May 30, 2023

Commissioner Michael Conway, Division of Insurance
Colorado Department of Regulatory Agencies
Via electronic submission

Re: Public Comments on Behalf of the Colorado Hospital Association
DOI-Initiated Colorado Option Complaints for Plan Year 2024

Commissioner Conway:

The Colorado Hospital Association ("CHA") submits these comments on behalf of the Colorado hospital and health system community, representing more than 100 hospitals and health systems throughout the state, in the Colorado Public Option Rate Reduction Hearings conducted by the Colorado Division of Insurance ("DOI"). These comments are submitted in response to CHA's concerns with the DOI-initiated Complaints or Cross-Complaints (generally "Complaints"), in which multiple hospitals have been identified as a source of a carrier's premium rate reduction ("PRR") failure, and will address procedural concerns with respect to the Complaints, as well as concerns with the data, methodology, and analysis relied upon in the Complaints.

The DOI initiated Complaints against Rocky Mountain Health Maintenance Organization, Kaiser Foundation Health Plan of Colorado, HMO Colorado, and Cigna Health and Life Insurance Company (collectively "the carriers"). Prior to filing the Complaints, the DOI commissioned several analyses from Wakely Consulting Group (collectively the "Wakely Reports"). The Wakely Reports were submitted as evidentiary exhibits in each of the respective Complaints, and contain common data, methodologies, and analysis further described below.[1] However, CHA asserts that the Wakely Reports have been improperly relied upon to bring the Complaints against numerous hospitals that did not cause the carriers to fail to meet PRR requirements. The DOI brought the Complaints against the hospitals seeking to reduce their reimbursement rates without any statutory basis and in a manner exceeding the authority of the Commissioner.

[1] Colorado Option Rate Target Methodology, Wakely, May 5, 2022 and 2024 Addendum dated January 13, 2023. This document is a single analysis submitted as evidence across all 2023 Complaints and listed as Exhibit D-001 in each proceeding listed below.
2024 Colorado Option Compliance Review and Response – Cigna, Wakely, April 6, 2023. Proceeding No. 2023-COH-001, Exhibit D-003.
2024 Colorado Option Compliance Review and Response – Rocky Mountain Health Maintenance Organization (RMHMO), Wakely, April 17, 2023. Proceeding No. 2023-COH-002, Exhibit D-002.
2024 Colorado Option Compliance Review and Response – Kaiser Permanente, Wakely, April 17, 2023. Proceeding No. 2023-COH-003, Exhibit D-002.
2024 Colorado Option Compliance Review and Response – HMO Colorado, Wakely, April 20, 2023. Proceeding No. 2023-COH-004, Exhibit D-002.

As a general matter, hospitals are facing financially precarious circumstances in 2023. Over half of Colorado hospitals were unable to make ends meet in 2022, putting a significant number of hospitals at risk of significant service loss or closure. In the wake of COVID, as of the end of 2022, Colorado hospitals incurred unprecedented losses relative to pre-pandemic levels. Further, expenses – particularly for staff necessary to ensure high-quality patient care – are up significantly and outpacing revenue. Finally, hospitals are seeing fewer patients and the patients coming to hospitals are sicker – likely a fallout from care deferred due to the pandemic. These circumstances are pertinent to the hearings as indicators of provider financial health, as defined in 3 Colo. Code Reg. 702-4:4-2-92 (Reg. 4-2-92), Section 16.2.d.

I. The Commissioner Lacks Jurisdiction Over the Hospitals Named in the Complaints

C.R.S. § 10-16-1306(11)(a) is very explicit in limiting the Commissioner's ability to set reimbursement rates for hospitals:

> (11) (a) The commissioner **shall** only set reimbursement rates pursuant to this section for hospitals or health-care providers that:
>
> ***(i) Prevented a carrier from meeting the premium rate requirements for a standardized plan being offered in a specific county***; or
>
> (ii) Caused the carrier to fail to meet network adequacy requirements.

Under the above statute, the Commissioner **has no jurisdiction** to set reimbursement rates for a hospital under C.R.S. § 10-16-1306 **unless** the hospital prevented the carrier from meeting the PRR requirement for a standardized plan in a specific county. Therefore, a preliminary jurisdictional requirement for any action, by the DOI or otherwise, seeking to set reimbursement rates for hospitals or health care providers must include allegations that the hospitals or health-care providers prevented the carrier from meeting the PRR requirements in a specific county. In these matters, however, the DOI has not satisfied the jurisdictional requirements against any of the hospitals.

The DOI filed four different Complaints in the PRR matters against four separate carriers, identifying and naming a total of nineteen hospitals, some of which were named in more than one matter. None of the hospitals were identified by a carrier as a cause for the carrier's failure to meet required PRRs, and the carriers identified other causes or factors as the reasons for their inability to meet the required reductions.[2] Instead of including any allegation that the reimbursement rates for the hospitals prevented a carrier from meeting the PRRs for the standardized plan in any specific county, the Complaints included the following allegations:

- The identified hospitals were identified as "impacting [the carrier's] ability to reduce premiums" in various rating areas.

[2] While reasons differed from carrier to carrier, with the exception of three hospitals named in the original Cigna complaint (in which the DOI filed a Cross-Complaint), carriers identified reasons other than hospitals for their inability to meet PRR targets.

- "if [the carrier's] reimbursement rates with the [identified hospitals] under the standardized plans are set at the rates identified . . . [the carrier] may achieve premium reductions"
- "if [the carrier's] reimbursement rates with the [identified hospitals] under the standardized plans are set at the rates identified . . . [the carrier] may reduce premiums"

None of the above allegations, even if assumed to be true, meet the statutory requirement that they "***prevented*** a carrier from meeting the premium rate requirements" in a specific county. Additionally, it is important to note that the Wakely Reports further acknowledge that in most cases, the carriers will not be able to meet PRRs as required by C.R.S. § 10-16-1306(4)(a)(I), even if hospital rates are driven to the maximum payment cut allowed by law. As such, it does not appear that the DOI would be able to establish under any circumstance that the named hospitals were the reason for carrier noncompliance with the PRR targets, and there is no basis for the Commissioner to proceed with setting reimbursement rates.

The DOI cannot expand the authority or jurisdiction of the Commissioner to set reimbursement rates through regulations beyond the express limitations set in C.R.S. 10-16-1306. *See, e.g. Hawes v. Colorado Div. of Ins.,* 65 P.3d 1008, 1017 (Colo. 2003)(agency has no power when it acts "contrary to express statutory provisions"). To the extent that existing regulations or future regulations that may be promulgated are used as the basis to justify rate setting actions against hospitals where there has been no underlying claim or allegation satisfying the required jurisdictional basis under C.R.S. § 10-16-1306(11)(a), CHA submits that the regulations are either inconsistent with statutory requirements or are being interpreted in a manner that exceeds the scope of the DOI's jurisdiction.

None of the hospitals should have been identified or named in the Complaints that were filed by the DOI given the lack of jurisdiction. These hospitals were named and have been subject to the process of defending themselves, negotiating with carriers and the DOI, and verifying that they are already at or below the rate that could theoretically be ordered by the Commissioner if all other elements were met, if they desire to avoid a public hearing and all the associated expense. If the underlying jurisdictional issue is not addressed, then CHA expects the DOI to file similar Complaints in subsequent years, and hospitals whose reimbursement rates could not be set by the Commissioner under C.R.S. § 10-16-1306(11)(a) will effectively be set once again in order to avoid a hearing. The Commissioner should rule that there is a lack of jurisdiction over any of the hospitals and that all of the Complaints in which the DOI added claims against the hospitals should be dismissed.

II. The DOI Lacks Authority to Bring Claims or Cross-Claims Against Hospitals

Similar to the jurisdictional argument, CHA asserts that there is no authority in either the statute or regulations for the DOI to have brough claims directly against the hospitals where none of the carriers had identified the hospitals as a reason why they failed to meet the PRR requirements. There is no language in C.R.S. § 10-16-1306 that contemplates the DOI filing an action against hospitals or health care providers that have not been identified by a carrier as a cause of its failure to meet the PRR requirements.

Under subsection (2), if a carrier is unable to meet the PRR targets, it is required to notify the Commissioner of the reasons why, the steps it is taking, and documentation related to the hospitals or providers that are the cause of the failure. Subsection (3)(a) states that if the carrier notifies the Commissioner that the PRR cannot be met or the Commissioner otherwise makes this determination, the DOI may hold a public hearing prior to approving the carrier's final rates.[3] Neither of these provisions states that the DOI may elect to add any hospital as a party to the public hearing.

Subsection (c)(i) specifies that the Commissioner shall give notice of the public hearing to carriers, hospitals, as well as other parties, while (c)(ii) sets out the items that the Commissioner shall establish by rule, including significantly:

> (D) The manner in which a carrier shall notify the division and affected hospitals, health-care providers, and the insurance ombudsman of a carrier's failure to meet the network adequacy requirements or the premium rate requirements in section 10-16-1305;

There is no similar provision allowing the DOI to identify affected hospitals and health-care providers with respect to the carrier's failure to meet PRR requirements. The statute contains no support for the concept that the DOI is able to independently identify hospitals or other health-care providers that it believes may be able to reduce the carrier's rates such that they should become parties to the public hearing.

CHA further submits that the DOI's Complaints against the hospitals are also not supported by the DOI Regulations. The DOI cited 3 Colo. Code Reg. 702-4:4-2-92 (Reg. 4-2-92) Sections 10.C and 11.B in support of its ability to file a Complaint identifying a hospital as a reason the carrier was unable to meet the PRR requirements. However, Section 10.C. only permits the DOI to file a Complaint alleging the failure of the carrier to meet the PRR requirements. It does not grant the DOI the authority to file a Complaint identifying hospitals or health-care providers responsible for the carrier's inability to meet the PRRs, as Section 10.A instructs a carrier to file. Section 11.B only addresses "answers" to original Complaints and provides no authority for the DOI to file initial complaints against providers as the DOI did in three of these matters. While Section 11.B could potentially apply to the Cigna Cross-Complaint, § 11.B only discusses the requirements for filing an "Answer," not a Complaint or Cross-Complaint and does not provide a basis for the DOI's election to bring actions against hospitals in order to strongarm them into negotiating rates at the maximum payment cut allowed by law.

As a practical matter, it makes little sense for the DOI to have the authority to identify hospitals as additional parties to a PRR hearing when they have not been identified as a cause for a carrier's inability to meet the PRR requirements. One reason for this is because the DOI is not in the best position to supplant a carrier's determination as to the cause of its failure to meet PRR targets. In filing these Complaints, the DOI relied upon information in the Wakely Reports, rather than information provided by the carriers, even though the Wakely Reports expressly stated, "Since 2023 contract negotiated rates are not available for this analysis, there is not enough information to accurately limit the provider rate reduction to 20% based on 2023 negotiate rates." When naming

[3] Prior to amendment the statute required the DOI to hold a hearing.

hospitals in the Complaints, the DOI also included hospitals without regard for whether they would be in-network or out-of-network providers. If the DOI had adhered to the constraints of the statute, hospitals that already were at the maximum payment cut allowed by law or that had already negotiated the maximum statutory rate reduction or that were out-of-network would not have been inappropriately added to these Complaints.

III. Evidence Related to Hospital Reimbursement Rates Is Not Admissible at the Hearing

Under the statute, C.R.S. § 10-16-1306(3)(c)(ii)(B), the Commissioner shall limit evidence presented at the public hearing to "information that is related to the reason the carrier failed to meet . . . the premium rate requirements in section 10-16-1305 for the standardized plan in any single county." Since there are no allegations in the Complaints that the hospitals are the reason the carriers failed to meet the PRR requirements, it does not appear that any statements related to the hospital reimbursements or whether reducing their reimbursement rates may achieve rate reductions should be admissible as to the reason the carrier failed to meet the PRR.

Additionally, while the DOI bases their Complaints on the Wakely analysis regarding materiality of individual hospital costs, no underlying data has been provided to support the DOI's assertions in this regard. The Wakely reports indicate that unique hospitals analyzed are responsible for somewhere between 0.0% and 60.1% of a carrier's premium in a particular geographic rating region, with the vast majority of hospitals accounting for less than 5% of total premium.[4]

The Division defines materiality as having a premium impact in a particular county of at least 0.15%, 3 Colo. Code Reg. 702-4:4-2-92 (Reg. 4-2-92), Section 7.a.2. However, this materiality threshold does not seem to be uniformly applied, and as such, the conclusions drawn by the DOI in reliance upon this information are invalid.

IV. The Wakely Reports Fail to Comport with Legal Standards Regarding Rate Setting

A significant deficit in the analysis within the Wakely Reports is that it does not objectively assess reasons that a carrier did not meet PRR requirements, as required in Reg. 4-2-92, and fails to appropriately consider the many other factors unrelated to hospitals that may have contributed to a carrier's rate projections, despite this information being available in the carrier PRR filings purportedly analyzed by Wakely. Instead, the analysis evaluates the impact on premium rates by arbitrarily selecting hospitals and setting them to erroneously calculated payment cuts, while incorrectly assuming that hospital prices are the reason for the carrier's failure to meet PRR targets.

The analyses also disregard the statutory requirement pursuant to C.R.S. §10-16-1306(5)(b), that prohibits reimbursement rates from being set more than twenty percent below the rate negotiated between the carrier and hospital for the previous plan year. The Wakely Reports acknowledged that Wakely did not have access to information about 2023 contract negotiated rates for its analysis: "Since 2023 contract negotiated rates are not available for this analysis, there is not enough information to accurately limit the provider rate reduction to 20% based on 2023

[4] See the Complaints, Exhibit D-002.

negotiated rates."[5] Thus, the hospital-specific maximum payment cuts and premium impacts reached in the Wakely Report are incomplete, and their conclusions cannot be relied upon.

V. The Wakely Report Is Materially Flawed

The analyses within the Wakely Reports rely on data submitted by carriers in the "Cost of Care" templates and "Target Rate Reduction" templates. Wakely states in each report that it performed basic reasonability checks but did not audit the data for accuracy. Inaccuracies in the data invalidate the conclusions drawn, as stated directly by Wakely: "To the extent that a carrier submitted incorrect data, such as data errors, the results of the analysis will be directly impacted." 2024 Colorado Option Compliance Review and Response – Cigna, p. 14. The data provided in these templates was based on data from plan years 2022 and earlier and thus does not include current or anticipated contract terms. Finally, 2023 is the first plan year with Colorado Option plan enrollment and so the analyses are not specific to utilization and pricing for these plans.

The analyses also exclude important data points that should be included in any analysis of this nature, and such an exclusion renders the conclusions invalid. While the Wakely Reports do include a discussion of Medicare reimbursement factors, they exclude outliers, distinct part units, and cost report settlement items. The analyses do not include any risk adjustment, reinsurance, or other non-claim factors that could materially impact provider-carrier negotiations and payment rates, such as changes in mandated benefits or authorization criteria. Finally, there is a review of administrative, profit, and other medical trends, but only for outliers or specific non-compliance with stated requirements.

Together, the above factors undermine the reliability and relevance of the data as it relates to pending Complaints. Additionally, the Wakely Reports made certain assumptions by attributing data from one rating area to other rating areas. For example, even though not material in one rating area, savings were estimated to other rating areas.

CONCLUSION

For all of the reasons outlined above, the lack of jurisdiction, the lack of authority to bring a complaint, the inadmissibility of evidence, and the flawed conclusions reached in the Wakely Reports, CHA asserts that the Complaints against the hospitals should be summarily dismissed. The DOI has not brought forward sufficient evidence that the hospitals it has named in these complaints are the reasons for a carriers inability to meet PRR requirements. CHA further asks the Commissioner to enter a ruling barring the DOI from bringing similar complaints on its own initiative against hospitals in the future or from bringing an action against a hospital where there is no allegation that a hospital is the cause of the failure to meet PRR requirements.

The statute does not give the DOI the authority to generally set hospital reimbursement rates or order hospitals to negotiate with carriers, and the DOI should not have the ability to indirectly accomplish what it has not been given the authority to do directly.

[5] See the Complaints, Exhibit D-003.