DATE FILED: August 6, 2018 6:50 PM
FILING ID: 20B84D4EF18BF
CASE NUMBER: 2015CV32305

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.

CYNTHIA H. COFFMAN, Attorney General
JENNIFER L. WEAVER, First Assistant Attorney General*
W. ERIC KUHN, Senior Assistant Attorney General*
Ralph L. Carr Colorado Judicial Center
1300 Broadway, 6th Floor
Denver, CO 80203
Telephone: (720) 508-6145/6143
FAX: (720) 508-6041
E-Mail: jennifer.weaver@coag.gov/eric.kuhn@ coag.gov
Registration Number: 28882/38083
*Counsel of Record

Case No. 2015 CV 32305

Div. 275

RESPONSE TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

CONTENTS

EXHIBITS

Defendants Colorado Department of Health Care Policy and Financing ("HCPF" or the "Department"), 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") submit the following as their response to Plaintiffs' Motion for Summary Judgment. No genuine issue of material fact is disputed and State Defendants are entitled to judgment as a matter of law.

Introduction

Plaintiffs argue that the Hospital Provider Fee and the CHASE Fee are taxes, and not fees, because they are not fee-for-service transactions and because the cost of the fees is not reasonably related to the cost of providing the services. Plaintiffs further argue that CHASE is not a valid enterprise because it has the power to tax, and that there are multiple provisions in S.B. 17-267, which violates the single subject requirement. Finally, Plaintiffs assert that the Excess State Revenues Cap had to be adjusted because CHASE was the "qualification" of the Hospital Provider Fee program.

As the undisputed facts here show, the fee paying hospitals receive services and benefits in exchange for the fees they pay. Supplemental payments increase their reimbursement for services they have provided, expansion populations provide them with an insurance source to bill against and fewer uninsured patients they have to care for, and non-fee paying hospitals are a critical market that fee paying hospitals need to access. The cost of the fee is closely related to the benefits and services—in fact, the programs return many times the value of the fee charged to the fee paying hospitals.

Plaintiffs' sole argument regarding enterprise status is that CHASE cannot be an enterprise because it has the power to tax. Thus, the status of the CHASE enterprise is determined by the answer to the fee v. tax question in this case. Senate Bill 17-267, and the evidence supplied with the State Defendants' Motion for Summary Judgment, shows that there is a single object or purpose in the Act, and multiple methods that tend to effectuate that purpose. As such, it does not violate single subject. Finally, Plaintiffs' materials show that CHASE is a new entity, not the "qualification" of the Hospital Provider Fee program. Contrary to Plaintiffs' conclusion, the fact that CHASE was created "as if by" by a Type 2 transfer shows that it was a new entity and there was nothing to transfer to it.

There are no genuine issues of material fact requiring a trial. As shown below, the defendants are entitled to judgment as a matter of law. Accordingly, the State Defendants ask this Court to deny Plaintiffs' Motion for Summary Judgment, and to grant their own.

Response to Plaintiffs' Enumerated Material Facts

A review of the material facts cited by Plaintiffs shows that there are no genuine issues of material fact and a trial is unnecessary. While there are some inaccuracies, and the following clarifications to Plaintiffs' enumerated material facts are required for context, no genuine issues have emerged. The numbers below correspond to the numbered paragraphs in the material facts section of Plaintiffs' Motion for Summary Judgment.

4. There is no requirement in federal regulation that some hospitals make money and some lose to receive waivers of the broad-based and uniformity requirements. Rather, the federal regulations state that waivers will be issued if the statistical tests at 42 C.F.R. § 433.68(e) are met.

5. House Bill 09-1293 authorized the Department to "charge and collect," not "levy," the Hospital Provider Fee. The proper name of the charge is the "Hospital Provider Fee." § 25.-4-402.3(3)(a), C.R.S.

8. The stated purpose of H.B. 09-1293 is contained in the text of the act and does not reflect the language in Plaintiffs' paragraph 8. § 25.-4-402.3(2), C.R.S. The Hospital Provider Fee program does not work by "increasing the cost of certain hospital services" in the way described in Exhibit 12, which demonstrates a misunderstanding of the program. The way the fee program works is described in the State Defendants' Motion for Summary Judgment. Further, Exhibit 12 does not meet the requirements of C.R.C.P. 56, and the State Defendants object to its use as an evidentiary basis to support a purported fact.

10. The CMS letter determines that the State has met the statistical tests necessary to waive the broad-based and uniformity requirements as to the proposed Hospital Provider Fee collection, but does not determine that the fee "qualified as a 'health care-related tax.'"

11. Fiscal year 2009-10 is outside the scope of this lawsuit, was barred from consideration by TABOR when this suit was filed, and should not be considered in any calculation. COLO. CONST. art. X, § 20(1). The dollar values provided are not the sum of the fees collected from, and supplemental payments made to, hospitals. The correct values of fees net of payments only, calculated from Plaintiffs' exhibits, between years 2010-11 and 2016-17 are:

a. Littleton Adventist Hospital – ($24.62 million)
b. Good Samaritan Medical Center – ($34.16 million)
c. Porter Adventist Hospital – ($28.71 million)
d. Parker Adventist Hospital – ($13.81 million)
e. Sky Ridge Medical Center – ($64.37 million)
f. OrthoColorado Hospital – ($10.64 million)
g. Broomfield Hospital – correct at ($138,939)

13, 14. Fiscal year 2009-10 is outside the scope of this lawsuit and was barred from consideration by TABOR when this case was filed. COLO. CONST. art. X, § 20(1). It should not be considered in any calculation.

16. S.B. 17-267 authorized CHASE to "charge and collect" the fee. S.B. 17-267 § 17.

17. S.B. 17-267 is not the general appropriation "long bill" for state fiscal year 2017-18.

18. The Hospital Provider Fee program collected $654 million in fees in state fiscal year 2016-17. Pls.' Mot. for Summ. J., Ex. 11 at A14 [hereinafter Pls.' MSJ]. The figure cited is the estimate from the fiscal note.

23. While the individuals did not change, their board appointments did. The Hospital Provider Fee Oversight and Advisory Board was abolished, the CHASE Board was created, and these individuals were appointed to the CHASE Board by operation of law. § 25.5-4-402.4(7)(a)(II), C.R.S.

ARGUMENT

I. The Hospital Provider Fee and CHASE Fee are fees and not taxes because the fee payers receive services and benefits in exchange for the fees that are reasonably related to the cost of providing those services and benefits.

Plaintiffs rely heavily on the idea that the Hospital Provider Fee and CHASE Fee are not, in their view, fee-for-service transactions and thus are not fees. Pls.' MSJ at 14. As discussed below in subsection I.B, Colorado law has specifically rejected the idea that a fee can only be charged to those using the service, and that non-fee payers cannot benefit from services funded with a fee. *Colo. Bridge Enter.*, 2014 COA 106 ¶¶ 38–39 (citations omitted); *City of Aspen*, 2018 CO 36 ¶¶ 28, 40. Thus, a fee-for-service transaction is not required of a valid fee.

Even if a strict fee-for-service transaction *were* a requirement for a valid fee, the facts in this case show that fee paying hospitals undoubtedly receive services in exchange for the fees they pay in connection with each of the challenged groups. They would thus be "fee-for-service" as described by Plaintiffs. Accordingly, the Court can find that the fee payers receive benefits in exchange for payment of the fee, and that the fee is reasonably related to the cost of providing those benefits based on the undisputed facts.

A. The fee paying hospitals unquestionably receive benefits in exchange for payment of the fees.

Plaintiffs identify three groups that they believe supports their theory that fee paying hospitals do not receive value in exchange for the fee: (1) hospitals that receive less in supplemental payments than they pay in fee, (2) hospitals that receive supplemental payments but don't pay a fee at all, and (3) non-hospital healthcare providers that receive claims payments but don't pay a fee. They are wrong that these groups show a constitutional violation because the hospitals receive services from each of these groups in exchange for paying the fee.

1. Hospitals receive a service in exchange for paying the fee in the form of supplemental payments.

Hospitals receive a significant array of services and benefits in exchange for the fees that they pay. The first of these is the supplemental payment, which has a number of components and is designed to increase hospital reimbursement for medical services they have already provided. *See* State Defs.' MSJ, Ex. A-9 at A17. This supplemental payment—paid to the hospital on the same banking day the hospital pays the fee—is the most obvious service provided back to fee paying hospitals. For most, it is also a significant benefit. Ex. L ¶ 4; Ex. M ¶¶ 4, 6; Ex. O ¶¶ 5–6; Ex. P ¶¶ 6–7; Ex. Q ¶ 6; Ex. T ¶ 9.

Plaintiffs identify six hospitals, however, that have had a loss in previous years. Pls.' MSJ at 15. Plaintiffs are correct that these hospitals paid more in fee than they received in supplemental payments. But they then argue that "[f]or these hospitals, there effectively was no 'service' provided, as they were not provided a new payer source for uninsured populations and their underpayments were not reduced." *Id.* This argument reflects a fundamental misunderstanding of the way the fee programs work.

First, none of these hospitals is a standalone entity; each belongs to a hospital system. Good Samaritan Medical Center is part of SCL Health, Sky Ridge Medical Center is part of HCA-HealthONE, OrthoColorado Hospital is part of Centura – CHI, and Littleton Adventist Hospital, Porter Adventist Hospital, and Parker Adventist Hospital are all part of the Centura – PorterCare Adventist Health System (PAHS). For each of these hospitals, the appropriate level to examine the payment of fee and receipt of supplemental payments is at the system level. Ex. N ¶ 3; Ex. O ¶ 3; Ex. T ¶ 3; State Defs.' MSJ, Ex. A ¶ 14.

For example, Plaintiffs argue that Sky Ridge Medical Center had a net loss in every year, which totaled $59.3 million over the seven fiscal years at issue here. Pls.' MSJ at 15. Sky Ridge Medical Center is not a separate entity from HCA-HealthONE. Ex. O ¶ 4. The summary exhibit provided by the Department and attested to by the program director, shows the total fee to supplemental payment benefit for the entire system because it is one integrated entity. For federal fiscal years 2010-11 through 2016-17, those at issue in this suit, the HealthONE system netted $93.27 million dollars. State Defs.' Cross-Mot. for Summ. J. Ex. A-2 [hereinafter State Defs.' MSJ]; Ex. O ¶ 6. Thus, even considering the "loss" attributed to Sky Ridge, the corporate entity

participating in the program netted nearly $100 million dollars attributable solely to supplemental payments received through the Hospital Provider Fee program.[1] *Id.*

Most of the other hospitals identified by Plaintiffs show a similar pattern. While an individual hospital may show a loss for some number of years, the system that hospital belongs to received significant benefit from the supplemental payments it received. From the annual reports:[2]

Hospital	Net Hospital Reimbursement (2010-11 – 2016-17)	System	Net System Reimbursement (2010-11 – 2016-17)
Good Samaritan	($34.16 million)	SCL Health[3]	$65.85 million
OrthoColorado	($10.64 million)	Centura – CHI	$169.91 million
Sky Ridge	($64.73 million)	HCA-HealthONE	$93.27 million

Contrary to Plaintiffs' assertions, while these three hospitals each individually showed a net loss over the course these seven fiscal years, the system level posted large net gains during the same time. The facts supplied by the Plaintiffs show, in fact, significant services and benefits to these hospitals.

[1] It is unclear how Plaintiffs arrived at a $59.3 million loss for Sky Ridge based on their exhibits. This suit addresses only fiscal years 2010-11 forward. 2d Am. Compl. at 12. The sum of net reimbursement for Sky Ridge for fiscal years 2010-11 through 2016-17 is -$64.73 million. While the difference is not material, this response will use the underlying data from the annual reports, even when at odds with Plaintiffs' calculations.

[2] The exhibits supplied by hospitals and hospital systems show similar numbers from their financial records. See Exhibit O for HCA-HealthONE, Exhibit S for Centura Health, and Exhibit T for SCL Health.

[3] Good Samaritan was part of the Exempla system in 2010-11 through 2014-15, which then joined SCL Health.

The one variance from this pattern for the hospitals identified by Plaintiffs is in the Centura – PAHS system. While the individual hospitals selected by Plaintiffs posted losses, other hospitals within the system posted net reimbursement gains. Thus:

Hospital	Net Reimbursement (2010-11 – 2016-17)	System	System Reimbursement (2010-11 – 2016-17)
Littleton Adventist	($24.62 million)	Centura – PAHS	($30.71 million)
Porter Adventist	($25.94 million)		
Parker Adventist	($13.81 million)		

While data for the individual hospitals looks significant, it does not reveal the entire picture to the fee payers. The Centura – PAHS system, over seven fiscal years, paid $30.71 million more in fee than it received in supplemental payments. This is because while some hospitals within the system paid more in fee than they received in supplemental payments, others were the opposite. This is the only system or hospital Plaintiffs identify in their motion that paid more in fee than it received in payments. Critically, however, this is not the end of the services provided to the hospitals under the fee program—it is merely one component.

2. Having more insured patients in exchange for paying the fee is also a service to hospitals.

Plaintiffs claim that this loss shows that "there effectively was no 'service' provided, as they were not provided a new payer source for uninsured populations." Pls' MSJ at 15. This is wrong. As described in the State Defendants' Motion for Summary Judgment, hospitals are required under federal law to stabilize and treat anyone presenting at an emergency department for care. 42 U.S.C. § 1395dd; State Defs.' MSJ, Ex. J ¶ 10. If these—or other patients the hospital sees—are uninsured, then the hospital must write off the cost of providing that care. In addition, the hospitals have charity care programs where they provide services at a discount to those who cannot pay. State Defs.' MSJ, Ex. J ¶ 6. Making up this gap between what can be recovered from

patients who cannot pay and the cost of providing services is what is known as the "cost shift." In essence, to stay in business a hospital must make up the loss on patients that pay less than cost with those who do not.

This is one of the key problems that the Hospital Provider Fee program was designed to address. § 25.5-4-402.4(2)(c)(IV), C.R.S. The method of accomplishing this goal is through Medicaid expansion, which is what provides an additional payer source for hospitals to bill against. § 25.5-4-402.4(2)(c)(I), (III). In essence, hospitals were required to treat certain populations of individuals without insurance resulting in uncompensated care. The Hospital Provider Fee program moves some of those individuals to public health insurance. When hospitals treat those individuals they no longer need to write off the cost of care and recover the losses from other payers. Instead, they can bill the Medicaid program. The Hospital Provider Fee, along with federal funds, permits this service to be provided to the hospitals.

As detailed in the State Defendants' Motion for Summary Judgment, approximately 30% of all claims paid for the expansion populations funded by the fee are paid to hospitals. State Defs.' MSJ, Ex. A ¶ 8. For state fiscal year 2016-17, that amounted to $554.97 million dollars that was reimbursed to hospitals for services that otherwise would have been written off or provided as charity care before the program.[4] This additional half billion dollars is paid to hospitals based on the services they are providing to individuals who now have insurance.

The Hospital Provider Fee and CHASE program reports demonstrate how this is a benefit to hospitals based on the amount of uninsured and charity care they have to provide. In calendar

[4] There was $1,849,899,000 paid in expansion population claims in state fiscal year 2016-17. State Defs.' MSJ, Ex. A-9 at A14 (STATE_000243). Of those, approximately 30% of these were paid to hospitals. *Id.* Ex. A ¶ 8.

year 2009, hospitals bore $225.61 million in bad debt and provided $438.43 million in charity care to individuals who were unable to pay for services. *Id.*, Ex. A-9 at A11 (STATE_000240). By calendar year 2016, that amount had decreased to $145.38 million and $147.18 million respectively. *Id.* The hospital community has had to bear $401.03 million *less* in bad debt and charity care than it did seven years before; a reduction of 58%. This reduction, and the corresponding revenue source for the newly insured patients, is a result of the Hospital Provider Fee and CHASE programs. These are direct services provided to fee paying hospitals. Ex. M ¶ 4; Ex. N ¶ 5; Ex. O ¶ 5; Ex. P ¶¶ 9–11; Ex. Q ¶ 4; Ex. R ¶ 4; Ex. S ¶ 7; Ex. T ¶ 7.

Moreover, this is true at the hospital or system level as well. The one instance Plaintiffs identify of a system paying more in fee than it received in supplemental payments over all years is the Centura – PAHS system. However, adding in expansion claims payments—which would not exist without the fee program—quickly flip the benefit to a positive.

In fiscal year 2016-17, Centura – PAHS paid $63.07 million in Hospital Provider Fee and received total supplemental payments totaling $51.06 million. This means that only considering fee and supplemental payments appears to show a loss of $11 million for the fiscal year. However, a portion of the types of expansion claims they received, for a portion of the populations supported by the fee, add an additional $30.44 million in reimbursement. Ex. K ¶¶ 4–8. Considering these two measures:

	Supplemental Payments	$ 51.06 million
Plus:	Expansion Claims	$ 30.44 million
Less:	Fee Paid	$ 63.07 million
		$ 18.43 million

For fiscal year 2016-17, Centura – PAHS received less in supplemental payments than it has paid in fee, but, in fact, still received a net benefit of at least $18.43 million. It is hard to argue that

a hospital system that receives more than $18 million dollars in net benefit has not received anything in exchange for the fee it paid to support the program. Ex. S ¶ 11.

3. Hospitals also receive services from the fee programs in the form of access to LTAC and rehabilitation hospitals.

The next group of services challenged by Plaintiffs is those hospitals who do not pay a fee, but do receive supplemental payments. Pls.' MSJ at 16. Plaintiffs assert this arrangement shows that "the charges paid and the services rendered [are] disconnected from one another." *Id.* at 17. This is not the case.

There are three types of hospitals that are exempt from paying fees: free standing psychiatric hospitals, long term acute care (or long term care) ("LTAC") hospitals,[5] and rehabilitation hospitals. State Defs.' MSJ, Ex. A-9 at A16 (STATE_000245). Of those, psychiatric hospitals are not eligible to receive any supplemental payments. *Id.* at A16–A17 (STATE_000245–46.) It is only LTAC and rehabilitation hospitals that don't pay the fee but receive supplemental payments.

Yet these payments *are* still a benefit to fee paying hospitals. The LTAC and rehabilitation hospitals serve a vital and unique role in the health care industry. They provide care to individuals who no longer need an acute hospital level of care, but nor are they ready to return home or to another setting. Hospitals must have access to this intermediate level of care. Otherwise, patients cannot be discharged and must be kept, even though they could be served elsewhere.

The supplemental payments made to long term acute care and rehabilitation hospitals helps ensure two things: (1) that this setting continues to exist and (2) that hospitals in this space are

[5] Long term acute care hospitals are licensed as general hospitals and certified by Medicare as long-term care hospitals. Both long term acute care hospital and long term care hospital are used in various materials to describe this same type of entity.

willing to accept Medicaid clients. Supplementing the reimbursement for services provided to Medicaid patients helps ensure that these hospitals are willing to take Medicaid patients upon discharge from fee paying hospitals. Ex. M ¶ 5; Ex. N ¶ 6; Ex. O ¶ 7; Ex. Q ¶ 5; Ex. R ¶ 5; Ex. S ¶ 8; Ex. T ¶ 8. This helps to ensure that hospitals efficiently move individuals to appropriate settings and free up beds that are needed by other individuals. Thus, maintaining this market, and access to it, is a benefit to fee paying hospitals. *Id.*

4. Hospitals also receive fee program services when payments are made to non-hospital providers for expansion clients.

Importantly, the healthcare industry is not siloed—it is a community of interconnected entities. Any provider that affects the health of a patient can affect the costs of a hospital later seeing that patient. Changes to one part of the equation will affect the other entities in the web.

This is the manner in which payments to non-hospital providers for expansion clients can benefit fee paying hospitals. As previously described, hospitals are required to take patients who present at emergency departments for stabilization and treatment. 42 U.S.C. § 1395dd. Individuals without insurance may defer seeking treatment and, as a consequence, may be sicker and have greater need when they arrive at the emergency department under these circumstances. State Defs.' MSJ, Ex. D ¶ 9. This also translates into more expensive care. *Id.*

Medicaid expansion can change this dynamic. Individuals who were uninsured but now have coverage do not need to wait to seek treatment for medical conditions. They now have the option of consulting a primary care physician, and seeking earlier intervention for an illness. As a result, individuals without excess means do not have to wait until they are sick enough to present to an emergency department where they must be provided care.

While these newly covered individuals are now a source of revenue rather than write off for hospitals, Medicaid is still not the most lucrative payer. It is a benefit to hospitals to ensure that they can provide services to individuals in a less expensive setting.

B. There is no requirement that a fee be part of a fee-for-service transaction in order to be constitutional.

As these materials show, Plaintiffs are incorrect in their theory that hospitals do not receive benefits and services if they receive less in supplemental payments than they pay in fees, from program payments to non-fee paying hospitals, and from claims payments to non-hospital providers. Ex. L ¶¶ 3–5, 8; Ex. M ¶¶ 3–6, 9, 11–12; Ex. N ¶¶ 5–6, 9; Ex. O ¶¶ 5–7, 10, 12; Ex. P ¶¶ 6–11, 13; Ex. Q ¶¶ 4–6, 9, 11–12; Ex. R ¶¶ 4–5, 8, 10; Ex. S ¶¶ 6–8, 11–13; Ex. T ¶¶ 7–9, 12, 14. But moreover, they are not correct in their assertion that a transaction has to be fee-for-service in the manner they suggest in order to be constitutional.

Plaintiffs' primary argument is that "a fee is proper when it is 'imposed only on those *using the services* provided[.]'" Pls.' MSJ at 15 (citing *Bruce v. City of Colorado Springs*, 131 P.3d 1187, 1192 (Colo. App. 2005)). They assert that since there are hospitals and non-hospital providers who received payments from the program, but didn't pay the fees, that shows that the transaction is not fee-for-service. Pls.' MSJ at 16–17.

Yet *Bruce* does not stand for the proposition that fees are only proper when they are imposed on those using the services. That statement is a reference to the reason that "charges for use of a public facility owned by a municipality are not ordinarily considered taxes." 131 P.3d at 1192. Rather, the case turned on the distinction between a fee, which "is a charge imposed on persons or property to defray costs of a particular government service," and a tax, which "is a means of distributing the general burden of the cost of government, rather than an assessment of benefits."

Id. at 1190 (citing *E-470 Pub. Highway Auth. v. 455 Co.*, 3 P.3d 18 (Colo. 2000); *Thorpe v. State*, 107 P.3d 1064 (Colo. App. 2004)).

The court went on to state that "[u]nder Colorado law, an ordinance creating a special fee will be upheld as long as the ordinance is reasonably designed to defray the cost of the particular service rendered by the municipality." *Id.* Notably, fees can be charged for what would otherwise be governmental functions. For example, the following fees have been upheld:

Transportation Utility Fees
Storm Drain and Flood Management Fees
Storm Drainage Fees
Water System Fees
Airport User Fees
Highway Expansion Fees
Public Transportation Fees
Sewer System Fees
Building Permit Fees

Id. (citing *Bloom v. City of Fort Collins*, 784 P.2d 304 (Colo. 1989); (upholding transportation utility fees); *Krupp v. Breckenridge Sanitation Dist.*, 19 P.3d 687 (Colo. 2001); (upholding wastewater treatment fees); *E–470 Pub. Highway Auth. v. 455 Co.*, 3 P.3d 18 (Colo. 2000) (upholding highway expansion fees); *City of Littleton v. State,* 855 P.2d 448 (Colo. 1993) (upholding storm drain and flood management fees); *Anema v. Transit Constr. Auth.,* 788 P.2d 1261 (Colo. 1990) (upholding public transportation fees); *Zelinger v. City & County of Denver*, 724 P.2d 1356 (Colo. 1986)(upholding storm drainage fees); *Loup–Miller Constr. Co. v. City & County of Denver*, 676 P.2d 1170 (Colo. 1984) (upholding sewer system fees); *City of Arvada v. City & County of Denver*, 663 P.2d 611 (Colo. 1983)(upholding water system fees); *Bainbridge, Inc. v. Bd. of County Comm'rs*, 964 P.2d 575 (Colo. App. 1998)(upholding building permit fees); *Thrifty Rent–A–Car Sys., Inc. v. City & County of Denver*, 833 P.2d 852 (Colo. App. 1992)(upholding airport user fees); *Westrac, Inc. v. Walker Field*, 812 P.2d 714 (Colo. App. 1991) (similar)).

Nor was the fee in *Bruce* a strictly fee-for-service arrangement. For the street light program, which had previously been supported by general fund, the city calculated the total overall cost of running the program. *Id.* at 1190. It then assessed the charges based on a ratio of commercial and residential property use within the city. *Id.* In fact, as the dissent pointed out, some property owners would have to pay the fee even though they received no service from the street lights, and some commercial property owners would pay more in fee even though they had less need for lighting. *Id.* at 1194 (Graham, J. dissenting). Despite these facts, the majority found that the "street light charge is reasonably related to the overall cost of operating street lights" and upheld the program on that basis. *Id.* at 1191.

The idea that a fee can only be charged to one who uses a service has also been specifically rejected by the court of appeals before. In *TABOR Foundation v. Colorado Bridge Enterprise*, 2014 COA 106, the court examined the bridge safety surcharge that was used to support the Colorado Bridge Enterprise. ¶ 3. During trial, the parties presented evidence that twenty-seven counties in Colorado did not have bridges that were covered by the program, and that there were no plans to repair or replace any bridges in Grand County. ¶ 12. Two TABOR Foundation members from Grand County objected to the surcharge. ¶ 13. In at least one case, the member had a vehicle that never left the county and, thus, never used a supported bridge. *Id.* There, as here, the TABOR Foundation argued that the bridge safety surcharge was a tax because some people had cars registered in counties with no bridges and, thus, "the surcharge is imposed upon persons who do not receive the benefit of [Colorado Bridge Enterprise]'s services or utilize its bridges." ¶ 37.

The court summarized the Foundation's argument as "essentially contend[ing] that the service must be utilized *only* by those who must pay the charge or alternatively by *all* those who must pay the charge." ¶ 38. The court rejected this assertion, observing that a fee can be imposed for street maintenance but with no benefit to any particular property, and that it appeared that

fees "may be charged to persons who may not utilize the service at all." ¶¶ 38–39 (citing *Bloom*, 748 P.2d at 309–11; *Loup-Miller Constr. Co.*, 676 P.2d at 1170; *Anema*, 788 P.2d at 1267).

The court concluded that "[e]ssentially, as long as a charge is reasonably related to the overall cost of providing the service and is imposed on those who are reasonably likely to benefit from or use the service, the charge is a fee and not a tax." ¶ 40. It further noted that "nothing in *Barber* instructs that the failure to provide a service to each individual or all individuals charged automatically renders a charge a tax." ¶ 42. The court instead found that even if it "were to conclude that there must be some kind of direct connection or nexus between the services provided and the individual's use of those services," it would not have found that factor as outcome determinative in that case. *Id.*

Similarly, a fee is not converted into a tax because non-fee payers receive a benefit from the program. In *Colorado Union of Taxpayers Foundation v. City of Aspen*, 2018 CO 36, the supreme court examined a fee-based program where grocery store customers paid a $0.20 fee for each paper bag they used. ¶ 4. The program provided a broad array of services in return. ¶ 7. The "benefits of the waste reduction program are shared by citizens and visitors to Aspen who never pay the charge because they never use a paper bag." ¶ 30. The court noted that these facts did not make the fee into a tax, and that it has "previously held that a charge may incidentally benefit the general public without becoming a tax." *Id.* (citing *Barber*, 196 P.3d at 250 n.15). The court's focus was not on whether non-fee payers received any benefits from the program. *Id.* Rather, it was focused on whether the charge bore a reasonable relationship to the cost of the services. *Id.*

Thus, even if some hospitals were not receiving services in return for the fee, that would not automatically convert the fee into a tax. Rather, a hospital need only be reasonably likely to benefit from paying the fee in order for it to be valid. ¶ 43. As demonstrated through the materials attached to the State Defendants' Motion for Summary Judgment and this response, each

hospital receives direct and significant benefit in exchange for the fee. Ex. L ¶¶ 3–5, 8; Ex. M ¶¶ 3–6, 9, 11–12; Ex. N ¶¶ 5–6, 9; Ex. O ¶¶ 5–7, 10, 12; Ex. P ¶¶ 6–11, 13; Ex. Q ¶¶ 4–6, 9, 11–12; Ex. R ¶¶ 4–5, 8, 10; Ex. S ¶¶ 6–8, 11–13; Ex. T ¶¶ 7–9, 12, 14. But not only are the fee paying hospitals reasonably likely to benefit from paying the fee, they are, in fact, enjoying those benefits. The proper inquiry here is whether the fee payer receives benefit from the fee, and whether there is a reasonable relationship between the fee and the cost of the benefits. The answer to both questions is yes. Indeed, even under the Plaintiffs' artificially stricter standard, every fee paying hospital still benefits from the fee.

C. There is a reasonable relationship between the Hospital Provider Fee and the CHASE Fee and the cost of services provided in exchange.

Plaintiffs rightly assert that there must be a reasonable relationship between the fee being charged and the cost of the service being provided with the fee. Pls.' MSJ at 18. But they then try to draw a line between the cost of a service itself, and the administrative overhead associated with providing that service. *Id.* at 20. They argue that while the administrative overhead of the Department or CHASE are appropriate as "costs," supplemental payments, expansion population funding, and revenue loss offsets are not. These non-administrative costs Plaintiffs categorize as "expenditures." *Id.* at 21. These, they argue, are not costs to the Department or CHASE, should not count, and therefore make the amount of the fee collection unreasonable. *Id.* 20–21. This argument is wrong, and their effort must fail.

1. The appropriate charges for services provided in exchange for the fee are much broader than urged by Plaintiffs.

First the argument confuses the cost of the service or benefit itself with the administrative overhead necessary to provide the service or benefit. Plaintiffs focus on statutory approval to

"pay the administrative costs to the state department in implementing and administering" the fee program" and argue that those are the only acceptable costs. Pls.' MSJ at 20. But that misses the entire point. The remaining language in the statute lists the services themselves that the Department or CHASE can provide using the fee funds, including (1) increasing reimbursement to hospitals for providing medical care; (2) increasing the number of individuals covered by public insurance to reduce the amount of uncompensated care hospitals must provide, and, for CHASE, to (3) provide additional business and consulting services. H.B. 09-1293 § 1, 67th Gen. Assemb., 1st Reg. Sess. (Colo. 2009), codified at § 25.5-4-402.3(3)(a), C.R.S. [hereinafter H.B. 09-1293]; S.B. 17-267 § 17, 71st Gen. Assemb., 1st Reg. Sess. (Colo. 2017); § 25.5-4-402.4(4)(a), C.R.S. [hereinafter S.B. 17-267].

Plaintiffs' argument is akin to saying that the Colorado Bridge Enterprise could pay for its administrative staff, but couldn't pay contractors to fix bridges. Or that the City of Aspen could fund staff to provide education, but couldn't buy reusable bags to give away or provide recycling containers. In all of these cases, including the fees here, both the cost of the ultimate service and the cost of providing that service are permissible. *City of Aspen*, 2018 CO 36 ¶ 30; *Colo. Bridge Enterprise*, 2014 COA 106 ¶ 44; *see also Bainbridge*, 964 P.2d at 577 (viewing direct costs and indirect costs as "part of the 'overall costs' required to operate that department"). The line that Plaintiffs attempt to draw would make staff salaries and information technology costs acceptable, but the actual costs of the services unacceptable. That line would make fees meaningless and must be rejected.

2. Supplemental payments and expansion population costs are all costs to the department and the enterprise, in addition to being services to the hospitals.

Second, supplemental payments and claims payments for expansion populations are undoubtedly costs for the Department or CHASE. As each year's annual report shows, the

Department or CHASE spends the funds that it receives. For example, in state fiscal year 2016-17, the Department spent a total of $2,905.03 million, including $979.91 million on supplemental payments and $1,849.90 million on expansion populations. State Defs.' MSJ, Ex. A-9 at A14 (STATE_000243).[6] For the corresponding same period, the Department collected $654 million in fees. *Id.* Simply put, the fees were spent providing services to the fee payers, and were not retained. Both "costs" and "expenditures" are acceptable if they are spent in support of providing services to those who pay the fees.

Plaintiffs' motion also contains an inaccuracy in its description of supplemental payments, indicating that they "relate to funds that the Department obtained from state general fund appropriations and federal matching funds." Pls.' MSJ at 21. This is incorrect on the face of the law, which specifies that the fees—not the General Fund—are to be used to provide supplemental payments. §§ 25.5-4-402.3(4)(B)(I), 25.5-4-402.4(5)(b)(I), C.R.S. The reference to General Fund expenditures could not be located in Plaintiffs' Exhibit 12. Regardless, that exhibit does not comply with the requirements of C.R.C.P. 56 and cannot serve as evidentiary support for Plaintiffs' assertion. The Department's sworn exhibits demonstrate that supplemental payments were made with fees, a fact Plaintiffs cannot rebut. *E.g.* State Defs.' MSJ, Ex. A-9 at A14 (STATE_000243).

[6] Contrary to Plaintiffs' contention, the CHASE's first report does not show that its programs are the same as the Hospital Provider Fee program. Pls.' MSJ at 20 n.8. The report indicates that it is produced both by the Department and CHASE, and that it contains information wrapping up the Hospital Provider Fee program for historic and reference purposes. State Defs.' MSJ, Ex. A-9 at 3 (STATE_000225).

3. Federal funds are a necessary and integral part of the fee programs and are services provided to hospitals.

Third, Plaintiffs assert that accessing federal funds for the expansion populations cannot count as a service because the Department is only a conduit for the federal funds and because it could have chosen to expand Medicaid in another way. This argument does not go to the reasonableness of the fee, but rather represents a disagreement with the choices made by the legislature. But our supreme court has held that "[b]ecause the setting of rates and fees is a legislative function that involves many questions of judgment and discretion, we will not set aside the methodology chosen by an entity with ratemaking authority unless it is inherently unsound." *Krupp v. Breckenridge Sanitation Dist.*, 19 P.3d 687, 694 (Colo. 2001) (citing *Bennet Bear Creek Farm Water & Sanitation Dist. v. City & Cnty. of Denver*, 928 P.2d 1254, 1268 (Colo. 1996)). The question before this Court is not whether the legislature could have made a different choice, it is whether the choice the legislature made is constitutional, as presumed.

Accepting the program as it is, access to federal funds for the expansion populations is made possible as a result of the fee programs. The fee paying hospitals receive massive benefit from the expansion itself and from access to the federal funds made possible by the program as detailed above in Section I.A. The fee paying hospitals unquestionably received benefit from these services. The funds are only available in connection with this program, and there is no reason they should not "count" as a benefit or service merely because they are federal in nature.

Plaintiffs' argument also suffers from a misunderstanding of how the matching federal funds works. For a given type of expenditure, the federal government pays a portion of each charge as a percentage, known as the Federal Medical Assistance Percentage or FMAP. The state pays the remaining portion of the charge. The FMAP varies not only by year, but also by the type of charge being submitted.

Plaintiffs assert that the federal government paid one hundred percent of expansion claims and therefore there was no cost to the department. Pls.' MSJ at 21. But this is not right. Administering the expansion populations involved, and continues to involve, a number of expenses at different FMAPs. For example, installing or adapting claims processing and information retrieval systems to work with the populations has an FMAP of 90%, maintaining those same systems is matched at 75%, and other activities are matched at 50%. 42 C.F.R. § 433.15. These expenses must be paid by the state, or CHASE, in order to access the federal funds. The fee programs are not mere conduits for the federal money—there is significant state investment in time and resources in order to make the funds available and pay them out appropriately.

As to the expansion populations themselves, Plaintiffs brush aside the five percent claims investment in order to obtain the federal matching funds. The most recent annual report shows total expansion population expenditures of $1,849.90 million. State Defs.' MSJ, Ex. A-9 as A-14. Purely as an example, because the actual numbers would be far more complicated as described above, at a 95% FMAP it would cost $92.49 million to obtain the $1,849.90 million, and hospitals would receive $554.97 million of that total. That would be a 6 times return on investment for the fees charged to hospitals, as well as being a significant benefit to the fee paying hospitals. Ex. M ¶ 4; Ex. N ¶ 5; Ex. O ¶ 5; Ex. P ¶¶ 9–11; Ex. Q ¶ 4; Ex. R ¶ 4; Ex. S ¶ 7; Ex. T ¶ 7.

4. The revenue loss offset is an administrative expense of the fee programs because they unavoidably displaced the prior source of those funds.

Plaintiffs' final argument in this section is that the revenue loss offset in the statutes is not a cost because it is revenue to the Department and is not relevant. Pls.' MSJ at 22. This expenditure of fee is authorized to offset the loss of any federal matching funds due to a decrease in the certification of public expenditures (CPE) process. §§ 25.5-4-402.3(4)(b)(VII), 25.5-4-402.4(5)(b)(VII), C.R.S. The process is one way in which the state can access federal

funds. Federal law permits the state to claim qualifying expenditures made by local governments as the state share of Medicaid expenditures. 42 U.S.C. § 1396b(w)(6)(A). So, for example, if a county hospital fully pays for the cost of providing a Medicaid-covered administrative activity, it can certify that expenditure to the state and the state can collect matching federal funds.

The CPE process cannot coexist with the fee programs. *Id.* Once the state implemented the Hospital Provider Fee program, it lost access to the federal funds otherwise made available through CPEs. The revenue loss offset authorized by statute replaces the lost federal funds as an administrative cost of the program. § 25.5-4-402.3(4)(b)(VII), C.R.S. The enterprise statute continued this authorization. § 25.5-4-402.4(5)(b)(VII), C.R.S. This is, however, a valid cost of implementing the program. As a consequence of the intricacies of federal law in this area, one cost of implementing the fee program was the loss of $15.7 million per year in federal funds. The General Assembly recognized this loss as an ongoing administrative expense, which does nothing more than make the program revenue neutral.

Examining all of these points shows that the fee bears a "reasonable relationship to the direct or indirect costs of the government of providing the service or regulating the activity." *City of Aspen*, 2018 CO 36 ¶ 23. First the Department, and now CHASE, collects the fee. It does not keep the fee, but rather matches it with federal funds and spends it on providing services to the hospitals: supplemental payments, fewer uninsured, a payer source to bill against, and administrative costs. These costs are reasonably related to the services provided, making the fees actual fees and not taxes.

II. Plaintiffs' argument that CHASE is an unlawful enterprise because it has the power to tax is subsumed in the question of whether the fee is a fee or a tax.

Plaintiff's Fourth claim for relief asserts that CHASE is an unlawful enterprise. An enterprise, for purposes 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). The power to tax is inconsistent with the characteristics of a business. *Nicholl v. E-470 Pub. Hwy. Auth.*, 896 P.2d 859, 873 (Colo. 1995).

In their second amended complaint, and the title of section I.C of their Motion for Summary Judgment, Plaintiffs assert that CHASE does not operate like a business. Pls.' MSJ at 25–26; 2d Am. Compl. ¶¶ 61, 148. They argue that CHASE is not a valid enterprise—and does not operate like a business—because the CHASE Fee is a tax rather than being a valid fee. Pls.' MSJ at 26–27. Because Plaintiffs' sole rationale for CHASE not being a business—or an enterprise—is based on whether the fee it charges is a tax, this argument is subsumed by that made in section I of this response.

III. The methods in S.B. 17-267 tend to carry out the general object of sustaining rural Colorado and, accordingly, the Act survives constitutional single-subject scrutiny.

Plaintiffs concede that S.B. 17-267 expresses, to use the language of the test they construct, one unifying subject and a purpose or modification of that subject that passes scrutiny. Pls.' MSJ at 30–31. Their challenge is centered in their belief that the various provisions do not directly relate to the sustainability of rural Colorado. *Id.* at 31. This is so, they believe, because several of the provisions apply to the entire state and are not limited to rural Colorado. *Id.*

However, if a bill "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 1076, 1079 (Colo. 1995). There is no constitutional prohibition on the measure benefitting the state more broadly, nor requiring the benefit to flow exclusively to rural Colorado; merely that the methods in the bill "tend to effect or carry out one general object or purpose." *Id.* As long as a bill has a common objective it will survive scrutiny, even if there are multiple methods to implement that objective. And the subject can be general, or broad, so long as there is only one subject. *In re Title, Ballot, and Submission Clause, and Summary for 1999-00 #256*, 12 P.3d 246, 253 (Colo. 2000).

Here, the various methods in the bill tend to carry out the general purpose of sustaining rural Colorado, even if there are ancillary benefits elsewhere. As the bill itself observes, rural Colorado "faces complex demographic, economic, and geographic challenges including: (I) an older population that require more medical care; (II) Less robust and diverse economic activity and associated lower average wages and household incomes; and (III) Greater challenges, due to distance and less adequate transportation infrastructure, in accessing critical services such as health care." S.B. 17-267 § 1. The stated purpose of the legislation was "to ensure and perpetuate the sustainability of rural Colorado by addressing some of these demographic, economic, and geographical challenges." The General Assembly also 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 evidence supplied with the State Defendants' motion show *how* those items that appear disconnected, or to benefit the whole state, have a disproportionately positive impact on rural

Colorado. For example, how the business personal property tax has a disproportionate impact in sustaining rural Colorado because that portion of the state had a slower recovery and less robust and diverse economic activity. State Defs.' MSJ, Ex. B ¶ 23; S.B. 17-267 § 1. Or how creating CHASE avoided cuts to rural Colorado, particularly to hospitals, and helped alleviate the greater challenges they have in accessing rural health care. State Defs.' MSJ, Ex. B ¶ 29–30; S.B. 17-267 § 1. Nor are these empty gestures. CHASE benefits hospitals state wide, but for rural hospitals the impact is particularly great. As one rural hospital put it, "these funds support critical life or death services." Ex. Q ¶ 5. Without CHASE, another could not survive, and this program is "important in ensuring that [it] can continue to provide quality medical care to rural Colorado." Ex. M ¶ 11.

Senate Bill 17-267 has one general object or purpose, which is expressed in its title. The bill details why its methods are employed to accomplish that goal, even if they also benefit other areas of the state. In doing so, it satisfies the constitutional single subject requirement. And contrary to Plaintiffs' characterization of the bill as a "transparent ruse," Pls.' MSJ at 27, the funds the bill makes available are a matter of life or death for rural Colorado.

IV. It was unnecessary to adjust the Excess State Revenues Cap because CHASE is a different entity from the Hospital Provider Fee program.

1. The Hospital Provider Fee program and CHASE are separate programs and entities.

Plaintiffs select a number of similarities between the Hospital Provider Fee program and the CHASE enterprise in support of the argument that they are the same program. They claim that "both charges were enacted with identical legislative findings." Pls.' MSJ at 34. While the first portion of the legislative findings are mostly the same but not identical, S.B. 17-267 contains an additional eight paragraphs of findings connected to the enterprise.

Plaintiffs then highlight the services provided by CHASE that are the same as the Hospital Provider Fee program, adding that S.B. 17-267 has only one additional objective: to provide certain business consulting services to hospitals." *Id.* This "one additional objective" is the source of considerable difference between the two bills. It comprises a significant source of services that can be provided by CHASE that were not provided by the Hospital Provider Fee program, including: (1) consulting with hospitals regarding cost efficiency and patient safety; (2) advising hospitals regarding potential changes to state and federal law related to reimbursement; (3) providing coordinated services to hospitals to help the transition and adapt to new systems; (4) providing any other services to hospitals that aid them in efficiently and effectively participating in the enterprise programs; (5) providing funding for, and supporting hospitals in, a delivery system reform incentive payment program. § 25.5-4-402.4(4)(a)(IV), C.R.S. Plaintiffs disregard these additional services, yet they are unquestionably unique to CHASE.

The next challenge argues that the programs are the same because both programs charge fees, require federal approval, and authorize federal waivers. Pls.' MSJ at 34–35. But this does not mean that they are the same program; it reflects the reality of participation in federal programs. The General Assembly can begin, end, restructure, and transfer state programs, but when a federal funding source is involved then federal requirements must be met. The source of matching funds here is federal, the federal approval of the methodology is required to receive those funds, and the waiver of certain requirements is authorized by federal law in connection with those funds. 42 C.F.R. § 433.68. Yet the reality of those extrinsic constraints cannot be the determining factor in whether the state programs are the same. A careful review of the statutes reveals not only similarities, but also significant differences between the programs.

2. The creation of CHASE "as if by" Type 2 transfer provides supports that it is a separate entity.

Plaintiffs next argue that the General Assembly signaled the continuation of the Hospital Provider Fee program because it was transferred to the Department by a Type 2 transfer. Pls.' MSJ at 36. This is incorrect for several reasons.

First, the General Assembly did not say that the Hospital Provider Fee program was transferred to CHASE by a Type 2 transfer. What it said was CHASE "shall exercise its power and perform its duties and functions *as if* the same were transferred by a Type 2 transfer." S.B. 17-267 § 6, codified at § 24-1-119.5(9), C.R.S. It is important that no program *was* transferred, because a new program was being created and there was nothing to transfer. It is to be treated *as if* it were transferred by a Type 2 transfer to help define where it fits in the Colorado state government organizational structure.

The Administrative Organization Act of 1968 supports this view. A Type 2 transfer "means the transferring of all or part of an existing department, institution, or other agency to a principal department established by" the Act. § 24-1-105(2), C.R.S. If a new program is being created, it cannot meet this definition, which requires an existing program to transfer. Instead, the General Assembly creates a new program and requires it to be treated as if it had existed and were transferred by a Type 2 transfer. In the context of an enterprise, this specifies that certain functions specified in statute are assigned to the principal agency it exists within, and that they may be exercised by that agency's executive director.[7] § 24-1-105(2), (4), C.R.S.

[7] The choice of a Type 2 transfer was likely driven by nothing more than the connection of CHASE to the Medicaid program and the requirement in federal law that there is a single point of oversight for that program. 42 U.S.C. § 1396a(a)(5).

Moreover, S.B. 17-267 reinforces this interpretation, because the General Assembly has used references to administrative transfers with precision in the Act. The Oversight and Advisory Board was the entity that oversaw many functions of the Hospital Provider Fee program. § 25.5-4-402.3(6). That board consisted of a number of gubernatorial appointees that served with the consent of the senate. *Id.* After the implementation of CHASE, this oversight board was no longer necessary. The General Assembly transferred the powers, duties, and functions of that board to CHASE by a Type 3 transfer and then abolished the board. § 25.5-4-402.4(7)(a)(II), C.R.S. A Type 3 transfer, unlike a Type 2, does not permit a transfer and abolition of part of an agency. It "means the abolishing of an existing department, institution, or other agency, and the transferring of all or part of its powers" to the head of the principal department where it has been transferred. A Type 3 transfer makes sense under these facts, since the Department had to wrap up the Hospital Provider Fee program and pay trailing claims, and because the whole board was being abolished. § 25.5-4-402.7, C.R.S.

Thus, the General Assembly used the right terms in the right places. When it completely abolished an advisory board, it did so with a Type 3 transfer and gave the Department's executive director the power to wrap up the Hospital Provider Fee program. When it created a new enterprise, as it specified in the statute, it did not transfer an existing program. Instead, it clarified the relationship of the enterprise to the department in which it resides, defining it *as if* the enterprise had been transferred by a Type 2 transfer. Contrary to Plaintiffs' argument, these points strengthen the General Assembly's intention to create the enterprise as a new undertaking. The General Assembly meant what it said: it ended the Hospital Provider Fee program and created the CHASE program. It did not convert one into the other.

3. A reduction in the Excess State Revenues Cap was not required under these circumstances.

The State Defendants' Motion for Summary Judgment explains why it was unnecessary to reduce the Excess State Revenues Cap. Primarily this is because the creation of CHASE here was not a "qualification" within the meaning of TABOR, and even if it were, lowering the cap would be inappropriate because the Hospital Provider Fee revenue was never included in calculating the cap in the first place.

Plaintiffs' motion is primarily premised on the General Assembly's "admission" that "a downward adjustment was warranted" in connection with creating the enterprise. Pls.' MSJ at 39. The General Assembly certainly did indicate that it believed it was appropriate to lower the cap by $200 million because more General Fund money would be available after the Hospital Provider Fee program was repealed. § 25.5-4-402.4(3)(c)(II), C.R.S. However, it also clearly and unmistakably declared its intention that the

> "repeal of the Hospital Provider Fee program, as it existed … before its repeal, … and the creation of the Colorado Healthcare Affordability and Sustainability Enterprise as a new enterprise … [is] a new enterprise for purposes of [TABOR], does not constitute the qualification of an existing government-owned business as an enterprise for purposes of [TABOR], and, therefore, does not require or authorize adjustment of the state fiscal year spending limit calculated pursuant to [TABOR] or the Excess State Revenues Cap."

§ 25.5-4-402.4(3)(c)(I), C.R.S. Whether Plaintiffs agree with this characterization, it cannot be said that the General Assembly "revealed its awareness that it was not simply terminating one program and creating something wholly new." Pls.' MSJ at 39. The General Assembly's very words indicate its belief and intention that it was creating a new enterprise, that it was not qualifying an existing government-owned business, and that it was not required to adjust the

TABOR or Excess State Revenues Caps. Plaintiffs' disagreement does not show that the General Assembly was wrong in this regard.

There are undoubtedly similarities between the Hospital Provider Fee program and the CHASE enterprise. There are also undoubtedly significant differences between the two. For the reasons stated in the State Defendants' Motion for Summary Judgment, the General Assembly possesses the inherent power to end one program and to create a similar, but different one. Moreover, the Excess State Revenues Cap need not have been adjusted because Hospital Provider Fee revenues were not used in setting it, and its removal has no effect on state spending.

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 and the undisputed facts show that the Hospital Provider Fee and the CHASE Fee were each collected and spent to provide services to the fee paying hospitals, and each is constitutional. Because CHASE charges a fee and not a tax, Plaintiffs' argument regarding its enterprise status fails. The methods in S.B. 17-267 tend to carry out the general purpose of the act, which is expressed in the title, and thus it satisfies the single subject requirements. Finally, CHASE is a new entity and is not a "qualification" of the Hospital Provider Fee program. Accordingly, the General Assembly was not required to adjust the Excess State Revenues Cap.

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: August 6, 2018

CYNTHIA H. COFFMAN
Attorney General

s/ W. Eric Kuhn

W. ERIC KUHN, 38083*
Senior Assistant Attorney General
JENNIFER L. WEAVER, 28882*
First Assistant Attorney General
Health Care Unit
State Services Section
Attorneys for the Colorado Department of Health Care Policy and Financing; Colorado Healthcare Affordability and Sustainability Enterprise; Kim Bimestefer, in her official capacity; the Colorado Department of the Treasury; Walker Stapleton, in his official capacity; and the State of Colorado.

CERTIFICATE OF SERVICE

I hereby certify that on August 6, 2018, I served a true and correct copy of the foregoing RESPONSE TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT to each of the following persons through Colorado Courts E-Filing, copied to pro hac vice counsel by email:

Michael Francisco
Statecraft PLLC
620 N. Tejon St. Ste. 101
Colorado Springs, CO 800-3

John J. Vecchione
R. James Valvo
Lee A. Steven
Cause of Action Institute
1875 Eye Street NW Ste. 800
Washington, DC 20006

Counsel for Plaintiffs

Sean R. Gallagher
Gerald Niederman
Bennett Cohen
Polsinelli PC
1401 Lawrence Street, Suite 2300
Denver, CO 80202
Counsel for Defendant-Intervenor
Colorado Hospital Association

s/ W. Eric Kuhn