

AGENDA

Legislative Health Benefit Exchange Implementation Review Committee

Wednesday, March 18, 2015

7:30 a.m.

State Capitol

Senate Committee Room 356

Call to Order

- 7:30 a.m. Opening Remarks
- *Senator Ellen Roberts*
- 7:35 a.m. Historical Overview of the Legislative Health Benefit Exchange Implementation Review Committee
- *Bill Zepernick, Legislative Council Staff*
- 7:45 a.m. Introduction of Connect for Health Colorado Board Members and Staff
- *Sharon O'Hara, Connect for Health Colorado Board Chair*
- 7:50 a.m. Presentation of Colorado Health Insurance Benefits Exchange: Connect for Health Colorado Limited Performance Report
- *Jenny Page, Office of the State Auditor*

Adjourn



Colorado Legislative Council Staff

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MEMORANDUM

March 9, 2015

TO: Members of the Legislative Health Benefit Exchange Implementation Review Committee

FROM: Amanda King, Senior Research Analyst, 303-866-4332
Bill Zepernick, Senior Fiscal Analyst, 303-866-4777

SUBJECT: Overview of the Legislative Health Benefit Exchange Implementation Review Committee

Summary

This memorandum provides an overview of the 2015 membership of the Legislative Health Benefit Exchange Implementation Review Committee, charge of the committee, bill limits, bill request deadlines applicable to the committee, and information regarding committee staff and the committee website.

2015 Committee Membership

Senator Ellen Roberts, Chair

Senator Irene Aguilar
Senator John Kefalas
Senator Kevin Lundberg
Senator Beth Martinez Humenik

Representative Beth McCann, Vice-Chair

Representative Lois Landgraf
Representative Dianne Primavera
Representative Su Ryden
Representative Lang Sias

Committee Details and Charge

The Legislative Health Benefit Exchange Implementation Review Committee (committee) is charged with reviewing grants applied for by the Colorado Health Benefit Exchange Board of Directors to implement the exchange, reviewing the financial and operational plans of the exchange, and approving the appointment of an executive director to administer the exchange. The board is required to submit a report on the exchange's financial and operational plans to the committee annually. Members of the committee serve without compensation, but may receive per diem and be reimbursed for travel expenses.¹

¹Section 10-22-107, C.R.S.

In addition to the committee, the Senate Health and Human Services Committee and the House Health, Insurance, and Environment Committee both have oversight responsibilities for the exchange.²

Meeting Dates

The committee is required to meet at the call of the chair at least two times during each calendar year, but no more than five times each calendar year. The committee met three times in 2014: on January 30, 2014, April 24, 2014, and September 23, 2014. At each meeting, the exchange's staff and board updated the committee on the implementation of the exchange. Additionally, at the January 30, 2014, meeting, the committee approved the exchange's initial financial and operational plans, as required by Section 10-22-106, C.R.S.

Committee Recommendations to Legislative Council

Bill limits. The committee may report up to five bills or other measures to the Legislative Council, unless the Executive Committee of the Legislative Council approves a greater number. Bills approved by the Legislative Council do not count against a member's five-bill limit for the regular legislative session.³ To date, the committee has not brought forth legislation.

Legislative Council review. The Legislative Council must meet by **November 15, 2015**, to approve draft legislation. Bills not approved by Legislative Council may be introduced in the regular session, but such bills will count against a member's five-bill limit. Interim committee bills must have prime sponsors prior to consideration by the Legislative Council.⁴ Legislative Council Staff will apprise the committee of the date of the Legislative Council meeting once it is confirmed.

Requirements for bill drafts. Bills should be requested and must be approved at a public meeting of the committee. Bills generally must be finalized two weeks prior to the Legislative Council meeting. The Office of Legislative Legal Services generally requests that bills be requested at least 21 days prior to the meeting at which the committee will approve legislation. The specific deadlines for committees to request and approve legislation have not been established yet for the 2015 interim.

Committee Staff and Website

The Legislative Council Staff is charged with assisting the committee in its activities. If you have any questions or would like any additional information about the committee or issues concerning the committee, please contact any of the following committee staff:

- Amanda King, Senior Research Analyst, amanda.king@state.co.us, 303-866-4332
- Bill Zepernick, Senior Fiscal Analyst, bill.zepernick@state.co.us, 303-866-4777

You may also visit the committee website at:

<http://www.colorado.gov/LCS/ExchangeReviewComm>.

²Joint Rule 25 (b).

³Section 10-22-107 (5), C.R.S., and Joint Rule 24 (b) (1) (D).

⁴Joint Rule 24 (b) (1) (E).



**Report to the
Colorado General Assembly**

**Legislative Health Benefit
Exchange Implementation
Review Committee**

Prepared by

*The Colorado Legislative Council
Research Publication No. 644
December 2014*

Legislative Health Benefit Exchange Implementation Review Committee

Members of the Committee

Representative Beth McCann, Chair
Senator Irene Aguilar, Vice-Chair

Representative Lois Landgraf	Senator David Balmer
Representative Dianne Primavera	Senator Kevin Lundberg
Representative Amy Stephens	Senator Jeanne Nicholson
Representative Max Tyler	Senator Jessie Ulibarri

Legislative Council Staff

Amanda King, Research Analyst
Bill Zepernick, Senior Fiscal Analyst

Office of Legislative Legal Services

Christy Chase, Managing Senior Attorney
Kristen Forrestal, Senior Attorney

December 2014

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This report is also available on line at:

www.Colorado.gov/LCS/ExchangeReviewComm

Committee Charge

In March 2010, federal health care legislation, also known as the Patient Protection and Affordable Care Act (PPACA), was adopted by the U.S. Congress and signed by the President. PPACA is intended to expand health care coverage by increasing access to private health insurance and public health programs through the use of state-based health insurance exchanges. Health insurance exchanges are regulated marketplaces in which individuals and small businesses can shop for health insurance, or be referred to public health programs.

In 2011, Colorado passed Senate Bill 11-200, which established the Colorado Health Benefit Exchange (exchange) and its governance structure. The bill created the exchange as a nonprofit public entity with a board of directors responsible for its operation. The exchange currently does business under the name Connect for Health Colorado.

Senate Bill 11-200 also established the Legislative Health Benefit Exchange Implementation Review Committee (committee) to guide the implementation of the exchange. State law authorizes the committee to:

- meet at least two times, but not more than five times, per calendar year;
- approve the appointment of the executive director of the exchange by the Colorado Health Benefit Exchange board of directors (board);
- review and approve the board's initial financial and operational plans;
- review annual financial and operational plans of the exchange;
- review and approve any grants for which the board wishes to apply; and
- recommend up to five bills for consideration by the General Assembly each year.

Committee Activities

The Legislative Health Benefit Exchange Implementation Review Committee met three times in calendar year 2014. The committee received briefings from the exchange board and staff at each meeting, and per its statutory charge, covered a range of topics pertaining to the operations and finances of the exchange.

Approval of Operational and Financial Plans

The committee voted to approve Connect for Health Colorado's operational and financial plans at its meeting on January, 30, 2014. The operational plan outlined the exchange's planning for the 2015 open enrollment period, sales and customer support strategies, information technology plans, and other strategic goals and priorities. The financial plan focused on the pursuing financial sustainability for the exchange once federal funding for exchange implementation ends. Thus, the financial plan discussed prior spending and future expenditures, as well as projected revenue from fees on health insurance plans sold through the exchange, the broad-based assessment charged to all health and dental insurance carriers statewide, revenue from tax credit-eligible donations by insurance carriers, and other potential funding sources. Additional discussion about the upcoming 2015 open enrollment period occurred at the committee meeting of September 23, 2014.

2014 Enrollment and the Health Insurance Market

At its meeting on April 24, 2014, the committee received information about the exchange's performance during the initial open enrollment period during 2014. The committee received information about the number of persons purchasing insurance through the exchange, the number of persons referred to Medicaid for coverage, and the number of carriers offering health plans through the exchange. Connect for Health Colorado staff also discussed its customer assistance services and certain problems in the enrollment process concerning Medicaid eligibility determination. The committee also heard testimony about the role of insurance brokers, the availability of supplemental insurance products on the exchange, and other topics.

Summary of Recommendations

The committee did not discuss or recommend any legislation for consideration by the General Assembly during the 2015 legislative session. The committee approved the 2014 operational plan (Attachments A and B) and financial plan (Attachments C) for Connect for Health Colorado. These documents are attached at the end of the report.

Resource Materials

Meeting summaries are prepared for each meeting of the committee and contain all handouts provided to the committee. The summaries of meetings and attachments are available at the Division of Archives, 1313 Sherman Street, Denver (303-866-2055). The listing below contains the dates of committee meetings and the topics discussed at those meetings. Meeting summaries are also available on our website at:

www.Colorado.gov/LCS/ExchangeReviewComm

Meeting Date and Topics Discussed

January 30, 2014

- ◆ Update from the Colorado Health Benefit Exchange
- ◆ Approval of the 2014 Operational Plan for the Colorado Health Benefit Exchange
- ◆ Approval of the Financial Plan for the Colorado Health Benefit Exchange

April 24, 2014

- ◆ Update from the Colorado Health Benefit Exchange

September 23, 2014

- ◆ Update from the Colorado Health Benefit Exchange



Connect for Health Colorado 2014 Operational Plan

January 27, 2014

Mission and Objectives of 2014 Operational Plan

- 12-month operational plan to prepare for the upcoming 2015 open enrollment cycle
- Links short term strategic goals with new initiatives and changes that span across people, process and technology
- Written to align with mission in Senate Bill 11-200 to increase access, affordability and choice for individuals and small employers purchasing health insurance in Colorado
- Focuses on financial sustainability, customer service, maintaining a competitive marketplace with choice, and technology enhancements.

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- Mission/Objectives
- Budget/Sustainability
- Sales Plan
- Customer Service Strategy and Operational Efficiency
- Marketing, Outreach and Communications
- Technology and Operational Support Systems
- HR/Administration
- Metrics/Dashboard

Operations Plan Highlights

- **Budget/Sustainability**
 - Reference to the Financial Plan as presented to the Legislative Implementation Review Committee along with updated enrollment/financial models as presented to the Board of Directors on January 13, 2014
- **Sales Plan**
 - Specific initiatives by channel
 - Increased focus on relationship management, lead management, additional partnerships (e.g., MGAs), sales and retention strategies and efficient/effective training strategies

Operations Plan Highlights

- **Customer Service**
 - Conduct analyses to inform changes to people, process and technology
 - Focus on business process improvement
 - People management
 - Technology improvements
 - Training and performance management

Operations Plan Highlights

- **Office of Conflict Resolution and Appeals**
 - Focus on volume stabilization
 - Improve integration between the Marketplace and appeals management software eliminating multiple points of entry
 - Improve integration of case management and content management systems
 - Improve intake process
 - Improve workflow management

Operations Plan Highlights

- **Communications, Outreach and Marketing**
 - Strengthen brand
 - Support enrollment
 - Data analysis
 - Broad range of marketing tactics
 - Heightened focus on Colorado young adults, uninsured, small business
 - Retention and renewals

Operations Plan Highlights

- **Applications and Technology Infrastructure**
 - Improved functionality and usability
 - Prioritize to maximize service experience and efficiencies
 - Increased automation
 - Reduce operational and maintenance costs
 - Maintain technology currency
 - Shared eligibility service with Medicaid

Operations Plan Highlights

- **HR and Administration**
 - Key hiring for permanent positions
 - Transition from the consulting staff needed for implementation
 - Adding new skill sets
 - Staff retention



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2014 Operational Plan

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Operational Plan

Definition: This operational plan is a 12 month work plan that links short-term strategic goals and objectives with tactical goals and objectives.

1. Mission & Objectives

The Connect for Health Colorado Operational Plan links the strategic goals of the organization in preparation for the upcoming 2015 enrollment cycle with tactical goals and objectives. This plan seeks to articulate new initiatives and changes that span across people, process and technology to further operational effectiveness and efficiency of the organization. This Plan will be driven by analysis of data (both quantitative and qualitative) that should inform the scope and direction of each initiative.

The 2014 Operational Plan is written to align with the legislative intent as articulated in Senate Bill 11-200 to increase access, affordability, and choice for individuals and small employers purchasing health insurance in Colorado. This plan will be reviewed quarterly by internal staff to ensure flexibility and alignment to current objectives. Tightly managed change management will be critical to ensure that as initiatives are undertaken, they are well understood and executed by staff, distribution channels and key stakeholders throughout the state.

2. Budget & Sustainability

In September 2013, Connect for Health Colorado presented its Financial Plan to the Legislative Health Benefit Exchange Implementation Review Committee. Financial information from that session has been included as attachments to this Operational Plan. In addition, we are providing a model that shows a more conservative enrollment projection than the models provided in September.

As a basic overview, Connect for Health Colorado is funded mostly by federal grants for its operations through 2014 and technology enhancements into 2016. Beginning in 2014, administrative fees are collected on all health insurance policies sold through the Marketplace. The administrative fee for 2014 was set at 1.4% of premiums and will be set annually by Connect for Health's Board of Directors for the



upcoming year. Notably, the administrative fee for States accessing the Federally Facilitated Marketplace is 3.5%. To create a stable revenue base while enrollments grow, House Bill 13-1245 was passed in 2013 to support Connect for Health Colorado. This legislation provides for the following: Transfer of CoverColorado reserves in 2013 (\$15,000,000) and in the spring of 2015 (25% of their remaining reserves at that time), Carrier Premium Tax Credit donations of up to \$5 million combined annually, a broad market assessment of up to \$1.80 per member per month (PMPM) through 2016 and revenue from the sale of ancillary products. Connect for Health Colorado's Board set the market assessment for 2014 at \$0 and will determine the amount of the assessment for 2015 in mid-2014.

See Appendix A for the current and anticipated budget and funding as presented to the Legislative Review and Implementation Committee in September of 2013 and as recently updated. Appendix A



Appendix A.docx

3. Sales Plan

Connect for Health Colorado enrolled 52,000+ individuals and small employer groups for the period 10/1/13-12/31/13. Sales efforts in 2013 were focused on the recruitment, training, certification and deployment of the following sales channels:

- 1,450 Certified Agents/Brokers
- 54 Assistance Sites with 144 locations and 425 Certified Health Coverage Guides;
- 200+ Customer Service Center staff
- 1,000+Carrier-based dedicated sales representatives
- Designated organizations representing over 400 Certified Application Counselors;
- Individual customers providing their own assistance through our website (self service).

Training will continue to be a key focus. 100% of the plan options were new, as was the technological platform, requiring all sales channels to be trained continuously throughout the initial 90 days post-launch. The "new market" dynamic created by the inter-relationship and combined eligibility determination between Medicaid and the Marketplace required a significant shift in sales approach by the sales channels based in the traditional commercial market, i.e.: Agent/Brokers and Dedicated Sales Representatives. This impacted the pace of enrollments and required significant training and resourcing by Subject Matter Experts. Because of the depth of the successful recruitment, training, and engagement of a significant and diverse "sales force", along with the early development of tools and sales support materials, Connect for Health Colorado is currently poised to shift into a more proactive and strategic sales partnership with its various sales channels.

Top Priorities and Strategic Sales Objectives

- a. Drive Enrollments by supporting a "customer first" focus.
- b. Facilitate long-term choice and competition of qualified health plans.
- c. Drive enrollment and service to the uninsured and under-insured populations in Colorado.



d. Train, support and effectively partner with sales channels.

Plan by Sales Channel

Connect for Health Colorado's sales channels are intentionally diverse in order to engage and advocate for the broad spectrum of consumers we intend to serve. Traditional sales philosophies have been expanded to include not only a focus on sales, but to include training and outreach as core areas of opportunity and partnership. The uncharted and fluid nature of the new market requires Connect for Health Colorado to honor and capitalize on the need for ongoing knowledge development, sales strategies, opportunity creation and outreach among its respective sales channels.

Each channel strategy will consider lines of business (individual, family, small group and large group) and whether certain activities will be more or less effective. This will help to further inform where to focus resources in 2014.

Agent/Brokers

As the most established sales channel, Agent/Brokers provide significant opportunity to guide, champion and effectuate enrollments across all consumer sectors. Connect for Health Colorado will continually recruit, train and certify Agent/Brokers, and will re-certify and manage the enrollment and service performance of this channel.

In the area of Sales Support, the following initiatives are planned: Establishment of Agent/Broker on-site relationship managers, continued development of Broker Toolkit materials, further develop book of business reporting, formalization of a lead management system, create coverage retention campaigns, foster partnerships with the Assistance Network, develop and implement an Agent/Broker advisory council, engage national web-based agents, establish follow-up and referral opportunities derived from focused outreach efforts.

Training for Agent/Brokers will focus on facilitating eligibility determinations, cross selling individual and small group plans and system based training. Leveraging the existing partnership and credibility that Managing General Agents (MGAs) have with the independent agents of Colorado will be critical to establishing a stable and effective relationship. Much of the current training and skill development is carried out through MGAs and so combining efforts will be a strategic focus for training efforts.

In the area of outreach involvement, Connect for Health Colorado's marketing team will engage the Agent/Broker channel in business and community based activities and will partner with Agent/Brokers on individual agency based co-branded campaigns.



Assistance Sites/Health Coverage Guides

As trusted local resources with specialized knowledge about reaching members of their community, the Assistance Network will have the greatest opportunity to educate, assist and enroll hard-to-reach consumers. Enrollment planning within this channel will include ongoing training on Marketplace products and plan design, increasing their visibility in the community through more targeted messaging and marketing opportunities, creating and refining systems of referral, and establishing relationships with the carriers to facilitate greater levels of service and resources for their clients. Ongoing development and additional resourcing to complement to their existing outreach and application assistance experience will result in increased enrollments among their constituents and targeted populations.

In the area of sales support, the Assistance Network will continue to identify opportunities for sharing best practices and fostering collaboration across Assistance Sites. Specific areas are: hard-to-reach populations, addressing obstacles and enrollment practices among sub-populations, such as those in the age 20 – 30 age demographic, and product portfolio education.

Outreach involvement related to the Assistance Network is addressed on the Outreach and Communications section of the Operational Plan. The Assistance Sites and Health Coverage Guides are equipped to provide awareness, education and significant pre-enrollment impact. Their grassroots and specific community perspectives are important to creating “enrollment readiness” among their constituents and community partners. In addition, their outreach influence becomes imperative during outreach efforts related to retention of coverage and renewal phases of the health insurance cycle.

Additional training for the Assistance Network will include: understanding the cycle of insurance coverage, features of product portfolio (networks, service areas, formularies), deeper knowledge of other insurance affordability programs and their eligibility requirements, expediting the financial application and determination process, coordination of benefits, and accountability for results.

Customer Service Center

Connect for Health Colorado’s customer service center (CSC) partners to assist the other sales channels and is a direct source for enrollments as new customers called 1-855-PLANS-4-YOU to make general inquiries and ultimately enroll.

Sales support for this channel includes bolstering sales techniques including assessing consumer need, presenting solutions and options to the customer, plan options choices, balancing call length with incoming volume and ensuring an efficient and effective “close” to the sale.



Outreach involvement for the CSC is based in service and support of external efforts by Connect for Health Colorado and its external 'partners' (Providers, Medicaid, Agent/Brokers, etc.). The CSC will be central to outbound campaigns including pursuing internal opportunities identified, following up on account holders who are not enrolled (aged accounts), individuals with a Medicaid denial who have not yet enrolled in a commercial health plan and specific topical outbound campaigns, such as: use of coverage, renewal, importance of coverage continuity, compliance, etc. Outbound efforts have been augmented through the addition of an expanded sales force, which can be scaled depending on the need and time of year.

Training is focused on closing techniques, balancing length of call versus completion of a sale, product portfolio, small business marketplace features and dynamics, expediting the financial application process.

Carrier based Designated Sales Representatives (DSRs)

This channel interfaces with the existing book of business of a particular carrier. While they are not "certified" as Agent/Brokers, they are licensed producers with high influence over plan selection and retention of their insured customers. This channel is required by the Division of Insurance to explicitly disclose to consumers that they have the option to purchase through Connect for Health Colorado. Like Agent/Brokers, they have access to plans on and off the Marketplace, so engaging this sales cohort with respect to the value proposition of Connect for Health Colorado is critical. This distribution channel has been underutilized in the 2014 enrollment period because 95% of the already covered market was offered early renewals. That provides great potential in the coming year.

Sales support for DSRs encompasses: enhanced proposal functionality, tools for quoting and book of business management, sales goals and performance measurements, co-branded sales and marketing (non-discriminatory or non favoritism based) materials, the opportunity to showcase (within Division of Insurance regulations) products, features and specialized services.

Outreach involvement with DSRs is approached through mutual planning and in careful consideration of their existing, company based marketing efforts, marketing regulations, balance among insurer mix (large, national vs. state-based, for-profit vs non-profit). Focus of messaging and activities is value of coverage, healthy Colorado and not promotion of specific Carriers.

Training efforts surround technological functionality and usability of the Marketplace, features of the Marketplace, expediting the financial application and determination process, federal guidance impacting sales.



Designated Agencies/Certified Application Counselors (CAC)

This sales channel is commonly represented by hospitals and their embedded enrollment counselors. Other agencies involved in this role, which is significantly focused on awareness and advocacy and not on “sales” in the traditional sense, are community based or condition specific organizations. Because Designated Agencies and Application Counselors are not “sales” oriented, sales support efforts are not anticipated.

Outreach involvement as outlined in the Outreach and Communications section will include the CAC members and their constituents. Significant outreach has occurred involving the medical and provider communities and due to the importance and high influence of the provider sector, collaboration and partnership of outreach and educational efforts will continue to be a focus.

Training efforts will persist and deepen in the areas of: importance of coverage, the role of an accessing the Marketplace, referral to Agent/Brokers, Health Coverage Guides, the Customer Service Center, plan selection and shopping readiness, features of the Connect for Health Colorado website, the role of the CAC, products offered through the Marketplace.

Self Service

This is the direct customer channel, representing individuals, families and small businesses that shop, compare and purchase insurance “unassisted” through the Marketplace website.

Sales support for self -service customers is absolutely focused on ease of doing business with the site and functionality. A functionality life cycle of use-ability feedback, specification development, prioritization, programming, testing and deployment will commence first through surveys and subsequently through user advisory councils. Web analytics will be developed to identify functionality and processes that are barriers to ease of use of the website. Self service tools, such as help pages, videos, and wizards have been created and will be expanded. Sales support also includes access to certified Agent/Brokers, Health Coverage Guides and the Customer Service Center when help is needed or desired. Analyses of cost and quality will aid self-service customers, as well.

Outreach Involvement includes customer and peer testimonials that are effective sales tools for direct purchasers, as is the messaging presented via marketing campaigns. Early feedback from direct purchasers indicates the alignment between media and marketing messaging and the experience of enrolling is positive. As mentioned previously, outbound campaigns also include self- service customers who have not completed enrollment and may require or desire assistance.

Training efforts will be focused on understanding the functionality, new resources, and products/plans/pricing/features of respective health plan options. Methods for training, as noted above, will include help pages, Quick Connects (which are very brief tutorials) and wizards. Connect for Health



Colorado's mobile application and other social media will be used to outreach and train specifically related to enrollment and self-service.

Broad based sales strategies also encompass a continued integration with marketing efforts and the promotion of the Marketplace across the communities of Colorado. Involvement with the diverse regions and populations of our state will effectively impact enrollment. Additionally, specific initiatives related to the following objectives are being developed with an eye toward 2015 (sustainability) and beyond:

- a. Continuously refine the renewal process and related system functions.
- b. Study and adopt best practices in sales from other Marketplaces and across industry.
- c. Refine messaging, value proposition, brand awareness across market sub-populations.
- d. Develop, with the Board guidance, a comprehensive Product Strategy (contemplated in sustainability planning).
- e. Explore feasibility and efficacy of Application Programming Interfaces (API) with market partners with a focus on impact by lines of business to drive priorities.
- f. Develop a large market (employers >100) strategy, approaching 2017.

4. Customer Service Strategy & Operations Efficiency

The Customer Service Center (CSC) staff was hired with an expectation that they will be committed to understanding and then solving the needs and issues of Connect for Health Colorado customers. Assistance Sites, Health Coverage Guides, Agents and Brokers were trained and certified to adhere to these same principles.

Connect for Health Colorado will continue to fulfill its commitment in 2014 to ensure that customers or potential customers are provided an end-to-end service experience from general inquiries, to the initial sale of qualified health plan, to life event changes, to retention and renewal of existing products. Our goal is to ensure that they continue to want to renew coverage with us year after year.

Connect for Health Colorado provides service to its customers through a variety of channels including Assistance Sites, Brokers/Agents, Certified Application Counselors, the Service Center and the customer themselves (self service). See Appendix A for a detailed description of each service/sales channel certified on behalf of Connect for Health Colorado.

Top Priorities and Customer Service Objectives

- a. Listen to Customers: Evaluate experiences of consumers to understand how to maximize the customer service experience.
- b. Respond to Customers: Establish a strategy based on people, process and technology
- c. Manage Change: Implement a strong change management process that ensures a responsive and flexible organization that responds to the needs of customers.



- d. Retain Customers: As a hallmark of an efficient and effective organization seek to retain our customer base year-after-year.
- e. Protect Customers and their Information: Continue to focus on processes, procedures and practices used to protect the confidentiality and privacy of customer information.

Customer Service Plan

With over three months of experience facilitating the purchase of insurance coverage for individuals, families and small businesses, Connect for Health Colorado has begun and will continue a comprehensive evaluation of the experiences of our customers to understand where improvements need to be made.

Analysis will be conducted and synthesized by the end of April 2014 to evaluate needed changes and enhancements focusing on people, processes and technology:

- a. Customer service surveys administered through our customer relationship management (CRM) tool beginning in January 2014 and evaluated on an ongoing basis. Feedback from stakeholders will be solicited as well.
- b. Targeted user groups that can provide input and feedback with respect to the overall customer experience.
- c. Formal evaluations including quarterly reviews of the Assistance Network and ongoing Quality Assurance reviews of the Customer Service Center representatives.
- d. Refine business process forecast model which examines and simulates the end-to-end experience of a consumer and identifies variables that may be inhibiting a customer from enrolling and ultimately retaining coverage
- e. Evaluation of data made available through our data warehouse. Two main areas will be considered:
 - a. Efficiency metrics
 - b. User experience
- f. Ongoing review of critical privacy and security related practices.

Based on analysis conducted, activities or technology enhancements will be identified that will have the most impact on customer satisfaction. A comprehensive strategy to improve the overall customer service experience will focus on needed changes to manage the performance of people, improve business processes and technology enhancements.

Business Process Improvement

The Customer Service Center (CSC) will focus through quality assurance efforts on call handling efficiency, first call resolution and training to maximize the number of calls that translate to enrollments and will focus on specializing representatives by task to further improve efficiencies and performance.

A strong change management process will help to support end-to-end changes that impact operations.

The performance of Customer Service Center Representatives is consistently evaluated through 10 -15 regular quality assurance reviews per month as is industry standard and best practice. This provides the quality assurance team a mechanism to evaluate the performance of a service agent including measuring ability to convert an enrollment and express interest and empathy towards customers who need assistance.

Throughout the individual open enrollment period (through the end of March 2014), an identification of high performing service representatives will be conducted to ensure they are retained on a permanent basis and career pathways are established to continue to motivate loyalty and retention for the long term. This includes evaluating overall customer satisfaction as they work with individual representatives and the representative's ability to convert a prospective customer into an enrollment.

Additional specialization of service representatives will help differentiate and support the needs of core lines of business (individual/family and small group) to enhance the overall customer service experience.

We will be evaluating the feasibility of using an outbound sales force to help expand service center capacity leading up to and during the 2015 open enrollment period. As a part of this strategy, performance evaluation of those service representatives who performed well based on quality assurance and team reviews for long- term retention.

We will continue ongoing 6-week and 90-day forecasts to anticipate staffing needs which should prove to be even more accurate for the 2014 open enrollment season as we will have actual data upon which to project resource needs. These resource assessments will also accommodate projections of staff attrition.

Training and Performance Management

Training and performance management will go hand in glove over the next year to continue to smooth out the service representative's ability to answer calls and resolve caller questions and situations in one interaction. Three significant areas of focus will be: 1) incorporating further sales training support to ensure all representatives have the tools to understand how to bring a customer from general interest to enrollment, 2) retention strategies to encourage service representatives to educate customers regarding the value of insurance and retaining that coverage throughout the year and year-over-year, 3) further focus on how to use existing technology to improve overall performance. This includes effective use of business process management tools and CRM.

In the service center, training strategies will focus on team lead review and opportunities for just in time support and performance enhancement along with formal, in-class training sessions.

In the field, our certified trainers will continue to provide in-person support to brokers, agents and health coverage guides who need additional tools and knowledge to assist customers. There will also be an increased focus on streamlining training including content and delivery (webinars etc.) to minimize



training time to the extent possible and maximize customer support. Recertification requirements are in development and will include continuing education on use of technology, roles, cross collaboration, plan designs, security and privacy.

Technology Improvements

There are a series of technology improvements that are needed to improve overall customer service and support. These include:

- a. Improving functionality and usability in specific areas including, broker tools, health coverage guide tools, service center technology, reporting, account maintenance, email and noticing.
- b. Increasing automation in specific areas to reduce operational load.
- c. Maximizing opportunities to work with partners to simplify processes.

Change Management

Connect for Health Colorado is tasked with managing changes from a policy, process and technology perspective to ensure smooth and effective implementation. In 2014, as we pivot to minor and major technical releases along with accommodating policy changes throughout the year, we will be utilizing a change control process to manage change. This will impact deliverables such as our knowledge base, service center scripts, training modules and policies and procedures. This is meant to ensure alignment of action and communication, as well as to expedite execution of meaningful improvements across the organization and across stakeholder groups.

Certification Standards

In the 2nd Quarter of 2014, Connect for Health Colorado will begin discussions regarding re-certification standards for carriers, the Assistance Network, Brokers/Agents and Certified Application Counselors. A framework for evaluation will be developed and for each stakeholder group major additions or changes will be considered relative to the 2013 certification standards.

Considerations for certification include:

- a. Carriers: Licensure and network and benefit design considerations (as regulated through the Division of Insurance);
- b. Assistance Network: Enrollment reach, Scope of training, population targets, geographic reach, training refresh, background checks, ongoing compliance with grant agreement, privacy and security requirements and conflict of interest policy;
- c. Brokers/Agents: Scope of training, maintenance of DOI licensing and continuing education requirements
- d. Certified Application Counselors and CAC Designated Organizations: Scope of training and adherence to federal certification requirements.
- e. Adherence to privacy and security requirements.



Driving Efficiencies as Customers Move Between Commercial Coverage and Medicaid

It will be critical to ensure efficient management of the portion of the population that, because of income fluctuations, shift between commercial coverage through Connect for Health Colorado and Medicaid. Maximizing efficiencies in this area has the opportunity to drive down operational costs over time.

Office of Conflict Resolution and Appeals

- Concurrent with the open enrollment period, and the time subsequent to, the Office of Conflict Resolution and Appeals is responsible for processing appeals made by individuals, families, and small business employers and employees. There are seven different types of appeals concerning eligibility for health insurance coverage through the Marketplace. The appeals process is managed in strict accordance with the laws and regulations that govern the appeals process. This process is managed collaboratively with the Colorado Department of Health Care Policy and Financing and both organizations are committed to evaluating and adapting strategies as the need arises.

Under those laws, the Office is primarily responsible for researching, analyzing, and processing individual appeals concerning the amount of Advance Premium Tax Credits and level of Cost Sharing Reductions (“APTC/CSR”) individuals receive through the Marketplace. The Office is also responsible for appeals concerning eligibility for coverage under the Colorado Young Adult Plan. The nature of these appeals often involves considerations of Medicaid eligibility. Consequently, the Office works closely with our partners at Colorado’s Department of Health Care Policy and Financing (“HCPF”) in order to process and resolve these unique eligibility cases.

The Office processes small business employers and employees’ appeals of their eligibility for coverage in the Small Business Marketplace, carrier contests of the de-certification of a qualified health plan (QHP) in the Marketplace, and Agent/Broker arbitration.

The Office aims to deliver upon the aforementioned with a high level of customer service and overall operational efficiency and compliance with laws and regulations governing the Marketplace.

The Office also proactively monitors legal and public policy trends in the health insurance sector via legislative tracking and regulatory comments and provides legal research and response as requested by internal departments. They provide policy consultation with various Connect for Health Colorado management and personnel. In addition, the Office provides review, drafting, and negotiation of legal documents and agreements.

The Office infrastructure includes:

- a. A new secured office area with technological infrastructure that was specifically designed for the purpose of protecting confidential information processed by the Appeals team.



- b. Phase 1 of case management software implementation.
- c. Policy and procedural documentation informed by discussions with health-consultant Manatt and the Department Health Care Policy and Financing.

Top Priorities and Objectives

Going forward, this group will continue to refine its effectiveness in 4 key areas:

1. Customer Service Excellence
2. Appeal Volume Stabilization
3. Operational Efficiency
4. Departmental Growth

Customer Service Excellence

The Office of Conflict Resolution and Appeals puts customer service at the forefront. They interact directly with consumers and strive to make each of those interactions meaningful and positive, with an outcome that is mutually agreeable for all parties.

This group was implemented with a baseline set of operational procedures and supporting technological tools. This baseline allows the department to surpass the basic standards for accepting and processing appeals.

Appeal Volume Stabilization

An important part of the team's strategic objective involves the education and outreach necessary to resolve questions and concerns through an informal process and thereby minimize the submission and processing of unnecessary appeals. Managing an appeal case takes time and resources, for the consumer as well as Connect for Health Colorado.

Education and training will be the best approach to stabilize and resolve concerns without formal appeals. After the initial open enrollment period, the team will begin looking at ways to provide more user-friendly information explaining how eligibility and other appealable decisions are made. The best mitigation tactic is making this information available and understandable.

Operational Efficiency

There are currently 3 full time employees and 2 half time employees in the Office of Conflict Resolution and Appeals. The goal is to maximize technology, resolve cases in the informal phase and keep resource allocation optimal for the workload. There is no plan to increase staffing in this group in the coming year.

At the end of the first annual open enrollment period, the team will evaluate lessons learned and the current state of processes, procedures, and supporting technology.



For the initial department set up, Connect for Health Colorado worked on a baseline version of the case management software for appeals. It includes basic software capability to process intake of appeals, manage processing of appeals, and provide a basic reporting capability. Upon evaluation of lessons learned, the team will create a Phase II for technological improvements.

Phase II will address refinements in the following areas:

- a. Improve the integration between the Marketplace and the appeals management software eliminating the need for multiple points of data entry.
- b. Improve the integration between the case management system and the content management system.
- c. Improve the case management software to simplify the appeals intake processing.
- d. Improve workflow management.
 - Automate more notices & correspondences.
 - Improve case coordination with HCPF.
 - Create case coordination with HHS Office of Marketplace Eligibility Appeals.
 - Identify case coordination procedures involving certification/decertification of Carriers/QHPs.
 - Improve case coordination and handoffs of eligibility appeals requiring formal evaluation with OAC.

Department Growth

Moving forward, this group has the potential and vision to mature into a well-rounded resource for policy and compliance. The Office of Conflict Resolution and Appeals has 3 attorneys who keep a pulse on legislative and regulatory developments as they continually unfold. Additionally, the Office staffs two individuals who handle special projects and administrative support.

The Office will continue to be a proactive resource for operational leaders and decision-makers within the organization.

5. Communications, Outreach and Marketing

Top Priorities and Objectives

Top priorities of the communications, outreach and marketing department are to strengthen the brand and support enrollments and customer relations consistent with the organization's mission. The strategic direction will be informed by enrollment and market data, customer and public surveys, target group analysis and re-targeting, best practices and lessons from other marketplaces. Strong grassroots outreach and community-level partnerships and clear and effective communication will also be utilized. Tailor communication to existing customers and potential customers through Customer Relationship Management (CRM) software will also be utilized to support marketing initiatives. This includes a focus on personalizing our messaging to current and future customers and engaging on a regular basis to ensure flexibility in responding to customer interests and needs. From a budget perspective, Connect



for Health Colorado will utilize federal grants in 2014 to fund paid media and outreach activities to support all sales channels and to grow enrollments and create a diversified customer base. In 2015, spending and resources will pare down in line with overall budget reductions and lessened need for aggressive paid media and outreach tactics, focusing on maintaining strong customer relations and brand loyalty. The team will continue to seek out innovative communication, outreach and marketing tactics, such as the mobile app that was released in November 2013 as a tool for Coloradans to find local in-person assistance and to browse plans and save their preferred plan, among other functions.

Target markets:

Based on early 2013 data from state sources, Connect for Health Colorado serves the state of Colorado with a potential customer base of almost 1 million people, including:

- a. Uninsured Coloradans with legal status: 299,405 of the 700,000 uninsured Coloradans with legal status are eligible for premium tax credits
- b. Small group market: 252,469 covered lives
- c. Individual market purchasers: 402,761 (195,007 eligible for premium tax credits)

Examples of potential customers include:

- A 27-year old restaurant worker who does not have employer-sponsored insurance and is eligible for a tax credit and catastrophic plans
- A 45 engineer leaving his company to start his own business
- A 38-year-old office manager who was laid off and is paying for COBRA
- A nail salon with 8 employees without employer-sponsored coverage and eligible for small business tax credit
- A law firm with 30 employees with employer-sponsored coverage
- A family on Medicaid with a parent who takes a job and then becomes eligible for commercial coverage with a premium tax credit

Connect for Health Colorado will continuously analyze enrollment data to identify levels of penetration into target markets and groups who need to be reached, and then to support sales and outreach channels, including Agent/Brokers, the Assistance Network, the Customer Service Center, partner groups and grassroots outreach teams with reaching these customers.

Paid Media:

In 2013, Connect for Health Colorado invested in significant levels of paid media, including statewide television, radio, print and out of home (OOH) advertisements, to build awareness of the new brand and new product channel. Online advertising, search engine marketing and mobile text campaigns yielded especially favorable return on investment, with thousands of click-throughs to the Connect for Health Colorado website. Paid media will still be necessary in 2014 and future years, albeit at lower levels, to maintain momentum and brand loyalty and to keep customers. Potential tactics include:



- a. Television spots featuring actual customers
- b. Targeted messaging for young adults through Hulu, television, Pandora, radio, text and social media.
- c. Targeted messaging for small businesses and entrepreneurs through radio, print, trade journals, online and social media.
- d. General audience/mid to high income messaging in television, radio, online and print to reach new customers
- e. Spanish-language and English-language messaging in television, radio, print and other channels targeting Hispanic customers
- f. Community-level spots in radio, print and online to support Assistance Sites and certified brokers and agents in those communities

Earned Media:

Connect for Health Colorado will focus resources on promoting positive relationships with the press to support public awareness of brand, accurate dissemination of information to the public and meeting transparency expectations. Activities will include:

- a. Promoting customer stories with media outlets
- b. Identifying opportunities for call-in shows and longer discussions to provide detailed information to customers
- c. Providing reporters with access to management staff for interviews
- d. Proactively contacting reporters, editors, producers and bloggers to pitch stories and outreach and enrollment events

Social Media:

Social media channels have been utilized since the organization's inception and will continue to be an important way to interact with customers, stakeholders and the public. Future activities will focus on customer and stakeholder relations and brand loyalty. Channels include Twitter, Facebook, YouTube, LinkedIn and Instagram. Contests, feedback mechanisms, videos and infographics and other creative tactics will support communications across our social media channels.

Collateral Materials:

Educational materials will continue to be available on our website and through an online store for partners, sales channels and customers to support operations and provide information for specific customer groups, such as American Indians, Coloradans with disabilities, immigrants and minority communities, and others. Materials will be updated and new ones will be created based on demand and evolving market dynamics. Collateral materials will include:

- a. Pamphlets and rack cards for specific audiences (individuals/families, small businesses, Hispanics, American Indians)
- b. Pamphlets addressing specific topics of interest of interest, including premium tax credits, value of insurance, using insurance to protect your health



- c. Pamphlets and rack cards and other materials that are co-branded for Assistance Sites and certified agents
- d. Online toolkits for the Assistance Network and certified agents/brokers
- e. Giveaway items to support marketing and sales activities, such as hats, sunscreen and t-shirts that will be available to the Assistance Network, certified agents, partners and outreach staff and volunteers

Grassroots Outreach:

Outreach and marketing activities at the community level, in places such as grocery stores and libraries, are effective ways to reach existing and new customers. In 2013, staff, partners, members of the Assistance Network and volunteers trained to serve in the Speakers Bureau conducted more than 600 presentations across the state in 2013, reaching over 25,000 Coloradans. The Communications staff provided a range of tailored PowerPoint presentations for these community meetings based on the audience. Similar outreach efforts are expected to continue in 2014 and beyond. When possible, enrollment-focused outreach events will be conducted with computers and Internet access to allow customers to sign up on site. A pilot initiative in December 2013 using this model saw positive response. This campaign, called the Holiday Connect to Coverage RV Tour, included a 24-foot RV wrapped with the Connect for Health Colorado brand that was driven more than 1,000 miles around the state to outreach events at grocery stores and high-traffic areas. The events were publicized to the media and included outreach staff and local Health Coverage Guides with laptops and Internet access. Customers seeking in-person help came to the events and received help on site, and many other Coloradans received information and were able to see the shopping website and get questions answered. Public response and earned media was strong. The approach provided help to Coloradans in their communities and at convenient locations.

Grassroots outreach tactics will include:

- a. Enrollment events at Assistance Sites or with Health Coverage Guides
- b. Coordination with Health Coverage Guides and certified agents to support enrollments at local events with outreach teams to attract customers and provide immediate support
- c. Coordination with Customer Service Center representatives to provide enrollment support by phone to customers identified by outreach street teams at community locations
- d. Enrollment events with the branded RV similar to the Holiday Connect to Coverage RV Tour that took place in December 2013. These events would provide direct assistance by Health Coverage Guides who are on site.
- e. Potential events for outreach presence include sports games, local health fairs, grocery stores, libraries, recreation centers, chambers of commerce, hospitals and clinics
- f. Presentations and meetings by volunteer members of the Speakers Bureau, staff, partner organizations and all Customer Support Network members
- g. Telephone and online town hall-style meetings to provide answers to questions
- h. Webinars and other educational opportunities for customers and partners



Stakeholder Partnerships:

Community-based organizations, medical providers and faith-based groups are trusted messengers and are key to supporting our mission and the success of our Marketplace. From the beginning, Connect for Health Colorado placed a strong emphasis on building strong relationships with a range of stakeholder groups, including consumer advocates, business organizations, medical providers, public service organizations and community groups. Stakeholders provided valuable input into the planning and launch of the Marketplace through Advisory Group meetings, informal meetings, online surveys and other mechanisms. We will continue to actively foster collaborative relationships with the more than 100 organizations we worked with in 2013 to support our mission. We will also leverage these relationships – including through enrollment drives and joint communications - to increase enrollments and customer relations.

Connect for Health Colorado continues to work collaboratively with the Colorado Department of Health Care Policy and Financing and the Division of Insurance in the arena of communication and outreach.

Clear and Consistent Communication:

The communications, outreach and marketing department will augment all areas of operations with regular internal communication vehicles, primarily through emails and e-newsletters. The department will continue frequent email communication, utilizing CRM software, to customers, stakeholders, Board members, Legislative Review Committee members and key partners at the state and federal levels. Messaging will be supported by social media channels and the website. The communications department will also support public Board meetings and posting of documents and minutes on the website as well as coordination of messaging with other departments, including training, policy development and sales.

6. Technology & Operational Support Systems

This section addresses the objectives and plan for the Connect for Health Colorado technology and operational support systems.

Note that the applications (including all product and custom software, database, underlying infrastructure, network and hardware required to support the application) included in the technology plan outlined below include the following:

- a. Individual and SHOP portals on the Marketplace
- b. Broker and Health Coverage Guide portals on the Marketplace
- c. Carrier interfaces
- d. SHOP invoicing and financial management application
- e. The service portal used by Service Representatives to support customer requests
- f. Our customer relationship management (CRM) software
- g. Business intelligence (BI) and reporting software
- h. Service Center telephony technology

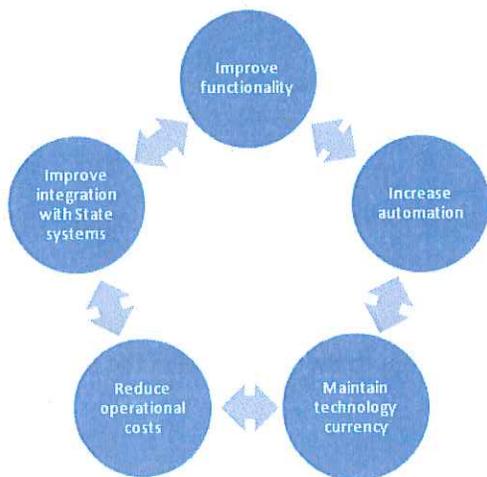


- i. Security and single sign on software
- j. Email and noticing software
- k. Appeals case management software
- l. Training and learning management software including tracking.
- m. Connect for Health main office administrative and support software (email, document management, accounting and general ledger, etc.).
- n. Service Center infrastructure to include desktops, laptops, servers, networking, and monitoring.

Connect for Health Colorado Applications and Technology Infrastructure

The Connect for Health Colorado technology infrastructure consists of commercial-off-the-shelf (COTS) products, custom components, and interfaces with State, Federal and commercial partners. As we enter 2014, the overall solution meets the functional and operational requirements for a State-based-marketplace. However, there are a number of areas for improvement. The development of the technology roadmap that will guide implementation will consider the percentage of projects dedicated to existing requirements versus new/innovative improvements to enhance the overall customer experience. To meet the critical Connect for Health Colorado sustainability goals, the strategic objectives for the technology and operational support systems for 2014 are listed below:

- *Continue to improve functionality and usability* in key areas including SHOP, Agent/Broker tools, health coverage guide tools, service portal financial management, reporting, account maintenance, and email and noticing. There will also be an ongoing improvement process that focuses on plan shopping and enrollment.



communications.

- *Increase automation* in areas that will reduce the number of back-office personnel needed to support operations during open enrollment periods and throughout the year.
- *Improve integration with State systems* for individual eligibility and life change processing.
- *Reduce operational and maintenance costs* by maturing the infrastructure and support processes and looking at alternatives to minimize the amount of custom code that must be maintained.
- *Maintain technology currency* – particularly in the areas of security, scalability, business-to-business integration, and business-to-customer

The sections below provide specific recommendations for an ongoing technology approach to support our strategic objectives.



Improve functionality and usability

Connect for Health Colorado has identified the following as high priority functional improvements needed to remain competitive, provide excellent customer service and keep current with CMS and CCIO requirements:

- a. Shared financial eligibility application and shared eligibility service with HCPF
- b. Additional renewal and re-determination functionality for individuals and families
- c. Creation of end of year tax statements (1095 statements) for individual exchange customers
- d. Implement improvements to life change event functionality for both SHOP and individual portals
- e. Implement improvements to SHOP account management, eligibility, enrollment and employee management functions
- f. Implement improvements to broker proposal, client management, account management, and tracking and reporting functions
- g. Implement improvements to health coverage guide account management, customer management and reporting functions
- h. Implement continual adjustments and improvements to shopping, payment and enrollment functions on both SHOP and individual portals
- i. Additional audit logging and system monitoring functionality, specifically around end-to-end tracking of transactions through the Connect for Health Colorado and partner systems.

In order to meet these objectives, Connect for Health Colorado will be working closely with our technology vendors to review their product release plans and align with business requirements and product direction. Our overall strategic and tactical objective is to drive product roadmaps to minimize the amount of custom code needed to maintain our system, thereby reducing technology costs.

Increase Automation

One key to meeting our sustainability goals is to automate as much of the day-to-day and open enrollment processing as possible. By automating some key areas, we will reduce cost, improve customer service and provide leadership with better tools to predict and manage work load. Based on a review of the business processes employed during the most recent open enrollment period. We will look to improve automation in the following high priority areas:

- a. Electronic data transfer
- b. Aspects of financial management and invoicing
- c. Metrics and reporting
- d. Call center work flows
- e. Work flows
- f. Regression testing software deployments for both system and user acceptance testing

Improve Interoperability with State Systems

Improved interoperability with the State Medicaid system will have a significant impact on the financial application enrollment process. The project is underway to create a single streamlined application to



be used by both HCPF and Connect for Health Colorado to determine eligibility for insurance affordability programs (IAPs) – Medicaid, CHP+, and APTC/CSR. By having a single shared system, we will reduce the time it takes a customer to apply for and enroll in a medical plan, reduce or eliminate the need for manual reconciliation processes, provide Connect for Health Colorado with alternatives to the Federal Data Services Hub (FDSH) for verifications, and provide a more streamlined approach to handling customers who move from one insurance affordability program to another during a plan year. Both Connect for Health Colorado and HCPF would like to have the single streamlined application available in advance of the next open enrollment period to provide ample testing time and to allow for an early renewal and early enrollment period.

Reduce Operational and Maintenance Costs

Connect for Health Colorado’s goal is to continue to reduce the cost of technology operations and maintenance costs. The three most significant ways to drive down those costs are to: reduce the amount of custom code utilized by our base COTS systems, reduce the number of COTS systems with which the Marketplace needs to integrate and to work to encourage the use of Colorado’s system with other states.

7. Human Resources and Administration

In 2014, as Connect for Health Colorado continues its transition from startup into maturity, the organization’s staffing and management policies will further evolve.

An initial staffing plan was developed in 2013 as part of the application for Level 2 Federal grant funding. This plan was a vision of the resource requirements of Connect for Health Colorado through 2014 and acts as a framework for further staffing development. During the upcoming year, key hires will be made and efforts will be focused on maximizing retention of long-term staff to ensure continuity of knowledge. New resources will have a forward-looking direction with emphasis on the skills and knowledge needed to ensure the organization’s upcoming initiatives are successful.

Beginning in 2014, some of Connect for Health Colorado’s contractual staff will begin rolling off the project. Planning for this transition is underway, with special attention being paid to the vast amount of knowledge transfer that must occur. A formalized effort, which includes training and documenting, will continue throughout this process and into 2015.

Organizational policies and procedures developed to this point will be updated during 2014, as appropriate, to align with the growth of Connect for Health Colorado. Staff training will continue and expand, assuring adherence in the areas of finance, security & privacy, audit and general regulatory and legal compliance.

Operating Metrics

In late September of 2013, the Connect for Health Colorado Board of Directors approved a series of metrics that provide an ongoing snapshot of current operations. These metrics are categorized in six key areas as outlined below:

Access, Affordability and Choice (Sales – Section 3)

- How many plans selected
- How many plans selected by type and market
- Who is selecting plans that were previously uninsured (*non-mandatory - soft metric*)
- Average premium (gross and net)
- How many selected APTC and/or CSR

Customer Service Center (Service/Operational Efficiency – Section 4)

- Total number of contacts (includes total number of calls and total number of chats, emails and webforms)
- Percentage of calls answered in 20 seconds
- Top three most common questions by category
- Top three most commonly used knowledgebase answers
- Average hold time

Brokers and Health Coverage Guides (Sales – Section 3)

- Total number of Brokers certified
- Total number of accounts assigned with Brokers
- Total number of certified HCGs
- Total number of accounts assigned with HCGs

System (Technology – Section 6)

- Availability (uptime) excluding maintenance (SLA = 99.5%)
- Percentage of web pages serviced within 5 seconds (SLA = 90%)
- How many visitors to home page
- Most commonly viewed pages (top 3)

Application Activity (Sales – Section 3)

- Total number of accounts created
- Total accounts created by channel (broker/agent, HCGs, customer service center, customers (employers, employees and individuals)
- Accounts Aging (how long has it been since an account was logged in) (15 day increments)



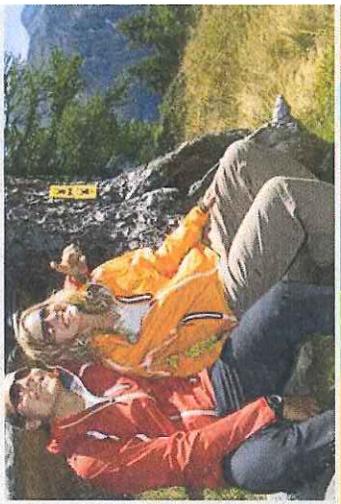
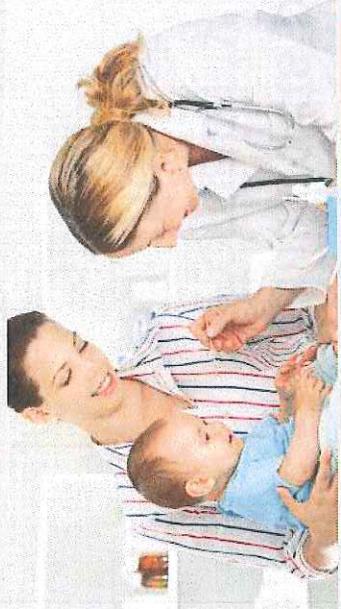
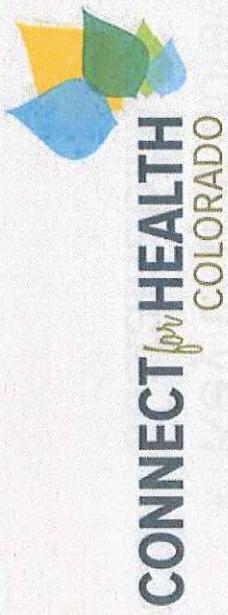
- Individual/Employees

Appeals (Service/Operational Efficiency – Section 4)

- Total number of appeals
- Total number of open and closed appeals

Conclusion

The 2014 Operations plan seeks to set a framework for delivery across the organization of Connect for Health Colorado in preparation for the 2015 coverage year. It will ensure that a holistic program plan is established that ensures that the organization continues to deliver on its mission as outlined by Senate Bill 11-200.



*Update for Legislative Health Benefit
Exchange Implementation Review Committee
Financial Plan Extract*

Presented September 5, 2013

FINANCIAL APPROACH

Sustainability Objective

- Connect for Health Colorado is committed to fulfilling its purpose to increase access, affordability and choice for individuals and small businesses purchasing health insurance in Colorado.
- Key to this objective is achieving financial sustainability.

Financial Approach: Guiding Principles for Sustainability

Bring about long-term financial balance

- Focus on providing value to consumers and communities
- Derive revenue from a range of sources
- Set the Marketplace up for success
- Focus on maintaining affordability

Financial Approach: Revenue Overview

Early Revenue

- Federal Grants
- High Risk Pool Reserves
- Broad Market Assessment (2015 & 2016 only) \$1.80 per policy per month maximum

Enrollment Based Revenue

- Administrative Fees: 1.4% in 2014 (federal states are 3.5%)

"Other"/Future Opportunities

- Supplemental Products
- Carrier Tax Credit Donations
- Website Advertising
- Cost Sharing with Other States
- Foundation Grants

Financial Approach: Expenditures

Budgeted Expenses		
Technology <ul style="list-style-type: none">• Technology Licenses• Technology Maintenance• Technology Upgrades• Technology Hosting• Data Warehousing• Security• Testing• QA• Eligibility	Operations <ul style="list-style-type: none">• Staff• Occupancy• General & Administrative• Marketing & Advertising• Audit	Services <ul style="list-style-type: none">• Customer Service Center• Scanning & Imaging• Training• Systems Reconciliations• Enrollment Assistance (Navigators)
Projected annual budget \$26 million		

Financial Approach

Budget Projections and Full Funding Model:

The following document models the current and anticipated budget and funding for Connect for Health Colorado through 2017.

Financial Modeling

On Thursday, December 12th, the Finance Committee met and discussed the modeling for various enrollment scenarios. This was not intended as an adjustment to Connect for Health Colorado's original conservative, mid, and aggressive enrollment scenarios from early 2013, but rather to illustrate how other enrollment scenarios may affect future administrative fees, market assessment, and the organization's overall sustainability. When reviewing these various scenarios, some considerations and assumptions are:

- Connect for Health Colorado's operations are fully funded by Federal grants in 2014.
- Any Federal grant funds that are not fully expended by Connect for Health Colorado during the grant periods will be forfeited.
- State-Based Marketplaces successfully petitioned the Department of Health & Human Services (Federal granting agency) that any operational revenues earned in 2014 would not reduce the grant amounts awarded.
- A grant from TCHF for \$2,010,000 is fully committed to the Assistance Network program for Navigator support. Navigator operational support cannot be funded under the Federal grant program.
- As a result of HB13-1245, which was passed in June of 2013, Connect for Health Colorado has already received \$15,000,000 from CoverColorado and premium tax credit contributions from insurance carriers totaling \$5,000,000.
- The Marketplace Administrative Fee for 2014 is set at 1.4%. The fee set for the Federal Marketplace is 3.5%.
- The market assessment allowed through HB13-1245 is set at \$0 for 2014. The Connect for Health CO Board will set the assessment amount, between \$0 and \$1.80 PMPM, for 2015. C4HCO will work with DOI on the specific date.

The Connect for Health Colorado Board will set the Marketplace's Administrative Fee and General Market Health Insurer Assessment for 2015 in spring of 2014.

Modeling Scenario Requested for Discussion Purposes Only by Finance Committee - 50,000

(this is not a revised projection)

COHBE's estimated portion of CoverColorado 2015 reserve is \$8.5 million
Annual operating budget of \$26 million

	2nd half 2013	2014	2015	2016	2017
<u>Enrollment & Premium Assumptions</u>					
Average Estimated Sales Projections	0	50,000	100,000	150,000	200,000
Average Estimated Premium per member per month	\$0	\$337	\$352	\$370	\$390
Administrative Fee	0.00%	1.40%	1.4%-2.0%	1.7%-2.3%	2.7%-3.0%
<u>Revenue Assumptions</u>					
Exchange Revenue from Admin Fees	\$0	\$2,830,800	\$5,913,600	\$11,322,000	\$26,208,000
Estimated portion of Federal Grant Funding (2013-2016)	\$66,069,622	\$60,984,119	\$15,386,639	\$0	\$0
Revenue from CoverColorado/Unclaimed Property Fund	\$15,000,000	\$0	\$0	\$0	\$0
Revenue from CoverColorado/Reserve Balance			\$8,500,000		
Revenue from General Market Health Insurer Assessment (\$1.50-\$1.80)			\$15,750,000	\$15,750,000	\$5,000,000
Revenue from Premium Tax Credit Donations	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000
Potential Foundation Grants	\$2,010,000	\$2,000,000			
Total Income	\$88,079,622	\$70,814,919	\$50,550,239	\$32,072,000	\$31,208,000
Expected Operating/Technology Budget	\$75,239,971	\$26,000,000	\$26,000,000	\$26,000,000	\$26,000,000
Remaining Implementation/Enhancement Costs estimated for 2014 & 2015		\$37,057,020	\$15,725,785		
Additional Implementation Expense (not Federally grant funded)	\$2,010,000	\$2,000,000			
Total Expenditures	\$77,249,971	\$65,057,020	\$41,725,785	\$26,000,000	\$26,000,000
Net Income/Expense by year	\$10,829,651	\$5,757,899	\$8,824,454	\$6,072,000	\$5,208,000
Technology Obsolescence Solution begins after Operational Reserve reaches 50% of annual budget	\$0	\$3,587,549	\$12,412,004	\$18,484,004	\$23,692,004
Cumulative Operational Reserve at approximately 50% of annual budget	\$10,829,651	\$13,000,000	\$13,000,000	\$13,000,000	\$13,000,000

Modeling Scenario Requested for Discussion Purposes Only by Finance Committee - 75,000 (this is not a revised projection)

COHBE's estimated portion of CoverColorado 2015 reserve is \$8.5 million
Annual operating budget of \$26 million

	2nd half 2013	2014	2015	2016	2017
Enrollment & Premium Assumptions					
Average Estimated Sales Projections	0	75,000	125,000	175,000	225,000
Average Estimated Premium per member per month	\$0	\$337	\$352	\$370	\$390
Administrative Fee	0.00%	1.40%	1.4%-1.9%	1.4%-1.9%	2.4%-2.9%
Revenue Assumptions					
Exchange Revenue from Admin Fees	\$0	\$4,246,200	\$7,392,000	\$10,878,000	\$26,325,000
Estimated portion of Federal Grant Funding (2013-2016)	\$66,069,622	\$60,984,119	\$15,386,639	\$0	\$0
Revenue from CoverColorado/Unclaimed Property Fund	\$15,000,000	\$0	\$0	\$0	\$0
Revenue from CoverColorado/Reserve Balance					
Revenue from General Market Health Insurer Assessment (\$1.50-\$1.80 PMPM)			\$8,500,000		
Revenue from Premium Tax Credit Donations	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000
Potential Foundation Grants	\$2,010,000	\$2,000,000			
Total Income	\$88,079,622	\$72,230,319	\$52,028,639	\$31,628,000	\$31,325,000
Expected Operating/Technology Budget					
Remaining Implementation/Enhancement Costs estimated for 2014 & 2015	\$75,239,971	\$26,000,000	\$26,000,000	\$26,000,000	\$26,000,000
Additional Implementation Expense (not Federally grant funded)	\$2,010,000	\$2,000,000	\$15,725,785		
Total Expenditures	\$77,249,971	\$65,057,020	\$41,725,785	\$26,000,000	\$26,000,000
Net Income/Expense by year	\$10,829,651	\$7,173,299	\$10,302,854	\$5,628,000	\$5,325,000
Technology Obsolescence Solution begins after Operational Reserve reaches 50% of annual budget					
Cumulative Operational Reserve at approximately 50% of annual budget	\$10,829,651	\$13,000,000	\$13,000,000	\$13,000,000	\$13,000,000
		\$0	\$15,305,804	\$20,933,804	\$26,258,804

Modeling Scenario at Original Mid-Level Enrollment Projection - 136,300

Connect for Health Colorado
Current and Anticipated Budget and Funding

Model Assumptions

COHBE's portion of CoverColorado 2015 reserve is \$8.5 million
Annual operating budget of \$26 million

	2nd half 2013	2014	2015	2016	2017
<u>Enrollment & Premium Assumptions</u>					
Average Estimated Sales Projections	0	136,300	220,000	250,000	300,000
Average Estimated Premium per member per month	\$0	\$337	\$352	\$370	\$390
Administrative Fee	0.00%	1.40%	1.4%-1.7%	1.4%-1.7%	1.8%-2.1%
Revenue Assumptions					
Exchange Revenue from Admin Fees	\$0	\$7,716,761	\$13,009,920	\$15,523,200	\$26,676,000
Estimated portion of Federal Grant Funding (2013-2016)	\$66,069,622	\$60,984,119	\$15,386,639	\$0	\$0

Revenue from CoverColorado/Unclaimed Property Fund

	\$15,000,000	\$0	\$0	\$0	\$0
Revenue from CoverColorado/Reserve Balance			\$8,500,000		
Revenue from General Market Health Insurer Assessment (\$1.00-\$1.50 PMPM)			\$10,500,000	\$10,500,000	
Revenue from Premium Tax Credit Donations	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000
Potential Foundation Grants	\$2,010,000	\$2,000,000			
Total Income	\$88,079,622	\$75,700,879	\$52,396,559	\$31,023,200	\$31,676,000

Expected Operating/Technology Budget
Remaining Implementation/Enhancement Costs estimated for 2014 & 2015
Additional Implementation Expense (not Federally grant funded)

	\$75,239,971	\$26,000,000	\$26,000,000	\$26,000,000	\$26,000,000
		\$37,057,020	\$15,725,785		
	\$2,010,000	\$9,716,761			
Total Expenditures	\$77,249,971	\$72,773,781	\$41,725,785	\$26,000,000	\$26,000,000

Net Income/Expense by year

	\$10,829,651	\$2,927,099	\$10,670,774	\$5,023,200	\$5,676,000
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Technology Obsolescence Solution begins after Operational Reserve reaches 50% of annual budget
Cumulative Operational Reserve/(Shortfall) at approximately 50% of annual budget

	\$0	\$756,749	\$11,427,524	\$16,450,724	\$22,126,724
	\$10,829,651	\$13,000,000	\$13,000,000	\$13,000,000	\$13,000,000



2015 Fiscal Year Budget

Approved by C4HCO Board – June 9, 2014

FY2015 Budget Context

- Budget period is 7/1/2014 through 6/30/2015 (C4HCO fiscal year)
- A significant portion of this budget (7/1/2014-12/31/2014) was previously approved as part of the Level 2 Grant Budget
- Technology implementations and enhancements will be funded by Federal grants throughout the full fiscal year
- Operations will be funded by Federal grants for the first 6 months of the fiscal year

FY2015 Budget Categories

- Customer Service Center
 - FY 2014 Budget \$22.5M, FY 2015 Budget \$13.6M
 - Includes:
 - Support for calls, chats and emails
 - Back office processing of applications, manual transactions and financial activities
 - Supervision, QA, and training
 - Facilities, technology in the center (fixed and variable)
- Marketing, Communications & Outreach
 - FY 2014 Budget \$10.1M, FY 2015 Budget \$4.8M
 - Includes:
 - Market research, paid media, outreach & enrollment events, collateral/materials, media relations

FY2015 Budget Categories – Cont'd

- Technology
 - FY 2014 Budget \$38.5M, FY 2015 Budget \$29.5M
 - Expensed Costs \$9.2M
 - Hosting
 - Licenses
 - Maintenance & Support
 - Security
 - PMO/IT Business Analysis
 - Capitalized Costs \$20.3M
 - System enhancements – individual marketplace, service portal, agent and small business portals
 - Shared Eligibility System
 - New functionality – integrated plan management and financial management, API, address validation, additional reporting

FY2015 Budget Categories – Cont'd

- Operations
 - FY 2014 Budget \$5.43M, FY 2015 Budget \$2.32M
 - Consulting, training, DOI/HCPF
- Assistance Network
 - FY 2014 Budget \$10.1M, FY 2015 Budget \$6.05M
 - Support 53 assistance sites, including 6 regional hubs
 - 890 qualified individuals support the Assistance Network, including 440 Health Coverage Guides
 - Enrollment support for difficult to reach and vulnerable populations, provides local presence and visibility and geographic, community and cultural relevance
- General & Administrative
 - FY 2014 Budget \$7.36M, FY 2015 Budget \$6.98M
 - Salaries, payroll taxes, employee insurance and benefits
 - Occupancy, travel, & insurance
 - Legal, accounting & other professional fees
 - Supplies, office equipment and copying
 - Conferences, conventions, meetings & memberships

Budget Totals

- FY 2015 Budget \$66,357,180 – including technology implementation and enhancements and other capital expenditures
 - Includes \$3M to purchase building in Colorado Springs, which was approved in the Level 2 Grant. Purchase will depend upon an analysis of ROI to be evaluated later this year.
- Operations will be funded by Federal grants for the first 6 months
- Technology will be funded by Federal grants for the entire fiscal year

Health Insurer Market Assessment

- Board establishes Health Insurer Assessment for calendar year 2015
- This will fund a portion of C4HCO's FY2015 Budget and a portion of the FY2016 Budget
- HB 13-1245 allows a Health Insurer Assessment of \$1.80 pmpm
- Recommendation that Health Insurer Assessment for 2015 is set at \$1.25 pmpm



*Update for Legislative Health Benefit
Exchange Implementation Review Committee
Financial Plan Extract*

Presented September 23, 2014

FINANCIAL APPROACH

Sustainability Objective

- Connect for Health Colorado is committed to fulfilling its purpose to increase access, affordability and choice for individuals and small businesses purchasing health insurance in Colorado.
- Key to this objective is achieving financial sustainability.

Financial Approach: Guiding Principles for Sustainability

Bring about long-term financial balance

- Focus on providing value to consumers and communities
- Derive revenue from a range of sources
- Set the Marketplace up for success
- Focus on maintaining affordability

Financial Approach: Revenue Overview

Early Revenue

- Federal Grants, expected extension through 6/30/2015
- High Risk Pool Reserves, Received \$10M to date
- Broad Market Assessment (2015 & 2016 only) \$1.80 per policy per month maximum, set at \$1.25 for 2015

Enrollment Based Revenue

- Administrative Fees: 1.4% in 2014 & 2015 (federal states are 3.5%)

“Other”/Future Opportunities

- Supplemental Products
- Carrier Tax Credit Donations
- Website Advertising
- Cost Sharing with Other States
- Foundation Grants

Financial Approach: Expenditures

Budgeted Expenses

Technology

- Technology Licenses
- Technology Maintenance
- Technology Upgrades
- Technology Hosting
- Data Warehousing
- Security
- Testing
- QA
- Eligibility

Operations

- Staff
- Occupancy
- General & Administrative
- Marketing & Advertising
- Audit

Services

- Customer Service Center
- Scanning & Imaging
- Training
- Systems Reconciliations
- Enrollment Assistance (Navigators)

Financial Approach

The Finance Committee will meet on September 24th to discuss target enrollments for 2015 and updated financial modeling. Revised financial projections, for 2015, will be presented to the Board at the October 13, 2014 Board Meeting.

Level 2 grant extension has been requested.

Fiscal year 2015 budget was approved by the Board in June.



COLORADO'S HEALTH BENEFIT EXCHANGE

by Kelly Stapleton

In March 2010, federal health care legislation, also known as the Patient Protection and Affordable Care Act (PPACA), was adopted by the U.S. Congress and signed by the President. PPACA expands health care coverage by increasing access to private health insurance and expanding eligibility for Medicaid. The law also increases regulations on health insurance providers and makes changes to how the health insurance market operates. PPACA also requires individuals to have health care coverage, and requires employers to offer health insurance to employees.

This issue brief, part of a series on the federal health care legislation, describes Senate Bill 11-200 which establishes the Colorado Health Benefit Exchange. Other topics in this series include:

- Medicaid expansion under PPACA (*Issue Brief #10-17*);
- changes to health insurance laws under PPACA (*Issue Brief #11-04*); and
- a general description of the structure and requirements for state-based health benefit exchanges (*Issue Brief #11-01*).

Introduction

Health insurance exchanges are regulated marketplaces in which individuals and small businesses can shop for health insurance. Under PPACA, state health insurance exchanges must be operational by January 1, 2014, or if a state has not taken action to establish an exchange by January 1, 2013, the federal government will set up the exchange. Although states have discretion in establishing

exchanges, federal law includes requirements that all must meet. Exchanges must:

- be administered by a governmental agency or a nonprofit entity;
- develop a process for certification of plans as qualified health plans; and
- offer health insurance plans to both individuals and small businesses.

Colorado Health Benefit Exchange

Senate Bill 11-200 creates a process for the implementation of a health benefit exchange by establishing the exchange's governance structure. The bill establishes the exchange as a nonprofit public entity with a board of directors responsible for its operation. Senate Bill 11-200 specifies that no General Fund dollars be used for the implementation of the exchange.

Board of directors. The board is comprised of 12 members — 9 voting members and 3 nonvoting members. The Governor appoints five members and the members of legislative leadership appoint four members. Members of the board must demonstrate expertise in at least one 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 services;
- the purchase of health insurance coverage;

- health care consumer navigation;
- health care economics or actuarial sciences;
- information technology; or
- starting a small business with 50 or fewer people.

The remaining three, nonvoting, members are the Executive Director of the Colorado Department of Health Care Policy and Financing (HCPF), the Commissioner of Insurance, and the Director of the Office of Economic Development and International Trade. Board members serve without compensation, but may receive a per diem for travel and other necessary expenses. Additionally, board members cannot profit from being on the board and cannot be held liable for an act or omission when, in good faith, administering, managing, or conducting business on behalf of the board.

Board duties. The board does not have authority to promulgate rules, cannot purchase insurance, and should not duplicate the duties of the Colorado Division of Insurance, which has the authority to regulate insurance companies in Colorado. The board is responsible for:

- creating an initial operating and financial plan for the exchange;
- applying for planning and establishment grants;
- creating technical and advisory groups as needed; and
- reviewing the Internet portal template put forth by the U.S. Department of Health and Human Services.

The board must consider the size of the exchange, and whether there should be one exchange for the individual market and another for small businesses, or whether the state should have one exchange to serve both individuals and small businesses. Colorado law defines a "small employer" as a business with 50 or fewer employees. The board will consider the appropriate size of the small employer market under the exchange, taking into consideration the existing statutory definition. The board also must consider the needs of rural Coloradoans and the affordability and cost of health care.

Current Activity Regarding Implementation

The HCPF applied for an initial federal planning grant and received \$1 million in October 2010. HCPF selected the Colorado Health Institute (CHI) to initiate the planning phase of the exchange. CHI is a nonprofit health information clearinghouse. CHI, in coordination with the HCPF, put out a request for proposals (RFP) in March 2011 to procure assistance with the research and development of a comprehensive report detailing the current state of health insurance coverage in Colorado. The RFP will aid the board in determining whether Colorado can sustain two separate exchanges for individuals and small businesses. A vendor was selected in May, and the report will be issued in mid-September. In June 2011, Governor John Hickenlooper announced the 12-member board of directors and their inaugural meeting was held July 11, 2011. Information on the board may be found on CHI's website:

www.coloradohealthinstitute.org

Legislative Oversight Committee

Senate Bill 11-200 also established the Legislative Health Benefit Exchange Implementation Review Committee to guide implementation of the exchange, such as reviewing grants applied for by the exchange and the financial and operational plans of the exchange. The committee is comprised of 10 members of the General Assembly. The President of the Senate and the Speaker of the House of Representatives have each appointed three members and the House and Senate Minority Leaders have each appointed two members. The committee's membership includes members who sit on the Health, Business, or Legislative Audit committees.

The committee's first meeting is scheduled for August 1, 2011. The committee may meet at the call of the chair up to five times each calendar year and may report up to five bills or other measures to the Legislative Council. Senator Betty Boyd was appointed the chair of the committee, and Representative Bob Gardner was appointed vice-chair. The committee's website can be found here:

www.colorado.gov/LCS/ExchangeReviewComm



FEDERAL HEALTH CARE REFORM: STATE HEALTH INSURANCE EXCHANGES

by Bill Zepernick

In March 2010, federal health care reform, also known as the Patient Protection and Affordable Care Act (PPACA), was adopted by the U.S. Congress and signed by the President. PPACA expands health care coverage by increasing access to private health insurance and expanding eligibility for Medicaid. The law also increases regulations on health insurance providers and makes changes to how the health insurance market operates. PPACA also places requirements on individuals to have health care coverage and on employers to offer health insurance to employees.

This issue brief, part of a series on federal health care reform, examines state-based health insurance exchanges. Other topics in this series include the expansion of Medicaid and changes to health insurance laws.

Introduction

A key component of health care reform is the creation of state-based health insurance exchanges. Health insurance exchanges are regulated marketplaces in which individuals and small businesses can shop for health insurance. Several goals of health insurance exchanges are to:

- foster a competitive marketplace that gives consumers and businesses access to health insurance;

- provide information about the coverage, costs, and quality of health plans to consumers;
- ensure that health plans meet minimum standards for costs and quality; and
- assist consumers who may qualify for federal subsidies to purchase insurance, or are eligible for public health plans.

Structure and Operations

State health insurance exchanges must be operational by January 1, 2014. If a state has not taken action to establish an exchange by January 1, 2013, the federal government is to create the exchange within that state. Although states have some discretion in establishing exchanges, federal law includes requirements that all state exchanges must meet. For example, exchanges must either be a governmental agency or a nonprofit entity that is established by the state. Also, among the various duties specified in federal law, the exchanges must:

- only offer qualified health plans;
- develop procedures for the certification of plans as qualified health plans; and
- offer health plans for both the individual and the small group markets.

States may elect to create a single exchange for both the individual and small group markets, or to operate two separate exchanges. States also have the option to make large group coverage available through exchanges beginning in 2017.

Eligibility to Participate in Health Exchanges

Only U.S. citizens and legal immigrants who are not incarcerated are allowed to purchase health insurance through a state exchange. To be eligible for federal subsidies to purchase insurance on an exchange, a person must meet one of the following criteria:

- not be offered health insurance by his or her employer;
- only be offered health insurance by his or her employer that does not provide essential benefits; has a high level of cost sharing (such as deductibles and co-payments); or requires the employee to pay more than 9.5 percent of family income for the employee share of the premium; or
- not be eligible for Medicaid, Medicare, or other public health program.

For small businesses, federal law states that only a qualified small business may purchase insurance for its employees through the exchange. States have the option of defining small businesses as having up to 100 employees. Additional rules specifying which businesses are qualified to purchase in the exchanges have not yet been established by the federal Department of Health and Human Services.

Determination of Federal Subsidies

Persons who purchase health insurance through a state-based exchange may qualify for federal premium subsidies if they have income between 133 percent and 400 percent of the federal poverty level. The health insurance exchanges are responsible for informing people about their eligibility for federal premium subsidies. Premium subsidies are made available through a refundable and advanceable tax credit, which means that the premium subsidy would be provided even if the person has no other tax liability. It is made available when insurance is

purchased, rather than at end of the year when a tax return is filed. The federal Department of the Treasury is required to make rules about how the premium tax credit will be provided and will set forth the duties of state-based exchanges in the process.

Qualified Health Plans

Federal health reform specifies that only qualified health plans may be sold through state insurance exchanges. It is the responsibility of the exchange to certify each health plan offered by insurers in the exchange. To be certified as a qualified health plan, insurance providers must, among other requirements:

- include essential health benefits in all health plans, as defined in law and rule (see Table 1);
- be properly licensed and in good standing in the state;
- offer at health plans at specified coverage levels on the exchange; and
- set premiums for plans offered through the exchange at the same level as identical plans offered outside the exchange.

Table 1
Essential Health Benefits for Qualified Health Plans on State Exchanges

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services
- Chronic disease management
- Pediatric services, including oral and vision care
- Other services as defined by the Secretary of Health and Human Services

Source: Patient Protection and Affordable Care Act.

Federal law allows qualified health plans on state exchanges to be offered at several coverage levels. The coverage levels are based on the actuarial value of the plans. A health insurance plan's actuarial value refers to the average share of medical spending that is paid for by the plan as opposed to by the covered person. Actuarial value depends on the plan's cost-sharing requirements, as well as the specific services that the plan covers. The coverage levels created by PPACA are intended to give consumers a simple way to judge how generous the benefits of health plans are when shopping for coverage. The coverage levels of health plans, in order of actuarial value, are bronze, silver, gold, and platinum. Plans at each of the coverage levels can be expected to pay at least the following percent of the costs typically incurred under the plan:

- Bronze - 60 percent;
- Silver - 70 percent;
- Gold - 80 percent;
- Platinum - 90 percent.

Insurance providers must offer at least one plan at the silver and gold coverage levels in order to have plans certified on the exchange. In addition, insurance providers may sell catastrophic health plans to persons under the age of 30. Insurance providers that sell health insurance on state exchanges are also required to submit justifications to the state exchange for any increase in premiums prior to the implementation of the increase.

Information for Consumers

State health insurance exchanges are required to make certain information about health care plans and services available to consumers. For example, each health exchange must:

- have a website and operate a toll-free consumer assistance telephone hotline;

- assign a rating to each plan offered on the exchange that takes into account the plan's costs and coverage level;
- present coverage options for health plans in a standardized format;
- establish a navigator program to help consumers evaluate insurance options, conduct public education activities, and refer persons with complaints or questions to assistance; and
- provide information to individuals about public programs, such as Medicaid, for which they may be eligible.

Key Implementation Questions

If the General Assembly wishes to take action to implement a health insurance exchange in Colorado, it would likely need to do so in the 2011 legislative session in order to meet the January 1, 2014, deadline for health exchanges to be operational. Key questions that the state must determine with regard to health insurance exchanges are whether to:

- operate an exchange or allow the federal government to set up the exchange within the state;
- operate separate exchanges for individuals and small businesses, or to combine these exchanges;
- operate a regional exchange with other states, or to operate multiple exchanges within geographically distinct regions of the state;
- permit large employers to purchase coverage through the exchanges in 2017; and
- establish a funding mechanism for the exchanges to replace federal funding that will end on January 1, 2015.



ESSENTIAL HEALTH BENEFITS FOR HEALTH INSURANCE PLANS

by Amanda King

A key addition to health insurance regulation under federal health care reform, also known as the Patient Protection and Affordable Care Act (PPACA), is the establishment of essential health benefits. Essential health benefits are a core set of health care services and coverage requirements that most fully insured health insurance plans in the individual and small group markets are required to include beginning in 2014. These essential health benefits apply to health insurance policies sold both in and out of the state-based health insurance exchanges created under PPACA.¹ Self-funded health plans, larger employer group plans, and certain other grandfathered plans are not required to offer essential health benefits.

This issue brief provides an overview of the essential health benefit categories and the process for selecting a benchmark plan for the essential health benefits. It discusses the benchmark plan selected by Colorado and how the costs associated with state-mandated health benefits are addressed under PPACA.

Essential Health Benefit Categories

States are required to select a benchmark plan that incorporates essential health benefits in ten categories, including:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management; and
- pediatric services, including oral and vision care.

Benchmark Plan Selection

While federal law defines the essential health benefit categories listed above, the federal Department of Health and Human Services (DHHS) delegated the responsibility of selecting a benchmark plan that incorporates these services to the states. The benchmark plan serves as a model for all health insurers in the state to offer

¹Health insurance exchanges are marketplaces where consumers can shop for and purchase health plans. Persons with incomes between 100 and 400 percent of the Federal Poverty Level may qualify for federal subsidies to assist in paying the costs of health insurance purchased through exchange.

plans that meet the coverage requirements under PPACA. States were, at a minimum, required to consider and select their benchmark plans from the following types of health plans:

- one of the three largest small employer group plans in the state by enrollment;
- one of the three largest health plans for state government employees by enrollment;
- one of the three largest health plan options for federal government employees by enrollment; or
- the largest health maintenance organization plan offered in the state's commercial market by enrollment.

In states that fail to select a benchmark plan, the small employer group plan with the largest enrollment in the state is established as the benchmark plan by default. The benefits covered by the benchmark plan will be in effect for 2014 and 2015. The federal DHHS is expected to promulgate rules updating the process for selecting the essential health benefits for 2016.

Colorado's Selected Benchmark Plan

In Colorado, the Division of Insurance in the Department of Regulatory Agencies, the Colorado Health Benefit Exchange, and the Office of the Governor worked together to select the benchmark plan for the essential benefits required in Colorado. On August 31, 2012, these entities recommended that the state's largest small employer group plan, a Kaiser HMO plan, be selected as the benchmark. After a period for public comment, this recommendation was submitted to the federal DHHS as the state's official selection. The selected benchmark plan does not cover the essential health benefit of pediatric dental services, which must be added as a supplemental benefit to the benchmark plan. Colorado has selected the pediatric dental

coverage under the Child Health Plan Plus to be used as the benchmark for this service.

State-mandated Health Benefits

Generally under PPACA, states must defray the additional costs for any state mandated health benefits in excess of the minimum essential health benefits that the federal government incurs when subsidizing health insurance premiums through state health insurance exchanges. However, for the two-year transition period in 2014 and 2015, if a state selects a state-regulated plan that includes state mandates for plans in both the individual and small group markets (as Colorado did with the Kaiser HMO plan), then the state does not have to pay for the cost associated with these state mandated benefits. As mentioned above, the federal DHHS will review its rules for the selection of essential health benefit benchmark plans for 2016, which could change how the costs of state mandated benefits are paid.

ARTICLE 22

COLORADO HEALTH BENEFIT EXCHANGE

Cross references: For the legislative declaration stating the purpose of and the provision directing legislative staff agencies to conduct a post-enactment review pursuant to § 2-2-1201 scheduled in 2016, see sections 1 and 2 of chapter 246, Session Laws of Colorado 2011. To obtain a copy of the review, once completed, view Colorado Legislative Council's web site.

Section

10-22-101. Short title.

10-22-102. Legislative declaration - intent.

10-22-103. Definitions.

10-22-104. Health benefit exchange - creation.

10-22-105. Exchange board of directors.

10-22-106. Powers and duties of the board.

10-22-107. Legislative health benefit exchange implementation review committee - creation - duties.

10-22-108. Moneys for implementation, operation, and sustainability of the exchange.

10-22-109. Funding for the operation of the exchange and reserves - special fees - rules.

10-22-110. Tax credit for contributions to the exchange - allocation notice - rules.

10-22-111. Tax exemption.

10-22-101. Short title.

This article is known and may be cited as the "Colorado Health Benefit Exchange Act".

Source: L. 2011: Entire article added, (SB 11-200), ch. 246, p. 1073, § 1, effective June 1.

10-22-102. Legislative declaration - intent.

The general assembly determines and declares that with the March 23, 2010, enactment of the federal "Patient Protection and Affordable Care Act", Pub.L. 111-148, and the March 30, 2010, enactment of the "Health Care and Education Reconciliation Act of 2010", Pub.L. 111-152, which allow each state to establish a health benefit exchange through state law or opt to participate in a national health benefit exchange operated by the federal department of health and human services, and although there are numerous federal lawsuits challenging the constitutionality of the federal act in multiple federal courts, the best option for the state of Colorado is to establish a health benefit exchange at the state level. The general assembly further finds that the federal act requires each state to establish a health benefit exchange to perform certain duties and to assume certain responsibilities set forth in the federal act or make sufficient progress in the creation of a health benefit exchange by January 1, 2013, or default to a federally

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run national health benefit exchange. Therefore, the general assembly intends to create a health benefit exchange to fit the unique needs of Colorado, seek Colorado-specific solutions, and explore the maximum number of options available to the state of Colorado. The Colorado health benefit exchange, including an American health benefit exchange, is intended to facilitate the access to and enrollment in health plans in the individual market in this state and include a small business health options program to assist small employers in this state in facilitating the enrollment of their employees in health plans offered in the small employer market. The intent of the Colorado health benefit exchange is to increase access, affordability, and choice for individuals and small employers purchasing health insurance in Colorado.

Source: L. 2011: Entire article added, (SB 11-200), ch. 246, p. 1073, § 1, effective June 1.

10-22-103. Definitions.

As used in this article, unless the context otherwise requires:

(1) "Board" means the board of directors of the exchange, appointed in accordance with section 10-22-105.

(2) "Committee" means the legislative health benefit exchange implementation review committee created in section 10-22-107.

(3) "Exchange" means the Colorado health benefit exchange created in this article.

(4) "Federal act" means the "Patient Protection and Affordable Care Act", Pub.L. 111-148, as amended by the "Health Care and Education Reconciliation Act of 2010", Pub.L. 111-152.

(5) "Group health plan" means an employee welfare benefit plan as defined in 29 U.S.C. sec. 1002 (1) of the federal "Employee Retirement Income Security Act of 1974" to the extent that the plan provides health care services, including items and services paid for as health care services, to employees or their dependents directly or through insurance reimbursement or otherwise. A "group health plan" includes a government or church plan.

(6) "Health benefit plan" has the same meaning set forth in section 10-16-102; except that the term includes a dental plan.

(7) "Insurer" means any entity that provides group health plans or individual health benefit plans subject to insurance regulation in this state, as well as any entity that directly or indirectly provides stop-loss or excess loss insurance to a self-insured group health plan including a property and casualty insurance company.

(8) "Medicaid" means federal insurance or assistance as provided by Title XIX of the federal "Social Security Act", as amended.

(9) "Medicare" means federal insurance or assistance as provided by Title XVIII of the

federal "Social Security Act", as amended.

(10) "Number of lives insured" means the number of employees and retired employees and individual policyholders or subscribers in the individual and group markets on March 1 of the previous calendar year for which a special fee is being assessed. For insurers providing stop-loss, excess loss, or reinsurance, "number of lives insured" does not include employees, retired employees, or individual policyholders or subscribers who have been counted by the primary insurer or primary reinsurer.

(11) "Secretary" means the secretary of the United States department of health and human services.

Source: L. 2011: Entire article added, (SB 11-200), ch. 246, p. 1074, § 1, effective June 1. **L. 2013:** (5) amended and (6) to (11) added, (HB 13-1245), ch. 258, p. 1359, § 1, effective May 23.

10-22-104. Health benefit exchange - creation.

There is hereby created a nonprofit unincorporated public entity known as the health benefit exchange. The board of directors shall govern the operation of the exchange. The board shall determine and establish the development, governance, and operation of the exchange. The exchange is an instrumentality of the state; except that the debts and liabilities of the exchange do not constitute the debts and liabilities of the state, and neither the exchange nor the board is an agency of the state. The board does not have the authority to promulgate rules pursuant to the "State Administrative Procedure Act", article 4 of title 24, C.R.S. The exchange shall not duplicate or replace the duties of the commissioner established in section 10-1-108, including rate approval, except as directed by the federal act. The exchange shall foster a competitive marketplace for insurance and shall not solicit bids or engage in the active purchasing of insurance. All carriers authorized to conduct business in this state may be eligible to participate in the exchange.

Source: L. 2011: Entire article added, (SB 11-200), ch. 246, p. 1074, § 1, effective June 1.

10-22-105. Exchange board of directors.

(1) (a) There is hereby created the board of directors of the exchange. The board consists of twelve members, of whom nine are voting members and three are nonvoting, ex officio members. On or before July 1, 2011, the governor shall appoint five voting members to the board, and the president of the senate, the minority leader of the senate, the speaker of the house of representatives, and the minority leader of the house of representatives shall each appoint one voting member to the board. The governor shall not appoint more than three members from the same political party. The board shall elect one of its members as chair of the board. Members of the board may be removed by their respective appointing authorities for cause. The person

making the original appointment or reappointment, or whoever is entitled to make the appointment on the date of a vacancy, shall fill the vacancy by appointment for the remainder of an unexpired term. Members may serve a maximum of two consecutive terms. If a member is appointed to fill a vacancy and serves for more than half of the unexpired term, the member shall be eligible for appointment to only one more consecutive term.

(b) The persons making the appointments shall coordinate appointments to ensure that there is broad representation within the skill sets specified in this paragraph (b) and shall consider the geographic, economic, ethnic, and other characteristics of the state when making the appointments. A majority of the voting members must be business representatives or individuals who are not directly affiliated with the insurance industry, and none shall be state employees. Of the members first appointed, in order to ensure staggered terms, four of the governor's appointees shall serve for a term of two years and the remaining governor's appointee and other initial appointees shall serve for a term of four years. Thereafter, the terms of the members shall be for four years. Each person appointed to the board should have demonstrated expertise in at least two, and in any case shall have demonstrated expertise in no less than one, of the following areas:

- (I) Individual health insurance coverage;
- (II) Small employer health insurance;
- (III) Health benefits administration;
- (IV) Health care finance;
- (V) Administration of a public or private health care delivery system;
- (VI) The provision of health care services;
- (VII) The purchase of health insurance coverage;
- (VIII) Health care consumer navigation or assistance;
- (IX) Health care economics or health care actuarial sciences;
- (X) Information technology; or
- (XI) Starting a small business with fifty or fewer employees.

(c) The executive director of the department of health care policy and financing, or his or her designee; the commissioner of insurance, or his or her designee; and the director of the office of economic development and international trade, or his or her designee, shall serve as nonvoting, ex officio members of the board.

(2) Each member of the board is responsible for meeting the requirements of this article and all applicable state and federal laws, rules, and regulations; serving in the public interest of the

individuals and small businesses seeking health care coverage through the exchange; and ensuring the operational well-being and fiscal solvency of the exchange.

(3) (a) Board members shall not receive compensation for performance of services for the board but may receive a per diem and reimbursement for travel and other necessary expenses while engaged in the performance of official duties of the board. Per diem and reimbursement expenses are paid through grant moneys received by the board.

(b) A member of the board shall not perform an official act that may have a direct economic benefit on a business or other undertaking in which the member has a direct or substantial financial interest.

(c) A board member or an officer or employee of the exchange is not liable for an act or omission when acting in his or her official capacity, in good faith, without intent to defraud, and in connection with the administration, management, or conduct of this article.

(4) (a) Board members are subject to articles 6, 18, and 72 of title 24, C.R.S.

(b) All moneys received by the board for the exchange are subject to audit by the legislative audit committee. The board shall report all moneys received for the exchange to the legislative audit committee.

(5) Any information provided to a board member pursuant to this article that is exempt from disclosure under either section 24-72-204, C.R.S., or part 4 of article 6 of title 24, C.R.S., shall be and remain confidential and may be used only by the board.

Source: L. 2011: Entire article added, (SB 11-200), ch. 246, p. 1075, § 1, effective June 1.

10-22-106. Powers and duties of the board.

(1) The board is the governing body of the exchange and has all the powers and duties necessary to implement this article. The board shall:

(a) Appoint an executive director to administer the exchange, subject to approval by the committee;

(b) Create an initial operational and financial plan, subject to approval by the committee;

(c) Apply for planning and establishment grants made available to the exchange pursuant to the federal act and apply for, receive, and expend other gifts, grants, and donations. Each grant application is subject to the review and unanimous approval of the board chair and the chair and vice-chair of the committee prior to the submission of the application. If there is not unanimous approval, each grant application is subject to review and the majority approval of the committee.

(d) Create technical and advisory groups as needed to report to the board. The advisory

groups shall meet regularly throughout the year to discuss issues related to the exchange and make recommendations to the board.

(e) Provide a written report, on or before January 15 of each year, to the governor and the general assembly concerning the planning and establishment of the exchange and present the report to the senate health and human services committee and the house of representatives health and environment committee, or their successor committees;

(f) Review the internet portal operated and maintained by the secretary and the model template for an internet portal made available by the secretary for use by the state exchanges and review other appropriate internet portals. The review must include an examination as to whether the model template may be used to direct individuals and employers to health plans, to assist individuals and employers in determining whether they are eligible to participate in the exchange or eligible for a premium tax credit or cost-sharing reduction, and to present standardized information regarding health plans offered through the exchange to assist consumers in making health insurance choices.

(g) Consider the desirability of structuring the exchange as one entity that includes two underlying entities to operate in the individual and the small employer markets, respectively;

(h) Consider the appropriate size of the small employer market under the exchange, taking into consideration the definition of "small employer" pursuant to section 10-16-102;

(i) Consider the unique needs of rural Coloradans as they pertain to access, affordability, and choice in purchasing health insurance;

(j) Consider the affordability and cost in the context of quality care and increased access to purchasing health insurance; and

(k) Investigate requirements, develop options, and determine waivers, if appropriate, to ensure that the best interests of Coloradans are protected.

(2) The board may enter into information-sharing agreements with federal and state agencies and other state exchanges to carry out its responsibilities under this article so long as the agreements include adequate protections with respect to the confidentiality of the information that is shared and comply with all state and federal laws, rules, and regulations.

(3) The board may create a separate program that shares resources and infrastructure with the exchange to offer ancillary products.

(4) The board may enter into an agreement with the department of personnel to authorize administrative law judges employed by the office of administrative courts to hear and decide matters arising from eligibility and other determinations made by the exchange consistent with applicable state and federal law.

Source: L. 2011: Entire article added, (SB 11-200), ch. 246, p. 1076, § 1, effective June 1. **L.**
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2013: (3) and (4) added, (HB 13-1245), ch. 258, p. 1360, § 2, effective May 23. **L. 2014:** (4) amended, (HB 14-1363), ch. 302, p. 1262, § 5, effective May 31.

10-22-107. Legislative health benefit exchange implementation review committee - creation - duties.

(1) For the purposes of guiding implementation of an exchange in Colorado, making recommendations to the general assembly, and ensuring that the interests of Coloradans are protected and furthered, there is hereby created the legislative health benefit exchange implementation review committee. The committee shall meet on or before August 1, 2011, and thereafter at the call of the chair at least two times during each calendar year, but no more than five times during each calendar year. The committee may use the legislative council staff to assist its members in researching any matters.

(2) (a) The president of the senate shall appoint three members to the committee. Two appointees shall be members of the senate health and human services committee, the business, labor, and technology committee, or the legislative audit committee, or their successor committees. One appointee shall be a representative of the senate at large.

(b) The speaker of the house of representatives shall appoint three members to the committee. Two appointees shall be members of the house health and environment committee, the economic and business development committee, or the legislative audit committee, or their successor committees. One appointee shall be a representative of the house of representatives at large.

(c) The minority leader of the senate shall appoint two members to the committee. One appointee shall be a member of the senate health and human services committee, the business, labor, and technology committee, or the legislative audit committee, or their successor committees. One appointee shall be a representative of the senate at large.

(d) The minority leader of the house of representatives shall appoint two members to the committee. One appointee shall be a member of the house health and environment committee, the economic and business development committee, or the legislative audit committee, or their successor committees. One appointee shall be a representative of the house of representatives at large.

(e) Members of the committee shall serve at the pleasure of the appointing authority.

(3) Members of the committee shall serve without compensation; except that each member shall receive the sums specified in section 2-2-307 (3) (a) and (3) (b), C.R.S., for attendance at meetings of the committee when the general assembly is in recess for more than three days or is not in session.

(4) During odd-numbered years, the president of the senate shall appoint the chair and the

speaker of the house of representatives shall appoint the vice-chair of the committee. During even-numbered years, the speaker of the house of representatives shall appoint the chair and the president of the senate shall appoint the vice-chair of the committee.

(5) In any year, the committee may report up to five bills or other measures to the legislative council created in section 2-3-301, C.R.S. These bills are exempt from any applicable bill limit imposed on the individual committee members sponsoring such bills if the bills have been approved by the legislative council under joint rules of the senate and house of representatives.

(6) The committee shall review grants applied for by the board to implement the exchange.

(7) The board shall send the committee an annual report that contains the financial and operational plans of the exchange. The committee shall review the financial and operational plans of the exchange.

Source: L. 2011: Entire article added, (SB 11-200), ch. 246, p. 1078, § 1, effective June 1. **L. 2013:** (1) and (7) amended, (HB 13-1245), ch. 258, p. 1360, § 3, effective May 23.

10-22-108. Moneys for implementation, operation, and sustainability of the exchange.

Moneys received by the board for the implementation of this article, and for building reserves for the operation and sustainability of the exchange pursuant to section 10-22-109, must be transferred directly to the exchange for the purposes of this article. The board shall deposit any moneys received in a banking institution within or outside the state. Moneys from the general fund shall not be used for the implementation of this article, except for the sums specified in section 10-22-107 (3) and for legislative staff agency services. The account of the banking institution must be insured by the federal deposit insurance corporation and compliant with the "Public Deposit Protection Act", article 10.5 of title 11, C.R.S.

Source: L. 2011: Entire article added, (SB 11-200), ch. 246, p. 1079, § 1, effective June 1. **L. 2013:** Entire section amended, (HB 13-1245), ch. 258, p. 1360, § 4, effective May 23.

10-22-109. Funding for the operation of the exchange and reserves - special fees - rules.

(1) On and after January 1, 2014, among other funding sources derived through the operation of the exchange, funding for the exchange may be from the following sources:

(a) Special fees assessed against insurers as provided in subsection (2) of this section;

(b) Any moneys accepted through gifts, grants, or donations received by the board for operation, reserves, and sustainability of the exchange, including contributions received pursuant to the premium tax credit allocation in section 10-22-110; and

(c) Moneys from the unclaimed property trust fund transmitted pursuant to section

38-13-116.5 (2.9), C.R.S.

(2) (a) On and after January 1, 2014, through December 31, 2016, the board shall assess special fees against insurers in an amount necessary to provide funding for the exchange. The board shall determine the amount of the special fees based on the board-approved financial plan and anticipated budgetary needs for the upcoming year to comply with this article and associated federal requirements. The special fees must not exceed one dollar and eighty cents per number of lives insured per month; except that the special fees assessed for lives insured under dental plans must not exceed eighteen cents per number of lives insured per month. The board shall use special fees assessed pursuant to this section for the operating expenses of the exchange, the reserves of the exchange, and related agreements.

(b) The board shall use any money received pursuant to section 10-8-536 (2), as enacted in House Bill 13-1115, enacted in 2013, from the reserves of CoverColorado, as created by part 5 of article 8 of this title, and any moneys received from the unclaimed property trust fund to offset the amount of the fees assessed against insurers pursuant to this subsection (2); except that the money received must not be used to offset the special fees paid by dental plans.

(c) Amounts assessed against insurers to be paid to the exchange pursuant to this subsection (2) are not considered premiums for any purpose, including the computation of gross premium tax or agents' commission.

(d) If an insurer fails to pay the special assessment fee, the commissioner may, after proper notice and hearing, suspend or revoke the insurer's certificate of authority to transact insurance business in this state.

(3) The commissioner shall promulgate rules to implement this section that include:

(a) The reasonable time periods for the billing and collection of the special fees; and

(b) The process for determining the allocation of the assessment among insurers, including the process for obtaining accurate information about the number of policies issued and lives insured by an insurer within the six months prior to the assessment.

Source: L. 2013: Entire section added, (HB 13-1245), ch. 258, p. 1361, § 5, effective May 23.

10-22-110. Tax credit for contributions to the exchange - allocation notice - rules.

(1) (a) For the tax year 2013 and each tax year thereafter, a credit against the tax imposed by sections 10-3-209 and 10-6-128 is allowed to any insurance company that becomes a qualified taxpayer by making a contribution to the exchange pursuant to this section.

(b) A qualified taxpayer claiming a credit against premium tax liability under this section is not required to pay any additional retaliatory tax as a result of claiming the credit.

(2) The commissioner may promulgate rules necessary for the administration of the tax credit allowed by subsection (1) of this section in accordance with article 4 of title 24, C.R.S.

(3) (a) Subject to paragraph (c) of subsection (4) of this section, an insurance company shall become a qualified taxpayer if all of the following conditions are met:

(I) The insurance company declares with its quarterly tax payment due on or about July 31 in the manner prescribed by the commissioner its intent to contribute to the exchange on or before October 31 an amount of money equal to the premium taxes paid by the company pursuant to the July 31 tax payment or a lesser amount as specified by the commissioner if required pursuant to paragraph (b) of subsection (4) of this section;

(II) The total amount of the tax credits granted by the commissioner does not exceed five million dollars; and

(III) The insurance company receives an allocation notice from the commissioner and the insurance company makes the contribution to the exchange as specified in the allocation notice on or before October 31.

(b) Subject to paragraph (c) of subsection (4) of this section, an insurance company that becomes a qualified taxpayer may claim the tax credit on one or more subsequent quarterly or annual tax payments beginning on or about October 31.

(c) The board shall promptly notify the commissioner when it receives a contribution pursuant to this section of the amount and date of the contribution and the name of the contributor.

(4) (a) Subject to paragraph (c) of this subsection (4), by September 30 of each year, the commissioner shall:

(I) Send an allocation notice to each insurance company whose declaration of intent to contribute to the exchange has been accepted pursuant to this subsection (4). The allocation notice shall specify the amount of tax credits allocated to the insurance company and the amount of cash the insurance company must contribute to the exchange by October 31, which amounts shall be identical and not exceed the amount of premium taxes paid by the insurance company in its quarterly tax payment due on or about July 31.

(II) Post on the division's web site whether the full amount of tax credits authorized to be allocated each year has been allocated.

(b) Subject to paragraph (c) of this subsection (4), the commissioner shall allocate no more than a total of five million dollars of premium tax credits per year. The commissioner shall allocate to an insurance company that has declared its intent to contribute to the exchange pursuant to this section tax credits in an amount equal to the amount of premium taxes paid by the insurance company in its quarterly tax payment due on or about July 31 in the order in which

the division receives such quarterly tax payments until the full amount of credits available pursuant to this section has been allocated; except that, if such amount of taxes or the sum of all the taxes filed by all the insurance companies on any one day would exceed, singly or in the aggregate, the annual maximum aggregate amount of tax credits available under this section, the commissioner shall reduce the allocation to the insurance company whose contribution first exceeds the annual maximum aggregate to the amount needed to satisfy the annual maximum aggregate. If the commissioner is unable to determine the order of receipt of tax payments on that day, the commissioner shall allocate the tax credits to the company or among the companies on a pro rata basis based on the ratio such company's quarterly tax payment bears to the total amount of all such companies' quarterly tax payments until the full amount of credits available pursuant to this section has been allocated.

(c) (I) The commissioner shall allow insurance companies to declare their intent to contribute to the exchange pursuant to this section on the insurance companies' quarterly tax payments due on or about October 31 and shall send such companies allocation notices by February 1 if:

(A) The full amount of tax credits available in any one year have not been fully allocated by the commissioner pursuant to statements of intent filed with insurance companies' quarterly tax payments due on or about July 31; or

(B) The total amount of tax credits has been claimed, but one or more insurance companies failed to timely make a contribution to the exchange.

(II) An insurance company that declares its intent to contribute to the exchange pursuant to this paragraph (c) shall make the contribution to the exchange as specified in the allocation notice on or before March 1 and may claim the tax credit on one or more subsequent quarterly or annual tax payments due on or about March 1.

(5) The board shall use moneys contributed to the exchange pursuant to this section and interest derived from the deposit and investment of the moneys to operate and sustain the exchange and to build reserves.

Source: L. 2013: Entire section added, (HB 13-1245), ch. 258, p. 1362, § 5, effective May 23.

10-22-111. Tax exemption.

The exchange is exempt from any tax levied by this state or any of its political subdivisions.

Source: L. 2013: Entire section added, (HB 13-1245), ch. 258, p. 1364, § 5, effective May 23.

NOTE: The governor signed this measure on 5/23/2013.

An Act

HOUSE BILL 13-1245

BY REPRESENTATIVE(S) McCann, Court, Fields, Fischer, Ginal, Hamner, Hullinghorst, Labuda, Lebsock, Melton, Mitsch Bush, Pabon, Pettersen, Rosenthal, Young, Exum, Kraft-Tharp, Lee, Schafer, Stephens; also SENATOR(S) Steadman, Aguilar, Giron, Guzman, Heath, Jones, Kefalas, Newell, Nicholson, Tochtrop, Todd, Morse.

CONCERNING FUNDING MECHANISMS FOR THE COLORADO HEALTH BENEFIT EXCHANGE.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, 10-22-103, **amend** (5) and **add** (6), (7), (8), (9), (10), and (11) as follows:

10-22-103. Definitions. As used in this article, unless the context otherwise requires:

(5) "~~Secretary~~" means ~~the secretary of the United States department of health and human services~~ "GROUP HEALTH PLAN" MEANS AN EMPLOYEE WELFARE BENEFIT PLAN AS DEFINED IN 29 U.S.C. SEC. 1002 (1) OF THE FEDERAL "EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974" TO THE EXTENT THAT THE PLAN PROVIDES HEALTH CARE SERVICES, INCLUDING ITEMS AND SERVICES PAID FOR AS HEALTH CARE SERVICES, TO EMPLOYEES

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

OR THEIR DEPENDENTS DIRECTLY OR THROUGH INSURANCE REIMBURSEMENT OR OTHERWISE. A "GROUP HEALTH PLAN" INCLUDES A GOVERNMENT OR CHURCH PLAN.

(6) "HEALTH BENEFIT PLAN" HAS THE SAME MEANING SET FORTH IN SECTION 10-16-102; EXCEPT THAT THE TERM INCLUDES A DENTAL PLAN.

(7) "INSURER" MEANS ANY ENTITY THAT PROVIDES GROUP HEALTH PLANS OR INDIVIDUAL HEALTH BENEFIT PLANS SUBJECT TO INSURANCE REGULATION IN THIS STATE, AS WELL AS ANY ENTITY THAT DIRECTLY OR INDIRECTLY PROVIDES STOP-LOSS OR EXCESS LOSS INSURANCE TO A SELF-INSURED GROUP HEALTH PLAN INCLUDING A PROPERTY AND CASUALTY INSURANCE COMPANY.

(8) "MEDICAID" MEANS FEDERAL INSURANCE OR ASSISTANCE AS PROVIDED BY TITLE XIX OF THE FEDERAL "SOCIAL SECURITY ACT", AS AMENDED.

(9) "MEDICARE" MEANS FEDERAL INSURANCE OR ASSISTANCE AS PROVIDED BY TITLE XVIII OF THE FEDERAL "SOCIAL SECURITY ACT", AS AMENDED.

(10) "NUMBER OF LIVES INSURED" MEANS THE NUMBER OF EMPLOYEES AND RETIRED EMPLOYEES AND INDIVIDUAL POLICYHOLDERS OR SUBSCRIBERS IN THE INDIVIDUAL AND GROUP MARKETS ON MARCH 1 OF THE PREVIOUS CALENDAR YEAR FOR WHICH A SPECIAL FEE IS BEING ASSESSED. FOR INSURERS PROVIDING STOP-LOSS, EXCESS LOSS, OR REINSURANCE, "NUMBER OF LIVES INSURED" DOES NOT INCLUDE EMPLOYEES, RETIRED EMPLOYEES, OR INDIVIDUAL POLICYHOLDERS OR SUBSCRIBERS WHO HAVE BEEN COUNTED BY THE PRIMARY INSURER OR PRIMARY REINSURER.

(11) "SECRETARY" MEANS THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

SECTION 2. In Colorado Revised Statutes, 10-22-106, **add** (3) and (4) as follows:

10-22-106. Powers and duties of the board. (3) THE BOARD MAY CREATE A SEPARATE PROGRAM THAT SHARES RESOURCES AND INFRASTRUCTURE WITH THE EXCHANGE TO OFFER ANCILLARY PRODUCTS.

(4) THE BOARD MAY ENTER INTO AN AGREEMENT WITH THE DEPARTMENT OF PERSONNEL AND ADMINISTRATION TO AUTHORIZE ADMINISTRATIVE LAW JUDGES EMPLOYED BY THE OFFICE OF ADMINISTRATIVE COURTS TO HEAR AND DECIDE MATTERS ARISING FROM ELIGIBILITY AND OTHER DETERMINATIONS MADE BY THE EXCHANGE CONSISTENT WITH APPLICABLE STATE AND FEDERAL LAW.

SECTION 3. In Colorado Revised Statutes, 10-22-107, **amend** (1) and (7) as follows:

10-22-107. Legislative health benefit exchange implementation review committee - creation - duties. (1) For the purposes of guiding implementation of an exchange in Colorado, making recommendations to the general assembly, and ensuring that the interests of Coloradans are protected and furthered, there is hereby created the legislative health benefit exchange implementation review committee. The committee shall meet on or before August 1, 2011, and thereafter at the call of the chair ~~as often as~~ AT LEAST TWO TIMES DURING EACH CALENDAR YEAR, BUT NO MORE THAN five times during each calendar year. The committee may use the legislative council staff to assist its members in researching any matters.

(7) THE BOARD SHALL SEND THE COMMITTEE AN ANNUAL REPORT THAT CONTAINS THE FINANCIAL AND OPERATIONAL PLANS OF THE EXCHANGE. The committee shall review the financial and operational plans of the exchange.

SECTION 4. In Colorado Revised Statutes, **amend** 10-22-108 as follows:

10-22-108. Moneys for implementation, operation, and sustainability of the exchange. Moneys received by the board for the implementation of this article, AND FOR BUILDING RESERVES FOR THE OPERATION AND SUSTAINABILITY OF THE EXCHANGE PURSUANT TO SECTION 10-22-109, must be transferred directly to the exchange for the purposes of this article. The board shall deposit any moneys received in a banking institution within or outside the state. Moneys from the general fund shall not be used for the implementation of this article, except for the sums specified in section 10-22-107 (3) and for legislative staff agency services. The ACCOUNT OF THE banking institution must be insured by the federal deposit insurance corporation and compliant with the "~~Savings and Loan~~

Association "Public Deposit Protection Act", article 47 10.5 of title 11, C.R.S.

SECTION 5. In Colorado Revised Statutes, **add** 10-22-109, 10-22-110, and 10-22-111 as follows:

10-22-109. Funding for the operation of the exchange and reserves - special fees - rules. (1) ON AND AFTER JANUARY 1, 2014, AMONG OTHER FUNDING SOURCES DERIVED THROUGH THE OPERATION OF THE EXCHANGE, FUNDING FOR THE EXCHANGE MAY BE FROM THE FOLLOWING SOURCES:

(a) SPECIAL FEES ASSESSED AGAINST INSURERS AS PROVIDED IN SUBSECTION (2) OF THIS SECTION;

(b) ANY MONEYS ACCEPTED THROUGH GIFTS, GRANTS, OR DONATIONS RECEIVED BY THE BOARD FOR OPERATION, RESERVES, AND SUSTAINABILITY OF THE EXCHANGE, INCLUDING CONTRIBUTIONS RECEIVED PURSUANT TO THE PREMIUM TAX CREDIT ALLOCATION IN SECTION 10-22-110; AND

(c) MONEYS FROM THE UNCLAIMED PROPERTY TRUST FUND TRANSMITTED PURSUANT TO SECTION 38-13-116.5 (2.9), C.R.S.

(2) (a) ON AND AFTER JANUARY 1, 2014, THROUGH DECEMBER 31, 2016, THE BOARD SHALL ASSESS SPECIAL FEES AGAINST INSURERS IN AN AMOUNT NECESSARY TO PROVIDE FUNDING FOR THE EXCHANGE. THE BOARD SHALL DETERMINE THE AMOUNT OF THE SPECIAL FEES BASED ON THE BOARD-APPROVED FINANCIAL PLAN AND ANTICIPATED BUDGETARY NEEDS FOR THE UPCOMING YEAR TO COMPLY WITH THIS ARTICLE AND ASSOCIATED FEDERAL REQUIREMENTS. THE SPECIAL FEES MUST NOT EXCEED ONE DOLLAR AND EIGHTY CENTS PER NUMBER OF LIVES INSURED PER MONTH; EXCEPT THAT THE SPECIAL FEES ASSESSED FOR LIVES INSURED UNDER DENTAL PLANS MUST NOT EXCEED EIGHTEEN CENTS PER NUMBER OF LIVES INSURED PER MONTH. THE BOARD SHALL USE SPECIAL FEES ASSESSED PURSUANT TO THIS SECTION FOR THE OPERATING EXPENSES OF THE EXCHANGE, THE RESERVES OF THE EXCHANGE, AND RELATED AGREEMENTS.

(b) THE BOARD SHALL USE ANY MONEY RECEIVED PURSUANT TO SECTION 10-8-536 (2), AS ENACTED IN HOUSE BILL 13-1115, ENACTED IN

2013, FROM THE RESERVES OF COVERCOLORADO, AS CREATED BY PART 5 OF ARTICLE 8 OF TITLE 10, AND ANY MONEYS RECEIVED FROM THE UNCLAIMED PROPERTY TRUST FUND TO OFFSET THE AMOUNT OF THE FEES ASSESSED AGAINST INSURERS PURSUANT TO THIS SUBSECTION (2); EXCEPT THAT THE MONEY RECEIVED MUST NOT BE USED TO OFFSET THE SPECIAL FEES PAID BY DENTAL PLANS.

(c) AMOUNTS ASSESSED AGAINST INSURERS TO BE PAID TO THE EXCHANGE PURSUANT TO THIS SUBSECTION (2) ARE NOT CONSIDERED PREMIUMS FOR ANY PURPOSE, INCLUDING THE COMPUTATION OF GROSS PREMIUM TAX OR AGENTS' COMMISSION.

(d) IF AN INSURER FAILS TO PAY THE SPECIAL ASSESSMENT FEE, THE COMMISSIONER MAY, AFTER PROPER NOTICE AND HEARING, SUSPEND OR REVOKE THE INSURER'S CERTIFICATE OF AUTHORITY TO TRANSACT INSURANCE BUSINESS IN THIS STATE.

(3) THE COMMISSIONER SHALL PROMULGATE RULES TO IMPLEMENT THIS SECTION THAT INCLUDE:

(a) THE REASONABLE TIME PERIODS FOR THE BILLING AND COLLECTION OF THE SPECIAL FEES; AND

(b) THE PROCESS FOR DETERMINING THE ALLOCATION OF THE ASSESSMENT AMONG INSURERS, INCLUDING THE PROCESS FOR OBTAINING ACCURATE INFORMATION ABOUT THE NUMBER OF POLICIES ISSUED AND LIVES INSURED BY AN INSURER WITHIN THE SIX MONTHS PRIOR TO THE ASSESSMENT.

10-22-110. Tax credit for contributions to the exchange - allocation notice - rules. (1) (a) FOR THE TAX YEAR 2013 AND EACH TAX YEAR THEREAFTER, A CREDIT AGAINST THE TAX IMPOSED BY SECTIONS 10-3-209 AND 10-6-128 IS ALLOWED TO ANY INSURANCE COMPANY THAT BECOMES A QUALIFIED TAXPAYER BY MAKING A CONTRIBUTION TO THE EXCHANGE PURSUANT TO THIS SECTION.

(b) A QUALIFIED TAXPAYER CLAIMING A CREDIT AGAINST PREMIUM TAX LIABILITY UNDER THIS SECTION IS NOT REQUIRED TO PAY ANY ADDITIONAL RETALIATORY TAX AS A RESULT OF CLAIMING THE CREDIT.

(2) THE COMMISSIONER MAY PROMULGATE RULES NECESSARY FOR THE ADMINISTRATION OF THE TAX CREDIT ALLOWED BY SUBSECTION (1) OF THIS SECTION IN ACCORDANCE WITH ARTICLE 4 OF TITLE 24, C.R.S.

(3) (a) SUBJECT TO PARAGRAPH (c) OF SUBSECTION (4) OF THIS SECTION, AN INSURANCE COMPANY SHALL BECOME A QUALIFIED TAXPAYER IF ALL OF THE FOLLOWING CONDITIONS ARE MET:

(I) THE INSURANCE COMPANY DECLARES WITH ITS QUARTERLY TAX PAYMENT DUE ON OR ABOUT JULY 31 IN THE MANNER PRESCRIBED BY THE COMMISSIONER ITS INTENT TO CONTRIBUTE TO THE EXCHANGE ON OR BEFORE OCTOBER 31 AN AMOUNT OF MONEY EQUAL TO THE PREMIUM TAXES PAID BY THE COMPANY PURSUANT TO THE JULY 31 TAX PAYMENT OR A LESSER AMOUNT AS SPECIFIED BY THE COMMISSIONER IF REQUIRED PURSUANT TO PARAGRAPH (b) OF SUBSECTION (4) OF THIS SECTION;

(II) THE TOTAL AMOUNT OF THE TAX CREDITS GRANTED BY THE COMMISSIONER DOES NOT EXCEED FIVE MILLION DOLLARS; AND

(III) THE INSURANCE COMPANY RECEIVES AN ALLOCATION NOTICE FROM THE COMMISSIONER AND THE INSURANCE COMPANY MAKES THE CONTRIBUTION TO THE EXCHANGE AS SPECIFIED IN THE ALLOCATION NOTICE ON OR BEFORE OCTOBER 31.

(b) SUBJECT TO PARAGRAPH (c) OF SUBSECTION (4) OF THIS SECTION, AN INSURANCE COMPANY THAT BECOMES A QUALIFIED TAXPAYER MAY CLAIM THE TAX CREDIT ON ONE OR MORE SUBSEQUENT QUARTERLY OR ANNUAL TAX PAYMENTS BEGINNING ON OR ABOUT OCTOBER 31.

(c) THE BOARD SHALL PROMPTLY NOTIFY THE COMMISSIONER WHEN IT RECEIVES A CONTRIBUTION PURSUANT TO THIS SECTION OF THE AMOUNT AND DATE OF THE CONTRIBUTION AND THE NAME OF THE CONTRIBUTOR.

(4) (a) SUBJECT TO PARAGRAPH (c) OF THIS SUBSECTION (4), BY SEPTEMBER 30 OF EACH YEAR, THE COMMISSIONER SHALL:

(I) SEND AN ALLOCATION NOTICE TO EACH INSURANCE COMPANY WHOSE DECLARATION OF INTENT TO CONTRIBUTE TO THE EXCHANGE HAS BEEN ACCEPTED PURSUANT TO THIS SUBSECTION (4). THE ALLOCATION NOTICE SHALL SPECIFY THE AMOUNT OF TAX CREDITS ALLOCATED TO THE

INSURANCE COMPANY AND THE AMOUNT OF CASH THE INSURANCE COMPANY MUST CONTRIBUTE TO THE EXCHANGE BY OCTOBER 31, WHICH AMOUNTS SHALL BE IDENTICAL AND NOT EXCEED THE AMOUNT OF PREMIUM TAXES PAID BY THE INSURANCE COMPANY IN ITS QUARTERLY TAX PAYMENT DUE ON OR ABOUT JULY 31; AND

(II) POST ON THE DIVISION'S WEB SITE WHETHER THE FULL AMOUNT OF TAX CREDITS AUTHORIZED TO BE ALLOCATED EACH YEAR HAS BEEN ALLOCATED.

(b) SUBJECT TO PARAGRAPH (c) OF THIS SUBSECTION (4), THE COMMISSIONER SHALL ALLOCATE NO MORE THAN A TOTAL OF FIVE MILLION DOLLARS OF PREMIUM TAX CREDITS PER YEAR. THE COMMISSIONER SHALL ALLOCATE TO AN INSURANCE COMPANY THAT HAS DECLARED ITS INTENT TO CONTRIBUTE TO THE EXCHANGE PURSUANT TO THIS SECTION TAX CREDITS IN AN AMOUNT EQUAL TO THE AMOUNT OF PREMIUM TAXES PAID BY THE INSURANCE COMPANY IN ITS QUARTERLY TAX PAYMENT DUE ON OR ABOUT JULY 31 IN THE ORDER IN WHICH THE DIVISION RECEIVES SUCH QUARTERLY TAX PAYMENTS UNTIL THE FULL AMOUNT OF CREDITS AVAILABLE PURSUANT TO THIS SECTION HAS BEEN ALLOCATED; EXCEPT THAT, IF SUCH AMOUNT OF TAXES OR THE SUM OF ALL THE TAXES FILED BY ALL THE INSURANCE COMPANIES ON ANY ONE DAY WOULD EXCEED, SINGLY OR IN THE AGGREGATE, THE ANNUAL MAXIMUM AGGREGATE AMOUNT OF TAX CREDITS AVAILABLE UNDER THIS SECTION, THE COMMISSIONER SHALL REDUCE THE ALLOCATION TO THE INSURANCE COMPANY WHOSE CONTRIBUTION FIRST EXCEEDS THE ANNUAL MAXIMUM AGGREGATE TO THE AMOUNT NEEDED TO SATISFY THE ANNUAL MAXIMUM AGGREGATE. IF THE COMMISSIONER IS UNABLE TO DETERMINE THE ORDER OF RECEIPT OF TAX PAYMENTS ON THAT DAY, THE COMMISSIONER SHALL ALLOCATE THE TAX CREDITS TO THE COMPANY OR AMONG THE COMPANIES ON A PRO RATA BASIS BASED ON THE RATIO SUCH COMPANY'S QUARTERLY TAX PAYMENT BEARS TO THE TOTAL AMOUNT OF ALL SUCH COMPANIES' QUARTERLY TAX PAYMENTS UNTIL THE FULL AMOUNT OF CREDITS AVAILABLE PURSUANT TO THIS SECTION HAS BEEN ALLOCATED.

(c) (I) THE COMMISSIONER SHALL ALLOW INSURANCE COMPANIES TO DECLARE THEIR INTENT TO CONTRIBUTE TO THE EXCHANGE PURSUANT TO THIS SECTION ON THE INSURANCE COMPANIES' QUARTERLY TAX PAYMENTS DUE ON OR ABOUT OCTOBER 31 AND SHALL SEND SUCH COMPANIES ALLOCATION NOTICES BY FEBRUARY 1 IF:

(A) THE FULL AMOUNT OF TAX CREDITS AVAILABLE IN ANY ONE YEAR HAVE NOT BEEN FULLY ALLOCATED BY THE COMMISSIONER PURSUANT TO STATEMENTS OF INTENT FILED WITH INSURANCE COMPANIES' QUARTERLY TAX PAYMENTS DUE ON OR ABOUT JULY 31; OR

(B) THE TOTAL AMOUNT OF TAX CREDITS HAS BEEN CLAIMED, BUT ONE OR MORE INSURANCE COMPANIES FAILED TO TIMELY MAKE A CONTRIBUTION TO THE EXCHANGE.

(II) AN INSURANCE COMPANY THAT DECLARES ITS INTENT TO CONTRIBUTE TO THE EXCHANGE PURSUANT TO THIS PARAGRAPH (c) SHALL MAKE THE CONTRIBUTION TO THE EXCHANGE AS SPECIFIED IN THE ALLOCATION NOTICE ON OR BEFORE MARCH 1 AND MAY CLAIM THE TAX CREDIT ON ONE OR MORE SUBSEQUENT QUARTERLY OR ANNUAL TAX PAYMENTS DUE ON OR ABOUT MARCH 1.

(5) THE BOARD SHALL USE MONEYS CONTRIBUTED TO THE EXCHANGE PURSUANT TO THIS SECTION AND INTEREST DERIVED FROM THE DEPOSIT AND INVESTMENT OF THE MONEYS TO OPERATE AND SUSTAIN THE EXCHANGE AND TO BUILD RESERVES.

10-22-111. Tax exemption. THE EXCHANGE IS EXEMPT FROM ANY TAX LEVIED BY THIS STATE OR ANY OF ITS POLITICAL SUBDIVISIONS.

SECTION 6. In Colorado Revised Statutes, 38-13-116.5, **amend** (1) (b); and **add** (2.9) as follows:

38-13-116.5. Unclaimed property trust fund - creation - payments - interest - appropriations - records - rules - repeal. (1) (b) Except as provided in subsections (2), ~~and~~ (2.7), AND (2.9) of this section, the principal of the trust fund shall not be expended except to pay claims made pursuant to this article. Moneys comprising the principal of the trust fund shall not constitute fiscal year spending of the state for purposes of section 20 of article X of the state constitution and are not subject to appropriation by the general assembly.

(2.9) (a) ON JULY 1, 2013, THE STATE TREASURER SHALL TRANSMIT FIFTEEN MILLION DOLLARS TO THE COLORADO HEALTH BENEFIT EXCHANGE, CREATED IN ARTICLE 22 OF TITLE 10, C.R.S., FROM THE UNCLAIMED PROPERTY TRUST FUND.

(b) THIS SUBSECTION (2.9) IS REPEALED, EFFECTIVE JULY 1, 2014.

SECTION 7. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Mark Ferrandino
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

John P. Morse
PRESIDENT OF
THE SENATE

Marilyn Eddins
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

Cindi L. Markwell
SECRETARY OF
THE SENATE

APPROVED _____

John W. Hickenlooper
GOVERNOR OF THE STATE OF COLORADO

Colorado Legislative Council Staff Fiscal Note

**FINAL
FISCAL NOTE**

Drafting Number: LLS 13-0790
Prime Sponsor(s): Rep. McCann
 Sen. Steadman

Date: June 12, 2013
Bill Status: Signed into Law
Fiscal Analyst: Bill Zepernick (303-866-4777)

TITLE: CONCERNING FUNDING MECHANISMS FOR THE COLORADO HEALTH BENEFIT EXCHANGE.

Fiscal Impact Summary	FY 2013-2014	FY 2014-2015
State Revenue		
General Fund	(up to \$7.5 million)	(\$5.0 million)
Cash Funds		
Administrative Hearings Fund	Increase.	Increase.
State Transfers		
Transfer from the Unclaimed Property Trust Fund to the Colorado Health Benefit Exchange	\$15.0 million	
State Expenditures	See State Expenditures section.	
FTE Position Change		
Effective Date: The bill was signed into law by the Governor and took effect on May 23, 2013.		
Appropriation Summary for FY 2013-2014: None required.		
Statutory Public Entity Impact: See Statutory Public Entity Impact section below.		
Local Government Impact: None.		

Summary of Legislation

The bill creates 2 funding mechanisms to support the operations of the Colorado Health Benefit Exchange (health exchange), as discussed below.

Insurance assessment. The health exchange board of directors may assess a fee on health plans in the small group and individual markets, as well as on dental plans, during the period from January 1, 2014, through December 31, 2016. The fee is limited to \$1.80 per member for month for health insurance carriers and up to \$0.18 per member per month for dental plans. The Commissioner of Insurance is required to promulgate rules for the collection and assessment of the fee on carriers.

Premium tax credit. The bill creates a tax credit against the premium tax owed by insurance carriers for donations to the health exchange. The tax credit is capped at \$5.0 million per year statewide and may be claimed by a carrier against its quarterly premium tax payment beginning in the 2013 tax year. To claim the credit, a carrier must follow the rules promulgated by the Commissioner of Insurance and complete the specified process for becoming a qualified taxpayer.

Other provisions. In addition, the bill specifies that any funds received from the reserves of CoverColorado under House Bill 13-1115 or from a transfer from the Unclaimed Property Trust Fund must be used to reduce the assessment charged to health plans. The bill also clarifies that the board of the health exchange is required to submit its operational and financial plans to the Legislative Health Benefit Exchange Implementation Review Committee and that the committee is required to meet at least 2 times per year. Also, the exchange board is authorized to create a separate program to offer ancillary products that shares resources and infrastructure with the exchange. Lastly, the board is authorized to enter into an agreement with the Office of Administrative Courts in the Department of Personnel and Administration (DPA) to use administrative law judges (ALJs) to hear matters resulting from the exchange.

Background

The Colorado Health Benefit Exchange was created by Senate Bill 11-200 to act as a state-based health insurance exchange under the federal Patient Protection and Affordable Care Act (federal health care reform). The health exchange is a market place for consumers to shop for and purchase health insurance, and is scheduled to begin operation in October 2013, with policies sold taking effect on January 1, 2014. Persons purchasing health insurance through the exchange may qualify for federal subsidies if their income is between 133 and 400 percent of the federal poverty level and they meet certain other requirements. The exchange is currently supported by federal grants and under federal law is required to be self-sufficient in funding its operations by 2015.

CoverColorado offers health insurance to individuals with preexisting conditions who are unable to qualify for health insurance in the private market. Under federal health care reform, health insurers must provide coverage to all persons applying for coverage regardless of any preexisting condition. Thus, CoverColorado will no longer be required to provide insurance to high-risk persons and will be repealed if House Bill 13-1115 becomes law. The tax credits and fees on health insurance carriers established in this bill are similar to those for CoverColorado, which will be repealed under House Bill 13-1115.

State Revenue

The bill reduces General Fund revenue by up to \$7.5 million in FY 2013-14 and \$5.0 million per year beginning in FY 2014-15. Insurance carriers may claim a credit against their premium taxes, up to a statewide total of \$5.0 million per year. This analysis assumes that insurance carriers will claim the full \$5.0 million credit each year, as has been the case under a similar tax credit for donations to CoverColorado. In FY 2013-14, General Fund revenue may be reduced by up to \$7.5 million if insurance carriers are able to take the full \$5.0 million credit for tax year 2013 and \$2.5 million for half of tax year 2014. This will depend on the tax credit allocation decisions made by the Commissioner of Insurance.

Revenue to the Administrative Hearings Fund will increase if the exchange enters an agreement with the DPA to use ALJs in the Office of Administrative Courts to hear cases arising from the exchange. At this time, the number of cases referred from the exchange and potential revenue to the Administrative Hearings Fund are unknown.

State Transfers

The bill transfers \$15.0 million from the Unclaimed Property Trust Fund to the Colorado Health Benefit Exchange at the start of FY 2013-14. This is a one-time transfer of funds.

State Expenditures

Under the bill, the Division of Insurance in the Department of Regulatory Agencies may have a small increase in workload to promulgate rules pertaining to the tax credit and the fee assessment on insurance carriers. Any increase in workload can be accomplished within existing appropriations to the department.

The Office of Administrative Courts in the DPA will have increased costs to hear cases arising from the exchange. It is assumed that the costs of such hearings will be paid by the exchange as outlined in any future agreement between the DPA and the exchange. To the extent that exchange-related case increase the need for ALJs, this will be addressed through the annual budget process. These costs are paid from the Administrative Hearings Fund.

Statutory Public Entity Impact

Ongoing operating expenses for the health exchange are estimated to be \$26 million per year. In addition to revenue generated by this bill, the health exchange anticipates revenue from fees on policies sold through the exchange, grants from private foundations, and other business revenue such as advertising. **Revenue to the Colorado Health Benefit Exchange created by this bill is estimated to be \$22.6 million in FY 2013-14 and \$19.4 million in FY 2014-15.** Revenue to the exchange is discussed below and summarized in Table 1.

Health insurer assessment. This analysis assumes that the health exchange board will begin charging an assessment of \$1.00 per member per month on health insurance carriers beginning on January 1, 2015, after transfers from the reserves of CoverColorado and the Unclaimed Property Trust Fund are used to offset the potential assessment on these carriers. Applying a \$1.00 assessment per member per month on the estimated 890,000 insured lives in the small group and individual health insurance markets will generate about \$10.7 million per year to the health exchange. The assessment may be collected by the exchange through December 31, 2016.

Dental insurer assessment. Exact data on insured lives subject to the dental plan assessment are not available. Assuming a rough estimate of 100,000 insured lives at \$0.18 per member per month, the dental assessment will result in \$216,000 in revenue per year to the exchange.

Donations under the premium tax credit. Revenue from donations under the premium tax credit are expected to be \$5.0 million per year. In FY 2013-14, tax credits for maybe be higher (up to \$7.5 million), if the full amount of the \$5.0 million credit for tax year 2013 and half of the amount for tax year 2014 are allocated by the Commissioner of Insurance.

CoverColorado reserves. At this time, it is preliminarily estimated that between \$6.8 million and \$10.8 million will be transferred from the CoverColorado reserves to the exchange if HB 13-1115 becomes law. Assuming the mid-point of this range and a March 2015 transfer date, the transfer from CoverColorado to the exchange will be \$8.8 million in FY 2014-15.

Table 1. Revenue to the Colorado Health Benefit Exchange Under HB 13-1245		
Cost Components	FY 2013-14	FY 2014-15
Assessment on Health Insurance Carriers*	\$0	\$5,340,000
Assessment on Dental Insurance Carriers*	108,000	216,000
Transfer from Unclaimed Property Trust Fund	15,000,000	0
Transfer of Cover Colorado Reserves (HB 13-1115)	0	8,800,000
Donations under Premium Tax Credit	7,500,000	5,000,000
TOTAL	\$22,608,000	\$19,356,000

* Assessments on dental insurance carriers in FY 2013-14 and on health insurance carriers in FY 2014-15 reflect 6 months of revenue.

Departments Contacted

Regulatory Agencies
Revenue

Health Care Policy and Financing
Personnel and Administration

Law
Governor

NOTE: This bill has been prepared for the signature of the appropriate legislative officers and the Governor. To determine whether the Governor has signed the bill or taken other action on it, please consult the legislative status sheet, the legislative history, or the Session Laws.

An Act

SENATE BILL 11-200

BY SENATOR(S) Boyd, Aguilar, Bacon, Carroll, Foster, Giron, Guzman, Heath, Hodge, Hudak, Jahn, Morse, Newell, Nicholson, Schwartz, Shaffer B., Steadman, Tochtrop, Williams S.;
also REPRESENTATIVE(S) Stephens, Casso, Duran, Fields, Gardner D., Hamner, Jones, Kagan, Labuda, Levy, Massey, Miklosi, Pabon, Pace, Peniston, Riesberg, Schafer S., Summers, Todd, Tyler, Vigil, Wilson.

CONCERNING A COLORADO HEALTH BENEFIT EXCHANGE, AND, IN CONNECTION THEREWITH, CREATING A PROCESS FOR THE IMPLEMENTATION OF A HEALTH BENEFIT EXCHANGE IN COLORADO.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Title 10, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW ARTICLE to read:

ARTICLE 22 **Colorado Health Benefit Exchange**

10-22-101. Short title. THIS ARTICLE IS KNOWN AND MAY BE CITED AS THE "COLORADO HEALTH BENEFIT EXCHANGE ACT".

10-22-102. Legislative declaration - intent. THE GENERAL

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

ASSEMBLY DETERMINES AND DECLARES THAT WITH THE MARCH 23, 2010, ENACTMENT OF THE FEDERAL "PATIENT PROTECTION AND AFFORDABLE CARE ACT", PUB.L. 111-148, AND THE MARCH 30, 2010, ENACTMENT OF THE "HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010", PUB.L. 111-152, WHICH ALLOW EACH STATE TO ESTABLISH A HEALTH BENEFIT EXCHANGE THROUGH STATE LAW OR OPT TO PARTICIPATE IN A NATIONAL HEALTH BENEFIT EXCHANGE OPERATED BY THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND ALTHOUGH THERE ARE NUMEROUS FEDERAL LAWSUITS CHALLENGING THE CONSTITUTIONALITY OF THE FEDERAL ACT IN MULTIPLE FEDERAL COURTS, THE BEST OPTION FOR THE STATE OF COLORADO IS TO ESTABLISH A HEALTH BENEFIT EXCHANGE AT THE STATE LEVEL. THE GENERAL ASSEMBLY FURTHER FINDS THAT THE FEDERAL ACT REQUIRES EACH STATE TO ESTABLISH A HEALTH BENEFIT EXCHANGE TO PERFORM CERTAIN DUTIES AND TO ASSUME CERTAIN RESPONSIBILITIES SET FORTH IN THE FEDERAL ACT OR MAKE SUFFICIENT PROGRESS IN THE CREATION OF A HEALTH BENEFIT EXCHANGE BY JANUARY 1, 2013, OR DEFAULT TO A FEDERALLY RUN NATIONAL HEALTH BENEFIT EXCHANGE. THEREFORE, THE GENERAL ASSEMBLY INTENDS TO CREATE A HEALTH BENEFIT EXCHANGE TO FIT THE UNIQUE NEEDS OF COLORADO, SEEK COLORADO-SPECIFIC SOLUTIONS, AND EXPLORE THE MAXIMUM NUMBER OF OPTIONS AVAILABLE TO THE STATE OF COLORADO. THE COLORADO HEALTH BENEFIT EXCHANGE, INCLUDING AN AMERICAN HEALTH BENEFIT EXCHANGE, IS INTENDED TO FACILITATE THE ACCESS TO AND ENROLLMENT IN HEALTH PLANS IN THE INDIVIDUAL MARKET IN THIS STATE AND INCLUDE A SMALL BUSINESS HEALTH OPTIONS PROGRAM TO ASSIST SMALL EMPLOYERS IN THIS STATE IN FACILITATING THE ENROLLMENT OF THEIR EMPLOYEES IN HEALTH PLANS OFFERED IN THE SMALL EMPLOYER MARKET. THE INTENT OF THE COLORADO HEALTH BENEFIT EXCHANGE IS TO INCREASE ACCESS, AFFORDABILITY, AND CHOICE FOR INDIVIDUALS AND SMALL EMPLOYERS PURCHASING HEALTH INSURANCE IN COLORADO.

10-22-103. Definitions. AS USED IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "BOARD" MEANS THE BOARD OF DIRECTORS OF THE EXCHANGE, APPOINTED IN ACCORDANCE WITH SECTION 10-22-105.

(2) "COMMITTEE" MEANS THE LEGISLATIVE HEALTH BENEFIT EXCHANGE IMPLEMENTATION REVIEW COMMITTEE CREATED IN SECTION 10-22-107.

(3) "EXCHANGE" MEANS THE COLORADO HEALTH BENEFIT EXCHANGE CREATED IN THIS ARTICLE.

(4) "FEDERAL ACT" MEANS THE "PATIENT PROTECTION AND AFFORDABLE CARE ACT", PUB.L. 111-148, AS AMENDED BY THE "HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010", PUB.L. 111-152.

(5) "SECRETARY" MEANS THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

10-22-104. Health benefit exchange - creation. THERE IS HEREBY CREATED A NONPROFIT UNINCORPORATED PUBLIC ENTITY KNOWN AS THE HEALTH BENEFIT EXCHANGE. THE BOARD OF DIRECTORS SHALL GOVERN THE OPERATION OF THE EXCHANGE. THE BOARD SHALL DETERMINE AND ESTABLISH THE DEVELOPMENT, GOVERNANCE, AND OPERATION OF THE EXCHANGE. THE EXCHANGE IS AN INSTRUMENTALITY OF THE STATE; EXCEPT THAT THE DEBTS AND LIABILITIES OF THE EXCHANGE DO NOT CONSTITUTE THE DEBTS AND LIABILITIES OF THE STATE, AND NEITHER THE EXCHANGE NOR THE BOARD IS AN AGENCY OF THE STATE. THE BOARD DOES NOT HAVE THE AUTHORITY TO PROMULGATE RULES PURSUANT TO THE "STATE ADMINISTRATIVE PROCEDURE ACT", ARTICLE 4 OF TITLE 24, C.R.S. THE EXCHANGE SHALL NOT DUPLICATE OR REPLACE THE DUTIES OF THE COMMISSIONER ESTABLISHED IN SECTION 10-1-108, INCLUDING RATE APPROVAL, EXCEPT AS DIRECTED BY THE FEDERAL ACT. THE EXCHANGE SHALL FOSTER A COMPETITIVE MARKETPLACE FOR INSURANCE AND SHALL NOT SOLICIT BIDS OR ENGAGE IN THE ACTIVE PURCHASING OF INSURANCE. ALL CARRIERS AUTHORIZED TO CONDUCT BUSINESS IN THIS STATE MAY BE ELIGIBLE TO PARTICIPATE IN THE EXCHANGE.

10-22-105. Exchange board of directors. (1) (a) THERE IS HEREBY CREATED THE BOARD OF DIRECTORS OF THE EXCHANGE. THE BOARD CONSISTS OF TWELVE MEMBERS, OF WHOM NINE ARE VOTING MEMBERS AND THREE ARE NONVOTING, EX OFFICIO MEMBERS. ON OR BEFORE JULY 1, 2011, THE GOVERNOR SHALL APPOINT FIVE VOTING MEMBERS TO THE BOARD, AND THE PRESIDENT OF THE SENATE, THE MINORITY LEADER OF THE SENATE, THE SPEAKER OF THE HOUSE OF REPRESENTATIVES, AND THE MINORITY LEADER OF THE HOUSE OF REPRESENTATIVES SHALL EACH APPOINT ONE VOTING MEMBER TO THE BOARD. THE GOVERNOR SHALL NOT APPOINT MORE THAN THREE MEMBERS FROM THE SAME POLITICAL PARTY. THE BOARD SHALL ELECT ONE OF ITS MEMBERS AS CHAIR OF THE BOARD. MEMBERS OF THE

BOARD MAY BE REMOVED BY THEIR RESPECTIVE APPOINTING AUTHORITIES FOR CAUSE. THE PERSON MAKING THE ORIGINAL APPOINTMENT OR REAPPOINTMENT, OR WHOEVER IS ENTITLED TO MAKE THE APPOINTMENT ON THE DATE OF A VACANCY, SHALL FILL THE VACANCY BY APPOINTMENT FOR THE REMAINDER OF AN UNEXPIRED TERM. MEMBERS MAY SERVE A MAXIMUM OF TWO CONSECUTIVE TERMS. IF A MEMBER IS APPOINTED TO FILL A VACANCY AND SERVES FOR MORE THAN HALF OF THE UNEXPIRED TERM, THE MEMBER SHALL BE ELIGIBLE FOR APPOINTMENT TO ONLY ONE MORE CONSECUTIVE TERM.

(b) THE PERSONS MAKING THE APPOINTMENTS SHALL COORDINATE APPOINTMENTS TO ENSURE THAT THERE IS BROAD REPRESENTATION WITHIN THE SKILL SETS SPECIFIED IN THIS PARAGRAPH (b) AND SHALL CONSIDER THE GEOGRAPHIC, ECONOMIC, ETHNIC, AND OTHER CHARACTERISTICS OF THE STATE WHEN MAKING THE APPOINTMENTS. A MAJORITY OF THE VOTING MEMBERS MUST BE BUSINESS REPRESENTATIVES OR INDIVIDUALS WHO ARE NOT DIRECTLY AFFILIATED WITH THE INSURANCE INDUSTRY, AND NONE SHALL BE STATE EMPLOYEES. OF THE MEMBERS FIRST APPOINTED, IN ORDER TO ENSURE STAGGERED TERMS, FOUR OF THE GOVERNOR'S APPOINTEES SHALL SERVE FOR A TERM OF TWO YEARS AND THE REMAINING GOVERNOR'S APPOINTEE AND OTHER INITIAL APPOINTEES SHALL SERVE FOR A TERM OF FOUR YEARS. THEREAFTER, THE TERMS OF THE MEMBERS SHALL BE FOR FOUR YEARS. EACH PERSON APPOINTED TO THE BOARD SHOULD HAVE DEMONSTRATED EXPERTISE IN AT LEAST TWO, AND IN ANY CASE SHALL HAVE DEMONSTRATED EXPERTISE IN NO LESS THAN ONE, OF THE FOLLOWING AREAS:

(I) INDIVIDUAL HEALTH INSURANCE COVERAGE;

(II) SMALL EMPLOYER HEALTH INSURANCE;

(III) HEALTH BENEFITS ADMINISTRATION;

(IV) HEALTH CARE FINANCE;

(V) ADMINISTRATION OF A PUBLIC OR PRIVATE HEALTH CARE DELIVERY SYSTEM;

(VI) THE PROVISION OF HEALTH CARE SERVICES;

(VII) THE PURCHASE OF HEALTH INSURANCE COVERAGE;

(VIII) HEALTH CARE CONSUMER NAVIGATION OR ASSISTANCE;

(IX) HEALTH CARE ECONOMICS OR HEALTH CARE ACTUARIAL SCIENCES;

(X) INFORMATION TECHNOLOGY; OR

(XI) STARTING A SMALL BUSINESS WITH FIFTY OR FEWER EMPLOYEES.

(c) THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING, OR HIS OR HER DESIGNEE; THE COMMISSIONER OF INSURANCE, OR HIS OR HER DESIGNEE; AND THE DIRECTOR OF THE OFFICE OF ECONOMIC DEVELOPMENT AND INTERNATIONAL TRADE, OR HIS OR HER DESIGNEE, SHALL SERVE AS NONVOTING, EX OFFICIO MEMBERS OF THE BOARD.

(2) EACH MEMBER OF THE BOARD IS RESPONSIBLE FOR MEETING THE REQUIREMENTS OF THIS ARTICLE AND ALL APPLICABLE STATE AND FEDERAL LAWS, RULES, AND REGULATIONS; SERVING IN THE PUBLIC INTEREST OF THE INDIVIDUALS AND SMALL BUSINESSES SEEKING HEALTH CARE COVERAGE THROUGH THE EXCHANGE; AND ENSURING THE OPERATIONAL WELL-BEING AND FISCAL SOLVENCY OF THE EXCHANGE.

(3) (a) BOARD MEMBERS SHALL NOT RECEIVE COMPENSATION FOR PERFORMANCE OF SERVICES FOR THE BOARD BUT MAY RECEIVE A PER DIEM AND REIMBURSEMENT FOR TRAVEL AND OTHER NECESSARY EXPENSES WHILE ENGAGED IN THE PERFORMANCE OF OFFICIAL DUTIES OF THE BOARD. PER DIEM AND REIMBURSEMENT EXPENSES ARE PAID THROUGH GRANT MONEYS RECEIVED BY THE BOARD.

(b) A MEMBER OF THE BOARD SHALL NOT PERFORM AN OFFICIAL ACT THAT MAY HAVE A DIRECT ECONOMIC BENEFIT ON A BUSINESS OR OTHER UNDERTAKING IN WHICH THE MEMBER HAS A DIRECT OR SUBSTANTIAL FINANCIAL INTEREST.

(c) A BOARD MEMBER OR AN OFFICER OR EMPLOYEE OF THE EXCHANGE IS NOT LIABLE FOR AN ACT OR OMISSION WHEN ACTING IN HIS OR

HER OFFICIAL CAPACITY, IN GOOD FAITH, WITHOUT INTENT TO DEFRAUD, AND IN CONNECTION WITH THE ADMINISTRATION, MANAGEMENT, OR CONDUCT OF THIS ARTICLE.

(4) (a) BOARD MEMBERS ARE SUBJECT TO ARTICLES 6, 18, AND 72 OF TITLE 24, C.R.S.

(b) ALL MONEYS RECEIVED BY THE BOARD FOR THE EXCHANGE ARE SUBJECT TO AUDIT BY THE LEGISLATIVE AUDIT COMMITTEE. THE BOARD SHALL REPORT ALL MONEYS RECEIVED FOR THE EXCHANGE TO THE LEGISLATIVE AUDIT COMMITTEE.

(5) ANY INFORMATION PROVIDED TO A BOARD MEMBER PURSUANT TO THIS ARTICLE THAT IS EXEMPT FROM DISCLOSURE UNDER EITHER SECTION 24-72-204, C.R.S., OR PART 4 OF ARTICLE 6 OF TITLE 24, C.R.S., SHALL BE AND REMAIN CONFIDENTIAL AND MAY BE USED ONLY BY THE BOARD.

10-22-106. Powers and duties of the board. (1) THE BOARD IS THE GOVERNING BODY OF THE EXCHANGE AND HAS ALL THE POWERS AND DUTIES NECESSARY TO IMPLEMENT THIS ARTICLE. THE BOARD SHALL:

(a) APPOINT AN EXECUTIVE DIRECTOR TO ADMINISTER THE EXCHANGE, SUBJECT TO APPROVAL BY THE COMMITTEE;

(b) CREATE AN INITIAL OPERATIONAL AND FINANCIAL PLAN, SUBJECT TO APPROVAL BY THE COMMITTEE;

(c) APPLY FOR PLANNING AND ESTABLISHMENT GRANTS MADE AVAILABLE TO THE EXCHANGE PURSUANT TO THE FEDERAL ACT AND APPLY FOR, RECEIVE, AND EXPEND OTHER GIFTS, GRANTS, AND DONATIONS. EACH GRANT APPLICATION IS SUBJECT TO THE REVIEW AND UNANIMOUS APPROVAL OF THE BOARD CHAIR AND THE CHAIR AND VICE-CHAIR OF THE COMMITTEE PRIOR TO THE SUBMISSION OF THE APPLICATION. IF THERE IS NOT UNANIMOUS APPROVAL, EACH GRANT APPLICATION IS SUBJECT TO REVIEW AND THE MAJORITY APPROVAL OF THE COMMITTEE.

(d) CREATE TECHNICAL AND ADVISORY GROUPS AS NEEDED TO REPORT TO THE BOARD. THE ADVISORY GROUPS SHALL MEET REGULARLY THROUGHOUT THE YEAR TO DISCUSS ISSUES RELATED TO THE EXCHANGE AND MAKE RECOMMENDATIONS TO THE BOARD.

(e) PROVIDE A WRITTEN REPORT, ON BEFORE JANUARY 15 OF EACH YEAR, TO THE GOVERNOR AND THE GENERAL ASSEMBLY CONCERNING THE PLANNING AND ESTABLISHMENT OF THE EXCHANGE AND PRESENT THE REPORT TO THE SENATE HEALTH AND HUMAN SERVICES COMMITTEE AND THE HOUSE OF REPRESENTATIVES HEALTH AND ENVIRONMENT COMMITTEE, OR THEIR SUCCESSOR COMMITTEES;

(f) REVIEW THE INTERNET PORTAL OPERATED AND MAINTAINED BY THE SECRETARY AND THE MODEL TEMPLATE FOR AN INTERNET PORTAL MADE AVAILABLE BY THE SECRETARY FOR USE BY THE STATE EXCHANGES AND REVIEW OTHER APPROPRIATE INTERNET PORTALS. THE REVIEW MUST INCLUDE AN EXAMINATION AS TO WHETHER THE MODEL TEMPLATE MAY BE USED TO DIRECT INDIVIDUALS AND EMPLOYERS TO HEALTH PLANS, TO ASSIST INDIVIDUALS AND EMPLOYERS IN DETERMINING WHETHER THEY ARE ELIGIBLE TO PARTICIPATE IN THE EXCHANGE OR ELIGIBLE FOR A PREMIUM TAX CREDIT OR COST-SHARING REDUCTION, AND TO PRESENT STANDARDIZED INFORMATION REGARDING HEALTH PLANS OFFERED THROUGH THE EXCHANGE TO ASSIST CONSUMERS IN MAKING HEALTH INSURANCE CHOICES.

(g) CONSIDER THE DESIRABILITY OF STRUCTURING THE EXCHANGE AS ONE ENTITY THAT INCLUDES TWO UNDERLYING ENTITIES TO OPERATE IN THE INDIVIDUAL AND THE SMALL EMPLOYER MARKETS, RESPECTIVELY;

(h) CONSIDER THE APPROPRIATE SIZE OF THE SMALL EMPLOYER MARKET UNDER THE EXCHANGE, TAKING INTO CONSIDERATION THE DEFINITION OF "SMALL EMPLOYER" PURSUANT TO SECTION 10-16-102;

(i) CONSIDER THE UNIQUE NEEDS OF RURAL COLORADANS AS THEY PERTAIN TO ACCESS, AFFORDABILITY, AND CHOICE IN PURCHASING HEALTH INSURANCE;

(j) CONSIDER THE AFFORDABILITY AND COST IN THE CONTEXT OF QUALITY CARE AND INCREASED ACCESS TO PURCHASING HEALTH INSURANCE; AND

(k) INVESTIGATE REQUIREMENTS, DEVELOP OPTIONS, AND DETERMINE WAIVERS, IF APPROPRIATE, TO ENSURE THAT THE BEST INTERESTS OF COLORADANS ARE PROTECTED.

(2) THE BOARD MAY ENTER INTO INFORMATION-SHARING

AGREEMENTS WITH FEDERAL AND STATE AGENCIES AND OTHER STATE EXCHANGES TO CARRY OUT ITS RESPONSIBILITIES UNDER THIS ARTICLE SO LONG AS THE AGREEMENTS INCLUDE ADEQUATE PROTECTIONS WITH RESPECT TO THE CONFIDENTIALITY OF THE INFORMATION THAT IS SHARED AND COMPLY WITH ALL STATE AND FEDERAL LAWS, RULES, AND REGULATIONS.

10-22-107. Legislative health benefit exchange implementation review committee - creation - duties. (1) FOR THE PURPOSES OF GUIDING IMPLEMENTATION OF AN EXCHANGE IN COLORADO, MAKING RECOMMENDATIONS TO THE GENERAL ASSEMBLY, AND ENSURING THAT THE INTERESTS OF COLORADANS ARE PROTECTED AND FURTHERED, THERE IS HEREBY CREATED THE LEGISLATIVE HEALTH BENEFIT EXCHANGE IMPLEMENTATION REVIEW COMMITTEE. THE COMMITTEE SHALL MEET ON OR BEFORE AUGUST 1, 2011, AND THEREAFTER AT THE CALL OF THE CHAIR AS OFTEN AS FIVE TIMES DURING EACH CALENDAR YEAR. THE COMMITTEE MAY USE THE LEGISLATIVE COUNCIL STAFF TO ASSIST ITS MEMBERS IN RESEARCHING ANY MATTERS.

(2) (a) THE PRESIDENT OF THE SENATE SHALL APPOINT THREE MEMBERS TO THE COMMITTEE. TWO APPOINTEES SHALL BE MEMBERS OF THE SENATE HEALTH AND HUMAN SERVICES COMMITTEE, THE BUSINESS, LABOR, AND TECHNOLOGY COMMITTEE, OR THE LEGISLATIVE AUDIT COMMITTEE, OR THEIR SUCCESSOR COMMITTEES. ONE APPOINTEE SHALL BE A REPRESENTATIVE OF THE SENATE AT LARGE.

(b) THE SPEAKER OF THE HOUSE OF REPRESENTATIVES SHALL APPOINT THREE MEMBERS TO THE COMMITTEE. TWO APPOINTEES SHALL BE MEMBERS OF THE HOUSE HEALTH AND ENVIRONMENT COMMITTEE, THE ECONOMIC AND BUSINESS DEVELOPMENT COMMITTEE, OR THE LEGISLATIVE AUDIT COMMITTEE, OR THEIR SUCCESSOR COMMITTEES. ONE APPOINTEE SHALL BE A REPRESENTATIVE OF THE HOUSE OF REPRESENTATIVES AT LARGE.

(c) THE MINORITY LEADER OF THE SENATE SHALL APPOINT TWO MEMBERS TO THE COMMITTEE. ONE APPOINTEE SHALL BE A MEMBER OF THE SENATE HEALTH AND HUMAN SERVICES COMMITTEE, THE BUSINESS, LABOR, AND TECHNOLOGY COMMITTEE, OR THE LEGISLATIVE AUDIT COMMITTEE, OR THEIR SUCCESSOR COMMITTEES. ONE APPOINTEE SHALL BE A REPRESENTATIVE OF THE SENATE AT LARGE.

(d) THE MINORITY LEADER OF THE HOUSE OF REPRESENTATIVES

SHALL APPOINT TWO MEMBERS TO THE COMMITTEE. ONE APPOINTEE SHALL BE A MEMBER OF THE HOUSE HEALTH AND ENVIRONMENT COMMITTEE, THE ECONOMIC AND BUSINESS DEVELOPMENT COMMITTEE, OR THE LEGISLATIVE AUDIT COMMITTEE, OR THEIR SUCCESSOR COMMITTEES. ONE APPOINTEE SHALL BE A REPRESENTATIVE OF THE HOUSE OF REPRESENTATIVES AT LARGE.

(e) MEMBERS OF THE COMMITTEE SHALL SERVE AT THE PLEASURE OF THE APPOINTING AUTHORITY.

(3) MEMBERS OF THE COMMITTEE SHALL SERVE WITHOUT COMPENSATION; EXCEPT THAT EACH MEMBER SHALL RECEIVE THE SUMS SPECIFIED IN SECTION 2-2-307 (3) (a) AND (3) (b), C.R.S., FOR ATTENDANCE AT MEETINGS OF THE COMMITTEE WHEN THE GENERAL ASSEMBLY IS IN RECESS FOR MORE THAN THREE DAYS OR IS NOT IN SESSION.

(4) DURING ODD-NUMBERED YEARS, THE PRESIDENT OF THE SENATE SHALL APPOINT THE CHAIR AND THE SPEAKER OF THE HOUSE OF REPRESENTATIVES SHALL APPOINT THE VICE-CHAIR OF THE COMMITTEE. DURING EVEN-NUMBERED YEARS THE SPEAKER OF THE HOUSE OF REPRESENTATIVES SHALL APPOINT THE CHAIR, AND THE PRESIDENT OF THE SENATE SHALL APPOINT THE VICE-CHAIR OF THE COMMITTEE.

(5) IN ANY YEAR, THE COMMITTEE MAY REPORT UP TO FIVE BILLS OR OTHER MEASURES TO THE LEGISLATIVE COUNCIL CREATED IN SECTION 2-3-301, C.R.S. THESE BILLS ARE EXEMPT FROM ANY APPLICABLE BILL LIMIT IMPOSED ON THE INDIVIDUAL COMMITTEE MEMBERS SPONSORING SUCH BILLS IF THE BILLS HAVE BEEN APPROVED BY THE LEGISLATIVE COUNCIL UNDER JOINT RULES OF THE SENATE AND HOUSE OF REPRESENTATIVES.

(6) THE COMMITTEE SHALL REVIEW GRANTS APPLIED FOR BY THE BOARD TO IMPLEMENT THE EXCHANGE.

(7) THE COMMITTEE SHALL REVIEW THE FINANCIAL AND OPERATIONAL PLANS OF THE EXCHANGE.

10-22-108. Moneys for implementation of the exchange. MONEYS RECEIVED BY THE BOARD FOR THE IMPLEMENTATION OF THIS ARTICLE MUST BE TRANSFERRED DIRECTLY TO THE EXCHANGE FOR THE PURPOSES OF THIS ARTICLE. THE BOARD SHALL DEPOSIT ANY MONEYS RECEIVED IN A BANKING INSTITUTION WITHIN OR OUTSIDE THE STATE.

MONEYS FROM THE GENERAL FUND SHALL NOT BE USED FOR THE IMPLEMENTATION OF THIS ARTICLE, EXCEPT FOR THE SUMS SPECIFIED IN SECTION 10-22-107(3) AND FOR LEGISLATIVE STAFF AGENCY SERVICES. THE BANKING INSTITUTION MUST BE INSURED BY THE FEDERAL DEPOSIT INSURANCE CORPORATION AND COMPLIANT WITH THE "SAVINGS AND LOAN ASSOCIATION PUBLIC DEPOSIT PROTECTION ACT", ARTICLE 47 OF TITLE 11, C.R.S.

SECTION 2. Accountability. Five years after this act becomes law and in accordance with section 2-2-1201, Colorado Revised Statutes, the legislative service agencies of the Colorado General Assembly shall conduct a post-enactment review of the implementation of this act utilizing the information contained in the legislative declaration set forth in section 1 of this act.

SECTION 3. No appropriation. The general assembly has determined that this act can be implemented within existing appropriations, and therefore no separate appropriation of state moneys is necessary to carry out the purposes of this act.

SECTION 4. Safety clause. The general assembly hereby finds,

determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Brandon C. Shaffer
PRESIDENT OF
THE SENATE

Frank McNulty
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Cindi L. Markwell
SECRETARY OF
THE SENATE

Marilyn Eddins
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

APPROVED _____

John W. Hickenlooper
GOVERNOR OF THE STATE OF COLORADO

Colorado Legislative Council Staff Fiscal Note

**FINAL
FISCAL NOTE**

Drafting Number: LLS 11-0249	Date: June 20, 2011
Prime Sponsor(s): Sen. Boyd Rep. Stephens	Bill Status: Signed into Law
	Fiscal Analyst: Kerry White (303-866-3469)

TITLE: CONCERNING A COLORADO HEALTH BENEFIT EXCHANGE, AND, IN CONNECTION THEREWITH, CREATING A PROCESS FOR THE IMPLEMENTATION OF A HEALTH BENEFIT EXCHANGE IN COLORADO.

Fiscal Impact Summary	FY 2011-2012	FY 2012-2013
State Revenue		
State Expenditures		
General Fund	\$29,638	\$29,638
FTE Position Change	0.4 FTE	0.4 FTE
Effective Date: The bill was signed into law by the Governor and took effect on June 1, 2011.		
Appropriation Summary for FY 2011-2012: See State Appropriations section.		
Local Government Impact: None.		

Summary of Legislation

This bill creates the Colorado Health Benefit Exchange Act in connection with federal health care laws enacted in 2010. It establishes a non-profit organization that is an instrumentality of the state to oversee the establishment and operation of a competitive insurance marketplace (exchange) in Colorado. The exchange will be governed by a board of directors consisting of 12 members, including 9 voting members of certain qualifications appointed by the Governor and legislative leadership, and 3 non-voting members representing the Department of Health Care Policy and Financing, the Commissioner of Insurance, and the director of the Office of Economic Development and International Trade. Board qualifications, powers, and duties are specified, to include:

- appointing an executive director and creating an initial operational and financial plan;
- applying for gifts, grants, and donations to fund the planning, establishment, and operation of the exchange;
- creating technical and advisory groups as needed;
- preparing and presenting a written report, on or before January 15 of each year, concerning the status of the exchange;
- reviewing the internet portal and templates for citizens to access information on health plans offered through the exchange;

- identifying the structure of the exchange, including whether to separate the individual and small employer markets and the appropriate size of the small employer market; and
- considering the unique needs of rural Coloradans.

All board members serve without compensation, although per diem and expenses may be reimbursed from gifts, grants, and donations. All other expenses of the exchange are to be paid with gifts, grants, and donations received by the board. Financial information is to be reported to the Legislative Audit Committee, which may audit moneys received by the board.

A 10-member Legislative Health Benefit Exchange Implementation Review Committee (review committee) is created to guide implementation of the exchange, make recommendations, and carry legislation. Members are appointed by legislative leadership and serve without compensation, although per diem and travel expenses may be provided. The committee is to meet on or before August 1, 2011, and may meet up to five times per year thereafter to review the exchange's financial and operational plans and grants applications. Legislative Council Staff is directed to assist the committee.

The bill clarifies that no General Fund moneys are to be used to implement the bill except as required to reimburse legislators serving on review committee and to pay for legislative service agency staff costs. The legislative service agencies are also required to conduct a post-enactment review within 5 years of the bill becoming law. As amended, the bill also clarifies that the General Assembly has sufficient resources to implement the bill within existing appropriations.

State Expenditures

This bill will increase state expenditures by up to \$29,638 in FY 2011-12 and FY 2012-13 to support the review committee created under the bill, as described in Table 1 and the discussion that follows.

Table 1. Expenditures Under SB11-200		
Cost Components	FY 2011-2012	FY 2012-2013
Personal Services	\$20,288	\$20,288
FTE Senior Research Assistant (0.3 FTE) and Staff Attorney (0.1 FTE)	0.4	0.4
Legislative Per Diem and Travel (10 members x \$187 x up to 5 meetings)	9,350	9,350
TOTAL	\$29,638	\$29,638

Legislative branch. Expenditures will increase by \$29,638 General Fund and 0.4 FTE per year, beginning in FY 2011-12. The review committee includes 10 legislators, for whom per diem and travel reimbursements may be paid. Assuming the committee meets up to 5 times per year at a cost of \$187 per member, costs are estimated to be up to \$9,350 per year. Legislative Council staff is tasked with providing research, and the fiscal note assumes that resources will be required to staff the committee and prepare legislation. Personal services costs total \$20,288 and 0.4 FTE per year.

The Office of the State Auditor may experience an increase in workload if the Legislative Audit Committee chooses to audit moneys received by the board of directors of the exchange. Costs for post-enactment review are expected to be minimal.

State agencies. Representatives from the Governor's Office, and the Departments of Health Care Policy and Financing and Regulatory Agencies are to serve on the committee. Participation is expected to have a minimal impact on agency workload, but does not require a new appropriation.

Board of directors of the exchange. The bill specifies that board expenses are to be paid with gifts, grants, and donations. To the extent that the board requires any services provided by state agencies and reimburses board members for per diem and travel expenses, these costs will be paid with gifts, grants, and donations.

Expenditures Not Included

Pursuant to a Joint Budget Committee policy, certain costs associated with this bill are addressed through the annual budget process and centrally appropriated in the Long Bill or supplemental appropriations bills, rather than in this bill. The centrally appropriated costs subject to this policy are summarized in Table 2.

Table 2. Expenditures Not Included Under SB11-200*		
Cost Components	FY 2011-12	FY 2012-13
Employee Insurance (Health, Life, Dental, and Short-term Disability)	\$2,840	\$2,840
Supplemental Employee Retirement Payments	918	1,082
TOTAL	\$3,758	\$3,922

**More information is available at: <http://colorado.gov/fiscalnotes>*

State Appropriations

Due to the Legislative Council's approval of this committee, no separate appropriations are required for FY 2011-12. The Legislature is budgeted each year with resources to support a limited number of interim committees of the General Assembly (5). While this committee is anticipated to be ongoing, its costs will be paid from the portion of the budget reserved for interim committees.

Departments Contacted

Governor's Office
Health Care Policy & Financing
Regulatory Agencies

Governor's Office of Information Technology
Legislative Branch
State Auditor



By the Numbers:

Colorado's Second
Open Enrollment

2015 Open Enrollment Report

On November 10, 2014 Connect for Health Colorado launched its second Open Enrollment Period for individuals and families who need private health insurance. With only half the time, the second open enrollment still outpaced the first enrollment period. And, by February 28, 2015 more than 141,000 Coloradans had health coverage for 2015 – making Connect for Health Colorado one of the top-performing state-based Marketplaces.

Total 2015 enrollments increased in 63 of the state’s 64 counties compared to year-end 2014 active policyholders. Rural counties, which represent 8% of the state’s population, had 10% of all Marketplace enrollments. This report contains more details, as well as links to maps, that show how Coloradans are gaining access, affordability and choice as they purchase health insurance.

197 Days

Open Enrollment Period for 2014 Coverage
(Oct. 1, 2013 - April 15, 2014)

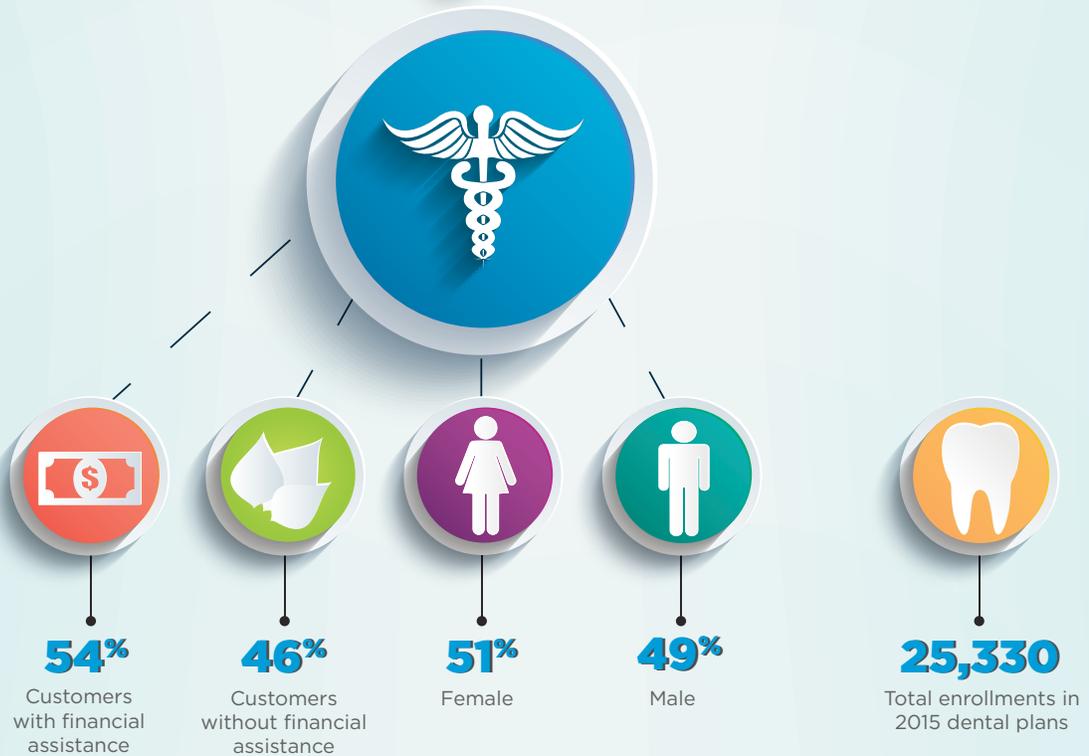
97 Days

Open Enrollment Period for 2015 Coverage
(Nov. 10, 2014 - Feb. 28, 2015)



Individual Marketplace
Total enrollments in 2015 medical plans

141,639

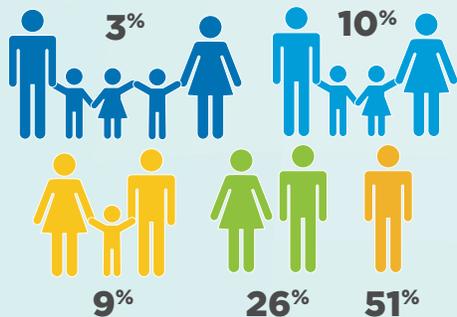


Who helped with enrollment?



- 40%** Brokers
- 6%** Health Coverage Guides
- 1%** Service Center
- .3%** Carrier Direct

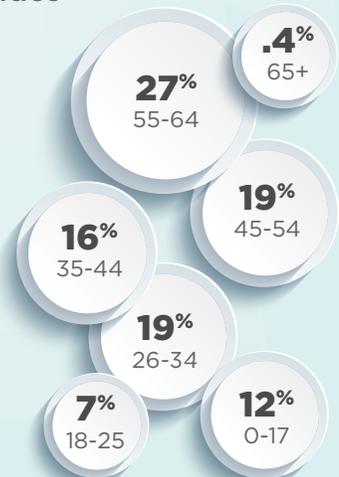
Enrollments by family size



807

American Indian/Alaska Native enrollments

Enrollments by age





Peak enrollment days



52,692
covered lives

\$228.95

2015 Average monthly tax credit amount statewide



10,820
covered lives

\$392.13/month

2015 Average premium of plan chosen (before tax credits) by those who qualified for financial assistance



3,043
covered lives

\$287.97/month

2015 Average premium of plan chosen by those without financial assistance



5,403
covered lives

\$251,000,000 Amount of federal tax credits returned to Coloradans to offset the cost of their monthly premium

\$273.21
2014 Average monthly tax credit statewide

\$399.70/month
2014 Average premium of plan chosen (before tax credits) by those who qualified for financial assistance

\$296.58/month
2014 Average premium of plan chosen by those without financial assistance



Renewals

17,390 76,995 47,254

2015 renewed/
different insurer

2015 renewed/
same insurer

2015 new
customers

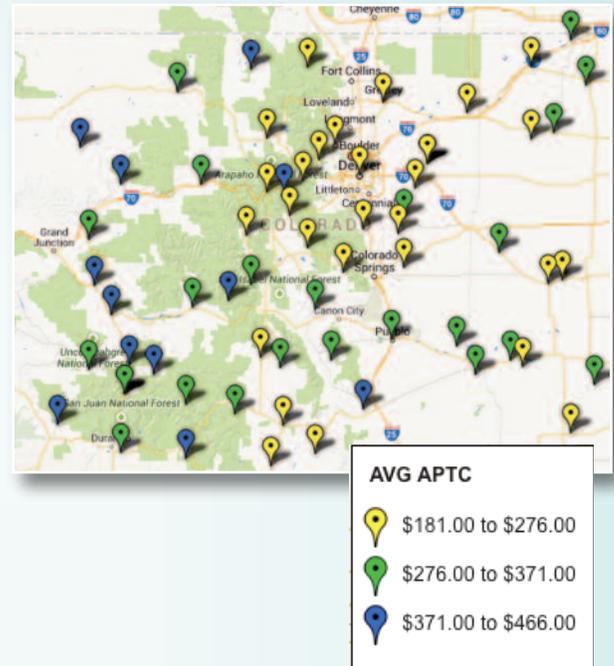
Enrollments increased in every county of the state except one

To see map of enrollments by county, [click here](#).

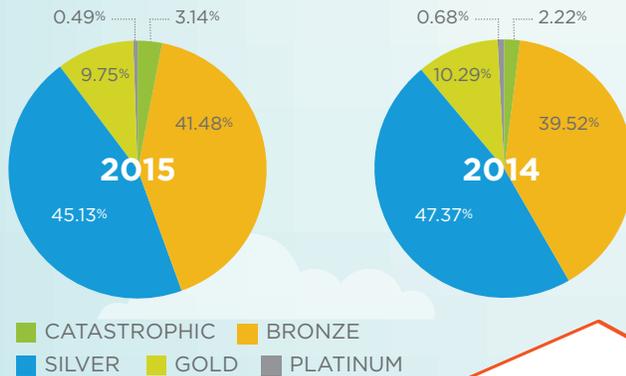
Covered Lives	2014	2015	Covered Lives	2014	2015	Covered Lives	2014	2015
ADAMS	6866	9438	FREMONT	541	765	MORGAN	312	478
ALAMOSA	288	343	GARFIELD	1337	1717	OTERO	228	296
ARAPAHOE	11212	15626	GILPIN	143	207	OURAY	282	353
ARCHULETA	509	626	GRAND	516	625	PARK	489	596
BACA	59	110	GUNNISON	1047	1318	PHILLIPS	113	140
BENT	55	64	HINSDALE	39	49	PITKIN	810	1009
BOULDER	10024	12612	HUERFANO	127	178	PROWERS	182	261
BROOMFIELD	1290	1879	JACKSON	40	49	PUEBLO	1479	2230
CHAFFEE	1037	1243	JEFFERSON	10947	15244	RIO BLANCO	81	102
CHEYENNE	26	29	KIOWA	37	35	RIO GRANDE	296	351
CLEAR CREEK	324	420	KIT CARSON	133	186	ROUTT	1192	1639
CONEJOS	174	209	LA PLATA	1776	2323	SAGUACHE	175	200
COSTILLA	46	69	LAKE	129	160	SAN JUAN	59	62
CROWLEY	38	53	LARIMER	7182	10438	SAN MIGUEL	536	722
CUSTER	126	143	LAS ANIMAS	197	241	SEDGWICK	53	61
DELTA	607	794	LINCOLN	93	124	SUMMIT	948	1303
DENVER	13697	19393	LOGAN	361	509	TELLER	314	460
DOLORES	49	54	MESA	2436	3304	WASHINGTON	141	177
DOUGLAS	5771	7956	MINERAL	42	49	WELD	3940	5730
EAGLE	1496	2081	MOFFAT	144	197	YUMA	296	342
EL PASO	6558	10100	MONTEZUMA	494	601	Others	910	1579
ELBERT	486	690	MONTROSE	964	1297			

(*compares active policies on Dec 31, 2014 against 2015 Open Enrollment figures)

2015 Average monthly tax credit by county



Enrollments by plan type



Rural counties represent 8% of Colorado's population, but 10% of Marketplace enrollments.

Shared Eligibility System

244,171

Total applications for financial assistance were submitted through the new Shared Eligibility System

76,783

Applications for Shared Eligibility System originated from Connect for Health Colorado during these 3 months

- Of the 224,171 total applications in SES:
 - 22,658 were denied Medicaid and sent to the Marketplace eligible for a tax credit
 - 29,040 were denied Medicaid and sent to the Marketplace eligible for both a tax credit and cost-sharing reduction

78%

Of Marketplace customers who went through the single application in the Shared Eligibility System received a real-time eligibility determination

Small Business enrollments for 2015

(small business annual enrollments occur throughout the year)

399

 Businesses

3,716

 Covered lives

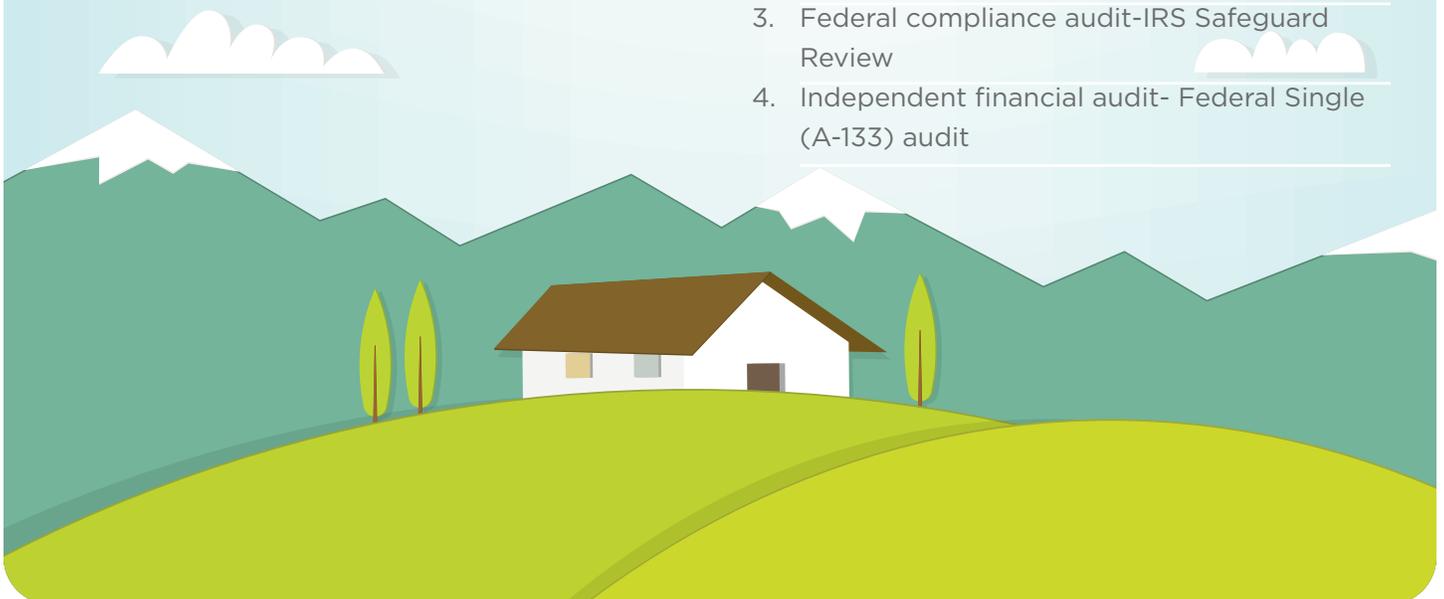
70%

 Small businesses offering choice of plans and insurers

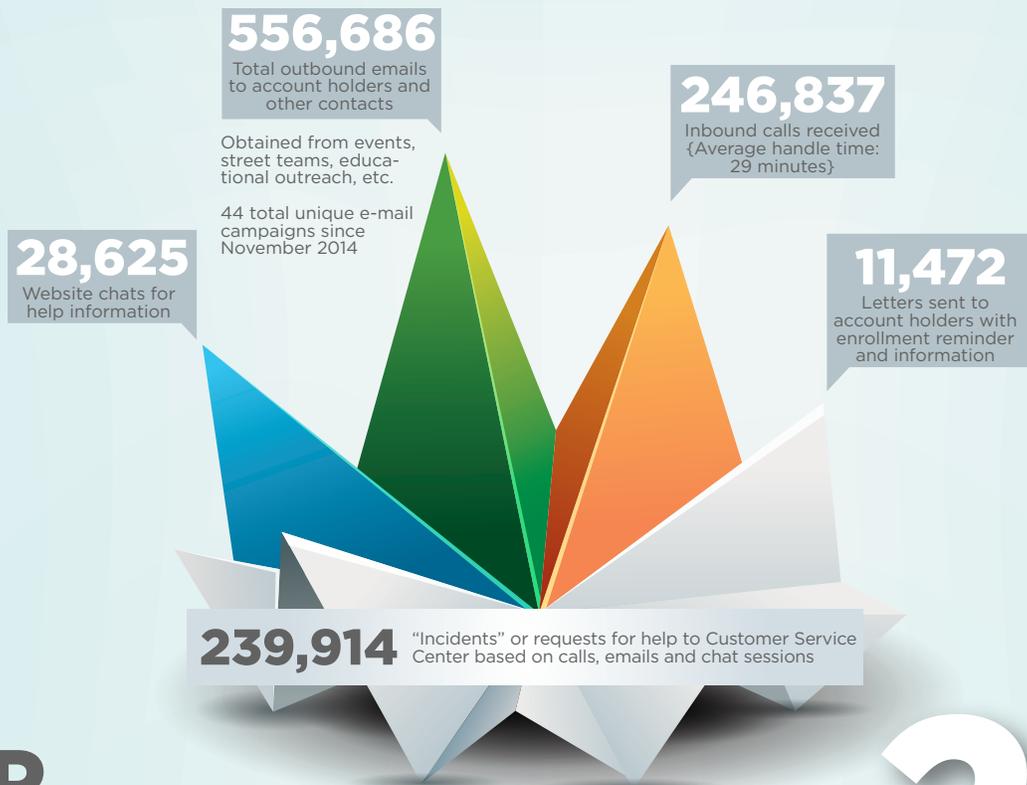
Audits and Oversight

Since mid-2012, federal and state officials have conducted more than 2 dozen audits and reviews of Connect for Health Colorado. During the Open Enrollment period from November 2014 through February 2015, another 4 audits were under way.

1. Federal compliance audit-OIG (HHS) Information Systems
2. Federal compliance audit-OIG (HHS) Eligibility/Enrollment Verification
3. Federal compliance audit-IRS Safeguard Review
4. Independent financial audit- Federal Single (A-133) audit



Customer Service Center



TOP eight?S

Top questions asked by customers who called/chatted with the Customer Service Center

Medicaid/PEAK/SES Questions

- *Why can't I enroll in a health plan – I have not received a determination from PEAK yet. Why?*
- *Medicaid issues and questions about Medicaid benefits (people calling Medicaid who refer them back to C4)*

Plan Renewal Questions

- *Why did/didn't my plan renew?*
- *Why did premiums go up?*
- *Why do I have to be re determined for a tax credit?*

Tax Questions

- *Where is my 1095A?*
- *Why did my tax credit go down?*
- *Why am I not getting a tax credit?*

24 languages

24 languages (non-English) requested of our translation services

Most requested:

SPANISH*	564
VIETNAMESE	51
KOREAN	47
MANDARIN	46
AMHARIC	25
RUSSIAN	17
NEPALI	17
CANTONESE	12

*Bilingual customer service representatives handle most Spanish language calls. Number reflects overflow calls to translation service.



Communications

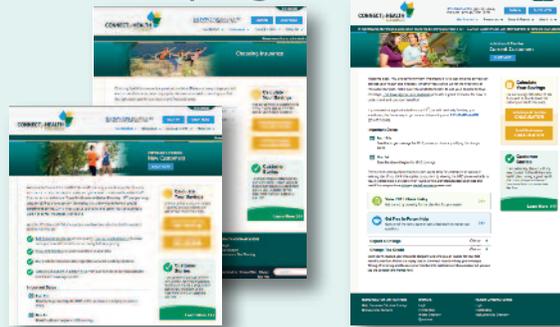


619,743

Unique website visits
(never been on site)

2,385,360

Website page views



482 Original Marketplace posts



952 Tweets **1,124** Mentions



45,745 Views
23,793 Estimated minutes watched

Decision Support

- More than 132,000 unique customers used PlanFinder tool to anonymously compare plans and prices.
- More than 135,000 unique visitors listened to Kyla the avatar. Most popular pages: Home page; PlanFinder comparisons.



Outreach

Special campaigns

108,167

The number of tax forms 1095-A (coverage and tax credit information) were mailed to households

84,446

Auto renewal notices were sent to households

170

Group coverage renewal notices were sent to Small Businesses

Walk-In Enrollment Centers

Enrollment centers hosted by the Marketplace (does not count 12 other Assistance Network or Liberty Tax affiliate sites)

2,500 Coloradans helped, 30% Medicaid

Open for a total of 245 days

- 16th Street, Denver = Open 74 days
- Regis University, Thornton = Open 4 days
- St. Anthony Hospital, Lakewood = Open 28 days
- Greeley = Open 61 days
- Lafayette = Open 39 days
- Southeast Denver/Aurora Broker Site = Open 39 days

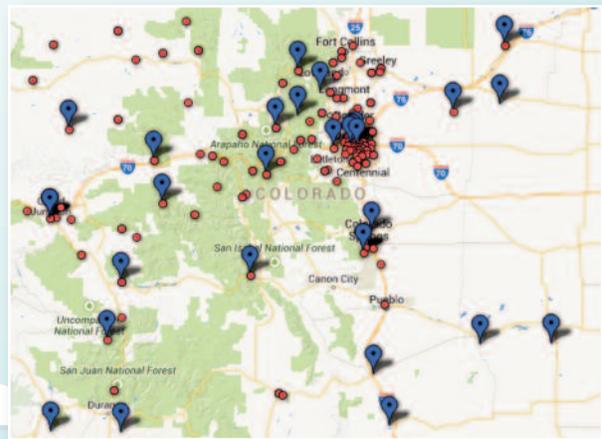
Latino outreach

Bilingual Assistance Sites, Brokers and Connect for Health Colorado were in Hispanic communities encouraging Latinos to enroll in coverage. Outreach took place at events such as Fiestas Patrias on September 14, and the Entravision Hispanic Health Fairs November 23 and December 6, 2014.



Education and Enrollment Events

More than 500 events by Connect for Health Colorado, Assistance Network, Brokers



African American outreach

“Continue the Dream” Social Media Campaign

- Goal: to encourage young adults to sign up for health insurance before Feb 15th
- Partnered with Denver’s top-5 urban entertainment promoters to:
 - Post dedicated Connect for Health Colorado enrollment deadline flyer on social media
 - Place flyer footer on their upcoming event flyers
 - Publish Connect for Health Colorado posts on their event Facebook page

25,720

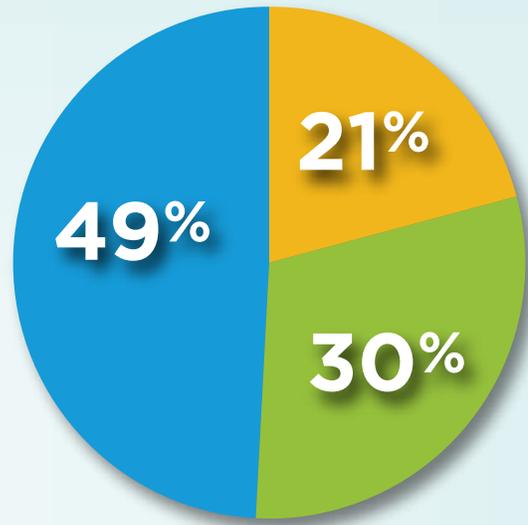
Individuals reached via Facebook timelines

5,700

Individuals reached via concert event pages



Earned media



Positive Negative Neutral

November 2014 - February 2015: 300+ Stories

Open Enrollment was the subject of, or mentioned in, more than 300 news media accounts. National, statewide and local coverage throughout Colorado — the Denver metro area, the Western Slope, Eastern Plains, Northern and Southern Colorado — carried our messages. Our story was told in the African American Voice, on Telemundo, Univision, Spanish language radio, in blogs and newsletters, in addition to dozens of traditional English language outlets large and small. Most coverage was positive or neutral in tone.





2014 Training Results Summary

Type of Training	Number/length of Sessions	Number Trained
Live Carrier Training	4 - 4hr sessions	100
Online Certification / Re-Certification	4 hrs (re-cert) 8 hrs (cert)	300
In-Person Broker Certification / Re-Certification	30 - 4hr sessions	1,000
Conference Re-Certification	21 - 1.5hr sessions	75
Webinars: · Brokers · Health Coverage Guides (HCGs) · Agencies	Brokers - Twice per week, 4 weeks HCG - Weekly Agencies - As needed, 8 weeks	500+
Tips and Other E-mails	Weekly	All sales channels
Broker Support Live Meeting	Weekly	Open to all
Carrier Call / In-person meeting	Weekly	Open to all
Train the Trainer Program for AN	2 sessions, 2 full days each	20 HCGs
SC Trainings - System, ACA changes, etc.	4 sessions 3 hours each	50 SRs
Liberty Tax Broker Training - Live sessions and webinars	15 sites	15

Certifications by sales channels

54

Assistance Network Sites

29

Certified Application Counselor Sites

1,306

Certified Brokers

471

Health Coverage Guides

169

Certified Application Counselors



Connect for Health Colorado Outreach Maps

(click on the map title to view)

2015 Connect for Health Colorado Outreach Events (OE2)

Connect for Health Colorado, Assistance Sites and certified Brokers conducted a minimum of 500 public outreach events across Colorado (September 1, 2014 - February 15, 2015).

2015 Connect for Health Colorado Enrollment by Zip Code (OE2)

2015 medical enrollment data (dental not included).

Date Range: 11/1/14-2/28/15.

"Other" data field: Represents the group of enrollments that had a primary address outside of the state or are missing a zip code.

2014 Connect for Health Colorado Enrollment by Zip Code

2014 medical plan enrollment data (dental not included).

2015 Average Premium Tax Credit by County

Average APTC awarded in 2015

2014 Premium Tax Credits by County

Total federal tax credits, by county, paid to help Coloradans lower their health insurance premium costs in 2014.



855-PLANS-4-YOU {855-752-6749}

TTY: 885-346-3432

ConnectforHealthCO.com



ADAMS COLORADO	\$16,308,578.00
ALAMOSA COLORADO	\$1,249,850.00
ARAPAHOE COLORADO	\$22,741,899.00
ARCHULETA COLORADO	\$2,236,319.00
BACA COLORADO	\$178,228.00
BENT COLORADO	\$366,535.00
BOULDER COLORADO	\$16,333,513.00
BROOMFIELD COLORADO	\$1,848,330.00
CHAFFEE COLORADO	\$3,206,123.00
CHEYENNE COLORADO	\$72,880.00
CLEAR CREEK COLORADO	\$1,192,933.00
CONEJOS COLORADO	\$601,777.00
COSTILLA COLORADO	\$210,607.00
CROWLEY COLORADO	\$236,737.00
CUSTER COLORADO	\$487,719.00
DELTA COLORADO	\$3,177,415.00
DENVER COLORADO	\$21,857,400.00
DOLORES COLORADO	\$223,246.00
DOUGLAS COLORADO	\$8,400,799.00
EAGLE COLORADO	\$9,172,454.00
EL PASO COLORADO	\$14,192,572.00
ELBERT COLORADO	\$1,013,538.00
FREMONT COLORADO	\$2,497,574.00
GARFIELD COLORADO	\$7,365,286.00
GILPIN COLORADO	\$379,362.00
GRAND COLORADO	\$2,034,626.00
GUNNISON COLORADO	\$3,656,471.00
HINSDALE COLORADO	\$181,145.00
HUERFANO COLORADO	\$464,550.00
JACKSON COLORADO	\$157,012.00
JEFFERSON COLORADO	\$16,802,999.00

KIOWA COLORADO	\$76,232.00
KIT CARSON COLORADO	\$411,021.00
LA PLATA COLORADO	\$7,434,303.00
LAKE COLORADO	\$604,872.00
LARIMER COLORADO	\$12,549,660.00
LAS ANIMAS COLORADO	\$927,395.00
LINCOLN COLORADO	\$220,130.00
LOGAN COLORADO	\$1,203,095.00
MESA COLORADO	\$8,378,246.00
MINERAL COLORADO	\$170,314.00
MOFFAT COLORADO	\$643,678.00
MONTEZUMA COLORADO	\$2,389,059.00
MONTROSE COLORADO	\$4,890,252.00
MORGAN COLORADO	\$930,591.00
OTERO COLORADO	\$713,523.00
OURAY COLORADO	\$1,382,963.00
PARK COLORADO	\$1,383,351.00
PHILLIPS COLORADO	\$326,005.00
PITKIN COLORADO	\$5,355,828.00
PROWERS COLORADO	\$537,897.00
PUEBLO COLORADO	\$4,997,261.00
RIO BLANCO COLORADO	\$439,114.00
RIO GRANDE COLORADO	\$978,278.00
ROUTT COLORADO	\$4,089,658.00
SAGUACHE COLORADO	\$672,438.00
SAN JUAN COLORADO	\$175,062.00
SAN MIGUEL COLORADO	\$1,729,173.00
SEDGWICK COLORADO	\$199,194.00
SUMMIT COLORADO	\$5,070,828.00
TELLER COLORADO	\$787,740.00

WASHINGTON COLORADO	\$433,560.00
WELD COLORADO	\$21,866,347.00
YUMA COLORADO	\$738,779.00
	\$251,554,324.00