DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Amended Regulation 4-2-92

CONCERNING COLORADO OPTION PUBLIC HEARINGS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-107, 10-16-109, 10-16-1304, 10-16-1305, 10-16-1306, and 10-16-1312, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the procedures for noticing and conducting public hearings on proposed Colorado Option Standardized Plans that fail to meet the Premium Rate Reduction Requirements or network adequacy requirements, as required by § 10-16-1306, C.R.S.

Section 3 Applicability

This regulation applies to public hearings that will occur on or after January, 1, 2025 and to carriers offering individual and small group Colorado Option Standardized Plans on or after January 1, 2026. This regulation further applies to hospitals and health-care providers subject to the requirements in § 10-16-1306, C.R.S.

Section 4 Definitions

A. "Aggregate Medicare Reimbursement Rate" shall have the same meaning as found in Section 4.C. of Colorado Insurance Regulation 4-2-91.

B. "Aggregate Negotiated Rate" shall have the same meaning as found at Section 4.D. of Colorado Insurance Regulation 4-2-91.

C. "Aggrieved" shall have the same meaning as found at § 24-4-102(3.5), C.R.S.

D. "All-Payer Health Claims Database" shall have the same meaning as described in § 25.5-1-204, C.R.S.

E. "Applicable plan year" shall mean, for the purposes of this regulation, the plan year for which the carrier is filing a notification on March 1 regarding compliance with Premium Rate Reduction Requirements or network adequacy requirements.

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

G. "Cause" shall mean, for the purposes of this regulation, that establishing a reimbursement rate pursuant to § 10-16-1306(4)(a), (b), (5), or (7), C.R.S., would reduce a carrier's Colorado Option Standardized Plan premiums, or in the case of network adequacy, assist the carrier in achieving network adequacy requirements.

H. "Colorado Option Standardized Plan" or "Standardized Plan" shall have the same meaning as found at § 10-16-1303(14), C.R.S.

I. "Colorado Open Records Act" means the Colorado Open Records Act, §§ 24-72-201, et seq., C.R.S.

J. "Commissioner" shall have the same meaning as found at § 10-16-102(13), C.R.S.

K. "Covered person" shall have the same meaning as found at § 10-16-102(15), C.R.S.

L. "CMS Certification Number (CCN)" shall mean, for the purposes of this regulation, the six-digit alpha-numeric code assigned to hospitals by the Centers for Medicare & Medicaid Services (CMS), outlined in the CMS Manual System, where all Colorado facilities start with a 06.

M. "Day" shall mean calendar day.

N. "Division" shall have the same meaning as found at § 10-1-102(7), C.R.S.

O. "Hospital" shall have the same meaning as found at § 10-16-1303(6), C.R.S.

P. “Health-care provider” shall have the same meaning as found at § 10-16-1303(8), C.R.S.

Q. “Health-care Provider Reimbursement Floor” shall have the same meaning as found at Section 4.M. in Colorado Insurance Regulation 4-2-91.

R. “Hospital Reimbursement Floor” shall have the same meaning as found at Section 4.T. in Colorado Insurance Regulation 4-2-91.

S. “Insurance Ombudsperson” means the Office of the Insurance Ombudsman established in § 25.5-1-131, C.R.S.

T. “Material Provider” shall mean, for the purposes of this regulation, an in-network hospital or health-care provider identified by the carrier, the Division, another provider, or another party that has a greater than or equal to 0.15% contribution to a carrier’s premium rate in a particular Rating Area. Any hospital or health-care provider that has less than 0.15% contribution to a carrier’s premium rate in a particular Rating Area shall not be considered a Material Provider and shall not be required to participate in the public hearing regarding a carrier’s failure to achieve the Premium Rate Reduction Requirements.

The contribution to a carrier’s premium shall be calculated, for the purposes of this regulation, as total medical claim paid amounts divided by total premiums for each Colorado Option plan by network and by Rating Area.

U. “Medicare Reimbursement Rate” shall have the same meaning as found at Section 4.X. of Colorado Insurance Regulation 4-2-91.

V. “National Provider Identifier” or “NPI” shall have the same meaning as found at § 25.5-4-420(1)(b), C.R.S.

W. “Negotiated Rate” shall mean, for the purposes of this regulation, the reimbursement rate, as a percent of Medicare, agreed upon between the carrier and hospital or health-care provider for a given plan year.

X. “Network” shall have the same meaning as found at § 10-16-102(45), C.R.S.

Y. “Non-Standardized plan” means, for purposes of this regulation, a health benefit plan that does not meet the definition of Standardized Plan found at § 10-16-1303(14), C.R.S.

Z. “Party” or “Parties” shall have the same meaning as found at § 24-4-102(11), C.R.S., and specifically includes the entities admitted by the Commissioner under Section 7.A.1-6.

AA. “Person” shall have the same meaning as found at § 10-16-102(48), C.R.S.

AB. “Premium Rate Reduction Requirements” shall mean the rates set forth in § 10-16-1305, C.R.S., and calculated pursuant to Colorado Insurance Regulation 4-2-85.

AC. “Rating Area” means, for the purposes of this regulation, a geographic area comprised of Colorado counties established pursuant to the fair health insurance premium requirements under 45 C.F.R. § 147.102. A list of the Rating Areas can be found in Colorado Insurance Regulation 4-2-39 Section 6.A.15.g.

AD. “Service” as used in Sections 9 and 12 of this regulation, shall have the same meaning as found at 42 C.F.R. § 400.202.

AE. “SERFF” means the System for Electronic Rates and Forms Filing.

AF. “SFTP” shall mean, for the purposes of this regulation, a Secure File Transfer Protocol that enables the transfer of secure files.

AG. “Statewide Hospital Median Reimbursement Rate” shall mean, for the purposes of this regulation, the median reimbursement rate of Colorado hospitals, measured as a percentage of the Medicare Reimbursement Rate for the 2021 plan year using data from the All-Payer Health Claims Database.

Section 5 Setting of Public Hearings and Notification of Parties

A. The Commissioner shall provide notice no later than January 31 of the year in which the hearings will be held of the proposed dates for public hearings pursuant to § 10-16-1306, C.R.S. The notice shall be posted on the Division’s website and emailed to all individuals on the Division’s email list.

B. After the filing of a Complaint, the Commissioner shall give final notice of the date, time, location, and estimated duration for the public hearing to the Parties at least fifteen (15) days prior to the date of the hearing.

C. In the absence of a Complaint, or after a Complaint has been resolved, the Commissioner may set a hearing for public comment, which shall include allowing the Parties and any person or entity the opportunity to comment on a Colorado Option Standardized Plan offered by a carrier, pursuant to § 10-16-1306(3)(c)(II)(B), C.R.S. The Commissioner shall give final notice of the date, time, location, and scope of the hearing for public comment at least fifteen (15) days prior to the date of the hearing.

Section 6 Applicable Federal and State Laws

For purposes of the March 1st notification and the public hearing only, federal and state laws in effect on March 1st of the year preceding the applicable plan year will be considered to determine whether a carrier has met the Premium Rate Reduction Requirements and network adequacy requirements required by §§ 10-16-1304 and 10-16-1305, C.R.S. The Commissioner, in their discretion, will determine what weight to give any changes in federal or state law between March 1 and the issuance of a final agency order pursuant to Section 23.

Section 7 Public Hearing Parties

A. The Parties to the public hearing before the Commissioner shall include the following entities:

1. A carrier that fails to meet the Premium Rate Reduction Requirements or network adequacy requirements or is alleged to have failed to meet the Premium Rate Reduction Requirements or network adequacy requirements.

2. Any Material Provider named in any complaint.

3. Any hospital or health-care provider that is named in a network adequacy complaint or cross-complaint.

4. The Insurance Ombudsperson to represent the interests of consumers.

5. The Division of Insurance.

6. A person who demonstrates to the Commissioner that they will be aggrieved by agency action and who demonstrates that their interests are not adequately represented by the Parties listed above.

a. Such a person must request admission as a Party to the public hearing that they seek to participate in within seven (7) days from the date the Commissioner posts the complaint on the Division's website.

b. An application for Party status must identify the person making the request, including an address, email address, and telephone number. The application must also contain a statement of the reasons for seeking Party status, the manner in which the person is aggrieved, an explanation as to why the existing Parties do not adequately represent the person's interests, a description of the legal and/or factual issues which the prospective party intends to raise, any responsive pleadings the person intends to file, and any potential witnesses the prospective Party intends to call at the hearing. In addition, the application must describe the evidence the applicant intends to present at the hearing.

B. Consistent with Section 21.B., interested persons, who are not Parties, including consumer advocacy organizations, shall be given the opportunity to comment during the public hearing.

Section 8 Service of Documents

A. A Party filing any pleading or other document shall serve a copy, including all supporting attachments or exhibits, on every other Party in the proceeding. Such service shall include service upon the Commissioner and their assigned staff and attorneys.

B. Service may be by hand, first class mail, or by email. Service by email may be accomplished on a Party if the Party has consented to service by email. After the initial filing of the Complaint and Answer, all Parties shall consent to service by email and shall provide an email address for each subsequent service.

C. Proof of service of a filing shall be demonstrated through a certificate of service identifying the document served, the method of service, and the date of service. For each public hearing proceeding, the Commissioner shall maintain an updated certificate of service template to be used for service by the Parties and shall update it with any changes.

Section 9 Carrier Notification Requirements

A. Pursuant to § 10-16-1306(2), C.R.S., a carrier shall notify the Commissioner of the reasons why the carrier is unable to meet the Premium Rate Reduction Requirements, as provided in §§ 10-16-1304 and 10-16-1305, C.R.S., and submit the notification, and related documents identified in Section 9.B, via SERFF or SFTP to the Commissioner no later than March 1 of the year preceding the applicable plan year The Notification shall be completed by the carrier using Division provided templates and shall include the following information:

1. A completed Premium Rate Reduction Notification template as required in Colorado Insurance Regulation 4-2-85.

2. A table showing the list of Material Providers with their relative contribution to the plan's premium in a Rating Area. The carrier must include the following information for each Material Provider:

a. The name, National Provider Identifier (NPI), CMS Certification Number (CCN), if applicable, and contact information of each Material Provider. Contact information shall include email address, physical and mailing address, and current contact information for the compliance or legal department for Colorado.

b. Whether the Material Provider is in-network for the applicable plan year and, if the Material Provider is in-network for only a subset of services, for which services they are in-network

3. A completed Negotiated Rate Template, confidentially submitted via SFTP, for the two years preceding the applicable plan year and for the applicable plan year for each Material Provider containing:

   a. The Aggregated Negotiated Rate for each Material Provider expressed as both a dollar and as a percentage of Medicare;

   b. The Negotiated Rate by service expressed as both a dollar amount and as a percentage of Medicare;

   c. The payment methodology (i.e. Diagnosis Related Group (DRG), Ambulatory Payment Classifications (APC), Per Diem, etc.) as outlined in rate sheets submitted in Section 9.A.2.d of this regulation;

   d. The analytic methodologies and tools used to aggregate the Negotiated Rates by service at the Material Provider level and to determine Negotiated Rates as a percentage of Medicare, including a service mix estimate; and

   e. If a carrier contracts and negotiates at the hospital system level, the Negotiated Rates, analyses, and agreements at the system level must also be submitted.

   f. For each Material Provider, the carrier must also identify in the Negotiated Rate Template whether the Aggregated Negotiated Rate for the applicable plan year is:

      (1) Above, consistent with, or below the reimbursement rates set forth in § 10-16-1306(5)(a) and (b) or § 10-16-1306(4)(b), C.R.S.

      (2) Above, consistent with, or below the reimbursement rate set forth in § 10-16-1306(4)(a), C.R.S., if the Material Provider is a hospital that qualifies for a reimbursement rate as set forth in § 10-16-1306(4)(a), C.R.S.

4. To demonstrate Negotiated Rates with Material Providers, the carrier shall submit confidentially via SFTP an unredacted copy of all of the carrier's Colorado Option Standardized Plan rate sheets, including addendums, for the year preceding the applicable plan year and for the applicable plan year. The rate sheets shall include the agreed upon rates by code or payment methodology and any additional payment agreements (add-on, outlier, stop-loss, etc.) and shall clearly outline whether the agreements are hospital or health-care provider- specific or if they apply to a health-care provider organization or hospital system. If non-Standardized Plan information is included in the same rate sheet as a Colorado Option Standardized Plan rate sheet, the carrier may redact the sections specific to non-Standardized Plans. The carrier must also disclose whether any contracts with Material Providers are set to expire, lapse, terminate, or otherwise end before or during the applicable plan year.

5. If a carrier has negotiated a reimbursement rate with a Material Provider that is a Hospital for the applicable plan year that is consistent with or below the reimbursement rate set forth in § 10-16-1306(4)(a), (5)(a) or (b), whichever is applicable to the Hospital, then the carrier must submit a joint attestation of those negotiated rates with the applicable Hospital to the Division as part of the March 1 filing.

6. A statement clarifying whether the carrier and the hospital or health-care provider engaged in nonbinding arbitration as allowed under § 10-16-1306(1)(b), C.R.S., or consent to participate in the opportunity for settlement afforded by Section 12.

7. An actuarial analysis, including trends and assumptions that includes the following information:

   a. For Material Providers with reimbursement rates that are above the reimbursement rates set forth in § 10-16-1306(4)(a) and (b), C.R.S., or § 10-16-1306(5)(a) and (b), C.R.S., the reimbursement rates for the year preceding the applicable plan year and the reimbursement rates for the applicable plan year.

   b. The impact on further reducing premiums on Colorado Option Standardized Plans, by plan, network, and Rating Area, if the carrier set the reimbursement rates for all of the Material Provider's referenced in subsection (a) reimbursement rates were set at to the reimbursement rates in § 10-16-1306(4)(a) or (b), C.R.S. or § 10-16-1306(5)(a) or (b), C.R.S.

B. Notwithstanding the carriers' notice in Section 9.A., every carrier shall submit the following documents to the Commissioner no later than March 1 of the year preceding the applicable plan year:

1. A completed Premium Rate Reduction Notification template as required in Colorado Insurance Regulation 4-2-85.

2. A statement outlining the good faith efforts the carrier made with in-network hospitals and/or health-care providers to negotiate reimbursement rates that would support the carrier in lowering premiums on Colorado Option Standardized Plans.

3. Pursuant to § 10-16-1306(3), C.R.S., if a carrier is unable to meet the network adequacy requirements, a carrier shall notify the Commissioner of the reasons why the carrier is unable to meet the network adequacy requirements. If the carrier is able to meet the network adequacy requirements, the carrier shall provide an attestation regarding the carrier's ability to meet network adequacy requirements for the applicable plan year and that the network for the Colorado Option Standardized Plan is no more narrow than the most restrictive network the carrier is offering for non-Standardized plans in the individual or small group market for the metal tier for that Rating Area. Nothing in this subsection shall preclude the Division from requesting additional information regarding a carrier's compliance with network adequacy requirements.

C. Upon request from the Division, the carrier shall submit a completed Cost of Care Data Template, confidentially submitted via SFTP, that summarizes the claims experience and cost of providing care by hospital or healthcare provider. If a hospital or healthcare provider constitutes a Material Provider, the carrier must also provide the summarized claims experience and cost of providing care by service.

D. The carrier shall respond to any follow up inquiries by the Division requesting additional information regarding the notifications required by Sections 9.A. and 9.B.

E. Documents provided pursuant to Sections 9.A., 9.B. and 9.C. must be bates numbered and clearly identify the Party submitting the documentary evidence.

F. The Commissioner shall post on the Division's website the information provided by the carrier pursuant to Section 9, including the Negotiated Rates except as provided in Section 14 relating to Confidential Information. If the carrier's submission is incomplete, the Division shall notify the

carrier and allow the carrier up to seven (7) days to submit complete information. The Commissioner shall post the information within three (3) days of the Division determining the information to be complete.

G. Upon the filing and service of a complaint, the carrier shall produce the notifications required by Sections 9.A., 9.B., and any additional information produced under 9.C. to all Parties. However, the Division shall produce the notifications submitted by the carriers pursuant to Sections 9.A., 9.B., and any additional information produced under 9.C. to the Insurance Ombudsperson.

H. The carrier has an affirmative duty to notify the Division of any changes, discrepancies, errors, or omissions regarding the notifications required under this Section 9.

Section 10 Complaint

A. Simultaneous with the filing of the carrier's notification detailed in Section 9, the carrier may file a Complaint identifying the Material Provider(s) that were a cause of the carrier's failure to meet the Premium Rate Reduction Requirements alleging:

1. The inability of the carrier to meet the Premium Rate Reduction Requirements;

2. The reasons the carrier failed to meet the Premium Rate Reduction Requirements including any reasons not tied to Material Providers;

3. The Material Provider(s) that were a cause of the carrier's failure to meet the Premium Rate Reduction Requirements.

4. Sections of the template(s) summarizing each Material Provider's contributions to premiums provided pursuant to Section 9 to support the carrier's identification of Material Providers as a reason the carrier claims it failed to meet the Premium Rate Reduction Requirements;

5. A reimbursement rate pursuant to §§ 10-16-1306(4), (5) and (7), C.R.S., applicable to such Material Provider(s) that would allow the carrier to further reduce premiums on its Colorado Option Standardized Plans; and

6. Any legal authority supporting the complaint.

B. If a carrier has notified the Division that it failed, or the Division alleges that the carrier has failed, to meet the Premium Rate Reduction Requirements, the Division may also initiate a Complaint or Cross-Complaint against any Material Provider and carrier after reviewing the carrier's March 1 Notice and filings. The Division's complaint may include the information set forth in Section 10.A.

C. A carrier may file a network adequacy Complaint, or Cross Complaint, which may name or include hospitals or health-care providers. The Division may also file a network adequacy Complaint, or Cross Complaint, which may name or include a carrier and hospitals or health-care providers. A network adequacy Complaint may be filed in conjunction with a Complaint specified in subsections A and B; however, a carrier or the Division is not required to bring both Complaints at the same time or in the same proceeding.

The Division's network adequacy complaint may contain allegations that a carrier failed to comply with § 10-16-1304(1)(f), C.R.S., and network adequacy requirements, including, but not limited to, Colorado Insurance Regulations 4-2-53, 4-2-54, 4-2-55, and 4-2-56 and may identify the hospital(s) or health-care provider(s) that were a cause of the Carrier failing to meet network adequacy requirements.

A carrier's network adequacy complaint may include the reasons why the carrier is unable to comply with § 10-16-1304(1)(f), C.R.S., and network adequacy requirements, including, but not limited to, Colorado Insurance Regulations 4-2-53, 4-2-54, 4-2-55, and 4-2-56, and shall identify the hospital(s) or health-care provider(s) that were a cause of the Carrier failing to meet network adequacy requirements.

If a Carrier is unable to comply with the network adequacy requirements under § 10-16-1304(1)(g), C.R.S., the carrier shall follow the action plan procedures set forth in Colorado Insurance Regulation 4-2-80. The Commissioner may issue a procedural order modifying any of the deadlines or requirements in this regulation as needed upon the filing of a network adequacy Complaint to ensure adequate notice and an opportunity to be heard to the Parties.

D. The Complaint shall be served on all Parties consistent with the requirements set forth in Section 8.

E. The Division will submit a status update to the Commissioner within four (4) weeks of the March 1 Notice and filings, which will provide a procedural update on the timeline for filing any complaints. The Division shall serve the status update on the carrier and the Insurance Ombudsperson. The Commissioner shall post the status update on the Division's website. Upon request of the Commissioner, the Division shall file other status updates.

F. Nothing in this regulation shall be interpreted to prohibit the Division from investigating and initiating an enforcement action at any time during the year if the Division has determined that the carrier is no longer in compliance with its network adequacy requirements.

Section 11 Answer to Complaint of Failure to Meet the Premium Rate Reduction or Network Adequacy Requirements

A. A carrier alleged by the Division to have failed to meet the Premium Rate Reduction Requirements or network adequacy requirements pursuant to Sections 10.B and 10.C shall file an Answer within twenty-one (21) days from the date of service of the Complaint. Simultaneously with the Answer, the carrier may also file a Cross-Complaint alternately or hypothetically that identifies the hospital(s) or health-care provider(s) that the carrier alleges were a cause of the carrier's failure to meet the requirements. The Cross-Complaint shall contain all of the information required of a Complaint in Sections 10.A and 10.B.

B. Any hospital or health-care provider named in a Complaint or Cross-Complaint shall file an Answer within twenty-one (21) days from the date of service of the Complaint or Cross-Complaint, as applicable. The Answer shall:

1. Respond to all allegations in the Complaint or Cross-Complaint;

2. Identify whether the carrier could have met the Premium Rate Reduction Requirements or network adequacy requirements, and if so, attach any analysis supporting this allegation;

3. Provide a substantive response as to why the hospital or health-care provider contends the reimbursement rates offered by the carrier are insufficient, if applicable, including any potential effects of the requested reimbursement rates on the hospital's or health-care provider's operations; and

4. To the extent known, provide a statement as to whether the carrier and the hospital or health-care provider engaged in nonbinding arbitration as allowed under § 10-16-1306(1)(b), C.R.S., or consent to participate in the opportunity for settlement afforded by Section 12.

C. Documents provided as exhibits to the Answer must be bates numbered and clearly identify the Party submitting the documentary evidence.

D. The Insurance Ombudsperson and the Division may, but are not required to, file a response to a Complaint or Cross-Complaint within twenty-one (21) days of receipt of the Complaint or Cross-Complaint. The Division may file a Cross-Complaint naming additional hospitals or health-care providers.

Section 12 Settlement

A. The carrier, hospital(s) and/or health-care provider(s), and the Division may negotiate a settlement. The Commissioner shall enter a final agency order approving or disapproving the settlement or recommend a modification as a condition for approval.

If the Commissioner does not approve the negotiated settlement or a settlement is not reached, the Parties shall proceed with the public hearing. All negotiations during the settlement period are considered confidential and shall not be introduced into the hearing.

B. If a settlement is achieved that concludes the adjudicatory session of the public hearing and is approved by the Commissioner, the Commissioner may still hold a hearing for public comment prior to the approval of the carrier's final rates. The Commissioner shall issue notice of the date, time, location, and scope of any public hearing held pursuant to this subsection B.

C. The Division may conduct settlement negotiations with the carrier and hospitals or health-care providers to determine whether a settlement may be reached prior to the Division filing a complaint.

D. Prior to a settlement being reached or upon request of the Division, the carrier shall provide the following documentation to the Division to verify the reimbursement rates and premium impact of the proposed reduction in those reimbursement rates:

1. The two years preceding the applicable plan year's and the applicable plan year's:

    a. Negotiated Rates for most common services, which account for 85% of spend between the carrier and named hospital or health-care provider.

    b. Payment methodology and tools outlining how the carrier reimburses the hospital or health-care provider for different services (i.e., Diagnosis Related Groups, Per Diem, etc.).

    c. The Aggregate Negotiated Rate, as a percent of Medicare, and documentation of the methodology and tools used to calculate the Aggregate Negotiated Rate as a dollar value and the rate as a percent of Medicare. The Medicare rates effective when March 1 filings are submitted must be used to determine the percent of Medicare.

    d. Premium impact statement demonstrating the overall impact of the hospital or health-care provider reimbursement Rate reduction by plan, metal tier, network, and Rating Area, including negotiated reimbursement rate reduction agreements entered into before and after the March 1 filing.

2. If a carrier and a hospital or health-care provider agree on a twenty percent (20%) reduction to the applicable plan year's Negotiated Rate compared to the current year's Negotiate Rate for the year preceding the applicable plan year, then the carrier must submit, for the year preceding the applicable plan year and the applicable plan year:

a. Negotiated Rates for most common services, which account for 85% of spend between the carrier and named hospital or health-care provider.

b. Payment methodology outlining how the carrier reimburses the hospital or health-care provider for different services (i.e., Diagnosis Related Groups, Per Diem, etc.).

c. The Aggregate Negotiated Rate, as a percent of Medicare and documentation of the methodology used to calculate the Aggregate Negotiated Rate and the rate as a percent of Medicare

d. The methodology, adjustments, and assumptions used to assess the twenty percent (20%) reduction on a service level, in aggregate, and as a percent of Medicare.

e. Premium impact statement demonstrating the overall impact of the hospital or health-care provider's reimbursement rate reduction by plan, metal tier, and Rating Area, including reimbursement rate reduction agreements entered into before and after the March 1 filing.

3. An attestation, and supporting documentation the Division requests, to verify that the hospital or health-care provider will be in-network for the entire applicable plan year.

E. At all times, the carrier has an affirmative duty to notify the Division of any changes, discrepancies, errors, or omissions regarding the information provided pursuant to this Section 12, including, but not limited to, in-network status, reimbursement rates, Negotiated Rates, and premium impact.

Section 13 Public Availability of Documents

A. In accordance with the Colorado Open Records Act and § 10-16-1306(3)(b), C.R.S., information submitted to the Commissioner as part of the public hearing process is presumed to be a public record and open for inspection, subject to restrictions specifically provided by law.

B. The Commissioner shall post all pleadings, documents submitted by the Parties, and orders of the Commissioner on the Division's website except as provided in Section 14 relating to Confidential Information.

Section 14 Confidential Information

A. Documents Submitted Pursuant to Section 9

1. In accordance with § 10-16-1306(3)(b), C.R.S., and subject to the requirements of the Colorado Open Records Act, the following information submitted for purposes of Section 9 and the public hearing may be filed under a claim of confidentiality as set forth in the procedures of this Section 14:

a. The premium data, Cost Sharing Reduction loads, and carrier assumptions and projections by service area included in the Premium Rate Reduction Notification template, as specified in Section 9.A.1 of this regulation

b. The Material Providers' relative contribution to the plan's premium in a Rating Area as included in the table specified in Section 9.A.2 of this regulation

c. The Negotiated Rate Template as specified in Section 9.A.3 of this regulation

d. The actuarial analysis as specified in Section 9.A.5 of this regulation

e. The Cost of Care Template as specified in Section 9.B.2 of this regulation

2. Information submitted pursuant to this Section 14.A.1.a, b, and d may be subject to the requirements set forth in § 10-16-107(1)(g)(I), C.R.S., and, subject to the provisions of the "Colorado Open Records Act," part 2 of article 72 of title 24, may be made public after carriers file premium rates with the Division in June.

3. Nothing in this Section 14.A. shall be interpreted to limit a Party's ability to submit other documentation or information under a claim of confidentiality.

B. Procedures for requesting confidentiality.

1. Any Party may make a claim of confidentiality as to information or documents submitted to the Parties and the Commissioner.

2. A claim of confidentiality constitutes a representation to the Commissioner that the Party has a reasonable and good faith belief that the subject document or information is, in fact, confidential under applicable state and federal law, including the Colorado Open Records Act. If a claim of confidentiality is made in violation of this subparagraph, the Commissioner may impose an appropriate sanction upon the claiming Party, including an order to pay the amount of reasonable expenses incurred because of the claim of confidentiality, and reasonable attorney's fees.

3. Any Party submitting documents or information under a claim of confidentiality shall file, as part of the public record (i.e., not confidential), a notice of confidentiality specifying each document, the nature of the document on which confidential information is found, and the basis(es) for the claim of confidentiality as to the information and the bates numbers of the confidential documents. The notice of confidentiality shall be served upon the Parties. Failure to file a notice of confidentiality will result in administrative rejection of the filing of the confidential information.

4. Each page of each document on which confidential information is contained shall clearly be marked as "CONFIDENTIAL." Confidential documents will be maintained in the record by the Commissioner separately from other public documents.

5. The Commissioner's acceptance of information or documents under a claim of confidentiality is not, and shall not be construed to be, an agreement or determination by the Commissioner that the subject information or document is, in fact, confidential.

6. The Commissioner may, at any time, sua sponte or after considering a motion from any Party, issue a decision as to whether the subject information or documents submitted under a claim of confidentiality is confidential.

7. In the event the Commissioner rules that information submitted under a claim of confidentiality is not confidential, any person with access to the information shall not disclose the information or use it in the public record for seven (7) days. During this time period, the Party making a claim of confidentiality may seek a stay or other relief permitted by law.

B. Protection of Confidential Information

1. Information or documents ruled by the Commissioner as confidential, or information or documents submitted under a claim of confidentiality for which no ruling has been made by the Commissioner, shall be treated as confidential ("Confidential Information").

2. Confidential Information will only be made available to the Commissioner, the Commissioner's staff, and Parties. Confidential Information will not be made available to the public.

3. The Office of the Insurance Ombudsperson as a Party to the public hearing will be provided access to Confidential Information, but shall not provide Confidential Information to consumers, advocacy organizations, or the public.

   The Office of the Insurance Ombudsperson shall immediately notify the Commissioner and the Parties of any requests under the Colorado Open Records Act for Confidential Information.

4. Confidential Information may only be used for purposes of public hearings, and may not be shared with other persons or entities.

5. Confidential lnformation may be disclosed to experts or advisors for the Parties only for the purposes of public hearings.

6. Confidential Information shall not be used or disclosed for purposes of business or competition.

7. The Parties shall take all reasonable precautions to keep Confidential Information secure.

8. When reference is made to Confidential Information in exhibits, testimony, or pleadings, it shall be by citation to the title or nature of the document, or by some other description that will not disclose the Confidential Information.

9. Failure by any person to comply with the requirements of this Section regarding Confidential Information, or disclosure of Confidential Information to any person or entity who is not a Party to the public hearing, may result in sanctions as set forth in the Colorado Rules of Civil Procedure (C.R.C.P.) 37(b)(2) and may result in monetary penalties up to $750,000 pursuant to §§ 10-3-1107 and 10-3-1108(1)(a), C.R.S., for violating a rule or order of the Commissioner.

10. Within thirty (30) days of the conclusion of the proceedings, including any appeal of the final agency order, the Confidential information retained by the Parties shall be destroyed.

C. Public Hearing

1. Upon a showing that it is necessary for a Party to refer to Confidential Information during testimony at the public hearing, the Commissioner may convene the public hearing with only the Parties present to hear such testimony. A recording of this portion of the public hearing will be maintained by the Commissioner and will be treated as Confidential Information. Other Parties may cross-examine the witness as to the Confidential Information during this confidential portion of the public hearing.

2. Time devoted to the closed portion of the public hearing shall count against the time allotted to the Party requesting the closed hearing. Where multiple Parties request a closed hearing, the time allotted to the closed portion of the hearing shall be equally divided amongst the Parties that made such request.

D. Division and Commissioner Maintaining Confidential Information

Notwithstanding the provisions of this Section 14, and subject to the requirements of the Colorado Open Records Act, the Division and the Commissioner shall retain all Confidential Information. The Division and Commissioner may use Confidential Information for any lawful regulatory purpose, including, but not limited to, rate review, investigations, and enforcement actions.

E. Appeal

In the event the Commissioner's final agency order from the public hearing is appealed or otherwise subject to judicial review, the Commissioner will file all Confidential Information under seal with the Colorado Court of Appeals in accordance with applicable rules and regulations.

Section 15 Conflicts of Interest Screen

A. Where the carrier and hospitals and/or health-care providers elect to participate in the Opportunity for Settlement afforded under Section 12, any Division representatives that participate in the negotiations shall be screened from the Commissioner for the entirety of the applicable public hearing process. Additionally, the Division representatives that participate in the negotiations shall not disclose any information from the negotiations to the Commissioner.

The Division's representatives and staff supporting those representatives shall be screened from the Commissioner, and their representatives and staff, for the entirety of the applicable public hearing.

B. "Screened" as used in this Section includes, specific to the matter that is the subject of the screen, remaining as separate entities for the public hearing and being restricted from ex parte communications. Except for filings submitted in SERFF or SFTP and documents submitted to the Parties and the Commissioner for a determination of confidentiality pursuant to Section 14, "screened" shall include prohibiting the Commissioner and their representatives' access to non-public filings and documents in the possession of Division staff and representatives on the opposite side of the screen from the Commissioner. It does not include restrictions on communications when all Parties and the Commissioner are included in the communication or communications. "Screened" does not include any procedural status updates filed by the Division prior to the filing of a complaint if the status update is publicly posted on the Division's website.

Section 16 Party Disclosures

A. Unless otherwise set in a procedural order issued by the Commissioner, no later than fourteen (14) days after the Parties submit Answers, each Party shall serve upon the Commissioner and all Parties the following information:

1. A witness list including the name, address, and telephone number of any witness whom the Party may call to provide testimony at the public hearing, together with a detailed statement of the content of that person's testimony. The Party shall indicate for each witness whether the witness's testimony will be written or oral.

2. Any of the following additional documentary evidence a Party may wish to include in the record at the public hearing related to a carrier's failure to meet the Premium Rate Reduction Requirements or network adequacy requirements in the Rating Area at issue may be submitted for the Commissioner's review including but not limited to:

    a. An actuarial analysis demonstrating why the Premium Rate Reduction Requirements were not met.

b. Negotiated rates with other hospitals or health-care providers in the same Rating Area.

c. Enrollee and utilization data for the Rating Area.

d. Hospital or health-care provider financial data, including but not limited to, profit and loss statements and balance sheets. Hospitals or health-care providers may also submit other data to demonstrate unique circumstances that may not be represented in the public hearing.

e. Hospital or health-care provider rates with other carriers.

f. Carrier initiatives and assumptions to reduce health care costs for the Rating Area.

g. Demographics and acuity of covered persons within the Rating Area.

3. All documents submitted to the Commissioner and the Parties pursuant to this Section will be included in the record for the public hearing, subject to Sections 14 and 21.

Section 17 Additional Discovery

A. The Colorado Rules of Civil Procedure (C.R.C.P.) 26 through 37 do not apply to the public hearing proceedings.

B. The Parties shall confer on any additional discovery beyond the disclosures identified in Section 16 and the written testimony in Section 21. The Parties are encouraged to keep discovery requests limited, targeted, and narrowly tailored to information that is related to the reason the carrier failed to meet network adequacy requirements or the Premium Rate Reduction Requirements. If the Parties cannot reach an agreement, the Party seeking discovery shall file a motion with the Commissioner before serving discovery on another Party. Additional discovery shall be at the discretion of the Commissioner. The Party seeking discovery shall set forth in the motion the following:

1. The specific data or information that the Party is requesting;

2. The rationale for the requested data or information;

3. The relevance to the carrier's failure to meet the Premium Rate Reduction Requirements or network adequacy requirements;

4. Whether the data or information is available from another source.

C. If the Commissioner grants the additional discovery, the Commissioner will issue an order setting the deadline for the Party to produce the discovery.

Section 18 Motions

Parties shall have five (5) days to respond to any motion submitted by an opposing Party, unless otherwise ordered by the Commissioner. No reply briefs are permitted. Time shall be calculated as provided in Section 25.

Section 19 Consolidation of Proceedings

The Commissioner has the discretion to consolidate proceedings involving the same carrier.

Section 20 Burden of Proof

A. The burden of proof shall be on the Party that is the proponent of a decision.

B. Nothing in this Section 20 shall preclude a hospital or health-care provider from presenting evidence that the carrier's proposed reimbursement rate is insufficient.

Section 21 Public Hearing Proceedings

A. No later than fifteen (15) days before the hearing, the Commissioner shall issue an order setting forth the allotted time for the Parties to present evidence and testimony at the hearing.

B. Public Comment by Interested Persons

In addition to the Parties identified in Section 7, consumer advocacy organizations, trade organizations, and other entities or individuals shall be given the opportunity to present evidence regarding the carrier's failure to meet the Premium Rate Reduction Requirements or network adequacy requirements during the public hearing. Members of the public, consumer advocacy organizations, small businesses, trade organizations, and other entities or interested persons who seek to comment at the hearing shall sign up at least two (2) days in advance of the hearing on the Division's website. The Commissioner may set time limits on public comment.

Members of the public may submit written comments up to two (2) days after the hearing, in lieu of public comments at the hearing, which will be posted on the Division's website.

C. Presentation of Evidence

1. The Commissioner shall limit evidence presented at the hearing to information that is related to the reason the carrier failed to meet the network adequacy requirements or the Premium Rate Reduction Requirements for the Standardized Plans at issue in the hearing. Evidence shall be limited to information that is relevant to the Commissioner's determination pursuant to §§ 10-16-1306(3) to (11), C.R.S.

2. The Colorado Rules of Evidence and requirements of proof shall conform, to the extent practicable, with those in civil nonjury cases in the district courts. However, when necessary to ascertain facts affecting substantial rights of the Parties to the proceeding, the Commissioner may receive and consider evidence not admissible under the Colorado Rules of Evidence, if the evidence possesses probative value commonly accepted by reasonable and prudent persons in the conduct of their affairs. Informality in any proceeding or in the manner of taking testimony shall not invalidate any order, decision, rule, or regulation. The Commissioner may exclude incompetent and unduly repetitious evidence.

3. Exhibits

a. Documentary evidence shall be admitted into the record, except as follows:

(1) Any Party may object under the Colorado Rules of Evidence to inclusion of documentary evidence in the record at the public hearing, provided the objection is made in writing to the Commissioner at least five (5) days prior to the public hearing. The Commissioner may rule on these objections in writing or on the record during the public hearing.

(2) At the Commissioner's discretion, the Commissioner may require the Party presenting a document in the record to present testimony or evidence as to the authenticity of that document.

b. The Commissioner encourages Parties to offer written stipulations resolving any evidentiary dispute, fact, or matter of substance or procedure at issue. Oral stipulations may be made on the record at the public hearing, but the Commissioner may require that the stipulation be reduced to writing, signed by the Parties or their counsel, and filed with the Commissioner. Any stipulation must be approved by the Commissioner, and the Commissioner may modify a stipulation as a condition of approval.

4. Witness Testimony

a. A Party may present the testimony of its witnesses through written testimony provided the Party has identified that the witness's testimony will be presented in writing in their witness list submitted pursuant to Section 16. Written testimony must be submitted to the Commissioner and the Parties no later than seven (7) days before the hearing.

b. All Parties may make objections to witness testimony, and all witnesses are subject to cross-examination by or on behalf of Parties to the hearing. Any witness who's oral and/or written testimony a Party wishes to have as part of the record shall be available for cross-examination at the hearing.

5. Where lengthy cross-examination would use undue time, the Commissioner may require each Party to estimate the amount of time necessary for cross-examination. To promote an efficient hearing, the Commissioner may limit each Party's time for cross-examination. Time devoted to cross-examination shall count against the time allotted to the Party conducting the cross-examination.

Section 22 Recording of Hearing

The public hearing shall be recorded and posted on the Division's website.

Section 23 Establishment of Reimbursement Rates, if Necessary, and Issuance of Final Agency Order

A. Based on the evidence presented at the hearing, the Commissioner may establish and require hospitals and/or health-care providers to accept carrier reimbursement rates for hospitals and/or health-care providers, if necessary, to meet the network adequacy requirements or the Premium Rate Reduction Requirements. "If necessary" means essential to the achievement of network adequacy or reduced premiums, but not in all instances sufficient for a carrier to meet network adequacy requirements or the Premium Rate Reduction Requirements.

B. In determining the hospital's reimbursement rate, the Commissioner may:

1. Consult with employee membership organizations representing health-care providers' employees in Colorado and with hospital-based health-care providers in Colorado.

2. Take into account the cost of adequate wages, benefits, staffing, and training for health-care employees to provide continuous quality care.

3. Take into account the most current Medicare prospective or cost-based payment rates available, or any rate modifications published by the Centers for Medicare and Medicaid

Services that may be relevant to the applicable plan year, including how the most current Medicare prospective or cost-based payment rates available may impact the applicable Premium Rate Reduction Requirements.

4. Utilize any publicly available hospital and provider data and cost tools.

C. The Commissioner may not set a reimbursement rate for a hospital or health-care provider that is lower than the Hospital Reimbursement Floor or Health-Care Provider Reimbursement Floor specific to that hospital or health-care provider.

D. The Commissioner cannot set the reimbursement rate for any hospital for any plan year at an amount that is more than twenty percent lower than the Negotiated Rate between the carrier and the hospital for the plan year preceding the applicable plan year. To determine the Aggregate Negotiated Rate between the carrier and hospital for the applicable plan year and the year preceding the applicable plan year, the carrier must submit the information required in Section 9.

E. For a hospital with an Aggregate Negotiated Rate that is at least ten percent less than the Statewide Hospital Median Reimbursement Rate measured as a percentage of the Medicare Reimbursement Rate for the 2021 plan year using data from the All-Payer Health Claims Database:

1. The Commissioner will set the hospital reimbursement rate for that hospital at no less than the greater of:

   a. The hospital's Aggregate Negotiated Rate minus one-third of the difference between the hospital's Aggregate Medicare Reimbursement Rate and the Hospital Reimbursement Floor established by Section 5 of Colorado Insurance Regulation 4-2-91.

   b. One hundred sixty-five percent of the hospital's Medicare Reimbursement Rate.

   c. The Hospital Reimbursement Floor established by Section 5 of Colorado Insurance Regulation 4-2-91.

2. If a hospital believes that their Aggregate Negotiated Rate is at least ten percent less than the Statewide Hospital Median Reimbursement Rate, then a hospital may work with the carrier to submit to the Division a joint attestation by March 1 of the year preceding the applicable plan year. The joint attestation must contain the applicable plan year's Aggregate Negotiated Rate, and documentation of the methodology to derive this estimate.

   If a joint attestation is not submitted for a hospital and carrier by March 1 of the year preceding the applicable plan year and the hospital does not provide the Division with any information regarding their Aggregate Negotiated Rate, the Division will calculate the Hospital Reimbursement Floor as the greater of:

   a. One hundred sixty-five percent of the hospital's Aggregate Medicare Reimbursement Rate.

   b. The reimbursement rate established by Section 5 of Colorado Insurance Regulation 4-2-91.

F. The Commissioner shall issue a final agency order which shall include the Commissioner's determination of the reimbursement rate, by hospital and/or health-care provider, that must be used by the carrier in its rate filings.

G. The decision of the Commissioner is a final agency order subject to judicial review pursuant to § 24-4-106(11) C.R.S.

Section 24 Modifications to Public Hearing Process

The Commissioner may issue appropriate orders to control the scope, course, and outcome of the public hearing including, but not limited to, dismissal.

Section 25 Computation and Modification of Time

A. In computing any time period pursuant to this regulation, the day of the event from which the time period begins shall not be included. If the due date falls on a weekend or state holiday, the due date will be the next business day.

B. At the Commissioner's discretion, a due date may be extended.

Section 26 Severability

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

Section 27 Incorporation by Reference

42 C.F.R. § 400.202 published by the Government Printing Office shall mean 42 C.F.R. § 400.202 as published on the effective date of this regulation and does not include later amendments to or editions of 42 C.F.R. § 400.202. A copy of 42 C.F.R. § 400.202 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 42 C.F.R. § 400.202 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 C.F.R. § 147.102 published by the Government Printing Office shall mean 45 C.F.R. § 147.102 as published on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 147.102. A copy of 45 C.F.R. § 147.102 may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 147.102 may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

Section 28 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 29 Effective Date

This regulation shall be effective on February 1, 2025

Section 30 History

New regulation effective February 14, 2023.

Amended regulation effective February 1, 2024.

Amended regulation effective February 1, 2025.