



3rd DRAFT

**Appendices to the Final Report to
the Colorado General Assembly**

January 2008

Table of Contents

Appendix 1:	Senate Bill 208.....	3
Appendix 2:	List of Submitted Health Care Reform Proposals.....	4
Appendix 3:	Full Proposals of the Four Selected Reform Proposals.....	5
	Proposal One: Better Health Care for Colorado, submitted by Service Employees International Union.	6
	Proposal Two: Solutions for a Healthy Colorado: Submitted by the Colorado State Association of Health Underwriters.....	43
	Proposal Three: A Plan for Covering Coloradans submitted by the Committee for Colorado Health Care Solutions	76
	Proposal Four: Colorado Health Services Program: Submitted by the Health Care For All Colorado Coalitions.....	110
Appendix 4:	Appendices to “Cost and Coverage Impacts of Five Proposals to Reform the Health Care System in Colorado;” Prepared by The Lewin Group.....	138
Appendix 5:	List of Task Force Members.....	139
Appendix 6:	Task Force Reports	140
	Business Task Force Report.....	141
	Provider Task Force Report	160
	Rural Task Force Report	169
	Vulnerable Populations Task Force Report	177
Appendix 7:	Medicaid Reform Ideas for Further Study.....	220
Appendix 8:	Legal Issues	222

Appendix 1: Senate Bill 208

Appendix 2: List of Submitted Health Care Reform Proposals

Name of Proposal	Organization
Uninsured Action Plan for Colorado	Anthem Blue Cross and Blue Shield
The Option to Die in Peace	Axiom Action LLC
Colorado Balanced Choice Health Care Reform	Balanced Choice Health Care, Inc.
A Comprehensive Health Care Plan for All Colorado Residents	Barry Bode
Comprehensive Health Care Plan for Colorado	CLUB 20
A System to Ensure an Effective and Efficient Medical Home for All Coloradans	Colorado Chapter of the American Academy of Pediatrics; et al
Healthy Colorado Now	Colorado Coalition for the Medically Underserved
Community of Caring	Colorado Community Health Network (CCHN), Colorado Children's Campaign (CCC), Colorado Access (CA)
Connecting Care and Health for Colorado	Colorado Consumer Health Initiative
Improving Our Health Care and Condition	Colorado Foundation for Medical Care with Colorado Clinical Guidelines Collaborative as partner
Colorado Health Coverage and Jobs Solution	The Colorado Health Coverage Solution Team
Solutions for a Healthy Colorado	Colorado State Association of Health Underwriters
A Plan for Covering Coloradans	Committee for Colorado Health Care Solutions
Telemedicine and Data Management Systems for Improvement of Healthcare Coverage Costs	Enigami Systems, Inc.
Colorado Fair Share	Douglas Gilbert
Universal Health Care Coverage Employer Mandate	Jan Gillespie
Colorado Health Services Program	Health Care for all Colorado Coalition
HealthTrans Pharmacy Care Fun	HealthTrans
A Phased Approach to Achieving Universal Health Coverage in Colorado	Kaiser Permanente Colorado
Neighborhood Nurse Practitioner Clinics	James McCalpin
Comprehensive Health Advancement Plan for Colorado	Edwin McConkey
Colorado Complete Healthcare Reform	PULSE of Colorado
Universal Colorado Health Insurance Plan	R. Joseph Roddy, William B. Yancey, MD
Colorado Comprehensive Care Coverage	Savant Solutions Co.
FAIR Health Care	Brian Schwartz
Better Health Care for Colorado	Service Employees International Union
An Individual Based Insurance System Combining Free Market Principles with an Appropriate Role for Government	South Metro Denver Chamber of Commerce
The Simple Healthcare Solution	Monte Uyemura
Locally Run and Administered Health Plans – A Solution for Colorado	David M. West, M.D. and Joan Cox, B.A
Colorado AllCare	Nathan Wilkes
Universal Capitation Plan	Stuart Zisman

Appendix 3: Full Proposals of the Four Selected Reform Proposals

Proposal One: Better Health Care for Colorado, submitted by Service Employees International Union.

Executive Summary:

Comprehensive Health Care Reform for Colorado



“... All Americans need financial security and quality health care they can afford. ...The time is long overdue for America to address these problems. America needs a plan for the 21st century. Not a Democratic or Republican plan, or a business or labor plan. We need an American plan; a plan to insure that the American Dream endures for our children and grandchildren.”

***Andy Stern
President, SEIU International
January 16, 2007***

The nurses and working families of the Service Employees International Union (SEIU) and the Colorado Association of Public Employees (CAPE) believe that health care is the most serious economic and social concern facing Coloradans today and that comprehensive health care reform is needed now.

Approximately 770,000 Colorado residents lack health insurance.¹ Businesses – particularly small businesses – find it increasingly difficult to provide their employees with even the most basic of health care, jeopardizing the ability to remain competitive in the state, national and global marketplace. Many working families, unable to afford the skyrocketing cost of coverage, take a huge risk with their family’s health and financial future, hoping that they will simply not get sick – often paying for it with their savings, their homes and their lives. Those who qualify for public programs receive care that could be more cost-effective and better managed. With projections that Colorado’s elderly population will increase by a staggering 59% during the next 15 years,² we find ourselves inadequately prepared to address what can be the most expensive care of all – long term supports and services.

SEIU and CAPE believe we need health care reform that puts us on a real path to universal coverage and delivers innovative, new ways to address the health care challenges ahead. At the same time, we need a pragmatic path – one that allows us to meet these goals while taking into account the financial realities facing our state.

The SEIU and CAPE proposal is a comprehensive plan that will:

- Provide a path to universal health care coverage in Colorado.
- Extend health care to low-income uninsured with Medicaid-funded premium subsidies to purchase insurance to protect and improve health.
- Ensure improved access to medically appropriate and cost-effective quality long term care services now and in the future.

¹ U.S. Census Bureau. Current Population Survey – 3 year average. Data collected in 2004 to 2006.

² Ari Houser, Wendy Fox-Grage and Mary Jo Gibson. “Across The States: Profiles of Long-Term Care and Independent Living. Colorado.” AARP Public Policy Institute. Dec. 2006.
http://assets.aarp.org/rgcenter/health/d18763_2006_atc_co.pdf

- Promote greater access, choice, personal responsibility and affordability for working families through the creation of a Health Insurance Exchange.
- Help Colorado's small businesses purchase quality, affordable health plans for their employees.
- Ensure quality care and promote accountability in Colorado's health care facilities to protect patients.
- Create incentives for preventive care, wellness, health education, quality outcomes and consumer empowerment.
- Adopt best practices, evidence-based medicine, and pay for performance to improve health care delivery.
- Ensure stable and sustainable funding that is fair, viable and cost-effective.

Creating a Path to Universal Health Care Coverage

Of the 770,000 uninsured residents in Colorado, almost 75% are low-income children, parents and childless adults with incomes under 300% of the federal poverty level (FPL).³ Approximately 20% of working age adults is uninsured. Almost 30% of employees who work for very small businesses are uninsured, compared to 12% of those who work for very large businesses.⁴

This proposal would extend health insurance coverage to uninsured low-income populations and small businesses by creating a platform for universal access to health care for all Colorado residents. The plan would enable Colorado to take advantage of the current interest the federal government has in working with states to expand coverage. Recent changes in federal law and policy and innovative Medicaid-funded state health care reform initiatives across the country support comprehensive reform and could extend coverage to an estimated 96% of Colorado residents.⁵ While the proposed approach establishes the building blocks for further reform, implementation would be phased in to ensure a gradual transition to a more cost-effective delivery system with continued support for the State's critical safety net providers.

³ U.S. Census Bureau. Current Population Survey – 3 year average. Data collected in 2004 to 2006.

⁴ "Profile of the Uninsured in Colorado: An Update for 2005." Issue Brief, Colorado Health Institute. Nov. 2006. Pp. 2.

⁵ Calculation based upon data from the U.S. Census Bureau Survey and "Profile of the Uninsured in Colorado" issue brief.

Key cornerstones of the proposal include:

- **New Subsidy.** A new Medicaid-funded subsidy would be established for low-income uninsured to purchase primary care health insurance.
- **Low-Income/Safety Net Care Pool.** To support subsidies to low-income uninsured, a low-income pool would be funded by a consolidation of funds the state now expends for uncompensated care and health services to the uninsured, efficiencies in the current Medicaid program, and other revenues approved under an agreement with the federal government. Low-income residents would be eligible for a Medicaid-funded subsidy to purchase a private health plan. Likewise, small businesses that have not offered employee coverage for one year and that have higher-income workers would be able to purchase products without a subsidy.

Although Medicaid-funded subsidies up to 300% of the federal poverty level (FPL) could be provided if funding were available and the proposal is consistent with federal reform objectives, priority populations in the initial years could include:

- Children up to 300% of the federal poverty level (FPL);
 - Parents up to 250% of the FPL; and
 - Childless adults up to 225% of the FPL.
- **New Agreement with the Federal Government.** To maximize federal claiming, a new agreement would be negotiated as part of a Medicaid section 1115 waiver and related Medicaid State Plan Amendments. The financing for the necessary state match for the waiver would come primarily from funds already spent in Colorado on health care for the uninsured, including disproportionate share hospital (DSH) payments, unexpended federal SCHIP funds, and financing mechanisms approved by the federal government for comprehensive reform (unmatched state and local public funds spent for health care services).
 - **System to Ensure Access to Affordable Coverage.** Health care would be provided through private market insurance products offered by a Health Insurance Exchange to ensure a choice of affordable plans with options for individuals and families. The plan would provide premium assistance to low-income uninsured for the purchase of health insurance on a sliding scale, based on income, and individuals would be allowed to voluntarily opt out to enroll in employer-sponsored insurance, using their premium assistance to pay for any required employee contribution.

SEIU and CAPE believe this is a cost effective and realistic approach to expanding health care coverage in Colorado at the present time. We would, however, encourage the Legislature, the Commission and the Governor to work with the federal government to continue to expand coverage in the future until every Coloradan is guaranteed affordable health care.

Improving the Long Term Care System

In the next 15 years, the median age in Colorado is increasing. Colorado faces an aging population that threatens to overwhelm the programs that care for some of our state's most vulnerable residents and Colorado's ability to control skyrocketing health care costs. The AARP "Across the States Report" projects there will be a 59% increase in Colorado's 85-plus population and a 124% increase in our state's Alzheimer's population during the next 15 years.⁶

This proposal would balance Colorado's long term care system, putting a greater emphasis on home-and community-based care, which both meets the preferences and dignity of elderly residents (80 percent of the Colorado AARP members surveyed in 2005 said it is extremely or very important to have long term care services that enable them to stay at home as long as possible) and reduces their dependence on higher cost nursing home facilities.⁷

The proposal would ensure that all individuals will have the freedom to choose between long term care models, all of which would have strong and integrated care management to provide services in the least restrictive setting and most cost effective manner. This is consistent with and builds on the findings of the Long-Term Care Advisory Committee's July 2006 final report to the Colorado Department of Health Care Policy and Financing, which called for the delivery of services in a person-centered and consumer directed manner.⁸

Components of the proposal include:

- **Development of Special Needs Plans and Other Integrated Models.** The Deficit Reduction Act (DRA) established Special Needs Plans (SNPs) as a tool that could be used by Colorado to integrate Medicare and Medicaid primary, acute and long term care, prescription drugs, and behavioral health services for dual eligibles. The goal of SNPs is to meet the important 3 H's of long term care - keeping the individual healthy, happy and at home. This proposal will also develop other integrated models that ensure access to well-coordinated and high quality long term care.
- **Consumer Directed Care.** Current enrollees, but especially baby boomers want more control of their health and support program. A CMS-sponsored study found that consumer directed care is less costly than other forms of home care and higher satisfaction rates may postpone nursing facility placements.⁹ Making consumer directed care more accessible is a central part of the plan to give consumers a fuller range of health care options.
- **Adjusting Eligibility and Utilization.** As noted in the Long-Term Care Advisory Committee report, long term care reimbursement should be used to encourage appropriate treatment in the least restrictive setting possible. This proposal lays out a number of incentives and disincentives to balance long term care, including right sizing incentives to create a higher quality and more home-like environment in nursing home facilities and the adoption of a tiered reimbursement for facilities that provide comprehensive health benefits. This proposal also

⁶ Houser, et al, Across the States.

⁷ Houser, et al, Across the States.

⁸ "Report of the Senate Bill 05-173 Long Term Care Advisory Committee." Submitted to the CO Department of Health Care Financing, July 1, 2006.

⁹ Kevin J. Mahoney and Kristin Simone. "History of and Lessons from the Cash and Counseling Demonstration and Evaluation." Scripps Gerontology Center, Robert Wood Johnson Foundation. July 6, 2006.

recommends increasing the threshold for clinical placement into a nursing home facility to ensure that the most restrictive setting (institutional care) is reserved for those with the highest acuity levels.

- **Commitment to Affordable Housing as a Long Term Care Priority.** States that have attempted to transition individuals from nursing homes have found that one of the largest barriers is the difficulty in obtaining affordable housing for lower income seniors. This can be overcome through policy tools like housing set asides or priority placements and the integration of housing experts into the program.
- **Quality Management.** Initiatives to improve quality include establishing a LTC Quality Management Committee, benchmarks and performance standards, a quality management strategy, a formal backup system, a training program, and a public authority.
- **Staff Training.** In light of Colorado’s significant projected increase in Alzheimer’s disease over the next few years, there should be specific focus on specialized units, specialized training and consistency in staffing. Certified nursing assistants should be transitioned to providing assisted living and consumer directed care.
- **Cost Savings of Non-Institutional Care.** In addition to consumers preferring assisted living care over institutional care, such care tends to be less expensive than traditional nursing facilities, as shown below.

Based on Full Year	Nursing Facility	Assisted Living	Aged/Disabled Waiver
Per User Per Day	\$154.61	\$42.47 ¹⁰	\$15.68
Per User Per Year	\$56,433	\$15,502	\$5,722 ¹¹

Strengthening Medicaid and the Health Care System

To support the building blocks for reform, it is critical that Medicaid and the health care system provide a sound basis to sustain enhancements to support consumer choice, quality and accountability and health care cost efficiencies.

Key components of this initiative include:

- **Giving Consumers Health Care Choices Through a Health Insurance Exchange.** A central feature of the SEIU/CAPE proposal is the creation of a Health Insurance Exchange that would enable low-income uninsured and workers in uninsured small businesses to choose among a menu of commercial insurance plans with a wide range of more affordable products. The Exchange would also offer an enhanced primary care case management program in Colorado’s rural areas to ensure that rural residents have access to care. For long term care consumers, the plan encourages the use of consumer directed care to give consumers a full range of health care options.
- **Ensuring Quality Care and Accountability.** While expanding coverage, this proposal also seeks to ensure quality care for all Colorado residents through significant reform of Colorado’s current Medicaid program. The proposal includes the following components:
 - **Establishment of a Medical Home.** All contracts will ensure that consumers receive necessary primary care services in a timely manner.

¹⁰ 05-173 Long Term Care Advisory Committee Report.

¹¹ Houser, et al, Across the States.

- **Robust reporting and transparency.** Creating effective pay for performance (P4P) programs for managed care organizations requires significant reporting systems. The managed care organizations pay for performance results and their quality reporting should be made public and readily available to consumers and providers.
 - **Hospital Pay for Performance.** Hospitals play a significant role in the health care system in general and hospital care is the single largest cost category in the Medicaid program. This proposal would tie future increases in Medicaid hospital payments to key quality performance measures, including hospital acquired infections, re-admission rates for chronic disease, initiatives that address workforce issues, and pharmacy error reduction. SEIU and CAPE are also proposing the creation of a grant program to provide hospitals with incentives to make improvements that require significant up front investments, such as the adoption of electronic medical records and computerized pharmacy order.
 - **Long Term Care Pay for Performance.** Pay for performance standards that seek improvements in health outcomes and consumer satisfaction should be adopted. These standards should focus on factors known to affect consumer outcomes, including staff retention/turnover, training, staffing ratios, uncovered shifts/no shows and career ladders. Additional standards should be developed in conjunction with the various long term care stakeholders, including but not limited to consumers, advocacy groups, home and community based providers and nursing home providers.
- **Containing Health Care Costs.** To ensure the delivery of quality care into the distant future, this proposal calls for:
- Coordinating a large low-income and small business population to secure more accessible and affordable health insurance coverage.
 - Cost sharing with the federal government.
 - The creation of a Health Insurance Exchange to serve as a clearinghouse and a vehicle to offer high-quality basic health plans that would be uniform across the market.
 - Better management of key Medicaid cost drivers like chronic disease and the introduction of effective prenatal programs.
 - An emphasis on preventative care.
 - The establishment of a high-quality managed care program for Colorado Medicaid.
 - The creation of a Medicaid preferred drug list and the creation of a specialty pharmacy program.
 - A new emphasis on home-based, long term care in anticipation of the rapid increase in the elderly population.
- It is anticipated that some savings derived from effective cost containment initiatives may help support targeted, enhanced provider payments.

Colorado Health Care Reform Proposal – Required Questions

□ Comprehensiveness

What problem does this proposal address? This proposal addresses the need to create a new, sustainable platform to ensure that all Coloradans have access to necessary and appropriate health care services through a system that provides quality care in the most efficient and cost-effective manner possible. Our comprehensive reform proposal focuses on:

- **Reducing the number of uninsured Coloradans.** Of the 770,000 uninsured Coloradans, roughly three-quarters have income below 300% of the FPL.¹² The proposed framework for reform builds on the strengths of Colorado's insurance industry and capitalizes on new opportunities in the Medicaid program to expand coverage to low-income uninsured and to create a platform to offer more affordable, accessible insurance to small businesses.
- **Building a stable and sustainable platform for reform.** A comprehensive approach to health care reform cannot succeed without a stable underlying system and network of care. Over the years, Colorado has maintained its Medicaid program, preserved individual and small group insurance markets, and built a critical network of safety net programs, including the Colorado Indigent Care Program and CoverColorado, the state's high-risk insurance pool. This proposal outlines additional reforms to strengthen Medicaid primary, acute and long term care services to ensure a strong and sustainable base for reform. By improving quality, care management, and accountability of existing resources, the expansion builds upon a more sustainable and cost-effective delivery system for reform.

What are the objectives of your proposal?

Our goals of our health care reform proposal are to:

- Provide a path to universal health care coverage in Colorado.
- Extend health care to low-income uninsured with Medicaid-funded premium subsidies to purchase insurance to protect and improve health.
- Ensure access to quality long term care services now and in the future.
- Promote greater access, choice, personal responsibility and affordability for working families.
- Help Colorado's small businesses purchase quality, affordable health plans for their employees.
- Ensure quality care and accountability in Colorado's health care facilities to protect patients.
- Create incentives for preventive care, wellness, health education, quality outcomes and consumer empowerment.
- Adopt best practices, evidence-based medicine, and pay for performance to improve health care delivery.
- Ensure stable and sustainable funding for Medicaid, long term care services and the expansion that is fair, viable and cost-effective.

□ General

Please describe your proposal in detail. Charts 1, 2 and 3 summarize the specific provisions of our reform proposal, including:

¹² U.S. Census Bureau. Current Population Survey – 3 year average. Data collected in 2004 to 2006.

- ❖ Creating a Path for Universal Health Care Coverage – Chart 1
- ❖ Improving the Long Term Care System – Chart 2
- ❖ Strengthening Medicaid and the Health Care System – Chart 3

Chart 1: Colorado – Creating a Path for Universal Health Care Coverage

Four Cornerstones for Reform	Establish Low-Income Funding Pool
<ul style="list-style-type: none"> ❖ Subsidy to purchase private insurance for low-income uninsured. ❖ Low-income pool to fund subsidies (DSH, SCHIP, other). ❖ Federal waiver to ensure funding for subsidies through the pool and flexibility to reform delivery system for uninsured. ❖ System to ensure access to affordable coverage, potentially through a Health Insurance Exchange, to facilitate the purchase of insurance for uninsured individuals and small businesses, with provisions to ensure quality and accountability. 	<p style="text-align: center;">Establish a funding pool to support subsidies for the purchase of insurance by low-income uninsured.</p> <ul style="list-style-type: none"> ❖ Dedicate funding for the pool from monies now used to cover the uninsured to : <ul style="list-style-type: none"> • Reallocate some or all of Colorado’s disproportionate share hospital (DSH) funds already spent on the uninsured. • Maximize unexpended federal SCHIP allocations. • Efficiencies in the current Medicaid program. • Leverage financing mechanisms approved in comprehensive reform waivers for unmatched state & local health care spending for the uninsured. ❖ Ensure financial support for critical safety net providers while ensuring a transition to more cost-effective care and care management.
Create System to Ensure Access to Affordable Coverage	Provide Subsidies for Low-Income Uninsured
<p style="text-align: center;">Create a system to ensure access to affordable coverage, potentially through a Health Insurance Exchange, administered by a new, quasi-public entity, to provide access to private insurance specifically tailored for the target population. The Exchange would enhance choice, coordinate health care financing from multiple sources, and engage consumers as informed and empowered purchasers. The Exchange would:</p> <ul style="list-style-type: none"> ❖ Offer products to subsidized uninsured and non-subsidized small businesses. ❖ Facilitate enrollment, certify plans, administer premium subsidies, collect premiums through payroll deductions, ensure portability, and leverage pre-tax contributions to reduce cost. ❖ Create an environment where providers would compete on price, quality, and provider networks. ❖ Provide a choice of insurance options, including: <ul style="list-style-type: none"> • Limited benefit health plan with first dollar coverage and annual benefit limit of \$25,000 to \$35,000; • A pre-paid and/or point-of-service plan; • A benchmark plan with more comprehensive coverage and higher participant cost sharing, such as the State Employee Health Insurance Plan; • State care initiatives (i.e., Colorado Indigent Care Program); and • If eligible, the Colorado high risk pool. ❖ Use the Exchange as the platform to offer more accessible, affordable products to uninsured small businesses with streamlined administration and portability for workers. 	<ul style="list-style-type: none"> ❖ Provide subsidies as part of a comprehensive framework to reform financing and delivery of health care to the uninsured. <ul style="list-style-type: none"> • Target Population. Through a voluntary program with crowd-out protections, extend access to Medicaid-funded subsidies to purchase insurance to: <ul style="list-style-type: none"> ➢ Uninsured children with income to 300% FPL. ➢ Uninsured parents with income to 250% FPL. ➢ Uninsured childless adults up to 225% FPL. • Benefits. Specify a minimum benefit tailored to the subsidized uninsured, with core benefits like ESI, including primary & preventive care, hospital, ER, prescription drug, and basic mental health services. • Delivery System. Require managed care approaches: <ul style="list-style-type: none"> ➢ Use care coordination, defined networks, higher cost sharing, wellness and healthy behavior incentives, and disease management. ➢ Ensure plans compete on price, provider networks, quality, and access. ➢ Provide Medicare or reasonable market rates. • Personal Responsibility. Create a “culture of insurance” with a “medical home,” incentives for consumers and providers, and market competition. • Employer-Sponsored Insurance. Allow ESI opt-out.
Ensure Quality & Accountability	
Pursue strategies to promote quality, safety	

and best practices:

- ❖ Utilize managed care approaches with a “medical home,” and care coordination with standards to support quality, consumer direction, disease management, efficiency, and access to primary and preventive care in a timely manner.
- ❖ Leverage evidence-based care, quality measures & pay for performance to improve health and health care outcomes.
- ❖ Utilize health information technology to reduce errors and improve efficiency and transparency.

- **Cost Sharing.** Provide subsidies on a sliding scale based on income with enforceable cost sharing.
 - Only point-of-service co-pays under 100% FPL.
 - Under 5% of income, between 100-200% FPL.
 - Over 200% FPL, could exceed 5% of income.
 - No deductibles; ensure primary/preventive care.

Obtain Federal Medicaid Agreement

Obtain a **Medicaid section 1115 waiver** to reform financing and delivery of health care for the uninsured.

Chart 2: Colorado – Improving the Long Term Care System

Cornerstones for Improving the System

- ❖ **Serve** as many persons needing services as possible.
- ❖ **Ensure** that care is available in least restrictive setting and of the highest possible quality.
- ❖ **Preserve** consumer choice in care plan and service delivery.
- ❖ **Protect** the fiscal integrity of the long term care system.

Enhance Care Delivery Options

- ❖ **Develop and implement models of care** that integrate services and care coordination for Medicaid and Medicare:
 - Medicare Special Needs Plans (SNPs)
 - Coordinated Care Programs
 - PACE and similar programs
- ❖ **Promote consumer directed care** in all integrated models.
- ❖ **Develop more integrated State-funded Program options.**
- ❖ **Develop Veterans' options** for home and community-based care.

Manage for Quality

- ❖ **Link payment to performance for all long term care providers.**
 - Establish a long term care quality management committee.
 - Develop measurable benchmarks and performance standards that include workforce measures.
 - Ensure accountability through accurate and timely reporting and administrative oversight.
- ❖ **Establish a public authority** to support high quality home and community-based services.
- ❖ **Establish cabinet level intra-department oversight.**
- ❖ **Develop a training program** for care providers including:
 - The patient's right to direct his/her care, patient safety and privacy.
 - Career progression coaching.
 - Training that addresses job displacement due to changes in technology, organizational structure, etc.
 - Develop a dedicated fund to support these training and upgrading efforts.
 - As a priority, focus on specialized units and specialized care, and consistency in staffing.
- ❖ **Establish protocols and procedures** to address situations in which a service provider does not arrive on time.
- ❖ **Promote retention of high quality long term care workforce.**
 - Consider a tiered reimbursement system to provide higher reimbursement for facilities and providers who offer comprehensive health benefits to their employees, and those that contribute beyond an established threshold toward the cost of employee health care.

Ensure Fiscal Sustainability

- ❖ **Secure all available federal funds for current long term care programs.**
- ❖ **Facilitate coordination** between programs funded by Medicaid and those funded by other funding sources.
- ❖ **Reinvest** right sizing savings in enhanced home and community based services.
- ❖ **Claim federal Medicaid matching funds for care provided to Veterans.**
- ❖ **Reconsider nursing home tax** to support quality care for those of highest acuity.

Promote Least Restrictive Care Settings

- ❖ **Develop nursing facility right-sizing strategy.**
 - Establish right-size reimbursement incentives, such as occupancy standards, and more targeted reimbursement for non-care cost centers.
 - Assist workforce training and transitioning to provide community based care.
 - Provide technical assistance to nursing homes to help expand their continuum of care.
- ❖ **Provide adequate reimbursement in all settings.**
 - Modify rate setting to minimize unreasonable disparities between institutional care and home and community-based care.
 - Develop acuity-adjusted rates for non-institutional providers to encourage these providers to treat higher acuity individuals.
 - Consider a cost-based reimbursement system for all home and community-based services, including assisted living and adult day care centers.
- ❖ **Expand all home and community-based services.**
 - Promote PACE, SNP and home and community based care across the state.
- ❖ **Reserve nursing facility utilization** for highest acuity levels.
- ❖ **Streamline eligibility** to avoid unnecessary institutionalization by allowing services for those reporting few assets, subject to final eligibility determination.
- ❖ **Implement spend down for home and community based services**, so individuals may receive coordinated care prior to Medicaid eligibility.

Improve Housing Options

- ❖ **Increase access** to affordable housing for long-term care consumers.
 - Establish housing set-asides and a process to give priority placements to long-term care consumers.
 - Develop models to integrate housing and support services.
- ❖ **Increase availability** of affordable and accessible housing.
 - Establish a housing fund for non-profit developers to create accessible, affordable housing.
- ❖ **Increase technical assistance** with housing.
 - Dedicate local housing experts to assist consumers and care managers to obtain affordable and accessible housing.
 - Assist nursing homes, developers and others in accessing programs to help finance affordable and accessible housing.

--	--

Chart 3: Colorado – Strengthening Medicaid and the Health Care System

<p style="text-align: center;">Cornerstones for Strengthening the System</p> <ul style="list-style-type: none"> ❖ Ensure a sound “base” Medicaid program. Even as Colorado considers expanding coverage to the uninsured, the basic Medicaid program should be strengthened and enhanced. ❖ Ensure Quality Care and Accountability. Implementing targeted reforms in Colorado’s existing Medicaid and SCHIP programs will improve the quality of and increase the accountability for the care delivered, strengthening the foundation for care delivery within Medicaid. ❖ Contain Health Care Costs. Colorado Medicaid can take advantage of strategies that will contain costs while not jeopardizing the quality of or access to health care. Improved efficiencies will help the State maintain a viable Medicaid program for its residents. ❖ Ensure Adequate Access. Coverage expansions can create opportunities to enhance provider rates in targeted ways to achieve reform objectives. 	<p style="text-align: center;">Expand Managed Care Options & Strategies</p> <p>Experience in other states strongly suggests that managed care increases access, improves quality and care coordination, and is more cost-effective than unmanaged fee for service programs. To create an efficient and more cost-effective delivery system:</p> <ul style="list-style-type: none"> ❖ Strengthen managed care in the Colorado Medicaid program. Leverage the savings and efficiencies in the delivery system to extend health care to more uninsured. ❖ Provide both a capitated model and a managed fee-for-service model to extend care management to urban and rural areas. ❖ Create a pay for performance system to align payment incentives with performance-driven goals for expected outcomes of the managed care organizations (MCOs) for ensuring access, high quality and cost-effective care.
<p style="text-align: center;">Link Hospital Pay to Performance</p> <p style="text-align: center;">Develop a performance-based hospital reimbursement system to:</p> <ul style="list-style-type: none"> ❖ Provide incentives for hospitals to actively engage in quality improvement strategies. ❖ Establish payment rates based on key quality of care performance benchmarks in areas such as: <ul style="list-style-type: none"> • Hospital-acquired infection rates. • Readmission rates for chronic diseases. • Pharmacy order error reduction. • Implementing and maintaining an Electronic Medical Record system. • Hospital investments in quality-related improvements, including measures to address the workforce shortage. 	<p style="text-align: center;">Establish Capitated Managed Care</p> <p style="text-align: center;">Establish statewide, full-risk capitation managed care.</p> <ul style="list-style-type: none"> ❖ Incorporate pay-for-performance principles within managed care contracts to provide incentives for high quality and cost effective care. ❖ Focus on care management instead of cost management. ❖ Require robust disease management programs for chronic conditions that include management of consumers with chronic disease co-morbidities. ❖ Incorporate case management for complex medical conditions and high-cost cases. ❖ Emphasize comprehensive prenatal care case management, including smoking cessation, and other wellness strategies and oral health. ❖ Promote the concept of a medical home along with a focus on ready access to primary health care to help ensure cost-effective, quality health care. ❖ Incorporate incentives to promote health and wellness to achieve long-term savings and improve the health status of Medicaid recipients. ❖ Allow recipients a choice of managed care plans based on price, benefits, and provider networks. ❖ Require robust reporting and transparency to improve health outcomes and allow consumers to make more informed choices about the plans and providers they select.
<p style="text-align: center;">Improve Pharmacy Benefits Management</p> <ul style="list-style-type: none"> ❖ Implement a Preferred Drug List (PDL) to: <ul style="list-style-type: none"> • Increase utilization of more cost-effective generic drugs. • Negotiate better rebate agreements with manufacturers for preferred drugs and devices on the PDL. ❖ Participate in a multi-state purchasing pool to leverage the negotiating power of a larger pool for both the ingredient costs of drugs and rebates. ❖ Implement a specialty pharmacy program for high cost products such as biologic agents, oncology drugs, blood factor products and other injectibles. This provides potential to: <ul style="list-style-type: none"> • Negotiate lower ingredient prices for products included in the specialty pharmacy program. • Secure supplemental rebates for the items covered 	<p style="text-align: center;">Offer Alternative Primary Care Case Management (PCCM)</p> <p>Provide flexibility for an alternate delivery system of enhanced PCCM for rural areas</p>

<p>through the specialty pharmacy program.</p> <ul style="list-style-type: none"> • Improve care coordination for individuals who need specialty products. ❖ Have appropriate safeguards in place, including a Pharmacy and Therapeutics Committee that will report to the Medicaid Agency and advise the State on issues pertaining to the PDL and specialty pharmacy program. 	<p>where the full-risk capitation model is not available.</p> <ul style="list-style-type: none"> ❖ Engage a vendor to manage the primary care delivery network. ❖ Incorporate pay-for performance targets to align incentives to promote high quality, cost effective care. ❖ Utilize the Medicaid program's capacity for functions such as enrollment and eligibility, pharmacy benefits management, prior authorization and other utilization review mechanisms.
--	---

Who will benefit from the proposal? Many groups in Colorado will benefit from the proposal.

- Low-income children, parents and childless adults will benefit from Medicaid-funded subsidies to access health care, and small business will have greater access to a choice of affordable health insurance products. Small business owners who cannot now afford to offer health insurance and their employees will benefit because they will be able to access affordable coverage, improving business competitiveness and the ability to attract and retain qualified employees. Coloradans will benefit from a healthier population as a result of increasing the number of people with stable and affordable health insurance, a more viable safety net system, and reduced premium for all other private payers.
- Health care providers will benefit from the increased number of individuals with health insurance and the anticipated reduction in uncompensated care.

- Insurers and agents will benefit because the foundation for expanding coverage is through the commercial insurance market.
- Safety net providers will benefit from a more cost-effective delivery system that provides coverage-based payments for care provided to low-income uninsured. By providing a subsidy to make coverage more affordable and choice to make coverage more attractive and accessible, the goal is to create a culture of insurance that spreads risk more fairly and that pays providers adequately for services delivered.
- Medicaid recipients and Colorado taxpayers will benefit from strategies that will reduce costs and improve the coordination and quality of acute and long-term care services. The elderly and persons with disabilities will benefit from high quality, consumer-directed care delivered in a cost-effective manner in the least restrictive and clinically appropriate setting. Nursing facilities will benefit from a higher acuity caseload and long term care workers will benefit from tiered reimbursement that is designed to encourage health insurance coverage.
- The state and federal Medicaid program will benefit from more appropriate use of public funds and the increased numbers of individuals with health coverage. Avoiding or reducing more costly acute or long term care through access to primary and preventive care should yield significant savings. The public sector will also benefit from more integrated and coordinated long term care and home and community based options.
- SEIU and its members in Colorado benefit by preserving a viable health care system that provides employment and by increased access to health care coverage for its members.
- All Coloradans will benefit by having access to health insurance and the benefits of a more efficient, effective and coordinated health care delivery system.

Who will be negatively affected by the proposal? Our reform is crafted carefully to minimize the extent to which Coloradans and key stakeholders are negatively impacted. By creating a platform to improve access to coverage and strengthen existing safety net providers and commercial insurance, the proposal is designed to complement and build upon Colorado's existing health care system. Some changes, however, may be met with resistance.

- Because this proposal would integrate some Medicaid Disproportionate Share Hospital (DSH) funds into the reform, safety net providers may be concerned. We believe greater integration of DSH into the reform will be a critical factor in securing federal approval for additional federal funding and will ultimately advantage the safety net care system overall through less uncompensated care.
- Insurers may be concerned that a reform effort will weaken their client base. However, our proposal relies on a new model to move more people into commercial insurance, using Medicaid funds to defray the costs of premiums.
- For long term care, some nursing facilities may be impacted by rate setting changes that focus on post-acute rehabilitation care and higher acuity caseloads.

- Though we have structured our proposal to take maximum advantage of additional federal funding, and reallocate existing Medicaid funds (such savings from efficiencies and a portion of DSH), additional state funds may be needed to achieve the goals of the Blue Ribbon Commission for Health Care Reform.

Finally, there is considerable flexibility built into the reform platform we propose. We believe this will allow the state to navigate stakeholder concerns, and determine the appropriate implementation and administration strategy while still moving ahead to expand coverage, improve health and reduce costs.

How will your proposal impact distinct populations (e.g., low-income, rural, immigrant, ethnic minority, disabled)? Distinct populations would benefit from the reform, including:

- Low-income Coloradans will have access to affordable health coverage, and will be able to choose the products that best meet their needs. Because they will own their policy, coverage will be portable and move with them as life situations, such as jobs or marital status, change.
- Our reform plan is statewide. Coloradans who reside in rural areas of the state may experience greater access to coverage as insurers expand their coverage areas to respond to the new insurance markets created by this reform.
- Since the foundation for this reform platform will be built upon commercial insurance products, we anticipate that, in order to compete for market share, insurers will develop products that will be responsive to rural citizens, as well as to ethnic minority and disabled populations.
- Our proposal incorporates strategies to improve long-term care. This would result in higher quality, more coordinated care for the elderly and persons with disabilities, including those in rural areas.
- Though immigrants would not be eligible for Medicaid-funded premium subsidies due to federal regulations, their care will continue to be funded with allowable state and federal funds. However, we anticipate that there may be greater capacity in the state's safety net system to provide needed care for immigrants as the state reduces significantly its number of uninsured individuals.

Please provide any evidence regarding the success or failure of your approach. Please attach. Recent changes in federal law and policy and innovative Medicaid-funded state health care reform initiatives across the country offer new strategies to create a platform for broad-based, comprehensive reform leveraging a Medicaid waiver and new authority under the federal Deficit Reduction Act to expand coverage to uninsured populations. Two articles which describe key features of other state-based reform initiatives, components of which are incorporated in our proposal, are attached as Appendices A and B.

How will the program(s) included in the proposal be governed and administered? In other states that have implemented or proposed a market-based approach to reform, a Health Insurance Exchange has been incorporated as an independent, quasi-governmental entity. Colorado could establish an Exchange to facilitate the purchase of private sector health insurance products for

uninsured individuals and small businesses. The Exchange, in consultation with the State Medicaid Agency and the State Department of Insurance, could administer the program.

The Exchange would have a Board, an Executive Director, and limited full-time staff. A third-party contractor could provide all administrative support for the Exchange. Funding for administrative costs would be included in plan premiums. The State Medicaid agency would oversee the determination of eligibility for the expansion population and would administer all Medicaid waiver requirements. The Exchange would certify and offer a choice of affordable products, providing options for individuals, families, and for small businesses, facilitate enrollment, administer premium subsidies, coordinate with employers on work site enrollment, payroll withholding, and any voluntary employer contributions, ensure portability and leverage pre-tax contributions to reduce cost, and collect and maintain data on health care outcomes.

Using these design principles, the Exchange will create a platform to establish the transparent purchase of health care for the low-income uninsured and small businesses. In particular, the Exchange will:

- Leverage market-based competition to offer high value health insurance.
- Compete on price, quality, and provider networks, as in the commercial marketplace.
- Leverage Medicaid-funded subsidies to help uninsured children, low-income parents and childless adults purchase private health insurance products, with coverage that meets State guidelines and that is portable, cost-effective and seamless, providing individuals a new incentive to increase family income without the loss of health care.

While the functions of the Exchange are critical to the success of reform and expansion, the creation of an Exchange could be accommodated through the existing administrative infrastructure. Alternatively, the State could perform the functions outlined above, or could choose to do so initially with a phase-in to the Exchange at a later date.

To the best of your knowledge, will any federal or state laws or regulations need to be changed to implement this proposal (e.g., federal Medicaid waiver, worker's compensation, auto insurance, ERISA)? If known, what changes will be necessary? This proposal will require approval of a federal Medicaid s. 1115 waiver to cover childless adults, and related Medicaid state plan amendments (SPAs) to establish eligibility for children and low-income parents. Flexibility to modify the delivery system, to design benefits tailored to the uninsured populations and to leverage and maximize federal financing would also require approval through a Medicaid section 1115 waiver. State enabling legislation and state budget authority will also need to be addressed prior to implementing the reform proposal. Medicaid SPAs and home and community based waivers would need modifications to incorporate the proposed reforms.

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

extend coverage initially to: (1) children up to 300% FPL; (2) parents up to 250% FPL; and (3) childless adults up to 225% FPL. The State has significant flexibility, however, in how to implement the plan. Depending upon available resources, the State could implement the Exchange and full coverage expansion for low-income children, parents and childless adults at the same time, or could opt to phase in the expansion, beginning with children, then parents, and finally childless adults. Alternatively, the state could expand access first to children, parents and childless adults under 100% FPL, then add groups incrementally at higher income levels.

Another approach could be to begin implementation with the State performing some of the functions that would be performed by the Exchange until enrollment reaches a certain level and then proceed with implementing the Exchange.

Transitioning from the current system to the reform will require federal approval of the waiver and related state plan amendments for Medicaid-funded subsidies. Depending on whether the state initially implements an Exchange and whether a phased-in is used, a minimum of six months will likely be required to implement the reform once federal approval is received.

□ **Access**

Does this proposal expand access? If so, please explain. Yes, this proposal significantly expands access. Under our proposal, which extends coverage to low-income uninsured, including children up to 300% FPL, parents up to 250% FPL and childless adults up to 225% FPL, more than 490,000 of the state's 770,000 uninsured, or 64%, would have access to health insurance. The State could choose, at any time, to pursue federal approval to extend coverage up to the maximum allowed under Medicaid of 300% FPL, expanding coverage up to 73% (561,000) of the uninsured.¹³

Additionally, the proposal provides a platform to extend more accessible and affordable coverage without subsidies to small businesses and, as the state moves forward to ensure universal coverage for all uninsured in Colorado, to any remaining uninsured.

Finally, the proposal is designed to increase access for rural long term care consumers, and to provide greater access to non-institutional, integrated care for all Coloradans.

How will the program affect safety net providers? This proposal is designed to strengthen Colorado's safety net system. As more Coloradans are able to obtain health care services covered by insurance, safety net providers would be an integral part of the system to provide the capacity and services needed by the expansion population, and would submit claims and be reimbursed by the insurer(s). Safety net providers will benefit from a more comprehensive delivery system that provides coverage-based payments for care provided to low-income persons who are currently uninsured. By providing a subsidy to make coverage more affordable and choice to make

¹³ U.S. Census Bureau. Current Population Survey – 3 year average. Data collected in 2004 to 2006.

coverage more attractive and accessible, the goal is to create a culture of insurance that pays providers adequately for services delivered.

In addition, safety net providers would continue to fulfill their critical role for populations not eligible for Medicaid-funded subsidies, including immigrants.

□ **Coverage**

Does your proposal “expand health care coverage”? (Senate bill 06-208) How? Yes, this proposal significantly expands access to health care coverage. Under our proposal, more than 490,000, or 64% of currently uninsured Coloradans would have access to health coverage, making it easier for them to purchase health care services. The State could choose, at any time, to pursue federal approval to extend subsidies up to the maximum allowed under Medicaid of 300% FPL, which would expand coverage up to 73% (561,000) of the uninsured. The proposal would also extend long term care services to higher-income individuals and Veterans.

How will outreach and enrollment be conducted? We anticipate that outreach and enrollment will be most effectively accomplished by building off systems currently used to make residents aware of Medicaid and safety net programs and services. In addition, we anticipate that insurers that offer products on the Exchange will advertise and raise awareness of not only their products, but of the new coverage opportunities as well.

By coordinating with the Exchange on workplace enrollment, payroll withholding and tax sheltering of worker contributions, a significant number of low-wage, uninsured workers will be enrolled into mainstream health plans with affordable premiums, consumer choice, and stable coverage.

Participation rates are substantially higher where workers enroll at their workplace and make their contributions through payroll deduction than through separate, stand-alone enrollment and billing processes. Current data show that many low-income workers and parents offered employer coverage do participate, and they often contribute substantially more for employment-based coverage than research indicates they would pay to enroll in a public program.¹⁴

Additionally, experience in other states has shown that effective outreach to parents when “family-based coverage” becomes available is the most effective strategy to increase enrollment among low-income children who are eligible for Medicaid and SCHIP, but who are not yet enrolled.¹⁵ Of the state’s uninsured, approximately 110,000, or 14%, are low-income children with income below 200% of the FPL who may be eligible currently for Medicaid or SCHIP.¹⁶

For long term care, outreach would be conducted through existing single entry points.

¹⁴ Ed Neuschler and Rick Curtis. “Use Of Subsidies To Low-Income People For Coverage Through Small Employers.” Health Affairs. Health Tracking: Market Watch Web Exclusive. 21 May 2003. <http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.227v1/DC1>

¹⁵ “Health Coverage for Low-Income Americans: An Evidence-Based Approach to Public Policy.” The Kaiser Commission on Medicaid and the Uninsured. Jan. 2007. Pp. 40. <http://www.kff.org/uninsured/upload/7476.pdf>

¹⁶ U.S. Census Bureau. Current Population Survey – 3 year average. Data collected in 2004 to 2006.

If applicable, how does your proposal define “resident”? Our proposal would use the definition of “resident” used by Colorado for its Medicaid program.

□ **Affordability**

If applicable, what will enrollee and/or employer premiums-sharing requirements be? This plan would provide premium assistance for the purchase of health insurance products to uninsured not eligible for government programs and unable to access private insurance. Health care premiums will be subsidized, on a sliding fee scale, for those in the expansion population.

- For persons in the expansion population with income under 100% of the FPL, cost sharing will be limited to co-payments at the point of service. Unlike Medicaid, co-payments would be enforceable. Health plan premiums for this very low-income expansion group will be fully subsidized.
- For persons with income between 100% and 200% of the FPL, cost sharing would be comprised of enforceable co-payments and premium payments, on a sliding scale based on income, up to a maximum of 5% of income.
- For persons with income above 200% of the FPL, cost sharing would be composed of enforceable co-payments and premium payments, and could exceed 5% of income.

In addition to enforceable co-payments and sliding scale premium payments, plan costs would be offset by utilizing voluntary employer contributions and pre-tax contributions from employers and employees to support plan costs. By taking advantage of existing federal and state tax subsidies available for employer contributions and for workers’ contributions through their employers, the amount of state and federal subsidies required for the expansion population will be reduced.

The new insurance products for non-subsidized small business workers are designed to complement, not supplant, ESI and existing individual and small group health insurance coverage. It is expected that plans will be designed to be relatively consistent with those for the subsidized expansion population. Accordingly, plans will be required to utilize managed care approaches and benefits that are comparable to ESI and small group market plans.

How will co-payments and other cost-sharing be structured? Benefit coverage, premium subsidies, copayments, and annual limits will be designed to ensure coverage for the maximum number of Colorado’s uninsured citizens within available funding by crafting a reform plan to:

- Focus on primary, acute and preventive care most needed by the target populations.
- Encourage enrollment with significant subsidies for premiums, particularly for low-income uninsured.
- Utilize co-payments to control inappropriate use and to promote access to services in the most appropriate setting. Copayments would range from \$10 for primary care office visits to \$100 for an inpatient hospital admission.

- Waive copayments and required cost sharing through a wellness/healthy behavior incentive to encourage primary and preventive care, including an annual physical, a health risk assessment and follow-up, and evidence-based care for prevention, high-risk individuals and chronic diseases.
- Leverage cost-effective plan rates for market products (potentially through the use of an annual benefit limit of \$35,000 to \$50,000 to limit exposure for catastrophic care costs, to minimize risk, and to foster participation of competing plans), with additional plan options to provide a choice of coverage and cost sharing.
- Continue to support DSH payments to fund catastrophic or uncompensated care costs not covered under the reform program.

For long term care, copayments would only be applicable to the Medicare component and the home and community based spend down.

□ **Portability**

Please describe any provisions for ensuring that individuals maintain access to coverage even as life circumstances (e.g., employment, public program eligibility) and health status change. The Exchange would provide coverage to low-income uninsured eligible for a subsidy and non-subsidized small businesses. Insurance coverage through the Exchange would be owned and controlled by the individual. As such, coverage would be portable, and workers, if they continue to meet income guidelines, could retain their health care coverage as they move to other jobs, work part-time or multiple jobs, or remain employed by small businesses eligible to participate in the Exchange. Having a seamless program that coordinates coverage under the expansion with employers and employer-sponsored insurance and that interfaces with Medicaid and SCHIP (some family members may be eligible for and covered under these programs) will be instrumental in ensuring continuity and access to coverage as circumstances change. All low-income uninsured individuals who qualify for a subsidy and uninsured small business without a subsidy would be eligible to participate in the Exchange regardless of health status. An option on the Exchange would be to allow participation in the state's high risk pool for individuals who would be eligible as high-risk; in this case the State could explore opportunities to provide a higher subsidy to ensure enrollment and access to benefits for higher-cost individuals in the high risk pool instead of commercial products offered through the Exchange.

For long term care, the proposal recommends options for state only or Medicare only programs that help individuals maintain integrated and coordinated care in the community.

□ **Benefits**

Please describe how and why you believe the benefits under your proposal are adequate, have appropriate limitations and address distinct populations. The reform platform leverages the commercial insurance market with coverage and benefits tailored to the expansion population, with a choice of affordable products, with linkages to employer sponsored insurance (ESI), and the individual and small group markets, and with underlying principles that provide options for distinct populations (urban-rural, different ethnic minorities).

All plans will be required to manage care to enhance services, including medical homes with defined networks, basic health benefits, tiered cost sharing, healthy behavior incentives, disease management, and drug formularies. Benefit packages will be comparable to ESI and small group market plans.

In extending health insurance coverage to the uninsured, our reform proposal assumes:

- A minimum, basic benefit package with coverage for primary and preventive care, hospital and emergency room services, prescription drugs, and mental health services that cover basic health services and that are the core of most health insurance plans.
- First dollar coverage with no deductibles to ensure that consumers make a connection with the health care system, especially primary care.
- Streamlined administration to simplify enrollment, to reduce administrative burdens and cost for insurers, employers and plan participants, and to create efficiencies through lower administrative costs.
- Care management and managed care delivery systems with risk-based capitation payments and enhanced primary care case management to:
 - Ensure access to care and adequate provider networks;
 - Focus on prevention and quality in the delivery of care, including disease management, patient safety and improved outcomes for health and performance;
 - Prevent fraud, waste and abuse in the provisions of health care services;
 - Utilize a “medical home” to promote coordinated care that leverages best practices and evidence-based medicine, and that reduces duplication of services;
 - Build on initiatives in the private insurance market to provide financial incentives, education and support for healthy living and improved health outcomes;
 - Provide the platform and infrastructure to extend cost-effective, quality care to all Coloradans.

- Market competition to reduce costs, with insurers competing on the basis of value. The Exchange will certify products for uninsured individuals eligible for low-income subsidies and for uninsured small businesses based on affordability, quality, provider networks and use of approved benefit plans.
- Clear communications for consumers to easily understand their options and choices and information to assist enrollees with an informed, cost-conscious choice.

For long term care, the individual consumer's clinical and social needs will determine the scope and duration of services needed.

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 difference between the existing benefit package and your benefit package.

The proposal would offer a range of products through the Exchange and consumers would be able to choose the product that best meets their needs. Products would include a "core benefit" plan for relatively healthy individuals seeking access to basic, affordable health coverage and a more catastrophic coverage type of plan for individuals with chronic or other health conditions who may be seeking coverage for potentially higher cost care related to their health status.

Based on available information, we believe that the premium, cost sharing and benefit structure for the "basic benefit" plan we propose for the expansion population could be considered comparable to Colorado's Small Group Standard HMO plan.¹⁷

Similarities include:

- Premiums for our proposal would be established based on age, gender and residence of the enrollee. Medical underwriting would not be used as a basis for determining premium levels.
- Enrollees would be responsible for cost-sharing obligations for most services; however there would be no deductibles.
- Covered services would include primary and preventive care, prescription drugs, hospital care (inpatient, outpatient and emergency room), mental health services, physical therapy, speech therapy and occupational therapy, laboratory and radiology services.
- Enrollees would receive their care through a network provider.

¹⁷ "2000 Small Group Health Insurance Premiums For Colorado." <http://www.dora.state.co.us/INSURANCE/pb/sg2000.pdf>

Differences include:

- Individuals who select the basic benefit plan would be subject to an annual benefit maximum to be determined by the State. Typically, these annual benefit maximums would be between \$25,000 and \$50,000. (Choosing a lower annual benefit limit would allow the State to keep premiums at the lowest possible levels for a generally young and healthy uninsured population).
- The proposal does not assume a waiting period for coverage of pre-existing conditions.
- Premium subsidies would be available for low-income enrollees.
- Total out-of-pocket costs (including premium and cost sharing obligations) would not exceed 5% of the family's income for persons with income under 200% of the FPL, and potentially less than 5% for the very low income (those with income under 100% of the FPL).
- The individual owns the insurance policy and, therefore, has the right to retain coverage regardless of job or other life changes as long as the individual remains eligible for the program.
- The proposal would incorporate a requirement for a healthy behaviors/wellness incentive.

In addition to a core benefit plan, alternative plans could be offered, including a pre-paid and/or point-of-service health plan, a benchmark plan with more comprehensive coverage (like the State Employee Health Insurance Plan), a state care program (like the Colorado Indigent Care Program), or, if eligible, the State's high risk pool, CoverColorado. For those who qualify for the State's high risk pool, a higher premium subsidy could potentially be provided.

Quality

How will quality be defined, measured, and improved? Quality will be improved through a number of initiatives that underlie the foundation for reform in the current Medicaid program (for both primary and acute care and long term care services) and by the extension of these initiatives to the expansion population covered under the reform.

Quality would be defined through measures that establish benchmarks for health and health care outcomes, performance standards and use of best practices for:

- Appropriate, evidence-based care;
- Use of comprehensive, shared patient records;
- Effective care coordination;
- Efficiency on a large scale.

To the extent possible, quality objectives would be supported in the Medicaid program by focusing on purchasing strategies that pay for cost-effective services, that utilize plans that control costs by managing care, and that involves providers and consumers as partners in defining quality measures for care. By monitoring care, setting benchmarks, ensuring standardized training, paying for performance, publishing outcomes, and improving coordination between Medicaid, SCHIP, and other payers, individuals would be able to seek quality care that meets their needs, regardless of whether that is primary, preventive, acute or long term care services and whether that care is provided through the existing Medicaid program or the Exchange.

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

- Utilize managed care models that promote and ensure quality.
- Incorporate Pay-for-Performance (P4P) by:
 - Establishing contractually-based and measurable performance standards in all contracts, with incentive-based payment provisions.
 - Linking hospital payments to performance against established benchmarks in areas such as hospital-acquired infections, pharmacy order error rates, readmission rates for chronic diseases as well as providing incentive-based payments for implementing and maintaining electronic medical records and other quality-related improvements.
 - Structuring all contracts to align payment incentives with performance-driven goals, emphasizing care management instead of cost management.
 - Building P4P benchmarks in long-term-care program design and evaluation in areas such as health outcomes, satisfaction, staffing ratios, staff retention/turnover, training, and uncovered shift/no shows.
- Leverage evidence-based care, quality measures and performance standards.
- Utilize health information technology to reduce errors and improve efficiency.
- Ensure accountability through robust reporting and transparency.
- Promote the concept of a medical home along with ready access to primary care services in a timely manner.

- Promote consumer-directed care in all models of managed care.
- Require disease management programs for chronic conditions as well as case management for high-cost and complex cases.
- Emphasize comprehensive prenatal care case management.
- Develop and implement models of long term care that integrate services and care coordination for Medicaid and Medicare in person-centered care plans:
 - Medicare Special Needs Plans
 - Coordinated Care Programs
 - PACE and similar programs.
- Establish new oversight structures dedicated to quality care improvements, including a long-term care Quality Management Committee and a Public Authority to support home and community-based services.
- Develop a training program for care providers that addresses patient safety and privacy, the patient's right to direct his/her care, career progression, and skills retooling to respond to the shift to more home and community based care and to job displacement.
- Implement a specialty pharmacy program to include care coordination for individuals who require specialty pharmacy drugs, biologics and other injectibles.
- Ensure availability of affordable products to encourage participation in a health plan.
- Provide premium subsidies and limits on cost sharing for low income Coloradans to increase the likelihood that they will enroll in a health plan and access primary and preventive care.
- Reduce uncompensated care costs by allowing scarce resources to be more effectively targeted to uninsured persons.
- Ensure care coordination in all delivery models.
- Promote wellness and healthy behavior incentives.

□ **Efficiency**

Does your proposal decrease or contain health care costs? How? The proposal would reduce health care costs through a number of initiatives to:

- Develop a more efficient and cost-effective system to provide care to the uninsured with a focus on care management, primary care and prevention, and benefits tailored to the target population.
- Leverage market competition and choice to reduce costs.
- Reduce uncompensated care costs and cost shifting to employer plans and other payers.
- Creative incentives for quality, cost-effective care in the most appropriate and least restrictive settings.
- Implement targeted reforms in Colorado's Medicaid and SCHIP programs to incorporate strategies that contain costs, such as:
 - Greater use of capitated managed care and primary care case management to ensure access, quality and more cost-effective care through initiatives to manage care, implement pay for performance, incorporate evidence-based care, promote health and wellness and improve health and health care outcomes through performance benchmarks.
 - More robust disease management for chronic conditions to incorporate best practices and evidence-based medicine in the delivery of care.
 - Reporting, monitoring and transparency to improve health and health care outcomes and to allow consumers to make cost-effective choices for plans and providers.
 - Hospital payments linked to quality of care performance benchmarks to contain hospital costs for hospital-acquired infections, readmissions for chronic diseases and pharmacy errors.
 - Improved pharmacy purchasing strategies to garner savings through a preferred drug list (PDL), a multi-state purchasing pool, and a specialty pharmacy program.
- Implement long term care reforms that contain health care costs, such as:
 - Revising long term care eligibility to ensure that the most restrictive setting (institutional care) is limited to those with the highest acuity levels.
 - Revising long term care offerings to provide more integrated and coordinated services for not only Medicaid funded services, but also programs funded solely by state funds.
 - Creating additional infrastructure, such as increased consumer directed care, to help make community-based care a more viable option for more Coloradans to ensure cost-effective care in the least restrictive setting.

To what extent does your proposal use incentives for providers, consumer, plans or others to reward behavior that minimizes costs and maximizes access and quality in the health care services? Please explain. The proposal creates incentives for providers, consumers, health plans/insurers to minimize costs and to maximize access and quality in the delivery of health care services both within Medicaid for primary, acute and long term care services and within the

expansion program for health care through commercial insurance products. The key incentives that would be incorporated for each of the groups cited above include:

- **Providers** – Use of appropriate care management, with effective care coordination and a focus on quality and prevention in the delivery of care, with incentives for disease management, pay for performance, evidence-based care and benchmarks for health and health care outcomes.
- **Consumers** – Access to affordable insurance with an emphasis on primary care and prevention and choices of insurance to best meet consumers’ needs, with incentives for wellness and healthy behaviors.
- **Plans/Insurers** – Opportunities to leverage choice, market competition and portability to increase access to more affordable insurance with Medicaid-funded subsidies for a large segment of the uninsured population.

Does this proposal address transparency of costs and quality? If so please explain. Yes, this proposal would utilize reporting and transparency for costs and quality to improve health and health care outcomes and to help consumers make more informed choices about the plans and providers they select for Medicaid primary, acute and long term care services, and state-only funded long term care services.

How would your proposal impact administrative costs? The proposal could build off current initiatives in Colorado for health care reporting and monitoring, including encounter data and HEDIS reporting. The proposal could utilize funding currently appropriated for Medicaid and SCHIP, and additional funding that could be available for health care reform through the low-income pool.

□ **Consumer Choice and Empowerment**

Does your proposal address consumer choice? If so, how? Consumer choice, consumer empowerment and consumer-directed care underlie the proposed reforms for Medicaid’s primary and acute care services, long term care services and the proposed expansion of health care to uninsured populations. The proposal addresses more consumer choice by: (1) providing a range of health insurance plans offered by a newly-created Health Insurance Exchange; (2) enhancing consumer-centered initiatives for primary, acute and long term care services; and (3) requiring best practices that effectively assist consumers to make informed decisions about their health plans and health care.

How, if at all, would your proposal help consumers to be more informed about and better equipped to engage in health care decisions? The proposal would utilize the Exchange to inform consumers of plans, providers and health care options available, and would support consumers, providers, plans and providers in making informed choices with appropriate information on quality, access, cost and provider networks.

New and enhanced systems of more managed care would include information and processes to assist consumers in care plan development and personal responsibility for health. The proposal

would promote wellness and healthy behaviors to assist consumers in making good health care decisions.

For long term care, the proposal would utilize the existing single entry points but with greater access to information about long term care options, as well as information about the quality of services.

□ **Wellness and Prevention**

How does your proposal address wellness and prevention?

All plans offering products through the Exchange for the subsidized population would be required to incorporate a healthy behaviors or wellness initiative to provide financial incentives, education, and support to achieve improved health and health care outcomes.

Healthy behaviors/wellness programs will be required to identify at least four lifestyle behaviors for which members, in conjunction with their primary care provider, would be responsible to actively follow a treatment plan and guidelines to reach a health goal. Intervention for lifestyle behaviors should have measurable benchmarks and a treatment plan, education and support to assist members in meeting their goals. Potential lifestyle behaviors/interventions could include a range of preventive behaviors.

Through the Exchange, managed care plans would be required to offer enrollees an opportunity to complete a health risk appraisal. For employed enrollees, employers will be given the option to be a part of the health partnership.

Components of a healthy behaviors/wellness program could specify:

- An assessment of health status based on a health risk appraisal.
- Follow-up with a primary care physician within 90 days of plan enrollment, with no co-pay for this physician follow-up.
- Based on the results of the appraisal, compliance with a treatment plan developed with the physician for healthy behavior interventions as part of the enrollee's plan of care.
- Financial incentives to encourage and reward healthy behaviors.
- Education, including classes, information on a website, or direct mailings. The plan should also offer enrollee-specific educational plans, tailored to the health status and needs of individual enrollees.
- Support for enrollees should include ongoing access to health professionals who can counsel and provide coaching and support.

- Employers would also be required to support healthy behaviors by having smoke-free work environments, encouraging employees to take the health assessment and participate in the healthy behaviors program, and offering opportunities for exercise or physical activity.

The healthy behavior/wellness initiative could be built on initiatives currently offered in the commercial market.

For long term care, greater integration between Medicare and Medicaid services would support wellness and prevention by aligning incentives and coverage to encourage better outcomes rather than fragmented care.

□ **Sustainability**

How is your proposal sustainable over the long-term? Significant reform of Colorado's current Medicaid program, and the primary, acute, and long term care health systems that support it, is essential to ensure the future viability of any expansion of health care coverage. The reforms to strengthen Medicaid and the overall health care system focus on creating long term savings by improving the care management and health status of Medicaid consumers and on improving management of pharmacy benefits, hospital reimbursement and chronic disease. Similarly, the proposed changes to long term care are designed to position the State to address the future growth in Colorado's elderly population through more cost-effective home and community based services with enhanced care delivery options, quality management and incentives to promote care in the least restrictive settings.

The efficiencies and savings from the current Medicaid program will create a more sustainable environment for the expansion proposal, including opportunities for targeted, enhanced provider rates. In addition, many of these initiatives would extend efficient and cost-effective practices to the proposed expansion of coverage for the uninsured.

Funding for the proposal would come from a variety of sources, including monies now expended for health care services to the uninsured (unmatched state and local spending and DSH funds), unexpended federal SCHIP allocations, efficiencies/savings in the current Medicaid program, enrollee cost sharing, voluntary employer contributions, savings from leveraging pre-tax contributions to reduce costs, federal funding authorized through a Medicaid s. 1115 waiver and related SPAs.

A partnership of shared responsibility between local entities, the State, the federal government and the private sector, including the business community, labor, providers, advocates and stakeholders, would increase the sustainability of a whole system approach by reducing the number of uninsured, improving the coordination of care for Medicaid recipients and guaranteeing better health and lower health care costs for the overall population.

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

Who will pay for any new costs under your proposal? Funding to expand coverage will come from several sources. First, new federal funding will be secured to support a portion of the costs of the expansion through federal approval of Medicaid section 1115 waiver and related state plan amendments. Savings realized from new efficiencies built into the new program to create a more sustainable base will be applied and any unexpended SCHIP funding as well as some portion of current DSH funds will be reallocated to fund a portion of this initiative. Finally, all avenues will be pursued to ensure that the State is taking maximum advantage of all opportunities to claim federal funds.

How will distribution of costs for individuals, employees, employers, government, or others be affected by this proposal? Will each experience increased or decreased costs? Please explain. Individuals, small business employers and their employees that access coverage through the Exchange would have premiums and cost sharing requirements. Medicaid-funded subsidies would be provided on a sliding scale based on income to make coverage more affordable for low-income uninsured. Small businesses would be eligible to participate in the Exchange (without a subsidy), and could make voluntary contributions towards the cost of insurance for their employees. Government would reallocate a portion of DSH payments from public subsidies for institutions to Medicaid-funded subsidies for the purchase of health insurance for low-income uninsured.

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. The new expansion program is voluntary and would leverage Medicaid-funded subsidies to purchase private insurance. No changes are recommended to insurance mandates; the expansion program could access products now available in the market, including “mandate-light” products.

The reform proposal does include recommendations for new Medicaid requirements for quality improvement, care coordination, pay for performance, evidence-based medicine, disease management, wellness and healthy behaviors, reporting and transparency, consumer-directed care, use of information technology, provider training, and pharmacy and hospital management. Some of these quality initiatives would also be incorporated in the guidelines for insurance products for the expansion population.

(Optional) How will your proposal impact cost-shifting? Please explain. The proposal is designed to reduce cost shifting from Medicaid and uncompensated care to other payers.

Are new public funds required for your proposal? Yes, the proposal is designed to maximize the claiming of federal funds, leveraging existing state and local spending. To the extent additional state funding is available, coverage could be expanded to additional uninsured.

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

Comprehensive Health Care Reform – Required One-Page Overview

“Designed to expand coverage, increase access to quality care, improve health, and decrease costs broadly for all Coloradans.”

Significantly Expands Access to Coverage. [Recommended initial phase is highlighted in shaded area of the table below.]

- Extends coverage with Medicaid-funded subsidies in the initial phase to more than 490,000 (64%) of low-income uninsured Coloradans.
 - 139,000 children up to 300% FPL
 - 179,000 parents up to 250% FPL
 - 175,000 childless adults up to 225% FPL
- Provides flexibility to extend coverage up to 300% FPL, the maximum allowed under federal Medicaid policy, which could extend coverage up to 73% (561,000) of the uninsured.
- Creates a platform for access to more affordable insurance for uninsured small business, and potentially other uninsured.
- Extends long term care to additional individuals and Veterans.

	100% to 200%		200% to 250%		250% to 300%		
%	#	%	#	%	#	%	
7.2%	55,047	7.2%	18,642	2.4%	10,395	1.4%	
8.8%	83,346	10.9%	28,957	3.8%	14,698	1.9%	
9.7%	80,794	10.5%	40,135*	5.2%	32,066	4.2%	
25.6%	219,187	28.6%	87,734	11.4%	57,159	7.5%	

Source: U.S. Census Bureau – Current Population Survey – 3 year average – Data collected in 2004 to 2006.

*Assumes approximately half of the childless adults between 200% and 250% FPL have income less than 225% FPL.

Increases Access to Quality Care

- Managed care models that promote and ensure quality.
- Pay-for-performance principles.
- Evidence-based care, quality measures and performance standards.
- Health information technology to reduce errors and improve efficiency.
- Robust reporting and transparency.
- Medical home concept along with ready access to primary care services in a timely manner.
- Consumer-directed care in all models of managed care.
- Disease management programs, including case management for high-cost and complex cases.
- Comprehensive prenatal care case management.
- New long-term care delivery models that integrate care coordination.
- New oversight structures dedicated to quality care improvements.
- Training programs for care providers that address patient safety & privacy, home and community based care.
- Adding specialty pharmacy program with care coordination for specialty drugs, biologics and other injectibles.
- Affordable products, along with premium subsidies and limits on cost sharing for low-income uninsured to encourage enrollment in a health plan and access to primary and preventive care.
- Care coordination in all delivery models.
- Promote wellness and healthy behavior incentives.

Improves Health

- Increased access to health coverage, ready access to primary and preventive care, along with an array of quality measures built into this proposal are designed to improve health and health care outcomes for low-income children, parents, childless adults covered by the expansion and employees of small business eligible to purchase products on the Exchange.
- Coloradans, in general, should benefit as the quality principles built into this proposal are likely to be incorporated in other health insurance plans over time.

Decreases Costs Broadly for All Coloradans

- Health care-related costs should decrease over time as significantly more Coloradans have access to coverage and as Medicaid implements cost-containment and care coordination strategies.
- Costs for long term care will also decline as the elderly and persons with disabilities benefit from high quality, consumer-directed care delivered in a cost-effective manner in the least restrictive and clinically appropriate setting.



SEIU submits this addendum to its “Better Health Care for Colorado” reform proposal to provide information that has become relevant after the date on which our proposal was submitted.

Long Term Care Reform

The population of Coloradans requiring access to long term care is at the beginning of a massive expansion. SEIU presented recommendations for improvement of Colorado’s long term care system to efficiently accommodate this growth with the provision of quality services in the least-restrictive setting possible. However, the Lewin Group did not perform economic modeling for significant portions of SEIU’s long term care recommendations, including: cost effective rate setting, an increase in access to affordable housing for long term care consumers and an implementation of a strategy to maximize access to home and community based services. We urge the state policy makers to consider these measures in order to offer consumers a true choice in where they receive long term care services, and to enable the state to administer services in a cost-effective fashion that promotes quality.

In addition, SEIU recommends that state policymakers consider and, as appropriate, act upon the recommendations of the committees created by Senate Bill 05-173 and House Bill 07-1374. Many of the recommendations of the 173 committee were contained in the long term care section of our proposal, and the 1374 group finished its work in December of 2007. We would like to highlight one common theme from the recommendations of these groups – Colorado needs to better coordinate the funding and program administration of long term care services among the various agencies and stakeholders in the system. We believe this should be a fundamental first step in preparing Colorado for the spike in demand that is already upon us.

Cost Transparency

As has become increasingly apparent during the Blue Ribbon Commission’s modeling process, cost – both in terms of costs to individual consumers and in terms of the total cost associated with covering all Coloradans – is a major factor in the equation of health care reform. Parallel to Blue Ribbon process here in Colorado, we have seen that comprehensive health care reform efforts in other states has not yet managed to adequately tame the spiraling cost of health care. To enable the accurate examination of cost, SEIU recommends that Colorado implements public policy that engenders a greater level of cost transparency from both providers and insurance carriers. The yielding of this information will be essential if our state is to intelligently tackle the challenge of skyrocketing costs in our health care system.

Proposal Two: Solutions for a Healthy Colorado: Submitted by the Colorado State Association of Health Underwriters

Healthy Solutions for Colorado
Colorado State Association of Health Underwriters
Keynote Author: Barry Teeters

A) Comprehensiveness

1) What problem does this proposal address?

Our proposal will address cost and access to health care coverage including financing for Medicaid eligible and 'Low Wage Workers'. In addition we will also recommend solutions in coverage benefit designs, provider payment models and reducing administrative barriers to coverage.

2) What are the objectives of your proposal?

To improve and expand access to quality health care coverage for all Coloradans through private market solutions. Also, to identify each segment of our society and system that requires change and to recommend the necessary improvements.

B) General

1) Please describe your proposal in detail

Our proposal is a comprehensive proposal that will identify the leading cost drivers of health care and health care coverage. It will also make recommendations on how to address these cost drivers. We will establish recommendations for reform along with identifying measures of reform. We will also suggest comprehensive steps to address the uninsured, Medicaid and CHP+ programs. We will recommend the creation of limited benefit programs along with a subsidy program and financing suggestions. Our proposal recommends the establishment of a uniform pricing model and explores the creation of a small group reinsurance pool as well.

2) Who will benefit from this proposal?

All Coloradans should benefit from our proposal.

Who will be negatively affected by this proposal?

Some potential exists for hospitals and insurance companies to experience some reduction in revenue or profits.

3) How will your proposal impact distinct populations?

This proposal deals primarily with the problem of insuring the uninsured population of Colorado. Our proposal impacts three distinct populations. Statistics show that nearly 25% of the uninsured population is eligible for a state assisted health coverage plan but is not currently enrolled. That group will be impacted through availability of the Colorado Health Plan Connector and through increased state sponsored outreach. A second group, of low income uninsured residents makes up about 50% of the uninsured population according to a study of the Colorado uninsured population conducted by the Colorado Health Institute. This population would be served through institution of an affordable, guaranteed issue Core Limited Benefit Plan and the implementation of sliding-scale premium subsidies. A third group which we refer to as the “voluntarily uninsured” represents another 25% of the uninsured population. This group, also referred to as “free-riders” would be compelled to purchase at least basic health insurance coverage that would assure that in most case when they are receive health care, that providers would be compensated

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

Portions of this approach are being tried in various states; however, it is too soon to measure their success of failure.

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

Appropriate laws and regulations would have to be created to impose an individual mandate on all Colorado residents and to enforce penalties for non-compliance.

6) To the best of your knowledge, will any federal or state laws or regulations need to be changed to implement this proposal?

State insurance regulations limited employer financial support of individual medical plans would have to be changed or eliminated. Ultimately federal tax law should be changed to allow an income tax deduction for the premiums paid by individuals form their health insurance coverage.

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

Several years.

C) Access

1) Does this proposal expand access?

Yes. It would expand access by increasing Medicaid reimbursement levels which would encourage more doctors to accept Medicaid. In most cases, access is limited primarily by affordability. People without the means to pay for health care often avoid seeking care until their problem becomes acute, then requiring more expensive care. By mandating a Core Limited Benefit Plan that assures almost all Colorado residents have at least a minimum basic level of coverage, more Coloradans will access the care they need when they need it.

2) How will the program affect safety net providers?

Safety-net providers will benefit by experiencing less uncompensated care since all Colorado residents will be mandated to carry a minimum Limited Core Benefit Plan.

D) Coverage

1) Does the proposal “expand health care coverage”?

Yes. By imposing an individual mandate, providing premium subsidies for low income residents and creating an affordable, guaranteed issue, Core Limited Benefit Plan, this proposal expands health care coverage to almost all Colorado residents and reduces the number of uninsured Coloradans.

2) How will outreach and enrollment be conducted?

The Colorado Health Insurance Connector would be an internet based system that would provide information to consumers about the state supported plans for which they may be eligible as well as private health insurance options. The Connector would make available the services of qualified health insurance brokers to those consumers who desired interactive, personal and expert advice in choosing the plan that best suits their needs. Members of the Colorado State Association of Health Underwriters who wished to participate in the Connector program would undergo a rigorous training program to familiarize themselves with all

aspects of state supported plans such as Medicaid and CHP+ as well as the Connector and any state sponsored subsidy programs for which applicants might be eligible.

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

Resident should be defined as a matter of law by the state of Colorado in order to facilitate the implementation of this and other proposals that deal with the general population of the state.

E) Affordability

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

Our proposal does not include an employer mandate; however we would expect that many employers will choose to support the Limited Core Benefit Plan by contributing to the cost. The sharing of premium would be open to negotiation between employer and employees but should be structured on a non-discriminatory basis. Employers who contribute to their employees premiums should be allow to set up Section 125 pre-tax premium plans and to receive appropriate state tax benefits for their contributions.

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

Exact benefits of the Limited Core Benefits Plan will only be available after consultation with the Colorado Division of Insurance and appropriate actuarial input to formulate pricing of the plan.

F) Portability

1) Please describe any provisions for assuring that individuals maintain access to coverage even as life circumstances and health status change.

Our proposal calls for the institution of a Limited Core Benefit Plan that would provide a level of basic healthcare benefits to all Colorado Residents. This plan would be offered on a guaranteed issue basis and could not be cancelled for health reasons. Through use of an individual mandate, Colorado residents who can afford to pay for health coverage would be compelled to do so through the purchase of at least the Limited Core Benefit Plan. However, Colorado residents below 250% of FPL could qualify for subsidies that would cover part of their premium. These subsidies would be available to individuals whose economic circumstance have deteriorated and can no longer afford to pay premiums.

G) Benefits

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

Our proposal calls for the institution of a Limited Core Benefit Plan that would provide a level of basic healthcare benefits available to all Colorado residents. All health insurance carriers doing business in Colorado would be required to offer this plan on a guaranteed issue basis at standardized, modified community rate pricing to any applicant. This approach, tied to our proposed individual mandate, and subsidy for Colorado residents whose income is at 250% of FPL or less, would serve all Coloradans. Specific benefits would be of the Limited Core Benefit Plan would only be finalized after appropriate consultation with the Division of Insurance.

2) Please identify an existing Colorado benefit package that is similar to the one you are proposing and describe any differences between the existing benefit package and your benefit package.

We are proposing that Colorado implement a standardized, guaranteed issue Limited Core Benefit Program. Limited benefit plans are currently available to employer sponsored groups through a variety of carriers; however, we recommend that the exact design of the plan be arrived at only after consultation with the Division of Insurance. Pricing of such a plan would need to be formulated only after proper actuarial studies.

H) Quality

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

Our proposal would tie all reimbursement schedules to one common basis. We believe that using the Medicare Reimbursement Schedule as the basis for all third party reimbursements would provide a uniform pricing model that could then be adjusted based on measurable quality benchmarks. Providers willing to sign a contract with a particular carrier would agree to quality, transparency and outcome guidelines that could result in a grading of reimbursements based on attaining Average, Above Average or Superior Quality .

2) How, if at all, will quality of care be improved?

Our proposal supports quality of care improvements in two ways. First, through the implementation of a uniform schedule for healthcare services with compensation levels to providers tied to outcomes, providers will have

an incentive to deliver the highest quality care to their patients. Second, we propose that the State of Colorado support the creation and development of internet and print based tools that will allow consumers to compare cost and quality of health care providers. These tools are already becoming available and our support can hasten their entry into mainstream use. When consumers are enabled to compare cost and quality of health care providers, pressure for quality improvement will result.

I) Efficiency

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

By linking provider reimbursements to quality of care, reducing the number of uninsured, providing guaranteed access to preventive care and wellness services this proposal would contain health care costs by enabling people to seek the care that they need in a timely manner and by supporting their ability to locate the highest quality care available to them in their locale.

2) To what extent does your proposal use incentives for provider, consumers, plan or others to reward behavior that minimizes costs and maximizes access and quality in the health care services?

Our proposal will recommend rewarding providers for quality of outcomes and higher reimbursement for providing services to lower income individuals. We will reward healthy life styles with reduced premiums.

J) Consumer choice and empowerment

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

All Colorado health insurers and HMOs would be required to participate in this program, thus allowing a choice of HMO, PPO or Indemnity plans according to their needs. In addition to the limited benefit guaranteed plan design that would be available to all Colorado residents, additional, expanded and medical underwritten options would be available.

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

For consumers to become informed, two components must be present. Information must be readily available and consumers must take the initiative to seek out and consider that information. Creation of a Colorado Health Plan Connector will assure that information on private health

insurance options and governmental programs for which consumers may be eligible will be available. By engaging the professional health insurance brokerage community to participate in the Connector program, consumers will have access to expert advice regarding the health insurance options that best meet their needs and budget. The institution of an individual mandate that requires residents to purchase healthcare insurance creates an incentive for consumers to seek out and consider information that will help them make better purchasing decisions. Our proposal supports improving and if necessary, subsidizing the creation of cost and quality transparency tools that will give consumers better access to information that will allow them to make better informed decisions about their medical care.

K) Wellness and Prevention

1) How does your proposal address wellness and prevention?

By providing a guaranteed level of basic and preventive healthcare coverage by policies that are guaranteed available to all Colorado residents; this program improves access to wellness and prevention programs to all Coloradoans.

L) Sustainability

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

By engaging the participation and support of governments, Colorado residents, insurers and healthcare providers, this proposal creates a broad base of sustainable support.

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

Estimates are not available at this time.

3) Who will pay for any new costs under your proposal?

A new tax should be enacted to support the costs of this proposal that is not covered by participant premiums.

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

Due to the elimination of “free-riders” in the system, and a reduction in cost shifting, many individuals should see their premium costs reduce under this proposal. Government costs will increase as the result of providing

subsidies to low income Colorado residents. Those Colorado residents who have been previously “irresponsibly uninsured” will be compelled to purchase coverage under this proposal and will see and increase in their costs.

5) Are there new mandates that put specific requirements on payers in your proposal?

Are any existing mandates on payers eliminated under your proposal?

We propose that all state mandates be re-examined and that any mandate that affects less than 1% of the insured population, but contributes more than 1% to the cost of coverage be removed.

6) How will your proposal impact cost shifting?

Cost shifting will be reduced by establishing a uniform pricing model and increasing Medicaid reimbursement levels. Also, by insuring almost all Colorado residents, the amount of uncompensated care would be reduced as well.

7) Are new public funds required for your proposal?

Although some funds currently allocated for uncompensated hospital care could be diverted to support this proposal, new sources of funds would be needed.

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

We would propose a Nutrition Sales Tax on all consumable food items that have little or no nutritional value. The exact amount of this tax could be determined by studies of the revenue required and the sales of these items in Colorado.

Solutions for a Healthy Colorado

The goal of the Colorado State Association of Health Underwriters in this outline is to identify the major issues that exist within our current system of health care coverage and access to coverage, then to propose a comprehensive plan through private market solutions to these problems. We contend that the main issue is not *access* to health care, but *affordability* of health care and therefore health care coverage.

We will outline recommendations for reform and identify the major indicators of reform. Our proposal will also identify the major cost drivers of health care and therefore health care coverage. We will make recommendations on several key issues, including:

- The Uninsured
- Medicaid and the CHP+ Program
- A Subsidy Program
- Benefit plan Designs
- Reinsurance
- A Uniform Pricing Model

We believe that any proposal for reform must be comprehensive. CSAHU believes that health care coverage and related market reforms need to build on the best aspects of our current health care system and encourage the creative power of a competitively driven marketplace.

**Solutions for a Healthy Colorado
Colorado State Association of Health
Underwriters:
Narrative Attachment**

Key Author
Barry Teeters

Contributors
James L. Sugden, CLU
Mitch Michener, RHU, REBC
Rodney Regalado, CFP
Cynthia Guldy, CLU
James Scholl, CLU, ChFC

National Association of Health Underwriters

Barry Teeters
Assured Benefit Solutions
1805 South Bellaire Street, Suite 545
Denver, CO 80222
303-504-6068 (ph)
303-531-5040 (fax)
bdteeters@absoln.com

Barry Teeters
April 6, 2007

Solutions for a Healthy Colorado
Colorado State Association of Health Underwriters

The guiding principles of the Colorado State Association of Health Underwriters (CSAHU) are to protect and improve the health status of all Coloradans. We believe the best possible solutions are driven by market competition that continues to offer choice and flexibility to health care consumers. We recognize the necessity to expand essential health care coverage to all Coloradans and realize that any reform must include an emphasis on the uninsured. We believe that the only way to achieve significant reform is for all participants to accept their responsibility as providers and consumers of health care services and to embrace change that establishes measures to ensure a high quality, cost effective system that is financially viable, sustainable and fair. It must also address the responsibility of the health care insurer and provider to provide a system that allows for choice, and emphasizes wellness, prevention, education and consumer empowerment.

As an organization of health insurance professionals, the majority of our membership spends every day of their business lives explaining the cost and benefits of health care coverage to employers and individuals. We understand as well as any organization what the issues really are. Few individuals in any segment of the health care industry if given the chance would design the system that we have in place today. But to design a new system is not our challenge. Our challenge is to reform what is in place today to better meet the needs of all Coloradans and all Americans.

If the challenge or *goal* is coverage for all Coloradans, then asking all Coloradans to be responsible for obtaining coverage should also be part of the solution. CSAHU agrees in principle with the idea of imposing an individual mandate that reduces the number of uninsured Coloradans through the utilization of the private market. However, the idea of an individual mandate also raises many questions and concerns that will need to be addressed. For example, will imposing an individual mandate do anything to reduce the rising costs of health care and thereby the costs of providing healthcare coverage?

This document provides both a benchmark with which the 208 Commission can measure all proposals, and also offers our own reform

ideas, which CSAHU believes are solutions for the health care challenges facing Colorado.

Requirements of Reform

- ▶ We believe any reform package must guarantee that all Coloradans have access to health care coverage.
- ▶ We believe reform must address and reduce skyrocketing medical care costs.
- ▶ We believe reform must not bankrupt families or Colorado.
- ▶ We believe reform must provide the state's diverse population with equally diverse health care coverage choices.
- ▶ We believe reform must promote ongoing and long-term innovation and experimentation that enable the state's health care system to adapt over time to the evolving needs of its citizens.
- ▶ We believe reform must provide consumers access to meaningful information that will enable wise treatment choices and expert advice and counseling from licensed and trained professionals.
- ▶ We believe reform must not displace the 83 percent of Coloradans that have health care coverage under the current system.
- ▶ We believe reform should not create preference toward any particular market or approach.

We believe the Five Indicators the 208 Commission should use are:

1. Cost Containment
 - Does it constrain rapidly rising medical costs?
2. Affordability
 - Can Colorado afford the plan?
 - Can Coloradans afford the plan?
3. Universal Participation
 - Does it guarantee that every Coloradan has access to health care coverage?
4. Consumer Choice
 - Does it empower Coloradans to find and choose the health care coverage which best fits their unique needs?
5. Evolving Needs

- Does it enable health care coverage to evolve with changes to the state's population, their needs and expectations?

Like the problem of the uninsured, there is neither one cause nor one solution to containing the rising cost of health care coverage. In order to develop effective private and public policy solutions to contain the cost of health care, we need to thoroughly examine the factors causing dramatic increases in health care spending.

Constraining Medical Costs

The key to the success of any health care reform plan will be its ability to address the true underlying problem with our existing system—the cost of medical care. The fact is that true accessibility to health care and private health insurance coverage is dependent upon whether or not it is affordable. Constraining skyrocketing medical costs is the most critical – and vexing – aspect of health care reform. It is the key driver in rising health insurance premiums and, consequently, it is driving the cost of health care coverage beyond the reach of many Americans.

Statistical evidence supports what the National Association of Health Underwriters (NAHU) has observed relative to the economic impact of health care spending. In 2006, health care spending in the United States will exceed \$2 trillion and account for 15.9 percent of the gross domestic product (GDP). This is an increase from \$1.3 trillion and 13.3 percent of GDP in 2000, and spending is only continuing to rise. Costs are projected to exceed \$2.7 trillion and 17 percent of GDP in 2010¹⁸. Furthermore, the annual increases in national health care spending consistently outpace both the rate of general price inflation and the average U.S. household income. According to a 2005 study by Hewitt Associates, LLC, health care cost increases have averaged 12 percent per year since 2000. During the same time, increases in the Consumer Price Index have averaged 2.7 percent and the U.S. household income 3.7 percent.

There are many reasons health care costs are skyrocketing, among them, uncontrollable issues like an aging population. New medical technologies and pharmaceuticals also contribute to rising health costs, but are among the greatest assets of our health care system. Addressing this massive societal problem will require a multitude of comprehensive actions by both individual citizens and elected officials. Many of the topics that will need to be addressed to truly lower health care costs in the country, like physical education for children or nutritional choices, are not ones where CSAHU members as a whole have any particular expertise. However, as health

¹⁸ U.S. Centers for Medicare and Medicaid Services

insurance producers and employee benefit specialists, we do have extensive knowledge of health insurance markets and factors that are directly driving up health insurance claims costs and as a result health insurance premium rates. CSAHU believes that health insurance and related market reforms need to build on the best aspects of the American health care system and unleash the creative power of a competitively driven marketplace. We feel that the following recommendations would make important improvements to the U.S. health care system to lower costs, improve quality, and create greater efficiency.

Behavioral and Lifestyle

Two key factors in the increased cost of health care are unhealthy behavioral and lifestyle choices. Research shows that behavior is the most significant determinant of health status¹⁹, with as much as 50 percent of health care costs attributable to individual behaviors such as smoking, alcohol abuse and obesity. According to the National Center for Health Statistics, 30 percent of adults (more than 60 million Americans) are obese and the problem is worsening. Obesity has risen by 10 percent in the past decade and the trend can now be observed among American children²⁰. Other sources show that smoking is responsible for approximately 7 percent of total U.S. health care costs²¹. These behaviors lead to many serious chronic health conditions such as cancer, diabetes, heart and cardiovascular disease, and consumers are seeking medical solutions for these lifestyle issues rather than correcting unhealthy behavior.

Recommendations:

We need to explore public-policy initiatives regarding wellness promotion. Health insurance premium costs are rising because Americans are utilizing more and more health care services. Promoting and achieving a healthier America is one way that we can reduce health insurance claims and overall health care costs, and employers are in a unique position to have a positive influence and benefit directly from a healthier workforce. We believe lawmakers should do everything possible to enable employers to provide benefit incentives and premium flexibility through legal protections and tax breaks to enable them to implement smoking, drug, alcohol and wellness programs to encourage healthy lifestyles for employees and their families.

We also believe that our state's largest employers and providers of health insurance coverage - the state governments - should incorporate wellness and disease management programs into both their plans for state government employees, and also all government- subsidized health coverage programs such

¹⁹ Mercer Management Journal 18; Centers for Disease Control and Prevention.

²⁰ Employee Benefit News, "Employers tackle obesity." Centers for Disease Control and Prevention; January 2006, <http://www.cdc.gov/nccdphp/dnpa/obesity/trend/maps/>

²¹ Centers for Disease Control and Prevention. *Morbidity and Mortality Weekly Report*. July 8, 1994 .

as Medicaid and CHP+, among others. Such programs could be modeled after the highly successful Healthy Arkansas Initiative, which targets the state's 50,000 state employees, Medicaid recipients and other state residents by encouraging them to stop smoking, lose weight, and exercise more. Arkansas state employees now receive nutrition counseling, "walking breaks" instead of smoking breaks, paid leave as a reward for healthy behaviors, and discounted health insurance premiums if they agree to undergo a voluntary personal health-risk assessment. The state's nearly 600,000 Medicaid recipients have similar incentives and the state Medicaid program now pays for nicotine patches and similar smoking-cessation tools. According to a recent national study, 26% of all adult Medicaid recipients in Arkansas used tobacco products in 2002, costing the state an estimated \$540 million. Nationally, approximately one of every seven dollars spent on Medicaid is related to tobacco use. The state Medicaid program is also implementing a highly successful disease management program to help curb costs and improve treatment of diabetes.

We need to create a safe-harbor for those well-meaning employers that take action to promote wellness and healthy activities among their employees from non-intentional discrimination by adopting regulatory changes which adopt bona fide wellness plans under recent federal Department of Labor regulations. We should encourage this behavior by employers the same way we require safety features such as fire sprinklers through commercial and residential real estate insurance policies. State and federal policymakers should adopt rating changes which would permit those employers who are implementing and operating these wellness plans to receive premium savings for their wellness plan adoption.

System Inefficiencies

Duplication of procedures and overuse of high-end procedures, in situations where they add little value, have driven up medical spending unnecessarily. Both patients and the provider community should focus on looking for less expensive but equally efficacious alternatives. Preventable mistakes caused by providers of medical care also help account for rising costs. The November 1999 report of the national Institute of Medicine (IOM) indicated that as many as 44,000 to 98,000 people die in hospitals each year as the result of medical errors.²² Those numbers don't even take into account medical errors that occur in other clinical settings. These medical errors are not only tragic; they also carry a strong financial consequence. IOM estimates that medical errors cost Americans approximately \$37.6 billion each year, and about \$17 billion of those costs are attributable to preventable medical errors. About \$8.5 billion annually is for direct health care payments for preventable errors.²³ Unnecessary medical treatments and prescriptions are also costing the U.S.

²² Institute of Medicine. *To Err Is Human: Building a Safer Health System*. 2000.

²³ *Ibid.*

health care system billions of dollars each year. For example, 25 percent of physician visits (costing \$11.4 billion annually) and 55 percent of emergency room visits (costing \$14.7 billion annually) are unnecessary according to American Institute for Preventive Medicine. Plus the inconsistent focus on quality outcomes, when providing treatment, is another inefficiency impacting medical costs. According to a report by the National Committee for Quality Assurance (NCQA), "The U.S. health care system is still saddled with an anachronistic payment system that rewards quantity, not quality, of care. This contributes to widespread variations in the way health care is delivered – from failure to deliver needed care, to huge numbers of unnecessary procedures that drive up costs and endanger patients."²⁴

Recommendations:

We must provide incentives for doctors and medical facilities with pay for performance, best practice guidelines and evidence based medicine to improve system inefficiencies and eliminate errors.

The government needs to create standards for interoperable electronic medical record technology to help unify the health care system, reduce errors and improve patient satisfaction. Advances in health IT will enable true collaboration between doctors and patients as consumers make more informed choices and doctors become more involved in their care. In the long run, improved technology will also provide better information to track public health problems and advance clinical research.

Medical Malpractice

The amount health care providers must pay for medical liability insurance coverage is on the rise, which has directly impacted health care costs in this country. But an even more costly side effect of rising medical malpractice insurance rates is the cost of defensive medicine (when doctors order more tests, prescribe more medication and make more referrals than they believe are necessary to protect themselves from being accused of negligence). Since 1975, when medical malpractice insurance data was first separated from other types of liability insurance, medical malpractice cost increases have outpaced other tort areas, rising at an average of 11.7 percent a year. In 2004 medical malpractice costs totaled over \$28.7 billion, up from about \$26.5 billion the previous year.²⁵ Medical liability costs and defensive medicine combined, currently account for 10 percent of medical care costs.²⁶

Recommendation:

We must enact comprehensive medical malpractice reform. Medical liability reforms that limit non-economic damage awards, allocate

²⁴ National Committee for Quality Assurance. "The State of Health Care Quality 2005."

²⁵ Towers Perrin. *U.S. Tort Costs: 2005 Update*. March 2006.

²⁶ PricewaterhouseCoopers for America's Health Insurance Plans. *The Factors Fueling Rising Healthcare Costs* 2006. February 2006.

damages in proportion to degree of fault; place reasonable limits on punitive damages and attorney fees with a statute of limitations on claims would all have a positive impact on medical liability insurance premium rates. If medical liability insurance costs were lower it would likely reduce the health care costs associated with the practice of defensive medicine. In addition, state authorities must do a better job disciplining incompetent doctors, thereby reducing costs associated with their liability rates and medical errors.

Cost-Shifting

Cost-shifting occurs when providers of medical care adjust the prices they charge to private insurance companies in order to offset losses from partial or non-payers. These losses are primarily attributable to uncompensated care costs and declining reimbursements from Medicare and Medicaid, and have a significant impact on health insurance costs. The New Hampshire Center for Public Policy Studies estimated that cost shifting added 17 percent to the charges that New Hampshire employers and individuals with private health insurance paid for hospital care in 2001.²⁷ In 2001, the uninsured received about \$35 billion in uncompensated health care treatment, with federal, state and local governments covering as much as 85 percent of the costs. Hospitals deliver two-thirds of uncompensated care and private practice physicians account for more than half of the private subsidies that underwrite the cost of uncompensated care.²⁸

Recommendations:

In order to eliminate cost-shifting from major federal health care programs like Medicaid, CHP+ and Medicare to private health insurance plans, the State of Colorado should begin reimbursing providers that participate in all health care coverage programs, including Medicaid, Medicare and CHP+ at the same level it compensates providers that give state employees medical care through the Colorado State Employees Health Benefit Plan. In addition to reducing costs for the thousands of Coloradans with coverage in the private insurance market, state programs paying their fair share will have the added benefit of drawing more providers into these programs. More participating providers will not only increase access to care for all public program participants, the increased competition will also have a positive impact on overall reimbursement rates.

²⁷ Peter Brodie, MBA student; Thomas Crawford, MBA; Scott Fabry, MBA student; Cindy Hayes, MBA student; Heather Hodgeman, MBA student; Martin Green, PhD. *Franklin Pierce White Papers*. "Cost Shifting: The Cyclical Inflation and Subsequent Erosion of the Health Care System."

²⁸ 2003 Health Affairs. Report for the Kaiser Commission on Medicaid and the Uninsured.

Increased Utilization

Americans are also consistently using health care services more and more, which has a tremendous impact on private health insurance premiums. In a report prepared by PricewaterhouseCoopers on behalf of America's Health Insurance Plans entitled *The Factors Fueling Rising Healthcare Costs 2006*, "higher utilization of services accounted for 43 percent of the increase, fueled by factors such as increased consumer demand, new and more intensive medical treatments and defensive medicine, as well as aging and unhealthy lifestyles." Americans need to become more engaged as consumers. Informed shoppers are more efficient consumers and efficient consumers spend less money.

Recommendations:

Expansion of access to consumer directed health insurance products, like Health Savings Accounts, Health Reimbursement Arrangements and Flexible Spending Accounts will allow the strength of the free market to help curb the problems and costs associated with over utilization of health care services. Recent changes to HSAs made as part of the Tax Relief and Health Care Act of 2006 will help make this consumer directed health care option much easier for employers and insurers to administer, thereby making HSAs more accessible to all Coloradans.

Transparency of cost is also a critical component of overall cost reduction. The advent of a more consumer directed approach to health insurance coverage is essential to reducing overall health care costs as it will help curb excessive utilization and claims, as well as drive down costs by increasing competition among providers. However, to be fully successful, Colorado consumers must be fully aware of the cost of the health care that they are purchasing.

The best option would be a private sector solution where the health plans and providers overcome policy concerns (e.g. prohibiting gag provisions in provider contracts) and bring a solution to the public as soon as possible. See section 10. But if progress isn't made quickly, we believe that legislative or regulatory action ought to be taken, but these should be seen as a last resort.

Health care coverage is expensive because of the high cost of health care. If we are to gain any advancement towards the goal of providing health care coverage to all Coloradans, we must address the **cost** of health care. As an organization, the number one thing for which we advocate is thoughtful, comprehensive reform that benefits consumers, employers, and the providers of health care and health care coverage. To make any

advancement in realizing our goal of coverage for all Coloradans, many things must occur, including:

1) Identifying those who currently have no coverage – the Uninsured

A) According to the Colorado Health Institute (CHI), 22.8% of the uninsured in Colorado are below the Federal Poverty Level (FPL)²⁹, therefore most of them are eligible for Medicaid, but not enrolled. While mass enrollment may be challenging, attempts to identify and cover this population is extremely important. If coverage for all is the goal, then locating, enrolling and funding for this population must be achieved.

B) Low Wage Workers (LWW) are working individuals between 60% and 250% of FPL. We oppose government expansion to include this population, yet acknowledge the need for some type of government assistance to help this segment of our population obtain health care coverage.

C) The Irresponsible Uninsured represents another significant problem. They have the access and income to purchase health care coverage, but do not. 39% of Colorado's uninsured have income levels above 200% of FPL (\$40,000 for a family of four).³⁰

D) The CHI update for 2005 on the uninsured reports that young adults ages 18 to 34 represent the largest percentage of the uninsured at 40%. This population is arguably the healthiest segment of our society. Because this segment also spans all socio-economic categories, any meaningful reform must address this population. Expansion of dependent status in the group market over the past few years has been a good start. However the market must continue to create plan designs and incentives that attract these individuals into the market place.

We strongly believe that new social programs should not be created without first demonstrating the ability to be successful with existing programs.

We believe the best solution is to create a subsidy program on a sliding scale that will assist these populations obtain coverage in the existing private market. See section 5 for subsidy program.

In addition, we believe that the private market must design and implement a scaled down product with a limited core benefit that will accommodate the needs of this population. See section 3 for core benefits.

²⁹ Colorado Health Institute. Profile of the Uninsured in Colorado, 2004. January 2006.

³⁰ Ibid.

Recognizing the need for age and health status rating flexibility in the Small Group Market are important incentives to encourage this population to obtain coverage. Requiring documentation of coverage at time of enrollment at colleges and universities should also be mandatory.

2) Reforming existing assistance programs to operate efficiently - Medicaid and the CHP+ Program

A) The Colorado Medicaid program is often described as one of the leanest programs in the country with an eligibility threshold at 60% or below FPL. Due in part to our higher than average per-capita income, we also have one of the lowest Federal funding matches (50%). Despite its relative leanness, Medicaid continues to consume a growing proportion of the state's general fund, 22% in fiscal year 2005-2006.³¹

While Medicaid eligibility is a problem, Medicaid reimbursement to providers is the major issue. Providers must be compensated fairly for the services they provide. We recommend reimbursing Medicaid on the same schedule that is used for Medicare. The establishment of a uniform pricing model must be introduced and will be discussed further under section 10. Medicaid managed care programs must be re-established that utilize coordinated care and cost efficiencies.

B) The Child Health Plan + was created in 1997 to provide full service health and dental coverage for Colorado's uninsured children ages 18 and younger. It has been expanded in recent years to include pregnant women and children up to 200 percent of FPL. Approximately 52,000 of the estimated 100,000 children eligible are currently enrolled.

The CHP+ program must continue to be funded and enrollment of all eligible children must be accomplished. We recommend increasing the eligibility for CHP+ to children living in households with incomes up to 250% of FPL.

Existing programs should be reviewed and required to prove their effectiveness. New outreach programs should be considered. Enrolling children and young adults in schools and other community organizations should also be considered.

3) Creating new health care benefit plans and promoting existing plans that work

A) Core Benefit Plans

³¹ Colorado Health Institute. Health Care Vision 2007 and Beyond: Colorado's Health Care Marketplace.

Responsible health care reform should recognize that consumers have different financial situations, risk tolerance levels and different health care needs.

We would recommend that the Commission work with existing insurance carriers in the marketplace to design a Core Benefit plan.

These plans would provide for:

A maximum benefit of \$50,000 per year

Wellness and preventative care

Routine doctor visits

Generic and possibly preferred formulary drugs

Hospital benefits and other medical procedures

They would require limited low out of pocket co-pays and deductibles

Limited mandates must be considered to keep these plans as affordable as possible. These plans should be made available on a guaranteed issue basis in the group and individual market, potentially with community rating. However, the disruption to the existing market must be considered.

Creating an initial six to twelve-month open enrollment window could be one solution to expand enrollment, just as the federal government has done with Medicare Part D. Beyond this initial open enrollment, individuals might potentially face surcharges and or preexisting condition periods.

Pueblo County has recently announced the formation of a community-based program designed to provide a similar type of limited benefit package.

We encourage the formation of public/private relationships in rural communities that have unique challenges and lack the ability to benefit from a competitive market.

B) Existing Medical Plans

Recognize and encourage the enrollment into existing major medical plans. As mentioned earlier, Consumer Directed Health Plans such as HSAs will allow the strength of the free market to help curb over-utilization and reward higher personal risk retention with lower premiums and pre-tax payment of health care expenses. By accepting the pre-tax benefit with a higher deductible, they have also encouraged health care consumers to inquire about the cost of care when appropriate.

4) Addressing the Mandate Issue

While we agree with the concept that everyone should be required to purchase coverage, we have great concern with everyone's accepting the responsibility to do so. Colorado has had a compulsory law requiring the purchase of auto insurance since 1979, yet according to the Insurance Research Council the number of uninsured motorists in Colorado still remains at approximately 15%.³² What this law has accomplished is establishing the expectation of personal responsibility and has then allowed for the punishment of those who do not comply. We believe that a personal responsibility law that establishes these same expectations is reasonable. We also believe the assumption that many may not comply with this requirement is a necessary reality.

There has been a lot of attention on recent reforms that have been implemented by the state of Massachusetts. California's governor has also recently proposed similar legislation that previously had been approved by the state's legislators mandating coverage for all.

In order for individual mandates to work, everyone must have equal access to health care coverage. Massachusetts and Colorado have very different situations. Massachusetts does not face the same geographical challenges that Colorado must recognize. Massachusetts currently has guaranteed issue, so mandating coverage for all is not a problem because all health insurance including individual coverage is issued on a guaranteed basis. No one - group or individual - can be denied coverage based on any preexisting medical condition.

Colorado, like 42 other states, does allow for risk adjustment, or medical underwriting in the individual market. While not having guaranteed issue, Colorado has enjoyed a competitive, thriving individual market. Colorado is one of 33 states that have implemented a high risk pool, CoverColorado, for individuals who may be denied coverage. Although CoverColorado has worked well and kept the private market healthy, a consistent funding program continues to be a challenge. There is much less concern currently voiced about the individual and large group market in Colorado because for the most part they work very well.

Mandating guaranteed issue to an individual market that is working well could have serious negative repercussions. With no mechanism in place to guarantee that all individuals eligible will purchase coverage, guaranteed issue will only undermine the individual market along with the high risk pool currently in place. Those who have or acquire a health condition will take advantage of the guaranteed issue and purchase individual coverage. Those who are young and remain healthy will continue to go without coverage as they do now, and cost will rise significantly in the individual market forcing the existing healthy in that

³² Insurance Research Council. *IRC Estimates More Than 14 Percent of Drivers Are Uninsured*. June 28, 2006.

market to drop coverage. For these reasons we do not believe that mandating guaranteed issue in the existing individual major medical market can be accomplished until it can be demonstrated that a high percentage (90 to 95%) of all Coloradans have obtained some type of coverage.

To begin with, we would recommend guaranteed issue only to the Core Benefit plans.

Risk Adjustment

Many would argue that the cost and benefit of health coverage should be the same for all.

But not everyone's health care needs are the same. Nor is there ability or willingness to pay for coverage. We believe that the individual and large group markets currently work well because they allow for risk adjustment. We do not believe that it makes sense to disturb these existing markets that are functioning well to reform the issues in the small group market. The ability to evaluate the potential utilization of care allows these markets to price coverage accordingly and spread the potential risk among the largest pool possible. In the individual market this is assisted by ceding the catastrophic risk in to a reinsurance pool, CoverColorado.

Reforms implemented in the small group market in 2003 have had a positive effect on the small group market. Rating flexibility utilizing the additional rating factors of claims experience, health status, and standard industrial code have been available in the Colorado small group marketplace on a phased-in basis since September 2003. The Colorado Division of Insurance surveyed carriers as to their use of RAFs at the end of the first year that they could be fully utilized (September 2005) and again a year later (September 2006). The following conclusions can be drawn from analysis of these survey results:

1. The small group market has been eroding or declining since 2000 but has shown a slight increase in both the number of groups and covered lives between year-end 2005 and September 2006.
2. Each market segment reviewed in this analysis shows very similar results in the percentages of small groups whose rates were discounted and issued at a premium on 9/30/05 and 9/30/06. A little over 60% of these groups received a discount and about half of that number of groups, or almost 30%, were rated up on 9/30/05 and 9/30/06. Between 2005 and 2006, there was movement of both groups and lives to the minimum and

maximum RAF-adjusted premium amounts (0.75 to 1.10 of the index rate).³³

3. Carriers perceive that the ability to use RAFs and rating flexibility has attracted new small groups to them, improved the overall risk profile of small groups, created stability in the small group market, and increased the carriers' willingness to remain and expand their participation in the small group market. As a result, Assurant Health has re-entered the Colorado Small Group Market and both Humana and Aetna have expanded their presence.

5) Deciding how to help those in need - Creating a Subsidy Program

We recognize that there is a significant percentage of the working population that cannot afford the cost of health care coverage. According to recent statistics published by the Colorado Health Institute, 52.1% of the uninsured live in households with annual incomes below 200% of FPL or \$40,000 a year for a family of four.³⁴

For this reason we believe that a subsidy program should be created that would provide financial assistance to individuals below 250% of FPL. Providing subsidies based on income to LWWs might be structured as follows:

90% assistance to individuals between Medicaid eligible and 150% of FPL

70% subsidy to those between 150% and 200% of FPL

50% for those between 200% and 250% of PFL

We strongly believe this subsidy should be created in the form of a voucher that could be used to purchase group coverage at their place of employment whenever possible. Many of the children of these LWWs are eligible for the CHP program and we encourage the State of Colorado to work with the federal government to restructure current SCHIP guidelines that make participation in employer-sponsored programs prohibitive. Allowing families to remain covered under the same plan reduces confusion and administrative issues.

6) Determining how to finance the assistance that is provided

The need to generate significant, sustainable revenue is critical to any proposal for health care coverage reform. The potential for any single

³³ Report of the Commissioner of Insurance to the Colorado General Assembly on Rating Flexibility. January 15, 2007.

³⁴ Colorado Health Institute. Profile of the Uninsured in Colorado, An Update for 2005. November 2006.

source to experience volatility is probable. Therefore we believe the establishment of multiple sources of revenue is necessary. We propose three potential sources.

A) We support the establishment of an income tax credit for those who do have coverage - and implementing a tax penalty for those who do not. The implementation of an employer tax credit should also be created to reward existing employers and encourage more small businesses to offer employer-sponsored coverage.

As previously mentioned, two key factors in the increased cost of health care are unhealthy behavioral and lifestyle choices. According to the National Center for Health Statistics, 30 percent of adults (more than 60 million Americans) are obese and the problem is getting worse. According to the National Soft Drink Association, consumption of soft drinks is now over 600 twelve-ounce servings per person per year. Since 1978, soda consumption in the United States has tripled for boys and doubled for girls. Last year soft drink companies grossed over \$57 billion in US sales alone.³⁵

B) We believe the majority of income could come through the imposition of a Nutrition Sales Tax. We would suggest taxing all consumable food items that contain little or no nutritional value at the point of sale. If we recognize smoking to be harmful to our health and impose a tobacco tax, we should recognize the impact of non-nutritional 'food' items as well. A 2 to 5% sales tax on all fountain sodas and walk-up coffee locations could generate millions of health subsidy dollars annually. Taxing chips, candy, soda and other 'junk' foods at the time of purchase in convenience stores and grocery stores would generate additional millions.

C) An employer-mandated contribution into the subsidy pool for employers who do not sponsor a group benefit plan is the third potential area of revenue. We have significant concerns of the burden this will place on the business community and believe it should only be implemented as a last resort.

7) Creating a Public/Private Health Care Connector

To address enrollment and access to health care coverage issues, we support the creation of a ***Public/Private Health Care Connector***. The connector would be created in a combined effort between established health care professional organizations such as CSAHU and CGIA, and the Colorado Division of Insurance. A limited agency/website would be

³⁵ Michael F. Jacobson, Ph.D. "Liquid Candy How Soft Drinks Are Harming Americans' Health."

created with the **Health Care Coverage Matrix** with links to public entities such as Medicaid and CHP.

Individuals and businesses looking to purchase coverage would be referred through a directory of approved health insurance professionals that have demonstrated proficiency in both individual and small group market knowledge and licensing.

The accreditation to participate in this process would be provided by Continuing Education Credits earned through membership and participation of these various established professional organizations. The cost to administer the Connector would be funded in part by fees paid by each producer licensed and registered to participate.

With a mandate to purchase health care coverage in place, Colorado residents can then be expected to show proof of coverage when renewing a driver's license, registering a car or applying for other state programs. When an individual presents for care at a hospital or clinic, proof of coverage can be requested. If no coverage is in place, then the individual's personal information is sent to the Health Care Connector. The Connector could then verify eligibility for various programs and/or provide the information to a licensed professional who would then contact these individuals. If eligible for assistance, then the Connector would provide a waiver or voucher that the individual could use to either enroll in an employer sponsored plan or purchase coverage in an individual or a Core Benefits plan. This would also allow penalties such as the inability to renew a driver's license or register a car, as is required currently for auto insurance.

8) Creating cost distribution measures that will benefit all

The true concept of insurance is to spread the risk among the largest possible population. However, over the past 6 years Colorado's small group market has diminished by 180,000 individuals, nearly a 35% reduction. A recent study shows that 10% of the insured population account for 50% of claims dollars spent, while 70% account for only 10% of expenses.³⁶ As an insured pool grows smaller, the percentage of unhealthy lives increases and adverse selection causes rates to rise even more disproportionately.

When and if Limited or Core Benefit plans are introduced in to the market place, the healthy will accept a lower maximum amount of coverage and the unhealthy will not. For these reasons we recommend that the State of Colorado research, develop and implement a small group re-insurance pool.

³⁶ Milliman. *USA Health Cost Guidelines – 2001 Claim Probability Distributions.*

Many states including New Mexico, Connecticut, New Hampshire, Idaho, Arizona, Massachusetts and New York have established re-insurance pools to help distribute large claim costs more efficiently. Several other states including Washington are exploring the implementation of a reinsurance pool. While issues such as mandatory vs. voluntary participation by insurance carriers exist, greater success is possible if government participation is involved. If government participates by enrolling and subsidizing Medicaid eligible and LWW's, then private insurers will have greater incentive to participate as well.

Potentially, a reinsurance pool would retain 100% of a claim to a specific amount such as \$50,000. Between \$50,000 and \$100,000, 20% would be retained by the primary insurer creating incentive to follow through with best practices care management. From \$100,000 to \$200,000 10% might be retained. Then reinsurance would cover 100% from \$100,000 to the specified maximum of \$500,000 or a \$1,000,000.

Creating limited benefit plans that have a benefit maximum adjacent to the reinsurance "floor" allows for seamless extension of coverage into the reinsurance pool when necessary. Once enough public financing is being generated to support the subsidy pool of limited benefit plans, then funding catastrophic risk ceded into the reinsurance pool would be possible. At some point blending CoverColorado with the newly created small group reinsurance pool would also be possible.

While financing must be secured and in place up front to fund the reinsurance pool, there is relief in later years when the number of insured lives reduces. When fewer uninsured large claims are incurred at health facilities, uncompensated care will reduce resulting in lower government spending on the back end. According to the most recent Joint Budget Committee proposal for 2008, Colorado will spend approximately \$325 million in 2007 on uncompensated care.³⁷

9) Developing, promoting and rewarding administrative efficiencies

As stated earlier under Constraining Medical Costs, duplication of procedures and overuse of high-end procedures have driven up medical spending unnecessarily. We must establish a reasonable deadline for health care providers to switch to the exclusive use of electronic medical records. This step alone could cut administrative expense and help eliminate medical errors.

³⁷ Proposed Department of Health Care Policy and Financing Budget.
http://www.state.co.us/gov_dir/leg_dir/jbc/hcpbrf.pdf

Rewarding hospitals and doctors for applying less expensive, cost effective outcomes instead of encouraging more expensive procedures must also be explored. In 2005 Seattle's Virginia Mason Medical Center worked in conjunction with Aetna Inc., Starbucks, Costco and other major clients to re-evaluate several expensive procedures. When it came to treatment of back pain they realized that no standardized path was being followed. By working together, a standardized path was created and the percentage of MRIs being prescribed was reduced by a third, from 15.4% to 10%. In return Aetna agreed to increase Virginia Mason's physical-therapy reimbursements by 16% to compensate the hospital for lost revenue.³⁸

We must work to reduce or eliminate other inefficiencies and or barriers currently in place. Some of these include:

- Requiring the purchase of life insurance when purchasing health care coverage
- Imposing a 35% penalty on individuals and businesses for coming back into the fully insured market
- Requiring high employee participation in group coverage
- Excluding dedicated 1099 employees from group-sponsored health care coverage.

10) Establishing measures that allow the consumer to understand health care pricing - Establish a Uniform Pricing Model

The issue of transparency begins with the ability of the consumer/patient to know before receiving care the possible costs associated with that care. This knowledge of cost should encompass the simplest of office visits and certainly more expensive hospital and outpatient related procedures. Further, the consumer/patient should be able to access this information readily and easily.

One of the largest areas of cost-shifting to the privately insured markets, group or individual, comes from the underpayment of services by Medicare and Medicaid. A recent study published jointly by Blue Shield of California and Milliman found that this cost-shift amounted to \$951 (9.5% of premium) in additional annual premiums paid on a typical family policy at the end of 2004. In 2000, the premium attributable to this cost-shifting element was only \$213(3.6% of premium). As Medicare and Medicaid reimbursements have continued to increase at less than general inflation for the past two years, this figure could well be over \$1,000 annually (10+% of premium).³⁹

³⁸ Vanessa Fuhrmans. *Withdrawal Treatment A Novel Plan Helps Hospital Wean Itself Off Pricey Tests*. January 12, 2007.

³⁹ Managed Care Magazine, "Confronting the Medicare Cost Shift." Blue Shield of California and Milliman. December 2006, <http://www.managedcaremag.com/archives/0612/0612.costshift.html>

In an effort to break this cycle, we believe that provider reimbursements should be linked to a percentage of Medicare reimbursement. As the Medicare insured population will dramatically rise over the next several years, we cannot allow the continued cost-shifting to occur at increasing rates to those in the private markets.

Today's cost of care structure is tied to the numerous payment and reimbursement sources. These sources include Medicare, Medicaid, the Workers Compensation fee schedule and a different payment structure for each private carrier network operating in the State of Colorado. In addition to these, any care received outside of a mandated fee structure (Medicare) or negotiated reimbursement schedule (carrier networks) may be billed at almost any rate the provider chooses.

Carriers for proprietary and competitive reasons have not made available their negotiated reimbursement schedules in any large scale fashion. While the Medicare fee schedule may be available, it is not easy to find in the public domain.

Our proposal would tie all reimbursement schedules, negotiated or otherwise, to one common basis. Since Medicare currently covers more than 45 million Americans and the possibility of the federal government changing the fee structure it uses appears remote, we believe using the **Medicare Reimbursement Schedule (MRS)** as the basis for all health care reimbursement structures should be implemented for both private and public pricing models.

Colorado-based health plans insured by a Colorado filed commercial carrier would be required to utilize the MRS as the model for all Colorado providers receiving payment for a Colorado resident/insured. The carriers would reimburse all non-contracted providers at 120% of MRS. For example if they paid 120% of MRS for a specific procedure, then the consumer could find the procedure on an MRS schedule, do the math and understand what the out of network cost would be. This would replace the carriers' Reasonable & Customary schedule. This enables a publishable reimbursement level for all health plans and providers in the state.

A study of California reimbursement fees showed the average doctor reimbursement was 120% of MRS.⁴⁰

Additionally, this would help to address the par/non-par issue. Currently, when a consumer/patient receives care from a non-contracted out-of-network provider the carrier's reimbursement payment is based upon that carrier's Reasonable & Customary schedule. Any amount above the R&C schedule is still owed to the provider by the patient. By moving to a standard mandated non-network payment structure the patient is protected from exorbitant additional out-of-pocket costs. Additionally,

⁴⁰ Managed Care Magazine, "Confronting the Medicare Cost Shift." Blue Shield of California and Milliman. December 2006, <http://www.managedcaremag.com/archives/0612/0612.costshift.html>

providers will have further incentive to join a carrier's provider network where higher reimbursement levels will be available (see following paragraph).

For those providers willing to sign a contract with a carrier's provider network, the baseline reimbursement would be at 125% of Medicare (this would become part of the "Standard Provider Contract"). Providers and Carriers would be able to negotiate quality, transparency and outcome guidelines and measures to increase this reimbursement schedule. Based upon the contractual measures the maximum reimbursement level could increase to 150% of the Medicare Reimbursement Schedule. Carriers would be required to publish the reimbursement levels available for various procedures on their websites.

Further, carriers would be required to post the providers' attained quality status of their contracted providers as part of their online provider directory information. We would propose having four levels of quality measurements for the carriers to utilize. The associated reimbursement levels would be something on the order of:

- Level One- 125% of Medicare (Entry-Level)
- Level Two- 130% of Medicare (Average quality measure)
- Level Three- 140% of Medicare (Above Average quality measure)
- Level Four- 150% of Medicare (Superior quality measure)

Carriers should also be required to publish the quality measures being utilized in their grading of providers. These measures would be published with the differences noted by the provider's practice specialty. In the case of hospitals, the quality measures should be delineated and published for different practice areas within the hospital i.e., cardiac care, maternity, etc. The basis for the quality measures should encompass the utilization of "best practice" standards and where applicable, evidenced based practices. These guidelines should be implemented over a two-year period to allow for the gathering of the necessary data to grade the different providers.

We have chosen 150% of Medicare as the maximum allowed reimbursement as it is similar to the current differential between privately insured in-network reimbursement and Medicare reimbursement levels.

Linking the providers' reimbursement levels to Medicare and capping the differentials at today's levels would effectively eliminate future cost-shifting to the privately insured markets.

Additionally, linking reimbursement levels will focus future reimbursement concerns at the federal level - the source of this inflationary cost-shifting.

11) Creating a Coordinated Time Table that establishes who, when and how solutions are implemented and develops measures to recognize their effectiveness

While many ideas could be implemented in a reasonably short period of time, exact dates are not possible due to the procurement of necessary revenue and the constraints of the Tabor Amendment. However, we advocate that any reform adhere to the initial Requirements of Reform and meet the Five Indicators outlined earlier in this proposal.

Any reform outline should recognize the following:

- Consensus must be obtained between all interested parties for any reform to be successful
- Existing social programs should be reformed to better serve their specific populations and the providers that serve them
- A stable revenue source must be established to support any subsidy programs and reinsurance pool which are paramount to any reform agenda
- A personal responsibility doctrine must be espoused to encourage all Coloradans to accept the responsibility to obtain health care coverage
- Core Benefit plans must be designed and implemented along with any subsidy programs necessary to guarantee coverage for all
- Cost and transparency must be addressed immediately and continuously
- Establish the measures to gauge achievements.

Conclusion

What is access to health care coverage? The reality is that doctors and medical facilities abound throughout our state. When necessary, Coloradans who present themselves to a hospital or doctor for treatment will receive care. The ability to pay for that care and any additional services needed are the real issues. Recognizing that regardless of whom the payer is - individual, government agency or insurance company - controlling the cost is what must be addressed.

NBC's today Show on Wednesday April 4, 2007 ran a report on the price drop of generic Zocor. They reported that the average cost of generic Zocor is now averaging \$38 per prescription. Lipitor which is not currently available as a generic medication averages \$241 for the same 90 day supply. Both medications are under the category of statins, which are used to control cholesterol. Should consumers have the choice of these two medications? Do they both claim to do a better job of reducing cholesterol? When the less expensive drug is appropriate, should it be recommended? Yes, both claim to do a better job of lowering cholesterol. We believe that one should have the choice of both, and the less expensive should be recommended when appropriate. This illustrates the

impact of both cost and competition as it applies to the health care industry today.

Without competition, recent medical and pharmaceutical advancements would not have occurred. Government should regulate industry to assure honesty and integrity in the marketplace. Government should also recognize that health is a personal responsibility that, to a degree, can be controlled and maintained. And it should neither compete with, nor abrogate, the private sector needlessly.

Proposal Three: A Plan for Covering Coloradans submitted by the Committee for Colorado Health Care Solutions

(a) COMPREHENSIVENESS

(1) What problem does this proposal address?

In many ways, America has an exceptional health care system, with caring providers, modern facilities, advanced technology, and dynamic research projects that are discovering so many new interventions that it's hard to keep track of them all.

Yet at the same time, Coloradans express great concern over the parts of our health care system that are not working. Historically, efforts have been made to “tweak” the system, but the health care system is tremendously complex, and small changes are not creating the changes that people realize need to be made.

For that reason, we have reached the point in our state where it is critical to tackle comprehensive health care reform – reform that will change not just one or two parts of the system, but because those parts are inextricably linked to one other, reform that makes multiple, linked changes intended to address the following problems:

- A. Spiraling health care costs, resulting in the inability to afford health care, which affects the middle class as well as those with low incomes
- B. Over 768,000 people living in Colorado without health insurance, most of whom do not have the financial reserves to protect them in case of moderate to major health expenses
- C. Unnecessary administrative costs which divert dollars from care
- D. An insurance system which has drifted away from its original goal of assuring that we are protected when we get sick
- E. A health care delivery and payment system that is not always aligned towards the most appropriate interventions nor the most coordinated care, causing fragmentation and restricting the actions most likely to lead to the highest efficiencies and the best health outcomes
- F. Barriers to achieving health information technologies and other measures that could be increasing the quality and safety of care

(2) What are the objectives of your proposal?

- A. Create a fair system in which everyone is covered by affordable health insurance
- B. Retain what works best in the current system but change what does not work well
- C. Contain the growth of health care costs

(b) GENERAL

(1) Please describe your proposal in detail.

Introduction

It is our belief that transformation at a national level is required in order to create the highest performance American health care system, one that is affordable and accessible to all. However, there is much that can be accomplished at a state level, and progress at the state level can inform national efforts. It is in this spirit that this proposal is submitted. It aims to address the core issues detailed above by introducing significant changes in many aspects of our current approach to health care in Colorado. The proposed changes emanate from both the Guiding Principles of the Blue Ribbon Commission for Health Care Reform and an additional set of principles developed by our committee in the course of its work:

Our Guiding Principles

- 1) Health care is a right, not a privilege, and all essential health care services should be affordable for all Coloradoans.
- 2) Although a single payer system may be the solution that would contain costs most effectively, there are tradeoffs in moving from the current U.S. system to a single-payer system, which could cause significant disruption and employment shifts. At the current time, it may be unrealistic to think that we can eliminate the current separation between the public and private systems, particularly at the state level, but it is critical that we improve and administratively simplify each system.
- 3) Because the current upward spiral in health care costs is unsustainable, compromises will be required on everyone's part to bring costs under control.
- 4) Though the problem is complex, our goal is to design a system that is easy to understand, administer, and implement.
- 5) Significant change is required and a comprehensive vision and long-term commitment is vital. Change efforts must consider impacts across other systems as well as in health care.
- 6) The most promising way to address both coverage for all and reduced cost is likely in the restructuring of the system at the national level. Our state should bring strong pressure at the federal level to push for a national system that would assure coverage for all and address access, cost and quality.

Although our group developed guidelines as we deliberated, we would recommend that a more formal process be used when a final health care plan is being chosen for Colorado, one which carefully develops an approved ethical framework for future decision. The justification for such a foundation has been developed by the Center for Bioethics and Humanities at the CU Health Sciences Center, and is included as Appendix A.

Goals of our Plan

- 1) Provide access to health insurance for all Colorado residents
- 2) Spread risk more evenly
- 3) Maximize federal matching funds
- 4) Reduce government, provider and issuer administrative costs
- 5) Target changes with the potential to improve health outcomes and contain costs

Key Elements of Our Proposal

Insurance Reform Measures

***Designed to enhance fairness, reduce cost, and stabilize the private market
(through risk pooling)***

- 1) Retain the private insurance market, but change it through the creation of a pooling mechanism through which issuers offer coverage and purchasers buy coverage, to include all issuers, individuals, and employers (except those exempt from state regulation who choose to offer self-funded coverage)
- 2) Create an independent, quasi-governmental Authority with a governance board responsible for setting policy and standards, and an administrative structure to manage the pool.
- 3) Provide assistance in purchasing health insurance for those who cannot afford the full cost

Revenue Enhancing Mechanisms

Designed to assure shared responsibility and adequate funding

- 1) Expand eligibility for Medicaid and Child Health Plan Plus to take advantage of federal matching funds
- 2) Set a reasonable employer assessment with a waiver for employers who provide adequate insurance coverage to their workers
- 3) Set an expectation that everyone will purchase coverage, with assistance for those unable to afford the full cost
- 4) Capture funding made available by the changes
- 5) Create new assessments to make up the difference in required revenue levels

Quality and Cost Control Mechanisms

- 1) Create incentives to further integrate care
- 2) Promote rapid development of Health Information Technology
- 3) Align incentives for and reward quality
- 4) Standardize forms and billing and payment systems
- 5) Create a comprehensive benefit package as the minimum for coverage
- 6) Promote “medical homes” and patient-centered care
- 7) Improve management of high-cost conditions and chronic disease

Our reform proposal is based on the premise that, if the approach is to improve our current system, attaining health coverage for all is a shared responsibility of individuals, employers, providers, insurers and the state. The state’s responsibility is to assure that affordable health insurance is available to everyone by creating funding for those for whom financial contribution is not possible, to simplify administrative processes, and to assure survival of the safety net. The employer’s responsibility is to contribute to coverage for their workers and families. The provider’s responsibility is to design and deliver

integrated systems of care, which are efficient and effective. The insurer's responsibility is to reduce administrative cost by simplifying offerings. The insurers and providers also have responsibility to provide the transparency and the innovation that will foster competition based on quality, satisfaction and cost. The individual's responsibility is to enroll in and pay a fair share of the premium of an affordable health plan for themselves and their family.

Insurance Reform Measures

Improving affordability is key to expanding health care coverage to all Coloradoans. The first component of our coverage strategy is to simplify the private insurance market, make it more competitive and create a means to make private insurance premiums affordable for individuals and families.

Creation of a Single Health Insurance Market

Currently, private health insurance is offered in several different "markets", primarily the individual market, the small-group market and the large-group market (see Appendix D). Each of these groups has different characteristics that have resulted in insurers treating them differently in terms of marketing, pricing and underwriting. We propose to eliminate these differences by combining all of these groups into one "market" in the form of a selling and purchasing pool. The following paragraphs describe this pooling concept.

Private insurers wishing to issue policies in the state of Colorado will have to provide them in the pool. Insurers will be required to guarantee issue and renewal of coverage and will be restricted from basing their premium rates on any attributes related to health status or risk (i.e., pure community rating would be required). Requiring insurers to issue coverage and set premiums without regard to health status assures that those who need coverage the most can get it, but without other protections, these rules can lead to healthy people leaving the market and higher quality plans attracting sicker enrollees (adverse selection). To protect the private market and individual health plans from adverse selection, all Coloradans will be expected to have insurance (see below) and the private insurance pool will administer a "risk equalization" mechanism for participating plans. An insurer must charge the same premium to all enrollees of a given health plan, whether or not they have preexisting conditions, but the insurance pool authority will use claims data to adjust payments to the plans to account for differences in the average risk of their enrollment pool. "Risk adjusted" payment is an incentive for health plans to compete solely on efficiency and quality and not on recruiting healthier enrollees.

Any individual or employer seeking health insurance through the private market will go to the pool to get it. Self-employed individuals and workers whose employers do not

offer coverage may enroll themselves and their families in the pool. Employers will combine their contributions with that of their employees and pay that to the pool. The insurance pool will provide portability of coverage when people move between jobs and allow dependent young adults to be covered under their parent's policies until they are 26 years old. In order to expand the size of the pool and realize some economies of scale, we are proposing that classified state employees be included in the pool.

To make the process of comparing and selecting plans simpler for consumers, there will be a limited set of standardized benefit packages, perhaps six to ten, from which to choose. All packages will have to cover a comprehensive list of essential services but may vary based on the characteristics of their provider networks (e.g., HMOs, PPOs) and the co-payments and deductibles allowed. Consumers will be able to compare products by price, the provider network and customer service ratings.

All employers will be required to allow workers to pay their share of premiums through a payroll deduction and establish Section 125 plans to allow employees to shelter their payments from taxation. The pool administrators will provide participating employers with information, a standard plan document, and enrollment forms to set up their own premium-only Section 125 plans for their employees.

With guaranteed issue/renewal, community rating, one large purchasing pool, standardized benefit designs, and a risk equalization mechanism for private health plans, there will no longer be a need for the state's high-risk plan, CoverColorado.

Creation of an Independent Public Authority with a Governing Board

The pool will be administered by a new public authority called the Colorado Health Insurance Purchasing Authority. We recommend that an independent board—the Authority Board—be created to govern the purchasing pool and the premium assistance program. The Authority Board will:

- define the minimum benefit package (see section (g))
- define and periodically update the set of standard benefit packages based on evidence of effectiveness and cost-effectiveness
- define and certify “high-value” providers
- define the requirements for participation of plans in a premium subsidy program
- define and periodically update an affordability standard below which individuals will be eligible for premium assistance described in the following section.

See section (b)(5) for complete description of the Authority Board and its responsibilities.

Provide Assistance in Purchasing Health Insurance for Those Unable to Afford It

Low to middle income individuals and families will be able to participate in a premium assistance program. The Board will define two benefit packages (similar to CHP Plus) that insurance carriers can offer those who elect and are eligible for premium

assistance. Both will have low deductibles, first dollar coverage for preventive services, minimal or no co-payments for chronic disease medications, and lower cost-sharing for use of safety net providers and other “high-value” providers. At least one plan will be an HMO (subject to geographic availability). The Authority and insurers will negotiate a benchmark premium for the subsidized plans. These plans will also be available at full cost to those not eligible for subsidies.

Based on available data on affordability (Glazner, 2000) (Dubay, Holahan, & Cook, 2007), our recommendation would be to provide full premium subsidies at family incomes at or below 200% of the federal poverty level (FPL) and slide up to full cost above 400% FPL. The value of the premium subsidy would be a function of income and family size. The net cost of a premium for low to middle income individuals and families would be the difference between the premium subsidy (plus the employers contribution if offered) and the benchmark premium.

Pool administrators will enroll individuals in the plan they choose and determine their eligibility for premium assistance. The Authority will collect payments from individuals and employers, combine them with subsidies from a premium assistance fund if enrollees are deemed eligible, and pay the insurance plans their premium, adjusted up or down based on the plan’s risk pool.

Insurance plans will have to meet standards established by the Authority to offer subsidized insurance to assure that public funds are directed to high value plans. We recommend inclusion of safety net providers, evidence of integration of provider networks (e.g., information sharing technologies, large multi-specialty groups, hospital-physician alliances) and of cost and quality management (e.g., use of formularies, disease-state management guidelines, performance measurement and feedback) be requirements for these plans. These standards would be gradually phased in to include all plans in the pool.

Employers offering health coverage that are self-insured will have the option of paying their contribution to the pool on behalf of their income eligible workers who choose to enroll in one of the pool’s subsidized plans. Alternatively, if the health plan benefit package offered by the self-insured firm meets minimum criteria established by the board, employees may apply for a premium assistance through the purchasing pool. While provision of premium assistance for self-funded employer sponsored insurance will require considerable administrative support and subsidies, it will reduce crowd-out and therefore generate savings in the Medicaid programs and not providing it would be unfair and potentially self-defeating.

Revenue Enhancing Mechanisms

Expand Eligibility for Medicaid and Child Health Plan Plus

Our plan will expand and administratively simplify Colorado’s Medicaid and State Children’s Health Insurance programs (SCHIP; Colorado’s program is titled CHP Plus). Such an expansion would provide comprehensive health benefits to the lowest income and most vulnerable Coloradoans. A key reason for expanding coverage through these public programs is to take advantage of federal matching funds that will maximize the effectiveness of Colorado’s contribution to health care for these groups. (See Appendices B and C for background on public coverage).

Table 1: Proposed Expansion of Eligibility for Public Programs Based on Income (FPL)

#	Age or Population Group	Current Eligibility	Expansion Proposed (FPL)
1	Children ages 0-5 years	133% (Medicaid) 200% (CHP Plus)	300%
2	Children ages 6-19 years	100% (Medicaid) 200% (CHP Plus)	300%
3	Pregnant Women and New Mothers	133% (Medicaid) 200% (CHP Plus)	300%
4	Parents of eligible children	60%	300%
5	Non-disabled adults without children	--	100%
6	Disabled working adults	--	300% buy-in
7	65+	74%	100%
8	Medically needy	--	50%
9	COBRA Premium Assistance	--	100%
10	Severely disabled children	--	HCBS waiver eligibility

FPL: Federal Poverty Level

CHP Plus: Colorado’s Children’s Health Insurance Program, Child Health Plan Plus

HCBS: Colorado Medicaid Home and Community Based Services

We recommend combining Medicaid and SCHIP (CHP Plus) into one program and streamlining the application and renewal process for families. Combining SCHIP with Medicaid has been shown to dramatically increase the level of enrollment in SCHIP (RAND Corporation, 2005). Currently, Medicaid has different income eligibility rules for family members depending on age (see Table 1, groups 1-4). In a family of three, a 5-year old child might be eligible for Medicaid, the 7 year old for CHP Plus, but the mom can’t enroll in either program. Parents are more likely to enroll their children if they are able to enroll themselves (Schneider, Elias, & Garfield, 2002). Therefore our plan focuses on entire families rather than only children. Our proposal will:

- remove the income eligibility “steps” for families (groups 1-4) by increasing eligibility for kids and their parents to 300% of the federal poverty level (FPL), phased in over two years. Families below 200% FPL will be covered with the Medicaid benefit package. Those between 200% and 300% FPL will be given a CHP-like benefit package.
- offer Medicaid coverage to non-disabled adults without children (group 5) up to 100% FPL using state-only dollars unless a waiver is approved by the federal Center for Medicare and Medicaid Services to cover these individuals under the federal program. Because poverty is associated with a whole constellation of needs, we believe this group is best covered by the comprehensive wrap around services of Medicaid.
- expand eligibility to the elderly and disabled by:
 - Raising the eligibility limit for Coloradoans who receive Supplemental Security Income (group 6) to 100% FPL; and
 - Establishing a Medicaid sliding fee “buy-in” for working people with disabilities (group 7) up to 300% FPL through the federal Ticket to Work and Work Incentives Improvement Act of 1999. Ticket to Work will allow them to receive access to critical personal assistance and other health and employment services.
- add a medically needy program under Medicaid which will allow children up to age 21, parents, disabled and elderly persons whose incomes are above Medicaid eligibility standards to obtain Medicaid coverage if high medical expenses drop their income to less than 50% of the FPL.
- seek federal matching funds to pay COBRA premiums for people between jobs with minimal assets (group 9) whose income is below 100% of FPL. (Due to data limitations this provision was not modeled by The Lewin Group).
- Expand coverage to all severely disabled children who qualify under Colorado’s Children’s Home and Community Based Services and Children with Extensive Support waivers (group 10). (Due to data limitations this provision was not modeled).

To assure access to services under this expansion, health care provider participation in Medicaid will need to increase. Current low Medicaid reimbursement rates in Colorado are a major barrier to participation. For modeling purposes, we propose increasing payment rates to Medicare levels.

Set a Reasonable Employer Assessment

In order to “even the playing field” for employers who offer coverage, to provide an incentive to sponsor coverage for those who don’t, to reduce incentives for “crowd-out”, to fund the subsidized premiums to those in the pool who do not have access to employer based insurance and to reach near universal coverage, employers must either offer coverage or pay an assessment. Given current case law regarding the Employer Retirement Income Security Act (ERISA) and the complexity of ERISA itself, we believe that the fee should be low enough that it does not unduly burden employers who now offer benefits, but spend relatively little on them. This group is most likely to challenge fees that are too high. Setting an appropriate fee should depend on the characteristics of employers in Colorado, taking into account their unique situation, particularly with respect to the amounts they spend on benefits and the characteristics of their workforce. Fee setting should therefore be assigned to the Authority Board. For the purposes of the analysis by

The Lewin Group, we propose that the assessment be \$347 per year per full-time equivalent worker not offered coverage meeting or exceeding the minimum benefit standard (see Section (g)(1)). Employers must contribute at least 85% of the median premium cost of a standard individual plan to be eligible for a waiver. All employers would be required to set up “Section 125 plans” so that workers could purchase health insurance with pre-tax dollars. Business groups of one and the federal government will be exempted.

Set an Expectation that Everyone Will Purchase Coverage

The combination of expansion of Medicaid/CHP Plus, insurance reforms, the group purchasing pool, premium subsidies and an employer mandate will raise coverage rates considerably, but will not lead to coverage for all. The only way to do that will be to combine these strategies with a requirement for all individuals and families to have a defined level of coverage meeting or exceeding the minimum benefit standard, phased in over two years for all residents. We hesitated to recommend an individual mandate because of our respect for individual liberties; however, we recognized that not requiring insurance would raise the risk of adverse selection. Also, experience has shown that premium subsidies would have to be very large to raise coverage levels substantially if coverage was voluntary (Reschovsky & Hadley, 2001).

Facilitated enrollment mechanisms will be used to presumptively identify and enroll those eligible for public programs—for instance, participation in other public programs such as food stamps or school lunch programs will automatically enroll individuals in Medicaid/CHP as applicable. Automatic enrollment mechanisms could be phased in for those who do not voluntarily enroll. Evidence of insurance will be required as part of the state income tax filing process. Individuals and families who are not insured but appear to be eligible for Medicaid will be presumptively enrolled. Individuals and dependents who are not insured and do not appear to be eligible for Medicaid will be assessed a fee by the Department of Revenue equal to the cost of the annual premium in the least expensive pool plan, or if they appear to be eligible for premium assistance, the individual or household’s portion of the annual premium, and provided plan selection and enrollment information.

Create New Assessments to Make Up the Difference

New sources of funding will be required for the expansions of Medicaid, the operations of the Authority and the Premium Assistance Fund. For the purposes of modeling, we propose:

- an employer assessment as described above.
- a premium assessment on insurers. This would redistribute a portion of insurer’s administrative costs savings under the proposal to the premium assistance fund.

- a health services (provider) assessment designed to recover a portion of the increase in reimbursement due to decreased uncompensated care under the proposal.
- Increases in alcohol and tobacco taxes.

Quality and Cost Control Mechanisms

Create Incentives to Further Integrate Care

Controlling costs, protecting patient's safety and enhancing the quality of care for all require coordination of care across the continuum and the alignment of incentives among patients, physicians, hospitals and other components of the health care system. We recommend that the Health Care Policy and Financing Department and the new Health Insurance Purchasing Authority in Colorado support the growth and development of vertically integrated health care delivery arrangements. The state should vigorously pursue strategies to support the reestablishment of Medicaid managed care plans in the state. That starts with paying actuarially sound rates to ensure plans and providers participate. The state must ensure adequate financing for safety net providers including allowing public safety net managed care providers to seek federal financial support through Medicaid financing mechanisms such as Certification of Public Expenditure. We recommend moving Medicaid enrollees into managed care organizations with integrated provider networks where available, through automatic "default" or "passive" enrollment. The state should explore ways to support the development of regional integrated models of care in major metropolitan areas utilizing safety net providers (community health centers, public/non-profit hospitals, public health departments, and school-based clinics) similar to Denver Health. Managed care contracts should have built in incentives for cost reduction and quality improvement—i.e., a base capitation rate with incentive payments to networks or providers for improvements in quality indicators. The Lewin Group did not model the effects of promoting managed care in the cost analysis.

Promote Rapid Development of Health Information Technology

Current fragmentation in care causes inefficiencies and increases costs and errors. Providing incentives for more efficient care will require data, information systems including electronic health records (EHRs) and processes for sharing information. However, the adoption of health information technology in ambulatory care environment has been slowed by the considerable capital investment required, needs for technical assistance and distrust of technology. Rapid deployment of health information technology will require state action. We propose that the Colorado Department of Health and Environment be funded to create an Office of Health Information Technology (OHIT) whose responsibilities are to 1) create standards of interoperability, 2) solicit bids for and certify a limited number of EHR product licenses that include essential elements such as stability, technical support services, registry functionality, tracking and reminder systems, evidence-based decision support and interoperability and 3) provide technical assistance to providers who are selecting systems. The infrastructure for information exchange is being developed in Colorado

(Colorado Regional Health Information Organization) but to be fully functional, all providers will need electronic health systems to communicate with each other. We recommend that the state identify opportunities to foster growth of information infrastructure such as offering grants through the OHIT, or providing tax credits, for implementing OHIT-certified electronic health record systems.

The state could remove barriers to the use of data to drive performance. Multiple reporting obligations are a burden for physicians. We suggest that coordination between payers be required. The state health insurance purchasing pool will provide a venue for coordination within the private market.

Aligning Incentives For and Rewarding Quality

There are currently both public and private initiatives in Colorado to improve quality and value in health care delivery by adopting clinical guidelines and holding physicians and hospitals accountable for delivering care according to guidelines through performance reporting and other incentives⁴¹. The Authority Board will be charged with convening these and other stakeholders to select robust outcome measures, preferably related directly to patient-oriented outcomes rather than process measures wherever possible, and determining how accountability is allocated. Incentives would likely include both enhanced capitation rates and higher fee for service rates where appropriate.

Standardize Forms and Billing and Payment Systems

Insurance related costs burden physicians and hospitals. Billing-related administration costs were estimated to account for 20% of private health care expenditures in California (Kahn, Kronick, Kreger, & Gans, 2005). The lack of coordination in credentialing, contract negotiation, and measuring quality is also costly. We envision the Authority bringing all stakeholders together to create a single viable, simple billing and payment system, standardize forms and codes, and require insurers to streamline and simplify processes to lower administrative burden for providers. Electronic claims must be utilized by all insurers and providers.

Utilize a Preferred Drug List for Medicaid and Capture 340b Drug Pricing

Pharmaceutical costs have been a substantial part of health care expenditure inflation. We recommend the adoption of an evidence-based preferred drug list for Medicaid and for the subsidized health plans. High quality evidence on effectiveness and cost-effectiveness will be needed. The state should consider contracting with Oregon's Center for Evidence-based Policy to use the Oregon Health Plans list like several other states have done. Our plan would also maximize use of federally qualified health center

⁴¹ Kaiser-Permanente, PacifiCare, Anthem BCBS, Colorado Business Group on Health, Colorado Clinical Guidelines Collaborative, Colorado Foundation for Medical Care, COPIC Insurance Company are examples.

and disproportionate share hospital pharmacies and require Medicaid enrollees to purchase their prescriptions at 340B in order to capture federal drug pricing.

Create a Comprehensive Evidence-Based Benefit Package as the Minimum for Coverage

The list of standard benefits will be determined and periodically updated by the Board based on preponderance of best available evidence of effectiveness. We propose that in general, all plans will cover prevention and early detection services, office visits, hospitalizations, ambulatory procedures, emergency care, diagnostic services, contraception and maternity care, physical, occupational and speech therapy, prescription drugs, mental health services, substance abuse treatment, limited dental, vision, hearing and podiatry care, home and hospice care and medical supplies and equipment. We suggest that over the initial two years, the Authority Board, using evidence-based medicine, create some limitation on hospitalization, procedures and tests so that we begin to impact on the overuse and misuse of services, which have been well documented.

Medical Homes and Patient Centered Care

A “medical home” is an approach to providing primary care which is comprehensive, continuous, coordinated, accessible and patient-centered. When care is patient-centered, considering patients’ preferences and values, and coordinated within a designated primary care “medical home”, unneeded, unwanted and duplicative services can be reduced. Patients often lack information about the risks as well as benefits of alternative treatment choices. They often receive little instruction or support to manage their care at home and are frequently left out of end-of-life care decisions. Patient-centered care in a “medical home” ensures that patients collaborate in making clinical decisions, are provided the tools they need for self-care, and experience coordinated and efficient transitions in care. There are actions the state can take to support initiatives that embrace these fundamental changes to the care delivery system. We recommend that enrollees in both the public programs and private plans through the pool be enrolled in primary care medical homes. Payment incentives to encourage and support physician practices that take such patient-centered care approaches should be piloted and adopted if shown to be cost-effective. We also recommend that certain information and decision processes be required and documented. For instance, documentation of advance directives should be required at or prior to the time of admission to a nursing home. For those without access to a medical home we recommend the development of a statewide 1-800 consumer nurse/doctor line available “24/7”.

Addressing High-Cost Care and the Increasing Prevalence of Chronic Disease

The cost containing recommendations we have made, to the degree that they address inefficiencies and waste, will deliver one time savings in health care expenditures. But the two major cost-drivers that have contributed to increases in health care spending

are: (1) a rise in treated disease prevalence (63% of increase), caused by changes in population factors (e.g., obesity), changing treatment thresholds (treating diseases that were not treated in the past) and innovation; and (2) a rise in spending for treated cases, caused by technological innovation (37%), (Thorpe, 2005). Absent massive restructuring of administration of the health care enterprise, we believe that the most promising methods of containing costs are, (1) increased management of high-cost cases and end-of-life care, including eschewing services considered to be futile; and (2) reducing obesity, which has been identified as one of the two major contributors to increase Medicare costs. These two items address two well-documented sources of high medical costs across the health care system. Addressing these would be long-term efforts.

Given that 10% of all patients account for 70% of health care costs, finding more effective ways to manage care for those with chronic and serious illness is critical in containing costs. There are proven approaches for management of high-cost complex cases and addressing high end-of-life expenditures. HMOs or other organizations responsible for the overall health of their enrollees can more easily adopt programs for high-cost case management. Some models of this have been found to be effective in reducing costs (Villagra & Ahmed, 2004; Crosson & Magvig, 2004).

More than half of all adult Medicaid enrollees have a chronic or disabling condition (Williams, 2004) We propose that the Medicaid program contract with and provide reimbursement to agencies that develop case management programs designed for Medicaid's disabled and chronically ill populations, similar to their current asthma program. Reimbursement could be tied to demonstrated cost savings. Similarly, we recommend that in the Purchasing Pool, high-cost patients and patients with certain chronic diseases are identified and enrolled in case management programs. In addition, organizing care around the "Chronic Disease Model" has been effective at improving care processes and short-term outcomes with certain chronic conditions and is a key attribute of a medical home. There are current efforts underway in community health centers and in private clinics in Colorado to implement this model. Incentives such as pay-for-performance or reimbursement for group, e-mail and phone visits, if found to be cost-effective, would support these efforts.

Obesity is clearly a growing problem and appears to be intractable. It is likely that a combination of efforts focused on radical transformations in individual behavior that will be impossible to achieve without simultaneous policy, social and cultural change. We did not come up with a strategy to address this problem in the context of state health care reform, believing the greatest impact will come from investing in public health initiatives. For instance, there was strong interest in our group in efforts to modify the school environment and curriculum to address the epidemic of childhood obesity and we noted

that recent research has found that the most important factor is preventing obesity is the presence of a full-service grocery store in the neighborhood (Powell, Ault, Chaloupka, O'Malley, & Johnston, 2006). States and municipalities have measures at their command to provide incentives for such interventions. Certainly, investigation into other possible mechanisms for reducing obesity is important.

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

Who Benefits: All state residents will benefit from the guarantee of affordable health care coverage and the assurance that they will be able to continue coverage if/when their health declines or their employment status changes. They will also benefit from a more conscious, rational, transparent system of care that aims to improve quality, reduce costs, and maximize Coloradans' share of federal tax revenue. Those whose incomes are not adequate to be able to afford the full cost of health care coverage (which now reaches into the middle class) but who do not currently qualify for government programs will benefit because they will receive assistance in purchasing coverage, and will have access to comprehensive benefits including preventive care. Businesses will benefit by the creation of a more even playing field and possibly from more affordable coverage. Insurers and providers will benefit from less administrative burden, less cost shifting, and for providers, significantly more patients with coverage and higher Medicaid reimbursement. Other key benefits include: time and resources saved from simplification of plans and forms (consumer, employer, plans, providers); health, quality of life and resources gained from access to comprehensive benefits (families, communities, state government); and those with the most complex/high cost health care problems and their families will benefit from assistance in coordinating their care.

Those for whom changes may be either a benefit or a detriment: There will be adjustments in the allocation of resources throughout the system, resulting in different economic impacts on different people and organizations. This proposal has the potential to reduce some jobs in some sectors, particularly the insurance industry and provider billing staff, although it is anticipated to increase jobs in others (employees of the pool, care managers, staff of the Colorado Health Insurance Purchasing Authority), for which the skill sets of insurance employees would be valuable. Individuals who have not accepted insurance when it's offered in the past will eventually be expected to take it and to pay their fair share (with assistance for those who cannot afford the full cost) and may experience increased costs. Others who have suffered from ill health and paid significantly more for their insurance or for out-of-pocket expenses will find that their costs will decline. Those businesses who have not contributed to their employees' coverage will be expected to offer insurance or pay a fee, yet other small businesses whose insurance was very

expensive and who had to spend significant amounts of time researching their options will have access to a simpler system, and will likely be able to offer more affordable insurance. While this proposal has advantages for insurance companies (maintaining the private market, having lower administrative costs due to less complexity in plans and forms, no medical underwriting, and an increased market of covered lives), they will have less opportunity to create diverse products. And although under this proposal providers will likely find it important to move more quickly towards technology, such as the use of electronic health records with immediate access to decision support based on clinical guidelines, and may have to remit an assessment on collected fees, they will benefit from receiving reimbursement for functions that are critical for both health and cost control, such as prevention and care management and from the simplification of plans and forms.

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

The most important difference is that all residents, regardless of their income, ethnicity, or health status, will have access to comprehensive coverage at affordable rates.

Low income and lower middle income: Premium assistance will be provided for those unable to afford the full cost of coverage, significantly decreasing both the number of uninsured and the chance that care will be inappropriately delayed.

Rural: Residents in rural areas, as throughout Colorado, will benefit from the creation of the statewide 1-800 consumer nurse/doctor line. Since the availability of providers and medical homes is limited in rural areas, the nurse/doctor line will assist residents in determining when it is important to seek care. While this proposal does not specify mechanisms for other changes specifically designed to benefit rural areas, we have included a list of possibilities that could be considered in Appendix D3.

Ethnic minorities: Coverage for all is the single most important element to enhance access for minorities, but having coverage available will not insure that it is purchased or used. Hispanics in particular are disproportionately represented among the uninsured: “although about 20% of the state’s total population identified themselves as Hispanic in 2005, Hispanics accounted for more than 40% of the state’s uninsured population in 2005” (Colorado Health Institute, 2006a) (Colorado Health Institute, 2006b). Since even the concept of health care coverage has cultural implications, culturally sensitive and effective outreach and enrollment will be essential for the success of this proposal. Over 300,000 Hispanics would be entering the health care coverage system under this proposal, and although not directly addressed in this proposal, the state should also seriously consider enhanced efforts to increase diversity in health care providers and to assure additional cultural competence training for all providers. Minorities other than

Hispanics make up a much smaller proportion of the uninsured, but several culturally sensitive approaches would need to be developed to meet the needs of diverse cultures. Of those who are uninsured, those who identified themselves as non-Hispanic Black accounted for 3%, non-Hispanic Asian 2%, non-Hispanic multiracial 1%, and non-Hispanic American Indian 1%. (Colorado Health Institute, 2006a) (Colorado Health Institute, 2006b). See Appendix D2.

People with Disabilities: Those who are disabled and currently are eligible for Medicaid will continue to have comprehensive benefits, and will be protected from the “bare bones” policies and inappropriate cost sharing being proposed by some policymakers. One of the worst gaps in health care coverage in Colorado, coverage for those who are on the Aid to Needy Disabled program awaiting determination on eligibility for SSI (Supplemental Security Income), will now become covered. Our plan raises the Medicaid eligibility limit for disabled and elderly Coloradoans who receive SSI from 74% to 100% FPL and establishes a Medicaid sliding fee scale buy-in for working people with disabilities up to 300% FPL, so that those with disabilities can be on the Medicaid plan, which offers enhanced benefits, rather than going into our standard plan for those who are receiving assistance. This plan adds a Medically Needy Program under Medicaid, which allows children up to age 21 and their parents, as well as disabled and elderly persons whose incomes are above Medicaid eligibility standards to obtain Medicaid coverage if high medical expenses drop their income to less than 51% FPL (this is a federal limit; to raise it would require a federal waiver). Our plan also calls for increased funding to provide services to all severely disabled children who qualify for Colorado’s Children’s Home and Community Based Services Program and Children with Extensive Support waivers, eliminating waiting lists for these critical services. Finally, the inclusion of preventive care and treatment for mental illness and substance use disorders at affordable rates will contribute to early identification and treatment of a variety of disorders, and can reasonably be expected to decrease disabilities in the future.

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

Among the core elements of our approach to covering all Coloradoans, the private insurance market strategy we propose has never been implemented in the US. Organizing the entire private insurance market (with the exception of self-insured plans, which are governed by federal law) within a purchasing pool, and providing premium subsidies to low- and middle-income individuals and families in the context of an individual mandate is an unusual approach and we believe it is suitable for Colorado’s particular needs. Vermont has taken a similar approach but without an individual mandate. In general, premium assistance program demonstrations without mandates have found that

the subsidies must be very high (>60%) to induce the uninsured to take up insurance (Yondorf, Tobler, & Oliver, 2004). Voluntary purchasing pools without premium subsidies have not been shown to increase coverage (Burton, Friedenzohn, & Martinez-Vidal, 2007),(RAND Corporation, 2005),(Wicks, 2002).

Employer responsibility legislation has been implemented in four states, two cities and a county (Families USA, 2006). A concern is that these laws may violate the federal ERISA law. Most ERISA experts believe that state laws can work around ERISA constraints (Butler, 2006). We discuss this in section (b)(1) and in next section.

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

Governance: Colorado Health Insurance Purchasing Authority Board: The workings of a health care system are extraordinarily complex, and significant changes have wide-ranging impact. Ideally, those changes would be made only after careful analysis by a neutral, expert board. We propose that a new board be established, whose purpose would be to formulate policy ensuring that all people in Colorado have adequate, affordable health care coverage provided in the most cost effective manner possible. In particular, the Authority Board would:

- 1) Commission a periodic study to project the cost of coverage, review what people in Colorado in various circumstances can truly afford, set an affordability standard (what the individual or family would be expected to contribute towards the cost of their coverage), then set the levels at which assistance will be provided to them. This objective analysis will determine the funding necessary for adequate assistance levels, which will be entered into the state budget prior to legislative deliberations. It will be expected that the revenues required to fully fund premium assistance will fluctuate, and it will be the job of the legislature to adjust revenue sources as necessary to provide adequate funding to maintain the guarantee of affordable coverage.
- 2) Adopt principles for designing benefits focused on aligning incentives for consumers to seek and providers to deliver appropriate, effective care
- 3) Determine the minimum standard of benefits by which every person in Colorado who is not covered by a self-funded plan would be covered; determine the titles and contents of a limited number of “set” benefit packages, into which all plans must fall; and determine the two (one PPO and one HMO, where an HMO exists) benefit packages that will be provided to those who do not qualify for the Medicaid/CHP+ plan but who will receive assistance in paying for health care coverage.
- 4) Define and certify “high-value” providers
- 5) Define the requirements for participation of plans in a premium subsidy program
- 6) Create a mechanism for assessing whether plans are experiencing adverse selection (a higher proportion of people with high health care needs choosing their plan) within the pool, and a fair mechanism for risk adjustment.
- 7) Define minimum quality and cost containment elements (e.g., integrated care, data reporting, etc.) that must be met in order for carriers to qualify to serve those whose coverage is subsidized by public funds.
- 8) Provide empirical cost analysis to inform the determination of provider reimbursement in the Medicaid/CHP+ pool.

- 9) Promulgate minimum standards and/or rules and regulations regarding such things as network adequacy, standardization of forms, unified billing and payment systems, and performance measures and standards for plans and provider networks.
- 10) Determine that rate-setting is sound, adopting regulations as necessary.
- 11) Periodically study the fiscal viability of the entire market and make recommendations for changes.
- 13) Perform other governance roles as appropriate.

The intent is to create a board that is neutral, fair, has expertise, and is not subject to ever-changing political climates or pressure from special interests but will consider the impact of changes for the benefit of all. Carefully modeled after the Federal Reserve Board, it would be an independent state entity that does not receive funding from the state legislature. It, along with the entire administrative structure for the Authority, would be funded through one or more of the options we've proposed for funding all the reforms in this proposal (see Section (b) (I)).

There will be 7 board members, appointed for 10.5 years each, with staggered terms so that a new member is appointed every one and a half years. Members must be committed to the purpose statement and to carrying out their duties as stated. Members will be appointed by the Governor and confirmed by the Senate, but the board would then function mostly independently, although it will be required to report periodically to the legislature. Members would need to have combined expertise in health economics, health coverage options and their impact, health care systems (public and private, nonprofit and profit), health care administration, health care provision, consumer and special needs populations advocacy, and envisioning and creating innovative futures. Members would not be able to be removed from office due to their views. Members would be paid a reasonable and appropriate amount for serving based on time required and comparable compensation for other similar boards. The Chair and Vice Chair would be chosen by the Governor from among the sitting members, and confirmed by the Senate, serving four-year terms. Funding would need to cover an adequately sized staff, hired by and answerable directly to the Authority Board, to perform research and analysis. The staff of the Board will be separate from the staff performing the administrative functions of the pool.

Administration: The Department of Health Care Policy and Finance would continue to administer what will now be the combined Medicaid/CHP+ Program, and the Medical Services Board will continue to oversee Medicaid. The Authority Board would have the responsibility for creating the policy, regulation and direction for the new purchasing pool, and for hiring an Administrator, who would then set up the administrative structure to run the purchasing pool. Administrative functions would include but not be limited to negotiating rates with the carriers in the pool, certifying plans, assuring regional

coverage and network adequacy, enrollment of individuals and groups in plans of their choosing, accepting and disbursing premium payments, managing the assistance program (including determination of eligibility for premium assistance), collecting claims data from insurers and managing the risk adjustment process, assuring public outreach and education, etc.

(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?

We believe that merging CHP Plus and raising Medicaid eligibility levels for the categorical and optional groups in our proposal will not require a federal Medicaid waiver, although we would defer to HCPF. We propose to seek a federal waiver to cover childless adults under the Medicaid program, but fund coverage with state-only dollars if a waiver is not approved. We have outlined changes in the regulation of the health insurance markets, the creation of a new quasi-governmental agency, the Health Insurance Purchasing Authority, a new governance board, The Authority Board and proposed financing methods and these will require new statutes and may require a popular vote.

We are optimistic that our employer assessment and the obligation to set up Section 125 plans will survive an ERISA challenge. Maryland's law has been successfully challenged in court by a large employer association, but the law was structured in such a way as to attract legal challenges. We have structured employer fees such that they will not impose an undue burden on any employer. As noted most ERISA experts believe employer assessments are feasible under ERISA.

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

We propose a two year phase-in of the expansion of Medicaid/CHP during which time the Health Insurance Purchasing Authority and Board will lay the ground work for the restructuring of the private insurance market and the creation of the purchasing pool mechanism. The private market will be pooled at the end of year two as will the employer assessment. There will then be a one-year phase in of the individual requirement.

(c) ACCESS

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

Yes. The greatest barrier to access is the inability to afford coverage, and this proposal assures that everyone in the state has affordable coverage, significantly improving access to the 768,000 people who are currently uninsured in Colorado as well

as to those whose income qualifies them to receive assistance in paying for coverage, and will be more likely to access necessary care instead of delaying it. The proposal also limits “underinsurance” by establishing a comprehensive minimum benefit design and assuring that high cost-sharing plans are purchased only by those most likely to have the means to afford them (400% FPL+), making it less likely that those who live in low or lower middle income families will put off necessary care.

However, the existence of affordable coverage does not assure that people will know about it, enroll in/purchase it, use it, or that the right kind of providers will be available when and where they need them. We discuss our strategies for informing the public about the changes and some of the methods for increasing the likelihood that they will use the program under section (d) (2) Outreach and Enrollment, below. The likelihood that people will enroll in/purchase insurance increases with both the availability of premium assistance for those living in families up to 400% FPL and a phase-in expectation that if 95% of the population is not enrolled by the end of the first 12 months, those not enrolled will be required to enroll or will automatically be enrolled and charged the appropriate amount for their coverage. Incentives for using the coverage are discussed in section (g) (1) Benefits, below. A problem in some parts of the state is that some providers do not accept patients with public coverage such as Medicaid, CHP+ or Medicare. Our proposal increases Medicaid provider reimbursement.

The major remaining issue is to assure that people will have access to the type of provider that they need when they need it. Due to the dispersion of health care providers, those who live in rural areas face particular challenges in accessing care. For both access issues and to encourage the appropriate use of care (both utilizing the appropriate level of the care system when needed and engaging in “watchful waiting” when not needed), our proposal creates incentives for enrollment in “medical homes” and includes the development of a statewide 24/7 1-800 nurse/doctor line that anyone can call to describe symptoms and ask for direction. Although not a part of this proposal, other ideas for enhancing access across the state, particularly in rural areas, are listed in Appendix D3.

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

This program will benefit safety net providers by assuring that nearly every person they serve will have health insurance. Safety net institutions are chronically underfunded and currently rely heavily on Medicaid, CHP+, and other federal and state funding to support their care for the uninsured. Medicaid alone can provide over 1/3 (37%) of operating revenues for safety net providers, and the Kaiser Family Foundation notes that increasing the number of patients served who are insured will strengthen the financial viability of the safety net (Kaiser Family Foundation, 2007). Safety net providers are likely

to be well positioned to continue to be the major providers of care for those receiving assistance because of their expertise in wrapping special services (case management, culturally competent care, etc.) around those with the greatest needs and because their structure fits well with managed care. Although safety net providers around the state vary, some have been the leaders in developing the most integrated models of care and quality/efficiency initiatives, and others are moving in that direction. These elements will provide an advantage in becoming providers of choice for those eligible for the combined Medicaid/CHP+, which will now serve families up to 300% of FPL. Safety net providers are experienced in minimizing costs, and may provide examples for other systems of care in realizing efficiencies. Also, safety net providers will be included in the networks participating in the subsidized health plans in the purchasing pool.

(d) COVERAGE

(1) Does your proposal “expand health care coverage?” How?

Yes, this proposal significantly expands health care coverage. One of its major goals is to assure that every resident has affordable health care coverage. People with low or lower-middle incomes who now have high cost-sharing insurance coverage and become eligible from premium assistance will have lower cost-sharing plans, leaving them open to less risk financially. In addition, more residents with disabilities will have access to Medicaid, which is the most appropriate health care benefits package for those with special needs because of its extensive coverage.

Also, because the new “standard” benefit package will now include parity for mental illness, coverage for substance use disorders, and limited oral health, vision, and hearing aid coverage, all residents will also benefit from expanded health care coverage.

(2) How will outreach and enrollment be conducted?

When the goal is coverage for all people, a shift in both attitude and practicality occurs – instead of keeping ineligible people out of the system, it is now important to bring everyone into the system, and to do it in the most administratively efficient way possible.

For the general population, the following measures will be essential, and should be managed at the state level. A coordinated effort between the Department of Health Care, Policy, and Finance (HCPF) and the administration of the Authority could create outreach and services for all Coloradans that, while meeting the needs of both the Medicaid/CHP+ recipients and those purchasing insurance from the pool, would appear seamless to the consumer:

- Major media campaign for public awareness (with targeted messages to specific populations)
- 1-800 customer service line

- Simple, easy to understand website for customers
- An office in each significant population area for people to receive in-person assistance in choosing their plan and signing up for coverage, if they choose

For those receiving assistance in paying for coverage, the following changes should be made in order to create administrative efficiency:

- Create joint/single simplified application process for Medicaid, CHP+, and perhaps the state-only assistance program too, if it is deemed to be more efficient
- Community-based enrollment centers (overseen by the state rather than by counties) with CBMS access
- Allow application by mail
- Adequate staffing for quick processing
- Eliminate unnecessary verification
- Provide presumptive eligibility for pregnant women and children of Medicaid mothers
- Allow continuous eligibility for 12 months
- Do passive re-enrollment
- Targeted outreach and marketing to specific populations

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

A resident would be a person living in Colorado. Eligibility for the Medicaid/CHP+ plan would continue to be determined by federal and state requirements. In the new purchasing pool, a resident would not be eligible for premium assistance until they had lived here for six continuous months, and then as allowable by law.

(e) AFFORDABILITY

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

Introduction

One of the most critical elements of creating a coverage system for all is to objectively determine how much a person or family can reasonably contribute to the cost of their own coverage. Estimates of that amount vary, and justification for estimates are rarely cited in the literature. One of the figures commonly cited is that families should be able to afford 5% of their income. However, a careful study of the expenditures of low-income families in Colorado in 2000 found that those with incomes below 185% of FPL had no disposable income left to spend on health insurance, those with incomes between 185%-250% had little or no funds available, and those between 250%-350% FPL, even with a noticeable increase in household income, still cannot afford the full cost of coverage without a partial subsidy. (Glazner, 2000) If a straight 5% of income is applied, a family of 4 would need to spend \$86/mo if their income is at 100% of '06-'07 FPL and \$172/mo at

200% FPL, whereas the Glazner study indicates that families below 185% have no disposable income to spend on health care costs, and those up to 250% have little or none.

Some studies rely on looking at what families already spend, but find disproportionate (significantly higher) spending on the part of lower income families, and do not take into account what sacrifices the families may be making in order to make those expenditures.

A recent process completed by the Greater Boston Interfaith Organization in order to determine whether the mandate that “as of July 1, 2007, individuals over 18 years old must obtain and maintain ‘creditable’ coverage so long as it is deemed ‘affordable’ under the schedule set by the Commonwealth Connector Board” found that “even with the most conservative approach in defining what people can afford based on their monthly income and essential expenses, almost half of all people in the 100-300% range and about 40% of the 300-500% cohort cannot afford the amount expected of them to purchase health insurance.” (Greater Boston Interfaith Organization, 2007)

Because of the critical nature of this question, this proposal tasks the Authority Board with doing carefully constructed periodic studies to objectively determine the true levels that families should be expected to contribute to their own health care costs.

Enrollee: For those individuals or families with income less than 400% FPL who purchase insurance through the new pool, there will be sliding fee scale premium assistance, to be set by the Authority Board based on their determination of affordability. Our proposal is that those living in families whose incomes are < 200% FPL are unlikely to have to pay premiums or deductibles, although they will have co-payments. Those whose income is 201-399% FPL will have premiums based on a sliding scale, and either co-payments, or a coinsurance requirement (depending on the health plan), but will have little or no deductible. For purposes of modeling, we propose the following premium subsidy schedule: Full (100%) subsidies for individuals and families at or below 200% FPL; from 201-250%, 90% subsidy; from 251-300%, 80% subsidy; from 301-350%, 60% subsidy; and from 351-400%, 25% subsidy. Because we anticipate that the Authority Board would be setting both the standard benefit levels and the total cost-sharing amounts, our committee was reluctant to present an ideal benefit plan. However, in order to get a sense of what the Authority Board might consider and for use in modeling, we have included an example of a benefit plan in Appendix G, which can be compared with current Colorado benefit plans in Appendix H.

Employer: For modeling purposes, we propose that the minimum employer premium contribution required in order for the assessment to be waived be 85% of the median cost of a standard individual plan in the Health Insurance Purchasing Pool.

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

This proposal does not change the co-payments or cost sharing for the Medicaid and CHP+ plans.

In the new pool, the cost sharing arrangements of those whose income is above 400% is determined by which plan the enrollee selects.

Cost sharing for those whose income falls below 400% and are receiving assistance in paying for health insurance will be required to enroll in one of two plans selected by the Authority, which will have low cost-sharing arrangements by design. Again, an example of a possible plan that might be considered by the Authority Board is included in Appendix H. In that plan, copayments for those whose incomes are at or under the poverty level are waived except for a small copayment for emergency services. Copayments for those with incomes between 101 and 250% FPL could range from \$3-\$15 for most services and up to \$25 for those between whose incomes are between 251 and 399% FPL. In addition, there will be little or no cost-sharing for those services, such as preventive care and chronic disease management, deemed to be particularly important for health outcomes and cost containment.

(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.

This plan assures that everyone will have access to affordable coverage no matter what their life circumstance is; that those under 400% of FPL will receive assistance in paying for coverage, and that health status and age will no longer be reasons for denials or increased costs of coverage. The creation of the new pool provides the option of portability (which includes not only continuous coverage, but the ability to stay with the same plan and the same provider) for anyone who is not in the Medicaid/CHP+ pool or in an employer's self-funded program, although the amount that the enrollee will pay may vary to some extent as life circumstances change. The plan also makes the transition between Medicaid and CHP+ more seamless, which is important because families at that level of income often move back and forth between programs as eligibility levels shift.

(g) BENEFITS

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

In the new pool, the Authority Board will set both the minimum benefit levels and the ceilings for coverage, but the Board's charge will be to set minimums that provide comprehensive coverage for all enrollees (in contrast to only either limited core benefits or catastrophic coverage), which would be similar to the state's current standard or CHP+ plan, with the addition of parity for identification and treatment of mental illness and substance use disorders, complex/chronic care management, and limited benefits for oral health, vision, and hearing aids. However, this is not meant to imply that all available care, regardless of efficacy, would be included. The Authority Board's goal will be to assure that all receive essential health care, but they will also carefully consider ceilings on care – not to prohibit necessary, efficacious care, but to make difficult choices when efficacy or appropriateness is in question.

The differences between plans that will allow enrollees choice will mainly consist of level of cost-sharing (for those not receiving assistance from the state, who will be limited to low cost-sharing plans), cost, type of plan (HMO or PPO), carriers' ability to provide quality service and adequate networks, and a limited number of plans that add some expanded benefits to the minimum comprehensive plan. These plans will be approved by the Authority Board, and the titles and benefits will be the exactly the same from carrier to carrier.

Our proposal continues to provide for an enhanced benefits package to those eligible for Medicaid because of the increased likelihood that those who qualify will need more wraparound services (expanded services) than the general population.

The challenge for the Authority Board is that there are very difficult choices to be made in coverage in order to keep health care affordable to all. The Authority Board will face challenging ethical dilemmas, and must retain the authority to make policy decisions on whether and how to cover high-cost interventions, particularly if their effectiveness is in question.

(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 package and your benefit package.

The benefit package that the Authority Board might consider for use for those receiving premium assistance (see Appendix G), is a hybrid of the CHP+ and state's Standard plans, adapted to acknowledge the different incomes of the enrollees (co-payments vary by income), and to add the benefits necessary to address key cost drivers (case management for high-cost cases) and provide comprehensive coverage. The benefit package uses zero copayments as a method of encouraging participants to receive targeted preventive and chronic disease management care, covers mental illness and

substance use disorder at parity with other illnesses, and includes limited dental, vision, and hearing aid coverage.

In addition to the benefit package offered to those getting premium assistance, the Authority will adopt perhaps 6-10 additional standardized benefit packages to be offered in the purchasing pool. To simplify analysis, we selected two plans for modeling from among those offered to federal employees in Colorado in 2007 under the Federal Employee Health Benefits Program—a standard PPO option and a high deductible plan with an Health Savings Account. Mental illness and substance use coverage at parity as well as limited dental, vision, and hearing coverage were added to meet our proposed minimum benefit criteria.

(h) QUALITY

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

The Institute of Medicine broadly defines quality as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (Davis et al., 2007). Inherent in that definition is appreciation for the fact that knowledge is constantly evolving. We set up mechanisms in the Health Insurance Purchasing Authority to convene stakeholders to adopt and continuously update quality standards and establish incentives for plans and providers to meet them.

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

This proposal will promote quality through a diverse set of strategies that directly address the IOM definitions above (we outline our strategies in Table 1, Appendix F). We propose two major approaches to creating a system that follows these basic rules of quality healthcare. The first approach is to reengineer the system of insurance in the state such that financial incentives are more properly aligned with achieving these basic rules of quality health care. These strategies are inherent in the risk pooling process proposed here. They include support for primary care and medical homes, case management of complex cases, promoting integrated systems of care, value-based benefit designs, evidence-based formularies, preserving patient choice and supporting decision making, and supporting continuous healing relationships. The second approach is to promote several key elements of quality that are not inherent to the new coverage proposal but cannot be adequately achieved without state intervention. The primary example is the need to promote rapid deployment of Health Information Technology—tools critical not only for quality improvement programs, but also the clinical integration of care.

(i) **EFFICIENCY**

(1) Does your proposal decrease or contain health care costs? How?

The proposal uses the following strategies to contain health care costs, but we believe that it is likely not possible to decrease total health care costs without both moving to a single payer system and achieving meaningful effort to redesign the delivery system.

We believe that *reducing* health care costs is not realistic, given the march of technology and medical research. Also, it is even less likely if, at the same time, one wishes to provide increased access to care for the uninsured. This will increase total expenditures, even if the newly insured have access to primary and preventive care in “medical homes” and therefore avoid more expensive care. Our proposal should, however, substantially reduce administrative costs, thereby assuring that any increases in expenditures go directly to patient care.

We also know there is evidence that savings by squeezing duplication and waste can be achieved while improving health outcomes, quality of care, and access to care (Davis et al., 2007), but this will require major restructuring, not just of the insurance market, but also the care delivery systems. Our proposal stresses the importance of integrated health care delivery models and recommends changes to support their further development. HMOs, particularly in a competitive market, have been shown to reduce costs (Agency for Health Care Research & Quality, 2004). Integrated health information systems and electronic medical records are key tools for “virtually” integrating clinical care. Investment in these technologies can be expected to reduce costs associated with redundant tests, unnecessary or inappropriate procedures, and avoidable errors. We control pharmaceutical expenses with Medicaid preferred drug lists and subsidized plan formularies based on evidence of effectiveness and maximization of 340B qualified health center drugs. We propose wrap-around case management services that come to bear whenever a high-cost case is identified, and support medical home enrollment and reimbursement for clinical activities needed for chronic disease management.

(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 health care services? Please explain.

Our plan recommends value-driven benefit designs that provide first dollar coverage for prevention services, minimal or no co-payments for chronic disease care and medications, which align patients and provider incentives to access these services. At the health system level, we stress the importance of managed care organizations and vertically integrated systems of care—such systems align the financial incentives of

hospitals and physicians and create coordination across the continuum of care, which maximizes quality and minimizes cost. We propose incentive payments to plans that meet national quality standards, establish expectations for plans to create similar performance incentives for networks and providers and propose incentives for consumers to seek care from “high-value” providers.

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

The purchasing pool we create standardizes the benefit packages that can be issued by health plans, allowing consumers to compare plans by price, networks and, when good ones are developed, quality measures.

(4) How would your proposal impact administrative costs?

Marketing, underwriting, multiple complex benefit designs, churning enrollments, and market fragmentation are major contributors to high overhead in the small group and individual markets (Davis et al., 2007), where administrative costs range from 15% to 40%. Our purchasing pool plan and market reforms will substantially reduce all these costs. To make sure those savings are turned into lower premiums, plans will be required to publicly report percentage of premiums spent on medical services (medical loss ratios). The added ease of comparing plans with standard benefit designs in the pool, electronic enrollment, support in setting up Section 125 plans and savings in broker fees may also reduce administration costs for small employers.

Standardization of electronic billing and payment processes, forms, codes and contracts, and data reporting will all lower administrative burden for providers.

(j) CONSUMER CHOICE AND EMPOWERMENT

(1) Does your proposal address consumer choice? If so, how?

Consumers who receive premium assistance will be guaranteed a choice between at least two low cost-sharing health care plan options, and within those options, adequate provider pool choices, to the extent that they exist or can be generated. These consumers will be encouraged to purchase a “high value” plan with slightly lower premium payments, and health plans will be expected to include safety net clinics in their provider panels for this population.

Consumers in the pool (everyone but those in self-funded plans) will have the level of choice most consumers say they want: a limited number of benefit plans (6-10) that provide enough choices to allow options (and easy comparability between carrier’s plans offering those benefit packages), but not so many that it is difficult or impossible to make informed choices. Choices available to the consumer will include cost-sharing options, provider panels, premium cost, and quality of carrier service. Since plans will be competing for customers based in part on their provider panels, it is anticipated that choice of providers will be provided, though it is likely that some plans will have greater choice than others.

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

The administration of the Authority would have the responsibility for outreach, enrollment, and education for the participants in the new pool, as detailed in question (d) (2).

(k) WELLNESS AND PREVENTION

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

Preventive services shown to be cost effective, such as vaccines, prenatal care, cervical cancer screening, and tobacco cessation counseling, will be promoted using strategies approved by the Authority Board such as first dollar coverage and zero copays . Providing full coverage for the screening and treatment of mental illness and substance abuse will also promote wellness and may even reduce costs (Holder & Blose, 1986).

(l) SUSTAINABILITY

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

The proposal is sustainable if adequate, ongoing funding mechanisms are approved. Just as public education, public safety, and Medicare rely on ongoing sources of funding, the public will need to approve dedicated, ongoing sources of funding to assure health care for all. The specific options for financing are discussed in questions (7) and (8), below.

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

See “Technical Assessment of Health Care Reform Proposals, Interim Report”, The Lewin Group, November 1, 2007.

(3) Who will pay for any new costs under your proposal?

In order for health care reform that truly assures everyone access to affordable coverage, everyone will need to compromise some so that no part of the system is overwhelmed. In order for our proposal to work, shared responsibility must be assumed by individuals (all will be required to pay for a portion of their care, with the exception of those whose income is less than 200% FPL), and employers (who will be expected to provide coverage or to pay a fee). Other options for raising the funding to support this proposal include having health insurance carriers assume shared responsibility through payment of an assessment, which may be a recapturing of what they have saved through administrative simplification, and placing an assessment on the fees collected by health care providers. Finally, higher taxes could be placed on the purchase of products with health-adverse impacts (e.g., alcohol, tobacco). The graphic in Appendix I illustrates the choices.

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

Please see the answer to Question (B) (2), above, regarding who will benefit and who will be negatively effected.

- (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.**

The private insurance market will be reorganized into a single purchasing pool and third party payers (called “insurers” in our proposal) will operate under new rules including guaranteed issue and pure community rating. Our proposal creates a new Health Insurance Authority Board charged with setting minimum benefit standards and standardizing all benefit packages in the private market. Coverage mandates would be based on best available evidence standards.

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

We believe the combination of public expansions, private market reforms, affordability standards and the expectations we place on employers and individuals will lead to high levels of health insurance coverage and consequently low levels of uncompensated care. We also propose increasing Medicaid reimbursements, which will further reduce cost-shifting onto privately insured.

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

Yes. While we have achieved administrative simplification, targeted interventions likely to result in improved health and cost containment, and spread risk so that those in poor health are not penalized, we have also provided subsidized coverage to nearly 770,000 uninsured people in order to assure coverage for all, created a new care coordination system for those with complex health care needs, and initiated a statewide nurse/doctor line.

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

Please see the answer to (I) (3), above.

Describe how your proposal is either comprehensive or would fit into a comprehensive proposal:

Our proposal is comprehensive (see Appendix J) because it assure coverage for all, creates a fair mechanism that expects people to pay for their coverage but assists

them when it is beyond their ability to afford, and assures that those least likely to be able to pay more later are covered by low-cost sharing plans. It provides mechanisms for administrative simplification, speeding up the adoption of health information technology, and the coverage and provision of health care services targeted to achieve the greatest health outcomes and at the same time contain costs.

(For description of how this proposal was created, see the Final Appendix)

Issues for Further Study

We would make the following changes in the proposal model for one of four purposes:

1. To bring the modeling assumptions fully in line with the intent of the proposal

- **Benefit Design**
 - Customize the benefit designs used in the model for the private market so that they precisely cover the proposed minimum standard benefit package, varying only on network design and cost-sharing (To simply modeling, two existing Colorado Federal Employee plans were selected to model the non-subsidized part of the private market. However, neither included the level of limited dental, vision and hearing benefits proposed for the minimum standard benefit package. Also, the high-deductible plan was more expensive than intended due to a generous health savings account premium pass-through. We would reduce the premium pass-through to reduce the cost).
 - Make Medicaid and CHP+ packages more synergistic (e.g., add limited dental benefits to all Medicaid beneficiaries).
- **Cost-Savings Options**
 - Include Medicaid managed care savings in model.

2. To modify the proposal to improve it based on what was learned in the first three iterations

- **Additional “Crowd-Out” Provisions**
 - Include strategies (e.g., 6 month waiting periods for CHP Plus or subsidized individual policies) to further reduce crowd-out of employer-based insurance in the proposal.
- **Subsidy Schedule Changes**
 - Address the “cliff effect” (sudden drop-off in enrollment) that occurs in the modeling of the proposal around 350% FPL by raising the subsidy levels for middle income households (350%-400% FPL) to conform to the Lewin’s affordability standard.
- **Financing Options/Changes**
 - Recalibrate the provider tax so that it renders private insurance premiums unchanged. As modeled, it had the unintended and unexpected result of increasing premiums.

3. To raise “what-if” questions, the answers to which could guide further refinements of the proposal, or decisions of policy makers

- **Reconsidering the Employer Assessment**
 - Model a higher employer assessment—similar to the current California Governor’s and AB-8 reform proposals (i.e., 4% to 7.5% of payroll, respectively)—to evaluate impacts on both ESI coverage and revenues generated, acknowledging that such an approach would increase the risk of an ERISA challenge and business opposition.
 - Model the proposal with no employer assessment (restricting the employer mandate to simply requiring employers to sponsor Section 125 plans).

4. To fill gaps in the scope of the original proposal.

- **Explore comprehensive long-term care (LTC) approaches**

Proposal Four: Colorado Health Services Program: Submitted by the Health Care For All Colorado Coalitions

a) Comprehensiveness

(1) What problem does this proposal address?

Our current health care system is fraught with inefficiency, inequality, and unfettered cost-shifting. Within the state of Colorado, we have regions where individuals have access to the best that money can buy, while other regions have uninsured rates that exceed 30 percent. The total number of uninsured within our state is approaching 800,000 and more and more are falling into those ranks each day as health insurance becomes more unaffordable to both employers and employees alike. Moreover, having insurance in our present system does not always mean we are truly insured against catastrophe. Of Americans forced into medically related bankruptcy, nearly 75 percent had health insurance at the start of their illness.

Providers are being squeezed from every direction. Reimbursements are not keeping pace with health care inflation, and ever-increasing administrative and non-patient care responsibilities are consuming provider staff resources and time. Providers are being faced with varying and sometimes conflicting standards of care depending on a patient's coverage. Many areas across the state face poor access to health care not just because of poor coverage but also due to a shortage of providers.

Business is losing its ability to successfully compete in a global market. Corporations are being faced with undesirable choices – sometimes having to choose between remaining competitive in the marketplace or keeping health care benefits for their workforce.

Everyone involved with the financing of health care is frustrated, as many feel that the quality of care does not equate with the money spent and there seems to be no effective means of cost containment.

Consumers, providers, business and those who finance health care are all concerned that our money could be spent more effectively and that medicine could be delivered in a safer and more uniform fashion, but the fragmentation of our current system makes change virtually impossible without major reformation on all fronts. In fact, with all the discussion over "Universal Health Care," the reality is that we don't just need universal access, we need universal reform.

** See Attachment A: "Illness and Injury As Contributors to Bankruptcy," Health Affairs, Feb. 2005; and Attachment B: "Accounting for the Cost of Health Care in the United States," McKinsey Global Institute, January 2007*

a)(2) What are the objectives of your proposal?

Our objective is to rein in the disparities of financing, delivery, access and consumption, and to provide quality, equitable health care in a cost-efficient manner. This proposal does not only lay out a path to universal coverage but actually creates a universal health care system that is publicly funded, with private coverage available as a choice above a standard benefits package. It is regulated by a governing board that is accountable to the people and operates much like a public utility. The main objectives are to standardize delivery of care and equalize, as much as possible, access to care across the state while minimizing administrative costs.

** See Attachment C: Eight Principles of Health Care Reform, adapted from “Building a Better Health Care System,” published by the National Coalition on Health Care, 2004*

b) General

(1) Please describe your proposal in detail.

The Health Care for All Colorado plan is a proposal that calls for the creation of the Colorado Health Services program (CHS). The CHS is a single, comprehensive, publicly financed program designed for the integration of the financing, delivery, and administration of health care. The CHS is funded publicly and the monies designated are separate and insulated from the legislature and the general budget of the state. Administration of the CHS is governed by a board representative of the entire state and accountable to the people. Although the financing of health care is public, the delivery of care remains primarily in the private sector, allowing participants to continue operating on a fee-for-service model, if they choose.

Every resident has equal access to the benefits outlined within the program, with access to the providers and hospitals of their choice. Each individual will have a “medical home” with choice of personal primary-care provider or community clinic.

The plan covers all primary and preventive care, specialty care, surgical care, hospitalization, laboratory and x-ray services, emergency care, automobile and work-related injuries, prescription drugs, durable medical equipment, pathology and autopsies, mental health services, substance abuse treatment, patient education, chiropractic services, dental services, basic vision care, audiology services and treatment, medical transport, physical therapy and rehabilitation and home health and hospice services. Full long-term care will be incorporated over time, with consideration for the increased demand that will occur upon its initial inclusion. In the first year there will be allowance for a 25% increase in home and community-based care (in addition to any savings from institutional care and anticipated savings from consolidation of all current programs for LTC, including

80 federal programs). Long-term care will be financed by CHS, with the exception of 'room and board' payments by patients who are not low-income requiring institutional care.

The program calls for a statewide, fully integrated Information Technology network that can be expanded upon with COHRIO Colorado Health Regional Information Organization. With expanded CORHIO we will be able to track outcomes, utilization, and expenditures, which are vital in deciding the allocation of resources and improving the delivery of care across the state. Since the profit motive is removed from the financing mechanism, the CHS is free to fulfill the mission statement of a true egalitarian health care system, where all residents of Colorado can enjoy equal access to quality health care, and health care providers can concentrate on what they do best — taking care of patients, and where business can concentrate on what it does best — remaining competitive in a global market and driving economic growth. In a sense, the CHS is a publicly owned, not-for-profit insurance company, administered and governed as a public utility. Its operations will be mandated by law to be fiscally responsible, transparent and accountable to the people.

** See Attachment D: Draft Bill for Single Payer and Background*

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

Every resident of the State of Colorado will benefit, as all will be fully covered with equal access under the benefits design laid out by the plan. They will have free choice of all eligible health care providers and hospitals across the state. No one will be subject to bankruptcy due to medical bills, and no one will be denied coverage due to a pre-existing condition.

All providers and hospitals will benefit as they no longer will have to design programs or build infrastructure to avoid seeing non-paying or poor paying patients. All providers and hospitals will be paid the same for the same level of service, thus eliminating the drive for profit in determining the quality of care. In fact, everyone will benefit because providers will start competing in areas where competition in medicine was meant to be — quality, safety, and outcomes. Because the burden of administration and bureaucracy is greatly reduced by dealing with only one system, the monetary savings can be re-invested into health initiatives, and providers can be freed up to do what they were trained to do — practice medicine. Because the playing field will be leveled, rural

communities will benefit as physicians in underserved areas will be able to maintain competitive salaries with their urban colleagues.

Health care provider education will benefit, as this plan will use a portion of its budget to subsidize education of all state-recognized and licensed health care professions, as well as providing student loan payback programs for those who practice in high need areas.

Business will benefit markedly, as all employers will utilize the same comprehensive health insurance plan. They will have a healthier workforce and be able to compete for it. Expanded preventive care programs in the workplace will insure that employees find more job satisfaction and are healthier, all at no additional cost to employers. Businesses will have the opportunity to compete against one another on the merits of their production, thus leveling the playing field, as health care funding will be even across the board. The medical expense portion (which is the lion's share) of liability, workers compensation, and fleet insurance will be rolled into the program, eliminating the need to adjudicate health care costs or to prove whether or not an injury was job related. Employers will be free to hire quality employees with previous injuries or pre-existing medical conditions without fear of driving up their insurance premiums.

Because health contributions for state and local government workers and retirees under the plan will be less than state and local governments now pay for worker and retiree health benefits, the net cost of the program to the state and local governments will result in significant savings. The public education system will also benefit from the ability to redirect funding to education.

A portion of those currently employed in the health insurance industry will be needed in other sectors. Many in that industry will be utilized in this program, as there will still be need for experienced administrators. For the others, it is the intent of this proposal to provide funding for re-education and job placement.

b)(3) How will your proposal impact specific groups of people (e.g. low income, rural, immigrant, ethnic minority, disabled)?

This proposal creates a single, statewide risk pool in which every resident is covered. Since clinics and hospitals are typically located in areas that attract patients with higher reimbursing coverage and many minority groups are clustered into specific geographic regions that represent a lower return on medical dollars invested; this program will level the playing field, as providers will receive the same reimbursement for the same level of care provided no matter what patient population they serve. The positive influence

on these groups cannot be overstated. In fact, under this program it will be easier to create incentives to providers and hospitals to invest in underserved areas. Creating equal access to health care is also a major step forward in the war against poverty.

As a practical matter, it is much easier to coordinate public health initiatives when barriers to access (which are typically a problem in high need groups) are removed.

b)(4) Please provide any evidence regarding the success or failure of your approach. Please attach.

Most industrialized nations have demonstrated that they can provide universal access to health care for half the cost per capita that the United States currently spends. Because the United States is the last industrialized nation in the world to adopt a universal health care system, we have the unique opportunity to learn from the successes as well as the challenges of those nations and design a superior plan that is truly American.

** See Attachment E: "Health Spending in the United States and the Rest of the Industrialized World," Health Affairs, July/August 2005; Attachment F: "How Much Would a Single-Payer System Cost?" summaries of 19 federal and state studies since 1991, Physicians for a National Health Program; and National Coalition for Health Care Study, 2005; and Attachment G: NCHC Study on Four Models of Health Care Reform*

b)(5)How will the program(s) included in the proposal be governed and administered?

The governance and administration of this program is structured around the concept of the Federal Reserve. This proposal creates the Colorado Health Services program (CHS). The CHS is administrated by a governing board comprised of 15 members. The state will have five regional districts under the governing board for the purpose of local administration, billing processing, medical directorship, and oversight of programs that may be specific to regional needs. Three members from each of the five districts shall be appointed by the governor in a four year rotating cycle, so that one member from each district is appointed every four years. Thus, each member shall serve for a total of not less than 12 years. Those appointed by the governor must be approved by the senate and by a majority of the house members from each respective district.

The governor shall appoint an executive director of the CHS who shall act as program administrator. That position shall come under review every four years.

The CHS Board shall be the body that provides oversight and administrative direction for the CHS. All decisions of the CHS Board will be final in regard to administration and implementation of health care within the state unless otherwise directed by the courts or state statute.

Since the delivery of health care is multi-faceted and the intent is to streamline administration and prevent duplication of state services, all state agencies that are related to health care will fall within the purview of the CHS Board. The department of Health Care Policy and Finance will be folded into the CHS since Medicaid will be eliminated.

To streamline and simplify licensing and credentialing of providers, hospitals, laboratories, etc., those offices under the Division of Regulatory Agencies (DORA) that regulate and license health-related providers will come under the administration of the CHS. This will greatly reduce redundant state bureaucracy, as well as reducing the administrative burden (and cost) to hospitals and providers for complying with state regulations.

Because this program is intended to promote the overall health of all Colorado, the Dept of Health shall work cooperatively with the CHS to implement various programs. Public health issues such as clean and safe water, air, and food supplies are vital to cost containment of the entire system. In the event of a natural disaster, such as an influenza epidemic, quick response and mass vaccination implementation is much easier within a comprehensive and integrated health system. This capability will result in the savings of many lives and resources. Public health education will also be an integral part of the CHS program, encompassing wellness, sex education in public schools, child rearing, anger management, etc., all of which have been shown to have positive outcomes toward saving resources. Because this program is unified, with centralized data-compiling capability, tracking the effects of such programs will be simplified, and adjustments made much easier in order to achieve desired goals and savings of valuable resources. Further, tracking chronic disease management will also be simplified, enabling the CHS to develop "best practices" programs that can then be implemented statewide.

The CHS board will convene quarterly. The Board must establish a process of open forum to the public. Their role is to discuss, debate, or refer to committee all issues related to the business and administration of the CHS. Once a year they will convene specifically for the purpose of meeting with providers to discuss and set provider fee schedules for the following year.

The CHS Board will also be responsible for creating statewide standards of care. With a standardized information technology program, reporting of outcomes, morbidity, mortality, resource utilization, etc., can then be utilized to improve on quality of care and to reward hospitals and providers with positive reinforcement for excellence. Because the CHS will be a not-for-profit entity, motivation is not to protect shareholder value, but to enhance the overall health of all Colorado residents.

Since malpractice is also a contributor to health care inflation, it, too, needs to be contained. The program calls for a Disciplinary and Litigation (D&L) Board under the auspices of the CHS, as well as a statewide CHS professional liability insurance pool for all participating providers. Since providers are part of the system, they will be covered by CHS professional liability insurance.

The D&L Board will be responsible for review of all claims to determine whether care provided deviated from accepted standards of care as laid out by the CHS. The main purpose of the D&L is to gather data on adverse outcomes, and to allow the malpractice accusation process to be educational instead of punitive. However, in order for this process to be successful, the findings and opinions of the D&L must be admissible as evidence in a court of law! This point cannot be overstated.

The CHS Board must create a yearly report and budget. The process of setting budgets, changes in benefits, etc., must be transparent and accountable to all the people.

This proposal calls for the establishment of the Colorado Health Services Trust (CHST), which is administered by the Colorado Health Services Board. The funds of the trust are to be used for the general operating budget of the CHS, reimbursement for care rendered, support of professional education, and for the health and general well-being of the people of Colorado. The trust will be separate and insulated from the general budget of the state Legislature in order to prevent health care dollars from being used as a political football as Medicare and Medicaid are currently.

In order for this system to remain viable, four key issues must be mandated by law:

1. The Legislature cannot remove funds allocated to the trust without the consent of the people.
2. The CHS cannot operate in a deficit.
3. The overhead of the CHS cannot exceed 5% of total expenditures.
4. The CHS must have constitutional powers to contain costs.

These four necessary elements provide the foundation for sustainability. This literally forces society to make the hard choices and establish priorities; and it does so on

a platform of public debate and through a democratic process — something that no other model can achieve.

In a sense, the CHS is a publicly owned, not-for-profit health insurance company run in a similar fashion to a public utility. Its operations must be fiscally responsible, transparent, and accountable to the people.

Although the mechanism of financing is publicly administered, the delivery of care is kept in the private sector. Hospitals and provider groups may practice on a fee-for-service, for-profit or not-for-profit status, but since reimbursement is equal across the board, innovation and competition will occur in medicine where it belongs — in quality, service, outcomes, and patient satisfaction.

One side issue to administration that will affect any program eventually chosen is the scenario of adverse selection, or the potential of a large influx of very sick people moving across state lines. (Countering this, of course, is the equally real potential of companies moving to Colorado because of the improved access to health care and favorable business climate). Many western states are currently looking at their own brand of “Universal Health Care.” Colorado should begin to work with other western states to address this vital issue opening for debate the possibility of a Mountain States Health Alliance (MSHA). Because many western states are so sparsely populated they do not have the financial leverage necessary to contain cost or absorb excessive adverse selection. By forming a health alliance, western states can begin to pool resources for such things as bulk pharmaceutical purchasing, health care provider education, and portability of coverage that can be equitably honored across state lines. This is especially important to states such as Wyoming or Montana that lack the resources needed to establish high tech centers of excellence, such as transplant centers. Colorado could help to fill that void.

Finally, regarding the administration of this plan, it is hoped that in the near future we will actually see a federal plan come to fruition. This plan is intended to have the flexibility to be incorporated into a national health program, but provide equitable, affordable access to care here in Colorado until that day arrives.

** See Attachment H: Medicaid Transformation Matrix — A Model for Health Care Reform*

b)(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, Workers’ Compensation, auto insurance, ERISA)? If known, what changes will be necessary?

Currently, Congress has recognized the need for major reform, but most recognize the lack of political will in our current leadership to move in that direction. However, Congress has appeared ready to help states with their individual plans. Since this proposal calls for a single risk pool, all federal and state monies currently earmarked for health care financing will be transferred to the CHS trust and fall under the budgetary purview of the CHS.

Medicaid and SCHIP waivers will be the easiest to achieve since the CHS program will be expanding access, eligibility, and benefits. Medicare will be slightly more complicated but doable. Currently, Medicare recipients are allowed to purchase “Medicare-Choice” type of private plans in which private plans “manage” their care for a small fee paid for by the federal government and the private plans are then reimbursed any payouts directly from the Center for Medicare and Medicaid Services (CMS). There is no reason that arrangement cannot be extended to this type of a program as long as it complies with federal CMS regulations for coverage.

The biggest potential stumbling block will be the federal Employee Retirement Income Security Act (ERISA). The 1974 Act was meant to protect employee retirement funds from unscrupulous employer groups. Although the emphasis was on retirement, some of the wording also dealt with health insurance coverage and protection of a “benefits” package. There have been a few major court decisions over the years in the application of ERISA preemption to health care. The most notable was the “Travelers Insurance” Supreme Court decision of 1995 and most recently *RILA vs. Fielder* federal district court case in July 2006 which struck down the Maryland “fair share act” or what we have come to recognize as the WAL-MART act.

It is beyond the scope of this proposal to prepare an in-depth brief on ERISA interpretation. However, the “Travelers” court did lay out some specific guidelines. A state law will be preempted if:

1. It passes legislation that refers to ERISA specifically or requires reference to an ERISA plan in order to comply with state law; or
2. If there is a connection to an ERISA plan that could substantially affect a plan’s benefits, administration, or structure, especially as it relates to multi-state corporations that have interstate-related benefits packages.

Nevertheless, it was not the intention of Congress to preempt laws of traditional state authority.

No matter what type of Colorado plan we eventually adopt, we will run into the potential of an ERISA-related suit; which is why a federal solution is ideal, but as of yet, we

do not have that luxury. So, for now, we must look to the RILA case for guidance because there is some hope in presiding Judge Motz's opinion: "In light of what is generally perceived as a national health care crisis, it would seem that to the extent ERISA allows, it is strongly in the public interest to permit states to perform their traditional role of serving as laboratories for experiment in controlling costs and increasing the quality of health care for all citizens" — especially if cost as well as access were spread proportionately across all business sectors and individuals.

It is conceivable that any "Universal Health Care Plan" (no matter how it is financed) could be subject to a preemptive challenge on the grounds that an employer may terminate or modify an ERISA plan to make contributions to a public program, or a multi-state corporation would not be able to provide uniformity of cost or administration of a plan between firms in different states.

Congress could have never imagined in 1974 the current dilemma that states are facing in trying to provide and finance health care for their citizens. Having a state publicly financed system would never have entered their minds when Congress entertained ERISA legislation and, therefore, interpretation of ERISA preemption under a new set of social problems that go much deeper than a few corporations' benefits packages is impossible to foresee; no matter what plan we adopt. There is no precedence!

We cannot, therefore, be timid in adopting a plan that is deemed proper for our state. If a plan is implemented and undergoes a challenge of ERISA preemption and the courts rule in favor of the plan, we go about our business. If the court strikes down the plan, then, in essence, no state plan will survive, or if they do, they will be greatly hampered in their attempts to provide state structured financing. If that occurs, it will then become painfully obvious that the only solution will be a federal solution and that will ultimately force the hand of Congress to act. We should not therefore get hung up on theoretical ERISA implications (no matter what plan we adopt) but move forward for what is felt to be best for all Coloradans and trust to Providence that we shall ultimately find a solution to our present condition no matter how the courts ultimately interpret ERISA.

There are also state laws such as TABOR that have the potential for hampering reform. However, when Representative Andrew Romanoff addressed the 208 Commission, he instructed them to find a visionary, workable system and the State Legislature would deal with financing and tax issues.

** See Attachment I: "ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland 'Fair Share Act' Court Decision"*

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

This program will most likely operate using the insurance model. Once federal waivers for funding are obtained the transition will be seamless. Although it will take from several months up to one year to implement the sign up period, for businesses and individuals it will be no more difficult than changing insurance companies.

The state will have five administrative regions:

1. North-central and Northwest
2. South-central and Southwest
3. Southeast and East-central
4. Northeast
5. Denver metro

Each of the five administrative regions has insurance companies with trained staff and infrastructure in place. Their expertise will be needed for the transition and many of their skilled workers will be retained. For others, funding will need to be provided for job retraining and reemployment. The state has the option to contract out administrative services or to purchase the infrastructure from the existing insurance companies.

c) Access

(1) Does this proposal expand access?

Yes, this proposal creates a single risk pool in which every Colorado resident is included. As a result of this program, the uninsured rate in Colorado will approach zero. In fact, even migrant workers can be covered, as they will be paying into the system as will all other workers.

c)(2) How will this program affect safety net providers?

The traditional role of community health centers, such as the Valley-Wide Health Services of Southern Colorado, is to provide care to the indigent and poorly insured. Since funding for health care coverage will no longer be an issue, the focus of these organizations may change, but they still have an important role to play. Many times, access can also be limited by other factors, such as those encountered in geographically isolated small communities, among non-English speaking groups, or migrant workers.

Community health centers already have the infrastructure to address those special needs so greater emphasis can be placed on minimizing the cultural, social, and geographical barriers that may hinder access.

d) Coverage

(1) Does your proposal “expand health care coverage?” How?

Yes, it creates a single risk pool and everyone residing in the state is covered. All residents are eligible for the same comprehensive benefits package which includes access to all primary and preventive care, specialty care, surgical care, hospitalization, laboratory and x-ray services, emergency care, automobile and work-related injuries, prescription drugs, durable medical equipment, pathology and autopsies, mental health services, substance abuse treatment, patient education, chiropractic services, dental services, basic vision care, audiology services and treatment, medical transport, physical therapy and rehabilitation and home health and hospice care.

Full long-term care will be incorporated over time, with consideration of the increased demand that will occur upon its initial inclusion. In the first year there will be allowance for a 25% increase in home and community-based care (in addition to any savings from institutional care and anticipated savings from consolidation of all current programs for LTC, including 80 federal programs). Long-term care will be financed by CHS, with the exception of ‘room and board’ payments by patients who are not low-income needing institutional care.

** See Attachment J: Outline of PNHP proposal for expanding long-term care based on “A National Long-term Care Program for the United States: A Caring Vision,” Dr. Christine Cassell, JAMA 12-4-91.*

d)(2) How will outreach and enrollment be conducted?

The five regional offices will be responsible for holding informational and sign up meetings through local community centers, clinics and hospitals. Outreach will occur through local media channels spearheaded by each of the five regional offices. Physician offices and hospitals can also be authorized to sign up their own patients. ID cards using magnetic stripes conforming to WEDI standards and with unique identification numbers not based on Social Security numbers will be issued upon registration. This process emphasizes the necessity for a single, standardized, statewide Patient Health Information Network (PHIN).

Having a sustainable and workable PHIN is vital to the success of this program, as we shall discuss later, and enrollment is just one of those reasons.

For the first two years of the program, everyone enrolled must be treated with presumption of eligibility and the program, not the providers, should carry that risk.

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

Anyone who has resided for three months or works in the state of Colorado or otherwise defined by the state legislature.

e) Affordability

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

This program establishes a publicly owned state wide insurance company. There will be a mandate that every one in the state participate. Premiums will be collected either through payroll deductions or on the state quarterly estimated income tax filing. Employers have the option to pay all, part or none of the employee’s contribution.

e)(2) How will co-payments and other cost-sharing be structured?

The RAND experiment of the 1970s and subsequent studies demonstrated that co-pays and deductibles do modify individual health behavior and utilization. However, there is no hard data to show that co-pays and deductibles actually save money within the system as a whole. In fact, we know that approximately 80 percent of health care spending is consumed by only 20 percent of the population in the form of chronic, long term, and catastrophic care in which co-pays and deductibles have no influence.

Co-pays and deductibles are just another mechanism for cost-shifting to the individual and, unfortunately, have their largest impact on the most vulnerable of the population. It also is a cost-shifting mechanism to the provider as it creates an additional layer of administration with a subsequent increase in the cost of doing business.

Patients must have some degree of personal responsibility for their own care. However, we are woefully lacking in sufficient data to suggest the most effective way to make people personally responsible for their health. Therefore, no co-pays or deductibles should be incurred for the first three to five years of this program until sufficient data on utilization can be scrutinized and the public have input on it through the process outlined by the CHS.

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.

Because everyone is covered continuously, portability within the state is not an issue. Eligibility is not determined by pre-existing conditions and is not changed in the event of a catastrophic illness, injury, job change or unemployment. The system will cover emergency services provided out-of-state. Those that leave the state will be allowed COBRA coverage for a monthly premium for the term mandated by federal law with payments for care provided equal to the reimbursement paid to providers within the Colorado system for that set amount of time.

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 plan covers all primary and preventive care; specialty care; surgical care, hospitalization; laboratory and x-ray services; emergency care; vehicular-, sports-, and work-related injuries; prescription drugs; durable medical equipment; pathology and autopsies; mental health services; substance abuse treatment; patient education; chiropractic services; dental services; basic vision care; audiology services and treatment; medical transport; physical therapy and rehabilitation; and home health and hospice services, to be expanded to full long-term care.

This comprehensive range of services actually encompasses a broader range of coverage than one can presently receive under a single plan in the private insurance market.

Distinct population issues are addressed in that the covered services are equivalent across the state and regional offices will have the authority to deal with specific regional needs.

The benefits package will need to have some limitations, but deciding those limitations is an ever-changing and dynamic process. The CHS Board will have oversight of administration and delivery of comprehensive health care services in all regions of the state.

g)(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 package and your benefit package.

At present, there is no single existing benefits package for comparison. This is a combination of a comprehensive group health insurance plan and the bodily injury and medical coverage portion of Workers' Compensation and auto insurance.

However, we do have two examples that are close:

(a) Medicare, a publicly financed universal health care system, has operated successfully since 1965.

(b) The University of Denver Student Health Service, a single-payer universal health care program, has operated successfully since 1947.

A distinct advantage for employer groups under this plan is that the overhead imposed by managing and contracting with multiple types of health-related coverage will be eliminated. The fear of driving up the cost of Workers' Comp claims due to an accident or illness will be eliminated. Liability insurance for any organization will be limited to property damage, death, disability, and economic losses.

* See Attachment K: Medicare at 40

h) Quality

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

The current definitions of quality have been well outlined in papers presented by numerous prestigious organizations. A few are attached for your review. It is the intent of this program for the CHS Board to review the literature and to define quality as it applies to the specific needs of Colorado.

The great advantage of this program is that we have a single governing body accountable to the people, providing the platform for public and professional input. Since the definition of quality is dynamic and may change as society and the practice of medicine changes, the CHS program outlines the process for defining the ever-changing definition of quality and how it is measured. The program utilizes various means of oversight, administration, and billing, as well as programs specific to regional needs. Further ensuring quality, the CHS maintains public channels of input and uses an electronic data system to permit transparency and determination of best practices and outcomes. Statewide coordination and administration of public health and infrastructure prevents duplication of state services. This process is more important than any static definition that may not meet the needs of Colorado in 20, 10, or even five years.

* See Attachment L: *The 10 key quality principles that guide single payer*, reprinted from “*A Better Quality Alternative: Single Payer National Health System Reform*,” Schiff et al, *JAMA* 9/14/94; Attachment M: *Colorado Quality Coalition*, compiled by Colorado Clinical Collaborative, Colorado Patient Safety Coalition, COPIC, and CFMC.

h)(2) How, if at all, will quality of care be improved (e.g. using methods such as applying evidence to medicine, using information technology, improving provider training, aligning provider payment with outcomes, and improving cultural competency including ethnicity, sexual orientation, gender identity, education and rural areas, etc.?)

The proposal calls for a confidential and secure statewide, integrated Patient Health Information Network (PHIN) system. (The foundation for such a program is already in place through the Colorado Regional Health Information Organization (CORHIO). Having single integrated tracking and reporting capabilities along with a single integrated program to interpret those results, the CHS has the unique opportunity to apply that data to the improvement of the system as a whole, something which is impossible under our current fragmented system.

A single, integrated system (Medicare being a current model) permits robust data collection that enables analyses of variations in spending and outcomes as well as over or under-utilization of services on a micro and macro level. This data can then be used to identify outliers or reward desired practice behaviors, from individual providers all the way to regional administration.

With simultaneous tracking of expenditures, utilization, and outcomes, we will be better able to implement policies that strengthen and improve the quality and safety of care while ensuring sensitivity to cultural, linguistic, and geographic needs. This will permit the CHS to direct resources and provide incentives for desired outcomes including education needs for future providers.

i) Efficiency

(1) Does your proposal decrease or contain costs? How?

This program provides savings through several avenues:

1. By moving to a single integrated system of financing, the complex, confusing, and many times irrational layers of administration and bureaucracy will be dramatically reduced on both the provider and governing side. It is estimated that this action alone will save 15-20 percent of our current expenditures.

2. With the use of integrated PHIN (as outlined above), it is possible to track evidence-based outcomes and continually adjust the system for improvement of quality and safety as well as desired cost/benefit ratios.

3. As new technology and treatment modalities are introduced, they must come under the scrutiny of the CHS Board to determine future cost savings or health benefits. Patients and providers are free to pursue new treatment modalities that are not yet covered, but do so at their own expense.

4. With all patients having access to primary/preventive services and wellness education, many diseases (including teenage drug use and pregnancy) can be prevented, or their effects diminished with early intervention; with great savings over time.

5. Data reveals that a large percentage of the population in our jails and prisons are there due to substance abuse or mental health related crimes. With access to proper outpatient mental health services, we can drastically reduce prison expenditures at city, county, and state levels while making room in our facilities for felons who are truly a menace to society.

6. By maintaining continuous access to care, malpractice awards will no longer have to consider continued treatment, creating savings for malpractice premiums.

7. The CHS will be authorized to maintain a single, statewide pharmacy formulary. Bulk purchasing will drive down pharmaceutical expenditures as well as durable medical goods, and encourage the use of generic medications when appropriate. Provider overhead will be reduced by having only one formulary to deal with. Because all pharmacies across the state will have access to the CHS drug pool, and because pharmaceuticals are a covered benefit, pharmacies will be reimbursed a dispensing fee, thus allowing small private pharmacies to compete and to remain in business, especially in rural communities where they are desperately needed.

8. Since providers and hospitals will be paid the same across the state for the same services, and with barriers to access for patients removed, the perpetual game of cost-shifting will end.

9. Considering that nursing home patient expenditures average \$70,000 per year, the emphasis of this program will be on wellness and dignity, with the intent to expand home services for the disabled and elderly in order to minimize institutional care and realize savings in nursing home expenditures.

10. When patients have access to timely and appropriate care, the incidence of serious and costly complications due to delayed care can be dramatically reduced.

The above list is extensive but certainly not exhaustive. The true savings (because of the accumulative effects of the efficiencies in this program) will be enjoyed and shared by all and not just one segment of the system.

* See Attachment N: *“Administrative Waste, a State-by-State Analysis of Single Payer, Physicians Group study; and Attachment O: Benchmarks*

i)(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 health care services? Please explain.

Once a few years' worth of data have been gathered, it will be very easy to initiate a pay-for-performance package for providers. It is the intent of this program to do so.

Providing incentives for consumers is more difficult. Health habits, diet, child rearing techniques, etc., are very “value laden” and culturally diverse. Molding healthy behavior should be done in a progressive, not a regressive or punitive, fashion. For example, society does not have the fortitude to say “Gee, I’m sorry Mr. Smith, you have lung cancer and because you smoked for 40 years, we are not going to treat you.” Instead, we estimate that the health care costs of a smoker are \$30,000 more over their lifetime than of a non-smoker, and we add that much in taxes to the price of a pack of cigarettes over the average smoker’s lifetime. We then take a portion of that to use for anti-smoking ads, smoking cessation programs, and most importantly, education beginning in primary school.

Because this is a publicly-financed program, the most effective ways to modify health behavior consist of applying “sin taxes” that go into the budget of the CHS, and to provide contribution incentives for individuals or groups who engage in wellness programs designated by the CHS.

i)(3) Does this proposal address transparency of costs and quality?

Yes, through the open forum process of the CHS Board. Data collection, outcomes, and expenditures etc. are all open to public review.

i)(4) How would your proposal impact administrative costs?

Through the streamlined process of a single integrated system of financing, the complex, confusing, costly, and many times irrational layers of administration and bureaucracy will be dramatically reduced on both the provider and governing side. By also removing the profit motive from the financing of health care, administrative costs can be reduced by as much as 15-20 percent:

A distinct advantage for employer groups is that under this plan the overhead imposed by managing and contracting with multiple types of health-related coverage will be dramatically curtailed, possibly reduced to one payroll contribution or annual tax payment. The fear of driving up the cost of Workers' Comp claims due to an accident or illness will be eliminated. Liability insurance for any organization will be limited to property damage, death, and disability.

** See Attachment P: Report of Medical Loss Ratios, Health Affairs, 2006; and Attachment Q: Graphic slide of Medicare vs. Private Insurance Overhead*

j) Consumer choice and empowerment

(1) Does your proposal address consumer choice? If so, how?

Consumers will have their choice of any licensed health care provider and hospital across the state. This program also allows for consumer purchase of private insurance for any benefits not covered under the CHS. Consumers and providers may engage in services not covered by the CHS, e.g. cosmetic surgery, but those consumers are responsible for payment and providers are responsible for collections. Consumers will be empowered in their choices through access to quality information provided within an integrated health care system that provides greater transparency and access to data.

This proposal changes health care delivery from a market-driven model of consumers/providers to a model of individual choice of personal primary-care providers and collaborative decision-making.

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

Wellness and education are a main emphasis of this program, and part of its budget will be dedicated to public classes, education in the schools, and online education access. The CHS is designed to promote transparency in the data it gathers, allowing patients access to specific data that will help them in their choice of high quality providers and hospitals.

k) Wellness and prevention

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

The single most effective way to promote wellness and prevention is by eliminating barriers to access. When preventive services are considered a standard of care and not a luxury, we have the opportunity to improve morbidity and mortality rates, as well as achieve earlier intervention in chronic diseases when treatment options are less costly. By including public health in the program we also have the opportunity to streamline a network of accessible statewide wellness projects.

l) Sustainability

(1) How is your proposal sustainable over the long term?

In addition to numerous cost-saving and oversight mechanisms, what makes this program sustainable is that it must, by legislative mandate, operate within its budget. The CHS needs to have the flexibility to grow with normal inflation, but if the public wishes to reduce the budget by reducing health care contributions and taxes, then they also must be involved in deciding what services are reduced or eliminated. If the public demands more services, then they must be willing to increase their health care contributions and taxes to do so. This program literally forces society to decide what it wants and needs, and what it can and cannot afford! In a sense, this is truly consumer-directed health care.

We assume that the amounts of state and county funding will be indexed by the allowable rate of growth in spending, i.e., GDP growth. Because health spending has grown considerably faster than rate of growth in state GDP, this will result in lower levels of health spending for state and county governments in future years. However, we assume that the amount of federal funding provided to the state in future years will be indexed to the average rate of growth in costs in these programs nationally - designed to assure that federal funding for the state is not reduced over time (thus, the program is budget neutral from the federal perspective).

We assume that the program is required to constrain the rate of growth in health spending so it does not exceed the long-term rate of growth in GDP for Colorado.

l)(2) How much do you estimate this proposal will cost? How much do you estimate this proposal will save? Please explain.

Regarding the funding of the CHS, Speaker of the House Andrew Romanoff was very clear that he wants us to build a sustainable program and let the legislature determine the funding specifics. We would however, expect a total budget of approximately \$16 billion in 2004 dollars, representing conservatively, a savings of 20 percent in 2004 dollars, or approximately \$4 billion.

l)(3) Who will pay for any new costs under your proposal?

In 2004 (the last year that we have good data), approximate total health care expenditures for the State of Colorado were just over \$20 billion. Approximately 60 percent or about \$12-\$13 billion of that came from private insurance and out-of-pocket consumer spending. (A portion of those private insurance premiums was paid for with tax dollars for government employees). The remainder was funded through federal and state programs (Medicare and Medicaid, etc.). Assume a conservative total savings to the system of 20 percent as outlined previously. We would expect a total budget of approximately \$16 billion in 2004 dollars.

Approximately \$7 billion of spending in 2004 came through government funding (in the form of Medicare, Medicaid, etc.). All current government health care dollars (federal, state, county and city) will be transferred into the CHS Trust Fund and continue to be a source of funding. This will require the CHS to come up with \$9 billion in additional funding.

Two mechanisms of funding have been proposed; the first is based on an income tax model.

In 2004, individual income tax returns were a little over \$100 billion with wages and salaries being approximately \$74 billion of that amount. By setting individual income tax at 6 percent with a 4 percent employer payroll tax, the system could be fully funded. Although this incurs a perceived tax increase, for a family of four at 300 percent of the federal poverty level (approx. \$58,000 per year), their total tax payment will still be less than half of the current average annual insurance premium per family (now at over \$10,000), but with far superior coverage.

The second possible funding mechanism is the insurance model, which allows for more flexibility and is insulated from the whims of the legislature and generalized statutory spending limitations. A Colorado Health Care Insurance Plan administered through the CHS will allow government entities to make premium payments just as they do now. Employers will continue to pay their medical portion of workers compensation as mandated by law to the CHS.

The Colorado Department of Revenue income tax withholding system could be used to receive employer/employee health care contributions at the same time they receive income tax withholding. Employers have the option to pay all, some, or none of the employee contribution.

When individuals file their Colorado income tax returns, their CHS premium/contribution will be entered under the designation "Colorado Health Services

Contribution,” so that consumers are conscious of their own and/or their employer’s contributions to the system.

The insurance model permits the CHS more flexibility by making use of actuarial social insurance science to set rates up or down in any given year depending on utilization, reimbursement standards, newly proposed government regulations etc.

Other funding mechanisms are available such as a gasoline tax to cover automobile-related injuries, additional alcohol and cigarette taxes, taxes on weapons and ammunition to cover firearm-related injuries, etc. Any monies derived from these sources could be used to expand services or decrease health care premium contributions.

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

This proposal will dramatically decrease cost for employers and individuals who are currently paying for private insurance. Because the insurance premium payment for state and local government workers and retirees under the plan will be less than state and local governments now pay for worker and retiree health benefits, the net cost of the program will result in significant savings. The public education system will also benefit from the ability to redirect funding to education. There will be increased cost for those who currently refuse to purchase health care coverage. For most Coloradans who desire coverage but cannot afford it, the plan makes coverage affordable. Since participation is mandated, everyone pays and everyone is covered.

1)(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.

Everyone pays into the system and everyone is covered.

1)(6) How will your proposal impact cost-shifting?

Under this plan, cost-shifting is eliminated as everyone is covered and providers are paid equally for their services rendered.

1)(7) Are new public funds required for your proposal?

Since those funds that are currently being driven into the private sector will be redirected as contributions to the CHS, essentially no new funds will be required.

l)(8) If your proposal requires new public funds, what will be the source of those new funds?

Other funding mechanisms are available such as a gasoline tax to cover automobile related injuries, additional alcohol and cigarette taxes, taxes on weapons and ammunition to cover firearm related injuries, etc. Any monies derived from these sources could be used to expand services or decrease health care premium contributions.

Description of the Comprehensiveness of the Health Care for All Colorado Plan

This plan encompasses the definition of major health care reform. Its changes are truly comprehensive. Coverage is comprehensive. Every resident of the State of Colorado has comprehensive coverage under the plan. Benefits are comprehensive. Everyone has the same basic coverage.

Quality and safety issues are comprehensive. With an integrated, statewide health information technology network, outcomes, expenditures, and utilization can be tracked across the entire state and meaningful adjustments made for resources that will enhance the overall well being of the entire population. It will also permit the ability to address the specific needs of regions, groups with special needs, and minorities.

Governance is comprehensive. All regions of the state have representation on the Board of the Colorado Health Services. The administration of the system is required to be transparent and the Board is required to plan open forums so that everyone has the opportunity to provide input into the budgetary process and the allocation of resources.

The changes made in the way that we practice medicine are comprehensive. Because hospitals and providers no longer have to compete to see who can avoid the poorest paying patients, they can actually start competing against one another on issues of quality, outcomes, and patient satisfaction — which is what medicine is supposed to be about.

The positive effects on business are comprehensive. Since all businesses contribute equally, it will level the playing field and promote competition. Since the administrative burden of contracting with several types of insurance is minimized and the overall cost of health care coverage is reduced, business will invariably become more profitable and competitive, thus attracting more business and industry to our state, resulting in improved wages for our middle class and increased state revenues. Also, since portability is not an issue, individuals have the option to return to school to enhance their education or to start their own small business without fear of losing their health coverage.

The positive effects on medicine, business, and Coloradans are truly comprehensive.

How this proposal was developed

A series of Colorado groups have promoted single-payer health care since the early '90s. The statewide Colorado Coalition for Single Payer (CCSP), the Boulder Health Policy Watch, and the Colorado Gray Panthers became Health Care for All Colorado. In 2000, retired public health professor Ron Forthofer and Bob Danknich authored a Colorado study illustrating the savings of a single-payer approach. Dr. Elinor Christiansen, HCAC board president, was one of 17 physicians to draft a national single-payer health care plan in 2000. (The current bill is HR676.) In 2006, statewide HCAC citizen health care hearings helped illuminate the many disparities and barriers to access, rising costs, frustrations and waste in health care in Colorado.

Actively involved since the early '90s in formulating health care solutions, the Colorado Nurses Association (CNA) worked on the Colorado Care Project for universal health care in 1993, and, with the American Nurses Association, worked toward creation of the comprehensive document – *Nursing's Agenda for Health Care Reform*. The CNA statewide health care task force contributed to the development of the Health Care for All Colorado proposal. In 2005 CNA's House of Delegates endorsed single-payer universal health care as the preferred solution to the U.S. health care dilemma.

The primary author, Dr. Rocky White, is a full time practicing primary-care physician in Alamosa, Colorado. In the last few years he has personally seen many of his patients, as well as others in the San Luis Valley, lose their jobs and their homes, have access to adequate care denied, and even die because of issues surrounding poor or no health care coverage. In fact in 2004 Dr. White's multi-specialty group in Alamosa had to close its doors because it could no longer survive financially due to the constraints of our current system.

Since that time he has become convinced that a single payer mechanism of financing is the only way to provide quality, affordable and accessible care to everyone in Colorado, and he has been actively engaged in working with groups across the state for its promotion.

In 2005 the Colorado Medical Society House of Delegates voted 91 percent in favor of comprehensive health care reform.

APPENDIX to CHSP Single Payer Program

Highlighting Key Points of the Proposal:

The CHSP Single Payer plan is a comprehensive approach to health care reform in Colorado. It is simple because it covers every Colorado resident in one comprehensive health care plan. This simplicity makes it inclusive, equitable and cost effective. Everyone has equal coverage and equal access with choice of their primary care provider. The state-wide cost savings of including everyone in one plan are considerable and will significantly reduce the per capita costs as well as improve health care outcomes and quality of life.

Establishment of a state wide unified system of secure electronic medical records is a vital component of this proposal and will expedite care and improve patient safety. This electronic network will also provide data for epidemiology, as well as vital data for budgeting, accountability and transparency of expenditures, staffing and professional training needs, and reallocation of resources to meet the needs of the people in various regions of Colorado.

Additional Explanations of elements of the CHSP Single Payer Proposal as it was presented in April 2007:

BENEFITS: Comprehensive coverage for all, from birth to death, includes preventive care, acute care, chronic care, mental health, dental care, and long term and hospice care. Medications, durable medical goods (equipment), physical therapy and rehabilitation are also included.

Although the Lewin Group used Colorado Medicaid for modeling and cost estimate purposes they added and included in their modeling and cost estimates preventive and restorative dental care as well as long term care at our request to make the costs nearly comparable with the CHSP proposal.

MEDICAL HOME: Every resident of Colorado will choose their personal primary care physician who becomes their "medical home", their trusted health care adviser and coordinator of all the patient's health care services. If the patient is not satisfied with the physician they have chosen, they may select another physician and notify the CHSP the name of their new "medical home" physician. If a primary care physician (family practice, internal medicine, pediatrics, ob/gyn or geriatrics) is not available, such as in rural areas, a nurse practitioner or physician assistant may fill the role of "medical home".

FUNDING: This new health care system is publicly owned and publicly funded with the cost fairly shared by all individuals and all employers through taxes or contributions to the CHS Trust Fund. This replaces mandates for individuals or businesses to purchase private or commercial insurance. The Trust Fund receives all health care funds and pays the health care bills, consequently the term Single Payer. Federal and state funds designated for health care will be deposited directly into the CHS Trust Fund. The Lewin Group called these various funding sources "taxes" rather than "contributions". However, optimally the CHSP will be established by the Colorado Legislature as a "state enterprise", an independent entity outside the state budget and independently governed by the CHSP Governing Board. If the CHSP is established as a state enterprise it will not be subject to the TABOR amendment.

Another essential component of funding for universal health care is the funding of the training of health care professionals, especially in primary care, in order to meet the staffing needs and remove the burdensome personal debt upon completion of training. This is included in the CHSP proposal. Note: All developed nations except for the U.S. have universal health care and they cover the cost of training their health care professionals. A year of service in an underserved area of our state (either inner city or

rural) could be required as payback for each year of professional training paid for by public funds.

GOVERNANCE: The CHSP Governing Board is responsible for the budgeting, staffing, delivery and quality of health care, HIT, determining standard fees for services (in consultation with the professional health care organizations), paying of bills for the services delivered, and monitoring of compliance with the standards of care recommended by the health care professionals. The Board is also responsible for transparency, accountability and reporting of the health care system to the public. The Governing Board includes geographic representation from all five geographic regions of Colorado and a wide range of provider and consumer representation.

Subsidiary to the CHSP Governing Board are five Regional CHSP Governing Boards to address staffing, facilities and delivery of services to meet the needs of residents in their region. This allows for regional adaptation of delivery to the cultural and economic factors and differences between regions of our state. The Regional Boards will include diverse representation from constituents of the region and will hold public meetings to assure services and priorities reflect the needs and preferences of the residents of the region.

IMPLEMENTATION: The original proposal submitted in April did not include how implementation would be accomplished. However many questions have been raised regarding implementation and discussions have ensued. One method to implement the CHSP Single Payer proposal would be to implement it in phases. It has been suggested that Phase I. would be Primary Care for all (including preventive care, mental health and addiction medicine) and unified electronic medical records in the first phase.

The Legislature will need to determine the best way to fund the CHSP Single Payer plan and determine whether to appoint or elect the Governing Boards.

The enormous savings, simplicity and equity produced by the single payer approach to assuring access to affordable health care for all residents of Colorado is both appealing and pragmatic. There are successful working models in every developed country of the world, each one doing it a little differently, but all spending less per capita per year and having better outcomes than we have.

Both federal and state financing of health care are discussed in the following paper, "Restructuring U.S. Federal & State Health Financing" by Eldon Van Der Wege, attached below. This is recommended reading for all who want to understand how current public financing of health takes place and how these resources can be reconstructed or redirected at the state level to fund the single payer universal health proposal, CHSP, by creating a state-owned mutual health insurance enterprise.

John Shiels of the Lewin Group stated that there should be little difficulty in getting funds for Medicare and federal matching funds for Medicaid transferred to the CHSP Trust Fund. At present there are three bills before Congress proposing grants to three to five states to fund pilot projects for implementation of state run universal health care. Russ Feingold of Wisconsin is the author of one of these bills.

Appendix 4: Appendices to “Cost and Coverage Impacts of Five Proposals to Reform the Health Care System in Colorado;” Prepared by The Lewin Group

Appendix 5: List of Task Force Members



Appendix 6: Task Force Reports

Note: The reports of the Commission Task Forces were due to the Commission before the Commission recommendations were finalized and before the final analysis of The Lewin Group was complete. Therefore, there may be inconsistencies between elements of the Task Force reports and the final Commission recommendations and The Lewin Group analysis.

Business Task Force Report

MEMORANDUM

To: The Blue Ribbon Commission on Health Care Reform
From: The Business Task Force
Subject: Final Report of the Business Task Force on the 5 proposals reviewed by the task force
Date: October 18, 2007

Pursuant to the charge of the Commission the Business Task Force has met on five occasions. The initial meeting was introductory in nature and included a general review of the four approaches to reform. The next two meetings were spent examining in more detail the original four proposals with two proposals being discussed at each meeting. The final two meetings were spent discussing proposal 5 and overall general considerations that were found in multiple proposals.

We recognize that health insurance coverage is, at least for the foreseeable future, tied to the workplace and we accept that responsibility. At the same time, though, it has evolved to the point where business finds itself diverting attention from its main business to health coverage with its concurrent expense of time and financial resources. We believe there must be a happy medium that will serve both employees' and employers' interests.

In general, the Business Task Force had concerns with elements in any of the proposals that would create additional administrative burdens and/or costs on employers, or that created an uneven playing field for businesses. At the same time, members noted that businesses are willing to play a role in education around healthy lifestyles and coverage options.

This final report regarding our discussions to date is forwarded to you with a caution that there may not be unanimity on all discussion points below and that some members of the Task Force may not have reviewed this document.

This document is an overview of key design considerations that were found in multiple proposals and how these considerations could have an effect on businesses. Attached are additional documents that highlight our discussion regarding specific considerations in each proposal.

- 1) The Task Force spent considerable time reviewing employer mandates and believes that, as a general rule, they would be harmful to business.

- a) The mandate for employers to offer insurance to employees creates an unequal playing field:
 - i) Not all employers (e.g., self-funded employers) would be subject to them.
 - ii) In-state (local) employers may be at a disadvantage compared to out of state employers who are not subject to a similar mandate.
 - iii) An employer mandate could create a disadvantage to an employer who wishes to remain in Colorado and could be a deterrent to an employer deciding upon moving to Colorado.
 - b) An employer assessment is another form of a mandate and would have the same negative impact on business as outlined above.
 - c) The exception to the generally negative view of employer mandates was a proposed requirement for employers to provide Section 125 plans. In general, the Task Force did not view this as an onerous burden, although they noted that there could be an increased cost to employers who currently do not offer this type of plan (e.g., through plan fees and increased HIPAA compliance needs). However, it was recognized that there are off-setting tax benefits that could help to ease the financial burden.
 - i) Despite its generally favorable view of the Section 125 plan mandate, the Task Force suggests that there be an exemption for very small businesses (e.g., less than 5 or 10 employees).
- 2) The Task Force generally felt that there may be a place for individual mandates.
- a) Individual mandates appropriately place responsibility for insurance on individuals rather than the employer. Employers should not be responsible for enforcing mandates.
 - b) Reducing the uninsured population would reduce the cost shifting to business that occurs today to pay for the medical care that uninsured individuals receive.
 - c) Requiring all individuals to be insured, and requiring individuals to elect their employer's coverage, could have a positive impact on business since it will reduce adverse selection by not allowing the healthy to purchase other plans.
 - d) However, Task Force members did note some concerns about individual mandates:
 - i) The depth and form of the mandate could have a negative cost consequence on business if wages must increase so that the employee can afford the mandate.
 - ii) There is concern regarding potential additional administrative costs on employers associated with enforcing an individual mandate such as coordination with the state, processing of subsidies, etc.
 - iii) There is a question as to whether or not there may be a shift of population from the uninsured to the underinsured because of the basic plan's modest annual maximum level of benefits.
 - iv) The requirement to purchase the employer's insurance has a potential negative consequence to employers: It could increase employers' costs since most employers assume only a certain percentage of employee will choose to be covered. Currently only businesses with fewer than 50 employees are required to pay at least 50% of the employee's premiums. This could create an unequal playing field if employees are required to select the employers insurance under an individual mandate unless the 50% rule applies to all.

- v) In addition, the requirement to purchase an employer's insurance could have a negative consequence for certain groups of employees. Some may end up paying higher premiums than they would if they were allowed to purchase in the individual market; others may find themselves underinsured or unable to enhance their coverage if required to purchase the employer's plan.
 - (1) Possible solutions include making a supplemental plan available through the Exchange/Connector, or allowing employees to purchase a voucher from the employer to secure coverage through the Exchange/Connector (if permitted by Colorado law) and without additional cost to the employer.
- 3) The Task Force supports expanding public programs but does so with a caution.
 - a) The Task Force recognizes the potential for public program expansions to reduce the cost shift due to uncompensated care. Members also applaud the idea of a Medicaid buy-in as a means of assuring that talented people can continue to work.
 - b) At the same time, though, some Task Force members noted concerns:
 - i) What would happen if those programs are expanded and the state experiences another recession?
 - ii) Increasing these program costs will affect all taxpayers.
 - iii) Without ensuring sufficient provider participation in Medicaid and CHP+ – which means, at least in part, increasing reimbursements – public program expansions could in fact exacerbate the existing cost shift.

Overall, the Task Force recommends that Medicaid expansion be considered carefully and done with a surgeon's knife rather than a blunt instrument.

- 4) Concerns re: insurance market reform
 - a) The Task Force noted the potential for reforms in the individual market and enhanced purchasing capacity through the Exchange/Connector to have a destabilizing impact on the small group market, encouraging employers to drop coverage and forcing employees to move into the individual market.
 - b) The question was raised on the need to review the definition of the small group market to see if it is still appropriate with the current business demographics of Colorado and if it creates a fair or unfair playing field for businesses.
- 5) Concerns re: subsidies.
 - a) There will be an increased administrative expense for employers who have a significant portion of their employees eligible for subsidies.
 - b) Events affect eligibility throughout the year (e.g., marriage, birth, etc.). Having to re-qualify based on these events could be a huge administrative burden to employers, but also an important necessity. The Task Force discussed using the Section 125 rules as a basis for these types of events.
 - c) Where the subsidy goes – i.e., to the employer or employee – must be clarified, since this will affect the administrative time and expense to employers.

- 6) Concerns re: financing.
 - a) We need to be wary of any financing measures that are directed at specific products and/or industries.
 - b) Funding with insurance premium tax would create an unequal playing field amongst employers since self-funded companies and government agencies don't pay these taxes.
- 7) Concerns re: benefit caps.
 - a) The Task Force expressed concerns regarding benefit caps in some proposals. While we recognize that maximum benefit levels of \$35,000 to \$50,000 would adequately cover most individuals, the group believes that such caps are insufficient for many others. Given the potential for anyone to experience a catastrophic event, the Task Force fears that this would not be sufficient.
 - b) In addition, benefits caps create the potential for underinsurance, which can exacerbate the cost-shift.
- 8) 24-hour coverage.
 - a) The Task Force was specifically asked to provide reactions to the 24-hour coverage option in the 5th proposal. However, the Task Force had difficulty understanding how this provision would work.
 - i) Positives:
 - (1) If it would remove all of an employer's liabilities for workers comp, it would appear to be an attractive alternative.
 - (2) Could eliminate some redundancies.
 - ii) Concerns:
 - (1) Potential long-term impact on health insurance premiums, noting that if all claims were to now go through health insurance and not workers comp, health coverage premiums would go up.
 - (2) They also noted concerns regarding the potential for increased regulation and having bureaucrats, rather than claims adjusters, making claims decisions.
 - (3) Task Force members noted that, when an employer has a workers comp claim, there is an incentive to get that employee back to work quickly. They were not sure that incentive would remain under a 24-hour system.

General Observations

- 9) When exploring health care reform, we must look at the broader economic climate and consider other potential economic impacts, both positive and negative.
- 10) In general, the Task Force noted that the proposals do not fully address the full spectrum of medical care cost drivers. They expressed concern that, in the absence of significant measures to rein in health care cost inflation, costs will likely continue to increase rapidly, which will mean future increased costs for employers.

- 11) The Task Force continues to have questions about the Exchange/Connector and Coverage Clearinghouse concepts and feels that there is insufficient understanding of how those elements would work to feel confident at this time that they would be effective.
- 12) The Task Force recommends the Commission work with subject matter experts to flesh out important detail specifications that are currently missing from most proposals.
- 13) The Task Force felt that the adoption of health information technology is an admirable goal and is best encouraged but not mandated.
- 14) The Task Force endorses efforts to promote healthy lifestyles and preventive care.
- 15) Reinsurance provisions are unclear and need more study.
- 16) The Task Force noted that it did not have time to explore in detail the impacts of any of the suggested reforms on workforce development and productivity. Some considerations along these lines that merit further exploration are:
 - a) Increased worker productivity through better access to preventive care.
 - b) Reducing the potential of discriminatory hiring and firing practices resulting from efforts to control an employer's health care costs.
 - c) How income limits and means testing for public programs discourage capable citizens from performing meaningful work and keeping them impoverished (adding to taxpayer burden and restricting the aggregate workforce).
 - d) Disparities in regulations across different groups (individual, small group, large group, ERISA), such as those that create additional burden to small employers (higher premium costs with less risk-pooling protection compared to large group & ERISA plans).
 - e) Increasing wellness initiatives to improve worker productivity.
- 17) The Task Force is basing its input on the information provided by the Lewin Group, but the Task Force questions some of that information.
- 18) The discussion of the 5th proposal did not take into account modeling results since those had not been released by the time this report was due.

###

	Better Health Care for Colorado	A Plan for Covering Coloradans
From a business standpoint, what issues does this proposal improve? What do you like about it?	Costs: Could level off rate increases in small group market; could reduce average cost for businesses	Costs: By getting more people into the insurance pool, could reduce average premium costs
	Small group market: Exchange enhances ability to purchase	Medium-sized businesses: Businesses with 51-250 employees have the hardest time finding affordable coverage, have been hit hardest by lack of guaranteed issue/community rating; this plan helps them
	Burden on employers: If Exchange is set up correctly, could minimize	
From a business standpoint, what issues does this proposal worsen? What concerns you about it?	Doesn't change the current system much - may not solve underlying problems	Financing: Everyone has to pay more under this plan
	Coverage: Plan design doesn't offer very good benefits, has significant gaps	
	Risk selection: Those with higher needs and costs won't stay in the Exchange - they'll look for more comprehensive coverage on the private market; minimum benefit package will attract healthy people into the Exchange; could create 2-tier system.	
General comments	Impact on the cost shift unclear: covers more people which could reduce the cost-shift; BUT if you increase the number of Medicaid eligibles without increasing provider reimbursement, in combination with low benefit cap, coverage could be moot and the cost-shift could worsen	

	Better Health Care for Colorado	A Plan for Covering Coloradans
Individual mandate	NA	Pro: Spread risk among larger pool, minimize adverse selection. Could help business: In theory, makes individual employee take more direct responsibility for his/her health care.
		Con: Doesn't work. Distasteful government intrusion. Don't address other reasons for escalating costs of care. Ultimately will increase the employer's cost of doing business, unless overall system costs come down
		This mandate could be tough on families making more than \$80k/year - don't qualify for subsidy but still may not be able to afford private insurance
		Could mean that employers would have to increase wages in order to ensure employees could purchase coverage
Individual mandate (cont'd)		Need to know perspective of low-wage employers and their workers on this
		What's the enforcement mechanism if someone refuses to pay the tax penalty - jail?
		Premium needs to be much lower than the penalty in order to incent people to get insurance
Employer mandate	NA	Assessment would incent employers to stop offering coverage - it's much less than the average annual premium
		Estimate would only pick up approx. 10% of the uninsured as a result of the mandate - not enough to materially reduce costs
Other employer provisions/implications	Is it legal to require businesses to establish S 125 plans?	Unclear how this plan affects small employers

	Better Health Care for Colorado	A Plan for Covering Coloradans
	Overall impact on employers unclear: Administrative costs for employers, esp. small businesses could increase because of need to coordinate with Exchange, set up S 125 plans, etc. But, if the Exchange is properly created, could reduce overall administrative burden on employers	
Benefit package/premium/subsidies	Subsidy structure could actually incent employers to keep wages down. Once you get above 300% FPL there's no subsidy, but insurance is still expensive. Employers could artificially depress wages in order to ensure that their employees have access to affordable health coverage	Positive: Coverage for mental health, substance abuse, oral health, vision, hearing
	\$35k benefit cap will cover needs of most people	Are the subsidies in this proposal appropriate/sufficient? Can someone at 300-350% FPL afford 40% of the proposed premium? Would still be a lot of money relative to their income, would be tough to make work
CHP+/Medicaid expansion	What is impact on cost-shift? Will expanding the pool of people in Medicaid/CHP+ reduce rates paid by employers? Or, by asking providers to see more patients at lower rates, will it exacerbate cost shift as those providers try to shift costs to privately-insured patients?	If you increase the number of people in the program but don't raise reimbursement rates, you will worsen access to care
		Presumptive eligibility can take a lot of effort. How much does it decrease administrative costs?
Residency	Not sure the approach in this proposal is legal	
	Would be great to have more undocumented workers in the pool; unsure that they could afford coverage w/o subsidy	
	Positive impact on public health from extending coverage	
Purchasing approaches	Exchange:	Large purchasing pool:

	Better Health Care for Colorado	A Plan for Covering Coloradans
	1. Why did the Alliance fail? Are there lessons we can learn from that to structure the Exchange appropriately?	1. Not sure this would make a significant impact - few large groups are not ERISA-exempt, so you wouldn't be bringing them in; only about 365,000 lives are in the small group market right now; how many individual lives would be brought in? How many people total would be in the pool
	2. No impact on large employers	
	3. Could increase portability for some people	
	4. Could worsen crowd-out -- encourage employers to stop offering coverage altogether. Waiting period is supposed to address that, but would be devastating to the employee to "go bare".	
	5. Will employers make voluntary contributions to the Exchange? Unclear	
	6. Could benefit only young and healthy - must have guaranteed issue in the Exchange to be successful	
LTC	Not enough data to understand implications -- would like to see impact on overall costs	
Financing		Sin taxes: Mixed reactions. Good to an extent, but not a sustainable revenue source.
		Assessment on for-profit health plans is problematic -- they'll leave the state. Could establish a range for medical loss ratios and apply the assessment according to that
		Premium tax will be passed along to employers in higher premiums and will reduce choice by driving carriers out of the market. Connecticut taxes for-profit plans only, creates uneven playing field. (Reasoning behind premium tax is to try to recoup savings from guaranteed issue and reduced claims costs - may be an incentive for plans to reduce overhead. But how do you measure and report cost savings?)
		Little public appetite for tax increases

	Better Health Care for Colorado	A Plan for Covering Coloradans
Questions/other issues	Doesn't really address cost drivers	Doesn't really address cost drivers
	Lots of idealistic claims/buzzwords - not enough detail to know if the ideas will work	Need to identify where there's waste in the system, try to eliminate that
	Differential impacts by region. For example, Grand Junction has low unemployment; employers may enrich benefit packages/coverage as way to attract employees	

	Solutions for a Healthy Colorado	Colorado Health Services Program
From a business standpoint, what issues does this proposal improve? What do you like about it?	To the extent this reduces overall number of uninsured and brings down costs, it is good for business	4% payroll tax cheaper than current insurance costs for some employers
	Individual mandate: If works as estimated, premiums for employers would go down because premiums will be spread and risk pool is larger. Also minimizes adverse selection.	Would be more competitive because insurance costs reduced
	Inclusive: Eliminates fewer people/groups than the other proposals	Addresses administrative cost drivers
	Has potential to control costs by increasing size of pool (through mandate) and limiting what's covered	Simplicity is appealing.
	Encourages healthy behavior/wellness programs	If imperative is coverage, this benefits employers : every employee is insured
		Establishes medical home - increases use of preventive care, enhances continuity of care
From a business standpoint, what issues does this proposal worsen? What concerns you about it?	Potential increase in underinsured: Limited benefits and potential elimination of some mandates results in "pretend" coverage; guaranteed issue only applies to core benefit package, which isn't very good	Cost: Is 4% payroll tax a realistic financing mechanism, and how long would it stay at that level with this benefit package and with medical inflation? Expect overutilization of services, which would drive up costs - employers would end up paying more
	Possibly a slightly increased admin burden (processing subsidy vouchers, etc.), but not much	Philosophically, believe that businesses can do things better and more efficiently than government
	Reinstatement of rating for health status would have adverse impact on small businesses that fill one significant claim	Unsure of impact of 6% surcharge - would employers pay more as a result?
	Concern about potential impact of 1% benefit mandate provision - don't know what the impact will be	Payroll tax unrelated to profitability of company

	Solutions for a Healthy Colorado	Colorado Health Services Program
	Employer contribution to subsidy pool: backdoor employer mandate	Impact on state budget troubling: between health care inflation and increased utilization, costs to state would go way up.
	Doesn't address major cost drivers	Could not be implemented unless TABOR is repealed.
		Business community will have hard time accepting this because of the impact on their checkbooks
		Concerned re: access implications - provider availability
		Cross-border competitive issues. As soon as you put additional tax burden on employer, takes option out of employers' hands as to their expenses.
From a business standpoint, what issues does this proposal worsen? What concerns you about it? (cont'd)		Free market system is way of rationing scarce resources. If you're not paying, utilization inevitably goes up. What form of rationing would replace it? Afraid it would be the bureaucracy.
		Counters efforts to teach health and wellness - no incentive for that
		Businesses that don't currently offer insurance will pay more
Individual mandate	If employer not mandated to provide insurance, market will address it - like that concept of putting responsibility at individual level	NA
	Could be good for business: Bring healthier, younger employees into plan; create a more equal playing field for employers	
	Concern re: potential negative impacts on employees, e.g., denial of drivers licenses, IDs - could limit their ability to get to work	
	Who provides proof of coverage? If employer has to play a role in this (e.g., with W-2), would be administrative burden	
	If employer has to pay higher wage to enable employee to get coverage, will have adverse impact on employer	

	Solutions for a Healthy Colorado	Colorado Health Services Program
	What happens to existing employer coverage? Unsure whether employers will continue to offer it or drop it.	
	Gives businesses options to offer coverage - like that preservation of choice	
	Minimizes options for employees, however, if employer chooses not to offer coverage - core limited benefit isn't great, if they need more they're subject to rating factors and will pay a lot. Employers could lose employees if they force employees into this scenario.	
Benefit package/premium/subsidies	Benefit cap is low; combined with limits on physician visits, would increase number of underinsured and potentially exacerbate cost shift	
	For 80% of people, \$50k cap would cover costs	
	Encouraging HSAs lets employers save money, but shifts more costs to employees - which also can increase problem of underinsured	
Insurance market reforms	Like eliminating some of the barriers that make it harder for small groups to purchase insurance (e.g., life insurance purchase, 35% penalty, high employee participation)	
	Don't want to change treatment of 1099 contract workers - they'd become employees	
	Guaranteed issue, modified community rating: Potential impact unclear	
Cost-sharing/co-pays		Doesn't do enough to incent individual responsibility - co-pays aren't sufficient
Residency		Impact on employers unclear: People can move here, get insurance coverage w/o ever working and employers pay - but employers are already paying higher premium costs from cost shift for uncompensated care

	Solutions for a Healthy Colorado	Colorado Health Services Program
		If this brings more healthy people into the pool, it's a benefit
		Impact on in-migration unclear. Could minimize it because people can't go back and forth; could increase it because 3 month residency requirement isn't too difficult to meet
Benefit mandate provision	Like this idea: As small group, pay for mandated benefits that members may not use	NA
	Talent does not always come as insurable risk - concerned about potential impact of this provision on business' ability to attract talent	
Exchange	Helps ensure accessibility for all citizens - no real impact on employers, but like the concept	NA
Financing	Employer contribution to subsidy pool is confusing; if it's required, it looks like backdoor mandate. If it's not, could be way for employers to attract employees	Do federal government, ERISA-exempt employers, out-of-state employers also pay payroll tax to Colorado? Not sure this financing mechanism is feasible
Reinsurance	As business owner want to know that high dollar claims will be covered	NA
	This provision is one of the things that will make currently insuring employers pay more	
	Reinsurance industry is really volatile - concern about this provision	
HIT		Unfunded mandate. Potential costs to business community and public. Will doctors leave because they can't afford to comply?
Other issues		Benefits could vary depending on money in plan. When the plan is rich, you add benefits; when it's not, you cut them.

**Business Advisory Task Force
Notes from October 10, 2007 Meeting
ASSESSMENT OF 5TH PROPOSAL**

Participants:

Dick Allison
Les Berkowitz
Kelly Esselman
Laurie Harvey
Jim Hertzell
Don Kortz
Steve Krell
Diane Schwenke-via phone
Dwayne Stevens
Gena Trujillo
David Westerlund
Nathan Wilkes

Guests: Sarah Schulte

Staff: Edie Sonn

Observers: Les Meyer
Pilar Ingargiola
Christie McElhinney

Recommendations are highlighted in yellow

Consensus concerns in green

Requests from Commission for input in pink

5th Proposal Questions

- Explain Cover Colorado – how would it work under this proposal?
 - With individual mandate, you can't rate on health status – must community rate; 5th proposal calls for modified community rating (on basis of age, geography)
 - But carriers were worried: if can't rate on health status, will have adverse selection and destabilize individual market
 - Compromise: Restructure existing high risk pool – Cover Colorado. For those who have certain conditions, they will be directed to Cover Colorado, not individual market. Subsidized by premium assessment on insurers, in order to equalize rates between Cover Colorado and individual market.
- Dick Allison: Extend guaranteed issue to small group market
- Small group market: Is assumption that it remains the same as current?
 - Yes: 50 or fewer
- Rec. # 8 – Create incentives for communities with good local solutions?
- Catastrophic pool: Is \$20mm/year forever?
 - Commission essentially guessed at that number.
- Catastrophic pool: Fund w/premium tax, but ERISA companies don't pay those neither does state.
- If most of my employees are eligible for subsidy, burden falls on me to administer this.
 - Eligibility will be determined 1s/year, don't have to worry re: monthly fluctuations.
 - Gena Trujillo: But events affect eligibility throughout the year (e.g., marriage, birth, etc.). Having to requalify based on these events, could be huge administrative burden. Commission would like recommendations on this.

- If you offer coverage to employees, they'll be required to purchase your coverage with their subsidy. That will be potentially administratively burdensome to employees. Commission would like to hear ideas about this.
 - Are employers collecting or remitting?
 - Would employees be required to provide proof of insurance at time of hire?
- Lots of detail that needs to be fleshed out – point a clear direction for future steps.
 - Task Force will suggest the Commission work with subject matter experts to flesh out.
- Rec. #20: End of life care – is this code for rationing care?
 - No. Based on consumer proposal calling for more patient direction.
- Attachment A: Commission would be interested to hear Task Force's comments on benefit package. Trying to hit approx. \$200 PMPM on average.

Rec. 1 What are employers' costs and other impacts from enforcing individual mandate?
(indiv employer mandate) - Administrative costs of enforcing individual mandate will hit employer

- If trying to hire employee who doesn't have proof of insurance, then what?
- Send to Coverage Clearinghouse, but how much time will it take, what admin burden will it require?
- Requirement for employees to take employer coverage if offered would minimize adverse selection for employers

Rec. 2 \$50-k cap shifts from risk management model to financing model – there will be a
(subsidy) large group of people who don't fit under the cap.

- Unsure re: how catastrophic pool will work
- Requirement for people to buy into employers' plan – what if spouse has coverage of own (e.g., through the military?). Forces individuals to take their employer's coverage, minimizes plan-shopping, good from a risk-spreading perspective.
- HOWEVER – potential for this to be a cost to employers. Employers count on a certain % of employees opting out. Now employers will know that 100% will select coverage. So employer's budget line item for insurance has gone up. Though depends on what employer's contribution is. Currently an inequity in Colorado: small groups required to pay 50% of premium, no such requirement for large employers. So if participation requirement for any employers, should be across the board.
- Changes in eligibility for subsidy: Follow S 125 rules – employers are used to dealing with that because they have to make modifications for those plans.
 - Premium tax: Funding of catastrophic pool should be equitable – ERISA employers are not subject to it, need a level playing field.
 - Where does the subsidy go: to the employee or employer?

Rec. 3 Would the changes here encourage exodus from small group market?
(indiv mkt changes)

- Look at definition of small group market – 51-100 employee businesses fall into limbo.

Rec. 4 Confusion – does Clearinghouse get you to private coverage as well
as Cover
(Cvg Clearhse) Colorado, etc.?

Rec. 6 In best interest of all small businesses – competitive advantage, tax
benefits.
(S125) - What if federal rules change? – Was just overhauled, don't see
much likelihood
of it happening again in near future, very stable, risk of unpredictability is small.
- (ref notes from last meeting re: cutoff)

- S125 takes you to the highest HIPAA requirements – places additional admin
burden

Rec. 7 Can't hire them so it's a moot point
(undoc'd)

Rec. 8 Some of these innovative local efforts minimize inappropriate use of
services –
(local exs) Task Force supports this recommendation

Recs. 9-14 Don't see specific impacts on business from these
(MK/CHP+) - By expanding Medicaid and CHP+ we'll increase program costs and that
will
impact all taxpayers

- Concern: Will MK expansion increase the cost shift because you're bringing
more people into the system w/o increasing reimbursements sufficiently?

Rec. 15 WC is cheaper for most employers – only ones who would want to opt out
are
(24 hr covg) those in high-risk industries (e.g., iron workers)

- Contrary view: Having duplicate systems doesn't make sense – can save
money
by combining them and make improvements in delivery of care.

- BUT: What happens with non-work related disability claims?

- Currently, WC pays out 66% but not taxed, so it's close to full salary. Disability
payments, though, are taxed.

- Some TF members like it; some don't.

- If you could take away all of employer's liabilities for WC, looks like good idea
on surface. But can't tell – "above our pay grade." Small businesses that haven't
had WC claim in years – have no idea of the impact.

- Scared to death re: health system that looks like WC system. If all claims go
through health insurance, premiums will go up. How long? Who decides?
Potential morass of regulation. Next logical step is removing medical coverage
from auto insurance.

- If I have WC claim, I have incentive to get that employee back to work and can

have a lot of opportunity to minimize impacts. What happens to that incentive if you move to 24-hour system? Worry that a bureaucrat out there will be making claim decisions, rather than a claims adjuster.

- Not sure you'll see savings from this. Might eliminate some redundancies but create potentially scary new downsides.

Rec. 16 Impact on business? See (v) – potential additional administrative costs
(cont covg) Could create adverse selection that would impact employer, don't save \$\$

Recs. 17-27 Anything that improves efficiencies is good – but not in position to
address #17-
27 in depth

Rec. 17 No comments
(access)

Rec. 18 Can be beneficial to employers
(safety net)

Rec. 19 - Admirable goal – will take a lot of money and time to implement
(HIT) - Appreciate that this isn't a mandate that could be a hardship to
business, but
rather a recommendation
- Providers/systems are so independent, hard to get everyone on common system
- A common system collaboratively created – rather than a competitive system –
could save money and improve quality

Rec. 20 Concern comes from “best scientific evidence” phrase – change to
“collaborative
(EOL care) decision-making among doctors, patients and family members”

Rec. 21 No comments
(care coordn)

Rec. 22 More informed consumers are good for business
(transparency) Proposal 5 adds so much more complexity to system that this seems
problematic

Rec. 23 Employers can play a role in promoting prevention and wellness
(prev care) - However, need some more subject matter experts to help with this. Lots of
businesses have moved to HSAs, yet this talks about expanding first-dollar
coverage. A lot of employers would not be able to avail themselves of first-\$
coverage for preventive care. Sounds good, but need to understand better.

- If employer covers wellness, does it become a provider for HIPAA
purposes?

Rec. 24 No comments
(local community efforts)

Rec. 25 Would like to see h.c. system cooperate, collaborate and communicate -
(admin costs) think this is potentially huge

- A very admirable goal – concern about health plans' ability to comply, potential
to drive costs up because they'll have to make changes to nationwide systems in

order to comply with Colorado law

Could shrink admin costs by minimizing stacking of networks, “rent a network”
w/l plans – streamline this, you’ll save \$\$

General comments

- What happens if we expand public programs and then go through another recession?
- From employer’s standpoint, question is: How much will it cost us in the end, and how much can we tolerate? Lots of good ideas here, but need to look at the potential total impact on business.
 - CAVEAT: We’re looking at 5th proposal w/o cost analysis
- Concern: Any plan that focuses a lot of attention on subsidies will hurt middle class – they’re paying their own insurance premiums as well as taxes to pay these subsidies
 - Contrary view: We’re paying now through the cost shift
- Concern: All proposals except single payer increase under-insurance
- Concern: Still not addressing underlying costs

Final report process

- EDS turn these notes over to group by Thurs. 10/11
- Small group (Don, David, Kelly) combine with prelim report
- Structure:
 - Executive summary identifying key concerns/recommendations
 - Supplement with specific comments on each plan

###

Provider Task Force Report

Provider Task Force –Final Report to the 208 Blue Ribbon Commission on Health Care Reform

October 18, 2007

The Provider Task Force – who represent a diverse spectrum of providers –is pleased to present this final report to the Commission and is hopeful the information will be given careful consideration by the Commission as it contemplates modeling revisions to the 5th proposal and prepares its final report to the legislature and governor.

Introduction

In addition to specifically reviewing and providing comment on the five reform proposals, the Provider Task Force studied statements submitted to the Commission and heard testimony from a broad constituency of stakeholders. Our task force asked representatives from several organizations / provider groups to inform it about key health care recommendations from providers that might benefit the development of the 5th proposal and aid the Commission in meeting its legislative charge. The task force studied documents and heard testimony from the following organizations / provider groups and used this input in addition to the rich perspectives brought by the 15 members of the Provider Task Force to inform the development of this report:

- Colorado Medical Society – *Ben Vernon, MD (CMS President-elect) and Mark Laitos, MD (Co-chair of the CMS Physicians' Congress on Health Care Reform)*
- Colorado medical student section of the Colorado Medical Society – *Mr. Trevor Neal, MS2 (Co-chair, CMS Student Section)*
- Colorado Safety Net and Community Health Centers – *Ms. Annette Kowal (CEO, Colorado Community Health Network)*
- Colorado Hospital Association – *Mr. Steven Summer (President and CEO, Colorado Hospital Association)*
- Colorado Public Health organizations – *Mark Johnson, MD, MPH (Executive Director, Jefferson County Department of Health and Environment)*
- Colorado Commission on Family Medicine and the Colorado Family Medicine Residencies – *Sue Hall, JD (Director of Governmental Affairs)*
- Oral Health Awareness Colorado! – *Deborah Colburn and Tracy Anselmo*
- Colorado Rural Health Resource Center – *Lou Ann Wilroy, Executive Director*
- Long-term Care Services – *Barry Rosenberg, President, Personal Assistance Services of Colorado*

Key Issues / Core Values from Providers' Perspective

Service Delivery System / Infrastructure

Resources must be committed to re-engineer an aligned, cohesive, and coordinated system that supports a primary care-based “healthcare home” as the cornerstone of care.

Stakeholder Responsibility & Accountability

The difficult responsibility of limiting care must fall to a broad representation of society, and not to insurers or individual providers who, by their roles, are inherently conflicted. These difficult decisions must consider not only what we need to start doing but also what we need to stop doing in order to expand access and decrease costs.

Quality

Quality must be defined and measured by a clinically qualified oversight group and publicly reported.

Payment / Funding

Expanding access to care will require reimbursement reform. However, funding is not just about reimbursement, it is about making an investment of resources to ensure not only a thriving primary care infrastructure affording everyone a healthcare home but also strong specialty, inpatient, and auxiliary services.

Health Information Technology / Data

Reform must plan for and allocate funding to support technology-enabled information management.

Strategic Considerations That Emerge From These Issues / Core Values

- A primary care-based healthcare home model that allows providers to incorporate both patient-based and population-based services is an essential foundational element for healthcare reform.
- Every primary care practitioner must have the tools necessary to track, measure and coordinate care.
- An effective healthcare home model necessitates investments in Health Information Technology (to include clinical guidelines and point-of-care decision support) and workplace / workflow re-engineering.
- Reform must include strategies to increase our primary care workforce in Colorado. Licensure and scope-of-practice should balance assuring quality care with the need to maximize provider capacity.

Final Recommendations to Blue Ribbon Commission

Using the issues, values and key considerations above as our starting point, the Provider Task Force has identified the following recommendations for the Blue Ribbon Commission.

Note: *All of the following speak to the goal of creating greater “system-ness”.*

Quality Improvement

- Enable the provision, coordination and integration of patient-centered care, including “healthy hand-offs”.
- Encourage the development of a statewide system aggregating data from all payer plans, public and private.
 - This retrospective claims database is a first step toward a system that would measure the efficacy and efficiency of care and identify opportunities for improvement. It would grow into a system that will help providers make prospective and point-of-care decisions.
 - Build upon regional systems or efforts already taking place for sharing data among providers (e.g., North Colorado Health Alliance, Pikes Peak Region and Mesa County initiatives).
 - System should be funded and organized by government, insurers and providers and administered by the state - the only player large enough to convince all payers to participate.

Administrative Simplification

- Standardize benefit packages, claims forms, payment processes, etc. across health plans to improve transparency and minimize administrative costs.

Stakeholder Responsibility / System Integration

- Integrate public and private physical health systems to incent consumer adherence and enable care to be provided by the most appropriate health care provider. For example, a primary care provider “hands off” a patient to the public health smoking cessation program. Upon completion of the program, the patient receives the health insurance premium incentive.

Payment Reform

- Get serious about changing reimbursements and incentives across all payers – public and private.
 - Statewide all-payer database must give information that can be used to structure incentive-based payment systems.
 - Ensure that payment systems are predictable as we implement change.

Healthcare Workforce

- Develop and expand state-based loan repayment / forgiveness systems / tax credits and other mechanisms to recruit and retain healthcare workers who will serve the underserved and provide a primary care-based healthcare home for all.

Final Note

We must acknowledge that currently we have no true healthcare system. Achieving “system-ness” will require adequate financing, political will and time. Our goal must be lofty, yet realistic about what will be required to achieve it. Incremental steps may indeed be necessary but we must clearly identify the final goal of reform and implement a roadmap to get there. An incremental implementation of reform can not be an excuse for compromising the Commission’s charge to cover all Coloradans while reducing health care costs. All stakeholders, including elected officials, must hold themselves and each other accountable for continuing along a path toward that ultimate goal of expanding coverage and reducing costs.

	Better Health Care for Colorado	Solutions for a Healthy Colorado
What do we like about this proposal?	<p>The phased-in approach can be a good way to expand coverage as it gives needed time to expand provider pools and time to test the impact on targeted groups. From the patient perspective the following elements are positive: choice; portability; waiving co-pays for healthy behavior; long term care and its housing components is good for the geriatric population; and first dollar coverage. From a business perspective expanding Medicaid to childless adults will bring healthy people in to the risk pool; and reimbursement at the Medicare fee scale is better than Medicaid reimbursement for private physicians. The residency approach would make it easier for those here legally to purchase insurance.</p>	<p>This proposal pulls in personal responsibility in a meaningful way with wellness and healthy life styles components. The plan explicitly addresses the cost shift cycle (although leaves out insurer component). Begins to address cost transparency in a meaningful way (needs to apply to all components). The "connector" component is a plus. Plans are required to offer at least a minimum core benefit package (essentially guaranteed issue). It is the only proposal that explicitly addresses medical malpractice. Establishes a deadline for HIT implementation. Realistic in acknowledging a long timeline for overall implementation of reform. Acknowledges provider reimbursement issues through proposed increased rates. The nutrition tax component of financing was attractive because it could help drive behavior change and affect obesity. It included at least some behavioral health coverage (not as much as other proposals). Uniform pricing model intriguing (but perhaps not workable.)</p>

<p>What concerns do we have about this proposal?</p>	<p>Costly plan covering the smallest number of currently uninsured. Reimbursements rates that disincentive provider participation will result in coverage in name only. A reliance on FFS payments is fundamentally flawed that does not reward outcomes and does support the "medical home" model. The benefit package is low with significant gaps. The \$35K annual cap is too low for high utilizers, pushing some currently insured in to CoverColorado. The subsidy may not be sufficient and cause people to be disenrolled for non-payment, contributing to churn, interrupted care and cost shifting. Co-payments linked to income would be a constant hassle to calculate and could not be done at the doctor's office or hospital. Having the exchange side-by-side with public program administration creates the potential for confusion.</p>	<p>P4P only addressed for providers but not insurance plans. Employers don't appear to have enough "skin in the game" to remain in it. The \$1,000 annual cap on DME and mental health is far too low. Medicaid-eligible recruitment scheme appears naïve (internet-based). Appears to be an imbalance in focus: too much on impact of medical malpractice (less than 1% of costs); far too little on administrative costs (20-30% of costs). Want to see proposal move beyond cliches and rhetoric to data and substance behind claims. Concern about short grace period before lack of premium payment sends individual back to ranks of uninsured and ED utilization. The proposal would be far more robust if it discussed regulation / rehab / responsibilities of insurance market. Need to focus healthy behavior incentives on evidence-based practices where results can be measured. Unrealistic and perhaps disingenuous to premise success on consumer decisions when most health care decisions are made by provider. Proposal makes false assumptions about numbers eligible for Medicaid.</p>
---	--	--

	A Plan for Covering Coloradans	Colorado Health Services Program
What do we like about this proposal?	<p>Covers a large percentage of uninsured; expansion of Medicaid/CHP+; emphasis on Medicaid managed care; the Health Insurance Purchasing Authority facilitating clinical oversight; individual and employer mandates combined with guaranteed issue and community rating; coordination among payers allows for the opportunity to aggregate data; large purchasing pool spreading the risk; addresses a key cost-driver - chronic illness; disabled adults can buy-in up to 300% FPL; rewards good outcomes; administrative efficiencies through standardized forms, billing, payment systems; eliminates multi-step process for families; COBRA assistance; safety net explicitly included in the plan; inclusion of vision, dental, mental health, substance abuse, and hearing benefits for Medicaid; aligns incentives and rewards quality; individual responsibility; everyone has to give a little - spreads the "hurt"; realistically addresses difficulties of reducing costs; sets the stage for the necessary discussions about limits on inappropriate care, good stewardship etc</p>	<p>This plan covers all Coloradans through a single payer model operated as a public utility. Administrative simplification will save money and improve provider billing efficiency by reducing "hassle" created by different payers. There is a strong rural component that could help reduce / eliminate the rural / urban disparity by improving provider reimbursement thereby assisting in the recruitment and retention of rural providers. It recognizes regional differences through its governance structure. Coverage is comprehensive and includes primary care (including preventive and a medical home), mental health, and specialty care. It folds workers' comp into a single system of care. The proposal is attractive because it levels the playing field for business, eliminates for-profit shareholder costs, and is the only proposal that could cost less than the current system of care. It simplifies drug coverage. Presumptive eligibility for first two years covers everyone quickly. Consumers have choice of any provider. Providers are part of the governance structure.</p>

<p>What concerns do we have about this proposal?</p>	<p>Two reimbursement strategies were identified but Medicare option not modeled; workforce concerns to handle proposed Medicaid/CHP+ expansion; unsure the employer participation/crowd-out assessment is enough to keep employers in the game; perceived bias toward safety net; HIT ideas good but will take time and dollars to accomplish; provider tax may need to be modified and uncertainty as to whether it applies to hospitals only or physicians, too; sin taxes may incent healthy behavior but are regressive; assessment on the for-profit health plans may cause the to leave the state.</p>	<p>This is a "government" system with its incumbent concerns (will a huge bureaucracy be created / exacerbated?) Would eliminate the benefits of the market (e.g., innovation, technology development, competition, etc.) A single governance and operating structure could impede providers' abilities to negotiate for additional resources. As proposed there are no incentives to integrate practices (consider incentives to manage populations rather than only individual patients.) Concern that won't incent innovation and system efficiency. Concern that governing authority will not have will to make necessary tough tradeoffs in adopting newer, higher-cost medical advances. Access will be limited by capacity. Adverse selection could occur drawing sick people into Colorado. The governing authority appears very powerful; membership would be critical. Are chiropractors qualified to be PCPs?</p>
---	--	--

	5th Proposal
What do we like about this proposal?	<p>Many of the positives of this proposal are also potential negatives (see below). Insurance market reforms are a plus, esp. guaranteed issue of basic plans, catastrophic coverage, end of life care (though need to be willing to explicitly discuss trade-offs). Medicaid and CHP+ expansions are important, esp. dental benefits for adults. Individual mandate will likely increase number of people getting care, including prevention services which could avert important public health problems. Administrative simplification is a plus for providers and can reduce costs. Coordination of care/payment methodologies across physicians and hospitals, improved transitions across care settings. 24/7 nurse advice line. Coverage for undocumented people is a positive, as these patients are cared for ultimately anyway. Quality improvement: Explicit call for data aggregation is key. Tax credit for health IT would assist providers in automating their practices, as cost concerns are a major prohibitor. Voluntary continuous coverage allows for some experimentation with single payor. Expanded APN scope of practice could improve access.</p>

What concerns do we have about this proposal?

Changing Medicaid to CHP+-like benefits will be a reduction for some, despite additions (e.g., dental). 3-4 basic plans may be underinsurance for many. Infrastructure components (case managers, 24/7 nurse help line, connector, data aggregation, quality improvement) are good things, but may not create a return on investment short-term. Without clear limits on care, costs may continue to rise unabated until programs take effect. Does not go far enough in admin simplification; workforce development; recruitment/retention; end-of-life care; risk-adjusted payments; public health, incl. nutritional education and the narrow definition of safety net providers; telemedicine; defining, measuring, and rewarding high quality care. APNs as primary providers controversial - questions of regulatory oversight and payment parity. Medicaid reimbursement as proposed is insufficient to attract enough private providers back. IT infrastructure, provider tax may raise costs for providers. Providers don't want to be used as an instrument of state immigration policy. CoverColo expansion, catastrophic coverage may be grossly underfunded.

Rural Task Force Report

**Rural Task Force Report
for the
Blue Ribbon Commission for Health
Care Reform**

October 18, 2007



Blue Ribbon Commission for Health Care Reform

I. Executive Summary

The Rural Task Force Members are pleased to submit this report to the SB 208 Blue Ribbon Commission for Health Care Reform. It is our hope that this report will provide the commissioners with the information necessary for them to complete their mandate in providing recommendations to the Governor and Legislature on how to improve health care in Colorado. The observations and recommendations contained in this report were reached using a consensus decision making process. This report was taken very seriously by the task force members and reflects many hours of meeting time, telephone conferencing and travel. We would also like to acknowledge the excellent work performed by staff assigned to our committee.

The participation in the task force very accurately captured the full range of what “rural” can mean in Colorado. With over 75% percent of the state’s land mass, rural is a very big tent to live in, for the nearly one million Coloradoans who call it home. Rural Colorado means everything from living in one of our frontier counties where the population density can be as low as 3 people per square mile, to our resort communities which experience huge, seasonal population swings.

Given the disparity of what “rural” can mean the task force agreed on several key characteristics which we felt could be applied universally throughout rural Colorado. These characteristics are as follows: large numbers of uninsured and underinsured, an economy dependent on small employers, distance, workforce availability, reliance on safety net, less access to capital and an IT infrastructure less developed than in urban areas. This list served as the lens which we used to examine the five proposals.

In the course of this examination a list of specific recommendations was developed. The recommendations contained in the final section of this report are meant as a guide for the SB 208 Commission as they contemplate their own recommendations for reforming health care for the benefit of all of Colorado’s citizens.

II. Key Considerations about Rural Colorado and General Reactions to the Proposals

The Rural Task Force met three times and specific detailed input on each of the proposals is available. In response to a request from the Proposals Committee, the Rural Task Force is also developing specific recommendations regarding effective strategies in rural Colorado.

Key Considerations about Rural Colorado

The group identified certain key characteristics of rural Colorado that informed their analysis of the proposals:

- Large numbers of uninsured and underinsured
- Economy dependent upon small employers

- Distance
- Workforce availability
- Reliance on safety net
- Less access to capital
- IT infrastructure less developed than in urban areas

General Reactions to the Proposals

Workforce considerations

- Access to coverage doesn't equal access to care, especially in rural Colorado. Expanding insurance coverage in rural areas is moot unless there are sufficient providers, of all types, to serve them. Some counties in Colorado have no Medicaid providers, mental health clinicians or dental providers.
 - Network adequacy is an associated problem. Even in areas that have sufficient numbers of providers, all may not participate in the insurance plans available.
 - Many of the proposals rely on multidisciplinary approaches to care delivery but that model presents challenges in rural Colorado when providers of all types are scarce.
 - Reimbursement is key in rural areas. Higher Medicaid reimbursements would be a boon to most providers. Providers (e.g., FQHCs, RHCs, CAHs) that receive cost-based reimbursement should be able to retain that system.
- Plan designs that depend on economies of scale – e.g., managed care and case management models – are more problematic in rural areas, because of lack of infrastructure, providers, support staff and distance.
- Healthcare providers in rural communities are many times the primary – or indeed only – source of access to health care services. They act as the safety net and any proposal that weakens or transitions this resource must be carefully implemented.
 - For example, as insurance rates go up, we may lose federal dollars for providing care to the uninsured through FQHCs and RHCs. In many communities, these are the only providers available. If these resources are diminished, we could conceivably lose providers. Similarly, many rural health clinics and hospital-based clinics cannot qualify to receive Primary Care Fund (tobacco tax) dollars with current HCPF eligibility criteria.
- Delay or phase in the penalty aspect for the individual mandate until access is fully understood and available. Rural communities will need time and capital to build the healthcare infrastructure before the mandate can be imposed.
- The provider tax is a disincentive for rural providers and is counterproductive to recruitment and retention.
- Recruitment and retention of health care providers is much more challenging in rural areas. Incentives are preferred over subsidies to ensure an adequate workforce.

Impact on employers, employees

- To the degree that we can make things simple for employers, it's beneficial for rural business. For example, anything that is funded through an administratively simple, relatively low payroll tax, is potentially attractive. Mandates/required buy-in, however, can be cumbersome. Small rural employers don't have administrative or personnel resources to manage complex compliance issues.
- Proposals that expand coverage for public programs could incent these employers to stop offering insurance themselves, putting even more rural Coloradans into public programs. Need to consider the implications of such transitions in coverage.

- Using the tax system to enforce an individual mandate could push more people into the underground cash economy and it would encourage tax fraud.

Plan design

- Subsidies for care when the federal poverty level is increased will cover a proportionately larger number of people in rural Colorado. In many areas this will include community leaders, politicians and professionals.
- Some of the plans had dramatic cliff effects that would disproportionately affect rural populations, because of the large number of individuals who fall between 200 and 300% FPL in rural areas.
- The steadily and substantively increasing deductibles offered by insurance plans to limit plan costs creates an added burden on the 200 to 300% of poverty population more prevalent in rural areas – decreasing access to healthcare and undermining prevention initiatives.
- Dental health must be included in preventive health care services. Many rural areas lack fluoridation, so access to dental care is especially important in these areas.
- Modified community rating, when based on geographic considerations, can be problematic in rural areas. In rural areas, acquisition of care is typically more costly; patients are older, less affluent, less likely to be insured. We encourage inclusion of rural areas with urban regions in ratings calculations.
- Connector is an important mechanism for rural communities where access to health insurance plans can be limited.
- Regarding the Continuous Coverage concept in the Fifth Proposal, the Rural Task Force is willing to support the modeling phase as it has the potential to have positive impacts for rural Coloradans.
- Concern exists about geographic rating issue. Even though residents of rural communities currently may have lower health care costs, there's a considerable lack of providers available. There may be substantial pent up demand. Once people have access to affordable health care, rural residents may have a spike in their utilization of services.

Administrative considerations

- The IT infrastructure is less developed in rural Colorado. Solutions to health care access that depend on this resource, for either providers or consumers, need to be carefully evaluated.
- Rural areas and providers have less access to capital. Any reform proposal that requires capital investment will require State support to level the playing field and will be slower to develop in rural areas.
- Processes – application, enrollment, billing – should be simplified. We encourage more entry points to the public system and simpler administrative systems.
- Auto Enrollment should occur at point of service. Front office staff will require training to effectively implement this new enrollment function.

General comments

- Distance will always have an impact on any reform ideas in rural Colorado. Lack of integrated services, not just co-located services (medical, mental health, and dental providers), will impact cost, access and efficiency.

- While the Rural Taskforce included numerous constituencies, including businesses and consumers, it was largely provider focused. The group was conscious of the need to ensure that all constituencies' views are included in their final report.
- Medicare reimbursement needs to be accelerated in Health Professional Shortage Areas to 100% Medicare reimbursement.
- For proposals moving forward that will have boards, committees and other decision-making entities, there must be rural representatives on a Congressional basis from rural zip codes.
- Utilize the following language when speaking about expanding scope of practice: "Non-physician providers within their scope of practice." This will help rural communities expand health services beyond primary care.

III. Specific Recommendations

Definition of Rural

- Healthcare reform, which considers the needs of rural residents, must begin with a definition of rural that meaningfully distinguishes rural populations from urban populations. The Rural Health Task Force proposes the use of the **Rural Urban Commuter Area** methodology, which describes urban census tracts in relation to predominant commuter patterns. *This approach will distinguish geographically isolated rural areas from less densely populated areas that can reasonably access urban health services and providers.*
depts.washington.edu/uwruca/rural.html

Rural Provider Capacity

- Test reform proposals to assure that **safety net** providers, such as Federally Qualified Health Centers, Rural Health Clinics, Sole Community Hospitals and school based clinics are not negatively impacted. *Rural communities are dependent upon safety net providers, often because they are the only source of care in a community. Safety net providers also have expertise in providing care to traditionally underserved population groups in rural areas such as non-English speaking and low income persons.*
- Expand the **scope of practice** for non-physician healthcare professionals. *Midlevel providers can substantively improve health care access and are an important and valuable part of the health care resource mix in rural areas.*
- Increase funding to **healthcare provider loan repayment** for providers who serve in Health Professional Shortage Areas. *Increasing the incentives for providers to locate in rural areas is crucial to healthcare access. Health insurance coverage alone will not assure access. Most rural counties have insufficient numbers of primary care, oral health, mental health and substance abuse providers to meet the care needs of the population regardless of their insurance status. Decreasing the numbers of the uninsured will not correlate to increased care access in many rural areas without more provider capacity.*
- Increase funding and marketing for **medical education** of providers who are on a rural track program in a primary care specialty. *The health care workforce is older in rural areas and thus the demand for new health personnel is greater than in urban areas.*

Rural Access to Health Care Services

- Assure basic plan coverage to include **oral health, behavioral health (mental health and substance abuse) and vision care** services., *Covering only the medical/physical part of health care perpetuates fragmentation and does not address the complexity of the many people who present with co-occurring conditions. This is especially applicable in rural areas,*

where people have less access and substantial unmet needs for holistic care. The Colorado Clinical Guidelines Collaborative offers strong support for delivery systems that utilize integrated approaches. Substantial evidence exists that providing coordinated care results in lowered utilization of ER and inpatient services.

- Modify state **regulations**, which prevent or set unacceptably high standards for the co-location and mixed use of some healthcare facilities. *Often rural areas cannot afford the infrastructure costs of separate healthcare facilities, particularly when small patient populations are served.*
- Increase **Medicaid reimbursement** to parity with Medicare reimbursement in designated Health Professional Shortage Areas, which are located in rural zip codes. *Rural providers lack economies of scale and higher commercial insurance populations, which can offset reimbursements that are well below the cost of care delivery.*
- Assure adequate technical infrastructure and staff for **Telemedicine programs** in rural areas to deliver chronic disease management and specialty consultation. *Telemedicine is not, however, a suitable substitute for most primary care services.*
- The use of a 24-hour telephone triage **nurse line** for patients will benefit rural populations. *A triage line is also likely to reduce the use of emergency departments for non-emergency healthcare services, reducing costs to small rural providers.*
- Increase **support for community based organizations and local governments** to assist families through eligibility and enrolment process. *Many local organizations in rural areas will not have sufficient capacity of training to assist families in enrolling in a plan.*
- **Enrollment** in any state mandated health plan must occur automatically at point of service, if the patient has not previously enrolled in an insurance plan.
- The use of an **insurance connector** is likely to benefit rural populations, however, access to a connector should not be limited to the web. *Rural areas have less Internet connectivity and some populations, particularly the elderly, will not reasonably be able to use web-based services.*

Rural Parity with Urban Populations

- Any governing body, which emerges from reform efforts, must include at least **proportional representation** from rural areas of Colorado. *The reality of healthcare acquisition is different in rural areas and must be represented on any governing body to assure that policies consider rural experiences.*
- Test any geographic **community rating** proposals, which isolate rural populations from urban populations to assure that they do not disadvantage rural populations. *Rural populations require more medical attention since they are generally older, poorer, and more hazardously employed than are urban populations. Though the per unit cost of care may sometimes be lower in rural areas, health care utilization may be higher.*

Containing Costs

- Test all proposed **financing mechanisms** to determine if they will disparately affect rural populations. *Because rural populations tend to have fewer liquid assets and less personal income, financing approaches must consider the socioeconomic differences between urban and rural populations.*
- Test **economic incentives** to providers and insurance plans to assure that modeling considers the limited healthcare provider capacity in most rural areas of Colorado. *Meaningful competition among providers seldom occurs in rural areas because there may be only one provider, or even no provider, in a county or service area. Higher percentages of Medicaid, Medicare and uninsured in rural areas discourage other providers from entering the market.*
- Establish rules to **protect rural providers from unreasonable financial risk**. The imposition of provider risk-sharing models that pass significantly higher financial risks to individual providers may force some rural practitioners into more concentrated risk environments. Furthermore, rural providers do not have adequate capital reserves (cash or investments) to

- bear prolonged risk or cash flow shortages. Healthcare reform must place a greater emphasis on wellness and prevention by increasing funding for the public health system.
- Health departments and public health nursing services play an important role in preventing disease, alleviating health disparities, reducing the burden of disease, and containing the costs of healthcare in rural areas. Moreover, behavior and environment, the key areas of emphasis in **public health**, are known to be stronger determinants of individual health than insurance status. Public health can help assure the desired outcome of reform, which is a healthier public, by addressing the non-medical determinants of health status

Vulnerable Populations Task Force Report

REPORT TO THE BLUE RIBBON COMMISSION
VULNERABLE POPULATIONS TASK FORCE

September 28, 2007

Vulnerable populations include those who have low income or are financially vulnerable; those with disabling, catastrophic or chronic illnesses; those unable to advocate or speak for themselves; those with mental health issues; those requiring the use of multiple systems or transitioning in life; and those facing barriers to access that may be physical, cognitive, age, language, cultural, literacy or stigma based.

Because the definition includes those who are financially vulnerable, any person whose only affordable option for health care coverage is a plan with a coverage ceiling, i.e. \$50,000, is potentially vulnerable. "One step away" from an event that changes their life forever. Mandating the purchase of a minimum benefits package forces residents to pay for *underinsurance* and is in direct conflict with the guiding principles of the Commission. We must not exchange our uninsured for masses of underinsured.

According to one study, in 2001 medical problems contributed to approximately 50% of all bankruptcy; 75.7% of these individuals had insurance at the onset of illness. When health care costs exceed the limits of an insurance policy, the consumer is forced to pay out of pocket until they are bankrupt. At that point costs are shifted to taxpayers via increased premiums to cover uncompensated care and possibly enrollment in Medicaid/Medicare, provided the individual qualifies. The business of medicine continues to thrive while the interests of consumers suffer. This cycle will not be stopped until legitimate health care reform is endorsed.

*If the misery of the poor be not by the laws of nature but by our institutions,
great is our sin. Charles Darwin.*

The Lewin analysis established that current expenditures in health care would finance comprehensive health insurance for all Colorado residents under the Colorado Health Services proposal with \$1.4 billion in savings to the state of Colorado. We should not consider healthcare to be a commodity, as we do not choose to get sick. The Vulnerable Populations Task Force asks the legislature to have the vision to do what is best for all of the residents of Colorado. If this is not possible, we offer our recommendations on elements of health reform that could benefit Vulnerable Populations.

GUIDING PRINCIPLES OF THE VULNERABLE POPULATIONS TASK FORCE

1. All residents of Colorado have the right to equal, affordable, comprehensive and high quality health care. Health care is the holistic integration of physical, behavioral/mental, and oral health. All people are deserving and valued. Unmet needs and uncompensated care will continue the current escalation in health care costs for all.
 - Health plans must be guaranteed issue and pure community rated.
 - Waiting lists for long term care services are unacceptable.
2. All deserve a choice of health plans and choice of providers. There are savings to be had in health care through prevention, both primary and secondary, that access to health care will help the state realize.

3. Access should be ensured based on best medical practices in the least restrictive environment.
4. Recognize that vulnerable populations are poorly represented in medical research studies resulting in a paucity of relevant evidence based medicine.
5. Ensure that Vulnerable Populations, whose needs may be extensive and who are frequently devalued by and invisible to society, are not denied access to medically necessary care. People do not cease to exist because they are ignored.
6. A household's total expenditure for health care (including long term care) should be limited to a percentage of income (or assets), defined to avoid impoverishment. When a family is forced into poverty the long term costs to the system are magnified and perpetuated through subsequent generations. Recognize that costs include premiums, co payments, deductibles, caps and full payment for uncovered care.
7. Health care should be provided to all people living in Colorado, regardless of documentation status.
8. Comprehensive and compassionate holistic health care should be provided with respect and dignity. This would entail:
 - Providing contextually and culturally appropriate care for those who are homeless, impoverished, low literacy, transitioning, and addressing sex, age, language, race, ethnic, geographic, sexual orientation, gender status, and disability issues. It is necessary to understand the overarching context or culture in order to provide appropriate care.
 - Supporting individuals to fully participate in joint decision making about their care.
 - Providing services in a variety of settings with convenient hours, upholding the values of a family centered Medical Home.
9. Colorado must support the value of continued health and independence of the individual. This support should include but are not limited to housing, food, safety, transportation, childcare, and basic daily living skills.
10. Primary, preventative, acute, chronic and long term care should be coordinated and integrated to ensure continuity of care from conception to death. A truly coordinated and integrated system would support seamless transition out of hospitalization, incarceration, foster care, institutionalization and the military.
11. Health insurance is necessary but not sufficient to ensure access to health care and improved health for vulnerable populations. The commission's goal of protecting and improving the health status of all Colorado residents cannot be met solely by providing health insurance. Barriers to access must be addressed.

The needs of Vulnerable Populations are multifaceted and complex. They should be intentionally and directly incorporated into any meaningful healthcare reform.

RECOMMENDATIONS OF THE VULNERABLE POPULATIONS TASK FORCE

- The safety net must be preserved and strengthened.
- Long term care needs to be evaluated and planned for *in detail*, both current and projected future needs.

- Any new proposal should include existing mandates provided by state law.
- Build on successful local initiatives that are working for vulnerable populations.
- Ensure that insurance plans provide comprehensive, high quality healthcare. This should include *but not be limited to*: primary, preventive, acute, chronic, specialty and long term care; 24/7 access for emergencies; oral/dental, vision, hearing; Mental Health; Substance Abuse; Specialty Care; Prescriptions, including high cost, second line and/or alternative treatments and off label uses; durable medical equipment and other assistive technology, hearing aids, and prosthetics.
- Focus on Wellness and Prevention. Incentivize consumers to engage in healthy behaviors and use appropriate preventive care. Eliminate co-payments for evidence based preventive care such as mammography screening.
- Decrease complexity of health care plans and provide consumer education in acceptable mediums. Provide tools that enable consumers to make informed choices. The health care plans should be easy to navigate.
- Provide consumer/family friendly appeals processes with advance notice and ombudsmen.
- Consumer satisfaction data should be collected and reported by an entity without conflict of interest.
- Provide transparency and accountability.
- Contain administrative costs while providing high quality comprehensive care, i.e. National Association of Community Health Centers.
- Expand Health Information Technology to allow quality seamless care, reduce medical error and forgo the need to duplicate care.
- Recognize the value of culturally appropriate and holistic medicine including non- allopathic medicine and traditional healers/ non-traditional western providers.
- Provide continuous coverage with portability that allows interstate travel and reciprocity with other states.
- Promote research into best medical practices for vulnerable populations.
- Expand Medicaid to Federal levels. Endorse Medicaid Buy-in and Ticket to Work.
- Decrease complexity of Medicaid via:
 - A joint/single simplified application process for Medicaid and CHP+ with continuous eligibility for 12 months, passive re-enrollment, and elimination of unnecessary verifications;
 - Presumptive enrollment of income eligible. Presumptive enrollment of those on AND while awaiting SSI. Fast tracking to facilitate transitions;
 - Expansion of the state definition of developmental disability to match the federal definition; consolidate the 14 Medicaid Waiver programs accordingly.
- Enhance Medicaid:
 - Increase reimbursement for providers, with incentives for those who provide quality care to high needs populations;
 - Build on the success of the Consumer Directed Attendant Support Program by expediting implementation of HB 05-1243;
 - Enable consumer directed care for DME purchase to maximize cost savings;
 - Allow services to be provided in the family home;
 - Encourage fraud detection via consumer education and incentives;
 - Expand benefits to include oral/dental, glasses, hearing aids, transportation and respite care;
 - Allow reciprocity with neighboring states;
 - Realize cost savings by facilitating the transition of nursing home residents desiring community placement out of institutions.
- Develop a process to evaluate in 2 years whether changes (*effected*) have had an impact on the health of Colorado's Vulnerable Populations and the number of uninsured.

VULNERABLE POPULATIONS TASK FORCE PROPOSAL COMMENTS

In defense of the proposals we would note that the solicitation criteria did not require comment on many of the issues that are important to vulnerable populations. Given this limitation, we submit the following comments on the four proposals we were provided for review. These comments are followed by detailed proposal specific analyses of the potential impacts, positive and problematic, for Vulnerable Populations.

Colorado Health Services Program (see full review)

Positive Aspects of the Proposal for Vulnerable Populations:

This proposal is the most affordable plan for vulnerable populations and the only plan that recognizes that healthcare needs to be taken out of the free-market economy. This proposal covers all state residents in a single combined risk pool with no discrimination for pre-existing conditions. The benefits package is the most comprehensive of any of the proposals and includes mental health, substance abuse, dental, vision, hearing aids, dentures, alternative care, medical transport and specialty care. This system allows the consumers to identify the provider of choice and make informed choices about providers. The openness will allow the public to contribute to quality. In general this plan has the best access for vulnerable populations with affordability, streamlined forms, use of medical homes, point of service model and cultural competency.

Problematic Aspects of the Proposal for Vulnerable Populations:

The proposal does not address all gaps in access to care especially with regard to adequate coverage of long term care, behavioral interventions and respite care. The benefits package is created by a board without sufficient and timely appeals process delineated. Coverage for off-label use of prescription drugs is not discussed. There is no discussion of in the field care provision or support services for housing and case management.

A Plan For Covering Colorado (see full review)

Positive Aspects of the Proposal for Vulnerable Populations

This proposal recognizes the value of the safety net system and strengthens health information technology. It takes the necessary first steps in health care reform via creation of a single insurance market with guaranteed issue and community rating. The need to decrease barriers to access is affirmed and preliminarily addressed. Providers would receive improved reimbursement for care of Medicaid patients and appropriate pay for quality care to individuals with high needs. Medicaid is expanded and individual mandates are subsidized for those in need.

Problematic Aspects of the Proposal for Vulnerable Populations

The 47,000 lives that are left uncovered are mostly low income. The Authority Board will have the power to make policy decisions on whether and how to cover high-cost interventions, particularly if their effectiveness is in question. This is a significant concern for vulnerable populations whose needs may be extensive and who are frequently devalued by society. Long term care and support services, including waiting lists, are not addressed in adequate detail to allow assessment. The product may be complex and difficult to navigate. There continues to be a requirement for individuals to spend down into poverty prior to qualifying to purchase Medicaid.

Better Health Care for Colorado (see full review)

Positive Aspects of the Proposal for Vulnerable Populations

This plan improves access to health care for vulnerable populations by providing guaranteed issue and community rating. In addition it calls for Medicaid and CHP+ expansion. This proposal addresses long-term care, including housing issues. Wellness and Prevention are incentivized. Medicaid reimbursement to providers is increased to the

Medicare rate. Quality is emphasized through pay for performance, standardized care measurements, protocols and transparency.

Problematic Aspects of the Proposal for Vulnerable Populations

The proposed benefit cap of \$35,000 is untenable; in addition the specific caps on outpatient, emergency services, prescription drugs and durable medical equipment are unrealistic and will put significant financial burden on vulnerable populations. This plan will keep the homeless, mentally ill and disabled in indigent care. The proposal does not adequately cover the current uninsured population in Colorado, extending coverage to only 7% of the uninsured population. Costs increase most for families with incomes under \$10,000 while decreasing for families with income over \$10,000. This proposal does not include some benefits that are currently mandated through Medicaid such as mental health services.

Solutions for a Healthy Colorado (see full review)

Positive Aspects of the Proposal for Vulnerable Populations

The proposal advocates for increases in Medicaid reimbursement rates and a pay for performance model. There is an emphasis on Prevention and Wellness with premium reduction for healthy lifestyles, outreach, longer enrollment periods and portability.

Problematic Aspects of the Proposal for Vulnerable Populations

This plan is the *least beneficial* and *most problematic* for vulnerable populations. This proposal carries a very high annual maintenance cost for the state while still leaving a substantial number of Coloradoans uninsured. Administration costs represent at least 19% of total plan costs. This plan limits coverage at \$50,000 per year, which would create an increase in vulnerable populations by forcing more people into poverty. This proposal does not attempt to address long term care, even at the most basic level. Nor does it sufficiently address chronic care. This void in the plan skews the financial analysis as these represent the largest health care expenditures. Costs are shifted back to the taxpayers and the insurance industry realizes a profit.

CLOSING

In closing we would refer you to the article by Dr. Steven A. Schroeder in the September 20, 2007 issue of the New England Journal of Medicine entitled "We Can Do Better-Improving the Health of the American People". In the article Dr. Schroeder discusses how despite spending more on health care than any other nation in the world the United States ranks poorly on nearly every measure of health status. He attributes our weak health status to "two fundamental aspects of our political economy. The first is that the disadvantaged are less well represented in the political sphere here than in most other developed countries...Without a strong voice from Americans of low socioeconomic status, citizen health advocacy in the United States coalesces around particular illness...led by middle class advocates whose lives have been touched by disease...*Because the biggest gains in population health will come from attention to the less well off, little is likely to change unless they have a political voice and use it to argue for more resources to improve health-related behaviors, reduce social disparities, increase access to health care, and reduce environmental threats.*"

We thank you for giving us this voice, and hope that you will use our information to help improve the health of all residents of Colorado.

REPORT TO THE BLUE RIBBON COMMISSION

VULNERABLE POPULATIONS TASK FORCE

REVIEW OF

Colorado Health Service Program

September 28, 2007

Executive Summary

Positive aspects of proposal

This proposal covers all state residents in a single combined risk pool. The benefits package has the best coverage of the four proposals including mental health, substance abuse, dental, vision, hearing aids, dentures, medical transport, and specialty care with no penalty for pre-existing conditions. The proposal best covers low income populations with subsidies up to 400% FPL. This plan has the best access for vulnerable populations with affordability, streamlined forms, use of medical home, point of service model, and cultural competency. This is the most affordable plan for vulnerable populations and the only plan that recognized that healthcare needs to be taken out of the free-market economy. The system allows the consumers to identify the provider of choice and make informed choices about providers. This openness will allow the public to contribute to quality.

Negative aspects of proposal

The proposal does not address all gaps in access to care especially with regard to safety net providers, adequate coverage for long-term care, behavioral interventions, and respite care used/needed by many vulnerable populations. We are concerned that the plan does not elaborate on access issues like transportation, undocumented, and multiple service providers/integrated care. Coverage for off-label medication use is unclear and a big concern for vulnerable populations with complicated on-going health/mental health issues. If people need to access care other than emergency care out of state, the proposal is unclear about portability out of state. This proposal doesn't address in home care services or consumer directed attendant supports, which are important to frail elderly and people with disabilities. A board without sufficient and timely appeals processes creates the benefits package. Pay for performance is not included until several years of data have been collected and data needs to address language diversity. This proposal substantially changes the financing of healthcare in Colorado and needs a strong reserve fund for sustainability during hard times.

Review of Critical Areas

1) Comprehensiveness

Positive Aspects of the Proposal:

- Proposal covers all state residents
- Proposal creates a single risk pool
- Most comprehensive of the four proposals
- Provides subsidies up to 400%FPL
- Emphasizes community and home based services

Negative Aspects of the Proposal:

- LTC plan is very limited and contains only two provisions:
 - NH room and board for Medicaid eligible
 - 25% increase in home and community care for the first year.
- 75% of those waiting for long-term care are ignored.
- Administration of plan and risk pool appears bureaucratically complex. Initial implementation will be very challenging.
- Respite care is not a covered benefit.
- Aging population needs more care than is addressed in the proposal.
- Lack of access to behavioral health care for children with autism – currently 1/166 children born has autism
- Lack of access to complete vision care – is of particular concern to populations with vulnerability to specific eye conditions.
- Unintended consequence - decreasing costs by rationing care to minorities. This is an element of tax supported programs

Questions regarding this Proposal

- How is authority board constituted? Who is on it?

2) Access

Positive Aspects of the Proposal:

- Proposal increases access. Calls for health care for all residents - better definition for undocumented residents than any other proposal.
- Proposal uses a medical home concept. Maximizes use of medical home in a structural way.
- Proposal streamlines forms and enrollment.
- Proposal best addresses cultural competency.
- Perk for providing financial incentives for providers (example: scholarships/pay back) for providing service in underserved areas.
- Proposal uses a point of service model.
- Helps maintain and enrich services for homeless populations.

Negative Aspects of the Proposal:

- Coverage does not equal access. Plan does not elaborate on acceptability of access issues like transportation, undocumented, and multiple service providers.

Questions regarding this Proposal:

No questions.

3) Coverage/ Eligibility

Positive Aspects of the Proposal:

- 1) Provides for Individual Mandate
- 2) Promotes Preventive services in Workplace.
 - For LTSS, promotes movement to home care service.
 - No denial of coverage for pre-existing conditions.
 - Benefits package is very comprehensive (mental health, substance abuse, dental, vision, medical transport, and specialty care..
 - Best coverage of any of the four proposals.
 - Provides enrollment at provider locations - reduces complexity.
 - Includes dentures and hearing aids
 - Regional body for bulk RX purchasing, and regional medical purchasing - addresses serious structural issues and potential migration issue

Negative Aspects of the Proposal:

- LTC sidestepped. LTC not addressed in great detail and "full-time care will be incorporated over time".
- Initial outreach and enrollment will be difficult due to fundamental re-structuring of state healthcare system.
- Doesn't address how vulnerable populations that need off label and experimental medication needs will be addressed - once a year determination is not sufficient.
- Proposal needs solid appeals process.

Questions regarding this Proposal:

- How does it make the movement to LTSS home care service?
- Concretely define basic vision services, dental and hearing services.

4) Affordability

Positive Aspects of the Proposal:

- No cost sharing for the first five years.
- No co-pays or deductibles are incurred in the first two to five years of the program.
- No employer mandate.
- Most affordable plan of all the proposals.
- The one plan that acknowledges that health care needs to be taken out of the free market economy—(strongly reinforced by members).
- Acknowledges that we can't afford everything - at least give everyone something.
- Rationed care now, with forty-four million uninsured. Paying for amenities for a portion of the population is currently now based on deficiencies and lack of care for others. Creates "rationalized rationing," instead of arbitrarily.
- Vulnerable populations are not driving up costs.
- Saves the most money and provides the most coverage.

Negative Aspects of the Proposal:

- No guarantees that zero cost sharing structure can be retained in practice over the long term. Co-pay, co-insurance, and deductibles.
- No employer mandate - if there are individual mandates – there should also be employer mandates.
- This is an all or nothing plan

Questions regarding this Proposal:

No Questions.

5) Portability

Positive Aspects of the Proposal:

- Proposal will cover all residents of Colorado after three months.
- No problems with portability within the state.
- Out of state emergency services covered.
- Provides guaranteed issue, eliminating pre-existing condition eligibility problems.

Negative Aspects of the Proposal:

- No portability from state to state (only COBRA).

- Needs to address poor population who come in state for three months to access care—possible migration issue——. Data shows that poor population migrates for economic reasons, not health care. There is already a global marketplace for the wealthy.
- Only emergency care is covered out of state - preventive care covered as well—(example: For seniors who live out of state part of year—need continuity of care.)
- Doesn't address specialty out of state care coverage.
- Fee for service oriented.

Questions regarding this Proposal:

- How will this work for newborns? Related to 3 month waiting period, how does this address early intervention – children born with special needs?
- For populations who need specialized care in another state, will this be provided for them?
- How would resident's medical care be covered when traveling outside the state?

6) Benefits

Positive Aspects of the Proposal:

- Proposal has very broad benefits
- Proposal creates statewide risk pool.
- Proposal provides for bulk purchasing of drugs
- No other proposal emphasizes alternative (non-mainstream) medical services and benefits..
- Proposal places significant focus on nursing facility services

Negative Aspects of the Proposal:

- Proposal side-steps issue about benefit limitations. Ultimately subject to CHS review.
- Distinct population issues are melded into equivalent covered services across the state that essentially ignores the system.
- Appeal process not addressed - No process for appeals other than on annual basis.
- Behavioral health care not specifically addressed.
- Doesn't address off label needs for certain populations - not enough pharmacy detail to determine if it would be adequate.
- Requires individuals to pay for "room and board" in nursing facilities.
- Doesn't address support services for in home care services. This is important to frail elderly and people with disabilities.
- Phased in Long-term care.

Questions regarding this Proposal:

- Will respite care and support services be included in this proposal? This is Important for seniors and people with disabilities?

7) Quality

Positive Aspects of the Proposal:

- Proposal promotes Medical home concept.
- Proposal provides for Integrated PHIN information network.
- Proposal encourages quality
- Proposal saves costs by equalizing quality for all patients.
- Language and culture are identified.
- Openness of the process to the public will contribute to the quality.
- Regional composition provides for a structure that is accountable and allows responsive.
- Board to ensure quality is both a good and bad.
- Transparent data for decision making to address a problem for consumers.
- System allows the user to identify the provider of choice and make informed choices about providers.

Negative Aspects of the Proposal:

- Emphasizes fee-for-service reimbursement
- No significant discussion regarding integrated care models.
- Patient centered, regionally and culturally competent care suffers due to systematic equivalency in covered benefit packages.
- Long Term Care plan is limited and/or deferred.
- There is no provider performance incentive, in the near term. P4P is not initiated until "several years' worth of data" is compiled.
- Quality is vague, the attachment is difficult to navigate, and needs detail.
- Data address language diversity; language for non-English speaking is identified and provided.
- Sustaining quality work in administrative costs of comprehensive program is challenging.
- How will the quality monitoring will be accomplished?

Questions regarding this Proposal:

- How will quality monitoring work?
- Will there be public reporting of quality outcomes? What kind of transparency?
- What will the state board monitor and how will services be monitored?

8) Efficiency

Positive Aspects of the Proposal:

- All providers will be paid the same.
- Proposal promotes chronic disease management
- Proposal promotes licensing and credentialing in the same agency that is responsible for services.
- Preserves and promotes the use of the current safety net systems.
- Single risk pool.
- Proposal allows enrollment in provider offices and locations.
- Creates an ID card for everyone enrolled.
- Centralized data collection and compiling capacity.
- Eliminates for profit insurance risk management and administration, which is extremely costly. See study by McKenzie Group
- Proposal creates cost savings.
- Single point administration may be more efficient and more consistent.
- Proposal creates a single statewide pharmacy formulary based upon bulk purchasing.
- Proposal eliminates cost shifting.
- From a provider's perspective it is "freeing to have everything under one system. This would address conflict of interest, which creates bad care (ex. Work Comp versus back to work ability).
- Consistency is covered regardless of where you go in Colorado.
- CAHI is a good model and would like to see more of this in the proposal.
- This proposal advocates a health care model widely accepted in the rest of the free world.

Negative Aspects of the Proposal:

- Different locations provide different services and have different costs. Urban facilities are at a disadvantage and rural facilities advantaged.
- Because this is a publicly financed program incentives modifying healthy behavior are dependent upon "sin taxes". Paying more for cigarettes does not reduce the smoking..
- Single payer systems have significant problems with long wait times for elective treatment.
- Regional jurisdictions will create a problem? (Little fiefdoms in the state?).
- One entity can take on an integrated organization and agency.
- Proposal dissolves other (state) organizations when creating the new entity. This presents a problem if HCPF was the entity and that process creates a bias.
- Uninsured in rural areas need to be covered..

- New management direction for the Umbrella organization
- The existing systems are not able to expand to meet the needs set by this proposal.
- How would one pharmacy be managed? This would take away the free market incentives.
- Enrollment will take time to achieve, and will create an inherent lag time

Questions regarding this Proposal:

- Does this proposal include community health clinics?
- Why create a new agency? Why not expand the authority of HCFP?
- Will this structure address the inconsistent care in rural areas? Would the educational services and equal payment increase providers in rural areas?
- Can the appeal process be set up within the regions?

9) Consumer Choice and Empowerment

Positive Aspects of the Proposal:

- Promotes consumer choice of providers. Allows provider choice.
- Provides for guaranteed issue and community rating.
- Single risk pool.
- Program allows for purchasing private insurance for benefits not covered by CHS.
- Proposal increases transparency.

Negative Aspects of the Proposal:

- Other single payer systems have significant problems with long wait times for elective treatment.
- CDAS model is needed.

Questions regarding this Proposal:

- How will this proposal provide for transparency and public reporting to support consumer choice?

10) Wellness and Prevention

Positive Aspects of the Proposal:

- Promotes wellness programs in the workplace.
- Prevention is a main emphasis of the proposal.
- Proposal provides expanded preventive care at no additional cost to employers.
- Monetary savings created by this proposal can be re-invested into preventive care health initiatives.
- Proposed plan is strong in promoting individual education and responsibility.

Negative Aspects of the Proposal:

- "Single most effective way to promote wellness and prevention is by eliminating barriers to access"

Questions regarding this Proposal:

No questions

11) Sustainability

Positive Aspects of the Proposal:

- Limits the administration budget to five percent of total cost.
- Lewin Group model shows savings of \$1.8 billion.
- Plan operates exclusively within predefined budget.
- More inclusive and equitable for all citizens.

Negative Aspects of the Proposal:

- A change will require a vote of the citizens. It will limit the ability to make changes without an expensive campaign.
- No provisions for a reserve funds. Funding will be impacted by downturns in the business cycle. What is the process for limiting coverage in economic downturns?
- Quality and extent of care is ultimately dependent on state taxpayer willingness to accept tax increases for inflation and expanded care. Colorado citizens have been historically opposed to regular tax increases.
- Plan needs to be indexed for cost of living increases based upon CPI or GDP, but health costs are increasing faster than GDP.
- Assumes federal funding will be indexed for growth.
- Plan funding ultimately depends on federal waivers. If waivers are not secured plan may not be sustainable.
- Initial implementation will be difficult given the fundamental restructuring of private to public health insurance system.
- Administration of plan and risk pool is complex. Difficult to adequately manage in the near term.
- Minimal negative effect from non-state residents moving to Colorado.
- Proposal does not address expansion of vulnerable populations represented by financially tenuous, retiring baby-boomers. This population looks good on paper now, but is poorly prepared financially for long term or chronic health issues that come with aging. This "VPOP in waiting" will place tremendous logistical and financial strains on the system. This population will limit the number of uninsured residents that can be insured in the future.
- Proposal does not make provisions for special state planning for high cost and high maintenance diseases without such provisions those VPOPs will place great financial and logistical strains on the proposed system.

Questions regarding this Proposal:

- Will the current TABOR limitations be applied to the revenue and spending streams?
- If cost effectiveness changes would that impact quality?
- Without waivers could we sustain this program?

12) Practicality of Implementation

Positive Aspects of the Proposal:

- Data is being captured on homeless population
- This gives the legislature the opportunity to express its willingness to dissolve the free market economy by purchasing the most financially viable health access for the welfare of all citizens.

Negative Aspects of the Proposal:

- Includes provision for funding medical education in the proposal.
- Will require waivers of Medicaid and SCHIP, Medicare, VA, malpractice, and ERISA. **ERISA challenges** are guaranteed.
- Plan is fundamentally dependent upon achieving a number of federal waivers, in order to ensure continued federal DSH funding.
- Transition from current system to this system will be difficult to achieve.
- Tax provisions are regressive. There is more impact on the low income than on higher income.
- Never implemented in any state.
- Problem with this plan is political and implementation barriers.
- Plan is essentially "all or nothing". Basic plan must be implemented to realize cost savings.
- Plan will result in substantial job losses in Colorado health insurance industry.
- Increases in payroll taxes and income tax surcharge are required. **TABOR** will represent a major stumbling block for this plan, and it is not addressed in any meaningful way within the proposal.
- The Popular "Socialized Medicine" stigma is a barrier to achieving this plan.

- Increases in-state bureaucracy.
- This plan will be strongly opposed by conservative groups, the private insurance industry, PhRMA .
- Current non-insuring employers will incur substantial costs, \$785 million. This may be particularly harmful to small business.
- Status of previously paid long-term care insurance premiums may be an issue.
- Initial implementation will be difficult given the fundamental restructuring of private to public health insurance system.
- Assumption of a cost of living increase being agreed by whole state.

Questions regarding this Proposal:

- Will the provision of the current of TABOR be in effect? Could limit revenues and expenditures?
- Do we need an independent evaluation to make sure that this is working?

REPORT TO THE BLUE RIBBON COMMISSION

VULNERABLE POPULATIONS TASK FORCE

REVIEW OF

A Plan for Covering Coloradans

September 28, 2007

Executive Summary

Positive Aspects of Proposal:

This proposal provides authentically comprehensive coverage for the uninsured. It takes necessary first steps in health care reform via creation of a single insurance market with guaranteed issue and community rating. Individual mandates are subsidized for those in need. Employer mandates would consider the characteristics of the employer and workforce. Insurance regulatory requirements will be unified and simplified. Providers will receive improved reimbursement for care of Medicaid patients and appropriate pay for quality care to individuals with high needs. The proposal focuses on provision of high-quality cost effective, efficient care while identifying the value of mental health treatment. The need to decrease barriers to access is affirmed and preliminarily addressed. The proposal recognizes the value of the safety net system and strengthens health information technology.

Negative Aspects of Proposal:

The proposal leaves 47,000 lives, mostly low-income, uncovered. The waiting lists for Supported Living Services, Comprehensive Services and Children with Autism are not addressed. In addition, care for undocumented residents is not addressed. Individuals are still required to spend down into poverty prior to qualifying to purchase Medicaid. Not enough details are provided to allow assessment of the adequacy of long term care and long term support services. This proposal (like the others under consideration) does not address the expansion of vulnerable populations represented by financially tenuous, retiring baby-boomers. The proposed Authority Board will have the power to make policy decisions on whether and how to cover high-cost interventions, particularly if their effectiveness is in question. This is a significant concern for Vulnerable Populations whose needs may be extensive and who society frequently devalues.

Review of Critical Areas

• **Comprehensiveness**

Positive Aspects of the Proposal:

- 1) Proposal covers 94% of uninsured Coloradans, approximately 745,000 residents.
 - a. Proposal limits "Free Riders" by requiring individual coverage mandate.
 - b. Proposal covers more children, including low-income children.
 - i. Expands two Children's Medicaid waivers to eliminate waiting list for services.
 - c. Proposal utilizes publicly funded programs and Medicaid expansion to assist low-income residents in complying with the mandate.
 - i. Adds adults in poverty to Medicaid.
 1. Proposal covers 100% of uninsured 65+ years old.
 2. Proposal provides stop-gap coverage for those on AND while awaiting SSI determination.
 - d. Proposal allows sliding scale Medicaid buy-in for workforce with disabilities.

- e. Proposal combines and expands Medicaid and SCHIP.
 - i. Improves SCHIP enrollment.
- 2) Combination of Private and Public Market
 - a. Creation of Single Insurance Market begins the process of true health care reform by limiting the profit margin in health care.
- 3) Guaranteed Issue, Community Rating
 - a. Provides more choice.
 - b. Provides for a purchasing pool for high risk/cost individuals.
- 4) Comprehensive basic benefit package
 - a. Preventive care.
 - b. Treatment for mental illness and substance abuse.
 - c. Dental, limited vision and hearing aids.
 - d. Includes OT, PT and Speech under private plans with reasonable co-pays.
- 5) Proposal addresses more of the requested components than any other proposal under consideration. (See Lewin: Comparative Analysis of Colorado Health Care Reform Options).
 - a. Provides for consumer direction.
 - b. Promotes outreach efforts.
 - i. 24 X 7, 1-800 number for nurse/doctor hotline.
 - ii. Provides expansion for ethnic and racial minorities.
 - c. Provides direction in containing costs and improving efficiencies.
 - d. Works appropriately with Safety Net providers.
 - e. Provides for COBRA premium assistance.
 - f. Sets minimum quality standards for carriers of insurance and providers of care.

Negative Aspects of the Proposal:

- Proposal doesn't cover 47,000 lives, mostly low-income, including 27,000 residents making less than \$30,000/yr. and 9,000 children.
 - Does not expand Children with Autism Waiver.
 - Does not expand Supported Living Services Waiver.
 - Does not expand Comprehensive Services Waiver.
- State implementation costs are approximately \$985 million.
- Makes coverage available for most; however, for significant proportions of some ethnic minorities (and some cultural subgroups), this may not lead to increased utilization. Coverage is necessary, but not sufficient in many cases.
- No provision for limiting health care costs to some reasonable proportion of a family's income.
- While Medicaid is significantly expanded, individuals are still required to spend down into poverty prior to qualifying for assistance.
- Long term care and home health expansions for children or adults are not included in private plans.
- Long Term Care (LTC) strategies are NOT addressed in sufficient scope and detail. Proposal:
 - Does not directly address long term support services;
 - Expands Medicaid but LTC coverage to populations with high needs is not specifically defined;
 - Does not specify whether coverage for home health, palliative and hospice care in private market will be equal to or greater than Medicare; and
 - Promotes LTC insurance through purchasing pool.
 - The focus on quality needs to be anticipated and led by the proposed independent Authority Board.
- Providers have limited time to introduce technology infrastructure.
- Proposal limits private insurance latitude in plan creation.
- Proposal appears to "negatively" impact insurance industry, some businesses and providers. Anticipate strong lobbying and opposition in the legislature.

Questions regarding this Proposal

- Would this proposal expand Medicaid benefits?

- Would proposal incorporate recommendations of the Colorado Long Term Care Advisory Committee (SB05-173) and strategies adopted in the Coordinated Care Pilot Program?

2) Access

Positive Aspects of the Proposal:

- Proposal provides access to 400% of FPL.
 - Proposal promotes access to high-quality care that is effective and efficient. It:
 - Promotes patient-centered services.
 - Promotes the medical home model, though detail is not provided.
 - Promotes the use of integrated systems.
 - Includes consumer education.
 - Promotes enrollment in variety of community-based settings and by mail.
 - Provides a joint/single simplified application process for Medicaid and CHP+ with elimination of unnecessary verification.
- 6) Provides continuous eligibility for 12 months with passive re-enrollment.
- 7) Allows presumptive enrollment of income eligible at tax time.
- 8) Allows presumptive enrollment of those on AND while awaiting SSI.
- 9) Provides 24x7, 1-800 number consumer line that will improve access in rural areas.
- Improves access through increased reimbursement for providers.
 - Promotes and provides focus on importance of safety net providers.
 - Places emphasis on IT and increasing effectiveness of care.
 - Provides positive risk adjustment payments for quality care to high-risk populations.

Negative Aspects of the Proposal:

- LTC would require an individual to be in poverty as a condition of eligibility.
- Proposal has potential to be complicated if there are many plans to purchase.
- Proposal does not adequately address “access” from perspective of cultural congruence of services, linguistic adaptations, distance (or other logistical issues). The proposed Authority Board needs to address these issues, as they relate directly to the intent behind successful “coverage” and “access” “Availability” (other than the 1-800 line) and “acceptability” may remain at the status quo.
- Proposal does not address community centered treatment.

Questions regarding this Proposal:

- No Questions

3) Coverage/ Eligibility

Positive Aspects of the Proposal:

- Proposal offers guaranteed issue and community rating. Principle of no health status-based discrimination.
- 10) Proposal provides comprehensive basic benefit package.
- Preventive care
 - Treatment for mental illness and substance abuse.
 - Dental and limited vision.
 - Includes OT, PT and Speech under private plans with reasonable co-pays.
 - Hearing aids.
- Proposal includes end-of-life coverage.
 - Proposal promotes strong case management.
 - Proposal creates greater access to Medicaid for persons with disabilities.
 - Proposal provides lower cost-sharing plans.
 - System appears to be easier to navigate, provided that the Department of Health Care Policy and Financing (HPCF) and the new Authority Board coordinate efforts efficiently.
 - Proposal focuses on integration of care and portability; would positively impact continuity of care.

11) Proposal provides for COBRA coverage.

Negative Aspects of the Proposal:

- Proposal does not cover the entire uninsured population.
- Those that can afford it can still purchase plans that give them more coverage.
- LTC and chronic care coverage detail is limited.
- Proposal's premium assistance requires 6 month residency.
- Proposal increases services that are more comprehensive but services do not extend far enough to meet all the needs of many vulnerable populations.
 - Coverage for oral health, vision and hearing aid is limited.
- This proposal does not specifically address behavioral health services for populations such as those with Autism.
- Proposal does not address off-label medication usage.
- While the proposal significantly expands Medicaid, it still requires individuals to spend down into poverty prior to qualifying for assistance.
- Long term care and home health expansions for children or adults are not included in private plans.
- Expansion is not adequately defined in this proposal.

Questions regarding this Proposal:

- What is burden of proof for 6 month residency?
- How does the residency requirement apply to newborns?

4) Affordability

Positive Aspects of the Proposal:

- Proposal provides guarantee issues and community rating.
- Proposal provides subsidies for those below 200 percent of FPL.
- Proposal promotes sliding scale for up to 400 percent of FPL.
 - For adults living in Metro Denver to become homeowners (increased likelihood of avoiding institutionalization as medical needs arise) an income at or above 400% of FPL is required.
 - There are studies on living wage available for review as needed.
- Proposal will provide for small business subsidies.
- Proposal will reward pay for performance.
- Proposal provides financial incentive for those caring for high-needs populations.

Negative Aspects of the Proposal:

- Proposal requires that persons with disabilities must be poor to access care.
- This plan may still pose problems in affordability for vulnerable populations. \$3-15 co-pays still exist for 101-250% FPL and \$25 co-pays exist for 251-399% FPL. Premiums are still applicable to some persons under 300%FPL.
- Employer mandate premium contributions are "to be determined".
- Premium assistance only applicable to HMO managed care model or PPO negotiated price break model.
- Utilization of a living wage, rather than FPL, would be more realistic.
- Some Vulnerable Populations may find it difficult to navigate complexity of formulas.

Questions regarding this Proposal:

- What will the fees be for enrollees and premium contributions for employers?
- Proposal calls for proposed Authority Board to determine cost sharing. What criteria will the Board use?
- Could the Board determine subsidies based on real needs of population, i.e., taking into account the cost of living and home ownership in Colorado today?

5) Portability

Positive Aspects of the Proposal:

- Guaranteed Issue – no discrimination based on health status or age.
- Proposal provides Single Insurance Pool.
- Proposal allows AND presumptive eligibility.
- Proposal provides option for portability via pool (including continuous coverage and allowing beneficiaries to stay with the same plan, and same provider regardless of employment).
- Proposal provides that individuals under 400% FPL will receive assistance in paying for coverage.

Negative Aspects of the Proposal:

- Proposal requires low income to buy into Medicaid.

Questions regarding this Proposal:

- Is this proposal removing the asset test and only using the income test?
- How will the network adequacy mandates be addressed in this proposal?
- To what degree does this proposal provide coverage out of state? There is a need to access coverage when out of state/country (some plans may not provide out of state care).

6) Benefits

Positive Aspects of the Proposal:

- Proposal expands current Medicaid and SCHIP benefits.
- Proposal provides adequate minimum benefit package:
 - a. Preventive care;
 - b. Treatment for mental illness and substance abuse;
 - c. Dental and limited vision, hearing aids; and
 - d. Includes OT, PT and Speech under private plans with reasonable co-pays.
- Proposal offers parity of mental health, substance abuse treatment, and chronic care management.
- Proposal waives co-payments for preventative health care treatment.
- Proposal provides that Authority Board will determine level of benefits, helping to standardize benefits across carriers.

Negative Aspects of the Proposal:

- CHP+ level is too limited.
- Unknown if there is coverage for behavioral (vs. mental illness) care for persons with autism who might need this kind of care.
- Wait lists for children with Autism and developmental disabilities are not considered.
- Authority Board will develop benefits for private insurance. Multi-tiered care approach is created with 6-10 different plans that may lead to confusion and ill informed choice.
- Proposal does not appear to address alternative or non-traditional health care options.
- Unable to know how adequate benefits are until Board sets benefits

Questions regarding this Proposal:

- Will there be any reinsurance provisions?
- What criteria will the Authority Board use to develop benefits? Will there be public input?
- Will there be consideration of off-label usage of medications?
- How will “Evidence Based Medicine” be utilized in populations that are poorly studied?

7) Quality

Positive Aspects of the Proposal:

- Proposal offers strong development of Health Information Technology, which will facilitate clinical care coordination. This is particularly important for people with complex medical needs.
- Proposal promotes integrated systems.
- Proposal promotes the use of Preferred Drug Lists.
- Proposal promotes the use of Pay for Performance.
- Proposal strengthens the use of 340b's.
- Proposal promotes patient-centered services.
- Proposal offers option for portability via pool (including continuous coverage regardless of employment), which allows continuity of care.
- Plan adds credentialing of providers to the process.
- Proposal promotes evidence based medicine.
- Proposal addresses provision of culturally competent care.
- Proposal allows for significant stakeholder input to update quality standards and incentives.

Negative Aspects of the Proposal:

- Proposal offers limited discussion of LTC and LTSS details.
- Proposes offers limited discussion of quality standard determinations by the Health Insurance Purchasing Authority, creating a concern that managed care approach (in practice) may cause quality to take a back seat to cost containment.

Questions regarding this Proposal

- No Questions

8) Efficiency

Positive Aspects of the Proposal:

- Proposal creates a single insurance market:
 - Purchasing pool would limit administrative costs allowing for savings redirected to consumer.
 - Folds Cover Colorado into the plan.
 - Would include high risk/cost individuals.
 - Combines Medicaid and SCHIP.
 - Streamlines eligibility and enrollment for benefits.
 - Promotes the use of standardized billing forms.
- Proposal will use and strengthen the existing systems.
 - Promotes and strengthens the existing safety net and CHC systems.
 - Increases Medicaid reimbursement.
 - Establishes no charge for prevention.
- Proposal allows small businesses to buy in and will subsidize premiums.
- Proposal promotes and supports integrated delivery health care models.
 - Provides for Medical home reimbursement.
 - Provides for complex care case management.
- Proposal promotes health information technology.
- Proposal offers a generally realistic approach that will dramatically increase coverage for the uninsured.

Negative Aspects of the Proposal:

- Proposal creates another State Agency.
- Proposal limits 65+ age group to 100 percent of FPL. The proposal needs to expand coverage in this population to same level as other groups.
- Preferred Drug Lists may provide advantages to some patients while limiting advantages for others.
- Proposed plan would increase total expenditures, creating barriers for legislation. Proposal asserts that reducing costs is only possible in a single payer plan.

Questions regarding this Proposal

- Could the proposal utilize an existing State Agency, i.e., HCFP with expanded authority?
- How will this proposal bring the data together for data analysis to support pay for performance?

9) Consumer Choice and Empowerment

Positive Aspects of the Proposal:

- Proposal offers guaranteed issue and Community Rating.
- Proposal provides six to ten plans any consumer may purchase.
- Proposal includes incentive payments for positive behaviors.
- Proposal provides incentives for use of integrated systems, i.e., additional benefits.
- Proposal offers first dollar payments for preventive services
- Proposal offers minimal or no co-payments for chronic disease care and medications.
- Proposal promotes billing standardization.
- Proposal allows medical services spending postmortem reporting.
- Proposal decreases complexity and provides education to consumer.

Negative Aspects of the Proposal:

- Proposal promotes the return of managed care in the State Medicaid program.
 - Managed care does not work in rural areas.
 - Managed Care models do not always work as advertised in practice. As we have seen in the Medicare program, over time that model can cost more than fee for service; restricts access to care (rationing); and makes the private plans “profitable”.
 - Managed care often turns into a mechanism for restricting care rather than assuring that patients receive the care they need in the most cost-effective manner.
- Variety in private insurance products/plans will be limited due to implementation of standardized benefits packages. Less of an issue if products comprehensive.
- Proposal does not mention use of CDAS type programs.

Questions regarding this Proposal

- No Questions

10) Wellness and Prevention

Positive Aspects of the Proposal:

- Proposal places emphasis on prevention and early detection with intervention.
- Proposal requires zero co-pays for evidenced based preventive care options (prenatal, cancer screening, etc.) and for evidence-based practices
- Proposal offers full coverage for screening and treatment of mental illness and substance abuse.
- Proposal provides case management for complex chronic illnesses.
- Proposal focuses on weight management as cost containment effort.

Negative Aspects of the Proposal:

- None

Questions regarding this Proposal:

- No Questions

11) Sustainability

Positive Aspects of the Proposal:

- If modeling is correct this program is the second cheapest proposal for the state to manage after the initial high implementation cost.

- Proposal begins to deal with reform of the free market economy of health care to allow profits to be redirected toward care of the citizen.
- Proposal is sustainable if there is a commitment from all parties involved (insurance companies, employers, the general public) and political will among the legislators.

Negative Aspects of the Proposal:

- Proposal would be impacted by business cycle.
- Proposal offers no reserve fund for economic down-turn periods.
- TABOR will impact and limit access to revenues and expenditures.
- Proposal (like others) does not address expansion of vulnerable populations represented by financially tenuous, retiring baby-boomers. This population looks good on paper now, but is poorly prepared financially for long term or chronic health issues that come with aging. This “Vulnerable Population in waiting” will place tremendous logistical and financial strains on any health care system.
- Proposal does not make provisions for special state planning for high cost/high maintenance diseases. Without such provisions those vulnerable populations will place great financial and logistical strains on the proposed system.
- Employer mandate may adversely impact smaller businesses through insurance mandate or incurring an annual assessment.
- Proposal will require the support of insurance companies, employers, and the general public to be sustainable.

Questions regarding this Proposal:

- How will the private insurance premium tax work with a single insurance pool?

12) Practicality of Implementation

Positive Aspects of the Proposal:

- Proposal presents no adverse selection issues.
- Proposal offers novel approach, with important changes in health system that could begin much needed health care reform.

Negative Aspects of the Proposal:

- Proposal is only sustainable if funding sources materialize.
 - Plan is based upon income and property taxes.
 - Tabor will represent a significant stumbling block, and funding would almost certainly require a public referendum. As a result, plan may be hard to sell.
 - The “sin tax” will require public vote.
 - Tax penalty for free riders may be difficult to implement.
- Proposal’s implementation cost is \$985 million.
- Proposal requires employer mandate. This could be opposed by small business community.
- Section 125 plans, employer assessments, etc. will likely cause an ERISA court challenge.
- The proposed private insurance industry reorganization is extensive and would likely be strongly opposed by that powerful industry.
- Private insurance market reforms recommended by this proposal have never been tried in the U.S.
- Proposal introduces significant new bureaucracy (Authority Board).
 - Authority Board will require the approval of new Colorado statutes.
- Health Information changes may create HIPAA issues.
- Proposal relies on public ultimately, with legislature needing to provide ongoing support.

Questions regarding this Proposal

- Does the proposer (Lewin) truly assume that state costs will be eliminated after initial implementation? Why will there not be additional costs at least during the 2 years of insurance industry restructuring?
- How will tax penalty for people not buying insurance be enforced?

REPORT TO THE BLUE RIBBON COMMISSION
VULNERABLE POPULATIONS TASK FORCE
REVIEW OF

Better Health Care for Colorado Proposal

September 28, 2007

Executive Summary

Positive aspects of proposal

This proposal expands Medicaid and provides for guaranteed issue and community rating. The proposal also addresses Long Term Care in more detail than the other proposals under consideration. Another positive aspect of the proposal is its emphasis on pay for performance criteria. SEIU will probably be the easiest system to implement because it is built upon the current system.

Negative aspects of proposal

The SEIU proposal does not sufficiently cover the current uninsured population in Colorado. Due to the lack of mandates the cost of covering each uninsured person is comparatively high. The proposed patient benefit cap of \$35,000 will put undue financial pressure on vulnerable populations. In addition, the proposal creates a “cliff effect” due to the 300% FPL cut-off. The proposed income category structure is too complex and will therefore be difficult to use and administer. SEIU does not have a defined appeals process or ombudsmen. Another objection to this proposal is that it creates a two-tiered system that can restrict benefits. Finally, SEIU does not provide appropriate coverage for vision and dental benefits.

Review of Critical Areas

1) Comprehensiveness

Positive Aspects of the Proposal:

- Covers more (about 43,000) children (under 18 years old), including low income children
- Addresses long term care in more detail than any of the other three proposals
- Addresses affordable housing issues as a critical component part of long term care
- Improves CHP enrollment
- **Safety net providers** will benefit from **a more cost-effective delivery system** that provides **coverage-based payments** for care provided to low-income uninsured.
- Utilizes public funded programs such as CHP+ and Medicaid
- Provides more choice and consumer direction

- Provides expansion for services to ethnic and racial minorities as Colorado **Insurers will develop products** that will be **responsive to such people**
- Provides direction in containing costs and improve efficiencies

Negative Aspects of the Proposal:

- Proposal does not sufficiently reduce the uninsured population. SEIU Proposal barely covers 50% of the current uninsured population. This is too low for the over-all cost of implementation and in our opinion does not meet the intended objectives for number insured.
- Unit cost to move a single individual from being uninsured to insured seems disproportionately high in this proposal compared to the other three proposals.
- Patient cost cap \$35,000 for persons with serious or chronic illness (such as cancer) is unrealistic and will put undue financial pressure on that population.
- There is concern that in this proposal individuals and families might still be driven into bankruptcy.
- Proposal does not sufficiently cover childless adults. Proposal requires additional measures to aid the needy adults in the community
- Catastrophic care coverage is insufficient
- Proposal still represents significant co-pay difficulties for very low income individuals
- Proposal does not adequately account for the significant impact of financially unprepared Baby boomer population that has very low personal savings rates
- Proposal advocates shifting DSH funds with resulting impact upon safety net providers.
- Income category structure is too complex
- Proposal does not provide sufficient attention to or detail regarding Mental Health
- Proposal does not provide sufficient attention to or detail regarding drug coverage
- Proposal does not sufficiently address coverage for persons in transition
- Proposal creates an income distinction for childless adults and adults with children
- Waiver concern. Proposal needs to be cost neutral covering people at the expense of Medicaid public health funding
- Proposal emphasis on Evidenced Based Medicine can be a concern especially for Mental Health, Autism, and other populations
- Proposal (all four proposals) does not provide sufficient attention to or detail regarding the Developmentally Disabled population
- Proposal does not sufficiently address cultural competency for ethnic and minority groups
- Proposal does not adequately address an increased labor pool to cover proposed plan expansion, particularly with regard to LTC.
- LTC eligibility requirement change from 2 to 3 ADL's will be harmful to a lot of people's eligibility. The solution would be to have step down levels of LTC rather than all or nothing approach. Providing community based care at the risk of LTC facilities does not address this point
- The proposal advocates moving individuals from nursing facilities to assisted living and the community without considering whether there are adequate resources to do so and the difficulties of transitioning people from nursing facilities with adequate chronic disease self management skills.
- Proposal does not sufficiently address Substance abuse and Mental Health Needs
- A possible solution is to provide PCP, catastrophic, and LTC within a matrix of service
- Navigating the proposed system will be difficult for vulnerable population individuals. VPOP individuals (particularly the homeless) will not understand coverage options or how to secure them allowing their underserved status to continue
- Residency is based upon Colorado Medicaid definition. Farm workers may have to wait 45 days to achieve eligibility.

Questions regarding this Proposal

- How this proposal will extend more accessible and affordable coverage **without subsidies to small businessse?**
- How does this proposal plan to increase coverage for rural citizens, minorities and the disabled?
- How is long term care coverage as proposed in this plan really cost effective? Reference the JBC report showing cost effectiveness nursing homes versus community care costs: State rate for nursing homes is \$4, 300 per person per month versus community care rate of \$1300 per person per month.
- Why is the unit cost (cost per person) of shifting an individual from uninsured to insured appear more costly in this proposal as opposed to the other three (based upon July 17 Lewin data)?

2) Access

Positive Aspects of the Proposal:

- Proposal promotes access to wellness options. Plans **offering products through the Exchange** for the subsidized population **would be required to incorporate a healthy behaviors or wellness initiative** to provide financial incentives, education, and support to achieve improved health and health care outcomes.
- Proposal Increases Medicaid reimbursement to Medicare levels (65 to 85%)
- Exchange system provides adequate consumer education and assistance
- Case management may have beneficial affect. NOTE: members have different experiences with Case managers and case worked. Different Vulnerable populations have different needs and realities

Negative Aspects of the Proposal:

- Case management can become a barrier to access and may only be a cost saving measure
- While it addresses children and parents of children, it does not improve access for a number of vulnerable populations
- It is not clear that the number of providers is improved and therefore is access improved
- Co-payment level required by this proposal constitutes a barrier to the low-income vulnerable population.
- Complexity of an Internet based exchange may limit access for vulnerable populations who do not have IT access or may be unable to navigate within that system.
- Proposal does not provide sufficient provider incentives to support vulnerable populations
- Proposal does not address issues critical to vulnerable populations such as language interpretation, transportation, etc. Vulnerable populations will have difficulties in accessing services without addressing these constraints
- The current model used in this proposal does not address the intensive support required by the homeless, disabled, and chronically ill vulnerable populations.
- Any change to reimbursement or Medicaid rates will impact private insurance. Solution requires greater parity.
- Proposal does not sufficiently address availability of services for underserved populations in rural areas.
- Redistribution of Disproportionate Share Hospital (DSH) funding will harm Safety Net providers and will therefore restrict access by limiting availability of services

Questions regarding this Proposal

- Require greater level of detail on how this proposal will provide access to benefits that the proposal claims to be available?
- Require more detail regarding proposal position of Medical Home?

3) Coverage/ Eligibility

Positive Aspects of the Proposal:

- Guaranteed Issue, provides insurance regardless of preexisting condition
- Will provide greater access to some Vulnerable populations, such as minorities, and ethnic populations

Negative Aspects of the Proposal:

- According to July 17 Lewin data 41% of the current uninsured population does not have health care coverage. 467.2 thousand will still be uninsured.
- Proposal would provide better coverage if parents and children were under the same plan. When the entire household is on the same plan it is easier to navigate through and understand coverage options
- Proposal does not provide sufficient consumer access and coverage choices
- Family plans with family deductible would help coordinate co-pays and out of pocket expenditures making coverage more affordable.
- Coverage in this proposal needs to address divorced families where care-givers may not have legal authority over coverage.
- Passive enrollment is a barrier to HMO Medicaid
- Limited benefit package in this proposal creates a significant impediment to access
- Proposal does not address Developmentally Disabled on the waitlist
- Proposal does not address or pay for off label medication

Questions regarding this Proposal

- How will this proposal work with Cover Colorado?

4) Affordability

Positive Aspects of the Proposal:

- No co-payments for individuals receiving wellness care
- Co-payment policy is trending in the right direction by being based upon the individual's ability to pay
- Proposal assists people to value healthcare and creates efficiency of utilization
- Proposal addresses a self sufficient living wage through 300% FPL
- Long Term Care coverage is appropriately addressed
- Proposal places focus on affordable housing as part of Long Term care Plan
- Proposal's plan to purchase medication in a method would work for the average low income individual but needs to address the formulary for some vulnerable populations

Negative Aspects of the Proposal:

- Proposal uses DSH payments as a reinsurance tool, however limited funding may be available in reality considering State restraints
- Proposal does not address a reserve fund to address fluctuations in the business cycle and changes in the state's economy
- Low income vulnerable populations may still encounter co-pay requirements that will be a barrier to care.
- Proposal creates a "cliff" effect because of 300% FPL cut-off
- Proposal should address holistic and better integrated health care
- Financial incentives for providers need to be more clearly defined

- Proposal should use a sustainable community rated living standard as opposed to FPL
- Long Term Care (LTC) access to affordable housing and transportation for consumer hard to find housing for vulnerable populations, often forced to utilize most expensive healthcare in more expensive versus community based model.
- Proposal uses public dollars to subsidize private insurance
- Proposal should eliminate co-payments and premiums by assessing co-payments and premiums after 300% FPL level.
- Lewin analysis shows the following limitations: All Benefits: \$35,000 max annual (pg 16), Outpatient services: \$5,000 max. annual (pg 16), Inpatient Services: \$25,000 max annual (pg 16), Emergency Services (not defined): \$1,000 max annual (pg 16), Durable Medical Supplies/Equipment: \$1,500 max annual (pg 16), Prescription drugs: \$2,500 max annual (pg 16) These caps are on top of the co-pays. These limitations will be a significant deterrent to affordability for vulnerable populations.
- Except for those under age 24, would increase family cost. (pg 38)
- Would increase the cost for families with incomes under \$10,000 while decreasing the cost for families with income over \$10,000. Not good. (pg 39).

Questions regarding this Proposal

- Why do 25% of individuals making more than \$50,000 per year remain uncovered? Benefit referenced on page 21.
- Require more information on how the proposal will make low income housing more affordable?
- Need more information on the proposal's drug prescription plan?

5) Portability

Positive Aspects of the Proposal:

- Individual owns the plan and takes the plan with when moving from job to job or place to place.
- Proposal supports Integrated concept

Negative Aspects of the Proposal:

- Managed care model cannot be applied to transient or homeless individuals.
- Proposal is not sufficiently clear about individuals in transition from Foster care or incarceration
- Proposal does not provide sufficient information on portability.
- Eligibility planning is unclear. The process appears to be complicated and as a result would exclude some vulnerable populations
- Proposal does not define clearly the process taken by small businesses related to health care of their employees.

Questions regarding this Proposal

- How will plan administration work within State and federal eligibility requirements?
- Don't see that movement between CHP/ Medicaid is addressed. What about people bouncing from one to the other?
- Require more detail on portability process and navigation via the Exchange?
- How will dual eligibility work within this proposal's planned portability module?

6) Benefits

Positive Aspects of the Proposal:

- Long term care is addressed as a benefit of this proposal.

Negative Aspects of the Proposal:

- Basic plan is poor and does not include Mental Health and state mandates are not part of the basic plan
- Proposal lacks mandated coverage which allows Mental Health and other conditions to be left out. Plan allows exclusions and there is a conflict in their terminology
- CHP using a PDL for safety Net is problematic and allows cost shifting to ER care.
- Drug prescription plan does not include off label medication
- Plan relies on Preferred drug list model
- Major concern with the SEIU plan is a managed care model. As we have seen in Medicare, over time that model can cost more than fee for service; restricts access to care (rationing); and makes the private plans “profitable”.
- Capitated managed care has been in Colorado and has had many problems; it is very consumer un-friendly. Medicaid clients have significant problems getting the care they need with the prior authorization process that currently exists for medications, durable medical equipment, home care, transportation, etc
- Capitated managed care just reduces people’s health care choices, gives them fewer benefits, longer waits, and creates “great” hassle for the providers who are reimbursed even less than through Medicaid fee for service.
- Captiated managed care saves the state money by potentially denying care, costing the state less money by design. It creates a profit center for the managed care organization, as they make a profit when they deny services and keep the capitation amount that is provided by the state
- Proposal creates two tiered system and denies choice
- Lack of adequate providers is not addressed
- Proposal does not address vision or dental care
- Limited cap for chronic conditions is too expensive for users
- Proposal’s emphasis on managed care does not include appropriate consumer protections
- Concerned that MH small group would have option to opt out
- Concerned that proposal does not assume that lab and radiology are not part of primary care
- 5% income requirement may create hardship on very low income population
- Drug formulary created in this proposal might adversely affect vulnerable populations. Evidenced based formulary is not based upon vulnerable populations and children. Evidence based is built upon 1 disability and 1 drug and not multiple disabilities and drugs.

Questions regarding this Proposal

- How does the plan address benefits if user does not have a medical home?
- How does the exchange ensure market competition to reduce cost?
- It is not clear what is meant by a two tiered healthcare system.

7) Quality

Positive Aspects of the Proposal:

- Utilizes many different ways to improve quality and contains cost as an out come
- Reporting and transparencies
- Proposal focuses on pay for performance
- Standardized care measurements provide for positive performance standards and protocols
- Long term care focus on HCBS
- Emphasized quality care based on performance
- Proposal allows provider choice
- Proposal begins to address efficiency and decreasing waste
- Defined managed care

Negative Aspects of the Proposal:

- Pay for performance creates a disincentive for Vulnerable populations in that providers may not be able to achieve the benchmarks when serving vulnerable populations.
- MEPS data excludes high needs populations and creates a bias in the system against these vulnerable populations
- We recommend that best practice and promising practice models be used to determining quality rather than standards which may not include the needs of vulnerable populations.
- Proposed system should provide a mechanism that will evaluate and validate provider competence level
- Wide variation of practice patterns may impact quality.
- Need to be careful not to have pay for volume rather than real quality.
- Proposal does not make it easier to assist individuals with limited capacity
- Proposal does not provide an incentive to take higher volume of individuals from vulnerable populations
- Need to increase electronic records in order to be more effective, and efficient.
- System advocated by this proposal should not be used as a platform for a denial. Evidenced based care does not work for some vulnerable populations.
- Proposal should include provisions for an outside evaluator to review the network.
- Competency requirements need to be applied to staff other than just the physician and needs to include frontline workers including nursing staff and other skilled and unskilled service providers.
- Medical Home requires emphasis on coordinated care.
- Complex care coordination is a higher quality managed care model
- Concerned that pay for performance criteria will become “cost driven”, rather than based upon the number of successful operations, treatments, etc., we just cost shift to another entity that is under-funded

Questions regarding this Proposal

- What detailed criteria will be used do create pay for performance standards, and how will a cost driven criteria be avoided?

8) Efficiency

Positive Aspects of the Proposal:

- Proposal begins to place emphasis on cost effectiveness and keeping health care costs lower overall
- Proposal promotes pay for performance reimbursement model
- Co-pays for therapies are \$10 could increase access for children and reduce LTC costs due to effective treatment.
- No co-pays for Family Planning
- The proposed Exchange might streamline eligibility and enrollment

Negative Aspects of the Proposal:

- Proposal may negatively affect safety net due to reallocation of DSH funds
- Proposal does not simplify the system and may affect areas that are currently working well
- Behavioral treatment is not apparent in this plan – these are much needed services for children with autism.
- Proposal does not sufficiently address Health Information Technology, and this is important for people with complex needs.
- The proposed Exchange might be a hurdle for some families due to the cliff effect
- Different enrollment levels for different groups, creates confusion and equity issues.
- Tiered cost sharing, will create issues for coordinating services

- The labor pool for LTC is a major problem; how will this proposal get private industry (or the government) to improve this labor pool. The institutional cultural change would be dramatic (and would require a shift in the major nursing home chains, hospital chains, and other health facilities to place greater emphasis at service delivery rather than profit.
- LTC housing recommendations are the weakest part of the proposal, as well as, the most expensive. The proposal recommendations have minimal substance. We need to be talking to developers and financiers of housing to figure out how to care for individuals who have multiple levels of need in the private and public market.
- Adequate funding in all settings is appropriate, however, paying Assisted Living Resident (ALR) \$2000 when NH get \$6000 for the same patient who meets the same level of criteria for care need on the ULTC 100.2 is not adequate.
- Some elderly patients are not appropriate for nursing home care (if they walk, talk, are alert, and very well managed on current drugs and their assisted living situation). We could collectively save a lot of money if there were intermediate levels of care or rules changes to accommodate the medical needs many elderly residents in assisted living. Cost shifting happens with home care a lot in ALR, due to rules and mostly poor planning on the part of public policy experts.
- Worry about increasing the ADL threshold for eligibility – couldn't find this in proposal but keep hearing that this is an issue.

Questions regarding this Proposal

- Are there limits placed upon the number of therapy visits?
- Where is behavioral health in this plan? Can someone provide benefits information?
- How will HEDIS data be pulled together with different payment groups?
- Will CHAPS data be used?
- How will appeals be addressed?? Will it be an easily navigated and transparent process? Will a consumer advocate be available for individuals?

9) Consumer Choice and Empowerment

Positive Aspects of the Proposal:

- Proposal provides for guarantee issue and community rating (concerned that this may not be adequately funded)
- Begins to address some education issues via the exchange.
- Proposal provides additional consumer choices based upon ability to pay
- Appropriate emphasis on Consumer directed care and self-determination
- Supports pay for performance and healthy outcomes
- Provides an appropriate range of coverage based upon ability to pay

Negative Aspects of the Proposal:

- The low cap for the basic benefit plan leaves consumer at risk for falling off cliff
- In this proposal complexity is not reduced, it may be increased
- Seems like if you have complex or a lot of needs you would have to pay more or buy Cover CO with a subsidy.
- The proposed coverage system appears to be difficult for many individuals in vulnerable populations to successfully navigate.
- Coverage system appears complicated and difficult to understand and efficiently use.
- Gaining access to Exchange may be difficult for individuals in vulnerable populations and this is not specifically addressed

Questions regarding this Proposal

- Who can access Cover Colorado? This would be critical for people with disabilities given the low caps

- How will vulnerable population users gain access to this system?
- How will vulnerable population users be educated in system access and navigation?
- How will appeals be addressed?
- Will it be an easily navigated and transparent process?
- Will a consumer advocate be available for individuals?

10) Wellness and Prevention

Positive Aspects of the Proposal:

- Wellness programs are well defined
- Proposal implies HCBS emphasis
- Proposal mentions some support services such as PT/OT but co-pay and limits not discussed
- Proposal emphasizes wellness and prevention
- I like their emphasis is placed on medical home and the proposal's definition of Medicaid Managed care – do what needs doing as early as possible.

Negative Aspects of the Proposal:

- Enforceable co-payment may restrict access to preventative care
- There is a co-payment for preventative care, even though it is small.
- Does not completely eliminate costs for low income vulnerable populations who cannot absorb even very limited expenses.
- ALL homeless populations are not being addressed. This is a concern for all proposals. There is a need for homeless to be served in their community. This population needs healthcare and needs it to be accessible.

Questions regarding this Proposal

- We need information on how much therapy will be covered? OT, PT, SLP are listed, but no information is provided on frequency and duration.
- Expand upon statement that co-payments are “enforceable”. What does this mean?

11) Sustainability

Positive Aspects of the Proposal:

- This proposal may be sustainable as it does not increase costs (or benefits) much.
- Proposal allows different benefits to be purchased
- Proposal seems to be meant as an incremental step to universal care.
- Proposal allows market choices
- Proposal accounts for expanding LTC needs
- Does expands insured population
- Plan addresses LTC care to a far greater extent than any other proposal. This is critical for long term financial sustainability.

Negative Aspects of the Proposal:

- Proposal does not address many of issues needing to be addressed for vulnerable populations
- LTC seems to be all in Medicaid.
- Doesn't expand insured population by large enough numbers
- Proposal does not address expansion of vulnerable populations presented by the changing demographic. This population looks good on paper now, but is poorly prepared financially for long term or chronic health issues that come with aging. This vulnerable population “in waiting” will place tremendous logistical and financial strains on the system advocated here. This population may further limit the number of uninsured residents that can be insured in the future.

- Proposal does not make provisions for special state planning for specific high cost / high maintenance diseases and chronic conditions.
- Not sure whether shifting currently institutionalized individuals into community-based care would save dollars over the long term.
- Proposal does not provide any reserve funding provisions for future periods of economic downturn in Colorado and changing business cycles.
- Long Term care plan is heavily dependent upon Medicaid.
- Proposal does not address the 8,000 people in Colorado waiting for DD services. The changing needs of these populations will continue to increase.
- \$35,000 cap is not realistic and a real problem especially for the vulnerable populations requiring them to become destitute and end up as the state's responsibility.
- Possible solution to place PCP services in the State Plan benefit in order to allow a level of care in home health services, rather than LTC.

Questions regarding this Proposal

- Can people that are over the 'over-income' threshold for Medicaid and who have disabilities pay for a market plan that will meet complex/high needs?
- Are there provisions for independent evaluation to determine if the proposal is working or not?
- How does the financial model and funding strategy for this proposal accommodate the rapidly aging demographic and resulting high maintenance/cost diseases related to aging populations?
- How is this proposal going to address the large number of aging?

12) Practicality of Implementation

Positive Aspects of the Proposal:

- Limited number of implementation barriers
- Not a big change from what we have right now
- No mandates
- Probably the least difficult to implement

Negative Aspects of the Proposal:

- DSH funding restructuring will impact safety net providers
- May not be used by a large percentage of the state's population because some people won't understand it and therefore will not use it.
- Seems to cost a lot for not much increase.
- Proposal does not appear to increase rates for Medicaid providers.
- Exchange could be good/could be bad
- Concerned about the problem raised by federal budget neutrality rules for waivers.
- Transfer of institutionalized individuals would be logistically very problematic.
- State enabling legislation and state budget authority for proposal implementation will be limited by Tabor restrictions, and would probably require State referendum.
- Complexity of Exchange could limit usage and render a key element of this proposal less effective.

Questions regarding this Proposal

- How will cost savings be achieved by shifting currently institutionalized individuals into community based care?
- How will Tabor restrictions be addressed?
- How will small businesses and their employees react to this model ?

REPORT TO THE BLUE RIBBON COMMISSION

VULNERABLE POPULATIONS TASK FORCE

REVIEW OF

Solutions for a Healthy Colorado (CSAHU)

September 28, 2007

Executive Summary

Positive Aspects of Proposal:

CSAHU advocates a number of positive components. Individual mandates would support additional funding for coverage of the uninsured and may assist in keeping premium rates more manageable.

We are especially supportive of an internet-based Health Insurance Connector which will help to centralize insurance coverage information, display available coverage options, and minimize administrative costs for government and small business. The Connector can be managed within current state agencies and would be successful with the appropriate outreach and education.

In addition, the Connector could facilitate the “hierarchy of funding” addressed in JBC Footnote 89, which reinforces public funds as “payer of last resort”.

This Task Force workgroup also supports the emphasis on prevention and wellness, premium reduction for healthy lifestyles, outreach, longer enrollment periods, and portability. We concur with the proposed increases in Medicaid re-imbursalment rates for the benefit of providers and a pay for performance model which we consider an important first step in ensuring quality care. We also support the increased pharmacy access provided in this proposal.

With the exception of individual mandates, this plan appears to be easier to implement than other proposals in that it uses mechanisms and administrative structures that are already in place. The changes advocated in the proposal could be comparatively minimal. The implementation of this plan will not require federal waivers.

Negative aspects of proposal

This plan is the least beneficial and most problematic for vulnerable populations. This is especially true for low income Coloradans. The proposal carries a very high annual maintenance cost for the state while still leaving a substantial number of Coloradans uninsured. Administration costs represent at least 19% of total plan costs.

This plan limits coverage at \$50,000/yr, which would force many middle and low income individuals and families facing significant health issues into financial hardship and/or bankruptcy. Cancer and other chronic long term conditions would cause individuals to reach that benefit cap very quickly. This would create an increase in vulnerable populations, by forcing more people into poverty. In fact, 50% of all bankruptcies are driven by Medical Debt. Offering Chronic and Long Term Care (LTC) components to this proposal may increase financial stability overall. One of our task force members has been the victim of this type of health issue. Fourth stage cancer has depleted her life savings, cost her family their home, and forced them into Medicaid. With proper assistance and planning this family would not have become financially dependent on taxpayer supports.

CSAHU does not appear to mandate a complete guaranteed issue, while it supports rating based upon age and health status. The concept of an individual mandate is that it should promote a pure community rating, which CSAHU does not.

This proposal only provides subsidies up to 250% of FPL, which is substantially too low. Subsidies up to 300% FPL would constitute meaningful health care reform. Subsidies up to 350% FPL would be most reasonable as the Federal Poverty Level has not been updated in far too many years. In addition, the CSAHU plan only provides 100% subsidies up to 100% of FPL, 90% subsidies for 100-150% FPL, 70% subsidies for 150-200%FPL, and 50% subsidies for 200-250% FPL. Many families simply will not be financially able to contribute 50% of premiums. This structure places an unacceptable financial burden on low income populations and would effectively restrict access to the very coverage that this plan purports to offer. In addition, the health plan benefit package is not clearly addressed. Coloradoans are #1 in “out of pocket” expenses, those health care needs NOT covered by private or public insurance. At a bare minimum, Standard benefit plans should not advocate requirements below the existing Colorado Division of Insurance Standard Plan. Please refer to the report for the Division of Insurance on SB 05-36, which shows that a health plan with insufficient benefits is of minimal value to the consumer and is a barrier to accessing care.

Of the four final proposals, this is the only one that does not attempt to address long term care, even at the most basic level. This void in the plan skews the financial and benefits analysis. Nor does it sufficiently address chronic care. This is a particularly significant deficiency in that Long Term and Chronic Health Care represent by far the largest health care expenditures; thereby cost shifting onto state programs funded by taxpayers.

The CSAHU proposal advocates a voucher based system of subsidies. Vouchers set up a market where each individual will be in their own risk pool. This will inevitably drive up costs, especially for sick and low income individuals and create high annual plan turnover. In addition, by its very nature, a voucher/subsidy approach will create administrative and implementation barriers for the very people it is intended to benefit, the most vulnerable and most in need.

We are very concerned about the emphasis on individual mandates alone. By promoting only individual mandates, this may in turn promote employers to eliminate or reduce the coverage they currently provide. This concern was echoed by Representative Stafford in the 208 Commission presentation to legislators on September 12, 2007. By including employers and providers in the mix, and placing less restrictive mandates on the private sector, their contribution would provide a foundation upon which to build an individual mandate while reducing employer overall contribution. This would still positively contribute to the employer's bottom line.

The CSAHU proposal advocates generic drugs and Preferred Drug Lists (PDL's) in order to reduce costs. Since most insurance companies use Pharmacy Benefit Managers (PBMs) to manage drug benefits it may be difficult to know if savings are passed back to the consumer without provisions for greater transparency. In addition, PDLs have the potential to be a significant barrier to access to critical medications for vulnerable populations. By definition, vulnerable populations vary in their response to medication, frequently deviating from the “evidence-based” approach used to develop the PDLs, due to ethnic diversity, diagnosis, multiple medications or off-label needs for medication.

In spite of our general approval of the Health Insurance Connector, it may be difficult for vulnerable individuals (especially the homeless, aged, and those with cultural or language barriers) to access and navigate. This is illustrated by the fact that there is a mandatory education program required for experienced health insurance professionals.

We are concerned that CSAHU will inevitably evolve into a multi-tiered health coverage system that will differentiate coverage and quality based upon ability to pay. We are concerned that this plan is primarily a financing mechanism that merely re-distributes public funds to private insurance companies in order to cover more of Colorado's uninsured. This proposal may not accomplish the statutorily mandated objectives of the 208 Commission.

The CSAHU plan will implement Health Savings Accounts on Colorado's Health Care system. HSAs are beneficial for tax and financial policy but may not be equally beneficial for health policy. While we support financial planning for those with high economic means, this is not feasible for others. Low income residents do not have sufficient income to truly benefit from HSA tax breaks.

It is important to note that "children are not little adults. Historically, the adult health care system has been retrofitted onto the pediatric population. A Rehabilitative model drives the health plan benefit package and has a tendency to deny Abilitative care. In other words, if an adult has a skill and loses it, they have insurance. If a child is developing the skill, they are frequently denied or may face additional administrative and access barriers. This is a particular barrier for children and adults with disabilities.

Recommendations

The Vulnerable Populations CSAHU group makes a number of recommendations to this proposal in order to ensure its overall effectiveness and provide opportunities to assist the state of Colorado in improving care for vulnerable populations.

We recommend that incentives be provided to promote individual mandates in addition to enforcement provisions alone. Effective promotion of individual mandates requires both carrots and sticks.

We suggest incorporating Chronic Care wrap-around and Long Term Care coverage options into the standard plan that is offered. These options could prevent undue financial hardship as well as mitigate the time and effort required to apply and qualify for separate chronic care or LTC coverage. Accidental injury and chronic conditions require immediate attention.

We would ask that the commission consider other less restrictive mandates in other areas (business, health plans, and providers), as opposed to individual mandates only. Should some health plans continue to have overheads that range from 20 to 30% while Medicaid is able to deliver better coverage for 2-3%? We believe actual overhead may lie somewhere in between.

We consider it appropriate to include an additional voluntary single payer option to provide another option of coverage for Colorado residents. This voluntary plan should be based upon a mandatory minimum number of enrollees to ensure program funding. A minimum enrollment period should be mandated to ensure the sustainability of the program over the long term. If an individual opts for this program, then subsidies should be re-directed from the standard benefit plan to this option.

We support a reserve fund for long term sustainability for fluctuations in the business cycle or downturns in local economies that will inevitably impact funding.

We are committed to the definition of Public Health under the guidelines of the Colorado Department of Public Health and Environment (CDPHE) as including all residents living the within the state of Colorado, without a period of ineligibility. We do not consider health care to be a commodity because individuals do not "choose" to get sick, thereby needing care.

The litmus test of quality health care is: Can you see a doctor when you need one?

Summary of Recommendations:

- Incentives for individual mandates in addition to enforcement.
- Include chronic and LTC in standard benefit plan.
- Include “best practices” in abilitative care for pediatric population.
- Recommend broader-based covered benefit package within standard plan enabling the \$50,000 cap to reflect real health costs.
- Promote both individual and narrower business mandates.
- Create and ensure access to health care in rural Colorado.
- Inclusion of a voluntary single payer option.
- Create a Reserve Fund.
- Demonstrate a commitment to Public Health by including all Colorado Residents.

Review of Critical Areas

1) Comprehensiveness

Positive Aspects of the Proposal:

- 12) Subsidized voucher for purchase of private insurance would be good but at higher poverty levels
- 13) Re-insurance pool if affordable might expand some coverage
- 14) Mandates insurance for “voluntary uninsured”
- 15) Some quality measures

Negative Aspects of the Proposal:

- Looks good on paper but is poorly prepared financially for long-term or chronic health issues;
- Does not make provisions for high cost/maintenance of chronic diseases.
- Long-term/chronic care coverage detail is lacking. Need these provisions to avoid great financial strain on proposed system
- Is cost prohibitive and by far the most costly for the state to implement and maintain. \$1.2 billion to implement and \$888 million in net costs.
- Leaves 75,000 people un-insured: 46,000 under \$30,000 and 12,000 under the age of 18.
- No Long term Care plan of any kind.
- Takes several years to implement.
- Health insurance only approach.
- Assumes no fundamental change in the status quo
- Cost of coverage is disproportionately higher for middle class Coloradans
- It is unclear as to whether this proposal would improve health
- Opposes coverage of the poor
- Provides scaled down product
- Limited core benefit
- “Age & Health status rating flexibility” – best prices to healthy; penalize ill
- Provides a max core benefit \$50,000/yr”, which is insufficient
- While not having guaranteed issue Colorado has enjoyed a “competitive, thriving individual market”
- The only plan with guaranteed issue is the LIMITED Core plan
- Advocates pricing coverage according to “potential utilization”, This openly discriminates against vulnerable populations
- “Improves the overall risk profile of small groups”. This encourages discrimination in hiring
- The plans nutrition sales tax places the greatest burdens on the poor (unless incentivize healthy food)

- Does not do much for children and adults with disabilities. They will be required to access Medicaid or Cover Colorado
- Requires the purchase of life Insurance policy to be issued with a health care policy, which is out of reach to the low income.
- The 50-64 age groups will be impacted in a negative way.
- Does not address Long Term Support Services
- Is the least comprehensive of the four proposals
- It's a great program if you are healthy and don't have to use it.
- Modified community rating, especially rating by health status, combined with elimination of the safety net, is outrageous
- Indicates that the authors are openly in it for the money
- Creates a two tiered system designed to segregate the healthy from the unhealthy exclusively for profit

Questions regarding this Proposal

- Does the plan continue modified community rating?
- How will this plan underwrite the unhealthy?
- What savings are generated through Malpractice Reform? This information is not in the Lewin model.
- Why is this proposal damaging to Medicaid?
- Please explain statements on pages 13 and 15 regarding small group market conflict?
- Did Lewin model account for cost of high deductibles on the individual?

2) Access

Positive Aspects of the Proposal:

- The Health care Connector idea is intriguing. However, the suggested implementation appears biased towards those already with insurance and the market
- Increases Medicaid reimbursement rates
- Promotes outreach
- Promotes longer enrollment periods
- Subsidizes program for populations under 250% of FPL
- Promotes family coverage under some plans
- Promotes "connector" to assist in obtaining coverage

Negative Aspects of the Proposal:

- The proposal advocates education regarding costs of products purchased but does not address education regarding the specific need for services.
- Proposal penalizes use of non medically necessary (not evidence based) services
- Increases complexity of receiving limited coverage
- Maintains administrative costs at 20%
- Discriminates based on needs of individuals
- No continuous coverage, no portability
- Proposed plan is not individually affordable.
- This proposal will continue to cost shift most needy populations to the government while allowing physicians and insurance industry to profit.
- Same access for people with disabilities as now – no real changes.
- Mental health care has high co-pays and low maximums.
- No information is provided on extra costs for people with high needs
- Assumes that coverage and affordability equals access. Does not address transportation, telemedicine, acceptability, etc. in any fundamental or meaningful way.
- Health Insurance Connector may be very difficult for VPOP individuals to access and navigate through. This system even requires a training program for insurance experts
- No HIT details (only internet tools described relate to insurance purchase)

- Does not cover 76,000 individuals that are mostly low income. This will limit access
- Promotes the HSA model. A big barrier to the low income. Low income populations will not be able to afford the deductibles
- Shifts risk and cost to the consumer
- Proposal is opposed to expanding the State Medicaid and SCHIP programs
- Limits coverage to \$50,000
- This proposal promotes vouchers. Vouchers would be a disaster for low income and very sick individuals.
- Proposal would drive up premiums
- The proposal needs to include native counselors/treatment centers under section on integrated treatment. Care needs to be culturally competent.

Questions regarding this Proposal

- How would the safety net and CHC be impacted concerning section on page 11?
- The proposal promotes the use of Medicare reimbursement rates. How would they impact the lack of access in LaPlata County?
- How will /can federal monies for health care and services be supplemented by this plan? (Existing services should be included, but does not assume that existing services are adequate).

3) Coverage/ Eligibility

Positive Aspects of the Proposal:

- Proposal promotes individual mandates
- Proposal promotes wellness initiatives
- Provides risk adjustment payments for high risk populations;
- Provides end-of-life coverage

Negative Aspects of the Proposal:

- Limits coverage to \$50,000
- Benefit plan as priced out by Lewin and Core Benefit plan are EXTREMELY LIMITED and in some cases provide less than mandates.
- Addresses increasing doctor reimbursement, however pays ABOVE Medicare to all
- Does not address continuum of care or integrated care models
- No detailed LTC plan
- Does not address long term care or long term support services. Individuals would be forced into high risk pools or Medicaid
- LTC insurance will be too expensive for most of these individuals
- Proposal side-steps resident definition
- Proposal advocates for high co-pays and low maximums
- Mental health, DME, have high co-pays and low limits
- No coverage for behavioral conditions or autism treatment
- Mandates for therapy for young children could be taken away
- In this proposal people with disabilities are still expected to access care through Medicaid and providers are still expected to get lower rates. Pay for performance quality issues are for non-Medicaid only
- Plan proposes high rates for brand name medications
- Does not cover 76,000 uninsured individuals
- Does not promote integrated systems
- Promotes flexibility coverage, but doesn't explain. Could mean forcing the very sick on older individuals into high risk pools
- HSAs promote adverse selection and may affect an individual's credit rating. And therefore may affect entrepreneurship
- Removes all consumer protections currently in place by limiting Medicaid for kids and adults with complex needs. Limits EPSDT

- Doesn't address pent up demand and wait list issues for medically necessary health care.
- Method for acquiring and managing coverage is more complicated. Will be difficult to access

Questions regarding this Proposal

- What kind of training will the public receive, in addition to the training of insurance agents receive?
- What are the variables in the flexibility coverage?

4) Affordability

Positive Aspects of the Proposal:

- Proposal uses pay for performance standards
- Proposal rewards cost effectiveness
- Proposal promotes Play or pay for employers
- Promotes transparency on cost of care. Does this include insurance companies and brokers?
- Minimal or no co-pays for chronic disease care and meds

Negative Aspects of the Proposal:

- Proposal shifts cost and risks to consumers
- This proposal has the highest cost and covers the least number of people
- Provides tax dollars to insurance carriers as a subsidy for profit
- Side-steps definition of exact benefit. Dependent upon actuarial input and review of Colo. Dept. of Insurance
- Subsidies are set at 50-90% of premium for those under 250% (as opposed to 300%) of FPL. Still places financial demand on very poor people.
- Limits coverage to \$50,000.
- Proposal notes that a high risk pool will be a "challenge." Will be out of the reach of low income. Does not provide for the expansion of Medicaid and SCHIP
- Recent studies show that tax credits have limited impact for covering the uninsured
- Promotes using the Medicare Reimbursement schedule for Payment. No provisions for adjustment. State will lose control over budget
- Promotes HSAs.
- High deductibles put health care out of reach for low income and sick individuals
- No change for people with disabilities – kids or adults
- Providers still paid more for non-Medicaid patients
- 6-mo. Residency requirement for premium assistance;

Questions regarding this Proposal

- What would the percentage of profit be and for whom? What would the profit become relative to what it is now? Should health care be for profit?

5) Portability

Positive Aspects of the Proposal:

- You own the policy therefore it is portable. However, the person must be able to afford it.

Negative Aspects of the Proposal:

- None

Questions regarding this Proposal

- No Questions

6) Benefits

Positive Aspects of the Proposal:

- Proposal advocates managed care
- Proposal promotes Preferred Drug Lists for medications
- This proposal mentions reinsurance provision
- Proposal establishes a pool for small business
- Proposal creates a rate based on health status, so if you are well and can afford it you can get the service.
- Current Medicaid benefits maintained

Negative Aspects of the Proposal:

- Describes incomplete, limited, benefit plan that would be the only option for the most ill
- Unknown how the wrap-around would work for catastrophic care.
- Proposal has limited benefits.
- Supports rating on age and health status
- Limits benefits to \$50,000
- Reinsurance may force individuals into individual market. Not an effective way to cover low income individuals
- Side-steps definition of exact benefit. Nature of benefits and pricing are dependent upon actuarial input and review of Colo. Dept. of Insurance
- Subsidies are set at 50-90% of premium for those under 250% (as opposed to 300%) of FPL. Still places financial demand on very poor people.
- No specific mention of alternative care
- No obvious integrated care model
- Unmet need and uncompensated care will drive costs up.
- Reinsurance will only meet the specific medical needs of vulnerable populations. Vulnerable populations have other needs with respect to health care that remain unmentioned.
- Reinsurance gets passed onto the client. This plan disenfranchises people who are not self sufficient
- This plan forces the consumer to buy a product that will contribute to their impoverishment

Questions regarding this Proposal

- Would reinsurance apply to LTC and LTSS?
- Does reinsurance become the safety net?
- Are we subsidizing the safety net at the highest cost?
- The standard benefits package is lower than most basic benefit packages. What is the total cost of the benefit package?

7) Quality

Positive Aspects of the Proposal:

- Proposal supports a pay for performance model
- Proposal addresses the need for Health Information Technology
- Proposal promotes evidence based Medicine, Pay for performance, and electronic medical record keeping and access

Negative Aspects of the Proposal:

- Does not address Long Term Care
- Proposal does not improve status quo for disabled populations
- Compensation is tied to outcomes but without any real detail as to how that will be accomplished.
- Compensation is loosely tied to "outcome guidelines" that will be considered for the grading of provider re-imburement
- No obvious integrated care plan or patient centered care options

- Native Americans are not included in the cultural competent care. Traditional counselors are not identified as reimbursable. More native practitioners need to be in the network for both physical and mental health
- Proposal reduces quality by reducing the mandates currently covered in Colorado
- Proposal discriminates against most vulnerable populations
- P4P model seems too cumbersome to assure payment.
- Does not allow the referral to either the cultural provider or western medicine, this is not culturally competent.

Questions regarding this Proposal

- How can the entity (Division of Insurance) monitor the quality of the performance of the business? This seems to be a conflict of interest.
- Does this proposal promote transparency on cost only? What about quality? Insurance companies and brokers?
- With a fragmented system, how will data and information be pulled together?
- How can the (Division of Insurance) monitor the quality of the care?
- What is the definition of care?
- Will alternative medicine approaches be compensated?
- Is the P4P model paid out for the referral or for the completed care of the patient?

8) Efficiency

Positive Aspects of the Proposal:

- Proposal creates incentives for healthy behavior
- Proposal emphasizes pay for performance model
- Promotes evidence based medicine, pay for performance, and electronic medical records
- Proposal provides for higher reimbursement for providing health care services for low income individuals

Negative Aspects of the Proposal:

- Proposal makes eligibility more complex
- Proposal identifies medical liability as a problem but does not elaborate upon a solution
- This plan benefits the insurance industry while decreasing the efficiencies in the current system
- Proposal promotes the current fragmented system and will add to overall complexity
- Does not alleviate the current high administrative cost system. It will add more administrative cost for both individuals and small business
- HSAs do not hold the increasing cost of services down. For low income they just delay services until they become acute. This may cost the system more over the long term.
- The Connector may be difficult for vulnerable individuals to access and use
- Not clear that Connector will significantly reduce administrative costs and make the system simpler.

Questions regarding this Proposal

- No questions

9) Consumer Choice and Empowerment

Positive Aspects of the Proposal:

- Addresses consumer education regarding costs
- Promotes outreach programs
- Connector can be powerful if supports are in place

Negative Aspects of the Proposal:

- Does not allow guaranteed issue or community rating (just discriminated rating)
- Proposal does not improve situation for individuals with disabilities
- Promotes rating on age and health status.
- Complexity will create barriers for individuals to make choice. With longer enrollment periods, individuals will be 'locked in' to plans that do not fit their needs
- Requires significant re-adjustment of medical malpractice laws, may limit consumer empowerment

Questions regarding this Proposal

- Does this proposal promote transparency on cost only? What about quality? Insurance companies and brokers?

10) Wellness and Prevention

Positive Aspects of the Proposal:

- Promotes Nutrition tax
- Provides access to preventive care and wellness services
- Proposal offers premium reduction for healthy lifestyles
- Rewards employers for employee's healthy life styles

Negative Aspects of the Proposal:

- Plan would discriminate against those with chronic illness
- Defensive treatment costs are acknowledged but not addressed

Questions regarding this Proposal

- Would healthy lifestyles premium be available to proactive chronic disease management as a form of healthy lifestyles. Will sick people be able to be incentives too?

11) Sustainability

Positive Aspects of the Proposal:

- Proposal will promote higher rates for Medicaid providers
- Proposal creates a uniform pricing model
- Proposal initiates a nutrition tax

Negative Aspects of the Proposal:

- Does not address Long Term Care
- Will be heavily impacted by business cycle. No provision for a reserve fund to protect from the downturn in business cycle
- In downturns, Medicaid and SCHIP become the safety net programs. Provides for limited programs
- May be cost prohibitive over the long term. Cost of implementation and maintenance is very high.
- New taxes will be required
- Connector may be difficult to use and access. If system use is not maximized it will have limited sustainable benefit.
- Adverse selection will put pressure on Medicaid and SCHIP. Provides for limited programs.
- Proposal does not address expansion of vulnerable populations represented by financially tenuous, retiring baby-boomers. This population looks good on paper now, but is poorly prepared financially for long term or chronic health issues that come with aging. This "VPOP in waiting" will place tremendous logistical and financial strains on the system advocated here. This population may further limit the number of uninsured residents that can be insured in the future
- Proposal does not make provisions for special state planning for high cost / high maintenance diseases. Without such provisions those VPOPs will place great financial and logistical strains on the proposed system.

Questions regarding this Proposal

- No provision for an independent evaluation to determine it will work after implementation. Should there be one?

12) Practicality of Implementation

Positive Aspects of the Proposal:

- Will not require waivers from the Federal government.

Negative Aspects of the Proposal:

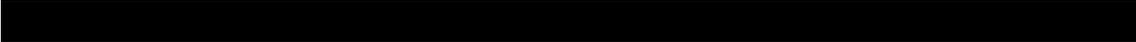
- Proposal carries a \$1.227 Billion price tag
- May require changes of health status categorization in current State statutes.
- Many groups will oppose HSAs and vouchers
- Requires implementation of new taxes. Tabor will represent a significant stumbling block and funding would almost certainly require a public referendum.
- Diversion of uncompensated hospital funds
- Demands significant regulation modification or de-regulation of insurance industry
- Suggests modifications of federal tax law to allow for premium deductions
- Nutrition Sales tax may be difficult to implement and has national implications.
- Requires significant re-adjustment of medical malpractice laws
- Does not accomplish what 208 was statutorily mandated to do

Questions regarding this Proposal

- No questions

Appendix 7: Medicaid Reform Ideas for Further Study

- Guarantee prompt (direct) reimbursement to clients and providers for any eligible expenses incurred during any delays in eligibility or periods in which the individual met all other periods that the client met all eligibility requirements, but for submission of an application (with a reasonable time limit), or if the client was required to self-pay, regardless of whether the service/supply was provided by a authorized Medicaid provider (e.g. hiring a neighbor for home care v. an agency).
- Require all Medicaid recipients to have needed care coordination that includes prescription coordination and management, including medication review of new and continuing prescriptions.
- Provide consumer training and education to allow consumers to identify savings in their own care and potentially provide incentives for doing so.
- Pursue strategies for providing more reliable transportation, including funding strategies for Medicaid recipients that address inter-agency conflicts.
- Combine waiver programs where appropriate (e.g. waivers with similar benefits thus saving on admin costs).
- Support strategies to increase access to home based care in a cost effective way, so that people currently hospitalized (example vent dependent kids) can go home- and receive adequate care in the community. Results in long term savings.
- Investigate stipend respite care as a benefit for eligible waiver participants. (Saves money because people can go home from hospital).
- Look at pooling DME purchasing. Can we purchase DME more cheaply or use equipment more efficiently? Set aside funding to help with this- example of potential savings is permitting recycling of wheelchairs, etc.
- Create consumer-directed program for supplies. For example, Medicaid enrollees can buy Depends much more cheaply over the counter in the market place than through a Medicaid supply company.
- Create new program for care coordinator to facilitate getting people transitioning out of corrections or the foster care system on to SSI and Medicaid as appropriate.
- Study how to provide health management and care coordination for foster care children.
- Facilitate transition to services for those on Medicaid aged 18-21, particularly across multiple systems.
- Assist veterans transitioning from VA medical Services to DDS and SSI

- Simplify and standardize entry into all HCBS programs.
 - Integrate systems so that mental health, education, and human services all work together to get appropriate services to children particularly when a child needs institutional care. Long term savings in getting appropriate care to kids when they need it.
 - Integrate mental health reform with health care reform. Look at the other recommendations for mental health coming from interim committees and DCCO.
 - Generally eliminate prior authorization requirement for over-the-counter products costing less than \$100, with appropriate utilization review.
- 

Appendix 8: Legal Issues

The Blue Ribbon Commission on Health Care Reform notes that a number of legal issues are raised by the five proposals that were submitted for economic modeling. Lewin expressly stated that it did not take into consideration potential issues of legality.

An in-depth legal analysis of such a myriad of issues was not possible, given the time constraints under which the Commission crafted its report, and the likelihood of disparate legal opinions among attorneys. As such, we chose not to secure legal advice, but rather to note that such legal issues must be considered, particularly with regard to the limitations and restrictions imposed by existing federal statutes, such as ERISA, HIPAA, and EMTALA.

In addition, there are specific legal issues that should be addressed in considering the actual recommendations of the Commission. By way of example only, we note the following legal issues that should be evaluated:

1. What religious exemptions, if any, must be provided if an individual health insurance mandate were adopted in Colorado?

2. What exemptions, if any, must be provided to Southern Ute and Ute Mountain Ute tribal members if an individual health insurance mandate were adopted in Colorado? Are there similar considerations that apply to members of other tribes, living in Colorado, that ought to be taken into account in an individual mandate environment?

3. Does the Americans with Disabilities Act permit a state to provide equal services and benefits through a quasi public program (e.g a reformed Cover Colorado) where people without chronic conditions are required to participate in the private health insurance marketplace? Are there any other state or federal laws that would prohibit this form of quasi governmental support only for those persons with chronic conditions?

4. May Colorado require employers to establish premium only Section 125 plans under ERISA?

5. What HIPAA considerations, if any, are involved in establishing a Connector?

6. What legal issues are raised by combining Medicaid and CHP+ family and children's programs? As examples:

a. What EPSDT issues must the State take into account?

b. What legal issues are raised, if any, in combining a managed care and a fee for service delivery system?

c. What waiting period, if any, may be imposed in a combined program and for Medicaid expansion populations?

d. What due process is required in a combined program?