First Regular Session
Seventy-second General Assembly
STATE OF COLORADO

INTRODUCED

LLS NO. 19-0421.01 Christy Chase x2008 **SENATE BILL 19-004**

SENATE SPONSORSHIP

Donovan,

HOUSE SPONSORSHIP

Roberts,

Senate Committees
Health & Human Services

House Committees

A BILL FOR AN ACT

CONCERNING MEASURES TO ADDRESS THE HIGH COSTS OF HEALTH INSURANCE IN THE STATE, AND, IN CONNECTION THEREWITH, AUTHORIZING THE STATE PERSONNEL DIRECTOR TO IMPLEMENT A PILOT PROGRAM TO ALLOW RESIDENTS OF A SPECIFIED REGION TO PARTICIPATE IN STATE EMPLOYEE MEDICAL BENEFIT PLANS AND MODIFYING THE HEALTH CARE COVERAGE COOPERATIVES LAWS TO INCLUDE CONSUMER PROTECTIONS AND ALLOW CONSUMERS TO COLLECTIVELY NEGOTIATE RATES DIRECTLY WITH PROVIDERS.

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.)

Sections 1 and 2 of the bill authorize the state personnel director to explore the feasibility of offering and, if feasible, to develop and implement a one-year pilot program in a limited geographic region of the state affected by high health insurance premiums to provide access to individuals in that region to participate in the group medical benefit plans offered to state employees. The pilot program would be available:

- In the portions of Eagle and Garfield counties that are within the service area of the state group benefit plans;
- To a limited number of individuals whose household income is more than 400 % but not more than 500 % of the federal poverty line; and
- In the 2019-20 benefit plan year.

Section 2 outlines the factors for the state personnel director to consider in determining the feasibility of the pilot program.

Sections 3 through 15 modernize laws authorizing health care cooperatives in the state to incorporate consumer protections such as coverage for preexisting conditions and to encourage consumers to help control health care costs by negotiating rates on a collective basis directly with providers.

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

SECTION 1. In Colorado Revised Statutes, 24-50-604, **add** (1)(n) as follows:

24-50-604. Powers and duties of the director. (1) The director shall administer and manage the state employees group benefit plans and, subject to the provisions of this part 6, has the following powers and duties:

(n) THE AUTHORITY TO DEVELOP AND IMPLEMENT A PILOT PROGRAM PURSUANT TO SECTION 24-50-620.

SECTION 2. In Colorado Revised Statutes, **add** 24-50-620 as follows:

24-50-620. Pilot program - participation in group medical benefit plans - individuals in high-cost areas - legislative declaration

- definitions - repeal. (1) THE GENERAL ASSEMBLY HEREBY FINDS AND DECLARES THAT:

(a) CURRENTLY, PREMIUMS FOR HEALTH INSURANCE ACROSS THE NINE HEALTH INSURANCE GEOGRAPHIC RATING REGIONS IN COLORADO, AS WELL AS THE NUMBER OF INSURANCE CARRIERS AVAILABLE AND THE NUMBER AND VARIETY OF PLANS OFFERED IN THE DIFFERENT REGIONS, VARY SIGNIFICANTLY;

(b) PREMIUMS IN RURAL AREAS, ESPECIALLY IN THE EASTERN PLAINS AND THE WESTERN SLOPE AREAS OF THE STATE, ARE CONSIDERABLY HIGHER THAN PREMIUMS IN METROPOLITAN AREAS, AND THE NUMBER OF CARRIERS AND THE DIVERSITY OF PLANS THEY OFFER ARE VERY LIMITED IN THOSE AREAS. IN FACT, ONLY ONE CARRIER IS CURRENTLY OFFERING PLANS ON THE HEALTH BENEFIT EXCHANGE IN SOME RURAL AREAS OF THE STATE.

(c) MANY COLORADANS IN RURAL AREAS WHOSE INCOMES FALL BETWEEN FOUR HUNDRED PERCENT AND FIVE HUNDRED PERCENT OF THE FEDERAL POVERTY LINE ARE COST-BURDENED IN THAT THEY SPEND MORE THAN TWENTY PERCENT OF THEIR HOUSEHOLD INCOME ON PREMIUMS FOR HEALTH INSURANCE BUT EARN TOO MUCH TO QUALIFY FOR SUBSIDIES AVAILABLE UNDER FEDERAL LAW;

(d) BECAUSE OF THE FINANCIAL BURDEN HIGH-COST HEALTH INSURANCE PLACES ON INDIVIDUALS IN RURAL AREAS OF THE STATE, A CONSIDERABLE NUMBER OF THESE COST-BURDENED INDIVIDUALS MAY NOT PURCHASE HEALTH INSURANCE IN 2019, EXACERBATING THE PROBLEMS OF FEW CARRIERS, FEW PLAN OPTIONS, AND HIGH COSTS OF HEALTH INSURANCE IN RURAL REGIONS OF THE STATE AS WELL AS INCREASING THE NUMBER OF UNINSURED INDIVIDUALS IN THOSE AREAS;

(e) IT IS THEREFORE IMPORTANT TO EXPLORE THE FEASIBILITY OF OFFERING AND, IF FEASIBLE, TO DEVELOP AND IMPLEMENT A PILOT PROGRAM IN A LIMITED GEOGRAPHIC REGION OF THE STATE AFFECTED BY HIGH HEALTH INSURANCE PREMIUMS TO PROVIDE ACCESS TO INDIVIDUALS IN THAT REGION TO PARTICIPATE IN THE GROUP MEDICAL BENEFIT PLANS OFFERED TO STATE EMPLOYEES.

(2) AS USED IN THIS SECTION:

(a) "FEDERAL POVERTY LINE" HAS THE SAME MEANING AS "POVERTY LINE", AS DEFINED IN 42 U.S.C. SEC. 9902 (2).

(b) "GROUP MEDICAL BENEFIT PLAN" MEANS A GROUP BENEFIT PLAN THAT PROVIDES MEDICAL BENEFITS.

(3) IF FEASIBLE, THE DIRECTOR SHALL DEVELOP AND IMPLEMENT A ONE-YEAR PILOT PROGRAM TO ALLOW ELIGIBLE INDIVIDUALS TO ENROLL IN AND RECEIVE MEDICAL BENEFITS THROUGH THE GROUP MEDICAL BENEFIT PLANS. IF THE DIRECTOR IS ABLE TO DEVELOP AND IMPLEMENT THE PILOT PROGRAM, THE DIRECTOR SHALL ALLOW ELIGIBLE INDIVIDUALS TO ENROLL IN GROUP MEDICAL BENEFIT PLANS FOR THE 2019-20 PLAN YEAR.

(4) (a) IN DETERMINING WHETHER THE PILOT PROGRAM IS FEASIBLE, THE DIRECTOR SHALL CONSIDER:

(I) WHETHER AND HOW THE STATE CAN ENROLL INDIVIDUALS WHO ARE NOT STATE EMPLOYEES, AND MANAGE THEIR PARTICIPATION, IN A GROUP MEDICAL BENEFIT PLAN; WHETHER THE STATE CAN CONTRACT WITH A THIRD PARTY FOR EITHER OR BOTH OF THOSE SERVICES; AND THE COST TO THE STATE TO PERFORM OR CONTRACT WITH A THIRD PARTY TO PERFORM THOSE SERVICES;

(II) ACTUARIAL INFORMATION ABOUT THE EFFECTS OF ENROLLING

ELIGIBLE INDIVIDUALS ON THE SOLVENCY AND VIABILITY OF A SELF-FUNDED GROUP MEDICAL BENEFIT PLAN;

(III) WHETHER, IN THE CASE OF A FULLY FUNDED GROUP MEDICAL BENEFIT PLAN, THE CARRIER IS WILLING TO ENROLL ELIGIBLE INDIVIDUALS IN THE PLAN AND WHETHER AND THE EXTENT TO WHICH THEIR ENROLLMENT WOULD AFFECT PREMIUMS FOR THE PLAN;

(IV) WHETHER TO LIMIT PARTICIPATION BY ELIGIBLE INDIVIDUALS TO EITHER SELF-FUNDED OR FULLY FUNDED GROUP MEDICAL BENEFIT PLANS;

(V) WHETHER ENROLLMENT IN A GROUP MEDICAL BENEFIT PLAN WILL REDUCE PREMIUM COSTS FOR ELIGIBLE INDIVIDUALS IN COMPARISON TO THE PREMIUM COSTS FOR AN INDIVIDUAL HEALTH BENEFIT PLAN AVAILABLE TO ELIGIBLE INDIVIDUALS IN THE PRIVATE MARKET, INCLUDING THROUGH THE COLORADO HEALTH BENEFIT EXCHANGE CREATED PURSUANT TO ARTICLE 22 OF TITLE 10, AND WHETHER THE STATE WOULD NEED TO CONTRIBUTE A PORTION OF THE PREMIUM AMOUNT TO EFFECTUATE REDUCED PREMIUMS FOR ELIGIBLE INDIVIDUALS; AND

(VI) ANY OTHER INFORMATION RELEVANT TO DETERMINING WHETHER THE PILOT PROGRAM IS FEASIBLE.

(b) UPON MAKING A FEASIBILITY DETERMINATION, THE DIRECTOR SHALL NOTIFY THE JOINT BUDGET COMMITTEE AND THE MEMBERS OF THE SENATE AND HOUSE OF REPRESENTATIVES FROM THE SENATE AND HOUSE DISTRICTS THAT INCLUDE GARFIELD AND EAGLE COUNTIES OF THE DETERMINATION. IF THE DIRECTOR DETERMINES THAT A PILOT PROGRAM IS FEASIBLE, THE DIRECTOR SHALL INCLUDE IN THE NOTICE REQUIRED BY THIS SUBSECTION (4)(b) INFORMATION ABOUT HOW AND WHEN THE DIRECTOR WILL IMPLEMENT THE PILOT PROGRAM.

(5) (a) TO BE ELIGIBLE TO PARTICIPATE IN THE PILOT PROGRAM, AN INDIVIDUAL MUST:

(I) RESIDE IN THE PORTIONS OF GARFIELD OR EAGLE COUNTIES THAT ARE WITHIN THE SERVICE AREA OF THE GROUP MEDICAL BENEFIT PLANS THAT ARE OFFERED THROUGH THE PILOT PROGRAM; AND

(II) HAVE A HOUSEHOLD INCOME OF MORE THAN FOUR HUNDRED PERCENT, BUT NO MORE THAN FIVE HUNDRED PERCENT, OF THE FEDERAL POVERTY LINE.

(b) THE DIRECTOR MAY DETERMINE THE METHOD BY WHICH AN INDIVIDUAL DEMONSTRATES ELIGIBILITY TO PARTICIPATE IN THE PILOT PROGRAM.

(6) THE DIRECTOR SHALL LIMIT PARTICIPATION IN THE PILOT PROGRAM TO THE FIRST ONE HUNDRED INDIVIDUALS WHO APPLY TO AND DEMONSTRATE ELIGIBILITY TO PARTICIPATE IN THE PILOT PROGRAM. AN ELIGIBLE INDIVIDUAL AUTHORIZED TO PARTICIPATE IN THE PILOT PROGRAM MAY ENROLL THE INDIVIDUAL'S DEPENDENTS IN THE PILOT PROGRAM.

(7) THIS SECTION IS REPEALED, EFFECTIVE DECEMBER 31, 2020.

SECTION 3. In Colorado Revised Statutes, 10-16-1001, **amend** (2)(a), (3)(a), (3)(e), (3)(f), (4)(a), and (4)(e); and **add** (3)(g) as follows:

10-16-1001. Legislative declaration. (2) The general assembly hereby finds that:

(a) Under the current health care system in this state, individuals risk losing their health care coverage when ~~they move, when~~ they lose or change jobs ~~when they become seriously ill,~~ or when coverage becomes unaffordable;

(3) The general assembly hereby determines that:

(a) Comprehensive health care benefits that meet the full range of

health needs, ~~including primary, preventive, and specialized care,~~ AS MANDATED BY COLORADO AND FEDERAL LAW, should be readily available to citizens of this state;

(e) All individuals should have a responsibility to pay their fair share of the costs of health care coverage; ~~and~~

(f) Colorado's health care system should build on the strength of the employment-based coverage arrangements that now exist in this state; AND

(g) IN ORDER TO HELP CONTROL HEALTH CARE COSTS, CONSUMERS SHOULD BE EMPOWERED TO ORGANIZE TO DIRECTLY NEGOTIATE HEALTH CARE PRICES WITH PROVIDERS.

(4) The general assembly, therefore, declares that the purposes of this part 10 are to:

(a) Promote control of the cost of health care for employers, employees, and ~~others~~ INDIVIDUALS who pay for health care coverage by pooling purchasing power among consumers and organizing providers so that health care services are delivered in the most efficient manner;

(e) Encourage all individuals to take responsibility for their health care coverage by ~~building on existing employment-based arrangements for health care benefits~~ POOLING CONSUMER PURCHASING POWER THROUGH THE ORGANIZATION OF HEALTH CARE MARKETS IN A MORE EFFICIENT AND EFFECTIVE MANNER.

SECTION 4. In Colorado Revised Statutes, 10-16-1002, **amend** (5) and (6)(b); **repeal** (1) and (11); and **add** (6.5) as follows:

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

(1) ~~"Class of business" means all or a distinct grouping of small~~

~~employers as shown on the records of a small carrier. Each class shall reflect substantial differences in administrative costs related to the use of health care cooperatives for the marketing and sale of health benefit plans to small employers.~~

(5) "Managed care" ~~means systems or techniques generally used by third-party payors or their agents to affect access to, and to control, payment for health care services. For example, and not for the purpose of limitation, managed care techniques most often include one or more of the following: Prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or of the site at which services are provided; contracts with selected health care providers; financial incentives or disincentives related to the use of specific providers, services, or service sites; controlled access to and coordination of services by a case manager; and payor efforts to identify treatment alternatives and modify benefit restrictions for high-cost patient care. "Managed care" also includes but is not limited to health maintenance organizations~~ HAS THE SAME MEANING AS "MANAGED CARE PLAN", AS DEFINED IN SECTION 10-16-102 (43).

(6) (b) If, pursuant to section 10-16-1009 (3)(l), a cooperative provides coverage to individuals and allows individuals to join the cooperative, "member" may also include an individual ~~and any dependent of such individual~~ who is covered by a plan purchased through a cooperative ~~is eighteen years of age or older, and is not:~~ AND ANY DEPENDENT OF THE INDIVIDUAL, INCLUDING A DEPENDENT CHILD WHO IS UNDER TWENTY-SIX YEARS OF AGE.

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

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

(6.5) "MEMBER CLASS" MEANS THE CLASS OF MEMBER BASED ON WHETHER THE MEMBER WOULD QUALIFY FOR COVERAGE IN THE INDIVIDUAL MARKET, THE SMALL EMPLOYER MARKET, OR THE LARGE EMPLOYER MARKET.

(11) ~~"Waivered health care coverage cooperative" means a cooperative that has been approved to receive a waiver from the commissioner pursuant to section 10-16-1011.~~

SECTION 5. In Colorado Revised Statutes, 10-16-1003, **amend** (1) as follows:

10-16-1003. Privacy of health information. (1) ~~The privacy of~~ Individually identifiable health information collected for or by a cooperative ~~shall be protected. Disclosure of such information is prohibited except for:~~ IS SUBJECT TO HIPAA.

~~(a) Disclosures by an individual identified in the information or whose identity can be associated with the information;~~

~~(b) Disclosures explicitly authorized through written informed consent procedures by an individual;~~

~~(c) Disclosures to federal, state, or local law enforcement agencies for lawful purposes;~~

~~(d) Subject to rules promulgated by the commissioner, disclosures for bona fide research projects.~~

SECTION 6. In Colorado Revised Statutes, 10-16-1004, **repeal** (5) as follows:

10-16-1004. Health care coverage cooperatives - establishment

- fees. (5) ~~Except as allowed by section 10-16-1014, the division of insurance shall not participate in the formation or administration of a health care coverage cooperative created pursuant to this part 10.~~

SECTION 7. In Colorado Revised Statutes, 10-16-1009, **amend** (2), (3)(f), (3)(l), and (4)(a); **repeal** (1)(d), (3)(a), (3)(c), (3)(d), and (3)(k); and **add** (1)(o) and (1)(p) as follows:

10-16-1009. Powers, duties, and responsibilities of cooperatives. (1) Each cooperative organized pursuant to this part 10 shall:

(d) ~~Except for groups over fifty, offer to all members and their eligible employees the standard and basic health benefit plans;~~

(o) CONSIDER ALL INDIVIDUALS IN ALL INDIVIDUAL HEALTH BENEFIT PLANS OFFERED THROUGH THE COOPERATIVE, INCLUDING THOSE INDIVIDUALS WHO DO NOT ENROLL IN THE PLANS THROUGH THE EXCHANGE, TO BE MEMBERS OF A SINGLE RISK POOL;

(p) CONSIDER ALL COVERED PERSONS IN SMALL EMPLOYER HEALTH BENEFIT PLANS OFFERED THROUGH THE COOPERATIVE, INCLUDING THOSE COVERED PERSONS WHO DO NOT ENROLL IN PLANS THROUGH THE EXCHANGE, TO BE MEMBERS OF A SINGLE RISK POOL.

(2) ~~Members that are not self-insured may only be offered plans or services offered by licensed provider networks, licensed individual providers, and other carriers.~~ For purposes of this part 10, "self-insured" means not insured under a plan underwritten by a carrier. ~~or licensed provider network.~~ A self-insured employer ~~or individual~~ may join a cooperative in order to have access to the discounted provider rates ~~(excluding capitated agreements)~~ that the cooperative may negotiate on behalf of its self-insured members.

(3) Each cooperative organized pursuant to this part 10 may:

(a) ~~Determine, from time to time, the need to establish classes of membership;~~

(c) ~~Offer any and all health benefit packages permitted under law in addition to the standard and basic health benefit plans;~~

(d) ~~Require, as a condition of membership, that all employers include all their employees or a minimum percentage of employees in coverage purchased through the cooperative. The cooperative may establish minimum percentages that differ according to the benefit plan or carrier offered. The cooperative may require an employer making membership application to a cooperative that would entail entering fewer than one hundred percent of such employer's eligible employees or dependents to demonstrate, under standards consistent with paragraph (g) of subsection (4) of this section, that such membership is not likely to result in an adverse selection group being brought into the cooperative and would not otherwise act as a form of risk selection or risk avoidance.~~

(f) Reject, or allow a carrier to reject, an employer from membership or drop, or allow a carrier to drop, an employer from membership if the employer or any of its employee members fails to pay premiums or engages in fraud or material misrepresentation in connection with a plan purchased through the cooperative. If an ~~employer or~~ employee is dropped from membership DUE TO THE EMPLOYER'S FAILURE TO PAY PREMIUMS OR ENGAGEMENT IN FRAUD OR MATERIAL MISREPRESENTATION, the ~~employee shall be entitled to continuation and conversion coverage as provided under applicable state or federal continuation laws and the state conversion law~~ COOPERATIVE MAY OFFER A SPECIAL ENROLLMENT PERIOD IN ACCORDANCE WITH SECTION

10-16-105.7 (3) TO ALLOW THE EMPLOYEE TO ENROLL IN THE INDIVIDUAL MEMBER CLASS, IF AVAILABLE.

(k) ~~Require that members and their eligible employees continue to pay administrative fees that are part of the contract with the cooperative if a member or eligible employee cancels prior to completion of a contract period;~~

(l) Offer coverage for individuals who are members; ~~If coverage is offered to individuals as members, the cooperative may require that individuals include all dependents under such coverage.~~

(4) No cooperative organized pursuant to this part 10 may:

(a) Exclude from membership in the cooperative any ~~small employer or eligible employee or dependent of a small employer~~ PROSPECTIVE MEMBERS, OR DEPENDENTS OF PROSPECTIVE MEMBERS, who ~~agrees~~ AGREE to pay fees for membership and any premium for coverage through the cooperative and who ~~abides~~ ABIDE by the bylaws and rules of the cooperative and ~~satisfies~~ SATISFY the requirements of the benefit plan selected;

SECTION 8. In Colorado Revised Statutes, **repeal** 10-16-1011 as follows:

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

~~(a) Establish fair, effective, and timely procedures for addressing consumer, contractor, and health plan grievances. Such rules shall include, without limitation, a requirement that health plans provide the cooperative written notification of all grievances filed with the health~~

~~plans and at least a quarterly summary of such grievances. This paragraph (a) shall not be construed to exempt participating carriers from any requirements of this title concerning grievance procedures.~~

~~(b) Require the cooperative to demonstrate that it provides coverage in every geographic area in which its participating carriers are authorized to do business by the division of insurance;~~

~~(c) Establish that small employers that purchase fully insured products through the cooperative are not permitted to offer their employees comparable fully insured or self-insured products through any means other than the cooperative;~~

~~(d) Ensure that the cooperative will at all times comply with the provisions of section 10-16-1009 (4)(g);~~

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

~~(2) A waiver shall be in effect for a period of not less than ten years after the date of issue, unless the commissioner determines that the waivered cooperative is in violation of subsection (1) of this section. In such a case, the waiver may be phased out over a period of three years by the commissioner in a manner that is consistent with the market viability of the cooperative.~~

~~(3) The commissioner may grant a permanent waiver effective upon expiration of a ten-year period. If at any time the commissioner determines that a waivered cooperative operating under a permanent waiver is in violation of subsection (1) of this section, the permanent waiver may be phased out by the commissioner over a period of three years in a manner that is consistent with the market viability of the cooperative.~~

~~(4) The commissioner shall promulgate rules for annual reporting requirements for waivered cooperatives. Reporting requirements shall be based only on the requirements for obtaining a waiver as outlined under subsection (1) of this section. Such reporting requirements shall be integrated with other reporting requirements for cooperatives operating under this part 10.~~

~~(5) (a) (I) Any carrier doing business with a waivered cooperative shall comply with all rules regarding underwriting, claims handling, sales, solicitation, and other applicable requirements specified pursuant to this title.~~

~~(II) Notwithstanding the provisions of subparagraph (I) of this paragraph (a), if a waivered cooperative requires its participating small employer carriers to offer a standardized health benefit plan that such carriers do not offer outside of the waivered cooperative, such carriers shall not be required to market that standardized plan either inside or outside the waivered cooperative in those areas of the state that are not part of the waivered cooperative's geographic service area.~~

~~(b) (I) Any carrier doing business with a waivered cooperative shall comply with all applicable rules regarding rating specified pursuant to this title.~~

~~(II) (A) Notwithstanding subparagraph (I) of this paragraph (b) and subject to the provisions of sub-subparagraph (B) of this subparagraph (II), a waivered cooperative and a participating carrier may negotiate a percentage discount off of what would otherwise be allowable rates under sections 10-16-107 (6)(a) and 10-16-1012 for a particular plan. That percentage discount shall be applied uniformly to all small employer members of the cooperative. Pursuant to section 10-16-1012, a carrier may apply rating factors differently for its business with a waivered cooperative than for the carrier's other business. Participating carriers shall notify the division of insurance of a negotiated cooperative discount at least thirty days prior to use.~~

~~(B) A waivered cooperative may negotiate the non-health-care expense component of the premium rates charged with participating health care coverage plans. As used in this sub-subparagraph (B), "non-health-care expense" includes but is not limited to marketing expenses, acquisition expenses, cost of paying claims, commissions, maintenance expenses, other administration costs, profits, and other contingency margins. "Non-health-care expense" does not include fees paid to health care providers for health care services regardless of the methodology of reimbursement or payment.~~

~~(C) Participating health care coverage plans, including those plans that are under consideration for participation, shall, upon request, disclose to waivered cooperatives a list and description of all relevant public information regarding all expenses of the health plans, including but not limited to: The plan's recent filings and previously required filings with the Colorado division of insurance; filings with the national association of insurance commissioners (NAIC); health employer data information~~

~~set (HEDIS) reports regarding provider compensation; and federal health care financing administration and federal office of personnel management filings relevant to provider compensation. Public information shall be provided upon request to a cooperative within fifteen days after such request.~~

~~(D) All health care plans participating in a cooperative shall sign an affidavit declaring that all coinsurance paid by the insured participants of the employer members of a waivered cooperative shall be based on the health plan's contracted rate within the health plan's provider network.~~

~~(6) If the commissioner does not act on an application for a waiver under this section within sixty days after submission of the application, the cooperative may request a formal hearing with the commissioner.~~

SECTION 9. In Colorado Revised Statutes, **repeal** 10-16-1012 as follows:

10-16-1012. Application of rating factors inside a waivered cooperative. ~~With the prior approval of the commissioner, a waivered cooperative may require all participating carriers to apply allowable rate adjustment factors and case characteristic factors to all of that waivered cooperative's business in a consistent fashion, as determined by the cooperative. If a waivered cooperative has received such approval, a participating carrier within that cooperative shall not be required to apply allowable rate adjustment factors and case characteristic factors in the same way for its waivered cooperative business as for its other business.~~

SECTION 10. In Colorado Revised Statutes, 10-16-1013, **amend** (3) as follows:

10-16-1013. Violations of article by persons involved with operations of cooperatives - enforcement - penalties. (3) Any person

adversely affected by an order issued pursuant to this section may, within twenty days after the date of the order, request judicial review under section 24-4-106 (11). ~~C.R.S.~~ An action for judicial review shall not operate to stay or vacate a decision or order; except that the court may issue a stay pending review. ~~The commissioner may recover reasonable attorney fees incurred to enforce the order.~~

SECTION 11. In Colorado Revised Statutes, 10-16-1014, **amend** (1)(h); and **repeal** (1)(a), (1)(b), (1)(c), and (1)(e) as follows:

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

(a) ~~Makes coverage available to employer members and covered individuals statewide to the extent possible;~~

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

(c) ~~Sets maximum employer member contributions to any plan for a covered individual at an amount not to exceed one hundred percent of the cost of the lowest-priced coverage for that employee's family composition for any particular plan package, with employee members paying the difference between the premium of the selected plan and the employer contribution;~~

(e) ~~Contracts with as many carriers as is allowed by the market and the cooperative's quality, access, and information reporting requirements;~~

(h) Gives each covered ~~individual~~ MEMBER the opportunity to choose among carriers that contract with the cooperative.

SECTION 12. In Colorado Revised Statutes, **amend** 10-16-1015 as follows:

10-16-1015. Health care cooperatives - rule-making authority. The commissioner may promulgate rules consistent with this part 10 for purposes of carrying out the commissioner's duties under this part 10. ~~The commissioner may promulgate rules to carry out the commissioner's duties under section 10-16-1005, so long as such rules impose no additional requirements beyond those specifically enumerated in section 10-16-1005.~~

SECTION 13. In Colorado Revised Statutes, **add** 10-16-1016 as follows:

10-16-1016. State innovation waiver - authority to apply. AS NECESSARY TO IMPLEMENT THIS PART 10, THE COMMISSIONER MAY APPLY TO THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR A FIVE-YEAR STATE INNOVATION WAIVER IN ACCORDANCE WITH SECTION 1332 OF THE FEDERAL ACT, CODIFIED AT 42 U.S.C. SEC. 18052, AND 45 CFR 155.1300. THE COMMISSIONER SHALL ENSURE THAT A WAIVER APPLICATION SUBMITTED PURSUANT TO THIS SECTION COMPLIES WITH THE REQUIREMENTS SPECIFIED IN SECTION 1332 OF THE FEDERAL ACT, CODIFIED AT 42 U.S.C. SEC. 18052, AND 45 CFR 155.1308.

SECTION 14. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.