

**JOINT ATTESTATION TEMPLATE REGARDING [CARRIER NAME]’S AND  
[PEDIATRIC HOSPITAL NAME]’S PLAN YEAR 2027 REIMBURSEMENT RATE**

[Carrier Name] and [Pediatric Hospital Name] (together, the “Parties”) agree to aggregate reimbursement rates (as a percentage of Medicare) for [Carrier Name]’s Colorado Option Standardized plans in the [individual/small group] market for [networks] in effect as of [effective date] (the “Negotiated Reimbursement Rates”) that reflects the reduction specified below that the Commissioner of the Colorado Division of Insurance is able to set pursuant to § 10-16-1306(5) or (7), C.R.S.

Instructions: Please complete the attestation below with the agreed-upon negotiated rate for Plan Year 2027. Pediatric hospitals that require this calculation are defined as “a hospital that is part of a pediatric specialty hospital system where over ninety percent of the hospital system’s population served is under eighteen years of age and has a level one pediatric trauma center” For pediatric hospitals, the negotiated rate should be repriced to a percentage of Medicare using the following calculation per § 10-16-1306(4)(a), C.R.S. The Medicare Reimbursement Rate shall be calculated using the Medicaid fee schedule ([Inpatient](#), [Outpatient](#), [all others](#)) effective as of October 2025 multiplied by 1.52. For example, if the Medicaid allowed amount is \$100, the Medicare allowed amount would be \$152, so the negotiated rate, as the equivalent rate, would be the carrier’s allowed amount divided by 1.52.

Date of Filing:

- March 1 (Maximum Allowable Reduction(s) pursuant to Colorado Insurance Regulation 4-2-92 Section 4.V. Only)
- Post-March 1

Amount of Reduction:

- 20% reduction from Plan Year 2026 Negotiated Reimbursement Rate
- Reduction to Plan Year 2027 Reimbursement Rate Floor
- Other: \_\_\_\_\_% Reduction

Plan Year 2027 Negotiated Reimbursement Rate: [\_\_\_\_\_] % of Medicare

Plan Year 2026 Negotiated Reimbursement Rate: [\_\_\_\_\_] % of Medicare

Notes (as needed)

[Notes as needed]

The Parties have caused this Joint Agreement to be executed by the signatures of the following authorized Officers to bind the Parties.

**CONFIDENTIAL**

**[Carrier Name]**

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**[Hospital Name]**

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_