Oct. 3, 2023

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 Colorado Hospital Association (CHA) and its more than 100 member hospitals and health systems statewide, I am writing to provide feedback on the proposed changes to Rule 4-2-91 Concerning the Methodology for Calculating Reimbursement Rates to Support Premium Rate Reductions for Colorado Option Standardized Health Benefit Plans and Rule 4-2-92 Concerning Colorado Option Public Hearings.

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

1. The DOI lacks authority to bring claims or cross-claims against hospitals.

The statutory framework for the Standardized Plan at 10-16-1306, C.R.S. does not enable the DOI to bring claims directly against hospitals. To the contrary, pursuant to 10-16-1306(2) and (3), 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. Neither of these provisions permits the DOI 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 a public hearing.

As such, CHA requests the division strike Sections 5.B, 10.B, 10.C as inconsistent with statutory authority, as well as make conforming amendments as needed throughout the rule.

2. Medicare reimbursement rates must be based on the most recent time period.

In Section 4.W of proposed rule 4-2-92, the division proposes using outdated payment 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 and creating the circumstances for unjust enrichment of the carriers. While I understand the need for carriers to know what rates to calculate for rate filing, for purposes of the Commissioner's imposition of mandatory payment rates, they must be the most current Medicare rates, as CHA has noted in prior comments.

The Medicare reimbursement rates established through the rate hearing process must be established 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.

CHA recommends modifying the language under 4-2-92 Section 4.W to read as follows:

> 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.~~ for the applicable plan year, if available. If not yet available, Medicare rates for the applicable plan year shall be projected forward using the most recently published Medicare rates, under the IPPS and OPPS system, inflated using the CMS Office of the Actuary aggregate Medicare expenditure growth rate for the applicable plan year.
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> 2. Long-term Care, Psychiatric, and Rehabilitation Hospitals' Medicare Reimbursement Rates will be determined using the Commercial Utilization Weighted Average of payment rates for services from the appropriate Medicare Prospective Payment System rates for each hospital for the applicable plan year, if available. If not yet available, Medicare rates for the applicable plan year shall be projected forward using the most recently published Medicare rates form the appropriate Medicare Prospective Payment System inflated using the CMS Office of the Actuary aggregate Medicare expenditure growth rate for the applicable plan year.
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> 3. For Critical Access Hospitals, the Medicare Reimbursement Rate will be 101 percent of allowable costs, as determined using the cost-to-charge ratio, for hospital based services as reported in an average of the hospital's three most recent Medicare Cost Reports as of each October prior to the year in which a public hearing may be held Medicare rates for the applicable plan year shall be projected forward using computed CAH cost calculation using the CMS Office of the Actuary aggregate Medicare expenditure growth rate for the applicable plan year. The DOI may also consider additional information provided by a Critical Access Hospital to

determine if further adjustments are required, such as, but not limited to, unreimbursed cost items.

Beyond the top-priority items discussed above, the following are additional comments and concerns with regard to the proposed rules 4-2-91 and 4-2-92:

4-2-91: Concerning the Methodology for Calculating Reimbursement Rates to Support Premium Rate Reductions for Colorado Option Standardized Health Benefit Plans

1. **The new definition of "Aggregate Medicare Reimbursement Rate" should make it clear that the aggregate rate is still hospital specific.**

CHA appreciates the addition of a definition to capture rates for all services; however, CHA recommends making it clearer that the aggregate rate is still hospital specific by referencing the "Medicare Reimbursement Rate" in 4.W, which lists out adjustments based on hospital type.

1. **The definition of "Hospital Net Patient Revenue" should be changed to reflect the correct column in the Medicare Cost Report.**

CHA recommends modifying the language to read as follows:

> "Hospital Net Patient Revenue" shall mean, for the purposes of this regulation, the revenue from providing services to patients and is found in Worksheet G-3, ~~Column 1~~ Column 2, Line 3 from Medicare Cost Reports 2552-10. An average of the hospital's three most recent Medicare Cost Reports will be used as of each October prior to the year in which a public hearing may be held.

4-2-92: Concerning Colorado Option Public Hearings

Section 4: Definitions

1. **CHA recommends deleting the definition for "cause" at Section 4.E as it is not consistent with the statute.**

As contemplated in the statute, C.R.S. § 10-16-1306(2) and (11), "cause" is only used in the context of black-and-white failure (a hospital may only be brought to a hearing if they are established as the "cause of the carrier's failure to meet [requirements]"). The proposed definition in 4-2-92 Section 4.E minimizes the causation inquiry, converting it into a mere contributing factor – e.g., causation would be met if it would even minimally reduce a carrier's premiums or "assist" in network adequacy. This is inconsistent with the statute in that it renders "cause" to a de minimis inquiry with no minimum threshold, as opposed to cause being a determinative factor of failure or compliance.

2. **The definition of "Material Provider" at Section 4.Q is inconsistent with statute and should be modified.**

As written and combined with other changes made in the regulation, virtually anyone can become a party and unilaterally determine a provider is "material." This is directly contradictory to the statutory requirement that the onus be on the carrier to determine which providers should be subject to complaints and potential rate setting. (See e.g. C.R.S. § 10-16-1306(2)(b), "provide to the Commissioner any supporting documentation related to the hospital or health-care provider **that the carrier claims is a cause** for the carrier's failure to meet the [PRR].") Furthermore, another provider – or the DOI or any other party – would not have sufficient information to assess whether any provider meets the test set forth in the regulation: 1) was a cause for the carrier's failure to meet PRR requirements; and 2) has >0.15% impact on premiums in a rating area. Thus, CHA recommends modifying the definition of "Material Provider" to solely allow carriers to identify providers as the cause for the carrier's failure to meet the premium rate reduction requirement.

Additionally, as noted in previous comments, the definition does not provide adequate clarity on how a "0.15% impact" is determined. The DOI should clarify this definition and calculation methodology. Moreover, the DOI should explain the actuarial and statutory basis for selecting the 0.15% as the threshold.

Section 5: Setting of Public Hearings and Notifications of Parties

1. **CHA requests the division remove Section 5.B regarding the division's ability to initiate claims and cross-claims to ensure consistency with the statutory framework.**
   Consistent with the priority comments at the start of this document, CHA recommends striking all references to the division's ability to initiate claims (or "complaints"), as this authority is not granted by the statute.
2. **Clarify the intent of the hearings under 5.B.**
   Pursuant to discussions with the division following the publication of this draft rule, CHA understands that the intended scope of the hearings contemplated in 5.B were non-adjudicatory hearings intended primarily for public comment. Should that be the case, CHA recommends clarifying the intent of the hearings under 5.B as solely for public comment and not an adjudicatory hearing, which requires appropriate notice to parties and due process.

Section 7: Public Hearing Parties

1. **Define "network adequacy complaint."**
   There is no provision in the statute for "complaints" related to network adequacy, nor is it provided for elsewhere in 4-2-92. CHA recommends defining a "network adequacy complaint" in a manner consistent with statutory authority.
2. **The DOI should not be a party to the complaint.**
   The appropriate role for the DOI – and the one established in statute – is to be the arbiter of disputes, not a party to the dispute. The only statutory role for the DOI within the Colorado Option administrative hearing process is to hold the public hearing and set reimbursement rates, as

warranted. This is apparent from the statutory language, which omits the DOI from the list of parties to be noticed: "[t]he commissioner shall give notice of the public hearing to the carriers, hospitals, health-care providers, insurance ombudsman, and public" C.R.S. § 10-16-1306(3)(c)(I).

3. **Remove section 7.A.6 permitting additional "aggrieved" parties.**
   This section is unnecessary and contrary to statutory framework. C.R.S. § 10-16-1306(3)(d) expressly obligates the Office of the Insurance Ombudsman to "participate in the public hearings and represent the interests of consumers." The current language in Section 7.A.6 would allow any Colorado resident or small business to be a party to the complaint, but the statute already makes accommodations – and requirements – for their interests to be represented through the Ombudsman. Further, while C.R.S. § 10-16-1306(3)(c)(II)(F) enables the commissioner to determine by rule how various interested persons may participate in hearings, it does not enable the commissioner to grant them party status, and it includes a limitation that only persons that "may be aggrieved by the commissioner's action" may participate.

Section 9: Carrier Notification Requirements

CHA recommends removing the additions to Section 9 as it is inconsistent with statute, incompatible with contract timelines, and would threaten confidentiality requirements.

a. C.R.S. § 10-16-1306(3) enables the DOI to hold a hearing for PRR failures, but only "with support from an independent actuary." The reporting schema in Section 9 burdens the carrier with actuarial analysis, but the carrier – as a party to a dispute – is inherently incapable of being "independent," such that the express requirements and intent of the statute are not being met.
b. Much of the information requested will not be known or finalized for a due date of March 1, 2024, which is 10 months before plans are offered. This impossible-to-meet deadline will yield imprecise information that could inaccurately implicate hospitals.
c. Information provided pursuant to 9A is subject to CORA pursuant to C.R.S. § 10-16-1306(3)(b), but also protected – at the Commissioner's discretion – pursuant to Section 14. How will the expanded set of parties (all "material providers," consumers/small businesses) be held accountable for maintaining confidentiality of these documents? This is a much larger universe than one carrier, one provider, and the DOI, and public release of this information would implicate state and federal antitrust and anticompetitive conduct laws.

Section 10:

CHA requests the division remove Section 10.B and 10.C regarding the division's ability to initiate claims and cross-claims to ensure consistency with the statutory framework.
Consistent with CHA's priority comments at the start of this document, the Association recommends striking all references to the division's ability to initiate claims (or "complaints"), as this authority is not granted by the statute.

CHA requests the division remove Section 10.B and 10.C regarding the division's ability to initiate claims and cross-claims to ensure consistency with the statutory framework.
Consistent with CHA's priority comments at the start of this document, the Association recommends striking all references to the division's ability to initiate claims (or "complaints"), as this authority is not granted by the statute.

Section 11: Answer to Complaint
CHA requests hospitals be provided with 30 days to file an answer, rather than the proposed 21 days.

The proposed shortened timeline for hospitals to file an answer is not enough time for a hospital to pull together the necessary information for a "substantive response," as required by the regulation. CHA requests that the regulation maintain 30 days to file an answer.

Section 12: Settlement
CHA recommends deleting Section 12 as it is outside the scope of the DOI's statutory authority and the option for nonbinding arbitration is sufficient.

Section 12 contravenes legislative intent by enabling the commissioner to approve non-adjudicated settlements between private parties. The statutory framework establishes that carriers and providers, acting without the DOI's involvement, may initiate nonbinding arbitration (C.R.S. § 10-16-1306(b)). Yet the insertion of the commissioner's authority in this Section 12 escalates that expressly "nonbinding" arbitration to a binding agency action without the benefit of due process for the parties. The commissioner's involvement in resolving these disputes is provided for in statute through the public hearing process, NOT through binding negotiation and settlement.

Sections 16, 17, and 21: Party Disclosures, Additional Discovery, Public Hearing Proceedings
The Proposed regulations exceed the DOI's statutory authority by creating open-ended evidentiary rules that are inconsistent with the statute.

The evidence at the hearing must be limited, as a legal matter, to "information that is related to the reason the carrier failed to meet the network adequacy requirements or the premium rate requirements" (C.R.S. § 10-16-1306(3)(c)). Thus, any attempt by the DOI to bring in other evidence would be in excess of its statutory authority. The proposed regulations significantly erode the statutorily defined limits on the scope of permissible evidence. The current regulations define the scope of discovery and party disclosures by reference to the statutory limitation on evidence "related to the reason the carrier failed to meet the network adequacy requirements or the premium rate reduction requirements for the Standardized Plan in any single county." However, the proposed regulation deletes this limitation in Section 16, and replaces it with an open-ended list of evidence that a party may seek in discovery and that "may be submitted for the commissioner's review," "including but not limited to" certain enumerated categories of evidence. Section 17 of the proposed regulations then creates an almost unbounded right to "additional discovery" at the "discretion of the commissioner."

The effect is to create an unbounded scope of discovery and information that may be "submitted for the commissioner's review." Although the statutory limitation noted above reappears in Section 21 of the

proposed regulations regarding what evidence may be "presented at the hearing," this restriction is rendered toothless by the preceding revisions. In practice, the commissioner has almost unfettered discretion to permit discovery and review materials "submitted for the commissioner's review" so long as it limits what evidence is "presented" at a hearing. These open-ended evidentiary standards thus create a potential end-run around the important limitations in C.R.S. § 10-16-1306(3)(c), which could substantially increase the burden on hospitals and allow the Commissioner to consider impermissible evidence.

Section 23: Establishing Reimbursement Rates

1. **CHA recommends deleting the option for a joint attestation under 23.E.2. and solely have the hospital submit an attestation.**

An individual carrier does not have insight to calculate the required components in the joint attestation. Rather, the hospital should attest on their own with the supporting information.

2. **In determining hospital reimbursement rates, the commissioner must take into account the most current Medicare prospective or cost-based payment rates available.**

Consistent with CHA's priority comments at the start of this document, the Association recommends modifying the language under 23.B.3 to require the commissioner to take into account the most current Medicare rates available to ensure Medicare reimbursement rates are based on the most recent time period.

3. **DOI should clarify how the "statewide hospital median reimbursement rate" is calculated.**

Section 23 sets a hospital's Aggregate Negotiated Rate in reference to the "statewide hospital median reimbursement rate." The DOI should clarify how this statewide hospital median reimbursement rate is calculated. In this regard, previously, regulation 4-2-91 defined how this was calculated using the all payer claims database, but that section was struck from the revised draft of that regulation.

CHA respectfully requests due consideration of these comments to ensure consistency with the statute and operational success for implementation of the Colorado Option, and I welcome further dialogue with the DOI on these issues.

Sincerely,

Katherine Blair Mulready

SVP & Chief Strategy Officer