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SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Executive Director Rule
2. Title of Rule: ED 13-01-14-B, Dept. of Health Care Policy and Financing, Health Care Coverage Cooperatives Repeal 10 CCR 2505-2
3. This action is an adoption of: a repeal of existing rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 10 CCR 2505-2, 2505 Department of Health Care Policy and Financing, Executive Director of Department of Health Care Policy and Financing (10 CCR 2505-5).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

The purpose of this rule change is to repeal 10 CCR 2505-2 in its entirety and replace with "This rule was repealed, effective May 15, 2013" This change is effective 05/15/2013.

*to be completed by rule administrator

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Title of Rule:	Dept. of Health Care Policy and Financing, Health Care Coverage Cooperatives Repeal 10 CCR 2505-2
Rule Number:	ED 13-01-14-B
Division / Contact / Phone:	Policy and Communications Office / Barbara Prehmus / x 2991

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   Repeals regulatory oversight of Health Care Coverage Cooperatives by the Department of Health Care Policy and Financing. SB 04-105 repealed Title 25.5 Article 1 Part 4 which statutorily transferred regulatory responsibility to Division of Insurance, effective August 4, 2004. The rule repeal is necessary to conform to statutory intent.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   N/A

4. State Authority for the Rule:

   25.5-1-108, C.R.S. (2012);
   Repeal of Title 25.5 Article 1 Part 4 (2003) pursuant to Senate Bill 04-105.
   25.5-1.108(d), C.R.S. (2012)

Initial Review | Final Adoption

Proposed Effective Date | Emergency Adoption

DOCUMENT #

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Title of Rule:	Dept. of Health Care Policy and Financing, Health Care Coverage Cooperatives Repeal 10 CCR 2505-2
Rule Number:	ED 13-01-14-B
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REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

No classes of persons will be affected by repeal of the rule, which is being done to conform to the statutory transfer of regulatory authority for Health Care Coverage Cooperatives to the Division of Insurance under SB 04-105, effective August 34, 2004. The Division of Insurance has confirmed there are no anticipated resulting negative consequences.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

Repeal of the rule to conform to statutory repeal will not result in negative quantitative or qualitative impact.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

There are no probable costs to the Department resulting from the repeal.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

Inaction will result in the Department having rules for Health Care Coverage Cooperatives without any supporting statutory authority.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

There are no other methods for conforming to statutory intent.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

No alternative methods were considered.

This rule was repealed, effective May 15, 2013

~~**2505 Office of Public and Private Initiatives**~~

~~**10 CCR 2505-2 HEALTH CARE COVERAGE COOPERATIVES**~~

~~**Rule OPPI 96-1 (pursuant to HB 94-1193 and HB 96-1264)**~~

~~**I. STATEMENT OF BASIS AND PURPOSE**~~

~~A. Basis. The authority for these rules is based on H.B. 94-1193 and HB 96-1264, as codified in C.R.S., sections 6-18-103(1)(d), 6-18-201(2), 6-18-202, 204, 205, 206, 207, 207.5, 207.7, and 208.~~

~~B. Purpose. This rule provides for the creation of entities called health care coverage cooperatives ("cooperatives"), established to increase the availability and affordability of health care coverage for people in the state of Colorado. The regulations define the criteria by which cooperatives will be judged when seeking licensure from the Executive Director ("director") of the Department of Health Care Policy and Financing. The rule also and defines what cooperatives need to do to be effective purchasers of health care.~~

~~The regulations also establish procedures for certified health care coverage cooperatives to apply for and obtain a waiver, pursuant to § 6-18-207.5, C.R.S., permitting them to negotiate rates with health plans that are different than would otherwise be permitted under the small group insurance reform law. The rule also establishes annual reporting requirements for waivered cooperatives. More specifically, the rule serves the following purposes:~~

~~1. to focus competition between health plans on cost and quality, rather than on underwriting ability;~~

~~2. to provide greater consumer choice of health plans;~~

~~3. to create standards to ensure that cooperatives act in the interests of consumers;~~

~~4. to define what types of entities will need to apply for licensure as health care purchasing cooperatives and the time-frame in which they must do so;~~

~~5. to set out a timeline for the director's review of such applications for licensure and subsequent annual reports;~~

~~6. to clearly enumerate the types of materials required for such applications and annual reports, in order to expedite the application procedure. Standardization of application and annual reporting materials will also ensure a greater degree of fairness in the department's decision-making;~~

~~7. to provide a standard procedure for cooperatives to protect the confidentiality of their members by limiting the use of individually-identifying health information to research approved by the director;~~

8. to clearly define the responsibilities and duties of cooperatives, in order to provide the department and the cooperatives themselves with an understanding of the standards by which a cooperative will be deemed to be in compliance with the law; and,.

9. to ensure that certified health care cooperatives granted a waiver pursuant to section 6-18-207.5, C.R.S., do not engage in riskskimming and/or cost-shifting behavior.

II. DEFINITIONS

A. "affiliate" or "affiliated" means any entity or person that directly or indirectly, through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

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 nonprofit 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. Carrier includes a "licensed provider network or individual provider" as defined in C.R.S. 6-18-102(11).

C. "case characteristics" shall have the same meaning as in section 10-8-602(3.2) and 10-16-105(8)(e), C.R.S.

D. "complaint" means a written communication primarily expressing a grievance.

E. "department" means the Department of Health Care Policy and Financing.

F. "director" means the executive director of the Department of Health Care Policy and Financing.

G. "existing coverage" means benefits or coverage provided under:

1. Medicare or Medicaid;

2. The Colorado Uninsurable Health Insurance Program;

3. an employer-based or group health insurance or health benefit plan; or

4. an individual health insurance policy or contract issued by an entity authorized to do business under the Colorado Health Care Coverage Act, Article 16, Title 10 C.R.S. "health care coverage plan" means any hospital or medical policy, contract, or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract, or any other plan of health benefits which is subject to regulation by the division of insurance.

H. "insurance producer" or "producer," except as otherwise provided in section 10-2-105, C.R.S. means a person who solicits, negotiates, effects, procures, delivers, renews, continues, or binds: (a) policies of insurance for risks residing, located, or to be performed in this state; (b) membership

in a prepayment plan as defined in parts 2 and 3 of Article 16, Title 10, C.R.S.; or (c) membership enrollment in a health care plan as defined in part 4 of Article 16, Title 10, C.R.S.

I. "rate adjustment factor" shall have the same meaning as in sections 10-16-105(8)(a) and (e), C.R.S.

J. "subscriber category" means a category specifying the number of persons, and their relationship to the primary subscriber, that are covered under a health insurance plan issued to an employee. For small employers, subscriber categories are limited to one adult, two adults, one adult plus any number of children, and two adults plus any number of children.

K. "waiver" means a waiver granted to a certified health care coverage cooperative pursuant to section 6-18-207.5, C.R.S.

III. APPLICABILITY OF OTHER HEALTH CARE REFORM LEGISLATION

Except as specifically permitted under sections 6-18-207.5 and 6-18-207.7, C.R.S. and section XII of these rules, under no circumstances are these rules to be construed as superseding the guaranteed issue and rating requirements for small employers as described in Article 8, Part 6, Title 10, C.R.S., the Small Employer Health Insurance Availability Program Act, and Article 16, Title 10, section 105, C.R.S.

IV. SCOPE OF REQUIREMENT TO HOLD A CERTIFICATE OF AUTHORITY

A. Any person or entity intending to operate or hold itself out as a cooperative after January 1, 1994, must first apply for and receive a Certificate of Authority from the director prior to securing health care coverage for its members (ref. 6-18-201(2)(b) by reference in 6-18-202(1)(a)(I)(B)). For purposes of this subsection IV(A), an entity shall be considered to be operating or holding itself out as a cooperative if it:

1. negotiates with multiple carriers for, or secures from multiple carriers, one or more sets of choices in regard to health care coverage plans, prices, health care quality or accessibility conditions, or services on behalf of multiple employers or individuals, and that offers such sets of choices from such multiple carriers to multiple employers or individuals; and,

2. conducts such negotiation with multiple carriers on behalf of multiple employers as a group, rather than as individual employers.

Administration-only entities that contract with certified cooperatives to provide services such as premium collection, marketing, or other administrative functions only shall not be considered to be operating or holding themselves out as a cooperative. Employers purchasing health care coverage for their individual employees shall not be considered to be operating or holding themselves out as a cooperative.

In determining whether an entity is a single employer for purposes of complying with this subsection IV(A), the director shall make determinations pursuant to section 10-16-

102(40), C.R.S., the stated policy of the Colorado Division of Insurance, and applicable federal law and regulation.

B. Any person or entity operating or holding itself out as a cooperative prior to January 1, 1994, may continue such activities without a Certificate of Authority until December 31, 1995, except that:

1. such a person or entity may not perform any additional activities which are permitted by C.R.S. 6-18-201 to 6-18-208 but which were not performed by the individual or entity in question prior to January 1, 1994, without first obtaining a Certificate of Authority, except as provided for in section IV(C) below (ref. 6-18-202(1)(b)); and,

2. all business activities permitted by C.R.S. 6-18-201 to 6-18-208 will be prohibited after January 1, 1996, whether such activities were conducted prior to January 1, 1994 or not, unless the person or entity in question has first obtained a Certificate of Authority (ref. 6-18-202(1)(a)(I)(B)).

C. Any person or entity conducting activities substantially similar to those authorized under C.R.S. 6-18-201 to 6-18-208 prior to January 1, 1994, that wishes to expand its activities beyond those being performed on that date, in order to effect a transition to becoming a cooperative, shall submit to the director an abbreviated business plan of the entity's proposed activities during the transition period.

V. SCOPE OF REQUIREMENT TO HOLD A WAIVER PURSUANT TO § 6-18-207.5, C.R.S.

A. Any health care coverage cooperative certified pursuant to C.R.S. § 6-18-101 et seq., seeking to negotiate the nonhealth care expense component of the premium rates with participating carriers, resulting in rates that are different than would otherwise be allowable under section 10-16-105(8)(a), C.R.S., and 6-18-207.7, C.R.S., must first apply for and obtain a waiver from the director.

B. Entities that are not yet certified as health care coverage cooperatives may submit a waiver application concurrently with an application for certification.

C. The director is required to act on waiver applications only if submitted by a certified health care coverage cooperative or submitted concurrently with an application for a certificate of authority to act as a health care coverage cooperative.

VI. APPLICATION REVIEW AND APPROVAL PROCESS (REF. 6-18-202(2) AND 6-18-207.5(6))

A. Within 30 days after receiving an application for a Certificate of Authority or an application for a waiver pursuant to § 6-18-207.5, the Director shall respond in writing by either approving such application or denying the same. If an application is denied, the director must notify the applicant of the application's deficiencies. Denial must be based upon a finding by the director that the application fails to satisfy the terms of the statute or rules promulgated thereunder.

B. Applicants have 30 days from receipt of notice of deficiencies to deliver a modified application to the director. If the applicant does not submit a modified application within 30 days, the director's denial of the application shall be final shall deny the application.

C. If the applicant cures the application's deficiencies, then the director shall grant the Certificate of Authority within 30 days of receiving the modified application.

D. If the applicant resubmits the application without fully curing its deficiencies the director shall respond, in writing, within 30 days of such submission and shall inform the applicant of the remaining deficiencies. This process shall be repeated until either a certificate is granted by the director or the applicant chooses not to re-submit the application.

E. If the director fails to act on an application for a waiver within 60 days of receipt of all pertinent information, the applicant may request a formal hearing with the director. Such hearing shall be granted within 30 days of request.

VII.ELEMENTS OF APPLICATION FOR A CERTIFICATE OF AUTHORITY

Applicants must submit two copies of all application materials.All information provided to the director in an application is subject to the Public Records Act, Article 72, Title 24, C.R.S. In accordance with Article 72, Title 24, any information that is considered a trade secret, or other privileged, confidential commercial or financial information will not be subject to public inspection (ref. 24-72-204(3)(a)(IV)). An application for a certificate of authority must include the following:

A. Name of the cooperative and any agent for service of process (6-18-202(1)(a)(I)(A)).

B. Names of the managing personnel of the cooperative and a description of the management and organizational structure (6-18-202(1)(a)(I)(A)).

C. Verification that the entity is not in the business of insurance as prohibited in 6-18-204, C.R.S.

1. An affidavit that the cooperative is not conducting the business of insurance as defined in 10-3-903, C.R.S., or the business of an HMO defined in 10-16-102 (8) (6-18-204, C.R.S.)

2. An affidavit that the cooperative is not assuming liability in any way for payment for health care services covered by a health care coverage plan purchased through the cooperative (6-18-205 (7)).

D. A description of procedures for handling individually identifiable health information as required by 6-18-103(2) and 6-18-103(3), C.R.S.

E. A copy of the articles of organization filed with the Secretary of State required by 6-18-201(2)(a), C.R.S.

F. An affidavit that the cooperative is in compliance with 6-18-201(2)(c) and 6-18-205(3). In order to effect an expedited transition to becoming a cooperative, in the case of an entity conducting

activities substantially similar to those authorized under C.R.S. 6-18-201 to 6-18-208 prior to January 1, 1994, persons or entities working for or under contract with such entity will not be considered organizers.

G. An application filing fee of $1,000 as authorized by 6-18-202 (1)(a)(I)(A)).

H. A copy of bylaws and other documents that describe provisions to govern the business and affairs of the cooperative:

1. Resumes of individuals on the governing body to determine compliance with 6-18-205(3).

2. A description of the administrative activities the cooperative will perform and the administrative activities the cooperative will provide through a contact or agent.

3. A description of the products and services the cooperative plans to offer to members, and how the cooperative plans to price its products and services to members. As required by section 6-18-206(1)(e), must offer, but is not limited to, the standard and basic plans promulgated pursuant to section 10-8-606, C.R.S.

4. A description of the cooperative marketing plan.

5. A description of all conditions of cooperative membership, as required by 6-18-206(1)(a), C.R.S., that if met by a potential employer member, will give the employer's eligible employees and dependents the right to join and continue membership in the cooperative; and a description of membership classes, the basis for distinguishing classes, the fees paid by members in different membership classes, and the benefits of membership for members in different membership classes.

6. Pursuant to 6-18-206(1)(b), C.R.S., a description of data that will be collected from contracting health plans and health providers and information that will be reported about each health plan and/or provider to members and their eligible employees.

7. A description of the proposed geographic service area defined by whole counties or zip codes as required by section XIV(A)(10) of these regulations.

8. Financial statements audited by a Certified Public Accountant for the two most recent years of operation, or for the first year of operation if in operation for fewer than two years, including any written and oral Management Comments. Budget "pro formas" for the first two years of operation including sufficient detail for review for compliance with C.R.S. 6-18 Part 2. (ref. 6-18-206(1)(j))

9. A description of the fee schedule that the cooperative will use to pay insurance producers. Indicate which arrangement(s) is(are) used:

Fee per enrollee_____ Specify amount:_____ _____

Fee per subscriber_____ Specify amount:_____

Fee per group_____ Specify amount:_____

Percent of benchmark premium_____ Specify amount:_____

Percent of premium for each policy sold_____ Specify amount:_____ _____

Variable % of benchmark premium___ _____ Specify amount:_____

Variable % of premium for each policy sold_____ Specify amount:_____

For percent of benchmark premium or variable percent of benchmark premium, describe method of calculating benchmark premium.

10. A description of the financial controls and procedures that will be used by the cooperative.

VIII. ELEMENTS OF APPLICATION FOR A WAIVER (REF. 6-18-207.5(1))

Applicants must submit two copies of all application materials. All information provided to the director in an application is subject to the Public Records Act, Article 72, Title 24, C.R.S. In accordance with Article 72, Title 24, any information that is considered a trade secret, or other privileged, confidential commercial or financial information will not be subject to public inspection (ref. 24-72-204(3)(a)(IV)). An application for a waiver must include the following:

A. Name of the cooperative.

B. A description of procedures to enable compliance with section 6-18-207.5(1)(a), C.R.S., regarding grievance procedures. This description shall include, at a minimum:

1. verification that the cooperative requires carriers to make available for the cooperative's inspection the carrier's complaint record as described in Colorado Division of Insurance regulation 6-2-1, "Complaint Record Maintenance." The cooperative shall also require participating carriers to submit at least quarterly reports from the complaint record, showing complaints received from the cooperative's members.

2. a description of the cooperative's policies and procedures for receiving and tracking both written and oral member complaints against the cooperative (as opposed to the health plans).

C. To verify compliance with section 6-18-207.5(1)(b), C.R.S. (regarding geographic service areas), section 6-18-207.5(1)(e), C.R.S. (regarding standardized benefit plans), and section 6-18-207.5(1)(7), C.R.S. (regarding employee choice), the following information:

1. An affidavit stating that the cooperative is in compliance with section 6-18-207.5(1)(b), C.R.S., regarding the provision of coverage in every geographic service area in which the cooperative's participating carriers are authorized to do business by the Division of Insurance, and a list of the cooperative's participating carriers.

2. A description of the cooperative's rules regarding standardized benefits plans, including provisions requiring all participating carriers to offer only those standardized plans. If the information under section VI(H)(3) of this rule has changed since the cooperative's last application for certification or annual report, include a description, if it is available, of the new standardized benefits plans, showing premiums, covered services, patient copays or coinsurance, and any deductibles, maximums, or other limits on coverage. Include a description of how the cooperative will enforce its standardized plans only policy. (ref. 6-18-207.5(1)(e)). As required by section 6-18-206(1)(e), the standardized plans must include, but are not limited to, the standard and basic plans promulgated pursuant to section 10-8-606, C.R.S.

3. An affidavit stating that the cooperative remains in compliance with section 6-18-207.5(1)(f) by offering each covered employee the opportunity to chose among all available carriers that contract with the cooperative.

D. Description or copy, if a copy is available, of rules the cooperative will implement so that small employers that purchase fully insured products through the cooperative are not permitted to offer their employees comparable fully insured or self insured products through any means other than the cooperative. Include a detailed description of what is considered a "comparable" product. (ref. 6-18-207.5(1)(c)).

E. Verification that the cooperative will not engage in risk skimming behavior and will at all times remain in compliance with the provisions of section 6-18-206(3)(g). (ref. 6-18-207.5(1)(d)). Verification shall include, but need not be limited to, an affidavit that the cooperative will to the extent reasonable and within the constraints of its budget, assist with state efforts to conduct risk assessment of small employer carriers, if such assistance is requested.

IX. ANNUAL REPORTING REQUIREMENTS FOR AUTHORIZED COOPERATIVES AND AUTHORIZED WAIVERED COOPERATIVES AS REQUIRED BY SECTIONS 6-18-202(1)(A)(I)(a) AND 6-18-207.5(4), C.R.S.

Cooperatives must submit two copies of all annual reporting materials.All information provided to the director in an annual report is subject to the Public Records Act, Article 72, Title 24, C.R.S. In accordance with Article 72, Title 24, any information that is considered a trade secret, or other privileged, confidential commercial or financial information will not be subject to public inspection (ref. 24-72-204(3)(a)(IV)). Annually, on the anniversary of the effective date of the certificate of authority,certified cooperatives shall submit:

A. An annual report fee of $1,000 as authorized by 6-18-202 (1)(a)(I)(A).

B. To determine compliance with 6-18-206 (1) (b),(e),(f),(g), C.R.S., a list of all contracts with carriers or requests for proposals for contracts with carriers executed or released since the previous annual report or since the approval of the initial certificate of authority. Listed contracts or requests for proposals for contracts must be kept on file with the cooperative for inspection by the director should such inspection be deemed necessary by the director.

C. A hard copy or an electronic copy of the following information to determine compliance with 6-18-206 (1) (b),(e),(f),(g), C.R.S.:

1. A copy of member or employee enrollment packets, distributed in the year since the last annual report or since the initial application, that include descriptions of all benefit packages available through the cooperative and the prices carriers charge for those benefit packages.

2. Summary reports of operations since the last annual report or the original application including: number of employees and enrollees choosing each plan by subscriber type; number of employees and enrollees choosing each plan by age range and sex; number of employees and enrollees choosing each plan by employee zip code; number of employers by size ranges, standard industrial classification, and employer zip code; employees and enrollees choosing each plan by eligibility status (active, disabled, retired, declined-dual coverage, declined-no contributions); employee participation rates by employer size ranges and industry; average contribution as a percent of premium by employer size ranges and industry.

D. To determine compliance with 6-18-206(3)(g), an inventory of unprocessed applications for health care coverage. This inventory is defined as the number of completed applications for coverage received by the cooperative for groups or individuals who are not yet enrolled in coverage through that cooperative, as of the date of the annual report. One inventory is required for small employer members of the cooperative. A second inventory is required for non-small employer members of the cooperative.

E. A description of efforts since the last annual report or since the approval of the initial certificate of authority to widely publicize the cooperative to potential members, their eligible employees, and the public as required by 6-18-206(1)(h). Submit the advertisements used, where they were run, and how often they were run. Describe other major outreach activities, where they occurred, and how often they occurred.

F. A copy of all materials broadly disseminated since the last annual report to communicate with members, potential members, and the public about the cooperative to determine compliance with 6-18-206(1)(h). Include the dates of mailing or distribution, the zip code destinations of the mailings or distributions, and the number of pieces mailed or distributed; or include other information that fully describes the targeted audience.

G. A description of any changes to the information required by sections VII(H)(5), VII(H)(8), and VII(H)(9) of these regulations since the application was submitted or the prior annual report was submitted.

H. A copy of the information that is reported about each fully-insured health plan or health provider to members and their eligible employees. Information regarding self-insured health plans and providers is exempt from this requirement.

I. If the report being filed is within three years of the organization of the cooperative, an affidavit, signed by the Executive Director of the cooperative, verifying that no individual or entity that served as an organizer of the cooperative has become a person with financial interest in the cooperative's business (ref. 6-18-201(2)(c)).

J. A description of any other changes in the information provided in previous annual reports or in the original application.

K. Waivered cooperatives shall submit an annual report each year on the anniversary of the effective date of certification, not on the anniversary of the effective date of the waiver. If a cooperative submitting an annual report is operating under a waiver obtained pursuant to section 6-18-207.5, C.R.S. and wishes to maintain that waiver, the cooperative must also include the following materials in its annual report:

1. To determine compliance with 6-18-207.5(1)(a), regarding grievance procedures:

a) Copies of the quarterly reports from each carrier's complaint record, showing complaints received from the cooperative's members.

b) A listing of all written and oral complaints received by the cooperative regarding the cooperative's service, rather than the service of the participating carries. Such list shall contain for each complaint: the subject of the complaint, the length of time to resolve the complaint, and the disposition of the complaint (in favor of the cooperative or in favor of the member/employer/employee/dependent).

2. A list of the cooperative's participating carriers if any changes have occurred since the last annual report or waiver application.

3. An update and any other changes in the information submitted by the cooperative in its application for a waiver, under section VIII of this rule.

4. To determine ongoing compliance with section 6-18-207.5(1)(d), C.R.S.:

a) a Healthplan Employer Data and Information Set (HEDIS) disenrollment ratio for each carrier in the cooperative. In addition, the cooperative must submit similar disenrollment ratios for the cooperative as a whole, using the same method of calculation as the HEDIS disenrollment ratio for health plans. Attachment “A” describes the cooperative ratios in more detail. Ratios submitted under this subparagraph (a) should be submitted after the close of the calendar year in which the annual report is submitted

b) verification that the cooperative can produce, as requested by the director, a list of employer disenrollments from the cooperative (both at open enrollment and other times) by employer size, zip code, and standard industry classification; and a list of employee disenrollments from the cooperative (both at open

enrollment and other times) by age/sex status, employment status (active, disabled, retired), zip code, and family status (single, employee plus one, etc.). The director may request such reports if other evidence presented in the annual report indicates that the cooperative may be engaging in risk skimming behavior.

In considering whether a waivered cooperative remains in compliance with section 6-18-207.5(1)(d), C.R.S., the director shall consult with the Commissioner of Insurance to determine whether the cooperative meets the following standards:

(1) The cooperative does not offer benefit packages that are likely to be attractive only to a healthy selection of people (for example, packages with very limited specialty networks);

(2) The cooperative has obtained actual enrollment of a diverse group of employees within the cooperative's geographic service area, in terms of geography, age, industry, and other risk status indicators (if such information is available);

(3) The cooperative has implemented policies that encourage competition among carriers based on price and quality (as opposed to risk-skimming), such as data collection for negotiations with carriers, quality management programs, etc.;

(4) There is no evidence, through the application of risk adjustment technologies, if any, that the cooperative as a whole is achieving a favorable selection relative to its participating carriers outside of the cooperative.

(5) There is no evidence that the cooperative has negotiated with any carriers a premium discount based on any adjustment for the health status, claims experience, or risk characteristics of the cooperative members relative to that carrier's overall small group book of business.

893945 X. TERMS OF A WAIVER GRANTED PURSUANT TO SECTION 6-18-207.5, C.R.S.

893946 If, at any time, a waivered cooperative loses its certification through the issuance of a cease and desist order by the director (pursuant to section 6-18-208, C.R.S.), such waiver shall become void.

XI. CARRIER NOTIFICATION OF NEGOTIATED COOPERATIVE DISCOUNT (REF. 6-18-207.5(5)(b)(II)(A), C.R.S.)

As required by section 6-18-207.5(5)(b)(II)(A), carriers must notify the division of insurance of a negotiated cooperative discount at least thirty days prior to use. At the time of such notification, carriers must also submit to the division of insurance appropriate supporting documentation to justify such

administrative cost discounts and to verify that such discounts are for the nonhealth care expense component of the premium only.

XII. APPLICATION OF RATING FACTORS INSIDE A WAIVERED COOPERATIVE (REF. 6-18-207.7, C.R.S.)

A. Before implementing consistent, standardized rate adjustment factors and factors for case characteristics as permitted under section 6-18-207.7, C.R.S., a waivered cooperative must obtain the approval of the director. Waivered cooperatives seeking approval of rate adjustment and case characteristic factors must submit the proposed factors and supporting documentation to the director in writing.

B. The executive director, in consultation with the commissioner of insurance, shall examine the proposed factors for appropriateness and either approve or disapprove the use of such factors within thirty days of receiving notice of the proposed factors.

XIII. DISCLOSURE OF HEALTH INFORMATION FOR BONA FIDE RESEARCH PROJECTS AS PERMITTED BY 6-18-103(1)(D), C.R.S.

A. In determining whether or not a research project is bona fide, the director may ask, but is not limited to, the following questions:

1. What are the qualifications of the researcher or researchers? (institutional affiliation, title, degree, etc.)

2. What is the purpose for which the research is being conducted? What are the anticipated benefits of the research? What parties will benefit from the research?

3. What is the study design of the research project?

4. How and to whom will the results of the research be disseminated?

5. What are the names of the persons who will have access to confidential or individually-identifying information? What are the researchers' specific plans for assuring confidentiality?

6. Have the researchers submitted to the cooperative a confidentiality agreement, signed by all who will have access to individuallyidentifying data, stating that

a) no identifying information will be released,

b) data provided by a cooperative to a researcher will not be released to a third party without the permission of the cooperative and the director,

c) in the case where analyses result in cell sizes of fewer than three in either numerator or denominator, all numbers and rates will be replaced with a symbol (e.g.

****) in publications, although these small numbers may be used by the researcher during computation and analysis.

B. Authorized cooperatives may not disclose individually identifying health information to any person or entity conducting a research project unless the research project is approved by the director.

C. Requests for information for research projects directed to authorized cooperatives shall be immediately referred to the director. An authorized cooperative shall notify the requester that the request has been referred to the director.

D. The director may approve the release of information for bona fide research projects that meet the requirements of subsection A above, and provide a time- limited letter of approval.

E. Cooperatives may disclose information only if a requester provides a letter of approval from the executive director.

XIV. POWERS, DUTIES, RESPONSIBILITIES AND MARKETING REQUIREMENTS FOR COOPERATIVES (REF. 6-18-202(1)(A)(II), 6-18-206, 6-18-207)

A. Cooperatives must do the following:

1. Establish conditions of membership, including the following (6-18-206(1)(a):

a) Cooperatives may include as a condition of membership a requirement that employers must include a minimum percentage of employees in coverage purchased through the cooperative, except that cooperatives may not set the minimum participation requirement any higher than 75% of eligible employees who are not covered by qualifying existing coverage. Affiliated companies must be treated as a single employer for the purposes of this section. In applying the minimum participation requirement a cooperative must not count employees who have existing coverage from another source or employer with benefits with an actuarial value equal to or in excess of the basic health benefit plan. Certification by the employee that the benefits of the alternative coverage exceed the basic health benefit plan is sufficient evidence of existing coverage. (ref. 6-18-206(2)(d))

b) A cooperative may apply specific restrictions or conditions on self-insured offerings by employers that offer employees a choice between a self-funded plan or plans and those plans offered through the cooperative. (ref. 6-18-206(2)(d)).

c) Cooperatives may offer membership to individuals who are not associated with a small employer member of the cooperative.

2. Protect its members against financial failure of the cooperative due to a breach of fiduciary duty on the part of any person or entity with the authority to collect, disburse, or otherwise gain access to the finances of the cooperative or premiums for health care

coverage. Such protection must include both sections XIV(A)(2)(a) and XIV(A)(2)(b) below (ref. 6-18-202(1)(a)(II)):

a) Either a bond or a deposit of funds with the director, as described below:

(1) a fidelity bond issued to the cooperative for the benefit of the cooperative's members in an amount equal to at least the most recent two months of total premium dollars collected by the cooperative or its contractor, estimated at the time of the approval of the initial application or the time of the filing of an annual report. The cooperative must provide the executive director with a copy of the executed bond which must clearly set forth:

(a) the name of the licensed insurance company, which is authorized to operate in the State of Colorado, issuing the bond;

(b) the amount of the bond;

(c) the type of bond;

(d) a list of all parties to the bond, including the cooperative, the state, and the bonding company;

(e) the bond shall provide for 90 days' notice to be given to the executive director by both the bonding company and the cooperative in the event of cancellation or renewal.

In the event of cancellation of the bond, the cooperative will notify the department, in writing of such cancellation at least forty (40) days prior to such cancellation.

In the event that the cooperative contracts with an outside entity to collect, disburse, or otherwise handle premiums dollars, the cooperative is not required to obtain a bond. In such instances, the cooperative must verity to the director that such outside contractor has obtained a bond that meets the same specifications as outlined in sections XIV(A)(2)(a)(1)(a) through (d) of this rule. A copy of the executed bond issued to said contractor and a signed statement by a representative of such contractor to the effect that the bond has not been canceled shall be considered verification.

(2) a certificate of deposit or securities, deposited with the executive director, in an amount equal to at least two months of total premium revenues estimated at the time of the approval of the initial application or the time of the filing of an annual report. Acceptable securities must at all

~~times be of a top quality nature, readily marketable, and at all times equal to the amount required by this subsection. In the event that the market value of the securities falls below the amount required by this subsection, it will be the cooperative's obligation to immediately increase the deposit to meet the minimum requirement. Any interest that accrues from a certificate of deposit will be the property of the cooperative.~~

~~b) Financial controls, including but not limited to~~

~~(1) A dual signature requirement for the expenditure of cooperative funds designated to pay premiums.~~

~~(2) A trust account in which premium moneys will be held prior to being paid out to the entities that contract with the cooperative to provide health care coverage.~~

~~(3) A separation of powers, whereby no single person may perform more than one of the following functions:~~

~~(a) deposit funds into a premium trust account described in sub-section (2) above;~~

~~(b) pay premiums from that premium trust account;~~

~~(c) reconcile cooperative bank records for that premium trust account.~~

~~In the event that the cooperative contracts with an outside entity to collect, disburse, or otherwise handle premium dollars, the above financial controls shall be required of such outside contractor, rather than of the cooperative. To verify compliance with this rule, the cooperative must provide the department with a copy of the cooperative's written agreement with such contractor, signed by representatives of both the contractor and the cooperative, stating that the contractor agrees to implement the required financial controls.~~

~~3. Offer the following types of health care coverage and services to members (6-18-206(1)(c)):~~

~~a) If a member does not notify a cooperative that it is self-insured, it may only purchase health care coverage licensed by the Division of Insurance pursuant to C.R.S. Title 10.~~

~~b) If a member notifies a cooperative that it is self-insured it may participate in negotiated prices with health care providers or it may purchase health care coverage negotiated by the cooperative. Notification by a self-insured member must include certification by an officer of the company:~~

~~(1) that it is a single-employer self-insured ERISA plan, or a self-insured collectively-bargained agreement; and,~~

~~(2) if the member has excess loss insurance, it must be in compliance with C.R.S. 10-16-105(7.4)(b)(II and III) and 10-16-119.~~

~~4. Offer dependent coverage~~

~~a) A cooperative must contract for and notify all members and potential members, through marketing in compliance with section 12 below, that coverage is available to all dependents of eligible employees (ref. 6-18-206(1)(d), 6-18-207).~~

~~b) A cooperative may not take any action that would discourage potential members interested in dependent coverage from joining the cooperative or that would encourage members buying dependent coverage to leave the cooperative (ref. 6-18-206(1)(d), 6-18-207, 6-18-206(3)(g))~~

~~5. Require entities that it contracts with for insurance functions listed in section 10-3-903, C.R.S. to show evidence that they hold a certificate of authority from the Division of Insurance pursuant to C.R.S. Title 10.~~

~~6. Establish administrative and accounting procedures for the operation of the cooperative and members' services, prepare "pro formas" and submit them for review by a Certified Public Accountant, and prepare financial statements and have them audited by a Certified Public Accountant. (ref. 6-18-206(1)(j))~~

~~7. Send annual program and fiscal reports to members and make them available to the public on request. (ref. 6-18-206(1)(m))~~

~~8. Maintain all records, reports, and other information of the cooperative. These materials may be subject to audit by the department. (ref. 6-18-206(1)(k))~~

~~9. Establish grievance procedures to monitor and fairly handle complaints against the cooperative and against participating health plans.~~

~~10. Define a geographic service area within which a cooperative must accept all members that meet the conditions of cooperative membership and within which a cooperative will advertise the availability of its services as required by 6-18-207, C.R.S. The geographic service area within a particular county may not be defined as smaller than the largest licensed service area within that county covered by any of the carriers with which the cooperative contracts.~~

~~11. Widely advertise their activities and the availability of coverage through the cooperative to potential members, their eligible employees and the public at large (ref. 6-18-206(1)(h),~~

and 6-18-207, C.R.S.). The marketing program must include at least the following elements:

a) Cooperatives shall use advertising modes that, taken together, are likely to be seen by members and potential members that are representative of the risk profile of the entire geographic service area. (ref. 6-18-207(1))

b) Cooperatives shall use marketing materials that clearly and uniformly communicate the full range of services offered by the cooperative to all members and potential members in their geographic service area (ref. 6-18-207(1)).

B. Cooperatives may perform the following functions, as stated in section 6-18-206(2). If a cooperative chooses to perform these functions, it will be subject to these further provisions:

1. Pursuant to 6-18-206(2)(b), set and collect reasonable fees for membership in the cooperative. If a cooperative chooses to set such fees, the amount is limited to that which is necessary to pay for the reasonable and necessary costs incurred in administering the cooperative. Fees are limited by the conditions enumerated in 6-18-206(1)(i), 6-18-206(3)(e), and 6-18-206(3)(f).

2. Offer any and all health benefit packages permitted under law in addition to the standard and basic health benefit plans promulgated pursuant to section 10-8-606, C.R.S. (ref. 6-18-206 (2) (c)). If a cooperative offers any plans other than the standard and basic plans, it must offer all such plans to all members (ref. 6-18-207(3)).

3. Contract with licensed insurance producers as permitted by 6-18-206(2)(h), C.R.S. If a cooperative chooses to make such contracts, the following related conditions apply:

a) Cooperatives may use a fee schedule based on percentages of premium but the percentages may not vary based on the actual or expected health status or medical utilization of the group to which coverage is sold.

b) Cooperatives may use insurance producers to widely publicize the cooperative to potential members, and to assist members in enrolling in the cooperative, but may not use them as a means for risk selection or risk avoidance. The publicity and enrollment activities of insurance producers must be consistent with the cooperative's marketing program as described in section XIV(A)(11) of these regulations, and with the provisions of section 6-18-206(3)(g), C.R.S.

Attachment A

Cooperative Disenrollment Ratios

In addition to the HEDIS disenrollment ratios for each participating carrier, cooperatives will sub following ratios:

~~**Cooperative disenrollment as a whole:**~~

~~Of the individuals in the denominator, total number still enrolled in the cooperative as of December 31, 199X (last day of the reporting year)~~

~~_____~~

~~Total number of lives in the cooperative as of December 31, 199X-1 (last day of the year preceding the reporting year)~~

~~**Cooperative disenrollment by carrier (one ratio for each carrier):**~~

~~Of the individuals in the denominator, total number still enrolled in the cooperative as of December 31, 199X (last day of the reporting year)~~

~~_____~~

~~Total number of lives in the cooperative under Carrier "X" as of December 31, 199X-1 (last day of the year preceding the reporting year)~~

THIS PAGE NOT FOR PUBLICATION

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Executive Director Rule
2. Title of Rule: ED 13-01-09-A, Revision to the Executive Director of the Department of Health Care Policy and Financing Rule Concerning All-Payers Claims Database,10 CCR 2505-5, Section 1.200.1
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) Section 1.200.1, 2505 Department of Health Care Policy and Financing, Executive Director of Department of Health Care Policy and Financing (10 CCR 2505-5).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). <Select One>

PUBLICATION INSTRUCTIONS*

Please replace the current text at the unnumbered paragraph beginning with "submission guide" with the new text provided. All text indicated in blue is for clarification purposes only and should not be changed. This change is effective 05/15/2013

*to be completed by rule administrator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Executive Director of the Department of Health Care Policy and Financing Rule Concerning All-Payers Claims Database,10 CCR 2505-5, Section 1.200.1
Rule Number:	ED 13-01-09-A
Division / Contact / Phone:	/ Joel Dalzell 303.866.3618 / CIVHC: Linda Green 720-484-4110

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   10 CCR 2505-5 contains the rules for the administration of the All-Payers Claims Database. Section 1200.1 Definitions incorporates the "submission guide" into the rule by reference to the document dated "August 2011 version 3." The submission guide requires updating to improve the data collection process. This amendment replaces "August 2011 version 3" with the words "January 2013 version 5." A copy of the January 2013 version 5 submission guide is provided with this amendment. The authority for this rule is contained in 25.5-1-105, C.R.S. (2010) and 25.5-1-204 C.R.S (2010).

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-108, C.R.S. (2012);
   25.5.-1-204, C.R.S and 25.5-1-105, C.R.S.

Initial Review | Final Adoption

Proposed Effective Date | Emergency Adoption

DOCUMENT #

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Executive Director of the Department of Health Care Policy and Financing Rule Concerning All-Payers Claims Database,10 CCR 2505-5, Section 1.200.1
Rule Number:	ED 13-01-09-A
Division / Contact / Phone:	/ Joel Dalzell 303.866.3618 / CIVHC: Linda Green 720-484-4110

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   This amendment affects the health insurance carriers and public payers that are required to submit data to the All-Payers Claims Database ("APCD"). The revisions will benefit all Colorado residents through improved information about health care cost and utilization.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   Data submitters may need to make minor alterations to file layouts. The revised data requirements provide clarifications of the requirements and will therefore reduce the number of resubmitted files. The submission guide adds data elements to support analysis of health system performance after implementation of the Affordable Care Act in 2014.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   A private nonprofit organization funded by foundation grants operates the APCD under the Department's supervision. No state funds were appropriated for this project. The Department does not expect to incur additional costs. This project does not affect state revenues.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The APCD will support reporting and analysis about health care cost and utilization in Colorado. These revisions ensure that data will be accurately transmitted and that the data will support analysis of health system performance under ACA and other system transformation efforts. Accurate, robust data ensures that reports are credible and representative of Colorado's health care environment.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   The submission guide requests the minimum amount of data needed to achieve the analytic purposes of the APCD. The January 2013 version includes clarifications that standardize the

data requirements and requires additional procedure codes for inpatient care; diagnosis codes from claims forms and information about the insurance group size in preparation for evaluating the effects of health care reform.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   Alternative data collection models create a greater burden on data submitters and the APCD without increasing the quality and accuracy of the data.

1.200 All-Payers Claims Database 10 CCR 2505-5

1.200.1 Definitions

"administrator" means the administrator of the APCD appointed by the director of the department.

"APCD" means the Colorado All-Payer Claims Database.

"department" means the Colorado Department of Health Care Policy and Financing.

"director" means the Executive Director of the department.

"eligibility data file" means a file that includes data about a person who receives health care coverage from a payer, according to the requirements contained in the submission guide.

"HIPAA" means the Health Insurance Portability and Accountability Act, .S.C. § 1320d – 1320d-8, and its implementing regulations, 45 C.F.R. Parts 160, 162 and 164, as may be amended.

"historic data" means eligibility data file(s), medical claims data file(s), pharmacy file(s) and provider file(s) for the period commencing January 1, 2009 through December 31, 2011. "Medical claims data file" means a file that includes data about medical claims and other encounter information, according to the requirements contained in the submission guide.

"medical claims data file" means a file that includes data about medical claims and other encounter information, according to the requirements contained in the submission guide.

"payer" means a private health care payer and a public health care payer.

"pharmacy file" means a file that includes data about prescription medications and claims filed by pharmacies, according to the requirements contained in the submission guide.

"private health care payer" means an insurance carrier as defined in C.R.S. § 10-16-102(8) covering an aggregate of 1,000 enrolled lives in health coverage plans as defined in CRS 10-16-102(22.5). For purposes, of this regulation, "private health care payer" includes carriers offering health benefits plans under C.R.S. 10-16-102(21)(a) and dental, vision, limited benefit health insurance, and short-term limited-duration health insurance. It does not include carriers offering only accident liability; credit; benefits for long term care, home health care, community-based care, or any combination thereof under Article 19 of Title 10; disability income insurance; liability insurance including general liability insurance and automobile liability insurance; coverage issued as a supplement to liability insurance; worker's compensation or similar insurance; or automobile medical payment insurance, specified disease, or hospital confinement indemnity insurance.

"provider file" means a file that includes additional information about the individuals and entities that submitted claims that are included in the medical claims file; and is submitted according to the requirements contained in the submission guide.

"public health care payer" means the Colorado Medicaid program established under articles 4, 5 and 6 of title 25.5, C.R.S., the children's basic health plan established under article 8 of title 25.5, C.R.S. and CoverColorado established under part 5 article 8 of title 10, C.R.S.

"submission guide" means the document entitled "Colorado All-Payer Claims Database Data Submission Guide" developed by the administrator that sets forth the required schedules, data file format, record specifications, data elements, definitions, code tables and edit specifications for payer submission of eligibility data files, medical and pharmacy claims data files and provider data files to the APCD dated ~~August 2011 version 3~~ March 2013 version 5, which document is hereby incorporated by reference.