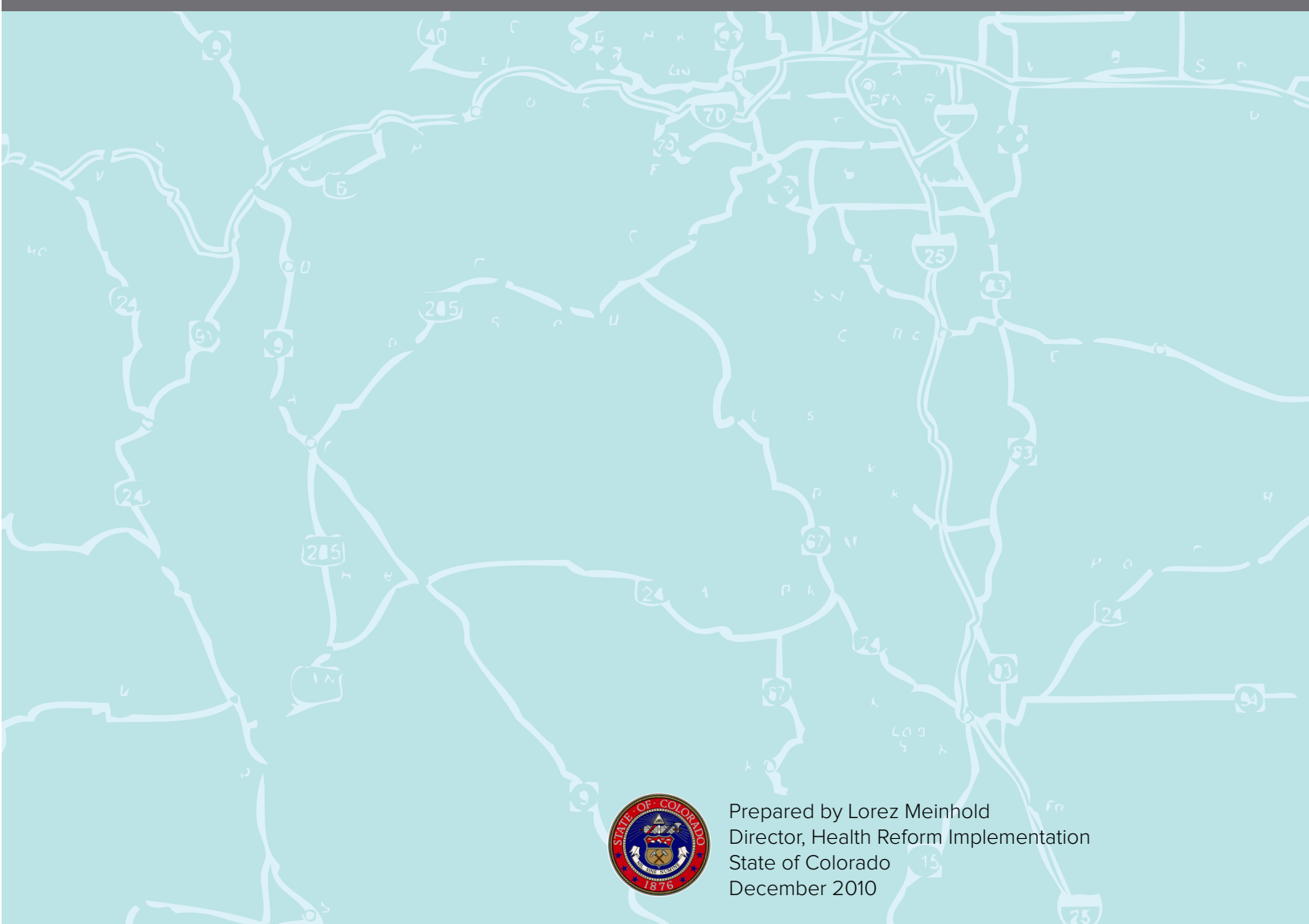


Implementing Health Care Reform: **A Roadmap for Colorado**



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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 output¹; 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 policies 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.

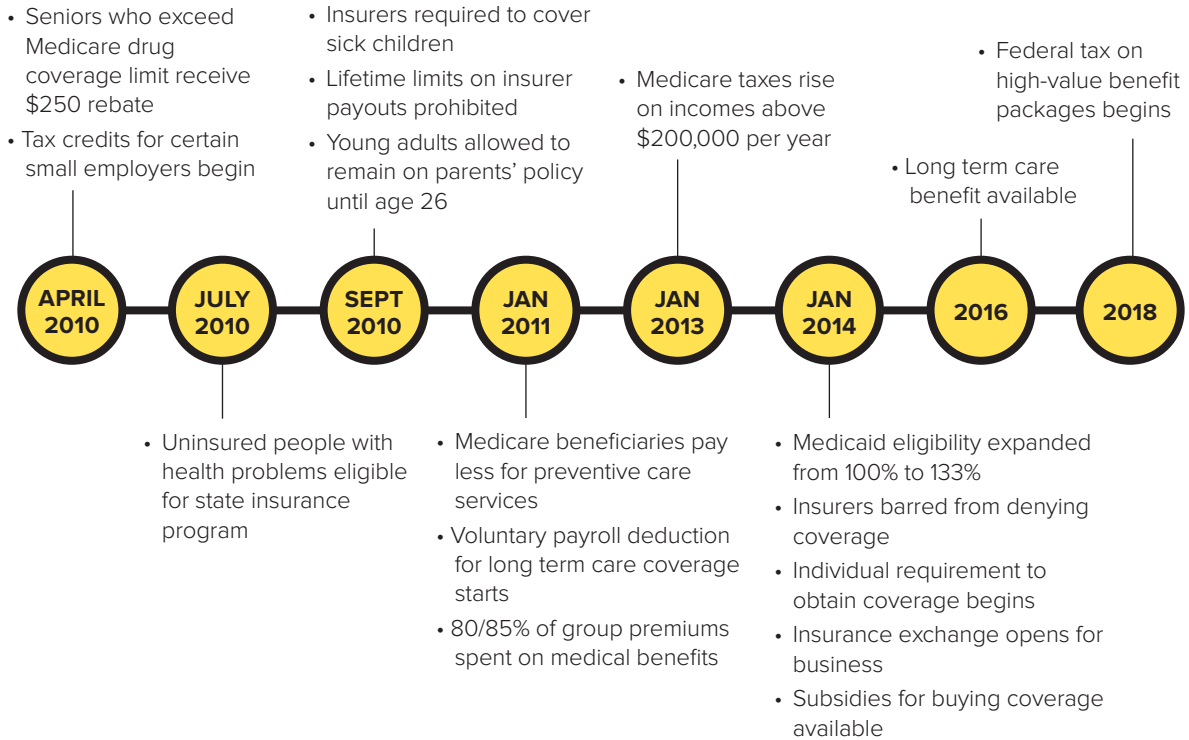
The Colorado Health Care Affordability Act of 2009

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 500,000⁶ 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.

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.

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

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 employees 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 Bey | 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 500,000¹⁰ uninsured Coloradans. Additionally, up to 90,000¹¹ 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' health 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 2025²⁰. 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 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.

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.

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.

Acknowledgements

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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

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 CHIP+ eligibility levels, standards and procedures.

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)
- CHIP 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)

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 CHIP+ to Medicaid. (1/1/14)

Changes in Eligibility and Enrollment Rules

- State must apply modified adjusted gross income formula for Medicaid and CHIP+. (1/1/14)
- State must implement procedures to simplify Medicaid and CHIP+ enrollment. (1/1/14)

Enhanced Federal Support for Children's Health

- State may transition CHIP+ -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 CHIP+. (10/1/15)
- State may start enrolling CHIP+ -eligible children in the exchange. (10/1/15)

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)

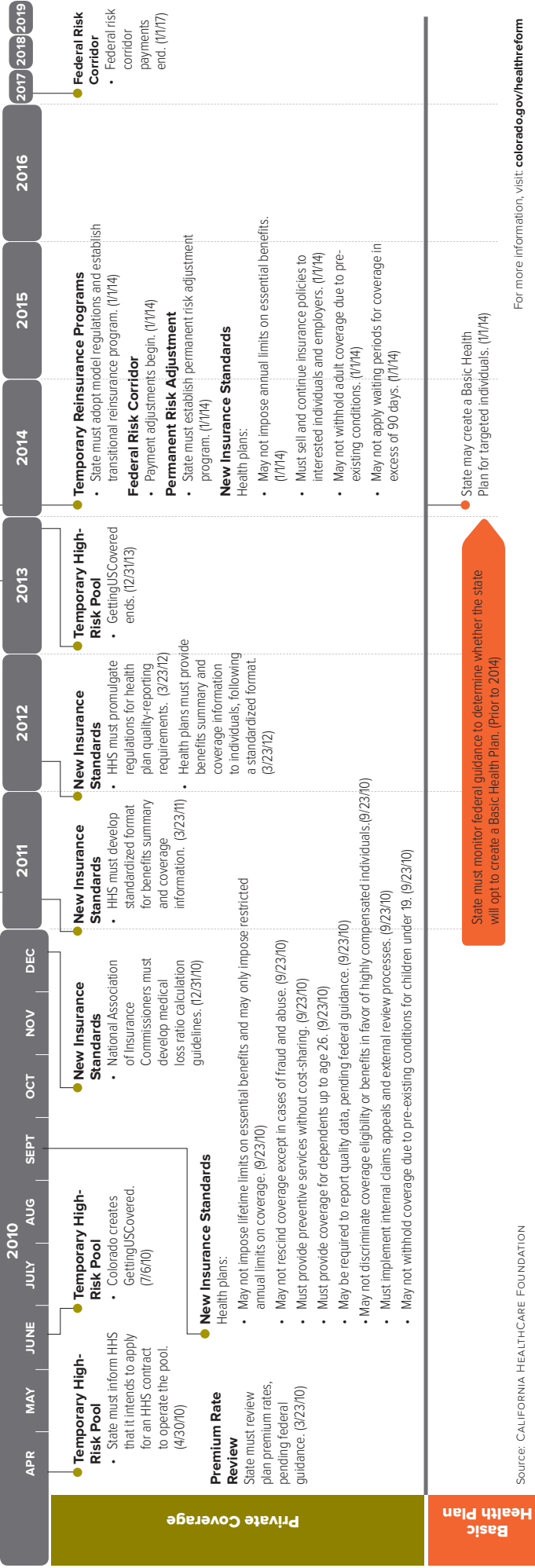
Health Insurance Exchange

- 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. (3/2/11)

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

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

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



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. |




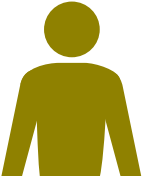



What if I'm sick and need coverage before 2014, but no insurer will sell it to me?

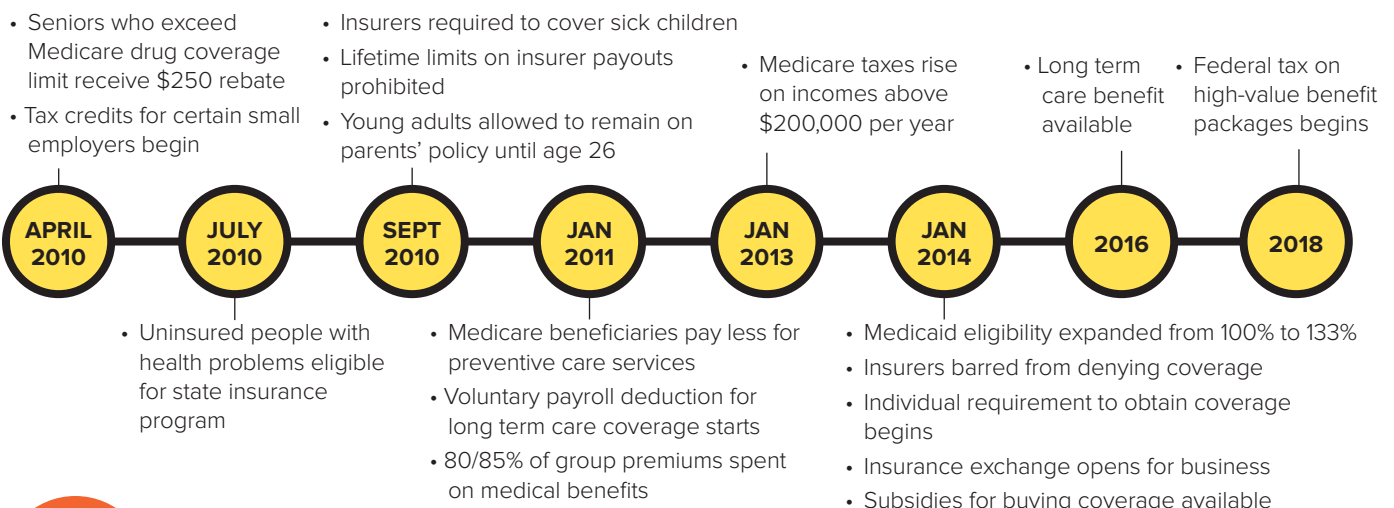
Uninsured Coloradans with health problems may qualify for insurance through a temporary, state-run program at standard market rates, with no lifetime or annual payout limits. Contact GettingUSCovered, www.gettinguscovered.org. For information on other public programs visit colorado.gov/hcpf.



Changes for Coloradans with insurance

| Source of Coverage | Coverage Options  | New Costs and Benefits  |
|---|--|---|
| Employer Plan  | <ul style="list-style-type: none"> • 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. | <p>Lifetime dollar limits on insurance payouts are eliminated.</p> <p>Medicare taxes will increase for individuals with annual incomes above \$200,000, or families earning more than \$250,000.</p> <p>Annual contributions to Flexible Spending Accounts will be capped at \$2,500, and can no longer be used for over-the-counter drugs.</p> <p>Employer-provided insurance valued at \$10,200 or higher (\$27,500 for families) will be subject to federal tax.</p> |
| Individual Policy  | <ul style="list-style-type: none"> • 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. | <p>Lifetime dollar limits on insurance payouts are eliminated. Caps on out-of-pocket costs apply.</p> <p>Medicare taxes will increase for individuals with annual incomes above \$200,000, or families earning more than \$250,000.</p> |
| Medicare  | <ul style="list-style-type: none"> • 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. | <p>Free annual check-ups and wellness programs, including screening tests.</p> <p>Gaps in drug coverage phased out, beginning with \$250 rebate.</p> <p>Monthly premium payments for drug coverage will increase for individuals with incomes above \$85,000 and households earning more than \$170,000.</p> |

Reform Timeline: When the Changes Happen

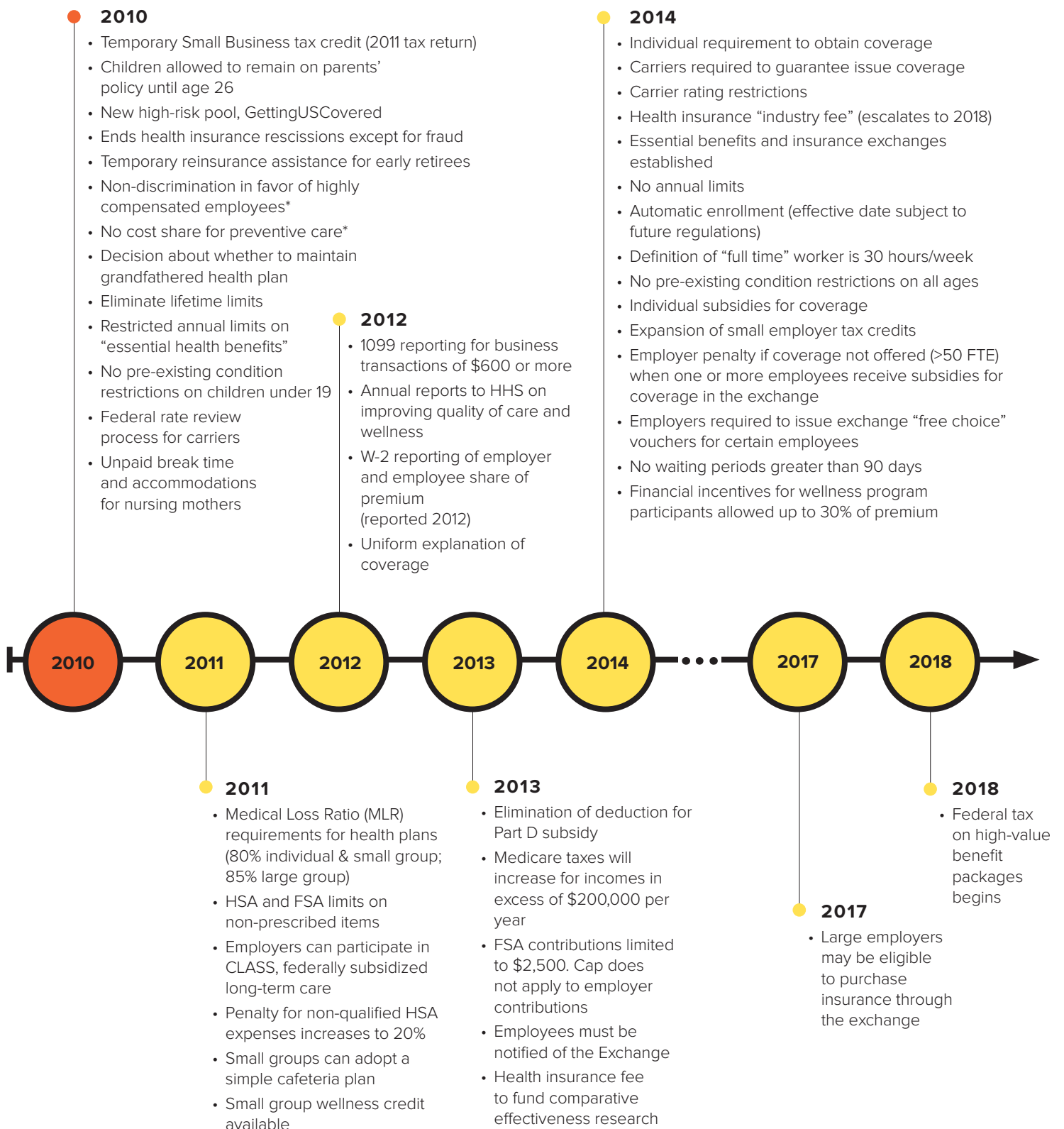


Where to go for more information

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



*subject to "grandfathered status"

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. The health reform law requires 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.

