

**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
(*indiv*
mandate)

What are employers' costs and other impacts from enforcing individual 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
(*subsidy*)

\$50-k cap shifts from risk management model to financing model – there will be a 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

(indiv mkt changes)

Would the changes here encourage exodus from small group market?

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

Rec. 4

(Cvg Clearhse)

Confusion – does Clearinghouse get you to private coverage as well as Cover Colorado, etc.?

Rec. 6

(S125)

In best interest of all small businesses – competitive advantage, tax benefits.

- 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

(undoc'd)

Can't hire them so it's a moot point

Rec. 8

(local exs)

Some of these innovative local efforts minimize inappropriate use of services – Task Force supports this recommendation

Recs. 9-14

(MK/CHP+)

Don't see specific impacts on business from these

- 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

(24 hr covg)

WC is cheaper for most employers – only ones who would want to opt out are 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-dollar 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/I 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

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