

**RECOMMENDATIONS FOR 2006**

**INTERIM COMMITTEE ON  
HEALTH INSURANCE**

**Report to the  
Colorado General Assembly**

**Research Publication No. 543  
December 2005**

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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**

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Senator Maryanne Keller  
Senator Andy McElhany  
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# EXECUTIVE SUMMARY

## **Committee Charge**

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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**

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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**

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***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**

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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**

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**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**

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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**

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**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**

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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**

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***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**

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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**

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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**

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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**

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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**

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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**

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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](http://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

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SENATE SPONSORSHIP

Keller, and Shaffer

HOUSE SPONSORSHIP

Green, and Boyd

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Senate Committees

House Committees

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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.

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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



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 COVERCOLORADO 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 COVERCOLORADO 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 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

Bill A

Colorado Legislative Council Staff

STATE FISCAL IMPACT

Drafting Number: LLS 06-0140
Prime Sponsor(s): Sen. Keller
Rep. Green

Date: December 15, 2005
Bill Status: Interim Committee on Health Insurance
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.

Table with 3 columns: Fiscal Impact Summary, FY 2006/2007, FY 2007/2008. Rows include State Revenues, State Expenditures, FTE Position Change, Effective Date, Appropriation Summary for FY 2006/2007, and Local Government Impact.

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

Summary of Legislation

This Interim Committee on Health Insurance bill creates the Healthy Business Healthy People (HBHP) five-year pilot program with the purpose of making standardized, low-cost health insurance available to qualifying small employers and individuals. It is funded through annual transfers of \$15 million to the Healthy Business Healthy People Fund. The total number of individuals and plans covered by the program cannot exceed the funding capacity of the monies available. Thus, this is not an entitlement program and enrollment may be suspended if determined necessary. The pilot program ends on December 31, 2011.

Starting January 1, 2007, small employer group health insurance carriers are eligible for reinsurance reimbursement payments for qualified employer plans. The bill designates two-thirds

of the fund balance, \$9.5 million the first year, for reinsurance to reduce the cost of health insurance premiums for qualified employer plans. To qualify for the program, **employers** must meet the following requirements:

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

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

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

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

## State Revenues

For FY 2006-07, and each year through FY 2010-11, the bill requires a transfer of \$15 million from the General Fund Exempt account to the HBHP Fund if the most recent Legislative Council Staff Forecast estimates that the General Fund Exempt account will receive more than \$115 million. The December 2005 forecast shows sufficient funds in the General Fund Exempt account to fund the program through FY 2010-11.

In addition, interest earned from the deposit and investment of moneys in the HBHP Fund shall be credited to the fund. At this time, the fiscal note does not estimate interest revenue because expenditures from the fund resulting from program enrollment are unknown. However, the interest

rate for funds held by the State Treasurer is estimated to be 3.75 percent for FY 2006-07, and the fund could expect interest additional revenue of up to \$534,375 ( $\$14,250,000 \times 3.75\%$ ).

## 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

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

**DRAFT**

LLS NO. 06-0141.01 Nicole Hoffman

**SENATE BILL**

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**SENATE SPONSORSHIP**

**Hanna,** Hagedorn, Keller, and Shaffer

**HOUSE SPONSORSHIP**

**Riesberg,** Boyd, Green, and McCluskey

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**Senate Committees**

**House Committees**

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**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.**

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**Bill Summary**

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

DRAFT

*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.

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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
<b>State Revenues</b>		
General Fund	\$5,202	
Cash Fund	\$61,120	
<b>State Expenditures</b>		
General Fund	\$5,202	
Cash Fund Exempt	\$61,120	
<b>FTE Position Change</b>	0.0 FTE	0.0 FTE
<b>Effective Date:</b> Upon signature of the Governor.		
<b>Appropriation Summary for FY 2006/2007:</b> None Required (see State Appropriations section)		
<b>Local Government Impact:</b> 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

## Bill B

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

# Bill B

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

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SENATE SPONSORSHIP

Hagedorn, and Shaffer

HOUSE SPONSORSHIP

Boyd, and Green

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Senate Committees

House Committees

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A BILL FOR AN ACT

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

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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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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

DRAFT

LLS NO. 06-0144.01 Jery Payne

SENATE BILL

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SENATE SPONSORSHIP

**Tapia,** Hagedorn, Keller, and Shaffer

HOUSE SPONSORSHIP

**Butcher,** Boyd, and Green

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Senate Committees

House Committees

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A BILL FOR AN ACT

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

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**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.

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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
Prime Sponsor(s): Sen. Tapia
Rep. Butcher

Date: December 15, 2005
Bill Status: Interim Committee on Health Insurance
Fiscal Analyst: Amy Larsen (303-866-3488)

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

Table with 4 columns: Fiscal Impact Summary, FY 2005/2006, FY 2006/2007, FY 2007/2008. Rows include State Revenues, State Expenditures, FTE Position Change, Effective Date, Appropriation Summary for FY 2005/2006 and FY 2006/2007, and Local Government Impact.

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.

# Bill D

**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.

<b>Table 1.</b>					
<b>Fee Impact on Individuals, Families or Business</b>					
<b>Type of Fee</b>	<b>Current Fee</b>	<b>Proposed Fee</b>	<b>Fee Change</b>	<b># of Affected Individuals</b>	<b>Total Fee Impact</b>
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
<b>Total</b>					<b>\$102,480</b>

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.

<b>Table 2.</b>		
<b>Expenditure Detail</b>		
	<b>FY 2005/06</b>	<b>FY 2006/07</b>
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
<b>Total Expenses</b>	<b>\$6,757</b>	<b>\$181,352</b>

**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

Second Regular Session  
Sixty-fifth General Assembly  
STATE OF COLORADO

DRAFT

LLS NO. 06-0145.01 Christy Chase

SENATE BILL

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SENATE SPONSORSHIP

Hagedorn,

HOUSE SPONSORSHIP

(None),

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Senate Committees

House Committees

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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.

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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.

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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**

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**Drafting Number:** LLS 06-0145

**Date:** December 13, 2005

**Prime Sponsor(s):** Sen. Hagedorn

**Bill Status:** Interim Committee on Health Insurance

**Fiscal Analyst:** Amy Larsen (303-866-3488)

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**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

Second Regular Session  
Sixty-fifth General Assembly  
STATE OF COLORADO

DRAFT

LLS NO. 06-0148.01 Christy Chase

SENATE BILL

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SENATE SPONSORSHIP

Hagedorn,

HOUSE SPONSORSHIP

Boyd,

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Senate Committees

House Committees

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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.

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Bill Summary

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

**Interim Committee on Health Insurance.** Establishes the Colorado premium subsidy program (program) to provide premium

subsidy payments to qualifying individuals enrolled in qualifying health benefit plans. Limits the scope of the program to counties with specified populations and the duration of the program to 5 years. Defines "qualifying individual" as a person:

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

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

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

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

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

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

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

Establishes the Colorado premium subsidy program fund (fund),



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: December 14, 2005
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.

Table with 3 columns: Fiscal Impact Summary, FY 2006/2007, FY 2007/2008. Rows include State Revenues, State Expenditures, FTE Position Change, Effective Date, Appropriation Summary for FY 2006/2007, and Local Government Impact.

\*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 is funded through annual transfers of \$15 million to the Colorado Premium Subsidy Program Fund.

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.

## Bill F

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 2006-07, and each year through FY 2010-11, 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.

In addition, interest earned from the deposit and investment of moneys in the 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 additional interest revenue of up to \$534,375 (\$14,250,000 X 3.75%).

### State Expenditures

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

### Departments Contacted

Regulatory Agencies

Treasury