DISTRICT COURT CITY AND COUNTY OF DENVER, COLORADO 1437 Bannock Street, Room 256 Denver, Colorado 80202 TABOR FOUNDATION, a Colorado non-profit corporation, COLORADO UNION OF TAXPAYERS FOUNDATION, a Colorado non-profit corporation; REBECCA R. SOPKIN, an individual; and JAMES S. RANKIN, an individual, Plaintiffs, v. COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING; COLORADO HEALTHCARE AFFORDABILITY AND SUSTAINABILITY ENTERPRISE; KIM BIMESTEFER, in her official capacity as Executive Director of the Colorado Department of Health Care Policy and Financing; COLORADO DEPARTMENT OF THE TREASURY; WALKER STAPLETON, in his official capacity as Colorado State Treasurer; and the STATE OF COLORADO, Defendants, and COLORADO HOSPITAL ASSOCIATION, Defendant-Intervenor.	DATE FILED: July 16, 2018 5:05 PM FILING ID: 5317DDE7898B2 CASE NUMBER: 2015CV32305
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STATE DEFENDANTS' CROSS-MOTION FOR SUMMARY JUDGMENT	

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EXHIBITS

Defendants Colorado Department of Health Care Policy and Financing ("HCPF"), Colorado Healthcare Affordability and Sustainability Enterprise ("CHASE"), Kim Bimestefer, in her official capacity, Colorado Department of the Treasury, Walker Stapleton, in his official capacity, and the State of Colorado (altogether the "State Defendants") move for the entry of summary judgment in their favor pursuant to C.R.C.P. 56(b). No genuine issue of material fact is disputed and State Defendants are entitled to judgment as a matter of law.

Certification of Conferral

Plaintiffs oppose this motion and Defendant-Intervenor does not oppose.

Introduction

From 2009 through the end of state fiscal year 2017, HCPF ran the Hospital Provider Fee program,[1] charging fees to hospitals, and providing an array of services and benefits in return. The General Assembly created the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE), as a TABOR enterprise after that program ended. CHASE also charges fees to hospitals, and provides benefits and services in return—some new and some similar to the Hospital Provider Fee program.

The Plaintiffs, a collection of two foundations and two individuals, challenge these fees as being taxes imposed without voter approval in violation of the Taxpayer's Bill of Rights ("TABOR"), COLO. CONST. art X, § 20. Plaintiffs also claim that CHASE is not a valid enterprise, that the TABOR cap was not correctly adjusted, and that the enabling legislation violated constitutional single subject requirements. Plaintiffs are wrong for several reasons.

[1] Because this case has been extensively briefed, the State Defendants incorporate the case history described in the Motion to Dismiss rather than recite it again here.

Standard of Review and Burden of Proof

I. Standard of review for summary judgment.

Summary judgment "is proper when the pleadings, affidavits, depositions, or admissions show that there is no genuine issue as to any material fact, and that the moving party is entitled to judgment as a matter of law." *Schultz v. Wells*, 13 P.3d 846, 848 (Colo. App. 2000). A material fact is one that will affect the outcome of the case. *Peterson v. Halsted*, 829 P.2d 373, 375 (Colo. 1992) (citing *Mt. Emmons Mining Co. v. Town of Crested Butte*, 690 P.2d 231, 239 (Colo. 1984)). The "purpose of summary judgment is to permit the parties to pierce the formal allegations of the pleadings and save the time and expense connected with trial when, as a matter of law, based on undisputed facts, one party could not prevail." *Id.* (citing *Mt. Emmons*, 690 P.2d at 238).

Summary judgment should only be granted upon a clear showing that there is no genuine issue as to any material fact and that all legal precedents are clearly established. *Id.* at 375–76 (citing *Jones v. Dressel*, 623 P.2d 370, 373 (Colo. 1981); *Gen. Ins. Co. v. City of Colorado Springs*, 638 P.2d 752, 760 (Colo. 1981)). The "nonmoving party is entitled to the benefit of all favorable inferences that may reasonably be drawn from the undisputed facts, and all doubts must be resolved against the moving party." *Id.* at 376 (citing *Mancuso v. United Bank of Pueblo*, 818 P.2d 732, 736 (Colo. 1991); *Tapley v. Golden Big O Tires*, 676 P.2d 676, 678 (Colo. 1983); C.R.C.P. 56(c)).

II. It is Plaintiffs' burden to prove the unconstitutionality of the fees, cap adjustment, and enterprise status challenged in this case.

Courts must uphold statutes, which are presumed constitutional, "unless a clear and unmistakable conflict exists between the statute and a provision of the Colorado Constitution." *E-470 Pub. Highway Auth. v. Revenig*, 91 P.3d 1038, 1041 (Colo. 2004) (internal quotations omitted). Thus, Plaintiffs bear the heavy burden of establishing beyond a reasonable doubt that

the statutes they challenge are unconstitutional because they violate TABOR. *See id.* at 1041, 1044; *Mesa Cty. Bd. of Cty. Comm'rs v. State*, 203 P.3d 519, 523 (Colo. 2009); *Barber v. Ritter*, 196 P.3d 238, 247–48 (Colo. 2008); *Colo. Union of Taxpayers Found. v. City of Aspen*, 2018 CO 36 ¶ 13 (noting and declining to revisit the beyond a reasonable doubt standard for TABOR challenges). In determining whether that is the case, this Court should not adopt a "rigid interpretation" of TABOR "which would have the effect of working a reduction in government services," *Bolt v. Arapahoe Cty. Sch. Dist. No. 6*, 898 P.2d 525, 537 (Colo. 1995), or otherwise "hinder basic governmental functions or cripple the government's ability to provide services, *City of Aspen*, 2018 CO 36 ¶ 17 (citing *Barber*, 196 P.3d at 248). In February 2016, the supreme court confirmed that a "statute is presumed to be constitutional; the challenging party bears the burden of proving its unconstitutionality beyond a reasonable doubt." *Dean v. People*, 2016 CO 14 ¶ 8 (citing *Hinojos-Mendoza v. People*, 169 P.3d 662, 668 (Colo. 2007); *People v. Black*, 915 P.2d 1257, 1261 (Colo. 1996)); *see also TABOR Found. v. Reg'l Transp. Dist.*, 2018 CO 29 ¶ 15 (declining to alter the beyond a reasonable doubt standard under the circumstances of that case). The court has since observed that "[a]lthough TABOR restrains government, reasonableness tempers TABOR's grip" and that the court has "consistently viewed TABOR through a lens of practicality and workability." *Reg'l Transp. Dist.*, 2018 CO 29 ¶ 29 (internal citations omitted).

Argument

A judgment of dismissal should enter in this case in the first instance because Plaintiffs cannot show that they have suffered injury to a legally protected interest of their own or their members and, thus, they lack standing to bring this suit. Even putting aside standing, judgment must enter for defendants because the Hospital Provider Fee and the CHASE fee are fees and not taxes. The fees were charged for the purpose of offsetting the cost of services provided to the fee-payors, and they did not generate revenue for general governmental spending. CHASE is a valid

enterprise and satisfies each of the constitutional requirements to receive such treatment. Contrary to Plaintiffs' claims, the TABOR excess state revenues cap did not need to be adjusted downward because CHASE was created, not qualified, as an enterprise and because the Hospital Provider Fee revenue was not used in calculating the cap. Finally, Senate Bill 17-267 encompasses one common objective with a number of methods to achieve that objective. Accordingly, it does not violate the constitutional single subject requirement. This motion will address in turn each of these reasons defendants are entitled to judgment in this case.

There are no genuine issues of material fact requiring a trial in this case. The structure of the Hospital Provider Fee and CHASE statutes themselves provide most of the framework necessary for the analysis. State officials are presumed to act in good faith in discharging their official duties. *Parker v. People*, 117 P.2d 316, 381 (Colo. 1941). The evidence supplied with this motion confirms that is the case. Any remaining fact disputes are not material and do not require trial.

Plaintiffs ask this Court to enter a judgment that would cripple the state budget. The state's General Fund is estimated at $11.6 billion for the 2017-18 fiscal year. The judgment sought by the plaintiffs would consume more than half of the entire state General Fund. Aff. of H. Sobanet ¶ 35. A judgment of this magnitude would be unprecedented, and would reasonably be expected to have impacts greater than any the state has ever seen. *Id.* ¶ 36. Such impacts would touch every aspect of state government. *Id.* It is just this sort of interpretation that our supreme court has warned against adopting. *TABOR Found. v. Reg'l Transp. Dist.*, 2016 COA 102 ¶ 49 (citing *Mesa Cty. Bd. of Cty. Comm'rs v. State*, 203 P.3d 519, 529 (Colo. 2009)).

I. Plaintiffs do not have standing to bring this suit (all claims).

A Colorado court does not have jurisdiction over a case unless the plaintiff has standing to bring it. *See, e.g., Hotaling v. Hickenlooper*, 275 P.3d 723, 725 (Colo. App. 2011). "Thus, standing is a threshold issue that a court must resolve before deciding a case on the merits." *Id.* (citing

Barber v. Ritter, 196 P.3d 238, 245 (Colo. 2008); *Ainscough v. Owens*, 90 P.3d 851, 855 (Colo. 2004)).

In Colorado, the standing analysis involves a two-part test: A plaintiff has standing if it (1) incurred an injury-in-fact (2) to a legally protected interest, as contemplated by statutory or constitutional provisions. *See, e.g., Brotman v. E. Lake Creek Ranch, L.L.P.*, 31 P.3d 886, 890 (Colo. 2001). The injury-in-fact component of this test is constitutional and cannot be excused or waived by the courts or the legislature; the legally protected interest prong is a prudential requirement that may be modified by statute. *See City of Greenwood Vill. v. Pet. for Proposed City of Centennial*, 3 P.3d 427, 436–38 (Colo. 2000) (discussing the constitutional and prudential components of Colorado standing requirements); *Maurer v. Young Life*, 779 P.2d 1317, 1323–24 (Colo. 1989) (same).

Although taxpayer standing is relatively broad in Colorado, it is not unlimited. The Colorado Supreme Court has made clear that a taxpayer who alleges an "overly indirect and incidental" harm fails to satisfy standing. *Barber*, 196 P.3d at 246 (internal quotation marks omitted). Under this rule, taxpayers have standing to challenge government expenditures of money raised by fees, when it is used to "defray general governmental expense." *Id.* at 247. But under *Barber* and other supreme court cases, this rule does not extend to the circumstances here, in which Plaintiffs are attempting to challenge the imposition of a fee itself, when they have never paid that fee.

In a recent case examining organizational standing in the context of a TABOR fee versus tax challenge, the supreme court held that in order to demonstrate standing, an organization had to show that "(1) its members would otherwise have standing to sue in their own right; (2) the interest it seeks to protect are germane to the organization's purpose; and (3) neither the claim asserted nor the relief requested requires the participation of individual members of the lawsuit." *City of Aspen*, 2018 CO 36 ¶ 10 (citations omitted). The court went on to explain that it has

"established that a plaintiff-taxpayer will have taxpayer standing when the plaintiff 'demonstrate[s] a clear nexus between his status as a taxpayer and the challenged government action.'" *Id.* ¶ 11 (quoting *Hickenlooper v. Freedom from Religion Found., Inc.*, 2014 CO 77 ¶ 12). Critically, the taxpayers in *City of Aspen* had paid the bag charge and, on that basis, the court found that they had satisfied the first prong of the test. *Id.* Thus, *City of Aspen* and *Freedom from Religion Foundation* require a nexus between the taxpayer and the challenged action, not merely any allegation of a constitutional violation. *Id.*

Here, the individual Plaintiffs cannot demonstrate that they have standing to bring this suit. As such, standing for the organizational Plaintiffs must fail as well. The harm that they claim is much more remote than that approved in *Barber*. The second amended complaint shows that the Plaintiffs' real concern is not with the transfer of funds, or the expenditure of funds, but rather that the fee was levied at all. 2d Am. Compl. ¶¶ 55, 94, 114, 130, 146.

The critical problem for the Plaintiffs here is that they are not fee payors. Indeed, any alleged injury-in-fact is confined to the hospitals and not taxpayers more generally. Yet the hospitals are not parties to the instant lawsuit, and the general rule is that absent any independent injury to themselves, the Plaintiffs cannot attempt to assert any claims on their behalf. *See, e.g., City of Greenwood Vill.*, 3 P.3d at 439; *People v. Rosburg*, 805 P.2d 432, 435 (Colo. 1991). The Colorado Hospital Association has intervened, but as a defendant and in support of the fee.

The individual Plaintiffs here cannot show that they have paid the fee. At the outset, the fee is charged to the hospitals and not to individual patients. §§ 25.5-4-402.3(3)(e)(I), -402.4(4)(e)(I), C.R.S. Moreover, undisputed evidence shows that the Plaintiffs could not have paid the fee.

First, the vast majority of hospitals receive more in supplemental payments than they pay in fee. Aff. of N. Dolson ¶ 16, attached as Exhibit A. Payment of the fee and receipt of the

supplemental payment occurs on the same banking day. *Id.* Under these circumstances there is no net loss that could be passed onto a patient.

Second, Plaintiffs cannot demonstrate that they paid the fee in their particular circumstances. Plaintiff Sopkin indicates that she or her family members received services at Children's Hospital, Lutheran Medical Center, and St. Anthony Hospital, all since 2010. Pls.' Resps. to Interrogatory 1. Lutheran Medical Center is part of the Exempla system, now part of SCL Health, and St. Anthony Hospital is part of the Centura Health – CHI system. The system level is the appropriate accounting level to consider when looking at net gain or loss from the fee. Aff. of N. Dolson ¶ 14. During the relevant timeframes, neither Children's Hospital, Exempla, SCL Health, nor Centura Health – CHI have ever been net negative in the Hospital Provider Fee program. Aff. of N. Dolson ¶ 15, Ex. A-2. In other words, they have always received more in supplemental payments than they paid in fees. As such, Ms. Sopkin's family has never received services at a hospital or system that has lost money on the fee program. The hospital paid the fee—not Ms. Sopkin, and, in addition, there was no loss to pass along to her.

Mr. Rankin's medical bills follow much the same pattern. He received services at Good Samaritan Medical Center in August of 2017. Pls.' Resps. to Interrogatory 1. That hospital is part of the Exempla system, which is now SCL Health. Aff. of N. Dolson ¶ 15. That system has never had a net negative for the fee program. *Id.*, Ex. A-2. Mr. Rankin did not pay the fee, and there was no negative amount from the fee to be passed along to him.

Plaintiffs TABOR Foundation and Colorado Union of Taxpayers Foundation rely on these two individuals as well as Bob Foland and Kaarl Hoopes for organizational standing. Mr. Foland received services at St. Joseph Hospital in February 2015, and Mr. Hoopes received services at Lutheran Medical Center in approximately 2015. Pls.' Resps. to Interrogatory 1. Both of these hospitals are part of the Exempla, and now SCL Health, systems. Aff. of N. Dolson ¶ 15. As

indicated above, these systems have never received less in supplemental payments on the same day they paid the fee. *Id.*, Ex. A-2. Neither Mr. Foland nor Mr. Hoopes paid the fee, and neither received services at a hospital system with a net loss that could be passed along to them.

The Plaintiffs here cannot demonstrate that there is a "clear nexus" between their status as taxpayers and the challenged government action. *City of Aspen*, 2018 CO 36 ¶ 11. They are not the fee payors. They cannot show that any of them have paid the fee. Nor can they even show the remote possibility that the fee was passed onto them—because every hospital providing services to them has received more money back on the same day it paid the fee. While Plaintiffs make the bald assertion that they would have received refunds absent action here, that is highly speculative at best and is not supported by the evidence. Aff. of H. Sobanet ¶ 28. As the individual members do not have standing, neither do the organizational plaintiffs.

The allegations in the complaint here are general disagreements with funding policy. But they do not show injury in fact to a legally protected interest of the Plaintiffs. At best, the injuries belong to the third-party hospitals. But those hospitals are not plaintiffs. To the contrary, their association has come to the defense of the fee on their behalf. Because the Plaintiffs cannot show injury in fact to a legally protected interest of themselves or their members, they lack standing to bring this suit. As such, this case—including all of Plaintiffs' claims—must be dismissed.

II. The Hospital Provider Fee and the CHASE Fee are fees and not taxes subject to TABOR (first, second, third, and fourth claims).

Putting aside standing, which is dispositive of this entire case, the critical question that will resolve the majority of Plaintiffs' claims is whether the Hospital Provider Fee and the CHASE Fee are fees or taxes. While TABOR requires a vote in order to approve "any new tax" or a "tax policy change directly causing a net tax revenue gain" to the state, that requirement does not apply to fees. COLO. CONST. art. X, § 20(4)(a); *Barber*, 196 P.3d at 249. If the Hospital Provider

Fee and CHASE Fee are not taxes, then the majority of the claims in this suit (the first through fourth claims) are without merit on that basis alone.

A fee is different from a tax because it is not designed to raise revenues to defray the general expenses of government, rather, it "'is a charge imposed upon persons or property for the purpose of defraying the cost of a particular governmental service.'" *Barber*, 196 P.3d at 248 (quoting *Bloom v. City of Fort Collins*, 784 P.2d 304, 308 (Colo. 1989)). The language and structure of the applicable statutes show that this is the case, and there are no genuine issues of material fact that must be resolved to answer the question.

The critical inquiry in determining whether a charge is a fee or a tax is the "primary or dominant purpose of such imposition at the time the enactment calling for its collection is passed." *Id.* (citing *Zelinger v. City & Cty. of Denver*, 724 P.2d 1356, 1358 (Colo. 1986)). Courts should look to whether the language of the enabling statute reveals that the primary purpose for the charge "is to finance a particular service utilized by those who must pay the charge" or "to raise revenues for general governmental spending." *Id.* at 249. If the former, then it is a fee.

In determining "the primary or dominant purpose" of the charge at the time of its enactment, the court of appeals has identified three factors relevant to the inquiry: (1) the primary purpose expressed in the language of the enabling statute; (2) "the primary or principal purpose for which the money is raised, not the manner in which it is ultimately spent"; and (3) whether "the primary purpose of the charge is to finance or defray the cost of services provided to those who must pay it." *TABOR Found. v. Colo. Bridge Enter.*, 2014 COA 106 ¶¶ 22–25 (citing *Barber*, 196 P.3d at 241, 248–49; *Bloom*, 784 P.2d at 307–08). Further, while the "fee amount must be reasonably related to the overall cost of the service; [] mathematical exactitude is not required." *Id.* ¶ 26 (citing *Bloom*, 784 P.2d at 308). A review of each of these factors reveals that the charges at question in this suit are fees and not taxes.

A. The language of the enabling statutes reveal that the primary purpose of the fees are to finance specific services to the fee-payors.

The first *Colorado Bridge Enterprise* factor directs courts to look at whether the language of the enabling statute reveals that the purpose of the charge is to raise revenues for general governmental spending or to finance a particular service. *Id.* ¶ 23. While this factor is not dispositive by itself, the court of appeals "cannot ignore the state legislative intent" when the General Assembly declares that a charge is a fee. *Id.* ¶ 30 (citing *Barber*, 196 P.3d at 248).

The Hospital Provider Fee was enacted through the Colorado Healthcare Affordability Act. H.B. 09-1293, 67th Gen. Assemb., 1st Reg. Sess. (Colo. 2009), codified at § 25.5-4-402.3, C.R.S. [hereinafter H.B. 09-1293]. At the outset, the General Assembly expressed its intention through categorizing the charge as a fee. *Id.* § 1. The choices made by the General Assembly in the Act shows that categorizing the charge as a fee was intentional. Section 1 of the bill, codified at § 25.5-4-402.3(3)(a), specifies that HCPF is authorized to "charge and collect hospital provider fees, as described in 42 C.F.R. 433.68(b)."

As Plaintiffs have pointed out repeatedly, that section of the federal regulations describes "health care-related taxes." 42 C.F.R. § 433.68(b). But the use of the word "tax" in the federal regulations does not shed light on the TABOR question before this Court, for two reasons. First, the regulation predates TABOR, making TABOR's fee versus tax distinction irrelevant to it. *See* Interim Final Rule with Comment Period, 57 F.R. 555118 (Nov. 24, 1992). The General Assembly specifically acknowledged that the federal regulation refers to a "health care-related tax" but intentionally chose to categorize it as a fee for its implementation in Colorado. Referring to the regulation, but rejecting the categorization of "tax" for "fee," demonstrates the General Assembly's intention that the Hospital Provider Fee truly be treated as a fee for TABOR purposes. Second, the language used by the federal regulation is neither binding nor persuasive

since there is no evidence the federal rulemaking body considered TABOR in any way. Moreover, whether a charge is a fee or a tax for purposes of TABOR is solely a question of Colorado law.

Besides the stated legislative intent, and the specific adoption of the fee nomenclature, the remainder of the act demonstrates that the purpose of the charge is to finance a particular service. In the act, the legislature first describes the problem that it is trying to solve, recognizing that "hospital providers within the state incur significant costs by providing uncompensated emergency department care and other uncompensated medical services to low-income and uninsured populations." H.B. 09-1293 § 1. In order to solve this problem, the Act sets up the Hospital Provider Fee program to provide the following services:

> (I) Providing a payer source for some low-income and uninsured populations who may otherwise be cared for in emergency departments and other settings in which uncompensated care is provided;
>
> (II) Reducing the underpayment to Colorado hospitals participating in publicly funded health insurance programs;
>
> (III) Reducing the number of persons in Colorado who are without health care benefits;
>
> (IV) Reducing the need of health care providers to shift the cost of providing uncompensated care to other payers; and
>
> (V) Expanding access to high-quality, affordable health care for low-income and uninsured populations.

Id. Specifically, the funds raised by the fees charged by the program were to be used to (1) increase reimbursement to hospitals for providing care to publicly insured populations, (2) increase the number of people covered by that insurance, and (3) pay for running the program. *Id.*

Each of these restricted uses of the fee represent a particular service to the fee-paying hospitals. The issue, as described in the legislation, is that hospitals were bearing the cost of providing care to individuals who didn't have health insurance. *Id.* This resulted in

uncompensated care—hospitals either writing off uncollectible accounts or providing charity care to those who couldn't pay. Uncompensated care created a need to shift the cost of that care to other payers, like private insurance. In response to this problem, the Hospital Provider Fee program charges hospitals fees, and the revenue from those fees are used to increase hospital reimbursement and increase the number of insured patients. These services decreased the amount of uncompensated care the hospitals had to provide. *Id.*

The act thus reveals that the primary purpose of the Hospital Provider Fee is not to raise revenues that can be used for any governmental spending. Rather, the revenues from the fee must be used to provide a particular service that benefits the fee-paying hospitals. The first factor weighs in favor of finding the Hospital Provider Fee to be a fee.

B. The primary purpose for raising revenues through the fees is to finance the services provided to hospitals.

The second prong of the analysis is somewhat a corollary of the first, requiring an examination of "the primary or principal purpose for which the money is raised, not the manner in which it is ultimately spent." *Colo. Bridge Enter.*, 2014 COA 106 ¶ 24 (citing *Bloom*, 784 P.2d at 307–08). In performing that examination, the *Colorado Bridge Enterprise* court focused on factors such as the restrictions on what the fee funds could be spent for, that the funds were put into a separate restricted cash fund, and that the fee did not pass into the General Fund or other Department of Transportation funds. *Id.* ¶¶ 32–33.

The enabling act of the Hospital Provider Fee reflects these same critical elements. The fee revenue can only be spent for specific purposes, each of which is a service provided to the fee-paying hospitals. H.B. 09-1293 § 1; § 25.5-4-402.3(3)(a)(I), C.R.S. (2016). The act created a separate cash fund, in which the fee revenue must be deposited, and restricted the purposes for which money could be spent out of that fund. H.B. 09-1293 § 1; § 25.5-4-402.3(4)(a)–(b), C.R.S.

(2016). The legislation also provides that "[a]ny unexpended and unencumbered moneys remaining in the fund at the end of any fiscal year shall remain in the fund and shall not be credited or transferred to the General Fund or any other fund but shall be appropriated by the General Assembly [for the Hospital Provider Fee program] in future fiscal years." H.B. 09-1293 § 1; § 25.5-4-402.3(4)(c), C.R.S. (2016).

The Department complied with this law in setting up and administering the program. As required, the State set up the Hospital Provider Fee Cash Fund. Aff. of J. Cotosman ¶ 6. The fee revenue that was received from fee-paying hospitals was deposited into that fund. *Id.* The expenditures made from that fund were only made for the purposes enumerated in the act. *Id.* With certain limited exceptions, fee funds remained in the cash fund and were not moved for any other purpose. *Id.* ¶¶ 7–8.

The exception to the above analysis is three transfers in three separate fiscal years from the Hospital Provider Fee Cash Fund to the Department's General Fund. *Id.* ¶ 7. But these transfers do not change the nature of the fees or the analysis for this prong of the fee test. In state fiscal years 2010-11, 2011-12, and 2012-13, the General Assembly transferred funds from the Cash Fund to the General Fund.

The first of these, 2010-11, was authorized by Senate Bill 10-169. The bill concerns the use of enhanced federal matching funds under the American Recovery and Reinvestment Act of 2009 ("ARRA") for certain Medicaid expenditures. S.B. 169, 67th Gen. Assemb., 2d Reg. Sess. (Colo. 2010), codified at § 25.5-4-402.3(4)(b)(VIII), C.R.S. [hereinafter S.B. 10-169]. The Medicaid program is a joint state and federal program, and for each expenditure made in the program, the state and federal governments each pay a share. The amount that the federal government pays is called the Federal Medical Assistance Percentage, or FMAP. 42 U.S.C. § 1396d(b). Before ARRA, the amount of the FMAP for the expenditures affected by S.B. 10-169 was 50%, meaning

that the state and federal governments would equally split the costs. 74 Fed. Reg. 62315, 62315–17 (Nov. 27, 2009). ARRA provided that there was an enhanced FMAP available to states under certain circumstances. American Recovery & Reinvestment Act of 2009, Pub. L. No. 111-5 § 5001, 123 Stat. 115, 496–502 (2009).

It is this amount—the extra money made available by the increased federal share of Medicaid expenditures—that was appropriated by S.B. 10-169. For state fiscal year 2010-11, the FMAP was increased from 50% to between 56.88% and 61.59%. 75 Fed. Reg. 66763, 66763–66 (Oct. 29, 2010) (FMAP adjustment for 7/1/2010–9/30/2010 to 61.59%); 76 Fed. Reg. 5811, 5811–13 (Feb. 2, 2011) (FMAP adjustment notice for 10/1/2010–12/31/2010 to 61.59%); 76 Fed. Reg. 32204, 32204–07 (June 3, 2011) (FMAP adjustment for 1/1/2011–3/31/2011 to 58.77% and 4/1/2011–6/30/2011 to 56.88%).This means that for each Medicaid program expenditure, the federal government paid between 6.88% and 11.59% more than it otherwise would have.

S.B. 10-169 used the money made available by the extra 6.88% to 11.59% in federal reimbursement to allow an offset in Medicaid spending from the Department's General Fund. There is no change in the amount of provider fee that was spent in support of the program. Rather, the money freed up by the extra matching federal funds permitted additional expenditures from the Department's General Fund. The funds were not used for general governmental spending, but were limited to the Medicaid program. Aff. of J. Cotosman ¶¶ 6–8. Further, because federal funds are specifically excluded from the TABOR definition of "fiscal year spending," the transfer of these funds does not implicate TABOR. As such, that transfer cannot be used to demonstrate a TABOR violation.

In state fiscal years 2011-12 and 2012-13, the General Assembly transferred $50 million and $25 million respectively from the Hospital Provider Fee Cash Fund to the Department's General Fund. S.B. 11-212 § 2, 68th Gen. Assemb., 1st Reg. Sess. (Colo. 2011), codified at

§ 25.5-4-402.3(4)(b)(IX). Regardless of whether the funds in 2010-11 were federal in nature, all three transfers are permissible under binding supreme court precedent.

The supreme court examined the theory that a transfer of fees to the General Fund could constitute a tax increase in *Barber v. Ritter*, 196 P.3d at 248. The court specifically examined whether transfers from cash funds to the General Fund constituted a "tax policy change directly causing a net tax revenue gain" to the state, and concluded that they did not. *Id.*

The primary consideration for the court there, which is applicable here, is that transferring fees does not change their essential character. In other words, transferring fees does not turn them into taxes. The inquiry for this Court is whether the funds were fees in the first place. If they were, then a "transfer does not change the fact that the primary object for which they were collected was not to defray the general cost of government." *Id.* at 250.

The Hospital Provider Fee program existed for eight state fiscal years, from 2009-10 through 2016-17. Of those, transfers were made in three years, one of which consisted of TABOR-exempt federal funds. Even those transfers were not made for general governmental spending—they went to the Department's General Fund and were used to provide medical care to Medicaid clients. Aff. of J. Cotosman ¶ 8. Under binding precedent, those isolated transfers of fees to the General Fund has no bearing on whether the funds are properly categorized as fees or taxes.

Rather, it is the primary purpose for which they were raised that answers the fee versus tax question. The legislation shows that, like in *Colorado Bridge Enterprise*, the funds were raised for restricted purposes, placed in a restricted fund, and spent in providing services to the fee-paying hospitals. *Colo. Bridge Enter.*, 2014 COA 106 ¶ 32–33. The undisputed evidence supplied in connection with this motion shows that the program was administered in compliance with the

statute. Under these circumstances, the second prong weighs in favor of a determination that the Hospital Provider Fee is properly categorized as a fee.

C. The primary purpose of the fees is to finance or defray the cost of services provided to the fee-paying hospitals.

The final factor for consideration is whether the primary purpose of the charge is to finance or defray the cost of services provided to the fee payer, or whether the primary purpose is to offset general governmental expense. If the former, then the charge is a fee. *Colo. Bridge Enter.*, 2014 COA 106 ¶ 35 (citing *Barber*, 196 P.3d at 241, 249 (a charge is a fee when the primary purpose is to "defray the costs of services provided to those charged" or to "finance a particular service utilized by those who must pay the charge")); *City of Aspen*, 2018 CO 36 ¶ 21 (citing *Zelinger*, 724 P.2d at 1359) ("if a charge is imposed as part of a comprehensive regulatory scheme, and if the primary purpose of the charge is to defray the reasonable direct and indirect costs of providing a service or regulating an activity under that scheme, then the charge is not raising revenue for the general expenses of government, and therefore, not a tax.").

In order to be a fee, a charge must be reasonably related to the overall cost of providing the service and must be imposed on those who are reasonably likely to benefit from or use the service. *Id.* ¶ 35. However, the court of appeals has rejected the idea that a fee must be paid only by people who will utilize the service provided with the fee revenue. ¶ 38. In fact, a fee may be charged to people who may not utilize the services at all. ¶ 39 (citations omitted). The *Colorado Bridge Enterprise* court concluded that even if it did find that there must be a direct connection between the fee payer and the fee payer's use of services, it would not find that factor to be outcome determinative. ¶ 42. The court declined to hold that a specific nexus is required between payment of a fee and use of the service or benefit. ¶ 45. Instead, the general public can receive an

incidental benefit from the charge, as long as it bears a reasonable relationship to the services provided to the charge payers. *City of Aspen*, 2018 CO 36 ¶¶ 30–31.

The question before this Court then is two-fold: (1) do hospitals receive a benefit or service in exchange for paying the fee and (2) is the amount of the fee reasonably related to the overall cost of providing that service or benefit? The answer to both questions is yes.

1. Benefit to fee-paying hospitals.

The Hospital Provider Fee program provides a number of services and benefits to fee-paying hospitals, including:

- Inpatient and outpatient supplemental payments
- Disproportionate Share Hospital payments
- Uncompensated care payments
- Hospital Quality Improvement Payments
- An insurance source to bill against for previously uninsured patients
- Decreased uncompensated and charity care

As explained below, the value of these services—taking into account the cost of the fee—exceeds one *billion* dollars per year.

The first benefit provided to fee-paying hospitals takes place in the form of a supplemental payment, which is designed to increase the inpatient and outpatient hospital reimbursements to up to the upper payment limits (UPL) described in federal law. § 25.5-4-402.3(4)(b)(I), C.R.S. (2016). The UPL for each category—inpatient and outpatient—refers to "a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare." 42 C.F.R. §§ 447.272(b)(1), 447.321(b)(1).

In other words, a reasonable estimate of the amount Medicare would have paid for hospital services is the ceiling or UPL. The amount that Medicaid pays, or the base rate for claim

payments, is less than the UPL. The supplemental payment permits the state to use some of the room under the UPL to reimburse hospitals to close to the UPL.[2]

These supplemental payments—additional hospital reimbursement—would not exist and would not be paid to hospitals but for the Hospital Provider Fee program. In exchange for paying the fee, fee-paying hospitals get access to federal funds and supplemental payments they could not otherwise access.

In addition to the inpatient and outpatient supplemental payments, there are additional supplemental payments provided under the Hospital Provider Fee program. There are also Disproportionate Share Hospital (DSH) payments, uncompensated care payments, and Hospital Quality Incentive Payments (HQIP). Each of these supplemental payments has its own set of requirements for a hospital to qualify. Once those requirements are satisfied, that hospital qualifies for an additional supplemental payment.

Notably, for the vast majority of hospitals all of the supplemental payments combined exceeds the amount of fee paid by the fee-paying hospitals. As shown in Exhibit A-2, considering only whether a hospital—or hospital system—made more in supplemental payments than it paid in fees for state fiscal year 2016-17 shows that only 3 of 49 hospitals or systems received less in supplemental payments than they paid in fees.

Thus, there is an immediate and tangible benefit to fee-paying hospitals: they receive more back in supplemental payments than they paid out in fee. Because the fee and supplemental payment transactions happen on the same day, these hospitals are immediately in a net positive position after paying the fee. Aff. of N. Dolson ¶ 16. Receiving more back in supplemental

[2] Exhibit K contains a graphical depiction of this phenomenon.

payments than they pay in fees is an unquestionable benefit to those hospitals. Aff. of P. Burnette ¶ 4; Aff. of C. Tholen ¶ 6.

Even for those hospitals that do not receive a supplemental payment greater than the fee they paid, there are numerous other benefits provided under the Hospital Provider Fee program. The next of these major benefits is a public insurance source for hospitals to bill against for previously uninsured patients.

Under federal law, hospitals are required to stabilize and treat anyone coming to an emergency department regardless of their insurance status or ability to pay. 42 U.S.C. § 1395dd; Aff. of C. Tholen ¶ 10. Virtually all hospitals also have charity care programs where they provide reduced fee services to individuals without an ability to pay. Aff. of C. Tholen ¶ 7. For patients who are unable or do not pay their bills, hospitals must write off the costs of those services provided. *Id.* ¶ 6. These amounts constitute uncompensated care, which hospitals must otherwise absorb into their operations.

This is one of the issues the Hospital Provider Fee program was designed to address. H.B. 09-1293 § 1, codified at § 25.5-4-402.3(2), C.R.S. When hospitals must write off care, or provide it below cost, the only way they can stay in business is to shift those costs to other payor sources—called the cost shift. While Plaintiffs contend that the cost shift is a consequence of the program, this is wrong on the face of the legislation. The cost shift is one of the problems the legislation attempts to *solve*. The Hospital Provider Fee program is designed to reduce the amount of uncompensated care hospitals must absorb. The undisputed evidence shows that it in fact does so. This in turn reduces the need to shift costs to other payors. *Id.*

It does this through providing Medicaid and CHP+ coverage to individuals who were not formerly covered by an insurance program, and for whom hospitals were required to provide care

even if they could not collect funds for that care. The Hospital Provider Fee program funds expansion populations under Medicaid and CHP+, which includes categories of people who could not have received benefits in Colorado prior to expansion. H.B. 09-1293 § 1, codified at § 25.5-4-402.3(4)(b)(IV), C.R.S. Hospital Provider Fee funds, along with matching federal funds, are used to pay claims incurred by individuals in those populations.

This is a benefit to fee-paying hospitals. On the whole, hospitals comprise about 30% of all Medicaid claims. Aff. of N. Dolson ¶ 8. In state fiscal year 2015-16, a total of $1,886,210,000 was paid in total funds for expansion population claims. *Id.*, Ex. A-8 at 14 (STATE_000196). Approximately 30% of that, or $565,863,000, was paid directly to hospitals. *Id.* ¶ 8. This half billion dollars inures to the benefit of each and every hospital statewide.

The data collected by the program shows that uncompensated care is falling as the program provides an additional source of insurance to bill against. In calendar year 2009, the total amount of bad debt and charity care that hospitals wrote off was $693,594,036. Aff. of N. Dolson, Ex. A-9 at p. A11 (STATE_000240). In calendar year 2016, seven years into the program, that number had fallen to $292,561,992. *Id.* Hospitals have not had to absorb nearly half a billion dollars a year in uncompensated care as a direct effect of paying the fees.

Thus, the benefits to fee-paying hospitals provided by the Hospital Provider Fee program are significant. For 2015-16:

Supplemental Payments [3]	$ 1,120,812,000
Expansion Populations[4]	$ 565,863,000

[3] Reported on a federal fiscal year 2015-16 basis (10/1/2015–9/30/2016). Aff. of N. Dolson, Ex. A-8 at 33 (Table 11) (STATE_000199).

Less: Hospital Provider Fee Paid[5]	- $	669,501,000
Net Benefit	$	1,017,174,000

Considering just these two benefits of the Hospital Provider Fee program—supplemental payments and the portion of expansion population claims that are paid to hospitals—shows that hospitals received more than a billion dollars in net benefit over the amount they paid in fee. These benefits and services are a direct consequence of the fee program, and are wholly unavailable to the hospitals without it.

These numbers do not consider the additional beneficial impacts to hospitals that are more difficult to directly quantify. For example, as described above, hospitals are required to provide care to anyone presenting at an emergency department regardless of whether they can pay. Individuals who are uninsured are less likely to receive preventative care and early treatment for conditions. Aff. of P. Burnette ¶ 9. As a consequence, those people presenting at an emergency department without insurance are not only unable to pay, they are often sicker and more expensive to treat. *Id.* Thus, even the portion of expansion population funds that do not go directly to hospital claims payments still benefit hospitals by reducing not only the amount but also the cost and severity of emergency department claims they would have had to bear before.

Hospitals receive services and benefits in exchange for paying the Hospital Provider Fee. They receive supplemental payments and insurance coverage for patients they would have had to

[4] Reported on a state fiscal year 2015-16 basis (7/1/2015–6/30/2016). Aff. of N. Dolson, Ex. A-8 at 14 (Table 9) (STATE_000196). This number represents 30% of the total expansion population claims. Approximately 30% of expansion population claims are paid to hospitals. *Id.* ¶ 8.

[5] Reported on a federal fiscal year 2015-16 basis (10/1/2015–9/30/2016). Aff. of N. Dolson, Ex. A-8 at 17 (Table 11) (STATE_000199).

treat regardless of ability to pay.

2. The amount of the fee is reasonably related to the cost of providing the service.

The second consideration for the final prong is whether the charge is reasonably related to the overall cost of providing the service, and whether it is imposed on those reasonably likely to benefit from or use the service. In order to be a fee, a charge must be reasonably related to the overall cost of providing the service and must be imposed on those who are reasonably likely to benefit from or use the service. *Colo. Bridge Enter.*, 2014 COA 106 ¶ 35.

Here, the value provided to hospitals vastly outweighs the amount that they are required to pay in fees. As shown in the table above, program year 2015-16, hospitals paid $669.50 million in fees and received $1,686.68 million in direct benefits.[6] Looking just at this portion of the program shows that the net value received by hospitals is more than a billion dollars more than they paid in fees. Because of the influx of TABOR-exempt federal funds, the program returned all of the state fee money to fee-paying hospitals, and there is no "extra" revenue that could be used for other purposes.

Adding in the cost of administering the Hospital Provider Fee program for the state and the expansion population claims not directly payable to hospitals brings the total funds made available to the state in the same period to $3.34 billion. In other words, hospitals paid $ .67 billion in fees and received $ 1.12 billion in supplemental payments. That single set of transactions returns almost twice as much value to the hospitals as they paid in fee, making the overall cost of the

[6] Aff. of N. Dolson, Ex. A-8 at 14, 17 (Tables 9 & 11) (STATE_000196, STATE_000199). Fees and supplemental payments are reported on a federal fiscal year basis. Thirty percent of expansion population claims, reported on a state fiscal year basis, are also added to supplemental payments to calculate direct benefit.

program reasonably related to the cost of the benefit or service provided to the fee-payor. Adding in the remaining value generated to the state triples the benefit. In other words, fee-paying hospitals—which is the only source of state funds at question here—account for 20% of the overall cost of the value provided under the program. Even considering only those benefits that are directly paid to hospitals shows that they bear under 40% of the cost of those benefits.

Under these circumstances, there are clearly identifiable services and benefits provided to the fee-paying hospitals. Those benefits include vastly increased compensation for services hospitals would otherwise still have to provide. The amount that the hospitals pay in fees is a fraction of the value provided to them in return. These facts satisfy the last *Colorado Bridge Enterprise* factor for finding the charge at question here to be a fee.

The primary purpose of the Hospital Provider Fee is to defray costs of that program. The evidence shows that it is administered in compliance with the statute. The funds from the charge are deposited into a cash fund, and are spent only on benefits and services provided under the program. Those benefits and services are directed to fee-paying hospitals, who receive much more in value than they pay in the charge. Accordingly, the Hospital Provider Fee was correctly categorized by the General Assembly as a fee.

D. The CHASE Fee also satisfies the *Colorado Bridge Enterprise* test as a fee and not a tax.

The CHASE Fee is new for this state fiscal year—the enterprise went in effect July 1, 2017. While the CHASE enterprise is different than the Hospital Provider Fee program, both share common elements as they relate to the determination of the charges as fees or taxes.

In the Colorado Healthcare Affordability and Sustainability Act of 2017, the General Assembly expressly determined that the CHASE Fee is a fee and not a tax. S.B. 17-267 § 17, 71st Gen. Assemb., 1st Reg. Sess. (Colo. 2017); § 25.5-4-402.4(2)(f), C.R.S. It specifically found that

the fee is imposed for the specific purpose of allowing the enterprise to defray the costs of providing the business services defined in statute to hospitals, and that the fee is collected at rates reasonably calculated on the benefits received by fee-paying hospitals. *Id.* The General Assembly again distinguished the charge as a fee for TABOR purposes in spite of the generic name for the federal program. § 25.5-4-402.4(4).

The CHASE statute also contains restrictions showing that the revenue raised from the fee can only be spent in support of the enterprise and the services it provides to fee-paying hospitals. *Id.* Revenues raised from the fee must be deposited into a restricted enterprise cash fund, and expenditures from that fund can only be made for the benefits and services to be provided to hospitals outlined in the statute. § 25.5-4-402.4(5)(a). Fee revenues are not permitted to be transferred to any other fund, and can only be used for the enterprise's purposes.

The enterprise has been administered as required by its enabling legislation. The fee funds that it collects are deposited into its cash fund. Aff. of J. Cotosman ¶ 13. It pays the expenses it incurs for providing benefits and services out of that cash fund. *Id.* ¶ 12. It has not paid for its expenses out of other funds, and it has not used fee revenue to pay for anything not authorized under the statutes. *Id.*

The benefits and services provided to CHASE Fee-paying hospitals are also significant. The enterprise program accesses the same source of federal funds that the Hospital Provider Fee program did. As such, hospitals receive increased reimbursement in the form of supplemental payments and an insurance source against which to bill for previously uninsured patients. Aff. of N. Dolson ¶ 4. While the enterprise is only in its first full year, the value of the benefits and services it is providing to fee-paying hospitals on these two items is significant. For example, in December 2017, the enterprise collected $69.35 million in fees from hospitals, and paid out $105.43 million in supplemental payments to the fee-paying hospitals. *Id.* ¶ 22. The hospitals

received a net benefit worth more than $36 million from that single transaction. The other months to date in the fiscal year show the same pattern. Hospitals receive services and benefits far in excess of the amount they pay in fees. As this one transaction shows, the cost of providing those services is reasonable—with hospitals paying 66% of the cost of the value they received in return for the fee. In addition, the General Assembly instructed that the fee should be "collected at rates that are reasonably calculated based on the benefits received by hospitals." § 25.5-4-402.4; *see also Colo. Bridge Enter.*, 2014 COA 106 ¶ 36 (noting similar language in the statute challenged there).

As described in section III, the enterprise provides additional services and benefits that the Hospital Provider Fee program did not. But it is not even necessary to consider these additional services to determine that the General Assembly's categorization of the fee is correct. The primary purpose of the fee is to collect revenue to support the services provided to the fee-paying hospitals. The revenue is collected for that purpose, and it is not spent in support of general governmental expenses or made available for general governmental spending. Hospitals receive benefits and services that are worth far more than they pay in fees. Under these circumstances, the CHASE Fee is properly categorized as a fee and not a tax.

E. Neither the Hospital Provider Fee nor the CHASE Fee are tax policy changes resulting in a net tax revenue gain to the state.

Plaintiffs separately claim that the fees they challenge in this case are tax policy changes in violation of TABOR. But as long as this Court finds that the charges are fees, they do not fall under TABOR's requirements and are necessarily not tax policy changes.

TABOR requires a popular vote in specific circumstances. Voter approval is only necessary for "any new tax, tax rate increase, mill levy above that for the prior year, valuation for

assessment ratio increase for a property class, or extension of an expiring tax, or a tax policy change directly causing a net tax revenue gain to any district." COLO. CONST. art. X, § 20(4)(a). Creation of a new fee does not fall within this definition.

Even if there was a tax policy change in this case, Plaintiffs must prove that it "directly caus[ed] a net tax revenue gain to" the State. COLO. CONST. art. X, § 20(4)(a). Under TABOR, the state as a whole is the district for purposes of TABOR. § 20(2)(b). The Colorado Supreme Court has found that the tax policy clause "only requires voter approval when the revenue gain exceeds the limits dictated by subsection (7)." *Mesa Cty. Bd. of Cty. Comm'rs*, 203 P.3d at 529.

Subsection 7 of TABOR is the provision that limits the growth of government through a spending limit. In the event spending exceeds a limit based on the prior year, the State must either refund the extra revenue or seek voter approval to keep it. COLO. CONST. art. X, § 20(7)(d). The Hospital Provider Fee was counted against the TABOR limit. Plaintiffs can offer no evidence, and indeed there is none, to show that the Hospital Provider Fee directly caused state revenues to increase above the TABOR cap. Aff. of H. Sobanet ¶¶ 26–29.

Not every tax policy change requires a popular vote. The supreme court found that interpreting TABOR to require a vote for *any* tax policy change—even one that does not lead to net revenue gains in excess of TABOR's spending limit— would cripple the functions of government. *Mesa Cty.*, 203 P.3d at 529. Instead, the tax policy change must be read in conjunction with the revenue limits, and a vote is required only when the tax policy change causes a net increase in revenue that exceeds the TABOR spending caps. *Id.*

Contrary to the Plaintiffs' conclusions in their second amended complaint, it is only a tax policy change that causes a net revenue gain for the state in excess of the TABOR spending limit without a popular vote that would constitute a violation of TABOR. There is no evidence that the

Hospital Provider Fee ever directly caused the state to exceed the TABOR cap. Indeed, the evidence before this Court is that the General Assembly ended the program rather than permitting that to happen. Aff. of H. Sobanet ¶¶ 26–29. Nor can CHASE form the basis of this claim. Because the enterprise funds are TABOR-exempt, they could not push TABOR-countable revenue over the applicable cap. Both charges are correctly categorized as fees. As such, plaintiffs cannot prevail on their tax policy change arguments.

III. CHASE satisfies TABOR's requirements and is a valid exempt enterprise (fourth claim).

An enterprise, within the meaning of TABOR, is "a government-owned business authorized to issue its own revenue bonds and receiving under 10% of annual revenue in grants from all Colorado state and local governments combined." COLO. CONST. art. X, § 20(2)(d). Plaintiffs specifically challenge CHASE's enterprise status based on their belief that it can levy taxes, and that it is not engaged in business functions. 2d Am. Compl. ¶¶ 61, 147–48.

Plaintiffs do not challenge, nor is there any reasonable way to challenge, that CHASE is "government-owned" or that it has authority to issue its own revenue bonds. The General Assembly specifically created CHASE as an enterprise, and as a government-owned business within HCPF. § 25.5-4-402.4(3)(a), C.R.S. The enterprise has the power to issue revenue bonds payable from the revenues of the enterprise in its enabling statute. § 25.5-4-402.4(3)(d)(IV).

There is also little doubt that CHASE receives less than 10% of its annual revenue in grants from all state and local governments combined. A "grant" means "any direct cash subsidy or other direct contribution of money from the state or any local government in Colorado which is not required to be repaid." § 24-77-102(7)(a). A grant specifically does not include any "revenues resulting from rates, fees, assessments, or other charges imposed by an enterprise for the provision of goods or services by such enterprise." § 24-77-102(7)(b)(II). It also does not include

any "federal funds, regardless of whether such federal funds pass through the state or any local government in Colorado prior to receipt by an enterprise." § 24-77-102(7)(b)(III). CHASE's revenues are generated solely from imposition of the fee and matching federal funds. Aff. of J. Cotosman ¶ 16. As such, it does not receive more than 10% of its annual revenue from state or local government grants. *Id.* ¶ 13.

The primary question before this Court with regard to enterprise status, then, is whether the enterprise is a "business." The starting point for this question is *Nicholl v. E-470 Public Highway Authority*, 896 P.2d 859 (Colo. 1995), where the supreme court observed that "[t]he term 'business' is generally understood to mean an activity which is conducted in the pursuit of benefit, gain or livelihood." *Id.* at 868 (citing *Lindner Packing & Provision Co v. Indust. Comm'n of Colo.*, 60 P.2d 924, 926 (Colo. 1936)). The *Nicholl* court determined that the enterprise there satisfied the definition of "business" when it functioned as the operator of a public roadway, providing access to the road to the public in exchange for collection of fees for that access. *Id.*

The *Colorado Bridge Enterprise* court reached the conclusion that the enterprise challenged there was a business providing a government service for a fee. *Colo. Bridge Enter.*, 2014 COA 106 ¶ 60. The service provided by the enterprise was financing, repairing, reconstructing, and replacing designated bridges. ¶ 3. It further noted the *Nicholl* court's observation "that the payment of a toll for access to a highway is not a competitive market exchange, yet it held that such a transaction is consistent with an enterprise and fits the definition of a business." ¶ 59 (citing *Nicholl*, 896 P.2d at 868).

Thus, a "business" for TABOR enterprise purposes is an activity that is conducted in the pursuit of a benefit, gain, or livelihood. *Nicholl*, 896 P.2d at 868. However, because it is a government-owned business, that benefit, gain, or livelihood can be one that otherwise would be a government undertaking. Charging fees to maintain public roadways and charging fees for

repairing bridges have both been upheld as valid business functions, conducted by valid enterprises, charging valid fees. *Nicholl*, 896 P.2d at 868; *Colo. Bridge Enter.*, 2014 COA 106 ¶ 60.

The enterprise here is no different. The "benefit, gain, or livelihood" provided in exchange for payment of the fee is described above in section II.C.1. In exchange for payment of the fee, hospitals receive a broad array of valuable "benefits" and "gains"—worth billions of dollars. That arrangement is constitutional—even if provided for an otherwise governmental function.

Further, while housed in HCPF, the enterprise is accounted for separately. Aff. of J. Cotosman ¶ 10. Revenues collected by the enterprise are deposited in its cash fund, which is kept separate from HCPF's fund. *Id.* ¶ 11. Matching for Medicaid expenses with federal funds is done within the enterprise's cash fund, and those moneys are never transferred to HCPF's fund or any other fund in the state.[7] Aff. of J. Cotosman ¶ 12. Expenses incurred by the enterprise are paid from the cash fund and not using state funds. *Id.* As such, the enterprise can demonstrate that it is independent from its agency host.

The final question for determining the enterprise's status is subsumed by the earlier analysis in this motion. If the enterprise has the ability to levy a tax, then it cannot be a valid enterprise, but if it funds its operations with fees, it can. *Nicholl*, 896 P.2d at 868–69. As the above analysis shows, the charges here are fees. As such, CHASE is a business because it "pursues a benefit and generates revenue by collecting fees from service users." *Colo. Bridge Enter.*, 2014 COA 106 ¶ 60 (citing *Nicholl*, 896 P.2d at 868). It is a valid enterprise, and is exempt for purpose of TABOR.

[7] The one exception permitted by statute is for the elimination of certified public expenditures. Aff. of J. Cotosman ¶ 12. This exception merely preserves a funding mechanism no longer available after implementing the fee and does not raise revenue. As such, it does not affect enterprise status.

IV. It was unnecessary to adjust the TABOR cap in connection with the creation of CHASE (fifth claim).

Plaintiffs argue that the CHASE enterprise "qualified" as an enterprise in 2017, and, as such, adjustments were required to the Referendum C spending cap. This is wrong for two reasons. First, CHASE was *created* in 2017; it did not "qualify" as an enterprise at that time. Second, the Hospital Provider Fee revenue was *not* included in calculating the Referendum C cap, so establishing CHASE as an enterprise had no effect on the cap.

A. The General Assembly exercised its plenary power to end one program and create a separate enterprise, which did not require an adjustment to the TABOR cap.

TABOR contains a number of limitations on state government. One of those is on the amount of revenue the State is authorized to collect and spend. Aff. of H. Sobanet ¶¶ 6. TABOR requires that the maximum increase in spending over the previous year is inflation plus the percentage change in the state population. *Id.*; COLO. CONST. art. X, § 20(7)(a). This is referred to as the limitation on state fiscal year spending. § 24-77-103, C.R.S. Voters passed Referendum C in 2005. The referendum set a five year time out period—from July 1, 2005 through June 30, 2010—during which the State was authorized to keep all revenue it raised. § 24-77-103.6. The year with the highest revenue in the time out period established the new excess state revenues cap, which grows not from the previous year's actual revenue but from the amount of the previous year's cap, plus inflation and change in population. *Id.* The excess state revenues cap, as with the limitation on state fiscal year spending, is also adjusted by debt service changes and the qualification or disqualification of enterprises. *Id.*; COLO. CONST. art. X, § 20(7)(d). Thus, after Referendum C, the State can keep more money than would otherwise have been provided by the original TABOR limitation on state fiscal year spending. The excess state revenues cap is the limit that is now used to determine whether refunds should be issued. Aff. of H. Sobanet ¶ 9.

It is the excess state revenues cap that was adjusted by Senate Bill 17-267 in connection with the creation of CHASE. The amount of the cap was reduced by $200 million. § 24-77-103.6(6)(b)(I)(C). Plaintiffs allege that the cap should have been reduced by a total of $600.6 million because that is the amount of revenue that was projected for the Hospital Provider Fee program. 2d Am. Compl. ¶¶ 164–66. That claim is based on their belief that the creation of CHASE was the "qualification" of an enterprise within the meaning of TABOR.

The phrase "qualification or disqualification of enterprises" is not defined in the constitution, and has not been interpreted by courts. The cases that involve that phrase do not address an agency becoming an enterprise, rather they address "qualifying" in the sense of meeting the TABOR requirements for an enterprise. *E.g., Bd. of Cty. Comm'rs v. Fixed Base Operators, Inc.*, 939 P.2d 464, 468 (Colo. App. 1997) ("Thus, we are not persuaded that the agreement with ECAT constitutes a governmental grant exceeding 10% of ECAT's annual revenues so as to disqualify it as an enterprise."); *Nicholl*, 896 P.2d at 869 n.11 ("We express no opinion concerning whether these entities qualify as enterprises, however.").

The most common scenario in which this situation arises is for the institutions of higher education. For example, during fiscal year 2015-16, Fort Lewis College received more than 10% of its revenue from state grants. Accordingly, it no longer met the TABOR definition of an enterprise, and was disqualified. Aff. of H. Sobanet ¶ 13. The state controller accounted for this disqualification by lowering the limitation on state fiscal year spending and the excess state revenues cap. OFFICE OF THE STATE CONTROLLER, 2016 COLO. COMPREHENSIVE FIN. REPORT 31–32 (2016), available at https://www.colorado.gov/pacific/sites/default/files/CAFR16.pdf, attached as Exhibit F. Then, in fiscal year 2016-17, Fort Lewis College rectified the situation, and again met the requirements to be a TABOR enterprise. At that point it re-qualified, and the controller adjusted the respective limits upward. OFFICE OF THE STATE CONTROLLER, 2017

COLO. COMPREHENSIVE FIN. REPORT 35–36 (2016), available at https://www.colorado.gov/pacific/sites/default/files/State%20of%20Colorado%20CAFR%20FY2017.pdf, Exhibit G.

That is *not* the same scenario as took place with the creation of CHASE. The Hospital Provider Fee program did not suddenly meet the requirements to be an enterprise, nor could it have; the previous statutory framework would not have permitted it to do so. The General Assembly chose to end the Hospital Provider Fee program. It then specifically created a new enterprise and clarified that it was not turning the old program into one. § 25.5-4-402.4(3)(c)(I); Aff. of H. Sobanet ¶ 20. But, as with institutions of higher education, the General Assembly clarified that the enterprise would only qualify for its TABOR-exempt status as long as it met the TABOR enterprise requirements. § 25.5-4-402.4(2)(g).

Plaintiffs have no authority for the proposition that the General Assembly does not have the plenary power to end one program and create a different one. In fact, the General Assembly's action in this regard carries a "heavy presumption of constitutionality." *Barber*, 196 P.3d at 247 (citing *Colo. Ass'n of Pub. Emps. v. Bd. of Regents*, 804 P.2d 138, 142 (Colo. 1990)). This is true unless Plaintiffs can show, *beyond a reasonable doubt*, that the action is unconstitutional. *Dean*, 2016 CO 14 ¶ 8 (citations omitted).

Here, the Plaintiffs cannot clear that bar. TABOR refers to an enterprise qualifying or disqualifying, which by convention has referred to whether the enterprise met the qualifications laid out in the constitution. As a practical matter, that reference has usually referred to whether more than 10% of the revenue of the enterprise has come from state or local governments. Here, there was no enterprise before the creation of CHASE. The Hospital Provider Fee program did not qualify as an enterprise—under its statute it could not have satisfied the constitutional requirements. Nor did the General Assembly turn it into an enterprise. Instead, the General Assembly created a new enterprise. § 25.5-4-402.4(3)(c)(I); Aff. of H. Sobanet ¶ 20. Under these

circumstances, it was not necessary to adjust the excess state revenues cap in connection with the creation of CHASE. *Id.*

B. Hospital Provider Fee revenue was not included in calculating the excess state revenues cap, and it would be inappropriate to lower the cap as a result of that program ending.

Even if Plaintiffs were correct that the General Assembly had to make an adjustment to the excess state revenues cap because there was the qualification of an enterprise, under these circumstances a downward adjustment to the cap would be inappropriate. One of the primary purposes of TABOR is to restrain the growth of government. COLO. CONST. art. X, § 20(1); *see also Bd. of Comm'rs v. City of Broomfield*, 7 P.3d 1033, 1037 (Colo. App. 1999). Case law interpreting this provision points out that the "objective of TABOR is to prevent state and local government from enacting taxing and spending increases above TABOR's *limits* without voter approval." *Olson v. City of Golden*, 53 P.3d 747, 753 (Colo. 2002) (emphasis added); *Campbell v. Orchard Mesa Irrigation Dist.*, 972 P.2d 1037, 1039 (Colo. 1998)("[TABOR]'s objective is to prevent governmental entities from enacting taxing and spending increases above [TABOR]'s *limits* without voter approval.") (emphasis added). Because the Hospital Provider Fee revenue was not used in calculating the cap, the cap—and the state—is in exactly the same position it would have been had the program been set up as an enterprise from the beginning. Aff. of H. Sobanet ¶ 19. Because the focus is on whether or not the limits are changed, and because the statute here doesn't affect the limits, no adjustment to the cap is necessary.

The purpose of adjusting the excess state revenues cap for the qualification or disqualification of an enterprise is to ensure that revenues that were captured are accounted for when those revenues are removed. Aff. of H. Sobanet ¶ 12. Otherwise, when the revenue that was

used to set the cap was removed, the cap would remain artificially high. But the inverse is also true. It would artificially lower the cap to remove revenue that was *not* used in setting it.

For the state programs that did contribute to setting the excess state revenues cap, the General Assembly has converted them to enterprises and made a corresponding downward adjustment to the cap. For example, in 2009 the General Assembly converted the Division of Unemployment Insurance into an enterprise. This division *was* considered in setting the excess state revenues cap. At the time the General Assembly converted the division into an enterprise, it also made a corresponding downward adjustment to the cap. *Id.* ¶ 18. For state fiscal year 2009-10, the TABOR limit was reduced by $424.3 million due to enterprise qualifications. OFFICE OF THE STATE CONTROLLER, 2010 COLO. COMPREHENSIVE FIN. REPORT 27–28 (2016), available at http://www.colorado.gov/pacific/sites/default/files/CAFR10_WithCovers.pdf, Exhibit H.

This shows that the General Assembly treated the Hospital Provider Fee program as different from other programs. With previous programs that were used in setting the excess state revenues cap, the General Assembly qualified the program as an enterprise and adjusted the TABOR limits. Here, it did not. This action reflects the General Assembly's recognition, whether or not stated in the bill, that this situation is different.

That critical difference is that the revenues from the Hospital Provider Fee program weren't contained in the excess state revenues cap calculation. Aff. of H. Sobanet ¶¶ 14-16. Removing them from the picture, whether in 2009 or 2017 does not affect the cap. And it does not affect the permissible size of government as authorized by the voters in Referendum C. As such the General Assembly's choice to end the Hospital Provider Fee program, create a new enterprise, and not adjust the cap is appropriate. *Id.* ¶¶ 20–21. It reflects the reality that the cap—and the size of government—do not change as a result of S.B. 17-267. And it reflects the General Assembly's implicit recognition of that fact.

In essence then, the state government has not "cheated" in calculating any of the applicable limits. There is no question that if a new fee-funded enterprise was created today, its revenue would not count against the excess state revenues cap. That is true whether it was a $3 million program or a $3 billion program. Creating or ending that enterprise would not cause an adjustment to the cap—because the revenue wasn't under the cap to begin with. The Hospital Provider Fee program is the same. The revenue was not used in calculating the cap, and it doesn't need to be removed as a consequence of the program ending. And in either scenario, the cap itself remains completely unchanged. Senate Bill 17-267 does not inappropriately enlarge the cap, and it honors the will of the voters.[8]

As such, there was no *requirement* that the limitation on state fiscal year spending or the excess state revenues cap be lowered. Nonetheless, the General Assembly agreed that it would reduce the excess state revenues cap by $200 million in connection with creation of the enterprise. Aff. of H. Sobanet ¶ 21. However, the legislature's agreement to lower the cap does not reflect a requirement that they lower it further. They have—and have exercised—the power to create a new enterprise that did not require such an adjustment. They have—and have exercised—their function of interpreting TABOR and properly accounting for the applicable caps imposed under law.

V. The methods encapsulated in SB 17-267 accomplish the single subject of the legislation, which is expressed in the title (sixth claim).

The Colorado constitution requires that all bills, except general appropriation bills, contain only one subject, which must be clearly expressed in the title of the bill. COLO. CONST. art. V,

[8] Exhibit K shows the excess state revenues and how removing the Hospital Provider Fee program has no effect.

§ 21. In examining whether a bill violates this section, courts must look at the issue "in light of the language and purpose of the mandate of Article V, Section 21," while also remaining "mindful of the familiar principal that a statute is presumed constitutional and cannot be declared unconstitutional unless that conclusion is established beyond a reasonable doubt." *In re House Bill No. 1353*, 738 P.2d 371, 372 (Colo. 1987). In order to have multiple subjects in violation of the constitution, "the text of the measure must relate to more than one subject and it must have at least two distinct and separate purposes which are not dependent upon or connected with each other." *In re a Proposed Initiative "Pub. Rights in Waters II,"* 898 P.2d 1076, 1078–79 (Colo. 1995) (citing *People v. Sours*, 74 P. 167, 177 (Colo. 1903); § 1-40-106.5(1)(e)(I), C.R.S.; *Catron v. Cty. Comm'rs*, 33 P. 513, 514 (Colo. 1893)).

It is not determinative that the subject of a bill appears to be broad on its face. As long as a bill has a common objective it will survive scrutiny, even if there are multiple methods to implement that objective. If an initiative "tends to effect or to carry out one general object or purpose, it is a single subject under the law." *In re a Proposed Initiative "Pub. Rights in Waters II,"* 898 P.2d at 1079. For example, the supreme court has upheld "concerning the creation of a public right to Colorado's environment" as a single subject. *In re Title, Ballot Title & Submission Clause for 2013-2014 #89*, 2014 CO 66 ¶ 14. The initiative in that case contained several sections, and the court found that they were all properly connected to the general subject expressed in the title. *Id.* ¶ 15. This was true even though some of the sections were implementation methods. *Id.* ¶ 16 (citing *In re 1999-2000 No. 200A*, 992 P.2d at 30 ("Implementation details that are tied directly to the initiative's central focus do not constitute a separate subject.")).

During the 2017 legislative session, the primary strategy that emerged to balance the state budget was to reduce revenues by making cuts to the Hospital Provider Fee program. Aff. of H. Sobanet ¶ 26. The structure of the fee, and its interaction with TABOR, was causing pressure on

the state budget. Hospital Provider Fee revenue was countable for TABOR purposes, and could drive the state revenues over the excess state revenues cap, which would trigger TABOR refunds. But those refunds could not be paid with Hospital Provider Fee because of the federal restrictions on the program. Instead, they would have to be paid from the General Fund the next year. Forcing refunds to be paid out of the General Fund would then put budgetary pressures on a completely different set of programs. *Id.* ¶ 27.

The proposed solution was to cut Hospital Provider Fee program revenue enough to keep the state revenues under the excess state revenues cap. The response from stakeholders was immediate and extreme. The testimony before the legislature confirmed that the impacts of such cuts would be severe. The cuts would disproportionately affect rural Colorado—and rural Colorado hospitals in particular. *Id.* ¶ 28. Senate Bill 17-267 was enacted to create CHASE, designed to provide significant benefits—and avoid significant harm—to rural Colorado. *Id.* ¶ 29.

The language of Senate Bill 17-267 shows that there is a single objective—to address the sustainability of rural Colorado—and multiple parts of a framework to implement that common objective. *Id.* ¶¶ 23-24. The legislative declaration of the act finds that rural Colorado "faces complex demographic, economic, and geographical challenges," which include an older population requiring more medical care, lower wages and incomes, and less adequate transportation infrastructure. S.B. 267 § 1, 71st Gen. Assemb., 1st Reg. Sess. (Colo. 2017) [hereinafter S.B. 17-267]; Aff. of H. Sobanet ¶ 24. The legislation states that its purpose is "to ensure and perpetuate the sustainability of rural Colorado by addressing some of these demographic, economic, and geographical challenges." S.B. 17-267 § 1. The General Assembly further found and declared that "the sustainability of rural Colorado is directly connected to the economic vitality of the state as a whole, and that all of the provisions of this act, including provisions that on their face apply to and affect all areas of the state but that especially benefit

rural Colorado, relate to and serve and are necessarily and properly connected to the general assembly's purpose of ensuring and perpetuating the sustainability of rural Colorado." *Id.*

The remainder of the bill provides implementation methods to achieve these goals. One of the methods designed to support rural Colorado is the lease purchase agreements program. It specifically provides that a minimum amount of the funds raised through the program are to be directed to maintain roads in rural Colorado. S.B. 17-267 §§ 12, 31. As legislators pointed out in handouts provided in committee hearings, "[a]lthough there are more lane-miles in rural areas of the state, the vast majority of the transportation dollars are spent in the populated areas of the state allowing the infrastructure in rural parts of the state to continue to decline." *Sen. Comm. on Fin. Hearing on S.B. 17-267*, 71st Gen. Assemb., 1st Reg. Sess. (Colo. Apr. 11, 2017) (Handout B, *Sustaining Rural Colorado*, by Sen. Sonnenberg, Sen. Guzman, R. K. Becker), available at http://coga.prod.acquia-sites.com/sites/default/files/html-attachments/s_fin_2017a_20170411t140356z2__hearing_summary/17SenateFin0411AttachB.pdf, Exhibit I. That same handout estimated that the bill would permit the state to "bond $1.3 billion for transportation projects in which 25% of that money would be required to be spent in counties with populations of 50,000 or less." *Id.* Thus, the bill addresses an issue with the sustainability of rural Colorado in the form of road maintenance by raising approximately $325 million to address that very problem. This is particularly compelling given the legislator materials showing that traditionally most of those funds would have gone to non-rural areas. *Id.*

Similarly, the use of retail marijuana taxes to fund schools has a nexus to rural Colorado. The Act creates definitions for "large rural districts" and "small rural districts." § 4. It then specifies how the retail marijuana sales tax revenue shall be directed to these two kinds of rural districts. *Id.* In doing so, it directed $30 million to rural Colorado school districts. Aff. of H. Sobanet ¶ 30.

In addition, 17-267 contained provisions that were designed to benefit rural Colorado in particular, even though they facially benefit the entire state. *Id.* ¶ 24. At the time the bill was passed, the rural areas of the state were not experiencing an economic recovery at the same rate as the more urban areas. *Id.* ¶ 31. The bill contained strategies designed to spur growth in those areas in particular. *Id.* ¶ 32. These included the business personal property tax credit, which was designed to benefit small businesses. *Id.* It also included protecting the senior homestead exemption program, particularly since the legislation also lowered the excess state revenues cap. *Id.* This program has a disproportionately high benefit in rural Colorado because those areas of the state have higher aging populations and more stagnant home values. *Id.* Thus, supporting these programs has a greater impact on those communities. *Id.*

Finally, the bill contained provisions regarding controlled maintenance funding for public buildings. A significant proportion of those funds were directed to rural Colorado. These included programs for the Department of Corrections, with correctional facilities in rural areas statewide, the State Fair, Adams State University, Colorado Mesa University, CSU Pueblo, Fort Lewis College, Western State Colorado University, Colorado Northwestern Community College, Lamar Community College, Morgan Community College, Pueblo Community College, and Trinidad State Junior College. Money directed to these institutions supports the rural communities they reside in. *Id.* ¶ 32.

And, as discussed before, there were serious concerns about the impact to rural Colorado hospitals. There were material concerns that some of those rural hospitals would have been forced to close if the General Assembly had to balance the budget through reducing the Hospital Provider Fee program. CHASE was directly targeted at this problem, directly benefitted rural Colorado, and directly avoided this harm.

Taken together, the subsections in the Act are mechanisms that serve to accomplish the purpose the General Assembly expressed in its declaration. The purpose of the bill was "to ensure and perpetuate the sustainability of rural Colorado by addressing some of the[] demographic, economic, and geographical challenges" faced by the region. S.B. 17-267 § 1. The General Assembly further found

> "that the sustainability of rural Colorado is directly connected to the economic vitality of the state as a whole, and that all of the provisions of this act, including provisions that on their face apply to and affect all areas of the state but that especially benefit rural Colorado, relate to and serve and are necessarily and properly connected to the General Assembly's purpose of ensuring and perpetuating the sustainability of rural Colorado."

Id. And, that single subject is reflected in the title.

Conclusion

There are no genuine issues of material fact in this case, and Defendants are entitled to judgment as a matter of law. The enabling statute, purpose for revenue collection, and way that the revenue is spent—in providing benefits and services to the fee-payors—all show that the Hospital Provider Fee and the CHASE Fee are fees and not taxes. CHASE meets the requirements to be a valid enterprise. The General Assembly was not required to adjust the excess state revenues cap, and properly accounted for the revenue when it ended the Hospital Provider Fee program and created CHASE. And Senate Bill 17-267 contains one objective expressed in the title, with a number of supporting methods to implement that objective. Moreover, the Plaintiffs lack standing to bring this suit.

The issues in this case are primarily legal, and those facts that are necessary to reach judgment are undisputed. Defendants are entitled to judgment as a matter of law on all of the claims before this Court, and ask the Court to enter judgment in their favor.

Dated: July 16, 2018

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CERTIFICATE OF SERVICE

I hereby certify that on July 16, 2018, I served a true and correct copy of the foregoing STATE DEFENDANTS' CROSS-MOTION FOR SUMMARY JUDGMENT to each of the following persons through Colorado Courts E-Filing, copied to pro hac vice counsel by email:

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