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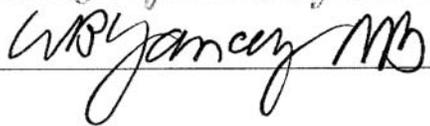
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Comprehensiveness

What problem does this proposal address?

This proposal (Universal Colorado Health Insurance Plan: U-CHIP) addresses universal health care for all residents of the State of Colorado. The objective is to provide affordable health care for every individual in the State of Colorado by providing each individual with health insurance for basic services. Secondary objectives are to provide the proposed medical care at a cost, per capita, less than is currently spent in the state; to establish a financial climate where the cost of medical care is reasonably stable and increases no faster than the nominal rate of inflation in the state; and to create a stable environment for businesses, insurance companies, the state, and individual, such that accurate budgeting for the future is possible. The tertiary objectives include maintaining a competitive, market-driven industry and avoiding the complete dismantlement of the present medical insurance industry in Colorado. It makes sense to fine tune that industry with regulation, such that it serves the entire population, rather than only the healthy, employed population. Additional tertiary objectives are to maintain the present health care system without major disruption in the way services are presently provided; and to keep medical care inflation under control by addressing major causes of inflation: bureaucratic red tape, cost shifting, fraud, abuse, and malpractice litigation.

What are the objectives of your proposal?

To provide medical health insurance to cover basic health care needs for every resident of the state.

General

Please describe your proposal in detail.

The entire State of Colorado's 4.5 million person population will be divided into large groups of approximately 10,000 individuals in each group. (The groups can be any size, 10,000 persons up to the entire state's population. Using 10,000 as a starting point allows smaller insurance companies to participate in the process.)

Persons are assigned to these groups at random (or by approved formula), such that each group has the same number of persons in each decade of life, the same number of women, men, and children. In short, the demographics of each group will be identical to every other group. A mechanism for maintaining the equitable distribution among the groups when new residents are added, or there are losses due to deaths and persons leaving the state, will have to be established. The object is to maintain equivalent group demographics. Children are in the same group as their parents (until age 18, high school graduation, college graduation, age 21, or some other definable point) at which time they are assigned to another group. Each group will contain the same number of newborns, 10 year olds, 20 year olds, 60 year olds, etc. Each will have the same number of females and males, females capable of getting pregnant, unemployed and employed, south, north, east, and west Coloradans, migrant workers, and the same number of persons with chronic diseases. These are large groups of patients. The two key points are these: *In every large group the healthy vastly outnumber the unwell. And, the demographics of each group are exactly the same as every other.*

The State of Colorado will appoint a Medical Benefits Commission to decide what minimal medical benefits will be available for these groups of individuals. Suggested possible benefits include: all vaccines required by the CDC, preventive medicine and dentistry, catastrophic care, hospitalization, and mental health care; discounted generic medications and office visits will require co-pays based on documented wealth and income to discourage unwarranted use. At minimum, preventive vaccinations, preventive dental care, and catastrophic care should be covered by this basic insurance. The actual benefits will be determined by what services the state can afford, those benefits which are high value (i.e., cost effective versus high intensity and less than cost effective), proven by research to be beneficial, lend themselves to evaluation for quality control, that its citizens choose to pay for, and the costs of those services. In most cases, the more preventive care provided, the lower the actual future expenses. (For instance providing prenatal care to decrease care for low birth weight babies; treating hypertension, hypercholesterolemia, and diabetes, to lower the amount spent later for heart attacks and

strokes; providing outpatient mental health care to avoid inpatient care, etc. See *Your Money or Your Life* by David M. Cutler; Oxford University Press, 2004.)

Insurance companies desiring to sell any health insurance in Colorado will be required to offer health insurance to cover the medical services the Medical Benefits Commission decides are essential. The cost of this insurance will be based on the demographics of the large groups. The purpose of the assignment of the population into large groups is to spread the risk of the need for medical care. Each insurance company can decide for how many groups of 10,000 it chooses to compete. This health insurance will be offered at the same price to each resident, regardless of employment or health status.

Physicians, all other medical practitioners and providers, and hospitals licensed in the state will be required to accept this group health insurance.

In return for accepting this insurance, physicians, medical practitioners and providers, and hospitals will be exempt from malpractice claims tried in a court of law in local, state, and federal courts, when treating patients who are covered by this insurance.

A Medical Outcomes Arbitration Board (made up of medical and legal professionals) will determine injury, compensation, and (if necessary) assign blame and punishment for bad medical outcomes (in concert with the state licensing board). This board will also arbitrate conflicts arising from Workers Compensation and automobile related injuries.

Every resident of the State of Colorado will be required to have at least the minimal basic health insurance as defined by the Medical Benefits Commission. Each individual in the state will choose a medical insurance plan based on its benefits (those required by the state, and those which are optional). Co-pays for services will be on a sliding scale and based on documented wealth and employment status. For some individuals the co-pays will be minimal. For some, the entire cost of the care will be borne by the patient. Again, at minimum, preventive vaccinations, preventive dental care, and catastrophic care should be included in the insurance plan.

Every employer in the state will be required to pay for insurance to cover the minimal state requirements for each employee and his dependents. If parents work for different employers, the dependents will be divided for coverage as equably as possible. The plan for each employee and his family will be chosen by the individual employee (preferably from a panel of 3-5 plans presented by the employer). Employers, or employees, can chose to add extra benefits, based on their willingness to pay for those benefits.

Those persons who are unemployed will have the insurance premium for basic health services paid by the state.

Who will benefit from this proposal?

If every segment of the health care industry (providers, patients, insurance companies, lawyers) gives a little, then everyone benefits. If individual greed prevails and special interests skew the plan, the entire population will bear the costs.

If the cost is spread over the entire population, the total expenses should be approximately the same as the current expenses for health care, but cover the entire population. The money for this health care is already being spent, by the state and taxpayer: through cost shifting to insured and uninsured; through state support of hospitals, and Medicaid and other programs; and on fraud, waste, malpractice expenses, and bureaucratic red tape. The overall goal is to provide better care for everyone at less than the present per capita cost.

1. The benefits from such a program for the health insurance companies are as follows: Participating insurance companies will have access to all of Colorado's population, 4.5 million people.

Insurance companies will be dealing with demographically known and stable groups of individuals. They should be able to calculate precisely, statistically, what their costs will be for each large group of insured citizens. Since healthy people in large populations far

outnumber the unhealthy, the insurance companies should be able to design programs that make a profit.

Small insurance companies can bid on as few as 10,000 individuals (one group); larger companies, more groups of 10,000. The more efficient an insurance company is at administering their plan, the more profit it will make. The more participating companies, the greater the competition, the lower the prices, and the better the health care.

Insurance companies will still be able to sell supplemental insurance to individuals who want more coverage than that supplied by the universal plan. Companies can offer any type of plan they like, managed care or fee-for-service, as long as the minimal requirements by the state are covered, any resident in the large group can enroll, and the premiums are the same for everyone. They may offer as many different plans as they want.

Insurance companies may be able to foster long term relationships with consumers, and thus profit from preventive measures by lowering their future expenses.

2. The benefits for the individual are these: Every person in the state will have health insurance for basic health care.

Individuals will have universal access to primary care physicians and will therefore have to use ERs less often. They will no longer wait until their disease process is out of control to seek medical care, making the treatment easier and less expensive.

In addition to real competition between insurance companies, there will be real competition between medical providers. Market forces will prevail in a regulated fair environment. As a result there will be lower prices for medical care.

The elderly and chronically ill will be in large groups and their insurance rates will reflect the health of the entire group. Thus, the costs are much lower than the insurance rates for individuals, especially sick individuals.

Since the prices will all be competitive, the choice of plans narrows down to essentially the most consumer friendly plan, ease of use, and low rates, forcing the insurance companies to be responsive to the consumer and patient.

Insurance companies will be forced to be efficient in order to profit, as will health care providers. It is likely the insurance companies will pay incentives to providers who provide better care, better hours, and who have better outcomes for their patients, because that lowers their expenses in the long run and attracts more customers.

If a person loses or changes his job, his healthcare insurance remains in force.

People who can afford and want even better coverage or supplemental coverage may buy it.

Since every medical provider in the state will accept the insurance, patients may use the physician of their choice, although there may be financial repercussions for using physicians outside a managed care plan.

Malpractice cases will be decided by a board of medical and legal experts, decreasing time spent on and costs of such cases and removing them from the courts.

3. Health care providers will benefit. Hospitals, doctors, and other health care providers can expect a certain fixed amount of reimbursement for every patient, guaranteed by the state in the contracts with the insurance companies. Cost shifting ends. There will be no need to pad the charges of the paying patients to pay for the uninsured, or to increase charges on the insured because the insurance company deigns to pay half of the fee.

With every resident having access to primary care physicians, the number of ER visits should drop.

The money saved on malpractice insurance can be reinvested in the practices.

Fewer unnecessary expensive tests or treatments will be ordered as malpractice precaution.

Patients will be more accepting of generic drugs, and avoiding unnecessary medications and tests, since their use directly affects the patient's pocketbook.

Patients will likely be able to see the doctor of their choice, allowing long term relationships, even if they change their insurance company.

4. Lawyers who deal mainly with personal injury will benefit if their main interest is their client. The review of cases by the Medical Outcomes Arbitration Board will be quicker, and the judgments more reasonable and more uniform, than those cases decided by juries with no medical or legal expertise. Bona fide malpractice claims will be handled more fairly. Real losses suffered by patients will be addressed in a fair, rather than an arbitrary, manner. Frivolous suits will be dealt with quickly and not tie up the courts.

5. Employers will benefit. Health care prices will be more stable.

The expense to companies already providing insurance is likely to be considerably less than what they pay for health insurance now, because the cost and risk will be spread over the entire population.

If every individual in the state is covered by medical insurance including covering workers compensation and injuries from automobile accidents, the costs of automobile and workers compensation insurance are also reduced.

The use of the Medical Outcomes Arbitration Board will decrease the costs of workers compensation, general liability, and automobile insurance.

6. For Colorado, a healthy population (protected from preventable diseases and the financial devastation of hospitalization and catastrophic disease) insures a healthy work force and tax base. The co-pays, being set by the insurance commission and based on the documented wealth of the individual, will discourage overuse and abuse by individuals, saving taxpayers' money.

Who will be negatively affected by this proposal?

1. Insurance company profits may possibly decrease. They will no longer be able to insure only healthy individuals, to deny service to individuals with medical problems, or to deny service to those at risk statistically (important in the coming age of genetic medicine). Their profits will no longer be dependent upon refusing health insurance to those persons in need. Instead, they will be forced to negotiate reasonable contracts with hospitals and providers based on the demographics of the large groups outlined above. They will be in competition with other insurance companies to arrive at fair prices for the services rendered. Companies unable or unwilling to be efficient will lose money and eventually go out of business.

2. Even though the individual worker will receive health care insurance, he may receive it at the expense of wages.

For the consumer (and sometimes patient) the downside will also include the expense of medical care on a sliding scale based on his documented wealth. At present, once a patient's deductible has been met, there are few consequences to demanding the most expensive drug, unnecessary treatments, the most expensive test, or more office visits or admissions than are necessary. Patients think of these services as being paid for with someone else's money, driving the costs up for everyone who is insured by the same insurance company, or government plan. The sense of entitlement will disappear when

the patient pays a reasonable fee, or portion of the fee, for the services, visits, and medication. When a patient sees how often he goes to the physician's office, just because he smokes, overeats, or doesn't get enough exercise, and he has to pay for those vices, he may want to reconsider his life style.

The individual will also pay taxes to support this plan, and for any increases in prices for consumer products produced by companies forced to participate. The question is whether these changes will foster a decrease in taxes or costs, or an increase. Total cost to the consumer depends upon what services the state chooses to include in the basic package, and the efficiency of the system.

3. There will be health care providers who provide services not covered by this universal insurance, such as cosmetic surgery and lasik eye surgery, for instance. For medical care not covered by the universal health plan, these practitioners will still need malpractice insurance. Their services will not be addressed by the Medical Benefits Commission.

Health care providers' bottom lines may possibly be negatively affected. They will have to negotiate with insurance companies, which will now deal with an entire population and will look more critically at expenses. Providers' charges will be more closely scrutinized. They will not be allowed to shift costs to cover for inefficiency or waste.

Since patients may see any medical provider, a provider will have to be more responsive to maintain his patient base.

Hospitals which derive most of their admissions from the ER will see a decline in need for services.

Also, because the acuity of ER visits will likely decline when everyone has access to regular medical care, the lengths of stay in the hospital will decrease, along with the expense. This would mean less income for the hospital.

The Medical Benefits Commission should study the quality of the health care it wants covered. For instance, the hospitals which do the most cardiac by-passes frequently have the best results. The published results of those quality studies may have an adverse affect on medical providers which provide lower quality care.

4. Attorneys whose main interest is in winning huge judgments for medical malpractice may lose income. They will, however, still be able to represent clients in front of the Medical Outcomes Arbitration Board.

5. Employers will have to pay for the insurance for each employee and his dependents. Some employers are not presently supplying insurance and this will be a financial burden. This will be one of the expenses of doing business in Colorado. A fair, reasonably priced, universal health plan will attract companies and workers. If the system is poorly run with extravagant costs, it will drive them out of the state.

6. If no insurance companies choose to participate, then the state becomes the default insurer. It will then have to collect premiums and disburse funds, creating a whole new bureaucracy. This plan de-evolves into a single-payer system, and social medicine. If that proves true, the Medical Outcomes Arbitration Board for malpractice, workers compensation, and automobile injuries becomes even more important as a cost saving measure.

7. Niche practitioners who over prescribe medication, surgery, therapy, etc. for Medicaid, Medicare, Workers Compensation, and automobile injuries may lose business.

How will your proposal impact distinct populations (e.g. low-income, rural, immigrant, ethnic minority, disabled)?

Every resident of the state receives health insurance for basic health care.

Please provide any evidence regarding the success or failure of your approach. Please attach.

There is no direct evidence. An incentive based system is likely to be more efficient and cost effective than social medicine, provided regulations insure fair competition and the inclusion of all residents. As Adam Smith pointed out, in *The Wealth of Nations*, those who seek wealth by pursuing their own goals, inadvertently stimulate the economy and assist society as a whole, through the invisible hand of the market economy.

How will the program(s) included in the proposal be governed and administered?

The state will need to appoint a Medical Benefits Commission. The duties of this commission include, but are not limited to:

1. Determining the list of benefits for which it wants to insure its residents.
2. Deciding the method for determining co-pays for services, based on a sliding scale linked to an individual's documented wealth.
3. Designing the formula to populate the 10,000 member, or larger, groups; whether at random, or by filling specific criteria, and a method for maintaining the equivalence between groups when adding or losing members.
4. Defining who is a resident, and addressing the definition of and who will pay the insurance expenses for migrant workers and illegal aliens.
5. Delineating how to measure the quality of care rendered.

The Medical Outcomes Arbitration Board will also have to be designed and implemented.

To the best of your knowledge, will any federal or state laws or regulations need to be changed to implement this proposal (e.g. federal Medicaid waiver, worker's compensation, auto insurance, ERISA)? If known, what changes will be necessary?

This plan replaces Workers Compensation and automobile insurance for injuries. The US Government may change the way it disburses funds for Medicaid in respect to this

plan. (It may decide on block grants, rather than per capita reimbursement.) Automobile insurance rates should decrease with inclusion in this plan. Also Workers Compensation rates will decrease when included in this plan.

How will your program be implemented? How will your proposal transition from the current system to the proposal program? Over what time period?

Once the Medical Benefits Commission decides on demographics of the large groups and the list of possible benefits for those groups, the information will be given to health insurance companies. They will be given three months to decide if they want to participate, what they will pay for those services to hospitals and health practitioners, and what to charge for insurance premiums. Cost information is readily available to most medical insurance companies, because they have existing contracts with medical providers already.

The participating insurance companies will give their cost estimates to the Medical Benefits Commission. The commission will then decide exactly which basic services its insurance will cover. Bids will be accepted for those services. The Medical Benefits Commission will decide which plans are acceptable and make that list available to employers.

Employers will decide which of the plans they want to offer their employees. Ideally, every plan accepted by the Medical Benefits Commission will be available to every employee. Realistically, the employer will choose to allow its employees to choose among the least expensive plans. As a recruiting tool, it may choose to offer other plans with better benefits to certain employees. Employees may choose to upgrade their insurance to add benefits, but at their own expense.

Employees and unemployed residents will choose to which plans they wish to belong.

Employers and the state begin to pay premiums.

Hospitals and medical providers will be notified to start accepting the insurances of the plans which the Medical Benefits Commission has approved.

The Medical Outcomes Arbitration Board has to be designed. The number of expected cases will determine the number of arbitration committees. Regulations for implementation need to be written.

The entire process should not take more than 1 year.

Access

Does this proposal expand access? If so, please explain.

This proposal expands health insurance coverage and, therefore, health care to every resident of the state.

How will the program affect safety net providers?

Safety net providers may no longer be required, as everyone will be insured. There will always be a role for charitable organizations to help bear the burden of costs that some individuals cannot easily afford. Those organizations will have to decide what support they will provide, co-pay free services, transportation, etc.

Coverage

Does your proposal “expand health care coverage?” (Senate Bill 06-208)

How?

This proposal expands health insurance coverage and, therefore, health care to every resident of the state.

How will outreach and enrollment be conducted?

The state has data on those receiving unemployment compensation, and persons paying state income tax. Employers have data on employees. Individuals not registered in those categories will have to register with the state.

If applicable, how does your proposal define “resident?”

It would likely use the same rules that apply to persons seeking other benefits from the state, i.e. in-state college tuition. Dependents will have the same residency as their parents. Migrant workers will have to be covered on a part time basis while employed in the state. The definitions will be determined by the Medical Benefits Commission.

Affordability

If applicable, what will enrollee and/or employer premium-sharing requirements be?

The employer gives the employee a choice of plans (ideally 3-5 plans) from which to pick. It pays for the health insurance chosen by the employee and his family to cover basic health care requirements as defined by the state. The employee (or employer, if it chooses to do so) pays for benefits above and beyond the minimum basic health insurance requirements.

How will co-payments and other cost-sharing be structured?

Co-pays will be based on documented wealth, likely determined from previous state and/or federal income tax returns. The costs to individuals will be determined by the Medical Benefits Commission.

Portability

Please describe any provisions for assuring that individuals maintain access to coverage even as life circumstances (e.g. employment, public program eligibility) and health status change.

When a person loses employment, he notifies the state (probably at the same time and place he applies for unemployment compensation) and the state takes over paying for the basic services insurance. The individual is still responsible for additional services and insurance to cover them. A new employer takes over the expense of basic services insurance when the employee reports to work. The employee may have to switch plans, if his new employer does not want to pay the premiums to the new employee’s former

insurance company. There should be no lapse in coverage or waiting periods in either case.

Benefits

Please describe how and why you believe the benefits under your proposal are adequate, have appropriate limitations and address distinct populations.

The benefits provided by the state (the insurance for basic health services) depend on the basic services that will be covered. These are chosen by the state appointed Medical Benefits Commission, and can vary from year to year depending upon costs. In addition to depending upon cost fluctuations and the population's willingness to pay for services, these benefits will also change as new technologies become available. Obviously, it will be less expensive to provide only preventive vaccinations, hospitalization, and catastrophic care, than if the state also decides to pay for all vaccines required by the CDC, preventive medicine and dentistry, catastrophic care, hospitalization, mental health care, medications, and office visits.

Please identify an existing Colorado benefit package that is similar to the one(s) you are proposing (e.g. Small Group Standard Plan, Medicaid, etc) and describe any differences between the existing benefit package and your benefit package.

This plan is probably most closely related to Medicare, with the state and employers providing basic coverage and the individual deciding what other options he wants to pay for.

Quality

How will quality be defined, measured, and improved?

Quality will be defined and judged by the Medical Benefits Commission. It should choose to include in the benefits package only medical care which is of proven scientific value. It will have the power to order quality control studies to determine if the benchmarks it defines are being met by insurance companies and medical providers, and the taxpayers' money is well spent.

Quality will also be judged by outcomes and total cost. Unfavorable outcomes can be challenged before the Medical Outcomes Arbitration Board. Medical and legal experts will determine true loss, and assign blame or punish the individual responsible (if necessary). If the system is too expensive for the benefits derived, employers and taxpayers will refuse to pay for it.

How, if at all, will quality of care be improved (e.g. using methods such as applying evidence to medicine, using information technology, improving provider training, aligning provider payment with outcomes, and improving cultural competency including ethnicity, sexual orientation, gender identity, education, and rural areas, etc.?)

These issues will have to be addressed by the Medical Benefits Commission, insurance industry, health care industry, providers, licensing boards, state legislature, and Medical Outcomes Arbitration Board on a case by case basis.

Efficiency

Does your proposal decrease or contain health care costs? How?

Competition and market economy force all participants to be efficient and cost effective.

To what extent does your proposal use incentives for providers, consumers, plans or others to reward behavior that minimizes costs and maximizes access and quality in the health care services? Please explain.

Competition and market economy force all participants to be efficient and cost effective.

Does this proposal address transparency of costs and quality? If so, please explain.

Competition and market economy force all participants to be efficient and cost effective. The stock owners of the corporations involved can demand their companies' finances be transparent.

How would your proposal impact administrative costs?

Competition and market economy force all participants to be efficient and cost effective.

Consumer choice and empowerment

Does your proposal address consumer choice? If so, how?

The consumer may choose among any plan his company allows, as long as it meets the state requirements for the minimal basic health insurance benefits. If he desires, he may also choose to upgrade that plan to whatever level he desires and can afford.

How, if at all, would your proposal help consumers to be more informed about and better equipped to engage in health care decisions?

Consumers who are well-informed about the plans they can choose between make better decisions. It is in their best interest to be well-informed. They should be more receptive to suggestions from physicians and insurance companies on how to maintain their health and lower their health related expenses, when the decisions they make affect their pocketbook.

When the health insurance company's bottom line is directly affected, it will be more proactive. Avoiding the cost of caring for low weight infants should lead to the promotion of prenatal care. The same is true for the avoiding the expense of a lifetime treatment for diabetes by the promotion of nutritional training and weight control for the insurance company's clients. In many cases, preventive care is far more cost effective than treating advanced disease states. Insurance companies will act to protect their bottom line, as will consumers, and medical providers.

Competition and market economy force all participants to be efficient and cost effective.

Wellness and prevention

How does your proposal address wellness and prevention?

The consumer who can maintain or improve his health pays less for medical care. It is also in the best financial interest of the health insurance companies to keep their

customers healthy to avoid paying for the treatment of advanced medical conditions. It is likely they will push wellness. Preventive care, preventive dental care, and vaccinations should be included in the minimal basic coverage provided in the sponsored plan.

Sustainability

How is your proposal sustainable over the long-term?

Increases in efficiency and decreases in costs brought about by market forces will keep expenses down for the state. The Medical Benefits Commission also has the option of decreasing the benefits for which it supplies insurance, if the population is unhappy with a growing tax burden. The Medical Benefits Commission also must guard against the inclusion of expensive benefits of little scientific value or cost effectiveness that would drive the state into bankruptcy.

(Optional) How much do you estimate this proposal will cost? How much do you estimate this proposal will save? Please explain.

“There are no good estimates of the net cost or benefit in economic activity of moving to a system of universal health insurance coverage.” (David M. Cutler, *Your Money or Your Life*, p 121) The cost depends on the basic health services the Medical Benefits Commission chooses to include in the insurance policy. One estimate has been made that (in a well designed and executed system) the cost for universal medical care will neither increase nor decrease over present expenses. Likely, there is about as much money lost in providing unneeded medical care and waste in red tape, fraud, and malpractice, as needed to include those who have no health care.

Who will pay for any new costs under your proposal?

The residents of the State of Colorado will pay the taxes that support this system. Some of the expenses by employers can be exported out of state, or to other countries. This would be done by participating companies when passing on any increased cost of goods (brought about by the expense of providing basic health insurance) to those who buy their products. It is hoped that the overall tax burden will decrease, secondary to savings from

the end of providing unnecessary and unnecessarily expensive care, cost shifting, fraud, bureaucratic red tape, and unwarranted malpractice claims.

How will distribution of costs for individuals, employees, employers, government, or others be affected by this proposal? Will each experience increased or decreased costs? Please explain.

Competition and market economy force all participants to be efficient and cost effective.

Are there new mandates that put specific requirements on payers in your proposal? Are any existing mandates on payers eliminated under your proposal? Please explain.

This plan requires the establishment of a Medical Benefits Commission and the Medical Outcomes Arbitration Board for malpractice, Workers Compensation, and automobile related injuries. Workers Compensation will have to be restructured. Automobile insurance within the state will have to be restructured. This plan requires employers to pay for basic health insurance for every employee and his family. It requires the State of Colorado to pay for basic health insurance for every other resident of the state.

(Optional) How will your proposal impact cost-shifting ? Please explain.

With every patient covered by insurance, there should be no cost shifting. The price of medical care is the same for every individual for comparable services.

Are new public funds required for your proposal?

Funds will be necessary to establish the Medical Benefits Commission and the Medical Outcomes Arbitration Board and maintain them. The hoped for result is that, with the end of cost shifting, improved efficiency in delivery of health care, and decrease in health insurance inflation, the overall costs will decrease, and the public funds input will decrease.

(Optional) If your proposal requires new public funds, what will be the source of these new funds?

Not applicable.

A single page describing how your proposal is either comprehensive or would fit into a comprehensive proposal.

This proposal is comprehensive. It calls for basic health insurance coverage for every resident of the State of Colorado. It requires participation by every medical provider licensed in the state and every insurance company licensed to sell medical insurance in the state. The plan necessitates the establishment of the Medical Benefits Commission to determine the health care covered. It requires all medical malpractice, workers compensation, and automobile injury disputes be decided by the Medical Outcomes Arbitration Board made up of medical and legal experts, to limit the expenses of such cases to true losses and to judge the competency of those practicing medicine.

(Optional) A single page describing how your proposal was developed.

A novel approach is needed to replace the dysfunctional medical care delivery system that exists in the United States at this time. This is an attempt to fix what is wrong: the exclusion of the persons who most need health insurance by the insurance industry; the under-utilization of the health network by those in need; the overuse of the health care network by some providers and patients; and the hyper-inflation of medical costs caused by frivolous suits and unwarranted million dollar judgments, cost shifting, fraud, red tape, and greed. It is also an attempt to retain what is good, a market economy that supports preventive medicine and research that leads to medical breakthroughs: wonder drugs, cancer treatments, imaging equipment, medical robots, genetics, and nano-technology. All these developments require incentive. A market economy provides that incentive. Social medicine will not fix these problems. It will lead to medical research stagnation, rationed care, and two systems of care: one for the wealthy, and one for the rest of us.