



# **5<sup>th</sup> Proposal Specifications:**

## **Third iteration**

November 4, 2007

**Note: Track changes in this document reflect changes made to the 5<sup>th</sup> Proposal by the Commission during its November 2, 2007 meeting**

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## **EXPAND AND REFORM PRIVATE HEALTH INSURANCE IN COLORADO**

### **Recommendation #1: Require all legal residents of Colorado to have health insurance coverage with basic plan coverage**

- i) To satisfy the insurance mandate, require purchase of at least basic plan coverage
  - (1) For modeling purposes, Lewin will model SEIU benefit package, with an annual benefit cap of \$50,000, instead of \$35,000 cap in the SEIU proposal (See Attachment A)
- ii) Enforce mandate by:
  - (1) Requesting proof of coverage at school enrollment
  - (2) Requesting proof of coverage at Department of Motor Vehicles
  - (3) Assessing penalty at tax filing without proof of coverage, equal to the cost of a year's coverage
  - (4) Creating central registry of uninsured
  - (5) Those who file an income tax without proof of coverage will be referred to the Coverage Clearinghouse for assistance with obtaining coverage
    - (a) Those who are eligible for a full-subsidy program will be automatically enrolled in a program and in a health plan
- iii) Individuals and families between 0% and 300% of the poverty level will be eligible for subsidies for coverage, through Medicaid, CHP+ and a new subsidy program.
- iv) Between 300% and 500% FPL, those who do not have access to a basic benefit plan that is less than 9% of their income will be exempted from the individual mandate; in addition, an exception process based on individual circumstances will be created.

### **Recommendation #2: Provide subsidies for low-income families and individuals to purchase private insurance**

- i) For all uninsured families and individuals with incomes between 200% and 300% FPL, provide subsidies through a Coverage Clearinghouse (discussed below) where people could get subsidized, guarantee issue, coverage. Subsidy would be based on family income.
  - (1) Lewin will model that subsidy enrollees receive the CHP+ benefit package

- ii) Require people to buy into their employer's plan with a state subsidy if the employer coverage is equivalent to or more comprehensive than the CHP+ plan coverage.
- iii) The Committee recommends that Lewin model the following subsidy schedule:
  - (1) Up to 250% FPL—100% subsidy of lowest-cost basic plan coverage or employee's share of employer's plan
  - (2) 251%FPL-300% FPL—80% subsidy of basic plan coverage or employee's share of employer's plan
- iv) Require those who receive a subsidy to have been uninsured for at least six months, e.g. a six month waiting period
  - (a) Implement asset test equal to \$100,000 minus car, home, qualified retirement and educational accounts and disability-related assets
- v) Add new premium subsidy for those between 300% FPL and 400% FPL who face premium that is more than 9% of their income. Provide subsidy that reduces their premium to 9% of income for the minimum benefit package (SEIU).
- vi) Pursue federal funds for the subsidy program
  - (1) Lewin will model with two assumptions: both with and without federal funding

**Recommendation #3: Reform the individual insurance market:**

- i) Important note: All recommendations about issuance rules and ratings in this section are predicated on an assumption that there is an enforceable individual mandate (and, as a result of the mandate, near universal coverage).
- ii) Guarantee issue all individual products, including the basic benefit plan, to “healthy” people who do not meet new criteria for CoverColorado.
  - (1) Enrollees who develop one of the conditions after enrolling will not move to CoverColorado
- iii) New CoverColorado criteria will be developed to identify people with chronic conditions. These criteria will be developed by a broad-based group.
  - (1) Lewin will use current CoverColorado condition list for modeling
  - (2) CoverColorado premiums will be set same as in individual market at 100% of standard rates . As now, rates would be set by looking at

rates for similar plans of the five largest individual carriers in Colorado.

- (3) Benefit packages will include a basic plan and a comprehensive plan, similar to packages offered in subsidy program and Connector.
  - (4) CoverColorado would not be available to those who wish to receive a subsidy, e.g. those who have one of the CoverColorado conditions will receive coverage through the subsidy program, along with “healthy” enrollees
- iv) All individual policies will be rated based on age and geography, similar to the small group market.
  - v) Existing guaranteed renewability will remain in place
  - vi) Tough rules will be developed to discourage people from being to shift markets when their circumstances change; e.g. people waiting until they are sick to buy comprehensive coverage.
  - vii) Create a basic benefit plan in the individual market
    - i) The will cost approximately \$200 per month per person ; the plan will be the minimum level of benefits that will satisfy the individual mandate
    - ii) The basic benefit plan will have an HSA option as well as delivery system options (HMO, PPO, etc)
    - iii) The basic benefit plan will offer mental health benefits on par with the physical health benefits offered
  - iv) Every insurance company that sells in the individual market will be required to offer these plans, appropriate to their type of network and with an HSA option
  - viii) Encourage standard benefit plans to not include limits on mental health, therapies, and prescription drugs
  - ix) Create process for annual development of basic plans; create multi-stakeholder group to conduct process and insulate process from political process; process to create the minimum benefit package should be transparent, participatory, equitable, compassion, sensitive to value, flexible and responsive
- x) Small group
    - (1) For small group health plans, current rating rules in the small group market would be the same as they are now, including a phase out of health status rating and a reliance on age and location rating. Current guarantee issue rules in the small group market would be as they are now, including age and geography rating bands. Business group of one rules will also stay the same.

- (2) Small group carriers will be required to offer the new basic benefit plan, in addition to the current required small group packages
- xi) For large group health plans, there would be no changes, except that large group health plans must offer the new basic benefit plan

## **Recommendation #4: Create a Coverage Clearinghouse**

- i) Administer the subsidy program
  - (1) Provide subsidies for qualified individuals to purchase an individual product offered by the Clearinghouse; products offered statewide
  - (2) For qualified individuals with access to an employer plan, provide subsidies to individual to purchase employer coverage
  - (3) Administer catastrophic care fund
- ii) Administer CoverColorado
- iii) Administer an optional Connector for small employers and employees, and individuals
  - (1) Offer group product to small businesses and individuals; products offered statewide
- iv) Encourage competition in both the subsidy and Connector programs
  - (1) Define benefit levels such as Gold, Silver and Bronze to be offered. At least two benefit packages offered at each level. Require carriers to offer at least one plan in each category to avoid adverse selection
    - (a) Bronze plans would mirror basic benefit plans
  - (2) Provide side-by-side comparisons of benefits and prices offered by carriers
  - (3) Encourage competition among plans, possibly auto assigning to lowest cost plans for those who don't make an election
- v) Offer plans based on same rating rules as outside of the Clearinghouse
- vi) Use brokers
- vii) Administer the Optional Continuous Coverage Program
- viii) Create and manage central registry of uninsured
- ix) Market subsidy and Connector programs through schools, employers, providers, social security offices, an insurance exchange, community-based educational programs, and/or a newly created state-level eligibility system for Medicaid/CHP+, the new subsidy program and the insurance mandate
- x) Create an Consumer Advocacy Program
  - (1) Create a program that is independent and consumer controlled
  - (2) Provide system navigators to guide people through the system
  - (3) Resolve problems
  - (4) Provide assistance with eligibility and benefit denials
  - (5) Help qualify people on Medicaid for Medicare
  - (6) Help people qualify for SSI

- (7) Coordinate with existing ombudsman and consumer assistance services

**Recommendation #5: Require all employers to create 125 premium-only plans**

- i) Require all employers to create 125 premium-only plans for their employees
  - (1) State will create standards that make it easier for Colorado employers to set up these plans; Lewin will provide more detail on this option
- ii) Require all employers who do not offer coverage to refer employees to the Coverage Clearinghouse for information on insurance
- iii) In addition, ask employers to distribute information, help people sign up for subsidies, contribute toward coverage in the Connector or subsidy program, or accept and process subsidy payments.

**Recommendation #6: Undocumented residents**

- i) The Commission recognizes the important public health, child health, and emergency room use issues relevant to this population. While undocumented residents may continue to purchase private coverage from their employer or an insurance company as they can today, undocumented residents will not be subject to the individual mandate and will not be eligible for the full benefits provided under Medicaid, CHP+ or the subsidy program. Undocumented residents will continue to be eligible for Medicaid emergency and delivery care, as they are today.

**Recommendation #7: Create incentives for communities with good local solutions**

## EXPAND AND REFORM COLORADO MEDICAID

### **Recommendation #8: Restructure and expand Medicaid and CHP+**

- i) Restructure Medicaid and CHP+
  - (1) Merge Medicaid and CHP+ into a single program for parents, childless adults and children; keep a separate Medicaid program for the aged and disabled
  - (2) For parents, childless adults and children, use current CHP+ delivery system including managed care and managed FFS network
  - (3) For disabled, aged, and foster care children, use existing Medicaid delivery system, with improvements to rates detailed in Recommendation #11
- ii) Expand Medicaid /CHP+ program
  - (1) Children
    - (a) Raise CHP+ eligibility to 250%
  - (2) For uninsured families with children that have family incomes under 200% FPL, expand eligibility for Medicaid /CHP+ to include parents of eligible children; and expand Medicaid/CHP+ to childless adults up to 200% FPL
    - (a) Lewin will model with two assumptions: with and without federal funding
    - (b) Require three-month waiting period for these expansion populations
    - (c) Implement asset test equal to \$100,000 minus car, home, qualified retirement and educational accounts and disability-related assets
    - (d) Lewin will also assume that policies will be put into place that will maintain SSI/SSDI coverage for people with disabilities at current levels (this assumption is intended to preserve current Medicare funding)
    - (e) Lewin will assume the disabled will be eligible for these expansions.
    - (f) The elderly who are eligible for Medicare will not be eligible for coverage under the parent/childless adults expansion, however, Lewin will also model providing Medicare premium and copay assistance for Medicare eligibles who are eligible for coverage

under the parent/childless adult expansion. Those elderly who not eligible for Medicaid, i.e. OAP eligibles, will be eligible for the expansion.

- (3) Create Medicaid look-alike to cover legal non -citizen residents who are not already covered by Medicaid and who are not eligible for federal Medicaid match; cover this group to the same income and asset level as other eligible populations, e.g. parents, childless adults, children
- (4) Create a first-dollar Medically Needy program for those up to 50% FPL
- (5) Create a Medically Correctable Program
  - (a) Program would be for:
    - (i) People for whom this one time expenditure would mean the difference between going back to work or not.
    - (ii) People who could use this to keep them out of or move them out of institutional care
    - (iii) People in circumstances where this one time expenditure was highly likely to result in substantial savings to the state long term.
  - (b) Program would be funded at \$5 million per year; pursue federal Medicaid match , possibly through vocational rehabilitation benefit
    - (i) Lewin will model both with and without federal match
- (6) Establish a Medicaid buy-in for adults with disabilities
  - (a) For adults who meet SSI disability criteria
  - (b) Income eligibility up to 450% FPL
  - (c) No asset test
  - (d) Premiums:
    - (i) 200% to 300%: 4.5% of income
    - (ii) 301% to 400%: 5.5% of income
    - (iii) 401%-450%: 7.0% of income
    - (iv) **Over 450% FPL: full premium**
  - (v) Premium is the average Medicaid cost for persons with a disability
- (7) Add HCBS waiver funding:
  - (a) Add 8,000 slots to DD waivers: \$72 million
  - (b) Add 500 slots to Children's HCBS waivers: \$82 million
  - (c) Add 686 slots to the Child Autism waiver: \$25 million
  - (d) Assume these are eligible for federal match

## **Recommendation #9: Restructure Medicaid and CHP+ benefits**

- i) Restructure Medicaid and CHP+ benefits for parents, children and childless adults
  - (1) Reduce standard Medicaid benefits to CHP+ package but include EPSDT preventive services as part of standard package.
  - (2) Provide all children with EPSDT wrap around services and make it easier to trigger EPSDT services (including substantial outreach, additional staff, provider education, ease of approval, etc.)
  - (3) Provide adults with trigger for wrap-around services, particularly for mental and additional dental benefits
  - (4) Lewin will assume Medicaid benefits, excluding nursing home, for all Medicaid/CHP+ expansion populations
- ii) Expand the CHP+/Medicaid benefit package to include:
  - (1) Dental coverage for adults
    - (a) A dental package will be based on the FamilyCare Proposal dental package
      - (i) This package will be provided to all Medicaid recipients, including the aged and disabled who qualify for full Medicaid benefits
    - (b) \$1000 annual cap
    - (c) It turns out that Family Care did not include an adult dental benefit. The Oral Health Awareness Colorado! Group submitted to the Commission a dental benefit for both adults and children, largely modeled on the FamilyCare child benefit. Staff reviewed the benefit package for consistency with the FamilyCare benefits and submitted the benefit package to Lewin for modeling.
  - (2) Remove prior authorization for medically -necessary over-the-counter medical products under \$100; this would apply to Medicaid FFS population
  - (3) Medical home services, including care management and care coordination
  - (4) Targeted case management services
  - (5) Elimination of copayments for preventive and chronic care management
  - (6) Telemedicine for recipients in geographically underserved areas

**Recommendation #10: Improve outreach and enrollment in Medicaid/CHP+**

- i) Create Fast Track eligibility for Medicaid, CHP+ and the subsidy program for children, parents, and childless adults through coordination with programs like Free and Reduced School Lunch
- ii) Provide one-year of continuous eligibility for Medicaid/CHP+ enrollees, as CHP+ enrollees currently receive
- iii) Provide presumptive eligibility for all Medicaid/CHP+ enrollees (child PE already exists)
- iv) Create single state-level entity for determining Medicaid/CHP+ eligibility—instead of current multiple county-level systems
  - (1) This element will not be modeled. To fully model this option would require time to understand costs and funding of the current county-based system, to specify an alternate state-based system, and to cost out the new state based system. Instead, this element will be included in the 5th proposal but will not be modeled.
- v) Increase number of provider offices that can conduct eligibility determination
- vi) Improve navigation of Medicaid eligibility and create expedited eligibility
  - (1) These will be goals of the restructured program, but will not be modeled by Lewin because of lack of specificity of recommendation

**Recommendation #11: Improve access to care in the Medicaid/CHP+ program**

- i) Use integrated delivery systems<sup>i</sup>
  - (1) Enroll at least 50% of disabled and aged Medicaid recipients in integrated delivery systems
- ii) Use managed care
  - (1) Pay actuarially sound rates to risk-based integrated delivery systems participating in Colorado Medicaid/CHP+ by using CHP+ rate methodology
  - (2) Enroll most parents, childless adults, and children into HMOs and managed FFS as currently done in the CHP+ program
- iii) Improve provider participation in Medicaid FFS

- (1) Raise Medicaid/CHP+ FFS reimbursement for physicians to 75% of Medicare, when existing reimbursement is lower, with eventual goal of 100% of Medicare; possibly vary rates by specialty
  - (2) Raise Medicaid FFS dental reimbursement to that used by the CHP+ program to set dental rates (e.g. 80% ADA)
  - (3) Provide Colorado Children’s Health Access Program (CCHAP) supports in minimum-sized practices
    - (a) Lewin will model this by adding a targeted case management benefit to the Medicaid/CHP+ benefit package
  - (4) Establish committees during health care reform including providers and consumers to make recommendations regarding Medicaid rates that are equitable and efficient and address problems, such as adequacy of participating providers
- iv) Cover services that improve access to care
- (1) Cover telemedicine as a Medicaid benefit in geographically underserved areas
  - (2) Cover medical home services for all Medicaid recipients

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**Recommendation #12: Improve quality of care in the Medicaid program**

- i) Increase use of Medicaid home-based and consumer -directed care
  - (1) Because of lack of specificity around this goal, this will be included as a goal of the Medicaid program, but will not be modeled by Lewin
  - (2) Current expansions of home-based and consumer -directed care are included in the baseline assumptions of the model
- ii) See recommendations that apply to all health care providers, including Medicaid providers, under “Health Care System Improvement”

**Recommendation #13: Increase Medicaid recipients’ enrollment in private coverage**

- i) Improve coordination of benefits for Medicaid so that Medicaid does not pay for services for which a primary insurer is responsible
- ii) Improve Medicaid’s Health Insurance Buy -In program so that Medicaid eligibles who are eligible for private insurance can enroll in that coverage
- iii) Lewin will not model these program changes due to lack of information about the administrative costs associated with them

## **CREATE NEW HEALTH INSURANCE OPTIONS FOR COLORADANS**

### **Recommendation #14: Allow employers to offer 24-hour coverage to their employees**

- i) Commission wants the proposal modeled with and without this option

### **Recommendation #15: Create an Optional Continuous Coverage Portable Plan**

- i) Commission wants the proposal modeled with and without this option
- ii) This is a voluntary program, individuals would enroll if they wanted to, providing another insurance coverage option; no mandatory enrollment for any group
- iii) Fund coverage by: collecting all existing governmental insurance plan subsidies for which people enrolled in the program would otherwise be eligible (e.g. Medicaid and CHP+); collecting other government program monies that enrolled individuals might otherwise qualify for collecting from the employer whatever voluntary contribution he has been making for this employees and applying it to those of his employees enrolled in the program; and making up the balance through an income tax surcharge to be paid only by those voluntarily enrolled in the program.
  - (1) Medicare beneficiaries would not be eligible for the program
- iv) Do not require employer participation, but require employers to take whatever contribution they would normally contribute and send it on behalf of an enrollee to the voluntary program
- v) Provide benefits similar to CHP+. Do not provide a choice of plans. Provide one comprehensive plan, similar to Medicare.
  - (1) Those who are eligible for Medicaid could apply to Medicaid to receive wrap around benefits through Medicaid
- vi) Like Medicare, do not involve insurance companies. An insurance company might be hired to perform administrative functions on behalf of enrollees; a single entity would be responsible for paying the bills of all providers
  - (1) Fee-for-service
    - (a) Medicare rates for providers
    - (b) Incentives for vertically integrated delivery systems
    - (c) Care management and pay for performance programs

(2) Optional HMO enrollment

- vii) Require an initial volume of enrollment prior to program implementation. (30,000,100,000?)
- viii) Control entry on the basis of risk (age), at least initially. Possibly use a waiting list in order to ensure a normal distribution of risk until a critical mass of enrollment is reached
- ix) Enrollees would enroll for a minimum time period; consequently there would have to be a strong enforcement provision to prevent individuals from leaving the program prior to the end of the prescribed enrollment period
- x) Families would have to enroll together, except any family member who was a Medicare beneficiary
- xi) There would be nominal copays and deductibles
- xii) There might be the opportunity for enrollees to purchase supplemental coverage if it was feasible

## IMPROVE COLORADO'S HEALTH CARE SYSTEM

Note: Due to the lack of specificity, data, studies, or time, Lewin will not model the Recommendations 17-24.

### **Recommendation #16: Improve access to care for all Colorado residents**

- i) Expand scope of practice for providers, such as advanced practice nurses, as appropriate to their training and experience
- ii) Provide 24 hour/7 day a week nurse line for all Colorado residents either through health plans or state; health plans that do not provide will fund state nurse line

### **Recommendation #17: Ensure that health care providers that serve low-income and rural populations have adequate funding**

- i) Require health plans participating in Medicaid/CHP+ and the subsidized insurance program to make good faith efforts to contract with these providers
- ii) Continue to reimburse these providers for Medicaid patients at 100% of cost

### **Recommendation #18: Strengthen Colorado's local public health infrastructure**

- i) Provide an additional \$23 million annually to local public health departments and nursing services to assure their ability to perform the essential public health functions

### **Recommendation #19: Increase use of health information technology**

- ii) Support the creation of a statewide health information network, focusing on interoperability, e.g. the Colorado Regional Health Information Organization
- iii) Support the creation of electronic health records and personal health records for every Coloradoan with protections for privacy
- iv) Support and incentivize use of health information technology

### **Recommendation #20: Improve end-of-life care**

- i) Identify a process to develop consensus decision, by a multi-stakeholder group, based upon best scientific evidence about clinically, ethically, and culturally appropriate end of life care
- ii) Ask patients, upon entry to a nursing home, home health, or other critical point of access, to complete an advanced directive. There would be no requirement to complete an advanced directive, patients would be fully-informed, there would be no outside pressure to complete the form, and revocation rights would be clear and simple.

### **Recommendation #21: Improve care coordination**

- i) Ensure access to a medical home for all Colorado residents, including Medicaid recipients, and require health plans to offer a medical home to all enrollees<sup>ii</sup>
- ii) Implement payment methodologies to reimburse primary care practices for medical home services, chronic care management, and wellness promotion ; create codes for care coordination
- iii) Require each medical home to have a centralized operational plan to coordinate each patient's care and the Division of Insurance or other agency shall audit outcome measures and provide financial incentives for compliance
- iv) Implement payment methodologies across physicians and hospitals to incent the provision, coordination and integration of care
- v) Improve transitions of care between care settings such as between hospital and home health
- vi) Provide community-based care managers to support coordinated health services within the community

**Recommendation #22: Increase transparency of cost and quality for consumers**

- i) Require DOI to produce annual report to legislature on financial status of licensed Colorado health carriers, including medical loss ratios and broker fees, by line of business

**Recommendation #23: Increase use of preventive care and promote wellness**

- ii) Encourage provision of first dollar coverage of primary and secondary prevention services
- iii) Insurers should be encouraged to provide health and wellness incentives as allowed by HIPAA
- iv) The State Employees Benefit Plan should encourage their health plans to provide health and wellness incentives to their enrollees
- v) Worksite wellness should be promoted with materials and education
- vi) Provision of health and wellness incentives should be a criteria for selection of health plans serving the premium subsidy program
- vii) Create rules such that Medicaid, CHP+ and subsidy program health plans can reimburse public health, mental health, and safety net providers for prevention and wellness services
- viii) Require physical and nutrition education in all schools

**Recommendation #24: Support local communities that wish to improve health care outcomes**

- i) Provide funds and technical assistance to local communities that wish to collaborate to improve quality of care and health outcomes

## **Recommendation #25: Reduce administrative costs**

- i) Lewin will estimate the savings in this section but these changes to administrative costs are not part of the model.
- ii) Require all health plans to issue ID cards that conform to ANSI and WEDI standards and require all ID cards to use magnetic strips that conform to WEDI standards
- iii) Streamline provider credentialing by:
  - (1) Requiring the use of standard electronic credentials application in lieu of Colorado paper application
  - (2) Select a single credentials verification vendor of the state and require its use by
  - (3) Fund the verification process through user fees all entities that credential health professionals
- iv) Simplify eligibility and coverage verification
  - (1) Require payers to conform to uniform standards for electronic eligibility and coverage verification
  - (2) Support current requirements for payers to indemnify providers who provider services in reliance on coverage information provided by payers that later proves to be inaccurate
- v) Standardize and streamline claims forms
- vi) Standardize claims attachments
  - (1) Create antitrust safe harbor to allow plans to agree on common rules and standards for claims attachments
  - (2) Involve providers in creation of these rules
  - (3) Include requirement that payers accept electronic attachments that conform to standards
  - (4) Require all plans to conform to those rules and standards
- vii) Standardize prior authorization procedures, including those of Medicaid
- viii) Create a standardized and simplified appeals process for all carriers, including Medicaid
  - (1) For Medicaid, apply Medicaid appeal rights to entire program with first level appeal like CHP+

## **CREATE SUSTAINABLE FINANCING AND GOVERNANCE**

### **Recommendation #26: Increase efficiency and access before expanding coverage**

### **Recommendation #27: Pursue new federal funds and state tax dollars to fund new programs**

- i) Savings from administrative efficiencies and other cost-saving measures in this proposal
- ii) Maximize federal funding
  - (1) Pursue an 1115 waiver for:
    - (a) Covering childless adults under Medicaid up to 200% FPL
    - (b) Providing subsidies to purchase private coverage between 200% and 400% FPL
    - (c) Using Medicaid funds to partially fund Medicaid-eligibles who choose to enroll in the Optional Continuous Coverage Portable Plan
    - (d) Using some DSH dollars to help fund coverage expansions
  - (2) Pursue SCHIP match for:
    - (a) Restructured Medicaid and CHP+ program (see HCPF's FamilyCare proposal)
- iii) Increase tobacco and alcohol taxes
  - (1) Increase tobacco from \$.84 per pack to \$2.00 per pack
  - (2) Increase alcohol:
    - (a) On spirits from \$.60 per liter to \$5.63 per liter
    - (b) On wine from \$.07 to \$.66 per liter
  - (3) The other four proposals used these same increases in alcohol and tobacco taxes
- iv) Implement snack and soda tax
  - (1) 5% tax on soda
  - (2) 5% tax on salty snacks
- v) Increase the state income tax
  - (1) Increase as necessary to fund whatever is not covered by alcohol, tobacco, soda and snack taxes
- vi) Possibly increased funds from insurer assessments to fund CoverColorado (*following up with Barbara Brett to understand current funding and possible changes*)

- vii) If additional funds are needed, provider taxes (clinics, hospitals, nursing homes, physicians) may also be considered
- viii) None of these funds should be used to replace existing health care funding

**Recommendation #28: Create three new entities to govern and administer the new programs**

- i) Create two new entities:
  - (1) Coverage Clearinghouse will be point of accountability for four programs:
    - (a) Administer subsidy program and catastrophic care fund
    - (b) Administer CoverColorado
    - (c) Administer Connector program for employers
    - (d) Administer Optional Continuous Coverage Portable Plan
    - (e) Where possible, the Coverage Clearinghouse will combine administrative functions, such as eligibility determination, marketing, plan and provider contracting, claims payment, etc.
  - (2) Improving Value Authority
    - (a) Create multi-stakeholder group to develop and implement cost and quality initiatives
- ii) For the Improving Value Authority and the Coverage Clearinghouse, consider one of the three following organizational structures:
  - (1) Utilize existing state agencies
  - (2) Create a private non-profit corporation
  - (3) Create a public authority
  - (4) Utilize both existing state agencies and a new public authority
  - (5) The Commission is not making a recommendation for what type of entity the Coverage Clearinghouse should be and what it's relationship to state government should be

# Attachment A

## Potential Colorado Benefit Design for Basic Benefit, Cost Sharing and Limits <sup>a/</sup>

Covered Benefits/Services	Copayments	Limits
All Benefits		\$50,000 Annual Maximum
All Outpatient Services		\$5,000 Annual Maximum
Physician Services	\$10	
Primary Care (including adult preventive services & specialist monitoring a chronic condition)	\$20	
Specialist Care		
Urgent Care	\$25	
Outpatient Hospital	\$50	
Surgical Services	\$25	
Other Outpatient Services		
Ambulance (emergency)	\$50	
Laboratory & X-Ray	\$0	
Family Planning Services	\$0	
Mental Health Services	Sliding scale	
Therapies (consistent w/HMO benefit)	\$10	
Other Services		
Inpatient Hospital Services	\$100	\$25,000 Annual Maximum
Emergency Services	\$50*	\$1,000 Annual Maximum
Durable Medical Supplies/Equipment	\$50	\$1,500 Annual Maximum
Prescription Drugs (Medicaid FFS carve-out, if broad-based PDL is implemented)	Generic-\$5 Brand-50% of cost, \$25 minimum	\$2,500 Annual Maximum

<sup>a/</sup> Plans would be allowed to offer a \$25,000 maximum annual limit for all services and enhanced benefits.

Source: Better Health Care for Colorado.

<sup>i</sup> An “integrated delivery system” is a network of health care providers and organizations which provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the clinical outcomes and health status of the population served. An integrated delivery system may own or could be closely aligned with an insurance product.

<sup>ii</sup> “Medical Home” is a source of usual care selected by the patient (such as a large or small medical group, a single practitioner, a community health center, or a hospital outpatient clinic). The medical home should function as the central point for coordinating care around the patient’s needs and preferences. The medical home should also coordinate between all of the various team members, which include the patient, family members, other caregivers, primary care providers,

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specialists, other healthcare services (public and private), and non-clinical services as needed and desired by the patient. Important characteristics of the medical home include:

- ? Enduring relationship. A true relationship is not established simply by continuity, but by comprehensive knowledge of the patient, the patient's choice of provider,<sup>3</sup> and the patient's identification of the source of his or her care as his or her healthcare home.
- ? Point of access. The patient and family know to communicate with the healthcare home as the appropriate point of access when any healthcare need arises and should have no difficulty contacting or obtaining care in a timely manner.
- ? Information about the patient and origins of interpretation of information from many sources. The healthcare home serves as a clearinghouse for all information about a patient's health status, including all related activities, services, and results. The healthcare home is responsible for synthesizing, reconciling, and interpreting the most current information from many sources to inform and educate the patient, identify needs, and establish goals.
- ? Routine, acute, and chronic care coordination. The healthcare home should promote and guarantee a system that coordinates continuous, comprehensive care for preventive services, acute or episodic illnesses, and chronic, complex conditions. (adopted from the National Quality Forum)