Second Regular Session
Seventy-second General Assembly
STATE OF COLORADO

DRAFT 4.28.20

**DRAFT**

LLS NO. 20-1144.01 Christy Chase x2008 **SENATE BILL**

**SENATE SPONSORSHIP**

**Moreno,**

**HOUSE SPONSORSHIP**

**(None),**

**BILL TOPIC:** "Health Insurance Affordability Enterprise Fee"

**A BILL FOR AN ACT**

**CONCERNING MEASURES TO ADDRESS THE AFFORDABILITY OF HEALTH INSURANCE FOR COLORADANS PURCHASING COVERAGE ON THE INDIVIDUAL MARKET, AND, IN CONNECTION THEREWITH, ESTABLISHING AN ENTERPRISE TO ADMINISTER A HEALTH INSURANCE AFFORDABILITY FEE ASSESSED ON CERTAIN HEALTH INSURERS TO FUND MEASURES TO REDUCE PREMIUMS FOR INDIVIDUAL HEALTH BENEFIT PLANS OFFERED ON THE COLORADO HEALTH BENEFIT EXCHANGE.** <{***first stab at title - needs work***}>

**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*

***Capital letters or bold & italic numbers indicate new material to be added to existing statute.***
***Dashes through the words indicate deletions from existing statute.***

*applies to the reengrossed version of this bill will be available at http://leg.colorado.gov.)*

The bill summary for this measure has been intentionally omitted and will appear on future redrafts of this measure.

---

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

**SECTION 1.** In Colorado Revised Statutes, **add** part 12 to article 16 of title 10 as follows:

PART 12

HEALTH INSURANCE AFFORDABILITY ACT

**10-16-1201. Short title.** THE SHORT TITLE OF THIS PART 12 IS THE "HEALTH INSURANCE AFFORDABILITY ACT".

**10-16-1202. Definitions.** AS USED IN THIS PART 12, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "ADVANCE PREMIUM TAX CREDIT" MEANS THE REFUNDABLE TAX CREDIT AVAILABLE PURSUANT TO THE FEDERAL ACT TO ASSIST CERTAIN INDIVIDUALS IN PURCHASING A HEALTH BENEFIT PLAN ON THE EXCHANGE.

(2) "BOARD" MEANS THE HEALTH INSURANCE AFFORDABILITY BOARD CREATED IN SECTION 10-16-1203.

(3) "ENTERPRISE" MEANS THE COLORADO HEALTH INSURANCE AFFORDABILITY ENTERPRISE CREATED IN SECTION 10-16-1204.

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

(5) "FEE" MEANS THE HEALTH INSURANCE AFFORDABILITY FEE ESTABLISHED AND ASSESSED PURSUANT TO SECTION 10-16-1204.

(6) "FUND" MEANS THE HEALTH INSURANCE AFFORDABILITY CASH

FUND CREATED IN SECTION 10-16-1205.

(7) "HOUSEHOLD INCOME" HAS THE SAME MEANING AS SET FORTH IN 26 U.S.C. SEC. 36B (d)(2) OF THE FEDERAL "INTERNAL REVENUE CODE OF 1986", AS AMENDED.

(8) "MEDICAID" MEANS FEDERAL INSURANCE OR ASSISTANCE AS PROVIDED BY TITLE XIX OF THE FEDERAL "SOCIAL SECURITY ACT", AS AMENDED, AND THE "COLORADO MEDICAL ASSISTANCE ACT", ARTICLES 4, 5, AND 6 OF TITLE 25.5.

(9) "MEDICARE" MEANS FEDERAL INSURANCE OR ASSISTANCE PROVIDED BY THE "HEALTH INSURANCE FOR THE AGED ACT", TITLE XVIII OF THE FEDERAL "SOCIAL SECURITY ACT", AS AMENDED, 42 U.S.C. SEC. 1395 ET SEQ.

(10) "REINSURANCE PROGRAM" MEANS THE COLORADO REINSURANCE PROGRAM CREATED IN PART 11 OF THIS ARTICLE 16.

**10-16-1203. Health insurance affordability board - creation - membership - powers and duties - subject to open meetings and public records laws.** (1) (a) THERE IS HEREBY CREATED THE HEALTH INSURANCE AFFORDABILITY BOARD, WHICH BOARD IS RESPONSIBLE FOR GOVERNANCE OF THE ENTERPRISE ESTABLISHED IN THIS PART 12. THE BOARD CONSISTS OF NINE VOTING MEMBERS APPOINTED BY THE GOVERNOR, WITH THE CONSENT OF THE SENATE, AS FOLLOWS:

(I) THE EXECUTIVE DIRECTOR OF THE EXCHANGE OR THE EXECUTIVE DIRECTOR'S DESIGNEE;

(II) ONE MEMBER WHO IS EMPLOYED BY A CARRIER;

(III) ONE MEMBER WHO IS A REPRESENTATIVE OF A STATEWIDE ASSOCIATION OF HEALTH BENEFIT PLANS;

(IV) ONE MEMBER OF THE HEALTH CARE INDUSTRY WHO DOES NOT

REPRESENT A CARRIER;

(V) TWO MEMBERS WHO ARE CONSUMERS OF HEALTH CARE WHO ARE NOT REPRESENTATIVES OR EMPLOYEES OF A HOSPITAL, CARRIER, OR OTHER HEALTH CARE INDUSTRY ENTITY. TO THE EXTENT POSSIBLE, THE GOVERNOR SHALL ENSURE THAT THE CONSUMER MEMBERS OF THE BOARD APPOINTED ARE INDIVIDUALS WITH AN ANNUAL HOUSEHOLD INCOME OF LESS THAN FOUR HUNDRED PERCENT OF THE FEDERAL POVERTY LINE, WHO LACK AFFORDABLE OFFERS OF COVERAGE FROM THEIR EMPLOYERS, AND WHO DO NOT QUALIFY FOR ADVANCE PREMIUM TAX CREDITS UNDER THE FEDERAL ACT.

(VI) ONE MEMBER WHO REPRESENTS A HEALTH CARE ADVOCACY ORGANIZATION;

(VII) ONE MEMBER WHO IS A REPRESENTATIVE OF A BUSINESS THAT PURCHASES OR OTHERWISE PROVIDES HEALTH INSURANCE FOR ITS EMPLOYEES; AND

(VIII) THE COMMISSIONER OR THE COMMISSIONER'S DESIGNEE.

(b) NO MORE THAN ~~SEVEN~~ FIVE <{***This would possibly allow a super majority affiliated with the same political party. You might want to lower this to 5 or 6.***}> MEMBERS OF THE BOARD MAY BE AFFILIATED WITH THE SAME POLITICAL PARTY, AND THE MEMBERSHIP MUST REFLECT THE DIVERSITY OF THE STATE WITH REGARD TO RACE, ETHNICITY, IMMIGRATION STATUS, INCOME, WEALTH, ABILITY AND GEOGRAPHY. <{***and disability?***}>

(2) (a) (I) EXCEPT AS PROVIDED IN SUBSECTION (2)(a)(II) OF THIS SECTION, THE TERM OF OFFICE OF THE MEMBERS OF THE BOARD IS FOUR YEARS. <{***any limit on number of terms?***}>

(II) IN ORDER TO ENSURE STAGGERED TERMS OF OFFICE, THE

**Comment [EM1]:** Recommend a limit of 2 terms.

INITIAL TERM OF OFFICE OF FIVE OF THE MEMBERS OF THE BOARD IS TWO YEARS AND THE INITIAL TERM OF OFFICE OF THE REMAINDER OF THE MEMBERS OF THE BOARD IS FOUR YEARS. <{***Do you want to specify which 5 members have initial 2-year terms or leave it to the governor to determine?***}>

(b) MEMBERS OF THE BOARD SERVE AT THE PLEASURE OF THE GOVERNOR AND MAY BE REMOVED BY THE GOVERNOR OR FOR CAUSE BY A MAJORITY VOTE OF THE BOARD MEMBERS.

(c) A MEMBER WHO IS APPOINTED TO FILL A VACANCY SHALL SERVE THE REMAINDER OF THE UNEXPIRED TERM OF THE MEMBER WHOSE VACANCY IS BEING FILLED.

(d) MEMBERS OF THE BOARD WHO RESIDE MORE THAN FIFTY MILES FROM THE LOCATION OF A BOARD MEETING ARE ENTITLED TO RECEIVE THE SAME PER DIEM COMPENSATION AND REIMBURSEMENT OF EXPENSES AS PROVIDED FOR MEMBERS OF BOARDS AND COMMISSIONS PURSUANT TO SECTION 12-20-103 (6). ALL MEMBERS MAY BE REIMBURSED FOR ACTUAL AND NECESSARY EXPENSES, INCLUDING ANY REQUIRED DEPENDENT CARE AND DEPENDENT OR ATTENDANT TRAVEL, FOOD, AND LODGING, WHILE ENGAGED IN THE PERFORMANCE OF OFFICIAL DUTIES OF THE BOARD. <{***Any change to this given current fiscal climate?***}>

(3) THE BOARD SHALL MEET AS OFTEN AS NECESSARY TO CARRY OUT ITS DUTIES PURSUANT TO THIS PART 12.

(4) THE BOARD IS AUTHORIZED TO:

(a) IMPLEMENT AND ADMINISTER THE ENTERPRISE; <{***Added this - OK?***}>

(b) ESTABLISH ADMINISTRATIVE AND ACCOUNTING PROCEDURES FOR THE OPERATION OF THE ENTERPRISE; <{***Added this - OK?***}>

**Comment [EM2]:** Recommend leave to Gov.

**Comment [EM3]:** I think this reimbursement is critical for equity in the Board and hopefully these funds can be taken out of the fee.

**Comment [EM4]:** OK.

**Comment [EM5]:** OK.

DRAFT
4.28.20

(c) DETERMINE THE TIMING AND METHODOLOGY FOR ASSESSING AND COLLECTING THE FEE;

(d) DETERMINE AN APPROACH TO IMPLEMENTING SECTION 10-16-1204 (4)(c), INCLUDING:

(I) PROCEDURES FOR DETERMINING ELIGIBILITY FOR REDUCED-COST COVERAGE OPTIONS AVAILABLE PURSUANT TO SECTION 10-16-1204 (4)(c);

(II) PROCEDURES FOR ENROLLMENT IN REDUCED-COST COVERAGE OPTIONS AVAILABLE PURSUANT TO SECTION 10-16-1204 (4)(c); AND

<{***Aren't these procedures already established by the exchange? What is the point of this provision?***}>

(III) AFFORDABILITY REQUIREMENTS FOR REDUCED-COST OPTIONS AVAILABLE PURSUANT TO SECTION 10-16-1204 (4)(c) THAT ARE BASED ON INCOME; <{***What is the meaning of this provision? Would the board be setting an amount by which carriers would have to reduce premiums for individuals receiving the APTC and those whose income is below 400% FPL who don't qualify for the APTC?***}>

(e) DETERMINE THE PAYMENTS TO BE MADE TO HEALTH BENEFIT PLANS/CARRIERS/INSURERS PURSUANT TO SECTION 10-16-1204 (4)(c); AND

<{***Need to determine who is the recipient of the payments - confer with DOI. Probably should be carriers that offer/issue health benefit plans on the individual market, right?***}>

(f) ESTABLISH BYLAWS, AS APPROPRIATE, AND CONSISTENT WITH THIS PART 12, FOR ITS EFFECTIVE OPERATION.

(5) MEETINGS OF THE BOARD ARE SUBJECT TO THE OPEN MEETINGS PROVISIONS OF THE "COLORADO SUNSHINE ACT OF 1972", CONTAINED IN PART 4 OF ARTICLE 6 OF TITLE 24. EXCEPT AS OTHERWISE PROVIDED IN THE

**Comment [EM6]:** They are established for the exchange, but the exchange bars participation by people without proper documentation and doesn't allow the provision of financial assistance to families in the family glitch. Therefore, we are standing up "exchange look-alike coverage" through this enterprise.

**Comment [EM7]:** That's right – they have to figure out how to give out the state-level subsidies. We have limited their discretion though to focus the benefit on those most in need.

**Comment [EM8]:** DOI: please inform.

DRAFT
4.28.20

"COLORADO OPEN RECORDS ACT", PART 2 OF ARTICLE 72 OF TITLE 24, OR OTHER APPLICABLE STATE OR FEDERAL LAW, RECORDS OF THE BOARD AND THE PROGRAM ARE SUBJECT TO THE "COLORADO OPEN RECORDS ACT".

**10-16-1204. Health insurance affordability enterprise - creation - powers and duties - assess and allocate health insurance affordability fee.** (1) (a) THERE IS HEREBY CREATED IN THE DIVISION THE COLORADO HEALTH INSURANCE AFFORDABILITY ENTERPRISE. THE ENTERPRISE IS AND OPERATES AS A GOVERNMENT-OWNED BUSINESS WITHIN THE DIVISION FOR THE PURPOSE OF CHARGING AND COLLECTING THE HEALTH INSURANCE AFFORDABILITY FEE FROM HEALTH BENEFIT PLANS AND USING THE FEE FOR THE PURPOSES SPECIFIED IN THIS SECTION.

<{***Draft provided to me used "health benefits plans" as the entity from whom the fee is collected. I assume this should actually refer to "carriers" or a specially-defined group of insurers, depending on which insurers will be subject to the fee. The fact sheet refers to individual, small group, large group, and Medicaid managed care organizations - so, I assume carriers/insurers offering health benefit plans to individuals and groups and then the Medicaid managed care organizations. Is that correct? But note my comment, below, where there is language exempting medicaid from the fee. Will need to make that provision consistent with this provision and the definition of insurers subject to the fee.***}>

(b) (I) THE ENTERPRISE CONSTITUTES AN ENTERPRISE FOR PURPOSES OF SECTION 20 OF ARTICLE X OF THE STATE CONSTITUTION SO LONG AS IT RETAINS THE AUTHORITY TO ISSUE REVENUE BONDS AND RECEIVES LESS THAN TEN PERCENT OF ITS TOTAL REVENUES IN GRANTS, AS DEFINED IN SECTION 24-77-102 (7), FROM ALL COLORADO STATE AND

**Comment [EM9]:** We want to include "carriers/insurers offering health benefit plans to individuals and groups." We do not intend to include Medicaid MCOs.

LOCAL GOVERNMENTS COMBINED. SO LONG AS IT CONSTITUTES AN ENTERPRISE PURSUANT TO THIS SECTION, THE ENTERPRISE IS NOT A DISTRICT FOR PURPOSES OF SECTION 20 OF ARTICLE X OF THE STATE CONSTITUTION.

(II) SUBJECT TO APPROVAL BY THE GENERAL ASSEMBLY, EITHER BY BILL OR JOINT RESOLUTION, AND AFTER APPROVAL BY THE GOVERNOR PURSUANT TO SECTION 39 OF ARTICLE V OF THE STATE CONSTITUTION, THE ENTERPRISE IS HEREBY AUTHORIZED TO ISSUE REVENUE BONDS FOR THE EXPENSES OF THE ENTERPRISE, SECURED BY REVENUES OF THE ENTERPRISE.

(2) THE ENTERPRISE'S PRIMARY POWERS AND DUTIES ARE:

(a) TO ASSESS AND COLLECT THE FEE SPECIFIED IN SUBSECTION (3) OF THIS SECTION;

(b) TO ALLOCATE MONEY IN THE FUND IN ACCORDANCE THE SUBSECTION (4) OF THIS SECTION;

(c) TO ENTER INTO AGREEMENTS WITH THE DIVISION TO THE EXTENT NECESSARY TO COLLECT AND ALLOCATE THE FEE; AND

(d) TO ADOPT AND AMEND OR REPEAL POLICIES FOR THE REGULATION OF ITS AFFAIRS AND THE CONDUCT OF ITS BUSINESS CONSISTENT WITH THIS PART 12.

(3) (a) THE ENTERPRISE SHALL CHARGE AND COLLECT FROM HEALTH BENEFIT PLANS/CARRIERS/INSURERS A FEE OF THREE PERCENT OF PREMIUMS COLLECTED BY HEALTH BENEFIT PLANS/CARRIERS/INSURERS FOR HEALTH BENEFIT PLANS ISSUED IN THIS STATE. THE ENTERPRISE SHALL USE THE FEE AS FOLLOWS:

(I) TO PROVIDE SUSTAINING FUNDS TO THE REINSURANCE PROGRAM;

**Comment [EM10]:** We need to include details on timing in this section

DRAFT
4.28.20

(II) TO INCREASE THE AFFORDABILITY OF HEALTH INSURANCE ON THE INDIVIDUAL MARKET FOR COLORADANS ~~WHO EITHER~~ RECEIVE THE ADVANCE PREMIUM TAX CREDITS

(III) TO MAKE AVAILABLE AFFORDABLE HEALTH CARE COVERAGE OPTIONS FOR INDIVIDUALS WHO DO NOT QUALIFY FOR MEDICAID, CHIP OR ADVANCED PREMIUM TAX CREDITS AND WHO HAVE A HOUSEHOLD INCOME OF LESS THAN TWO HUNDRED AND SIXTY PERCENT OF THE FEDERAL POVERTY LINE. ~~OR ARE INELIGIBLE FOR THE ADVANCE PREMIUM TAX CREDIT AND MEDICAID? BUT HAVE A HOUSEHOLD INCOME OF LESS THAN FOUR HUNDRED PERCENT OF THE FEDERAL POVERTY LINE;~~

AND <{***Should "and medicaid" be added to make it clear this program is not available for individuals who are eligible for medicaid?***}>

(III) TO PAY THE ENTERPRISE'S ACTUAL ADMINISTRATIVE COSTS, LIMITED TO THREE PERCENT OF THE ENTERPRISE'S EXPENDITURES BASED ON A METHODOLOGY APPROVED BY THE OFFICE OF STATE PLANNING AND BUDGETING, INCLUDING THE FOLLOWING COSTS: <{***Typically, admin cost limits are tied to a percent of revenues, NOT expenditures. It looks like this language comes from the healthcare affordability and sustainability fee, which is unique. I recommend that if you want to cap admin costs, tie the percentage to revenues, not expenditures. I also don't think you need the OSPB methodology language.***}>

(A) THE ADMINISTRATIVE EXPENSES OF THE ENTERPRISE;

(B) THE ENTERPRISE'S ACTUAL COSTS RELATED TO IMPLEMENTING AND MAINTAINING THE FEE, INCLUDING PERSONAL SERVICES AND OPERATING EXPENSES; AND

(C) THE COSTS FOR CONDUCTING ANALYSES NECESSARY TO ESTABLISH THE FEE AND TO DETERMINE THE PAYMENTS TO BE MADE TO HEALTH BENEFIT PLANS/CARRIERS/INSURERS PURSUANT TO SUBSECTION (4) OF THIS SECTION AND THE REQUIREMENTS FOR REDUCED-COST COVERAGE OFFERED BY HEALTH BENEFIT PLANS/CARRIERS/INSURERS

**Formatted:** Not Expanded by / Condensed by

**Comment [EM11]:** I think we need to break out these two uses.

**Formatted:** Indent: Left: 0", Right: 1.37"

**Comment [EM12]:** Good catch.

**Comment [EM13]:** I think OK to tie to 3 percent of revenue and eliminate the OSBP methodology.

~~26~~25 PURSUANT TO SUBSECTION (4) OF THIS SECTION.

~~27~~26 (b) (I) EXCEPT AS PROVIDED IN SUBSECTION (3)(b)(II) OF THIS

SECTION, THE ENTERPRISE SHALL CHARGE AND COLLECT THE FEE FOR ANY BENEFIT YEAR STARTING ON OR AFTER JANUARY 1, 2021. <{***If the fee is collected starting in 2021, what is the timing of when the fees are actually received by the enterprise and then when would the revenues be available to allocate to reinsurance and to the carriers?***}>

~~(II) IF A FEDERAL WAIVER IS REQUIRED FOR THE ENTERPRISE TO COLLECT THE FEE, IMPLEMENTATION OF THE FEE IS CONTINGENT UPON APPROVAL OF THE FEDERAL WAIVER PURSUANT TO SECTION 10-16-1207. IF THE FEDERAL WAIVER IS APPROVED, THE ENTERPRISE SHALL BEGIN COLLECTING THE FEE FOR ANY BENEFIT YEAR STARTING AFTER THE APPROVAL.~~

(c) THIS SUBSECTION (3) DOES NOT APPLY TO PLANS OR BENEFITS PROVIDED UNDER MEDICARE, MEDICAID, OR THE "CHILDREN'S BASIC HEALTH PLAN" ESTABLISHED UNDER ARTICLE 8 OF TITLE 25.5. <{***I know this comes from the special assessments provision in the reinsurance program. This language appears to preclude the program from assessing fees on medicaid MPOs - is that the intent? The fact sheet says that medicaid MPOs would be subject to the fee. If that is the case, the above language needs to be modified.***}>

(4) THE ENTERPRISE SHALL TRANSMIT THE FEES COLLECTED PURSUANT TO THIS SECTION TO THE STATE TREASURER FOR DEPOSIT IN THE HEALTH INSURANCE AFFORDABILITY CASH FUND. THE ENTERPRISE SHALL ALLOCATE THE MONEY IN THE FUND ANNUALLY AS FOLLOWS:

(a) NINETY MILLION DOLLARS EACH YEAR TO THE REINSURANCE PROGRAM CASH FUND CREATED IN SECTION 10-16-1107; <{***Considering whether this allocation to another enterprise is problematic.***}>

(b) OF THE REMAINING BALANCE IN THE FUND AFTER DEDUCTING

**Comment [EM14]:** Need to continue to address timing and allowed for reconciled payments with DOI.

**Comment [EM15]:** A federal waiver should not be required here, but is required for reinsurance.

**Comment [EM16]:** We do want to EXCLUDE Medicaid MCOs.

**Comment [EM17]:** We need to allow for the possibility that a federal reinsurance program is established and these resources are not needed.

THE ALLOCATION SPECIFIED IN SUBSECTION (4)(a) OF THIS SECTION, UP TO THREE PERCENT FOR THE ENTERPRISE'S ADMINISTRATIVE COSTS; AND

(c) OF THE REMAINING BALANCE AFTER DEDUCTING THE AMOUNTS REQUIRED PURSUANT TO SUBSECTIONS (4)(a) AND (4)(b) OF THIS SECTION:

(I) TWENTY PERCENT TO HEALTH BENEFIT PLANS/CARRIERS/INSURERS TO REDUCE THE COSTS OF INDIVIDUAL HEALTH PLANS FOR INDIVIDUALS WHO PURCHASE AN INDIVIDUAL HEALTH BENEFIT PLAN ON THE EXCHANGE AND RECEIVE THE ADVANCE PREMIUM TAX CREDIT; AND

(II) EIGHTY PERCENT TO HEALTH BENEFIT PLANS/CARRIERS/INSURERS TO REDUCE THE COSTS OF INDIVIDUAL HEALTH PLANS FOR INDIVIDUALS, REGARDLESS OF THE IMMIGRATION STATUS, WHO:

(A) PURCHASE AN INDIVIDUAL HEALTH BENEFIT PLAN ON THE EXCHANGE;

(B) HAVE A HOUSEHOLD INCOME OF LESS THAN ~~FOUR~~ TWO HUNDRED AND SIXTY ~~HUNDRED~~ PERCENT OF THE FEDERAL POVERTY LINE; AND

(C) ARE NOT ELIGIBLE FOR THE ADVANCE PREMIUM TAX CREDIT, MEDICAID OR CHIP=.

~~17~~18 (D) Coverage with an actuarial value of at least 90 percent must be available for a zero-dollar premium for the lowest-income customers.

~~18~~19 (5) THE ENTERPRISE SHALL MAKE THE ALLOCATIONS SPECIFIED IN

~~19~~20 SUBSECTION (4)(c) OF THIS SECTION IN ACCORDANCE WITH THE

~~20~~21 REQUIREMENTS DETERMINED BY THE BOARD PURSUANT TO SECTION 10-16-1203 (4)(d) AND (4)(e).

**10-16-1205. Health insurance affordability cash fund - creation.** (1) THERE IS HEREBY CREATED IN THE STATE TREASURY THE HEALTH INSURANCE AFFORDABILITY CASH FUND. THE FUND CONSISTS OF THE FEE COLLECTED PURSUANT TO SECTION 10-16-1204 AND ALL

**Comment [EM18]:** We wanted to add in allowable outreach activities in the early years here. Need to fully explain waterfalling of priories in first two year and in third year +.

**Comment [EM19]:** Is this language problematic since we want to indicate the PBC?

**Formatted:** Not Expanded by / Condensed by

**Comment [EM20]:** We are continuing to think through prioritization/waterfalling.

INTEREST AND INCOME DERIVED FROM THE DEPOSIT AND INVESTMENT OF MONEY IN THE FUND.

(2) MONEY IN THE FUND SHALL NOT BE TRANSFERRED TO ANY OTHER FUND, EXCEPT AS PROVIDED IN SECTION 10-16-1204 (4)(a), AND SHALL NOT BE USED FOR ANY PURPOSE OTHER THAN THE PURPOSES SPECIFIED IN THIS PART 12.

(3) ALL MONEY IN THE FUND IS CONTINUOUSLY AVAILABLE AND APPROPRIATED TO THE ENTERPRISE TO USE IN ACCORDANCE WITH THIS PART 12.

(4) THE FUND IS PART OF THE ENTERPRISE ESTABLISHED PURSUANT TO SECTION 10-16-1204 (1).

**10-16-1206. Rules.** THE COMMISSIONER SHALL PROMULGATE RULES NECESSARY FOR THE ADMINISTRATION AND IMPLEMENTATION OF THIS PART 12, INCLUDING RULES TO PREVENT THE REINSURANCE PROGRAM FROM CAUSING A DECLINE IN THE PURCHASING POWER OF EXCHANGE CONSUMERS WHOSE HOUSEHOLD INCOME IS UP TO FOUR HUNDRED PERCENT OF THE FEDERAL POVERTY LINE. IN PROMULGATING RULES FOR THE ADMINISTRATION AND IMPLEMENTATION OF THIS PART 12, THE COMMISSIONER MAY CONSIDER THE RESULTS OF THE EVALUATION AND STUDY OF THE REINSURANCE PROGRAM CONDUCTED PURSUANT TO SECTION 10-16-1104 (2). <{***I changed the rulemaking authority to the commissioner instead of the division as the commissioner has rulemaking authority for the division. However, I'm not sure this provision is necessary, or even appropriate in this part 12. Consider whether this provision, if needed, should be included in the reinsurance program statutes.***}>

**10-16-1207. Federal waiver - division to assist - fee contingent on ~~waiver approval - notice to general assembly.~~** ~~(1) (a) IF A FEDERAL WAIVER IS REQUIRED FOR THE ENTERPRISE TO COLLECT THE FEE PURSUANT~~

**Comment [EM21]:** I think this should move to reinsurance.

DRAFT
4.28.20

~~TO THIS PART 12, THE ENTERPRISE, ACTING IN CONCERT WITH OR THROUGH AN AGREEMENT WITH THE DIVISION, SHALL SEEK ANY FEDERAL WAIVER NECESSARY TO ALLOW THE ENTERPRISE TO COLLECT THE FEE.~~

~~(b) AN APPLICATION FOR A FEDERAL WAIVER MUST CLEARLY STATE THAT COLLECTION OF THE FEE IS CONTINGENT ON APPROVAL OF THE WAIVER.~~

~~(c) THE ENTERPRISE SHALL ENSURE THAT A WAIVER APPLICATION SUBMITTED PURSUANT TO THIS SECTION COMPLIES WITH THE REQUIREMENTS SPECIFIED IN FEDERAL LAW.~~

~~(2) THE ENTERPRISE SHALL NOTIFY THE FOLLOWING IN WRITING OF ANY FEDERAL ACTIONS REGARDING THE WAIVER REQUEST:~~

~~(a) THE JOINT BUDGET COMMITTEE OF THE GENERAL ASSEMBLY;~~

~~(b) THE SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES OR ANY SUCCESSOR COMMITTEE; AND~~

~~(c) THE HOUSE OF REPRESENTATIVES COMMITTEES ON HEALTH AND INSURANCE AND PUBLIC HEALTH CARE AND HUMAN SERVICES OR ANY SUCCESSOR COMMITTEES.~~

**10-16-1208. Repeal of part - notice to revisor of statutes.** (1) THE ENTERPRISE SHALL NOTIFY THE REVISOR OF STATUTES IN WRITING, BY E-MAIL SENT TO REVISOROFSTATUTES.GA@STATE.CO.US, UPON RECEIPT FROM THE FEDERAL GOVERNMENT OF NOTICE OF APPROVAL OR DENIAL OF A FEDERAL WAIVER REQUESTED PURSUANT TO SECTION 10-16-1207.

(2) (a) IF THE NOTICE FROM THE ENTERPRISE STATES THAT THE WAIVER WAS DENIED, THIS PART 12 IS REPEALED, EFFECTIVE UPON THE DATE IDENTIFIED IN THE NOTICE THAT THE WAIVER WAS DENIED OR, IF THE

**Formatted:** List Paragraph, Indent: Left: 0.16", Hanging: 0.53", Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 10 + Alignment: Left + Aligned at: 0.16" + Indent at: 1.19", Tab stops: 0.69", Left + 0.69", Left

**Comment [EM22]:** A federal waiver should not be required to collect this fee, though the reinsurance portion will still require a waiver.

NOTICE DOES NOT SPECIFY THAT DATE, UPON THE DATE OF THE NOTICE OF

DENIAL TO THE REVISOR OF STATUTES.

(b) IF THE NOTICE FROM THE ENTERPRISE STATES THAT THE WAIVER WAS APPROVED, THIS SECTION IS REPEALED, EFFECTIVE UPON THE DATE IDENTIFIED IN THE NOTICE THAT THE WAIVER WAS APPROVED OR, IF THE NOTICE DOES NOT SPECIFY THAT DATE, UPON THE DATE OF THE NOTICE OF APPROVAL TO THE REVISOR OF STATUTES.

**SECTION 2.** In Colorado Revised Statutes, 10-16-1104, **amend** (1)(f) as follows:

**10-16-1104. Commissioner powers and duties - rules - study and report.** (1) The commissioner has all powers necessary to implement this part 11 and is specifically authorized to:

(f) Assess special fees against hospitals ~~and, if applicable, carriers~~ for the continuous operation of the reinsurance program, as provided in section 10-16-1108;

**SECTION 3.** In Colorado Revised Statutes, 10-16-1105, **amend** (1)(e)(I) as follows:

**10-16-1105. Reinsurance program - creation - enterprise status - subject to waiver or funding approval - operation - payment parameters - calculation of reinsurance payments - eligible carrier requests - definition.** (1) (e) (I) On a quarterly basis during the applicable benefit year:

(A) Each eligible carrier shall report to the commissioner its claims costs that exceed the attachment point for that benefit year; AND

(B) Each hospital that is subject to the special fees assessed pursuant to section 10-16-1108 shall report to the commissioner the amount the hospital is responsible for funding in the benefit year. ~~and~~

(C) ~~If special fees are assessed against carriers pursuant to section~~

~~10-16-1108 (1)(b), each carrier that is subject to the special fees shall report to the commissioner on its collected assessments in that benefit year.~~

**SECTION 4.** In Colorado Revised Statutes, 10-16-1107, **amend** (1)(a)(II), (1)(a)(IV), and (1)(a)(V); and **add** (1)(a)(VI) as follows:

**10-16-1107. Funding for reinsurance program - sources - permitted uses - reinsurance program cash fund - calculation of total funding for program.** (1) (a) There is hereby created in the state treasury the reinsurance program cash fund, which consists of:

(II) Special fees assessed against hospitals ~~and, if applicable, carriers~~ as provided in section 10-16-1108;

(IV) An amount of premium tax revenues deposited in the fund pursuant to section 10-3-209 (4)(a)(III); ~~and~~

(V) Any money the general assembly appropriates to the fund for the program; AND

(VI) NINETY MILLION DOLLARS ALLOCATED TO THE FUND PURSUANT TO SECTION 10-16-1204 (4)(a).

**SECTION 5.** In Colorado Revised Statutes, 10-16-1108, **amend** (1)(a)(I) introductory portion, (1)(a)(I)(A), (4), and (5); and **repeal** (1)(b) as follows:

**10-16-1108. Special assessments against hospitals and carriers - rules - enforcement.** (1) (a) (I) For the ~~2020 and 2021~~ 2022 benefit ~~years, as applicable~~ YEAR, the commissioner may assess special fees against hospitals, subject to the following:

(A) Fees assessed against hospitals must comply with and not violate 42 CFR 433.68 and ~~in any year,~~ must not exceed the lesser of ~~forty~~ EIGHTY million dollars or the maximum amount allowed under 42 CFR

433.68; and <{***If $80M is assessed in one year, 2022, will that exceed the amount allowed under 42 CFR 433.68? I'm not sure the assessment can be moved to a single year and then doubled. As I understand it, the $40M cap is essentially the maximum amount allowed under the federal regulation, so these changes may not work.***}>

(b) ~~(I) For any benefit year starting on or after January 1, 2020, if, after carriers have filed and the commissioner has approved rates for the benefit year, the federal government suspends the fee imposed pursuant to section 9010 of the federal act for that benefit year, the commissioner shall assess against carriers a special fee of two and two-tenths percent of premiums collected by carriers, or a special fee in an amount equal to the amount of the fee imposed by the federal government pursuant to section 9010 of the federal act if that fee amount is different than the amount specified in this subsection (1)(b)(I), for the period that carriers collected the fee imposed pursuant to section 9010 of the federal act.~~

~~(II) This subsection (1)(b) does not apply to plans or benefits provided under medicare, medicaid, or the "Children's Basic Health Plan" established under article 8 of title 25.5.~~

(4) If the federal centers for medicare and medicaid services in the United States department of health and human services informs the state that the state will not be in compliance with 42 CFR 433 as a result of the special fees assessed on hospitals pursuant to this section, the commissioner shall reduce the amount of the special fees as necessary to avoid any reduction in the healthcare affordability and sustainability fee collected pursuant to section 25.5-4-402.4. <{***I understand this provision may be getting modified so have included it as a placeholder.***}>

(5) If a hospital ~~or carrier, if applicable,~~ fails to pay a special fee

to the commissioner in accordance with the time periods established by rule, the commissioner may use all powers conferred by the insurance laws of this state to enforce payment of the special fees.

**SECTION 6. 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. <{***Recommend safety clause due to complications created by later session adjournment. Sponsor OK?***}>