

Health Care Reform Proposal
Submitted by:
The Committee for Colorado Health Care Solutions
April 6, 2007

APPENDICES

An Ethical Foundation for Colorado Health Care Reform

Submitted by

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The provision of health care is an ethical act at every level. Dialogue concerning Colorado health care reform should be framed by ethical principles and values drawn from the moral fabric of our state. A values framework is a prerequisite to a cohesive and justifiable end product. The identification of principles and values will not produce a flawless healthcare plan. Rather, consensual state values will foster critical thinking and assist analysis. Without prior agreement on values, agreement on solutions will likely be arduous and contentious. There is precedent for both a bioethical working group in the Clinton health care reform planning in the 1990s (Brock and Daniels, 1994) and for an ethical framework in the creation of the Massachusetts health access reform law (Steinbrook, 2006). Underneath the debate in both instances was a foundation of consensual values. The reason is that even the best plan will not be able to provide everything to everyone. A proposal will, by necessity, influence choice and negotiate benefit, and the justification will be ethical. The faculty at the Center for Bioethics and Humanities at the University of Denver and Colorado Health Sciences Center proposes foundational principles for Colorado health care reform planning that include, but are not limited to inclusiveness, access, distributive justice, choice, responsibility, community consultation, effectiveness, transparency and sustainability.

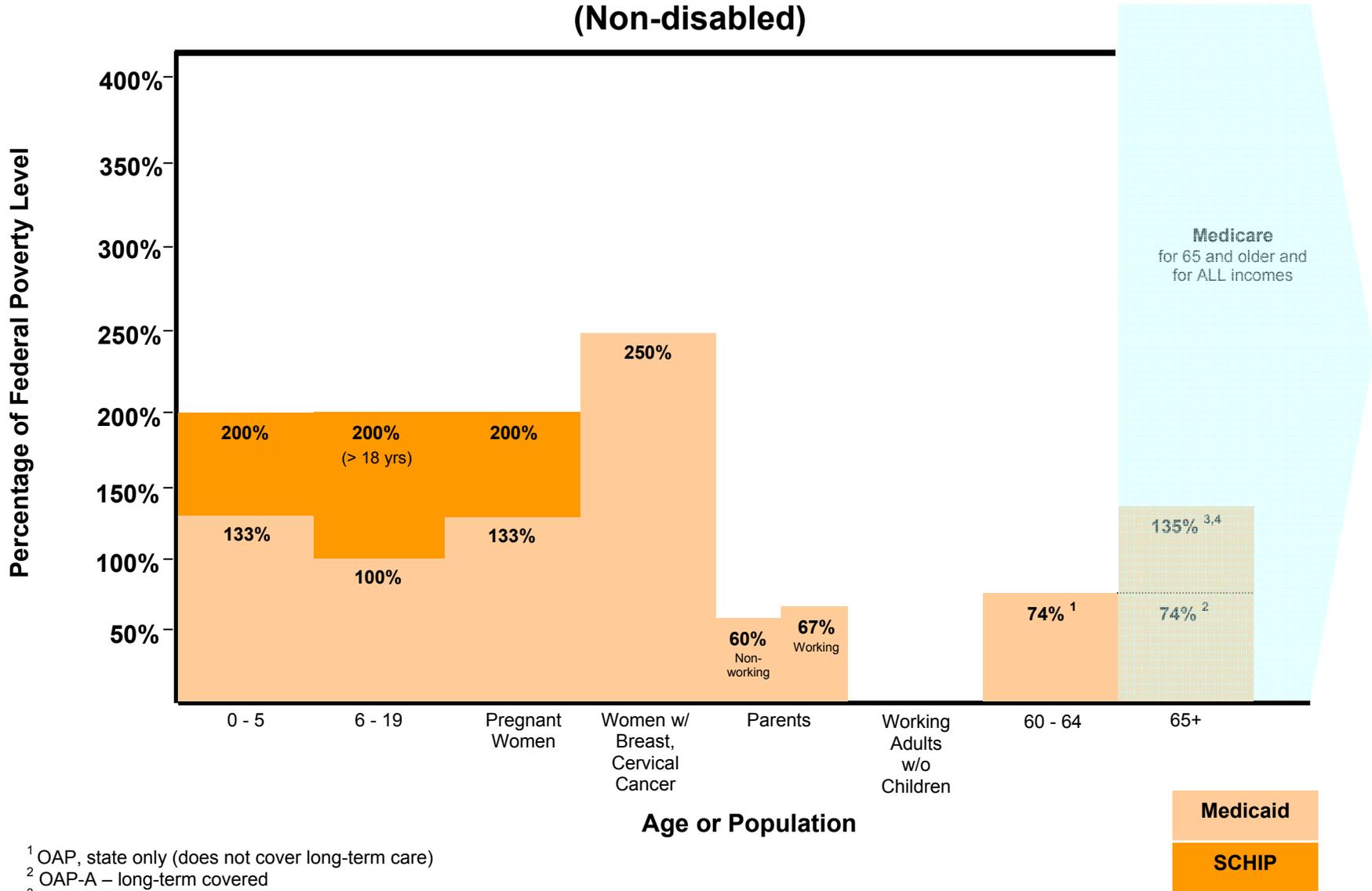
References

Brock Dan W., Daniels, Norman. (1994). "Ethical Foundations of the Clinton Administrations' Proposed Health Care System." *The Journal of the American Medical Association*, 271: 1189-1196.

Steinbrook, Robert. (2006) "Health Care Reform in Massachusetts—A Work in Progress. *New England Journal of Medicine*, 354: 2095-2098

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Income Eligibility for Public Health Insurance in Colorado^A (Non-disabled)



¹ OAP, state only (does not cover long-term care)

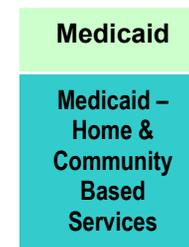
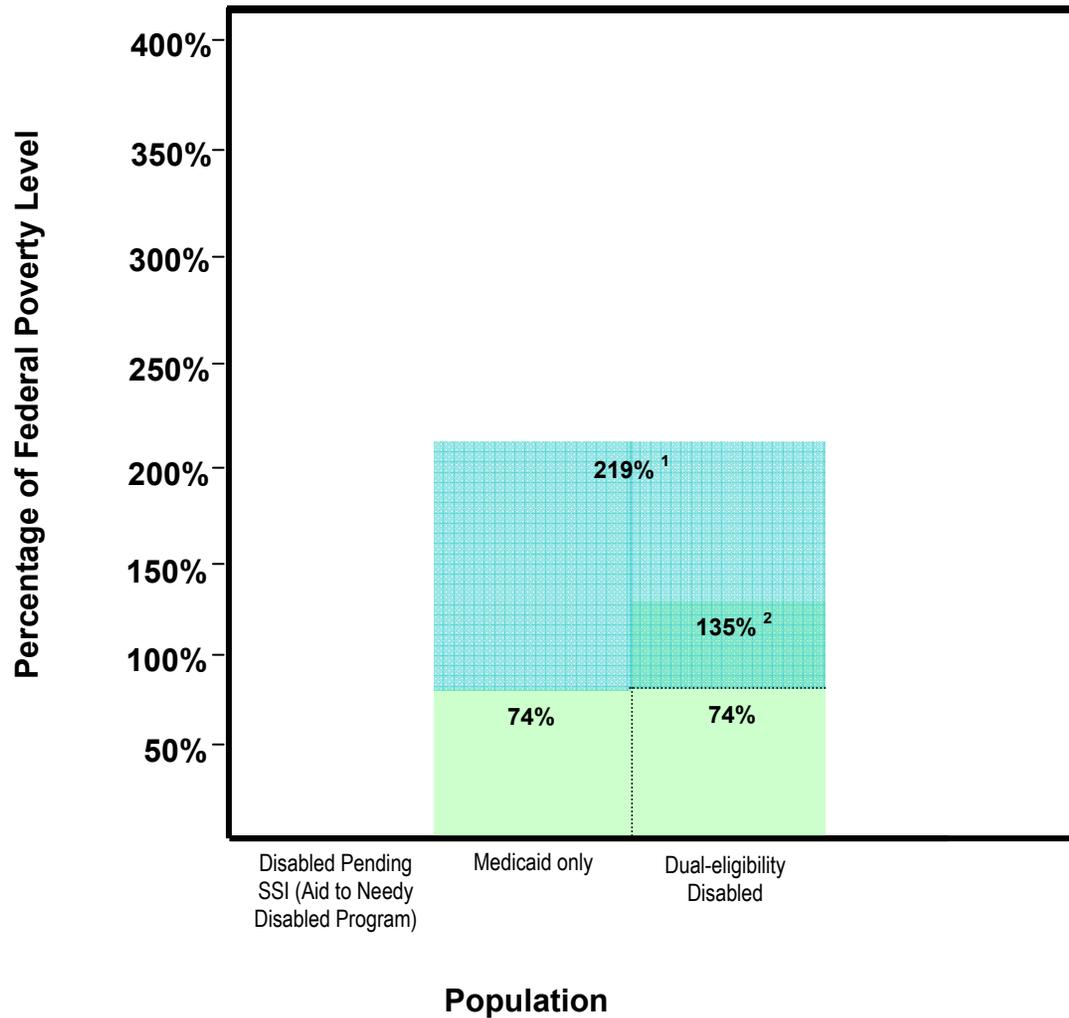
² OAP-A – long-term covered

³ QMB & SLMB – Pays MCR B premium, copay and deductibles

⁴ Medicare Part D Extra Help

^A **CoverColorado – Eligibility:** resided in Colorado as a legal resident for at least 6 months; not eligible for Medicaid, Medicare or any other health insurance; no age or income limitations. **Premium cost:** based on Standard Market Rate (up to 150%), age, gender, smoker/non-smoker status, County reside in. **Premium discounts:** \$40,000 or less annual income = 50% discount; \$40K-\$50K = 40% discount. No dependent coverage – each family member would be enrolled as individual with own premium cost.

Income Eligibility for Public Health Insurance in Colorado (DISABLED)



¹ “300 Percenters”

² QMB & SLMB – Pays MCR B premium only

Characteristics of Public Program Beneficiaries

MEDICAID

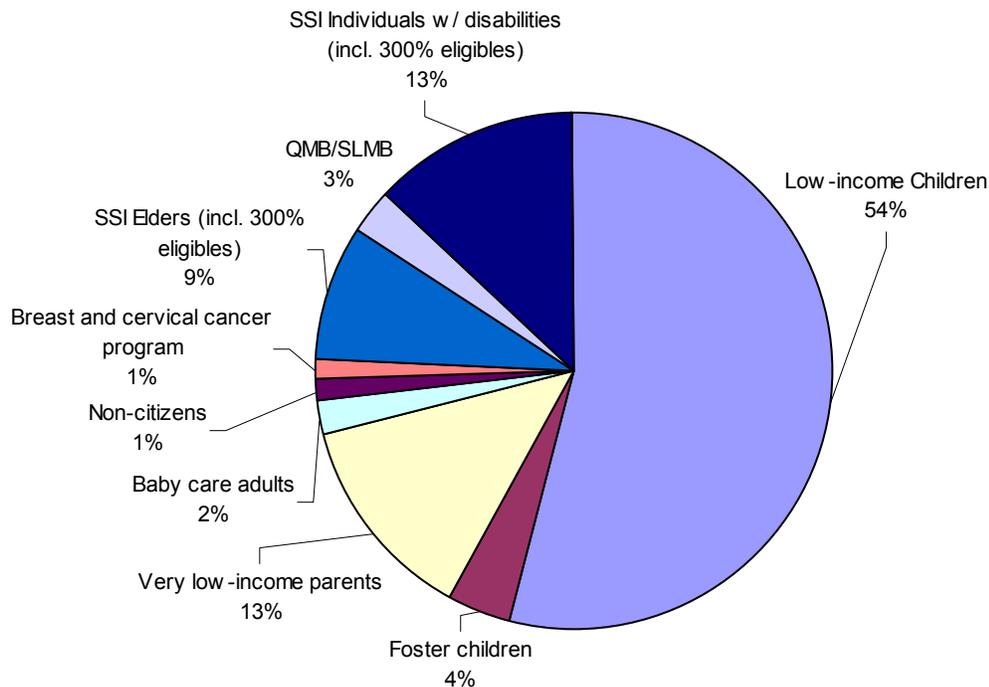
{Colorado Health Institute 2005 #450}

Medicaid provides three types of health care coverage:

- 1) health-care services for low-income families with children and low-income individuals who are elderly (>60) or have disabilities;
- 2) long-term care for older low-income Americans (65+) and individuals with disabilities; and
- 3) assistance with co-pays and deductibles for low-income Medicare beneficiaries

Who is covered by Medicaid?

Projected Medicaid Enrollees in CO, FY 2004-05



In 2002, 38% of Medicaid enrollees were also enrolled in Medicare, as virtually all elderly Medicaid enrollees are also enrolled in Medicare.

Characteristics of Medicaid Enrollees

{Kaiser Family Foundation 2007 #2470} {Kaiser Family Foundation 2006 #630}

Nonelderly (0-64)	CO#	CO%	US%
Children (0-18) - 2003	259,700	55%	50%
Adults (19-64) - 2003	99,200	21%	26%
Elderly (65+) - 2003	49,900	11%	11%
Disabled - 2003	64,900	14%	14%
At least 1 full time worker	175,470	58%	52%
Part time workers	35,430	12%	13%
Non workers	93,940	31%	35%
Under 100% FPL	143,090	47%	53%
100-199% FPL	98,710	32%	28%
Low income subtotal	241,790	79%	81%
200% or more	63,050	21%	19%
Female	165,030	54%	54%
Male	139,810	46%	46%
White	120,270	39%	45%
Black	NA	NA	24%
Hispanic	131,570	43%	25%
Other	NA	NA	6%

The Colorado Health Institute estimates that approximately 65,000 uninsured children (36% of all uninsured children) in Colorado were eligible for Medicaid coverage but not enrolled (2002-2004).

Medicaid Enrollees and Expenditures, FY 2004-2005

{Colorado Health Institute 2005 #450}

(For multiple years of data please see tables on the next page)

Population	Enrollees	Expenditures
Total	388,257	\$1,959,301,734
Children	58%	16%
Adults	17%	18%
Individuals with Disabilities	13%	33%
Elders	11%	33%

Total Medicaid payments for health care services have nearly doubled in the past 10 years. The primary factor contributing to the growth in spending has been the escalating cost of health care goods and services. Eligibility expansions for children and caseload growth fueled by the downturn in the state's economy have also driven costs upward. {Colorado Health Institute 2005 #450}

Recent cost-containment actions include:

- reductions in provider rates and reimbursements;
- changes to streamline enrollment processes and limit services;
- prescription drug controls; and
- increases in certain copays.

Medicaid Enrollment and Expenditures Over Multiple Years for Categories of Enrollees

{Colorado Health Institute from HCPF 2007 #2460}

	Total #	Total \$	Elders#	Elders\$	Disabled#	Disabled\$	Children#	Children\$	Adults#	Adults\$
FY 95-96	254,083	991,479,107	35,258	360,807,622	48,997	313,355,859	121,815	163,439,590	48,013	153,632,406
FY 96-97	250,098	1,128,159,480	36,396	440,706,430	50,519	367,405,925	119,847	158,821,358	43,336	160,986,073
FY 97-98	238,594	1,105,199,723	37,224	436,022,497	50,499	370,480,737	114,365	167,233,287	36,506	131,234,472
FY 98-99	237,598	1,176,460,610	39,111	468,460,266	51,219	408,108,490	113,600	174,695,791	33,668	124,968,863
FY 99-00	253,254	1,308,664,681	40,732	509,491,411	51,478	457,718,675	122,290	197,098,765	38,754	144,111,250
FY 00-01	275,399	1,416,808,001	41,806	527,102,590	51,203	507,939,508	136,297	224,300,431	46,093	157,192,878
FY 01-02	295,413	1,537,118,749	42,344	583,264,485	51,533	522,230,721	157,030	253,761,727	44,506	177,547,756
FY 02-03	327,395	1,652,031,633	43,434	576,748,650	51,834	576,929,455	180,380	265,561,035	51,747	232,431,733
FY 03-04	362,531	1,842,152,597	43,936	628,543,855	52,093	631,603,965	206,838	277,233,017	59,664	304,358,084
FY 04-05	402,802	1,893,758,090	45,187	661,515,733	53,729	625,542,908	236,261	336,517,777	67,625	269,709,150
FY 05-06	399,706	1,982,855,898	47,231	686,292,042	53,613	642,277,946	229,911	357,077,395	68,951	296,748,693
FY 06-07	427,933	2,115,639,640	49,263	702,715,307	54,525	654,512,658	246,714	409,483,926	77,431	348,434,321
FY 07-08	452,128	2,256,877,927	50,528	747,940,390	55,125	679,452,550	261,676	439,615,150	84,799	389,346,485

Percent of Total Medicaid Enrollment and Expenditures for Multiple Years Enrollees

{Colorado Health Institute from HCPF 2007 #2460}

	Elderly #	Elderly \$	Disabled #	Disabled \$	Children #	Children \$	Adults #	Adults \$
FY 95-96	14%	36%	19%	32%	48%	16%	19%	15%
FY 96-97	15%	39%	20%	33%	48%	14%	17%	14%
FY 97-98	16%	39%	21%	34%	48%	15%	15%	12%
FY 98-99	16%	40%	22%	35%	48%	15%	14%	11%
FY 99-00	16%	39%	20%	35%	48%	15%	15%	11%
FY 00-01	15%	37%	19%	36%	49%	16%	17%	11%
FY 01-02	14%	38%	17%	34%	53%	17%	15%	12%
FY 02-03	13%	35%	16%	35%	55%	16%	16%	14%
FY 03-04	12%	34%	14%	34%	57%	15%	16%	17%
FY 04-05	11%	35%	13%	33%	59%	18%	17%	14%
FY 05-06	12%	35%	13%	32%	58%	18%	17%	15%
FY 06-07	12%	33%	13%	31%	58%	19%	18%	16%
FY 07-08	11%	33%	12%	30%	58%	19%	19%	17%

CHP+

{Colorado Health Institute 2006 #660}

CHP+ is a health insurance program for uninsured Colorado children under age 19 whose families earn or own too much to qualify for Medicaid, but who cannot afford or do not have access to private insurance. Children whose families have incomes at or below 200% FPL are eligible for coverage. In addition, uninsured women who are at least 19 years of age and whose income is less than 185% FPL are also eligible for coverage. Approximately 36,500 children were covered by Child Health Plan Plus (CHP+) in 2002-2004.

CHP+ Caseload, FY 1998-99 to YTD FY 2006-07

	Children	Pregnant Women
FY 1998-99	12,825	
FY 1999-00	22,935	
FY 2000-01	29,305	
FY 2001-02	39,843	
FY 2002-03	49,216	531
FY 2003-04	46,694	179
FY 2004-05	40,005	607
FY 2005-06	46,928	1,135
YTD FY 2006-07	49,877	1,268

Of the almost 180,000 children who were not covered by and kind of health insurance, the Colorado Health Institute estimates that 57,200 (32%) were eligible for CHP+ but not enrolled (2002-2004).

Of those enrolled in CHP+ (for 2002-2004), 26% were aged 0-5 years and 74% were aged 6-18 years. Of those estimated to be eligible for CHP+ coverage, 32% were aged 0-5 years and 68% were aged 6-18 years.

COVERCOLORADO

{Brett 2005 #460}

The mission of CoverColorado:

“The mission of CoverColorado is to provide a health insurance program that expands and preserves access to health care for Coloradoans whose health prohibits or substantially limits access to commercial health insurance.”

The individuals covered through CoverColorado are primarily those who have enough money to pay for health insurance, but no commercial carrier will cover them because they have a pre-existing condition. In addition, individuals in the following categories are also eligible for coverage: individuals who have lost their jobs through the Trade Act; individuals whose pension plans and early retiree health plans have

been turned over to the Pension Benefit Guaranty Corp.; individuals who have used 18 months of COBRA benefits and are now HIPAA eligible.

In 2005, the Executive Director of CoverColorado reported the following characteristics of its enrollees:

- 4,783 participants
- 80% over the age of 40, but under 65
- 50% have a \$5K deductible or more
- All tax paying, voting citizens of Colorado
- 56% are in the program 2 years or less
- 44% are in the program more than 2 years

It was also reported that the average medical, prescription drug and admin cost for CoverColorado is \$8,500 per year, compared to \$2,500 per year for the average commercially insured person.

MEDICARE

Medicare is the primary source of health insurance coverage for the population aged 65 and older. In 2005, 512,523 individuals in Colorado were enrolled in Medicare, which is 11% of the entire population.

Medicare Enrollees (2004-2005) {Kaiser Family Foundation 2005 #650}

Medicare Enrollees (2004-2005)	CO#	CO%	US%
0-64	74,164	15%	16%
65-69	126,832	25%	23%
70-74	104,203	21%	20%
75-79	85,475	17%	17%
80-84	63,090	13%	13%
85+	51,814	10%	11%
Aged	433,476	86%	85%
Disabled	71,747	14%	15%
Under 100% FPL	63,510	14%	17%
100-199% FPL	116,640	26%	30%
Low-income Subtotal	180,140	40%	47%
200%+ FPL	267,480	60%	53%

Of all Medicare enrollees (2005), 11% had dual eligible enrollment in Medicaid. {Kaiser Family Foundation 2005 #560}

In 2003, 54,054 individuals (1.2% of total population) in Colorado had federal Supplemental Security Income (SSI). Of those aged 65+ in Colorado (2003), 1.9% had aged SSI.

GENERAL
Public Insurance in Colorado and the US
(Based on Census Bureau's March 2005 and 2006 Current Population Survey)
 {Kaiser Family Foundation 2007 #490}

For the following tables, "Medicaid" includes Medicaid, SCHIP and dual eligibles; "Other Public" includes military, VA and non-elderly Medicare.

Of total population	CO#	CO%	US%
Medicaid	338,250	7%	13%
Medicare	386,020	8%	12%
Other Public	90,900	2%	1%
Total Public	815,170	17%	26%

Of nonelderly (0-64)	CO#	CO%	US%
Medicaid	304,840	7%	14%
Other Public	112,180	3%	2%
Total Public	417,020	10%	16%

Of nonelderly (0-64) living in poverty (<100% FPL)	CO#	CO%	US%
Medicaid	56,980	16%	27%
Other Public	12,620	3%	4%
Total Public	69,600	19%	31%

Of nonelderly (0-64) women	CO#	CO%	US%
Medicaid	78,030	5%	10%
Other Public	46,160	3%	3%
Total Public	124,190	8%	13%

Of nonelderly (0-64) men	CO#	CO%	US%
Medicaid	44,000	3%	6%
Other Public	36,270	2%	3%
Total Public	80,270	5%	9%

Of children (0-18)	CO#	CO%	US%
Medicaid	182,810	15%	26%
Other Public	29,750	2%	1%
Total Public	212,560	17%	27%

Of children (0-18) living in poverty (<100% FPL)	CO#	CO%	US%
Medicaid	86,110	40%	59%
Other Public	4,460	2%	2%
Total Public	90,570	42%	61%

Of children (0-18) living near poverty (<100% - 199% FPL)	CO#	CO%	US%
Medicaid	61,250	27%	39%
Other Public	12,170	5%	2%
Total Public	73,420	32%	41%

How Many Coloradans Are Covered by Various Forms of Insurance?

2004-2005 Averaged		2006
Total Population {Kaiser Family Foundation 2006 #620}	4,557,130	4,753,377
58% Employment-based Coverage{Kaiser Family Foundation 2006 #620} Includes employer-sponsored coverage for employees and their dependents	2,649,000	
Small group {State of Colorado 2007 #1510} (<50)	358,300 ^a	359,781 ^d
Large Group {State of Colorado 2007 #1510} (>50)	966,000 ^b	
ERISA/self-funded, any size {State of Colorado 2007 #1510}	1,324,500 ^c	
7% Individual, private purchase{Kaiser Family Foundation 2006 #620} Those covered by private insurance other than employer-sponsored coverage.	324,750 ^e	
7% Medicaid {Kaiser Family Foundation 2006 #620} (includes ~73,000 dual eligible & ~47,000 ^g SCHIP) Includes those covered by Medicaid, SCHIP, and those who have both Medicaid and another type of coverage, such as dual eligibles who are also covered by Medicare.	338,250	~400,000 ^f
8% Medicare {Kaiser Family Foundation 2006 #620} Includes those covered by Medicare only and those with supplemental coverage from another source, such as private retiree insurance.	386,020	
2% Other Public Insurance {Kaiser Family Foundation 2006 #620} Those covered under the military or Veterans Administration as well as some non-elderly Medicare enrollees.	90,900 ^h	
17% Uninsured{Kaiser Family Foundation 2006 #620} Those without health insurance and those who have coverage under the Indian Health Service only.	768,150	

^a Colorado Division of Insurance small group rating flexibility study on 9/30/2005

^b Remainder after accounting for ERISA self-funded and small group

^c AHIP reports that approximately 50% of people having employer provided health insurance are covered under an ERISA self-funded plan. 50% of 2,649,000= 1,324,500

^d Colorado Division of Insurance small group rating flexibility study on 9/30/2006

^e US Census CPS Table Creator for Colorado for years 2004-2005 averaged reports 483,510 with “direct purchase” insurance.

^f Colorado Health Institute, estimates 400,000 Coloradans on Medicaid in 2005-06. *Issue Brief, the Colorado Health Care Marketplace*, Nov 2006, page2.

^g Colorado Health Institute, estimates nearly 47,000 Colorado children covered by CHP+ in 2005-06. *Issue Brief, the Colorado Health Care Marketplace*, Nov 2006, page3.

^h US Census CPS Table Creator for Colorado for years 2004-2005 averaged reports 228,913 with “Military” benefits (e.g. Tri-care or CHAMPVA)

Components for the Small Group Market, 2006 {State of Colorado 2007 #1510}

	# of Groups	# of Covered Lives (%)
Group of One (BG1)	11,932	22,129 (6%)
2-15 Employees	31,321	226,782 (66%)
16-50 Employees	2,311	93,445 (27%)

CICP

Colorado Health Institute reports in *Issue Brief, the Colorado Health Care Marketplace*, November 2006, “around 180,000 uninsured or underinsured Coloradans received services partially subsidized by CICP in FY 2004-05” {Colorado Health Institute 2006 #660}. The Colorado Indigent Care Program is “used to partially reimburse medical providers for services given to the State's non-Medicaid indigent residents. The CICP provider network consists of 49 hospitals, 18 clinics, and 51 satellite facilities. The benefits vary from clinic to clinic and from hospital to hospital. The Colorado Indigent Care Program **is not an insurance program** but rather a financial vehicle for providers to recoup their medical cost at a

discount.” {Colorado Indigent Care Program 2007 #2440} Reimbursements are prioritized for primarily for emergency care and urgent care, and CICP clients are responsible for a co-payment for services, based on eligibility. {Colorado Department of Health Care Policy and Financing 2007 #2450}

Employment Based Insurance: Own and Dependent

According to the US Census Current Population Survey, Annual Social & Economic Supplement, 2005 for State of Colorado, approximately 2,884,000 persons are covered by employer-based health insurance. {U.S. Census Bureau 2005 #2500} Of that:

1,504,000 (52%) own policy

1,380,000 (48%) are dependents on some else's policy

Premium Cost Sharing – Employers and Workers

Single (employee only)

- Nationally, in 2006, 76% of workers with coverage were required to make a contribution to their single medical plan premium. {Employee Benefit Research Institute 2006 #390}
- In Colorado, in 2004, 21% of private sector employees were enrolled in a single-coverage health insurance plan that required no employee contribution. Thus, 79% of private sector employees cost-shared some portion of their single health insurance premium. {Agency for Health Care Research & Quality 2004 #1520}
- **Small Group Cost Share:** From the Medical Expenditure Panel Survey 2004, for Colorado
 - The small-firm employee cost-share, on average, on an individual premium was \$685 of \$3,929 or 17%. {Agency for Health Care Research & Quality 2004 #1520}
 - 53% of small group private-sector employees enrolled in a health insurance plan made some contribution to their health insurance plan. {Agency for Health Care Research & Quality 2004 #1520}
- **Large Employer Cost Share:** From the Medical Expenditure Panel Survey 2004, Colorado
 - Private-sector employees at large firms cost share for a single plan was \$675 of \$3,602 or 19%. {Agency for Health Care Research & Quality 2004 #1520}
 - 88% of large group private-sector employees enrolled in a health insurance plan made some contribution to their health insurance plan. {Agency for Health Care Research & Quality 2004 #1520}
- **Deductibles** – In 2006, the national average annual individual deductible for a single PPO plan was \$431. {Employee Benefit Research Institute 2006 #390}
- **Maximum Out-of-Pocket Expense Limit** – In 2006, the national annual maximum on a single out of pocket expenses (PPO) was \$1,982 {Employee Benefit Research Institute 2006 #390}

Family (employee plus spouse and children)

- Nationally, 88% of workers with coverage are required to make a contribution to a family plan. {Employee Benefit Research Institute 2006 #390}
- In Colorado in 2004, 13% of private sector employees were enrolled in a family-coverage health insurance plan that required no employee contribution. Thus, 87% of private sector employees cost-shared some portion of their employer-provided family health insurance premium. {Agency for Health Care Research & Quality 2004 #2550}
- **Small Group Cost Share:** From the Medical Expenditure Panel Survey 2004, for Colorado
 - The average small firm employee cost share for a family plan in 2004 was \$3,267 of \$9,988 or 33%. {Agency for Health Care Research & Quality 2004 #1520}
 - 75% of small group private-sector employees enrolled in a health insurance plan made some contribution to their family health insurance plan in 2004 {Agency for Health Care Research & Quality 2004 #2550}

- **Large Employer Cost Share:** From the Medical Expenditure Panel Survey 2004, Colorado
 - Private-sector employees at large firms cost share for a single plan was \$675 of \$3,602 or 19%. {Agency for Health Care Research & Quality 2004 #1520}
 - 89% of large group private-sector employees enrolled in a health insurance plan made some contribution to their family health insurance plan {Agency for Health Care Research & Quality 2004 #2550}

Deductibles – In 2006, the national average annual individual deductible for a single PPO plan was \$1,124. {Employee Benefit Research Institute 2006 #390}

Maximum Out-of-Pocket Expense Limit – In 2006, the national annual maximum on family out-of-pocket expenses (PPO) was \$3,944 {Employee Benefit Research Institute 2006 #390}

Characteristics of Employers that pay 100% of the premium- according to a 2005 study by the Center for Economic Studies of the US Census Bureau, establishments that tended to fully pay employee health insurance premiums were, “young, small, single-units, with a relatively high paid work-force. Plans that were fully paid generally required referrals to see specialists, did not cover pre-existing conditions or outpatient prescriptions, and had the highest out-of-pocket expense limits. These plans were also more likely than plans not fully paid by employers to have had a fee for service or exclusive provider arrangement, had the highest premiums, and were less likely to be self-insured.” {Zawacki & Taylor 2005 #2520}

Employee Contribution and Take-Up Rates

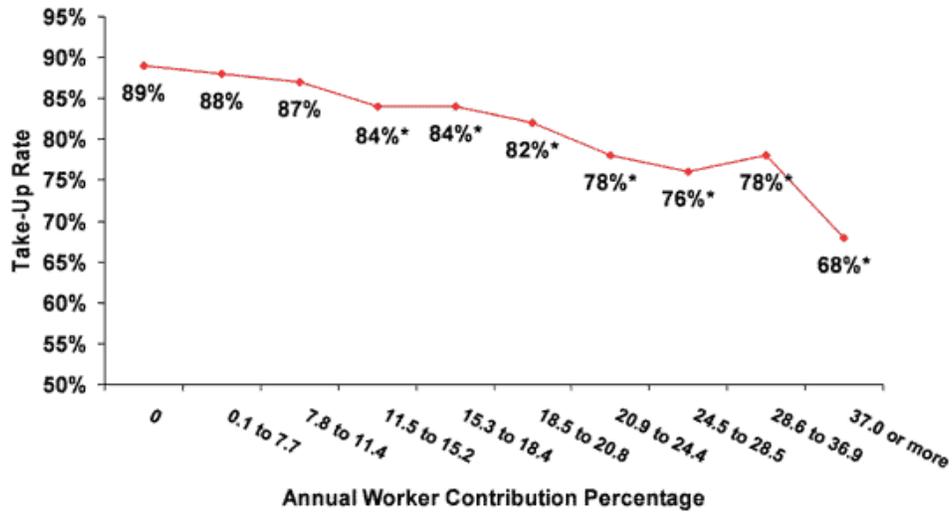
- In 2003, nationally, 75% of workers who had access to an employer-provided plan participated in the plan – that “take-up rate. {Employee Benefit Research Institute 2006 #390}⁵
- An employee may choose to opt out of employer-provided coverage for several reasons, including {Kaiser Family Foundation 2006 #270}
 - Cannot afford required costs of premium contribution
 - ability to obtain coverage through a spouse or
 - enrollment in publicly provided programs, if eligible
 - elect to go without coverage entirely
- Kaiser Family Foundation reports, “There was a 5.8 percent fall in the take-up rate of employer-sponsored insurance for low-income workers from 1999 to 2002. Over this same period, the decline in take-up for individuals above 200 percent of poverty was 1.5 percent.” {Kaiser Family Foundation 2006 #270}

Employee Contribution Toward Single Coverage, Colorado, 2006

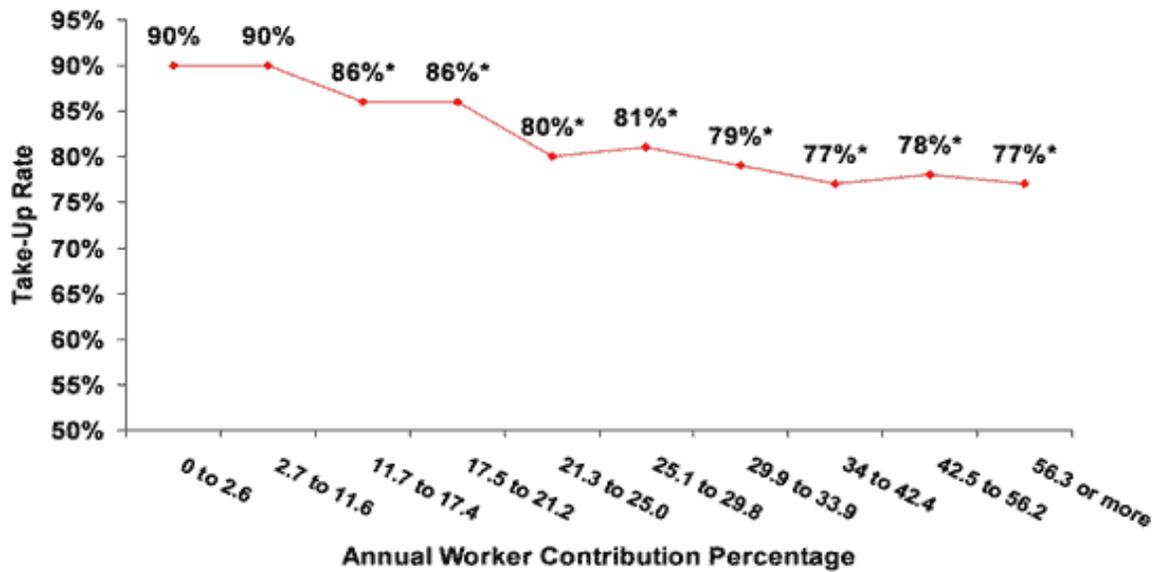
{Lockton Companies of Colorado 2007 #1970}

% of Premium Paid by Employee	% of Employers
0-9%	31%
10-19%	26%
20-29%	21%
30-39%	7%
40-49%	4%
Over 50%	10%

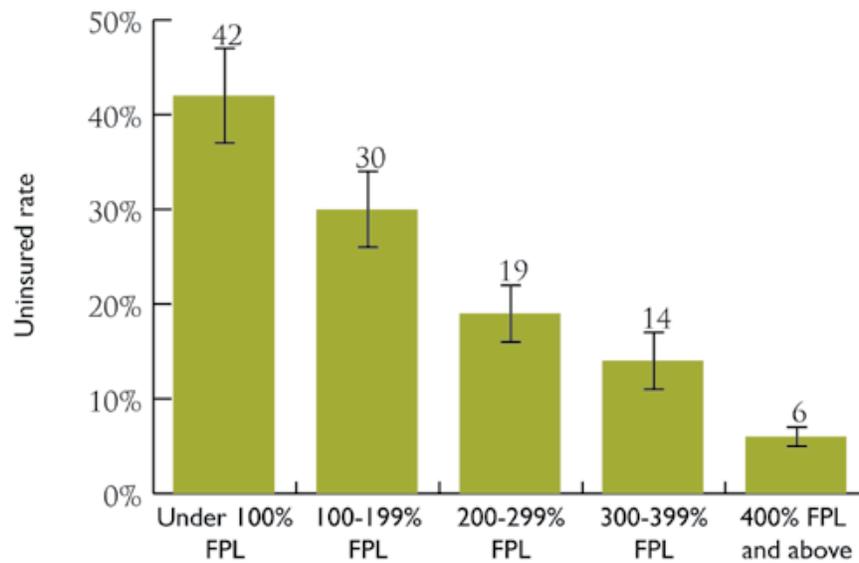
Firm Health Insurance Take-Up Rate by Percentage Contribution For Single Coverage, 2005-06
 {Kaiser Family Foundation 2006 #270}



Firm Health Insurance Take-Up Rate by Percentage Contribution For Family Coverage
 {Kaiser Family Foundation 2006 #270}



Colorado Uninsured Rates by Federal Poverty Level (FPL) 2003-2005
 {Colorado Health Institute 2006 #20}



Colorado's Uninsured Population by Race/Ethnicity 2003-2005
 Estimates for non-Hispanic Hawaiian/Pacific Islanders not available

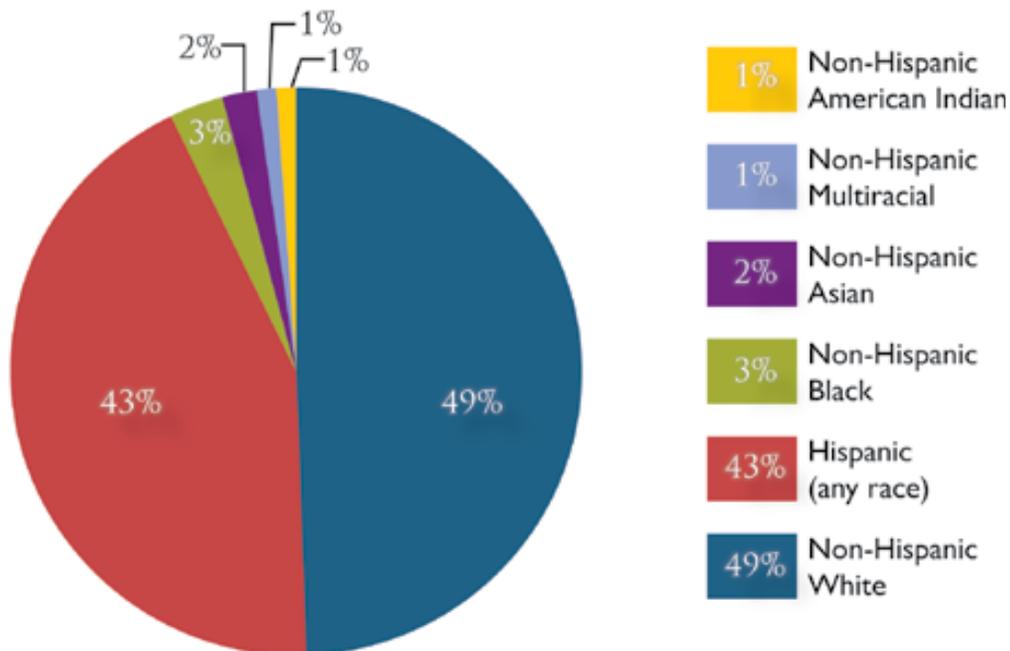


Table 1: Number of Uninsured Coloradoans by Income Category, 2004
 {Colorado Health Institute 2006 #20}

FPL Income Category	# Uninsured Coloradoans	Example: % of 2004 FPL for a Family of One	Example: % of 2004 FPL for a Family of Four
<100 %	175,560	Less than \$9,645	Less than \$19,307
100 - 199%	225,610	\$9,645 - 19,289	\$19,307 - 38,613
200 - 299%	157,850	\$19,290 - 28,934	\$38,614 - 57,920
300 -399%	86,240	\$28,935 - 38,579	\$57,921 - 77,227
400% +	124,740	\$38,580+	\$77,228+
Approximate Total Number of Uninsured Coloradoans	770,000		

Table 2: Number of Uninsured Coloradoans by Age and Income Level, 2004
 {Colorado Health Institute 2006 #20}

Age Group	<200% FPL	At or Above 200% FPL	
Under 18	111,124	58,643	
18-34	165,282	139,417	
35-44	66,193	70,815	
45-64	56,565	98,477	
Totals	399,164	367,352	766,516

Trends and Projections

From the CHI Policy Brief, November 2006 *The Colorado Health Care Marketplace*:

- Between 1996 and 2004, Colorado saw higher increases in health insurance premiums than the rest of the nation as a whole. {Colorado Health Institute 2006 #2530}

	1996 Total Single & Total Family	2004 Total Single & Total Family	Trend in cost 1996 to 2004 (% change)	Comparisons
Overall	\$1,910 \$4,717	\$3,684 \$10,228	+93% +117%	US 86% US 102%
Large Group	\$1,925 \$4,852	\$3,602 \$10,269	+87% +112%	US 88% US 102%
Small group	\$1,877 \$4,244	\$3,929 \$9,988	+110% +135%	US 82% US 100%

{Agency for Health Care Research & Quality 2004 #1520}

Additional Rural Health Strategies to Be Considered

The following are strategies to consider to improve access to health care for rural areas of Colorado:

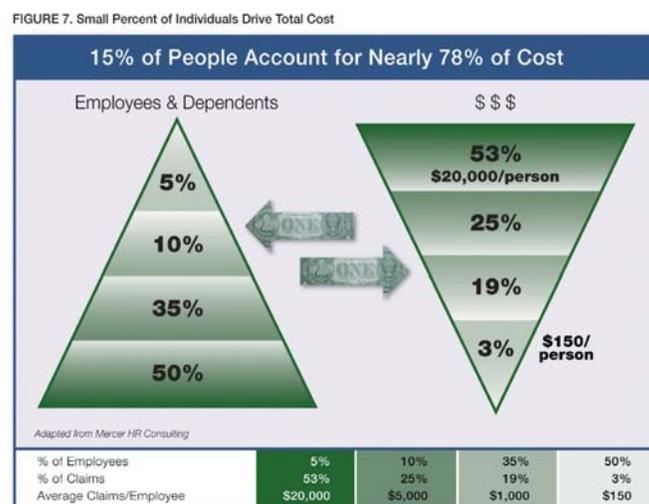
- State should enhance telemedicine capabilities through both infrastructure and specialist payment incentives.
- Provide additional incentives to encourage physicians to practice in rural areas such as more generous loan repayment programs and start-up assistance.
- Support rural rotations for health professionals.
- Allow additional appropriate services to be provided by midlevel providers.
- Create a linkage of rural emergency medical systems (EMS) with the regional health system.
- Provide capital and operational funding for mobile medical vans that would regularly access the most remoter parts of the state.

Cost Drivers

Judy Glazner {Glazner 2007 #100} reported that increased treated disease and increased spending in treated cases due to technological advances are the two leading causes of the increase in healthcare spending (63% of increase and 37% of increase, respectively). {Glazner 2007 #100}

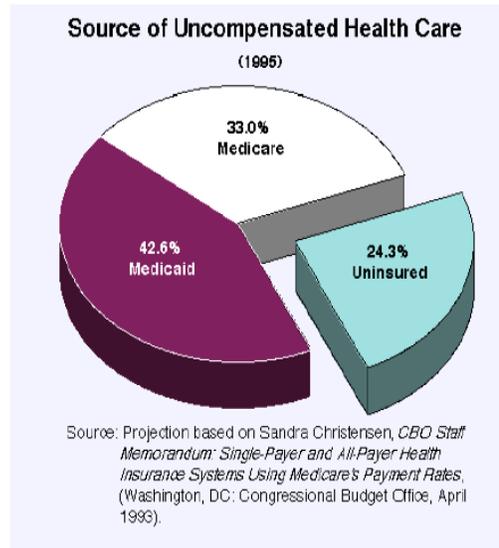
Kenneth Thorpe (2005) also attributes increasing healthcare costs to treated disease prevalence and treatment innovations, in addition to changes in clinical thresholds for treatment. {Thorpe 2005 #970}

- **Treated Disease Prevalence** {Tokar 2007 #340}
 - Increased healthcare spending is partly due to the rise in treated disease prevalence (63% of increase {Glazner 2007 #100}, caused by changes in population factors (e.g., obesity), changing treatment thresholds (treating diseases that were not treated in the past) and innovation
- **Medical technology** {Tokar 2007 #340}
 - Technology accounts for >50% of the rise in health care costs - Increases in technology availability equal increases in utilization and spending on the technology
- **Aging population** {Tokar 2007 #340}
 - Adding an extra year of life for the elderly costs \$145,000
 - The top-spending 25% of Medicare beneficiaries (in 2001) incurred average per-person costs of \$24,800
 - The elderly and disabled accounted for about 70% of Medicaid spending in 2003
 - An Urban Institute study showed that the prevalence of disability among the elderly (65+) has been decreasing, showing that not only are the elderly living longer, but that they are living healthier longer {Freedman, Crimmins, et al. 2004 #1050}
 - In 2002, the elderly made up around 13% of the U.S. population, but they consumed 36% of total U.S. personal health care expenses

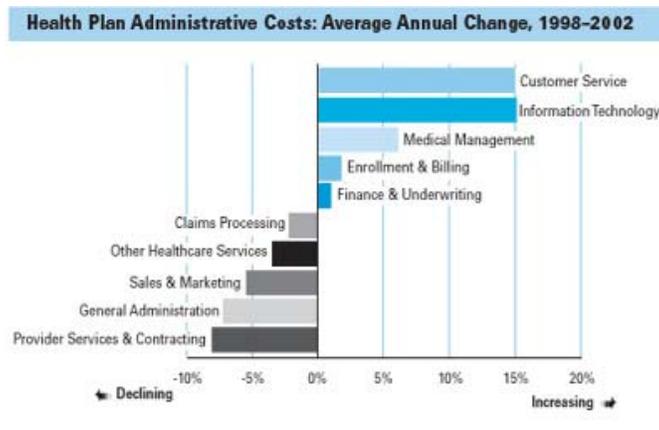


- **Health Behaviors** {Dietz, Wechsler, et al. 2007 #160}
 - Approximately 27% of the change (increase) in health care spending between 1987 and 2002 can be attributed to preventable population risk factors (obesity cost \$117 billion in 2000)

- **Moral hazard (insurance)** {Tokar 2007 #340}
 - Moral hazard and technology: cause and effect
- **Health care delivery inefficiencies**
 - The overuse of urinalysis, x-ray, and electrocardiogram, which are widely accepted as non-recommended, during routine PHE costs between \$47 million and \$194 million annually {Merenstein, Daumit, et al. 2006 #140}
- **Cost shifting (public-private)**
 - The cost of providing care to the uninsured was estimated to add as much as 8.5% to the cost of premiums {Families USA 2005 #1060}
 - Uninsured pay ~30% of the health care they receive (source: CBO) {Tokar 2007 #340}



- **Administrative inefficiencies**
 - US: \$399 billion (20%) per year on health care bureaucracy {Thorpe 2005 #970}
 - Administrative costs account for 25% of health care spending; in California 20-22% of privately insured spending is attributable to billing and insurance-related functions {Kahn, Kronick, et al. 2005 #2360}
 - Public insurance programs generally have administrative costs less than or equal to 5%, while private insurance programs have administrative costs above 20% {Mathews 2006 #1070}



- **Legal environment {Tokar 2007 #340}**

Cost of Medical Liability and Defensive Medicine as a Share of the Premium Dollar, 2005			
Component	Total Share of Premium	Medical Liability Share of the Premium Cost	Benefit Share of Premium Less Medical Liability
Physician	24%	3%	21%
Outpatient	22%	4%	18%
Hospital Inpatient	18%	1%	17%
Prescription Drugs	16%	1%	15%
Other Medical Services	6%	1%	5%
Total	86%	10%	76%

Source: PricewaterhouseCoopers' estimates, December 2005.

	<p>systems development and dissemination</p> <p>3. Case management for severely complex cases⁺⁺</p> <p>4. Promoting integrated systems of care</p>	<p>a. Create an Office of Health Information Technology in the CDPHE (OHIT)</p> <p>i) OHIT solicits bids for and certifies a limited number of EHR product licenses that include such essential elements as stability, technical support services, interoperability and evidence-based decision support</p> <p>ii) Reduce financial barriers to implementation through low-/no-cost loans or grants for implementing OHIT-certified EHRs</p> <p>3. Case Management</p> <p>a. Provide incentives for intensive multidisciplinary case management for high priority conditions that currently suffer from gaps in coverage that prevent effective care*</p> <p>4. Integrated systems</p> <p>a. Reestablish Medicaid managed care</p> <p>i) Default passive enrollment in existing highly integrated health services organizations where available (e.g. DHHA, Kaiser)</p> <p>ii) Ensure adequate rates to ensure solvency of such plans</p> <p>b. Provide financial incentives for organizations that demonstrate effective care coordination*</p> <p>i) Performance measures focus on longitudinal outcomes rather than intermediate process measures</p> <p>c. Authority Board will create a process for advanced multidisciplinary case management of complex, high-utilization cases*, ++</p> <p>i) May take several forms, such as expansion of benefits, contracting with existing health service organizations, or state-run service</p>
Comprehensive	<p>1. Extensive pre-defined set of benefits</p> <p>2. Expansion of essential benefits</p>	<p>1. Standardized Benefits</p> <p>a. List of benefits will be standard across plans, to be determined and periodically updated by the Board based on evidence of effectiveness and cost-effectiveness</p> <p>2. Expanded Benefits</p> <p>a. First-dollar coverage for evidence-based health promotion (e.g. proven tobacco cessation strategies)</p> <p>b. Low or waived co-pays for other high-priority, high-morbidity conditions and chronic disease management programs</p> <p>c. Dental coverage, mental health parity, and</p>

		substance abuse treatment
Accessible	<ol style="list-style-type: none"> 1. Coverage for nearly all Coloradoans 2. Guaranteed medical home for all covered lives 3. Primary care support++ 4. Remove certain incentives for patients to avoid effective early intervention++ 5. Improve access to specialists 	<ol style="list-style-type: none"> 1. Coverage for nearly all Coloradans <ol style="list-style-type: none"> a. Expand CHIP/Medicaid eligibility b. State wide risk pool c. Subsidized premiums 2. Medical home – see above 3. Primary Care – see above, ++ 4. Remove disincentives to appropriate utilization ++ <ol style="list-style-type: none"> a. Strategically expanded first dollar/low- or no-copay benefits (see above) b. Inclusion of capitated managed care in plan choices c. Creation of toll-free, state-wide after-hours advice/triage line for patients modeled on the Children’s Hospital nurse line*# 5. Improve access to specialists <ol style="list-style-type: none"> a. Pilot reimbursement for telehealth initiatives/phone consultation* b. Promotion of integrated care systems (see above)*
Safe	<ol style="list-style-type: none"> 1. Voluntary, protected error reporting system* 2. Improving communication and reducing fragmentation through Health IT promotion 3. Improve training in patient safety across all disciplines 	<ol style="list-style-type: none"> 1. Voluntary, protected error reporting systems*# <ol style="list-style-type: none"> a. One model is based on the Advanced Strategies In Patient Safety program (ASIPS) of protected, voluntary anonymous and/or confidential error reporting to central authority such as BME to allow for identification of previously unrecognized systematic threats to patient safety and share strategies for risk reduction. 2. Improving communication and reducing fragmentation through Health IT promotion (see above) 3. Mandate patient safety curricula across health education sector (medical, nursing, pharmacy, and other allied health professional schools and Health Care Administration degree programs) #
Evidence based	<ol style="list-style-type: none"> 1. Including only those benefits supported by a preponderance of the best available evidence++ 	<ol style="list-style-type: none"> 1. Including only those benefits supported by a preponderance of the best available evidence++ (e.g. no routine MRI coverage for routine mechanical low back pain)

	<p>2. Pay for performance*</p> <p>3. Rational, evidence based formulary++</p> <p>4. Promote evidence based point of care decision support</p>	<p>2. Pay for performance*</p> <ul style="list-style-type: none"> a. Authority Board will be charged with determining robust outcome measures, preferably related directly to patient-oriented outcomes rather than process measures wherever possible, and determining how accountability is allocated. b. Would likely include both enhanced capitation rates and higher fee for service rates where appropriate c. Would include specific incentives for adopting OHIT-certified EHRs, care coordination, and care integration innovation. d. Phase in standardized electronic reporting and publication of quality indicators appropriate to site of care to provides incentives to providers and service organizations to compete on performance. <p>3. Rational, evidence based formulary</p> <ul style="list-style-type: none"> a. Colorado Department of Health Care Policy and Financing will adopt preferred drug list for Medicaid and the subsidized health plans. b. Contracting with Oregon’s Center for Evidence-based Policy to use the Oregon Health Plan’s list like several other states have done. <p>4. Advanced care decision support*</p> <ul style="list-style-type: none"> a. Built in to OHIT HER certification process (see above)
Patient centered	<p>1. Preserve patient choice</p> <p>2. Eliminate “rationing by fine print”</p> <p>3. Promote the concept of a consistent medical home</p> <p>4. Reduce involuntary turnover in provider panels</p>	<p>1. Proposal preserves patient choice</p> <ul style="list-style-type: none"> a. Choice of provider b. Choice of plans <p>2. Proposal simultaneously promotes rational decision making by patients</p> <ul style="list-style-type: none"> a. Reduces the “tyranny of choice” phenomenon seen recently with Medicare Part D plans or the current overwhelming diversity of insurance products b. Reduces the problem of hidden underinsurance <p>3. Provides guaranteed dedicated medical home (see above),</p> <p>4. Provider turnover</p> <ul style="list-style-type: none"> a. Pool eliminates the frequent churning of multiple plans by employers that currently drives involuntary provider turnover b. Simplified and standardized contracting stabilizes network provider panels c. Preventing insurance gaps and loss of

	5. Pay for performance*	coverage through prohibiting differential premiums based on any attributes related to health status or risk 5. Pay for performance models will include patient satisfaction indicators*
Efficient	<ol style="list-style-type: none"> 1. Reducing administrative waste and overhead++ 2. Maximize federal subsidies 3. Pay for performance* and care integration incentives* and capitated HMO plans will provide incentives for efficient systems (see above) 4. Supporting primary care++ 5. Development of state-wide after hours advice line to ensure appropriate use of services++ 6. Reduce duplication of services rendered 	<ol style="list-style-type: none"> 1. Reducing administrative waste and overhead, <ol style="list-style-type: none"> a. Standardized electronic credentialing b. Standardized contracting / negotiation c. Standardized billing and claims management++ (see above) 2. Maximizes federal subsidies <ol style="list-style-type: none"> a. Expand Medicaid/CHIP 3. Pay for performance* and care integration incentives* and capitated HMO plans will provide incentives for efficient systems (see above) 4. Supporting primary care++ (see above) 5. After hours advice line++ (see above)* 6. Reduce duplication of Services <ol style="list-style-type: none"> a. Adoption of OHIT-certified, interoperable EHRs (see above) b. Improved integration and coordination (see above)
Transparent	<ol style="list-style-type: none"> 1. Allow rational decision making by members 2. Public reporting of quality data 3. Authority Board transparency 	<ol style="list-style-type: none"> 1. Manageable number of plan choices and standardization of terminology, absence of hidden costs / exclusions, etc to allow for rational plan choice (see above) 2. Phased-in mandatory public reporting of site/specialty specific quality measures (see above)* 3. HCB transparency <ol style="list-style-type: none"> a. Propose Authority Board minutes will be public records after a predetermined period to allow some freedom of decision making b. Mandatory periodic reporting by Authority Board to legislature c. Structure of Authority Board assures a reasonable degree of independence and sheltering from special interests.

Continuous healing relationships	<ol style="list-style-type: none"> 1. Primary care support++ 2. Support patient choice 3. Support medical home concept 4. Promote long term doctor-patient relationships 5. Incent with pay for performance 	<ol style="list-style-type: none"> 1. Primary care support++ (see above) 2. Preserved patient choice of providers (see above) 3. Provides guaranteed dedicated medical home (see above) 4. Reduces involuntary turnover in providers (see above) 5. Including measures of patient centeredness and patient satisfaction in performance reporting*
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Key elements of quality that are not inherent to the new coverage proposal but cannot be adequately achieved without state intervention

***These strategies are supported in principle in this proposal, but currently lack the data to recommend a specific means of implementation. The Authority Board would determine the best methods for implementing these strategies.**

++These items also directly address questions of cost containment simultaneously.

TYPE OF BENEFIT PLAN THE AUTHORITY BOARD *MIGHT* CONSIDER
(not necessarily a complete listing)

	New Pool's Product for those Receiving Assistance (Not eligible for Medicaid/CHP+ but FPL < 400%)
Premiums/Deductible	None for < 250% FPL 251– 400%: Sliding scale premium
Max Annual Out-of-Pocket	0-5% of yearly income
Coinsurance/Copays	Copays: Families <101% FPL all copays waived, except for \$3 copay for emergency services. Families between 101-150% FPL \$1-3 copays for most Families between 150-250% FPL \$3-15 copays for most Families 251% - 399%: \$10-25 copays for most; 90% coins.
Lifetime Benefit Max Paid by Plan	\$2 million
SERVICES	
Emergency Services	0-200%: \$3 or \$15 copay (<i>if appropriate</i>) 251-399%: \$25-50 copay
Emergency Transport/Ambulance Services	0-200%: covered in full (<i>if appropriate</i>) 251-399%: \$25-50 copay
Inpatient Hospital Stay	0-250%: covered in full 251-399%: 90% coinsurance
Outpatient/Ambulatory Surgery	0-250%: Covered in full 251-399%: 90% coinsurance
Lab, xray, diagnostic	0-250%: Covered in full 251-399%: 90% coinsurance
Med office visit	0-250%: 0, \$2, or \$5 copay 251-399%: \$10 copay
Preventive Services / Chronic Disease Management (Expanded)	0-250%: Covered in full 251-399%: Covered in full
Maternity care	0-250%: Covered in full 251-399%: 90% coinsurance
Neurobiologically based MI	Parity: inpatient same as hospitalization; outpatient same as medical office visit
Other Mental Services	Parity: inpatient same as hospitalization; outpatient same as medical office visit
Alcohol and Substance Abuse Tx	Residential: same as inpatient hospital Outpatient: \$0, \$2, or \$5 copay
Physical, Occupational, and Speech Therapy	0-250%: \$0, \$2, or \$5 copay 251-399%: 90% coinsurance
Durable Medical Equipment	0-250%: covered in full (max \$2,000) 251-399%: 90% coinsurance (max \$2,000)
Prescription drugs	0-250%: 0 - \$5 depending on generic/name brand 251-399%: \$10 copay preferred generic; \$15 copay preferred brand; \$25 copay non-preferred
Vision services	0-250%: Exam, specialty care covered; 0, \$2, or \$5 \$100 towards lenses, frames, or contacts 251-399%: 90% coinsurance for exam, specialty care \$50 towards lenses, frames, or contacts
Audiological Services	0-250%: Hearing aids, copay 0 - \$25, max \$1000 251-399%: Hearing aids, 90% coinsurance, max \$1000
Transplant Services	0-250%: Coverage for limited w/prior auth 251-399%: 90% coinsurance for covered transplants
Dental Care	0-250%: Periodic cleaning, exams, xrays, fillings, extractions, root canals. Max \$750 251-399%: “, 90% coinsurance (max \$750)
Skilled nursing facility	0-250%: Covered in full 251-399%: 90% coinsurance
Hospice care	0-250%: Covered in full 251-399%: 90% coinsurance
Home health care	0-250%: Covered in full 251-399%: 90% coinsurance

Comparison of Colorado Public and Private Health Insurance Options-Coverage and Costs

	MEDICAID ¹	CHP PLUS ²	Basic Small Group PPO Plan ³	Standard Small Group PPO Plan ³	Basic Limited Mandate Small Group PPO Plan ³
Premium/Deductible	None	Premium-Families < 151% FPL fee waived. 151% - 200% \$25 for 1 child, \$35 for 2 children.	In Network: Individual \$3,000 Family \$6,000	In Network: Individual \$1,500 Family \$4,500	In Network: Individual \$3,000 Family \$9,000
Max Annual Out-of-Pocket	None	5% of yearly income	Individual: \$5,100 (includes deductibles, coinsurance, copays) Family: \$10,200 (includes deductibles, coinsurance, copays)	Individual: \$3,000 excluding flat dollar copays Family: \$6,000 excluding flat dollar copays	Individual: \$6,000 excluding flat dollar copays Family: \$12,000 excluding flat dollar copays
Coinsurance/Copays	Limited copays for some services if enrolled in Primary Care Physician Program (PCPP). No copays if enrolled in HMO, 18 or younger, pregnant, or in a nursing home	Copays: Families < 151% FPL all copays waived except for \$3 copay for emergency services. Families between 101%-150% FPL \$1-3 copays. Families between 151%-200% FPL \$3-15 copays	70% coinsurance	80% coinsurance	70% coinsurance
Lifetime Benefit Max Paid by Plan			\$2 million	\$2 million	\$2 million
Services					
Emergency Services	Covered in full-no copay	\$3 or \$15 copay	70% coinsurance	80% coinsurance	70% coinsurance
Emergency Transport/ Ambulance Services	Covered in full-no copay	Covered in full	70% coinsurance	\$125 copay then 80% coinsurance	\$250 copay then 70% coinsurance
Inpatient Hospital Stay	\$15	Covered in full	70% coinsurance	80% coinsurance	70% coinsurance
Outpatient/Ambulatory Surgery	\$3/visit	Covered in full	70% coinsurance	80% coinsurance	70% coinsurance
Laboratory, X-ray and Diagnostic Services	Covered in full-no copay	Covered in full	70% coinsurance	80% coinsurance	70% coinsurance
Medical Office Visit	\$2/visit	\$0, \$2 or \$5 copay	70% coinsurance PCP or Specialist	PCP: \$25 copay Specialist: \$40 copay	PCP: \$40 copay Specialist \$80 copay
Preventative Services	Covered in full-no copay	Covered in full	Children: \$40 copay (no deductible) Adults: \$40 copay (no deductible)	Children: \$25 copay (no deductible prior to application of coinsurance) Adults: \$25 copay	Children: \$40 copay (no deductible prior to application of coinsurance) Adults: \$40 copay
Maternity Care	Covered in full-no copay	Covered in full	70% coinsurance	80% coinsurance (1 PCP copay then deductible and coinsurance apply)	70% coinsurance (1 PCP copay then deductible and coinsurance apply)
Neurobiologically Based Mental Illness	Covered in full-no copay	\$0, \$2 or \$5 copay	Covered the same as any other medical condition	Covered the same as any other medical condition	Covered the same as any other medical condition
Other Mental Services	Covered in full-no copay	45 inpatient days or 90 outpatient treatment days per benefit period. 20 outpatient visits. \$0, \$2, or \$5 copay per outpatient visit	Inpatient: 50% coinsurance. Max 45 inpatient or 90 partial days/year Outpatient: 50% coinsurance. Max \$1,000/year	Inpatient: 50% coinsurance. Max 45 inpatient or 90 partial days/year Outpatient: 50% coinsurance. Max \$1,500/year	Excluded
Alcohol and Substance Abuse Treatment	Covered in full-no copay	20 outpatient visits per diagnosis-\$0, \$2, \$5 copay depending on income. No inpatient.	Acute detox: Max 5 days per episode and 2 episodes per lifetime. 50% Coinsurance	Acute detox: Max 5 days per episode and 2 episodes per lifetime. 50% Coinsurance	Excluded
Physical, Occupational, and Speech Therapy	Covered in full-no copay	30 outpatient visits per diagnosis. \$0, \$2 or \$5 copay	70% coinsurance (Limited to 25 visits per year)	80% coinsurance (Limited to 25 visits per year)	\$40 copay (Limited to 25 visits per year)
Durable Medical Equipment	Covered in full-no copay	Max \$2000	70% coinsurance (\$1,000 max)	80% coinsurance (\$2,000 Max)	70% coinsurance (\$1,000 max)
Prescription Drugs	\$.50 generic or \$2 name brand	\$0-\$5 depending on generic/name brand	50% coinsurance	\$10 preferred generic, \$30 copay preferred brand, \$50 copay non-preferred	\$20 copay preferred generic, \$50 copay preferred brand, \$70 copay non-preferred
Vision Services	\$2/visit	Coverage of age appropriate preventative and specialty care. \$50 benefit for lenses, frames, or contacts. \$0, \$2, or \$5 copay	Excluded	Excluded	Excluded
Audiological Services	Covered in full-no copay	Coverage for age appropriate preventative care, hearing aids. Max \$800	Excluded	Excluded	Excluded
Transplant Services	Covered in full-no copay	Coverage for limited transplants with prior authorization	70% coinsurance for covered transplants	80% coinsurance for covered transplants	70% coinsurance for covered transplants
Dental Care	Excluded unless surgical	Periodic cleanings, exams, x-rays, fillings, root canals. Max \$500	Not covered unless dental care needed as a result of accident	Not covered unless dental care needed as a result of accident	Not covered unless dental care needed as a result of accident
Podiatry Services	\$2/visit	Excluded	Excluded	Excluded	Excluded
Skilled Nursing Facility	Long term care-may have to pay portion of income	Covered in full	70% coinsurance (not to exceed 100 days/yr)	80% coinsurance (not to exceed 100 days/yr)	70% coinsurance (not to exceed 100 days/yr)
Hospice Care	Long term care-may have to pay portion of income	Excluded	70% coinsurance	80% coinsurance	Excluded
Home Health Care	Long term care-may have to pay portion of income	Covered in full	70% coinsurance	80% coinsurance	Excluded
Spinal Manipulation	Excluded	Excluded	Excluded	80% coinsurance	Excluded

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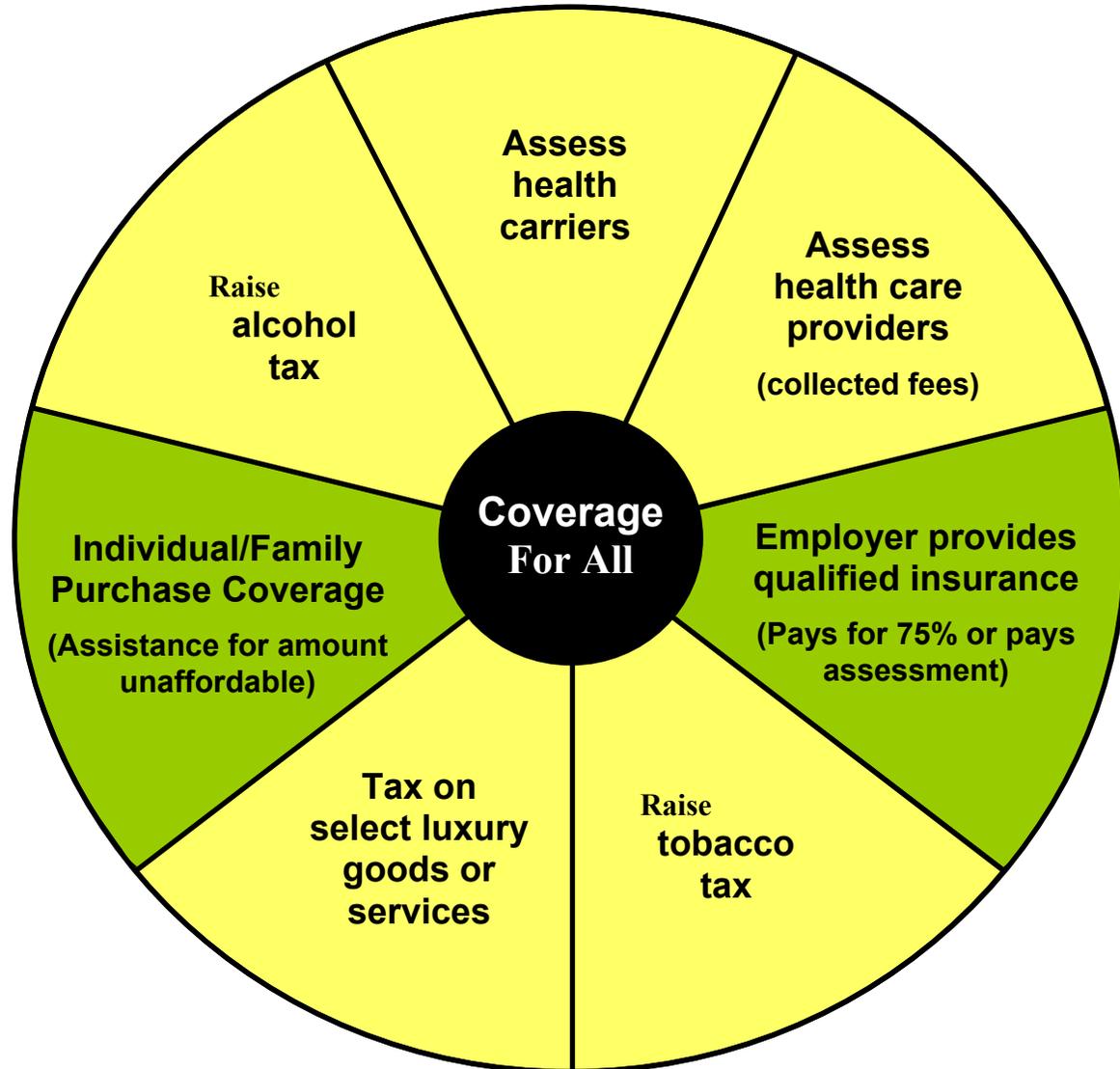
A Plan for Comprehensive Health Care Reform in Colorado

**Shared Responsibility For Financing:
Considering the Options**

4.

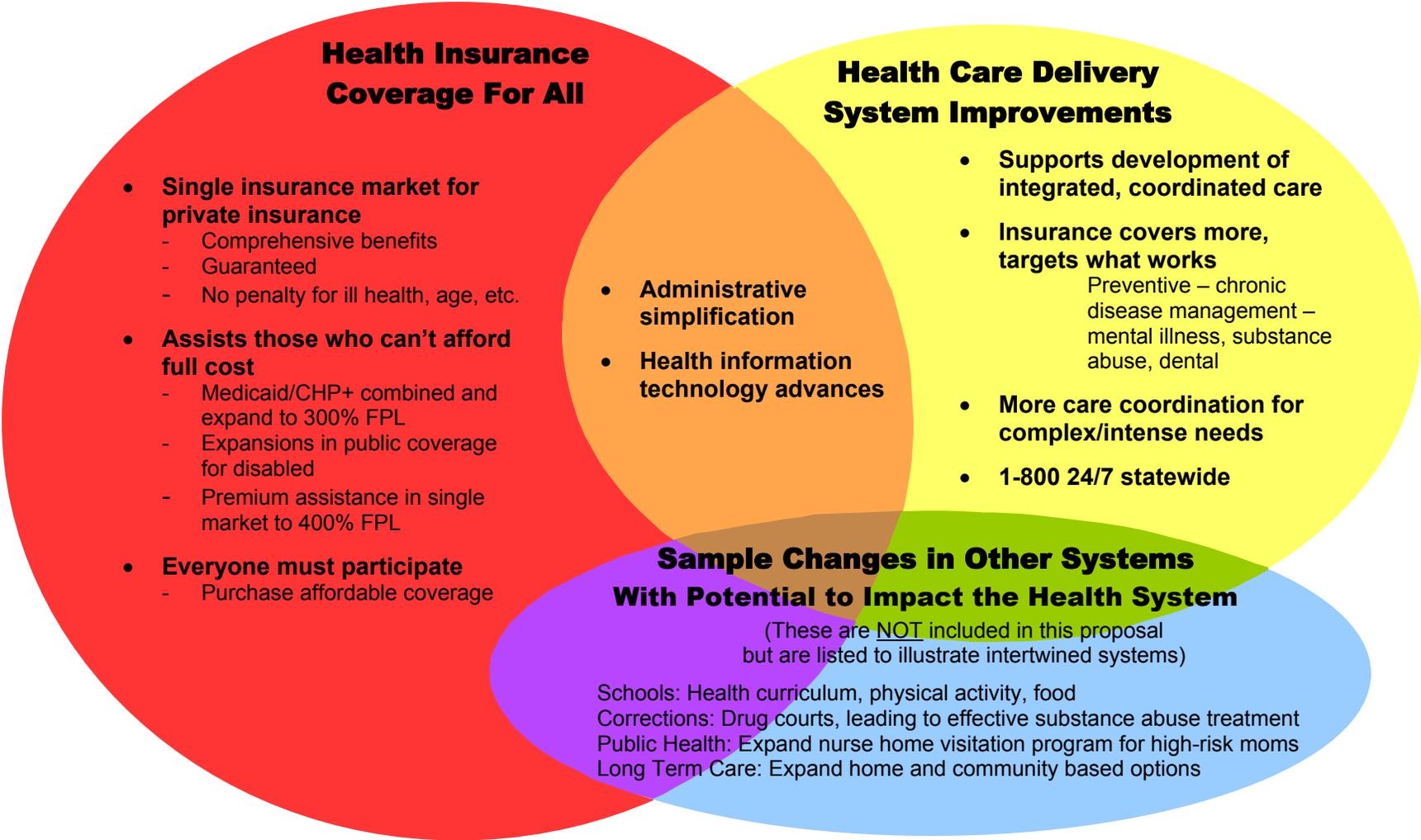
Key:

-  Necessary for plan to work
-  Combination of 1 or more of these options required for adequate funding



A Plan for Comprehensive Health Care Reform in Colorado

Key Changes



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(Optional) Describe how your proposal was developed (limit: 1 page):

Given the Commission's desire to receive a broad range of proposals for consideration, a small group of diverse people with extensive experience in health care and health care policy gathered to see if it would be possible to create, in just six weeks, a proposal worthy of the Commission's attention. Most of the members of the group came into the process with no advocacy of any particular plan, system, or constituency. The group began by developing a long list of questions to be answered before a proposal could be developed, then discussing the Commission's Guiding Principles and expanding them.

In the course of assuring adequate information for deliberations, over 220 resources were reviewed (see Bibliography, Appendix __), at least 10 outside state and national experts were consulted, and a large notebook was developed for each committee member's reference. The group reviewed facts about Colorado, approaches by other states, ERISA limitations, cost drivers, and menus of options for expansion of existing programs, cost containment, quality and access improvement, and financing. The committee did not engage a consultant to create this proposal, but did have the assistance of the research team from the Health District of Northern Larimer County for the purpose of finding and organizing the information they sought.

The result is a proposal based on our understanding of Colorado's particular needs, a lengthy menu of options, changes implemented or considered by others, and allowing ourselves to think creatively and to reach for the ideal embodied by the charge of the Commission.

This proposal differs from the direction that states are moving in some notable ways: it takes very seriously the need to determine accurately how much families can be expected to contribute to the cost of care; it is careful not to move those least able to afford future costs into high cost-sharing plans, and it does not cut out benefits that people are likely to need later. The group is aware that the tradeoff for these decisions, if we are to cover everyone, is cost, but believes that the costs, if shared, are well worth the gain.

Our members made the commitment at the outset of our work that none of us are tied to this proposal, and that any of us are free to support more than one proposal. The organizations with which we may be affiliated have not had the time to review and agree or disagree with what has been proposed, so the contents do not necessarily represent their viewpoints. Most of our members participated solely as individuals, not as representatives of the organizations in which they work. We offer this proposal as ideas, not ideology, and are open to discussing revisions.