

## **Healthcare Taskforce – Proposed Charter for Healthcare Reform**

*South Metro Denver Chamber of Commerce*

### **Executive Summary**

Healthcare is becoming increasingly more expensive. Medical advances, technological improvements, and inefficient management have contributed to a startling scenario. Annual double-digit rate increases are straining consumer finances, the economic viability of businesses of all sizes, and governmental budgets. Reimbursement issues contribute to providers leaving the practice of medicine at a surprising rate. Pricing rates and quality scores do not reflect a level of transparency necessary for effective decision-making. The current trend of cost escalation will continue to have a detrimental effect on the United States economy unless bold changes are made. At the present time, the healthcare industry lacks the competition and efficiency drivers that are apparent in other industries. Healthcare providers and insurers have a strong voice in purchasing and delivery decisions. However, consumers (businesses and individuals) have a lesser voice.

With guiding principles, cost/value initiatives, information sharing/efficiency solutions implemented through the private market with an appropriate level of government regulation, our proposal offers a distinct contrast from the single payer or heavily government managed plans under consideration. A major component of the South Metro Chamber plan focuses on the payment for healthcare from an interrelated three-tiered perspective featuring preventative, maintenance, and catastrophic tiers. Preventative care promotes good health as well as treats conditions at an early stage prior to the development of long-term, chronic problems. Maintenance refers to treatable conditions without a major cost. Catastrophic are the conditions with high costs.

By shifting the management of healthcare insurance from the employer to the consumer, hopefully, individuals will see a greater connection between their own health choices and later medical treatment. When a consumer sees positive lifestyle choices, such as a healthy diet and the decision not to smoke, make a favorable impact on their personal finances and overall health, both in the short-term as well as the long haul, then additional individuals will take the path of most responsibility resulting in optimal choices. As more and more consumers assume greater control over their health, then the cumulative costs of healthcare will decrease, quality will increase, and we will all enjoy greater healthcare value.

## **Introduction**

The crisis in the American healthcare system impacts every sector of society. The solution requires a broad-based approach. More than two years before the legislature created the Colorado Blue Ribbon Commission on Healthcare, the South Metro Denver Chamber of Commerce assembled a task force of diverse stakeholders in healthcare to address these concerns and to craft creative and innovative answers. Participants include healthcare consumers and business executives, as well as managers with extensive experience in such areas as healthcare delivery, health insurance, public policy, preventative medicine, technology and automation, hospital administration, legal, actuary, and accounting. This proposal is the product of over three years of extensive study, debate, and drafting.

From the beginning, the South Metro Chamber taskforce decided to craft a plan without a commitment to retaining any component of the current healthcare system. By adopting a “blank slate” approach, the taskforce focused on how to resolve deficiencies in the healthcare system without catering to any specific stakeholder or special interest group. The taskforce acknowledges that the recommendations are innovative and not constrained by current systems. Other proposals may not always be amenable to precise cost estimates based on historical data.

Unlike proposals that address only limited aspects of the problem, or shift the problem from one area to another, the diversity and balance of the taskforce has produced a comprehensive plan that tackles both the major cost and payment sides of the equation, while promoting the concepts of a free market economy and emphasizing individual choice and personal responsibility. This proposal looks beyond the “sacred cows” inherent in many healthcare reform proposals to ensure barriers to creative solutions are removed. Equally as important, unlike many proposals that address only how healthcare is purchased, this plan creates options to reduce costs and to improve the quality of services. Any plan that focuses solely on payment without addressing costs and improving quality will prove futile. The South Metro Chamber plan will assure that healthcare dollars will be spent more productively.

The South Metro Chamber plan relies on the same power of a competitive marketplace that has eliminated inefficiencies and fostered creative solutions in many other industries. We believe competition will cause healthcare providers and insurers to develop cost-effective and high-

quality products in order to thrive in the marketplace. This competition will also foster new levels of personal accountability and responsibility by the consumer.

Healthcare, which is vital to the personal security of every individual, is an area where carefully crafted government programs and regulations can bring an appropriate level of compliance. This level of regulation is similar to other industries where government involvement strengthens an industry by ensuring fair behavior among the key participants. While recognizing an appropriate role for government, the South Metro Chamber proposal provides a distinct contrast to the many single payer plans where government occupies the primary role in the delivery and financing of services. The South Metro Chamber plan provides a state governmental framework which limits the excesses of the current healthcare situation, encourages high quality healthcare, and fosters transparency in both quality and cost, while allowing the best features of the free market system to work.

Our plan's essence is a philosophical shift away from looking at healthcare insurance as an employee benefit where the management and financing are the responsibility of someone other than the healthcare consumer. Due to the escalating costs over time, healthcare as an employee benefit has decreased the number of people covered by insurance. By moving the responsibility for managing healthcare insurance to the consumer, decisions will be made by the person most impacted by those decisions. Included in our plan are economic incentives to adopt a healthy lifestyle, prevent illness in the early stages, and make the most practical and cost-effective medical decisions. This shift's cumulative impact will be reduced costs and higher quality.

## Questions

### A Comprehensiveness

#### 1) What problem does this proposal address?

Healthcare costs are growing dramatically, financially straining governments, businesses, and consumers. As a result, an ever-increasing number of businesses cannot provide insurance coverage to employees, and individuals are unable to afford this protection. Uncompensated expenses associated with the cost of catastrophic care for the uninsured/underinsured are burdening our entire system, often destroying financial nest eggs and causing personal bankruptcies. At the same time, due to decreasing reimbursements, increased outside involvement in medical judgment, and other issues, providers are leaving healthcare at an alarming rate. Without bold and sweeping changes, these concerns will have an increasingly detrimental effect on the economy and severely limit access to quality healthcare. Our country has long demonstrated the ability to face significant challenges.

The healthcare industry currently lacks the competitive factors and efficiency drivers that are inherent in other free-market industries. For example, these factors decrease costs and improve quality in retail, telecommunications, manufacturing, agriculture, and financial services. The absence of transparent information regarding cost and quality of healthcare services prevents the consumer from making informed financial and value decisions. At the same time, insurers and employers with employer-sponsored benefit plans, and government entities through safety-net social programs, have become the primary participants in healthcare, with consumers increasingly removed from both price and treatment decisions. Too often, healthcare payers have developed complex payment rules which frustrate providers and enrollees and increase administrative costs. Insufficient resources are applied to the prevention of disease, leading to escalating expenditures for treatment. Consumer education, lifestyle choices including diet and exercise, and other inexpensive preventative measures are underutilized while extensive resources are devoted to healthcare treatment of conditions which could have been managed or avoided.

In many ways, the application of competition has decreased quality and increased costs. Healthcare system participants have minimized transparency in the costs and charges as well as concealed information necessary to evaluate and improve the quality of care. Consumers cannot determine which services represent the best value; providers cannot obtain comprehensive protocols for best practices; and payers cannot assure that dollars are spent for the most effective and necessary practices.

**2) What are the objectives of your proposal?**

- Universally affordable and accessible healthcare
- Increased personal accountability and responsibility for health and lifestyle choices with improved outcomes for society and individuals
- A better definition of healthcare value
- Tools for quality measurement with easy consumer access to quality information
- A rational way to deliver healthcare as an alternative to socialized medicine
- Reduced role for employers in the healthcare system
- Transparency of healthcare quality and price
- Enhanced application of free market principles for payers, medical service providers, and facilities competing for the best interests of the consumer

**B. General**

**1) Please describe your proposal in detail.**

**Guiding Principles**

Whenever a dilemma exists as complex as our current healthcare system, involving so many different stakeholders, solutions must be comprehensive and consistent with well-considered guiding principles. In order to develop a proposal that is well-grounded in key fundamental principles, the taskforce developed the following foundational framework:

- 1) **The fundamental player in healthcare transactions is the individual.** The patient/consumer must be in control of healthcare decisions.
- 2) **The fundamental relationship within healthcare is between the individual (patient) and a provider (physician or other healthcare provider).** Anything that hinders this relationship should be minimized. Efforts that enhance this relationship are to be encouraged.
- 3) **Healthcare services should be provided to an individual with limited outside intervention.** Individual responsibility, transparency, efficiency, and market forces need to be apparent when services are provided.
- 4) **Increased value within healthcare should be a goal for all participants.** Value is directly proportional to quality and inversely proportional to cost. Increasing quality and/or decreasing cost both increase *value*. Quality may be defined by *excellence* in the following four characteristics: effective delivery of a service or product; positive outcome of that service or product; efficient use of resources; and ongoing efforts to achieve improvement in the service or product.
- 5) **There is no automatic connection between healthcare and employment.** This current system developed in World War II when employers needed an extra incentive for workers during a time of critical demand for production from a reduced workforce. This assumed connection has contributed significantly to the healthcare crisis and to a lack of responsibility by consumers of healthcare from resultant uncontrolled spending. Making the consumer a key participant in both financial participation and decision-making is important. As long as the patient/consumer has no stake in the cost/quality aspects of procedures or treatment, costs will continue to escalate. Battles between providers and insurers will continue unabated over the necessity and reimbursement for care, and enrollees will fight over denial of benefits.

The link between employment and healthcare coverage is already diminishing as employers reduce or end healthcare coverage for employees. By making

healthcare coverage more universal and affordable and employees more responsible for their healthcare choices, employers can choose to use healthcare coverage, reimbursement, or other options as a competitive advantage in the labor market instead of an expectation.

**As movement toward an individual healthcare system evolves, employees will become less dependent upon their employers as a source of healthcare coverage and more responsible for the costs of coverage. This transition will necessitate several employee attributes:**

- a. An increase in employee salary or compensation as the employer does not have to solely fund the costs of coverage
  - b. Improved tax-advantaged options for healthcare expenses
  - c. Portable policies follow the employee to a new job
  - d. Healthcare purchasing consultants to advise decisions
  - e. Available data regarding the cost and extent of coverage and performance of providers (transparency)
- 6) **Excessive regulations frequently cause unintended negative consequences or issues.** These actions should be developed and used only with careful consideration to the related costs and benefits.

### **Cost/Value Initiatives**

In order to assure that healthcare is not only made more affordable and available, but that savings in payment and reimbursement are not offset by increases in costs and reductions in quality, cost/value drivers impacting today's healthcare system must be addressed. The most significant cost/value drivers and recommendations include:

### **Issue 1: Inherent inefficiencies**

Inefficiencies in the administration and delivery of healthcare services impact nearly every area of the system and both increase cost and decrease quality. Frequently, at each hand-off from one provider to another, the patient must communicate some or all of the medical/demographic information previously transmitted to other providers, and hand-carry their medical paperwork. This repetition of information wastes time and may lead to a dangerous lack of data critical to diagnosis and treatment. The incidence of repetitious diagnostic tests, prescription of drugs which are contraindicated with other drugs or cause an allergic reaction, and unnecessary delays in treatment are frequent. The lack of seamless exchange among providers, clinics, hospitals, pharmacies and labs is not only costly and inefficient, yet can cause fatal medical errors. Inefficiencies are not limited to hand-offs among providers. These problems can occur within facilities where diagnostic results cannot be located by one department when stored in another department. We suggest the following:

- ◆ **Promote the adoption of more information technology and automation** across all segments of healthcare – hospitals, rural/community facilities, diagnostic clinics and labs, physicians’ practices, and other healthcare providers. Healthcare often has under-invested in information technology when compared to other industries, choosing to invest in new medical devices and diagnostic technologies. To help medical providers finance investment in information technology and automation, a state tax credit, similar to the IRS Section 179 deduction, could be implemented to permit certain qualifying capital expenditures to be deducted fully in the year the technology is implemented rather than depreciated over a number of years. This provision would provide incentives to medical providers who have under-invested in technology and automation to catch up. Other options might include assisting qualified medical institutions with grants for federal funds from those agencies which offer initiatives to improve the quality and access of healthcare to certain segments of the population (e.g., rural markets, under-served populations, and dependent children)
  
- ◆ **Adopt uniform standards and data formats for health history and patient records.** Providers and facilities at all levels should have compelling incentives to increase automation. HL7, an industry data standard is a beginning, but is not the sole answer to

the fragmentation resulting from the development and use of proprietary data formats, systems, and interfaces by device manufacturers and software vendors.

- ◆ **Improve secure information sharing and communication** among information systems across episodes of care. In spite of certain regulatory and competitive issues (e.g. the need to satisfy HIPAA Privacy and Security, and avoiding collusion and price-fixing), financial and operational incentives should be implemented to encourage healthcare providers to improve the transfer and sharing of data.
  
- ◆ **Create standards for and implement a portable, personal health record (PHR).** If each patient carried a health card imbedded with health history, inefficient, duplicated and mistaken hand-offs would be eliminated. These records need to be secure, encrypted, portable, and inter-operable with all healthcare technology systems. Patients who satisfactorily maintain their PHR should be rewarded with shorter check-in times, lower fees, and other benefits.

## **Issue 2: Evidence-based medicine and quality measures.**

Most associations within specific medical specialties have developed these standards and protocols of best practices, but have not created incentives or formal processes to broadly implement and utilize the practices across all healthcare disciplines. Transparency of quality and the application of scientifically proven treatment plans are impaired by the failure to implement such standards, with a negative impact on the cost and quality of healthcare. In addition, the means for collecting, using, and managing healthcare costs and outcomes based on evidence-based medicine are lacking. Currently, the only standardization uniformly applied relates to payment for a treatment procedure and not for a favorable outcome. The establishment of best practices and clinical guidelines will help ensure a clear dividing line between appropriate courses of treatment and malpractice. Clearer standards can be another important tool in tort reform. Also, publishing best practices and other data used to determine which providers are following those practices will motivate consumers and other payers to make better decisions based on quality and value.

We suggest the following:

- ◆ **Set up, promote, and utilize data clearinghouses that aggregate treatment, diagnostic data, and outcome data** to analyze and continuously improve healthcare and to create best practice protocols. RHIOs (regional health information organizations) are an initial step in this process, yet they have been largely created in silos – regionally – and there is evidence that these RHIOs are not all developed with the same principles or with the same level of sophistication and outcome. Therefore, there is likely to be large gaps in the quality and usefulness of these efforts.
  
- ◆ **Give incentives to providers to submit data to these clearinghouses and follow medical best practices** that emphasize not only cost, but quality outcomes. Currently, some *pay for performance* efforts can penalize certain providers who may have better outcomes, yet who have higher costs for certain procedures, and reward other providers who have a lower cost for specific procedures, but whose patients end up with poorer outcomes, ultimately increasing costs. Providers who submit data will receive free access to the aggregated data and to the evidence-based medicine criteria developed from that data. Non-subscribers would pay a premium. Providers who submit data will be reimbursed at higher rates by payers who also will be given free access as part of their reimbursement processes.
  
- ◆ **Establish and support healthcare education programs and wellness programs and clinics.** This recommendation is apparent and addressed later in the proposal. Currently, far more funded research, capital expenditures by medical device manufacturers and drug companies, medical facilities and clinics as well as reimbursements are devoted to the treatment and cure of diseases than is dedicated to the prevention of those diseases. Indeed, the severity of most major diseases that end up in the catastrophic category, such as heart disease, high blood pressure, certain cancers, and diabetes, can be diminished by consumer education and lifestyle choices. Far more incentives need to be available to those who promote and adopt healthy lifestyles.

### **Issue 3: The consumer does not manage the process.**

The healthcare consumer today is so far removed from the payment process that little understanding exists of the costs involved, and even less incentive to help manage those costs.

Instead, the payer is typically the consumer's insurance carrier (which in most cases significantly involves the consumer's employer as well) or a government entity. Consumers have little incentive to seek a more cost-efficient course of treatment. Since the provider is most often reimbursed a fixed amount based on a predetermined set of diagnosis/treatment codes, there is limited incentive for the provider to explore the best course of treatment with the patient.

The absence of quality measures and transparency in healthcare, similar to other industries, aggravates this concern. (By transparency, we mean price and outcome transparency, not cost transparency. Cost transparency – in which a business's costs on a specific transaction are disclosed to its customers – is inconsistent with free-market principles.) In healthcare, not only is changing providers a major undertaking, the typical healthcare consumer does not have the information necessary to even consider a change.

For example, evaluating an automobile by checking *Consumer Reports* or *Car and Driver* magazine or by looking at crash test results at the NHTSA website is a common practice. A healthcare consumer does not have this type of data available. Establishing a market-driven healthcare system will foster new business opportunities for the collection and distribution of price and value data as well as encourage the development of new consulting businesses to assist clients in navigating the healthcare system.

We suggest the following:

- ◆ **Promote the creation and proliferation of processes, institutions and entities that help healthcare consumers evaluate quality measure systems and transparency.** Just as in the example of the automobile industry, recommendations should encourage a mix of public (government) and private (business) organizations that help collect and distribute this information.
- ◆ **Encourage the focus of healthcare to adopt a customer-focused approach.** Providers need to become healthcare advocates rather than merely deliverers of drugs and treatment. When providers help educate the public on healthcare issues and opportunities, the quality and value of their services will improve. Advertising prices and outcomes as well as offering incentives will improve provider competitiveness. Income potential will

then depend on advising patients rather than only providing treatment. The provider will guide the patient towards the best overall healthcare value (in terms of cost and outcomes) that involves a comprehensive offering of preventative measures, diagnostic tests, medication, hospitalization, surgery centers, and similar services.

### **Implementation of Cost/Value Initiatives**

A permanent Colorado Health Commission, similar in structure to the Colorado Blue Ribbon Commission on Healthcare, can be created to implement many of the cost/quality drivers recommended by this proposal. The Governor and leaders of both legislative houses will make appointments that assure expertise from throughout the healthcare and business worlds and a diversity of backgrounds and skills to develop creative recommendations for the state legislature. These recommendations would be focused on incentives, structures, and institutions required to implement cost drivers and best practices, data exchange and collection, and record sharing.

### **Payment Initiatives**

The second major component of the South Metro Chamber plan focuses on the payment for healthcare from an interrelated three-tiered perspective preventative, maintenance, and catastrophic tiers. **Preventative** care promotes good health as well as treats conditions at an early stage prior to development of long-term, chronic problems. **Maintenance** refers to treatable conditions without a major cost. **Catastrophic** are the conditions with high costs.

This proposal's main component is for individuals to purchase their own insurance for the maintenance tier. Preventative and catastrophic tier financing will occur from group pools resulting in reduced costs for the maintenance tier. With an effort towards preventing health problems at an early stage and removing the highly expensive catastrophic care from insurance policies, the overall costs of providing insurance will undoubtedly fall.

Preventative and catastrophic pools would be administered by a reinsurance system which could be either a government-sponsored agency, such as Cover Colorado, or a private association similar to the Pension Benefit Guarantee Association which would administer the purchase of reinsurance. The threshold for the catastrophic tier is conditions requiring over \$100,000 in

annual treatment costs. A portion of premiums from each maintenance policy (*e.g.*, 5% for preventative and 20% for catastrophic) would be deposited into the respective pools. Since the claims and risks will be spread over significantly large population groups, the pools should remain financially solvent. Funds from each maintenance policy would be deposited into the preventative and catastrophic pools. The Colorado Health Commission, in partnership with the State Legislature, should conduct periodic, actuarial reviews of the threshold for catastrophic claims and the premium percentages necessary to fund preventative and catastrophic care.

### **Preventative Care**

Preventative healthcare must receive a significantly greater emphasis. As demonstrated by numerous studies and experts, improved lifestyle choices including diet, exercise, smoking and drinking, and weight management will reduce the frequency and severity of many diseases. The current insurance system of managed care, with a focus more on treatment/cure and less on prevention and lifestyle, offers little financial incentive for healthy lifestyle choices.

**An annual healthcare evaluation would be an important part of the plan with significant incentives to receive discounts on health insurance premiums.** Although a sufficient number of practitioners are available in the populated areas of Colorado to provide annual evaluations, a modified schedule may be required in rural areas. Unless incentives can be developed to staff rural clinics with physician assistants and other healthcare professionals, healthcare evaluations in rural areas could be reduced to every two or three years for young and healthy adults with an accelerated schedule for older or chronically ill adults as recommended by the American Medical Association. In addition to improving overall health, the consumer will be provided with documentation of healthy lifestyle choices, over which the patient has a degree of control, and related discounts from their healthcare insurer. All consumers would start with a standard policy. A three percent reduction would be given for proof of healthy lifestyle choices, verified in an evaluation, along with a seven percent reduction for achieving all metrics for a maximum discount of 25%. Discounts would be provided for choices, such as:

- Non-smoking
- Abstinence from illegal drug use
- Avoidance of substance abuse including alcohol and prescription drugs

- Normal weight
- Healthy blood pressure
- Healthy cholesterol/triglyceride levels

The discounts provide an incentive to maintain good health and would not be considered a punitive measure. **Any type of punitive pricing based upon genetic screening would not be permissible.** Patients with treatable conditions, such as high blood pressure and cholesterol which have a variety of causes, would receive discounts for complying with disease management plans. Incentives which encourage consumers to adopt a healthy lifestyle will result in individual and community-wide benefits including better health for individuals, fewer claims for maintenance care as a result of proactive choices of the consumer, and a decrease in the overall number of catastrophic claims over time as healthy lifestyle choices become ingrained. As many wise people have said, “A ounce of prevention is worth a pound of cure.”

### **Maintenance Care**

This area of insurance coverage represents the plan’s core and will provide insurance coverage for most predictable, treatable, and common illnesses and injuries. Obtaining health coverage would be an important part of personal accountability and responsibility. **Participation in a maintenance plan would be made mandatory for three reasons.** First, a person who does not obtain coverage is at risk for developing a major medical condition, which must be funded by a third party, such as family or the government. Second, insurance rates for the maintenance tier funds the preventative and catastrophic tiers. To permit a consumer to opt out of the maintenance tier and receive the benefits of the other two tiers would go against the fundamental premise of risk sharing. Third, receiving the benefits of the preventative and catastrophic tiers without contributing to the pools is simply not fair to those who do contribute. **Individuals would be able to deduct 25% of the amount that they contribute to health insurance or an HSA from their state tax return.** A maintenance insurance policy will be entirely managed by the consumer. Funding could be shared by a combination of employee and employer contributions, or at certain income levels, government subsidized with vouchers.

With an increase in healthy lifestyle choices and the shift of catastrophic claims to group pooling, insurers of maintenance coverage will have a significantly decreased underwriting risk.

Due to the assurance that claims will not exceed \$100,000, actuarial rating based upon prior conditions would become unnecessary. **Consequently, raising of rates or denial of coverage based upon pre-existing conditions or age would not be allowed.** In the same manner that group pooling reduces the risk of high dollar claims, insurers that provide maintenance insurance to a large number of individuals would see the risk of insuring individuals with chronic conditions spread over a large pool. This spread would mitigate the risk of losing profitability based upon a small number of expensive claims. **A Massachusetts' style health connector portal and search engine could be established in Colorado to link health insurance providers to consumers as well as provide quality information to assist individual consumers and health care advisors with available healthcare choices.**

By mandating individual ownership of maintenance insurance policies, the plan's most significant change in healthcare funding is the shift of responsibility from the employer to the individual. This shift continues the current trend towards consumer-driven healthcare with the adoption of recent health savings accounts and tax incentives. However, employers could choose to reimburse employees on a voluntary basis or help fund HSAs or similar plans. With the anticipated cost savings from our plan, a decision to cover employee insurance would occur with far less financial strain than currently exists today. By encouraging price/quality transparency in healthcare, purchasers can make informed decisions about coverage which will be offered at more competitive rates. In addition, by reducing the burden of health insurance from the employer, the financial condition of many small businesses will substantially improve. Tax incentives may encourage employers to make contributions towards employee health coverage without suffering a net financial loss.

Insurance will be portable and carriers as well as coverage can be easily changed. An employee will be able to continue an individual policy at new positions of employment during periods of transition as well as self-employment. At any time, the consumer could change a policy instead of only accepting the employer's choice of insurance carriers. Insurance carriers will be more attuned to consumer needs. As a result, the market for insurance will change fundamentally. The customer will be the individual, not employers or groups. Insurance providers will be forced to develop more customized plans to address a more individualized consumer market and offer each purchaser greater choice and ability to purchase a policy suited to individual needs. Consumers will move to a stronger position in the healthcare market. Competition requires that

companies manage costs and improve quality in order to compete successfully. In recent years, consumer costs for computers, cell phones, and many other product innovations have substantially decreased at the same time quality has increased. The health insurance market can have the same consumer-driven passion when we are willing to allow the forces of competition to enter the arena. In a similar manner, insurance providers who do not satisfy the needs of consumers with respect to cost, quality and service will see their revenues decrease or may go out of business.

At the present time, only a limited amount of companies underwrite individual or small group market insurance policies in Colorado. Upon review of these policies, there is little differentiation among the policies, a sign of a non-competitive market. By ending the practice of group policies and moving to a more competitive market, the number of companies writing individual policies will substantially rise. With increased competition, a greater variety of insurance products will be offered, customer service will improve, insurers will engage in more informative advertising to communicate product differentiation, and insurance companies will become driven to increase consumer satisfaction levels. The recent trend of insurance companies decreasing the areas of coverage, increasing deductibles and out of pocket payment portions will diminish since the companies will use more comprehensive coverage to gain a competitive advantage.

### **Catastrophic Care**

In their book, *Epidemic of Care*, George Halvorson and George Isham report 20% of the population incur no healthcare cost at all and 70% account for 10% of the total cost. The remaining 10% consume 90% of the overall healthcare expenditures, largely due to payments to treat catastrophic conditions. The creation of a risk pool from a portion of maintenance policy premiums and appropriate reinsurance will more effectively spread the risk of catastrophic coverage without forcing only healthy policyholders to subsidize catastrophic care. Investing in preventative care will reduce the costs of catastrophic care by catching many diseases in the early stages or lessening the severity of the conditions. Thousands of Colorado citizens will become healthier.

The catastrophic tier covers conditions of very high cost (over \$100,000) and potential loss of life requiring life-saving action. Catastrophic coverage focuses on a per incident basis. Once the

bills for high dollar claims exceed \$100,000, then the catastrophic coverage from group pooling would begin. If an illness or accident left a person unable to fully regain their health, Medicare would fund that person's continuing coverage.

At the present time, the concept of group pooling through reinsurance is a theoretical construct. Using 20% of maintenance policy premiums to fund the catastrophic pool came from a preliminary discussion with an insurance actuarial company. The appropriate percentage eventually will be determined through claims experience and subject to periodic adjustment in the same way that all insurance risk now is adjusted by carriers. To ensure adequate solvency in the event of an unexpected surge in high dollar claims, financial backing of the catastrophic pool from a state governmental safety net may be necessary similar to the role of the FDIC.

### **Minimum Coverage Levels**

Insurers competing in the maintenance market in Colorado will be required to provide a basic level of care which covers a reasonable number of incidents similar to the legislatively mandated coverage today. Since the claims of over \$100,000 will be paid out of pooled funds in the catastrophic tier, insurance companies no longer will need to, or be permitted to, exclude specific conditions from their policies. More individualized forms of policies will feature a broader range of deductibles and co-payments. Exclusions involving normal and reasonably expected claims will not be allowed. However, companies can limit claims around the following areas, such as:

- Cosmetic treatment
- Self-inflicted injuries
- Excessive repetitive injuries caused by extreme choices
- Treatment without a reasonable scientific basis
- Highly experimental treatment
- Infertility treatment

These exclusions would apply to a minimum level of coverage only. This expanded, luxury version of the maintenance tier with a cafeteria style of high-risk options can be made available to consumers willing pay for the higher levels of coverage.

## **Role of Business**

Currently, businesses of all sizes have experienced the negative financial consequences of rapidly rising healthcare costs. This proposal offers a comprehensive solution, improving the healthcare scenario for all stakeholders. By moving the management of healthcare to the consumer, our proposal attempts to bring the management of healthcare decisions to the individual, the one most impacted by those decisions. This shift is not an attempt to remove the business owner entirely from a role in the healthcare process, only to remove the business owner from assuming the main role.

Businesses need to be motivated with financial incentives to reimburse employees for their health insurance. **We propose that Colorado business owners be able to deduct from state taxes 25% of the reimbursement costs of employee health insurance and health savings account funding.** By making the individual the owner/manager of each policy, policies will be portable as an individual moves from company to company, and the excessively high fees of COBRA coverage, which hit individuals during times of transition, will be eliminated. Individual policies can remain with each consumer until a decision is made to change policies or move into Medicare.

By making health insurance more affordable and portable, businesses will be able to use creative reimbursement and funding options to compete for employees in a market where the labor pool is shrinking and becoming more competitive. Changing demographics with the emerging transition of the baby boomer generation to retirement is distinctly altering the labor market. By defining the baby boom generation as those individuals born between 1944 and 1964, the population totals approximately 80 million people. Generation X, which includes those born during the next twenty years of 1965 to 1985, contains nearly 50% fewer individuals than the previous generation, at 46 million. Thus, businesses of all sizes face significant potential labor shortages in the years ahead. Competing for these fewer number of employees will be paramount to survival. Providing adequate reimbursement of healthcare policies and making volunteer contributions to individual health savings accounts will be vital ways for businesses to remain competitive in the labor market.

## **Vouchers**

By applying for and receiving a Medicaid waiver, the State of Colorado can underwrite vouchers

for those individuals who currently receive Medicaid. The vouchers would provide a dollar amount at least 30% above the mid-point average of individual policies for each participant. This level ensures that a Medicaid recipient could purchase at least 80% of the individual policies with their voucher. The State of Colorado would print and mail vouchers to each Medicaid recipient who would then use the voucher to purchase and manage their own maintenance policy.

To prevent individuals under 250% of the federal poverty level from not having insurance, the state can cover the cost of vouchers for low-income people in Colorado under 150% of the Federal Poverty Level. According to the United States Census Bureau, approximately 11% of Colorado residents live under the poverty level. With a state population of 4.5 million, the figure would include about 495,000 residents. Of course, a significant portion of these residents are covered by Medicare or Medicaid. An additional eight percent of the state's residents are between 100%–150% of the federal poverty level. These 360,000 residents would also be eligible to receive state vouchers to purchase insurance. The number of residents between 150%-250% of the poverty level is approximately 725,000 residents. The residents in this range could receive a partial subsidy to purchase insurance. By using an annual cost of \$2,000 per person for a full subsidy and \$1,000 for a partial subsidy, the overall annual cost to the state would total \$144 million. Thus, the residents of Colorado with incomes in the lowest 19% would be guaranteed health coverage with costs shared between federal resources from a Medicaid waiver and state funds. Another 16% of residents in this category would receive a partial subsidy of their health insurance.

### **Clinic Care for the Minimally Insured and Uninsured**

The State of Colorado would administer a statewide system of clinics to provide inexpensive care for individuals with minimal insurance and a safety net for the uninsured. Each of Colorado's 64 counties would feature at least one clinic. Some counties in rural areas may need to share a clinic or fund mobile medical clinics that travel to remote locations. Funding can occur from a combination of state funds, business gifts, and non-profit donations. Staffing for rural clinics would utilize physician assistants and other medical personnel. Funding would include bonuses for serving in rural areas similar to current incentive packages. An uninsured individual who arrives at a hospital emergency room would be directed to the county clinic as long as the move could occur without risking the person's life or violating EMTALA. **Medicaid-eligible**

**individuals would be enrolled in the state voucher program and otherwise healthy adults would be notified that carrying health insurance is part of state law.** The issue regarding illegal immigrants needs to be handled within a larger context.

Individuals without insurance who are treated at a hospital or state clinic would be reported to the Colorado Department of Revenue. These individuals then can receive vouchers from the state to purchase their own medical insurance with a financial reconciliation occurring with the submittal of a state tax return.

**2) Who will benefit from this proposal? Who will be negatively affected by this proposal?**

Consumers of all income levels will benefit from the shift to an individual based market where their purchasing behavior can have a direct impact on healthcare providers and insurers.

Insurance products can be purchased which meet individual consumer needs instead of products designed for groups or intended to dictate coverage to enrollees based on the best interests of insurers. Employers will benefit from a reduced role in managing the insurance process for their employees. By reducing the burden of employer-funded health insurance, the financial health and competitiveness of Colorado employers will be enhanced.

Many stakeholders who financially benefit from the current system may be adversely affected in the short-term with the adoption of our proposal. Market sensitive and innovative companies will gain an immediate advantage. Healthcare providers and facilities will experience greater profitability as a result of several conditions including: greater volume from increased utilization of insured patients, fewer uninsured and underinsured cases decreasing the resources of hospitals and similar facilities, reduced receivables as a result of cash payments from HSAs, and more reliable payment by insurers eager to compete through better service. Successful implementation of cost/driver initiatives will serve to reduce administrative expenses, decrease the duplication of services and enhance the quality of medical services with a reduction in unnecessary procedures and improper treatment. Certainly, administrative costs will increase as can occur in any major transition. However, once the transition is complete, the healthcare industry will operate in a healthier market with the competitive forces in place that exist for other businesses and industries.

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

All of these distinct populations will benefit in the same manner as other healthcare consumers. In addition, due to the removal of ratings and exceptions from coverage, population groups previously underserved will now obtain coverage. Low-income and those on government assistance (Medicaid) can use their vouchers obtained from the State of Colorado through a Medicaid waiver to have a more direct impact on their healthcare choices than with the current system where they are limited to providers who accept Medicaid reimbursement, a number that decreases yearly. State residents under 250% of the federal poverty level will receive direct assistance with both full and partial subsidies. Currently, there are shortages of healthcare providers in many rural areas due to the low reimbursement rates physicians receive through public as well as private insurance. The shift to a more consumer driven approach may serve to improve the availability of providers in rural areas, and state health care clinics will add an important healthcare resource to those areas. Competitive market forces will reduce costs for consumers and give providers a level of compensation that is consistent with the quality of their service.

Legal immigrants will benefit in the same way as any other consumer. Illegal immigrants will receive treatment for any life-threatening emergency since federal law prohibits withholding services for any potentially catastrophic situation. However, service could be denied for any non-emergency condition. The disabled will undoubtedly benefit from the enhanced consumer empowerment discussed above.

**4) Please provide any evidence regarding the success or failure of our approach.**

Two examples of the positive effects of competition are telecommunications and technology. Prior to the early 1960s, almost all telephone equipment purchases occurred through one company. Attaching a personally-owned telephone to the network was illegal. Virtually all telephones were black or putty in color and had limited features. After deregulation of the telephone market, a virtual explosion of product features from dozens of companies occurred, and end-users were able to select a variety of powerful options. On the network side, prior to the early 1980s, a coast-to-coast long distance call cost over \$.60 per minute, and AT&T had a proposal before the FCC to raise rates. Today, after deregulation and open competition, the same

call costs less than \$.05 per minute, and the call connects much faster with higher quality and more bundled features. Bringing competition to the telecom equipment and network businesses has no doubt contributed to many of the advanced features and services we currently enjoy, such as caller ID, cordless phones, “smart” cell phones, teleconferencing, call waiting, voice dialing, text messaging, DSL, fax machines, and many other features; all at tremendously lower cost, higher quality, and greater access.

Competition has benefited the computer industry in much the same way, as those developments have paralleled telecommunications. In the early 1980s the PC market was very tightly controlled by a few entities, and computers were expensive and did little for most businesses and individuals. In fact, outside of the classic “geek” culture, computers were not used much at all. In less than 20 years, competition has reduced the cost by more than 50%, while the speed and horsepower are at least 1,000 times faster than when the first PCs came to market. New applications and functionality are arising almost daily, and today, products such as WiFi, Tablet PCs, PDAs, instant messaging, file sharing, web conferencing, Bluetooth, and many others are taken for granted.

The value principles that we are advocating in our proposal – lower cost, higher quality, more feature/functionality and broader access to services – have proven to be important outcomes of a free-market, competitive environment with limited, but important government oversight.

##### **5) How will the program(s) be governed and administered?**

The program would be enacted primarily through legislation and regulation. Establishment of maintenance policies would comply with statutory mandates in the same manner as the law currently mandates certain coverages. Compliance could be monitored and enforced by the Colorado State Dept. of Insurance. Administration of the preventative and catastrophic tiers is yet to be determined. A government sponsored agency, such as Cover Colorado or a private association, such as the Pension Benefit Guarantee Association for the purchase of reinsurance are two options which require further study. Data clearinghouses may be created by governmental action and run by private enterprise selected through standard RFP procedures. Seed capital to create personal health records may be provided by a portion of Medicaid funds, but a competitively awarded franchise would grant one vendor exclusive rights to produce and maintain those cards. The cost of cards may be borne by all benefiting stakeholders – patients,

facilities, providers, and insurers. The Colorado Medical Society and specialty societies may take the lead in creating evidence-based treatment protocols and practices using among other sources, information from collective databases.

**6) 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?**

A federal Medicaid waiver will be needed to allow the State of Colorado to issue vouchers to purchase individual insurance policies. In our opinion, ERISA provides rules for how a company manages its employee benefit plans, especially group insurance and retirement/pension plans. By moving to individual policies, ERISA employee benefit rules would not apply since the notion of group insurance would not exist in Colorado. Prior to 2003 carriers could only adjust rates in the small group market for age, geographic location, and family classification. In 2003 health and smoking status, claims experience, and industry classification became part of the rating process. With our proposal, pre-existing conditions would have no importance regarding underwriting risk since insurance companies would be protected from the risk of high dollar claims.

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

Our program would be phased in over a twelve-month period when group policies come up for renewal. This phase-in period would be critical given the processing challenge of converting an entire state of 4.5 million residents to individual policies. A second year may be required for changes in administration and adjustments for unanticipated occurrences. Thus, the complete transition could occur within two years.

### **C. Access**

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

The proposal expands access by lowering costs and increasing choices to employers and individuals through competitive factors and the removal of catastrophic coverage from standard policies and insurer risk pools. Overall, the entry into a competitive arena will lower the costs associated with medicine for healthcare providers as well. The state voucher system ensures that

19% of individuals with the lowest incomes would receive assistance through federal and state resources and another 16% would receive partial assistance. County clinics would provide greater access to any person without adequate coverage.

**2) How will the program affect safety net providers?**

Safety net providers are experiencing the same skyrocketing price trends as others. Reducing costs through competition will reduce public expenditures and improve the financial condition of government programs.

**D. Coverage**

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

Yes, by ensuring mandatory coverage and affordability through the implementation of cost driver initiatives. Our proposal expands health coverage by attacking root causes of the healthcare crisis, a lack of competitive forces in the healthcare industry, absence of personal choice and responsibility, systemic inefficiencies, and uncontrolled costs. Since many employers as well as individuals are pushed out of the system by spiraling costs, health insurance will become much more affordable. Mandatory maintenance coverage will bring uninsured and underinsured into the system, and those of low income means will receive insurance either through mandatory individual coverage or a state sponsored voucher system.

**2) How will outreach and enrollment be conducted?**

The State of Colorado will need to conduct a significant public information campaign to inform residents about the switch to a new insurance system. This campaign will need to use the standard tools of radio advertising, newspaper articles, web content and direct mail to residents. By having a target year for changes in 2009 and then another year to catch late participants, the overall transition can occur within two years. Each company would terminate group policies during the month when current policies expire.

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

Our proposal defines resident as a person who is legally residing in Colorado for at least six months, or who lists Colorado as their primary place of residence on their prior year tax return.

## **E. Affordability**

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

The employee, through an individual based system similar to automobile insurance, will handle the management of the policies. However, the specific premium-sharing arrangements would be negotiated between the employer and employee.

### **2) How will co-payments and other cost sharing be structured?**

Co-payments and cost sharing will be subject to competitive market forces and will vary as a more diverse variety of insurance coverage options are created to meet the diverse needs of individual consumers.

## **F. Portability**

### **1) 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)?**

Policies will be completely portable and follow the consumer/owner. Since the catastrophic tier will cover all high dollar claims and excluding or rating up for pre-existing conditions will not occur, there should be little concern regarding access as changes in health status occur.

## **G. Benefits**

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

The preventative and catastrophic tiers cover the most important aspects of healthcare. Many people choose to forgo annual healthcare evaluations due to the costs or the unwillingness to face the possibility of a health problem. Since periodic healthcare evaluations would be required, many illnesses will be proactively managed in the early stages which will improve health and substantially reduce costs. The claims for preventative treatment will be covered at 100%. Catastrophic claims over \$100,000 will also be covered at 100% which will reduce concerns for

coverage for treatment of debilitating illness which drain individual finances. The mid-level claims in the maintenance tier would be managed by the individual and subject to competitive market forces ensuring a reasonable cost and coverage level.

**2) 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 plan and your benefit package.**

Our proposal is unique and not similar to other plans.

## **H. Quality**

**1) How will quality be defined, measured, and improved?**

Quality may be defined by *excellence* in the following four characteristics: delivery of a service or product, outcome of that service or product, efficient use of resources, and ongoing efforts to achieve improvement in the service or product.

**2) How, if at all, will the 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.)**

- Promote the adoption of more information technology and automation across all segments of healthcare.
- Adopt uniform standards and data formats for health history and patient records.
- Improve secure information sharing and communication among information systems across episodes of care (hand-offs).
- Create standards for and implement a portable, personal health record (PHR).
- Set up, promote and utilize data clearinghouses that utilize treatment and outcome data to analyze and continuously improve healthcare.
- Set up and support healthcare education programs and wellness programs and clinics.

We think that a permanent commission, similar to the 208 commission, could play a strong role in making recommendations to Colorado's Governor, State Legislature, and State Department of Insurance concerning several areas discussed in this question.

## **I. Efficiency**

### **1) Does your proposal decrease or contain healthcare costs? How?**

Our proposal will significantly reduce healthcare costs through the integration of stronger competitive factors into the healthcare industry. We are committed to the concept of increased quality and decreased costs through consumer purchasing behavior. There undoubtedly will be distinct transition costs in moving to an individually based system. However, the decreased costs for the individual, employer, as well as the state and potentially the federal government will be considerable. Of course, entities that financially benefit from the current system may see decreased profit margins. Nonetheless, when the transition is complete, most forms of compensation within the industry will be in sync with an ability to compete in a market-oriented industry.

### **2) 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 healthcare services. Please explain.**

- Incentives are given to providers to submit data to these clearinghouses and follow medical best practices that emphasize not only cost, but quality outcomes.
- Promote the creation and proliferation of processes, institutions, and entities that help healthcare consumers evaluate quality measure systems and transparency.
- The main aspect of incentives focuses on the preventive tier. Consumers would receive discounts for healthy lifestyle choices. As positive lifestyle choices become more consistent, costs will be considerably reduced as conditions do not escalate to more significant health concerns.

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

As the healthcare industry becomes more competitive and information-sharing methods become widely adopted, transparency of costs and quality will be a vital part of competition. When health insurance policies become more individualized, health insurance companies will be forced to more clearly describe the differences in coverage and cost in order to compete. The widespread use of best practices will provide standards against which the quality of healthcare services can be measured and reported, leading to greater transparency in quality data.

#### **4) How would your proposal impact administrative costs?**

Some administrative cost increases will occur for the State of Colorado to play a key role in the transition to a new system. The Dept. of Insurance will have a greater workload to ensure compliance with the new system. Yet, the improvement in the financial condition of businesses and individuals, as well as the migration of businesses relocating to Colorado to profit from reduced healthcare costs, will enhance revenues. As this plan becomes fully implemented, the overall costs of administration will fall. Covering low-income residents who are not covered by Medicare will bring additional costs to the state.

### **J. Consumer Choice and Empowerment**

#### **1) Does your proposal address choice? If so, how?**

Choice is the central principle of our plan. As individualized maintenance insurance policies become well established, insurers will survive by creating products which satisfy the diverse needs of a varied population rather than focusing on group plans and employer based policies. Transparency in price and quality data will empower consumers to make more informed choices. With individual policies becoming widespread, health insurance companies will move to offer more customized policies, better define the benefits covered by each policy, and offer customers additional menu choices of coverage, all linked to the health and financial condition and needs of each covered person. Other benefits of choices from this plan include: (1) a greater choice in benefits due to individual policies more customized to meet the needs and risks of the individual patient and (2) consumers will have a greater choice of physicians as insurance companies expand panels of physicians to compete with each other as policies and benefits become increasingly transparent.

**2) How, if at all, would your proposal help consumers be more informed about and better equipped to engage in healthcare decisions?**

When the purchase and management of healthcare insurance is shifted from the employer to the consumer, individuals will be motivated to become more informed about choices and consequences. If the consumer is going to make the best possible medical decisions, price/quality transparency must be evident. Currently, little data is available concerning the actual costs of procedures and confusing information exists regarding the types of treatment within those procedures. This lack of information impairs informed price comparison and hampers real competition. Common procedures, such as an MRI, can have widely varied prices due to negotiations between providers and insurers with the consumer presently left out of the discussion. With price transparency, the consumer can shop rates among many different providers and be more in control of the purchasing decisions.

Internet comparison systems are in development around the country by universities and private evaluation firms to assess price as well as quality. Published *standards of care* enable the consumer to consider what is generally regarded as appropriate for their condition. Consumers can learn to request certain major tests as part of their treatment plan. In addition, when a new need exists, a business will arise to fill it. Our taskforce predicts the future growth of medical consultants will assist consumers with their healthcare decisions, most importantly in the beginning, yet for major decisions as well, such as cancer treatment.

**K. Wellness and Prevention**

**1) How does your proposal address wellness and prevention?**

The recommended healthcare evaluations in the prevention tier and incentives for positive lifestyle choices will substantially promote wellness and proactively reduce the incidence of many illnesses. When a consumer sees that positive lifestyle choices, such as a healthy diet and the decision not to smoke, increase disposable income and improve overall health, wellness and prevention of disease will improve. Currently, enrollees see no direct correlation between insurance coverage and wellness/prevention. When the patient is responsible for funding healthcare, the correlation becomes vivid.

## **L. Sustainability**

### **1) How is your proposal sustainable over the long-term?**

Sustainability of our proposal is dependent upon and guaranteed by the impact of competitive market forces that govern most other industries. At the present time, the healthcare system is reliant upon an inadequate system of laws which artificially sustain an arrangement where healthcare providers and insurers battle for short-term gains with little attention paid to the concerns of the consumer. The shift to an individual system will bring consumers into this arena armed with a potential weapon - personal purchasing behavior – which will force distinct changes and bring the healthcare industry into competitive equilibrium.

### **2) How much do you estimate this proposal will cost? How much do you estimate this proposal will save?**

Since the South Metro Chamber plan is comprehensive, innovative, and not comparable to programs in other states, there is little data available regarding specific estimates of costs or savings. Nonetheless, the cost savings to consumers and employers will be substantial from the shift to a more competitive based system of delivery. Implementation of cost driver initiatives will decrease the costs of administrative duplication and inefficiency; improve the quality of healthcare services through the standardization of evidence-based protocols and processes; and reduce the significant costs of medical errors. There will be additional administrative and funding costs to the state due to the transition to this new system and underwriting the voucher costs for non-compliance and covering low-income residents. However, the tax revenues the State of Colorado will generate from the improved economic condition of employers and residents and the attractiveness of businesses relocating to Colorado should offset the costs and enhance revenues. In the event of an excessive number of catastrophic claims exceeding the solvency of the catastrophic pool, state funds may be applied to restore the catastrophic pool to solvency while modification of the funding pool occurs.

### **3) Who will pay for new costs?**

The short-term increase in administrative costs and voucher system will need to be paid for by the citizens of Colorado until the economic performance from area companies returns positive

proceeds to the state and cost savings from bringing more uninsured into the market produces significant results.

**4) How will the distribution of costs for individuals, employees, employers, government, or others be affected by this proposal? Will each experience increase or decrease costs? Please explain.**

Individuals/employees may see a short-term increase in insurance costs as mandatory maintenance policies are incorporated into the marketplace and until market forces serve to reduce those costs and insurance products become more suited to their individual needs. These individuals will also have the long-term security of knowing that they will not be placed in a desperate financial situation due to a catastrophic medical condition.

Employers will see relief from the burdensome trend of double-digit annual price increases for insurance. However, to remain competitive in the labor market, employers should make an effort to reimburse employees for individual policies, fund HSAs, or increase worker wages. Although the state government will see a short-term increase in administrative costs during the transition, within a short time, savings should be substantial.

**5) 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.**

Certain coverage of maintenance policies and limitations on exclusions from coverage would be mandated, as described above. Also, the removal of exclusions based upon pre-existing conditions and the inability to rate up for age would pose significant changes as well.

**6) How would your proposal impact cost shifting?**

Our plan is more of a responsibility shift, which is vitally important. However, the following cost shifts will occur: (1) costs of catastrophic care shift from healthy individuals sharing the burden to a pool where the percentage contributed through premiums is equal for all enrollees, sick and healthy; (2) costs of uninsured and underinsured shift from hospitals (particular inner city hospitals) and the insured to the pool and to the citizens of the state in general; (3) medical catastrophic induced bankruptcy costs shift from businesses and the citizens of Colorado (in

terms of increased costs) to the pool; and (4) the personal health records and uniform data protocols shift costs associated with administrative paperwork and duplication to patient care. In addition, the plan anticipates that the costs of healthcare will be reduced substantially from the forces of competition, improvements in efficiency, reduction in medical errors, and improvement of healthcare quality through the implementation of evidence-based protocols and treatment processes. The costs for employers will decline from less reliance on the financing of employee insurance costs. Mandated maintenance policies stripped of costs of prevention and catastrophic illness will reduce costs to enrollees and costs will decline further as the forces of competition take hold and equity between employees and employers emerge.

**7) Are new public funds required for your proposal?**

Yes, a modest amount of state funds to cover the administration of the transition and voucher system would be needed.

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

The answer to this question would be best answered by the state legislature.

**Is this proposal comprehensive?**

This proposal attempts to comprehensively address problems in healthcare by examining and offering solutions on both the cost and payment side of the healthcare equation. The South Metro Chamber plan offers solutions to enhance the quality of medical services. This proposal is not a simulation of other plans and differs considerably from the reform proposals under consideration in states such as California or Massachusetts. If enacted, the ideas contained in this proposal would have a far-reaching impact on nearly every citizen, business, and government entity in Colorado. We believe this impact would be distinctly positive, revolutionize healthcare in Colorado, and put the state on the national map with a plan that could be implemented in other states or nationally.

There are areas of our plan which will need further refinement or possible additions from other plans. We have proposed a competitive, free-market approach to healthcare with a reasonable amount of government involvement in the preventative and catastrophic tiers as well as the

development of tax incentives and best practices monitored by a Colorado Healthcare Commission. Our plan does have some limitations concerning the interaction with existing state and federal laws, Medicaid and other safety net concerns. This plan does provide a solid framework for a new approach to healthcare. However, the plan can substantially benefit from the expertise of the Colorado Blue Ribbon Commission Healthcare or other proposals concerning the impact of various current aspects of governmental involvement in healthcare.

This largely individual oriented approach can harness the best aspects of our free market system which has solved so many problems over our country's history. Of course, we are realists as well and do believe that there is reasonable role for the government to play in assisting in areas where the free market alone will not always produce the results that our consumers definitely need. The current financial services industry provides a good example of where government involvement can assure a fair playing field and sustain the viability of our free market system.

### **How was our proposal developed?**

In early 2004 the South Metro Chamber of Commerce discussed the idea of developing a solution for healthcare at a leadership retreat. This chamber of commerce has a long history of tackling controversial issues. Chamber leaders formed a taskforce and invited a diverse mix of small business owners, healthcare professionals, insurance industry specialists and executives, consumers and anyone interested in contributing to a solution. Over the following two years, the group met for monthly discussions, committee groups performed research and analysis, and we attempted to reach a consensus on potential solutions.

In late 2005 we decided to put our ideas on paper. After a review by the Chamber Board of Directors, a proposal gained the attention of the Business Editor for Colorado Business Magazine, who ran a feature article about our proposal followed by articles in the Denver Business Journal and Littleton Independent. With positive feedback from many state and business leaders throughout Colorado, we decided to move ahead with finishing our proposal. Just as our ideas began to take form, we learned about the creation of the Colorado Blue Ribbon Commission on Healthcare and were excited to know that a process existed to present our proposal.

## **Conclusion**

Simply put, “We can’t live like this anymore!” What consumer or business can sustain 10%-20% annual price increases for major expenditures? This situation’s less than ideal results are more expensive goods and services, strained family incomes, reduced profits, decreased employee compensation, business failures, and rapidly rising governmental expenditures. Many people agree the problem needs to be solved. Yet disagreement exists concerning the solution. Many proposed solutions involve excessive regulations or nationalized insurance plans. Our taskforce believes these types of solutions will not address the causal factors and instead create new consequences without confronting the issue in a substantive way.

Our plan seeks to unleash the power of competition to correct the tangled mess in place today. Getting healthcare providers and insurers to compete for the best ways to serve the interests of the consumer is the road out of this dilemma. This competition will not reach full potential without new levels of personal accountability and responsibility on behalf of the consumer. On behalf of the South Metro Board of Chamber of Commerce, we thank the Colorado Blue Commission on Healthcare for their efforts in this arena and we are pleased to present our proposal.