Nov. 18, 2022

Commissioner Michael Conway
Colorado Division of Insurance
Consumer Services, Life and Health Section
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner Conway:

On behalf of the Colorado Hospital Association (CHA) and our more than 100 member hospitals and health systems statewide, we are writing to provide feedback on Proposed Rule 4-2-91 Concerning the Methodology for Calculating Reimbursement Rates to Support Premium Rate Reductions for Colorado Option Standardized Health Benefit Plans and Proposed Rule 4-2-92 Concerning Colorado Option Public Hearings. The following comments reiterate past recommendations that CHA has submitted to the Division of Insurance (DOI) to support operational success of the Colorado Option.

Below are two top priority items that CHA requests immediate attention to, in addition to more recommendations detailed further below:

1. Medicare reimbursement rates must be based on the most recent time period.
The proposed rule uses outdated rates without accounting for data lags or routine inflationary factors, such that the 2025 plan year payments would be based on 2023 rates, creating a de facto rate cut to providers inconsistent with the statutory methodology for establishing hospital payment rates. The Medicare reimbursement rates established through the rate hearing process must be based on the plan year for which a rate is being set, using the most current Medicare prospective or cost-based payment rates available, trended forward to the applicable plan year and accounting for rate modifications through recent fiscal intermediary letters and/or Centers for Medicare and Medicaid Services (CMS) published trend factors applicable to the proposed rating period. While we understand the need for carriers to know what rates to calculate for rate filing, for purposes of the commissioner having the ability to impose rates during the hearing, they must be the most current Medicare rates. As noted in prior comments submitted to DOI on Sept. 16, it is crucial that Medicare reimbursement rates are based on the most recent time period, and so we reiterate our request that this be addressed in the final rule.

We suggest the following revised language for section 4-2-91.4.U.1:

> For hospitals that Medicare reimburses under its Hospital Inpatient Prospective Payment System (IPPS) and the Hospital Outpatient Prospective Payment System (OPPS), the Medicare Reimbursement Rate will be the commercial utilization weighted average of the hospital specific rates for services effective as of ~~each October prior to the year in which a public hearing may be held.~~ January 1 of the year to which the rates will apply, using prospective hospital specific rates or trended rates based on the most recently published CMS rate forecast.

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2. Evidence provided pursuant to the public hearing must not conflict with antitrust laws. The proposed rule would require the disclosure at public hearings of confidential contracts negotiated between hospitals and health plans, including the current prices paid under those contracts. This required disclosure conflicts with antitrust law, which generally prohibits competitors from exchanging confidential information about prices. This compelled disclosure of confidential prices could reduce price competition between hospitals and between health plans that compete for favorable contracts with hospitals. That would undermine the policy of the antitrust laws.

The Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ) have brought many enforcement actions against businesses that violate antitrust law by exchanging price information with their competitors.[1] The proposed regulation conflicts with antitrust enforcement policy, which aims to reduce health care costs by promoting competition among providers, and among insurers. The FTC and DOJ have warned that "information exchanges among competing providers may facilitate collusion or otherwise reduce competition on prices or compensation, resulting in increased prices, or reduced quality and availability of health care services."[2] Therefore, the FTC and DOJ recommend that any price information exchanged should not include current prices and should be "sufficiently aggregated such that it would not allow recipients to identify the prices charged or compensation paid by any particular provider."[3] The proposed regulation would require both hospitals and insurers to violate these recommendations.

Some providers or insurers may argue that a Colorado regulation that permits or requires them to violate antitrust law would arguably create a new "state action" exemption from the federal antitrust laws. That would be an unintended consequence of the proposed regulation, with far-reaching effects. The FTC has a long history of advocacy against state laws and regulatory actions that create federal antitrust exemptions.[4] CHA believes state-created antitrust exemptions for anticompetitive conduct are bad public policy and should be avoided. Additionally, the Colorado statute provides the following: "The commissioner shall limit the evidence presented at the hearing to information that is related to the reason the carrier failed to meet the network adequacy

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[1] See, e.g., *In re Bosley, Inc.*, Docket No. C-4404 (FTC May 30, 2013) (FTC consent decree prohibiting communication to competitors of "non-public information relating to pricing or pricing strategies, costs, revenues, profits, margins, output, business or strategic plans, marketing, advertising, promotion, or research and development"); *United States v. Brown University*, Civil Action 91-CV-3274 (E.D. Pa. 1991) (DOJ consent decree prohibiting communication among Ivy League colleges of confidential information about "student fees (such as tuition, room and board) or faculty salaries").

[2] FTC and DOJ, *Statements of Antitrust Enforcement Policy in Health Care* at 49 (1996).

[3] *Id.* at 50.

[4] See, e.g., *FTC Staff Submission to NYS Health Department Regarding the COPA Application of SUNY Upstate Medical University and Crouse Health System* (October 14, 2022), available at https://www.ftc.gov/legal-library/browse/advocacy-filings/ftc-staff-submission-nys-health-department-regarding-copa-application-suny-upstate-medical; *FTC Staff Expresses Concern that New York's Certificate of Public Advantage Regulations Can Harm Competition* (April 24, 2015), available at https://www.ftc.gov/news-events/news/press-releases/2015/04/ftc-staff-expresses-concern-new-yorks-certificate-public-advantage-regulations-can-harm-competition.

requirements or the premium rate requirements in section 10-16-1305 for the standardized plan in any single county." 10-16-1306(2)(c), § C.R.S.

Consequently, the addition of other evidence exceeds the statutory authority granted to the commissioner. As noted in prior CHA comments submitted to DOI on Oct. 4, it is crucial that the requirements in the proposed rule do not conflict with antitrust law, and so we reiterate that this request be addressed in the final rule.

Additional Recommendations

3. Hospitals should have the opportunity to demonstrate unique circumstances.

The proposed rule does not provide adequate opportunity for hospitals to demonstrate their unique circumstances. CHA appreciates the addition of language to the proposed regulations providing hospitals with this opportunity in the discovery phase of the public hearings. However, CHA asks that additional language is added to ensure that the opportunity is adequately available throughout the rate setting process, especially to preserve the opportunity to comment on formulas establishing efficiency metrics. The formulas do not provide adequate comparison of hospital operations or performance, and hospitals should have the opportunity to demonstrate unique circumstances. As noted in prior CHA comments submitted to DOI on Sept. 16 and Oct. 4, it is crucial that the rule provides adequate opportunity for hospitals to demonstrate their unique circumstances. We reiterate our request that this be addressed in the final rule.

We suggest the following revised language for section 4-2-91.5.A.2.d:

> Hospitals efficient in managing the underlying cost of care as determined by the hospital's net patient revenue, operating expenses, and total margins will receive up to a forty-percentage point increase. Hospitals will be provided with the opportunity to demonstrate their unique circumstances, including comparison to more appropriate peer groups, case mix/acuity, specific cost factors, service offerings/mix, and other efficiency metrics.

Additionally, given the variation between hospitals as well as different communities in Colorado, it is important that a process be established for calculating the hospital-specific share of the total health care premium and that the final rate determination does not expect hospitals to contribute more than their fair share.

4. An established burden of proof should be used in determining whether a public hearing is warranted, in addition to during the public hearing.

Under the proposed regulations, carriers are not required to engage in any good faith effort to negotiate with hospitals or providers in order to achieve premium rate reductions prior to proceeding to a public hearing. The regulations only require that they provide a statement outlining the good faith efforts the carrier made in Section 9.c.2.b. If a carrier makes a statement outlining no actual efforts to negotiate, it can then proceed through the rate hearing process.

Similarly, a carrier could submit grossly inadequate or deficient submissions (but not incomplete or missing items) for all the elements required for a Notice in Section 9C and still be allowed to

proceed to the public rate hearing process. Under Section 9.D, the commissioner only notifies the carrier if the submission is incomplete, allowing the carrier up to seven days to submit complete information. A carrier's allegations that it failed to meet premium rate reduction requirements due to a particular hospital or provide in a complaint or cross-complaint also may contain similarly grossly inadequate or deficient factual or legal assertions.

As noted in prior CHA comments submitted to DOI on Oct. 4, the final rule should allow a process for the commissioner to dismiss a complaint before going forward with a public hearing regarding compensation of a provider when a carrier has not reasonably met procedural requirements to proceed to a hearing. We reiterate our request that this be addressed in the final rule.

We recommend adding to 9D:

> The Commissioner shall post on the Division's website the information provided by the carrier pursuant to the Section 9, including the contract reimbursement rates except as provided in Section 14 relating to Confidential Information. If the carrier's submission is incomplete or insufficient, the Commissioner shall notify the carrier and allow the carrier up to seven (7) days to submit complete information. The Commissioner may consider whether a carrier has engaged in good faith efforts to negotiate with a hospital or provider in determining whether the information submitted is sufficient or complete.

While DOI is required by statute to hold a hearing prior to approving the carrier's rates if a carrier notifies the commissioner that the carrier is unable to offer the standardized plan at the required, it does not mean that DOI is required to proceed with a public hearing if procedural requirements have not been met. CHA suggests that an additional section be added to the regulations following Section 12 Opportunity for Negotiation and Settlement, called "Dismissal."

> New Section 13 Dismissal:
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> Upon review of the allegations in the Complaint, Cross-Complaint, and the Answer(s), the Commissioner may determine that there are insufficient allegations to support a public hearing.

5. Hospitals should have the opportunity to react to DOI-calculated rates before the final rate determination.

The proposed rule does not allow for any dialogue between the hospital and DOI regarding DOI-calculated rates before the final rate determination, setting up the potential for a lengthy and costly appeals process. Rather than requiring hospitals and other providers to immediately appeal decisions of the commissioner regarding the rate reimbursement amount to court as a final agency action, a process to permit hospitals and providers to submit a request for reconsideration before the order becomes a final agency action would permit additional due process to entities that are not normally regulated by DOI. It would be fair and reasonable to allow this procedural step to submit comments to demonstrate unique circumstances not accounted for in life of having to pursue expensive judicial action, given the significant compensation this impacts. As noted in prior CHA comments submitted to DOI on Oct. 4, the rule should provide hospitals with the opportunity to

react to DOI-calculated rates before the final rate determination. We reiterate our request that this be addressed in the final rule.

We recommend the following revision to Section 21:

The Commissioner shall issue an ~~final agency~~ order which shall include the Commissioner's determination of the reimbursement rate, by hospital and/or provider, that must be accepted by the identified hospital and/or provider and must be used by the carrier in its rate filings to achieve the premium rate reduction requirements. The reimbursement rate shall be set in accordance with the methodology in Regulation 4-2-91.

A hospital and/or provider may submit a request for reconsideration of a reimbursement rate within ____ days of receipt of the order. If reconsideration is not granted, or if the order is otherwise amended, t~~T~~he decision of the Commissioner becomes ~~is~~ a final agency order subject to judicial review within ___ days, pursuant to § 24-4-106(6) C.R.S.

6. The evidence presented during the hearing should be clearly linked to the final rate determination.

The rule does not contain adequate protection for providers' procedural rights. While the proposed regulations provide some protections to ensure evidence supports the final order, CHA believes they should go further to protecting providers' procedural rights.

10-16-1306(4) states: "Based on evidence presented at a hearing held pursuant to subsection (3) of this section and other available data and actuarial analysis . . . ." Section 21 states that the reimbursement methodology shall be consistent with Regulation 4-2-91, which specifies in Section 7.A that the reimbursement rate shall be based on evidence presented at the hearing, but states in 7.A.2 that the commissioner may consult with employee membership organizations, take into account cost of wages, benefits, staffing, and training, and utilize any publicly available hospital and provider data and cost tools. Section 7.A.2 should specify that the rates are dependent upon presented evidence in the hearing, rather than additional items the commissioner may consider outside the hearing. This is necessary to ensure due process in order to permit cross examination and expand the record of the hearing to allow for a full and open process for the parties to a hearing.

CHA proposes the additional language below:

4-2-91.A. Based on evidence presented at a hearing held pursuant to § 10-16-1306, C.R.S., the Commissioner may establish reimbursement rates between a carrier and a hospital or health-care provider. . . .

2. If presented as evidence at a hearing, ~~I~~in determining the hospital's reimbursement rate, the Commissioner may: . . . .

CHA also proposes additional language specifying that the methodology and all evidence relied upon by the commissioner in the order should be clearly tied in the final rate determination so that

it can be determined that the evidence was presented in the hearing. CHA suggests the following language be added to Section 21, including the modifications suggested above, with new modifications in green:

> The Commissioner shall issue an ~~final agency~~ order which shall include the Commissioner's determination of the reimbursement rate, by hospital and/or provider, that must be accepted by the identified hospital and/or provider and must be used by the carrier in its rate filings to achieve the premium rate reduction requirements. The reimbursement rate shall be set in accordance with the methodology in Regulation 4-2-91. The order shall detail the evidence relied upon by the Commission in making the determination with respect to the reimbursement rate.
>
> A hospital and/or provider may submit a request for reconsideration of a reimbursement rate within ___ days of receipt of the order. If reconsideration is not granted, or if the order is otherwise amended, t~~T~~he decision of the Commissioner becomes ~~is~~ a final agency order subject to judicial review within ___ days, pursuant to § 24-4-106(6) C.R.S.

As noted in prior CHA comments submitted to DOI on Oct. 4, the rule should ensure that the evidence presented during the hearing is clearly linked to the final rate determination. We reiterate our request that this be addressed in the final rule.

7. Hospital non-patient care related charges should be excluded from calculations.

The calculations in the proposed rule will disproportionately advantage certain hospitals over others for reasons unrelated to patient care. In the calculations for adjusted discharges, net patient revenue, and net income, DOI uses data from the Medicare Cost Report that includes charges that are not hospital specific and thus not directly related to hospital patient care. Thus, these non-patient care revenues will have a significant impact on the adjustment factors used in these calculations and disproportionately advantage hospitals that include large non-patient charges compared to hospitals that report little or no non-patient care charges. CHA recommends that the DOI use Worksheet G2 from the Medicare Cost Report with hospital non-patient care related charges removed. CHA made this recommendation that hospital non-patient care related charges are excluded from calculations in a letter to DOI on Sept. 16 and reiterates the request that this be addressed in the final rule.

8. Carriers should be the sole entity to identify hospitals and/or providers as the cause for a carrier's inability to meet premium rate reductions.

The proposed rule allows parties with incomplete information to identify hospitals and/or providers as the cause for a carrier's inability to meet premium rate reduction. CHA recommends that the division remove language in the proposed regulation 4-2-92 that allows the division and providers, in addition to carriers, to identify hospitals or providers as a reason the carrier was unable to meet the premium reduction requirements. CHA believes it is important that carriers are the only entity that can identify a hospital or provider because only carriers have a full assessment of all of the data and assumptions that are included in the buildup of premium rates. Allowing other parties, including DOI or other providers, to identify why a carrier was unable to meet the premium

reduction targets would be speculative and non-factual. CHA made this recommendation in a letter to the division on Oct. 4, and we reiterate our request that this be addressed in the final rule.

> We suggest the following revised language for section 4-2-92.11.B:
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> Any hospital or health-care provider identified by the carrier~~, the Division, or another provider~~ as the reason a carrier was unable to meet the premium requirements shall file an Answer within thirty (30) days from the date of service of the Complaint or Cross-Complaint, as applicable.

9. Hospital payer mix calculation should use total charges by payer.
CHA appreciates the update that DOI made to the hospital payer mix calculation to use the proportion of total charges by payer as this is a better metric than using discharges. CHA made this recommendation in a letter to DOI on Oct. 4 and would ask that the update stay in the final rule.

10. Updating the definition of "Utilization Weighted Average."
CHA appreciates the update that DOI made in changing the utilization weighted average to commercial utilization weighted average to ensure that the hospital-specific rates are used for commercial services. CHA made this recommendation in a letter to DOI on Oct. 4 and would ask that this update stay in the final rule.

11. Additional adjustments made for Critical Access Hospitals.
CHA appreciates the update that DOI made under the definition of the Medicare Reimbursement Rate for Critical Access Hospitals to allow the consideration of additional information to determine if further adjustments are required, such as, but not limited to, unreimbursed cost items. CHA made this recommendation to DOI on Oct. 4 and would ask that the update stay in the final rule.

We request consideration of these recommendations to ensure operational success for implementation of the Colorado Option, and we welcome further dialogue with the DOI on these issues.

Regards,

/S/ Adeline Ewing
Adeline Ewing
Policy Analyst