS,
20 EXCEPT FOR EMERGENCY CARE. THE FIVE-THOUSAND-DOLLAR AND
21 SEVENTY-FIVE-THOUSAND-DOLLAR FIGURES IN THIS PARAGRAPH (b) SHALL
22 BE ADJUSTED BY THE EXPANDED BOARD PERIODICALLY, BUT NO MORE
23 THAN ONCE EACH YEAR, TO REFLECT THE INFLATION IN MEDICAL CARE
24 COSTS PAID BY CARRIERS.

25 (c) CLAIMS SHALL BE REPORTED AND REINSURANCE
26 REIMBURSEMENTS SHALL BE DISTRIBUTED ON A QUARTERLY BASIS.
27 CLAIMS SHALL BE ELIGIBLE FOR REIMBURSEMENT ONLY FOR THE
28 CALENDAR YEAR IN WHICH THE CLAIMS ARE PAID. ONCE CLAIMS PAID ON

1 BEHALF OF A COVERED INSURED EQUAL OR EXCEED SEVENTY-FIVE
2 THOUSAND DOLLARS IN A GIVEN CALENDAR YEAR, NO FURTHER CLAIMS
3 PAID ON BEHALF OF SUCH INSURED IN THAT CALENDAR YEAR SHALL BE
4 ELIGIBLE FOR REIMBURSEMENT.

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

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

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

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

23 (IV) THE EXPANDED BOARD SHALL SEPARATELY ESTIMATE THE
24 PER-INSURED ANNUAL COST OF TOTAL CLAIMS REIMBURSEMENT FOR
25 QUALIFYING PLANS BASED UPON AVAILABLE DATA AND APPROPRIATE
26 ACTUARIAL ASSUMPTIONS. UPON REQUEST, EACH CARRIER SHALL FURNISH
27 CLAIMS EXPERIENCE DATA TO THE EXPANDED BOARD FOR USE IN SUCH
28 ESTIMATIONS.

1 (V) THE EXPANDED BOARD SHALL DETERMINE TOTAL ELIGIBLE
2 ENROLLMENT UNDER QUALIFYING PLANS. THE TOTAL ELIGIBLE
3 ENROLLMENT SHALL BE DETERMINED BY DIVIDING THE TOTAL MONEYS
4 AVAILABLE FOR DISTRIBUTION FROM THE HEALTHY BUSINESS HEALTHY
5 PEOPLE FUND BY THE ESTIMATED PER-INSURED ANNUAL COST OF TOTAL
6 CLAIMS REIMBURSEMENT FROM THE FUND.

7 (VI) THE EXPANDED BOARD SHALL SUSPEND THE ENROLLMENT OF
8 NEW INSURED'S IF IT DETERMINES THAT THE TOTAL ENROLLMENT
9 REPORTED BY ALL CARRIERS EXCEEDS THE TOTAL ELIGIBLE ENROLLMENT,
10 THEREBY RESULTING IN ANTICIPATED ANNUAL EXPENDITURES FROM THE
11 HEALTHY BUSINESS HEALTHY PEOPLE FUND IN EXCESS OF THE TOTAL
12 AMOUNT AVAILABLE FOR DISTRIBUTION.

13 (VII) THE EXPANDED BOARD SHALL PROVIDE CARRIERS WITH
14 NOTIFICATION OF ANY ENROLLMENT SUSPENSIONS AS SOON AS
15 PRACTICABLE AFTER RECEIPT OF ALL ENROLLMENT DATA.

16 (VIII) IF, AT ANY POINT DURING A SUSPENSION OF ENROLLMENT,
17 THE EXPANDED BOARD DETERMINES THAT FUNDS ARE SUFFICIENT TO
18 PROVIDE FOR THE ADDITION OF NEW ENROLLMENTS, THE EXPANDED
19 BOARD MAY REACTIVATE NEW ENROLLMENTS AND NOTIFY ALL CARRIERS
20 THAT ENROLLMENTS MAY AGAIN COMMENCE.

21 (IX) THE SUSPENSION OF ENROLLMENTS SHALL NOT PRECLUDE
22 THE ADDITION OF NEW EMPLOYEES OF AN EMPLOYER ALREADY COVERED,
23 OR NEW DEPENDENTS OF EMPLOYEES ALREADY COVERED, UNDER
24 QUALIFYING PLANS.

25 **10-8-709. Healthy business healthy people premium subsidy**
26 **program - eligibility for subsidy payments.** (1) THE BOARD SHALL
27 ESTABLISH A PREMIUM SUBSIDY PROGRAM FOR QUALIFIED INDIVIDUALS
28 WHO APPLY FOR COVERAGE ON OR AFTER JANUARY 1, 2007, UNDER A

1 COVERCOLORADO BENEFIT PLAN DESIGNATED BY THE BOARD.

2 (2) THE PREMIUM SUBSIDY MAY BE SET ON AN INCOME-BASED,
3 SLIDING FEE SCALE; EXCEPT THAT IN NO EVENT SHALL A QUALIFIED
4 INDIVIDUAL PAY MORE THAN EIGHTY PERCENT OF THE PREMIUM
5 NORMALLY CHARGED BY COVERCOLORADO.

6 (3) PREMIUM SUBSIDIES SHALL BE PAID FROM HEALTHY BUSINESS
7 HEALTHY PEOPLE FUND MONEYS EARMARKED FOR SUBSIDIES FOR
8 QUALIFYING INDIVIDUALS. IN THE EVENT THAT AN ASSESSMENT ON
9 CARRIERS IS TRIGGERED UNDER SECTION 10-8-530(1.5), CARRIERS SHALL
10 NOT BE ASSESSED FOR ANY CLAIMS COSTS FOR QUALIFYING INDIVIDUALS.
11 INSTEAD, SUCH COSTS SHALL BE PAID FOR OUT OF HEALTHY BUSINESS
12 HEALTHY PEOPLE FUND MONEYS EARMARKED FOR SUBSIDIES FOR
13 QUALIFYING INDIVIDUALS.

14 (4) BEFORE IMPLEMENTING THE PREMIUM SUBSIDY PROGRAM, THE
15 BOARD SHALL DEVELOP A TABLE OF PROPOSED PREMIUM SUBSIDIES AND
16 SHALL HOLD A PUBLIC HEARING AND TAKE COMMENTS ON THE PROPOSED
17 TABLE OF SUBSIDIES.

18 (5) (a) THE BOARD SHALL DETERMINE THE TOTAL PREMIUM
19 SUBSIDIES FOR THE CALENDAR YEAR FOR WHICH SUBSIDIES ARE PAID.

20 (b) IF THE FUNDS AVAILABLE FOR DISTRIBUTION FOR PREMIUM
21 SUBSIDIES PAID DURING A CALENDAR YEAR EXCEED THE TOTAL AMOUNT
22 OF SUBSIDIES DURING THAT SAME CALENDAR YEAR, ANY EXCESS FUNDS
23 SHALL BE CARRIED FORWARD AND MADE AVAILABLE FOR DISTRIBUTION IN
24 THE NEXT CALENDAR YEAR.

25 (c) THE BOARD SHALL SEPARATELY ESTIMATE THE PER-INSURED
26 ANNUAL COST OF ALL SUBSIDIES FOR DESIGNATED COVERCOLORADO
27 PLANS BASED UPON AVAILABLE DATA AND APPROPRIATE ACTUARIAL
28 ASSUMPTIONS.

1 (d) THE BOARD SHALL DETERMINE THE TOTAL ELIGIBLE
2 ENROLLMENT UNDER DESIGNATED COVERCOLORADO PLANS. THE TOTAL
3 ELIGIBLE ENROLLMENT SHALL BE DETERMINED BY DIVIDING THE AMOUNT
4 OF MONEYS AVAILABLE FOR DISTRIBUTION FROM THE HEALTHY BUSINESS
5 HEALTHY PEOPLE FUND FOR PREMIUM SUBSIDIES BY THE ESTIMATED
6 PER-INSURED ANNUAL COST OF ALL PREMIUM SUBSIDIES FROM THE FUND.

7 (e) THE BOARD SHALL SUSPEND THE ENROLLMENT OF NEW
8 INSUREDS IN DESIGNATED COVERCOLORADO PLANS IF IT DETERMINES
9 THAT THE TOTAL ENROLLMENT REPORTED BY COVERCOLORADO EXCEEDS
10 THE TOTAL ELIGIBLE ENROLLMENT, THEREBY RESULTING IN ANTICIPATED
11 ANNUAL EXPENDITURES FROM THE HEALTHY BUSINESS HEALTHY PEOPLE
12 FUND IN EXCESS OF THE MONEYS AVAILABLE FOR DISTRIBUTION.

13 (f) IF, AT ANY POINT DURING A SUSPENSION OF ENROLLMENT, THE
14 BOARD DETERMINES THAT FUNDS ARE SUFFICIENT TO PROVIDE FOR THE
15 ADDITION OF NEW ENROLLMENTS, THE BOARD MAY AGAIN ACCEPT NEW
16 ENROLLMENTS.

17 (g) THE SUSPENSION OF ENROLLMENT IN DESIGNATED
18 COVERCOLORADO PLANS SHALL NOT PRECLUDE THE ADDITION OF NEW
19 DEPENDENTS OF INDIVIDUALS ALREADY COVERED UNDER SUCH PLANS.

20 **10-8-710. Healthy business healthy people fund - creation.**

21 (1)(a) THERE IS HEREBY CREATED IN THE STATE TREASURY THE HEALTHY
22 BUSINESS HEALTHY PEOPLE FUND, ALSO REFERRED TO IN THIS SECTION AS
23 THE "FUND". THE FUND SHALL CONSIST OF MONEYS CREDITED THERETO
24 PURSUANT TO THIS PART 7.

25 (b) IN FISCAL YEAR 2006-07, AND EACH OF THE FOUR FISCAL
26 YEARS THEREAFTER, IF THE MOST RECENT LEGISLATIVE COUNCIL STAFF
27 ECONOMIC AND REVENUE FORECAST ESTIMATES THAT THE GENERAL FUND
28 EXEMPT ACCOUNT, CREATED IN SECTION 24-77-103.6 (2), C.R.S., WILL

1 RECEIVE MORE THAN ONE HUNDRED FIFTEEN MILLION DOLLARS, FIFTEEN
2 MILLION DOLLARS OF THE MONEYS IN SUCH GENERAL FUND EXEMPT
3 ACCOUNT SHALL BE APPROPRIATED TO THE HEALTHY BUSINESS HEALTHY
4 PEOPLE FUND CREATED IN THIS SUBSECTION (1).

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

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

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

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

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

26 **10-8-503. Definitions.** As used in this part 5, unless the context
27 otherwise requires:

28 (17.3) "Program" or "CoverColorado" means CoverColorado and

1 its administration and implementation of the health benefit plans
2 permitted under this part 5 AND PART 7 OF THIS ARTICLE.

3 **SECTION 3.** 10-8-530 (1), Colorado Revised Statutes, is
4 amended BY THE ADDITION OF A NEW PARAGRAPH to read:

5 **10-8-530. Funding of program - repeal.** (1) The program shall
6 be funded by the following:

7 (f) MONEYS TRANSMITTED PURSUANT TO SECTION 10-8-710 (2).

8 **SECTION 4.** 10-16-105, Colorado Revised Statutes, is amended
9 BY THE ADDITION OF A NEW SUBSECTION to read:

10 **10-16-105. Small group sickness and accident insurance -**
11 **guaranteed issue - mandated provisions for basic and standard health**
12 **benefit plans - rules - definitions.** (16)(a) AS USED IN THIS SUBSECTION
13 (16):

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

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

18 (b) ON AND AFTER JANUARY 1, 2007, EACH SMALL EMPLOYER
19 CARRIER SHALL ISSUE QUALIFYING SMALL EMPLOYER PLANS TO
20 QUALIFYING SMALL EMPLOYERS WHO APPLY FOR COVERAGE PURSUANT TO
21 PART 7 OF ARTICLE 8 OF THIS TITLE.

22 (c) ON AND AFTER JANUARY 1, 2007, IN ADDITION TO ANY OTHER
23 RATING FACTOR ALLOWED UNDER THIS SECTION, SMALL EMPLOYER
24 CARRIERS SHALL APPLY A RATING FACTOR FOR HEALTH BENEFIT PLANS
25 ISSUED TO QUALIFYING SMALL EMPLOYERS UNDER THE HEALTHY BUSINESS
26 HEALTHY PEOPLE PROGRAM PURSUANT TO PART 7 OF ARTICLE 8 OF THIS
27 TITLE.

28 (d) ON AND AFTER JANUARY 1, 2007, THE PREMIUMS FOR

1 QUALIFYING SMALL EMPLOYER PLANS SHALL FACTOR IN THE AVAILABILITY
2 OF REIMBURSEMENT FROM THE HEALTHY BUSINESS HEALTHY PEOPLE
3 PROGRAM.

4 (e) THE DETERMINATION OF WHETHER A SMALL EMPLOYER IS A
5 QUALIFYING SMALL EMPLOYER SHALL BE MADE AT THE TIME A SMALL
6 EMPLOYER APPLIES FOR COVERAGE, AND SHALL BE REDETERMINED
7 ANNUALLY AT RENEWAL. A SMALL EMPLOYER THAT NO LONGER
8 QUALIFIES AS A QUALIFYING SMALL EMPLOYER AT RENEWAL MAY
9 CONTINUE ON THE SAME COVERAGE, BUT SUCH COVERAGE SHALL NOT BE
10 ELIGIBLE FOR REINSURANCE, AND THE SMALL EMPLOYER CARRIER SHALL
11 ADJUST THE SMALL EMPLOYER'S RENEWAL RATE ACCORDINGLY. THE
12 COMMISSIONER SHALL PROMULGATE RULES SETTING FORTH THE PROCESS,
13 INCLUDING ANY NECESSARY FORMS, THAT SMALL EMPLOYER CARRIERS
14 SHALL USE TO DETERMINE WHETHER A SMALL EMPLOYER APPLYING FOR
15 COVERAGE UNDER A QUALIFYING SMALL EMPLOYER PLAN MEETS THE
16 DEFINITION OF A QUALIFYING SMALL EMPLOYER UNDER SECTION 10-8-703
17 (13).

18 (f) ON AND AFTER JANUARY 1, 2007, THE COMMISSIONER SHALL
19 ANNUALLY PUBLISH SAMPLE RATES FOR QUALIFYING SMALL EMPLOYER
20 PLANS OFFERED PURSUANT TO PART 7 OF ARTICLE 8 OF THIS TITLE.

21 **SECTION 5.** 10-16-107, Colorado Revised Statutes, is amended
22 BY THE ADDITION OF A NEW SUBSECTION to read:

23 **10-16-107. Rate regulation - approval of policy forms -**
24 **benefit certificates - evidences of coverage - loss ratio guarantees -**
25 **disclosures on treatment of intractable pain - definitions.** (1.9)(a) AS
26 PART OF ITS REVIEW OF SMALL EMPLOYER HEALTH BENEFIT PLAN RATE
27 FILINGS, THE DIVISION SHALL ENSURE THAT SAVINGS FOR SMALL
28 EMPLOYER CARRIERS FROM THE AVAILABILITY OF REINSURANCE THROUGH

1 THE HEALTHY BUSINESS HEALTHY PEOPLE PROGRAM FOR QUALIFYING
2 SMALL EMPLOYER PLANS UNDER PART 7 OF ARTICLE 8 OF THIS TITLE IS
3 PASSED ALONG TO QUALIFYING SMALL EMPLOYERS IN THE FORM OF LOWER
4 RATES.

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

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

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

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

17 (2) In addition to any other appropriation, there is hereby
18 appropriated, out of any moneys in the healthy business healthy people
19 fund created in section 10-8-710, Colorado Revised Statutes, not
20 otherwise appropriated, to the department of regulatory agencies, for
21 allocation to the division of insurance, for the fiscal year beginning July
22 1, 2006, the sum of ten thousand six hundred forty-four dollars (\$10,644),
23 or so much thereof as may be necessary, for the implementation of this
24 act.

25 **SECTION 7. Safety clause.** The general assembly hereby finds,
26 determines, and declares that this act is necessary for the immediate
27 preservation of the public peace, health, and safety.

DRAFT

Colorado Legislative Council Staff

STATE
FISCAL IMPACT

Drafting Number: LLS 06-0140 **Date:** December 15, 2005
Prime Sponsor(s): Sen. Keller **Bill Status:** Interim Committee on Health Insurance
 Rep. Green **Fiscal Analyst:** Amy Larsen (303-866-3488)

TITLE: 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.

Fiscal Impact Summary	FY 2006/2007	FY 2007/2008
State Revenues		
Cash Funds Exempt - Transfer to Healthy Business Healthy People Fund	\$15,000,000	\$15,000,000
State Expenditures		
General Fund Exempt - Transfer to Healthy Business Healthy People Fund	\$15,000,000	\$15,000,000
Cash Funds Exempt - Department of Regulatory Agencies*	10,444	8,271
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.

Bill A

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 ($\$14,250,000 \times 3.75\%$).

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

Bill B

Second Regular Session
Sixty-fifth General Assembly
STATE OF COLORADO

DRAFT

LLS NO. 06-0141.01 Nicole Hoffman

SENATE BILL

SENATE SPONSORSHIP

Hanna, Hagedorn, Keller, and Shaffer

HOUSE SPONSORSHIP

Riesberg, Boyd, Green, and McCluskey

Senate Committees

House Committees

A BILL FOR AN ACT

101 **CONCERNING THE PROVISION OF HEALTH CARE SERVICES BY LOCAL**
102 **GOVERNMENTAL ENTITIES, AND, IN CONNECTION THEREWITH,**
103 **ALLOWING SUCH DISTRICTS TO BE CREATED IN ANY PART OF**
104 **THE STATE, AUTHORIZING SUCH DISTRICTS TO LEVY A SALES**
105 **TAX, AND AUTHORIZING COUNTIES TO IMPOSE A SALES TAX FOR**
106 **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

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adopted.)

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.

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

2 **SECTION 1.** 32-1-103, Colorado Revised Statutes, is amended
3 BY THE ADDITION OF A NEW SUBSECTION to read:

4 **32-1-103. Definitions.** As used in this article, unless the context
5 otherwise requires:

6 (8.5) "HEALTH ASSURANCE DISTRICT" MEANS A SPECIAL DISTRICT
7 THAT IS CREATED TO ORGANIZE, OPERATE, CONTROL, DIRECT, MANAGE,
8 CONTRACT FOR, FURNISH, OR PROVIDE, DIRECTLY OR INDIRECTLY, HEALTH
9 CARE SERVICES TO RESIDENTS OF THE DISTRICT WHO ARE IN NEED OF SUCH
10 SERVICES AND TO FAMILY MEMBERS OF SUCH RESIDENTS.

11 **SECTION 2.** 32-1-202 (2), Colorado Revised Statutes, is

1 amended BY THE ADDITION OF A NEW PARAGRAPH to read:

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

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

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

9 **32-1-301. Petition for organization.** (2) The petition shall set
10 forth:

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

14 (X) HEALTH ASSURANCE DISTRICT;

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

19 **32-1-1003.5. Health assurance districts - additional powers**
20 **- legislative declaration.** (1) The general assembly hereby finds,
21 determines, and declares that access to health care services in rural areas
22 is an increasing problem in Colorado AND THAT some rural Coloradans
23 do not have access to a primary care provider. in their town and are forced
24 to travel. It is the intent of the general assembly to ease the strain on rural
25 Coloradan's health care needs by allowing a special district to be created
26 to directly contract with a physician, a nurse practitioner, or a physician's
27 assistant to provide health care services. to rural areas. It is the intention
28 of the general assembly to review the success of such efforts as

1 authorized by subsection (2) of this section to determine the effectiveness
2 of the program.

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

6 (a) To organize, operate, control, direct, manage, contract for, or
7 furnish, ~~health care services from a physician, nurse practitioner, or~~
8 ~~physician's assistant licensed in this state and such health care provider~~
9 ~~shall be known as a "community contracted health care provider"~~ OR
10 PROVIDE, DIRECTLY OR INDIRECTLY, HEALTH CARE SERVICES TO
11 RESIDENTS OF THE HEALTH ASSURANCE DISTRICT WHO ARE IN NEED OF
12 SUCH SERVICES AND TO THE FAMILY MEMBERS OF SUCH RESIDENTS;

13 (c) TO CONTRACT WITH OR WORK COOPERATIVELY AND IN
14 CONJUNCTION WITH A HEALTH SERVICE DISTRICT OR OTHER EXISTING
15 HEALTH CARE PROVIDER OR SERVICE TO PROVIDE HEALTH CARE SERVICES
16 TO THE RESIDENTS OF SUCH DISTRICTS; AND

17 (d) TO SEEK APPROVAL FROM THE ELIGIBLE ELECTORS IN THE
18 HEALTH ASSURANCE DISTRICT TO COLLECT, RETAIN, AND SPEND ALL
19 REVENUE GENERATED BY ANY TAX APPROVED BY SUCH ELIGIBLE
20 ELECTORS IN EXCESS OF THE LIMITATION PROVIDED IN SECTION 20 OF
21 ARTICLE X OF THE STATE CONSTITUTION.

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

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

25 **32-1-1003.5. Health assurance districts - additional powers**
26 **- legislative declaration.** (5) ANY HEALTH ASSURANCE DISTRICT THAT
27 IS CREATED PURSUANT TO THIS ARTICLE SHALL HAVE THE POWER, UPON
28 APPROVAL BY THE ELIGIBLE ELECTORS OF THE DISTRICT, TO LEVY AND

1 COLLECT A UNIFORM SALES TAX THROUGHOUT THE ENTIRE GEOGRAPHIC
2 AREA OF THE DISTRICT UPON EVERY TRANSACTION OR OTHER INCIDENT
3 WITH RESPECT TO WHICH A SALES TAX IS LEVIED BY THE STATE PURSUANT
4 TO THE PROVISIONS OF ARTICLE 26 OF TITLE 39, C.R.S., SUBJECT TO THE
5 FOLLOWING PROVISIONS:

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

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

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

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

18 **ARTICLE 18**

19 **Health Assurance Districts**

20 **32-18-101. Legislative declaration.** THE GENERAL ASSEMBLY
21 HEREBY FINDS, DETERMINES, AND DECLARES THAT ACCESS TO HEALTH
22 CARE SERVICES IS AN INCREASING PROBLEM IN COLORADO AND THAT
23 SOME COLORADANS DO NOT HAVE ACCESS TO A PRIMARY CARE PROVIDER.
24 IT IS THE INTENT OF THE GENERAL ASSEMBLY TO EASE THE STRAIN ON
25 COLORADAN'S HEALTH CARE NEEDS BY ALLOWING A SPECIAL DISTRICT TO
26 BE CREATED TO PROVIDE HEALTH CARE SERVICES.

27 **32-18-102. Definitions.** AS USED IN THIS ARTICLE, UNLESS THE
28 CONTEXT OTHERWISE REQUIRES:

1 (1) "DISTRICT" MEANS A HEALTH ASSURANCE DISTRICT CREATED
2 PURSUANT TO THIS ARTICLE TO ORGANIZE, OPERATE, CONTROL, DIRECT,
3 MANAGE, CONTRACT FOR, FURNISH, OR PROVIDE, DIRECTLY OR
4 INDIRECTLY, HEALTH CARE SERVICES TO RESIDENTS OF THE DISTRICT WHO
5 ARE IN NEED OF SUCH SERVICES AND TO FAMILY MEMBERS OF SUCH
6 RESIDENTS.

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

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

12 **32-18-103. Applicability of "Special District Act".**

13 (1) EXCEPT AS PROVIDED IN THIS ARTICLE, A DISTRICT CREATED
14 PURSUANT TO THIS ARTICLE SHALL BE GOVERNED BY THE APPLICABLE
15 PROVISIONS OF THE "SPECIAL DISTRICT ACT", ARTICLE 1 OF THIS TITLE,
16 INCLUDING, BUT NOT LIMITED TO:

17 (a) PART 1 OF ARTICLE 1 OF THIS TITLE CONTAINING GENERAL
18 PROVISIONS;

19 (b) PARTS 2 AND 3 OF ARTICLE 1 OF THIS TITLE CONCERNING THE
20 ORGANIZATION OF A SPECIAL DISTRICT;

21 (c) PART 6 OF ARTICLE 1 OF THIS TITLE CONCERNING THE
22 CONSOLIDATION OF SPECIAL DISTRICTS;

23 (d) PART 7 OF ARTICLE 1 OF THIS TITLE CONCERNING THE
24 DISSOLUTION OF SPECIAL DISTRICTS;

25 (e) PART 8 OF ARTICLE 1 OF THIS TITLE CONCERNING ELECTIONS;

26 (f) PARTS 9, 10, AND 11 OF ARTICLE 1 OF THIS TITLE CONCERNING
27 THE BOARD OF DIRECTORS FOR A SPECIAL DISTRICT AND THE BOARD'S
28 GENERAL AND FINANCIAL POWERS; AND

1 (g) PARTS 13 AND 14 OF ARTICLE 1 OF THIS TITLE CONCERNING
2 REFUNDING OF BONDS AND SPECIAL DISTRICT INDEBTEDNESS.

3 (2) THE FOLLOWING PROVISIONS SHALL NOT APPLY TO A DISTRICT
4 CREATED PURSUANT TO THIS ARTICLE:

5 (a) PARTS 4 AND 5 OF ARTICLE 1 OF THIS TITLE CONCERNING THE
6 INCLUSION AND EXCLUSION OF TERRITORY IN A SPECIAL DISTRICT;

7 (b) PART 12 OF ARTICLE 1 OF THIS TITLE CONCERNING THE LEVY
8 AND COLLECTION OF AD VALOREM TAXES; AND

9 (c) PART 16 OF ARTICLE 1 OF THIS TITLE CONCERNING
10 CERTIFICATION AND NOTICE OF SPECIAL DISTRICT TAXES FOR GENERAL
11 OBLIGATION INDEBTEDNESS.

12 **32-18-104. Special districts file - notice of organization or**
13 **dissolution.** (1) FOR PURPOSES OF COMPLYING WITH SECTION 32-1-104
14 (2), A DISTRICT CREATED PURSUANT TO THIS ARTICLE SHALL PROVIDE THE
15 REQUIRED NOTICE TO THE DEPARTMENT OF REVENUE INSTEAD OF THE
16 COUNTY ASSESSOR.

17 (2) FOR PURPOSES OF COMPLYING WITH SECTION 32-1-105, THE
18 COUNTY CLERK AND RECORDER SHALL FILE A CERTIFIED COPY OF THE
19 DECREE OR ORDER CONFIRMING THE ORGANIZATION OR DISSOLUTION OF
20 A DISTRICT CREATED PURSUANT TO THIS ARTICLE WITH THE DEPARTMENT
21 OF REVENUE INSTEAD OF NOTIFYING THE COUNTY ASSESSOR OF THE
22 ACTION.

23 **32-18-105. Service area of district - governmental immunity.**
24 (1) A DISTRICT MAY INCLUDE ALL OF THE TERRITORY OF ONE OR MORE
25 MUNICIPALITIES OR COUNTIES, AS MAY BE PROPOSED. THE DISTRICT SHALL
26 BE A BODY CORPORATE AND POLITIC AND A POLITICAL SUBDIVISION OF THE
27 STATE.

28 (2) EACH OF THE DIRECTORS, OFFICERS, AND EMPLOYEES OF THE

1 DISTRICT SHALL BE A PUBLIC EMPLOYEE FOR PURPOSES OF THE
2 "COLORADO GOVERNMENTAL IMMUNITY ACT", ARTICLE 10 OF TITLE 24,
3 C.R.S.

4 **32-18-106. Service plan required - contents - action on plan.**

5 (1) PERSONS PROPOSING THE ORGANIZATION OF A DISTRICT, EXCEPT FOR
6 A DISTRICT THAT IS CONTAINED ENTIRELY WITHIN THE BOUNDARIES OF A
7 MUNICIPALITY AND SUBJECT TO THE PROVISIONS OF SECTION 32-18-107,
8 SHALL SUBMIT A SERVICE PLAN IN ACCORDANCE WITH THE REQUIREMENTS
9 OF SECTION 32-1-202 (1) AND SHALL PAY ANY FEE REQUIRED PURSUANT
10 TO SECTION 32-1-202 (3).

11 (2) NOTWITHSTANDING THE PROVISIONS OF SECTION 32-1-202 (2),
12 THE SERVICE PLAN FOR THE DISTRICT SHALL CONTAIN THE FOLLOWING
13 INFORMATION:

14 (a) A DESCRIPTION OF THE PROPOSED HEALTH SERVICES TO BE
15 PROVIDED AND THE PERSONS WHO WILL BE ELIGIBLE TO RECEIVE THOSE
16 SERVICES;

17 (b) A DESCRIPTION OF THE PROPOSED HEALTH SERVICES TO BE
18 PROVIDED IN CONJUNCTION WITH A HEALTH SERVICE DISTRICT, IF ANY, AS
19 DEFINED IN SECTION 32-1-103 (9);

20 (c) QUALITY ASSURANCE MEASURES;

21 (d) A FINANCIAL PLAN SHOWING HOW THE PROPOSED SERVICES
22 ARE TO BE FINANCED, INCLUDING THE PROPOSED OPERATING REVENUE
23 DERIVED FROM SALES TAXES FOR THE FIRST BUDGET YEAR OF THE
24 DISTRICT, WHICH SHALL NOT BE MATERIALLY EXCEEDED EXCEPT AS
25 AUTHORIZED PURSUANT TO SECTION 32-1-207. ALL PROPOSED
26 INDEBTEDNESS FOR THE DISTRICT SHALL BE DISPLAYED TOGETHER WITH
27 A SCHEDULE INDICATING THE YEAR OR YEARS IN WHICH THE DEBT IS
28 SCHEDULED TO BE ISSUED. THE BOARD OF DIRECTORS OF THE DISTRICT

1 SHALL NOTIFY THE BOARD OF COUNTY COMMISSIONERS OR THE
2 GOVERNING BODY OF THE MUNICIPALITY, WHICHEVER IS APPLICABLE, OF
3 ANY ALTERATION OR REVISION OF THE PROPOSED SCHEDULE OF DEBT
4 ISSUANCE SET FORTH IN THE FINANCIAL PLAN.

5 (e) A MAP OF THE PROPOSED DISTRICT BOUNDARIES;

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

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

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

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

28 (j) SUCH ADDITIONAL INFORMATION AS THE BOARD OF COUNTY

1 COMMISSIONERS OR THE GOVERNING BODY OF THE MUNICIPALITY,
2 WHICHEVER IS APPLICABLE, MAY REQUIRE ON WHICH TO BASE ITS FINDINGS
3 PURSUANT TO SECTION 32-1-203.

4 (3) EXCEPT AS PROVIDED IN SECTION 32-18-107, THE BOARD OF
5 COUNTY COMMISSIONERS OF EACH COUNTY THAT HAS TERRITORY
6 INCLUDED WITHIN THE PROPOSED DISTRICT SHALL CONSTITUTE THE
7 APPROVING AUTHORITY FOR THE PROPOSED DISTRICT AND SHALL REVIEW
8 ANY SERVICE PLAN FILED BY THE PETITIONERS OF A PROPOSED DISTRICT IN
9 ACCORDANCE WITH THE PROVISIONS OF SECTION 32-1-203. THE
10 PROVISIONS OF SECTION 32-1-203 (3.5) SHALL NOT APPLY TO A DISTRICT
11 PROPOSED PURSUANT TO THIS ARTICLE.

12 **32-18-107. Approval by municipality.** IF THE BOUNDARIES OF
13 A DISTRICT PROPOSED PURSUANT TO THIS ARTICLE ARE WHOLLY
14 CONTAINED WITHIN THE BOUNDARIES OF A MUNICIPALITY, THE PERSONS
15 PROPOSING THE ORGANIZATION OF THE DISTRICT SHALL COMPLY WITH THE
16 PROVISIONS OF SECTION 32-1-204.5; EXCEPT THAT THE SERVICE PLAN
17 SUBMITTED TO EACH GOVERNING BODY SHALL CONTAIN THE INFORMATION
18 REQUIRED BY SECTION 32-18-106 (2). THE GOVERNING BODY OF EACH
19 MUNICIPALITY SHALL HAVE THE AUTHORITY SET FORTH IN SECTION
20 32-1-204.5 WITH REGARD TO THE REVIEW OF THE SERVICE PLAN.

21 **32-18-108. Public hearing on service plan - procedures -**
22 **decision - judicial review - modifications - enforcement.** (1) FOR
23 PURPOSES OF SECTION 32-1-204 (1) AND (1.5), THE BOARD OF COUNTY
24 COMMISSIONERS OR THE GOVERNING BODY OF THE MUNICIPALITY,
25 WHICHEVER IS APPLICABLE, SHALL BE DEEMED TO HAVE COMPLIED WITH
26 THE PROVISIONS OF SUCH SECTIONS IF THE BOARD OR GOVERNING BODY
27 PROVIDES WRITTEN NOTICE OF THE DATE, TIME, AND LOCATION OF THE
28 HEARING TO THE PETITIONERS AND, AT LEAST TWENTY DAYS PRIOR TO THE

1 HEARING DATE, PUBLISHES NOTICE OF THE DATE, TIME, LOCATION, AND
2 PURPOSE OF THE HEARING. THE PUBLISHED NOTICE SHALL CONSTITUTE
3 CONSTRUCTIVE NOTICE TO THE INTERESTED PARTIES IN THE PROPOSED
4 DISTRICT.

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

7 (3) THE BOARD OF COUNTY COMMISSIONERS OR THE GOVERNING
8 BODY OF THE MUNICIPALITY, WHICHEVER IS APPLICABLE, SHALL CONDUCT
9 THE HEARING AND MAKE ITS DECISION IN ACCORDANCE WITH THE
10 REQUIREMENTS OF SECTION 32-1-204 (3) AND (4). THE DECISION OF THE
11 BOARD OF COUNTY COMMISSIONERS OR THE GOVERNING BODY OF THE
12 MUNICIPALITY, WHICHEVER IS APPLICABLE, IS SUBJECT TO JUDICIAL
13 REVIEW IN ACCORDANCE WITH SECTION 32-1-206; EXCEPT THAT, FOR
14 PURPOSES OF JUDICIAL REVIEW, "INTERESTED PARTY" SHALL HAVE THE
15 SAME MEANING AS SET FORTH IN SECTION 32-18-102 (3).

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

25 **32-18-109. Organization.** (1) EXCEPT AS PROVIDED IN THIS
26 SECTION, THE ORGANIZATION OF A DISTRICT PURSUANT TO THIS ARTICLE
27 SHALL BE GOVERNED BY THE PROVISIONS OF PART 3 OF ARTICLE 1 OF THIS
28 TITLE.

1 (2) FOR PURPOSES OF COMPLYING WITH THE PROVISIONS OF
2 SECTION 32-1-301 (1), A PETITION FOR THE ORGANIZATION OF A DISTRICT
3 PROPOSED PURSUANT TO THIS ARTICLE SHALL BE SIGNED BY NOT LESS
4 THAN THIRTY PERCENT OR TWO HUNDRED ELIGIBLE ELECTORS OF THE
5 PROPOSED DISTRICT, WHICHEVER NUMBER IS SMALLER.

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

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

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

22 (6) FOR PURPOSES OF THE FILING REQUIREMENTS IN SECTION
23 32-1-306, INSTEAD OF FILING A MAP OF THE DISTRICT WITH THE COUNTY
24 ASSESSOR, THE DISTRICT SHALL FILE A CERTIFIED COPY OF THE FINDINGS
25 AND ORDER OF THE COURT ORGANIZING THE DISTRICT WITH THE
26 DEPARTMENT OF REVENUE.

27 **32-18-110. Persons entitled to vote at health assurance**
28 **district elections.** NOTWITHSTANDING THE PROVISIONS OF SECTION

1 32-1-806, ANY PERSON WHO IS AN ELIGIBLE ELECTOR AS DEFINED IN
2 SECTION 32-18-102 (2) SHALL BE ELIGIBLE TO VOTE IN AN
3 ORGANIZATIONAL ELECTION OR ANY ELECTION CONDUCTED BY THE BOARD
4 OF DIRECTORS FOR A DISTRICT.

5 **32-18-111. Financial powers.** ANY HEALTH ASSURANCE
6 DISTRICT CREATED PURSUANT TO THIS ARTICLE SHALL HAVE ALL OF THE
7 FINANCIAL POWERS DESCRIBED IN SECTION 32-1-1101; EXCEPT THAT THE
8 LEVY AND COLLECTION OF AD VALOREM TAXES SHALL BE SUBJECT TO THE
9 PROVISIONS OF SECTION 32-18-115. THE DISTRICT SHALL ALSO HAVE THE
10 POWER, UPON VOTER APPROVAL, TO LEVY AND COLLECT A UNIFORM SALES
11 TAX THROUGHOUT THE ENTIRE GEOGRAPHICAL AREA OF THE DISTRICT
12 UPON EVERY TRANSACTION OR OTHER INCIDENT WITH RESPECT TO WHICH
13 A SALES TAX IS LEVIED BY THE STATE PURSUANT TO THE PROVISIONS OF
14 ARTICLE 26 OF TITLE 39, C.R.S. ANY SALES TAX AUTHORIZED PURSUANT
15 TO THIS SECTION SHALL BE LEVIED AND COLLECTED AS PROVIDED IN
16 SECTION 32-18-112.

17 **32-18-112. Sales tax imposed - collection - administration of**
18 **tax.** (1) (a) UPON THE APPROVAL OF THE ELIGIBLE ELECTORS IN THE
19 DISTRICT AT AN ELECTION HELD IN ACCORDANCE WITH SECTION 20 OF
20 ARTICLE X OF THE STATE CONSTITUTION AND PART 8 OF ARTICLE 1 OF THIS
21 TITLE, THE DISTRICT SHALL HAVE THE POWER TO LEVY A UNIFORM SALES
22 TAX THROUGHOUT THE ENTIRE GEOGRAPHICAL AREA OF THE DISTRICT
23 UPON EVERY TRANSACTION OR OTHER INCIDENT WITH RESPECT TO WHICH
24 A SALES TAX IS LEVIED BY THE STATE PURSUANT TO THE PROVISIONS OF
25 ARTICLE 26 OF TITLE 39, C.R.S.

26 (b) THE SALES TAX IMPOSED PURSUANT TO PARAGRAPH (a) OF
27 THIS SUBSECTION (1) SHALL ALSO BE LEVIED ON THE FOLLOWING SALES
28 AND PURCHASES:

1 (I) PURCHASES OF MACHINERY OR MACHINE TOOLS THAT ARE
2 OTHERWISE EXEMPT PURSUANT TO SECTION 39-26-709(1), C.R.S., TO THE
3 EXTENT THAT SUCH SALES AND PURCHASES ARE SUBJECT TO THE SALES
4 TAX LEVIED BY THE REGIONAL TRANSPORTATION DISTRICT PURSUANT TO
5 SECTION 29-2-105 (1) (d), C.R.S.;

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

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

11 (c) THE SALES TAX IMPOSED PURSUANT TO PARAGRAPH (a) OF
12 THIS SUBSECTION (1) SHALL NOT BE LEVIED ON:

13 (I) THE SALE OF TANGIBLE PERSONAL PROPERTY DELIVERED BY
14 A RETAILER OR A RETAILER'S AGENT OR TO A COMMON CARRIER FOR
15 DELIVERY TO A DESTINATION OUTSIDE THE DISTRICT; OR

16 (II) THE SALE OF TANGIBLE PERSONAL PROPERTY ON WHICH A
17 SPECIFIC OWNERSHIP TAX HAS BEEN PAID OR IS PAYABLE WHEN SUCH SALE
18 MEETS THE FOLLOWING CONDITIONS:

19 (A) THE PURCHASER DOES NOT RESIDE IN THE DISTRICT, OR THE
20 PURCHASER'S PRINCIPAL PLACE OF BUSINESS IS OUTSIDE THE DISTRICT.

21 (B) THE PERSONAL PROPERTY IS REGISTERED OR REQUIRED TO BE
22 REGISTERED OUTSIDE THE GEOGRAPHICAL BOUNDARIES OF THE DISTRICT
23 UNDER THE LAWS OF THIS STATE.

24 (d) THE SALES TAX IMPOSED PURSUANT TO PARAGRAPH (a) OF
25 THIS SUBSECTION (1) IS IN ADDITION TO ANY OTHER SALES OR USE TAX
26 IMPOSED PURSUANT TO LAW AND IS EXEMPT FROM THE LIMITATION
27 IMPOSED BY SECTION 29-2-108 (1), C.R.S.

28 (2) (a) THE COLLECTION, ADMINISTRATION, AND ENFORCEMENT

1 OF THE SALES TAX SHALL BE PERFORMED BY THE EXECUTIVE DIRECTOR OF
2 THE DEPARTMENT OF REVENUE IN THE SAME MANNER AS THAT FOR THE
3 COLLECTION, ADMINISTRATION, AND ENFORCEMENT OF THE STATE SALES
4 TAX IMPOSED PURSUANT TO ARTICLE 26 OF TITLE 39, C.R.S., INCLUDING,
5 WITHOUT LIMITATION, THE RETENTION BY A VENDOR OF THE PERCENTAGE
6 OF THE AMOUNT REMITTED TO COVER THE VENDOR'S EXPENSE IN THE
7 COLLECTION AND REMITTANCE OF THE SALES TAX AS PROVIDED IN SECTION
8 39-26-105, C.R.S. THE EXECUTIVE DIRECTOR SHALL MAKE MONTHLY
9 DISTRIBUTIONS OF SALES TAX COLLECTIONS TO THE DISTRICT. THE
10 DISTRICT SHALL PAY THE NET INCREMENTAL COST INCURRED BY THE
11 DEPARTMENT OF REVENUE IN THE ADMINISTRATION AND COLLECTION OF
12 THE SALES TAX.

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

24 (II) A QUALIFIED PURCHASER THAT PROVIDES A DIRECT PAYMENT
25 PERMIT NUMBER TO A VENDOR OR RETAILER SHALL BE LIABLE AND
26 RESPONSIBLE FOR THE AMOUNT OF SALES TAX LEVIED ON A SALE MADE TO
27 THE QUALIFIED PURCHASER PURSUANT TO THE PROVISIONS OF THIS
28 ARTICLE IN THE SAME MANNER AS LIABILITY WOULD BE IMPOSED ON A

1 QUALIFIED PURCHASER FOR STATE SALES TAX PURSUANT TO SECTION
2 39-26-105 (3), C.R.S.

3 **32-18-113. District revenues.** ANY REVENUES RAISED OR
4 GENERATED BY THE DISTRICT SHALL BE IN ADDITION TO AND SHALL NOT
5 BE USED TO REPLACE ANY FUNDING THE COUNTIES IN THE DISTRICT WOULD
6 OTHERWISE BE ENTITLED TO RECEIVE FROM THE STATE OR FEDERAL
7 GOVERNMENT.

8 **32-18-114. Cooperation with health service district or other**
9 **existing providers permitted.** A DISTRICT SHALL HAVE THE AUTHORITY
10 TO CONTRACT WITH OR WORK COOPERATIVELY AND IN CONJUNCTION WITH
11 A HEALTH SERVICE DISTRICT OR ANY EXISTING HEALTH CARE PROVIDERS
12 OR SERVICES TO PROVIDE HEALTH CARE SERVICES TO THE RESIDENTS OF
13 SUCH DISTRICTS.

14 **32-18-115. Levy and collection of ad valorem taxes.** (1) ANY
15 HEALTH ASSURANCE DISTRICT THAT IS CREATED PURSUANT TO THIS
16 ARTICLE SHALL HAVE THE POWER, UPON APPROVAL BY THE ELIGIBLE
17 ELECTORS OF THE DISTRICT, TO LEVY AND COLLECT AD VALOREM TAXES
18 ON AND AGAINST ALL TAXABLE PROPERTY WITHIN THE DISTRICT SUBJECT
19 TO THE FOLLOWING PROVISIONS:

20 (a) FOR PURPOSES OF THIS SECTION, "ELIGIBLE ELECTOR" SHALL
21 HAVE THE SAME MEANING AS SET FORTH IN SECTION 32-1-103 (5).

22 (b) THE LEVY AND COLLECTION OF AD VALOREM TAXES SHALL BE
23 SUBJECT TO THE APPLICABLE PROVISIONS OF THE "SPECIAL DISTRICT ACT",
24 ARTICLE 1 OF THIS TITLE.

25 **SECTION 7.** Article 2 of title 29, Colorado Revised Statutes, is
26 amended BY THE ADDITION OF A NEW SECTION to read:

27 **29-2-103.8. Sales tax for health care services.** (1) IN ADDITION
28 TO ANY SALES TAX IMPOSED PURSUANT TO SECTION 29-2-103, EACH

1 COUNTY IN THE STATE IS AUTHORIZED TO LEVY A COUNTY SALES TAX FOR
2 THE PURPOSE OF PROVIDING, DIRECTLY OR INDIRECTLY, HEALTH CARE
3 SERVICES TO RESIDENTS OF THE COUNTY WHO ARE IN NEED OF HEALTH
4 CARE SERVICES AND TO FAMILY MEMBERS OF SUCH RESIDENTS.

5 (2) (a) ANY COUNTY IN WHICH HEALTH CARE SERVICES ARE
6 PROVIDED MAY ENTER INTO INTERGOVERNMENTAL AGREEMENTS WITH
7 ANY MUNICIPALITY OR OTHER COUNTY OR MAY ENTER INTO CONTRACTUAL
8 AGREEMENTS WITH ANY PRIVATE PROVIDER OR HEALTH SERVICE DISTRICT,
9 AS DEFINED IN SECTION 32-1-103 (9), C.R.S., FOR THE PURPOSE OF
10 PROVIDING HEALTH CARE SERVICES WITHIN THE COUNTY.

11 (b) ANY COUNTY THAT USES SALES TAX REVENUES IMPOSED
12 PURSUANT TO THIS SECTION FOR THE PROVISION OF HEALTH CARE
13 SERVICES SHALL ESTABLISH STANDARDS FOR SUCH SERVICES.

14 (3) (a) NO SALES TAX SHALL BE LEVIED PURSUANT TO THE
15 PROVISIONS OF SUBSECTION (1) OF THIS SECTION UNTIL THE PROPOSAL HAS
16 BEEN REFERRED TO AND APPROVED BY THE ELIGIBLE ELECTORS OF THE
17 COUNTY IN ACCORDANCE WITH THE PROVISIONS OF THIS ARTICLE. THE
18 BALLOT QUESTION FOR ANY PROPOSAL FOR A SALES TAX INCREASE
19 PURSUANT TO THIS SECTION SHALL CLEARLY STATE THAT THE APPROVAL
20 OF THE SALES TAX MAY RESULT IN A SALES TAX RATE IN EXCESS OF THE
21 CURRENT LIMITATION IMPOSED BY SECTION 29-2-108.

22 (b) ANY PROPOSAL FOR THE LEVY OF A SALES TAX IN
23 ACCORDANCE WITH PARAGRAPH (a) OF THIS SUBSECTION (3) SHALL ONLY
24 BE SUBMITTED TO THE ELIGIBLE ELECTORS OF THE COUNTY ON THE FIRST
25 TUESDAY AFTER THE FIRST MONDAY IN NOVEMBER OF EACH YEAR, AND
26 ANY ELECTION ON THE PROPOSAL SHALL BE CONDUCTED BY THE COUNTY
27 CLERK AND RECORDER IN ACCORDANCE WITH THE "UNIFORM ELECTION
28 CODE OF 1992", ARTICLES 1 TO 13 OF TITLE 1, C.R.S.

1 (4) ALL REVENUES COLLECTED FROM A COUNTY SALES TAX
2 IMPOSED PURSUANT TO THIS SECTION SHALL BE CREDITED TO A SPECIAL
3 FUND IN THE COUNTY TREASURY KNOWN AS THE COUNTY HEALTH CARE
4 SERVICES FUND. THE FUND SHALL BE USED ONLY FOR THE PURPOSE OF
5 PROVIDING MENTAL HEALTH CARE SERVICES IN ACCORDANCE WITH THIS
6 SECTION.

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

9 **29-2-108. Limitation on amount.** (3) A tax imposed pursuant
10 to ~~section 24-90-110.7 (3) (f), 29-1-204.5 (3) (f.1), 29-2-103.7,~~
11 ~~29-2-103.9, 30-11-107.5, 30-11-107.7, or 37-50-110, C.R.S.~~ SECTION
12 24-90-110.7 (3) (f), 29-1-204.5 (3) (f.1), 29-2-103.7, 29-2-103.8,
13 29-2-103.9, 30-11-107.5, 30-11-107.7, OR 37-50-110, C.R.S., and the
14 additional tax authorized by section 30-20-604.5, C.R.S., if imposed, shall
15 be exempt from the six and ninety one-hundredths percent limitation
16 imposed by subsection (1) of this section.

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

19 **24-34-104. General assembly review of regulatory agencies**
20 **and functions for termination, continuation, or reestablishment.**

21 (39) (b) The following agencies, functions, or both, shall terminate on
22 July 1, 2008:

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

27 **SECTION 10. Safety clause.** The general assembly hereby

- 1 finds, determines, and declares that this act is necessary for the immediate
- 2 preservation of the public peace, health, and safety.

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Bill B

Colorado Legislative Council Staff

**STATE and LOCAL
CONDITIONAL FISCAL IMPACT**

Drafting Number: LLS 06-0141
Prime Sponsor(s): Sen. Hanna
Rep. Riesberg

Date: December 14, 2005
Bill Status: Interim Committee on Health
Insurance
Fiscal Analyst: Chris Ward (303-866-5834)

TITLE: 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.

Fiscal Impact Summary	FY 2006/2007	FY 2007/2008
State Revenues		
General Fund	\$5,202	
Cash Fund	\$61,120	
State Expenditures		
General Fund	\$5,202	
Cash Fund Exempt	\$61,120	
FTE Position Change	0.0 FTE	0.0 FTE
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

Bill C

Second Regular Session
Sixty-fifth General Assembly
STATE OF COLORADO

DRAFT

LLS NO. 06-0143.01 Michele Hanigsberg

SENATE BILL

SENATE SPONSORSHIP

Hagedorn, and Shaffer

HOUSE SPONSORSHIP

Boyd, and Green

Senate Committees

House Committees

A BILL FOR AN ACT

101 CONCERNING THE PROVISION OF HEALTH CARE SERVICES TO
102 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.

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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.

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

2 **SECTION 1.** Title 25.5, Colorado Revised Statutes, is amended
3 BY THE ADDITION OF A NEW ARTICLE to read:

4 **ARTICLE 4**

5 **Colorado Primary Care**

6 **25.5-4-101. Short title.** THIS ARTICLE SHALL BE KNOWN AND
7 MAY BE CITED AS THE "COLORADO PRIMARY CARE ACT".

8 **25.5-4-102. Definitions.** AS USED IN THIS ARTICLE, UNLESS THE
9 CONTEXT OTHERWISE REQUIRES:

10 (1) "ELIGIBLE PERSON" MEANS A PERSON WHO IS:

11 (a) A RESIDENT OF COLORADO AND WHO IS A CITIZEN OF THE
12 UNITED STATES OR A QUALIFIED ALIEN AS DEFINED IN SECTION 26-2-703
13 (17.7), C.R.S.;

14 (b) AT LEAST NINETEEN YEARS OF AGE AND LESS THAN
15 SIXTY-FOUR YEARS OF AGE;

1 (c) AT OR BELOW ONE HUNDRED PERCENT OF THE FEDERAL
2 POVERTY LEVEL;

3 (d) NOT ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO
4 ARTICLE 4 OF TITLE 26, C.R.S., OR THE CHILDREN'S BASIC HEALTH PLAN
5 PURSUANT TO ARTICLE 19 OF TITLE 26, C.R.S., OR ENROLLED IN HEALTH
6 INSURANCE COVERAGE FROM ANY OTHER THIRD-PARTY PAYOR; AND

7 (e) NOT ELIGIBLE FOR VETERAN'S ADMINISTRATION MEDICAL
8 BENEFITS OR THE TREATMENT OF THE QUALIFYING MEDICAL CONDITION
9 THROUGH WORKERS' COMPENSATION COVERAGE.

10 (2) "PRIMARY CARE" MEANS THE BASIC, ENTRY-LEVEL HEALTH
11 CARE PROVIDED BY HEALTH CARE PRACTITIONERS OR NON-PHYSICIAN
12 HEALTH CARE PRACTITIONERS THAT IS GENERALLY PROVIDED IN AN
13 OUTPATIENT SETTING.

14 (3) "PROGRAM" MEANS THE COLORADO PRIMARY CARE PROGRAM.

15 (4) "QUALIFYING MEDICAL CONDITION" MEANS A CONDITION
16 THAT REQUIRES A PLAN OF CARE AND AT LEAST FOUR VISITS ANNUALLY TO
17 A MEDICAL CARE PROVIDER.

18 **25.5-4-103. Colorado primary care - benefits - providers.**

19 (1) THERE IS HEREBY CREATED THE COLORADO PRIMARY CARE PROGRAM
20 FOR THE PURPOSE OF PROVIDING PRIMARY CARE SERVICES TO
21 LOW-INCOME, UNINSURED ADULTS WHO HAVE A QUALIFYING MEDICAL
22 CONDITION. THE STATE DEPARTMENT SHALL ADMINISTER AND IMPLEMENT
23 THE PROGRAM CONSISTENT WITH THE PROVISIONS OF THIS ARTICLE.

24 (2) SUBJECT TO AVAILABLE APPROPRIATIONS, AN ELIGIBLE
25 PERSON MAY RECEIVE THE FOLLOWING PRIMARY CARE SERVICES WHEN
26 ENROLLED IN THE PROGRAM:

27 (a) OFFICE VISITS FOR ACUTE AND CHRONIC HEALTH CARE
28 CONDITIONS;

- 1 (b) AGE AND GENDER APPROPRIATE HEALTH CARE SCREENINGS;
2 (c) LABORATORY TESTS FOR BASELINE STUDIES AS WELL AS TESTS
3 NEEDED TO DIAGNOSE OR TREAT MEDICAL CONDITIONS;
4 (d) BASIC X-RAYS;
5 (e) OUTPATIENT DRUG AND ALCOHOL TREATMENT AS PRESCRIBED
6 BY THE PARTICIPATING MEDICAL CARE PROVIDER;
7 (f) DIABETIC CARE, INCLUDING MEDICAL SUPPLIES;
8 (g) FOUR PRESCRIPTIONS PER MONTH THAT ARE WRITTEN BY AN
9 AUTHORIZED PROVIDER; AND
10 (h) ANY OTHER PRIMARY CARE SERVICE THE STATE BOARD
11 AUTHORIZES BY RULE THAT IS MEDICALLY NECESSARY FOR THE ELIGIBLE
12 PERSON TO RECEIVE AND THAT IS WITHIN THE PROGRAM'S ANNUAL
13 APPROPRIATION.

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

17 **25.5-4-104. Financial management - rules.** (1) THE STATE
18 DEPARTMENT SHALL PROPOSE RULES FOR APPROVAL BY THE STATE BOARD
19 TO IMPLEMENT FINANCIAL MANAGEMENT OF THE PROGRAM. PURSUANT TO
20 SUCH RULES, THE STATE DEPARTMENT SHALL ADJUST BENEFIT LEVELS AND
21 PROVIDER REIMBURSEMENT TO ENSURE THAT SUFFICIENT FUNDS ARE
22 PRESENT TO IMPLEMENT THE PROVISIONS OF THIS ARTICLE. THE
23 DEPARTMENT SHALL DEVELOP AND USE QUALITY ASSURANCE MEASURES
24 TO ENSURE THAT APPROPRIATE HEALTH CARE OUTCOMES ARE MET.

25 (2) (a) NOTHING IN THIS ARTICLE OR ANY RULES PROMULGATED
26 PURSUANT TO THIS ARTICLE SHALL BE INTERPRETED TO CREATE A LEGAL
27 ENTITLEMENT IN ANY PERSON TO COVERAGE UNDER THE PROGRAM.
28 ENROLLMENT IN THE PROGRAM SHALL BE LIMITED BASED UPON ANNUAL

1 APPROPRIATIONS MADE BY THE GENERAL ASSEMBLY AND ANY GIFTS,
2 GRANTS, AND DONATIONS RECEIVED BY THE STATE DEPARTMENT. THE
3 GENERAL ASSEMBLY SHALL ANNUALLY ESTABLISH MAXIMUM
4 ENROLLMENT FIGURES FOR ELIGIBLE PERSONS IN THE PROGRAM. THE
5 ENROLLMENT CAPS SHALL NOT BE EXCEEDED BY THE STATE DEPARTMENT
6 REGARDLESS OF WHETHER THE FUNDING COMES FROM ANNUAL
7 APPROPRIATIONS OR GIFTS, GRANTS, AND DONATIONS. WHEN
8 ENROLLMENT IN THE PROGRAM MUST BE LIMITED PURSUANT TO THIS
9 SUBSECTION (2), THE STATE DEPARTMENT SHALL ESTABLISH A WAITING
10 LIST FOR THE PROGRAM.

11 (b) THE DEPARTMENT SHALL REPORT QUARTERLY TO THE JOINT
12 BUDGET COMMITTEE ON ANY ENROLLMENT CAPS THAT HAVE BEEN
13 INSTITUTED FOR THE PROGRAM AND THE NUMBER OF ELIGIBLE PERSONS
14 WHO ARE ON THE WAITING LIST.

15 (3) THE STATE BOARD SHALL PROMULGATE RULES NECESSARY TO
16 IMPLEMENT AND ADMINISTER THIS ARTICLE THAT SHALL INCLUDE, BUT
17 NOT BE LIMITED TO, AN APPEAL PROCESS FOR THE PROGRAM, QUALITY
18 ASSURANCE MEASURES FOR PROVIDERS PARTICIPATING IN THE PROGRAM,
19 AND FINANCIAL MANAGEMENT OF THE PROGRAM.

20 **25.5-4-105. Report.** ON OR BEFORE JULY 1, 2007, THE STATE
21 DEPARTMENT SHALL REPORT TO THE JOINT HEALTH AND HUMAN SERVICES
22 COMMITTEES OF THE SENATE AND THE HOUSE OF REPRESENTATIVES ON
23 THE USE OF THE MONEYS IN THE HEALTH CARE SERVICES FUND
24 ESTABLISHED IN SECTION 25.5-1-114 AND THE IMPLEMENTATION AND
25 OPERATION OF THE COLORADO PRIMARY CARE PROGRAM.

26 **SECTION 2.** Part 1 of article 1 of title 25.5, Colorado Revised
27 Statutes, is amended BY THE ADDITION OF A NEW SECTION to
28 read:

1 **25.5-1-114. Health care services fund - creation.**

2 (1) (a) THERE IS HEREBY CREATED IN THE STATE TREASURY THE
3 COLORADO HEALTH CARE SERVICES FUND, ALSO REFERRED TO IN THIS
4 SECTION AS THE "FUND". THE FUND SHALL CONSIST OF MONEYS CREDITED
5 THERETO PURSUANT TO THIS SECTION.

6 (b) IN FISCAL YEAR 2005-06, AND EACH OF THE FOUR FISCAL
7 YEARS THEREAFTER, IF THE MOST RECENT LEGISLATIVE COUNCIL STAFF
8 ECONOMIC AND REVENUE FORECAST ESTIMATES THAT THE GENERAL FUND
9 EXEMPT ACCOUNT, CREATED IN SECTION 24-77-103.6 (2), C.R.S., WILL
10 RECEIVE MORE THAN ONE HUNDRED FIFTEEN MILLION DOLLARS, FIFTEEN
11 MILLION DOLLARS OF THE MONEYS IN THE GENERAL FUND EXEMPT
12 ACCOUNT SHALL BE APPROPRIATED TO THE COLORADO HEALTH CARE
13 SERVICES FUND CREATED IN THIS SUBSECTION (1).

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

20 (2) IN FISCAL YEAR 2006-07, AND EACH OF THE FOUR FISCAL
21 YEARS THEREAFTER, OF THE MONEYS DEPOSITED INTO THE FUND:

22 (a) SEVEN MILLION FIVE HUNDRED THOUSAND DOLLARS SHALL BE
23 APPROPRIATED FOR THE COLORADO PRIMARY CARE PROGRAM
24 ESTABLISHED IN ARTICLE 4 OF THIS TITLE; AND

25 (b) (I) SEVEN MILLION FIVE HUNDRED THOUSAND DOLLARS SHALL
26 BE APPROPRIATED TO INCREASE ELIGIBILITY IN THE MEDICAL ASSISTANCE
27 PROGRAM PURSUANT TO SECTION 26-4-301 (1) (u), C.R.S.

28 (II) THE MONEYS SPECIFIED IN THIS PARAGRAPH (b) SHALL BE

1 USED ONLY TO PAY FOR SERVICES PROVIDED TO PERSONS IN THE
2 ELIGIBILITY CATEGORY SPECIFIED IN SECTION 26-4-301 (1) (u), C.R.S.,
3 WHO ARE ABOVE SIXTY PERCENT OF THE FEDERAL POVERTY LEVEL.

4 **SECTION 3. Effective date.** This act shall take effect July 1,
5 2006.

6 **SECTION 4. Safety clause.** The general assembly hereby finds,
7 determines, and declares that this act is necessary for the immediate
8 preservation of the public peace, health, and safety.

Bill D

Second Regular Session
Sixty-fifth General Assembly
STATE OF COLORADO

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LLS NO. 06-0144.01 Jery Payne

SENATE BILL

SENATE SPONSORSHIP

Tapia, Hagedorn, Keller, and Shaffer

HOUSE SPONSORSHIP

Butcher, Boyd, and Green

Senate Committees

House Committees

A BILL FOR AN ACT

101 **CONCERNING A STUDY TO ANALYZE FACTORS THAT DRIVE THE COST OF**
102 **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

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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.

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

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

5 **10-16-131. Study of health insurance premiums charged in**
6 **Pueblo county - repeal.** (1) (a) THE DIVISION SHALL CONDUCT AN
7 INDEPENDENT AND OBJECTIVE STUDY PURSUANT TO SUBSECTION (2) OF
8 THIS SECTION TO GATHER AND ANALYZE DATA TO IDENTIFY:

9 (I) THE FACTORS THAT DRIVE HEALTH INSURANCE COSTS FOR
10 INDIVIDUALS AND GROUPS IN PUEBLO COUNTY;

11 (II) THE STATISTICAL INTERACTION, RELATIONSHIPS, AND
12 DEPENDENCIES OF THE FACTORS;

13 (III) THE DEMOGRAPHIC, HEALTH SERVICES, AND OTHER COST
14 COMPONENTS OF HEALTH INSURANCE PREMIUMS FOR INDIVIDUALS AND
15 GROUPS IN PUEBLO COUNTY;

16 (IV) THE ROLE OF MODIFIED COMMUNITY RATING FOR PUEBLO
17 COUNTY; AND

18 (V) WHETHER HEALTH COVERAGE FOR INDIVIDUALS AND GROUPS
19 IN PUEBLO COUNTY IS REASONABLY AVAILABLE.

1 (b) THE DIVISION MAY CONTRACT WITH A NONPROFIT ENTITY TO
2 ANALYZE DATA COLLECTED BY THE DIVISION AND PREPARE A REPORT OF
3 THE ANALYSIS OF SUCH DATA.

4 (2) (a) THE COMMISSIONER SHALL CONVENE A MEETING OF ALL
5 INTERESTED PERSONS RELATED TO THE STUDY NO LATER THAN JUNE 15,
6 2006. INTERESTED PERSONS INCLUDE, BUT ARE NOT LIMITED TO,
7 PROVIDERS AND CONSUMERS OF HEALTH INSURANCE, THE CHAIRS OF THE
8 BOARD OF MEDICAL EXAMINERS AND ANY OTHER **TYPE 1** BOARD THAT
9 REGULATES A HEALTH CARE PROFESSION, THE DIRECTOR OF THE DIVISION
10 OF REGISTRATIONS, AND THE EXECUTIVE DIRECTOR OF THE DEPARTMENT
11 OF PUBLIC HEALTH AND ENVIRONMENT. THE MEETING SHALL INCLUDE A
12 DISCUSSION OF THE EXACT DATA TO BE GATHERED, IF ANY, IN ADDITION TO
13 THE DATA SPECIFIED IN SUBSECTION (3) OF THIS SECTION, THE METHOD
14 AND TIME FRAMES FOR COLLECTION OF THE DATA, AND THE OBJECTIVES
15 AND STANDARDS FOR THE ANALYSIS THEREOF.

16 (b) UPON COMPLETION OF THE ANALYSIS, THE DIVISION SHALL
17 PRESENT A DRAFT OF THE REPORT TO THE COMMISSIONER FOR APPROVAL
18 AND TRANSMISSION TO THE GENERAL ASSEMBLY PURSUANT TO
19 PARAGRAPH (c) OF THIS SUBSECTION (2).

20 (c) THE COMMISSIONER SHALL SUBMIT A REPORT OF THE STUDY
21 CONTAINING CONCLUSIONS AND AN ANALYSIS OF THE FACTORS THAT
22 DRIVE THE COST OF HEALTH CARE, THE COST OF HEALTH INSURANCE
23 COVERAGE ON AN INDIVIDUAL AND GROUP BASIS, AND THE IMPACT OF
24 MODIFIED COMMUNITY RATING ON PUEBLO COUNTY TO THE PRESIDENT OF
25 THE SENATE, MAJORITY LEADER OF THE SENATE, MINORITY LEADER OF THE
26 SENATE, SPEAKER OF THE HOUSE OF REPRESENTATIVES, MAJORITY LEADER
27 OF THE HOUSE OF REPRESENTATIVES, MINORITY LEADER OF THE HOUSE OF
28 REPRESENTATIVES, AND CHAIRS OF THE HEALTH AND HUMAN SERVICES

1 AND BUSINESS AFFAIRS COMMITTEES OF THE SENATE AND THE HOUSE OF
2 REPRESENTATIVES NO LATER THAN JANUARY 15, 2008.

3 (d) THE COMMISSIONER SHALL AGGREGATE DATA COLLECTED
4 FROM THE DIVISION OF REGISTRATIONS WITHIN THE DEPARTMENT OF
5 REGULATORY AGENCIES AND THE DEPARTMENT OF PUBLIC HEALTH AND
6 ENVIRONMENT PURSUANT TO SECTIONS 24-34-102 (15) AND 25-1.5-103
7 (5), C.R.S. IF THE COMMISSIONER CONTRACTS WITH A NONPROFIT ENTITY
8 TO ANALYZE DATA COLLECTED PURSUANT TO THIS SECTION, SUCH
9 AGGREGATED DATA MAY BE TRANSMITTED TO SUCH NONPROFIT ENTITY
10 FOR ANALYSIS.

11 (e) NOTHING IN THIS SECTION SHALL WAIVE ANY CLAIM TO
12 PRIVILEGED OR CONFIDENTIAL INFORMATION PURSUANT TO FEDERAL OR
13 STATE LAW.

14 (3) THE DATA TO BE COLLECTED SHALL INCLUDE THE AMOUNT OF
15 CLAIMS PAID BY HEALTH INSURERS IN PUEBLO COUNTY FOR THE PERIOD
16 BEGINNING _____ AND ENDING _____; THE RATES CHARGED FOR HEALTH
17 INSURANCE DURING THIS PERIOD; THE CHARGES BILLED BY LICENSED,
18 CERTIFIED, OR REGISTERED HEALTH CARE PROVIDERS DURING THIS SAME
19 PERIOD; THE CHARGES BILLED BY ALL LICENSED HEATH CARE FACILITIES
20 DURING THIS PERIOD; THE NUMBER OF LICENSED, CERTIFIED, OR
21 REGISTERED HEALTH CARE PROVIDERS IN PUEBLO COUNTY DURING THIS
22 PERIOD; THE NUMBER OF HEALTH INSURERS CONDUCTING BUSINESS IN
23 PUEBLO COUNTY DURING THIS PERIOD; WHETHER THE PRACTICE PATTERNS
24 OF HEALTH CARE PROVIDERS IN THE PUEBLO COMMUNITY DIFFER FROM
25 ACCEPTED STANDARDS AND GUIDELINES; WHETHER THE HEALTH STATUS
26 OF THE PUEBLO COMMUNITY DRIVES HEALTH INSURANCE COSTS; AND ANY
27 OTHER INFORMATION DETERMINED NECESSARY BY THE COMMISSIONER.

28 (4) THIS SECTION IS REPEALED, EFFECTIVE JANUARY 15, 2008.

1 **SECTION 2.** 24-34-102, Colorado Revised Statutes, is amended
2 BY THE ADDITION OF A NEW SUBSECTION to read:

3 **24-34-102. Division of registrations - creation - duties of**
4 **division and department heads - definitions - license, registration, or**
5 **certification renewal and reinstatement - repeal.**

6 (15) (a) NOTWITHSTANDING ANY **TYPE 1** TRANSFER, AS SUCH TRANSFER
7 IS DEFINED BY SECTION 24-1-105, THE DIRECTOR OF THE DIVISION OF
8 REGISTRATIONS SHALL CONDUCT A SURVEY OF EACH LICENSED, CERTIFIED,
9 OR REGISTERED HEALTH CARE PROFESSIONAL CONCERNING THE CHARGES
10 BILLED TO HEALTH INSURERS AND CONSUMERS IN PUEBLO COUNTY FOR
11 THE PERIOD BEGINNING _____ AND ENDING _____. THE DIRECTOR
12 SHALL FORWARD THE SURVEY RESULTS TO THE DIVISION OF INSURANCE
13 PURSUANT TO SECTION 10-16-131, C.R.S., BY _____ 200_. THE DIRECTOR
14 SHALL CREATE THE SURVEY QUESTIONNAIRE AFTER CONSULTATION WITH
15 THE INSURANCE COMMISSIONER.

16 (b) THIS SUBSECTION (15) IS REPEALED, EFFECTIVE JANUARY 15,
17 2008.

18 **SECTION 3.** 25-1.5-103, Colorado Revised Statutes, is
19 amended BY THE ADDITION OF A NEW SUBSECTION to read:

20 **25-1.5-103. Hospitals and community mental health centers**
21 **- powers and duties of the department - limitations on rules**
22 **promulgated by the department - repeal.** (5) (a) THE EXECUTIVE
23 DIRECTOR OF THE DEPARTMENT SHALL SURVEY ALL LICENSED HEALTH
24 FACILITIES IN PUEBLO COUNTY FOR CHARGES BILLED TO HEALTH INSURERS
25 AND CONSUMERS FOR THE PERIOD BEGINNING _____ AND ENDING
26 _____. THE EXECUTIVE DIRECTOR SHALL FORWARD THE SURVEY
27 RESULTS TO THE DIVISION OF INSURANCE PURSUANT TO SECTION
28 10-16-131, C.R.S., BY _____ 200_. THE EXECUTIVE DIRECTOR SHALL

1 CREATE THE SURVEY QUESTIONNAIRE ON CONSULTATION WITH THE
2 INSURANCE COMMISSIONER.

3 (b) THIS SUBSECTION (5) IS REPEALED, EFFECTIVE JANUARY 15,
4 2008.

5 **SECTION 4. Safety clause.** The general assembly hereby finds,
6 determines, and declares that this act is necessary for the immediate
7 preservation of the public peace, health, and safety.

DRAFT

Bill D

Colorado Legislative Council Staff

STATE
FISCAL IMPACT

Drafting Number: LLS 06-0144 **Date:** December 15, 2005
Prime Sponsor(s): Sen. Tapia **Bill Status:** Interim Committee on Health Insurance
Rep. Butcher **Fiscal Analyst:** Amy Larsen (303-866-3488)

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

Fiscal Impact Summary	FY 2005/2006	FY 2006/2007	FY 2007/2008
State Revenues			
General Fund	(\$6,757)	(\$20,904)	
Cash Fund - Division of Registrations		20,496	\$81,984
State Expenditures			
General Fund		\$58,708	
Cash Fund - Division of Insurance	\$6,757	20,904	
Cash Fund - Division of Registrations		101,740	
FTE Position Change		0.0 FTE	0.0 FTE
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

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 1.					
Fee Impact on Individuals, Families or Business					
Type of Fee	Current Fee	Proposed Fee	Fee Change	# of Affected Individuals	Total Fee Impact
License fees for various health professionals - 20% in FY 2006-07	\$34 - \$38		\$0.85	24,400	\$20,496
License fees for various health professionals - 80% in FY 2007-08	\$34 - \$38		\$0.85	97,600	\$81,984
Total					\$102,480

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 2. Expenditure Detail		
	FY 2005/06	FY 2006/07
Division of Insurance - Personal Services	\$6,757	\$20,904
Division of Registrations - Mailing Expenses		\$101,740
Subtotal Department of Regulatory Agencies	\$6,757	\$122,644
Department of Public Health and Environment - Personal Services & Operating		\$58,708
Total Expenses	\$6,757	\$181,352

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

Bill E

**Second Regular Session
Sixty-fifth General Assembly
STATE OF COLORADO**

DRAFT

LLS NO. 06-0145.01 Christy Chase

SENATE BILL

SENATE SPONSORSHIP

Hagedorn,

HOUSE SPONSORSHIP

(None),

Senate Committees

House Committees

A BILL FOR AN ACT

101 **CONCERNING THE TYPES OF HEALTH BENEFIT PLANS REQUIRED TO BE**
102 **OFFERED BY SMALL EMPLOYER CARRIERS TO SMALL**
103 **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

DRAFT

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.

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

2 **SECTION 1.** 10-16-105 (5) (g), (7.2), (7.3) (a), (7.3) (c) (I),
3 (7.3) (f), and (7.3) (g), the introductory portion to 10-16-105 (7.3) (i), and
4 10-16-105 (7.5) (b) and (11), Colorado Revised Statutes, are amended to
5 read:

6 **10-16-105. Small group sickness and accident insurance -**
7 **guaranteed issue - mandated provisions for basic health benefit plans**
8 **- rules.** (5) Each small group sickness and accident insurer or other
9 entity shall make reasonable disclosure in solicitation and sales materials
10 provided to small employers the following information in a form and
11 manner prescribed by the commissioner and upon request of any such
12 small employer shall provide such information in detail:

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

1 and prosthetic devices.

2 (II) That a small employer purchasing a basic health benefit plan
3 AS DESCRIBED IN SUBPARAGRAPH (I) OR (III) OF PARAGRAPH (b) OF
4 SUBSECTION (7.2) OF THIS SECTION is waiving coverage for low-dose
5 mammography screening, mental illness, prostate screening,
6 hospitalization and general anesthesia for dental procedures for children,
7 the availability of treatment for alcoholism, and the availability of hospice
8 care.

9 (7.2) The commissioner shall promulgate rules to implement a
10 basic health benefit plan ~~and a standard health benefit plan~~ to be offered
11 by each small employer carrier as a condition of transacting business in
12 this state. The commissioner shall survey small group carriers to
13 determine the range of health benefit plans available annually. The
14 commissioner shall implement a basic plan that approximates the lowest
15 level of coverage offered in small group health benefit plans. ~~and shall~~
16 ~~implement a standard plan that approximates the average level of~~
17 ~~coverage offered in small group health benefit plans~~ In determining such
18 levels of coverage, the commissioner shall consider ~~such~~ factors SUCH as
19 coinsurance, copayments, deductibles, out-of-pocket maximums, and
20 covered benefits. The commissioner shall amend the rules to implement
21 the basic ~~and standard plans~~ HEALTH BENEFIT PLANS no more frequently
22 than once every two years. ~~Such~~ THE rules shall be in conformity with
23 the ~~provisions of~~ article 4 of title 24, C.R.S., and shall incorporate the
24 following BASIC HEALTH BENEFIT PLAN DESIGNS:

25 (a) ~~The standard health benefit plan shall reflect the benefit~~
26 ~~design of common plan offerings in the small group market and may~~
27 ~~reflect a plan design that has a deductible amount of two thousand five~~
28 ~~hundred dollars for which the covered person is responsible after the first~~

1 ~~one thousand dollars of coverage has been provided by an employer in a~~
2 ~~manner similar to a personal care account, and~~

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

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

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

25 (IV) A BASIC HEALTH BENEFIT PLAN WITH THE SAME OR SIMILAR
26 BENEFIT DESIGN AS IS AVAILABLE TO A MEDICAL ASSISTANCE RECIPIENT
27 ENROLLED WITH A MANAGED CARE ORGANIZATION UNDER THE STATEWIDE
28 MANAGED CARE SYSTEM IN SUBPART 2 OF PART 1 OF ARTICLE 4 OF TITLE

1 26, C.R.S.

2 (c) Notwithstanding any provision of law to the contrary, a small
3 employer carrier may offer and a small employer may accept or reject
4 coverage for employees' domestic partners and their dependents under a
5 ~~standard or~~ basic health benefit plan.

6 (7.3) (a) Except as otherwise provided in this subsection (7.3),
7 effective ~~January 1, 1995~~ JANUARY 1, 2007, every small employer carrier
8 shall, as a condition of transacting business in this state with small
9 employers, actively offer to such small employers ~~the choice of~~ a basic
10 health benefit plan. ~~or a standard health benefit plan~~ Effective ~~July 1,~~
11 ~~1997~~ JANUARY 1, 2007, every small employer carrier shall also offer to
12 small employers a choice of all the other small group plans the carrier
13 markets in Colorado; except that this requirement shall not apply to a
14 health benefit plan offered by a carrier if such plan is made available in
15 the small group market only through one or more bona fide association
16 plans and except as provided in paragraph (i) of this subsection (7.3).

17 (c) (I) A small employer carrier shall issue a basic health benefit
18 plan, ~~or a standard health benefit plan~~, except as provided in paragraph
19 (i) of this subsection (7.3), to any eligible small employer that applies for
20 such health benefit plan and agrees to make the required premium
21 payments and to satisfy the other reasonable provisions of the health
22 benefit plan that are consistent with this article. A small employer carrier
23 shall also issue any of its other small employer plans to any small
24 employer that applies for such a plan; except that this requirement shall
25 not apply to a business group of one where the business group of one does
26 not meet the carrier's normal and actuarially based underwriting criteria.
27 The requirements of this paragraph (c) shall not apply to a health benefit
28 plan offered by a carrier if such plan is made available in the small group

1 market only through one or more bona fide association plans.

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

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

10 (i) In lieu of accepting applications from and guarantee issuing
11 ~~the A basic and standard plans~~ HEALTH BENEFIT PLAN to business groups
12 of one year round, small employer carriers may limit their issuance of
13 coverage as provided in this paragraph (i). A small employer carrier may
14 establish open enrollment periods for guarantee issued basic ~~or standard~~
15 HEALTH BENEFIT plan applications from business groups of one for a
16 period of thirty-one days following the birth date of the person qualifying
17 as a business group of one. A small employer carrier may establish
18 annual open enrollment periods for business groups of one for thirty-one
19 days following the birth date of the applicant and may limit issuance of
20 a basic health benefit plan ~~and a standard health benefit plan~~ to such
21 thirty-one-day period. Carrier marketing and sales materials for business
22 groups of one shall clearly disclose the open enrollment period. If a
23 person qualifying as a business group of one applies for coverage under
24 a plan other than the basic ~~or standard~~ HEALTH BENEFIT plan, and if the
25 business group of one is denied coverage as provided by law, then the
26 small employer carrier shall offer the business group of one a choice of
27 coverage under the basic ~~or standard~~ HEALTH BENEFIT plan during the
28 applicant's appropriate open enrollment period. A small employer carrier

1 shall accept applications from business groups of one for a basic or
2 ~~standard~~ HEALTH BENEFIT plan through the thirty-first day after the birth
3 date of the person qualifying as a business group of one. The date upon
4 receipt of the signed application and the applicant's birth date shall be
5 used in determining whether the thirty-one day open enrollment applies
6 to a particular person qualifying as a business group of one. Eligible
7 dependents of such person may also be covered at the same time as the
8 applicant. Small employer carriers that use open enrollment periods shall
9 also accept applications from business groups of one and issue a basic or
10 ~~standard~~ HEALTH BENEFIT plan as provided by law if such applications are
11 submitted within thirty-one days of any one of the following events:

12 (7.5) (b) A small employer carrier shall not modify a basic health
13 benefit plan ~~or a standard health benefit plan~~ with respect to a small
14 employer or any eligible employee or dependent through a rider,
15 endorsement, or otherwise, if the effect of such modification is to restrict
16 or exclude coverage for certain diseases or medical conditions that are
17 otherwise covered by such plan.

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

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

25 **10-3-1104. Unfair methods of competition and unfair or**
26 **deceptive acts or practices.** (1) The following are defined as unfair
27 methods of competition and unfair or deceptive acts or practices in the
28 business of insurance:

1 (v) Failure to comply with all provisions of section 10-16-108.5
2 concerning fair marketing of basic ~~and standard~~ health benefit plans, and
3 section 10-16-105 concerning guaranteed issue of basic ~~and standard~~
4 health benefit plans;

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

7 **10-16-102. Definitions.** As used in this article, unless the
8 context otherwise requires:

9 (7) "Capped employees" means the number of employees and
10 dependents with health problems at the time the plan of which such
11 employees are a part was issued who are in small groups covered by the
12 carrier where the small employer group would have failed the carrier's
13 normal and actuarially based small group underwriting criteria
14 specifically because of the health status of those employees with health
15 problems at the time the plan was issued, but who were issued basic ~~or~~
16 ~~standard~~ health benefit plan coverage as required under section 10-16-105
17 (7.3)(c) regardless of the health status of the group. "Capped employees"
18 only includes employees and dependents covered by a small employer
19 group health benefit plan of a carrier at the time the carrier proposes to
20 suspend its duty to issue basic ~~or standard~~ health benefit plan coverage as
21 required under section 10-16-105 (7.3) (c).

22 (43) ~~"Standard health benefit plan" means a health benefit plan~~
23 ~~developed pursuant to section 10-16-105 (7.2).~~

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

26 **10-16-104. Mandatory coverage provisions.** (11) **Child**
27 **health supervision services.** (a) For purposes of this subsection (11),
28 unless the context otherwise requires, "child health supervision services"

1 means those preventive services and immunizations required to be
2 provided in A basic ~~and standard~~ health benefit plans PLAN pursuant to
3 section 10-16-105 (7.2), to dependent children up to age thirteen. Such
4 services shall be provided by a physician or pursuant to a physician's
5 supervision or by a primary health care provider who is a physician's
6 assistant or registered nurse who has additional training in child health
7 assessment and who is working in collaboration with a physician.

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

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

15 **10-16-105.2. Small employer health insurance availability**
16 **program.** (1) (c) (I) The provisions of this article concerning small
17 employer carriers and small group plans shall not apply to an individual
18 health benefit plan newly issued to a business group of one that includes
19 only a self-employed person who has no employees, or a sole proprietor
20 who is not offering or sponsoring health care coverage to his or her
21 employees, together with the dependents of such a self-employed person
22 or sole proprietor if, pursuant to rules adopted by the commissioner, all
23 of the following conditions are met:

24 (D) As part of its application form, an individual carrier requires
25 a business group of one self-employed person purchasing an individual
26 health benefit plan pursuant to this subparagraph (I) to read and sign a
27 disclosure form stating that, by purchasing an individual policy instead of
28 a small group policy, such person gives up what would otherwise be his

1 or her right to purchase a business group of one ~~standard~~, basic or other
2 health benefit plan from a small employer carrier for a period of three
3 years after the date the individual health benefit plan is purchased, unless
4 a small employer carrier voluntarily permits such person to purchase a
5 business group of one policy within such three-year period. The
6 disclosure form shall also briefly describe the factors used to set rates for
7 the individual policy being purchased in comparison with the factors used
8 to set rates for a business group of one small group policy. The
9 individual carrier shall provide to the business group of one
10 self-employed applicant a copy of the health benefit plan description form
11 ~~for the Colorado standard health benefit plan in addition to the description~~
12 ~~form for the individual plan being marketed.~~ The disclosure form may be
13 included within any other certification form that the carrier uses for the
14 plan. ~~The division of insurance shall make available a standard plan~~
15 ~~description form to individual carriers upon request.~~

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

19 **10-16-108. Conversion and continuation privileges.**

20 **(1) Group sickness and accident insurance - conversion privileges.**

21 (d) (I) A converted policy issued upon the exercise of the conversion
22 privilege of paragraph (c) of this subsection (1) shall offer ~~a choice of a~~
23 ~~basic or standard~~ health benefit plan.

24 **(4) Special provisions for small group health benefit plans.**

25 (a) Effective January 1, 1995, each small employer carrier shall, upon
26 termination of a group policy by the carrier or employer for reasons other
27 than replacement with another group policy or fraud and abuse in
28 procuring and utilizing coverage, offer to any individual ~~the choice of a~~

1 basic or standard health benefit plan. ~~except as provided in paragraph (b)~~
2 ~~of this subsection (4)~~. Reasons for termination include, but are not
3 limited to, the group no longer meeting participation requirements,
4 cancellation due to nonpayment of premiums, or the policyholder
5 exercising the right to cancel.

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

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

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

19 **10-16-108.5. Fair marketing standards.** (1) Each small
20 employer carrier shall actively market health benefit plan coverage,
21 including the basic health benefit plan, ~~and the standard health benefit~~
22 ~~plan~~, to eligible small employers in the state. If a small employer carrier
23 denies coverage to a small employer on the basis of the health status or
24 claims experience of the small employer or its employees or dependents,
25 the carrier shall offer the small employer the opportunity to purchase a
26 basic health benefit plan. ~~or a standard health benefit plan.~~

27 (4) A small employer carrier shall provide reasonable
28 compensation, as provided under the plan of operation of the small

1 employer health reinsurance program, to a producer, if any, for the sale
2 of a basic or standard health benefit plan.

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

5 **10-16-120. Legislative review of requirements for guaranteed**
6 **issue of basic and standard health benefit plans.** ~~(1) During the~~
7 ~~regular session of the general assembly in the year 2001, the legislative~~
8 ~~council of the general assembly shall conduct a review of the operation~~
9 ~~of requirements contained in section 10-16-105 for small employer~~
10 ~~carriers to issue basic and standard health benefit plans. Such review~~
11 ~~shall consider, but not be limited to, the effect of such requirement on the~~
12 ~~availability and affordability of health care coverage to residents of~~
13 ~~Colorado. As a result of the review required by this subsection (1), the~~
14 ~~legislative council may recommend to the general assembly any~~
15 ~~legislation determined to be necessary based on such review.~~

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

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

22 **10-16-902. Authority to self-fund - pilot program - rules - fees**
23 **- cash fund.** (1) (c) A MEWA shall offer standard and A basic health
24 benefit plans PLAN AS defined in section 10-16-105 (7.2).

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

27 **10-16-1002. Definitions.** As used in this part 10, unless the
28 context otherwise requires:

1 (6) (b) If, pursuant to section 10-16-1009 (3) (l), a cooperative
2 provides coverage to individuals and allows individuals to join the
3 cooperative, "member" may also include an individual and any dependent
4 of such individual who is covered by a plan purchased through a
5 cooperative, is eighteen years of age or older, and is not:

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

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

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

13 **10-16-1011. Requirements for waived health care coverage**
14 **cooperatives - rules.** (1) The commissioner shall promulgate rules
15 setting forth the application procedure for cooperatives seeking a waiver
16 under this section that:

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

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

28 **10-16-1014. Technical assistance to authorized cooperatives**

1 **from the division of insurance.** (1) Subject to available appropriations,
2 the commissioner may provide technical assistance to any cooperative
3 that:

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

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

9 **26-19-107. Duties of the department - schedule of services -**
10 **premiums - copayments - subsidies.** (1) In addition to any other duties
11 pursuant to this article, the department shall have the following duties:

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

27 **SECTION 14. Effective date - applicability.** (1) Except as
28 provided in subsection (2) of this section, this act shall take effect January

1 1, 2007, and shall apply to basic health benefit plans offered on or after
2 said date.

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

7 **SECTION 15. Safety clause.** The general assembly hereby
8 finds, determines, and declares that this act is necessary for the immediate
9 preservation of the public peace, health, and safety.

DRAFT

Bill E

Colorado Legislative Council Staff
NO FISCAL IMPACT

Drafting Number: LLS 06-0145
Prime Sponsor(s): Sen. Hagedorn

Date: December 13, 2005
Bill Status: Interim Committee on Health Insurance
Fiscal Analyst: Amy Larsen (303-866-3488)

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

Bill F

Second Regular Session
Sixty-fifth General Assembly
STATE OF COLORADO

DRAFT

LLS NO. 06-0148.01 Christy Chase

SENATE BILL

SENATE SPONSORSHIP

Hagedorn,

HOUSE SPONSORSHIP

Boyd,

Senate Committees

House Committees

A BILL FOR AN ACT

101 CONCERNING THE CREATION OF A PROGRAM TO PROVIDE PREMIUM
102 SUBSIDIES TO CERTAIN INDIVIDUALS ENROLLED IN A
103 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

DRAFT

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.

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

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

4 **PART 11**

5 **COLORADO PREMIUM SUBSIDY PROGRAM**

6 **10-16-1101. Short title.** THIS PART 11 SHALL BE KNOWN AND
7 MAY BE CITED AS THE "COLORADO PREMIUM SUBSIDY PROGRAM ACT".

8 **10-16-1102. Definitions.** AS USED IN THIS PART 11, UNLESS THE
9 CONTEXT OTHERWISE REQUIRES:

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

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

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

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

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

24 (1) A HIGH DEDUCTIBLE PLAN THAT WOULD QUALIFY FOR A

1 HEALTH SAVINGS ACCOUNT PURSUANT TO 26 U.S.C. SEC. 223; OR

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

6 (b) THE BOARD, IN COOPERATION WITH THE COMMISSIONER,
7 SHALL FURTHER DEFINE THE SPECIFICATIONS OF A QUALIFYING PLAN FOR
8 PURPOSES OF THIS PART 11.

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

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

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

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

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

1 EQUIVALENT OF SUCH NET INCOME LEVEL;

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

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

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

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

17 **10-16-1103. Colorado premium subsidy program - creation.**

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

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

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

27 (2) THE BOARD SHALL OPERATE THE COLORADO PREMIUM
28 SUBSIDY PROGRAM. THE PROGRAM SHALL BE AN INSTRUMENTALITY OF

1 THE STATE; EXCEPT THAT THE DEBTS AND LIABILITIES OF THE PROGRAM
2 SHALL NOT CONSTITUTE DEBTS AND LIABILITIES OF THE STATE, AND
3 NEITHER THE PROGRAM NOR THE BOARD SHALL BE AN AGENCY OF STATE
4 GOVERNMENT.

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

8 (4) THE COLORADO PREMIUM SUBSIDY PROGRAM SHALL OPERATE
9 AS A FIVE-YEAR PILOT PROGRAM THAT SHALL TERMINATE ON DECEMBER
10 31, 2011, UNLESS EXTENDED OR MADE PERMANENT BY THE GENERAL
11 ASSEMBLY.

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

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

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

27 (a) FOUR SHALL BE REPRESENTATIVES OF CARRIERS, ONE OF
28 WHICH REPRESENTATIVES SHALL REPRESENT A HEALTH MAINTENANCE

1 ORGANIZATION, ONE OF WHICH SHALL REPRESENT A SICKNESS AND
2 ACCIDENT INSURANCE CARRIER, AND ONE OF WHICH SHALL REPRESENT A
3 STOP-LOSS OR EXCESS LOSS INSURANCE CARRIER;

4 (b) ONE SHALL BE A MEDICAL PROFESSIONAL;

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

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

9 (3) THE COMMISSIONER OR HIS OR HER DESIGNEE AND A MEMBER
10 OF THE GENERAL ASSEMBLY SHALL SERVE AS EX OFFICIO NONVOTING
11 MEMBERS OF THE BOARD. THE INITIAL APPOINTEE OF THE GENERAL
12 ASSEMBLY SHALL BE A MEMBER OF THE SENATE APPOINTED BY THE
13 PRESIDENT OF THE SENATE, THE NEXT APPOINTEE SHALL BE A MEMBER OF
14 THE HOUSE OF REPRESENTATIVES APPOINTED BY THE SPEAKER OF THE
15 HOUSE OF REPRESENTATIVES, AND THEREAFTER SUCH APPOINTMENT
16 SHALL ROTATE IN LIKE MANNER BETWEEN THE SENATE AND THE HOUSE OF
17 REPRESENTATIVES.

18 (4) THE BOARD SHALL ELECT ONE OF ITS MEMBERS TO SERVE AS
19 CHAIR.

20 (5) ANY FOUR MEMBERS OF THE BOARD SHALL CONSTITUTE A
21 QUORUM FOR THE PURPOSE OF TRANSACTING BUSINESS AND CARRYING
22 OUT THE PROVISIONS OF THIS PART 11.

23 (6) ANY MEMBER OF THE BOARD MAY BE REMOVED BY THE
24 APPOINTING AUTHORITY FOR MISCONDUCT, INCOMPETENCY, OR NEGLECT
25 OF DUTY.

26 (7) A MEMBER OF THE BOARD SERVING A FOUR-YEAR TERM SHALL
27 NOT SERVE FOR MORE THAN TWO CONSECUTIVE TERMS.

28 (8) MEMBERS OF THE BOARD SHALL SERVE WITHOUT

1 COMPENSATION; EXCEPT THAT THEY SHALL BE REIMBURSED FOR ANY
2 ACTUAL AND NECESSARY EXPENSES INCURRED IN THE PERFORMANCE OF
3 THEIR DUTIES UNDER THIS PART 11, WITH MILEAGE RATES NOT TO EXCEED
4 THOSE AUTHORIZED FOR THE DIVISION OF INSURANCE.

5 **10-16-1105. Board - powers and duties.** (1) THE BOARD SHALL
6 BE THE GOVERNING BODY OF THE COLORADO PREMIUM SUBSIDY PROGRAM
7 AND SHALL HAVE ALL POWERS NECESSARY TO IMPLEMENT THIS PART 11
8 AND SHALL HAVE THE FOLLOWING SPECIFIC AUTHORITY TO:

9 (a) ENTER INTO SUCH CONTRACTS AS ARE NECESSARY OR PROPER
10 TO CARRY OUT THE PROVISIONS AND PURPOSES OF THIS PART 11,
11 INCLUDING THE AUTHORITY TO ENTER INTO CONTRACTS WITH
12 APPROPRIATE ADMINISTRATIVE STAFF, CONSULTANTS, AND LEGAL
13 COUNSEL AND TO SELECT AND CONTRACT WITH THE ADMINISTERING
14 CARRIER IN ACCORDANCE WITH SECTION 10-16-1106. IN ADDITION, THE
15 BOARD SHALL HAVE THE AUTHORITY, WITH THE APPROVAL OF THE
16 COMMISSIONER, TO ENTER INTO CONTRACTS WITH OTHER STATES WITH
17 SIMILAR PLANS FOR THE JOINT PERFORMANCE OF COMMON
18 ADMINISTRATIVE FUNCTIONS OR WITH OTHER PERSONS OR ORGANIZATIONS
19 FOR THE PERFORMANCE OF ADMINISTRATIVE FUNCTIONS. NO CONTRACT
20 ENTERED INTO PURSUANT TO THIS PARAGRAPH (a) SHALL BE SUBJECT TO
21 ARTICLE 103 OF TITLE 24, C.R.S.

22 (b) SUE OR BE SUED, INCLUDING TAKING ANY LEGAL ACTION AS
23 NECESSARY OR PROPER ON BEHALF OF THE COLORADO PREMIUM SUBSIDY
24 PROGRAM;

25 (c) TAKE SUCH LEGAL ACTION AS NECESSARY TO AVOID THE
26 PAYMENT OF IMPROPER CLAIMS AGAINST THE COLORADO PREMIUM
27 SUBSIDY PROGRAM OR TO DEFEND THE COVERAGE PROVIDED BY OR
28 THROUGH THE PROGRAM;

1 (d) ESTABLISH APPROPRIATE RATES FOR QUALIFYING INDIVIDUALS
2 WHO ARE ELIGIBLE FOR A PREMIUM SUBSIDY PURSUANT TO SECTION
3 10-16-1108, AND ANY OTHER ACTUARIAL FUNCTIONS APPROPRIATE TO THE
4 OPERATION OF THE COLORADO PREMIUM SUBSIDY PROGRAM;

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

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

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

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

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

25 (j) ACCEPT AND EXPEND GIFTS, GRANTS, AND DONATIONS FOR
26 OPERATION OF THE COLORADO PREMIUM SUBSIDY PROGRAM. MONEYS
27 FROM SUCH GIFTS, GRANTS, AND DONATIONS SHALL BE TRANSMITTED TO
28 THE STATE TREASURER AND CREDITED TO THE COLORADO PREMIUM

1 SUBSIDY PROGRAM FUND CREATED IN SECTION 10-16-1109.

2 (k) DEVELOP PROCEDURES FOR HANDLING AND ACCOUNTING FOR
3 THE FUNDS AND OTHER ASSETS OF THE COLORADO PREMIUM SUBSIDY
4 PROGRAM, INCLUDING RECORDS OF ALL FINANCIAL TRANSACTIONS AND AN
5 ANNUAL FISCAL REPORT TO THE COMMISSIONER;

6 (l) DEVELOP PROCEDURES FOR SELECTION OF AN ADMINISTERING
7 CARRIER AS PROVIDED IN SECTION 10-16-1106;

8 (m) DEVELOP PROCEDURES TO ESTABLISH AND MAINTAIN PUBLIC
9 AWARENESS OF THE COLORADO PREMIUM SUBSIDY PROGRAM, INCLUDING
10 ITS ELIGIBILITY REQUIREMENTS AND ENROLLMENT PROCEDURES;

11 (n) DEVELOP PROCEDURES TO ENSURE PUBLIC KNOWLEDGE
12 CONCERNING AVAILABILITY OF THE COLORADO PREMIUM SUBSIDY
13 PROGRAM;

14 (o) ESTABLISH REGULAR TIMES AND PLACES FOR MEETINGS OF
15 THE BOARD;

16 (p) DEVELOP PROCEDURES UNDER WHICH APPLICANTS AND
17 PARTICIPANTS CAN REPORT GRIEVANCES TO THE BOARD, WHICH
18 GRIEVANCES SHALL BE FAIRLY AND IMPARTIALLY CONSIDERED, AND
19 ADMINISTRATIVE REMEDIES FOR SUCH GRIEVANCES; AND

20 (q) ESTABLISH ANY OTHER PROVISIONS NECESSARY TO
21 IMPLEMENT THIS PART 11.

22 (2) AN APPLICANT OR PARTICIPANT REPORTING A GRIEVANCE
23 PURSUANT TO PARAGRAPH (p) OF SUBSECTION (1) OF THIS SECTION SHALL
24 EXHAUST ALL ADMINISTRATIVE REMEDIES AS SET FORTH BY THE BOARD
25 BEFORE THE GRIEVANCE MAY BE THE BASIS FOR LEGAL ACTION. THE
26 VENUE FOR ANY LEGAL ACTION INVOLVING THE COLORADO PREMIUM
27 SUBSIDY PROGRAM SHALL BE THE CITY AND COUNTY OF DENVER.
28 NOTHING IN THIS SUBSECTION (2) SHALL PROHIBIT THE BOARD FROM

1 REQUIRING BINDING ARBITRATION FOR THE FINAL ADJUDICATION OF ANY
2 GRIEVANCE.

3 (3) FOR ANY ACT PERFORMED WITHIN THE COURSE AND SCOPE OF
4 AUTHORITY UNDER THIS PART 11, THE BOARD, THE INDIVIDUAL MEMBERS
5 OF THE BOARD, AND THE EMPLOYEES AND AGENTS OF THE BOARD SHALL
6 BE ENTITLED TO THE IMMUNITY GRANTED PURSUANT TO SECTION
7 24-10-106, C.R.S., UNLESS SUCH ACT OR OMISSION CONSTITUTES WILLFUL
8 AND WANTON MISCONDUCT.

9 **10-16-1106. Administering carrier.** (1) THE ADMINISTERING
10 CARRIER SHALL PERFORM ALL ADMINISTRATIVE, ELIGIBILITY, AND CLAIMS
11 PAYMENT FUNCTIONS RELATING TO THE COLORADO PREMIUM SUBSIDY
12 PROGRAM, INCLUDING:

13 (a) ASSURING TIMELY PAYMENT OF PREMIUM SUBSIDIES TO
14 QUALIFYING INDIVIDUALS, INCLUDING:

15 (I) MAKING AVAILABLE INFORMATION RELATING TO THE PROPER
16 MANNER OF SUBMITTING CLAIMS FOR PREMIUM SUBSIDIES; AND

17 (II) EVALUATING THE ELIGIBILITY OF EACH CLAIM FOR PREMIUM
18 SUBSIDY PURSUANT TO GUIDELINES ESTABLISHED BY THE BOARD;

19 (b) SUBMITTING REGULAR REPORTS TO THE BOARD REGARDING
20 THE OPERATION OF THE PROGRAM. THE FREQUENCY, CONTENT, AND FORM
21 OF THE REPORTS SHALL BE AS DETERMINED BY THE BOARD.

22 (c) DETERMINING THE EXPENSE OF ADMINISTRATION AND THE
23 PAID AND INCURRED LOSSES FOR EACH YEAR AND REPORTING SUCH
24 INFORMATION TO THE BOARD AND THE COMMISSIONER IN A FORM AND
25 MANNER PRESCRIBED BY THE COMMISSIONER.

26 (2) THE BOARD SHALL ESTABLISH ITS OWN COMPETITIVE BIDDING
27 PROCESS TO SELECT A CARRIER OR THIRD-PARTY ADMINISTRATOR TO
28 SERVE AS THE ADMINISTERING CARRIER AND TO SELECT ONE OR MORE

1 VENDORS TO PROVIDE SERVICES THAT MAY BE NECESSARY TO ADMINISTER
2 THE COLORADO PREMIUM SUBSIDY PROGRAM. THE BOARD SHALL
3 EVALUATE BIDS SUBMITTED BASED ON THE CRITERIA IT ESTABLISHES AND
4 SHALL NOT BE SUBJECT TO THE PROVISIONS OF ARTICLE 103 OF TITLE 24,
5 C.R.S., IN MAKING SUCH SELECTIONS.

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

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

17 **10-16-1107. Program - examination - financial report.**

18 (1) NOT LATER THAN MARCH 1, 2008, AND BY MARCH 1 OF EACH
19 SUCCEEDING YEAR, THE BOARD SHALL SUBMIT AN AUDITED FINANCIAL
20 REPORT FOR THE COLORADO PREMIUM SUBSIDY PROGRAM FOR THE
21 PRECEDING CALENDAR YEAR TO THE COMMISSIONER IN A FORM PROVIDED
22 OR PRESCRIBED BY THE COMMISSIONER.

23 (2) THE FINANCIAL STATUS OF THE COLORADO PREMIUM SUBSIDY
24 PROGRAM SHALL BE SUBJECT TO EXAMINATION BY THE COMMISSIONER OR
25 THE COMMISSIONER'S DESIGNEE. SUCH EXAMINATIONS SHALL BE
26 CONDUCTED AT LEAST ONCE EVERY FIVE YEARS.

27 **10-16-1108. Colorado premium subsidy program - eligibility**
28 **for subsidy payments.** (1) THE BOARD SHALL ESTABLISH A PROGRAM

1 FOR ADMINISTERING PREMIUM SUBSIDIES FOR QUALIFIED INDIVIDUALS
2 WHO APPLY FOR COVERAGE ON OR AFTER JANUARY 1, 2007, UNDER A
3 QUALIFYING PLAN.

4 (2) THE PREMIUM SUBSIDY SHALL BE FIFTY PERCENT OF THE
5 PREMIUM FOR THE QUALIFYING PLAN, NOT TO EXCEED ONE HUNDRED
6 DOLLARS PER MONTH PER QUALIFYING INDIVIDUAL.

7 (3) PREMIUM SUBSIDIES SHALL BE PAID FROM THE COLORADO
8 PREMIUM SUBSIDY PROGRAM FUND TO THE CARRIER PROVIDING A
9 QUALIFYING PLAN TO THE QUALIFYING INDIVIDUAL. IF THE QUALIFYING
10 INDIVIDUAL IS ENROLLED IN A QUALIFYING PLAN AS DESCRIBED IN SECTION
11 10-16-1102 (5) (a) (I), THE QUALIFYING INDIVIDUAL SHALL PAY THE
12 ENTIRE PREMIUM TO THE CARRIER, AND THE PREMIUM SUBSIDY SHALL BE
13 PAID DIRECTLY TO THE QUALIFYING INDIVIDUAL'S HEALTH SAVINGS
14 ACCOUNT.

15 (4) (a) THE BOARD SHALL DETERMINE THE TOTAL PREMIUM
16 SUBSIDIES FOR THE CALENDAR YEAR FOR WHICH SUBSIDIES ARE PAID.

17 (b) IF THE FUNDS AVAILABLE FOR DISTRIBUTION FOR PREMIUM
18 SUBSIDIES PAID DURING A CALENDAR YEAR EXCEED THE TOTAL AMOUNT
19 OF SUBSIDIES DURING THAT SAME CALENDAR YEAR, ANY EXCESS FUNDS
20 SHALL BE CARRIED FORWARD AND MADE AVAILABLE FOR DISTRIBUTION IN
21 THE NEXT CALENDAR YEAR.

22 (c) UPON THE REQUEST OF THE BOARD, THE QUALIFYING PLAN
23 CARRIER SHALL BE REQUIRED TO FURNISH DATA THE BOARD DEEMS
24 NECESSARY TO OVERSEE THE OPERATION OF THE COLORADO PREMIUM
25 SUBSIDY PROGRAM. THE DATA SHALL BE FURNISHED IN A FORM
26 PRESCRIBED BY THE BOARD. THE CARRIER SHALL PROVIDE THE BOARD
27 WITH MONTHLY REPORTS OF THE TOTAL ENROLLMENT IN THE QUALIFYING
28 PLAN. THE REPORTS SHALL BE IN A FORM PRESCRIBED BY THE BOARD.

1 (d) THE BOARD SHALL SEPARATELY ESTIMATE THE PER-INSURED
2 ANNUAL COST OF ALL SUBSIDIES FOR QUALIFYING PLANS BASED UPON
3 AVAILABLE DATA AND APPROPRIATE ACTUARIAL ASSUMPTIONS.

4 (e) THE BOARD SHALL DETERMINE THE TOTAL ELIGIBLE
5 ENROLLMENT UNDER QUALIFYING PLANS. THE TOTAL ELIGIBLE
6 ENROLLMENT SHALL BE DETERMINED BY DIVIDING THE AMOUNT OF
7 MONEYS AVAILABLE FOR DISTRIBUTION FROM THE COLORADO PREMIUM
8 SUBSIDY PROGRAM FUND FOR PREMIUM SUBSIDIES BY THE ESTIMATED
9 PER-INSURED ANNUAL COST OF ALL PREMIUM SUBSIDIES FROM THE
10 PROGRAM FUND.

11 (f) THE BOARD SHALL SUSPEND THE ENROLLMENT OF NEW
12 INSUREDS IN QUALIFYING PLANS IF IT DETERMINES THAT THE TOTAL
13 ENROLLMENT REPORTED BY CARRIERS EXCEEDS THE TOTAL ELIGIBLE
14 ENROLLMENT, THEREBY RESULTING IN ANTICIPATED ANNUAL
15 EXPENDITURES FROM THE COLORADO PREMIUM SUBSIDY PROGRAM FUND
16 IN EXCESS OF THE MONEYS AVAILABLE FOR DISTRIBUTION.

17 (g) IF, AT ANY POINT DURING A SUSPENSION OF ENROLLMENT, THE
18 BOARD DETERMINES THAT FUNDS ARE SUFFICIENT TO PROVIDE FOR THE
19 ADDITION OF NEW ENROLLMENTS, THE BOARD MAY AGAIN ACCEPT NEW
20 ENROLLMENTS.

21 (h) THE SUSPENSION OF ENROLLMENT IN QUALIFYING PLANS
22 SHALL NOT PRECLUDE THE ADDITION OF NEW DEPENDENTS OF INDIVIDUALS
23 ALREADY COVERED UNDER SUCH PLANS.

24 **10-16-1109. Colorado premium subsidy program fund -**
25 **creation.** (1) (a) THERE IS HEREBY CREATED IN THE STATE TREASURY
26 THE COLORADO PREMIUM SUBSIDY PROGRAM FUND. THE FUND SHALL
27 CONSIST OF MONEYS CREDITED THERETO PURSUANT TO THIS PART 11.

28 (b) IN FISCAL YEAR 2005-06, AND EACH OF THE FOUR FISCAL

1 YEARS THEREAFTER, IF THE MOST RECENT LEGISLATIVE COUNCIL STAFF
2 ECONOMIC AND REVENUE FORECAST ESTIMATES THAT THE GENERAL FUND
3 EXEMPT ACCOUNT, CREATED IN SECTION 24-77-103.6 (2), C.R.S., WILL
4 RECEIVE MORE THAN ONE HUNDRED FIFTEEN MILLION DOLLARS, FIFTEEN
5 MILLION DOLLARS OF THE MONEYS IN THE GENERAL FUND EXEMPT
6 ACCOUNT SHALL BE APPROPRIATED TO THE COLORADO PREMIUM SUBSIDY
7 PROGRAM FUND CREATED IN THIS SUBSECTION (1).

8 (c) ALL MONEYS APPROPRIATED TO THE COLORADO PREMIUM
9 SUBSIDY PROGRAM FUND SHALL BE USED AS PROVIDED IN THIS PART 11
10 AND SHALL NOT BE DEPOSITED IN OR TRANSFERRED TO THE GENERAL FUND
11 OF THIS STATE OR TO ANY OTHER FUND. NOTWITHSTANDING ANY
12 PROVISION OF SECTION 24-36-114, C.R.S., TO THE CONTRARY, ALL
13 INTEREST DERIVED FROM THE DEPOSIT AND INVESTMENT OF MONEYS IN
14 THE PROGRAM FUND SHALL BE CREDITED TO THE PROGRAM FUND.

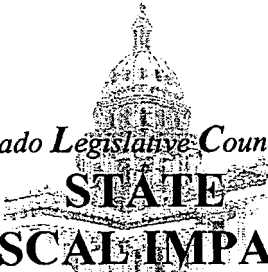
15 (2) (a) OF THE MONEYS IN THE COLORADO PREMIUM SUBSIDY
16 PROGRAM FUND, NO MORE THAN FIVE PERCENT SHALL BE USED FOR
17 PROGRAM ADMINISTRATIVE COSTS, INCLUDING ADMINISTRATIVE COSTS OF
18 THE DIVISION OF INSURANCE.

19 (b) THE MONEYS REMAINING IN THE COLORADO PREMIUM
20 SUBSIDY PROGRAM FUND AFTER THE PAYMENT OF PROGRAM
21 ADMINISTRATIVE COSTS SHALL BE USED FOR PREMIUM SUBSIDY PAYMENTS
22 UNDER SECTION 10-16-1108.

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

DRAFT

Bill F


 Colorado Legislative Council Staff
STATE
FISCAL IMPACT

Drafting Number: LLS 06-0148
Prime Sponsor(s): Sen. Hagedorn
 Rep. Boyd

Date: January 5, 2006
Bill Status: Interim Committee on Health Insurance
Fiscal Analyst: Amy Larsen (303-866-3488)

TITLE: CONCERNING THE CREATION OF A PROGRAM TO PROVIDE PREMIUM SUBSIDIES TO CERTAIN INDIVIDUALS ENROLLED IN A QUALIFYING HEALTH BENEFIT PLAN.

Fiscal Impact Summary	FY 2005-06	FY 2006-07	FY 2007-08
State Revenues			
General Fund Exempt	(\$15,000,000)	(\$15,000,000)	(\$15,000,000)
Cash Funds Exempt - Colorado Premium Subsidy Program Fund	15,000,000	15,000,000	15,000,000
State Expenditures			
General Fund Exempt	\$15,000,000	\$15,000,000	\$15,000,000
Cash Funds Exempt - Colorado Premium Subsidy Program Fund	15,000,000	15,000,000	15,000,000
Cash Funds Exempt - Dept. of Regulatory Agencies*		9,721	7,616
FTE Position Change	0.0 FTE	0.0 FTE	0.0 FTE
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.

Bill F

- *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