THE COLORADO TRUST

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ISSUE BRIEF

COMPARISON OF PROVISIONS FROM COLORADO'S BLUE RIBBON COMMISSION FOR HEALTH CARE REFORM AND FEDERAL HEALTH CARE REFORM

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As the implementation of federal health care reform begins, Coloradans perhaps hold an advantage over other states as a result of the state's earlier efforts to bring about health care reform. In 2006, the Colorado General Assembly established the Blue Ribbon Commission for Health Care Reform – also known as the 208 Commission, after its enabling legislation Senate Bill 06-208 – and charged it with identifying a sustainable future for the state's health care system. Governors Bill Owens (R) and Bill Ritter (D) collaborated with bipartisan leadership of the Colorado General Assembly to appoint 27 Commissioners representing consumers, health insurance purchasers, providers, business leaders and health care experts. The Commission solicited and received 31 Colorado-specific proposals to reform the Colorado health care system, and it selected four options to price and analyze more closely. In addition, it received extensive input through task force and community meetings held around the state. The Commission then created and analyzed its own proposal, which informed its nearly unanimous recommendations to the legislature. Submitted in January 2008, this package of bipartisan recommendations to expand health insurance coverage, reduce health care costs and improve the delivery of health care services received broad-based support and continues to represent the clearest consensus statement to date on Colorado's health care reform priorities.

Two years later, on March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (PPACA). The new federal health care reform law shared similar policy goals with the 208 Commission and mirrored many of the panel's recommendations. For example, the Colorado recommendations and federal provisions share in common several broad policy tools to address coverage gaps such as requiring individuals to purchase coverage, expanding Medicaid for the lowest-income individuals and families, subsidizing private health insurance for the middle class and creating a mechanism to make it easier for individuals and small businesses to purchase insurance. Similarly, both the 208 Commission recommendations and the PPACA paired efforts to extend coverage to the uninsured with changes in health care delivery and reimbursement, with the aim of reducing costs while improving the quality of care for everyone.

At the same time, there are some differences between the recommendations of the 208 Commission and federal health care reform. For example, although both approaches sought to sustain employer-based coverage, they used different policy tools to achieve this outcome. The Commission recommended employee subsidies and tax-advantaged health plans, whereas the new federal reform law requires employers to provide coverage paired with small employer subsidies. Another difference is the strategy used to ensure that Coloradans with pre-existing conditions are able to purchase coverage.

The following table notes similarities and differences by comparing and contrasting the recommendations of Colorado's 208 Commission to federal health care reform. All major shared components are compared in the table below, with the following exceptions:

- **Temporary provisions:** The chart compares federal health care reform, as fully implemented, to the 208 Commission recommendations. As such, time-limited federal provisions that phase-out upon full implementation in 2014 (e.g., temporary high risk pools, temporary reinsurance program) are not detailed.
- **Exhaustive listing of grants, pilots and demonstration projects:** Federal health care reform authorizes numerous pilot programs and demonstration projects, especially in the areas of workforce development and payment and delivery system reform. Because many of these programs are authorized but not yet appropriated, they are described collectively by topic area and not individually enumerated.
- **Medicare provisions:** Because Medicare is a federal program and largely outside of state control, the 208 Commission did not make any recommendations in this area. Federal health care reform changes to Medicare are not exhaustively detailed here but referenced primarily when there is a corresponding 208 Commission recommendation.
- **Financing:** The 208 Commission recommendations did not include financing provisions beyond several cost containment recommendations. Therefore, tax changes related to health insurance and other sources of federal financing are not included in the comparison table.

COVERAGE PROVISION

	Federal Health Care Reform Patient Protection and Affordable Care Act (2010)	**Colorado Health Care Reform** 208 Commission Recommendations (2008)
COVERAGE **Provisions overview**	**Individual Mandate:** Require most U.S. citizens/legal residents to have at least minimum health coverage; enforce through federal tax penalties; provide exemptions based on affordability and other situations	**Individual Mandate:** Require most Colorado citizens/legal residents to have at least minimum health coverage; enforce through state tax penalties; provide affordability exemptions
	Employer Requirements: Require employers to offer employees minimum coverage or pay penalties; small employer exceptions	**Employer Requirements:** Require employers to establish plans that enable employees to purchase health insurance on a pre-tax basis; no penalties for not offering insurance
	Small Business Subsidies: Encourage small employers to offer coverage through subsidies to small businesses	**Small Business Subsidies:** No subsidies for small businesses
	Employee Subsidies: No subsidies for employees to purchase employer coverage	**Employee Subsidies:** Encourage employees to participate in employer-sponsored coverage through public subsidies for low-income employees

	Federal Health Care Reform Patient Protection and Affordable Care Act (2010)	Colorado Health Care Reform 208 Commission Recommendations (2008)
COVERAGE Provisions overview *(continued)*	**Medicaid Expansion:** Provide coverage to low-income uninsured adults and children in Medicaid (up to 133% of federal poverty level)	**Medicaid Expansion:** Provide coverage to low-income uninsured adults and children in Medicaid (up to 205% federal poverty level)
	Insurance Purchasing: Provide coverage to middle-income adults and children who are without employer coverage in subsidized private insurance through health benefit "Exchanges" (133-400% federal poverty level); permit high-income uninsured adults and children as well as small businesses to purchase insurance through Exchanges	**Insurance Purchasing:** Provide coverage to middle-income uninsured adults and children who are without employer coverage in subsidized private insurance through a Colorado-based "Connector" (205-400% federal poverty level); permit high-income uninsured adults and children as well as small businesses to purchase insurance through the Connector
	Private Insurance Requirements: Change insurance market rules to standardize regulations and benefits across individual and group markets, reduce variation in premiums and ensure access to coverage for those with pre-existing conditions	**Private Insurance Requirements:** Change individual insurance market rules to ensure access to minimum benefits, reduce variation in premiums and ensure access to coverage for those with pre-existing conditions
INDIVIDUAL MANDATE		
Individual requirement to obtain coverage	**Legal Requirement:** Require most U.S. citizens/legal residents to have at least minimum health coverage	**Legal Requirement:** Require most Colorado citizens/legal residents to have at least minimum health coverage
	Penalties: Enforce through phased-in federal tax penalties: ■ **Financial Penalty:** - 2014: $95 or 1% taxable income - 2015: $325 or 2% taxable income - 2016: $695 or 2.5% taxable income (up to $2085)	**Penalties:** Enforce through state tax penalties and administrative mechanisms: ■ **Financial Penalty:** one year's worth of coverage ■ **Administrative Methods:** Refer uninsured to Connector; auto-enroll those eligible for full subsidies
	Exemptions: Provide affordability/hardship exemptions including for those not required to file taxes and those for whom premiums for lowest cost health benefit option exceed 8% income; provide exemptions for undocumented immigrants, religious objections, American Indians, short-term uninsured (<3 months), incarcerated persons	**Exemptions:** Provide affordability exemptions (not specified) or other mechanisms to address affordability of premiums/co-payments; provide exemptions for undocumented immigrants

	Federal Health Care Reform Patient Protection and Affordable Care Act (2010)	**Colorado Health Care Reform** 208 Commission Recommendations (2008)
EMPLOYERS AND EMPLOYER-SPONSORED COVERAGE		
Employer requirements to offer and facilitate coverage	**Coverage Requirement:** Require employers to offer employees minimum coverage or face possible penalties; small employer exceptions	**Coverage Requirement:** Require employers to establish at least a 125 premium-only plan for employees that permits them to purchase coverage on a pre-tax basis; employer contribution not required
	Penalties: Fine employers (>50 employees ONLY) that have employees receiving subsidized coverage through the Exchange ■ For employers that offer coverage, fee is lesser of $3,000 for each employee receiving a subsidy OR $2000/full time employee, excluding the first 30 employees ■ For employers that do not offer coverage, fee is $2000/full time employee, excluding the first 30 employees	**Penalties:** No penalties for employers who do not offer coverage; require employers who do not offer coverage to refer employees to the Connector for insurance information
	Auto-Enrollment: Require employers (>200 employees) to auto-enroll employees into employer-sponsored coverage unless employees opt-out	**Auto-Enrollment:** No requirement for employers to auto enroll
	Small Business Subsidies: Provide variable tax credits (up to 50% employer premium contribution) to qualified small employers, including tax-exempt employers; qualifications include: ■ <25 employees ■ Average annual wages <$50K ■ Employer contribution >50% of total premium	**Small Business Subsidies:** No small business subsidies for offering employee coverage
	Employee Vouchers: Require employers that offer coverage to provide vouchers to enable qualified employees to opt out of employer coverage and purchase Exchange coverage ■ Voucher set at employer share of premium ■ Available to low- and middle- income employees (<400% federal poverty level) whose premium share exceeds affordability standards	**Employee Vouchers:** No requirement for employee vouchers

	Federal Health Care Reform Patient Protection and Affordable Care Act (2010)	Colorado Health Care Reform 208 Commission Recommendations (2008)
Employer requirements to offer and facilitate coverage *(continued)*	**Employee Subsidies:** No public subsidies to employees to purchase employer coverage	**Employee Subsidies:** Provide graduated subsidies to uninsured low-income employees (<400% federal poverty level) to purchase employer-sponsored coverage; ■ For employees (<300% federal poverty level), subsides equal 80-100% employee share of premium ■ For employees (300-400% federal poverty level), subsidies ensure employee share of premium <9% of income
	Market Requirements: Standardize many of the market rules (e.g., waiting periods, dependent coverage, minimum benefits, medical loss ratios, premium increases) across all insured markets (large group, small group and individual markets) (see, Insurance market requirements, page 10)	**Market Requirements:** No changes to group market rules; enforce waiting periods for eligibility for public subsidies (minimum periods of being uninsured)
MEDICAID AND CHIP (CHP+)		
Medicaid/CHIP (CHP+) expansions for uninsured low-income populations	**Program Redesign:** None specified, except expansion (see below)	**Program Redesign:** Restructure and merge Medicaid and CHP+ into a single program for low-income childless adults, parents and children; retain separate Medicaid programs for the aged and people with disabilities
	Expansion Population: ■ **Medicaid:** Expand eligibility for adults (<65 years) and children with modified adjusted gross income up to 133% federal poverty level; enhanced federal matching available for newly eligible groups ■ **CHIP:** Require states to maintain current eligibility levels through 2019; provide enhanced federal matching beginning in 2015	**Expansion Population:** ■ **Medicaid:** Expand eligibility to adults (<65 years) with incomes up to 205% federal poverty level ■ **CHP+:** Expand eligibility to children with incomes up to 250% federal poverty level
	Eligibility Period: No change to length of eligibility	**Eligibility Period:** Provide one year continuous eligibility to adults and children in program

	Federal Health Care Reform Patient Protection and Affordable Care Act (2010)	**Colorado Health Care Reform** 208 Commission Recommendations (2008)
Medicaid/CHIP (CHP+) expansions for uninsured low-income populations *(continued)*	**Benefit Package:** Provide benefit package for newly eligible adults that includes essential health benefits; continue to provide current Medicaid benefit package to existing enrollees	**Benefit Package:** Modify standard Medicaid benefits to the CHP+ benefit and cost-sharing package, with the addition of: ■ Provide access to Medicaid supplemental benefits including EPSDT preventive services and "wrap-around" treatment services for children ■ Dental benefits for adults with a $1,000 annual cap ■ Care coordination and targeted case management benefits
	Provider Rates: Increase rates for primary care (See Payment reform, page 14)	**Provider Rates:** Increase physician and hospital rates (see Payment reform, page 14)
Medicaid expansions for the elderly and people with disabilities	**Medicaid Buy-In:** None specified	**Medicaid Buy-In:** Permit qualifying people with disabilities to purchase Medicaid coverage, with subsidies for those with incomes 75-450% federal poverty level
	Medicaid Waivers: Permit states to provide qualifying people with home and community-based services (HCBS) and community-based attendants through the regular Medicaid benefit (state plan), as well as through HCBS waivers	**Medicaid Waivers:** Increase the number of people served by the Medicaid home and community based (HCBS) programs by the current waiting list
	Autism Funding: None specified	**Autism Funding:** Increase the per child funding for the Medicaid Autism Waiver program to $36,000 per child and increase the number of slots
	Rebalancing Incentives: Provide enhanced federal matching to eligible states that reduce the proportion of people with disabilities who receive nursing home/institution-based care	**Rebalancing Incentives:** None specified
	Premium Assistance: None specified	**Premium Assistance:** Provide Medicare premium and copayment assistance for the low-income elderly (>65 years, <205% federal poverty level)
	Medicaid Alternatives: Create cost-effective alternatives to the Medicaid program: ■ Establish a national program that provides cash benefits to people with disabilities to purchase community living assistance services and supports (CLASS program)	**Medicaid Alternatives:** Create cost-effective alternatives to the Medicaid program: ■ Create a catastrophic fund for insured individuals (300-500% federal poverty level) who have uncovered, catastrophic needs ■ Create a medically correctable program for one-time expenses that help people return to work/avoid Medicaid enrollment

	Federal Health Care Reform Patient Protection and Affordable Care Act (2010)	Colorado Health Care Reform 208 Commission Recommendations (2008)
PRIVATE INSURANCE IN INDIVIDUAL, SMALL GROUP AND LARGE GROUP MARKETS		
Health purchasing mechanism for individuals and businesses	**Health Purchasing for Individuals:** Create state-based or regional American Health Benefit Exchanges to offer four standardized plan options for purchase	**Health Purchasing for Individuals:** Create a Connector to offer 3-4 standardized plan options for purchase
	Health Purchasing for Businesses: Permit small businesses (up to 100 employees) to purchase coverage through Small Business Health Options Program (SHOP) Exchanges; after 2017, permit larger businesses to participate	**Health Purchasing for Businesses:** Permit small businesses to purchase coverage through the Connector
	Health Purchasing Administration: Permit states to merge individual and small business Exchanges; administer Exchanges through a governmental agency or nonprofit	**Health Purchasing Administration:** Individuals and small businesses use the same Connector infrastructure; administrative entity not specified
	Exchange Functions: Require Exchanges to perform the following functions: ■ **Certification:** Certify that health plans meet minimum standards, according to four defined benefit tiers and other state/federal rules ■ **Quality Rating:** Assign a quality rating to qualified plans ■ **Eligibility/Enrollment:** Use a uniform enrollment form; streamline eligibility and enrollment procedures between the Exchange, Medicaid and other state and federal programs ■ **Subsidy Eligibility:** Accept applications and determine eligibility for Exchange subsidies (133-400% federal poverty level) ■ **Purchasing:** Facilitate purchase of qualified (certified) health benefit plans by individuals and employers ■ **Premium Review:** Review justification submitted by qualified health plans for any premium increases ■ **Consumer Support:** Maintain a toll-free hotline and a website with standardized plan information and provide consumer education and support ■ **Individual Mandate Exemptions:** Certify individuals as exempt from the requirement to purchase coverage ■ **Employer Mandate Enforcement:** Track employees receiving subsidies and employees who cease coverage ■ **Reporting:** Submit financial and operational reports to Health and Human Services	**Exchange Functions:** Require Connector to perform the following functions: ■ **Certification:** Certify that health plans meet minimum standards, according to 3-4 standard options ■ **Quality rating:** Present easily comparable quality and pricing information ■ **Eligibility/Enrollment:** Facilitate enrollment through administrative mechanisms (e.g., auto-enrollment, presumptive eligibility, etc.) into Medicaid, CHP+ and Connector options ■ **Subsidy Eligibility:** Facilitate access to subsidies for Connector coverage (200-400% federal poverty level) ■ **Purchasing:** Collect individual contributions and aggregate employer and employee contributions to pay premiums to carriers

	Federal Health Care Reform Patient Protection and Affordable Care Act (2010)	**Colorado Health Care Reform** 208 Commission Recommendations (2008)
Health purchasing mechanism for individuals and businesses *(continued)*	**Health Plan Requirements:** Require Exchange health plans be accredited, to contract with essential community providers and outreach and enrollment navigators, to justify any premium increases and to meet standards regarding marketing, provider networks and quality/safety performance	**Health Plan Requirements:** None specified
	Public Plan Option: Require the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange	**Public Plan Option:** Study the feasibility of an optional continuous coverage portable plan
	Exclusions: Prohibit undocumented immigrants and incarcerated individuals from purchasing coverage or receiving subsidies through the Exchange	**Exclusions:** Prohibit undocumented immigrants from receiving subsidies through the Connector
Premium and cost-sharing subsidies to middle-income populations	**Premium Subsidy Eligibility:** Provide refundable and advanceable tax credits toward the purchase of an Exchange plan for eligible adults and children; eligibility includes: ■ **Legal Status:** verified U.S. citizen/legal resident ■ **Income Level:** 133-400% federal poverty level ■ **Access to Coverage:** those ineligible for Medicaid/CHIP and without access to affordable comprehensive employer coverage	**Premium Subsidy Eligibility:** Provide public subsidies toward the purchase of a Connector or an employer plan for eligible adults and children; eligibility includes: ■ **Legal Status:** verified U.S. citizen/legal resident ■ **Income Level:** 200-400% federal poverty level ■ **Access to Coverage:** those ineligible for Medicaid/CHP+; those with access to coverage at the workplace are eligible for subsidies to purchase employer- based health benefits
	Subsidy Amount: Provide sliding-scale subsidies (tax credits) based on income and on the price of a mid-tier Exchange plan (second lowest cost "silver" plan), such that required premium contributions by income are: ■ Up to 133% federal poverty level: 2% of income ■ 133-150% federal poverty level: 3-4% of income ■ 150-200% federal poverty level: 4-6.3% of income ■ 200-250% federal poverty level: 6.3-8.05% of income ■ 250-300% federal poverty level: 8.05-9.5% of income ■ 300-400% federal poverty level: 9.5% of income	**Subsidy Amount:** Provide sliding scale public subsidies for those who are: ■ Under 300% federal poverty level: provide sliding-scale subsidies based on 80%-100% of the premium cost of the benefit package ■ Between 300-400% federal poverty level: provide sliding-scale subsidies based on income and price of lowest cost Minimum Benefit Plan, such that required premium contributions by income are no more than 9% of income

	Federal Health Care Reform Patient Protection and Affordable Care Act (2010)	Colorado Health Care Reform 208 Commission Recommendations (2008)
Premium and cost-sharing subsidies to middle-income populations *(continued)*	**Auto enrollment:** No provisions to auto-enroll individuals into coverage	**Auto enrollment:** Require state to automatically enroll individuals eligible for Medicaid or subsidized insurance using existing state data to determine eligibility
	Cost-sharing Subsidies: Provide graduated cost-sharing subsidies that reduce both point-of-service cost sharing and out-of-pocket limits, for those <400% federal poverty level	**Cost-sharing Subsidies:** Not included
	Waiting period: Limit the waiting period for coverage to 90 days	**Waiting Period:** Enforce a waiting period for coverage
	Use of Subsidy: Limit use of subsidy to purchase qualified plans in the exchange	**Use of Subsidy:** Permit subsidy to be used to purchase plans inside and outside of the Connector, including to purchase employer health benefits
Benefit design	**Minimum Creditable Coverage:** Require that health plans that satisfy the individual mandate requirement cover "essential health benefits" and 60% of the benefit costs, with Health Savings Account (HSA) out-of-pocket limit	**Minimum Creditable Coverage:** Require that every health carrier in Colorado must offer a minimum benefit plan that satisfies the individual mandate
	Benefit Requirements for Exchange, Individual and Small Group Markets: ■ Conform to one of four benefit tiers (bronze, silver, gold or platinum) ■ Provide "essential health benefits" as defined by Health and Human Services through an annual transparent public process ■ Meet specified actuarial values and out-of-pocket limits ■ Existing individual and employer-sponsored plans do not have to comply with new benefit standards as "grandfathered plans"	**Benefit Requirements for Plans Offered through Connector:** ■ Require CHP+-like benefits for those <300% federal poverty level ■ For 300%+ federal poverty level, limit options offered by the Connector to 3-4 standardized options (defined by the Improving Value Authority) ■ Meet premium target of approximately $200 per month for the minimum benefit plan ■ Does not apply outside Connector (e.g., in individual and group markets)
	Catastrophic Plan: Provide an HSA-like catastrophic plan option to those exempt from the coverage mandate or who are less than 30 years of age	**Catastrophic Plan:** Define the Minimum Benefit Plan to permit variations in benefit design, including a Health Savings Account option
	Benefit Design Responsibility: Secretary of Health and Human Services through an annual, transparent public process	**Benefit Design Responsibility:** Multi-stakeholder Improving Value Authority through a periodic transparent public process

	Federal Health Care Reform Patient Protection and Affordable Care Act (2010)	**Colorado Health Care Reform** 208 Commission Recommendations (2008)
HEALTH INSURANCE IN INDIVIDUAL AND SMALL GROUP MARKETS		
Insurance market requirements	**Market-wide Requirements:** Standardize regulations across all insured markets (individual, small group and large group), as well as the new Exchanges; grandfathered plans are exempted from some requirements: ■ **Waiting Period:** Limit the waiting period for coverage for employees to 90 days (all group plans) ■ **Dependent Coverage:** Require coverage of children up to age 26 ■ **Benefits:** Limit benefit categories of health plans to four standardized options that cover "essential health benefits" (defined by Health and Human Services) and adhere to specified actuarial values and cost-sharing limits; permit grandfathering of existing benefit designs ■ **Medical Loss Ratios:** Limit to 80% for individual and small group; 85% for large groups ■ **Premium Increases:** Require states to monitor premium increases ■ **Issue/Renewal:** Require guarantee issue and renewal; prohibit pre-existing condition and health status related exclusions ■ **Rescission and Dollar Limits:** Prohibit rescinding coverage (except for fraud) as well as annual and lifetime dollar limits	**Market-wide Requirements:** No new regulations affecting all markets (e.g., large, small and individual insurance)
	Individual/Small Group Market Requirements: Create new regulations in the individual and small group markets, as well as the Exchanges: ■ **Benefits:** See above ■ **High-risk Pool:** Temporary high-risk pool only; after 2014, pre-existing condition exclusions are no longer permitted ■ **Premiums:** Limit premium rating variation to the following factors: age (3 to 1 ratio maximum), geographic rating area, family composition and tobacco use (1.5 to 1 ratio maximum) ■ **Issue/Renewal:** See above ■ **Risk adjustment:** Implement risk adjustment of health plans in individual and small group markets and the Exchange ■ **Medical loss ratios:** Limit medical loss ratios to 80%	**Individual Market Requirements:** Create new regulations in the individual market (not the small group market)[1]: ■ **Benefits:** Require health insurance carriers in Colorado to offer a Minimum Benefit Plan in the individual market ■ **High Risk Pool:** Restructure and finance CoverColorado, such that individuals with pre-existing conditions receive coverage at standard individual market rates ■ **Premiums:** For those not eligible for CoverColorado, allow health plans to set premiums only based on age and geographic region (no health status rating) ■ **Issue/Renewal:** Require guarantee issue and renewal for individuals who apply for coverage and do not qualify for CoverColorado ■ **Risk adjustment:** No risk adjustment required because individuals with pre-existing conditions are enrolled in CoverColorado ■ **Medical Loss Ratios:** Require reporting to Division of Insurance on medical loss ratios

[1] The Commission focused on the individual market because many of these provisions already exist in Colorado's small group market.

	Federal Health Care Reform Patient Protection and Affordable Care Act (2010)	Colorado Health Care Reform 208 Commission Recommendations (2008)
Insurance market requirements *(continued)*	**Market Consolidation:** Permit states to merge individual and small group markets	**Market Consolidation:** Preserve separate individual and small group markets
COVERAGE PILOTS AND STUDIES		
Grants, pilots and studies related to coverage	■ Create the Consumer Operate and Oriented Plan (CO-OP) program to spur the development of nonprofit, enrollee-driven health plans for the Exchanges ■ Study self-insured and fully-insured market dynamics with a special focus on adverse selection in insured markets	■ Study the feasibility of allowing employers to offer 24-hour continuous coverage ■ Study the feasibility of giving Coloradans the option to enroll in an optional continuous coverage portable plan
» PROVISIONS TO IMPROVE DELIVERY SYSTEM AND REDUCE COSTS		
DELIVERY SYSTEM Provisions overview	**Planning:** Develop comprehensive, national strategies for reforming the health care delivery system, coordinating public health activities, maximizing clinical effectiveness and improving patient and population health	**Planning:** Create a statewide, multi-stakeholder Improving Value in Health Care Authority to work across constituencies to create a vision and a consensus for realigning incentives to reduce costs and improve outcomes
	Primary Care Infrastructure and Incentives: Increase funding for primary care provider training and increase reimbursement for Medicare/Medicaid primary care providers, provide incentives to use key Medicare/Medicaid primary care and preventive services, foster the development of medical homes and care coordination	**Primary Care Infrastructure and Incentives:** Increase reimbursement for Medicaid primary care and acute care providers, provide incentives to use key primary care and preventive services, study barriers to the greater use of mid-level providers, foster the development of medical homes and the adoption of HIT, and reimburse care coordination
	Wellness: Provide incentives for wellness in individual and group coverage	**Wellness:** Provide incentives for wellness in individual and group coverage
	Delivery System and Payment Reform: Fund program and demonstration projects for Medicare, Medicaid and private payers to improve the delivery of health care services and to align payment with achieving quality outcomes	**Delivery System and Payment Reform:** Study and implement strategies to improve the delivery of health care services and to align payment with achieving quality outcomes

	Federal Health Care Reform Patient Protection and Affordable Care Act (2010)	Colorado Health Care Reform 208 Commission Recommendations (2008)
DELIVERY SYSTEM Provisions overview *(continued)*	**Reporting:** Require additional data collection and public reporting on quality of care and monitor trends in disparities by race, ethnicity, language or disability	**Reporting:** Require additional data collection and public reporting on the cost and quality of care, using standardized measures; develop a data infrastructure to study cost, utilization and quality trends by aggregating information from all public and private payers
	Administrative Savings: Reduce administrative costs through standardizing processes	**Administrative Savings:** Reduce administrative costs through administrative simplification, standardizing processes and regulatory streamlining
IMPLICATIONS FOR NATIONAL AND STATE PLANNING TASK FORCES AND COMMITTEES		
National and state agenda setting for delivery system reform	**Delivery System Reform Agenda:** Develop comprehensive, national quality improvement strategies for reforming the health care delivery system, aligning public and private sectors, coordinating public health activities, maximizing clinical effectiveness and improving population health. Specific duties include: ■ **Implementation:** Define quality metrics for payment and reporting purposes; report annually to Congress ■ **Research:** Establish a nonprofit Patient-centered Outcomes Research institute to conduct comparative effectiveness research on medical treatments; Establish a Center for Innovation at the Centers for Medicare & Medicaid Services	**Delivery System Reform Agenda:** Create a multi-stakeholder Improving Value in Health Care Authority to work across constituencies to create a vision and a consensus for realigning incentives to reduce costs and improve outcomes. Specific duties include: ■ **Implementation:** Implement Commission recommendations relating to administrative simplification, health care transparency, design of the Minimum Benefit Package, design of the Consumer Advocacy Program and creation of an all-payer claims database ■ **Research:** Study and make recommendations regarding Commission recommendations relating to prevention, end-of-life care, medical homes, health information technology, evidence-based medicine and provider reimbursement; assess and report on the effectiveness of reforms and their impact on vulnerable populations
	Public Health: Create the National Prevention, Health Promotion and Public Health Council to develop a national strategy to coordinate federal public health activities and improve the nation's health	**Public Health:** Increase funding for local public health agencies in Colorado to engage in public health activities
	Workforce: Develop a national workforce strategy	**Workforce:** Commission an independent study to explore ways to minimize barriers to such midlevel providers as advanced practice nurses, dental hygienists and others from practicing to the fullest extent of their licensure and training.

	Federal Health Care Reform Patient Protection and Affordable Care Act (2010)	Colorado Health Care Reform 208 Commission Recommendations (2008)
INFRASTRUCTURE AND INCENTIVES FOR PRIMARY CARE		
Infrastructure and incentives for primary care	**Medical Homes and Care Coordination:** Create new multi-payer demonstration projects to better coordinate care and implement patient-centered medical homes	**Medical homes and Care Coordination:** Provide a medical home to all Coloradans; reimburse care coordination and case management through Medicaid and CoverColorado
	Health Information Technology: None specified	**Health Information Technology:** Support the creation of a statewide health information network to ensure efficient communication of patient information to and from the medical home (see, Delivery system reform, page 14)
	Cost-sharing for Primary Care: Tie Medicare, Medicaid, Exchange coverage, cost-sharing and financing policies for key primary care services to the recommendations of the U.S. Preventive Services Task Force: ■ Eliminate Medicare cost-sharing for certain recommended services ■ Provide enhanced federal matching to states that eliminate cost-sharing for certain recommended services ■ Require qualified health plans to cover and eliminate cost-sharing for certain recommended services	**Cost-sharing for Primary Care:** Eliminate copayments for preventive care and prescription drugs, and reduce patient copayments for chronic care management services
	Primary Care Shortage Strategies: Increase funding for residency and nurse practitioner training in primary care; provide grants, scholarships and loans to increase workforce supply in primary care	**Primary Care Shortage Strategies:** Study ways to minimize barriers to greater deployment of mid-level providers such as advanced practice nurses and dental hygienists
WELLNESS		
Incentives for wellness	**Employer-based Wellness:** Provide incentives for employer-based wellness programs ■ Provide grants to small employers	**Employer-based Wellness:** Provide incentives for employer-based wellness programs ■ Encourage workplace wellness programs and individual responsibility for health, wellness and healthy behaviors
	Financial Incentives: ■ Permit premium discounts up to 30% for employee participation in wellness programs ■ Create wellness demonstration projects for individual market enrollees	**Financial Incentives:** ■ Permit health insurance premiums to be reduced for enrollees who engage in healthy behaviors, where allowed by federal law

	Federal Health Care Reform Patient Protection and Affordable Care Act (2010)	**Colorado Health Care Reform** 208 Commission Recommendations (2008)
IMPROVING VALUE		
Delivery system reform demonstrations and projects	**Delivery System Reforms:** Implement grants, demonstration projects and delivery system reforms that improve patient outcomes, examples (not exhaustive) include: ■ Patient-centered medical homes ■ Comparative effectiveness research of clinical treatments ■ Care coordination for dual eligibles and other populations with special needs ■ Patient navigators ■ Technical assistance for quality improvement ■ Medication management for individuals with chronic disease ■ Mandatory quality reporting for physicians, hospitals and other providers	**Delivery System Reforms:** Study and make recommendations on ways to improve patient outcomes; examples include: ■ Provide medical homes to all Coloradans ■ Adopt population-specific care guidelines using evidence-based research ■ Implement prevention strategies ■ Establish a statewide, interoperable health information network ■ Create an electronic health record for every Coloradan ■ Analyze aggregated data from all public and private payers to identify areas for cost and quality improvement
	Financial Incentives: Provide financial incentives for improved patient outcomes (see, Payment Reform, below)	**Financial Incentives:** Provide financial incentives for improved patient outcomes (see, Payment Reform, below)
Payment reform and cost containment	**Medicaid/Medicare Reimbursement:** Increase reimbursement for Medicare/ Medicaid primary care physicians to increase access to primary care ■ Increase Medicaid primary care physician reimbursement for primary care services to 100% of Medicare rates ■ Provide a 10% bonus to Medicare primary care providers (2011-15)	**Medicaid Reimbursement:** Increase reimbursement to Medicaid providers to reduce cost-shifting; pay plans actuarially-sound rates ■ For merged Medicaid/CHP+ program, increase Medicaid physician rates to at least CHP+ rates (80% of Medicare) ■ For traditional Medicaid program serving the elderly and people with disabilities, increase Medicaid physician rates to 75% of Medicare ■ Increase hospital rates to 65% of billed charges

	Federal Health Care Reform Patient Protection and Affordable Care Act (2010)	Colorado Health Care Reform 208 Commission Recommendations (2008)
Payment reform and cost containment *(continued)*	**Payment Reform:** Fund new demonstration projects to align payment methodologies to cost and quality outcomes; examples (not exhaustive) include: ■ Bundled payments for an episode of care ■ Value-based purchasing for hospitals and other providers ■ Global capitated payments to safety net hospital systems ■ Shared savings programs and accountable care organizations for Medicare and Medicaid ■ Care transitions programs ■ Payment reductions for Medicare hospital readmissions ■ No payment for hospital acquired conditions	**Payment Reform:** Implement payment reforms that pay providers based on their use of care guidelines, performance on quality measures, coordination of patient care and use of health information technology; study and make recommendations to improve long-term care and end-of-life care
	Administrative Savings: Reduce administrative costs through standardizing financial and administrative processes	**Administrative Savings:** Reduce administrative costs through standardization of administrative processes, consolidation of administrative functions for public programs, and regulatory streamlining
	Medicare Savings: Multiple strategies designed to reduce Medicare costs (not detailed here).	**Medicare Savings:** None specified due to Commission's state-level focus.

DATA SOURCES

- Patient Protection and Affordable Care Act (PPACA), enacted March 23, 2010.
- Summary of New Health Reform Law – Last Modified: June 18, 2010. Kaiser Family Foundation.
- In Brief: Key Decisions for States Establishing a Health Insurance Exchange. McKenna, Long & Aldridge, 2010.
- Final Report to the General Assembly. Blue Ribbon Commission for Health Care Reform. January 31, 2008.
- Patient Protection and Affordable Health Care Act of 2009: Health Insurance Exchanges. National Association of Insurance Commissioners. Updated 4/20/2010.
- Patient Protection and Affordable Health Care Act of 2009: Health Insurance Market Reforms. National Association of Insurance Commissioners. Updated 4/20/2010.

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