DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE ACCIDENT AND HEALTH

Amended Regulation 4-2-72

CONCERNING STRATEGIES TO ENHANCE HEALTH INSURANCE AFFORDABILITY

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109(1), 10-16-107(3.5), and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of the regulation is to establish standards for health insurance carriers to enhance the affordability of their products by implementing payment system reforms. These reforms reduce overall health care costs by increasing utilization of primary and preventive care and value-based alternative payment models. The regulation establishes requirements for carrier investments in primary care and for alternative payment model (APM) parameter alignment reporting for primary care services offered through health benefit plans.

Section 3 Applicability

This regulation applies to all carriers marketing and issuing non-grandfathered individual, small group, and/or large group health benefit plans in Colorado on or after the effective date of this regulation.

Section 4 Definitions

A. “Alternative payment model” or “APM” means, for the purposes of this regulation, health care payment methods that use financial incentives to promote greater value – including higher quality care at lower costs – for patients, purchasers, and providers. Unlike traditional fee for service payments, APMs utilize cost and quality control strategies that benefit consumers by increasing the value of care delivered and, ultimately, the affordability of care.

B. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

C. “Fee For Service” or “FFS” payment means, for the purposes of this regulation, the payment of a set amount per health care service, and payment based solely on the number of services provided or procedures rendered.

D. “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

E. “Primary care” shall have the same meaning as found at § 10-16-157(2)(c), C.R.S.

F. “Primary care provider” means, for the purposes of this regulation, the provider taxonomies identified in Appendix A, when the provider is practicing general primary care in an outpatient setting.

G. “Prospective payment” means, for the purposes of this regulation, payments that are made in advance of service delivery.

H. “Total medical expenditures” means, for the purposes of this regulation, payments to reimburse the cost of physical and behavioral health care provided to enrollees, excluding prescription drugs, vision care and dental care, whether paid on a fee for service basis or as part of an alternative payment model.

Section 5 General Requirements

A. The standards to enhance affordability of health benefit plans are as follows:

1. Requirements for carrier investments in primary care.

a. Carriers shall increase the proportion of total medical expenditures in Colorado allocated to primary care by one (1) percentage point annually in calendar years 2022 and 2023, compared to each carrier’s baseline primary care spending.

1) A carrier’s baseline for primary care spending will be the proportion of total medical expenditures allocated to primary care for the calendar year 2021.

2) The one percentage point annual increase will be calculated by comparing the percent of a carrier’s total medical expenditures allocated to primary care in 2022 and 2023 to the carrier’s 2021 baseline.

b. Of a carrier’s total primary care expenditures, carriers should target twenty-five (25) percent of the expenditure to be made through prospective payments by the end of calendar year 2023.

2. Targets for carrier total medical expenditures made through APMs.

a. Carriers should target fifty (50) percent of a carrier’s total medical expenditures in Colorado to be made through APMs by the end of calendar year 2022.

b. Of a carrier’s total APM expenditures, carriers should target ten (10) percent of the expenditure to occur through prospective payments by the end of calendar year 2022.

Section 6 Primary Care Investment and Reporting Requirements

A. Primary care investment requirements.

1. The proportion of a carrier’s total medical expenditures allocated to primary care for the 2022 calendar year shall be one (1) percentage point higher than the proportion of a carrier’s total medical expenditures allocated to primary care for the baseline period.

2. The proportion of a carrier's total medical expenditures allocated to primary care shall increase by one (1) additional percentage point for the 2023 calendar year, compared to the baseline period (i.e. in 2023 primary care spending will increase by two (2) percentage points from the baseline).

3. Carriers shall not translate increased primary care spending into higher premiums, and should adopt strategies that improve value and quality of care without increasing total medical expenditures.

B. Primary care expenditure reporting requirements.

1. Carriers must annually submit data regarding primary care expenditures and investment strategies to the Division using the Primary Care and Alternative Payment Model Reporting Template provided by the Division in SERFF.

2. Carriers must submit the Primary Care and Alternative Payment Model Reporting Template to the Division via SERFF no later than September 15, 2025, and no later than September 15 annually thereafter.

C. Primary care expenditure calculations.

1. Carriers shall submit data on an annual basis for primary care and total medical expenditures made through paid claim amounts and non-claims payments to the Colorado All-Payer Claims Database (APCD), in the manner and timeline prescribed by the Colorado Department of Health Care Policy and Financing (HCPF), pursuant to HCPF Regulation 1.200.

2. The Division will determine whether a carrier has met the required one percentage point increase in the proportion of total medical expenditures allocated to primary care in 2022 and 2023 by comparing the carrier's primary care expenditure percentage reported in the current calendar year with that reported in the baseline year (2021).

3. Targets established under this section do not apply in the case of a nonprofit, nongovernmental health maintenance organization with respect to managed care plans that provide a majority of covered professional services through a single contracted medical group.

Section 7 Alternative Payment Model Targets and Reporting Requirements

A. APM expenditure targets.

1. Carriers should target fifty (50) percent of a carrier's total medical expenditures in Colorado to be made through APMs by the end of calendar year 2022.

2. Fully integrated payment and delivery systems shall be considered to meet the APM minimum standards in this section, provided the integrated system of care is contractually obligated to use a value-based payment model.

3. Carriers should target ten (10) percent of the APM spend to be paid through prospective payments by the end of 2022 with a focus on primary care.

B. APM expenditure reporting requirements.

1. Carriers must annually submit data regarding APM expenditures and investment strategies to the Division using the Primary Care and Alternative Payment Model Reporting Template provided by the Division in SERFF.

2. Carriers must submit the Primary Care and Alternative Payment Model Reporting Template to the Division via SERFF no later than September 15, 2025, and no later than September 15 annually thereafter.

C. APM alignment reporting requirements.

1. Carriers must annually submit data regarding compliance with the aligned primary care APM parameters set forth in Colorado Insurance Regulation 4-2-96 using the Primary Care and Alternative Payment Model Reporting Template provided by the Division in SERFF.

2. Carriers must submit the Primary Care and Alternative Payment Model Reporting Template to the Division via SERFF no later than September 15, 2025, and no later than September 15 annually thereafter.

D. APM expenditure calculations.

1. Carriers shall submit data for primary care and total medical expenditures made through FFS and APM payment arrangements on an annual basis to the Colorado APCD, in the manner and timeline prescribed by HCPF, pursuant to HCPF Regulation 1.200.

2. The Division will determine whether a carrier has met the target for medical expenditures made through APMs by evaluating the carrier's percentage of total medical expenditures made through APMs at the end of calendar year 2022.

Section 8 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 9 Incorporated Materials

HCPF Regulation 1.200 shall mean Regulation 1.200, found at 10 CCR 2505-5, as published on the effective date of this regulation and does not include later amendments to or editions of Regulation 1.200, found at 10 CCR 2505-5. A copy of Regulation 1.200, found at 10 CCR 2505-5, may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A certified copy of Regulation 1.200, found at 10 CCR 2505-5, may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A charge for certification or copies may apply. A copy may also be obtained online at https://www.sos.state.co.us/CCR/Welcome.do.

Section 10 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 11 Effective Date

This regulation shall be effective May 30, 2025.

Section 12 History

New regulation effective January 15, 2021.

Amended regulation effective May 30, 2025.

Appendix A: Primary Care Provider Taxonomies

1. Family medicine physicians in an outpatient setting when practicing general primary care;

2. General pediatric physicians and adolescent medicine physicians in an outpatient setting when practicing general primary care;

3. Geriatric medicine physicians in an outpatient setting when practicing general primary care;

4. Internal medicine physicians in an outpatient setting when practicing general primary care (excludes internists who specialize in areas such as cardiology, oncology, and other common internal medicine specialties beyond the scope of general primary care);

5. OB-GYN physicians in an outpatient setting when practicing general primary care;

6. Providers such as nurse practitioners and physicians' assistants in an outpatient setting when practicing general primary care; or and

7. Behavioral health providers, including psychiatrists, providing mental health and substance use disorder services when integrated into a primary care setting.