APPENDICES

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

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*Except Grandfathered Plans

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

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

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

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

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

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

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

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

*Except Grandfathered Plans

Funding Opportunities Detail

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

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

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

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

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

22 QUESTIONS

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

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

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

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

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

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

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

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

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

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

2 When does it go into effect?

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

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

3 What if you don't comply?

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

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

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

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

Who do you contact with questions?

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

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

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

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

What is a Health Exchange?

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

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

How will it affect self-insured companies?

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

Prior to 2014

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

2014

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

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

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

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

8

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

9

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

10

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

11

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

12

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

13

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

14

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

15

What will be the governance and structure of the exchange?

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

16

Will employers be allowed to keep the insurance coverage they currently purchase?

Group and individual coverage can be kept or "grandfathered" under reform (as long as the plan was in existence before reform was enacted in March 23, 2010).

Grandfathered plans will be required to meet some insurance reform conditions:

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

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

17

Who is eligible for the business tax credit? How much is the tax credit?

Small employers that provide healthcare coverage are eligible if:

- They have fewer than 25 full-time equivalent employees (FTEs) for the tax year
- The average annual wages paid are less than $50,000 per FTE
- The employer pays at least 50% of the premium cost under a "qualified arrangement"

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

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

18

How does the change in pre-existing condition exclusions affect the coverage I offer my employees?

Insurers and health plans are prohibited from denying coverage, excluding certain categories of coverage, or charging high premiums due to an individual's pre-existing conditions. These prohibitions generally become effective in 2014.

19

Will there be limits on what insurance companies can charge me or my employees?

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

What does the new law do to control costs?

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

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

Will there be malpractice reform under this new law?

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

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

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

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

Where to go for more information

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

B 2010-006

EXECUTIVE ORDER

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

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

I. Background and Purpose

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

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

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

II. The Director of Health Reform Implementation

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

III. Mission and Scope of the Board

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

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

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

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

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

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

F. Provide transparent access to information;

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

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

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

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

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

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

IV. Membership

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

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

2. The Director of Health Reform Implementation;

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

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

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

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

7. The Executive Director of the Department of Revenue;

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

9. The Director of the Office of Information Technology;

10. Chief Legal Counsel to the Governor; and

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

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

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

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

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

V. Staffing and Resources

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

VI. Directives

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

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

VII. Duration

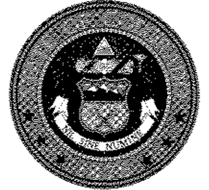
This Executive Order shall remain in force until modified or rescinded by future Executive Order of the Governor.

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

Bill Ritter, Jr.
Governor

STATE OF COLORADO

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



Bill Ritter, Jr.
Governor

May 27, 2010

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

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

Dear Secretary Sebelius:

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

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

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

Thank you for your Department's assistance and guidance.

Sincerely,

Bill Ritter, Jr.
Governor

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

BILL RITTER, JR.
GOVERNOR

April 26, 2010

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

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

Dear Secretary Sebelius:

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

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

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

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

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

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

Sincerely,

Bill Ritter, Jr.
Governor

BILL RITTER, JR.
GOVERNOR

136 STATE CAPITOL BUILDING
DENVER, COLORADO 80203

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

September 23, 2010

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

Dear Secretary Sebelius,

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

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

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

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

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

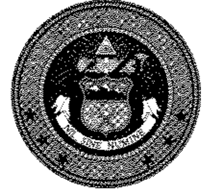
This is a pivotal time for healthcare reform in the United States, and for CMS to show that it can lead the way with demonstrations that result in sustainable, substantial, and effective transformation. I respectfully encourage you to increase the target number of MAPCP Demonstration states and to consider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

Sincerely,

Governor Bill Ritter Jr.

STATE OF COLORADO

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



Bill Ritter, Jr.
Governor

August 25, 2010

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

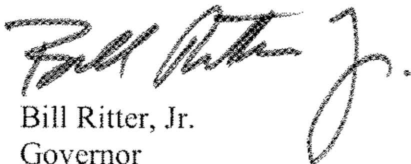
Dear Secretary Sebelius:

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

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

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

Sincerely,



Bill Ritter, Jr.
Governor

2010 Health Care Reform Outreach and Education Detail.xls

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

2010 Health Care Reform Outreach and Education Detail.xls

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

Draft: 11/1/10
A new model

AMERICAN HEALTH BENEFIT EXCHANGE MODEL ACT

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Section 1. Title

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

Section 2. Purpose and Intent

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

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

Section 3. Definitions

For purposes of this Act:

A. "Commissioner" means the Commissioner of Insurance.

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

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

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

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

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

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

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

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

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

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

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

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

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

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

(a) Limited scope dental or vision benefits;

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

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

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

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

(b) Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Resides in this State;

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

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

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

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

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

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

(2) For purposes of this subsection:

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

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

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

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

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

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

Section 4. Establishment of Exchange

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

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

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

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

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

B. The Exchange shall:

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

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

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

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

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

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

Section 5. General Requirements

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

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

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

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

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

Section 6. Duties of Exchange

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

The Exchange shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) The name and taxpayer identification number of:

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

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

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

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

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

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

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

(3) Facilitate enrollment in qualified health plans;

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

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

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

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

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

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

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

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

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

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

R. Meet the following financial integrity requirements:

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

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

(a) Investigate the affairs of the Exchange;

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

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

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

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

Section7. Health Benefit Plan Certification

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

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

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

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

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

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

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

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

(5) The health carrier offering the plan:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Claims payment policies and practices;

(ii) Periodic financial disclosures;

(iii) Data on enrollment;

(iv) Data on disenrollment;

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

(vi) Data on rating practices;

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

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

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

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

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

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

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

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

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

Section 8. Funding; Publication of Costs

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

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

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

Section 9. Regulations

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

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

Section 10. Relation to Other Laws

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

Section 11. Effective Date

This Act shall be effective [insert date].

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Responses to OCIIO provisions regarding the Exchange in ACA

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

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

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

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

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

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

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

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

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

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

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

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

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

Responses to OCIIO provisions regarding the Exchange in ACA

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

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

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

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

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

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

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

Thanks for your consideration of these issues,

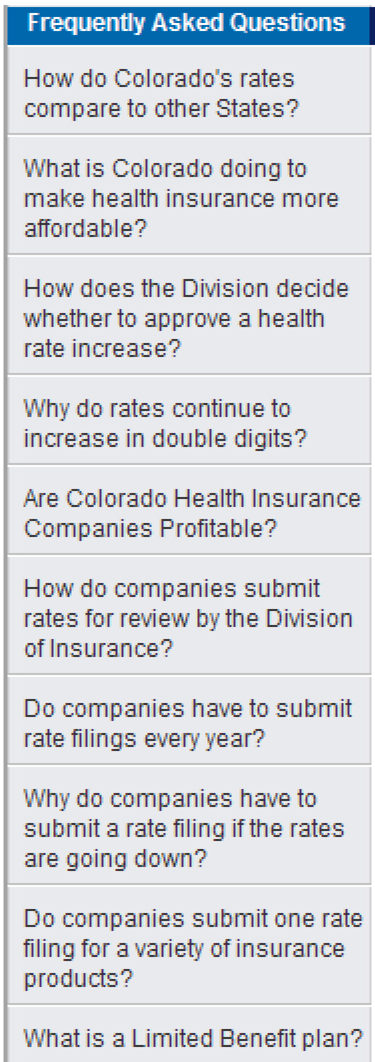
Lorez Meinhold
Director of Health Reform Implementation

Joan Henneberry
Chair of the Interagency Health Reform Implementation Board

Comment Tracking Number: 80b6427f

Dora Division of Insurance
Department of Regulatory Agencies

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



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

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

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

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

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

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

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

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

What are Division of Insurance analysts looking for when they review a rate filing?

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

Why can't the Division of Insurance predict how much a rate increase will impact individual consumers?

How long does it take to review a rate filing?

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

How many health insurance product rate filings are review annually?

Why did my health insurance rates go up when I didn't have any claims?

Where can I send a question not answered here?

Other Resources

Frequently Asked Questions on HB 08-1389: Concerning Increased Oversight of Health Insurance Rates ("Prior Approval") *link*

§10-16-107 C.R.S. (F.A.I.R. Law) written on HB 08-1389 Fair Accountable Insurance Rates Act *link*

§10-16-111 C.R.S. Annual Statements and Reports *link*

What is Colorado doing to make health insurance more affordable?

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

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

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

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

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

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

Why do rates continue to increase in double digits?

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

Are Colorado health insurance companies profitable?

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

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

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

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

The Colorado HR1 form includes information on:

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

The actuarial memorandum must include the following:

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

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

Do companies have to submit a rate filing every year?

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

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

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

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

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

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

What is a limited benefit plan?

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

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

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

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

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

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

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

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

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

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

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

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

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

The review time depends on many factors, including the size of the filing, the number of consumers potentially affected, the company's history in Colorado, the amount of increase requested, the justification included in the filing and the company's experience with this insurance product. A rate analyst may spend several hours on the review with the option of referring to an actuary or senior manager if there are additional questions.
After a rate has been submitted to the Division of Insurance, the Division of Insurance can disapprove the rate within 30 days if the rate filing is incomplete. If there is a substantial issue, a letter is sent within 45 days – giving the company the opportunity to resolve the issue(s). The Division of Insurance has 60 days to approve or disapprove a rate.

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

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

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

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

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

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

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

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

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

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

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

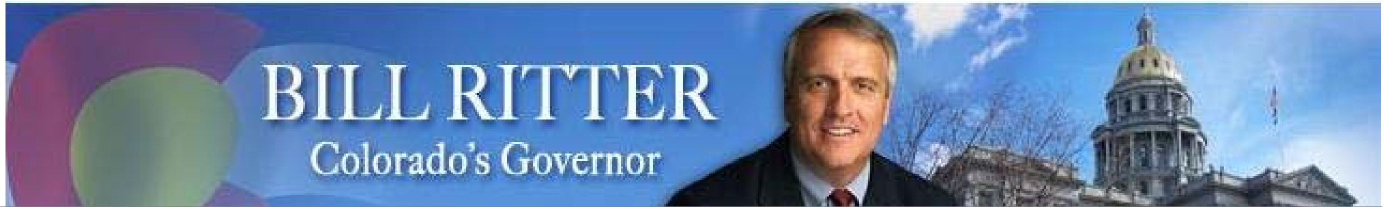
Insurance is a pooling of risks, so individuals pay a share of the pooled experience in exchange for getting the coverage they purchased. Otherwise, if an individual had to pay the full rate for their claims paid by the insurance company it would not be insurance. Consumers purchase insurance to protect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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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