

ACA Implementation—Monitoring and Tracking

Colorado

Site Visit Report

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EXECUTIVE SUMMARY

Colorado has made substantial progress in expanding access to health coverage, creating consumer protections for purchasers of insurance, and implementing a new health insurance exchange. The state got a head start on national health reform in 2006 when its Blue Ribbon (or 208) Commission developed a template for reform that included many of the same components that ultimately appeared in the Affordable Care Act (ACA). This bipartisan deliberative effort helped build broad consensus on critical issues surrounding the need to expand access to more affordable health coverage, and led to several important Medicaid and private insurance reforms that were implemented pre-ACA.

However, adopting a “Colorado-specific” version of health reform was critical for state policymakers as they later responded to the ACA and began considering the design of the state’s own health insurance exchange. Washington, D.C.’s contentious battle over reform, coupled with emerging Tea Party influence on politics in Colorado, significantly eroded the cooperative, bipartisan spirit that had animated the Blue Ribbon Commission. Yet strong relationships among key stakeholders prevailed, and policymakers succeeded in moving forward with implementing Colorado solutions to health system challenges.

Health Insurance Exchange: Planning and Implementation—Colorado has taken important steps in establishing its health insurance exchange, but much work remains. As described in this case study, the state’s exchange legislation addressed primarily structure and governance issues, rather than establishing operational policies. A broad-based Exchange Board has been appointed that draws upon substantial health insurance expertise among members

who have worked collaboratively in the interest of the exchange. Very talented staff leadership was in place throughout the first planning year, along with a Board chairperson who has a strong advocacy background oriented to underserved populations. Workgroups composed of diverse stakeholders helped the Board develop information and options for future design and decision making. Despite this progress, many difficult and technical decisions remain on exchange operations, enrollment methods, plan participation, risk adjustment and reinsurance, and subsidy determination and management. The extent to which the state’s unusual Legislative Review Committee’s supervision of exchange activities might inject politics into ongoing decision-making also concerned many informants.

Critical to the success of the early exchange planning effort was the involvement of a wide range of stakeholders, before and after the ACA passed. Broad stakeholder engagement succeeded in garnering their buy-in, support, and ongoing commitment. Strong support from the business community helped ensure that the state’s exchange legislation passed, even as some support for the law was unraveling. And during the first year of exchange implementation, issue-oriented workgroups have allowed diverse stakeholders to continue being involved in system design.

Health Insurance Exchange: Enrollment and Subsidy Determination—State officials are aggressively tackling the challenge of establishing a modern, interoperable IT infrastructure for exchange and Medicaid/CHP+ eligibility determination and an enrollment systems that can perform seamless, real-time, and data-driven operations as called for in the ACA. However, this daunting task is made all the more challenging in Colorado because of several

environmental circumstances. Like most states, Colorado is starting with a flawed foundation, a legacy computer system—CBMS—that is inflexible and difficult to modify. Additionally, the state is challenged because eligibility determination for Medicaid and a host of other human services programs is the responsibility of the counties, which have adopted unique processes and may also be resistant to the changes required for successful IT implementation. Finally, responsibility for IT remains diffused across multiple agencies at the state level, including the exchange, Medicaid, and the relatively new Office of Information Technology, and thus far it is not clear that these offices can work in complete harmony. Still, the state has made rapid progress over the past several months, and expects to award vendor contracts for exchange IT development and upgrades to CBMS and its accompanying PEAK internet interface by mid-2012.

Insurance Reforms—Colorado has thus far made only one statutory change to accommodate the new ACA insurance rules required through 2011—a consensus bill to assure that child-only policies would remain available. Yet insurer compliance has been good, officials said. These informants liked the improved information and power to review rates that administrators acquired from recent state legislation and federal-grant-funded upgrades to their capabilities. They do worry about the Division of Insurance’s ability to sanction noncompliance without explicit state statutory authority, but expect to rely on federal enforcement if truly needed. Other concerns expressed included some discrepancies between the state and federal rules, the adequacy of high-risk pool funding for both state and federal pools, and the need to improve consumer education. Additional legislation will be sought before 2014, but likely not in 2012.

Medicaid Policy—Recent expansions in Colorado Medicaid and CHP+ programs provide a reasonably strong foundation upon which to build. Colorado’s Medicaid program, historically, was somewhat limited in scope. But in the last several years, it has implemented several important changes that should help smooth

the state’s transition to full ACA implementation. A newly legislated hospital fee generated critical revenues that helped bolster hospital reimbursement rates, while also allowing broad expansions of coverage to pregnant women, children, parents, persons with disabilities, and some adults without dependent children. Federal grants have also allowed the state to invest in important Medicaid eligibility system reforms including improvements within the CBMS system upon which to build further enhancements.

Providers and Insurers—The current organization of providers and insurers in Colorado creates a promising environment for reform. Colorado is characterized by competitive hospital, physician, and managed care markets. No dominant systems exist, which allows a healthy mix of competition and collaboration.

There is broad agreement that Colorado’s primary care capacity will be seriously strained by reform’s increases in coverage, but a strong network of safety net providers will play a critical role in serving the newly insured. The state’s vast rural and frontier regions—where population density is low—will be especially hard pressed. There was also nearly uniform recognition, however, of the importance of the safety net in Colorado, along with praise for the quality of care provided by the state’s FQHCs and other safety net systems. These providers are likely to absorb the largest share of newly insured populations, and certainly most, if not all, of those gaining coverage through the Medicaid expansion.

Conclusions—With less than two years to go before the Affordable Care Act is fully implemented, the State of Colorado is reasonably well positioned. A bipartisan foundation was built before the ACA was signed into law, and stakeholders have largely worked collaboratively to begin putting various required policies and structures in place. Yet much work remains, and strong leadership, bipartisan political support, and continued aggressive action will be needed for Colorado to succeed in implementing reform on time.

With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform in Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island and Virginia to help states, researchers and policy-makers learn from the process as it unfolds. This report is one of 10 state case study analyses. The quantitative component of the project will produce analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally. For more information about the Robert Wood Johnson Foundation's work on coverage, visit www.rwjf.org/coverage.

BACKGROUND

Politically, Colorado is a thoroughly “purple” state. Historically quite conservative and Republican, the state’s political landscape began to change in the last decade after years of steady economic and population growth. As recently as 2002, Republicans controlled all of state government, holding the governorship and both houses of the state legislature. Two years later, Democrats regained both houses and in 2006 the Governorship as well, when Bill Ritter won handily.¹ In 2010 Democrats retained the Governorship and the Senate, but Republicans retook the House,² and incoming Tea Party-influenced Republicans created a new legislative dynamic. It is against this backdrop that the state’s progress toward developing a “Colorado-specific” version of health care reform must be considered.

Colorado’s initial steps toward reform date back to the 2006 passage of Senate Bill 06-208, the Access to Affordable Health Care Act,³ which authorized a “Blue Ribbon” Commission to consider strategies for increasing access to health care for all Coloradans at more affordable cost. Also called the 208 Commission, the group was purchaser-oriented, bipartisan, and funded by almost wholly by private foundation funds. The Commission invited reform proposals from stakeholders and considered 31 submissions from a variety of organizations. Four proposals were analyzed in depth, along with a fifth developed by the Blue Ribbon Commission itself.

In its January 2008 report, the Commission made recommendations that, notably, closely resembled key parts of the federal Patient Protection and Affordable Care Act (ACA), including expansion of Medicaid and the Children’s Health Insurance Program (CHIP), private market insurance reforms, the creation of a health insurance exchange (patterned after the Massachusetts “Connector”), and an individual insurance mandate.⁴ Its recommended package of reforms was deemed too expensive to adopt in its entirety (with a price tag of roughly \$1 billion), but many of the Commission’s core ideas became Governor Bill Ritter’s “building blocks” for health care reform. As one prominent stakeholder interviewed for this study noted, the Commission “...shaped everything.”

Under the leadership of Governor Ritter, the administration’s first step was to begin building upon Colorado’s existing public health insurance infrastructure—its Medicaid and Children’s Health Insurance Program (called CHP+ in Colorado) programs. Colorado has never possessed what would be considered a generous Medicaid program, and the state’s uniquely strong legal restraints on state and local taxation—exemplified by the Taxpayer Bill of Rights (a.k.a., TABOR⁵), added to the state constitution in 1992 by a voter initiative—have long constrained its scope. But Administration officials knew that additional revenues would be needed if Medicaid were to expand, and devised a new TABOR-compliant

fee on hospitals that could draw down additional federal Medicaid matching funds to support both coverage expansions and provider fee increases.

Careful negotiations with the Colorado Hospital Association built consensus for the strategy—which was seen as a “win-win” for both the state and hospitals—and ultimately led to the passage of House Bill 09-1293, The Colorado Health Care Affordability Act.⁶ The Act established the fee and earmarked revenues to support enhanced hospital reimbursement rates, as well as a five-tiered expansion of coverage that included, among other changes, Medicaid and CHP+ eligibility increases for children, pregnant women, parents, persons with disabilities and, for the first time in the state’s history, adults without dependents.

To the surprise of many key informants interviewed for this study, Governor Ritter announced in January 2010 that he would not seek re-election that fall. But work on health reforms continued nonetheless. By the time the ACA was passed in March 2010, Colorado had already invested considerable time and energy in health system reforms, and the “Colorado vision” of reform that was called for by the 208 Commission had begun to take shape. Yet the contentious 18-month federal reform debate in Washington, D.C. had begun to color the tone of policy debates in Colorado, as well. The bipartisan spirit that had surrounded much of the state’s early health reform efforts was beginning to fray, as Republican legislators feared their state-driven solutions might be replaced by a heavy-handed, top-down federal law.

To help assuage these fears and create an open, visible process for responding to the ACA, Governor Ritter appointed his senior health policy advisor as Director of Health Reform Implementation and created an Interagency Health Reform Implementation Board,⁷ chaired by the director of the Department of Health Care Policy and Financing (HCPF), which runs Medicaid and other health programs. The Board was composed of the heads of all state government departments affected by federal reform, and met regularly to consider Colorado’s policy options under the ACA. The group also coordinated applications for numerous federal and foundation grants, all designed to support health system improvement. In all, several hundred million dollars in grants flowed to the Division of Insurance, Departments of Public Health and Environment, HCPF, Human Services, and the Governor’s office.

Perhaps the most important action taken by this Board was its extensive outreach effort to stakeholders. During the summer of 2010, it sought input from stakeholders on how the state should set priorities and exercise its flexibility in implementing health reform. The Board partnered with two state-level consumer advocacy organizations to convene and facilitate 10 town hall-style meetings in Denver and other communities across the state, with discussions particularly focused on how Colorado should design its health insurance exchange.⁸ According to key informants interviewed for this study, the forums were extremely well attended, with roughly 1,200 participants in all. Key informants generally agreed that the meetings succeeded in drawing a range of consumers, advocates, business representatives, and officials from the provider and insurance industries, but some suggested that perspectives of the business community were insufficiently drawn out. Still, input from the forums helped policymakers develop a “shared perspective” on how the state should proceed, which directly informed the ultimate drafting of legislation for the Colorado Health Benefits Exchange. In the interim, the forums also set the stage for Colorado’s successful application for a nearly \$1 million federal Health Insurance Exchange Planning Grant, received in September 2010 and run out of the Governor’s Office of Policy and Initiatives.

Adopting a ‘Colorado-specific’ version of health care reform was critical for policymakers as they...responded to the ACA and began considering the design of the state’s own health insurance exchange.

As a final act to smooth the transition for his successor, Governor Ritter directed his staff to produce a “roadmap” document to detail the steps already taken by his administration to advance health reform, and to identify the tasks that still lay ahead.⁹ Indeed, when former Denver Mayor John Hickenlooper took office as Governor in January 2011, he maintained considerable policy continuity with his predecessor. For example, he asked one of Ritter’s health policy advisors to stay on with a broader role, he hired Ritter’s former HCPF director to lead interim planning for Colorado’s health insurance exchange, and he retained the Roadmap as a prominent planning document on the state’s health reform webpages.¹⁰

In 2011, 59 percent of Colorado’s 4.5 million residents under age 65 had employer-sponsored health insurance coverage, according to estimates from the Urban

Institute's Health Insurance Policy Simulation Model (HIPSM). More than 7 percent had non-group coverage, and nearly 16 percent had Medicaid, CHIP, or other public coverage. Just over 18 percent of the population was uninsured. Once the ACA is fully implemented,

480,000 individuals will gain health coverage through the exchange (336,000 non-group and 144,000 employer-sponsored) and 243,000 more through Medicaid and CHIP, reducing the uninsurance rate to 9.6 percent.

HEALTH INSURANCE EXCHANGE: PLANNING AND IMPLEMENTATION

Colorado received its Health Insurance Exchange Planning Grant in September 2010 and planning began in earnest in January 2011, after Governor Hickenlooper took office. As described above, Colorado's exchange has roots in Colorado-specific developments. The state's Blue Ribbon (208) Commission recommended a connector-style exchange in 2008, and the 2010 Roadmap document also laid out general parameters for an exchange, reflecting input from the forums recently held across the state.

Planning staff proceeded to nurture support from a broad range of stakeholders—consumer advocates as well as business groups, health plans and medical

providers, and insurance carriers and brokers. On the political front, some conservative legislators supported the envisioned exchange because they wanted a non-federal entity operating as a passive clearinghouse to facilitate voluntary competition, while more liberal legislators supported it as a key strategy for expanding coverage. In the end, a bipartisan bill—SB 11-200—was introduced in March 2011 by a Democrat in the Senate, with a Republican co-sponsor in the House.¹¹ Some eleventh-hour pressure from Tea Party activists caused the Republican cosponsor to waiver in her support of the legislation. But strong support from the business, consumer, and broker communities helped the bill prevail and the law to establish the Colorado Health Benefits

Key Provisions of Colorado's Health Insurance Exchange Legislation (SB 200)

- Creates the Colorado Health Benefits Exchange (COHBE) as a nonprofit unincorporated public entity rather than a state agency—which is accordingly exempt from public procurement rules, under its articles of governance.
- Calls for a governing Board with 9 voting members, appointed by the governor and legislative leaders.
 - Makes 3 agency heads non-voting members.
 - Requires Board members to reflect specified types of expertise.
- Provides no state funding, and directs the Board to seek grant funding.
- Gives the Board general power over “the development, governance, and operation of the exchange,” along with “all the powers and duties necessary” for implementation.
- Circumscribes COHBE's authority, however, with very strong legislature oversight.
 - Gives the Board no authority to tax or tap state funds or promulgate regulations, directs it not to replicate or displace the duties of the insurance commissioner.
 - Creates a special legislative “Implementation Review” Committee to oversee COHBE, its 10 members appointed by majority and minority leadership in each house.
 - Requires Committee approval of all grant applications, COHBE's executive director, and its plans of operation and financing.
 - Requires all monies received to be reported to the legislative audit committee, which may audit the monies.

Exchange (COHBE) was enacted on June 1st, making Colorado one of the first states to enact exchange legislation.¹² (See text box for key elements of SB 200)

On the political front, conservatives on the right supported the envisioned exchange because they wanted a non-federal entity operating as a passive clearinghouse to facilitate voluntary competition, while liberals on the left supported it as a key strategy for expanding coverage.

As was the goal of policymakers, the law has a distinctively homegrown flavor, meant to meet what the legislative text describes as the “unique needs of Colorado” with “Colorado-specific solutions.” It addresses primarily structure and governance issues rather than establishing operational policies, except for the requirement that it operate as a clearinghouse open to all licensed insurance carriers authorized to do business in the state. The law expressly prohibited the exchange from engaging in the “active purchase” of insurance. Key informants described this prohibition as a nonnegotiable provision of the bipartisan law.

The exchange Board is governed by nine voting members, and three ex-officio/non-voting members representing the directors of HCPF, the Division of Insurance, and the Office of Economic Development and International Trade. Among the voting members, five are appointed by the Governor (though no more than three can be from the same political party) and four are appointed (one each) by the legislative leaders of each party in each chamber. The law states that each Board member is to possess expertise in at least two of 11 areas: individual health insurance, small employer health insurance, health benefits administration, health care finance, administration of a public or private health care delivery system, provision of health services, purchase of health insurance coverage, health care consumer navigation or assistance, health care economics or actuarial sciences, information technology, or starting a small business. As implied by the list, this required expertise almost inevitably means that some Board members will represent the health care industry—a fact that generated some controversy among consumer advocates—though the law states that no more than 50 percent of the Board can be composed of individuals with “direct ties to the industry.”

Another ingredient critical to the passage of SB 11-200 was the law’s inclusion of a Legislative Implementation Review Committee. This committee, expressly created to allow the state legislature to oversee and monitor the actions of the new exchange entity, retains several important powers. These include the power to approve or disapprove the appointment of the exchange’s Executive Director, as well as all grant applications, especially important given that the law does not provide any state funding to support the exchange. The committee also must approve the exchange’s budgetary and operational plans.¹³ Finally, the law specified that the oversight committee be composed of 10 members, with the President of the Senate and Speaker of the House appointing three members each, and the Minority Leaders each appointing two. Given the makeup of the House and Senate at the time (and at this writing), this meant the initial membership was made up of five Democrats and five Republicans, setting up the potential for deadlock. Several key informants raised concerns about the committee and its role, describing it as “unusual, even for Colorado.”

Broad stakeholder engagement succeeded in garnering their buy-in, support, and ongoing commitment.

Early Operational Progress, Decision Making, and Sources of Controversy

As mentioned above, Governor Hickenlooper invited the former HCPF Director to serve a one-year appointment as interim executive director of the exchange planning effort, housed at the Colorado Health Institute. In turn, this individual quickly hired a deputy with long experience in the private sector, including health plan start-up. Since the law establishing the exchange did not deal with much beyond governance, the planning group quickly formed four workgroups to develop information and options for future design and decision making, including the:

- **Eligibility, Verification, and Enrollment Workgroup (EVE)**, charged with considering the health exchange’s intersection with Medicaid, and addressing the question of how eligibility determination processes, and related data and IT systems, will be coordinated between the exchange and Medicaid;
- **Data Advisory Work Group (DAWG)**, assigned the task of completing background research on the

characteristics of the uninsured, and developing estimates of the impacts reform will have on the population and their insurance status;

- **Small Employer Work Group (SEWG)**, asked to consider alternatives for the SHOP portion of the exchange and identify administrative features that will make it easier for small employers to provide health insurance for their employees; and
- **Marketing, Education, and Outreach Workgroup (MEOW)**, expected to create a website for the exchange and to design education, marketing, and outreach campaign materials for various target populations.

At the time of our site visit, these groups were at various stages of their work. EVE had developed a “white paper” on alternatives for integrating eligibility systems for the exchange, Medicaid, CHIP, and other human services programs. DAWG had selected Jonathan Gruber from MIT to develop empirical population estimates, including likely exchange enrollment, and the Wakely Consulting Group to develop actuarial information and identify outcome metrics for measuring the exchange’s performance. SEWG had completed crucial information gathering through discussion with the business community and was identifying decisions regarding SHOP design for the Board to consider. MEOW, meanwhile, had identified a URL for the exchange—GetCoveredCO.org—and established a “speakers bureau” for volunteers and other officials to make presentations about the exchange across the state.

The nine exchange Board members were named in June 2011, and have been meeting twice monthly since.¹⁴ The composition of the Board—which includes four members representing health insurers, and another that does considerable business with the provider and insurance industries—generated some objections from consumer advocates over its potential for conflicts of interest.¹⁵ But, in the words of one prominent exchange planner, “We needed people on the Board who know the health care industry, who know how to make this work.” Indeed, thus far, key informants agree that Board members have acted in the collective interest of the exchange, rather than representing their own parochial interests. Meetings are public and, reportedly, well attended. Consumer and business group representatives attend regularly and are encouraged to participate in discussions. Participants reported that a positive atmosphere of collegiality has been established, that Board members “bring expertise to the table and engage in good conversations,” and that the workgroups have thus far done “yeoman’s work.”

As summarized above, the new exchange is making progress, though one setback occurred in September 2011. Republican members of the legislative review committee signaled their intent to conduct vigorous oversight when they stalled the exchange’s application for \$24 million in federal Level 1 Establishment grant monies. These members argued that they had not been given sufficient time to review the application and that the application made too many references to the ACA, as opposed to Colorado’s own health exchange legislation. There were also objections to the proposed salaries for exchange staff, which seemed too high to some committee members. However, these hurdles were cleared relatively easily; after exchange staff reworked and refocused the application, nearly unanimous approval was obtained from the legislative review committee before the end of the year.¹⁶

In the two months following our site visit, the Board also chose a permanent Chair (who is a consumer advocate by profession) and Vice Chair, hired an IT expert and other staff, and chose an inaugural Executive Director, who was unanimously approved by the legislative review committee. Workgroups, meanwhile, are presenting their research findings to the Board for consideration. Still, a large number of critical design and policy decisions have yet to be made by the Board. These include, but are not limited to, deciding:

- Whether to merge or keep separate the individual and small business functions in the exchange;¹⁷
- What IT system to adopt and to what extent the exchange should integrate its eligibility and enrollment function with that of Medicaid and other human services programs (discussed in more detail in the next section);
- How to qualify health plans for participation in the exchange;
- What form of risk adjustment to employ in setting payment rates; and
- How to transition high risk pool enrollees into the exchange.

According to many key informants, the main enemy facing the Board is time. These individuals expressed concern that Colorado was “playing catch up,” and that the large number of complex and challenging decisions that must be made over the next two years was extremely daunting. Moreover, the ACA is very polarizing—not just in the state legislature but also in the populace at large—which could continue to color the nature of decision-

making moving forward, just as it did during enactment of the initial exchange legislation. Key informants both from business and consumer organizations spoke somewhat wistfully of the loss of positive consensus that surrounded the initial pre-ACA development of Colorado

health reforms. Whether and how deep-seated divisions about the ACA will affect the exchange and its legislative oversight as key decisions are reached throughout 2012 is an issue that bears watching.

HEALTH INSURANCE EXCHANGE: ENROLLMENT AND SUBSIDY DETERMINATION

With only two years to go before full implementation of the ACA coverage expansions, much work remains to establish COHBE's application, eligibility determination, and enrollment processes. COHBE has made considerable progress over the past several months, however, culminating in the recent release of a Request for Proposals (RFP) to acquire a comprehensive web portal solution and call center operation. The rapid pace of the state's work in this area is evident, given that at the time of our site visit (in late October 2011) COHBE did not have a clear roadmap for its eligibility and enrollment system development, and was still grappling with key decisions about its functionality. Moreover, the Exchange Board had not yet named its Executive Director (ED) and was between IT consultants, which key informants noted had delayed those decisions; since then, however, COHBE has hired both an ED with more than 25 years of experience as a private sector benefits executive, as well as an IT project manager who most recently worked on Exchange design and planning in the neighboring State of Kansas. A Communications Manager was also hired toward the end of 2011, allowing COHBE to move forward with planning in that area (discussed in more detail below).

In mid-January 2012, COHBE released an RFP to establish Technology Systems and Customer Service Operations, with the expectation of contract awards in May 2012.¹⁸ The RFP lays out an aggressive timeline for completing system development, with pilot phases beginning a year into the project and full deployment by September and October 2013 for the SHOP and individual exchange, respectively. Four distinct service and technology components may be bid separately or in combination—(1) technology and (2) services for the SHOP Exchange, and (3) technology and (4) services for the individual exchange—and vendors are also encouraged to consider partnering arrangements. Key informants described COHBE's decision to out-source solutions for both technology and customer service as one that was necessary given time constraints and

lack of specific expertise, noting that the best model for Colorado's exchange "is to have well-designed partnerships with people who know what they are doing. Then, in five years we can choose to in-source those things once the business processes are figured out."

Consistent with what key informants in Colorado described as their vision for an exchange that is accessible, easy-to-use, and provides a first-class customer experience, the RFP requests the following capabilities for the exchange: a web portal; a single, streamlined online application; real-time subsidy eligibility determination in accordance with federal rules; online education/decision support tools (including calculators to estimate tax credits and cost-sharing reductions); online customer assistance; plan comparison; broker support; navigator support; kiosk capability; insurance administrative services; premium collection; and plan and rate administration.

Integration with Eligibility and Enrollment Processes for Public Programs

A key decision point in Colorado's exchange development process involved determining the extent of integration between the eligibility and enrollment systems used for the exchange, Medicaid/CHP+, and human services programs (e.g., those providing cash or food assistance). As an initial step, the EVE workgroup prepared a white paper on different options for "horizontal integration" in August 2011.¹⁹ The four options explored by the workgroup ranged from a full, horizontally integrated model (creating a new, functioning eligibility and enrollment system for all health subsidy and human services programs) to one where the exchange would operate quite separate from the systems used by human services programs. At the same time, COHBE had to decide on its approach to "vertical integration," that is, to determine how closely linked the eligibility and enrollment systems for health coverage programs (the exchange and Medicaid/CHP+) would be.

Ultimately, the Board indicated its interest in pursuing minimum interoperability and the RFP describes this approach, where the exchange's eligibility and enrollment system is separate but interoperable with the system used for Medicaid/CHP+ and for human services programs (see box). According to key informants, this decision was influenced by a number of factors, including potential costs associated with increased enrollment in public benefits programs and an unwillingness to risk successful implementation of the exchange's system for the sake of integration with the systems for public coverage. As one key informant frankly noted, "If [the exchange] can help improve the current eligibility systems for Medicaid, we are happy to do that. But, we will not do that at the expense of having the exchange built right, on time, and on budget."

Regarding horizontal integration, the exchange will take a 'referral' type approach: findings from the exchange eligibility determination process could deem exchange customers as likely eligible for other forms of state assistance, and such a finding would trigger a message

with links to provide the customer with more information about these additional programs. The RFP also suggests that any relevant data captured during the customer's interaction with the exchange will be transmitted electronically to the human services programs and used to pre-populate application forms, easing the process for customers who wish to apply for those programs. Notably, there was some indication that the state could transition to a more integrated eligibility and enrollment system (both vertically and horizontally) in the future, when there might be greater support for such a move; one key informant suggested that the state could use 90/10 enhanced federal matching funds available from the Centers for Medicare and Medicaid (CMS) to finance a future integration effort, since those funds are available through 2015.²⁰

Concurrent Investments in Eligibility and Enrollment Systems for Medicaid/CHP+

The state's eligibility and enrollment system for Medicaid/CHP+ is the Colorado Benefits Management System (CBMS); as an integrated system, CBMS also includes

Interoperability between COHBE and Medicaid/CHP+ Eligibility and Enrollment Systems

Colorado will procure an eligibility and enrollment system for its exchange which is separate from, but interoperable with, the systems used to determine eligibility for and enroll individuals in Medicaid and CHP+. The recently-released RFP for the exchange's technology systems emphasizes the requirement for "sound operability between the exchange systems and the State Medicaid system" with regard to both technology implementation and the establishment of business processes. Specific requirements for interoperability include (among others) a single, shared MAGI¹ eligibility process in the Individual Exchange for private insurance and Medicaid/CHP+, as well as a single sign-on, so that those accessing the Exchange or the Medicaid/CHP+ web-based portal (called PEAK, and described in more detail below) can use the same username and password.

The exchange will conduct MAGI eligibility and verification of information using the federal data hub, both for customers that enter the exchange portal and for those who use PEAK. In other words, if a customer

accesses the PEAK portal and applies for coverage, MAGI eligibility is determined through the exchange system (via interfaces between PEAK and the exchange). If the customer is determined eligible for Medicaid, they enroll through PEAK. If the customer is determined eligible for a tax subsidy to purchase coverage through the exchange, they move to the exchange system and enroll/select a plan through that portal. The RFP describes several steps that contractors must take to ensure that this process is as seamless as possible; in addition to the single sign-in mentioned above, the systems will share a single Master Person Index (i.e., the state Master Data Management service as the authoritative source for customer information), and data elements entered by customers in either system will be stored and reused so that customers will not be required to enter the information again.

¹ Under the ACA, eligibility for some Medicaid populations—primarily non-disabled adults and children—will be determined using their Modified Adjusted Gross Income (MAGI). Eligibility determination for other Medicaid populations—primarily aged, blind, and disabled beneficiaries—will use traditional methods for determining income.

human services programs that provide cash and food assistance. Though only seven years old, CBMS has been plagued with problems since its launch, including vendor management issues, lack of funding, and system glitches that resulted in wrongful terminations, large backlogs, and eventually led to a lawsuit, which the state lost. Criticism of CBMS was near-universal among key informants, and experience with this flawed system was another influential factor in determining desired levels of horizontal and vertical integration for the exchange. A particularly frustrating feature of CBMS is the time it takes to make even a minor change to the system—informants suggested that this is a consequence of both the system being “hard-coded” and of the governance structure, which involves collaboration between three agencies—Medicaid, the Department of Human Services, and the Governor’s Office of Information Technology.

Despite the challenges posed by CBMS, Colorado has made considerable progress in simplifying eligibility and enrollment for its public health coverage programs in recent years. With support from a federal grant²¹ the state created electronic database interfaces for verifying information on identity and income (e.g., an interface with the Social Security Administration to verify identity and citizenship data, for instance, yielded a 95% matching rate in the first month of implementation) and developed a web-based portal called PEAK that consumers can use to apply online for Medicaid and other benefits. In its initial (and current) phase, PEAK does not result in real-time eligibility determination—a caseworker must enter the application into CBMS after it is submitted online and sent to an electronic mailbox. However, state officials noted plans to modify both CBMS and PEAK in the 2012-2014 timeframe, to allow for real-time eligibility determinations and automated application processing, per the ACA’s requirements. In December 2011, Colorado submitted an Implementation Advanced Planning Document (IAPD) to CMS, a required step in applying for the enhanced 90/10 federal matching funds. The IAPD outlines the state’s plans to upgrade CBMS and PEAK so that 1) these systems can interact seamlessly with the exchange, and 2) the state will better be able to handle the influx of new Medicaid/CHP+ enrollees in 2014. Key informants noted that they are considering a module-by-module replacement of CBMS; they would begin by procuring an “off-the-shelf” rules engine as part of their modernization efforts and, over time, migrate CBMS programs into the new system until the old one could be disabled.

Challenges to Developing and Modernizing IT Systems

Key informants described several challenges related to implementing ACA-compliant exchange and Medicaid/CHP+ eligibility and enrollment systems. Without a doubt, the aggressive timeline for implementation is the foremost concern—one informant joked, “I’m pretty sure that we’re already out of time.” Another challenge noted during the site visit was the role of county governments—as autonomous authorities, county social service agencies are responsible for Medicaid (and some CHP+) eligibility and enrollment processing, and wide variations in practice from county-to-county are not uncommon. Counties embrace the current system and, according to key informants, often resist the changes that are viewed as necessary for successful ACA implementation. As one informant noted, “The counties take pride in their differences, which is contradictory to a business process improvement mentality where you might try to standardize things.” Another spoke more candidly and said, “As efficient as we make the eligibility side of things, we still aren’t going to be able to reduce our county administrative [budget] line, because of politics.” State officials are aware of the challenges ahead with regard to managing changes in the roles and functions of current stakeholders in the eligibility and enrollment process for Medicaid/CHP+, and were planning a summit of county social service caseworkers—likely to happen in Fall 2012—as part of the ‘change management’ process.

Existing structures for outreach and enrollment assistance in Colorado should prove helpful as the state develops its plan for outreach and public education.

Maximizing Enrollment in the Exchange, Medicaid, and CHIP

The state is still in planning stages for its outreach efforts related to the exchange and public coverage programs. As noted above, COHBE hired a Communications Manager, whose responsibilities include co-leading (with a manager from HCPF) the MEOW group, which meets regularly. Recent MEOW activities have included identifying potential outreach contacts (such as media outlets, health care providers and insurance carriers, and community-based organizations or CBOs) and several high priority target populations such as “young invincibles” (i.e., young, healthy, uninsured adults), the small business

community, legal immigrants, and communities of color. In addition, the customer service components of the RFP include not only the development and operation of a customer Contact Center, but also outreach, training, and communications. Specifically, the contractor(s) responsible for this component of the individual and SHOP exchange must develop curricula and administer comprehensive training programs delivered through a variety of tools and adult learning methodologies at both the Contact Center and in remote locations for eligibility workers, navigators, brokers, and others.

Existing structures for outreach and enrollment assistance in Colorado should prove helpful as the state develops its plan for outreach and public education. For instance, the state has a multi-tiered system of application assistance for Medicaid and CHP+, including: Medical Assistance sites that conduct on-site application processing; Presumptive Eligibility sites that determine presumptive eligibility for pregnant women and children; and Certified Application Assistance sites—typically community groups that do application assistance as part of their mission. In addition, outreach subcontracts funded through a recent federal grant (described in greater detail in the Medicaid Policy section) have helped Colorado build an “outreach army” of CBOs who are trained to reach and enroll the Medicaid and CHP+ eligible populations.

While the network of CBOs and application assistors currently working with the Medicaid and CHP+ programs could be a valuable resource for reaching some

populations of new ACA eligibles, key informants also noted the need for other types of enrollment assistance, including through the Navigator program and insurance brokers/agents. The details of the state’s Navigator program haven’t been decided yet, and informants expressed different opinions on how it might be structured—some described distinct roles for navigators and brokers/agents. One informant said, for instance, “Navigators and brokers do very different things, though with a certain amount of overlap. Some people think navigators will replace brokers. [There is] a definite role for navigators, such as instructing, providing information, and teaching, but not necessarily providing the hands-on professional services that brokers provide.”

Others suggested that currently licensed brokers/agents might become navigators. If this is the case, informants were concerned about how the exchange would monitor the Navigator program to deter “steering” (i.e., encouraging enrollment in a particular health plan) by broker/agent navigators who might have existing relationships with insurance carriers. Regardless of the form that Colorado’s Navigator program ultimately takes, key informants described clear goals for consumer assistance, noting that stakeholders at the series of forums held in summer 2011 agreed on “the need to have trusted educated consumer assistors, whether they are current brokers [and/or] navigators. The notion of it being a highly structured role—a role that has continuing education requirements, quality assurance, and trust—was clear.”

INSURANCE REFORMS

Since 1968, the Colorado Division of Insurance (DOI) has been one of nine divisions within the Department of Regulatory Agencies (DORA), a wide-ranging consumer protection agency. Traditionally, only small group and individual health coverage was much regulated, but in 2008, the Fair Accountable Insurance Rates (FAIR) Act gave DOI “prior approval” authority to review all health insurance premium rates before they are used in the marketplace.²² (Still, DOI regulates only about a third of coverage; many more people are in self-insured private coverage or in public plans.²³)

During the years leading up to the passage of the ACA, Colorado also enacted a number of other protections for private health insurance consumers. A 2007 statute, for example, restored a ban on the use of health or

claims history in setting premiums for small employers initially established in 1994.²⁴ The 2008 legislature created several new protections for the Division of Insurance to implement in addition to the FAIR Act just noted.²⁵ In 2009, the state required coverage for certain preventive services and for autism spectrum disorders.²⁶ In 2010, it barred the use of gender as a premium rating factor for individuals, created an all-payer claims database, and mandated that most insurance policies have 10th grade readability.²⁷

Early (2010) Market Reforms

As just noted, the state’s earlier insurance consumer protections resembled many of those contained in the ACA. There were differences, said state officials, such as

covering adult children through parents' private policies to age 25 rather than 26, defining fraud differently in the ban on unjustified rescissions, and the like. Thus, state statutory change was not vital, and a decision was taken at higher levels of the administration to postpone any legislative response to the ACA.

To improve understanding of and compliance with the early private insurance reforms, DOI issued a bulletin supporting the law in August 2010, the month before the new rules were to take effect.²⁸ This guidance covered each of the federal provisions in turn, including the new restrictions on rescissions and annual limits of essential benefits; the bans on lifetime dollar limits and on exclusions of preexisting conditions for children; the requirements to extend dependent coverage to adult children to the age of 26; to provide coverage without cost sharing for proven preventive services; to cover emergency services and within-network OB-GYN services without prior approval; and to allow enrollees to choose any willing pediatrician as a child's primary care provider; as well as other provisions.²⁹ The bulletin notes that "Carriers are not only required to comply with Colorado's laws, but also all applicable laws, in the conduct of their business," including the ACA.

Overall, carriers seem to be positioning themselves for 2014, for instance, seeming to move their premiums toward a three to one rate band for age.

The agency planned to enforce the ACA's early private market reforms indirectly: carriers must certify in their policy filing forms that they are in compliance with applicable law. If a DOI review finds that the carrier is actually not in compliance, DOI can sanction that mis-certification. In the past, however, DOI has not routinely done such reviews. A well placed observer elsewhere noted that the Division mainly takes enforcement action in response to complaints. DOI sources say they are "dancing a fine line" in promoting consumer rights without explicit enforcement authority." Indeed, DOI staff conceded that, without an underlying state statute, the 2010 bulletin itself carries little "real authority," which suggests that the state might find it difficult to impose sanctions on violators. If state efforts prove insufficient, they expect that the federal government will enforce the

law. During the 2011 legislative session, DOI did propose draft legislation to align state and federal law—which would have given it statutory authority to enforce the early market reforms—but the administration did not move a bill forward. The DOI draft had low priority relative to the Exchange bill, which required substantial attention to shepherd through both houses, as already described. DOI does not expect to advance any legislation in 2012, but does want to do so before additional ACA insurance market reforms take effect in 2014. Later submissions will be more successful, respondents surmised, because the provisions could be portrayed as a way to harmonize Colorado's legal requirements with those elsewhere, thus allowing insurers to operate more efficiently. Multi-state carriers and consumer advocates may well help promote this approach.

Even if the state moves to give DOI legal authority to enforce the ACA's private market reforms, state officials noted the challenge of having sufficient resources to do so. Federal grants have offered much start-up assistance, but not money for ongoing enforcement. Here, respondents emphasized that finding new state revenues for new responsibilities is an enormous challenge in Colorado. They even noted that, while it might make sense for DOI to field consumer complaints about insurance sold through the exchange, just as they do for other coverage, the exchange would have to reimburse the agency for the extra effort.

Even without legislative action, early-reform implementation proceeded smoothly, with voluntary compliance by the industry, according to numerous respondents. Child-only coverage was an exception. Initially, DOI feared enrollees' "hopping in and out" of the child-only market as their medical needs dictated, and sought to address this by limiting open enrollment to twice a year.³⁰ The agency subsequently realized that a bigger problem was keeping carriers in the market since nationally (not just in Colorado) carriers were exiting the child-only market out of fear of adverse selection. In Colorado, however, each carrier indicated willingness to sell child-only policies if all other carriers had to, and advocates agreed. So, consensus legislation was passed that required any plan that sells individual policies to also offer child-only policies, during two open enrollment periods each year. DOI quickly issued an emergency regulation, effective in August 2011.³¹

As to the early market reforms' impact on the insurance industry in Colorado, one source termed it "no big deal."

For example, implementation of the ACA's prohibition on lifetime dollar limits for essential health benefits was not a problem because most insurers in Colorado had already shifted from dollar limits on benefits to volume limits. (Informants explained that a complicating factor is that it is hard for carriers to maintain spending data over multiple years, especially when their IT systems change. Carrier consolidation also makes it “tricky” to track multiple-year spending across formerly separate companies.) More broadly, one administration official predicted that all the big carriers would readily accommodate to the totality of new rules, but that some “fringe” carriers would leave the individual market, such as those enrolling as few as 20 or 50 “lives.” The respondent viewed this prospect with equanimity; nearly 400 carriers now sell some form of health coverage in the state, although 10 big ones have 70 percent of the market.³²

Key informants reported that, while premiums in Colorado's private insurance markets continue to rise, the ACA is not the primary reason for increasing rates. According to DOI analyses, the ACA's early market reforms contributed from zero to a maximum of 5 percent of the 2011 premium rate increases.³³ Informants noted in particular that the ACA's restriction on annual dollar limits for covered benefits is “much more problematic” than the prohibition on lifetime dollar limits, in terms of contributing to premium increases. On the other hand, DOI officials noted that carriers may be preemptively filing reduced rates to avoid having to issue rebates related to the new medical loss ratio or MLR requirements (described below), but only one carrier has so informed DOI. Overall, carriers seem to be positioning themselves for 2014, for instance, seeming to move their premiums toward a three to one rate band for age.

According to DOI staff, they have heard of only relatively minor problems from consumers with regard to the private insurance market reforms that have taken effect so far. For example, consumer complaints often derive from a perception that it is now illegal to increase premiums by more than 10 percent, whereas the 10 percent figure actually is only a trigger for rate review: “Peopleglom onto whatever they can with only a limited understanding of the provisions” in the law, noted one informant. Improved consumer understanding was seen as a substantial looming challenge, including not only correct appreciations of consumers' new rights but also realistic expectations. This includes the understanding that the Division alone cannot halt premium increases, and that addressing growth in medical costs (such

as through the state's efforts to improve health care coordination) is also necessary.

Preparation for the 2014 Market Reforms and Other Future Policy Decisions

Key informants said that state legislation was needed to help implement the 2014 federal reforms in Colorado insurance markets. (Such federal reforms include requiring guaranteed issue of coverage and prohibiting exclusions of pre-existing conditions for adults.) One official explained that DOI is identifying just what state changes are needed, since some of the reforms may be addressed through federal implementation; any changes would need to pass by the end of the 2013 legislative session. As noted above, the expectation is that this legislation will harmonize state and federal rules and will give the state the statutory authority it needs to enforce the rules. However, the extent to which the state's political process will agree is unknown.

DOI staff noted many other decisions related to private health insurance markets that have yet to be made. The state had only just begun to think about the temporary reinsurance program it must have in place for 2014-2016, under which a nonprofit entity must collect payments from insurers in the individual and group markets and then disburse payments to individual-market insurers that cover high-risk individuals. One interested nonprofit entity has reportedly contacted the state about this, but DOI officials noted, “we're putting them off because we're not ready to make that decision yet.” What to do about any state health benefit mandates that exceed the essential health benefit (EHB) package—and hence might have to be subsidized by the state in accordance with the ACA—was also recognized as an important but still outstanding decision. (Notably, our site visit occurred before the federal bulletin giving states wide discretion to decide on the contents of the EHB package.³⁴) Mandates are seen to have very strong constituencies; one source said that any discussion of their fate will be “quite robust. We haven't even started to have [that] conversation.”

Other issues that the state is grappling with include sustaining the recent enhancement of regulatory activities after 2014, when federal grant funds are no longer available, and deciding how to approach Colorado's “groups of one,” that is, self-employed people who can be defined as a small group in Colorado insurance law, but perhaps not under the ACA.

The outcome of other outstanding decisions seemed evident, according to key informants. For instance, there

is no talk in Colorado of going beyond changes required by the federal reforms. Businesses and carriers are wary of more mandates or regulation such as tighter age rating bands. Greater standardization of benefits within the exchange's Bronze/Silver/Gold/Platinum tiers appeals to some, but is impossible in Colorado absent "massive political change with the 2012 [legislative elections]." Finally, regardless of uncertainties and how many issues remain open, one informant expressed strong confidence about the future of the state's private insurance markets, reasoning that, under the ACA, "carriers will figure out how to proceed because there is money to be made."

Premium Rate Review

During the early 2000s, Colorado had "file and use" authority over insurers' premiums. That is, companies were obligated to file copies of their rates with DOI, with a minor level of justification for their pricing, and then could immediately begin to use the premiums in the marketplace.³⁵ Thus, DOI was reviewing rates, but could not block their implementation. Regulators could only object later and attempt to roll the rate back. The FAIR Act of 2008, already noted (HB 08-1389), instead gave DOI "prior approval" authority over premium increases, so that a carrier must not only file the intended premium, but it must also obtain DOI permission before it puts the new premium into effect; DOI has 60 days within which to make a decision on a rate, and has explicit authority to deny approval.³⁶ The 2008 law also required carriers to supply more information, including a full actuarial memorandum, not just a certification that the rate meets actuarial standards, and allowed DOI to look at more factors when considering the reasonableness of rates—loss ratio benchmarks, carrier profits, investment income, surplus, and other items). The 2008 legislation has taken longer than expected to implement, according to state officials, and became fully effective only in 2012.³⁷

Given the existence of this process prior to the ACA, DOI has not sought additional authority from the legislature to comply with ACA requirements for rate review. As one official noted, "We were deemed an effective rate review process all along."³⁸ Indeed, the federal Government Accountability Office ranked Colorado the 6th highest state in the share of rate filings changed by review.³⁹

At the same time, Colorado officials noted that their rate review process had improved as a result of the ACA. They described the new NAIC supplemental filings as providing good data and more tools to focus rate reviews on actuarial justification, noting that, "Before the supplement we didn't even have a breakdown of

the markets." The process has also improved because of additional staffing and better IT, helped by federal Cycle I & II rate review grants totaling about \$5 million over four years.⁴⁰ DOI had hired 6 new staff and will add a few more under the second grant. The extent of new staff does not tell the whole story, as "Even those who aren't grant funded are doing this work, and taking time away from other duties." New IT capability is under way that will support immediate review and "automatically populate" potential objections, facilitated by the fact that the NAIC filings already come in an electronic form that the state plans to upload into its new system. Better IT extends also to a consumer-friendly rate summary and the ability for Coloradans to request email notification of rate increases.⁴¹

Medical Loss Ratios

State regulators see minimal problems with the ACA's Medical Loss Ratio (MLR) requirements, which require that carriers spend a certain share of their premium dollars (at least 80% in individual and small group markets, and 85% in large group markets) on medical care and quality improvement activities, as against administrative expenses. DOI has used its own MLRs as part of rate review for many years. The percentage shares are somewhat different from the new federal standards—85% for large group and 80% for small group, but 65% for individual coverage.⁴² Moreover, DOI benchmarks premiums against a straightforward ratio of benefits paid out to premiums taken in, which staff see as "more pure" than the ACA federal MLR and which they will continue to use. They described the federal approach as useful but less credible (presumably because it has not been verified by years of usage).⁴³ State officials are also a bit unsure how to use some of the factors listed in federal guidelines, citing executive salaries as an example.

DOI will seek to use its state MLRs at the "front-end" of overseeing rates through prior approval, but in doing so will seek to minimize the rebates provided to consumers on the "back end" of the policy year if carriers do not meet federal MLR requirements that are also applicable. There is no direct requirement that a carrier meet federal MLR standards in order to receive prior approval from the state, but state officials noted, "We don't feel comfortable if a carrier anticipates providing a rebate, and we will work with them to address this." Regarding DOI's role in overseeing the MLR rebate process, they see the rebate as a federal issue for which the state will simply supply annual statement data. The first rebates will likely occur

in June 2012, and officials noted that 2011 was “a good year” of lower claims. At least two carriers will seek to avoid rebating by offering enrollees some alternative, like a free month of coverage at renewal. They especially want to avoid a “de minimus” rebate that would be apt to anger rather than please a customer, especially one who has just received a notice of rate increase.

Consumer Awareness and Education

In fall 2011, DOI rolled out a new educational website to “glowing reviews” from consumer groups and from the regional director for HHS.⁴⁴ The Division has also created a 30-minute informational video and other materials on ACA-related private insurance reforms.⁴⁵ Notably, Colorado did not apply for a Consumer Assistance Program (CAP) grant given the limited one-year funding available to states for the program.

Despite these activities, some key informants mentioned shortfalls in public communication. DOI staff also said they often fielded calls from consumers confused about the ACA’s private market reforms, reporting “There is a lack of consumer understanding, and an information gap. People aren’t sure about when different pieces go into effect or what it entails.”

High-Risk Pools

Colorado’s own high-risk pool, CoverColorado, began in 1991. It offers comprehensive insurance to people refused conventional coverage, using a statewide PPO network and a range of deductibles and corresponding out-of-pocket limits.⁴⁶ Rocky Mountain Health Plans administers medical benefits and Express Scripts administers prescriptions.⁴⁷ Informants described the pool as generally successful, pointing to its enrollment of almost 13,000, making it the 7th largest in the nation.⁴⁸ The program’s key problem has been repeated financing shortfalls, necessitating a recurrent search for stable funding to supplement enrollees’ premiums.⁴⁹ Policymakers have also sought to economize, calling for

a fee schedule to limit medical reimbursements,⁵⁰ which began in April 2011 despite some objections.⁵¹

The federal high-risk pool required by the ACA (also known as the Pre-existing Condition Insurance Plan or PCIP), called GettingUSCovered, opened in July 2010.⁵² It operates under federal rules, but is state-administered and was created through close consultation among DHHS, the Governor’s office, Rocky Mountain Health Plans, and CoverColorado. All funding beyond premiums comes from the federal fixed allotment of \$90 million for three years.

The two pools differ somewhat. Arguably the biggest difference is that federal eligibility requires an uninsurance period of at least 6 months, whereas the state imposes a 6-month waiting period for prior lapses in coverage of over 90 days. The premiums in the state financed high-risk pool seem a bit higher than in the federally financed one, but benefits are also somewhat more generous.⁵³ Though key informants described their goal of seamlessly coordinating the state and federal high-risk pool programs—Rocky Mountain Health Plans helps run both, and the pools cross-refer applicants to one another—a consumer advocate noted that enrollees were still often confused by the existence of the two pools.⁵⁴

Enrollment in the federal high-risk pool, which was around 1,000 people at the time of our site visit, was criticized by many key informants as low. They suggested that both high premiums and the rule requiring 6-months without insurance contributed to low enrollment, and also thought that outreach had been insufficient. One informant said that the state pool’s success left little unmet need for the federal pool, while several others felt that enrollment was low only relative to inflated federal expectations. They noted that per capita enrollment is above average compared to other states, and growth is what state officials projected.⁵⁵ Officials do worry that the very high cost enrollees attracted into the pool could “blow through” the fixed federal allotment before 2014.

MEDICAID POLICY

The ACA Medicaid expansion and related reforms will build on relatively recent actions in Colorado to expand eligibility for public coverage programs and to simplify enrollment processes. As described above, the Colorado Health Care Affordability Act of 2009 established a hospital provider fee that draws down federal matching funds and generates new revenue for

enhanced hospital reimbursement, as well as Medicaid and CHIP expansions. Specifically, the Act authorized a CHIP expansion for children and pregnant women in families with incomes up to 250 percent of the FPL level; a Medicaid expansion for parents with incomes up to 100 percent of the FPL; an expansion to adults without dependents with incomes up to 100 percent of the FPL;

the creation of a Medicaid buy-in option for individuals with disabilities who have incomes up to 450 percent of the FPL; and 12-month continuous eligibility for Medicaid children (12-month continuous coverage already exists for CHIP). These provisions are being phased in over time; coverage expansions for children, pregnant women, and parents/caretakers have already taken effect. The state plans to expand Medicaid to adults without dependents in spring 2012, but this expansion will initially be limited to only those with incomes up to 10 percent of the FPL and capped at 10,000 enrollees.⁵⁶ Current eligibility levels for several key populations under both Medicaid and CHIP, as a percentage of the federal poverty level, are presented in Table 1.

Table 1: Colorado’s Medicaid and CHIP Eligibility Levels, as a Percent of the Federal Poverty Level (FPL), January 2012

	Medicaid Eligibility Limit	CHIP Eligibility Limit
Children ages 0-5	133%	250%
Children ages 6-19	100% ^a	250%
Pregnant women	133%	250%
Parents	100%	N/A
Adults without Dependent Children	N/A ^b	N/A
Adults with Disabilities	75%	N/A

Notes: (a) Colorado passed a law in 2011 that will align children’s coverage levels in Medicaid and CHIP across age groups. The law, which will raise the Medicaid eligibility level for children ages 6-19 to 133% of the FPL, will take effect in 2013; (b) In Spring 2012, the state plans to extend Medicaid to adults without dependent coverage with incomes up to 10% of the FPL.

Source: Kaiser Family Foundation, Income Eligibility Limits for Children, Low-Income Adults, and Pregnant Women as a Percent of the Federal Poverty Level (FPL), Available at <http://statehealthfacts.org/comparecat.jsp?cat=4&rgn=6&rgn=1>.

Though the 2009 law authorized a more significant expansion to single adults, funds from the hospital provider fee were instead used to address the increased Medicaid caseload resulting from the economic downturn. Key informants likened the limited adult expansion to a pilot project that would provide valuable information on the characteristics of a target population (low-income adults without dependents) that the state has had no experience with covering. Restricting the expansion would also allow the state to provide this population, which officials assumed would have higher-than-average mental health and/or substance abuse needs, with the full Medicaid benefit package. Advocacy-oriented informants,

in particular, noted that they “would much rather see a richer Medicaid benefit provided to fewer people than a watered-down benefit to more people.”

While Colorado’s 2009 Medicaid/CHIP legislation did not include funding for outreach and enrollment activities, the state received a federal State Health Access Program (SHAP) grant from 2009-2011.⁵⁷ Informants described the grant as complementary to the Medicaid/CHIP expansion law because it was used for community-based outreach efforts and a range of important improvements to the state’s eligibility and enrollment systems. In addition to the PEAK web portal and the electronic data interfaces mentioned earlier in this report, SHAP funds supported:

- Contracts with community-based organizations to conduct outreach and enrollment assistance for public coverage programs;
- Development of an Express Lane Eligibility program;⁵⁸ and
- Implementation of automated, ex-parte renewal processes.

Informants noted that the SHAP grant was integral in helping Colorado build a foundation for many of the ACA requirements related to simplified eligibility and enrollment processes for public coverage programs.

Since Colorado enacted policies to expand public coverage in the year before the ACA was passed, key informants noted that the federal health reform law’s Medicaid expansion did not garner much attention during the state’s broader political discourse surrounding ACA. At the same time, some state officials expressed concern about the implications of the ACA Medicaid expansion for the state budget, which is uniquely limited by TABOR. One informant stated, “The program in its current state is unaffordable. The Medicaid caseload has grown exponentially since 2008 [due to the economic downturn]...and the state may never be able to restore the cuts it is currently making to other programs in order to pay for Medicaid.” Another informant expressed concern about changes in the federal government’s approach to provider fees as a financing mechanism, and the proposed federal limitations or elimination of these fees; Colorado, since 2009 especially, relies heavily on provider fees for these expansion populations under ACA, so this potential change could have negative effects on the state’s Medicaid program. Colorado’s program has a \$5.1 billion budget, which includes \$1.7 billion from general funds, \$2.5 billion from federal funds, and roughly \$700 million

in 15 different cash funds, which are primarily raised from hospital and nursing home provider fees.

Though the diversion of funds from the 2009 Medicaid hospital provider fee has helped to relieve some of the recession-related pressure on the state budget, Colorado has implemented a series of other policies to contain costs in the Medicaid program, including:

- A total of about 5.5 percent in provider rate cuts over the last three years;
- “Targeted efficiencies,” described as rate cuts to specific services or medical equipment for which the state was paying more than the private sector or Medicare;
- Redesign of the pharmacy program and other benefits; and
- Restrictions and limitations to benefits.

Notably, the state recently formed a Medicaid Benefits Collaborative involving the Medicaid agency and various stakeholders (e.g., clients, providers, contractors) to define the amount, duration, and scope of Medicaid fee-for-service benefits so that consumers and providers would better understand what enrollees were entitled to receive. Key informants suggested that the Collaborative, though not designed for this purpose, could also allow policymakers to take a more “rational approach to cutting benefits.”⁵⁹

Opportunities for Cost Savings

Colorado waited to implement its Medicaid expansion for parents and caretakers with incomes up to 100 percent of the FPL until May 1, after the ACA was signed into law in April 2010; the state took this approach so that it would receive 100 percent “enhanced” federal matching funds for the expansion group beginning in 2014, rather than the 50 percent match rate it currently receives—a critical savings for the state.⁶⁰ While no decisions have been made regarding changes in Colorado’s Medicaid/CHIP eligibility levels once the ACA’s Maintenance-of-Effort provisions expire,⁶¹ officials indicated that the state would consider transitioning beneficiaries with incomes above the new federal minimum eligibility level of 138 percent of the FPL (in Colorado, this would be pregnant women and children) into federally-subsidized private coverage available through the Exchange, since this would result in further savings for the state.

Medicaid Managed Care

Fewer than 10 percent of Colorado’s Medicaid beneficiaries are enrolled in a comprehensive risk-based managed care,⁶² and the state currently has only one risk-based contract with the Denver Health Medicaid Choice managed care organization. In the late 1990’s a

much larger proportion of the Medicaid population was enrolled in risk-based managed care, but after losing a lawsuit contesting the state’s capitation rate setting, the Medicaid program largely dismantled its managed care program. Nearly every health plan left the Medicaid managed care market; only Denver Health remained and was able to create a sustainable business model within the rate constraints.

Colorado’s Medicaid program, historically somewhat limited in scope...has implemented several important changes that should help smooth the state’s transition to full ACA implementation.

Now, the state is pursuing more managed and efficient health care delivery using a different approach with its new Accountable Care Collaborative (ACC) initiative. State officials described the ACC as a quasi-managed care model that is aligned with ACA principles of improving health and reducing costs through the development of “accountable care organizations.” They compared the model to a primary care case management program “but with more players,” including three distinct entities that each have incentives to collaborate and improve coordination: a Regional Care Collaborative Organization (RCCO, of which there are currently seven across the state), a Primary Care Medical Provider (PCMP), and a statewide data repository (SDAC). Each of these entities receives per member per month (PMPM) payments in addition to the traditional fee-for-service (FFS) reimbursement,⁶³ but the state would like to eventually (and slowly) replace the FFS structure with a more advanced payment model. The ACC effort currently includes incentives for reductions in emergency room use, imaging, and hospital readmissions; the state plans to introduce gains-sharing and a hold-back (i.e., placing a portion of payments at-risk, only to be paid if certain desirable outcomes are achieved) next year, and is also exploring a global payment model for certain ACCs. The state launched the ACC effort in mid-2011, with the intent of enrolling all Medicaid beneficiaries into an ACC within a few years; at this time, beneficiaries are passively enrolled in the program and continue to receive the regular Medicaid benefit package.

Other ACA-Related Medicaid Issues

Key informants felt that Medicaid provider capacity would be inadequate to serve the influx of newly-eligible Medicaid enrollees beginning in 2014. Colorado is already experiencing a shortage of Medicaid

providers, particularly dental and behavioral health providers, and especially in rural frontier areas. The state did not, however, expect to increase Medicaid provider reimbursement as a mechanism to encourage greater participation in the program, for instance by supplementing the federally funded temporary increase in reimbursement for certain primary care services in 2013-14. Given current state budget pressures, state officials suggested that it was very unlikely that they could afford to increase rates, noting that “with the series of rate reductions over the past several years due to cost containment, we’re more focused on hanging onto what we have!”

With respect to Medicaid benefit changes related to the ACA, key informants reported that no decisions had been made regarding the benchmark benefit package that will be provided to beneficiaries who are newly eligible as a result of the 2014 expansion. Notably, Colorado plans

to provide adults without dependents who are eligible via the limited expansion planned for spring 2012 with the full Medicaid benefits package, at least initially. Key informants suggested that the state might later modify the benefit package for this group, or create tiered benefit packages for different expansion populations.

Basic Health Program (BHP) Option

There has been very little discussion of creating a BHP in Colorado and—while they had not ruled it out—state officials did not appear to be seriously considering the option. Most key informants noted the disadvantages of the BHP, with a primary concern being a BHP’s potential to divert too many covered lives away from the Exchange and, presumably, diminish its ability to effectively pool risk. As one informant stated, “There is already worry that the Exchange market won’t be big enough in general; establishing a BHP could exacerbate the problem.”

PROVIDER AND INSURANCE MARKETS

The success of health reform, in Colorado and nationally, may well hinge on issues surrounding access to care. The organization and capacity of health systems, and responses to reform by both providers and insurers will directly affect access, coverage, premiums, subsidy costs and, ultimately, the sustainability of reform efforts. Colorado, at this early stage of implementation, has enjoyed generally strong support and involvement from the provider, insurer, and small business communities, though the capacity of the primary care system, especially in the state’s large rural areas, was of great concern to the key informants interviewed for this study.

The current organization of providers and insurers in Colorado creates a promising environment for reform.

Key Characteristics of the Provider and Insurer Systems

Colorado’s hospital system includes many small, critical access facilities in the rural and frontier regions, as well as very large, integrated systems located along the more populous Front Range. Some of the most prominent players include the University of Colorado Hospital—a private, not-for-profit academic medical center with a network of primary care and specialty clinics; Denver

Health—a comprehensive, integrated system that is the largest “safety net” institution in the state and includes acute care facilities, a health plan, eight primary care community health centers, and a network of 13 school-based health systems; Children’s Hospital Colorado, a pediatric-focused non-profit system also affiliated with the University of Colorado; and Centura Health—the state’s largest health system, a not-for-profit integrated network composed of 13 hospitals, seven senior living facilities, and a 6,000 member physician group spanning the state.

At least along the urban Front Range, the hospital market was described as quite competitive. There have not been many hospital mergers in the last 15 years, but there has been increasing consolidation as hospitals have “bought up” physician practices. As described by one stakeholder, “This trend is not a response to the ACA, as much as a physician response to the mechanics of running a practice. Frustration is driving physicians to hospitals, though hospitals are also actively recruiting in anticipation of delivery changes [under health reform].”

The physician market in Colorado tends to be dominated by small, independent practices, though some larger groups exist in the urban markets of Denver and Colorado Springs. Kaiser Permanente, Centura, and the University of Colorado represent some of the largest physician groups, “...though no single, dominant group serves as a ‘voice’ for that community,” according to

one key informant. Kaiser, according to many, has been particularly aggressive and successful in expanding its networks beyond Denver to such areas as Boulder, Colorado Springs and Pueblo, and was said to be poised to move north to the Fort Collins market.

No national managed care companies have their headquarters in Colorado, and no single health plan dominates the state's private insurance market. Rather, four major plans—including Kaiser, United Health Care, Anthem Blue Cross, and Rocky Mountain Health Plan—divide most of the business, with smaller shares going to Cigna, Aetna, and Humana. This relatively competitive environment, and lack of significant market-share leverage possessed by any single carrier, "... helps explain why hospitals are getting paid pretty well," according to one industry stakeholder. Kaiser's managed care program was described as particularly effective—"It's scaring the bejeebers out of other plans!" said one informant—because the plan efficiently manages its provider network and has invested heavily in quality improvement initiatives and electronic health record systems. Meanwhile, Rocky Mountain Health Plans, an independent nonprofit plan based in Grand Junction—on Colorado's Western Slope—operates statewide, is involved in administering both the state- and federally-funded high risk pool, and continues to garner national attention for its innovations in chronic care management.

As discussed above, Colorado largely disassembled its Medicaid managed care program in the late-1990s. Currently, Denver Health Medicaid Choice is the only health plan that holds a full risk-based contract with the state to deliver a comprehensive set of health services to Medicaid beneficiaries.⁶⁴ Colorado Access—a plan originally born of the state's safety net community health centers—is the largest Child Health Plan Plus (Colorado's Children's Health Insurance Program) health plan.

Primary Care Capacity and the Safety Net

Without exception, key informants from all sectors expressed significant concern about Colorado's primary care capacity. Most believed that capacity was already stretched, and therefore questioned how the roughly 500,000 newly insured Coloradans would gain access to care after the implementation of health care reform in 2014. This concern was especially acute with regard to the state's vast rural areas; Colorado has a geographically mal-distributed physician workforce with the majority of health professionals practicing in urban or suburban communities along the Front Range. Interestingly, however, a new report by the Colorado

Health Institute suggests that the workforce challenge may be more manageable than anticipated, projecting that the state would need an increase in supply of primary care providers of approximately two to three percent to accommodate demand from newly insured persons.⁶⁵

A large portion of the care burden will fall upon the state's network of Federally Qualified Health Centers (FQHCs). According to the Colorado Community Health Network (CCHN), there are 15 distinct FQHC organizations in the state, operating a total of 130 service delivery sites. These centers have a wide reach—serving as the primary care medical home for about 500,000 Coloradans annually in 57 of Colorado's 64 counties. They also range in size from very large (e.g., Denver Health's 13 health centers serve roughly 100,000 patients per year) to "tiny" centers on the Western Slope that may serve fewer than 1,000 patients annually.

Colorado's primary care capacity will be seriously strained by reform's increases in coverage, but a strong network of safety-net providers will play a critical role in serving the newly insured.

Steady federal funding of FQHCs over the past decade has allowed Colorado's centers to double their capacity since the year 2000—from 250,000 to 500,000 patients per year. "But demand has always outstripped supply," according to one stakeholder, and little has changed in the profile of the individuals these providers serve: almost 95 percent of FQHC clients have incomes below 200 percent of poverty, 45 percent are uninsured, and one-third are covered by Medicaid. CCHN estimates that it could double its network capacity again by 2015, with the new revenues it will obtain by virtue of having so many of its currently uninsured clients gaining Medicaid coverage under reform. As one Denver Health official said, "We could take the uninsured adults we're already seeing and put them into Medicaid—it wouldn't require expanding, we'd just be getting paid for them!" But while doubling capacity might allow health centers "to get close to meeting the demand," stakeholders also feared that there are large numbers of currently eligible-but-not-enrolled adults across the state that might come out of the woodwork after 2014, "that are not getting care at all [right now]."

Many informants interviewed for this study felt it would be critical, moving forward, for Colorado to address not

only its shortage of providers, but also the manner in which resources were used to deliver care. On the supply side, few were optimistic that private physicians were the answer—their willingness to serve increasing numbers of Medicaid recipients will be suppressed by reimbursement rates that are generally viewed as insufficient. Colorado does, however, possess a robust medical school loan repayment program, called the Colorado Health Services Corps. It mimics the federally funded National Health Service Corps and helps new physicians pay off their school loans in return for their commitment to practice in underserved areas of the state for specified periods of time. At the time of this writing, Colorado had roughly 200 state-funded, and 200 nationally-funded health professionals in the loan repayment programs, including not only primary care physicians, but also nurse practitioners, physician assistants, dentists, dental hygienists, and mental/behavioral health professionals. State funds for this program have not been plentiful; rather, private foundation support has funded the bulk of the Colorado program⁶⁶, and combined state and foundation monies are used to draw down the second largest amount of federal matching funds in the nation.

Strong support from the business community helped ensure that the state's exchange legislation passed, even as some support for the law was unraveling.

With regard to improving efficiency of the delivery of care, one stakeholder said, “The system needs more providers, but it also needs to organize current providers in a smarter way, for example, by using nurses to screen patients...” As described in the Medicaid section of this report, that program’s ACC initiatives appear to hold significant promise for improving the organization and coordination of care, while also using payment incentives to promote improved quality. Beyond this, Denver Health reported being very invested in exploring other service delivery innovations, including telemedicine, broader use of email and text messaging to remind patients to take medications, nurse care management, and the use of community health workers and promotoras to provide outreach and support to clients. Finally, Governor Ritter in 2010 promulgated an Executive Order creating the Center for Improving Value in Health Care (CIVHC) in response to one of the 208 Commission’s recommendations that Colorado form an agency to

monitor quality.⁶⁷ CIVHC was originally housed in HCPF, but was later spun off as an independent not-for-profit 501(c)(3) organization. CIVHC’s main efforts to date have been focused on the development of an All Payers Claim Database. Several key informants noted that CIVHC is also very interested in the potential of ACO-type arrangements as a means of improving quality and efficiency.

There is also perennial interest among non-physician providers to expand scope of practice rules for advance practice nurses (e.g., family nurse practitioners), physician assistants, dental hygienists, and others. But resistance to such expansions is also consistent and strong, in particular among physicians who prefer to push team-based care and coordination, while non-physician providers strive for more independence and freedom to practice. At the time of our visit, there was an active lawsuit between the state and the Colorado Medical Society/Colorado Society of Anesthesiologists, over the state’s decision to allow (under Medicare) certified nurse anesthetists to administer anesthesia without a physician’s supervision. This suit was described as emblematic of the ongoing tension over scope of practice issues.

Anticipating Health Reform’s Potential Effects

With full implementation of reform less than two years away, stakeholders in Colorado’s health care delivery system are trying to gauge how they will be affected. Hospital officials acknowledge that seeing more insured patients will mean stronger revenues, hopefully enough to offset the ACA’s provisions that will reduce Disproportionate Share Hospital payments. But they also express uncertainty, stating that “...it will be hard to know what reimbursement will be from the new privately insured patients [gaining coverage in the Exchange].” Still, hospital stakeholders remain largely supportive and optimistic: “[The] difficulty in the ACA is not where we’re going, it’s the journey. It’s a destination we’re all willing to go to, but there is no sensitivity in the public or private sectors regarding how much work it takes to get there. Hospitals are like Boeing 747s... it takes some time to move this system.”

FQHCs are less equivocal with their support and recognize that having nearly half of their patients gain Medicaid coverage—coverage that brings with it advantageous cost-related reimbursement—is a clear “win.” All of the major health plans in the state are expected to compete in Colorado’s new health insurance exchange, including Denver Health’s plan. Because the ACA requires exchange-participating plans to contract

with “essential community providers,” FQHCs also see the Exchange as an opportunity to expand their reach and serve a broader patient base. At the same time, they are cognizant of the fact that serving families with incomes potentially as high as 400 percent of poverty could be inconsistent with their core mission of serving low income and underserved individuals and families.

Although most small businesses reportedly don’t understand the complexities of the ACA and don’t yet fully understand how Colorado’s Exchange will affect them, the state’s chapter of the National Federation of Independent Business (NFIB) was emphatic in its support of SB 200 and Colorado’s efforts to form a health

insurance exchange. It was a choice of whether Colorado would “take the bull by the horns...and establish our own health benefit exchange unique to Colorado” or allow the federal government to impose its model on the state, said one small business representative. Indeed, the organization and the support of the business community it represents was credited by more than one informant for helping to ensure that SB 200 passed the state legislature, particularly at the end of last year’s session when support for the bill was wavering. As long as the Exchange is implemented in a way that allows “free market competition and choice,” NFIB expects reform to benefit a large portion of small businesses in Colorado, who have long sought more affordable health coverage.

CONCLUSIONS

At this early point in the implementation process, it is possible to identify a number of factors that have helped Colorado officials in their initial, successful launch of health care reform. It is also possible to see numerous challenges that lie ahead. Important lessons, shared by informants interviewed for this study, include the following:

- Colorado got a head start on national health reform by creating its Blue Ribbon (208) Commission in 2006, which developed a template for reform that included many of the same components that ultimately appeared in the ACA. This bipartisan deliberative effort helped build broad consensus on critical issues surrounding the need to expand access to more affordable health coverage, and led to several important Medicaid and private insurance reforms that were implemented pre-ACA. The leadership of former Governor Bill Ritter also led to a health reform Roadmap left for his successor, a systematic explication of the state’s options, drawing upon meetings with stakeholders statewide during the balance of 2010 after the ACA passed.
- Adopting a “Colorado-specific” version of health reform was critical as state policymakers responded to the ACA and began considering the design of its health insurance exchange. Washington’s contentious battle over reform, coupled with emerging Tea Party influence on politics in Colorado, significantly undermined much of the cooperative, bipartisan spirit that had surrounded the state’s pre-ACA reform efforts. Yet strong relationships among key stakeholders prevailed, and the foundation created by 208 Commission reforms helped policymakers move forward with implementing Colorado solutions to health system challenges.
- Involving a broad range of stakeholders in the health reform process, before and after the ACA passed, succeeded in garnering their buy-in, support, and ongoing commitment. The 208 Commission set the initial tone of bipartisan, broad-based cooperation. A subsequent series of 10 town hall-style meetings across the state during the summer and fall of 2010, attended by roughly 1,200 residents, providers, advocates, and insurance industry representatives, continued the process of developing a shared vision for how Colorado should structure its health benefits exchange. Strong support from the business community helped ensure that the state’s exchange legislation passed, even as some support for the law was unraveling. And during the first year of Exchange implementation, issue-oriented workgroups have allowed diverse stakeholders to continue being involved in system design. Stakeholders interviewed for this study were nearly unanimous in their belief that they had been at the table during negotiations, that their voices had been heard throughout the process, and that broad stakeholder involvement had been critical to early success.
- Colorado has taken important steps in establishing its health insurance exchange, but much work remains. As described in this case study, the state’s exchange legislation addressed primarily structure and governance issues, rather than establishing operational policies. A broad-based and talented Board has been appointed that draws upon substantial health insurance expertise among

members who appear to have “done very well with leaving [their] day jobs at the door” and working collaboratively in the interest of the exchange. Very talented staff leadership was in place throughout the first planning year, along with a Board chairperson who has a strong advocacy background oriented to underserved populations. Workgroups composed of diverse stakeholders helped the Board develop information and options for future design and decision making. Despite this progress, many informants felt that the ticking clock was “[their] worst enemy,” as many difficult and technical decisions remain on exchange operations, enrollment methods, plan participation, risk adjustment and reinsurance, and subsidy determination and management. The extent to which the exchange’s unusual legislative review committee might inject politics into ongoing decision-making also concerned many informants.

- Establishing interoperable IT infrastructures for exchange and Medicaid/CHP+ eligibility determination and enrollment will be especially challenging for Colorado. State officials are aggressively tackling the challenge of establishing modern exchange and Medicaid/CHP+ eligibility and enrollment systems that can perform seamless, real-time, and data-driven operations as called for in the ACA. However, this daunting task is made all the more challenging in Colorado because of several environmental circumstances. Like most states, Colorado is starting with a flawed foundation, an old legacy computer system—CBMS—that is inflexible and difficult to modify. But the state is also challenged by the fact that eligibility determination for Medicaid and a host of other human services programs is the responsibility of the counties, which have adopted unique processes and may also be resistant to the changes required for successful IT implementation. Finally, a prior administration’s attempt to centralize state IT within one main office has not truly succeeded. Responsibility for IT development is diffused across multiple agencies at the state level, including the exchange, Medicaid, and the relatively new Office of Information Technology, and thus far it is not clear that these offices can work in complete harmony. Still, the state has made rapid progress in this area over the past several months, and expects to award vendor contracts for exchange IT development and upgrades to CBMS and the accompanying PEAK interface by mid-2012.
- Insurance market reforms: So far so good. The only statutory change made to accommodate the new ACA insurance rules required through 2011 was a consensus bill to assure that child-only policies would remain available. Yet insurer compliance has been good, officials said. Informants liked the improved information and power to review rates they acquired from recent state legislation and federal-grant-funded upgrades to their capabilities. They do worry about DOI’s ability to sanction noncompliance without explicit state statutory authority, but expect to rely on federal enforcement if truly needed. Other concerns expressed included some discrepancies between the state and federal rules, the adequacy of high-risk pool funding for both state and federal pools, and the need to improve consumer education. Additional legislation will be sought before 2014, but likely not in 2012.
- Recent expansions in Colorado Medicaid and CHP+ programs provide a reasonably strong foundation upon which to build. Colorado’s Medicaid program, historically, has been somewhat limited in scope. But in the last several years, it has implemented several important changes that should help smooth the state’s transition to full ACA implementation. A newly legislated hospital fee generated critical revenues that helped bolster hospital reimbursement rates, while also allowing broad expansions of coverage to pregnant women, children, parents, persons with disabilities, and some adults without dependent children. Federal grants have also allowed the state to invest in important Medicaid eligibility system reforms that have laid an improved foundation within the CBMS system upon which to build further enhancements.
- The state’s Accountable Care Collaboratives represent a promising new direction for coordinating and improving the quality of care. Colorado Medicaid, unlike most states, has not operated a significant risk-based managed care program for over a decade. Yet, on the cusp of health care reform implementation, the program instituted a promising new model of care delivery that has potential to coordinate care across health care providers, incentivize providers to save costs while improving quality, and (ultimately), move away from traditional fee for service reimbursement. The Accountable Care Collaboratives taking shape provide another example of a “Colorado-specific” vision of how the ACA concept of Accountable Care Organizations (ACOs) can be adapted to local circumstances.

- The current organization of providers and insurers in Colorado creates a promising environment for reform. Colorado is characterized by competitive hospital, physician, and managed care markets. No dominant systems exist, which leads to a healthy mix of competition and collaboration. As one informant described the state’s providers and insurers, “[they’re] competitive but not cut-throat.” Uncertainty, however, is challenging providers as they attempt to plan for reform implementation. Informants pointed to the forthcoming decision of the U.S. Supreme Court on the ACA’s constitutionality, as well as the impending presidential election, as factors that make it very difficult to know what the future holds, and how to plan for it.
- Colorado’s primary care capacity will be seriously strained by reform’s increases in coverage, but a strong network of safety net providers will play a critical role in serving the newly insured. Key informants were in full agreement that Colorado will face severe challenges meeting the primary care needs of its residents after implementation of health reform. The state’s vast rural and frontier regions—where population density is low—will be especially hard pressed. Yet there was also nearly

uniform recognition of the importance of the safety net in Colorado, along with praise for the quality of care provided by the state’s FQHCs and other safety net clinics, as well as integrated delivery systems like Denver Health. Indeed, with slim prospects for growth in private provider participation in Medicaid, and few prospective health plans showing interest in entering the Medicaid business, these safety net providers are likely to absorb the largest share of newly insured populations, and certainly most, if not all, of those gaining coverage through the Medicaid expansion. Yet even though these systems will be stretched, there is a sense that these patients will be in good hands.

With less than two years to go before the Affordable Care Act is fully implemented, the State of Colorado is reasonably well positioned. A strong, bipartisan foundation was built before the ACA was signed into law, and stakeholders have largely worked collaboratively to begin putting various required policies and structures in place. Yet much work remains, and strong leadership, bipartisan political support, and continued aggressive action will be needed for Colorado to succeed in implementing reform on time.

About the Authors and Acknowledgements

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33. See also an early press release "Federal Health Reform Accounts for less than 5% of Health Rate Increase in Colorado," November 4, 2010, <http://www.dora.state.co.us/insurance/pr/2010MediaReleases/newsHealthRate&FHCReffect110410.pdf>.
34. Center for Consumer Information and Insurance Oversight, Essential Health Benefits Bulletin, December 16, 2011, accessible from <http://cciio.cms.gov/resources/regulations/index.html>. Thus, although Colorado officials were anticipating some controversy over which mandates to maintain and which to repeal, it is possible they could sidestep some of that controversy because of the December 16th guidance issued by HHS. The HHS bulletin on essential health benefits suggested that, instead of one national standard for EHB, states may choose among four benchmark options for their EHB: (1) the largest small employer plan in the state, (2) any of the three largest state employee health benefit plans, (3) any of the largest three national Federal Employee Health Benefits Plan options, or (4) the largest commercial health maintenance organization operating in the state. If Colorado chooses a benchmark plan that already includes existing state benefit mandates, they will be included as part of the minimum EHB, and the state will not need to account or pay for them as additional benefits.
35. See Bob Sembro and Joe Watt, "Straight talk about health care reform: Health insurance rate review," Denver, CO: Bell Policy Center, December 14, 2010, accessible from <http://bellpolicy.org/content/straight-talk-health-care-reform-health-insurance-rate-review-0>.
36. Medicaid, Medicare and the Children's Basic Health Plan are not included. See DORA/DOI, "Frequently Asked Questions For Health Carriers, HB 08-1389: Concerning Increased Oversight of Health Insurance Rates ("Prior Approval") (Emergency Regulations 08-E-04 and 08-E-05, Regulations 4-2-11 and 4-4-1)," July 28, 2008, <http://www.dora.state.co.us/INSURANCE/legi/legiHB389FAQ072808.pdf>; DORA/DOI, "Frequently Asked Questions on Rate Filing, Rate Reviews and Approval of Health Insurance Rates in Colorado," dated 2012, <http://www.dora.state.co.us/insurance/consumer/HealthRateFAQs.htm>.
37. Implementation amended Reg. 4-2-11 (above).
38. CCIIO scores Colorado as "effective," and DOI will review insurers' proposed rate increases in all market segments, unlike a substantial number of other states, see CCIIO, "List of Effective Rate Review Programs" in "Health Insurance Rate Review: Lowering Costs for American Consumers and Businesses," Updated December 9, 2011 http://cciio.cms.gov/resources/factsheets/rate_review_fact_sheet.html.
39. United States Government Accountability Office, Private Health Insurance: State Oversight of Premium Rates, Report to Congressional Requesters, July 2011, GAO-11-701, <http://www.gao.gov/new.items/d11701.pdf>.
40. DORA/DOI, "Colorado Division of Insurance Awarded \$4 Million Federal Grant for Enhanced Premium Rate Review," press release, September 21, 2011, <http://www.dora.state.co.us/insurance/pr/2011MediaReleases/newsColoradoReceivesHHSGrant%20092011.pdf>, and CCIIO, Rate Review Works: Early Achievements of Health Insurance Rate Review Grants, September 20, 2011, http://cciio.cms.gov/resources/files/Files2/09192011/rate_review_report_092011.pdf.pdf.
41. CCIIO, "Health Insurance Premium Grants: Detailed State by State Summary of Proposed Activities," <http://www.healthcare.gov/news/factsheets/2010/08/rateschart.html#>.
42. DOI, also Reg. 4-2-11. It is unclear how the 65 percent individual rule meshes with the federal 80 percent standard, with different adjustments to numerator and denominator of the ratio. The federal final rule on MLRs was issued in December 2011, after our interviews.
43. The underlying standard of review is the age-old rule that rates not be "excessive, inadequate or unfairly discriminatory." See Reg. 4-2-11 (above).
44. See DOI, "Health Insurance," <http://doraapps.state.co.us/Insurance/Consumer/pages/main.aspx> and "Division of Insurance Unveils New Health Insurance Website," The Colorado Regulator, Volume 9, Issue 1, Fall/Winter 2011, <http://www.dora.state.co.us/insurance/pb/2011/Regulator2011FallWinter120611.pdf>.
45. "Are You Prepared for Changes in Health Insurance?" accessible from <http://doraapps.state.co.us/Insurance/Consumer/pages/moreMeetings.aspx>.
46. Colorado High Risk Health Insurance Act, H.B. 90-1305, Colo. Rev'd Statutes sects. 10-8-501 & following. See Elizabeth Burger, CoverColorado, Legislative Council pub. no. 09-07, September 2, 2009, accessible from <http://www.colorado.gov/cs/Satellite/CGA-LegislativeCouncil/CLC/1231331487338>. The pool's website is <http://www.covercolorado.org>.
47. <https://www.covercolorado.org/default.asp?contentID=668>.
48. Enrollment was 12,732 on December 31, 2010. DOI, "High Risk Health Insurance, CoverColorado" in Health Insurance 101, <http://doraapps.state.co.us/Insurance/Consumer/pages/health101HighRisk.aspx>; national ranking in "State High Risk Pool Programs and Enrollment, as of December 31, 2010," <http://www.statehealthfacts.org/comparetable.jsp?ind=602&cat=7>.
49. Additional funding first came from a fee on income tax returns, then successively from funds unclaimed by businesses, interest from the state Unclaimed Property Trust Fund, principal from that Fund, contributions from insurers (for which they receive premium tax credits) and, since 2008, a regular annual per-enrollee assessment on all health insurers, which had previously been only occasional. For calendar 2012, premiums are expected to be 52 percent of revenues, unclaimed property funds and insurer assessments 22 percent each, with other revenues of 4 percent including the premium tax credits, federal grants, and interest. Kelly Stapleton and Bill Zepernick, 2011 Colorado Health Care Resource Book: A Guide to Major Health Care Issues and Programs, Colorado Legislative Council, December 2011, accessible from <http://www.colorado.gov/cs/Satellite/CGA-LegislativeCouncil/CLC/1231331487338>.
50. The Adams Group for the CoverColorado Long-Term Funding Task Force, Final Report to the Colorado General Assembly, March 31, 2009, <https://www.covercolorado.org/downloads/CoverColorado-Task-Force-Final-Report.pdf>. The legislation referred to is SB 10-020.
51. See "State Mandated Fee Schedule for CoverColorado Plan," Rocky Mountain Health, Provider Edition [newsletter of Rocky Mountain Health Plans, the administrator of CoverColorado], Spring 2011, http://www.rmhp.org/pdf/newsletters/Good_Health_Provider_Spring_2011.pdf.
52. "GettingUSCovered Opens for Enrollment, New Federally Funded Health Plan Opens for Uninsured Coloradans with Pre-Existing Conditions," Gov Monitor, source: Off of Gov Bill Ritter, July 7, 2010, http://www.thegovmonitor.com/world_news/united_states/colorado-opens-gettinguscovered-health-plan-for-enrollment-35052.html.
53. The state premiums target 140 percent of standard (task force), although in practice only about 125 percent given available income based discounts—whereas the federal uses the standard rate. The federal plan has a deductible of \$2500 and an out of pocket limit of \$5,950, compared with the state's offer of a menu of deductibles with varying OOP limits, typically at twice the deductible level. The federal plan has a separate pharmacy deductible but the state does not. For full comparisons see RMHP, "Overview of Differences between

- GettingUSCovered and CoverColorado,” http://www.rmhp.org/pdf/BBNF/Differences_GettingUSCovered_&Cover%E2%80%A6.pdf and Renee Hopkins, Colorado Covering Kids and Families, Colorado Community Health Network (CCHN), March 25, 2011, http://www.cchn.org/ckf/pdf/CoverColorado_for_APWG_March_2011.pdf.
54. One consumer advocate said that after a recent conversation with a consumer about the HRP, the response was “I understand what you’re saying, but it still doesn’t make sense.”
 55. In its first year, the Colorado pool enrolled only 600 people, according to the task force report.
 56. At the time of the site visit, there were no scheduled implementation dates for either the Medicaid buy-in or continuous 12-month eligibility.
 57. Colorado received a State Health Access Program (SHAP) grant program from the US Department of Health and Human Services’ Health Resources and Services Administration (HRSA) in FFYs 2010 and 2011. More information about Colorado’s SHAP grant can be found at: <http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1251574721186>.
 58. Need to add definition of this (have in MD report).
 59. More information about the Benefits Collaborative can be found at <http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1236342370137>.
 60. The state’s CHIP expansion for pregnant women and children also occurred in spring 2010, but because this expansion (from 205% to 250% of the FPL) does not target the population of new Medicaid eligibles under the ACA (i.e., those at or below 138% of the FPL), the pregnant women and children populations are not eligible for enhanced 100% federal matching funds as the parent/caretaker population is.
 61. I.e., in 2014 for adults and 2019 for children, and contingent on the state’s Health Insurance Exchange being fully operational.
 62. <http://statehealthfacts.org/comparetable.jsp?ind=218&cat=4>. By comprehensive, risk-based managed care, we mean that the managed care organization is contracted to provide most or all acute health care services on a capitated basis. Colorado also operates a Primary Care Case Management (PCCM) program where services are provided on a fee-for-service basis. Enrollment in risk-based managed care and the PCCM program is on a voluntary basis.
 63. Within the ACC structure, Medicaid pays a \$20 PMPM for each enrollee—\$4 to the PCMP, \$12 to the RCCO, and \$3 to the SDAC.
 64. The state also has limited-benefit risk-based managed care contracts with several behavioral health plans to provide inpatient behavioral health services. Two health plans—Colorado Access and Rocky Mountain Health Plans—have contracts with the state to deliver comprehensive services, but these are not full risk contracts.
 65. Colorado Health Institute, A Half A Million Newly Insured: Is Colorado Ready? December 2011; <http://www.coloradohealthinstitute.org/Projects/Newly-Insured.aspx>.
 66. For example, The Colorado Health Foundation provided a \$6.4 million grant to CHSC to support primary care providers. Colorado Health Foundation “Progress Report.” Volume 6, No. 1. January 2012.
 67. Office of Gov. Bill Ritter, Jr., “Gov. Ritter Announces ‘Building Blocks For Health Care Reform,’” Press Release, February 13, 2008, <http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251602770845&binary=true>.