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MANAGING HEALTH REFORM

COLORADO: ROUND 1

State-Level Field Network Study of the Implementation of the Affordable Care Act

March 2014

Rockefeller Institute of Government
State University of New York

Fels Institute of Government
University of Pennsylvania

The Public Policy Research Arm of the State University of New York

411 State Street
Albany, NY 12203-1003
(518) 443-5522

www.rockinst.org

Field Research Associates

Jeff Bontrager, Director of Research on Coverage and Access

bontragerj@coloradohealthinstitute.org

Jeff Bontrager, director of research on coverage and access, joined the Colorado Health Institute (CHI) in March 2005. Jeff coordinates CHI's research efforts related to health insurance, the uninsured, Medicaid and Child Health Plan Plus (CHP+) eligibility modeling, as well as Colorado's health care safety net. Jeff earned a master of science degree in public health from the University of Colorado Health Sciences Center and has a bachelor's degree in psychology from Goshen College in Goshen, Indiana. Jeff was selected in 2013 by the *Denver Business Journal* as one of Denver's "Forty Under 40" up-and-coming leaders.

Kevin Butcher, Research Assistant

butcherk@coloradohealthinstitute.org

Kevin Butcher joined the Colorado Health Institute in October 2013 as a research assistant. While his work spans an array of topics, he has a special interest in mental health and substance use. Kevin has experience working in hospital psychiatric units and mental health treatment facilities. Kevin graduated in 2013 from Augsburg College in Minneapolis, Minnesota, with a bachelor of science in biopsychology and a bachelor of arts in psychology: clinical.

Sara Schmitt, Director of Community Health Policy

schmitts@coloradohealthinstitute.org

Sara Schmitt studies issues such as health care cost drivers, payment reform, and population health. She also tracks Colorado's efforts to promote healthy eating and active living, as well as oral health. Before joining CHI, Sara was a policy analyst at the Colorado Rural Health Center, the State Office of Rural Health. She spent several years in managed care and program development at the University of Chicago Medical Center. She also has worked in policy advocacy and providing supportive services for people living with HIV/AIDS. She earned her bachelor's degree from DePaul University and a master's degree from the University of Chicago.

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State University of New York
411 State Street
Albany, New York 12203
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www.rockinst.org

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COLORADO: ROUND 1

State-Level Field Network Study of the Implementation of the Affordable Care Act

Part 1 – Setting the State Context

"Colorado was at the forefront of health care reform, even before it was in the national spotlight."

– Steve ErkenBrack, president and CEO of Rocky Mountain Health Plans and Board member of Connect for Health Colorado, the state-based exchange, October 9, 2013

1.1. Decisions to Date

Introduction

Colorado is one of fourteen states and the District of Columbia that elected to operate a state-based health insurance exchange and to expand Medicaid in 2014 as part of the rollout of the Affordable Care Act (ACA).[1] These decisions are consistent with Colorado's approach to health care reform. Before the ACA was signed into law in 2010, the state had made incremental expansions in Medicaid eligibility and laid the groundwork for an insurance marketplace.

Paving the Way for the ACA

Colorado's health reforms picked up steam in the early 1990s. In 1991, the General Assembly created a high-risk pool called CoverColorado, similar to the ACA's Pre-Existing Condition Insurance Plan, to cover people who had been denied insurance because of their medical status. Colorado had a small insurance plan

for children prior to the 1997 federal CHP legislation.[2] The General Assembly also passed major market reforms (H.B. 94-1210), which mandated guaranteed issue and renewal for small group plans two years before the same provisions were required under the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996.[3]

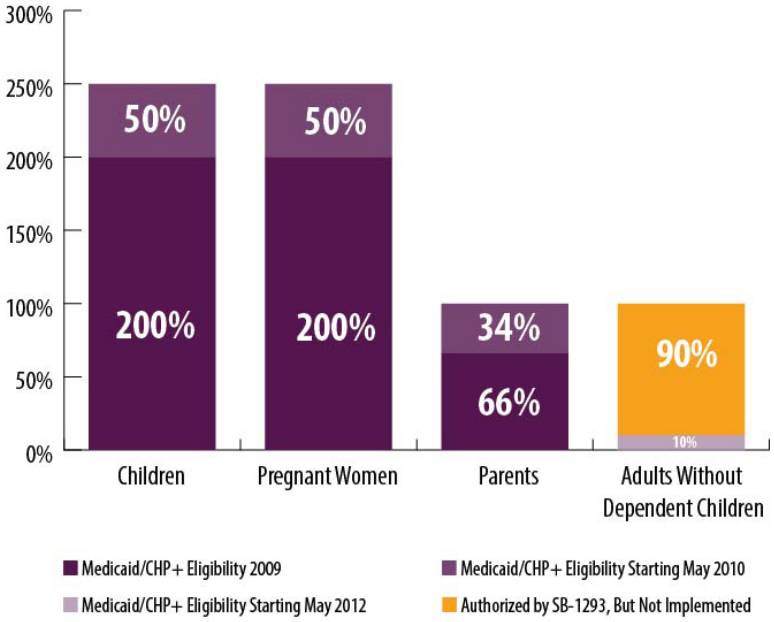
In 2006, Governor Bill Owens signed Senate Bill 06-208, the Access to Affordable Health Care Act, which created the Blue Ribbon Commission for Health Care Reform (also known as the 208 Commission).[4] Recommendations from the bipartisan commission included expanding Medicaid and creating a "Connector," or health insurance exchange — two components of what would later become key provisions in the ACA.[5, 6]

> "Some people simply cannot afford private insurance coverage. Those people should have access to public coverage or sliding scale subsidies for basic health care needs," the commission wrote. It noted that "individuals should have meaningful choices and options that give them control over their own care and coverage decisions."

The 208 Commission's work set the stage for future legislation. By 2009, the state legislature determined the Blue Ribbon reform package was too expensive to adopt in its entirety.[7] The Connector idea never gained traction, but lawmakers did expand eligibility for state insurance programs. The Joint Budget Committee, a bipartisan panel responsible for setting the annual state spending plan, sponsored the Colorado Health Care Affordability Act of 2009 (HB 09-1293). The goal was to improve the quality of care for people with public insurance and to reduce cost-shifting by expanding eligibility for Medicaid and Child Health Plan *Plus* (CHP+).[8] To finance these expansions, the act authorized the Colorado Department of Health Care Policy and Financing (HCPF), the state's Medicaid agency, to assess a hospital provider fee that is matched with federal dollars (1115 Demonstration waiver).[9,10,11] The bill was signed into law on April 21, 2009.[12]

The law, which took effect in May 2010, expanded Medicaid to parents with incomes up to 100 percent of the federal poverty level (FPL) and increased the income threshold to 250 percent of FPL for children and pregnant women. Most notably, it expanded Medicaid for the first time to nondisabled adults without dependent children to 100 percent of FPL (see Figure 1.1).[13] Due to budget constraints, HCPF decided to cap enrollment at 10,000 for adults with incomes at or below 10 percent of FPL.[14,15] The department plans to raise the enrollment cap to 21,691 by the end of 2013 and end the 1115 Demonstration waiver on December 31, 2013.[16]

Figure 1.1 Colorado Medicaid/CHP+ Income Thresholds by Federal Poverty Level Pre- and Post-House Bill 2009-1293



Colorado Department of Health Care Policy and Financing, "Expanding Colorado Medicaid: Caseload and Cost Projections."[17]

A Bumpy Road

Colorado's efforts at health care reform enjoyed a degree of bipartisan support. The 2009 reforms stemmed from the 208 Commission, which began under Owens, a Republican, and became the building blocks for programs led by his successor, Democrat Bill Ritter. But as federal health reform took center stage, opponents turned up the volume against what they called a one-size-fits-all solution for Colorado.

A citizen initiative on the November 2010 election ballot proposed a state constitutional amendment opposing the individual mandate and employer mandate of the ACA. More than half (53 percent) of Colorado voters rejected the measure.[18] Colorado had a Republican state House and a Democratic Senate and Democratic governor the following year, yet the General Assembly passed SB 11-200, the Colorado Health Benefit Exchange Act. This bill created a Board to oversee the establishment of a state-based insurance marketplace. Its bipartisan sponsors were Democrat Betty Boyd, Senate president pro-tem and chair of the Senate Health and Human Service Committee, and Republican Amy Stephens, House majority leader, although it was opposed by most Republicans in the House and Senate.

Stephens was no fan of the ACA but she recognized the need for health reform, saying a homegrown marketplace would drive down health care costs while helping small businesses provide benefits to their employees.[19] The bill attracted support from prominent business groups, including the Colorado Association of Commerce and Industry, and advocacy groups such as the MS Society. But bipartisan sponsorship and backing from unlikely allies did not ensure smooth sailing.

Senator Shawn Mitchell led Republican opposition in the Senate, saying the proposed exchange was simply a "cog in the machinery of Obamacare." He argued that the insurance industry would be better off with less government involvement, not more.[20] Tea Party activists also objected to the measure, which opponents derisively dubbed "Amycare," and hinted that Republicans who supported it would pay at the polls.

In response, Stephens proposed an amendment that would require the state to seek a full waiver from the federal government's health care reform law. She said she wanted to "make absolutely sure that the health care exchanges are implemented only after the State of Colorado opts out of Obamacare." The Senate Health and Human Services Committee rejected Stephens' amendment on a party-line vote.[21,22] Ultimately SB 11-200 garnered enough support to pass both chambers, and Governor John Hickenlooper signed the bill into law on June 1, 2011.[23]

Addressing Colorado's response to health care reform, Hickenlooper, a business-friendly Democrat, cited efforts to work across the aisle. "This isn't about Republicans and Democrats," he said in a 2011 interview. "I don't think it's about kowtow[ing] to the federal government. I think it's about trying to solve our problem."

The Exchange Takes Shape

The Colorado Health Benefit Exchange was established as a quasigovernmental agency.[24] The Colorado Health Institute, a nonpartisan, nonprofit policy center, served as fiscal agent until the exchange was incorporated in March 2012 as an independent nonprofit entity.[25]

The exchange is governed by a Board of twelve members, including three ex-officio nonvoting members. Oversight is provided by the bicameral and bipartisan Legislative Health Benefit Exchange Implementation Review Committee.[26] The Board met for the first time on July 11, 2011, under the leadership of its planning director, Joan Henneberry, the former executive director of HCPF. Henneberry voluntarily left the exchange on November 4, 2011.[27] The following month, the Legislative Health Benefit Exchange Implementation Review Committee confirmed the Board's nomination of Patty Fontneau as executive director. She was previously chief operating officer at Holme Roberts & Owen, an international law firm.[28]

SB 11-200 prohibited Colorado from using state general funds to finance the exchange.[29] The federal government provided $178 million to get the exchange up and running.[30] Additionally, Colorado is one of ten states to receive technical assistance from the Robert Wood Johnson Foundation's State Health Reform Assistance Network.[31]

The state legislature passed House Bill 13-1245 in May 2013 to establish long-term financing mechanisms to fund the exchange. HB 13-1245 shifts excess reserves from CoverColorado, the

high-risk pool that will close in 2014 as enrollees with pre-existing conditions gain access to coverage.[32] The law allows the Exchange to assess a monthly fee on small group and individual health insurers of up to $1.80 per member per month for health insurance carriers and up to 18 cents per member per month for dental plans. It also creates a tax credit for insurance carriers that voluntarily contribute to the Exchange, capped at $5 million annually statewide. Proponents say the law will help the Exchange remain financially viable after federal funding ends in 2015.[33]

The Colorado Health Benefit Exchange changed its name to Connect for Health Colorado in March 2013. Enrollment began on October 1, with some glitches.[34] Coverage began January 1, 2014, for those who enrolled prior to December 27, 2013. The open enrollment period is scheduled to close on March 31, 2014, barring any additional delays.[35]

Medicaid Expansion, Part II

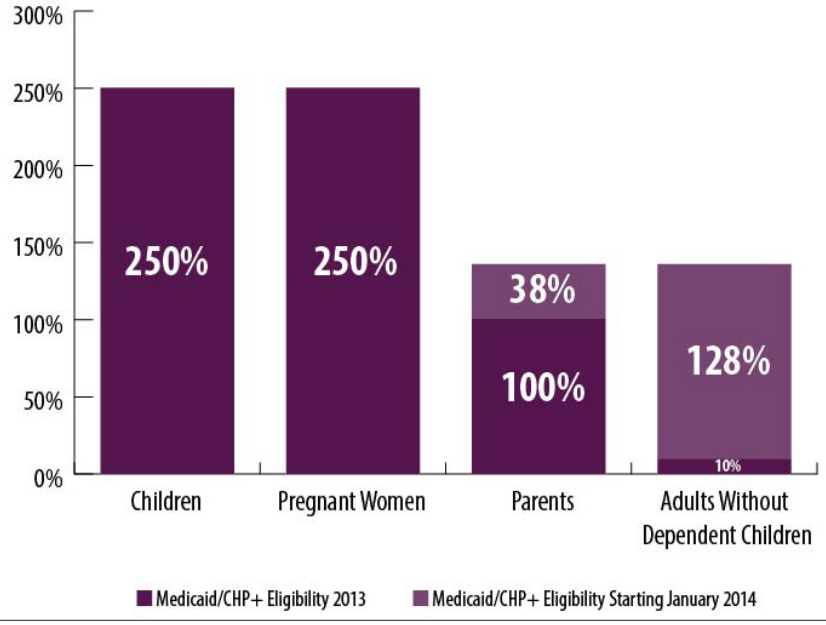
The Supreme Court, in response to a lawsuit challenging the constitutionality of the ACA, in June 2012 upheld the individual mandate, the centerpiece of the law. However, the justices also said that Medicaid expansion under the ACA was optional for states. States that decided to expand eligibility would receive subsidies from the federal government. Colorado waited a year before taking the federal government up on its offer.

Colorado's Medicaid expansion bill, SB 13-200, passed the General Assembly in 2013, when Democrats were in control of the House, Senate and Governor's Office. Senator Larry Crowder of Alamosa was the only Republican in either chamber to vote for the bill. Crowder opposed the ACA, but said four of the seven hospitals in his district were in serious financial trouble and that he wanted to help uninsured patients pay their bills.[36] Republican Senator Kevin Lundberg expressed concern that Colorado could not afford the expansion, calling it a "very cruel joke."[37]

The bill, which took effect on January 1, 2014, increased the income threshold for Medicaid eligibility up to 138 percent of the federal poverty level (FPL) for parents and adults without dependent children (see Figure 1.2), which is $15,856 for an individual, $21,404 for a couple and $32,499 for a family of four in 2013.[38] HCPF estimates the expansion will cover nearly 160,000 uninsured adults.[39] The Colorado Health Institute estimates the new law will add 240,000 Coloradans to Medicaid by 2022.[40]

The Governor's Office estimates that Medicaid expansion will cost $128 million over ten years (see Figure 1.3). But Hickenlooper indicated that cost containment, payment reform, better use of technology, and waste reduction would allow Colorado to save $280 million in Medicaid spending over a decade.[41,42] Some critics have questioned whether these savings can be achieved.[43]

Figure 1.2 Colorado Medicaid/CHP+ Income Thresholds Pre- and Post-ACA



Colorado Department of Health Care Policy and Financing, "Expanding Colorado Medicaid: Caseload and Cost Projections."[44]

Figure 1.3 Ten-Year Projection of Medicaid Expansion Expenditures

	Caseload and Cumulative Expenditure Projections*, 2013-2022 (Representing Net Change, Costs in Millions)		
	Colorado Medicaid Expansion in 2009	ACA	Total**
Caseload	220,300	59,500	271,000
Total Cost	$11,709.7	$2,039.2	$13,548.3
State Share: Provider Fee/Other	$1,267.3	**$128.3**	$1,395.6
State Share: General Fund/Other	$0	$0	($179.5)
Federal	$10,382.3	$1,910.9	$12,280.0

*Preliminary estimate of caseload and expenditures does not include administrative costs or effects of other programs.
** The total estimates column takes into account calculations for eligible but not enrolled individuals and changes to the CHP+ costs and caseload.
Source: Colorado Department of Health Care Policy and Financing, "Expanding Colorado Medicaid: Caseload and Cost Projections."

1.2. Goal Alignment

Colorado began legislative efforts to put state law in step with the ACA after the Supreme Court ruling. House Bill 13-1266 aligns Colorado statutes with the ACA's insurance mandates. It also enables Colorado's insurance commissioner to require health insurers to meet the requirements of the federal law. HB 13-1115

repealed CoverColorado, the state's high-risk pool, which became obsolete in 2014 when private insurers could no longer deny coverage based on prior medical history.[45]

Most Democratic and Republican leaders in Colorado agree that rising health care costs jeopardize the state economy and put a financial strain on businesses and individuals. Still, health reform measures have garnered more support in Colorado when proposed as state-initiated solutions. Before passage of the ACA, Colorado brought thousands of additional low-income people under the Medicaid umbrella and more will be eligible this year because the state opted to expand Medicaid under the ACA. It is also one of the few states to set up and operate its own exchange, perhaps reflecting what a former *Denver Post* columnist called the state's "rugged individualism."[46]

Hickenlooper spoke frankly about health reform in a 2011 interview with *Colorado Public Radio*. He suggested that everyone, even people who work for relatively low wages, need to have some skin in the game, saying, "Everyone will have to pay something for health care." By establishing a state-based exchange, the governor said, Colorado will have more control, more quality choices, and lower cost insurance. Many governors have rejected federal funds for health reform, but Hickenlooper defended his decision to accept support.

"Colorado [gets] back way too few of the tax dollars we send to Washington," he said. "And so to suddenly say, we're not going to [accept] millions [in] grants to implement an exchange … to help lower costs for individuals and small businesses in Colorado, I think we'd be chumps not to do it."[47]

Part 2 – Implementation Tasks

2.1. Exchange Priorities

Connect for Health Colorado, the state-based health insurance exchange, opened its Web portal and phone banks for enrollment on October 1, 2013, though efforts leading up to the on-time launch began long before.

Established in 2011, the exchange is a quasigovernmental agency that does not receive money from the state general fund. As a clearinghouse exchange, it does not have the authority to set premium rates, except as directed by the ACA, and all insurance carriers authorized to sell plans in Colorado are eligible to participate in it. As noted above, a volunteer Board of twelve members governs the exchange, and a bicameral and bipartisan Legislative Health Benefit Exchange Implementation Review Committee provides oversight.[48]

The Board had its inaugural meeting in July 2011. Early decisions included electing Board leadership and forming subcommittees; appointing an exchange director to replace the planning director; and establishing rules regarding conflicts of interest. The exchange planning director initially created four workgroups

during summer 2011: Marketing Outreach and Education, Data Analysis, Eligibility Verification and Enrollment, and Small Employer. The groups were comprised of researchers, community members, advocates, health providers, and insurers. They made structure and operations recommendations to the Board in their respective topic areas, though they did not have decision-making authority. Massachusetts Institute of Technology Professor Jonathan Gruber worked with Jeff Bontrager of the Colorado Health Institute to estimate insurance enrollment through the exchange and presented an insurance coverage simulation model to the Data Analysis workgroup.[49] Committees have since been restructured and now consist of the Executive Committee, Finance Committee, Operations Committee, and Policy and Regulations Committee.[50]

Key Board decisions in 2012-13 included outsourcing its technology systems and customer service operations. Connect for Health Colorado contracted with a U.S. subsidiary of CGI, Canada's largest information technology company, to build IT systems that powered the exchange. CGI was the principal contractor and systems integrator, dispersing work among about eight other technology vendors and contractors.[51] In explaining why the exchange hired CGI, Executive Director Patty Fontneau told members of the Legislative Health Benefit Exchange Implementation Review Committee that the tech company employed proven technology and had the experience and references to succeed.[52] The Urban Institute, a nonpartisan policy research and educational organization, characterized Colorado's decision to outsource its IT work to experts as a necessary one, given time constraints and the lack of in-house experience.[53]

The Board also created an eligibility and enrollment system for the exchange that is separate from, but interoperable with, the one used for Medicaid/CHP+, citing the cost and time constraints of creating a combined Medicaid/exchange platform, among other reasons.[54] Individuals seeking a federal subsidy through Connect for Health Colorado must first apply for Medicaid. If denied, applicants are rerouted to Connect for Health Colorado, where they can shop for coverage and apply for a subsidy.

The Board voted on February 27, 2012, to separate the small group and individual risk pools and to revisit the issue by October 2016.[55] However, the Board decided the two markets would share an administrative structure so as not to duplicate efforts.[56] Businesses eligible to purchase on the Small Employer Health Options Program (SHOP) must have no more than fifty employees, although this number will increase to 100 in 2016, per an ACA requirement.[57,58]

Connect for Health Colorado announced in June 2013 that fifty-eight official consumer Assistance Sites throughout Colorado would receive $17 million to hire and train navigators called Health Coverage Guides.[59] These guides "conduct outreach and education and provide unbiased in-person assistance with plan evaluation and the health coverage application process" to both

individuals and small business employers.[60] More than 1,300 licensed and certified health insurance agents and brokers across the state also help customers understand coverage options available on Connect for Health Colorado.[61] In addition to in-person assistance with a navigator, agent or broker, customers can also call a customer service center or access information through an online chat.

2.2. Leadership – Who Governs?

Introduction

Leadership and oversight of Connect for Health Colorado reflect a balance of the public and private sectors. The Board of Directors is appointed by elected officials and includes state executives. The bipartisan, bicameral legislative committee reviews its finances and operations.

Requirements for Board Appointments

Connect for Health Colorado has nine voting members on its Board. According to the Colorado Health Benefit Exchange Act, the governor appoints five voting members to Connect for Health Colorado's Board. The act stipulates that no more than three of the five gubernatorial appointees may be from the same political party. The other four voting members are appointed by the state Senate president, the state Senate minority leader, the Speaker of the House of Representatives, and the House minority leader.[62,63] Each appoint one member. Board members then elect a chairperson.

Board members must have expertise in at least two of the following areas:

- Individual health insurance coverage;
- Small employer health insurance;
- Health benefits administration;
- Health care finance;
- Administration of a public or private health care delivery system;
- The provision of health care service;
- The purchase of health insurance coverage;
- Health care consumer navigation or assistance;
- Health care economics or health care actuarial sciences;
- Information technology;
- Starting a small business with fifty or fewer employees.

Senate Bill 11-200 also calls for three ex-officio, nonvoting members to sit on the Board. These members shall be the executive director of HCPF, the Colorado commissioner of insurance and the director of the Office of Economic Development and International Trade, or the designee of said members.[64] The Board is

responsible for providing a report to the governor and General Assembly by January 15th of each year detailing the progress of the exchange.[65]

Board Members

The nine voting members were first appointed June 29, 2011, although two membership changes occurred in 2013. Voting members of the Board represent urban and rural regions of the state. The most common backgrounds of Board members include health benefits administration, health care finance, information technology, and small business.[66] Some consumer advocates suggested that there was not enough consumer representation among the original appointees.[67] In 2013, the governor replaced two of his original appointees with a consumer advocate and a small business owner (see Figure 2.1).

Some Board members have political backgrounds and connections to policymakers. Mike Fallon was the 2010 Republican nominee to represent Colorado's 1st Congressional District.[68] Board member Arnold Salazar's wife, Marguerite Salazar, served as the Region VIII director for the U.S. Department of Health and Human Services (HHS)[69] and is currently Colorado's insurance commissioner; therefore, she serves as an ex-officio, nonvoting member of the Board.

Legislative Oversight

The ten-member Legislative Health Benefit Exchange Implementation Review Committee reviews the Board's federal grant applications as well as financial and operational plans (see Figure 2.2). It can meet up to five times a year and can recommend up to five bills to the General Assembly. The House and Senate each appoint five members. The Senate President appoints three members, two of whom must be members of either the Senate Health and Human Services Committee, the Business, Labor and Technology Committee or the Legislative Audit Committee, and one of whom must be a representative of the Senate at large. The Senate Minority Leader appoints one member from the committees listed above and one at-large member. The same system is used in the House. During odd-numbered years, the Senate president appoints the chair of the review committee and the speaker of the House appoints the vice chair. During even-numbered years their appointments are vice-versa.[70] The committee first met on August 1, 2011.

Committee Activities: Grant Review

The committee must approve all Connect for Health Colorado's HHS grant requests. Connect for Health Colorado has been awarded three HHS awards since the Board was established, including an $18 million Level One Establishment Grant in February 2012, a $43 million Level One Establishment Grant in

Figure 2.1. Connect for Health Colorado Board Members[71,72]

2011 Board Members	2013 Board Members
Chair Gretchen Hammer Denver Executive Director Colorado Coalition for the Medically Underserved	**Chair** Gretchen Hammer Denver Executive Director[73] Colorado Coalition for the Medically Underserved
Vice Chair Richard Betts Telluride Owner ASAP Accounting & Payroll, Inc.	**Vice Chair** Richard Betts Telluride Owner ASAP Accounting & Payroll, Inc.
Secretary Arnold Salazar San Luis Valley Executive Director Colorado Health Partnerships, LLC	**Secretary** Arnold Salazar San Luis Valley Executive Director Colorado Health Partnerships, LLC
Robert Ruiz-Moss Lone Tree Micro-Market Lead West Anthem Blue Cross Blue Shield	Ellen Daehnick Denver Former Management Consultant Helliemae's Handcrafted Caramels
Steve ErkenBrack Grand Junction President Rocky Mountain Health Plans	Steve ErkenBrack Grand Junction President Rocky Mountain Health Plans
Mike Fallon, MD Denver Emergency Room Physician North Colorado Medical Center	Mike Fallon, MD Denver Emergency Room Physician North Colorado Medical Center
Eric Grossman Englewood Vice President of Strategy & Government Affairs Independent Consultant	Eric Grossman Englewood CEO NextHealth Technologies
Elizabeth Soberg Centennial Chief Executive Officer UnitedHealthcare of Colorado	Sharon O'Hara Denver Executive Vice President National Multiple Sclerosis Society – Colorado-Wyoming Chapter
Nathan Wilkes Denver Founder and Principal Consultant Headstorms, Inc.	Nathan Wilkes Denver Founder and Principal Consultant Headstorms, Inc.
Ex-Officio (nonvoting member) Susan Birch, RN, MBA Executive Director Colorado Department of Healthcare Policy and Financing	**Ex-Officio (nonvoting member)** Susan Birch, RN, MBA Executive Director Colorado Department of Healthcare Policy and Financing
Ex-Officio (nonvoting member) Ken Lund Executive Director Office of Economic Development and Information Technology	**Ex-Officio (nonvoting member)** Kevin Patterson Deputy Chief of Staff and Chief Administrative Officer, Governor's Office.
Ex-Officio (nonvoting member) Jim Riesberg Commissioner of Insurance Colorado Department of Regulatory Agencies	**Ex-Officio (nonvoting member)** Marguerite Salazar Commissioner of Insurance Colorado Department of Regulatory Agencies

Figure 2.2. Legislative Health Benefit Exchange Implementation Review Committee Members

2012 Legislative Review Committee[74]	2013 Legislative Review Committee [75]
Rep. Bob Gardner, Chair (R)	Sen. Irene Aguilar, Chair (D)
Sen. Betty Boyd, Vice Chair (D)	Rep. Beth McCann, Vice Chair (D)
Sen. Irene Aguilar (D)	Rep. Bob Gardner (R)
Rep. Jim Kerr (R)	Sen. Kevin Lundberg (R)
Sen. Kevin Lundberg (R)	Sen. Jeanne Nicholson (D)
Rep. Beth McCann (D)	Sen. Ellen Roberts (R)
Sen. Jeanne Nicholson (D)	Rep. Dianne Primavera (D)
Sen. Ellen Roberts (R)	Rep. Amy Stephens (R)
Rep. Ken Summers (R)	Rep. Max Tyler (D)
Rep. Max Tyler (D)	Sen. Jessie Ulibarri (D)

September 2012, and a $116 million Level Two Establishment Grant in July 2013.[76]

Two requests created conflict between the Board and the legislative review committee. The first clash accompanied the initial Level One Establishment Grant application. Despite unanimous Board approval, some committee members, primarily Republicans, expressed concerns about not being able to predict how many people would use the exchange and about how the exchange would remain financially stable without federal financing.[77] During review of the Level Two Establishment Grant, some committee members suggested the exchange should use its own revenue, not federal dollars, to finance itself. While both applications ultimately received committee approval and were funded by HHS, the partisan disagreements highlighted ongoing concerns about the ACA and the sustainability of Connect for Health Colorado.[78]

2.3. Staffing

Connect for Health Colorado is led by a three-member executive office. Patty Fontneau, chief executive officer, was most recently the chief operating officer of the Denver-based international law firm Holme Roberts & Owen LLP and also has a background in Denver's finance sector. She serves on boards of the Downtown Denver Partnership, the University of Denver Business School Advisory Board, and the Auraria Foundation.[79] Cammie Blais, chief financial officer, has decades of management experience and owned a business that provided financial, human resource, and administrative services to other businesses. [80] Lindy Hinman, chief operating officer, has extensive experience in the health care and insurance sector. She worked for Horizon Blue Cross Blue Shield, America's Health Insurance Plans, Centers for Medicare & Medicaid Services (CMS), and the White House Office of Management and Budget.[81]

The Connect for Health Colorado Web site lists a variety of directors, coordinators, managers, and analysts, thirty-four in all.[82] Its implementation and operational organizational chart details

six functional sections, including financial, operational, communications, and technology.[83]

The exchange's main office is located in Denver, but there are numerous Assistance Sites throughout the state and a customer service center in Colorado Springs. As of December 9, 2013, the customer service center employed more than 160 representatives, not including back-office workers.[84,85] The center provides phone and online chat assistance in both English and Spanish, and workers have access to experts who speak other languages.[86] Center staff members reportedly earn between $11 and $20 per hour and receive health benefits.[87]

Contractors are an important supplement to Connect for Health Colorado's workforce. The most notable contract has been with CGI. Fontneau has acknowledged that a team of contractors is working to improve the online marketplace, although information about the number of team members and the companies they represent is unclear.[88]

Connect for Health Colorado awarded a variety of contracts in 2012: PILGRIM Advertising (December 2012) for marketing help; Corona Insights (December 2012) for market research assistance; First Data (November 2012) to develop verification and validation services; reVision Inc. (August 2012) for privacy and security efforts; and North Highland (March 2012) for customer service and technology support.[89] Connect for Health Colorado also hired OnSight Public Affairs in April 2013 to manage its public relations.[90]

2.4. Outreach and Consumer Education

Connect for Health Colorado Activities

Connect for Health Colorado launched a $4 million enrollment campaign on October 1, 2013, which includes television, radio, print, online, mobile, billboard and search engine marketing tactics. In one ad, a baseball team celebrates the insurance options available to a middle-aged woman sitting in her kitchen as if they had won the World Series. Connect for Health Colorado also is using a "boots-on-the-ground" approach at high-traffic locations such as sports events and central transit stations.[91,92]

Connect for Health Colorado has partnered with more than 100 organizations statewide and in 2013 had a presence at about thirty events each week, including fairs, festivals, concerts, and sporting events. In addition to its staff, the exchange also has a volunteer speakers' bureau that trains professionals to make presentations at venues such as Rotary Club meetings.

Connect for Health Colorado's Level Two Establishment Grant earmarks about $14 million for marketing. As of September 30, 2013, just over $5.1 million had been spent on outreach, marketing, and communications. The amount reflects approximately $3 million from the Level Two Grant and the remaining $2 million

from Connect for Health Colorado's first and second Level One grants.[93]

Community Activities

Several organizations are conducting education and outreach activities to raise awareness of Connect for Health Colorado and drive customers to the exchange. Nonprofit organizations ProgressNow, the Colorado Education Association, and the Colorado Consumer Health Initiative funded a social media ad campaign called "got insurance?" with donations and individual contributions. This edgy campaign, modeled after the "got milk?" ads and targeted at young adults, uses provocative pictures and slogans that became somewhat controversial.[94,95] Health insurers are also providing information on Connect for Health Colorado, and several insurers, including Rocky Mountain Health Plans and Cigna, include tax premium subsidy calculators on their Web sites.[96]

2.5. Navigational Assistance

Assistance for navigating coverage options on Connect for Health Colorado is offered through three entities — Assistance Sites, Health Coverage Guides, and Application Counselors. In June 2013, Connect for Health Colorado established its Assistance Network, granting approximately $17 million to fifty-six organizations.[97] The network consists of public, private, and nonprofit organizations that demonstrated understanding of Connect for Health Colorado's target population and an ability to provide appropriate education and outreach. Funding for the Assistance Network includes $14 million in federal dollars with additional resources from philanthropic organizations.[98]

Grantees included nineteen community/nonprofit and faith-based groups, two trade associations, eighteen hospitals and clinics, and thirteen public health or human services organizations.[99] Twenty-three organizations serve small business clients and assist individuals in purchasing insurance plans. Many organizations serve specific populations, including the Asia Pacific Development Center; Colorado African Organization; Center for African American Health; Denver Indian Health and Family Services; The Gay, Lesbian, Bisexual and Transgender Community Center of Colorado; Servicios de la Raza; and the Women's Resource Center.[100]

The Assistance Network includes six regional hubs to support navigation efforts. Regional hubs provide support, supervision and training for Assistance Sites throughout their region, as well as communications help to Connect for Health Colorado. Assistance Sites are responsible for employing and supervising Health Coverage Guides, who perform in-person education and application assistance services.[101]

Connect for Health Colorado trained and certified 400 Health Coverage Guides, 150 of whom are full-time, in September

2013.[102] In many cases, Assistance Sites tasked existing staff members to serve as Health Coverage Guides.[103] They provide impartial information about the application process and how to select a plan as well as education and outreach services.

Connect for Health Colorado is also certifying 250-300 Application Counselors.[104] Unlike Health Coverage Guides, counselors require minimum training and are not paid. They, too, help individuals access coverage information and enroll in plans. Applications from interested organizations were accepted through September and additional information about this program is forthcoming.[105]

To date, there has been little evaluation of the Assistance Network or its ability to meet enrollment and navigation needs, although some information is beginning to surface. In December 2013, the Consumer Engagement Project, a group that works closely with Connect for Health Colorado and consists of four Colorado organizations that advocate for affordable, high-quality health insurance, released a report based on fifty-six consumer surveys collected in October 2013. Among those who visited an Assistance Site, half reported that the Health Coverage Guide's help was what they liked best about the Connect for Health Colorado shopping and enrollment experience.

The report does recommend additional Medicaid enrollment training for guides since many guides indicated they felt "inadequately" prepared for this part of the application process. The report also recognizes that obtaining Medicaid denial before being able to apply for a subsidy is an obstacle for consumers. Other recommendations to maximize enrollment include a dedicated phone line to provide technical assistance for guides and a "quick reference guide" to address highly technical eligibility questions.[106]

2.6. Interagency and Intergovernmental Relations

2.6(a) Interagency Relations. Colorado has separate agencies that oversee Medicaid and private health insurance providers. HCPF manages enrollment, administration and financing of the state Medicaid program. Individual and small group insurers are regulated by the Division of Insurance (DOI), located in the Department of Regulatory Agencies (DORA). Both the executive director of HCPF and the commissioner of insurance are ex-officio, nonvoting members of Connect for Health Colorado's Board of Directors. A consortium with representatives of the Governor's Office, HCPF, Connect for Health Colorado, DORA, the Colorado Department of Human Services, which administers food and cash assistance programs, and the Colorado Department of Public Health and Environment developed a Web site (www.colorado.gov/health) to direct consumers to health- and health care-related resources without having to navigate multiple state agencies' Web sites.[107]

2.6(b) Intergovernmental Relations. Connect for Health Colorado's eligibility and enrollment system is separate but interoperable with the state's Medicaid eligibility system, requiring close collaboration with HCPF.[108] Connect for Health Colorado has worked directly with HCPF on streamlining the Medicaid eligibility and enrollment processes. Several county human service agencies are Connect for Health Colorado Assistance Sites (see Part 2.5).

2.6(c) Federal Coordination. The exchange characterizes its relationship with federal partners, including the Center for Consumer Information and Insurance Oversight and the Internal Revenue Service, as "very positive" and "collaborative," for providing technical assistance to staff at Connect for Health Colorado.[109]

2.7. QHP Availability and Program Articulation

2.7(a) Qualified Health Plans (QHPs). Health insurance carriers participating in the exchange must be licensed, and must offer QHPs compliant with eighteen federal requirements.[110,111] Connect for Health Colorado's Board adopted guiding principles and technical approaches that are detailed below to address these requirements.

The Board voted on June 25, 2012, on an approach for adopting existing federal accreditation standards and creating a two-year transition period for plans to become accredited. Connect for Health Colorado developed a new process for addressing enrollment complaints. The Board also voted to collect claims payment and financial data and provide this information on the Connect for Health Colorado Web site. It decided to partner with DOI and other entities to validate insurance carrier licensure; gather Medical Loss Ratio information; and assist with network adequacy issues, out-of-network payment disclosures, rate review, and solvency requirements.[112]

In August 2012, Connect for Health Colorado's Board voted to recognize the DOI's role in certifying health plans. DOI's responsibilities include defining requirements for validation of essential health benefits, discriminatory benefit design, and plan differentiation. The Board also voted to require QHP marketing materials to disclose any connection with Connect for Health Colorado in order to protect Connect for Health Colorado logos. Lastly, the federal Medicaid provider list was expanded to include essential community providers, with essential community provider coverage to be evaluated through DOI's existing network adequacy requirements validation.[113]

To discourage insurance plans from frequently entering and leaving the marketplace, the Board instituted a one year waiting period for plans not sold on Connect for Health Colorado in 2014 and a two year wait for plans that were removed and want to be reintroduced.[114]

Approximately 150 individual and family health plan choices, ninety small group plans, and sixty-eight dental plans are

considered QHPs and are offered on Connect for Health Colorado.

2.7(b) Clearinghouse or Active Purchaser Exchange. Connect for Health Colorado serves as a "clearinghouse" and is required by its enabling legislation to contract with all QHPs that meet the minimum standards outlined in the ACA. Connect for Health Colorado "shall not solicit bids or engage in the active purchasing of insurance."[115]

2.7(c) Program Articulation. At the end of December 2013, 86,432 low-income Coloradans had qualified for Medicaid coverage that began on January 1, compared with 51,728 individuals and families who signed up for private plans through Connect for Health Colorado.[116] The exchange enrollment process seems to be successful in connecting low-income Coloradans to public insurance programs; however, it is not clear whether HCPF and Connect for Health Colorado will be able to seamlessly transition Coloradans who experience income fluctuations that result in a change in eligibility between public and private coverage.

2.7(e) Government and Markets. Colorado passed legislation in 2013 to modernize the state's stop-loss insurance law for policies used by self-insured employers with no more than fifty employees. Stop-loss insurance limits the financial liability of employers who self-insure their employees. House Bill 13-1290 raises the individual attachment point, the amount an employer is responsible for before stop-loss insurance kicks in, from $15,000 to $30,000 and requires stop-loss issuers to offer plans that do not discriminate against, or medically underwrite, an individual. Consumer advocates supported this policy change, citing concerns that the existing stop-loss law would destabilize the small-group market by promoting adverse selection (the disproportionate enrollment of individuals with greater health needs and the lack of enrollment of healthier individuals) into the Small Employer Health Options Program (SHOP).[117]

The DOI approved 2014 health insurance rates for individual and small group plans in August 2013. Monthly premiums varied considerably across the eleven geographic rating areas. Individual bronze-level plan premiums ranged from $177 to $524, with the highest premiums found in the mountain resort counties.[118,119] DOI cited two factors that "significantly affected" premiums in those counties — direct costs of health care and higher utilization of health care services.[120]

An analysis of pre- and post-ACA health insurance premiums conducted by the Manhattan Institute for Policy Research found that, on average, individual plan premiums in Colorado went down by approximately 22 percent.[121]

2.8. Data Systems and Reporting

Since its adoption in 2004, the Colorado Benefits Management System (CBMS), the state's eligibility and enrollment system for Medicaid and CHP+, has been plagued with problems, including

vendor management issues, lack of funding, and system glitches that led to wrongful terminations and case backlogs.[122] HCPF has been working with the Colorado Department of Human Services and the Governor's Office of Information and Technology to modify and upgrade policies and computer systems. Colorado submitted and received approval of an Implementation Advanced Planning Document (IAPD) from CMS, allowing the state to receive 90 percent federal matching funds to improve CBMS and its Web-based self-service application portal, PEAK.[123]

Part 3 – Supplement on Small Business Exchanges

3.1. Organization of Small Business Exchanges

Creation of the SHOP attracted support for the Colorado Health Benefit Exchange Act from the business community and other stakeholders. Small businesses often pay more than large ones for employee health insurance. Small businesses have less purchasing power, a greater concentration of risk, and a higher administrative cost per enrollee.[124]

Connect for Health Colorado estimates about 35 percent of small businesses in Colorado provide health insurance to their employees. The SHOP aims to increase participation and decrease cost for owners.[125] Focus groups organized by Connect for Health Colorado before the exchange opened showed that 80-85 percent of employers providing coverage wanted to continue it. Of those who did not offer coverage, 80-85 percent did not plan to purchase it.[126]

In the SHOP, small business owners with two to fifty employees will have four choices:[127]

1. The employer chooses one QHP for all employees.
2. The employer chooses a carrier and employees select any QHP from that carrier.
3. The employer chooses a "metal-tier" (i.e., bronze, silver, gold, platinum) and employees choose any QHP within that tier.
4. The employer chooses two *adjacent* tiers (e.g., bronze and silver; gold and platinum) and employees choose any QHP from those two tiers.

Tax credits are not available to every small business that enrolls in the SHOP. To qualify, an employer must have fewer than twenty-five full-time employees and offer coverage to all of them; pay average annual wages below $50,000;[128] and cover at least 50 percent of the cost of coverage for a single employee (not including family or dependent). A small business calculator is available on the Connect for Health Colorado Web site to help businesses determine whether they are eligible for tax credits and how much aid to expect.[129] The Colorado Center on Law and Policy estimates that more than 100,000 small businesses in Colorado are eligible for tax credits through Connect for Health Colorado.[130]

The Colorado SHOP uses the same Web site and IT platform as the individual marketplace[131] and offers ninety-two plans from six carriers.[132] The SHOP risk pool is separate from the individual marketplace pool, although a study is scheduled for 2016 to investigate the potential repercussions of merging the two.[133]

SHOP outreach efforts are varied. Twenty-three sites in Colorado's Assistance Network include SHOP education and assistance. Two sites are identified as "statewide." One concentrates its efforts on small businesses, while the other concentrates on the trucking industry.[134]

Insurance brokers are influential in small employer enrollment. A report from the Urban Institute says that 93 percent of the estimated 33,000 small groups in Colorado provide coverage through a broker.[135] As a result, Connect for Health Colorado encourages brokers to educate employers on the value of small group coverage and to expand their outreach to industries that do not traditionally offer coverage to their workers, such as restaurants.[136]

Part 4 – Summary Analysis

Marketplace Enrollment Summary

At the end of 2013, 51,728 Coloradans had signed up for private insurance through Connect for Health Colorado's individual marketplace. Of those, nearly a third (31 percent) were between the ages of fifty-five and sixty-four. "Young invincible" adults represented 22 percent of all enrollees, with 7 percent ages eighteen to twenty-five and 15 percent ages twenty-six to thirty-four. Females signed up at a slightly higher rate (53 percent) than males (47 percent).[137]

More than 86,400 Coloradans joined Medicaid between October 1 and December 31, 2013. The largest age group was eighteen to twenty-five (27 percent), while the smallest — following children ages zero to seventeen at 1 percent — was fifty-five to sixty-five (18 percent). Young invincibles comprised 47 percent of new Medicaid enrollees. Females represented slightly more than half of Medicaid enrollees at 52 percent.[138]

Small employers created 3,683 accounts with Connect for Health Colorado by the end of the year, 1,345 of which initiated an open enrollment period for their employees and 101 of which have finalized their enrollments. An estimated 1,050 individuals (employees and dependents) are signed up through Connect for Health Colorado's SHOP marketplace.[139]

4.1 Policy Implications

Summary and Policy Implications

Colorado's health insurance landscape is undergoing rapid change, and the pace will only accelerate in 2014. Changes will be largely driven by increases in private insurance enrollment

through Connect for Health Colorado, public insurance enrollment in Medicaid, and the commencement of health benefits in both.

Attempting to identify who is winning and who is losing in Colorado as a result of national health reform is complicated. Those deemed winners and losers often are defined by political philosophy and interpretation of data. Researchers, pundits, and policymakers alike will be monitoring the impact of health reform, both negative and positive, as it relates to three groups: health care consumers, health care stakeholders, and political parties.

Consumers

Colorado's estimated 741,000 uninsured residents — arguably the focus of the ACA — represent an example of this complicated picture.[140] Already, 86,432 Coloradans have signed up for Medicaid and gained coverage starting January 1, 2014, due to Colorado's decision to expand Medicaid.[141] This represents more than one-third of the 240,000 people that the Colorado Health Institute projected to enroll by 2022.[142]

Some observers tout this robust Medicaid enrollment as the unheralded success of the ACA, saying the law extended coverage to many people who may not have realized that they had been eligible for Medicaid all along.[143] These boosters include consumer groups that advocate for strong public insurance programs to increase access to care and promote economic security among low-income individuals and families.[144] On the other side are those who see public insurance as precisely the problem. They say Medicaid is an example of a government program that achieves negligible health outcomes and insufficient access to care and places a burden on taxpayers.[145,146]

How have consumers fared on the private insurance side? This question can be answered in a number of ways. Enrollment figures indicate that 51,728 individuals and families signed up for private coverage by the end of 2013, and that just over half of these new enrollees (51 percent) received advance tax credits.[147] In November 2013, enrollment was substantially lower than the exchange's own worst-case projection, garnering much negative attention.[148] The numbers for December 2013, however, showed that both the cumulative and monthly enrollment projections increased above the worst-case range.[149]

Examining the purchasing experience is another way to gauge whether consumers are benefiting. Anecdotal evidence suggests that some consumers are having trouble navigating the exchange and buying health insurance,[150] and some communities are experiencing "sticker shock" at the cost of the premiums.[151] Colorado's decision to require subsidy-seekers to first apply for Medicaid (see Part 2.1) has resulted in what many perceive to be a burdensome step.[152] Efforts continue to address backlogs and streamline the system.[153]

Another group of consumers who are often portrayed as victims of ACA fallout consists of the estimated 250,000 Coloradans who received policy cancellation letters from their insurers.[154] This group represents about 58 percent of the relatively small proportion of Coloradans — 8.2 percent or 425,000 individuals — who purchase health coverage directly from an insurance company.[155] Colorado's insurance commissioner, Marguerite Salazar, decided against requiring insurers to reinstate canceled policies, citing potential market problems and increased consumer confusion down the road. The commissioner indicated that 95 percent of individuals receiving cancellation letters were invited by their insurance carriers to renew their plans early, allowing them to continue their policies into 2014.[156]

Finally, enrollment in Medicaid and the individual marketplace often overshadows the majority of consumers who are covered (or will be covered) through their employer. The latest data from the 2013 Colorado Health Access Survey indicate that 59.0 percent of Coloradans were covered by employer-sponsored insurance, up from 57.8 percent in 2011, but not yet reaching prerecession levels of 63.7 percent in 2009.[157] The jury is still out — largely due to the limited availability of data — about how the SHOP marketplace will affect enrollment in small group plans.

Other Health Care Stakeholders

Whether Colorado's health care stakeholders — such as insurers and health care providers — are losing or benefiting because of the ACA is unclear as well. Front and center is Connect for Health Colorado itself. Criticism over initial Web site glitches, lagging enrollment, and challenges in streamlining Medicaid eligibility (requiring mediation at one point) have plagued the exchange since it launched in October, largely overshadowing successes and improvements.[158]

Connect for Health Colorado gained additional negative publicity when CEO Fontneau requested a raise and year-end bonus.[159] The request came amid calls by at least one Board member for additional scrutiny of the leadership and amid the resignations of four CEOs or top leaders in other state-based exchanges – Hawaii, Maryland, Minnesota, and Oregon.[160,161] U.S. Rep. Cory Gardner, a Colorado Republican, announced he would introduce legislation that would ban executives of health insurance exchanges from seeking taxpayer-backed bonuses or raises.[162] Fontneau eventually withdrew the request in mid-December 2013.[163]

Insurers continue to carefully monitor enrollment. Of primary concern is whether financial risk will be adequately dispersed, given predictions of adverse selection within the health insurance risk pool. Exchange metrics indicate that adults between the ages of fifty-five and sixty-four — many of whom may have more health needs than younger people — are disproportionately enrolling in private marketplace products. This age group represents

14 percent of Colorado's population, but 31 percent of enrollees as of December 31, 2013.[164,165]

Colorado has taken steps to mitigate the prospect of adverse selection. The Urban Institute identified four strategies that Colorado has embraced, such as regulating insurer service areas (to discourage insurers from cherry-picking healthier geographic areas) and broker compensation inside and outside the exchange (to discourage insurance brokers from steering clients from one market and into another).[166] On the consumer side, Colorado has received national attention for a series of controversial advertisements aimed at persuading young adults, who tend to be healthier, to purchase health insurance (see Part 2.4), thereby balancing the risk pool. Critics claim the ads are degrading and promote drinking and sexual promiscuity.[167]

It is unclear how health care providers will be affected by increases in insurance enrollment and other ACA provisions. National reports indicate that at least one insurer is beginning to drop physicians from its Medicare Advantage managed care networks. The insurer cited rising health care costs and quality standards, as well as federal funding reductions, as reasons for the cuts.[168] Cuts to Medicare Advantage are among the financing mechanisms of the ACA.

Other providers, including safety net entities such as Federally Qualified Health Centers (FQHCs) and Rural Health Clinics, are planning for more patients and new revenue streams. Colorado has received approval over the past year to expand FQHCs under federal New Access Point grants.[169,170] Other safety net clinics, such as faith-based clinics or free and charitable clinics, are assessing whether it makes financial sense to invest administrative resources into billing private insurance or Medicaid.

The true impact on providers will be revealed once newly insured individuals attempt to use their benefits and gain access to the system.

Policymakers

The year 2014 marks the beginning of many ACA reforms — and the start of an election year. Many pundits and policy analysts will be closely monitoring the continued rollout of the ACA to understand its impact on both state and national races.

Democrats hold majorities in both houses of Colorado's General Assembly, as well as the Governor's Office. They proposed and passed a host of divisive bills during the 2013 legislative session, including gun control, renewable energy requirements, and civil unions.[171] Significant health legislation was passed as well — most notably the expansion of the state's Medicaid program to 138 percent of FPL under the ACA (see Part 1.1).

Developments at the 2013 ballot box made Democrats, in particular, more politically cautious. First, the successful recall of two Democratic state senators in 2013 for their support of gun bills has narrowed the party's control in the state Senate from eighteen to

seventeen. A third state senator resigned rather than face a potential gun-related recall election, allowing Democrats to appoint a replacement and maintain the majority.[172,173] Analysts also cited the troubled rollout of the ACA as contributing to the defeat of a completely unrelated state ballot measure, which would have raised income taxes to pay for education reforms. It was opposed by nearly 66 percent of Colorado voters. The landslide prompted speculation that the "Obamacare Effect" may have raised voter mistrust of government.[174,175] As a result, only relatively small and incremental changes in health and health care are likely to emerge in the 2014 legislative session.[176]

Hickenlooper is up for re-election as governor in 2014. He is relatively popular, though some political analysts cite polls that suggest the race will be closer than first thought.[177] It is unclear whether the ACA will be a campaign issue in Colorado's gubernatorial race.

The ACA is likely to be more of an issue in Congressional midterm elections. Two Colorado congressmen from different sides of the aisle have each recently gained national attention for their ACA-related proposals. Rep. Jared Polis — a Democrat and supporter of health care reform — indicated in October 2013 that he would seek a waiver from the individual mandate for part of his district. The proposal drew attention because it would have covered certain mountain resort communities where health insurance premiums on the exchange are much higher than other areas of the state.[178] Polis eventually stopped short of requesting the waiver, instead asking the Obama administration to work with the communities on a solution. Rep. Gardner's proposal to ban exchange executives from seeking raises (described above) also made headlines.

The ACA remains relatively unpopular among a majority of Americans, so efforts to reform the law will likely be touted in 2014 election campaigns.[179] Despite potential leadership changes, health care reform, in Colorado at least, may not necessarily be in jeopardy given that the state already has initiated and passed reform measures (see Part 1.1).

Conclusion

Health reform has provided Colorado with some important lessons. It has brought to light the cost and variation of health insurance premiums in a way that few understood before. The health insurance exchanges have demonstrated the potential — and the weaknesses — of an entirely new Web-based service. And the rollout of the ACA has illustrated how decisions and failures nationally can have ripple effects on the states — the defeat of Colorado's recent education initiative as a case in point.

There are a host of questions to monitor in 2014. How will premiums change over time? Will more or fewer insurers offer products in the marketplace in 2015? How will employer incentives to

offer insurance or penalties for not offering it affect the ability of individuals and families to gain coverage? Perhaps most significantly is whether reforms will lead to a stable health insurance market — whether enough healthy individuals enroll to sufficiently spread risk across the entire insurance pool, whether individuals who sign up for coverage follow through and pay their premiums, and whether the provider network is sufficient to give newly insured individuals the care they need.

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