

**First Regular Session
Seventy-fourth General Assembly
STATE OF COLORADO**

PREAMENDED

*This Unofficial Version Includes Committee
Amendments Not Yet Adopted on Second Reading*

LLS NO. 23-0847.01 Kristen Forrestal x4217

HOUSE BILL 23-1224

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A BILL FOR AN ACT

101 **CONCERNING CHANGES TO THE "COLORADO STANDARDIZED HEALTH**
102 **BENEFIT PLAN ACT".**

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 makes changes to the "Colorado Standardized Health Benefit Plan Act" to:

- Require the Colorado health benefit exchange (exchange), with the consent of the commissioner of insurance (commissioner), to develop a format for displaying the standardized plans on the exchange;

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

HOUSE
3rd Reading Unamended
March 21, 2023

HOUSE
Amended 2nd Reading
March 20, 2023

- Grant the commissioner 120 days to review the rate filings for standardized plans instead of the current 60 days;
- Require a carrier to notify the commissioner of the steps the carrier will take to meet premium rate requirements if the carrier is unable to offer a standardized plan;
- Make changes to the requirements for public hearings held by the commissioner for carriers who are unable to offer the standardized plan; and
- Specify that decisions of the commissioner are final agency actions subject to judicial review in the court of appeals.

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

2 **SECTION 1.** In Colorado Revised Statutes, 10-16-1303, **amend**
 3 **(3)(a) and (10)** as follows:

4 **10-16-1303. Definitions.** As used in this part 13, unless the
 5 context otherwise requires:

6 (3) (a) "Equivalent rate" means, for a hospital that is PART OF a
 7 pediatric specialty hospital ~~with~~ SYSTEM WHERE OVER NINETY PERCENT
 8 OF THE HOSPITAL SYSTEM'S POPULATION SERVED IS UNDER EIGHTEEN
 9 YEARS OF AGE AND THAT HAS a level one PEDIATRIC trauma center, the
 10 payment rate determined by the medicaid fee schedule for the hospital
 11 from the most recent year for which a complete set of hospital financial
 12 data is publicly available ~~June 16, 2021~~ AS OF THE EFFECTIVE DATE OF
 13 THIS SUBSECTION (3)(a), AS AMENDED, multiplied by a conversion factor
 14 equal to the ratio of the statewide payment-to-cost ratio for medicare to
 15 the hospital's specific payment-to-cost ratio for the most recent set of
 16 publicly available hospital financial data ~~June 16, 2021~~ AS OF THE
 17 EFFECTIVE DATE OF THIS SUBSECTION (3)(a), AS AMENDED, which is 1.52.

18 (10) "Medical inflation" means the annual percentage change in
 19 the medical care index component of the United States department of
 20 labor's bureau of labor statistics consumer price index for medical care

1 services and medical care commodities FOR THE
2 DENVER-AURORA-LAKEWOOD AREA, or its applicable predecessor or
3 successor index, based on the average change in the medical care index
4 over the previous ~~ten~~ THREE years.

5 **SECTION 2.** In Colorado Revised Statutes, 10-16-1304, **amend**
6 (3) as follows:

7 **10-16-1304. Standardized health benefit plan - established -**
8 **components - rules - independent analysis - repeal.** (3) (a) The
9 standardized plan must be offered in a manner that allows consumers to
10 easily compare the standardized plans offered by each carrier.

11 (b) THE EXCHANGE, IN COLLABORATION WITH THE COMMISSIONER,
12 AND AFTER A STAKEHOLDER ENGAGEMENT PROCESS WITH CONSUMERS,
13 PRODUCERS, AND CARRIERS, SHALL DEVELOP A FORMAT FOR DISPLAYING
14 THE STANDARDIZED PLANS ON THE EXCHANGE IN A MANNER THAT ALLOWS
15 FOR STANDARDIZED PLANS TO BE EASILY IDENTIFIED AND COMPARED.

16 **SECTION 3.** In Colorado Revised Statutes, **add** 10-16-1305.5 as
17 follows:

18 **10-16-1305.5. Rate filings.** (1) IN THE RATE FILINGS REQUIRED
19 PURSUANT TO SECTION 10-16-107, EACH CARRIER MUST FILE RATES FOR
20 THE STANDARDIZED PLAN AT THE PREMIUM RATES REQUIRED IN SECTION
21 10-16-1305 (2).

22 (2) IN REVIEWING THE RATES FOR THE STANDARDIZED PLANS, THE
23 COMMISSIONER MAY ESTABLISH UNIFORM LIMITS ON ALL CARRIERS'
24 ADMINISTRATIVE COSTS AND PROFITS FOR A STANDARDIZED PLAN, IF THE
25 RESULTING PREMIUM RATES ARE ACTUARIALLY SOUND AND DO NOT
26 ENTAIL COST SHIFTING TO PLANS OTHER THAN STANDARDIZED PLANS.

27 == ==

1 **SECTION 4.** In Colorado Revised Statutes, 10-16-1306, **amend**
2 (2), (3)(a), (3)(c), (4)(a)(V), (7) introductory portion, and (8); and **repeal**
3 (1)(a) as follows:

4 **10-16-1306. Failure to meet premium rate requirements -**
5 **notice - public hearing - rules.** (1) (a) ~~In the rate filings required~~
6 ~~pursuant to section 10-16-107, each carrier must file rates for the~~
7 ~~standardized plan at the premium rates required in section 10-16-1305~~
8 ~~(2).~~

9 (2) If a carrier is unable to offer the standardized plan as required
10 by section 10-16-1305 (1) at the premium rate required in section
11 10-16-1305 (2) in any year, the carrier, BY MARCH 1 OF THE YEAR
12 PRECEDING THE YEAR IN WHICH THE PREMIUM RATES GO INTO EFFECT,
13 shall:

14 (a) Notify the commissioner of the reasons why the carrier is
15 unable to meet the requirements ~~as follows:~~

16 ~~(a) For premium rates applicable in 2023, by May 1, 2022; and~~

17 ~~(b) For premium rates applicable in 2024 or any subsequent year,~~
18 ~~by March 1 of the year preceding the year in which the premiums rates go~~
19 ~~into effect~~ AND THE STEPS THE CARRIER WILL TAKE TO MEET THE PREMIUM
20 RATE REQUIREMENTS; AND

21 (b) PROVIDE TO THE COMMISSIONER ANY SUPPORTING
22 DOCUMENTATION RELATED TO THE HOSPITAL OR HEALTH-CARE PROVIDER
23 THAT THE CARRIER CLAIMS IS A CAUSE FOR THE CARRIER'S FAILURE TO
24 MEET THE PREMIUM RATE REQUIREMENTS.

25 (3) (a) If, on or after January 1, 2023, and pursuant to subsection
26 (2) of this section, a carrier notifies the commissioner that the carrier is
27 unable to offer the standardized plan at the premium rate required in

1 section 10-16-1305 (2) or the commissioner otherwise determines, with
2 support from an independent actuary and based on a review of THE
3 NOTIFICATION SUBMITTED PURSUANT TO SUBSECTION (2) OF THIS SECTION
4 OR the rate and form filings, that a carrier has not met the premium rate
5 requirements in section 10-16-1305 (2) or the network adequacy
6 requirements, the division ~~shall~~ MAY hold a public hearing prior to the
7 approval of the carrier's final rates; except that, for the purposes of
8 holding a public hearing, if a carrier does not meet the network adequacy
9 requirements in section 10-16-1304 (1)(g), the commissioner shall
10 consider a carrier to have met network adequacy requirements if the
11 carrier files the action plan required in section 10-16-1304 (2)(b). A
12 PUBLIC HEARING HELD PURSUANT TO THIS SUBSECTION (3)(a) MUST BE
13 CONDUCTED IN ACCORDANCE WITH SUBSECTION (3)(c) OF THIS SECTION
14 AND THE RULES PROMULGATED PURSUANT TO SUCH SUBSECTION AND IS
15 NOT SUBJECT TO SECTION 24-4-105.

16 (c) (I) ~~The commissioner shall provide public notice and~~
17 ~~opportunity to testify at the public hearing to all affected parties,~~
18 ~~including carriers, hospitals, health-care providers, consumer advocacy~~
19 ~~organizations, and individuals. All affected parties shall have the~~
20 ~~opportunity to present evidence regarding the carrier's ability to meet the~~
21 ~~premium rate requirements and the network adequacy requirements. The~~
22 ~~commissioner shall limit the evidence presented at the hearing to~~
23 ~~information that is related to the reason the carrier failed to meet the~~
24 ~~network adequacy requirements or the premium rate requirements in~~
25 ~~section 10-16-1305 for the standardized plan in any single county~~ GIVE
26 NOTICE OF THE PUBLIC HEARING TO THE CARRIERS, HOSPITALS,
27 HEALTH-CARE PROVIDERS, INSURANCE OMBUDSMAN, AND PUBLIC AT

1 LEAST FIFTEEN DAYS PRIOR TO THE DATE OF THE HEARING.

2 (II) THE COMMISSIONER SHALL ESTABLISH BY RULE:

3 (A) THE MANNER IN WHICH THE COMMISSIONER WILL NOTIFY THE
4 PARTIES SPECIFIED IN SUBSECTION (3)(c)(I) OF THIS SECTION AND
5 INTERESTED PERSONS OF THE PUBLIC HEARINGS;

6 (B) THE MANNER IN WHICH THE PUBLIC MAY PARTICIPATE IN
7 PUBLIC HEARINGS. THE COMMISSIONER SHALL LIMIT THE PUBLIC COMMENT
8 AND EVIDENCE PRESENTED AT THE HEARING TO INFORMATION THAT IS
9 RELATED TO THE REASON THE CARRIER FAILED TO MEET THE NETWORK
10 ADEQUACY REQUIREMENTS OR THE PREMIUM RATE REQUIREMENTS IN
11 SECTION 10-16-1305 FOR THE STANDARDIZED PLAN IN ANY SINGLE
12 COUNTY.

13 (C) THE MANNER IN WHICH DOCUMENTS MUST BE SERVED ON THE
14 PARTIES;

15 (D) THE MANNER IN WHICH A CARRIER SHALL NOTIFY THE DIVISION
16 AND AFFECTED HOSPITALS, HEALTH-CARE PROVIDERS, AND THE
17 INSURANCE OMBUDSMAN OF A CARRIER'S FAILURE TO MEET THE NETWORK
18 ADEQUACY REQUIREMENTS OR THE PREMIUM RATE REQUIREMENTS IN
19 SECTION 10-16-1305;

20 (E) THE TIME FRAMES WITHIN WHICH THE PARTIES WILL BE GIVEN
21 THE OPPORTUNITY TO SUBMIT A COMPLAINT AND ANSWER AND ANY OTHER
22 NECESSARY PLEADINGS FOR THE HEARING;

23 (F) THE MANNER IN WHICH THE CARRIER, AFFECTED HEALTH-CARE
24 PROVIDERS, AFFECTED HOSPITALS, THE INSURANCE OMBUDSMAN, AND ANY
25 OTHER PERSON THE COMMISSIONER DETERMINES MAY BE AGGRIEVED BY
26 THE COMMISSIONER'S ACTION MAY PRESENT EVIDENCE, EXAMINE AND
27 CROSS-EXAMINE WITNESSES, AND OFFER ORAL AND WRITTEN ARGUMENTS

1 AT THE HEARING;

2 (G) THE PROCEDURES FOR KEEPING REQUESTED INFORMATION
3 CONFIDENTIAL AND FOR HANDLING CONFIDENTIAL INFORMATION; AND

4 (H) ANY OTHER MATTER THE COMMISSIONER DEEMS NECESSARY
5 FOR THE IMPLEMENTATION OF THE PUBLIC HEARINGS.

6 (III) THE COMMISSIONER MAY ISSUE PROCEDURAL ORDERS DURING
7 THE PUBLIC HEARING PROCESS TO FACILITATE THE EFFICIENT OPERATION
8 OF THE PUBLIC HEARING, INCLUDING ORDERING THE CONSOLIDATION OF
9 PROCEEDINGS INVOLVING THE SAME CARRIER, HOSPITALS, OR
10 HEALTH-CARE PROVIDERS IN COUNTIES IN THE SAME GEOGRAPHIC RATING
11 AREA AS ESTABLISHED BY THE COMMISSIONER PURSUANT TO SECTION
12 10-16-107 (5) AND THE LIMITATION OF DISCOVERY.

13 (4) Based on evidence presented at a hearing held pursuant to
14 subsection (3) of this section and other available data and actuarial
15 analysis, the commissioner may:

16 (a) (V) A hospital that is PART OF a pediatric specialty hospital
17 with SYSTEM WHERE OVER NINETY PERCENT OF THE HEALTH SYSTEM'S
18 POPULATION SERVED IS UNDER EIGHTEEN YEARS OF AGE AND THAT HAS a
19 level one pediatric trauma center must receive a
20 fifty-five-percentage-point increase in the base reimbursement rate and
21 is not eligible for additional factors under this subsection (4).

22 (7) Notwithstanding subsections (4) and (5) of this section, for a
23 hospital with a negotiated reimbursement rate that is lower than AT LEAST
24 ten percent of LESS THAN the statewide hospital median reimbursement
25 rate measured as a percentage of medicare for the 2021 plan year using
26 data from the Colorado all-payer health claims database described in
27 section 25.5-1-204, the commissioner shall set the reimbursement rate for

1 that hospital at no less than the greater of:

2 (8) A carrier or health-care provider may appeal a decision by the
3 commissioner made pursuant to subsection (4) of this section to the
4 ~~district court in the applicable jurisdiction~~ COLORADO COURT OF APPEALS.
5 The decision of the commissioner is a final agency action subject to
6 judicial review pursuant to section 24-4-106 ~~(6)~~ (11).

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