First Regular Session
Seventy-third General Assembly
STATE OF COLORADO

ENGROSSED

This Version Includes All Amendments Adopted on Second Reading in the House of Introduction

LLS NO. 21-0050.02 Kristen Forrestal x4217 **HOUSE BILL 21-1232**

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A BILL FOR AN ACT

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

Bill Summary

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

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

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters or bold & italic numbers indicate new material to be added to existing statute.
Dashes through the words indicate deletions from existing statute.

HOUSE
Amended 2nd Reading
May 7, 2021

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

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

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

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

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

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

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

The bill makes the failure to accept consumers who are covered

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

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

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

2 **SECTION 1.** In Colorado Revised Statutes, **add** part 13 to article
3 16 of title 10 as follows:

4 PART 13

5 COLORADO STANDARDIZED HEALTH BENEFIT PLAN

6 **10-16-1301. Short title.** THE SHORT TITLE OF THIS PART 13 IS THE
7 "COLORADO STANDARDIZED HEALTH BENEFIT PLAN ACT".

8 **10-16-1302. Legislative declaration - intent.** (1) THE GENERAL
9 ASSEMBLY, THROUGH THE EXERCISE OF ITS POWERS TO PROTECT THE
10 HEALTH, PEACE, SAFETY, AND GENERAL WELFARE OF THE PEOPLE OF
11 COLORADO, HEREBY FINDS THAT:

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

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

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

1 THE STATE'S RURAL AREAS AND FOR COLORADANS WHO HAVE
2 HISTORICALLY AND SYSTEMICALLY FACED BARRIERS TO HEALTH,
3 INCLUDING PEOPLE OF COLOR, IMMIGRANTS, AND COLORADANS WITH LOW
4 INCOMES;
5 (d) THE HEALTH-CARE SYSTEM IS A COMPLEX SYSTEM WHEREIN
6 CONSUMERS RELY ON HEALTH INSURANCE CARRIERS TO NEGOTIATE THE
7 RATES PAID TO HEALTH-CARE PROVIDERS, PHARMACEUTICAL COMPANIES,
8 AND HOSPITALS FOR SERVICES PROVIDED AND EXPECT THAT THE
9 NEGOTIATED RATES ARE CLOSELY TIED TO THE AMOUNT OF THE HEALTH
10 INSURANCE PREMIUMS PAID;
11 (e) DESPITE EFFORTS TO ADDRESS ACCESS TO AND AFFORDABILITY
12 OF HEALTH CARE, UNDERLYING HEALTH-CARE COSTS CONTINUE TO RISE,
13 THUS DRIVING UP THE COSTS OF HEALTH INSURANCE PREMIUMS, OFTEN AT
14 DISPROPORTIONATE RATES IN RURAL AREAS OF THE STATE; AND
15 (f) IN ORDER TO ENSURE THAT HEALTH INSURANCE IS AFFORDABLE
16 FOR COLORADANS, IT IS CRITICAL THAT THE STATE ESTABLISH A
17 STANDARDIZED PLAN FOR CARRIERS TO OFFER IN THE STATE AND SET
18 PREMIUM REDUCTION TARGETS FOR CARRIERS TO ACHIEVE.
19 **10-16-1303. Definitions.** AS USED IN THIS PART 13, UNLESS THE
20 CONTEXT OTHERWISE REQUIRES:
21 (1) "ADVISORY BOARD" MEANS THE BOARD ESTABLISHED IN
22 SECTION 10-16-1307.
23 (2) "CRITICAL ACCESS HOSPITAL" MEANS A HOSPITAL THAT IS
24 FEDERALLY CERTIFIED OR UNDERGOING FEDERAL CERTIFICATION AS A
25 CRITICAL ACCESS HOSPITAL PURSUANT TO 42 CFR 485, SUBPART F.
26 (3) (a) "EQUIVALENT RATE" MEANS, FOR A HOSPITAL THAT IS A
27 PEDIATRIC SPECIALTY HOSPITAL WITH A LEVEL ONE TRAUMA CENTER, THE

1 PAYMENT RATE DETERMINED BY THE MEDICAID FEE SCHEDULE FOR THE
2 HOSPITAL FROM THE MOST RECENT YEAR FOR WHICH A COMPLETE SET OF
3 HOSPITAL FINANCIAL DATA IS PUBLICLY AVAILABLE UPON THE EFFECTIVE
4 DATE OF THIS PART 13, MULTIPLIED BY A CONVERSION FACTOR EQUAL TO
5 THE RATIO OF THE STATEWIDE PAYMENT TO COST RATIO FOR MEDICARE TO
6 THE HOSPITAL'S SPECIFIC PAYMENT COST RATIO FOR THE MOST RECENT SET
7 OF PUBLICLY AVAILABLE HOSPITAL FINANCIAL DATA UPON THE EFFECTIVE
8 DATE OF THIS PART 13, WHICH IS 1.52.
9 (b) IN ANY GIVEN YEAR, THE RATE IN SUBSECTION (3)(a) OF THIS
10 SECTION MUST BE ADJUSTED ANNUALLY FOR CUMULATIVE INFLATION BY
11 A FACTOR EQUAL TO THE AVERAGE PERCENTAGE INCREASE IN THE
12 MEDICARE INPATIENT AND OUTPATIENT PROSPECTIVE PAYMENT SYSTEMS
13 OVER THE PREVIOUS THREE YEARS.
14 (4) "ESSENTIAL ACCESS HOSPITAL" MEANS A CRITICAL ACCESS
15 HOSPITAL OR GENERAL HOSPITAL LOCATED IN A RURAL AREA WITH
16 TWENTY-FIVE OR FEWER LICENSED BEDS.
17 (5) "ESSENTIAL COMMUNITY PROVIDER" HAS THE SAME MEANING
18 AS SET FORTH IN SECTION 25.5-8-103 (6).
19 (6) "GENERAL HOSPITAL" MEANS A HOSPITAL LICENSED AS A
20 GENERAL HOSPITAL BY THE COLORADO DEPARTMENT OF PUBLIC HEALTH
21 AND ENVIRONMENT.
22 (7) "HEALTH-CARE COVERAGE COOPERATIVE" HAS THE SAME
23 MEANING AS SET FORTH IN SECTION 10-16-1002 (2).
24 (8) "HEALTH-CARE PROVIDER" MEANS A HEALTH-CARE
25 PROFESSIONAL REGISTERED, CERTIFIED, OR LICENSED PURSUANT TO TITLE
26 12 OR A HEALTH FACILITY LICENSED OR CERTIFIED PURSUANT TO SECTION
27 25-1.5-103.

1 (9) "HEALTH SYSTEM" MEANS A CORPORATION OR OTHER
2 ORGANIZATION THAT OWNS, CONTAINS, OR OPERATES THREE OR MORE
3 HOSPITALS.
4 (10) "MEDICAL INFLATION" MEANS THE ANNUAL PERCENTAGE
5 CHANGE IN THE MEDICAL CARE INDEX COMPONENT OF THE UNITED STATES
6 DEPARTMENT OF LABOR'S BUREAU OF LABOR STATISTICS CONSUMER PRICE
7 INDEX FOR MEDICAL CARE SERVICES AND MEDICAL CARE COMMODITIES,
8 OR ITS APPLICABLE PREDECESSOR OR SUCCESSOR INDEX, BASED ON THE
9 AVERAGE CHANGE IN THE MEDICAL CARE INDEX OVER THE PREVIOUS TEN
10 YEARS.
11 (11) (a) "MEDICARE REIMBURSEMENT RATE" MEANS THE
12 FACILITY-SPECIFIC REIMBURSEMENT RATE FOR A PARTICULAR
13 HEALTH-CARE SERVICE PROVIDED UNDER THE "HEALTH INSURANCE FOR
14 THE AGED ACT", TITLE XVIII OF THE FEDERAL "SOCIAL SECURITY ACT",
15 42 U.S.C. SEC. 1395 ET SEQ., AS AMENDED.
16 (b) FOR A HOSPITAL THAT IS REIMBURSED THROUGH THE MEDICARE
17 PROSPECTIVE PAYMENTS SYSTEMS RATE FOR A CRITICAL ACCESS HOSPITAL,
18 "MEDICARE REIMBURSEMENT RATE" MEANS THE RATE BASED ON
19 ALLOWABLE COSTS AS REPORTED IN MEDICARE COST REPORTS AND THE
20 HISTORICAL COST-TO-CHARGE RATIOS FOR THE SPECIFIC HOSPITAL.
21 (12) "PUBLIC BENEFIT CORPORATION" MEANS A PUBLIC BENEFIT
22 CORPORATION FORMED PURSUANT TO PART 5 OF ARTICLE 101 OF TITLE 7
23 THAT MAY BE ORGANIZED AND OPERATED BY THE EXCHANGE PURSUANT
24 TO SECTION 10-22-106 (3).
25 (13) "SMALL GROUP MARKET" MEANS THE MARKET FOR SMALL
26 GROUP SICKNESS AND ACCIDENT INSURANCE.
27 (14) "STANDARDIZED PLAN" MEANS THE STANDARDIZED HEALTH

1 BENEFIT PLAN DESIGNED BY RULE OF THE COMMISSIONER PURSUANT TO
2 SECTION 10-16-1304.
3 **10-16-1304. Standardized health benefit plan - established -**
4 **components - rules - independent analysis - repeal.** (1) ON OR BEFORE
5 JANUARY 1, 2022, THE COMMISSIONER SHALL ESTABLISH, BY RULE, A
6 STANDARDIZED HEALTH BENEFIT PLAN TO BE OFFERED BY CARRIERS IN
7 THIS STATE IN THE INDIVIDUAL AND SMALL GROUP MARKETS. THE
8 STANDARDIZED PLAN MUST:
9 (a) OFFER HEALTH-CARE COVERAGE AT THE BRONZE, SILVER, AND
10 GOLD LEVELS OF COVERAGE AS DESCRIBED IN SECTION 10-16-103.4;
11 (b) INCLUDE, AT A MINIMUM, PEDIATRIC AND OTHER ESSENTIAL
12 HEALTH BENEFITS;
13 (c) BE OFFERED THROUGH THE EXCHANGE AND IN THE INDIVIDUAL
14 MARKET THROUGH THE PUBLIC BENEFIT CORPORATION;
15 (d) BE A STANDARDIZED BENEFIT DESIGN THAT:
16 (I) IS CREATED THROUGH A STAKEHOLDER ENGAGEMENT PROCESS
17 THAT INCLUDES PHYSICIANS, HEALTH-CARE INDUSTRY AND CONSUMER
18 REPRESENTATIVES, INDIVIDUALS WHO REPRESENT HEALTH-CARE WORKERS
19 OR WHO WORK IN HEALTH CARE, AND INDIVIDUALS WORKING IN OR
20 REPRESENTING COMMUNITIES THAT ARE DIVERSE WITH REGARD TO RACE,
21 ETHNICITY, IMMIGRATION STATUS, AGE, ABILITY, SEXUAL ORIENTATION,
22 GENDER IDENTITY, OR GEOGRAPHIC REGIONS OF THE STATE AND THAT ARE
23 AFFECTED BY HIGHER RATES OF HEALTH DISPARITIES AND INEQUITIES;
24 (II) HAS A DEFINED BENEFIT DESIGN AND COST-SHARING THAT
25 IMPROVES ACCESS AND AFFORDABILITY; AND
26 (III) IS DESIGNED TO IMPROVE RACIAL HEALTH EQUITY AND
27 DECREASE RACIAL HEALTH DISPARITIES THROUGH A VARIETY OF MEANS,

1 WHICH ARE IDENTIFIED COLLABORATIVELY WITH CONSUMER
2 STAKEHOLDERS, INCLUDING:
3 (A) IMPROVING PERINATAL HEALTH-CARE COVERAGE; AND
4 (B) PROVIDING FIRST-DOLLAR, PREDEDUCTIBLE COVERAGE FOR
5 CERTAIN HIGH-VALUE SERVICES, SUCH AS PRIMARY AND BEHAVIORAL
6 HEALTH CARE;
7 (e) BE ACTUARIALLY SOUND AND ALLOW A CARRIER TO CONTINUE
8 TO MEET THE FINANCIAL REQUIREMENTS IN ARTICLE 3 OF THIS TITLE 10;
9 (f) COMPLY WITH THE FEDERAL ACT, INCLUDING THE RISK
10 ADJUSTMENT REQUIREMENTS UNDER 45 CFR 153, AND THIS ARTICLE 16;
11 AND
12 (g) HAVE A NETWORK THAT IS:
13 (I) CULTURALLY RESPONSIVE AND, TO THE GREATEST EXTENT
14 POSSIBLE, REFLECTS THE DIVERSITY OF ITS ENROLLEES IN TERMS OF RACE,
15 ETHNICITY, GENDER IDENTITY, AND SEXUAL ORIENTATION IN THE AREA
16 THAT THE NETWORK EXISTS; AND
17 (II) NO MORE NARROW THAN THE MOST RESTRICTIVE NETWORK
18 THE CARRIER IS OFFERING FOR NONSTANDARDIZED PLANS IN THE
19 INDIVIDUAL MARKET FOR THE METAL TIER FOR THAT RATING AREA.
20 (2) (a) IN DEVELOPING THE NETWORK FOR THE STANDARDIZED
21 PLAN PURSUANT TO SUBSECTION (1)(g) OF THIS SECTION, EACH CARRIER
22 SHALL:
23 (I) INCLUDE AS PART OF ITS NETWORK ACCESS PLAN A DESCRIPTION
24 OF THE CARRIER'S EFFORTS TO CONSTRUCT DIVERSE, CULTURALLY
25 RESPONSIVE NETWORKS THAT ARE WELL-POSITIONED TO ADDRESS HEALTH
26 EQUITY AND REDUCE HEALTH DISPARITIES; AND
27 (II) INCLUDE A MAJORITY OF THE ESSENTIAL COMMUNITY

1 PROVIDERS IN THE SERVICE AREA IN ITS NETWORK.

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

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

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

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

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

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

1 WHICH SURVEY ADDRESSES CONSUMERS' EXPERIENCE.

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

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

6 **10-16-1305. Standardized health benefit plan - carriers**
7 **required to offer - premium rates - rules.** (1) BEGINNING JANUARY 1,
8 2023, A CARRIER THAT OFFERS:

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

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

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

1 CARRIER OFFERED HEALTH BENEFIT PLANS IN THE INDIVIDUAL AND SMALL
2 GROUP MARKETS IN 2021 PRIOR TO THE APPLICATION OF THE COLORADO
3 REINSURANCE PROGRAM PURSUANT TO PART 11 OF THIS ARTICLE 16.
4 (II) FOR CARRIERS OFFERING THE STANDARDIZED PLAN IN THE
5 2023 PLAN YEAR IN A COUNTY IN WHICH THE CARRIER DID NOT OFFER A
6 HEALTH BENEFIT PLAN IN THE INDIVIDUAL OR SMALL GROUP MARKET IN
7 THE 2021 CALENDAR YEAR, EACH CARRIER THAT OFFERS THE
8 STANDARDIZED PLAN SHALL OFFER THE STANDARDIZED PLAN:
9 (A) IN THE INDIVIDUAL MARKET AT A PREMIUM RATE THAT IS AT
10 LEAST SIX PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR
11 INDIVIDUAL HEALTH BENEFIT PLANS OFFERED IN THAT COUNTY IN 2021,
12 CALCULATED BASED ON THE AVERAGE PREMIUM RATE FOR INDIVIDUAL
13 HEALTH BENEFIT PLANS OFFERED IN THAT COUNTY, AS ADJUSTED FOR
14 MEDICAL INFLATION, PRIOR TO THE APPLICATION OF THE COLORADO
15 REINSURANCE PROGRAM PURSUANT TO PART 11 OF THIS ARTICLE 16; AND
16 (B) IN THE SMALL GROUP MARKET AT A PREMIUM RATE THAT IS AT
17 LEAST SIX PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR SMALL
18 GROUP PLANS OFFERED IN THAT COUNTY IN 2021, AS ADJUSTED FOR
19 MEDICAL INFLATION.
20 (b) (I) IN THE INDIVIDUAL MARKET, FOR THE PLAN YEAR
21 BEGINNING JANUARY 1, 2024, AND IN THE SMALL GROUP MARKET,
22 BEGINNING JANUARY 1, 2024, EACH CARRIER SHALL OFFER THE
23 STANDARDIZED PLAN AT A PREMIUM RATE THAT IS AT LEAST TWELVE
24 PERCENT LESS THAN THE PREMIUM RATE FOR HEALTH BENEFIT PLANS THAT
25 THE CARRIER OFFERED IN THE 2021 CALENDAR YEAR, AS ADJUSTED FOR
26 MEDICAL INFLATION, IN THE INDIVIDUAL AND SMALL GROUP MARKETS.
27 THE COMMISSIONER SHALL CALCULATE THE PREMIUM RATE REDUCTION

1 BASED ON THE RATES CHARGED IN THE SAME COUNTY IN WHICH THE
2 CARRIER OFFERED HEALTH BENEFIT PLANS IN THE INDIVIDUAL AND SMALL
3 GROUP MARKETS IN 2021 PRIOR TO THE APPLICATION OF THE COLORADO
4 REINSURANCE PROGRAM PURSUANT TO PART 11 OF THIS ARTICLE 16.
5 (II) FOR CARRIERS OFFERING THE STANDARDIZED PLAN IN THE
6 2024 PLAN YEAR IN A COUNTY IN WHICH THE CARRIER DID NOT OFFER A
7 HEALTH BENEFIT PLAN IN THE INDIVIDUAL OR SMALL GROUP MARKET IN
8 THE 2021 CALENDAR YEAR, EACH CARRIER THAT OFFERS THE
9 STANDARDIZED PLAN SHALL OFFER THE STANDARDIZED PLAN:
10 (A) IN THE INDIVIDUAL MARKET AT A PREMIUM RATE THAT IS AT
11 LEAST TWELVE PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR
12 INDIVIDUAL PLANS OFFERED IN THAT COUNTY IN 2021, CALCULATED
13 BASED ON THE AVERAGE PREMIUM RATE FOR INDIVIDUAL PLANS OFFERED
14 IN THAT COUNTY, AS ADJUSTED FOR MEDICAL INFLATION, PRIOR TO THE
15 APPLICATION OF THE COLORADO REINSURANCE PROGRAM PURSUANT TO
16 PART 11 OF THIS ARTICLE 16; AND
17 (B) IN THE SMALL GROUP MARKET AT A PREMIUM RATE THAT IS AT
18 LEAST TWELVE PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR
19 SMALL GROUP PLANS OFFERED IN THAT COUNTY IN 2021, AS ADJUSTED FOR
20 MEDICAL INFLATION.
21 (c) (I) IN THE INDIVIDUAL MARKET, FOR THE PLAN YEAR
22 BEGINNING JANUARY 1, 2025, AND IN THE SMALL GROUP MARKET,
23 BEGINNING JANUARY 1, 2025, EACH CARRIER SHALL OFFER THE
24 STANDARDIZED PLAN AT A PREMIUM RATE THAT IS AT LEAST EIGHTEEN
25 PERCENT LESS THAN THE PREMIUM RATE FOR HEALTH BENEFIT PLANS THAT
26 THE CARRIER OFFERED IN THE 2021 CALENDAR YEAR, AS ADJUSTED FOR
27 MEDICAL INFLATION, IN THE INDIVIDUAL AND SMALL GROUP MARKETS.

1 THE COMMISSIONER SHALL CALCULATE THE PREMIUM RATE REDUCTION
2 BASED ON THE RATES CHARGED IN THE SAME COUNTY IN WHICH THE
3 CARRIER OFFERED HEALTH BENEFIT PLANS IN THE INDIVIDUAL AND SMALL
4 GROUP MARKETS IN 2021 PRIOR TO THE APPLICATION OF THE COLORADO
5 REINSURANCE PROGRAM PURSUANT TO PART 11 OF THIS ARTICLE 16.
6 (II) FOR CARRIERS OFFERING THE STANDARDIZED PLAN IN THE
7 2025 PLAN YEAR IN A COUNTY IN WHICH THE CARRIER DID NOT OFFER A
8 HEALTH BENEFIT PLAN IN THE INDIVIDUAL OR SMALL GROUP MARKET IN
9 THE 2021 CALENDAR YEAR, EACH CARRIER THAT OFFERS THE
10 STANDARDIZED PLAN SHALL OFFER THE STANDARDIZED PLAN:
11 (A) IN THE INDIVIDUAL MARKET AT A PREMIUM RATE THAT IS AT
12 LEAST EIGHTEEN PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR
13 INDIVIDUAL PLANS OFFERED IN THAT COUNTY IN 2021, CALCULATED
14 BASED ON THE AVERAGE PREMIUM RATE FOR INDIVIDUAL PLANS OFFERED
15 IN THAT COUNTY, AS ADJUSTED FOR MEDICAL INFLATION, PRIOR TO THE
16 APPLICATION OF THE COLORADO REINSURANCE PROGRAM PURSUANT TO
17 PART 11 OF THIS ARTICLE 16; AND
18 (B) IN THE SMALL GROUP MARKET AT A PREMIUM RATE THAT IS AT
19 LEAST EIGHTEEN PERCENT LESS THAN THE AVERAGE PREMIUM RATE FOR
20 SMALL GROUP PLANS OFFERED IN THAT COUNTY IN 2021, AS ADJUSTED FOR
21 MEDICAL INFLATION.
22 (d) FOR THE PLAN YEAR BEGINNING ON OR AFTER JANUARY 1,
23 2026, AND EACH YEAR THEREAFTER, EACH CARRIER AND HEALTH-CARE
24 COVERAGE COOPERATIVE SHALL LIMIT ANY ANNUAL PERCENTAGE
25 INCREASE IN THE PREMIUM RATE FOR THE STANDARDIZED PLAN IN BOTH
26 THE INDIVIDUAL AND SMALL GROUP MARKETS TO A RATE THAT IS NO MORE
27 THAN MEDICAL INFLATION, RELATIVE TO THE PREVIOUS YEAR.

1 (3) THE PREMIUM RATE REQUIREMENTS IN SUBSECTIONS (2)(a),
2 (2)(b), AND (2)(c) OF THIS SECTION FOR THE STANDARDIZED PLAN OFFERED
3 IN THE INDIVIDUAL AND SMALL GROUP MARKETS MUST ACCOUNT FOR
4 POLICY ADJUSTMENTS DEEMED NECESSARY TO PREVENT PEOPLE WITH LOW
5 AND MODERATE INCOMES FROM EXPERIENCING NET INCREASES IN
6 PREMIUM COSTS.
7 (4) THE COMMISSIONS PAID TO INSURANCE PRODUCERS FOR THE
8 SALE OF THE STANDARDIZED PLAN MUST BE COMPARABLE TO THE
9 AVERAGE COMMISSIONS PAID FOR THE SALE OF OTHER PLANS OFFERED IN
10 THE INDIVIDUAL AND SMALL GROUP MARKETS.
11 **10-16-1306. Rate filings - failure to meet premium**
12 **requirements - notice - public hearing - rules.** (1) (a) IN THE RATE
13 FILINGS REQUIRED PURSUANT TO SECTION 10-16-107, EACH CARRIER MUST
14 FILE RATES FOR THE STANDARDIZED PLAN AT THE PREMIUM RATES
15 REQUIRED IN SECTION 10-16-1305 (2).
16 (b) IF A CARRIER OR HEALTH-CARE PROVIDER ANTICIPATES THAT
17 THE CARRIER WILL BE UNABLE TO MEET NETWORK ADEQUACY STANDARDS
18 OR THE PREMIUM RATE REQUIREMENTS IN SECTION 10-16-1305 DUE TO A
19 REIMBURSEMENT RATE DISPUTE FOR THE STANDARDIZED PLAN, THE
20 CARRIER OR HEALTH-CARE PROVIDER MAY INITIATE NONBINDING
21 ARBITRATION PRIOR TO FILING RATES FOR THE STANDARDIZED PLAN. THE
22 RATE FILING DEADLINE ISSUED BY THE COMMISSIONER PURSUANT TO
23 SECTION 10-16-107 MUST STILL BE MET AND MAY NOT BE DELAYED DUE
24 TO ARBITRATION. THE COMMISSIONER SHALL NOT BE REQUIRED TO
25 PARTICIPATE OR OTHERWISE MANAGE ANY NONBINDING ARBITRATION
26 IMPLEMENTED UNDER THIS SECTION.
27 (2) IF A CARRIER IS UNABLE TO OFFER THE STANDARDIZED PLAN AS

1 REQUIRED BY SECTION 10-16-1305 (1) AT THE PREMIUM RATE REQUIRED
2 IN SECTION 10-16-1305 (2) IN ANY YEAR, THE CARRIER SHALL NOTIFY THE
3 COMMISSIONER OF THE REASONS WHY THE CARRIER IS UNABLE TO MEET
4 THE REQUIREMENTS AS FOLLOWS:
5 (a) FOR PREMIUM RATES APPLICABLE IN 2023, BY MAY 1, 2022;
6 AND
7 (b) FOR PREMIUM RATES APPLICABLE IN 2024 OR ANY SUBSEQUENT
8 YEAR, BY MARCH 1 OF THE YEAR PRECEDING THE YEAR IN WHICH THE
9 PREMIUMS RATES GO INTO EFFECT.
10 (3) (a) IF, ON OR AFTER JANUARY 1, 2023, AND PURSUANT TO
11 SUBSECTION (2) OF THIS SECTION, A CARRIER NOTIFIES THE COMMISSIONER
12 THAT THE CARRIER IS UNABLE TO OFFER THE STANDARDIZED PLAN AT THE
13 PREMIUM RATE REQUIRED IN SECTION 10-16-1305 (2) OR THE
14 COMMISSIONER OTHERWISE DETERMINES, WITH SUPPORT FROM AN
15 INDEPENDENT ACTUARY AND BASED ON A REVIEW OF THE RATE AND FORM
16 FILINGS, THAT A CARRIER HAS NOT MET THE PREMIUM RATE
17 REQUIREMENTS IN SECTION 10-16-1305 (2) OR THE NETWORK ADEQUACY
18 REQUIREMENTS, THE DIVISION SHALL HOLD A PUBLIC HEARING PRIOR TO
19 THE APPROVAL OF THE CARRIER'S FINAL RATES; EXCEPT THAT, FOR THE
20 PURPOSES OF HOLDING A PUBLIC HEARING, IF A CARRIER DOES NOT MEET
21 THE NETWORK ADEQUACY REQUIREMENTS IN SECTION 10-16-1304 (1)(g),
22 THE COMMISSIONER SHALL CONSIDER A CARRIER TO HAVE MET NETWORK
23 ADEQUACY REQUIREMENTS IF THE CARRIER FILES THE ACTION PLAN
24 REQUIRED IN SECTION 10-16-1304 (2)(b).
25 (b) INFORMATION SUBMITTED BY A PARTY FOR PURPOSES OF A
26 PUBLIC HEARING HELD PURSUANT TO SUBSECTION (3)(a) OF THIS SECTION
27 IS SUBJECT TO THE "COLORADO OPEN RECORDS ACT", PART 2 OF ARTICLE

1 72 OF TITLE 24.

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

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

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

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

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

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

1 IS INDEPENDENT AND NOT PART OF A HEALTH SYSTEM MUST RECEIVE A
2 TWENTY-PERCENTAGE-POINT INCREASE IN THE BASE REIMBURSEMENT
3 RATE.
4 (IV) A HOSPITAL THAT IS AN ESSENTIAL ACCESS HOSPITAL THAT IS
5 NOT PART OF A HEALTH SYSTEM MUST RECEIVE A
6 FORTY-PERCENTAGE-POINT INCREASE IN THE BASE REIMBURSEMENT RATE.
7 (V) A HOSPITAL THAT IS A PEDIATRIC SPECIALTY HOSPITAL WITH
8 A LEVEL ONE PEDIATRIC TRAUMA CENTER MUST RECEIVE A
9 FIFTY-FIVE-PERCENTAGE-POINT INCREASE IN THE BASE REIMBURSEMENT
10 RATE, AND IS NOT ELIGIBLE FOR ADDITIONAL FACTORS UNDER THIS
11 SUBSECTION (4).
12 (VI) A HOSPITAL WITH A COMBINED PERCENTAGE OF PATIENTS
13 WHO RECEIVE SERVICES THROUGH PROGRAMS ESTABLISHED THROUGH THE
14 "COLORADO MEDICAL ASSISTANCE ACT", ARTICLES 4 TO 6 OF TITLE 25.5,
15 OR MEDICARE, TITLE XVIII OF THE FEDERAL "SOCIAL SECURITY ACT", AS
16 AMENDED, THAT EXCEEDS THE STATEWIDE AVERAGE MUST RECEIVE UP TO
17 A THIRTY-PERCENTAGE-POINT INCREASE IN ITS BASE REIMBURSEMENT
18 RATE, WITH THE ACTUAL INCREASE TO BE DETERMINED BASED ON THE
19 HOSPITAL'S PERCENTAGE SHARE OF SUCH PATIENTS.
20 (VII) A HOSPITAL THAT IS EFFICIENT IN MANAGING THE
21 UNDERLYING COST OF CARE AS DETERMINED BY THE HOSPITAL'S TOTAL
22 MARGINS, OPERATING COSTS, AND NET PATIENT REVENUE MUST RECEIVE
23 UP TO A FORTY-PERCENTAGE-POINT INCREASE IN ITS BASE
24 REIMBURSEMENT RATE.
25 (VIII) NOTWITHSTANDING SUBSECTIONS (4)(a)(III) TO (4)(a)(VII)
26 OF THIS SECTION, IN DETERMINING THE REIMBURSEMENT RATES FOR
27 HOSPITALS, THE COMMISSIONER MAY CONSULT WITH EMPLOYEE

1 MEMBERSHIP ORGANIZATIONS REPRESENTING HEALTH-CARE PROVIDERS'
2 EMPLOYEES IN COLORADO AND WITH HOSPITAL-BASED HEALTH-CARE
3 PROVIDERS IN COLORADO, AND SHALL TAKE INTO ACCOUNT THE COST OF
4 ADEQUATE WAGES, BENEFITS, STAFFING, AND TRAINING FOR HEALTH-CARE
5 EMPLOYEES TO PROVIDE CONTINUOUS QUALITY CARE.
6 (b) ESTABLISH REIMBURSEMENT RATES UNDER THE STANDARDIZED
7 PLAN, IF NECESSARY, FOR HEALTH-CARE PROVIDERS FOR CATEGORIES OF
8 SERVICES WITHIN THE GEOGRAPHIC SERVICE AREA FOR THE STANDARDIZED
9 PLAN TO MEET NETWORK ADEQUACY REQUIREMENTS OR THE PREMIUM
10 RATE REQUIREMENTS IN SECTION 10-16-1305 (2), WHICH RATES MAY NOT
11 BE LESS THAN ONE HUNDRED THIRTY-FIVE PERCENT OF THE MEDICARE
12 REIMBURSEMENT RATES WITHIN THE APPLICABLE GEOGRAPHIC REGION FOR
13 THE SAME SERVICES;
14 (c) REQUIRE HOSPITALS THAT ARE LICENSED PURSUANT TO
15 SECTION 25-1.5-103 TO ACCEPT THE REIMBURSEMENT RATES ESTABLISHED
16 PURSUANT TO SUBSECTION (4)(a) OF THIS SECTION IF NECESSARY TO
17 ENSURE THE STANDARDIZED PLAN MEETS THE PREMIUM RATE
18 REQUIREMENTS AND THE NETWORK ADEQUACY REQUIREMENTS;
19 (d) (I) REQUIRE HEALTH-CARE PROVIDERS TO ACCEPT THE
20 REIMBURSEMENT RATES ESTABLISHED PURSUANT TO SUBSECTION (4)(b)
21 OF THIS SECTION, IF NECESSARY, TO ENSURE THE STANDARDIZED PLAN
22 MEETS THE PREMIUM RATE REQUIREMENTS AND THE NETWORK ADEQUACY
23 REQUIREMENTS.
24 (II) THE COMMISSIONER SHALL NOT REQUIRE A HEALTH-CARE
25 PROVIDER, OTHER THAN A HOSPITAL THAT PROVIDES A MAJORITY OF
26 COVERED PROFESSIONAL SERVICES THROUGH A SINGLE, CONTRACTED
27 MEDICAL GROUP FOR A NONPROFIT, NONGOVERNMENTAL HEALTH

1 MAINTENANCE ORGANIZATION, TO CONTRACT WITH ANY OTHER CARRIER;
2 AND
3 (e) REQUIRE THE CARRIER TO OFFER THE STANDARDIZED PLAN IN
4 SPECIFIC COUNTIES WHERE NO CARRIER IS OFFERING THE STANDARDIZED
5 PLAN IN THAT PLAN YEAR IN EITHER THE INDIVIDUAL OR SMALL GROUP
6 MARKET. IN DETERMINING WHETHER THE CARRIER IS REQUIRED TO OFFER
7 THE STANDARDIZED PLAN IN A SPECIFIC COUNTY, THE COMMISSIONER
8 SHALL CONSIDER:
9 (I) THE CARRIER'S STRUCTURE, THE NUMBER OF COVERED LIVES
10 THE CARRIER HAS IN ALL LINES OF BUSINESS IN EACH COUNTY, AND THE
11 CARRIER'S EXISTING SERVICE AREAS; AND
12 (II) ALTERNATIVE HEALTH-CARE COVERAGE AVAILABLE IN EACH
13 COUNTY, INCLUDING HEALTH-CARE COVERAGE COOPERATIVES.
14 (5) NOTWITHSTANDING SUBSECTION (4) OF THIS SECTION, THE
15 COMMISSIONER SHALL NOT SET THE REIMBURSEMENT RATES FOR:
16 (a) A HOSPITAL AT LESS THAN ONE HUNDRED SIXTY-FIVE PERCENT
17 OF THE MEDICARE REIMBURSEMENT RATE OR THE EQUIVALENT RATE; AND
18 (b) ANY HOSPITAL FOR ANY PLAN YEAR AT AN AMOUNT THAT IS
19 MORE THAN TWENTY PERCENT LOWER THAN THE RATE NEGOTIATED
20 BETWEEN THE CARRIER AND THE HOSPITAL FOR THE PREVIOUS PLAN YEAR.
21 (6) (a) THE COMMISSIONER SHALL PROMULGATE RULES TO ENSURE
22 THAT THERE IS NOT AN UNFAIR COMPETITIVE ADVANTAGE FOR A CARRIER
23 THAT INTENDS TO OFFER THE STANDARDIZED PLAN IN THE INDIVIDUAL OR
24 SMALL GROUP MARKET IN A COUNTY WHERE IT HAS NOT PREVIOUSLY
25 OFFERED HEALTH BENEFIT PLANS IN THAT MARKET OR WITH A HOSPITAL
26 WITH WHICH THE CARRIER HAS NOT PREVIOUSLY HAD A CONTRACT.
27 (b) THE RULES PROMULGATED PURSUANT TO THIS SUBSECTION (7)

1 MUST ALIGN WITH THE HOSPITAL REIMBURSEMENT METHODOLOGIES
2 DESCRIBED IN SUBSECTIONS (4), (5), AND (6) OF THIS SECTION.
3 (7) NOTWITHSTANDING SUBSECTIONS (4) AND (5) OF THIS SECTION,
4 FOR A HOSPITAL WITH A NEGOTIATED REIMBURSEMENT RATE THAT IS
5 LOWER THAN TEN PERCENT OF THE STATEWIDE HOSPITAL MEDIAN
6 REIMBURSEMENT RATE MEASURED AS A PERCENTAGE OF MEDICARE FOR
7 THE 2021 PLAN YEAR USING DATA FROM THE COLORADO ALL-PAYER
8 CLAIMS DATABASE DESCRIBED IN SECTION 25.5-1-204, THE COMMISSIONER
9 SHALL SET THE REIMBURSEMENT RATE FOR THAT HOSPITAL AT NO LESS
10 THAN THE GREATER OF:
11 (a) THE HOSPITAL'S COMMERCIAL REIMBURSEMENT RATE AS A
12 PERCENTAGE OF MEDICARE MINUS ONE-THIRD OF THE DIFFERENCE
13 BETWEEN THE HOSPITAL'S 2021 COMMERCIAL REIMBURSEMENT RATE AS
14 A PERCENTAGE OF MEDICARE AND THE RATE ESTABLISHED BY SUBSECTION
15 (4) OF THIS SECTION;
16 (b) ONE HUNDRED SIXTY-FIVE PERCENT OF THE HOSPITAL'S
17 MEDICARE REIMBURSEMENT RATE OR EQUIVALENT RATE; OR
18 (c) THE RATE ESTABLISHED BY SUBSECTION (4) OF THIS SECTION.
19 (8) A CARRIER OR HEALTH-CARE PROVIDER MAY APPEAL A
20 DECISION BY THE COMMISSIONER MADE PURSUANT TO SUBSECTION (4) OF
21 THIS SECTION TO THE DISTRICT COURT IN THE APPLICABLE JURISDICTION.
22 THE DECISION OF THE COMMISSIONER IS A FINAL AGENCY ACTION SUBJECT
23 TO JUDICIAL REVIEW PURSUANT TO SECTION 24-4-106 (6).
24 (9) FOR THE PURPOSE OF MAKING THE DETERMINATION IN
25 SUBSECTION (3) OF THIS SECTION:
26 (a) A HEALTH-CARE COVERAGE COOPERATIVE, AND A CARRIER
27 OFFERING HEALTH BENEFIT PLANS UNDER AGREEMENT WITH THE

1 HEALTH-CARE COVERAGE COOPERATIVE, THAT HAS OFFERED ONE OR MORE
2 HEALTH BENEFIT PLANS TO PURCHASERS IN THE INDIVIDUAL AND SMALL
3 GROUP MARKETS THAT PREVIOUSLY ACHIEVED AND MAINTAINED AT LEAST
4 AN EIGHTEEN PERCENT REDUCTION IN PREMIUM RATES, REGARDLESS OF
5 THE FIRST YEAR THE HEALTH BENEFIT PLANS WERE OFFERED, SHALL BE
6 DEEMED BY THE COMMISSIONER AS HAVING MET THE REQUIREMENTS FOR
7 CARRIERS IN SECTIONS 10-16-1304 AND 10-16-1305 WITH RESPECT TO THE
8 COUNTIES IN WHICH THE INDIVIDUAL AND SMALL GROUP PLANS ARE BEING
9 OFFERED BY THE HEALTH-CARE COVERAGE COOPERATIVE.
10 (b) THE COMMISSIONER SHALL TAKE INTO ACCOUNT:
11 (I) ANY ACTUARIAL DIFFERENCES BETWEEN THE STANDARDIZED
12 PLAN AND THE HEALTH BENEFIT PLANS THE CARRIER OFFERED IN THE 2021
13 CALENDAR YEAR;
14 (II) ANY CHANGES TO THE STANDARDIZED PLAN; AND
15 (III) STATE OR FEDERAL HEALTH BENEFIT COVERAGE MANDATES
16 IMPLEMENTED AFTER THE 2021 PLAN YEAR.
17 (10) IF THE 1332 WAIVER APPLIED FOR PURSUANT TO SECTION
18 10-16-1308 IS DENIED, SUSPENDED, OR OTHERWISE RESCINDED, THE
19 COMMISSIONER IS REQUIRED TO SET THE PREMIUM RATE REQUIREMENTS
20 TO MAXIMIZE SUBSIDIES FOR COLORADANS.
21 (11) A HOSPITAL OR A HEALTH-CARE PROVIDER IN COLORADO
22 SHALL NOT BALANCE BILL CONSUMERS ENROLLED IN THE STANDARDIZED
23 PLAN FOR SERVICES COVERED BY THE STANDARDIZED PLAN AND SHALL
24 ACCEPT THE REIMBURSEMENT RATES ESTABLISHED BY THE COMMISSIONER
25 PURSUANT TO SUBSECTION (4) OF THIS SECTION, IF APPLICABLE, FOR THE
26 SERVICE PROVIDED TO THE CONSUMER.
27 (12) (a) THE COMMISSIONER SHALL ONLY SET REIMBURSEMENT

1 RATES PURSUANT TO THIS SECTION FOR HOSPITALS OR HEALTH-CARE
2 PROVIDERS THAT:
3 (I) PREVENTED A CARRIER FROM MEETING THE PREMIUM RATE
4 REQUIREMENTS FOR A STANDARDIZED PLAN BEING OFFERED IN A SPECIFIC
5 COUNTY; OR
6 (II) CAUSED THE CARRIER TO FAIL TO MEET NETWORK ADEQUACY
7 REQUIREMENTS.
8 (b) THE CARRIER SHALL PROVIDE THE COMMISSIONER WITH
9 REASONABLE INFORMATION NECESSARY TO IDENTIFY WHICH HOSPITALS OR
10 HEALTH-CARE PROVIDERS WERE THE CAUSE OF THE CARRIER'S FAILURE TO
11 MEET THE PREMIUM RATE REQUIREMENTS OR TO MEET NETWORK
12 ADEQUACY REQUIREMENTS.
13 (13) THE COMMISSIONER SHALL NOT USE THE FAILURE OF A
14 CARRIER TO MEET THE PREMIUM RATE REQUIREMENTS FOR THE
15 STANDARDIZED PLAN IN A COUNTY AS A REASON TO DENY PREMIUM RATES
16 FOR A NONSTANDARDIZED PLAN OF A CARRIER IN THAT COUNTY.
17 **10-16-1307. Advisory board - members - rules.** (1) (a) THE
18 COMMISSIONER SHALL CONSULT WITH AN ADVISORY BOARD TO IMPLEMENT
19 THIS PART 13. THE GOVERNOR SHALL APPOINT THE MEMBERS OF THE
20 ADVISORY BOARD ON OR BEFORE JULY 1, 2022, AND SHALL ENSURE THAT
21 THE MEMBERSHIP OF THE ADVISORY BOARD HAS DEMONSTRATED
22 EXPERIENCE AND EXPERTISE IN MOST OF THE AREAS LISTED IN SUBSECTION
23 (2) OF THIS SECTION.
24 (b) TO THE EXTENT POSSIBLE, THE GOVERNOR SHALL APPOINT
25 ADVISORY BOARD MEMBERS WHO ARE DIVERSE WITH REGARD TO RACE,
26 ETHNICITY, IMMIGRATION STATUS, AGE, ABILITY, SEXUAL ORIENTATION,
27 GENDER IDENTITY, AND GEOGRAPHY. IN CONSIDERING THE RACIAL AND

1 ETHNIC DIVERSITY OF THE ADVISORY BOARD, THE GOVERNOR SHALL
2 ATTEMPT TO ENSURE THAT AT LEAST ONE-THIRD OF THE MEMBERS ARE
3 PEOPLE OF COLOR. IN CONSIDERING THE GEOGRAPHIC DIVERSITY OF THE
4 ADVISORY BOARD, THE GOVERNOR SHALL ATTEMPT TO APPOINT MEMBERS
5 FROM BOTH RURAL AND URBAN AREAS OF THE STATE.
6 (2) THE GOVERNOR MAY APPOINT UP TO ELEVEN MEMBERS TO THE
7 ADVISORY BOARD AND, TO THE EXTENT PRACTICABLE, SHALL INCLUDE
8 INDIVIDUALS WHO:
9 (a) HAVE FACED BARRIERS TO HEALTH ACCESS, INCLUDING PEOPLE
10 OF COLOR, IMMIGRANTS, AND COLORADANS WITH LOW INCOMES;
11 (b) HAVE EXPERIENCE PURCHASING THE STANDARDIZED PLAN;
12 (c) REPRESENT CONSUMER ADVOCACY ORGANIZATIONS;
13 (d) HAVE EXPERTISE IN HEALTH EQUITY;
14 (e) HAVE EXPERTISE IN HEALTH BENEFITS FOR SMALL BUSINESSES;
15 (f) REPRESENT CARRIERS OR WHO HAVE EXPERIENCE WITH
16 DESIGNING A HEALTH INSURANCE PLAN AND SETTING RATES;
17 (g) REPRESENT HOSPITALS OR WHO HAVE EXPERIENCE WITH
18 CONTRACTS BETWEEN HOSPITALS AND CARRIERS;
19 (h) REPRESENT HEALTH-CARE PROVIDERS OR WHO HAVE
20 EXPERIENCE WITH CONTRACTS BETWEEN HEALTH-CARE PROVIDERS AND
21 CARRIERS;
22 (i) REPRESENT AN EMPLOYEE ORGANIZATION THAT REPRESENTS
23 EMPLOYEES IN THE HEALTH-CARE INDUSTRY; OR
24 (j) ARE LICENSED OR RETIRED PHYSICIANS PRACTICING OR WHO
25 PRACTICED IN THIS STATE.
26 (3) THE MEMBERS SERVE AT THE PLEASURE OF THE GOVERNOR.
27 (4) IN ADDITION TO CONSULTING WITH THE COMMISSIONER

1 PURSUANT TO SUBSECTION (1)(a) OF THIS SECTION, THE ADVISORY BOARD
2 MAY:
3 (a) CONSIDER RECOMMENDATIONS TO STREAMLINE PRIOR
4 AUTHORIZATION AND UTILIZATION MANAGEMENT PROCESSES FOR THE
5 STANDARDIZED PLAN;
6 (b) RECOMMEND WAYS TO KEEP HEALTH-CARE SERVICES IN THE
7 COMMUNITIES WHERE PATIENTS LIVE; AND
8 (c) CONSIDER WHETHER ALTERNATIVE PAYMENT MODELS MAY BE
9 APPROPRIATE FOR PARTICULAR SERVICES, TAKING INTO CONSIDERATION
10 THE IMPACTS OF SUCH MODELS ON HEALTH OUTCOMES FOR PEOPLE OF
11 COLOR.
12 (5) THE DIVISION SHALL PROVIDE TECHNICAL AND
13 ADMINISTRATIVE SUPPORT TO ASSIST THE ADVISORY BOARD.
14 **10-16-1308. Federal waiver - commissioner application - use**
15 **of money.** (1) ON OR AFTER THE EFFECTIVE DATE OF THIS SECTION, THE
16 COMMISSIONER MAY APPLY TO THE SECRETARY OF THE UNITED STATES
17 DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR A STATE INNOVATION
18 WAIVER TO WAIVE ONE OR MORE REQUIREMENTS OF THE FEDERAL ACT AS
19 AUTHORIZED BY SECTION 1332 OF THE FEDERAL ACT TO CAPTURE ALL
20 APPLICABLE SAVINGS TO THE FEDERAL GOVERNMENT AS A RESULT OF THE
21 IMPLEMENTATION OF THIS PART 13.
22 (2) (a) UPON APPROVAL OF THE 1332 WAIVER APPLICATION, THE
23 COMMISSIONER MAY USE ANY FEDERAL MONEY RECEIVED THROUGH THE
24 WAIVER FOR THE IMPLEMENTATION OF THIS PART 13 OR FOR THE
25 COLORADO HEALTH INSURANCE AFFORDABILITY ENTERPRISE CREATED IN
26 SECTION 10-16-1204. THE COMMISSIONER MAY ALLOCATE FEDERAL
27 MONEY TO THE HEALTH INSURANCE AFFORDABILITY CASH FUND CREATED

1 IN SECTION 10-16-1206 FOR THE PURPOSES DESCRIBED IN SECTION
2 10-16-1205 (1)(b) FOR USE BY THE COLORADO HEALTH INSURANCE
3 AFFORDABILITY ENTERPRISE TO INCREASE THE VALUE, AFFORDABILITY,
4 QUALITY, AND EQUITY OF HEALTH-CARE COVERAGE FOR ALL
5 COLORADANS, WITH A FOCUS ON INCREASING THE VALUE, AFFORDABILITY,
6 QUALITY, AND EQUITY OF HEALTH-CARE COVERAGE FOR COLORADANS
7 HISTORICALLY AND SYSTEMICALLY DISADVANTAGED BY HEALTH AND
8 ECONOMIC SYSTEMS.
9 (b) THE IMPLEMENTATION AND OPERATION OF SECTION 10-16-1305
10 (2) IS CONTINGENT ON THE APPROVAL OF THE 1332 WAIVER APPLICATION
11 AND THE RECEIPT OF FEDERAL FUNDS.
12 **10-16-1309. Standardized plan - cost shift.** (1) IF THE
13 ADMINISTRATOR OF A SELF-FUNDED HEALTH INSURANCE PLAN
14 VOLUNTARILY PROVIDES TO THE COMMISSIONER ITS CONTRACTED RATES
15 AND ANY OTHER INFORMATION DEEMED NECESSARY AND AGREED UPON BY
16 THE ADMINISTRATOR AND THE COMMISSIONER, THE COMMISSIONER MAY
17 EVALUATE WHETHER THE RATES OF THE SELF-FUNDED HEALTH INSURANCE
18 PLAN REFLECT A COST SHIFT BETWEEN THE SELF-FUNDED PLAN AND THE
19 STANDARDIZED PLAN OFFERED BY A CARRIER PURSUANT TO SECTION
20 10-16-1305.
21 (2) IF THE COMMISSIONER DETERMINES THERE IS A COST SHIFT, THE
22 COMMISSIONER SHALL, TO THE EXTENT PRACTICABLE, PROVIDE A
23 DESCRIPTION OF WHICH CATEGORIES OF SERVICES HAVE EXPERIENCED THE
24 GREATEST COST SHIFT TO THE ADMINISTRATOR OF THE SELF-FUNDED
25 HEALTH INSURANCE PLAN.
26 **10-16-1310. Reports required - repeal.** (1) THE COMMISSIONER
27 SHALL CONTRACT WITH AN INDEPENDENT THIRD-PARTY ORGANIZATION TO

1 PREPARE THREE SEPARATE REPORTS AS SPECIFIED IN SUBSECTION (4) OF
2 THIS SECTION, TO THE EXTENT THAT INFORMATION IS AVAILABLE
3 REGARDING THE IMPLEMENTATION OF THIS PART 13 AS IT RELATES TO THE
4 STAFFING, WAGES, BENEFITS, TRAINING, AND WORKING CONDITIONS OF
5 HOSPITAL WORKERS AND AS IT RELATES TO PROVIDER WORKLOAD,
6 INCLUDING ANY IMPACT ON THE SIZE OF THE PROVIDER PANELS, IF
7 AVAILABLE.
8 (2) IN CHOOSING AN INDEPENDENT THIRD-PARTY CONTRACTOR,
9 THE COMMISSIONER SHALL CONSIDER ORGANIZATIONS WITH EXPERIENCE
10 CONDUCTING IN-PERSON INTERVIEWS WITH HEALTH-CARE EMPLOYERS AND
11 EMPLOYEES IN COLORADO.
12 (3) THE INDEPENDENT THIRD-PARTY CONTRACTOR MAY MAKE
13 POLICY RECOMMENDATIONS RELATED TO INFORMATION IN THE REPORTS
14 AND MAY INCLUDE DATA COLLECTED FROM EMPLOYERS, EMPLOYEES, AND
15 OTHER THIRD-PARTY SOURCES.
16 (4) THE INDEPENDENT THIRD-PARTY CONTRACTOR SHALL DELIVER
17 THE REPORTS TO THE COMMISSIONER AS FOLLOWS:
18 (a) THE FIRST REPORT BY JULY 1, 2023;
19 (b) THE SECOND REPORT BY JULY 1, 2024; AND
20 (c) THE THIRD REPORT BY JULY 1, 2025.
21 (4) THIS SECTION IS REPEALED, EFFECTIVE JULY 1, 2026.
22 **10-16-1311. State measurement for accountable, responsive,**
23 **and transparent (SMART) government act report.** (1) THE
24 COMMISSIONER SHALL REPORT DURING THE HEARINGS CONDUCTED
25 PURSUANT TO THE "STATE MEASUREMENT FOR ACCOUNTABLE,
26 RESPONSIVE, AND TRANSPARENT (SMART) GOVERNMENT ACT", PART 2
27 OF ARTICLE 7 OF TITLE 2:

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

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

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

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

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

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

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

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

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

1 TOTAL COST OF HEALTH CARE IN MAKING THIS DETERMINATION.

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

4 **10-16-1206. Health insurance affordability cash fund -**
5 **creation.** (1) There is hereby created in the state treasury the health
6 insurance affordability cash fund. The fund consists of:

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

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

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

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

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

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

23 **SECTION 5.** In Colorado Revised Statutes, **add** 12-30-116 as
24 follows:

25 **12-30-116. Acceptance of patients enrolled in standardized**
26 **plan - acceptance of reimbursement rate requirements - warning -**
27 **fine.** (1) THE COMMISSIONER OF INSURANCE MAY REQUIRE A

HEALTH-CARE PROVIDER, AFTER A HEARING PURSUANT TO SECTION 10-16-1306, TO PARTICIPATE IN A STANDARDIZED PLAN, AS DEFINED IN SECTION 10-16-1303 (14), AND ACCEPT THE REIMBURSEMENT RATE DESCRIBED IN SECTION 10-16-1306.

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

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

(4) THE IMPOSITION OF AN ADMINISTRATIVE FINE PURSUANT TO THIS SECTION DOES NOT CONSTITUTE A DISCIPLINARY ACTION PURSUANT TO THIS TITLE 12 AGAINST A HEALTH-CARE PROVIDER.

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

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

1 SECTION 10-16-1304.

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

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

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

15 (b) IN DETERMINING THE APPROPRIATE PENALTY, THE
16 DEPARTMENT SHALL CONSIDER ANY PENALTIES RECOMMENDED BY THE
17 COMMISSIONER OF INSURANCE, THE HOSPITAL'S FINANCIAL
18 CIRCUMSTANCES, AND OTHER CIRCUMSTANCES DEEMED RELEVANT BY THE
19 DEPARTMENT.

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

22 **25.5-1-131. Insurance ombudsman - consumer advocate -**
23 **duties.** (1) THERE IS HEREBY CREATED IN THE STATE DEPARTMENT THE
24 OFFICE OF THE INSURANCE OMBUDSMAN TO ACT AS THE ADVOCATE FOR
25 CONSUMER INTERESTS IN MATTERS RELATED TO ACCESS TO AND THE
26 AFFORDABILITY OF THE STANDARDIZED HEALTH BENEFIT PLAN CREATED
27 PURSUANT TO SECTION 10-16-1304. THE OMBUDSMAN SHALL:

1 (a) INTERACT WITH CONSUMERS REGARDING THEIR ACCESS TO, THE
2 AFFORDABILITY OF, AND COVERAGE ISSUES WITH THE STANDARDIZED
3 PLAN;
4 (b) EVALUATE DATA TO ASSESS THE STANDARDIZED PLAN'S
5 NETWORK AND AFFORDABILITY; AND
6 (c) REPRESENT THE INTERESTS OF CONSUMERS IN PUBLIC
7 HEARINGS HELD PURSUANT TO SECTION 10-16-1306.
8 (2) IN THE PERFORMANCE OF THE OMBUDSMAN'S DUTIES, THE
9 OMBUDSMAN SHALL ACT INDEPENDENTLY OF THE STATE DEPARTMENT.
10 ANY RECOMMENDATIONS MADE OR POSITIONS TAKEN BY THE OMBUDSMAN
11 DO NOT REFLECT THOSE OF THE STATE DEPARTMENT.
12 **SECTION 8. Appropriation.** (1) For the 2021-22 state fiscal
13 year, $1,199,637 is appropriated to the department of regulatory agencies.
14 This appropriation is from the division of insurance cash fund created in
15 section 10-1-103 (3), C.R.S. To implement this act, the department may
16 use this appropriation as follows:
17 (a) $948,667 for use by the division of insurance for personal
18 services, which is based on an assumption that the division will require
19 an additional 5.4 FTE;
20 (b) $38,290 for use by the division of insurance for operating
21 expenses; and
22 (c) $212,680 for use by the executive director's office and
23 administrative services for the purchase of legal services.
24 (2) For the 2021-22 state fiscal year, $212,680 is appropriated to
25 the department of law. This appropriation is from reappropriated funds
26 received from the department of regulatory agencies under subsection
27 (1)(c) of this section and is based on an assumption that the department

of law will require an additional 1.1 FTE. To implement this act, the department of law may use this appropriation to provide legal services for the department of regulatory agencies.

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

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

(b) $13,750 for operating expenses.

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