Implementing Health Care Reform: **A Roadmap for Colorado**

Prepared by Lorez Meinhold
Director, Health Reform Implementation
State of Colorado
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A MESSAGE FROM GOVERNOR RITTER

For four years we have worked together to advance our shared vision of making high quality, affordable health care a reality for every Coloradan. Despite the worst economy in 70 years, we have made significant and material progress. We took important steps to expand access to care and improve quality through our Building Blocks to Health Care Reform.

Now, with the advent of national health care reform, we have another tool in the toolbox, and fortunately the work we have already completed makes Colorado one of the best positioned states in the nation to integrate and benefit from federal reform. Health care reform presents an opportunity for Colorado to deliver better value for each health care dollar, to create a culture of health with a focus on healthy living and wellness, and to expand access to health care that is affordable.

The attached report, Implementing Health Care Reform: A Roadmap for Colorado, provides an assessment of the work done to date and what still lies ahead. This report identifies key issues and opportunities for Colorado as the state and its partners address the federal Affordable Care Act.

Thank you for your support and tireless efforts over these past four years. By continuing to work together and by collaborating on smart, forward-thinking and common-sense solutions, we will keep moving toward a healthier Colorado.

Sincerely,

Bill Ritter Jr.
Governor

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Executive Summary

The passing of the federal Patient Protection and Affordable Care Act of 2010 ("Affordable Care Act") provides the State of Colorado an unprecedented opportunity to improve the health of all Coloradans. By expanding access, improving quality and containing costs, this comprehensive health care bill has the potential to dramatically enhance the way Americans receive and pay for health care. Although federally legislated, individual states will take the lead role in implementing the policy and programmatic changes necessary to achieve the Affordable Care Act's ultimate goal – improved health outcomes for every citizen.

The Affordable Care Act is a step toward bringing relief to the sick and underserved and providing protection for those who may become so, and will begin to transform the system from one that pays for value rather than volume. The Affordable Care Act has new penalties, administrative requirements and gaps in adequate reform of anti-trust governance and other policies. These provisions may be addressed by Congress and through implementing regulations over the next several years. It will require patience, as the changes will take time and will not occur overnight.

IT IS VITAL THAT THE IMPLEMENTATION AND OUTREACH OCCUR WITH BIPARTISAN PARTNERSHIP.

Colorado must ensure that the Affordable Care Act is implemented properly. The state must remain focused on lowering the cost of health care, but must not forget that health care is an economic and employment generator – every additional dollar in new health care spending in Colorado will generate $2.44 in new economic output[1]; and most of those dollars will be spent locally. The Affordable Care Act seeks to reduce the cost-shift of uninsured and public payer underpayments to the private sector, i.e., to employers through higher health care prices and premiums. It has been estimated that Colorado families pay an additional $1,100 in premium costs and individual insurance premiums are $380 higher due to cost-shifting.[2]

It is vital that the implementation and outreach occur with bipartisan partnership. It will take collaboration among all stakeholders to maximize opportunities and minimize unintended consequences of the new law.

This collaboration must occur among numerous government, business, consumer, provider and nonprofit stakeholders to ensure effective processes that will meet the various federal deadlines beginning this year and continuing through 2014 and beyond. Colorado already has a strong foundation on which future health care improvements can be built. Improved health and health care have been a priority for Gov. Bill Ritter who, since elected in 2006, has developed and supported myriad programs and policies to achieve greater health outcomes for all Coloradans.

Each year since 2006, Gov. Ritter's administration has adopted a robust policy agenda resulting in increased enrollment of children and low-income adults into public health insurance programs; improvements to private insurance that better protect consumers; enhanced eligibility and enrollment systems; greater collaboration with community organizations to inform consumers about public and private insurance; and a focus on cost-containment and quality improvement in health care.

1 New America Foundation and University of Denver's Center for Colorado's Economic Future, "The Future of Colorado Health Care: A preview to the forthcoming report on an economic analysis of health care reform and the impact on Colorado's economy." coloradohealth.org/studies.aspx

2 Center for American Progress update of research performed by Kenneth Thorpe for Families USA; CMS; MEPS

The capstone policy of the administration was the passage of the Colorado Health Care Affordability Act of 2009, which enables the state to enroll an additional 130,000 low-income children and adults into public insurance programs. The financing for these efforts also allows for improved payments and reimbursement to hospitals and clinics for seeing Medicaid clients and to provide reimbursement for providers who serve large numbers of the uninsured.

With the change in administration and leadership in January 2011, mid-stream in planning and implementation, it is essential that this great momentum in Colorado is not halted. While Colorado is ahead on many of the issues related to health reform, there are many early requirements of the Affordable Care Act to be completed and this plan will serve, in large part, as a roadmap to ensure no deadlines or activities are missed and to help all stakeholders – from members of the public to the legislature – understand the federal legislation and how it interacts with state policies and programs.

Among the many responsibilities Colorado will have in implementing the Affordable Care Act, the state must:

- Oversee the planning, development and implementation of health care reform in Colorado;
- Coordinate efforts among state agencies;
- Ensure that the state applies for grants that are strategic, i.e., those that align with state priorities and leverages the work of the community and local foundations;
- Assure accurate and complete compliance with the law;
- Understand the choices available to the state under the Affordable Care Act and use data and engagement to make the most beneficial decisions;
- Ensure outreach and education to all impacted, especially consumers and businesses;
- Ensure transparency in processes and decision-making;
- Be a catalyst for market reforms and protecting consumers; and
- Expand health information technology and the establishment of electronic medical records to meet the requirements of the Affordable Care Act, reduce administrative costs and improve health outcomes.

To help foster these priorities, Gov. Ritter created an implementation board and designated an implementation director soon

Nathan's son, Thomas, was born with hemophilia. At the time, Nathan and his family had great insurance through the high tech telecommunications company that he helped start. He felt very fortunate, but his sense of well-being was short lived. The insurance company raised the price for the entire group of 100-150 employees to compensate for the costs associated with Thomas's treatments. After searching in vain for other insurers to cover the company, Thomas exceeded the $1 million cap on coverage. Nathan wasn't sure what to do. One social worker suggested that he and his wife get a divorce so that Thomas could qualify for Medicaid.

The new health care law bans lifetime and annual limits. People like Nathan can rest assured that if they pay for insurance coverage, it will be there for them when they need it – so they can focus on their family's health and not their medical bills.

after the Affordable Care Act was enacted. Chaired by the executive director of the Colorado Department of Health Care Policy and Financing and staffed by the implementation director, the role of the Interagency Health Reform Implementation Board (the "Board") is to oversee and evaluate these implementation efforts, advise the governor on pursuing certain grant and pilot opportunities, engage stakeholders and ensure there is coordination of efforts among all of the state agencies responsible for the various provisions of the federal legislation.

To ensure these goals are achieved, the Board adopted this plan to help focus the priorities and guide the following activities:

- Colorado's process for implementing new legislation, including proposals for statutory and regulatory changes;
- Analysis of how federal legislation will impact the state budget;
- Identification of available funding sources, local and national;
- Analysis of available data necessary to prepare for implementation;
- Coordination of state agencies in the implementation;
- Development of a timeline for implementation that allows phase-in of reform and implementation of new systems; and
- Colorado's education and outreach efforts with advocates, legislators, federal partners, health care providers, small and large employers and other stakeholders as health care reform progresses.

This report serves as a roadmap for reform in Colorado, capturing the momentum of state policies already adopted and implemented and documenting future requirements to ensure compliance with federal legislation. Its goal is to help the next administration understand Colorado's health landscape and guide its immediate next steps, provide a status report to state legislators and serve as a reference document to the greater public interested in learning more about the transformation that is taking place now and will continue well into the future.

Patient Protection and Affordable Care Act of 2010

The passage of the Affordable Care Act provides unprecedented opportunities to increase the value spent on health care, create a culture supporting healthy living and wellness and expand access to affordable care. Signed into law on March 23, 2010, the Affordable Care Act seeks to improve the quality of health of all Americans by providing increased options, more ownership over health decisions and lowering costs, while ensuring more accountability and transparency from insurance companies. Beginning immediately and continuing through 2014 myriad changes to existing polices and implementation of new ones will result in the most comprehensive health reform effort in history.

Summary of the Legislation

The Affordable Care Act is wide-ranging in its attempt to achieve greater health outcomes and complex in its approach. The Kaiser Family Foundation published an extensive summary of the new law, some of which is highlighted here. See the full version at kff.org/healthreform/upload/8061.pdf.

Private insurance changes – among many things, requires dependent coverage for children up to age 26, adopts standards for administrative simplification, requires insurance plans to report

proportion of premium dollars spent on clinical services, quality and other costs and provides rebates to patients and establishes a process for reviewing premium increases, requiring justification. See full version for details on market rules and consumer protections.

Cost containment – specifies a number of provisions to contain costs in Medicaid, Medicare and for prescription drugs; see full version for details.

Temporary high-risk pool – immediately creates a high-risk pool that is effective until 2014 to provide coverage to those with pre-existing conditions.

American Health Benefit Exchanges – creates exchanges to allow individuals, families and employers to purchase health coverage; those with incomes between 133-400 percent of the federal poverty level (FPL), which is between $29,326 and $88,200 for a family of four, have access to premium and cost-sharing subsidies. The state will determine whether to create separate exchanges for individuals and businesses or one to serve both purposes.

Employer tax credits – provides tax credits through a phased-in approach to employers with no more than 25 employees making average annual wages of less than $50,000.

Medicaid expansion – expands Medicaid to children, pregnant women, parents, and adults without dependent children with incomes up to 133 percent of the FPL or $29,326 for a family of four by 2014. Additionally, increases payment to 100 percent of Medicare rates for fee-for-service and managed care for primary care services for two years.

Prevention/wellness – directs the development of a national strategy on prevention and wellness and ensures coverage of certain preventive services. Additionally, creates five-year grants for small businesses to create wellness programs.

Individual mandate – requires most citizens and legal residents to have qualifying health coverage by 2014 to avoid penalties; some exemptions apply.

Employer requirements – requires employers with more than 50 employees to offer health coverage by 2014 to avoid penalties; some exemptions apply. Employers with more than 200 employees will be required to automatically enroll them into the employer's insurance plan.

Children's Health Insurance Program (CHIP) expansion – extends CHIP funding through 2015 and requires states to maintain current income eligibility requirements for children through 2019.

Tax changes – there are a number of tax changes related to health insurance and financing the Affordable Care Act; see full version for details.

Health system performance – includes a number of provisions to improve the quality of care and the quality of the health system; see full version for details.

Long-term care – establishes a national, voluntary insurance program to facilitate community living services and supports. The CLASS Act (Community Living Assistance Services and Support Act) provides those who participate help in paying for needed assistance, if they become functionally limited.

Other investments – outlines substantial investments to improve Medicare and workforce training and development, in addition to community health, trauma care and public health/ disaster preparedness, among others.

While this is a grossly understated summary of this complex legislation, it demonstrates the comprehensive approach to improving health outcomes.

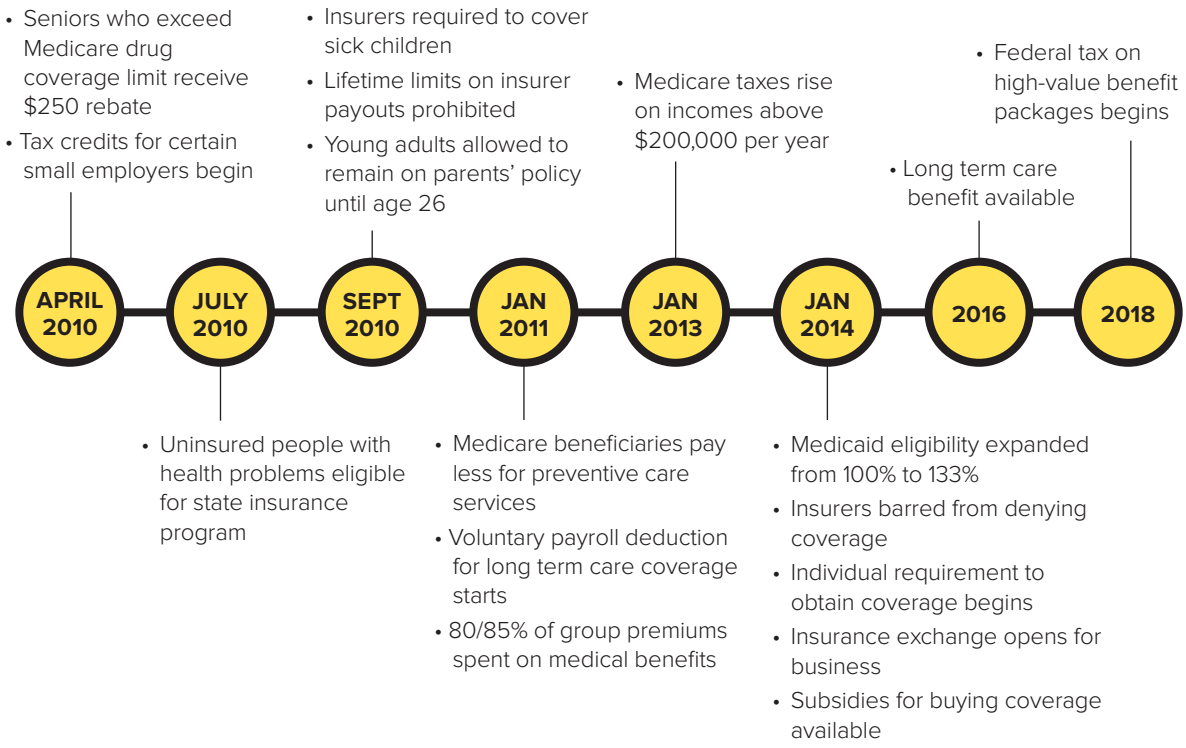
The Colorado Health Care Affordability Act of 2009

The Colorado Health Care Affordability Act, signed by Gov. Ritter on April 21, 2009, generates new revenue to expand public health care coverage. The legislation allowed the Colorado Department of Health Care Policy and Financing to assess a provider fee on hospitals to generate additional federal Medicaid matching funds to expand health care access, improve the quality of care for clients serviced by public health insurance programs, increase funding for hospital care for Medicaid and uninsured clients and reduce cost-shifting to private payers. The public program enhancements and expansions covered with the increased funds include covering parents with incomes of up to 100 percent of the Federal Poverty Level (FPL), Medicaid eligible children and pregnant women to 250 percent of the FPL and childless adults with incomes of up to 100 percent FPL. In addition, it creates a Medicaid buy-in program for disabled adults and children whose family incomes are too high for Medicaid eligibility but are under 450 percent FPL, implements twelve month continuous eligibility for Medicaid eligible children, increases Medicaid hospital inpatient rates up to 100 percent of Medicare rates, increasing Medicaid hospital outpatient rates to up to 100 percent of costs, increases hospital reimbursement rates through the Colorado Indigent Care Program up to 100 percent of cost and implements quality incentive payments for hospitals. The federal Centers for Medicare and Medicaid Services approved the hospital provider fee and payments in March 2010. The first expansion was made May 1 to parents, pregnant women and children. Since these expansions were made after the federal Affordable Care Act was passed, they are eligible for the enhanced matches available in 2014 – 100 percent federally funded for the first three years and eventually dropping to 90 percent federally funded in 2020. The Colorado Health Care Affordability Act of 2009 means that Colorado is better positioned for the federal expansions required by 2014.

Implementation Timeline

The Affordable Care Act will not be fully implemented until 2014 and will be fully operational by 2019. The timeline below demonstrates some of the major milestones that have occurred and will take place well in to the future.

Reform Timeline: When the Changes Happen



Cost Implications

It is estimated that an additional 32 million people will be covered by 2019 when expansions to Medicaid are in place and the health exchanges are fully operational.[3] But this vast expansion comes at a price – of roughly $938 billion nationally. According to the Kaiser Family Foundation, "these costs are financed through a combination of savings from Medicare and Medicaid and new taxes and fees, including an excise tax on high-cost insurance, which [the Congressional Budget Office] estimates will raise $32 billion over ten years [and] that the health reform law will reduce the deficit by $124 billion over ten years."[4]

While the onus will fall on states to implement the changes within the national framework, it provides tremendous opportunity to leverage state health policies and funding with federal funding and support to achieve a greater impact on health.

Legal Challenge

Twenty states, acting through their respective Governor or Attorney General, as well as two private citizens and one business organization, the National Federation of Independent Business, brought suit in federal court in the Northern District of Florida challenging the constitutionality of the Affordable Care Act. See State of Florida v. United States Department of Health and Human Services, Case No. 3:10-cv-91-RV/EMT ("Florida health care litigation"). The plaintiffs in the suit brought six claims for relief:

3 Kaiser Family Foundation, "Focus on Health Reform." March 26, 2010. kff.org

4 Kaiser Family Foundation, "Focus on Health Reform." March 26, 2010. kff.org

1. The individual mandate and penalty exceed Congress' Commerce Clause powers and violate the Ninth and Tenth Amendments of the United States Constitution (Count 1);

2. The individual mandate and penalty violate substantive due process rights under the Fifth Amendment of the United States Constitution (Count 2);

3. If the "penalty" for not purchasing health insurance is a tax, it violates the constitutional prohibition on unapportioned capitation or direct taxation (Count 3);

4. The Act coerces and commandeers the states with respect to Medicaid by altering and expanding the program in violation of Article I and the Ninth and Tenth Amendments of the United States Constitution (Count 4);

5. The Act coerces and commandeers the states with respect to health benefit exchanges in violation of Article I and the Ninth and Tenth Amendments of the United States Constitution (Count 5);

6. The employer mandate interferes with state sovereignty as large employers and in the performance of governmental functions in violation of Article I and the Ninth and Tenth Amendments of the United States Constitution (Count 6).

The United States government filed a motion to dismiss the action, contending, among other things, that: (1) the "penalty" was in fact a "tax" and therefore, under the Anti-Injunction Act, could not be enjoined at this time; and (2) that each of the claims failed as a matter of law.

On October 14, 2010, Judge Vinson issued a sixty-five page order, resolving certain legal questions and dismissing some claims and permitting others to proceed. Specifically, he held that the "penalty" on individuals who do not purchase health insurance is just that, a penalty, and not a tax. He then went on to dismiss counts 2, 3, 5, and 6, but denied the motion with respect to counts 1 and 4. Below is a brief explanation of the judge's analysis of each claim.

DISMISSED CLAIMS

Count 2 (substantive due process as individual mandate): The judge noted that the rights that are implicated by the Act are economic rights (e.g., the right not to purchase health insurance), not "fundamental" rights. Because only economic rights are implicated, the government need only have a "rational basis" for the action taken, and the judge held that, based on Congress' factual findings contained in the Act, there was a rational basis for the individual mandate. Therefore, the court dismissed the substantive due process challenge to the individual mandate.

Count 3 (penalty as a tax violates prohibitions on capitalized tax): Plaintiff's third count is predicated on the assumption that the court concludes that the penalty for failure to purchase health insurance is a tax and not a penalty. But the court held, without ambiguity, that the "penalty" is, in fact, a penalty and not a tax. Indeed, the court did so for five separate reasons, the explanation of which covered seventeen pages of the opinion. Because the court concluded that the penalty is not a tax, count 3 was dismissed as moot.

Count 5 (coercion and commandeering as to health insurance exchanges): The health insurance exchanges are voluntary. That is, a state can either opt to establish its own health insurance exchange or decline to do so. If the state declines to do so, the federal government will develop and implement the program for that particular state. Because of the voluntary nature of the exchange program, the court dismissed the claim and held that this is the type of "cooperative federalism" that the cases in this area of the law clearly authorize.

Count 6 (interference with state sovereignty): The plaintiff-states contended that by requiring them, as large employers, to offer and automatically enroll employees in federally-approved insurance plans with extensive new (and expensive) benefits, the federal government was invading the sovereignty of the states. The court dismissed this claim, concluding that such requirements are more akin to wage, hour, and overtime pay requirements, which have long been held as properly enforceable against states as large employers.

SURVIVING CLAIMS

Count 1 (individual mandate as exceeding Commerce Clause powers): Under the Commerce Clause of the United States Constitution, Congress can regulate activities affecting interstate commerce. Plaintiffs contend that the individual mandate does not regulate "activity," but instead regulates "inactivity" (i.e., the decision not to purchase health insurance). As such, plaintiffs contend, the Act exceeds Congress' Commerce Clause powers. The United States responds that the "appearance of inactivity is just an illusion" because the decision not to purchase health insurance is, in and of itself, economic activity (because nearly all of those who do not purchase health insurance will, at some point in time, be in need of health services and many of those individuals will be unable to pay for such services). Thus, the United States contends that the individual mandate does not require individuals to pay for a service they do not want, but only dictates how they must pay for a service they will almost certainly use in the future. The court concludes that the Act presents a novel and unprecedented application of the Commerce Clause, and without definitively resolving the issue, concludes that the plaintiffs have raised a "plausible claim" that will be resolved at a later stage of the litigation.

Count 4 (coercion and commandeering as to Medicaid): Participation by the states in the Medicaid is voluntary. Those states that participate in the program must comply with the program's requirements in order to be eligible for the federal match, which on average is about 55 percent. The fact is that Medicaid is the largest federal "grant-in-aid program to the states, accounting for over 40 percent of all federal grants to the states." Indeed, most states are heavily reliant on Medicaid (and the attendant federal matching funds) for serving the health care needs of their most vulnerable citizens. The Act imposes a number of new requirements on the states as a condition of continued participation in the Medicaid program. Plaintiffs contend that conditioning continued participation in Medicaid on meeting the new requirements contained in the Act unconstitutionally coerces the states to meet the requirements of the Act. The United States, on the other hand, contends that Medicaid participation is voluntary and that merely creating difficult political decisions is not tantamount to coercion; thus, there is no coercion or commandeering. Judge Vinson notes that the threshold for a coercion or commandeering claim is very high, but that, according to the case law on the subject, there is a line somewhere between "mere pressure and impermissible coercion." Without resolving on which side of the line the Act lies, Judge Vinson held that plaintiffs at least stated a "plausible claim" that the Act falls on the impermissible-coercion side of the line.

NEXT STEPS

The parties filed their motions for Summary Judgment on November 4, 2010. The court has set a hearing on those motions for December 16, 2010. It is expected that the court will issue an order on those motions within thirty to sixty days after the hearing. The court could either resolve the case in favor of either side on summary judgment or decide that one or more of the surviving claims requires the presentation and consideration of evidence, in which case he would deny both sides' motions and set the matter for trial. Regardless of the outcome at the trial court, this case almost certainly will make its way to the United States Supreme Court.

What The Affordable Care Act Means For Colorado

The implementation of national reforms that are part of the Affordable Care Act are designed to lower health care costs for Colorado families and small businesses, potentially reducing the cost of family health insurance premiums by $1,510 - $2,160.[5] Coupled with state-led efforts such as the Colorado Health Care Affordability Act, national reform will provide coverage to 500,000[6] uninsured Coloradans. Additionally, up to 90,000 small businesses in Colorado might be eligible for tax credits to help make coverage for employees more affordable.[7] For those who seek health care from community health centers, there could be additional funding for some or all of the 123 centers throughout the state.

When it comes to the state's economy, it is estimated that expanding health coverage could create up to 23,000 new jobs in Colorado by 2019, according to a report from the New America Foundation and University of Denver's Center for Colorado's Economic Future.[8] The same report cites a U.S. Department of Commerce analysis concluding that every additional dollar spent on health care, due to health coverage expansion, would generate $2.44 in economic activity. Additionally, coverage expansion could boost Colorado's economic input by $8.9 billion by 2019, but the net output is $3.8 billion after considering the cost of tax-financed care at $5.1 billion.

State Roles and Requirements

Although Colorado is well on its way to improving quality and access to care and decreasing costs, ongoing challenges with the state budget and a change in the administration could pose a risk to the state in meeting the requirements and timeline set forth by the Affordable Care Act. A timeline has been created to help foster collaboration and ensure accountability in meeting deadlines.

REQUIREMENTS (2011-2015 AND BEYOND)

2011

- Implementation of fraud, waste, and abuse programs.
- Implementation of provider screening and other enrollment requirements.
- Termination of provider participation under Medicaid if terminated under Medicare or other State plan.
- Requirement to report expanded set of data elements under Medicaid Management Information System (MMIS) to detect fraud.
- Prohibition on payments to institutions or entities located outside of the United States.
- Prohibition of participation relating to certain ownership, control and management affiliations.
- Prohibition of Medicaid payment for services related to a health care-acquired condition.
- Public awareness campaign launched to educate Medicaid enrollees on availability and coverage of preventive and obesity-related services.

5 State of Colorado. "Capital Health Reform in Colorado: Frequently Asked Questions," colorado.gov/cs/Satellite/GovernorsHealthReform/GOVR/1251573982023.

6 State of Colorado. "Capital Health Reform in Colorado: Frequently Asked Questions," colorado.gov/cs/Satellite/GovernorsHealthReform/GOVR/1251573982023.

7 U.S. Department of Health and Human Services, "The Affordable Care Act: Immediate Benefits for Colorado," whitehouse.gov/healthreform.

8 New America Foundation and University of Denver's Center for Colorado's Economic Future, "The Future of Colorado Health Care: A preview to the forthcoming report on an economic analysis of health care reform and the impact on Colorado's economy." coloradohealth.org/studies.aspx

- Nursing home facilities must provide written notification to residents, representatives of residents, the state and other parties including HHS Secretary at least 60 days in advance of closing.

2012

- Implementation of improved data collection related to diabetes and other chronic diseases.

2013

- State must demonstrate that it is willing and able to implement the exchange by January 1, 2014.
- Medicaid payment for primary care services (furnished on or after January 1, 2013 and before January 1, 2015 by a family practice physician, general internal medicine physician, or pediatric medicine physician) must be at a rate not less than 100% of Medicare payment rates (100% federally funded).

2014

- Exchange must be operational.
- Medicaid Coverage available for all individuals up to 133% federal poverty level (FPL) ($29,326 for a family of four); modified adjusted gross income (MAGI) (as also used under the exchanges) will determine Medicaid eligibility.
- Premium Assistance for Employer-Sponsored Insurance (ESI) offered; both premium assistance and "wrap-around" benefit coverage (i.e., Medicaid covered services not included in the private plans) provided to Medicaid beneficiaries to whom ESI is offered, if doing so is both cost-effective and consistent with the requirements.
- Former foster care children (through age 26) receive coverage.
- Current CHIP reauthorization period extended by 2 additional years, through September 30, 2015. From October 1, 2015 through September 30, 2019, state receives a 23% increase in their regular CHIP match rate (not to exceed 100%).
- As a condition of receiving federal Medicaid matching funds, state establishes procedures to apply and enroll (or re-enroll) in Medicaid, CHIP, or the exchange, through a state-run, secure website.
- List of coverage-excluded drugs removed from Medicaid: Agents used to promote smoking cessation, including agents approved by the FDA under the over-the-counter monograph process; barbiturates; and benzodiazepines.
- Disproportionate Share Hospital (DSH) payments to state reduced.
- Annual reporting to the Secretary on: (1) the state-specific adult health quality measures applied by the state; and (2) state-specific information on the quality of health care furnished to Medicaid-eligible adults.
- State laws regulating insurance must conform with the provisions in the new federal law including:
  - » Plans may vary premiums in the individual and small group markets based only on a geographic rating area, age of policyholder (no more than 3:1), tobacco use (no more than 1.5:1) and whether the policy is for individual or family coverage. Also applies to large groups if states permit them to enter exchanges.
  - » Prohibits discrimination against individuals based on health status.
  - » Requires guaranteed issue and renewal by plans for every employer or individual in a state who applies for coverage.
  - » Allows people to keep current coverage if they choose (grandfathering).

» Waiting periods for individual or group coverage cannot exceed 90 days. Applies to all plans except grandfathered self-insured plans.

» Requires any state or federal law to apply equally to all qualified health plans whether in exchanges or multi-state plan.

» Establishes a state-based reinsurance program in the individual market. Program will be funded by health insurers to cover some of the cost of high-risk enrollees and will last three years.

» Requires states to collect payments from health plans that have less than average actuarial risk and make payments to those that have higher than average risk.

State Legislation Needs

Colorado implementation efforts include harmonizing state statutes and regulations with the new federal law and regulations to assist with implementation efforts. Part of the implementation effort includes a review of Colorado's statutes and regulations to identify where there may need to be modifications to meet Affordable Care Act requirements.

In some cases, Colorado will need to act sooner to bring state requirements into line and take full advantage of opportunities to improve state health care programs and obtain federal funds the state needs to help carry out the new law. While other provisions of the Affordable Care Act will not go into effect for two or three years or more, legislative and regulatory action must be taken in advance of the effective dates to permit the agencies and marketplace to incorporate the changes. It is important for the legislature and state government to begin considering what initial steps must be taken to implement some of these measures.

INSURANCE

The Affordable Care Act establishes a number of new requirements for health plans and insurers. These provisions apply to group health plans, including self-insured plans, and insurers offering individual and small group coverage both inside and outside the state exchange. The federal government has issued preliminary regulations in several areas to implement provisions of the Affordable Care Act. More guidance from the federal government related to standards and state enforcement will be necessary, and the state will need to align current state requirements with the Affordable Care Act health insurance standards for enforcement, consistency and to avoid confusion and uncertainty.

For example, Colorado has a statute which provides dependent coverage up to age 25, while the new federal law provides dependent eligibility for coverage to age 26. To avoid confusion and conflict, and permit efficient enforcement, the state should consider raising the dependent coverage age from 25 to 26. The Colorado Division of Insurance (DOI) has developed an inventory of the Affordable Care Act and identified the state insurance statutes, regulations, bulletins and procedures which differ from requirements under the Affordable Care Act. DOI is continuing this analysis as to specific requirements and the changes that need to be made in accordance with the federal law requirements.

GRANT AUTHORITY

Some departments such as the Colorado Department of Human Services might need added authority to apply for federal grant opportunities.

HEALTH INSURANCE EXCHANGES

Colorado is required to make a decision about the creation of the exchange and report details to the federal government by January 2013. In order to meet this deadline, the state needs to have some initial legislation in the 2011 legislative session to create the authority within a state agency or create a quasi-governmental entity or nonprofit and to identify the governance, authority and purpose of a state exchange. Colorado will also need to conduct an economic modeling exercise and actuarial analysis to determine if it is feasible to move ahead. Funding for states is available through federal planning grants; Colorado recently received its first grant of close to $1 million to start the analysis.

DELIVERY REFORM

The state may need to address anti-trust issues, especially as they relate to delivery system reforms that promote medical homes and the delivery of integrated care.

WORKFORCE

The individual mandate and expanded coverage options created under the Affordable Care Act will likely create a surge in demand for health care services. However, coverage alone does not ensure access to health care services. Individuals who have a source of payment for care still may be unable to find a provider to meet their needs. Successful implementation of federal health care reform will depend on the state's response to health access issues, including workforce and infrastructure capacity. The legislature will need to consider how well Colorado is educating, training, recruiting, using and retaining health professionals, particularly those needed for preventive and primary care. Identifying alternative ways to deliver health care services, such as telemedicine, is also an important factor.

MEDICAID ELIGIBILITY

Changes will be required in Medicaid eligibility levels and processes for determining eligibility. These changes do not take effect until January 1, 2014.

Budget Implications

States are still identifying costs and savings related to the provisions in the Affordable Care Act. There are many grant opportunities available to states; a listing of these grants can be found in the on-line Appendix to this report. These grants generally have not required state matching funds, nor do the grants require programs to be continued once funding has ended. However, many of the grants do require that the expanded funding be used to increase programs' reach or capacity and not supplant existing state funds.

IMPACTS TO DEPARTMENTS:

Department of Health Care Policy and Financing

In June 2009, the Department applied to receive grant funding from the federal Health Resources and Services Administration (HRSA) State Health Access Program (SHAP) for the Colorado Comprehensive Health Access Modernization Program (CO-CHAMP). The purpose of the grant funding is to augment the funding appropriated under House Bill 09-1293 ("Colorado Health Care Affordability Act") and ensure its successful and full implementation. In September 2009, the Department received notice that its application was approved to fund seven comprehensive and inter-related projects totaling $42,773,029 over the next five years beginning in Fiscal Year (FY) 2009-10. For an in-depth description of the CO-CHAMP initiative please visit: colorado.gov/cs/Satellite/HCPF/HCPF/1251574721186.

Because the Colorado Health Care Affordability Act and the CO-CHAMP initiative are providing funding for administrative functions to implement the state reforms, they are by default funding a lot of the prep work needed to implement the Affordable Care Act. With the existing funding from

the grant and the Colorado Health Care Affordability Act, the Department will be hiring many new employees by FY 2011-12, so the Department anticipates that it will have sufficient staffing for these projects and implementation of national reform.

The Department anticipates that modifications to the Colorado Benefits Management System (CBMS) and the Medicaid Management Information System (MMIS) will be required for many of the requirements under the Affordable Care Act, including but not limited to implementing the Medicaid expansions, allowing for the increased enrollee and claims volume from the expansions and developing the interface with the exchange. Costs specific to the Department will be addressed in the future through the standard budget process.

The main components of the Affordable Care Act that will impact the Department will not be implemented until 2014, when Medicaid coverage will expand to 133 percent of poverty. Federal funds will pay most of the resulting new costs, but there will be increases in state Medicaid spending – starting at 5 percent of the cost in 2017 and growing to 10 percent by 2020 and beyond.

Federal funding for newly eligible individuals is as follows:

100% from 2014 through 2016
95% in 2017
94% in 2018
93% in 2019
90% in 2020 and thereafter

Colorado's expansion of coverage to 100 percent of poverty through the Colorado Health Care Affordability Act means Colorado is better positioned than most states. Under the Affordable Care Act, there will be no cost to the State for the Medicaid expansions to 133 percent of poverty until 2017. At that time, the state will need to cover the following estimated costs for medical services:

$31 million in 2017
$39.1 million in 2018
$48.2 million in 2019
$72.3 million in 2020

It is anticipated that enrollment may reach beyond initial estimates due to the individual mandate, streamlining of enrollment and retention procedures and increased investments in outreach.

It is likely the state will witness savings from several sources. First, the state may save funds as it shifts state and locally funded uncompensated care into federally matched Medicaid. Second, beginning in 2016, states will receive a 23 percent point increase in federal matching rates for Children Health Insurance Program (CHIP), up to a cap of 100 percent. This will reduce current state costs on the program. Third, the Affordable Care Act helps states achieve savings with their elderly and disabled populations. The bill permits greater integration of funding and services for dual-eligible individuals. If efficiencies result, this should generate savings to both federal and state governments. The bill also increases investments in home- and community-based services, which has been shown to save money and increase the quality of care in Colorado specifically.

Department of Regulatory Agencies/ Division of Insurance

Based on analysis there are no long-term Affordable Care Act costs at this time. There are several areas that the Affordable Care Act interfaces with the Division of Insurance's regulatory scope. Most specifically, the Division must review health insurance premiums with regard to the Affordable Care Act's requirements, and for this purpose the Division was provided with a grant from the

federal government (specifically the Department of Health & Human Services) for $1 million, which is expected to cover 5 full-time positions, for a three-year period subject to renewal each year. Additionally the Division will serve in an advisory capacity and provide key information and data as state insurance exchanges are set up, and the Division is receiving $52,307 through of a federal grant administered by the Governor's Office on the creation of exchanges.

Other areas where the Division will be required to make changes include outreach and website modifications to be consistent with Affordable Care Act changes in law as well as educate consumers and industry representatives about the new changes; participation in conferences and training with the National Association of Insurance Commissions (NAIC) to remain abreast of developments in the Affordable Care Act's implementation; fielding whatever inquiries might be directed to the Division regarding federal health insurance requirements; carrying out state laws with a view to how they interface with the federal law and recommending any necessary changes in state law. These are the general areas in which the Division will likely end up performing work; however, many of these responsibilities already are in the charge of the Division of Insurance; therefore no additional costs to the state are anticipated.

Department of Personnel and Administration

Based on analysis, the self-funded UnitedHealthcare options and the fully insured Kaiser Permanente options are non-grandfathered. Therefore the state's medical plan must comply with all the Affordable Care Act requirements. This would apply at renewal to the next plan year. The changes would include the addition of dependent coverage to age 26 and increased preventive services coverage with no copays or deductibles. In 2012 the state will need to report both employers' and employees' share of health insurance premium.

All other departments do not anticipate being impacted by health reform implementation in fiscal years 2010-11 and 2011-12.

Funding Opportunities

Health care reform comes with many funding opportunities and direct support to participate in health and wellness, insurance reform and rate review, consumer protection and assistance, early childhood investments and the building of exchanges. One of the challenges is that the Affordable Care Act did not come with administrative dollars to assist with implementation. State foundations have stepped in to help the state meet these needs.

ONE OF THE CHALLENGES IS THAT THE AFFORDABLE CARE ACT DID NOT COME WITH ADMINISTRATIVE DOLLARS TO ASSIST WITH IMPLEMENTATION.

In some instances, the Affordable Care Act made available funding for the first fiscal year (2010) to help support state implementation of the law. Additional funding will be made available in subsequent years, but many details (such as timing, total amounts and distribution) remain to be determined. The U.S. Department of Health & Human Services is overseeing procurement processes for a number of funding opportunities and staff have developed a database to track opportunities and progress on those to which the state has applied. Below is a summary of both funding opportunities received to date and those in which the state has applied. In addition, there is a list of upcoming opportunities in the report Appendices, available online; staff will continue to monitor future considerations.

Grants Received and Pending

Subject
Health Care Workforce

Grant title
Primary Care Workforce Planning

Lead agency
CDPHE

Amount funded
$150,000

Description
Complete a comprehensive workforce plan that will expand the primary care workforce in Colorado. The planning process will engage the Colorado Health Professions Workforce Policy Collaborative to identify multiple, achievable objectives that will lead to a 25% increase in the primary care workforce in Colorado.

Subject
Insurance Reform

Grant title
Health Insurance Exchange Planning

Lead agency
Governor's office

Amount funded
$999,987

Description
Funds planning related to the establishment of a state-based health insurance exchange. Funding for economic modeling, actuarial analysis, data collection from DOI and identification of IT infrastructure needed for the successful operation of a state-based exchange.

Provides resources for Colorado to determine how its exchange will be operated and governed, including:

1. Assessing current information technology systems and infrastructure and determining new requirements.
2. Developing partnerships with community organizations to gain public input into the exchange planning process.
3. Hiring key staff and determining ongoing staffing needs.
4. Planning the coordination of eligibility and enrollment systems across Medicaid, the Children's Health Insurance Program, and the exchanges.
5. Developing performance metrics, milestones and ongoing evaluation.

Subject
Insurance Reform

Grant title
Health Insurance Premium Rate Review

Lead agency
DOI

Amount funded
$1,000,000

Description
Improves the oversight of proposed health insurance premium increases, takes action against insurers seeking unreasonable rate hikes and ensures consumers receive fair value for their premium dollars. Allows the DOI to hire temporary staff: rate financial analysts and actuaries to review rate filings; staff in Consumer Complaints and outreach; and web enhancements to make rate filings more accessible and understandable to consumers.

1. Improve quality of information used in rate reviews and reduce the amount of time needed to complete each, in compliance with new federal requirements.
2. Enhance consumer protection, education and outreach relative to health insurance rates.

Subject
Insurance Reform

Grant title
High Risk Health Insurance Pool

Lead agency
DOI

Amount funded
$90,000,000 over 3.5 years

Description
Establishes temporary high-risk health insurance pool to provide health insurance coverage until January 1, 2014.

Subsidize health insurance for up to 4,000 people rejected by private health insurers because of pre-existing medical conditions.

Grants Received and Pending

Subject
Long-term Services/ Support

Grant title
Affordable Care Act; ADRC Options Counseling and Assistance Programs

Lead agency
CDPHE

Amount funded
$492,469

Description
Develop and implement a standardized procedure for options counseling to ensure all consumers statewide receive accurate and effective information to assist them in making decisions in their long-term care needs under the guidance and supervision of the CDHS, Division of Aging and Adult Services, State Unit on Aging.

Subject
Long-term Services/ Support

Grant title
Affordable Care Act; ADRC Evidence-Based Care Transition Programs

Lead agency
CDPHE

Amount funded
$394,476 over 2 years

Description
Funds Mesa County DHS to implement the Care Transitions Intervention (CTI) in the local hospital and Regional Medical Center. The goal is to increase effective self-management capacity following hospitalization and to reduce unplanned rehospitalizations.

Subject
Medicaid and Medicare

Grant title
Person Rebalancing Demonstration Financial Planning (HCBS)/Money Follows the Person Planning Grant

Lead agency
HCPF

Amount funded
$200,000

Description
Extends existing demonstration authority to award grants for the Medicaid Money Follows the Person program, established by the Deficit Reduction Act.

Build and improve upon infrastructure supporting home and community based services (HCBS) for people of all ages with long term care needs to:

1. Improve access to HCBS services.
2. Make the system easier to navigate.
3. Support the transition of institutionalized clients who have indicated an interested in finding out about community long-term care options and have the potential to return to the community.
4. Support nursing facilities in assisting clients to explore their long term care choices including community-based care.
5. Expand current infrastructure for housing, benefits and information technology.

Subject
Medicaid and Medicare

Grant title
Affordable Care Act;
The Medicare Improvements for Patients and Providers Act (MIPPA)

Lead agency
CDPHE

Amount funded
$345,072

Description
Coordinate efforts to provide outreach to beneficiaries with limited incomes statewide, for general Medicare Part D outreach and assistance to beneficiaries in rural areas, and for outreach activities aimed at preventing disease and promoting wellness under the guidance and supervision of the CDHS, Division of Aging and Adult Services, State Unit on Aging.

continues on next page

Grants Received and Pending

Subject
Prevention Services Divisions

Grant title
Early Childhood Home Visiting Program

Lead agency
CDPHE

Amount funded
$1,894,843 over 14 months

Description
Increase home visitation services to at-risk families who are expecting or who have new babies to support the family's physical, psychological and emotional needs in order to improve infant mortality, prevent child abuse and neglect, reduce future unwanted pregnancies and reduce substance abuse. This program requires participating States to utilize at least 75% of funding for evidence-based home visiting models and allows States to use up to 25% of funding for promising home visiting models.

Subject
Quality, Prevention and Wellness

Grant title
Healthy Communities, Behavioral Risk Factors Surveillance System (BRFSS) Supplemental Funding

Lead agency
CDPHE

Amount requested
$186,917

Description
Twelve questions on influenza-like illness will be added to BRFSS survey between September of 2010 and March of 2011. This will allow Colorado to assess the prevalence of influenza-like illness at the state and local levels to support Pandemic Influenza response and preparedness activities.

Subject
Quality, Prevention and Wellness

Grant title
Epidemiology and Laboratory Emerging Infections Program

Lead agency
CDPHE

Amount funded
$1,000,000 over 2 years

Description
Conduct influenza molecular testing from laboratory-confirmed hospitalized cases of influenza to support influenza surveillance and vaccine effectiveness studies through the 2010-2011 flu season; adapt and implement improved methods of estimating seasonal influenza burden in Colorado; collaborate with CDC on information systems to improve data quality and efficiency.

Subject
Quality, Prevention and Wellness

Grant title
Public Health Systems and Infrastructure

Lead agency
CDPHE

Amount funded
$300,000 per year for 5 years

Description
Coordinating with the Colorado Public Health Act of 2008 (SB08-194) activities, the grant will support strategic implementation of the 2009 Colorado Public Health Improvement Plan and other identified areas of local and state public health planning and implementation needs.

Subject
Quality, Prevention and Wellness

Grant title
Epidemiology and Laboratory Capacity for Infectious Diseases (ELC)

Lead agency
CDPHE

Amount funded
$800,000 over 22 months

Description
Enhances Colorado's ability to perform surveillance, investigation and control of communicable diseases statewide.

Grants Received and Pending

Subject
Quality, Prevention and Wellness

Grant title
Title V - State Abstinence Education Program

Lead agency
CDE

Amount funded
$647,131 per year for 5 years

Description
Funds to support decisions to abstain from sexual activity until marriage by providing abstinence education as defined by Section 510(b)(2) of the Social Security Act with a focus on groups that are most likely to bear children out-of-wedlock.

Subject
Quality, Prevention and Wellness

Grant title
Healthy Communities, Tobacco Prevention and Control – Supplemental Quit Line Funding

Lead agency
CDPHE

Amount funded
$73,927 over 2 years

Description
Expands tobacco cessation services for smokers ready to quit tobacco, ultimately reducing health care costs related to tobacco use.

Subject
Quality, Prevention and Wellness

Grant title
Personal Responsibility Education Program (PREP)

Lead agency
DHS

Amount funded
$793,058 per year for 5 years

Description
Implements innovative strategies for preventing teenage pregnancy and targets services to high-risk, vulnerable, and culturally under-represented youth populations.

Subject
Transparency and Fraud Abuse

Grant title
Background Checks On Direct Patient Access Employees Of Long-Term Care Facilities and Providers

Lead agency
CDPHE

Amount requested
$3,000,000 over 3 years PENDING

Description
Evaluate the state's current background check processes then work with stakeholders to define workable improvements. If Colorado is successful in defining improvements and creating a self-sustaining cost model, the consultant will also craft the phase II grant proposal to obtain implementation funds.

The Business of Health Reform

The Affordable Care Act intends to address the needs of individuals and of businesses that have been (or fear being) forced out of the business of providing coverage to employees due to rising costs. The new law includes several short- and long-term provisions designed to help small businesses pay for and maintain health insurance for their workers, and to allow workers without employer coverage to gain access to affordable, comprehensive health insurance.

These provisions include a small business tax credit to offset premium costs for firms that offer coverage, establishment of state-based insurance exchanges that promise to lower administrative costs and pool risk more broadly and the creation of new market rules and an essential benefit package to protect small firms and their workers.

The new law also creates a temporary reinsurance program to reimburse participating employment-based plans for part of the cost of providing health benefits to retirees ages 55 to 64 and their families. The insurance program will be eliminated in 2014, after the health insurance exchanges have been established. To date, 23 Colorado companies, unions and state and local entities have become eligible for early retiree subsidies.

Beginning in 2012, employers will be required to report the value of employer-sponsored health coverage on each employee's W-2 form.

In 2014, there is an employer responsibility requirement for employers with more than 50 full-time equivalent employees to offer health insurance coverage to full-time employees and dependents or be subject to a penalty. Employers with more than 200 workers must automatically enroll employees into the company's health coverage. There is also an expansion of the business tax credits and an introduction of wellness incentives.

Health insurance exchanges will make available to all Colorado small employers or sole proprietors, the same economies of scale of administration, marketing and risk pooling that are available to workers in large firms.

There are concerns about administrative costs of these new requirements as well as continued growth in health care premiums. Increasing premiums make it more challenging for businesses and self-employed individuals to maintain insurance. Ultimately it makes business in Colorado less competitive, so there must be a focus on cost containment – turning pilots and grants in the Affordable Care Act into policies that result in a bending or flattening of the cost curve. The state must also address issues around anti-trust in health care to create new systems in the delivery of care. Outreach and partnership with the business community to provide accurate and reliable information is also key to successful implementation.

Brian is a small business owner. He's had his auto company for many years and is proud to have always provided health care coverage for his employees because, as he puts it, "If you buy a car and take care of it, it will last you many years. If you don't, it won't." But every year Brian worries about the 15-20 percent hike in premiums.

The new health law provides Brian and other small business owners with a tax credit to help with the costs of covering their employees… a wise investment that also makes the health care system fairer.

IMPLEMENTATION TIMELINE

Several provisions of the Affordable Care Act, including the tax credit and the early retiree reinsurance program, were implemented in 2010. The expansions in public programs, creation of health insurance exchanges and employer responsibility requirements begin in 2014. See Supporting Reference for a business implementation timeline.

CONTROLLING COSTS

The law attempts to control and stabilize costs in a variety of ways by expanding coverage to those previously uninsured to reduce cost-shifting, combining the purchasing power of small businesses and individuals through the exchanges and investing in wellness initiatives. The new law also encourages development of more efficient and cost-effective payment and delivery models for the long-term. This includes the creation of pilots, such as medical homes and chronic care management, to lower health care costs; testing of different models of paying doctors and hospitals to reward patient outcomes, rather than number of visits and tests ordered; and research into the relative effectiveness of various treatments for specific conditions and illnesses.

EXCHANGE FOR SMALL BUSINESSES

As part of the Affordable Care Act, Colorado will create a new entity to advance a more organized and competitive market for health insurance. Health insurance exchanges will make available to all Coloradans, especially those who work for small employers or who buy health insurance on their own, the same economies of scale of administration, marketing, and risk pooling that are available to workers in large firms. The small group market is defined as employers with one to 100 employees; however, a state may limit small group participation to employers with 50 or fewer workers from 2014 through 2016. Beginning in 2017, all employers with 100 or fewer employers may participate in the exchange. States may allow businesses with more than 100 employees to participate after 2017. States can also choose to combine the individual and small business exchanges.

Businesses are not mandated to purchase within the exchange. However, employers will need to provide written notice to employees regarding: (1) the existence of an exchange; (2) the employee's potential eligibility for a premium assistance tax credit and cost-sharing reduction if the benefits provided under the employer plans' shares of total allowed costs is less than 60 percent; and (3) the potential loss of the employer contribution to any employer-sponsored health care plan if the employee purchases health insurance through the exchange.

Group coverage that is currently purchased by employers can be kept or "grandfathered" under reform (as long as the plan was in existence before reform was enacted in March 23, 2010). If an employer makes any significant changes in coverage or increases cost sharing, copays, deductibles or co-insurance, the plan can no longer keep its grandfathered status.

EARLY RETIREE REINSURANCE PROGRAM

Over the past 20 years, the percentage of large businesses that provide workers with retiree health coverage has decreased by more than 35 percent.[9] To help employers combat rising costs that make it difficult to provide such insurance, the Affordable Care Act created a new program for employees who retire early, but who are not yet eligible for Medicare. The Early Retiree Reinsurance Program allocates $5 billion in financial assistance to help employees age 55 and older maintain coverage until they are eligible for Medicare. Businesses are enrolled through an application process; those accepted receive reimbursement on medical claims for early retirees and their

9 U.S. Department of Health & Human Services. "Early Retiree Reinsurance Program: Colorado." healthcare.gov/law/provisions/retirement/states/co.html. October 27, 2010.

families. As of October 10, 2010, the US Department of Health & Human Services approved 23 Colorado businesses (although additional applications are being approved daily). A complete list is available at healthcare.gov/law/provisions/retirement/states/co.html.

ADDITIONAL INFORMATION

A business timeline, which can be found in Supporting Reference, details additional provisions of the Affordable Care Act and answers important questions for Colorado businesses.

Interagency Health Reform Implementation Board

On April 20, 2010, Gov. Bill Ritter, Jr. signed Executive Order B 2010-006 creating the Interagency Health Reform Implementation Board and designating an implementation director. The mission of the Board is to provide the governance, rules and regulation and administrative infrastructure to facilitate planning and implementation of the Affordable Care Act in Colorado. In addition, the Board is charged with extensively engaging stakeholders to assist in improving Colorado's health care system. This effort must be collaborative, rooted at the community level and embraced by stakeholders to ensure changes made in Colorado are effective and sustainable.

Board Members

The Board is comprised of cabinet members and the director of health reform implementation, a staff designate. Subject-specific task groups will be formed as needed and existing boards and commissions will be included for advisory purposes. The members are listed below.

Joan Henneberry, Chair	Executive Director, Department of Health Care Policy and Financing
Karen Beye	Executive Director, Department of Health & Human Services
Roxanne Huber	Executive Director, Department of Revenue
Leah Lewis	Acting State Chief Information Officer
Lorez Meinhold	Director of Health Reform Implementation
Guy Mellor	Human Resources Division Director, Dept. of Personnel and Administration
Lisa Miller	Acting Chief Medical Officer, Department of Public Health and Environment
Marcy Morrison	Commissioner, Division of Insurance
Todd Saliman	Executive Director, Office of State Planning and Budgeting
Ken Weil	Deputy Chief of Staff, Governor's Office of Policy and Initiatives
Craig Welling	Chief Legal Counsel, Office of the Governor

Among many responsibilities, the Board is charged with four primary tasks:

- Develop a strategic plan for implementation of the Affordable Care Act, building on Colorado's successful health reform efforts;
- Collaborate with appropriate federal agencies, state agencies and stakeholders when necessary regarding the establishment of new rules, regulations or mechanisms for the implementation of the Affordable Care Act;
- Pursue federal and state grants to assist in implementing any aspects of the Affordable Care Act;
- Extensively engage stakeholders to advise and assist in implementation of the Affordable Care Act.

Strategic Plan

This report serves as a roadmap for reform in Colorado, capturing the momentum of state policies already adopted and implemented and documenting future requirements to ensure compliance with federal legislation. Its goal is to help the next administration understand Colorado's health landscape and guide its immediate next steps, provide a status report to state legislators and serve as a reference document to the greater public interested in learning more about the transformation that is taking place now and will continue well into the future.

Interagency Collaboration

Implementing the Affordable Care Act will require state departments to collaborate in ways they never have before. The health insurance exchange, for example, will require four government agencies to interface. These include the Colorado Department of Health Care Policy and Financing, the Department of Revenue, the Colorado Division of Insurance and the Internal Revenue Service. These agencies will need to leverage resources and coordinate activities, which is especially important at a time when state resources are limited. To date, several agencies have identified areas of responsibility under the Affordable Care Act.

Colorado Department of Health Care Policy and Financing – Primarily responsible for implementing Medicaid expansions required under the Affordable Care Act. In addition, it will interface with the exchange to ensure seamless eligibility for Medicaid recipients, secure grants related to home- and community-based services, accountable care organizations and chronic care management, etc.

Colorado Department of Public Health and Environment – Primarily responsible for securing grants related to public health improvement, HIV, tobacco cessation, obesity prevention, pregnancy prevention, workforce planning and student loan repayment.

Colorado Division of Insurance – Primarily responsible for implementing health insurance reforms and promulgating rules and regulations, as appropriate. In addition, it will enhance its review of insurance premium rates and participate with the National Association of

David was covered under his employee plan for a year before the insurance company went back in his record and cancelled his plan retroactively. The company claimed that David didn't disclose all of his medical history on his original form. Unfortunately for David, he had no idea hemorrhoids fell under the category 'digestive disorders.' They also cited no mention of his high triglycerides and high cholesterol, which David didn't even know he had. He appealed the decision. Four months later, he got a letter from the insurance company saying "it is irrelevant whether or not you intentionally or inadvertently failed to reveal all of your previous medical history." His appeal was denied.

Under the new law, it is illegal for health insurance companies to take coverage away from people like David who play by the rules, pay all of their premiums, and just want their insurance to be there for them when they need it. The new law includes tough and fair regulations to protect us from the worst insurance company abuses of the past.

Insurance Commissioners to help determine medical loss ratios (the amount of premium that goes to medical costs and quality improvement). DOI will also provide consumer assistance and protection, secure grants related to rate review and consumer assistance.

Governor's Office of Information Technology – Primarily responsible for ensuring that state systems are able to exchange data among themselves, with the Colorado Regional Health Information Organization, private providers and federal agencies. In addition, OIT will advise the Board and other stakeholders on system integration, technology options, issues and opportunities. OIT will also monitor national health information technology requirements and act as the primary advisor to help build a scope and cost estimates for the information technology aspects of grant requests.

Most of these collaborating agencies created teams to address implementation issues and to work toward a smooth transition to the next administration. These teams meet regularly to discuss funding opportunities and to streamline processes. Constant communication ensures quality health outcomes are delivered in the most effective manner. For example, when the state applied for a comprehensive pregnancy prevention grant, the Colorado Departments of Education, Human Services and Public Health and Environment worked together on the application and will coordinate prevention efforts for key populations.

Implementation Support Funding

With the help of the Board, the director of health reform implementation has been successful in identifying funding to help with implementation support.

A generous $150,000 grant from the Rose Community Foundation is helping the governor's office maintain materials and content for the health reform portion of the website, develop and distribute fact sheets for specific stakeholder groups, participate in speaking engagements and other educational opportunities, track and report on all outreach activities and contract staffing to assist departments in applying for federal funding opportunities.

Funding from Caring for Colorado Foundation in the amount of $5,000 will support staff in outreach efforts related to the health insurance exchanges. This grant will support in- and out-of-state travel expenses to ensure staff is engaging stakeholders on key issues and working with local and national partners to identify best practices and models.

It is this type of implementation support funding that will allow state staff to engage key stakeholders and develop systems and processes to ensure an effective transition to the next administration.

Stakeholder Education and Engagement

From Fort Collins to Alamosa and Grand Junction to Holyoke – and beyond, staff from the Ritter administration participated in more than 150 forums, events, conferences, media interviews and other outreach and education activities since April, right after the Affordable Care Act was signed into law. These efforts have been vital to engaging stakeholders in, and educating citizens on, the Affordable Care Act.

In addition to these outreach activities, the director of health reform implementation has held "open" office hours every week for stakeholders and members of the public to ask questions and learn more about health reform in Colorado. Staff have also developed industry- and stakeholder-specific fact sheets and timelines, as demonstrated in Supporting Documents, to help translate complicated requirements and timelines.

Information is also available on the State of Colorado's health reform web pages, which are part of colorado.gov. The website, which is updated weekly, has vast resources for opportunities for engagement, timelines for implementation, answers to frequently asked questions and much more.

Opportunity for Reform In Colorado

Colorado has embraced increased health care quality at a decreased cost for a number of years by making state reform a priority. That means the state already has a framework in place and infrastructure from which to build an unprecedented system that will result in improved health outcomes for all Coloradans. The implementation of national reforms that are part of the Affordable Care Act are designed to lower health care costs for Colorado families and small businesses, potentially reducing the cost of family health insurance premiums by 10 to 25 percent. Coupled with state-led efforts such as the Colorado Health Care Affordability Act, national reform will provide coverage to 500,000[10] uninsured Coloradans. Additionally, up to 90,000[11] small businesses in Colorado may be eligible for tax credits to help make coverage for employees more affordable. For those who seek health care from community health centers, there will be additional funding for some or all of the 123 centers throughout the state.

Even though the Affordable Care Act was signed into law at the end of March, several provisions of the legislation were enacted in the months immediately following its passage to lay the foundation for several years of changes and ensure protection for those consumers who cannot wait until 2014, when the law is fully implemented.

Implemented as of December 2010

The following is a brief list of immediate provisions of the Affordable Care Act enacted as of September 23, 2010, which marked its six-month anniversary. These immediate provisions are meant to protect consumers from insurance company abuses and provide new benefits to Coloradans, as summarized by the U.S. Department of Health and Human Services.[12]

- Up to 18,600 young adults may be able to stay on their parents' plan until they turn 26.
- Insurance companies can no longer impose a lifetime limit on care on the 2,846,000 residents of Colorado with private health insurance coverage.
- Insurance companies will be prohibited from dropping the coverage of any of the 2,846,000 residents of Colorado with private health insurance coverage if they get sick or made an unintentional mistake on their applications.
- Insurance companies will be prohibited from denying children with pre-existing conditions access to health insurance, but will be able to charge more based on their health status until 2014.
- Tax-free rebate of $250 for seniors who exceed their prescription drug limit in Medicare Part D.
- Free preventive services for the 574,000 Medicare beneficiaries in Colorado.
- Access to a reinsurance programs to cover retirees age 55 and older and who are not yet eligible for Medicare. Twenty-three Colorado companies, unions, state and local entities became eligible for early retiree subsidies.
- Authority, and funding, provided to the Colorado Division of Insurance to enhance its review of rate increases by insurance companies.

10 State of Colorado. "Capital Health Reform in Colorado: Frequently Asked Questions," colorado.gov/cs/Satellite/GovernorsHealthReform/GOVR/1251573982023.

11 U.S. Department of Health & Human Services, "The Affordable Care Act: Immediate Benefits for Colorado," whitehouse.gov/healthreform.

12 U.S. Department of Health & Human Services, "The Affordable Care Act: Immediate Benefits for Colorado," whitehouse.gov/healthreform.

- Access to GettingUSCovered, a health plan for people with pre-existing conditions who have been uninsured for at least six months. As of November, 471 people have gained coverage through this new program.
- Insurance provider requirement to cover certain preventive services and eliminate copays.
- Small business tax credits – up to 90,000 small businesses in Colorado may be eligible for the new small business tax credit that makes it easier for businesses to provide coverage to their workers and makes premiums more affordable.

Colorado's Health Care Priorities

In addition to these intermediate milestones, national reform will help advance ongoing work in the areas of health information technology, cost containment/payment reform, safety net, health care workforce and coverage for those with pre-existing conditions. Improving these areas of Colorado's health care system are vital to achieving increased quality of care for all Coloradans. Government, consumer, provider, nonprofit and business stakeholders have been working together for years to improve efficiency and decrease costs and the Affordable Care Act will leverage the progress made to date to fast-track results.

COORDINATING CARE THROUGH HIT

Health information technology (HIT) is a means of improving the quality of health care, the health of populations and the efficiency of health care systems. Coloradans receive health care via 100 hospitals and nursing facilities, from more than 10,000 physicians and through 15 federally qualified health centers.[13] Although most of the state's population resides in one of several urban centers, the wide geographic and rural span of the state dictates the necessity for eight medical referral regions (both in and out of the state's boundaries). Together these factors create challenges in coordinating and sharing patient care; however, statewide adoption of HIT provides efficient solutions that increase quality and decrease cost.

Together, the Affordable Care Act and the Health Information Technology for Economic and Clinical Health (HITECH) Act, under the American Recovery and Reinvestment Act (ARRA), have created significant opportunities for Colorado to expand and accelerate strategies for building statewide interoperability through a health information infrastructure. These efforts are designed to improve the quality, efficiency and coordination of health care through financial incentives for providers to adopt and meaningfully use electronic health records (EHRs). HITECH's funding priorities will shape the country's transformation from paper to digital health records.

The HITECH Act also created new responsibilities and resources for state Medicaid agencies to advance the adoption and meaningful use of HIT and EHRs to significantly improve the quality and cost-effectiveness of health care services and systems. The leads for each of the HITECH-funded programs at the state are working on a coordinated response for completion of the State Medicaid HIT Plan and Implementation Advanced Planning Document for submission to the Centers for Medicare and Medicaid Services and the State Strategy for Meaningful Use for submission to the Office of National Coordination for HIT in December 2010.

The ultimate measure of HITECH's success will be if the state creates a health care system characterized by true integration—succeeding in changing the organization of how health care is delivered.

13 The Colorado Health Foundation, "Recommendations for Advancing Colorado's Health Information Network Using Federal Stimulus Funds," June 2009. coloradohealth.org/studies.aspx

The Colorado Regional Health Information Organization (CORHIO) is one of the state's leading nonprofit, public-private partnerships working to improve health care quality for all Coloradans through cost-effective and secure implementation of health information exchange (HIE). As the state-designated facilitator of HIE, CORHIO will coordinate the state's initiatives under ARRA HITECH. CORHIO works closely with and among communities across Colorado to develop and implement secure systems and processes for sharing clinical information. CORHIO collaborates with health care stakeholders including physicians, hospitals, clinics, mental health, public health, long-term care, laboratories, imaging centers, health plans and patients. By 2011, CORHIO plans to transmit patient care summaries, referrals, medication, allergy and problem lists and public health notifications and alerts, among many other things. Also by early 2011, CORHIO is committed to launching two communities on HIE; by 2015 it will be launching two to three communities each year.

CONTROLLING COSTS THROUGH PAYMENT REFORM

Projections indicate that U.S. health expenditures will grow to over one-third of the economy by 2040.[14] Health insurance premiums for Coloradans consumed nearly 22 percent of median family income in 2008; this figure is predicted to rise well above 30 percent in ten years unless dramatic changes are made.[15] Meanwhile, consumers struggle to find affordable coverage and forego or delay needed medical treatment.[16] Misaligned payment incentives and delivery systems compound these negative trends. Additionally, the lack of available and transparent health care cost and quality data prevents consumers, providers, businesses and others from making value-based purchasing decisions.

While Colorado spends $30 billion in health care every year, costs continue to increase while value decreases. Yet, Colorado is better poised than many states to take on the challenge of improving health outcomes and stabilizing and/or decreasing costs due to its examples of structured, coordinated health care delivery systems (western slope and Denver Health, for example). A recent study by the New America Foundation and University of Denver's Center for Colorado's Economic Future concluded the following about Colorado's opportunity for containing costs.

> "...we conclude that delivery system reforms could yield between $11 and $38 billion in savings over the next decade in Colorado. This leaves $11 to $38 billion more to spend on other Colorado business, household, and governmental priorities. These dollars, like the resources spent on coverage expansion, will generate multiplier effects throughout the Colorado economy. In addition, these savings would lead to premiums that are 5.5 to 17 percent lower in 2019 than they would have otherwise been without delivery system reform. Again, federal reform (or more active federal involvement in state delivery system reform efforts, if federal reform fails) could lead to even greater savings."[17]

14 Peterson, Peter G. (2010, May). Plain Talk about the Budget Gap. PowerPoint presented at the Institute for Health Improvement conference, Washington D.C.

15 Nichols, L., & Sobanet, H. (2009). The Future of Colorado Health Care: A preview to the forthcoming report on an economic analysis of health care reform and the impact on Colorado's economy. Paper presented to the Denver Metro Chamber of Commerce and The Colorado Health Foundation, Denver, CO.

16 Deloitte Center for Health Solutions. (2009). 2009 Survey of Health Care Consumers. Key Findings, Strategic Implications. Retrieved July 12, 2010, from http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_chs_2009SurveyHealthConsumers_March2009.pdf

17 New America Foundation and University of Denver's Center for Colorado's Economic Future, "The Future of Colorado Health Care: A preview to the forthcoming report on an economic analysis of health care reform and the impact on Colorado's economy." coloradohealth.org/studies.aspx

Like many efforts underway in Colorado, reforming payment structures and other initiatives to contain costs must be approached in a collaborative spirit. As part of Gov. Ritter's 2008 Building Blocks to Health Care Reform, the Center for Improving Value in Health Care (CIVHC) was formed to coordinate and advance such initiatives.

CIVHC is a public-private entity created to identify and advance initiatives across Colorado that enhance consumers' heath care experiences, contain costs and improve the health of Coloradans by creating an efficient, high quality and transparent health care system in collaboration with consumers, providers, payers, businesses and policy makers. CIVHC is working on payment reform and an all-payer claims database, managed by a newly-created Advisory Committee to guide the process. While CIVHC is currently housed within the Colorado Department of Health Care Policy and Financing, it has filed to become an independent 501(c)(3) nonprofit.

INCREASING CARE FOR LOW-INCOME COLORADANS

Colorado's "safety net" provides comprehensive primary care to thousands of low-income families throughout the state. The safety net is comprised of several different associations of clinics including federally qualified health centers also referred to as community health centers, community mental health centers, rural health clinics and community-funded safety net clinics.

All provide primary care and preventive services to patients who are uninsured, underinsured and otherwise in need. Although these centers share a mission to provide care, regardless of a patient's ability to pay, community-funded safety net clinics and rural health clinics are not federally qualified, which makes them ineligible to receive federal funding for start-up costs and to support the provision of patient care services.

Currently there are 26 community-funded safety net clinics and 51 rural health clinics operating sites in 33 counties. In 2008, these clinics provided an estimated 700,000 clinic visits to 250,000 patients. Colorado Community Health Network (CCHN) is the association that represents the federally qualified health centers. Colorado has 123 clinic sites, operated by 15 community health centers. According to CCHN, in 2009 these 15 community health centers "provided more than 1.8 million visits, including medical, dental and mental health, to more than 452,000 patients. More than 190,000 Colorado children received primary health care from community health centers in 2009."[18]

With the enactment of the Affordable Care Act came funding, a total of $11 billion over five years, to support federally qualified health centers throughout the country. With a significant increase in the insured population by 2015, more people will seek affordable care and communities must be poised to meet the increased demand.

On October 8, 2010, the US Department of Health & Human Services announced Capital Development grants to 143 Community Health Centers (CHCs) across the country to address pressing construction and renovation needs and expand access to quality health care. Through the [Affordable Care Act], Congress has directed investments in federally qualified health centers nationally to:

- Help meet the health care needs of the uninsured now;
- Provide access to the millions of individuals that will gain coverage under the Medicaid expansions and state health insurance exchanges beginning in 2014;

18 Colorado Community Health Network. "What is a community health center?" Website: October 20, 2010. cchn.org/health_centers.php.

- Continue to care for the 20 million individuals that are expected to remain uninsured after health care reform.[19]

Three federally qualified health centers in Colorado received funding to address infrastructure needs and expand care. These grants are summarized below, courtesy of CCHN.

Clinica Family Health Services, Inc.: $3,785,700 to expand the Thornton facility, including adding 11 medical exam rooms, three dental operatories and two multiuse group visit rooms. This will allow Clinica to provide care to an additional 3,400 patients, up from the 8,000 patients seen at the Thornton site in 2009. The Colorado Health Foundation provided a matching grant of nearly $1.5 million to support the federal grant to Clinica.

Metro Community Provider Network (MCPN), Inc.: $10,247,940 to build a new facility in Jefferson County (JeffCo) to replace the current JeffCo facility. JeffCo Clinic in Lakewood cared for 5,000 patients in 2009; the new facility to be called Jefferson County Family Health Center is expected to care for an additional 10,000. The Colorado Health Foundation awarded $3 million to MCPN to purchase the land for the new clinic. Nearly 11 percent of Colorado's population lives in Jefferson County, with approximately 37 percent earning below 200 percent of the Federal Poverty Level.

Valley-Wide Health Systems, Inc.: $4,863,000 to replace two established primary care facilities to address significant and pressing capital improvement needs through modernization, renovation and construction. Valley-Wide will build a larger medical office building in La Junta to meet growing community needs and will renovate a recently purchased building in Monte Vista to replace the current Rio Grande Medical Center. The Colorado Health Foundation awarded $1.6 million in matching dollars to Valley-Wide to support these efforts. These grants will increase Valley-Wide's capacity to care for an additional 1,300 patients in La Junta and 500 at the Rio Grande Medical Center. Caring for the Colorado and Colorado Department of Local Affairs provided grants to help complete the funding for the Rio Grande Medical Center project.

STRENGTHENING THE HEALTH CARE WORKFORCE

Parts of Colorado, rural and frontier in particular, are already dealing with shortages in the health care workforce. Statewide, Colorado could be facing a shortage of more than 2,000 health care professionals by 2025[20]. Colorado's population is not evenly distributed across the state and that residential pattern is reflected in the distribution of primary care providers. Though many urban counties have no overall shortage of primary health care providers, most have a severe shortage of providers serving publicly insured and uninsured people.

According to the state's Office of Primary Care, demand from the aging Baby Boomer generation is expected to expand the number of health care job openings by 20 percent over the next decade. Unless something is done to increase the health care workforce supply, change its geographic distribution and alter its composition toward primary physical, oral and mental health services, there will not be nearly enough providers to fill new demand, much less make up for the current shortages. In Colorado, as in the rest of the nation, the demand for health care professionals far exceeds the

19 Colorado Community Health Network. "Federal Grants to Provide New Health Care Access For 15,200 People in Colorado." News release: October 12, 2010. cchn.org/newsroom.php.

20 Colorado Health Institute. "What impact will state and national health reforms have on Colorado's primary care workforce?" Presentation to AcademyHealth Research Meeting: June 26, 2010. coloradohealthinstitute.org/Presentations/2010/062610-ARM-WF.aspx

supply, particularly among rural and urban low-income communities. For example, the state's nursing shortage is twice the national average, and the nursing shortfall is expected to triple by 2020.

The magnitude of the current and predicted shortage is so great it cannot be solved by local communities, health care and educational institutions, foundation and other entities alone. Their contributions are critical, but significant action is needed by the state and federal governments to have a lasting and sustainable impact. Colorado needs to focus not only on student loan repayment as a way to increase its primary care workforce, but also look to technology and ways to better utilize the state's health care professionals to their full potential in many primary care settings in Colorado.

In Walden, Colorado, at the northern edge of the state, if one gets the flu, one can go to a clinic in Walden, but one probably won't see a primary care physician, because she's only there three days a month. If a child gets a toothache in Walden, his parents must drive two-lane mountainous roads to a neighboring county for treatment, because there are no dentists in Jackson County. If that child is covered by Medicaid, he may have to travel even farther because 20 of Colorado's 64 counties do not have a single dentist that accepts Medicaid. If one experiences a medical emergency in Walden, transit to the nearest hospital is 60 miles.

In the fall of 2008, The Colorado Trust recognized the magnitude of the health workforce challenges facing Colorado and the absence of a collaborative body dedicated to the specific planning, investment and policy needs unique to the health care sector and its workforce. In partnership with several organizations and state agencies, The Trust formed The Colorado Health Professions Workforce Policy Collaborative to address the need for a health professions focused collaborative body.

Administered by the Colorado Rural Health Center, the Workforce Collaborative is a multidisciplinary group of more than 40 organizations committed to ensuring a highly qualified health care workforce to provide all Colorado residents with access to quality health care. The Workforce Collaborative convenes policy leaders, health care providers, educational institutions and economic development and workforce planning authorities to collectively establish a strategic public policy framework for Colorado that will advance health professions workforce priorities to alleviate provider shortages and strengthen the health care system. There are a number of workforce components outlined in the Affordable Care Act and the state can leverage the work of the Workforce Collaborative to establish the framework to strengthen Colorado's workforce.

PROVIDING COVERAGE FOR THOSE WITH PRE-EXISTING CONDITIONS

Thousands of Coloradans are not able to obtain health insurance through a job for a variety of reasons – they are self-employed, their employer does not offer an insurance plan and/or they are too sick to work. Their only choices exist in the individual market. According to the Commonwealth Fund, 36 percent of those who tried to purchase health insurance directly from an insurance company in the individual insurance market were in fact discriminated against because of a pre-existing condition in the previous three years.[21]

21 The Commonwealth Fund. "New Report: Individual Health Insurance Market Failing Consumers," July 21, 2009. commonwealthfund.org/Content/News/News-Releases/2009/Jul/New-Report-Individual-Health-Insurance-Market-Failing-Consumers.aspx.

Together, a statewide program in existence for nearly 20 years and a new federal program that is part of the Affordable Care Act will work to address this growing concern.

CoverColorado is a nonprofit organization established by the Colorado legislature in 1991 to help more Coloradans gain access to health care. CoverColorado currently provides health insurance for more than 12,000 individuals with pre-existing conditions that prevent them from getting coverage in private health plans. CoverColorado's existing program is funded 50 percent from member premiums, 25 percent from insurance carrier assessments and 25 percent from the state's unclaimed property fund. For more information, visit covercolorado.org.

GettingUSCovered, a new, comprehensive health plan created by the federal government through the Affordable Care Act, provides health care coverage to individuals unable to purchase comprehensive health insurance because of a medical condition. It is funded with federal dollars and member premiums and was the first step in national health care reform. Rocky Mountain Health Plans (RMHP), a locally-owned, Colorado-based nonprofit organization, has contracted with the U.S. Department of Health & Human Services to administer GettingUSCovered. RMHP is working jointly with CoverColorado and pharmacy benefit manager Express Scripts to administer the program. GettingUSCovered expects to expand coverage to up to 4,000 currently uninsured individuals and to continue through December 31, 2013. The plan is a bridge to 2014, when individuals with pre-existing conditions will be able to purchase health coverage through health insurance exchanges.

Johanna's insurance coverage ended after she lost her job and her COBRA coverage ran out. After she was diagnosed with depression, she found it impossible to obtain health insurance because depression is considered a pre-existing condition. Johanna recently joined Colorado's Pre-Existing Condition Insurance Plan and now has health insurance.

GettingUSCovered is a new, comprehensive health plan created by the federal government. It was established to expand coverage to uninsured Coloradans with medical conditions.

Additional Opportunity for Reform

Among some of the most anticipated provisions of the Affordable Care Act is authority to set up a formal process by which states will review insurance company rate increases and the establishment of health insurance exchanges – virtual marketplaces where individuals, families and businesses can review and purchase health coverage.

RATE REVIEW

In 2009, Colorado ranked 26 among states in the annual amount paid by a family for health insurance premiums involving employers of all sizes, according to the federal government's Medical Expenditure Panel Survey (MEPS). That means families in 25 states paid higher average premiums than in Colorado. The average annual premium for a Colorado family getting coverage through an employer was $13,360 in 2009, compared to $9,522 five years earlier. The average monthly premium for a single employee was $4,570 in 2008, compared to $3,645 five years earlier.[22]

22 Colorado Division of Insurance. "FAQs on Health Rate Review," September 2, 2010.

Colorado also has a number of protections for consumers and businesses who buy health insurance plans in the state. Among those protections is a health premium rate review to help combat excessive increases in health premiums by insurance companies. Through the Affordable Care Act, the Colorado Division of Insurance received a $1 million grant to enhance its health premium rate review process for individual, small group and large group coverage, in addition to expanding consumer outreach and education.

HEALTH INSURANCE EXCHANGES

The goal of these new exchanges is to create a marketplace that makes it easier for consumers and businesses reviewing and purchasing health care coverage. Currently, Americans who work for small employers or who purchase health insurance on their own do not have access to the same negotiated economies of scale of administration, marketing and risk pooling that are available to employees working in large firms. However, the exchanges will change that. Under the Affordable Care Act, states can create two types of health insurance exchanges; they will organize the health insurance marketplace so individuals and businesses have clear, transparent and understandable choices; and assure through sliding scale federal subsidies that health insurance is affordable for individuals. An "American Health Benefit Exchange" will facilitate the purchase of qualified health plans by individual consumers. A "Small Business Health Options Program (SHOP) Exchange" will assist qualified employers with up to 100 employees in enrolling employees in small group health benefit plans. Or, states may also choose to establish a single exchange that performs both functions. It is estimated that the exchange will provide insurance to at least 300,000 uninsured individuals. Colorado has the opportunity to make key decisions about the structure, governance and role of the programs.

Exchanges will perform five basic functions:

1. Certification of health plans to ensure they meet minimum benefits standards.
2. Customer Service via a toll-free phone line and a website with standardized information on plans, and help for individuals and employers to purchase and enroll in certified plans.
3. Quality assurance using a standardized rating system.
4. Assistance for eligible individuals and small businesses in accessing premium and cost sharing subsidies.
5. Streamlining access to subsidized health insurance programs including Medicaid, Medicare, and Child Health Plan Plus.

Exchanges will offer health insurance products based on the "Essential Health Benefits Package," which is a set of services defined by the federal government. These services include emergency services, hospital care, prescription drugs, lab services, preventive and wellness services, chronic disease management, rehabilitation, mental health and substance abuse, among others. All of the products sold in the exchange will cover the same set of services. They differ only in the value (and therefore cost) of benefits provided.

The products will be named based on their levels of coverage. "Bronze" is the minimum coverage package, followed by "Silver," "Gold," and "Platinum," which will offer the highest level of coverage. The Bronze package will cover roughly 60 percent of the costs of services it covers. Silver will cover roughly 70 percent, Gold will cover roughly 80 percent of costs and Platinum will cover roughly 90 percent of the costs of the benefits provided. The fifth product offered in the exchange is a "Catastrophic Plan" which is primarily intended for people 30 years and younger or those who

would otherwise be exempt from the requirement to purchase coverage because the premium exceeds eight percent of their income. Catastrophic Plans must provide first-dollar coverage (no cost-sharing) for at least three primary care visits.

Each state has the opportunity to make decisions about the structure and operation of the exchanges. The first key decision for the state is to determine whether to "elect" to establish an exchange through state law or regulation, or to leave the responsibility to operate an exchange to the federal government. That is a decision the federal government will require Colorado to make by January 1, 2013. The federal government is providing grants to states for planning and establishing exchanges.

To solicit feedback from a wide range of stakeholders on Colorado's structure, the governor's office, in conjunction with the Colorado Consumer Health Initiative and the Colorado Coalition for the Medically Underserved, hosted a number of Exchange Forums throughout the summer and fall of 2010.

The forums, in an attempt to build a shared understanding of the exchanges and collect input, focused on five key decisions the state must make regarding the structure of the exchange:

- Identify goals;
- Determine influence over Colorado insurance market;
- Identify role in helping consumers and small businesses understand, compare and purchase insurance;
- Identify role in supporting compliance with federal and state regulations and requirements;
- Determine the best structure for governance and sustainability.

The forums helped stakeholders envision what a successful exchange might entail, such as setting standards, facilitating subsidies, reducing costs and expanding outreach, enrollment and education. More than 150 people representing advocates, underwriters, health plans, provider groups and business, in addition to health care consumers, actively participated in the forums.

Some of the stakeholders' shared values around successful exchanges are summarized below; a full report is available at colorado.gov/healthreform under "meetings."

A successful health insurance exchange in Colorado will:

- Successfully connect people to stable coverage.
- Organize the marketplace so that consumers and small businesses can find understandable and reliable information about health insurance products.
- Establish certification criteria for participating plans that ensure consumers and small businesses have meaningful choice between high quality, affordable plans.
- Ensure all plans sold in the exchange offer the federally defined essential benefits package.
- Maximize participation in the exchange to create a stable risk pool and minimize adverse selection.
- Enable consumers and small businesses to purchase coverage without assistance and ensure support for consumers and small businesses that want and need assistance navigating the exchange.

- Maximize continuity of coverage and seamless transitions between public and private health coverage.
- Not duplicate the current regulatory functions of the Division of Insurance.
- Include robust data collection mechanisms to support transparency and accountability.
- Operate efficiently and aim to minimize administrative costs.

As the state works toward decisions on the establishment of the exchanges, staff will continue to solicit input and feedback from stakeholders through additional forums.

National Collaboration and Resources

This certainly is not the first reference to collaboration in this report; it is what will allow for the most effective implementation and maintenance of the Affordable Care Act. While there are a number of organizations working together in Colorado to avoid duplication and leverage knowledge, resources and existing progress, the state will do the same when it comes to best practices and interpreting their role in this complicated process. There are a number of national organizations perfectly suited to serve as clearinghouses for sharing among states and other organizations.

State Consortium on Health Care Reform Implementation

Due to the significant role states will play in the implementation of the Affordable Care Act, four national organizations joined forces to create the State Consortium on Health Care Reform Implementation to provide governors and other state officials and staff the tools and resources needed to develop the most effective implementation plan for their states. The four founding organizations are as follows; each has additional expansive information on their websites.

National Academy for State Health Policy: nashp.org

National Association of Insurance Commissioners: naic.org

National Association of State Medicaid Directors: nasmd.org

National Governors Association: nga.org

ADDITIONAL RESOURCES

There are several national, nonpartisan organizations set up to deliver topic-specific information on the many provisions of the Affordable Care Act. Some of these organizations are summarized below.

The Commonwealth Fund (commonwealthfund.org)

The Commonwealth Fund is a private foundation that aims to promote a high-performing health care system that achieves better access, improved quality and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children and elderly adults.

Kaiser Family Foundation (kff.org | healthreform.kff.org | kaiserhealthnews.org | statehealthfacts.org)

A nonprofit, private foundation focusing on the major health care issues facing the U.S., as well as the U.S. role in global health policy. Unlike grant-making foundations, nonpartisan Kaiser develops and runs its own research and communications programs, sometimes in partnership with other nonprofit research organizations or major media companies.

National Conference of State Legislatures (ncsl.org)
The National Conference of State Legislatures is a bipartisan organization that serves the legislators and staffs of the nation's 50 states, its commonwealths and territories. NCSL provides research, technical assistance and opportunities for policymakers to exchange ideas on the most pressing state issues.

State Coverage Initiatives (statecoverage.org)
The State Coverage Initiatives (SCI) program provides timely, experience-based information and assistance to state leaders in order to help them move health care reform forward at the state level. SCI is a national program of the Robert Wood Johnson Foundation, administered by AcademyHealth.

State Quality Improvement Institute (academyhealth.org)
An intensive, competitively selected effort to help states plan and implement concrete action plans to improve performance across targeted quality indicators. Colorado is one of eight states selected to participate in this effort founded by AcademyHealth and The Commonwealth Fund. Chosen for its leadership and resources necessary to build on previous success and conceptualize and implement substantive new quality improvement efforts, Colorado will receive tools, resources and knowledge as it works toward improving the quality of health care across the state.

U.S. Department of Health & Human Services (healthcare.gov)
Provides consumers with state-by-state information about coverage options, access to the Pre-Existing Condition Insurance Plan and explanatory materials on the health reform law and its implementation.

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Supporting Reference

Insurance Provisions Timeline for Colorado
What Coloradans Need to Know Fact Sheets
What Colorado Businesses Need to Know Timeline

Insurance Provisions of the Affordable Care Act: An Implementation Timeline for Colorado

Public Coverage

Medicaid Expansion
- State may expand Medicaid coverage to a new eligibility group. (4/1/10)
- State must define "benchmark benefits," including "wraparound" benefits for children.
- State must make changes to state law, amend the Medicaid State Plan, and modify application and enrollment systems.

Changes in Eligibility and Enrollment Rules
- State must monitor CMS guidance to determine how to implement the modified adjusted gross income (MAGI) formula and its effect upon eligibility for beneficiaries already in the program.

Maintenance of Effort (MOE)
- State must maintain Medicaid and CHP+ eligibility levels, standards and procedures.

MOE requirements for adults lifted. State may begin modifying Medicaid eligibility levels, standards, and income levels for adults. (1/1/14)

MOE requirements for children lifted. State may begin modifying Medicaid eligibility levels, standards, and income levels for children. (1/1/19)

Dual Eligible Coverage Coordination
- State may pursue Home and Community Based Services option. (4/1/10)
- State may pursue new Money Follows the Person Demonstration Projects. (4/22/10)
- CHP kids and pregnant women eligibility raises to 250%. (5/1/10)

Enrollment Standards
- HHS Secretary to develop interoperable and secure standards and protocols for enrollment in federal and state health and human services programs. (9/23/10)

Dual-Eligible Coverage Coordination
- State may pursue health homes for the chronically ill. (1/1/11)
- State may pursue Balancing Incentive Payments. (1/1/11)
- State may pursue Medicaid Community First Choice Option. (10/1/11)

State may pursue Hospitalization Care Integration- Payment Bundling. (1/1/12)

Dual-eligible Special Needs Plans must contract with state. (1/1/13)

Medicaid Expansion
- State must provide Medicaid coverage for all individuals under 133% FPL. (1/1/14)
- State must transition children ages 6-18 with family incomes between 100-133% FPL from CHP+ to Medicaid. (1/1/14)

Changes in Eligibility and Enrollment Rules
- State must apply modified adjusted gross income formula for Medicaid and CHP+. (1/1/14)

Enrollment Simplification
- State must implement procedures to simplify Medicaid and CHP+ enrollment. (1/1/14)

Enhanced Federal Support for Children's Health
- State may transition CHP+-eligible children to Medicaid or comparable coverage in the exchange. HHS must certify pediatric coverage in the exchange is comparable. (4/1/15)
- Last year of new federal CHIP funding. (9/30/15)
- State will start drawing 88% federal matching funds rate for CHP+. (10/1/15)
- State may start enrolling CHP+-eligible children in the exchange. (10/1/15)

Health Insurance Exchange

State may be able to get federal support for an existing consumer assistance office or establish a new one, pending federal guidance. (3/23/10)

Comptroller General must appoint CO-OP Advisory Board. (6/23/10)

HHS must establish an Internet portal for consumers to identify coverage options. (7/1/10)

HHS must make available exchange planning grants for the state. (3/21/11)

HHS must award loans and grants for CO-OPs. (7/1/13)

State must possess an operational exchange. (1/1/14)

State must monitor federal guidance around the exchange. (Prior to 2014)

2010: APR | MAY | JUNE | JULY | AUG | SEPT | OCT | NOV | DEC

2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019

Private Coverage

Temporary High-Risk Pool
- State must inform HHS that it intends to apply for an HHS contract to operate the pool. (4/30/10)

Temporary High-Risk Pool
- Colorado creates GettingUSCovered. (7/6/10)

New Insurance Standards
- National Association of Insurance Commissioners must develop medical loss ratio calculation guidelines. (12/31/10)

New Insurance Standards
- HHS must develop standardized format for benefits summary and coverage information. (3/23/11)

New Insurance Standards
- HHS must promulgate regulations for health plan quality-reporting requirements. (3/23/12)
- Health plans must provide benefits summary and coverage information to individuals, following a standardized format. (3/23/12)

Temporary High-Risk Pool
- GettingUSCovered ends. (12/31/13)

Temporary Reinsurance Programs
- State must adopt model regulations and establish transitional reinsurance program. (1/1/14)

Federal Risk Corridor
- Payment adjustments begin. (1/1/14)

Permanent Risk Adjustment
- State must establish permanent risk adjustment program. (1/1/14)

New Insurance Standards
Health plans:
- May not impose annual limits on essential benefits. (1/1/14)
- Must sell and continue insurance policies to interested individuals and employers. (1/1/14)
- May not withhold adult coverage due to pre-existing conditions. (1/1/14)
- May not apply waiting periods for coverage in excess of 90 days. (1/1/14)

Federal Risk Corridor
- Federal risk corridor payments end. (1/1/17)

Premium Rate Review
State must review plan premium rates, pending federal guidance. (3/23/10)

New Insurance Standards
Health plans:
- May not impose lifetime limits on essential benefits and may only impose restricted annual limits on coverage. (9/23/10)
- May not rescind coverage except in cases of fraud and abuse. (9/23/10)
- Must provide preventive services without cost-sharing. (9/23/10)
- Must provide coverage for dependents up to age 26. (9/23/10)
- May be required to report quality data, pending federal guidance. (9/23/10)
- May not discriminate coverage eligibility or benefits in favor of highly compensated individuals.(9/23/10)
- Must implement internal claims appeals and external review processes. (9/23/10)
- May not withhold coverage due to pre-existing conditions for children under 19. (9/23/10)

Basic Health Plan

State must monitor federal guidance to determine whether the state will opt to create a Basic Health Plan. (Prior to 2014)

State may create a Basic Health Plan for targeted individuals. (1/1/14)

Source: California HealthCare Foundation

For more information, visit: **colorado.gov/healthreform**

The Affordable Care Act: What Coloradans Need to Know

December 2010

Signed into law in March 2010, the federal legislation known as the **Affordable Care Act** is designed to make it easier for millions of Americans to obtain, pay for, and keep the coverage they need. After the law is fully implemented in 2014, estimates are that over 500,000 Coloradans will be insured through a new exchange market or expansions to public benefit programs. This guide is intended to orient Colorado consumers to the coming changes in the coverage landscape, the key reforms the law contains, and what their options will be once all the pieces are in place.

Highlights of the law

Bars insurers from:
- Denying coverage because of pre-existing medical conditions.
- Dropping the coverage of people who become sick.
- Charging higher premiums because of health issues.

Requires large employers to:
- Provide health insurance, or be subject to potential penalties.

Encourages small employers to:
- Provide coverage in exchange for tax credits.

Requires individuals to:
- Obtain health insurance or pay a penalty, unless they qualify for certain exemptions.

Allows parents to:
- Extend their health insurance to children up to the age of 26.

Changes for Coloradans with NO insurance

Annual Income		Coverage Options	Cost
Individual	Family of Four		
Up to $14,400	Up to $29,327	Eligible for Medicaid. Low-income Coloradans who are legal residents can enroll in the state's Medicaid program.	Copayments of $1 to $5 for selected services. A provider may not refuse emergency care if a patient cannot pay for the cost of a visit.
Up to $43,320	Up to $88,200	Eligible to buy subsidized private coverage through a new health insurance exchange market. Participating insurers must offer a package of "essential" benefits that covers at least 60% of health care expenses.	Buyer's share of premium may not exceed 2% of annual income at the low end of the earning scale to 9.5% at the top. Yearly limits on out-of-pocket costs also apply.
$43,321 and above	$88,201 and above	Required to buy private coverage. Ineligible for subsidy.	Subject to market rates. Individuals who remain uninsured will be liable for penalties of up to 2.5% of their income unless they qualify for certain exemptions.

What if I'm sick and need coverage before 2014, but no insurer will sell it to me?
Uninsured Coloradans with health problems may qualify for insurance through a temporary, state-run program at standard market rates, with no lifetime or annual payout limits. Contact GettingUSCovered, www.gettinguscovered.org. For information on other public programs visit colorado.gov/hcpf.

Source: California HealthCare Foundation

For more information, visit: **colorado.gov/healthreform**

Changes for Coloradans with insurance

Source of Coverage	Coverage Options	New Costs and Benefits
Employer Plan	• **Stay in employer plan.** If your employer continues to offer coverage, you can keep it. • **Shop for coverage through the insurance exchange.** Small businesses and people whose employer offers only minimal benefits, or who must pay more than 9.5% of their income in premiums, can look for better options in the exchange. • **Participate in long term care insurance.** A new payroll deduction will allow employees to qualify for long term care benefits after a five-year waiting period. The program is voluntary; those who do not opt out will be enrolled automatically.	Lifetime dollar limits on insurance payouts are eliminated. Medicare taxes will increase for individuals with annual incomes above $200,000, or families earning more than $250,000. Annual contributions to Flexible Spending Accounts will be capped at $2,500, and can no longer be used for over-the-counter drugs. Employer-provided insurance valued at $10,200 or higher ($27,500 for families) will be subject to federal tax.
Individual Policy	• **Keep current plan.** If your insurer continues to offer the same coverage, you can renew it. However, new policies must comply with federal minimum coverage standards; older plans that don't meet this test cannot enroll new customers. • **Shop for coverage through the insurance exchange.** Individuals with incomes below $43,320 can qualify for federal tax credits to help offset premium costs.	Lifetime dollar limits on insurance payouts are eliminated. Caps on out-of-pocket costs apply. Medicare taxes will increase for individuals with annual incomes above $200,000, or families earning more than $250,000.
Medicare	• **Basic benefits and eligibility.** No change. All Coloradans who qualify under today's rules will continue to do so. • **Medicare Advantage.** Federal subsidies for Medicare Advantage plans will be eliminated, which may cause the private insurers who sell them to cut benefits, reduce enrollment, or raise premiums. • **Access to services.** Physicians who treat Medicare patients in rural areas, inner cities, and other underserved areas will be paid a 10% bonus, which may make it easier for beneficiaries to obtain care.	Free annual check-ups and wellness programs, including screening tests. Gaps in drug coverage phased out, beginning with $250 rebate. Monthly premium payments for drug coverage will increase for individuals with incomes above $85,000 and households earning more than $170,000.

Reform Timeline: When the Changes Happen

APRIL 2010
- Seniors who exceed Medicare drug coverage limit receive $250 rebate
- Tax credits for certain small employers begin

JULY 2010
- Uninsured people with health problems eligible for state insurance program

SEPT 2010
- Insurers required to cover sick children
- Lifetime limits on insurer payouts prohibited
- Young adults allowed to remain on parents' policy until age 26

JAN 2011
- Medicare beneficiaries pay less for preventive care services
- Voluntary payroll deduction for long term care coverage starts
- 80/85% of group premiums spent on medical benefits

JAN 2013
- Medicare taxes rise on incomes above $200,000 per year

JAN 2014
- Medicaid eligibility expanded from 100% to 133%
- Insurers barred from denying coverage
- Individual requirement to obtain coverage begins
- Insurance exchange opens for business
- Subsidies for buying coverage available

2016
- Long term care benefit available

2018
- Federal tax on high-value benefit packages begins

Where to go for more information

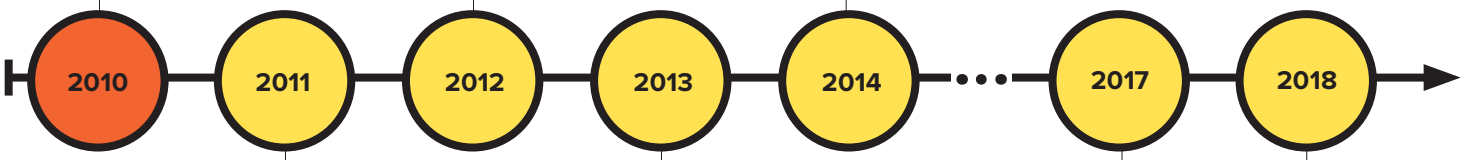
Details on the health reform law are available at **colorado.gov/healthreform**.
Questions can be emailed to healthreform@state.co.us.

The Affordable Care Act:
What Colorado Businesses Need to Know

2010
- Temporary Small Business tax credit (2011 tax return)
- Children allowed to remain on parents' policy until age 26
- New high-risk pool, GettingUSCovered
- Ends health insurance rescissions except for fraud
- Temporary reinsurance assistance for early retirees
- Non-discrimination in favor of highly compensated employees*
- No cost share for preventive care*
- Decision about whether to maintain grandfathered health plan
- Eliminate lifetime limits
- Restricted annual limits on "essential health benefits"
- No pre-existing condition restrictions on children under 19
- Federal rate review process for carriers
- Unpaid break time and accommodations for nursing mothers

2012
- 1099 reporting for business transactions of $600 or more
- Annual reports to HHS on improving quality of care and wellness
- W-2 reporting of employer and employee share of premium (reported 2012)
- Uniform explanation of coverage

2014
- Individual requirement to obtain coverage
- Carriers required to guarantee issue coverage
- Carrier rating restrictions
- Health insurance "industry fee" (escalates to 2018)
- Essential benefits and insurance exchanges established
- No annual limits
- Automatic enrollment (effective date subject to future regulations)
- Definition of "full time" worker is 30 hours/week
- No pre-existing condition restrictions on all ages
- Individual subsidies for coverage
- Expansion of small employer tax credits
- Employer penalty if coverage not offered (>50 FTE) when one or more employees receive subsidies for coverage in the exchange
- Employers required to issue exchange "free choice" vouchers for certain employees
- No waiting periods greater than 90 days
- Financial incentives for wellness program participants allowed up to 30% of premium



2011
- Medical Loss Ratio (MLR) requirements for health plans (80% individual & small group; 85% large group)
- HSA and FSA limits on non-prescribed items
- Employers can participate in CLASS, federally subsidized long-term care
- Penalty for non-qualified HSA expenses increases to 20%
- Small groups can adopt a simple cafeteria plan
- Small group wellness credit available

2013
- Elimination of deduction for Part D subsidy
- Medicare taxes will increase for incomes in excess of $200,000 per year
- FSA contributions limited to $2,500. Cap does not apply to employer contributions
- Employees must be notified of the Exchange
- Health insurance fee to fund comparative effectiveness research

2017
- Large employers may be eligible to purchase insurance through the exchange

2018
- Federal tax on high-value benefit packages begins

*subject to "grandfathered status"

For more information, visit: **colorado.gov/healthreform**

Glossary

The definitions of the following terms are a compilation of state and national resources including the Kaiser Family Foundation (healthreform.kkf.org), the U.S. Department of Health & Human Services (healthcare.gov) and the State of Colorado Health Care Reform website (colorado.gov/healthreform).

Actuarial Value: A measure of the average value of benefits in a health insurance plan. It is calculated as the percentage of benefit costs a health insurance plan expects to pay for a standard population, using standard assumptions and taking into account cost-sharing provisions. Placing an average value on health plan benefits allows different health plans to be compared. The value only includes expected benefit costs paid by the plan and not premium costs paid by the enrollee. It also represents an average for a population, and would not necessarily reflect the actual cost-sharing experience of an individual.

Annual Limit: Insurers place a ceiling on the amount of claims they will pay in a given year for an individual. Individuals would then have to pay the full cost for any claims incurred above this ceiling during the course of the year. Beginning in 2010, annual benefit limits will be restricted and will be prohibited in 2014 under health reform.

Benefit Package: The set of services, such as physician visits, hospitalizations and prescription drugs, that are covered by an insurance policy or health plan. The benefit package will specify any cost-sharing requirements for services, limits on particular services, and annual or lifetime spending limits.

Children's Health Insurance Program (CHIP): Enacted in 1997, CHIP is a federal-state program that provides health care coverage for uninsured low-income children who are not eligible for Medicaid. States have the option of administering CHIP through their Medicaid programs or through a separate program (or a combination). The federal government matches state spending for CHIP but federal CHIP funds are capped.

Chronic Care Management: The coordination of both health care and supportive services to improve the health status of patients with chronic conditions, such as diabetes and asthma. These programs focus on evidence-based interventions and rely on patient education to improve patients' self-management skills. The goals of these programs are to improve the quality of health care provided to these patients and to reduce costs.

Community Living Assistance Services and Supports (CLASS): A new program created to assist individuals with functional limitations in purchasing supportive services so they can maintain community residence.

COBRA: When employees lose their jobs, they are able to continue their employer-sponsored coverage for up to 18 months through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under the original legislation, individuals were required to pay the full premium to continue their insurance through COBRA. The American Recovery and Reinvestment Act (ARRA) provides a temporary subsidy of 65 percent of the premium cost for the purchase of COBRA coverage to people who have lost their job between September 1, 2008 and May 31, 2010.

Co-insurance: A method of cost-sharing in health insurance plans in which the plan member is required to pay a defined percentage of their medical costs after the deductible has been met.

Community Rating: A method for setting premium rates for health insurance plans under which all policy holders are charged the same premium for the same coverage. "Modified community rating" generally refers to a rating method under which health insuring organizations are permitted to vary premiums based on specified demographic characteristics (e.g. age, gender, location), but cannot vary premiums based on the health status or claims history of policy holders. Under health reform, beginning in 2014, health plans will be required to adopt modified community rating. Variations in premiums will only be allowed for differences in geography, family structure, age (limited to a 3 to 1 ratio) and tobacco use (limited to a 1.5 to 1 ratio).

Co-payment: A fixed dollar amount paid by an individual at the time of receiving a covered health care service from a participating provider. The required fee varies by the service provided and by the health plan.

Cost-Sharing: A feature of health plans where beneficiaries are required to pay a portion of the costs of their care. Examples of costs include co-payments, co-insurance and annual deductibles.

Deductible: A feature of health plans in which consumers are responsible for health care costs up to a specified dollar amount. After the deductible has been paid, the health insurance plan begins to pay for health care services. Under health reform, beginning in 2014, deductibles for new plans sold in the small group insurance market will be limited to $2,000 for individual policies and $4,000 for family policies.

Doughnut Hole: A gap in prescription drug coverage under Medicare Part D, where beneficiaries enrolled in Part D plans pay 100 percent of their prescription drug costs after their total drug spending exceeds an initial coverage limit until they qualify for catastrophic coverage. Under the standard Part D benefit, Medicare covers 75 percent of total drug spending below the initial coverage limit ($2,830 in 2010), and 95 percent of spending above the catastrophic level ($6,440 in 2010). These thresholds are indexed to increase over time.

The doughnut hole or coverage gap specifically refers to the range between these two levels ($3,610 in 2010) in which beneficiaries are responsible for all costs incurred for prescription drugs. The coverage gap will be gradually phased out under health reform, so that by 2020, beneficiaries will only be responsible for 25 percent of all prescription drug costs up to the catastrophic level.

Employer Health Care Tax Credit: An incentive mechanism designed to encourage employers, usually small employers, to offer health insurance to their employees. The tax credit enables employers to deduct an amount, usually a percentage of the contribution they make toward their employees' premiums, from the federal taxes they owe. These tax credits are typically refundable so they are available to nonprofit organizations that do not pay federal taxes. The health reform law includes a tax credit for small employers that provide health coverage to their employees. The tax credit is available to employers with 25 or fewer employees and average annual wages of less than $50,000.

Essential Health Benefits: A set of health care service categories that must be covered by certain plans, starting in 2014. These include doctor office visits, hospitalizations, and prescriptions. Insurance policies must cover these benefits to be certified and offered in exchanges, and all Medicaid State plans must cover these services by 2014. Starting with plan years or policy years that begin on or after September 23, 2010, health plans can no longer impose a lifetime dollar limit on spending for these services and all plans, except grandfathered individual health insurance policies, must phase out annual dollar spending limits for these services by 2014.

Exchange: A new transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Exchanges will offer you a choice of health plans that meet certain benefits and cost standards. Starting in 2014, Members of Congress will be getting their health care insurance through exchanges and you will be able buy your insurance through exchanges too.

Federal Poverty Level (FPL): The federal government's working definition of poverty that is used as the reference point to determine the number of people with income below poverty and the income standard for eligibility for public programs. The federal government uses two different definitions of poverty. The U.S. Census poverty threshold is used as the basis for official poverty population statistics, such as the percentage of people living in poverty. The poverty guidelines, released by the U.S. Department of Health and Human Services (HHS), are used to determine eligibility for public programs and subsidies. For 2009, the Census weighted average poverty threshold for a family of four was $21,947 and HHS poverty guideline was $22,050.

Guarantee Issue/Renewal: Requires insurers to offer and renew coverage, without regard to health status, use of services, or pre-existing conditions. This requirement ensures that no one will be denied coverage for any reason. Beginning in 2014, the health reform law will require guarantee issue and renewability.

Home & Community Based Services (HCBS): Services and support provided by most state Medicaid programs in your home or community that gives help with such daily tasks as bathing or dressing. This care is covered when provided by care workers or, if your state permits it, by your family.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Through the Health Insurance Portability and Accountability Act of 1996, individuals can maintain coverage while changing jobs or for a temporary period of unemployment without a waiting period. Individuals in many states who lose group health coverage after a loss of employment have access to coverage through high-risk pools, with no pre-existing condition exclusion periods. HIPAA also sets standards that address the security and privacy of personal health data.

Health Savings Account (HSA): A tax-exempt savings account that can be used to pay for current or future qualified medical expenses. Employers may make HSAs available to their employees or individuals can obtain HSAs from most financial institutions. Employers and employees can contribute to the plan. In order to open an HSA, an individual must have health coverage under an HSA-qualified high-deductible health plan. These HSA-qualified high-deductible health plans must have deductibles (the amount of health care costs that must be paid for by the consumer before the insurance plan begins to pay for services) of at least $1,200 for an individual and $2,400 for a family in 2010.

High-Deductible Health Plan: Health insurance plans that have higher deductibles (the amount of health care costs that must be paid for by the consumer before the insurance plan begins to pay for services), but lower premiums than traditional plans. Qualified high-deductible plans that may be combined with a health savings account must have a deductible of at least $1,200 for single and $2,400 for family coverage in 2010.

High-Risk Pool: State programs designed to provide health insurance to residents who are considered medically uninsurable and are unable to buy coverage in the individual market. As of early 2009, high-risk pools operated in 34 states but varied by eligibility requirements, cost-sharing requirements, availability of premium subsidies, and funding sources. The health reform law creates temporary high risk pools in each state (referred to as the Preexisting Condition Insurance Plan) to provide coverage for those with pre-existing conditions who are uninsured. These temporary pools will provide coverage until 2014.

Lifetime Limit: A cap on the amount of money insurers will pay toward the cost of health care services over the lifetime of the insurance policy. Lifetime limits are prohibited under health reform.

Long-term Care: Services that include those needed by people to live independently in the community, such as home health and personal care, as well as services provided in institutional settings such as nursing homes. Medicaid is the primary payer for long-term care. Many of these services are not covered by Medicare or private insurance. The health reform law includes several new options in Medicaid for states to expand the availability of home and community-based long-term care services and creates the new Community Living Assistance Services and Supports (CLASS) program to assist individuals with functional limitations in purchasing supportive services so they can maintain community residence.

Medicaid: Enacted in 1965 under Title XIX of the Social Security Act, Medicaid is a federal entitlement program that provides health and long-term care coverage to certain categories of low-income Americans. States design their own Medicaid programs within broad federal guidelines including setting eligibility levels. Medicaid plays a key role in the U.S. health care system, filling large gaps in the health insurance system, financing long-term care coverage, and helping to sustain the safety-net providers that serve the uninsured. The health reform law expands Medicaid eligibility to non-elderly individuals (children pregnant women, parents, and adults without dependent children) with incomes up to 133 percent of poverty, establishing uniform eligibility for adults and children across all states by 2014.

Medical Home or Health Home: A health care setting where patients receive comprehensive primary care services; have an ongoing relationship with a primary care provider who directs and coordinates their care; have enhanced access to non-emergent primary, secondary, and tertiary care; and have access to linguistically and culturally appropriate care.

Medical Loss Ratio (MLR): The percentage of premium dollars an insurance company spends on medical care, as opposed to administrative costs or profits. The health reform law requires insurers in the large group market to have an MLR of 85 percent and insurers in the small group and individual markets to have an MLR of 80 percent.

Medicare: Enacted in 1965 under Title XVIII of the Social Security Act, Medicare is a federal entitlement program that provides health insurance coverage to 45 million people, including people age 65 and older, and younger people with permanent disabilities, end-stage renal disease and Lou Gehrig's disease.

Medicare Advantage: Also referred to as Medicare Part C, the Medicare Advantage program allows Medicare beneficiaries to choose to receive their Medicare benefits through a private insurance plan rather than the traditional fee-for-service program percent higher than the costs of the traditional fee-for-service program in 2010, will be reduced under health reform, bringing them closer to the average costs of care under the traditional fee-for-service program.

Out-of-Pocket Costs: Health care costs, such as deductibles, co-payments, and co-insurance that are not covered by insurance. Out-of-pocket costs do not include premium costs.

Out-of-Pocket Maximum: A yearly cap on the amount of money individuals are required to pay out-of-pocket for health care costs, excluding the premium. The health reform law requires new plans offered beginning in 2014 to include an out-of-pocket maximum set at the current HSA level or $5,950 for an individual policy or $11,900 for a family policy in 2010.

Payment Bundling: A form of provider payment where providers or hospitals receive a single payment for all of the care provided for an episode of illness, rather than per service rendered. Total care provided for an episode of illness may include both acute and post-acute care. The health reform law establishes pilot programs in Medicare and Medicaid to pay a bundled payment for episodes of care involving hospitalizations.

Pre-existing Condition Exclusions: An exclusion from coverage of an illness or medical condition for which a person had received a diagnosis or treatment within a specified period of time prior to becoming insured. Health care providers can exclude benefits for a defined period of time for the treatment of medical conditions that they determine to have existed within a specific period prior to the beginning of coverage. Pre-existing condition exclusions are prohibited by the health reform law beginning in 2010 for children and in 2014 for adults.

Premium: The amount paid, often on a monthly basis, for health insurance. The cost of the premium may be shared between employers or government purchasers and individuals.

Preventive Care: Health care that emphasizes the early detection and treatment of diseases. The focus on prevention is intended to keep people healthier for longer, thus reducing health care costs over the long term. The health reform law requires new qualified health plans and Medicare to provide coverage without cost-sharing for certain preventive services. The law also includes incentives for states to offer the same coverage in their Medicaid programs.

Qualified Health Plan: Refers to insurance plans that have been certified as meeting a minimum benchmark of benefits (i.e. essential health benefits) under health reform. This will allow consumers to verify that the plan they have purchased will meet at least the minimum requirements of the individual mandate.

Rate Review: A process that allows state insurance departments to review rate increases before insurance companies can apply them to you.

Reinsurance: Reinsurance is insurance for insurance companies and employers that self-insure their employees' medical costs. Through government-funded reinsurance programs, federal or state governments pay for a portion of the high costs experienced by insurers. By limiting insurers' exposure to very high health costs, reinsurance programs enable insurers to lower the premiums they charge to employers and individuals. This type of program is a form of subsidy to the insurer that lowers the premium cost for all purchasers. The Healthy New York program and the Health Care Group of Arizona are examples of state reinsurance programs. The health reform law provides for a temporary federal reinsurance program for employers that insure early retirees over age 55 who are not eligible for Medicare.

Rescission: Also referred to as "post-claims underwriting," this is a practice in the individual insurance market where an approved policy is rescinded by the insurer, often after a large claim has been filed, on the grounds that the individual misrepresented their health history on their initial application. The condition not disclosed to the insurer can be unrelated to the current claim. This practice occurs in the individual market because, unlike the large group/ employer market, until the passage of health reform, there were no restrictions against insurers for underwriting or denying coverage based on pre-existing conditions. Under health reform, insurers will only be able to rescind policies in cases of fraud.

Self-Insured Plan: A plan where the employer assumes direct financial responsibility for the costs of enrollees' medical claims. Employer sponsored self-insured plans typically contract with a third-party administrator or insurer to provide administrative services for the plan.

Wellness Plan/Program: Employment-based program to promote health and prevent chronic disease. Goals of these programs include: reducing health care costs, sustaining and improving employee health and productivity and reducing absenteeism due to illness.

Appendices

In an attempt to be socially and fiscally responsible, the following appendices and other supporting documents for this report are available online at colorado.gov/healthreform.

- Legal Harmonization Chart
- Funding Opportunities Detail
- FAQ Business Questions
- Executive Order B 2010-006
- Letters of Support from Gov. Ritter
- Outreach and Education Detail
- NAIC Exchange Model Act
- Colorado Comments on Exchange
- FAQ on Filing Rate Reviews

Visit colorado.gov/healthreform to download the full electronic version of the report.

Office of the Governor
136 State Capitol, Denver CO 80203
lorez.meinhold@state.co.us
colorado.gov/healthreform

APPENDICES

Implementing Health Care Reform: **A Roadmap for Colorado**

Legal Harmonization Chart

Topic	Federal Provisions Summary	PPACA/PHS/Federal Register Citations	Implementation Date	CO State Provisions Summary	CRS Citation	CO Reg/Bulletin Citation
				Immediate Health Insurance Reforms		
Lifetime & Annual Limits	No annual or lifetime limits after 1/1/2014; prior to 1/1/2014 restricted limits on essential benefits, of which the following must be included in the plan: 1. ambulatory services 2. emergency services 3. hospitalization 4. maternity/newborn care 5. prescription drugs 6. lab services 7. preventative/wellness services 8. chronic disease management, and 9. pedriatic services	PPACA 1302(b) - pg 59 PHS Section 2711 June 28, 2010 Fed Reg	6 months after enactment (September 23, 2010)*	10-16-104(1.3)(b)(II): Required early intervention services coverage has a $5,725 annual limit per child (adjusted for inflation) 10-16-104(1.4)(XIII)(b)(I): Required autism coverage for children under 9 has a $34,000 limit; for children 9-18, the annual limit is $12,000 10-16-407(3)(a): Limited Health Benefit Plans may impose a limit on the total maximum benefit amount available for services. Bulletin 4.31: Sets annual Maximum Benefit for Early Intervention Services.	10-16-104(1.3)(b)(II); 10-16-104(1.4)(XIII)(b)(I) 10-16-407(3)	B 4.31
Rescissions	No retroactive cancellations except in the case of fraud or intentional misrepresentation	PPACA 1001(A)(II) - pg 14 PHS Section 2712 June 28, 2010 Fed Reg	9/23/2010*	10-16-202(3): Within first two years, insurance company can rescind. After two years, can only rescind for fraudulent statement	10-16-202(3)	
Coverage of Preventive Health Services	Plans must provide coverage without cost sharing for: -Services recommended by the US Preventive Services Task Force (inc. breast cancer screenings beginning at age 40) -Immunizations recommended by the Advisory Cmomittee on Immunization Practices of the CDC -Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration -Preventive care and screenings for women supported by the Health Resources and Services Administration Secretary of HHS determines interval (not less than one year) for incorporating recommendations Federal rule also includes OBGYNs and pediatricians	PPACA 101 PHS 2713	9/23/2010*	(11) Child Supervision Services (and Regulation 4-6-5, Bulletin B-4.24) (13) Diabetes (includes education) (17) Cervical Cancer Vaccines (18) Preventive services: alcohol abuse-adults, cervical cancer screening, mammograms, cholesterol screening, colorectal cancer screening, childhood immunizations, flu vaccinations, pneumonia vaccinations, tobacco use-adults. (and Regulation 4-6-5--attachment) 10-16-104(18)(b)(III): "Coverage for breast cancer screenings shall be the lesser of one hundred dollars per mammography screening or the actual charge for such screening, but in no case shall the covered person be required to pay more than the co-payment required by the policy or contract for preventive health services." 10-16-107(5) - access to OB patient protections.	10-16-104 (1) - (20) 10-16-104(18)(b)(III) 10-16-107(5)	4-2-13 (mammography) (Repealed as of 1/1/2010) 4-6-12 (mental health) 4-6-5 (small group) 4-2-30 (hearing aids) E-11-02
Extension of Dependent coverage (Age 26)	Children under 26 yrs must be extended coverage, even if offered by their own employer	PPACA 1001(A)(II) - pg 15 June 28, 2010 Fed Reg	9/23/2010	10-16-102(10)(b)(I)(A) - newborn to Age 19, unless full time student covered as dependent, then to age 24. 10-16-104(6)(b) - Dependent Child should not be refused coverage for following reasons: (I) does not live at home of parent, (II) Does not live in insurers service area, (III) was born out of wedlock, or (IV) is not claimed on tax return of parent. 10-16-104.3(1) Students who take a Medical Leave of Absence under age 25 must be covered for 1 year after first date of absence, or until plan naturally ends, which ever comes first. 10-16-104.3(2) - Coverage to age 25 for uninsured and has same legal residence or is financially dependent, for additional premium.	10-16-102(10) 10-16-104(6); 10-16-104.3(1); 10-16-104.3(2)	Colo. Reg. 4-6-7
Preexisting Conditions	A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage	PPACA1201(C)(I) - pg 45 PHS Section 2704 June 28, 2010 Federal Register	6 months after enactment for under 19 years of age January 1, 2014 for all others	10-16-118(a)(1): - group plan: shall not deny, exclude or limit benefits because of a preexisting condition for losses incurred; group plan - 6 months following enrollment date, business groups of one - 12 months following enrollment date 10-16-104(1.7)(c): Coverage described in this subsection (therapies for congenital defects and birth abnormalities) is subject to provisions of section 10-16-118(1)(b) (waiver of affiliation period for preexisting condition if previously covered by credible coverage that was continuous to a date not more than 90 days prior to the effective date of the new coverage)	10-16-118; 10-16-104 (1.7)(c)	For under Age 19: 4-2-33

*Except Grandfathered Plans

Topic	Federal Provisions Summary	PPACA/PHS/Federal Register Citations	Implementation Date	CO State Provisions Summary	CRS Citation	CO Reg/Bulletin Citation
Uniform Explanation of Coverage Documents and Standardized Definitions	Uniform definitions and coverage explanation in policy summaries	PPACA 1001 PHS 2715	Standards developed within 12 months (March 23, 2011) Documents implemented within 24 months	10-16-135: Commissioner shall adopt rules that describe the format of the information card. They shall include a standard size, require that the card be legible and photocopied, and shall delineate the information to be contained on the card including but not limited to: (I) covered person's name, plan number; (II) copayment and deductible amounts; (III) contact information for the carrier; and (IV) indication of whether the health plan is regulated by the state 10-16-107.2(2)(c): Commissioner shall implement an initial application form for individual health benefit plans on or after 1/1/2012 which will be required to be used 10-16-137: Commissioner shall determine standardized format for policy forms and explanation of benefits forms. The rules shall apply to plans issued or delivered on or after January 1, 2012. Reg 4-2-29:Definitions and specific information that should appear on all policy ID cards, including legal name of carrier; covered person's first name, middle initial,last name; number identifying the person to the policy, plan name/number; plan type; levels of coverage; and contact information for carrier (name, address, phone, website, statement of preauthorization if necessary, provider network information). *NOTE: NAIC is working on standardized explanation of benefits and definitions for recommendation to HHS.	10-16-108.5(11) 2010 legislation on policy form format requirements (10-16-137) 10-16-135 10-16-107.2(2)(c)	Colo. Reg. 4-2-29
Provision of Additional Information	Insurance providers must submit and make public the following info on their plans: 1. claims payment policies and practices 2. periodic financial disclosures 3. data on enrollment and disenrollment 4. data on # of claims denied 5. data on rating practices 6. info on cost sharing/out-of-network coverage payments 7. other info as determined by Secretary	PPACA 1001 PHS 2716 IRS Code 105(h)(2)	9/23/2010*	10-16-106.3: On or before 7/1/2002 carriers shall accept claim forms adopted by the American dental association, centers for medicare/Medicaid services claim form. All carriers shall accept claim forms from health care providers in electronic format. A carrier shall not be prohibited from requiring a form be submitted in hard copy form. 10-16-106.5: Within 10 business days of receipt of a claim, carrier shall indicate that the claim has been received. Clean claims (claim submitted on the uniform claim form with all required fields completed with complete information) shall be paid, denied, or settled w/in 30 calendar days after electronic receipt and w/in 45 days if submitted by other means. If extra information is needed the carrier should give notification within 30 days in writing. Absent fraud, all other claims shall be paid w/in 90 days after receipt by the carrier. If a carrier fails to pay, deny or settle a clean claim within the specified time frame it will be responsible to pay the covered benefit and interest at a rate of 10 percent annually. If a carrier fails to pay, deny or settle a claim w/in 90 days the carrier shall pay to the insured or health care provider a penalty equal to 20% of the total amount ultimately allowed on the claim. 10-16-704(4): If treatment or procedure is preauthorized by plan, benefits can't be retrospectively denied except for fraud or abuse. If health carrier provides preauthorization for treatment or procedures not covered under the plan, the carrier shall provide those benefits as authorized with no penalties to the covered person	10-16-106.3 10-16-106.5 10-16-107 10-16-704(2) 10-16-704(3) 10-16-704(4) 10-16-704(4.5) 10-16-709	Colo. Reg. 4-2-31
Prohibition of Discrimination based on Salary	Extends current law provisions prohibiting discrimination in favor of highly compensated employees in self-insured group plans to fully insured group plans. The Secretary of HHS will develop rules.	PPACA 1001 PHS 2716 IRS Code 105(h)(2)	9/23/2010*	10-16-102(15): definition of eligible employee: employee with a regular work week of 24 or more hours including a sole proprietor and a partner of a partnership, if sole proprietor or partner is included as an employee under a health plan of a small employer. Does not include a person who works on a temporary or substitute basis. 10-16-107(6): (a)carrier offering a group health plan may not require an individual to pay a premium or contribution greater than premium/contribution for a similarly situated individual enrolled in the plan because of a health status-related factor in relation to the individual or the individual's dependent. (b) This shouldn't be construed to (I) restrict the amount an employer may be charged (II) prevent a carrier from establishing premium discounts or rebates or modifying applicable copayments, coinsurance or deductibles in return for: (A) adherence to health promotion and disease prevention programs allowed under state or federal law (B) participation in wellness/prevention program pursuant to 10-16-136 satisfaction of standard related to risk factor pursuant to wellness/prevention program authorized by 10-16-136. 10-16-136 - Standardized Wellness Programs (b) Incentives or rewards are uniformly applied based on the wellness and prevention program, and not based on the size or composition of the small group participating in the program, and that there is a reasonable justification for the amount, frequency, and nature of the incentives or rewards; (d) (I) The full incentive under the wellness and prevention program is made available to all similarly situated individuals.	10-16-102(15) 10-16-107(6) 10-16-136	

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Topic	Federal Provisions Summary	PPACA/PHS/Federal Register Citations	Implementation Date	CO State Provisions Summary	CRS Citation	CO Reg/Bulletin Citation
Ensuring Quality of Care	Plans must submit annual reports to the Secretary of HHS on whether the benefits under the plan: *Improve health outcomes through activities such as quality reporting *Implement activities to prevent hospital readmission *Implement activities to improve patient safety and reduce medical errors *Implement wellness and health promotion activities	PPACA 1001, pg 19 PHS 2717	2 years after enactment (March 23, 2012)*	10-16-136 - Wellness and Prevention programs: (1)(a) - find innovative ways to reduce costs and make health coverage more affordable for individuals and small employer groups. (c) Carriers should be afforded the ability to develop innovative and flexible ways to encourage covered persons . . . to engage in activities that promote their overall health and prevent or reduce the impacts of disease; and (d) it is important to allow carriers to provide incentives or rewards, including premium discounts and reduced out-of-pocket costs for health-care services, to encourage covered persons to participate in wellness and prevention programs. Reg 4-2-31: Uniform reporting, filing and data retention requirements for thehospital reimbursement rate report and the Annual Cost Report	C.R.S. 10-16-136	Colo. Reg. 4-2-31
Bringing Down the Cost of Health Care	Carriers must report to the Secretary of HHS the ratio of incurred losses (incurred claims) plus loss adjustment expense (change in contract reserves) to earned premiums. The report must include the percentage of total premium revenue, after accounting for risk adjustment, premium corridors and payments of reinusrance that is expended on: *Reimbursement for clinical services *Activites that improve health care quality *All other non-claims expenses, including the nature of the costs, excluding Federal and State taxes and licensing of regulatory fees Insurers must provide a rebate to consumers if the percentage of premiums expended for clinical services and activities that improve health care quality is less than 85% in the large group market and 80% in the small group and individual markets. All hospitals must establish and make public a list of its standard charges for items and services including for diagnosis-related groups.	PPACA 1001, pg 21 PHS 2718	1/1/2011 (all plans)	10-16-11(1)(a) - all corporations . . . Shall make and file annually a statement under oath stating the amount of membership dues or subscriber fees collected; the amounts actually paid during the year for hospital, medical-surgical, and other health services for members/subscribers; and the amounts placed in established reserves for cases billed but not yet paid, unreported and unbilled cases, retroactive cost adjustments, membership dues/fees paid in advanced but not yet earned, and all other liabilities and obligations required of domestic insurers. 4-2-11: Prior Approval: Any proposed rate increase for other than dental insurance or a rate increase of 5% or more annually for dental insurance, which is effective on or after January 1, 2009, is subject to prior approval by the Commissioner and must be filed with the Division of Insurance at least 60 calendar days prior to the proposed implementation or use of the rates. All companies must submit rate filings at least annually, and anytime the rates charged are different from what is on file with the Division of Insurance,	C.R.S. 10-16-11(1)	Colo. Reg. 4-2-31? Colo Reg. 4-2-11
Appeals Process	Internal claims appeal process: *Group plans must incorporate the Department of Labor's claims and appeals prcedures and update them to reflect standards established by the Secretary of Labor *Individual Plans must incorporate applicable law requirements and update them to reflect standards established by the Secretary of HHS. External review: *All plans must comply with applicable state external review processes that, at a minimum, include consumer protections in the NAIC Uniform External Review Model Act (Model 76) or with minimum standards established by the Secretary of HHS that is similar to the NAIC model.	PPACA 1001 PHS 2719	9/23/2010*	10-16-113 (internal review) - 2 levels (at choice of insured) internal appeal to carrier of denial. Reg 4-2-21: External Review of Benefit Denials - carrier should notify covered person in writing of their right to external review and the procedures for expedited and standard review.	10-16-113 10-16-113.5	4-2-17 4-2-21
Patient Protections	1. Choice of Health Care Professional - pediatrician must be accepted for children; women do not need prior authorization for OB-GYN services 2. Emergency Services - must be covered comparably to in-network care, even if provided by an out-of-network service provider.	PPACA 1001 PHS Section 2719A June 28, 2010 Fed Reg	9/23/2010*	10-16-107(5) - direct access to Ob-Gyn for women 10-16-704 - Network adequacy 10-16-704(2) - (a) Carrier shall arrange for referral Reg 4-2-16: Women can directly access Ob-Gyn, midwife, etc. under Managed Care Plans	10-16-704 10-16-704(2) (emergency services) 10-16-107(5) (obstetrics)	Colo. Reg. 4-2-16
Health Insurance Consumer Assistance Offices and Ombudsmen	The Secretary of HHS shall provide $30 million in grants to states to establish and operate offices of health insurance consumer assistance or health insurance ombudsman programs to: *Assist with the filing of complaints and appeals *Collect, track, and quantify problems and inquiries *Educate consumers on their rights and responsibilities *Assist consumers with enrollment in plans *Resolve problems with obtaining subsidies As a condition of receiving a grant, a state must collect and report data on the types of problems and inquiries encountered by consumers. The data shall be used to identify areas where enforcement action is necessary and shall be shared with state insurance regulatorsm the Secretary of Labor and the Secretary of Treasury.	PPACA 1002 PHS 2793	Date of enactment (March 23, 2010)	10-16-128: Commissioner shall report to the business affairs and labor committee of the house of representatives and the business, labor and technology committee of the senate, or any successor committees, no later than 10/1/2004 and every Oct. 1 thereafter 10-16-316: 10-16-409: NOTE: A federal grant opportunity to expand consumer assistance resources was offered. CO did not apply for the initial round of funding.	C.R.S. 10-16-128	

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Topic	Federal Provisions Summary	PPACA/PHS/Federal Register Citations	Implementation Date	CO State Provisions Summary	CRS Citation	CO Reg/Bulletin Citation
Ensuring that Consumers get Value for Their Dollars	The Secretary, in conjunction with the states, shall develop a process for the annual review of unreasonable premium increases for health insurance coverage. The process shall require insurers to submit to the State and the Secretary a justification for an unreasonable premium increase and post it online. The Secretary shall award $250 million in grants to states over a 5-year period to assist rate review activities, including reviewing rates, providing information and recommendations to the Secretary, and establishing Medical Reimbursement Data Centers to develop database tools that fairly and accurately reflect market rates for medical services.	PPACA 1003 PHS 2794	2010 Plan Year	10-16-107: Rates are not to be excessive of benefits. Expected rate increases must be submitted 60 days prior to intended increase. NOTE: CO received a $1 million, 1 year federal grant to expand/enhance premium rate review process.	10-16-107 10-16-107.1	
Temporary High-Risk Pool Program	The Secretary shall establish a temporary high risk health insurance pool program to provide coverage to individuals with preexisting conditions who have been without coverage for at least six months. The program may be carried out directly or through contracts with states or nonprofit entities. States msut agree not to reduce the annual amoutn expended for current high risk pools before enactment. Provides $5 billion to fund pools through 2013 Pools funded through these grants must: *Have no preexisting condition exclusions *Cover at least 65% of total allowed costs *Have an out-of-pocket limit no greater than the limit for high deductible health plans *Utilize adjusted community rating with maximum variation for age of 4:1 *Have premiums established at a standard rate for a standard population	PPACA 1101	90 days after enactment (June 23, 2010)	NOTE: Under federal grant, CO has contracted with federal governement to operate a temporary high risk pool program.		
Temporary Reinsurance Programs for Early Retirees	Temporary reinsurance program to reimburse employment-based plans for 80% of consists incurred by early retirees over the age of 55 but not eligible for Medicare between $15,000 and $90,000 annually. Payments under program must be used to lower costs of the plan. Provides $5 billion to fund the program.	PPACA 1102, pg 33	90 days after enactment (June 23, 2010)	Federal Program NOTE: further analysis of applicability to PERA required.		
Web Portal to Identify Affordable Coverage Options	Website through which individuals and small businesses may identify affordable health insurance coverage. It will allow them to receive information on: *Health insurance coverage *Medicaid *CHIP *Medicare *A high risk pool * small group coverage, including reinsurance for early retirees, tax credits, and other information The standard format used to present information will include: *The percentage of total premiums spent on nonclinical costs *Availability *Premium rates *Cost sharing	PPACA 1103	60 days after enactment (May 23, 2010)	Federal Program	N/A	N/A
Administrative Simplification Requirements	Requires the Secretary to develop operating rules for the electronic exchange of health information, transaction, transaction standards for EFT and requirements for financial and administrative transactions.	PPACA 1104 SSA 1171	Federal rules to be adopted by July 1, 2011, to become effective, January 1, 2013	NOTE: Important consideration for establishment of Exchange(s)		
2014 Market Reforms						
Preexisting Condition Exclusions	A plan may not impose and preexisting condition exclusions	PPACA 1201 PHSA 2704	6 months after enactment for individuals 19 years and younger (9/23/2010), plan years beginning 1/1/2014 for all others.*	see previous		

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Topic	Federal Provisions Summary	PPACA/PHS/Federal Register Citations	Implementation Date	CO State Provisions Summary	CRS Citation	CO Reg/Bulletin Citation
Fair Health Insurance Premiums	Premiums may only vary by: *Age (3:1 maximum) *Tobacco (1.5:1 maximum) *Geographic rating area *Whether coverage is for an indiviudal or a family Each state shall establish one or more rating areas for the purposes of geographic rating. The secretary shall review them and determine their adequacy. If they are not adequate, or if a state fails to establish them, the Secretary may establish rating areas for the state.	PPACA 1201 PHSA 2701	Plan years beginning 1/1/2014*		10-16-102(10) 10-16-104.9	
Guaranteed Availability of Coverage	Insurers must accept every employer and every individual that applies for coverage except that: an insurer may restrict enrollment based upon opoen or special enrollment periods	PPACA 1201 PHSA 2702	Plan years beginning 1/1/2014*		10-16-105(3) 10-16-105(7.3) 10-16-105(7.5) 10-16-105(3) - small group 10-16-201.5	
Guaranteed Renewability of Coverage	Insurers must renew coverage or continue it in force at the option of the plan sponsor or the individual	PPACA 1201 PHSA 2703	Plan years beginning 1/1/2014*		10-16-105(30) - small group 10-16-201.5	
Prohibition of Discrimination Based on Health Status	A plan may not establish rules for eligibility based on any of the following health status-related factors: *Health status *Medical condition *Claims experience *Receipt of health care *Medical history *Genetic information *Evidence of insurability (including conditions arising out of domestic violence) *Disability *Any other health-status related factor deemed appropriate by the Secretary Health promotion and disease prevention programs that base the conditions for obtaining a premium discount or any other reward upon a health staus related factor must limit such rewards to 30% of the cost of coverage. Secretaries of HHS, Labor and Treasury may increase the cap on rewards up to 50% if deemed appropriate. Wellness programs must be reasonably designed to promote health or prevent disease and must give eligible individuals the opportunity to qualify for the reward at least once per year, and rewards must be made, available to all similarly situated indiviudals. Existing wellness programs established before March 23, 2010 may continue to be carried out. Creates a Wellness Program Demonstration Program in 10 states to allow states to design wellness programs for individual market enrollees.	PPACA 1201 PHSA 2705	Plan years beginning 1/1/2014*	10-16-105(7): Shall not request more than five years of medical history. 10-16-107(6): May not require a premium greater than similarly situated individual on the basis of any health-status related factor 10-16-214(2): other jurisdictions/multistate associations 10-16-214(4): no rules for eligibility based on health-status related factors. 10-3-1104.7 (1)(d): information obtained from genetic testing should not be used to deny access to insurance; (3)(b) - may not use for underwriting purposes connected with provision of insurance coverage. 10-16-408(3): enrollment periods shall not be used to hinder the enrollment by persons eligible for medical benefits. 10-16-136	10-16-105 10-16-107(6) 10-16-214(2) 10-16-214(4) 10-3-1104.7 10-16-408 10-16-136	
Non-discrimination in Health Care	Plans may not discriminate against any provider operating within their scope of practice. Does not require that a plan contract with any willing provider or prevent tiered networks. Plans may not discrimintate against individuals or employers based upon: *Whether they receive subsidies *Whether they provide information to state or federal investigators or cooperate in the investigation of a violation of the Fair Labor Standards Act	PPACA 1201	Plan years beginning 1/1/2014*	10-16-107(6): may not require an individual to pay a higher premium than a similarly situated individual on the basis of any health status-related factor. 10-16-104(7): fee schedules should be the same for health services that are substantially identical although performed by different professions.	10-16-107(6) 10-16-104(7)	
Comprehensive health insurance coverage	All plans must include the essential benefits package required of plans sold in the Exchanges and must comply with limitations on annual cost-sharing for plans sold in the Exchanges. (see 1302(a) and (c))	PPACA 1201 PHSA 2707	Plan years beginning 1/1/2014*		10-3-1104.7 10-16-102(22)	4-2-33

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Topic	Federal Provisions Summary	PPACA/PHS/Federal Register Citations	Implementation Date	CO State Provisions Summary	CRS Citation	CO Reg/Bulletin Citation
Prohibition on Excessive Waiting	Group health plans and group health insurance may not impose waiting periods that exceed 90 days,	PPACA 1201 PHSA 2708	Plan years beginning 1/1/2014*	10-16-408: Open enrollment period of one month	10-16-408	
Clinical Trials	Prohibits health insurance issuers from dropping coverage because an individual (who requires treatment for cancer or another life-threatening condition) chooses to participate in a clinical trial. Issuers also may not deny coverage for routine care that they would otherwise provide because an individual is enrolled in a clinical trial.	PPACA 1201 PHSA 2709	Plan years beginning 1/1/2014*	10-16-104(20)(a)- coverage for routine patient care costs received during a clinical trial if: (I) physician recommends participation in clinical trial to achieve a therapeutic health benefit; (II) the trial is approved under 9/19/00 Medicare decision; (III) the care is provided by registerred/qualified personnel; (IV) Statement of consent - out of network rates apply; and (V) patient condition that is disabling, progressive, or life-threatening. 10-16-104(21)	10-16-104(20) 10-16-104(21)	
Other Provisions						
Maintaining Existing Coverage (Grandfathered Plans)	The following provisions apply to grandfathered plans: *Excessive Waiting Periods *Lifetime Limits only *Rescissions *Extension of Dependent Coverage *Uniform summary of benefits and coverage/standardized definitions *Medical loss ratios *Annual Limits (when plan normally renews) *Preexisting conditions (when plan normally renews) Plans can lose their grandfathered status by: *Eliminating substantial benefits for a particular condition *Any increase in cost-sharing requirements *Increase in fixed-amount cost-sharing other than copayment *decrease in the proportion of premiums paid by the employer of more than 5% *Addition/decrease of annual limit	PPACA 1251 42 U.S.C. 18011 Fed Reg June 17	Date of Enactment (March 23, 2010)	10-16-201.5 (1): guaranteed renewability of any health benefit plan 10-16-201.5 (8): small group/individual - renew plan with reasonable modifications	10-16-201.5	
Rating reforms apply uniformly	"Any standard or requirement adopted by a State pursuant to this title, or any amendment made by this title, shall be applied uniformly to all health plans in each insurance market to which the standard and requirements apply. The preceding sentence shall also apply to a State standard or requirement relating to the standard or requirement required by this title (or any such amendment) that is not the same as the standard or requirement but that is not preempted under section 1321(d)."	PPACA 1252	Plans beginning after 1/1/2014	None		
EXCHANGES						
EXCHANGES: Qualified Health Plans Defined	Qualified health plans are: A) certified in accordance with 1311(c) issued or recognized by each Exchange through which the plan is offered; B) provides the Essential Health Benefits package described in 1302(a); and C) is offered by a health insurer that: i) is licensed and in good standing in the State offered; ii) agrees to offer at least one qualified health plan at the silver level and at least on plan at the gold level in each such Exchange; iii) agrees to charge the same premium rate for each qualified health plan of the issuer without regard for whether the plan is sold through the Exchange or whether the plan is offered directly from the issuer or appointed agent; and iv) complies with regulations developed by the Secretary under section 1311(d) and such other requirements as an applicable Exchange may establish.	PPACA 1301	1/1/2014			

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Topic	Federal Provisions Summary	PPACA/PHS/Federal Register Citations	Implementation Date	CO State Provisions Summary	CRS Citation	CO Reg/Bulletin Citation
EXCHANGES: Essential Health Benefits Requirements	"Essential Health Benefits Package" means, coverage that: 1) provides the essential health benefits defined by subsection (b); 2) limits cost-sharing in accordance with subsection (c); and 3) subject to subsection (e), provides either the bronze, silver, gold or platinum level of coverage described in subsection (d). (b) Essential Health Benefits: such benefits shall include at least the following general categories and the items and services covered within the categories: (A) Ambulatory patient services; (B) Emergency services; (C) Hospitalization; (D) Maternity and newborn care; (E) Mental health and substance use disorder services, including behavioral health treatment; (F) Prescription Drugs; (G) Rehabilitative services; (H) Laboratory services; (I) Preventive and wellness services and chronic disease management; (J) Pediatric services including oral and vision care	PPACA 1302	1/1/2014			
EXCHANGES: Special Rules/Abortion coverage	States may elect to prohibit abortion coverage in qualified health plans offered through an Exchange.	PPACA 1303	1/1/2014	4-6-5 5. G. Family Planning Services: Family planning services shall be included as a covered benefit under both the basic and standard health benefit plans. At a minimum, family planning services shall include maternity care, prenatal and postnatal care and counseling, treatment and screening as appropriate for sexually transmitted diseases, sterilization, contraceptives, and contraception counseling.*	None	Reg 4-6-5
EXCHANGES: Related Definitions	Eligible employees should be compliant by 2016	PPACA 1304	01/01/14 State option to define market as 1-50 ends 01/01/16	10-16-102(40) - small employer is 50 eligibles or less 10-16-102(15) - eligibles vs. employees	10-16-102(40) 10-16-102(15)	
EXCHANGES: Affordable choices of health benefits plans	(a) ASSISTANCE TO STATES TO ESTABLISH AMERICAN HEALTH BENEFIT EXCHANGES.— (1) PLANNING AND ESTABLISHMENT GRANTS.—There shall be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, an amount necessary to enable the Secretary to make awards, not later than 1 year after the date of enactment of this Act, to states in the amount specified in paragraph (2) for the uses described in paragraph (3). Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an ''Exchange'') for the State that— (A) facilitates the purchase of qualified health plans; (B) provides for the establishment of a Small Business Health Options Program (in this title referred to as a ''SHOP Exchange'') that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State; and (C) meets the requirements of subsection (d).	PPACA 1311 Grant Announcement on July 29	Beginning not later than 1 year after the date of enactment, lasting until 01/01/15	NOTE: Colorado received a $1 million Exchange Planning Grant.	Co-op statute	
EXCHANGES: Consumer Choice	SEC. 1312 CONSUMER CHOICE. (a) CHOICE.— (1) QUALIFIED INDIVIDUALS.- As revised by section 10104(i)(1)¿ A qualified individual may enroll in any qualified health plan available to such individual and for which such individual is eligible. (2) QUALIFIED EMPLOYERS.— (A) EMPLOYER MAY SPECIFY LEVEL.—A qualified employer may provide support for coverage of employees under a qualified health plan by selecting any level of coverage under section 1302(d) to be made available to employees through an Exchange. (B) EMPLOYEE MAY CHOOSE PLANS WITHIN A LEVEL.— Each employee of a qualified employer that elects a level of coverage under subparagraph (A) may choose to enroll in a qualified health plan that offers coverage at that level.	PPACA 1312	1/1/2014			

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Topic	Federal Provisions Summary	PPACA/PHS/Federal Register Citations	Implementation Date	CO State Provisions Summary	CRS Citation	CO Reg/Bulletin Citation
EXCHANGES: Financial integrity	SEC. 1313 - FINANCIAL INTEGRITY. (a) ACCOUNTING FOR EXPENDITURES.— (1) IN GENERAL.—An Exchange shall keep an accurate accounting of all activities, receipts, and expenditures and shall annually submit to the Secretary a report concerning such accountings.	PPACA 1313	1/1/2014			
EXCHANGES: Level Playing Field	Notwithstanding any other provision of law, any health insurance coverage offered by a private health insurance issuer shall not be subject to any Federal or State law described in subsection (b) if a qualified health plan offered under the Consumer Operated and Oriented Plan program under section 1322, or a multi-State qualified health plan under section 1334, is not subject to such law.	PPACA 1324	1/1/2014	10-16-201.5 - Renewability of health benefit plans	10-16-201.5	
EXCHANGES: State flexibility to establish basic health programs for Low-Income Individuals Not Eligible for Medicaid	State may enter into contracts to offer 1 or more standard health plans providing at least the essential health benefits described in section 1302(b) to eligible individuals in lieu of offering such individuals coverage through an Exchange. Plans must be approved by Secretary of HHS, and meet specific cost-sharing and other requirements.	PPACA 1331		HCPF - The Department administers the Medicaid and Child Health Plan Plus programs as well as a variety of other programs for Colorado's low-income families, the elderly and persons with disabilities.		
EXCHANGES: Provisions relating to offering of plans in more than one state	No later than July 1, 2013, Secretary shall, in consultation with NAIC, develop rules for health care choice compacts between 2 or more States. States may NOT enter into such compact until it enacts legislation that permits such compact after the date of enactment of this bill (March 23, 2010). Plans must be licensed in each State where they sell coverage.	PPACA 1333	1/1/2016			
EXCHANGES: Transistional reinsurance	States must establish temporary reinsurance program. Reinsurance entities must be non-profit organizations to stabilize premiums for the first 3 years of Exchange operation.	PPACA 1341	Plans beginning 1/1/2014 and thru 2016	10-16-119. Requirements for excess loss insurance used in conjunction with self-insured employer benefit plans under the federal "Employee Retirement Income Security Act". (1) Any entity issuing excess loss insurance shall file all policy forms with the division and certify compliance with the provisions of this title. (2) All excess loss insurance shall be issued to cover the employer's liability under the employer's self-insured obligation. Excess loss insurance shall meet the following requirements: (a) The policy shall only be issued to insure an employer and not the employer's employees; (b) Payment by the issuer of the insurance shall only be made to the employer and not the employees or providers; (c) Commencing with policies issued or renewed on and after January 1, 2003, the minimum retention to the employer shall be no less than fifteen thousand dollars per person per plan year with a minimum one hundred twenty percent of expected claims aggregate Cover Colorado	10-16-119	
EXCHANGES: Risk Corridors	The Secretary shall establish and administer a risk corridor program for 2014-2016 based upon the risk corridor program for Medicare PDPs. Plans will receive payments if their ratio of nonadministrative costs, less any risk adjustment and reinsurance payments, to premiums, less administrative costs, is above 103%. Plans must make payments if that ratio is below 97%.	PPACA 1342	Calendar years 2014 - 2016			
EXCHANGES: Risk Adjustment	Each state shall assess health plans if the actuarial risk of all of their enrollees in state is less than the average risk of all enrollees in fully-insured plans in that state and make payments to health plans whose enrollees are have an actuarial risk that is below the average actuarial risk in that state. The Secretary of HHS, in consultation with the states, shall establish criteria and methods for these risk adjustment activities, which may be similar to those for Medicare Advantage plans and Prescription Drug Plans.	PPACA 1343	1/1/2014*			

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Topic	Federal Provisions Summary	PPACA/PHS/Federal Register Citations	Implementation Date	CO State Provisions Summary	CRS Citation	CO Reg/Bulletin Citation
EXCHANGES: Refundable Tax Credit	Persons below defined federal poverty lines receive tax credit for difference between premium paid and capped amount	PPACA 1401	1/1/2014			
EXCHANGES: Streamlining Procedures	Establish a system for individuals to apply for enrollment in Medicaid, SCHIP through an Exchange. Provide a single form to be used in applying for all applicable state health subsidy programs.	PPACA 1413		10-16-107.2(1) All sickness and accident insurers, health maintenance organizations, and nonprofit hospital and health service corporations authorized by the commissioner to conduct business in Colorado shall submit an annual report to the commissioner listing any policy form, endorsement, or rider for any sickness, accident, nonprofit hospital and health service corporation, health maintenance organization, or other health insurance policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado. Such listing shall be submitted by January 15, 1993, and not later than December 31 of each subsequent year and shall contain a certification by an officer of the organization that each policy form, endorsement, or rider in use complies with Colorado law. The necessary elements of the certification shall be determined by the commissioner. 10-16-107.2(2)(c) - individual plans (I) The commissioner shall implement an initial uniform application form for individual health benefit plans and, on and after January 1, 2012, shall require all individual sickness and accident insurers, health maintenance organizations, nonprofit hospital and service corporations, health insurance producers and producer organizations, and other entities providing individual health care coverage authorized by the commissioner to conduct business in this state to exclusively use the uniform application form for the conduct of business in this state. The initial uniform application form shall include the name of the applicant, contact information for the applicant, other demographic information approved by the commissioner, and questions concerning medical conditions for which the carrier may refuse to issue coverage. (II) The commissioner shall consider recommendations regarding the initial uniform application form and content of the application that are submitted to the division by members of the insurance industry on or before January 1, 2011. (III) The commissioner shall promulgate rules to implement the initial uniform application form on or before September 1, 2011. (IV) On and after January 1, 2012, all individual sickness and accident insurers, health maintenance organizations, nonprofit hospital and service corporations, health insurance producers and producer organizations, and other entities that issue individual health benefit plans shall use the initial uniform application form for an individual's coverage.	10-16-107.2(1)(b) 10-16-107.2(2)(c)	
EXCHANGES: Employer Responsibilities						

*Except Grandfathered Plans

Funding Opportunities Detail

Subject	Grant title	Lead agency	Amount	Status	Description
Health Care Workforce	Primary Care Workforce Planning	CDPHE	$150,000.00	Awarded	Complete a comprehensive workforce plan that will expand the primary care workforce in Colorado. The planning process will engage the Colorado Health Professions Workforce Policy Collaborative to identify multiple, achievable objectives that will, in implementation, lead to a 25% increase in the primary care workforce in Colorado.
Health Care Workforce	State-Regional Centers Health Workforce Analysis	CDPHE	$0.00	Pipeline	HHS to award grants to states and eligible entities to support data collection and analysis and provide technical assistance to local entities for such activities. Data will be used by the National Center for Health Care Workforce Analysis. Eligible entities may also be selected to conduct longitudinal evaluation of individuals who have received education, training, or financial assistance from certain workforce programs.
Health Care Workforce	Promote the Community Health Workforce	CDPHE	$0.00	Pipeline	CDC to award grants to states and eligible state agencies to use community health workers to promote positive health behaviors and outcomes in medically underserved communities.
Health Care Workforce	Training Programs for General Medicine	Other	$0.00	Pipeline	Provides grants to develop and operate training programs, provide financial assistance to trainees and faculty, enhance faculty development in primary care and physician assistant programs, and to establish, maintain, and improve academic units in primary care. Priority given to programs that educate students in team-based approaches to care, including the patient-centered medical home. Authorized but not funded.
Health Care Workforce	Loan Repayment	CDPHE	$0.00	Pipeline	Various loan repayment programs to encourage medical providers.
Health Care Workforce	Nurse Managed Health Clinics	CDPHE	$0.00	Pipeline	Creates an operations grant program in primary care for nurse managed health clinics. Expands use of midlevel operated primary care clinics.
Insurance Reform	Health Insurance Premium Rate Review	DOI	$1,000,000.00	Awarded	Improves the oversight of proposed health insurance premium increases, takes action against insurers seeking unreasonable rate hikes, and ensures consumers receive fair value for their premium dollars. Allows the DOI to hire temporary staff: rate financial analysts and actuaries to review rate filings; staff in Consumer Complaints and outreach; and web enhancements to make rate filings more accessible and understandable to consumers. 1) Improve quality of information used in rate reviews and reduce the amount of time needed to complete each, in compliance with new federal requirements. 2) Enhance consumer protection, education, and outreach relative to health insurance rates.
Insurance Reform	High Risk Health Insurance Pool	DOI	$90,000,000.00	Awarded	Establishes temporary high risk health insurance pool to provide health insurance coverage until January 1, 2014. Subsidize health insurance for up to 4,000 people rejected by private health insurers because of pre-existing medical conditions.
Insurance Reform	Health Insurance Exchange Planning	Gov Office	$999,987.00	Awarded	Funds planning related to the establishment of a state-based health insurance exchange. Funding for economic modeling, actuarial analysis, data collection from DOI, and identification of IT infrastructure needed for the successful operation of a state-based exchange. Provides resources for Colorado to determine how its exchange will be operated and governed, including: 1) Assessing current information technology systems and infrastructure and determining new requirements. 2) Developing partnerships with community organizations to gain public input into the exchange planning process. 3) Hiring key staff and determining ongoing staffing needs. 4) Planning the coordination of eligibility and enrollment systems across Medicaid, the Children's Health Insurance Program, and the exchanges. 5) Developing performance metrics, milestones, and ongoing evaluation.

Insurance Reform	Transitional Reinsurance Program	DOI	$0.00		Pipeline	States are required to establish or contract with one or more applicable entities to operate a temporary reinsurance program for individuals and small businesses, which would provide reimbursement for partial costs of premiums.
Insurance Reform	Evaluate Alternatives to Current Medical Tort	Gov Office	$0.00		Pipeline	HHS to award demo grants to states to develop alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations. Funding may be awarded for up to give years. HHS may use part of the appropriated funds to provide $500,000 planning grants to the states.
Insurance Reform	Certified HER Technology for LTC	CORHIO	$0.00		Pipeline	Grants to long-term care facilities to assist with costs related to purchasing, leasing, developing, and implementing certified EHR technology. Directs the Secretary to adopt electronic standards for the exchange of clinical date by long-term care facilities.
Long-term Services/Support	Affordable Care Act; ADRC Options Counseling and Assistance Programs	CDPHE	$492,469.00		Awarded	Develop and implement a standardized procedure for options counseling to ensure all consumers statewide receive accurate and effective information to assist them in making decisions in their long-term care needs under the guidance and supervision of the CDHS, Division of Aging and Adult Services, State Unit on Aging.
Long-term Services/Support	Affordable Care Act; ADRC Evidence-based Care Transition Programs	CDPHE	$394,476.00		Awarded	Funds Mesa County DHS to implement the Care Transitions Intervention (CTI) in the local hospital and Regional Medical Center. The goal is to increase effective self-management capacity following hospitalization and to reduce unplanned rehospitalizations.
Medicaid and Medicare	Person Rebalancing Demonstration Financial Planning (HCBS)/Money Follows the Person Planning Grant	HCPF	$200,000.00		Awarded	Extends existing demonstration authority to award grants for the Medicaid Money Follows the Person program, established by the Deficit Reduction Act. Build and improve upon infrastructure supporting home and community based services (HCBS) for people of all ages with long-term care needs to: 1) Improve access to HCBS services. 2) Make the system easier to navigate. 3) Support the transition of institutionalized clients who have indicated an interest in finding out about community long-term care options and have the potential to return to the community. 4) Support nursing facilities in assisting clients to explore their long-term care options including community-based care. 5) Expand current infrastructure for housing, benefits, and information technology.
Medicaid and Medicare	Medicaid Community First Choice Option	HCPF	$0.00		Pipeline	Establishes the Community First Choice program. States that take up the option would receive an FMAP increase for providing HCBS for people with disabilities who require an institutional level of care. States that take up the option will receive a 6 percentage point increase in FMAP for HCBS attendant services.
Medicaid and Medicare	Medicaid Home and Community Based Services	HCPF	$0.00		Pipeline	Creates the State Balancing Incentives program to provide a temporary FMAP increase for HCBS for states that undertake structural reforms to increase diversion from institutions and expand the number of people receiving HCBS.
Medicaid and Medicare	Medicaid Home Health - Chronic Conditions Planning	HCPF	$0.00		Pipeline	Beginning January 1, 2011 there is a Medicaid state option to provide coordinated care to enrollees with chronic conditions. HHS to establish the minimum standards for health homes. States will receive a 90 percent FMAP for such health home services during the first eight fiscal year quarters that the state plan amendment is in effect. $25 million max. grant award per state.
Medicaid and Medicare	Medicaid Integrated Care Hospitalization Demo	CIVHC	$0.00		Pipeline	Establishes a demonstration program to allow states to use bundled payments to promote integration of care around hospitalization. HHS may select up to eight states to participate.
Medicaid and Medicare	Medicaid Global Payment System Demo	CIVHC	$0.00		Pipeline	Establishes the Medicaid Global Payment System demonstration program to allow states to test paying a safety net hospital system or network using a global capitated payment model. Will operate in coordination with CMS. HHS may select up to five states to participate.
Medicaid and Medicare	Medicaid Emergency Psychiatric Demo	HCPF	$0.00		Pipeline	Establishes program for emergency psychiatric demo to provide incentive payments to certain institutions for mental disease. Funded, waiting on guidance.

Medicaid and Medicare	Medicaid Preventive Services	HCPF	$0.00		Pipeline	Provides FMAP incentive payment to states that eliminate cost-sharing requirements for Medicaid clinical preventive services that have been recommended by the US Preventive Services Task Force and for vaccines for adults. One percentage point increase in FMAP for states that eliminate cost-sharing. Available beginning January 1, 2013
Medicaid and Medicare	CHIP Obesity Demonstration	HCPF	$0.00		Pipeline	Extends funding for the childhood obesity demonstration program established under CHIPRA.
Medicaid and Medicare	CHIP Outreach Grants	HCPF	$0.00		Pipeline	Extends and increases funding for a program to award grants to states and other eligible entities to improve outreach and enrollment in the CHIP program, as established under CHIPRA.
Medicaid and Medicare	Affordable Care Act; The Medicare Improvements for Patients and Providers Act (MIPPA)	CDPHE	$345,072.00		Awarded	Coordinate efforts to provide outreach to beneficiaries with limited incomes statewide, for general Medicare Part D outreach and assistance to beneficiaries in rural areas, and for outreach activities aimed at preventing disease and promoting wellness under the guidance and supervision of the CDHS, Division of Aging and Adult Services, State Unit on Aging.
Quality, Prevention and Wellness	Early Childhood Home Visiting Program	CDPHE	$1,894,843.00		Awarded	Increase home visitation services to at-risk families who are expecting or who have new babies to support the family's physical, psychological, and emotional needs in order to improve infant mortality, prevent child abuse and neglect, reduce future unwanted pregnancies and reduce substance abuse. This program requires participating States to utilize at least 75% of funding for evidence-based home visiting models and allows States to use up to 25% of funding for promising home visiting models.
Quality, Prevention and Wellness	Public Health Systems and Infrastructure	CDPHE	$1,500,000.00		Awarded	Coordinating with the Colorado Public Health Act of 2008 (SB08-194) activities, the grant will support strategic implementation of the 2009 Colorado Public Health Improvement Plan and other identified areas of local and state public health planning and implementation needs.
Quality, Prevention and Wellness	Public Health Infrastructure - Local	CDPHE	$0.00		Not Awarded	Provides funding to support CDPHE and local public health agencies to implement the Public Health Act SB194-08. As system improvements are implemented, performance can be benchmarked against key health indicators and changes in the health priorities identified and targeted through local and state public health improvement plans can be monitored. These improvements will result in a public health system that equitably provides public health services to all Coloradans and help to restrain the rate of growth in health care costs.
Quality, Prevention and Wellness	Consumer Related Initiatives		$0.00		Not Applied	Not applied for because of lack of sustainability.
Quality, Prevention and Wellness	Background Checks on Direct Patient Access Employees of Long-term Care Facilities	CDPHE	$3,000,000.00		Applied	Evaluate the state's current background check processes, then work with stakeholders to define workable improvements. If Colorado is successful in defining improvements and creating a self sustaining cost model, the consultant will also craft the phase II grant proposal to obtain implementation funds.
Quality, Prevention and Wellness	Epidemiology and Laboratory Emerging Infections Program	CDPHE	$1,000,000.00		Awarded	Conduct influenza molecular testing from laboratory-confirmed hospitalized cases of influenza to support influenza surveillance and vaccine effectiveness studies through the 2010-2011 flu season; adapt and implement improved methods of estimating seasonal influenza burden in Colorado; collaborate with CDC on information systems to improve data quality and efficiency.
Quality, Prevention and Wellness	Epidemiology and Lab Capacity for Infectious Disease (ELC)	CDPHE	$800,000.00		Awarded	Enhances Colorado's ability to perform surveillance, investigation, and control of communicable diseases statewide.
Quality, Prevention and Wellness	Healthy Communities, Tobacco Prevention and Control - Supplemental Quitline Funding	CDPHE	$73,927.00		Awarded	Expands tobacco cessation services for smokers ready to quit tobacco, ultimately reducing health care costs related to tobacco use.
Quality, Prevention and Wellness	Healthy Communities, Behavioral Risk Factors Surveillance System (BRFSS) Supplemental Funding	CDPHE	$186,917.00		Awarded	Twelve questions on influenza-like illness will be added to BRFSS survey between September of 2010 and March of 2011. This will allow Colorado to assess the prevalence of influenza-like illness at the state and local levels to support Pandemic Influenza response and preparedness.

Quality, Prevention and Wellness	Aging and Disability Resource Centers	DHS	$0.00		Pipeline	The ARDC program provides states with funding to streamline access to long-term care supports and services.
Quality, Prevention and Wellness	Personal Responsibility Education Program (PREP)	DHS	$3,965,290.00		Awarded	Implements innovate strategies for preventing teenage pregnancy and targets services to high-risk, vulnerable, and culturally under-represented youth populations.
Quality, Prevention and Wellness	Pediatric Accountable Care Organization Demo	HCPF	$0.00		Pipeline	Established the Pediatric Accountable Care Organization demonstration project which authorizes a participating state to allow pediatric medical providers that meet certain requirements to be recognized as an accountable care organization for purposes of receiving incentive payments.
Quality, Prevention and Wellness	Trauma Care Centers	CDPHE	$0.00		Pipeline	Grant program to promote universal access to trauma care services provided by trauma centers and trauma-related physician specialties. States would apply for grants and then award them to eligible entities. Authorized, but not funded.
Quality, Prevention and Wellness	Medicaid Chronic Disease Incentive Payment	HCPF	$0.00		Pipeline	CDC to award grants to states to test approaches that may encourage behavior modification for healthy lifestyles among Medicaid enrollees and to determine scalable solutions. HHS to conduct outreach and education campaign to make states aware. Grants will be for a five year period beginning January 1, 2011.
Quality, Prevention and Wellness	Community Transformation Grant	CDPHE	$0.00		Pipeline	Establishes competitive grant program for states and local governmental agencies and community-based organizations to promote evidence-based community preventive health activities intended to reduce chronic disease rates, address health disparities, etc. (Likely in partnership with HCPF) No appropriation yet.
Quality, Prevention and Wellness	Healthy Aging, Living Well Public Health Grant	CDPHE	$0.00		Pipeline	CDC to award grants to states or local health departments and Indian tribes for pilot programs to provide public health community interventions, screenings, etc. for individuals between ages 55 and 64.
Quality, Prevention and Wellness	Immunization Coverage Improvement Program	CDPHE	$0.00		Pipeline	CDC demonstration program to award grants to states to improve immunization coverage for children, adolescents, and adults.
Quality, Prevention and Wellness	Primary Care Extension Program	CDPHE	$0.00		Pipeline	AHRQ to administer a primary care extension program. HHS will competitively award grants to states to establish state or multistate-level primary care extension program state hubs. States must develop a six year plan. Two year planning grants may be available to states with the goal of developing a plan.
Quality, Prevention and Wellness	Elder Justice Services	DHS	$0.00		Pipeline	Expands the permissible uses for grants under the Social Service Block Grant (SSBG) program to include elder justice related activities.
Quality, Prevention and Wellness	Adult Protective Services Program	DHS	$0.00		Pipeline	Establishes program for HHS to award grants to states to enhance the provision of APS. Grant amount based on appropriated funds multiplied by percentage of total number of elders in that state. Grants may not supplant other resources for such purposes.
Quality, Prevention and Wellness	State Demonstration Program Concerning Elder Abuse	DHS	$0.00		Pipeline	Establishes grant program for states to conduct demonstration programs to test methods of elder abuse detection and prevention.
Quality, Prevention and Wellness	Primary and Specialty Care Comm-based Men. Health	CDPHE	$0.00		Pipeline	Authorizes grants for coordinated and integrated services through the co-location of primary and specialty care in community-based mental and behavioral health settings. Funds can be directed to facility modifications and information technology.
Quality, Prevention and Wellness	Quality Measure Development	CORHIO	$0.00		Pipeline	Likely in partnership with CIVHC. Directs the Secretary, the Director of AHRQ and the Administrator of CMS to identify gaps where no quality measures exist and where existing quality measures need improvement, updating, or expansion. The Secretary shall develop quality measures for use in a pilot program and shall specify that date on measures be submitted through the use of a qualified electronic health record.

Quality, Prevention and Wellness	Data Collection; Public Reporting	CIVHC	$0.00		Pipeline	Requires the Secretary to collect and aggregate consistent data on quality and resources use measures from information systems used to support health care delivery to implement the public reporting of performance information. Allows the Secretary to award grants or contracts to eligible entities to support new or improve existing efforts to collect and aggregate quality and resource use measures.
Quality, Prevention and Wellness	Oral Health Care Prevention	CDPHE	$0.00		Pipeline	Establishes an oral health care prevention education campaign at CDC focusing on preventive measures and targeted towards key populations including children and pregnant women. Funding for school-based sealants, oral health infrastructure, and surveillance.
Quality, Prevention and Wellness	Chronic Disease Grants for Medicaid Population	CDPHE	$0.00		Pipeline	Comprehensive and uniquely suited grants to address the needs of Medicaid eligible beneficiaries and must have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight, quit smoking, and/or manage or prevent diabetes, and may address co-morbidities associated with these conditions.
Quality, Prevention and Wellness	Chronic Disease Grants	CDPHE	$0.00		Pipeline	Promotes individual and community health and prevent the incidence of chronic disease associated with obesity, tobacco use, or mental illness, or other activities that are consistent with the goals of promoting healthy communities.
Quality, Prevention and Wellness	Adult Vaccine Grant	CDPHE	$0.00		Pipeline	Purchase of adult vaccines and implement demo program to improve immunization rates.
Quality, Prevention and Wellness	State Abstinence Education Program	DOE	$3,235,655.00		Awarded	Funds to support decisions to abstain from sexual activity until marriage by providing abstinence education as defined by Section 510(b)(2) of the Social Security Act with a focus on groups that are most likely to bear children out of wedlock.
Quality, Prevention and Wellness	Support of Pregnant and Parenting Teens and Women	DHS	$0.00		Not Applied	Support pregnant and parenting teens at high schools and community centers. Improve services for pregnant women who are victims of domestic violence, sexual violence, sexual assault, and stalking. Increase public awareness and education.
	Enrollment HIT for Health and Human Services	HCPF	$0.00		Pipeline	For eligible entities, including states, to develop new and adapt existing technology systems to implement HIT enrollment standards and protocols. Enrollment HIT systems adopted using these grants would be available to other qualified state, political subdivisions, or other qualified entities at no cost.

22 QUESTIONS

About the Affordable Care Act:
What Colorado Businesses Need to Know

1 **What is the Affordable Care Act? Who is impacted (small, large businesses and self-insured)?**

The Patient Protection and Affordable Care Act (PPACA) is a federal statute that was signed into law on March 23, 2010.

The law includes numerous health-related provisions to take effect over a four-year period, including expanding Medicaid eligibility, subsidizing insurance premiums, providing tax credits for businesses to provide health care benefits, prohibiting denial of coverage/claims based on pre-existing conditions, establishing health insurance exchanges, and support for medical research.

The Act includes several short- and long-term provisions designed to help small businesses pay for and maintain health insurance for their workers, and to allow workers without employer coverage to gain access to affordable, comprehensive health insurance.

Provisions include a small business tax credit to offset premium costs for firms that offer coverage, establishment of state-based insurance exchanges that promise to lower administrative costs and pool risk more broadly, and creation of new market rules and an essential benefit standard to protect small firms and their workers.

Also creates a temporary, reinsurance program to reimburse participating employment-based plans for part of the cost of providing health benefits to retirees ages 55 to 64 and their families. The insurance program will be eliminated in 2014, after the health insurance Exchanges have been established. To date, 16 Colorado companies, unions, state and local entities became eligible for early retiree subsidies.

The new law also establishes an employer responsibility requirement for employers with more than 50 full-time employees to offer health insurance coverage to full-time employees and dependents or be subject to a penalty per full-time employee.

The law also requires larger employers with more than 200 employees must automatically enroll employees into the company's health coverage. Employees who do not want to be auto-enrolled must actively opt out of the plan.

In addition, beginning in 2012, employers will be required to report the value of employer-sponsored health coverage on each employee's W-2 form.

2 **When does it go into effect?**

Several provisions of the Affordable Care Act were implemented in 2010, including a tax credit to offset premium costs, and early retiree reinsurance program.

The expansions in public programs, creation of health insurance exchanges, and employer responsibility requirements begin in 2014.

3 **What if you don't comply?**

Most small businesses are exempt. Employers with fewer than 50 FTEs are not subject to the provision that takes effect January 1, 2014.

A business is defined as "large" if it has at least 50 FTEs, not counting seasonal workers. Also, the first 30 employees are subtracted from the total when calculating the amount of the assessment.

The Federal government will assess a fee of $2,000 per full-time employee – excluding the first 30 employees – on all employers with more than 50 employees who do not offer coverage and have at least one full-time employee receiving a premium tax credit.

If an employer offers coverage that is unaffordable, or exceeds 9.5 percent of an employee's household income, and the employee opts out of employer-sponsored coverage, the employer will be required to pay a penalty of the lesser of: (1) $3,000 for each full-time employee receiving the subsidy; or (2) the number of total employees minus 30 multiplied by $2,000.

4 Who do you contact with questions?

Many business associations are developing resources for their partners at a state level. In addition to these resources, there are several state and national resources.

The U.S. Department of Health & Human Services maintains a portal, www.healthcare.gov, with information about the Act. The small business site includes information about small business tax credits, coverage options, reinsurance for retirees and more.

The IRS website, www.irs.gov/newsroom/article/0,,id=220839,00.html has tips, a detailed FAQ and eligibility worksheets.

The state also maintains a website, www.colorado.gov/healthreform.

5 What is a Health Exchange?

A new entity intended to create a more organized and competitive market for health insurance by offering a choice of plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help consumers better understand the available options.

States have the option of joining together to form regional exchanges or allowing more than one exchange to operate in a state. Individuals and small businesses with less than 100 employees may purchase coverage through these Exchanges.

6 How will it affect self-insured companies?

Under self-insurance, the organization itself bears the risk for covering medical expenses. The provisions that impact self insured as well as small group insurance include:

Prior to 2014

- Prohibits lifetime benefit limits
- Restricts annual benefit limits
- Restricts rescissions
- Extends dependent coverage to age 26
- Requires uniform explanation of plan benefits
- Requires coverage for preventive services with no cost-sharing (non-grandfathered self-insured plans)
- Requires internal and external appeals processes (non-grandfathered self-insured plans)
- Requires reporting of medical loss ratio and provision of rebates (grandfathered self-insured plans)

2014

- Prohibits excessive waiting periods
- Prohibits coverage exclusions for preexisting conditions
- Prohibits discrimination based on health factors and against medical providers (non-grandfathered self-insured plans)
- Limits out-of-pocket spending (non-grandfathered self-insured plans)
- Requires coverage for clinical trials for qualified individuals (non-grandfathered self-insured plans)

7 What's the difference between the exchange for individuals and SHOP for small businesses?

The law provides for a separate exchange for small businesses (Small Business Health Options Program, SHOP) and one for individuals. The small group market is defined as employers with 1–100 employees. However, a state may limit small group participation to employers with 50 or fewer workers from 2014 through 2016. Beginning in 2017, all employers with 100 or fewer employers may participate in the exchange. States may allow businesses with more than 100 employees to participate after 2017.

States can also choose to combine the individual and small business exchanges.

Will businesses be mandated to purchase within the Exchange?
Businesses are not mandated to purchase within the exchange. Employers though will need to provide written notice to employees regarding: (1) the existence of an exchange; (2) the employee's potential eligibility for a premium assistance tax credit and cost-sharing reduction if the benefits provided under the employer plan's share of total allowed costs is less than 60 percent; and (3) the potential loss of the employer contribution to any employer-sponsored health care plan if the employee purchases health insurance through the Exchange.

If so, are there penalties for non-compliance?
There was not a penalty identified in the Affordable Care Act if an employer does not provide written notice. It is likely this will be developed as the rules and regulations are developed by the U.S. Department of Health & Human Services.

If not, what choices will be available for businesses that prefer not to purchase within the exchange?
It is envisioned that a market would continue to exist outside of the exchange. Many of the insurance reforms apply to products sold inside and outside of the exchange.

How will an Exchange affect the insurance benefits currently offered by Colorado employers?
Unknown yet – the essential benefit package that is to be offered in the health insurance exchange has not been defined yet by the U.S. Department of Health & Human Services.

Will there be vouchers, and how will they work? Do they apply to small businesses?
An employer who offers and contributes to employee coverage must provide a free choice voucher to any employee who qualifies for the affordability exemption from the individual responsibility requirement and whose contribution under the employer plan would be between 8 and 9.5 percent of his or her adjusted gross income. The amount of the voucher must be equal to the contribution the employer would have made through its own plan. This is unlikely to affect more than a small percentage of employers.

Will Colorado employers be charged an assessment to cover the uninsured receiving subsidies within the exchange?
The subsidies available to low income Coloradans, those over 133% of poverty of poverty ($14,404 for a single adult or $29,327 for a family of four) and 400% of poverty ($43,320 for a single person and $88,200 for a family of four) are fully federally funded.

Will all Colorado insurance carriers be allowed to offer plans within the exchange?
All plans are required to be certified in order to be sold through the exchange. The certification requirements will be set by the U.S. Department of Health & Human Services prior to 2014. States may decide to have additional standards on plans sold through the exchanges.

What will be the governance and structure of the exchange?
The Affordable Care Act provides states with two governance options: a government agency or nonprofit. States also have the option of joining together to form regional Exchanges.

Will employers be allowed to keep the insurance coverage they currently purchase?
Group and individual coverage can be kept or "grandfathered" under reform (as long as the plan was in existence before reform was enacted in March 23, 2010).

Grandfathered plans will be required to meet some insurance reform conditions:
- Coverage must be extended to those up to age 27
- Waiting periods cannot exceed 90 days
- Lifetime limits on coverage must be eliminated
- No pre-existing condition exclusions are allowed for children
- Rescissions of coverage are not allowed
- Before 2014, only annual limits approved by the HHS secretary are allowed

If an employer makes any significant changes in coverage, the plan can no longer keep its grandfathered status including a change in insurance carriers, or increases cost sharing, copays, deductibles, or co-insurance.

Who is eligible for the business tax credit? How much is the tax credit?
Small employers that provide healthcare coverage are eligible if:
- They have fewer than 25 full-time equivalent employees (FTEs) for the tax year
- The average annual wages paid are less than $50,000 per FTE
- The employer pays at least 50% of the premium cost under a "qualified arrangement"

Credits are available on a sliding scale. Employers with ten or fewer employees and average wages of less than $25,000 are eligible for the full credit.

In 2010-2013, eligible small employers can receive a tax credit for up to 35 percent of their contribution to each employee's health insurance premium, and tax-exempt small businesses are eligible for a tax credit of up to 25 percent of their contribution.

How does the change in pre-existing condition exclusions affect the coverage I offer my employees?
Insurers and health plans are prohibited from denying coverage, excluding certain categories of coverage, or charging high premiums due to an individual's pre-existing conditions. These prohibitions generally become effective in 2014.

Will there be limits on what insurance companies can charge me or my employees?
Guaranteed issue—requiring insurers to take all applicants, including people with pre-existing conditions—will eventually apply to everyone. If you currently offer coverage there is no change now in how pre-existing conditions are handled. Beginning in 2014, qualified health plans will no longer be able to deny coverage or charge a different premium based on pre-existing conditions, health status or claims history.

What does the new law do to control costs?

The law attempts to control and stabilize costs in a variety of ways by expanding coverage to those previously uninsured to reduce cost-shifting; combining the purchasing power of small businesses and individuals through the exchanges; and investing in wellness initiatives.

The new law also encourages development of more efficient and cost-effective payment and delivery models for the long-term. This includes the creation of advisory boards to explore ways to lower healthcare costs; testing of different models of paying doctors and hospitals to reward patient outcomes, rather than number of visits and tests ordered; and research into the relative effectiveness of various treatments for specific conditions and illnesses.

Will there be malpractice reform under this new law?

The law establishes a demonstration grant program for states to develop, implement and evaluate alternatives to the current system. The new grants will help states and health care systems test models that: (1) put patient safety first and work to reduce preventable injuries; (2) foster better communication between doctors and their patients; (3) ensure that patients are compensated in a fair and timely manner for medical injuries, while also reducing the incidence of frivolous lawsuits; and (4) reduce liability premiums.

Does the law offer incentives to create or participate in wellness programs?

Wellness initiatives are encouraged—the Affordable Care Act provides for a 5-year, $200 million grant program to small employers who initiate wellness programs, and allows employers to vary cost-sharing based on employee participation in these programs.

Sources: Small Business Majority; Patton Boggs: Impact of Health Reform on Employers; The Commonwealth Fund: Realizing Health Reform's Potential; Congressional Research Service: Self-Insured Health Insurance Coverage.

Where to go for more information

Details on the health reform law are available at **colorado.gov/healthreform**.
Questions can be emailed to healthreform@state.co.us.

B 2010-006

EXECUTIVE ORDER

Creating the Position of Director of Health Reform Implementation and the Interagency Health Reform Implementing Board

Pursuant to the authority vested in the Office of the Governor of the State of Colorado, I, Bill Ritter, Jr., Governor of the State of Colorado, hereby issue this Executive Order creating the position of Director of Health Reform Implementation and the Interagency Health Reform Implementing Board.

I. Background and Purpose

The Patient Protection and Affordable Care Act, enacted by Congress and signed by the President, is now the law of the land. The federal law builds on Colorado's successes, allowing the state to continue leading the way and ensuring access to affordable health care to 500,000 Colorado residents who would otherwise lack health coverage. All Colorado residents and businesses will benefit from this new law through enhanced access to quality and affordable health care, insurance market reforms, and cost containment measures.

The successful operation of Colorado's health care system is essential to the state's economic well-being and the quality of life of its citizens. Thus, the State must demonstrate leadership to ensure successful implementation of national health reform, which will by its very nature cut across traditional lines of agency and department responsibility.

This Executive Order creates the Interagency Health Reform Implementing Board (the "Board"). The Director of Health Reform Implementation (the "Director") shall be responsible for the coordination of agencies in order to implement reform. The Board shall extensively engage stakeholders to assist in improving Colorado's healthcare system. The work of the Board will improve the health of Coloradans by integrating federal and state policy to create an efficient, high quality, and transparent health care system.

II. The Director of Health Reform Implementation

The Director shall be responsible for the coordination of and facilitation between agencies in order to implement health care reform in Colorado.

III. Mission and Scope of the Board

The mission of the Interagency Health Reform Implementing Board is to provide the governance, rules and regulation, and administrative infrastructure to facilitate planning and implementation of the Patient Protection and Affordable Care Act (the "Act") in Colorado. In support of this, the Interagency Health Reform Implementing Board shall:

A. Develop a strategic plan for implementation of the Act, building on Colorado's successful health reform efforts;

B. Coordinate agency efforts to implement, and monitor the Act;

C. Provide dedicated leadership and be accountable for implementation of state and federal health reform;

D. Extensive engagement of stakeholders to advise and assist in implementation of the Act;

E. Collaborate with appropriate federal agencies, state agencies, and stakeholders when necessary regarding the establishment of new rules, regulations, or mechanisms for the implementation of the Act;

F. Provide transparent access to information;

G. Launch and regularly update a new website that will provide Colorado residents with information about the Act, the phases of implementation, and how changes may benefit them;

H. Identify opportunities for collaboration within the State, as well as regionally and nationally;

I. Analyze the impact of the Act on state departments and agencies;

J. Recommend executive action or legislation to effectively implement the Act;

K. Report quarterly to the Governor on the status of implementation; and

L. Pursue federal and state grants to assist in implementing any aspects of the Act.

IV. Membership

A. The interagency oversight board shall consist of 11 voting members and be comprised as follows:

1. The Executive Director of the Department of Health Care Policy and Financing, who shall serve as the Chair of the Committee;

2. The Director of Health Reform Implementation;

3. The State's Chief Medical Officer. If there is no Chief Medical Officer, the Executive Director of the Department of Public Health and Environment;

4. The Executive Director of the Department of Human Services;

5. The Director of the Division of Human Resources in the Department of Personnel and Administration;

6. The Commissioner of Insurance in the Department of Regulatory Agencies;

7. The Executive Director of the Department of Revenue;

8. The Budget Director of the Governor's Office of State Planning and Budgeting;

9. The Director of the Office of Information Technology;

10. Chief Legal Counsel to the Governor; and

11. A representative of the Governor's Policy Office, appointed by and serving at the pleasure of the Governor.

B. The Board will establish an interagency workgroup to develop operational plans for executive branch agencies.

C. The Board may establish advisory groups, task forces, or other structures from within its membership or outside its membership as needed to address specific issues or to assist in its work. These groups may include representatives of non-governmental entities including, without limitation, doctors, nurses, economists, actuaries, health care professionals, patient

advocates, public health, consumer advocates, representatives from health plans and insurers, and businesses.

D. The Board shall meet regularly. The Board will direct other advisory groups, task forces or other structures established by the Board regarding meeting schedules, and will provide appropriate staffing and technical assistance and subject matter expertise.

V. Staffing and Resources

The Colorado Department of Health Care Policy and Financing shall provide the Director and the Board with necessary staff support and resources. The Director and the Board shall have the power to accept money and in-kind contributions from private entities and persons to the extent such donations are necessary to cover its expenses. Assuming necessary resources are secured, the Director may hire or contract any needed staff with specific health care expertise. Any money contributed to the Board shall be directed to the Office of the Governor and deposited with the Treasurer of the State of Colorado in an account within the Office of the Governor's budget or to the Department of Health Care Policy and Financing.

VI. Directives

A. The position of Director of Health Reform Implementation is hereby created

B. The Interagency Health Reform Implementing Board is hereby created.

VII. Duration

This Executive Order shall remain in force until modified or rescinded by future Executive Order of the Governor.

GIVEN under my hand and the Executive Seal of the State of Colorado this twentieth day of April, 2010.

Bill Ritter, Jr.
Governor

STATE OF COLORADO

OFFICE OF THE GOVERNOR
136 State Capitol Building
Denver, Colorado 80203
(303) 866 - 2471
(303) 866 - 2003 fax

Bill Ritter, Jr.
Governor

May 27, 2010

Secretary Kathleen Sebelius
United States Department of Health and Human Services
Washington, DC 20201

Re: Colorado's Intent with Respect to Implementing Section 1101 of the Patient Protection and Affordable Care Act

Dear Secretary Sebelius:

As indicated in my letter dated April 26, 2010, Colorado intends to submit an application through a designated entity that will enter into a contract with Health and Human Services (HHS) to operate an appropriate high risk pool.

This designated entity for the State of Colorado is Rocky Mountain Health Plan. We have evaluated that this entity can best meet the letter of the law while also ensuring no harm to the current high risk pool and the 11,000 individuals it currently covers.

We look forward to working with HHS closely on implementing this provision of the Patient Protection and Affordability Act.

Thank you for your Department's assistance and guidance.

Sincerely,

Bill Ritter, Jr.
Governor

BILL RITTER, JR.
GOVERNOR

136 STATE CAPITOL BUILDING
DENVER, COLORADO 80203
TEL 303-866-2471
FAX 303-866-2003

April 26, 2010

Secretary Kathleen Sebelius
United States Department of Health and Human Services
Washington, DC 20201

Re: Colorado's Intent with Respect to Implementing Section 1101 of the Patient Protection and Affordable Care Act

Dear Secretary Sebelius:

Thank you for your inquiry concerning Colorado's interest and intentions concerning the implementation of Section 1101 of the Patient Protection and Affordable Care Act. Colorado intends to move forward and explore the possibility of implementing a new federal high risk pool.

Accordingly, Colorado intends to submit an application through a designated entity that will enter into a contract with Health and Human Services (HHS) to operate an appropriate high risk pool. This designated entity may be CoverColorado, Colorado's existing high risk pool, or another appropriate non-profit. We will evaluate which entity can best meet the intent of the law while first ensuring no harm to the current high risk pool and the 11,000 individuals it currently covers.

Based on the minimum statutory requirements of the new risk pool, I anticipate that Colorado's designated entity would be able to establish an appropriate plan and begin operations by July 1, 2010.

This expectation is highly dependent on the final form of federal regulations and the assumption that the current statutory minimum requirements are a fair guide to the scope of the undertaking. It also depends on the determination that the expected federal allocation of $90 million to Colorado is sufficient to operate this new high risk pool our state.

We look forward to working with HHS closely on implementing this provision of the Patient Protection and Affordability Act.

Thank you in advance for your Department's assistance and guidance.

Sincerely,

Bill Ritter, Jr.
Governor

BILL RITTER, JR.
GOVERNOR

136 STATE CAPITOL BUILDING
DENVER, COLORADO 80203

TEL 303-866-2471
FAX 303-866-2003

September 23, 2010

The Honorable Kathleen Sebelius
The Secretary of Health and Human Services
Washington, DC 20201

Dear Secretary Sebelius,

I am writing to request that CMS consider an approach to the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration that will support its ability to successfully meet the goals of improved delivery system models, enhanced health outcomes, and better control of escalating healthcare costs. The best way to assure broad success of the demonstration is to include more than six states, and to build on the substantial capacity that has already been established by a multi-state collaborative committed to successful MAPCP programs.

With the MAPCP Demonstration becoming a reality and the Milbank Memorial Fund honoring our request for continued support, the states of Vermont, New Hampshire, Maine, Rhode Island, Massachusetts, Pennsylvania, Minnesota, and Colorado have worked together to initiate a framework for a true multi-state learning health system. Leaders in each of these states realize the opportunity offered by a structured and systematic approach to comparative assessment and shared learning, and each state has committed to common metrics, shared learning, and rapid-cycle, data-guided improvement of their respective MAPCP models.

While the participating states are employing different tactics and strategies, and vary in their stage of implementation, our MAPCP models are based on similar principles. This presents an ideal opportunity to identify the most effective strategies across different settings. As part of the MAPCP Demonstration, the collaborative states will commit to the following activities designed to support interactive shared learning:

1. Regular phone calls (monthly)
2. Attendance at regular multi-state learning collaborative meetings
3. Common core measures across states to support comparative assessment
4. Incorporating core measures (as possible) into the assessment of MAPCP programs
5. Sharing the results of core measures with participating states
6. Sharing the methods and strategies that are associated with the results
7. Sharing lessons learned, promising trends, and future directions
8. Technical assistance and support for other states in areas of strength
9. Transparency across states in order to develop the most effective models
10. An offer to CMS to be an active participant

11. An offer to other states in the MAPCP demo to be active participants
12. Establishing policies for data sharing and common informatics platforms
13. An evolution towards data sharing and common analytic and reporting platforms

This is a pivotal time for healthcare reform in the United States, and for CMS to show that it can lead the way with demonstrations that result in sustainable, substantial, and effective transformation. I respectfully encourage you to increase the target number of MAPCP Demonstration states and to consider the added value that our established multi-state collaborative provides for sustainable and generalizable reforms as a compelling case to do so.

Sincerely,

Bill Ritter Jr.

Governor Bill Ritter Jr.

STATE OF COLORADO

OFFICE OF THE GOVERNOR
136 State Capitol Building
Denver, Colorado 80203
(303) 866 - 2471
(303) 866 - 2003 fax

Bill Ritter, Jr.
Governor

August 25, 2010

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S. W.
Washington, D.C. 20201

Dear Secretary Sebelius:

Please accept this letter as an indication of my full support of Colorado's application and the proposed planning activities for the Colorado State Planning and Establishment Grant for the Affordable Care Act Exchanges and to designate my Office of Policy and Initiatives as the lead entity responsible for executing the implementation of the grant, if awarded.

Colorado has achieved significant progress on ensuring access to high quality, affordable health care for all Coloradans. These funds will help Colorado continue on the path by expanding and exploring models for an exchange at a state level. This will give the state the resources needed to assess the feasibility of moving forward with a state exchange.

My Office of Policy and Initiatives has the authority and leadership needed to oversee and coordinate the activities outlined in this project. Lorez Meinhold will be the project manager of this grant and can be contacted at 303.866.5856 or lorez.meinhold@state.co.us. I offer my support of this initiative of such consequence to the health of our state's residents.

Sincerely,

Bill Ritter, Jr.
Governor

2010 Health Care Reform Outreach and Education Detail.xls

Month	Event	Location	Attendance
March	Healthcare Day of Action	Denver	150
April	NCLS Magazine Interview	Denver	NA
April	The Denver Post Interview	Denver	NA
April	KNUS Radio interview	Parker	NA
April	Jefferson County Town Hall Meeting	Lakewood	65
April	The Colorado Trust Staff Meeting	Denver	6
April	University of Colorado Health Science Center	Denver	15
April	The Truth Radio interview	Denver	NA
April	State of the State Annual Meeting	Denver Tech Center	100
April	Greeley Town Hall Meeting	Greeley	50
April	KFKA Radio	Northern Colorado	NA
April	Radio FM107 Interview	Denver	NA
April	Professional Liability Underwriters Society	Denver	45
April	Golden Town Hall Meeting	Golden	30
April	Progressive 15	Holyoke	50
April	Healthcare Financial Management Association Meeting	Denver	150
April	High Risk Pool Stakeholder Meeting	Denver	40
April	Inner City Health Center Board of Directors Meeting	Denver	10
April	Mental Health Collaborative	Denver	50
April	Colorado Medical Society Physician's Congress	Denver	50
April	Fort Collins Town Hall Meeting	Fort Collins	50
April	Colorado Institute for Leadership Training	Fort Collins	40
April	Colorado Association of Health Underwriters Annual Conference	Denver	500
May	Colorado Association of School Based Health Care Conference	Centennial	75
May	Colorado Consumer Health Initiative Membership Meeting	Denver	25
May	The Colorado Health Foundation Staff Meeting	Denver	25
May	Colorado Senior Lobby Membership Meeting	Denver	30
May	Colorado Coalition for the Medically Underserved Annual Meeting	Denver	75
May	The Colorado Trust Board of Directors Meeting	Denver	15
May	Colorado Hospital Association Board of Directors Meeting	Englewood	20
May	Greenwood Village Chamber of Commerce Panel Discussion	Greenwood Village	160
May	Small Business Development Center Membership Meeting	Denver	90
May	Denver Chamber Health Committee Meeting	Denver	65
May	Peak Vista Community Health Centers	Colorado Springs	25
June	Colorado Public Radio Interview	Denver	NA
June	Colorado Counties, Inc. Summer Conference	Vail	250
June	Mountain States Employer Council Meeting	Denver	5
June	American Academy of Pediatrics Residents	Denver	20
June	Vistage International Panel Discussion	Denver	150
June	University of Colorado Cancer Center	Aurora	100
June	Colorado Safety Net Clinics	Denver	25
June	State Medical Services Board Meeting	Denver	20
June	MOP	Denver	25
June	Colorado Refugee Health Consortium	Denver	40
June	ClinicNet Board of Directors Meeting	Denver	25
June	Fremont County Site Visit	Canon City	50
June	CIVHC Community Meeting	Denver	30
June	SBIRT/Behavioral Health Conference	Denver	150
July	Colorado Rural Health Annual Conference	Breckenridge	150
July	Colorado News Service Radio interview	Denver	NA
July	Colorado Forum	Denver	30
July	ADAP Case Workers	Denver	20
July	March of Dimes	Denver	4
July	North Forty News Interview	Loveland	NA
July	Colorado Commission on Aging	Denver	15
July	Frisco Senior and Community Center	Frisco	50
July	Weekly Health Reform Roundtable	Denver	30
July	Brokers	Colorado Springs	6
July	Northern Colorado Business Report Panel Discussion	Fort Collins/ Loveland	100
July	Exchange Public Forum	Denver	140
July	Weekly Health Reform Roundtable	Denver	30
July	Safety Net Meeting	Denver	20
July	Colorado Health Symposium panel Discussion	Keystone	80
August	Alliance for Health Reform DC Staffer Briefing with CSPAN coverage	Washington, DC	250
August	Chamber of Commerce Health Care Leaders Meeting	Denver	50
August	Consumer Assistance Grant Stakeholder Meeting	Denver	50
August	Swedish GME Resident Program	Denver	20
August	CCHN Board Meeting	Denver	20
August	Innovations in Mental Health Meeting	Denver	200
August	Colorado Association of Family Physicians	Aurora	25
August	House District 4 Denver Dems	Denver	40
August	Case Management Society of America	Denver	40
August	The Healthy Colorado Youth Alliance/Colorado Youth Matter	Denver	10
August	Centura Health Policy Committee Meeting	Denver	25
August	Business and Industry Council Meeting	Denver	10

2010 Health Care Reform Outreach and Education Detail.xls

August	Exchange Public Forum	Denver	150
August	Weekly Health Reform Roundtable	Denver	15
August	Mountain States Employer Council Panel Discussion	Denver	50
August	Mountain States Employer Council Panel Discussion	Colorado Springs	20
August	Mountain States Employer Council Panel Discussion	Fort Collins	35
August	National Meeting of the Academy for Health Equity Panel Discussion	Denver	100
August	Colorado Providers Association	Denver	60
August	Colorado Behavioral Healthcare Council	Denver	50
August	Weekly Health Reform Roundtable	Denver	15
August	Arvada and Westminster Town Hall Meeting	Arvada	20
August	Mountain States Employer Council Panel Discussion	Glenwood Springs	20
August	Greeley League of Women Voters Community Meeting	Greeley	40
August	Weekly Health Reform Roundtable	Denver	15
August	Exchange Public Forum	Arvada	200
August	Legislative Briefing - Majority	Denver	20
September	Weekly Health Reform Roundtable	Denver	15
September	American Academy of Pediatrics - Policy Committee Meeting	Aurora	15
September	Colorado Hospital Association Policy Committee Meeting	Englewood	20
September	Alliance for Retired People	Denver	40
September	Colorado Multi-Ethnic Cultural Consortium (CMECC)	Denver	20
September	Rep. DeGette Panel Discussion on Health Care Reform	Denver	35
September	Weekly Health Reform Roundtable	Denver	10
September	Public Health in the Rockies Conference	Denver	250
September	Health Care for All Monthly Meeting	Denver	40
September	Exchange Public Forum	Denver	150
September	Boulder Chamber of Commerce	Denver	30
September	CMS National Eligibility Annual Conference	Denver	250
September	Colorado Organization of Nurse Leaders Annual Conference	Keystone	200
September	Town Hall Meeting	Aurora	40
September	Caring for Colorado Board of Directors Meeting	Denver	15
September	University of Colorado	Denver	75
September	Rose Board Retreat on Health Care Reform	Denver	30
September	Fall 2010 State of the State of Health Care	Colorado Springs	40
September	Safety Net Meeting	Denver	15
September	Colorado Healthcare Financial Management Association Fall Meeting	Glenwood Springs	50
September	League of Women Voters Fall Meeting	Denver	140
September	Exchange Public Forum	Denver	150
September	FRHAU Education Day	Denver	40
October	Fall 2010 State of the State of Health Care	Denver	150
October	Denver Chamber of Commerce Health Care Committee Meeting	Denver	50
October	9th Culture of Data Conference	Denver	100
October	Leeds School of Business Leadership Program	Denver	30
October	Exchange Public Forum	Alamosa	20
October	Denver Early Childhood Commission	Denver	30
October	Bringing Health Home Learning Collaborative Fall Meeting	Denver	50
October	Brain Injury Association of Colorado Annual Conference	Colorado Springs	250
October	CO Culture of Health Conference	Denver	300
October	Vectra Bank	Denver	80
October	ASTHO	Colorado Springs	150
October	Exchange Public Forum	Grand Junction	35
October	ARC Colorado DD Summit	Denver	150
October	CDPHE	Denver	130
October	Exchange Public Forum	Colorado Springs	50
October	DU Psychology Club	Denver	40
October	Ft Collins Business Group	Fort Collins	40
October	Exchange Public Forum	Greeley	50
October	Broker Briefing	Statewide	300
November	DHS Division Directors	Denver	10
November	Planned Parenthood Board and Staff Meeting	Denver	15
November	Colorado Gerontological Society	Denver	40
November	HCPF	Denver	50
November	University of Colorado	Aurora	20
November	Children's Hospital	Aurora	50
November	CEOs of Non-profit Health Insurers	Denver	35
November	Arapahoe Community College	Littleton	50
November	APHA National Conference	Denver	60
November	Bioscience Association	Denver	20
November	Boulder Tomorrow	Boulder	20
November	Health Care for All	Fort Collins	75
November	Tele-town Hall for Businesses on Health Care Reform	Statewide	60
November	Statewide Independent Living Council	Fort Morgan	20
November	Economic Development Council of Colorado	Denver	TBD
December	Greater Colorado Springs Chamber of Commerce Annual Healthcare Summit	Colorado Springs	TBD
December	Aurora Health Reform	Aurora	TBD
December	The Colorado Health Foundation	Denver	TBD
December	2040 Partners for Health	Denver	TBD

Draft: 11/1/10
A new model

AMERICAN HEALTH BENEFIT EXCHANGE MODEL ACT

Table of Contents

Section 1. Title

This Act shall be known and may be cited as the American Health Benefit Exchange Act.

Section 2. Purpose and Intent

The purpose of this Act is to provide for the establishment of an American Health Benefit Exchange to facilitate the purchase and sale of qualified health plans in the individual market in this State and to provide for the establishment of a Small Business Health Options Program (SHOP Exchange) to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans offered in the small group market.

Drafting Note: States expanding the definition of "qualified employer" to include large employers, as permitted beginning in 2017 under the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (Federal Act), should remove the reference to "small" employers.

Section 3. Definitions

For purposes of this Act:

A. "Commissioner" means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

B. "Educated health care consumer" means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical and scientific matters.

C. "Exchange" means the [insert name of State Exchange] established pursuant to section 4 of this Act.

D. "Federal Act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under, those Acts.

E. (1) "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

Drafting Note: The Federal Act uses the terms "health plan" and "health insurance coverage." "Health benefit plan," as defined above, is intended to be consistent with the definition of "health insurance coverage" contained in Title XVIII of the Public Health Service Act, as enacted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and amended by the Federal Act.

(2) "Health benefit plan" does not include:

(a) Coverage only for accident, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics; or

(h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

(3) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(4) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(a) Coverage only for a specified disease or illness; or

(b) Hospital indemnity or other fixed indemnity insurance.

(5) "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

(c) Similar supplemental coverage provided to coverage under a group health plan.

F. "Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

G. "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with section 7D of this Act.

H. "Qualified employer" means a small employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the SHOP Exchange, and at the option of the employer, some or all of its part-time employees, provided that the employer:

(1) Has its principal place of business in this State and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed; or

(2) Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in this State.

Drafting Note: Beginning in 2017, the Federal Act permits States to expand eligibility for Exchange participation beyond small employers. States that do so should amend subsection H accordingly.

I. "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and section 7 of this Act.

J. "Qualified individual" means an individual, including a minor, who:

(1) Is seeking to enroll in a qualified health plan offered to individuals through the Exchange;

(2) Resides in this State;

(3) At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

(4) Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

K. "Secretary" means the Secretary of the federal Department of Health and Human Services.

L. "SHOP Exchange" means the Small Business Health Options Program established under section 6 of this Act.

M. (1) "Small employer" means an employer that employed an average of not more than 100 employees during the preceding calendar year.

Drafting Note: The Federal Act permits States to define "small employers" as employers with one to 50 employees for plan years beginning before Jan. 1, 2016.

(2) For purposes of this subsection:

(a) All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as a single employer;

(b) An employer and any predecessor employer shall be treated as a single employer;

(c) All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer;

Drafting Note: This issue is discussed in HHS Bulletin 99-03 (Group Size Issues Under Title XXVII of the Public Health Service Act).

(d) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that is reasonably expected that employer will employ on business days in the current calendar year; and

(e) An employer that makes enrollment in qualified health plans available to its employees through the SHOP Exchange, and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of this Act as long as it continuously makes enrollment through the SHOP Exchange available to its employees.

Section 4. Establishment of Exchange

A. The [insert official title of the Exchange] is hereby established as a [insert description and governance provisions here, either establishing the Exchange as a governmental agency or establishing the Exchange as a nonprofit entity].

Drafting Note: States have different options to consider when establishing the Exchange. This Act does not include any specific option for governance. Section 1311(d) of the Federal Act, requires that any Exchange established must be a governmental agency or nonprofit entity. As such, the Exchange could be located at a new or existing State agency. Some possible advantages to having the Exchange within a State agency include having a direct link to the State administration and a more direct ability to coordinate with other key State agencies, such as the State Medicaid agency and the State insurance department. Some possible disadvantages include the risk of the Exchange's decision-making and operations being politicized and the possible difficulty for the Exchange to be nimble in hiring and contracting practices, given most States' personnel and procurement rules. The Exchange could also be established as an independent public agency, or a quasi-governmental agency, with an appointed board or commission responsible for decision-making and day-to-day operations. Some possible advantages to establishing the Exchange as an independent public agency, or a quasi-governmental agency, include possible exemption from State personnel and procurement laws and more independence from existing State agencies, which could result in less of a possibility of the Exchange being politicized. The Exchange's enabling legislation would specify how the Board members would be appointed, including its size, composition and terms. The Board would also select the Exchange's Executive Director. Some possible disadvantages include the possible difficulty for the Exchange to coordinate health care purchasing strategies and initiatives with key State agencies, such as the State Medicaid agency and the State insurance department and their employees because the Exchange would not be located at a State agency (unless those decisions are subject to the approval of a State official, such as the State insurance commissioner or the Governor). The Exchange also could be established by creating a non-profit entity. This means that most likely it would not be directly accountable to State government or subject to State government oversight nor would it most likely be subject to State personnel and procurement laws. Some possible advantages of establishing the Exchange as a non-profit include flexibility in decision making and less of a chance for those decisions being politicized and some possible disadvantages include isolation from State policymakers and key State agency staff and the potential for decreased public accountability. In addition, States can establish an Exchange using a combination of the options described above. The NAIC, through the Exchanges (B) Subgroup, intends to review the options for governance above and others related to establishing Exchanges and develop an issues paper on the topic to assist States in this area.

Drafting Note: States should be aware that section 1311(f) of the Federal Act permits States, with the approval of the Secretary of the federal Department of Health and Human Services, to establish regional or interstate Exchanges. This Act does not specify how to establish these Exchanges or how they would operate. The NAIC, through the Exchanges (B) Subgroup, intends to review those issues and others related to establishing regional or interstate exchanges and develop an

issues paper on the topic to assist those states that wish to establish such exchanges. States participating in interstate Exchanges or establishing regional Exchanges should modify the relevant portions of this Act accordingly.

Drafting Note: Depending on how a State establishes its Exchange, a State may need to consider whether the Exchange should be exempt from the State's insurance producer or consultant licensing requirements or whether the Exchange or its employees need to obtain such a license.

B. The Exchange shall:

(1) Facilitate the purchase and sale of qualified health plans;

(2) Provide for the establishment of a SHOP Exchange to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans; and

(3) Meet the requirements of this Act and any regulations implemented under this Act.

C. The Exchange may contract with an eligible entity for any of its functions described in this Act. An eligible entity includes, but is not limited to, the [insert name of State Medicaid agency] or an entity that has experience in individual and small group health insurance, but a health carrier or an affiliate of a health carrier is not an eligible entity.

Drafting Note: States should be aware that when establishing the Exchange they will have to include additional sections in this Act that set out the appointment process, powers, duties and other responsibilities of any board, committee or other entity that will have day-to-day responsibility for carrying out the duties and responsibilities of the Exchange, as provided in this Act.

D. The Exchange may enter into information-sharing agreements with federal and State agencies and other State Exchanges to carry out its responsibilities under this Act provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all State and federal laws and regulations.

Section 5. General Requirements

A. The Exchange shall make qualified health plans available to qualified individuals and qualified employers beginning on or before January 1, 2014.

B. (1) The Exchange shall not make available any health benefit plan that is not a qualified health plan.

(2) The Exchange shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the Exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Federal Act.

C. Neither the Exchange nor a carrier offering health benefit plans through the Exchange may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

Drafting Note: States should be aware that in addition to the general requirements of the Exchange provided in this section, section 1311(d)(3) of the Federal Act states that the Exchange may make available a qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 1302(b) of the Federal Act. Section 1311(d)(3) of the Federal Act states also that a State may require a qualified health benefit plan offered in the State to offer benefits in addition to the essential health benefits specified under section 1302 of the Federal Act. However, if a State chooses this option, it must defray the additional costs of premium and cost-sharing assistance to an individual enrolled in a qualified health plan.

Section 6. Duties of Exchange

Drafting Note: The provisions in this section are the minimum requirements of the Federal Act. States are encouraged to consider assigning additional duties, consistent with the Federal Act, to the extent appropriate to the State's market conditions and policy goals.

The Exchange shall:

A. Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the Secretary under section 1311(c) of the Federal Act and section 7 of this Act, of health benefit plans as qualified health plans;

B. Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

C. Provide for enrollment periods, as provided under section 1311(c)(6) of the Federal Act;

D. Maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

E. Assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria developed by the Secretary under section 1311(c)(3) of the Federal Act, and determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under section 1302(d)(2)(A) of the Federal Act;

F. Use a standardized format for presenting health benefit options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the PHSA;

G. In accordance with section 1413 of the Federal Act, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that any individual is eligible for any such program, enroll that individual in that program;

H. Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the Federal Act;

I. Establish a SHOP Exchange through which qualified employers may access coverage for their employees, which shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP Exchange at the specified level of coverage;

Drafting Note: States may elect to operate a unified Exchange by merging the SHOP Exchange and the Exchange for individual coverage, but only if the Exchange has adequate resources to assist these individuals and employers.

J. Subject to section 1411 of the Federal Act, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because:

(1) There is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or

(2) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

K. Transfer to the federal Secretary of the Treasury the following:

(1) A list of the individuals who are issued a certification under subsection J, including the name and taxpayer identification number of each individual;

(2) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because:

(a) The employer did not provide minimum essential coverage; or

(b) The employer provided the minimum essential coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(3) The name and taxpayer identification number of:

(a) Each individual who notifies the Exchange under section 1411(b)(4) of the Federal Act that he or she has changed employers; and

(b) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

L. Provide to each employer the name of each employee of the employer described in subsection K(2) who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

M. Perform duties required of the Exchange by the Secretary or the Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing or individual responsibility requirement exemptions;

N. Select entities qualified to serve as Navigators in accordance with section 1311(i) of the Federal Act and award grants to enable Navigators to:

(1) Conduct public education activities to raise awareness of the availability of qualified health plans;

(2) Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Federal Act;

(3) Facilitate enrollment in qualified health plans;

(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act (PHSA), or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint or question regarding their health benefit plan, coverage or a determination under that plan or coverage; and

(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange;

O. Review the rate of premium growth within the Exchange and outside the Exchange, and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers;

P. Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the Federal Act, and collect the amount credited from the offering employer;

Q. Consult with stakeholders relevant to carrying out the activities required under this Act, including:

(1) Educated health care consumers who are enrollees in qualified health plans;

(2) Individuals and entities with experience in facilitating enrollment in qualified health plans;

(3) Representatives of small businesses and self-employed individuals;

(4) The [insert name of State Medicaid office]; and

(5) Advocates for enrolling hard to reach populations; and

R. Meet the following financial integrity requirements:

(1) Keep an accurate accounting of all activities, receipts and expenditures and annually submit to the Secretary, the Governor, the commissioner and the Legislature a report concerning such accountings;

(2) Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Federal Act and allow the Secretary, in coordination with the Inspector General of the U.S. Department of Health and Human Services, to:

(a) Investigate the affairs of the Exchange;

(b) Examine the properties and records of the Exchange; and

(c) Require periodic reports in relation to the activities undertaken by the Exchange; and

(3) In carrying out its activities under this Act, not use any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or State legislative and regulatory modifications.

Drafting Note: States should consider revising the language above to ensure that the commissioner, consistent with the provisions of the State insurance code and regulations, is given specific authority to investigate the affairs of the Exchange, examine the properties and records of the Exchange and require the Exchange to provide periodic reporting to the commissioner in relation to the activities undertaken by the Exchange under this Act, as may be appropriate given the structure and governance of the Exchange.

Section7. Health Benefit Plan Certification

A. The Exchange may certify a health benefit plan as a qualified health plan if:

(1) The plan provides the essential health benefits package described in section 1302(a) of the Federal Act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as provided in subsection D, if:

(a) The Exchange has determined that an adequate choice of qualified dental plans is available to supplement the plan's coverage; and

(b) The carrier makes prominent disclosure at the time it offers the plan, in a form approved by the Exchange, that the plan does not provide the full range of essential pediatric benefits, and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the Exchange;

(2) The premium rates and contract language have been approved by the commissioner;

Drafting Note: States should modify the language in paragraph (2) above for consistency with their State law and regulations governing rate and form review and approval.

(3) The plan provides at least a bronze level of coverage, as determined pursuant to section 6E of this Act unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

(4) The plan's cost-sharing requirements do not exceed the limits established under section 1302(c)(1) of the Federal Act, and if the plan is offered through the SHOP Exchange, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the Federal Act;

(5) The health carrier offering the plan:

(a) Is licensed and in good standing to offer health insurance coverage in this State;

(b) Offers at least one qualified health plan in the silver level and at least one plan in the gold level through each component of the Exchange in which the carrier participates, where "component" refers to the SHOP Exchange and the Exchange for individual coverage;

(c) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the Exchange and without regard to whether the plan is offered directly from the carrier or through an insurance producer;

Drafting Note: States whose licensing laws do not use the term "producer" should substitute the appropriate terminology.

(d) Does not charge any cancellation fees or penalties in violation of section 5C of this Act; and

(e) Complies with the regulations developed by the Secretary under section 1311(d) of the Federal Act and such other requirements as the Exchange may establish;

(6) The plan meets the requirements of certification as promulgated by regulation by the Secretary under section 1311(c)(1) of the Federal Act and by the Exchange pursuant to section 9 of this Act; and

Drafting Note: Section 1311(c)(1) of the Federal Act provides minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage, and information on quality measures for health plan performance.

(7) The Exchange determines that making the plan available through the Exchange is in the interest of qualified individuals and qualified employers in this State.

Drafting Note: States should consider whether the Exchange should delegate all or part of plan certification function to the commissioner pursuant to the commissioner's rate and form review responsibilities.

B. The Exchange shall not exclude a health benefit plan:

(1) On the basis that the plan is a fee-for-service plan;

(2) Through the imposition of premium price controls by the Exchange; or

(3) On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

C. The Exchange shall require each health carrier seeking certification of a plan as a qualified health plan to:

(1) Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its Internet website. The Exchange shall take this information, along with the information and the recommendations provided to the Exchange by the commissioner under section 2794(b) of the PHSA, into consideration when determining whether to allow the carrier to make plans available through the Exchange;

Drafting Note: States with additional rate filing requirements should review the language in paragraph (1) above to ensure that it does not conflict with other applicable State law.

(2) (a) Make available to the public, in the format described in subparagraph (b) of this paragraph, and submit to the Exchange, the Secretary, and the commissioner, accurate and timely disclosure of the following:

(i) Claims payment policies and practices;

(ii) Periodic financial disclosures;

(iii) Data on enrollment;

(iv) Data on disenrollment;

(v) Data on the number of claims that are denied;

(vi) Data on rating practices;

(vii) Information on cost-sharing and payments with respect to any out-of-network coverage;

(viii) Information on enrollee and participant rights under title I of the Federal Act; and

(ix) Other information as determined appropriate by the Secretary; and

(b) The information required in subparagraph (a) of this paragraph shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act; and

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet website and through other means for individuals without access to the Internet.

D. (1) The provisions of this Act that are applicable to qualified health plans shall also apply to the extent relevant to qualified dental plans except as modified in accordance with the provisions of paragraphs (2), (3) and (4) of this subsection or by regulations adopted by the Exchange;

(2) The health carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits;

(3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage, and shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary pursuant to section 1302(b)(1)(J) of the Federal Act, and such other minimum dental benefits as the Exchange or the Secretary may specify by regulation; and

(4) A health carrier and a dental carrier may jointly offer a comprehensive plan through the Exchange in which the dental benefits are provided by the dental carrier and the other benefits are provided by the health carrier.

Section 8. Funding; Publication of Costs

A. The Exchange may charge assessments or user fees to health carriers or otherwise may generate funding necessary to support its operations provided under this Act.

Drafting Note: As provided in section 1311(d)(5)(A) of the Federal Act, in establishing an Exchange under this Act, the State must ensure that the Exchange is self-sustaining by January 1, 2015.

B. The Exchange shall publish the average costs of licensing, regulatory fees and any other payments required by the Exchange, and the administrative costs of the Exchange, on an Internet website to educate consumers on such costs. This information shall include information on monies lost to waste, fraud and abuse.

Section 9. Regulations

The Exchange may promulgate regulations to implement the provisions of this Act. Regulations promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary under title I, subtitle D of the Federal Act.

Drafting Note: States that do not establish the Exchange in a governmental agency with rulemaking authority should substitute the agency responsible for the administration or oversight of the Exchange. As appropriate, the commissioner should be granted rulemaking authority to promulgate regulations to implement the provisions of this Act within the scope of the commissioner's authority, as provided under State law or regulations.

Section 10. Relation to Other Laws

Nothing in this Act, and no action taken by the Exchange pursuant to this Act, shall be construed to preempt or supersede the authority of the commissioner to regulate the business of insurance within this State. Except as expressly provided to the contrary in this Act, all health carriers offering qualified health plans in this State shall comply fully with all applicable health insurance laws of this State and regulations adopted and orders issued by the commissioner.

Section 11. Effective Date

This Act shall be effective [insert date].

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Responses to OCIIO provisions regarding the Exchange in ACA

Jay Angoff, Director
Office of Consumer Information and Insurance Oversight
Department of Health and Human Services

Re: Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act
File code OCIIO–9989–NC

P.45587
B. Implementation Timeframes and Considerations
2. What kinds of guidance or information would be helpful to States?

The details of eligibility requirements, definition of MAGI, and decisions on aligning eligibility administrative requirements between Medicaid and the exchange are essential. If states are to modify or build new systems that have to be ready for testing July 2013 (in order to be ready to go live January 2014), we need some of the policy requirements before the end of 2010 in order to develop business requirements, estimate costs, hire developers and vendors, etc. For instance, it appears that the exchange will use tax records (historic income information) to determine eligibility for subsides where Medicaid uses pay stubs, or self declaration with verification (real-time income information). It would be best to use one or the other, and to also align these requirements with other social services programs that families apply for including SNAP.

The easiest way to verify relevant data is electronically, where state agencies agree to give one another access to various databases. Some of these data are federal, or at least governed by federal requirements that make it difficult for state entities to share information. HHS should work with their sister agencies to ensure that relevant data can be shared even when those data are housed or controlled by other departments such as Agriculture or the IRS.

P.45587
C. State Exchange Operations
3. What kinds of systems are stakes likely to need…
Many states are working with decade-old systems that if it were not for the current economic crisis, states would be looking to upgrades or modernization of the systems. We encourage HHS to consider the efficiencies of building one eligibility system for the newly eligible (Medicaid and exchange) where states could then build portals and access the rules engines, data bases, etc. With the national policy for Medicaid eligibility being standardized after 2014 (raising the floor for the entire country), and the administrative requirements being the same for the entire country, the need for 50 different systems and processes is lessened dramatically. States would still need to manage eligibility for other categories of clients, but over time perhaps those systems could be consolidated as well. It would not make sense for a state that has recently build/bought a new system to be forced to change, but for states with old systems, or states that are going to re-procure a

system in the near future, having a system to "buy into" vs building from scratch makes sense.

Although the systems and IT issues are the most pressing and need planning to begin immediately, states welcome guidance on the criteria HHS will be using to certify benchmark benefits packages as soon as possible. As states begin stakeholder and consumer input processes, this is the area consumers are most concerned about. In stakeholder meetings in Colorado we repeatedly hear that choice of products is important, but the choice must be meaningful. In other words, consumers need to know and understand the value of what they will be buying, and understand clearly the amount, duration and scope of benefits they will receive with each product in order to make the right choice for their family and their healthcare needs. Too many choices are likely to confuse people; too few choices will not make purchasing through the exchange an attractive option. Knowing what HHS is thinking about a set of benchmark packages would make early conversations with consumers, and state policy development and rule-making more effective and consistent with the intent of the legislation.

P.45587-88
D. Qualified Health Plans
2. What are some of the major considerations involved in certifying QHPs under the Exchanges, and how do those considerations differ in the context of individual and SHOP State Exchanges, subsidiary Exchanges, regional or interstate exchanges,…

A qualified plan is a qualified plan; the mechanism or governance structure that markets and sells the plan should not matter. However consumers are buying their plan or whatever the subsidies they received, they should be able to clearly understand what they are choosing and buying in terms of benefits and total out-of-pocket responsibilities.

The factors that should be used to develop certification criteria should be standard, national quality indicators already familiar to the insurance industry, health plans, and safety net providers. Use of information technology towards meaningful use should be factored in the criteria.

Plans should also use standard, agreed-upon criteria to ensure that consumers have a sufficient choice of providers and that all health professionals should be allowed full scope-of-practice based on their academic training, certification, and licensure. Plans should be recognized and rated based on the use of efficient and effective service delivery models that offer geographic and market-driven flexibility to states and other purchasers. In other words, plans can be risk-based capitated models, or they can work off of an accountable care/medical home structure with quality and cost measures that reward providers for reaching pre-determined outcomes. Plans should be required to include traditional safety net providers in their networks.

5. What factors are important in establishing minimum requirements for the actuarial value/level of coverage?

Responses to OCIIO provisions regarding the Exchange in ACA

There are a number of important aspects of benefit design that will affect the care delivered and the costs to the system. The federal government should consider a benefit design or give states the flexibility to incorporate evidence-based benefits, consumer incentives for value-based purchasing, and other benefit features that promote appropriate utilization and high quality care.

States should have input on the essential benefit package content, and how additional benefits will be addressed. Decisions will have fiscal implications, as states will be responsible for costs related to any additional mandated benefits beyond the essential package. It would be important for states to be able to weigh in on the process for adding state mandated benefits to the essential package.

P.45588
G. Enrollment and Eligibility
3. How can eligibility and enrollment be effectively coordinated between Medicaid, CHIP, and Exchanges? How could eligibility systems be designed or adapted to accomplish this? What steps can be taken to ease consumer navigation between the programs and ease administrative burden? What are the key considerations related to States using Exchange or Medicaid/CHIP application information to determine eligibility for all three programs?

The Exchange should be structured to maximize continuity of coverage and seamlessness between public and private health coverage Efforts should be made to maximize continuity of coverage for consumers to enable consumers to stay with their health plan of choice over time and ensure easy transitions for consumers moving between public coverage and subsidized private coverage sold through the Exchange. The Exchange should be designed to manage statistically predictable transitions of populations groups, especially consumers who may transition between public health insurance coverage through Medicaid and CHP+ and subsidized private coverage available through the Exchange.

P.45589
L. Risk Adjustment, Reinsurance, and Risk Corridors
3. What issues are States likely to consider in carrying out risk adjustment for health plans inside and outside of the Exchanges? What kinds of technical assistance might be useful to States and QHPs?

A successful Exchange should maximize participation and minimize adverse selection of risk into Exchange based products. The exchanges must be protected against adverse selection. If only sick or high-risk individuals enroll in the plans offered, coverage will become expensive for participants and unattractive to insurers. A number of provisions of the Affordable Care Act seek to level the playing field inside and outside of the exchange, but states can further enhance protections against adverse selection. Examples of this are having defined open-enrollment periods or the same required compensation for brokers inside and outside the exchange. Another potential for adverse selection that deserves mentions has to do with the producers. States and HHS must be aware that financial incentives can be created for producers that will results in adverse selection. It is

important that whatever commissions or producer compensation that is developed be structured in a way to maintain the level playing field inside and outside the exchange as well as among carriers within the exchange.

Thanks for your consideration of these issues,

Lorez Meinhold
Director of Health Reform Implementation

Joan Henneberry
Chair of the Interagency Health Reform Implementation Board

Comment Tracking Number: 80b6427f

Dora Division of Insurance
Department of Regulatory Agencies

Frequently Asked Questions on
Rate Filing, Rate Reviews and Approval of Health Insurance Rates in Colorado

Frequently Asked Questions

As the cost of health care continues to rise, many insurance companies are raising premium rates. The Division of Insurance reviews health insurance rates for individual, small group, and large group coverage before these rates can take effect in Colorado. Most health rate increases are prior approval, which means the rates have to be approved before an insurance company can use them.

Below are frequently asked questions about how health insurance rates are set as well as some new initiatives to strengthen the rate review process and make it more transparent.

How do Colorado's health insurance rates compare to other states?

Premium rates are going up across the country. In 2009, Colorado ranked 26th among states in the annual amount paid by a family for health insurance premiums involving employers of all sizes, according to the federal government's Medical Expenditure Panel Survey (MEPS). That means families in 25 states paid higher average premiums than in Colorado.

The average annual premium for a Colorado family getting coverage through an employer was $13,360 in 2009, compared to $9,522 five years earlier. The average annual premium for a single employee was $4,570 in 2008, compared to $3,645 five years earlier.

Unlike some states where consumers have few options, Colorado has a competitive health insurance market. There are currently 392 companies that sell one or more of the different types of health insurance coverage, so Colorado consumers have many choices of companies and plans. The top ten carriers account for about 72.3 percent of the market.

Colorado also has a number of protections for consumers who buy individual insurance plans. Individual health benefit plans, as defined in Colorado law, also are "guaranteed renewable," meaning these types of policies cannot be cancelled due to the health condition or claims of the person insured. However, premium rates for the whole market continue to rise as the cost of medical services goes up.

What is Colorado doing to make health insurance more affordable?

Because health care costs drive insurance rates, health care costs affect any effort to improve affordability and accessibility of insurance. The changes to the rate review process are part of a larger effort by Colorado to address the rising cost of health care.

House Bill 08-1389 (which became law in 2008) includes many other steps to lay the foundation for meaningful health reform in Colorado, including giving consumers the tools to make better health care decisions and requiring transparency and accountability of health care dollars. Major changes to health care are occurring at the federal level. National health reform is intended to have a significant impact on how health insurance is structured in Colorado and other states.
As part of Federal Patient Protection and Affordable Care Act (ACA), the Federal Health Care Reform effort has also provided a $1 million grant to Colorado to enhance the premium rate review process and consumer education and outreach. Link to News Release. This will allow the Division to make the rate review process more transparent and accessible for consumers.

How does the Division of Insurance decide whether to approve a requested rate increase?

When a carrier requests a rate increase, the Division looks at many factors, including the cost of medical care and prescription drugs, the company's past history of rate changes, the financial strength of the company, actual and projected claims, premiums, administrative costs, and profit. The Division approves the request if the carrier can show that the new rate is reasonable in relation to the benefits provided. If the carrier's data does not fully support the increase, the Division can ask for more information, approve a smaller increase, or reject an increase.

In 2008, House Bill 1389 strengthened the Division's rate review process to help better protect consumers. The law, effective July 2008, does the following:

- Makes health insurance rate increases prior approval (dental rates have to exceed a 5% rate increase to require prior approval).
- Provides a penalty to a person or organization, who knowingly withholds information concerning rates or premiums or gives false or misleading information to the Commissioner or any statistical agent, advisory organization, or carrier.
- Allows the Division to consider an insurance company's overall finances, including profits, investment income, and surplus, when reviewing a proposed rate.

Why do rates continue to increase in double digits?

Rates are driven by medical spending, which is growing because of many factors including increased use of health care services, new technologies, prescription drugs, an aging population, and unhealthy lifestyles. Rate changes can vary depending on a company's financial situation and whether its existing premiums cover its projected claims and administrative costs.

Are Colorado health insurance companies profitable?

Most of Colorado's large insurers are for-profit organizations. During a five-year period ending in 2008, the average net income for the ten largest health insurers in Colorado was 4.6 percent. The “income” is the remainder after the company has paid its expenses and covered losses. It can be used as profit, for financial reserves, to expand services, or to build surplus.

I read that companies must submit their rates for review by the Division of Insurance, but what does that mean?

All health rate filings must be submitted electronically to the Division of Insurance.

The rate filing will include a Colorado HR1 form and actuarial memorandum.

The Colorado HR1 form includes information on:

- The product involved;
- Number of consumers impacted by rate changes;
- Average increase or decrease;
- Minimum/Maximum increase or decrease;
- Number of years of experience used; and
- Source of experience (Colorado, nationwide)

The actuarial memorandum must include the following:

- Summary of the reasons for making the rate filing;
- The period for which rates will be effective;
- Description of the underwriting used;
- Effect of any changes in state or federal law;
- Recent history of rate changes for the product;
- Support for the relationship between claims paid and premiums collected;
- Provision for the amount of profit;
- Complete explanation of how the proposed rates were determined;
- Trend assumptions;
- Company experience (premiums collected and claims paid) for at least the last 3 years;
- Discussion of the credibility of the company’s experience;
- Side-by-side comparison of all proposed rate changes; and
- Projections of premiums and losses.

The rest of the filing, which can average about 60 pages, must provide the data to support the rate change, detail the company’s experience (such as premiums collected vs. claims they paid in previous years) and expenses.

Do companies have to submit a rate filing every year?

They must file rates if there is going to be a change in premium rates, whether rates are going up or down. The only products that require an annual rate filing are Medicare supplement insurance and small group health benefit rates. Additionally, companies must file at least on an annual basis, justification for the continued use of rating factors that change on a predetermined basis, such as trend.

Why do insurance companies have to submit a filing if the rates are going down?

The Division of Insurance must review whether a company is financially secure. We do not want rates that are so low there will not be adequate financial resources to cover policyholder claims (inadequate rates). This could result in policyholders' claims not being paid or the possible bankruptcy of the insurance company.

Additionally, sometimes proposed decreases should be lower – the rate reviewer looks at the proposed decrease to determine if rates are still excessive with the proposed rate decrease.

Do companies submit one rate increase for a variety of insurance products?

Companies must submit a rate filing for each "product" they offer. Types of **products** might be "long term care," "hospital/surgical," "limited benefit," or "major medical," for example.

What is a limited benefit plan?

A limited benefit health insurance is a health policy, contract or certificate offered or marketed as supplemental health insurance. It usually pays specified amounts according to a schedule of benefits to pay the costs of care, services, deductibles, copayments or coinsurance amounts not covered by a more comprehensive health plan. "Limited benefit health insurance" does not include short-term, limited duration health insurance policies. If a person has a "specified disease" limited benefit policy such as a cancer policy and breaks a leg, the care and treatment of that injury would not be covered by the "specified disease" policy.

Can the Division of Insurance approve some products and deny others from same company?

Yes, because a separate rate filing is required for each product, from each company.

What are the Division's analysts looking for when they review a rate filing?

The analysts review to see if the rate that will be charged is excessive, inadequate, or unfairly discriminatory. They also look for math errors, justification of rates, and other factors used to support the proposed rate.

What are important factors that the Division of Insurance looks at in reviewing rates?

The Division of Insurance has the authority to review rates to ensure the rates are not excessive, inadequate or unfairly discriminatory.

Excessive Rates – are rates that produce a long run profit that is unreasonably high for the insurance coverage being provided or where the expenses are unreasonably high for the coverage being provided. Insurance policies that are costly and provide little benefit to consumers or provide high profits to insurance companies could be considered to have excessive rates.

Inadequate Rates – are rates that are clearly so low that it cannot pay projected claims and/or expenses, or low rates intended on creating a monopoly. It is important that we have financially solvent companies that can pay the benefits they promised in an insurance policy.

Unfairly Discriminatory Rate – is charging different rates for the same benefits provided to individuals who have the same expectations of loss or when, after allowing for practical limitations, the rates do not appear to be equitable. Unfairly discriminatory rates result in some consumers paying excessive rates and other consumers paying inadequate rates.

What does it mean when the Division of Insurance cannot state how much the rate increase will impact individual consumers?

Companies will provide the overall average rate impact of the changes it is making. Depending on the different rate factor changes, some consumers may only be impacted by reductions the company is making in certain factors while other consumers may be impacted by the rating factors that are being increased. Rate filings list the average rate impact and the minimum and maximum rate increase amounts. The Division of Insurance may receive general information about the distribution of the increases/deceases based on a range, but not by consumer name.

How long does it take to review a rate filing? Is there a time limit?

The review time depends on many factors, including the size of the filing, the number of consumers potentially affected, the company's history in Colorado, the amount of increase requested, the justification included in the filing and the company's experience with this insurance product. A rate analyst may spend several hours on the review with the option of referring to an actuary or senior manager if there are additional questions.

After a rate has been submitted to the Division of Insurance, the Division of Insurance can disapprove the rate within 30 days if the rate filing is incomplete. If there is a substantial issue, a letter is sent within 45 days – giving the company the opportunity to resolve the issue(s). The Division of Insurance has 60 days to approve or disapprove a rate.

How many people at the Division of Insurance review health rate filings?

The Division of Insurance employs four rate analysts for health insurance. There is a supervisor of the Rates and Forms section who may be called upon for a secondary review, two actuaries, as well as a chief actuary who may review all or part of a filing. The Colorado Commissioner of Insurance may also review rate filings after other reviews have been completed, if additional questions remain.

The Division's Rates and Forms Section also receives, in addition to the rate filings, over 2,000 calls a year; 3,000 other types of filings, such as Medicare form filings, long term care partnership policy forms, valid multistate associations reviews, bone fide association reviews, preneed filings, credit filings, viatical/life settlement form filings, discontinuance of products and other filings. The section is also involved in statutory reports, such as the annual health insurance cost report and other special studies. For example, the Medicare supplement plan changes effective June 1, 2010 required the Division to ensure companies are making the appropriate rate and form filings that are in compliance with Colorado laws and regulations.

The Division's Actuarial Section, in addition to reviewing rate filings, is also involved with financial examinations and ensuring domestic companies are financially solvent as well as participating in a number of reports and studies undertaken by the Division. Both of these sections assist other sections within the Division of Insurance, as needed.

(***Note:*** *In addition to staff who specialize in life and health filings, there are also four rate analysts and two actuaries who focus on property and casualty filings for the Division of Insurance.*)

Update for 2011 and 2012: The Colorado Division of Insurance has received a Federal Grant to improve the oversight of proposed health insurance premium increases, take action against insurers seeking unreasonable rate hikes, and ensure consumers receive fair value for their premium dollars.

Colorado will use this grant to hire additional rate financial analysts and actuaries to review rate filings (for one year); hire additional staff in Consumer Complaints and outreach (for one year); and to create web enhancements to make rate filings more accessible and understandable to consumers. The grant is for one year, with the possibility of an additional year and funding being added.

(See news release following this document for more information on the Federal Grant.)

How many health insurance product rate filings are reviewed annually by the Division of Insurance?

There are approximately 1,000 to 1,200 health rate filings submitted for review each year.

Why did my health insurance rates go up when I didn't have any claims (didn't see a doctor, go to the hospital or get any prescriptions)?

Insurance is a pooling of risks, so individuals pay a share of the pooled experience in exchange for getting the coverage they purchased. Otherwise, if an individual had to pay the full rate for their claims paid by the insurance company it would not be insurance. Consumers purchase insurance to protect themselves for unforeseen financial misfortunes. Consumers may not have any, or only minor health-related claims for months or years and then experience a serious accident or illness that they don't have the financial ability to cover on their own.

Where can I submit a new question that wasn't answered here?

You may send additional insurance questions for the Colorado Division of Insurance to:
insurance@dora.state.co.us

If you would like the Division of Insurance to review an insurance complaint or question about your individual situation, please contact us for assistance:

(303) 894-7490 - Consumer Information
(800) 930-3745 - Toll Free from Outside Denver

OFFICE OF GOV. BILL RITTER JR. MONDAY, AUG. 16, 2010

CONTACT Evan Dreyer, 720.350.8370 evan.dreyer@state.co.us
Craig Bannister, 303.854.4536 craig.bannister@state.co.us
Cameron Lewis, 303.894.2261 cameron.lewis@dora.state.co.us

GOV. RITTER APPLAUDS $1 MILLION GRANT TO ENHANCE HEALTH INSURANCE PREMIUM RATE REVIEW PROCESS AND INCREASE CONSUMER EDUCATION AND OUTREACH EFFORTS

Colorado's Division of Insurance will receive a $1 million federal grant to improve the oversight of proposed health insurance premium increases, take action against insurers seeking unreasonable rate hikes, and ensure consumers receive fair value for their premium dollars. The District of Columbia and 45 states, including Colorado, received grants from the U.S. Department of Health and Human Services (HHS) totaling $46 million.

"We did not wait to protect Coloradans, and along with our partners in the legislature, have consistently been ahead of the game," said Gov. Ritter. "This grant will provide Colorado with additional tools to review rates and educate consumers about health insurance."

The grant is part of the Federal Affordable Care Act, which provides states with $250 million in Health Insurance Premium Review Grants over a five year period. It will help create a more level playing field by improving how states review proposed health insurance premium increases, as well as hold insurance companies accountable for unjustified premium increases.

"This grant is a good first step to enhance how the Division of Insurance reviews rates and will help us make information on premium rates more understandable to consumers," said Colorado Insurance Commissioner Marcy Morrison. "Our focus is, and will continue to be, about protecting consumers."

Twenty six states – including Colorado – and the District of Columbia currently have the authority to reject a proposed increase that is excessive, lacks justification or otherwise exceeds state standards. Colorado gained that authority in 2008 with the passage of HB1389.

In its grant proposal, the Colorado Division of Insurance proposed hiring additional rate financial analysts and actuaries to review rate filings; hiring additional staff in Consumer Complaints and outreach; and web enhancements to make rate filings more accessible and understandable to consumers. The grant is for one year, with the possibility of an additional year being added.

A chart summarizing how each state will use the new resources can be found at http://www.healthcare.gov/news/factsheets/rateschart.html.

The Affordable Care Act includes a wide variety of provisions designed to promote a high-quality, high-value, health care system for all Americans and to make the health insurance market more consumer-friendly and transparent. Some of the provisions that take effect by the end of next year, or are already in effect, include prohibitions on pre-existing condition exclusions for children; prohibition on lifetime dollar limits in all health plans; extended access to insurance for many young adults; and an unprecedented level of transparency about health insurance through www.HealthCare.gov.

To read more about the grants, visit http://www.healthcare.gov/news/factsheets/rates.html.