

DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Proposed New Regulation 4-2-31

ANNUAL HEALTH REPORTING AND DATA RETENTION REQUIREMENTS

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Section 1 Authority

This regulation is promulgated under the authority of §§ 10-1-109, 10-3-109, 10-16-111(4), and 10-16-134, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to define uniform reporting, filing and data retention requirements for the hospital reimbursement rate report and the Annual Cost Report.

Section 3 Applicability

This regulation applies to all carriers, as defined in Section 4(B) of this regulation, operating in the state of Colorado with written health premium in the data year. This includes, but is not limited to carriers operating with the following types of business: comprehensive health insurance, Health Maintenance Organization (HMO) coverage, supplemental health, limited service licensed provider network business, long-term care, disability income, accident-only, specified or dread disease, hospital indemnity, vision only, dental only, other limited-medical payment plans and excess loss insurance (pursuant to § 10-16-119, C.R.S.).

Reporting of information is waived for the following lines of business for each report:

A. Hospital Reimbursement Rate Report

Limited medical-payment plans (including disability income, accident only, specified or dread disease, hospital indemnity, vision only, and dental only), Medicare, Medicaid, long term care, and Medicare supplement insurance.

B. Annual Cost Report

Third party administration for fully self-funded plans, undeveloped rates that involve Medicare, Medicaid and Medicare Part D, and Medicare supplement insurance and excess loss insurance (pursuant to § 10-16-119, C.R.S.).

Section 4 Definitions

- A. "Average Reimbursement Rate" is the average of all reimbursement rates that a carrier paid, by MS-DRG code, to only hospitals/facilities reporting to the Colorado Hospital Association during the previous calendar year including both in-network and out-of-network facilities.
- B. "Carrier" means any entity that provides health coverage in this state including a franchise insurance plan, a fraternal benefit society, a health maintenance organization, a non profit hospital and health service corporation, a sickness and accident insurance company, and any other entity providing a plan of health insurance or health benefits subject to the insurance laws and regulations of Colorado.
- C. "Diagnostic Related Group" means, for purposes of this regulation, the classification assigned to an inpatient hospital service claim based on the patient's age and sex, the principal and secondary diagnoses, the procedures performed, and the discharge status.
- D. "Dividends" means, for purposes of this regulation, both policyholder and stockholder dividends.
- E. "MS-DRG code" (Medicare Severity Diagnosis Related Group code) is a code within a system developed for Medicare as part of their payment system to classify each hospital case into one of approximately 500 groups.
- F. "Premium" means, for purposes of this regulation, the amount of money paid by the insured as a condition of receiving health care coverage. The premium paid normally reflects such factors as the carrier's expectation of the insured's future claim costs and the insured's share of the carrier's claims settlement, operational and administrative expenses, and the carrier's cost of capital. This amount is net of any adjustments, discounts, allowances or other inducements permitted by the health care coverage contract.
- G. "Reimbursement rate" means the amount, by MS-DRG code, that a carrier paid for a procedure at a facility or hospital, plus any expected deductible, copayment, and/or coinsurance. It is important that only the entire hospital/facility reimbursement be included in this rate, not just the carrier's portion. Provider reimbursement charges should be excluded from this total. Private room, personal item and other charges that are generally the responsibility of the policyholder should also be excluded.
- H. "Trend," for the purposes of this regulation, means the rate of increase in costs for the reporting period.
- I. "Stop Loss" means Individual or group policies providing coverage to a health plan, a self-insured employer plan, or a medical provider providing coverage to insure against the risk that any one claim or an entire plan's losses will exceed a specified dollar amount.

Section 5 Hospital Reimbursement Rate Record Retention and Report

- A. The Division will annually publish on its website or communicate directly to carriers the list of MS-DRG codes associated with the twenty-five most common inpatient procedures performed in Colorado for each reporting year. This will include more than twenty-five MS-DRG codes, as there are multiple codes for different levels of severity in many of the identified procedures.

- B. Pursuant to the Health Care Transparency Act, § 10-16-134, C.R.S., each carrier shall report to the Division the average reimbursement rates and number of procedures on a statewide basis for the twenty-five most common inpatient procedures performed in Colorado at hospitals/facilities reporting to the Colorado Hospital Association. This information shall be filed electronically using the Division of Insurance website in a format made available by the Division.
- C. Timing and Submission: The required data shall be filed on or before March 1 of each year. Pursuant to § 10-3-109, C.R.S., failure to file this report by March 1 may result in a late penalty not to exceed \$100 per day and any applicable surcharges. Reports not containing all of the information specified in this section may be subject to a fine for an incomplete report.
- D. Each entity subject to the Health Care Transparency Act shall:
 - 1. Maintain its books, records, and documents in a manner that ensures the necessary data can be readily ascertained and reported to the Division.
 - 2. Format records for Each Diagnosis Related Group to be recorded and classified using the MS-DRG coding format and procedures at the time of discharge.
 - 3. Ensure that reimbursement/claim records shall:
 - (a) be maintained so as to show clearly the MS-DRG code assigned and reimbursement rate of each procedure.
 - (b) be sufficiently clear and specific so that the pertinent dates, locations, cases and charges of these events can be reconstructed.
 - (c) include and if necessary calculate the complete reimbursement rate, hospital/facility, and MS- DRG Code for each inpatient procedure.

Section 6 Annual Cost Report

- A. Pursuant to § 10-16-111(4)(a), C.R.S., companies subject to this regulation shall file an Annual Cost Report as described in this section. This report must comply with the requirements of this section and must contain the information specified in Subsection C of this section and shall be filed electronically via a form provided on the Division of Insurance's website www.dora.state.co.us/insurance.
- B. Timing and Submission: All Annual Cost Reports shall be filed electronically in a format made available by the Division of Insurance via the Division's website on or before June 1 of each year. Failure to file this report by June 1 will result in a late penalty not to exceed \$100 per day. Reports not containing complete and accurate information specified in Subsection C of this section may be subject to a fine for an incomplete report.
- C. Annual Cost Reports filed by companies identified in Section 3 must contain, where applicable, all of the information in this subsection. For every company the report shall include the following information from the previous calendar year.
 - 1. The information required in this report identified in Subsection 2 of this section must be itemized in the following categories by:
 - a. Market group size: individual, small group, large group, and association; and

- b. Lines of business: comprehensive health insurance, Health Maintenance Organization (HMO) coverage, long term care, disability income, accident, specified or dread disease, hospital indemnity, vision and dental.
2. The following information referred to below is to be reported from the carrier's financial annual statement or provided using the allocation method detailed in Subsection D:
- a. Earned premium, not reduced by dividends.
 - b. Written premium, not reduced by dividends.
 - c. Net reinsurance premiums.
 - d. Dividends.
 - e. Reserves on hand.
 - f. Net investment income.
 - g. Realized capital gains and losses.
 - h. Net Income.
 - i. The cost of providing or arranging health care services. Costs for providing pharmacy benefits shall be reported also, but separately, if applicable.
 - j. Net reinsurance recoveries.
 - k. Expenditures for disease or case management programs or patient education and other cost containment or quality improvement expenses.
 - l. Insurance producer commissions.
 - m. Payments to legal counsel.
 - n. Advertising and marketing expenditures.
 - o. General administrative expenses, including expenses that are not otherwise mentioned in this subsection.
 - p. Non-executive staff salaries.
3. The following information may not be available on the annual statement and must be reported;
- a. The number of policyholders covered. This represents the number of actual policies issued for a product. For group coverage, this represents the number of primary subscribers to the groups and not the number of groups.
 - b. The number of groups covered.
 - c. The number of lives covered. This represents the number of individuals, including dependents that are covered under the policies or groups covered under a product type.

- d. Paid lobbying expenditures.
- e. Charitable contributions.
- f. Healthcare cost trend must be itemized by product type as follows:
 - (1) Major Medical: This subsection shall be applicable for product types that provide comprehensive medical coverage, including but not limited to covering basic healthcare services and prescription drugs.
 - (a) Medical trend, excluding pharmacy trend, itemized by provider price increases, utilization changes, medical cost shifting, and new medical procedures and technology;
 - (b) Medical insurance trend, excluding pharmacy insurance trend, itemized by underwriting wear-off, deductible leveraging and anti-selection.
 - (c) Pharmacy trend, itemized by provider price increases, utilization changes, medical cost shifting and new medical procedures and technology.
 - (d) Pharmacy insurance trend, itemized by underwriting wear-off, deductible leveraging and anti-selection.
 - (2) All other products: This subsection shall be applicable for all other product types not described in Subsection 3(f)(1) of this section. For each product type, the company shall report the trend applicable to the product for the prior year.

- 4. The following information can be found in the financial annual statement on the Supplemental Compensation Exhibit and should be reported on a national basis.

Executive salaries, which includes but is not limited to base salary, bonuses and stock options. This item should be reported in total for the company and should not be allocated or reduced to represent a major line of business or product type. The executives that should be included are those required to be included in the Supplemental Compensation Exhibit in the financial annual statement.

- D. The information provided in Subsection C of this section shall be provided on a Colorado only basis, with the exception of executive salaries which is defined in Subsection C(4) of this section. A carrier licensed in multiple jurisdictions may satisfy the requirements of Subsection C of this section by filing the Colorado-allocated portion of national data if the actual Colorado only data is not otherwise available. The methods of allocation that should be used, if necessary, will be provided by the Division prior to the release of the report for completion.
- E. If any of the items listed in Subsection C of this section are not applicable to the carrier, the carrier shall indicate in the filing which items are not applicable and the reason why such items are not applicable.
- F. The information provided to the Division of Insurance in Subsection C of this section will be aggregated for all carriers and will be published on the Division of Insurance's website, www.dora.state.co.us/insurance.

Section 7 Incorporated Materials

The MS-DRG is incorporated by reference, but this rule does not cover amendments to this law or model act that were promulgated later than the effective date of this rule. A copy of the MS-DRG codes may be examined at any state publications depository library. For additional information regarding how relevant portions of these codes can be obtained or examined, contact the Director of Market Regulation, Colorado Division of Insurance, 1560 Broadway, Ste 850, Denver, CO 80202.

Section 8 Severability

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

Section 9 Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, 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 fines, issuance of cease and desist orders, and/or suspensions or revocation of certificates of authority. Among others, the penalties provided in §§ 10-3-109, 10-3-1108 and 10-1-205, C.R.S., may be applied.

Section 10 Effective Date

This regulation shall be effective as of January 1, 2010.

Section 11 History

New Regulation 4-2-31, Effective January 1, 2010.