

# A Bill

To provide for comprehensive health care coverage for all residents of the State of Colorado and for other purposes.

## **Section 1.** Short Title; Table of Contents.

(1) SHORT TITLE. – This Act may be cited as the Health Care for All Colorado Act.

(2) TABLE OF CONTENTS. – The table of contents of this Act is as follows:

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    1. It is the intent of this Act to provide universal access to health care for all individuals within the State of Colorado, to promote and improve the health of all its residents, and to contain costs to make the delivery of this care affordable.
    2. Should legislation of this kind be enacted on a federal level, it is the intent of this Act to become a part of a nationwide system.
  - ii. Section 402. Incorporation of other federal programs.
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- e. TITLE V – EFFECTIVE DATE
  - i. Section 501. Effective Date.
    1. Except as otherwise specifically outline, this Act shall take effect on July 1, 2008

**Section 2. Definitions and Terms.**

In this Act:

- (1) CHS (Colorado Health Services) Program. – The terms “CHS Program” and “Program” mean the program of benefits provided under this Act.
- (2) CHS Governing Board. – The term “CHS Governing Board” means such Board established under Section 301.

- (3) Regional Office. – The term “regional office” means a regional office established under Section 201
- (4) Secretary. – The term “Secretary” means, in relation to the Program, the Secretary appointed under Section 303

## **TITLE 1 – ELIGIBILITY AND BENEFITS**

### **Section 101. Eligibility and Registration.**

- (1) IN GENERAL. – All individuals residing in the State of Colorado are covered under the CHS Program and shall receive a card with a unique number in the mail. An individual’s social security number shall not be used for purposes of registration under this section.
- (2) REGISTRATION. – Individuals and families shall receive a CHS Insurance Card in the mail after filling out a CHS application form at a health care provider. Such application form shall be no more than 2 pages long.
- (3) PRESUMPTION. – Individuals who present themselves for covered services from a participating provider shall be presumed to be eligible for benefits under this Act, but shall complete an application for benefits in order to receive a CHS Insurance Card and have payment made for such benefits.

### **Section 102. Benefits and Portability.**

- (1) IN GENERAL. – The health coverage benefits under this Act cover all medically necessary services, including –
  - a. primary care and prevention;
  - b. specialty care (other than what is deemed elective cosmetic);
  - c. inpatient care;
  - d. outpatient care;
  - e. emergency care;
  - f. emergency transportation services;
  - g. prescription drugs;
  - h. durable medical equipment;
  - i. long term care;
  - j. mental health services;
  - k. the full scope of dental services (other than elective cosmetic dentistry);
  - l. substance abuse treatment services;
  - m. chiropractic services;
  - n. basic vision care and vision correction and
  - o. audiology and correction.
- (2) PORTABILITY. – Such benefits are available through any licensed health care provider or facility anywhere in the State of Colorado that is legally qualified to provide the benefits and for emergency care anywhere in the United States.
- (3) NO COST-SHARING. – No deductibles, co-payments, coinsurance, or other cost-sharing shall be imposed with respect to covered benefits except for those goods or services that exceed what is defined by the Governing Board as basic covered benefits.

**Section 103. Qualification of Participating Providers**

- (1) IN GENERAL. – Health care delivery facilities must meet regional and State quality and licensing guidelines as a condition of participation under such program, including guidelines regarding safe staffing and quality of care.
- (2) LICENSURE REQUIREMENTS. – Participating health care providers must be licensed as recognized by the Division of Regulatory Agencies and meet the quality standards for their area of care. No health care provider whose license is under suspension or been revoked may be a participating provider.
- (3) PARTICIPATION OF HEALTH MAINTENANCE ORGANIZATIONS. – Health maintenance organizations that actually deliver care in their own facilities and employ clinicians on a salaried basis may participate in the program.
- (4) FREEDOM OF CHOICE. – Patients shall have free choice of participating eligible providers, hospitals, and inpatient care facilities.

**Section 104. Prohibition Against Duplicating Coverage.**

- (1) IN GENERAL. – It is unlawful for a private health insurer to sell health insurance coverage that duplicates the benefits provided under this Act.
- (2) CONSTRUCTION. – Nothing in this Act shall be construed as prohibiting the sale of health insurance coverage for any additional benefits not covered by this Act.

**TITLE II – FINANCES**

**Section 201. Budgeting Process.**

- (1) ESTABLISHMENT OF THE COLORADO HEALTH SERVICES TRUST. – To carry out this Act, the State of Colorado hereby authorizes the establishment of the Colorado Health Services Trust (CHST), whose sole purpose is to provide the financing reserve for the purposes outlined in this Act. Specifically, the Trust shall provide –
  - a. The funds for the general operating budget of the CHS.
  - b. Reimbursement for those benefits outlined in Section 102.
  - c. Education and primary preventive services.
  - d. Capital expenditures for construction or renovation of health care facilities or major equipment purchases deemed necessary throughout the state and approved by the Governing Board.
  - e. The support of health care provider education.
  - f. Re-education and job placement of those in the health insurance industry who have lost their jobs as a result of this transition, limited to the first 5 years.
- (2) OTHER FUNDING. – The General Assembly or the Governor’s Office of the State of Colorado as authorized may, from time to time, provide funds to the CHST but may not remove or borrow funds from the Trust without the expressed approval from the Governing Board in the form of a 2/3 vote and a simple majority of the general electorate in the form of a ballot issue.

- (3) OVERSIGHT. – The CHST shall be administered by the Governing Board as outlined in Title II under the oversight of the State Legislature.
- (4) FUNDING. – Funding of the CHST shall include but is not limited to –
  - a. Funds appropriated as outlined by the General Assembly on a yearly basis.
  - b. Payroll deductions or monthly contributions for the self employed and others in the form of premiums as set by the CHS board.
    - i. Payroll deductions are considered pre-tax dollars under the Colorado State Income Tax guidelines.
    - ii. Employers may elect to contribute some or all of the employee’s contribution.
  - c. All federal monies which are designated for health care.
    - i. This would include but not be limited to all monies designated for Medicaid.
    - ii. The CHS shall be authorized to negotiate with the federal government for funding of Medicare recipients.
  - d. Grants and contributions both public and private.
  - e. Any other tax revenues designated by the General Assembly.
  - f. Any other funds specifically ear-marked for health care or health care education, such as settlements from litigation, etc.
- (5) ADMINISTRATION LIMITS. – The total overhead and administrative portion of the CHS budget may not exceed 12 percent of the total operating budget for the first 2 years, 8 percent for the following 2 years, and 5 percent per year thereafter.
- (6) PAYMENT TO HEALTH CARE PROVIDERS AND HEALTH DELIVERY SYSTEMS. – The CHS shall pay all health care providers and health delivery systems as outlined in Section 102 Paragraph (1) on a fee-for-service basis.
  - a. The CHS shall provide a simple and uniform fee schedule for all clinicians with reimbursement for both clinical and procedural charges based on the ICD-9 or its current update.
  - b. All health delivery systems shall be reimbursed with those fees set by the Governing Board that follow the current DRG system as outlined by federal Medicare guidelines for both outpatient surgery and inpatient hospitalization, short term rehabilitation and long term care services, both at home or institutionally.
  - c. The CHS may not adjust or attach modifiers to discriminate against or for health care providers and/or health care delivery systems based upon race, religion, ethnicity, gender, country of origin, color, sexual orientation, profit or non-profit, public or privately sponsored.
  - d. The Governing Board may make upward modifying adjustments to the fee schedule to encourage providers or institutions to practice in specific areas determined to be a shortage area or an area of high need.
- (7) REGIONAL DISTRICTS AND BILLING. – The CHS shall be divided into 5 regional districts for the purposes of local administration, billing processing, and medical directorship, as well as oversight of programs that are specific to each region’s needs.

- a. The Governing Board may elect to establish their own regional billing offices or to sub-contract out to current insurance companies for the necessary personnel and infrastructure to implement the claims and billing process only.
- b. Claims billing from all providers must be submitted electronically and in compliance with current state and federal privacy laws within 5 years of passage of this Act.
- c. Electronic claims and billing must be uniform across the state without regard to region.
- d. The Governing Board shall make a good faith effort to create and implement a statewide uniform system of electronic medical records that is in compliance with current state and federal privacy laws within 7 years or less of the passage of this Act.
- e. The 5 regions shall be the Western Region, the South-Central Region, the Northeastern Region, the Southeastern Region, and the Denver Metro Region.
- f. Payments to providers must be paid in a timely fashion as outlined under current state and federal law.
- g. Providers who accept payment from the CHS for services rendered may not balance bill any patient for covered services.
- h. Providers, hospitals, and institutions may elect to participate fully, partially, or not at all in the CHS.
- i. All providers that participate in the CHS must fully disclose with informed consent any service provided to patients that is not a covered benefit of the CHS for which they intend to charge for services.
  - i. If full disclosure and informed consent is not obtained, the provider or institution may not collect or sue for services rendered.
- j. Any provider that participates in the CHS, whether partially or fully, may not discriminate against any patient that is covered under the CHS.

**Section 202.** Payment for Long Term Care.

- (1) IN GENERAL. – The Governing Board shall at its discretion or as directed by the General Assembly establish funding for long term care services including in-home, nursing home, and community-based care.

**Section 203.** Mental Health Services.

- (1) IN GENERAL. – The Program shall provide coverage for all medically necessary mental health care on the same basis as the coverage for other conditions.
- (2) FAVORING COMMUNITY-BASED CARE. – The CHS Program shall cover supportive residences, occupational therapy, and ongoing mental health and counseling services outside the hospital for patients with serious mental illness. In all cases the highest quality and most effective care shall be delivered, and, for some individuals, this may mean institutional care.

**Section 204.** Payment for Prescription Medications, Medical Supplies, and Medically Necessary Assistive Equipment.

(1) PRESCRIPTION DRUG AND DURABLE MEDICAL GOODS FORMULARY.

- a. IN GENERAL. – The CHS shall establish a single prescription drug formulary and list of approved durable medical goods and supplies.
- b. PHARMACEUTICAL AND DURABLE MEDICAL GOODS COMMITTEE. The Governing Board shall by itself or by a committee of health profession related individuals appointed by the Governing Board meet on a quarterly basis to discuss, reverse, add to or remove items from the formulary according to sound medical practice (called the Pharmaceutical and Durable Medical Goods Committee).
- c. The Pharmaceutical and Durable Medical Goods committee shall be appointed the task of negotiating the prices of pharmaceuticals and durable medical goods with suppliers or manufacturers on an open bid competitive basis. Prices shall be reviewed, negotiated or re-negotiated on no less than a yearly basis.
- d. The Pharmaceutical and Durable Medical Goods committee shall establish a process of open forum to the public for the purposes of grievance and petition from suppliers, provider groups, and the public regarding the formulary on no less than a twice yearly basis.
- e. To support local business and local economies, all pharmaceutical and durable medical goods must be dispensed through privately owned and operated retailers , whether for or not for profit.
- f. It is expressly forbidden for the CHS or its designated appointees to distribute or dispense to patients pharmaceutical or durable medical goods through a central clearinghouse or mail-in pharmacy benefits manager.
- g. The Pharmaceutical and Durable Medical Goods committee shall be authorized to establish or subcontract out to regional clearinghouses where pharmaceutical and durable medical goods can be ordered from by local retail pharmacy and durable medical goods vendors.
- h. Pharmacy and durable medical goods vendors are expressly forbidden from purchasing at wholesale and marking up prices for re-sale any pharmaceutical or durable medical goods that is a covered benefit as outlined by the Governing Board.
- i. Pharmacy and durable medical goods vendors shall be paid a dispensing and handling fee that is fair and reasonable based upon sound business principles for each dispensing transaction and pro-rated according to the item dispensed.
- j. All pharmacy and durable medical goods vendors must be licensed to distribute medical goods through the regulations as outlined by the Governing Board.
- k. Exceptions to the Pharmacy and Durable Medical Goods regulations:
  - i. The Pharmacy and Durable Medical Goods committee may, at its discretion, determine that certain drugs or durable medical goods may be deemed necessary but have some component of convenience or niceties that go beyond what is considered basic care. Those items may be assigned a flat rate of coverage and the patient may be allowed to purchase at their own expense above and

beyond the flat rate of coverage. An example of this would be prescription eyewear where the CHS provides \$100 per year for glasses or contacts and anything beyond that, such as designer frames, may be purchased at the patient's expense for the difference owed after the \$100.

1. PHARMACY AND DURABLE MEDICAL GOODS OVERSIGHT. – All decisions and determinations of the Pharmacy and Durable Medical Goods committee must be presented to and approved by the Governing Board on a yearly basis.

### **TITLE III – ADMINISTRATION**

**Section 301.** Creation of the CHS and the Governing Board.

- (1) IN GENERAL. – By passage of this Act, the legislature hereby creates the Colorado Health Services Program and the Colorado Health Services Governing Board, along with the necessary funding for its establishment.

**Section 302.** Definition of the Colorado Health Services Governing Board.

- (1) The Colorado Health Services Program shall be the administrative body that oversees and implements those provisions outlined in this Act and any other forthcoming health related provisions and regulations outlined by the CHS Governing Board, the State Legislature, or ballot issues of the general electorate.

**Section 303.** Role of the Colorado Health Services Governing Board.

- (1) The Colorado Health Services Governing Board shall be the body that oversees and provides administrative direction for the CHS. The decisions of the Governing Board shall be determined to be final in regards to administration and implementation of the provisions of this Act and any other subsequent healthcare related provisions of law unless otherwise specified by the courts or the State Legislature.
- (2) The Colorado Health Services Governing Board shall consist of 15 members (3 from each region) who shall be appointed by the Governor. 1 member from each region shall be replaced or reappointed on a 4 year rotating cycle so that each member shall serve for no less than 12 years. Appointees must be approved by the senate and by a majority of those house members from each respective region. It is the intent of this Act that the appointing Governor should choose someone who is familiar with and has experience in the healthcare industry.
- (3) Secretary of the Colorado Health Services Program.
  - a. The Governor of the State of Colorado shall appoint one individual to be the chief administrator of the CHS, who shall be referred to as the Secretary of the CHS. The Secretary shall serve for as long as the Governor remains in office and wants the individual in that appointment.
  - b. The role of the Secretary of the CHS is to administrate and implement in a supervisory capacity those provisions outlined in this Act and any further provisions as directed by the Governing Board or the State Legislature.

- The Secretary shall also preside over the Governing Board but may not vote except in the case of a tie.
- c. The Secretary may appoint one regional director for each of the 5 regions. That individual shall serve for as long as the Secretary remains in office and wants the individual in that appointment.
- (4) The Governing Board shall convene no less than on a quarterly basis. The length of the meetings shall be determined by the amount of business needed to be addressed.
- a. The role of the Governing Board is to discuss, direct, debate, refer to committee, and to vote upon those issues related to healthcare and the provisions of the CHS.
  - b. All provisions and regulations voted on as related to the CHS shall be passed by a simple majority.
  - c. In terms of decision-making and administration of the CHS, unless otherwise directed by the courts or the State Legislature, the decision of the Governing Board is final.
  - d. The Governing Board must provide and establish a process of open forum to the public for the purposes of grievances, appeals, and recommendations; this process is to coincide with the quarterly conventions and in conformance with the open records and open meetings laws.
  - e. A special convention of the Governing Board shall meet every October and be open to providers and delivery systems to discuss and set the fee schedules for the proceeding year.
- (5) The Governing Board must create a yearly report to the State Legislature every January for its fiscal year, which shall begin every July 1.
- (6) It shall be the role of the Governing Board to determine the number of administrative personnel per region needed, but the regional director shall be appointed the task of filling those positions and all other necessary positions by himself or an appointed administrator.

**Section 304.** The role of the CHS at large.

- (1) The role of the CHS is to implement the provisions of this Act previously stated and, but not limited to, the following unless otherwise outlined by the courts or the State Legislature:
- a. To create a single and simple method for licensing and credentialing across all 5 regions.
  - b. To create a single and uniform system for accreditation of laboratories, hospitals, and procedural centers.
  - c. To provide for public education on health related issues.
  - d. To establish minimal standards of care for each region and locale.
  - e. To create guidelines for difficult ethical issues.
  - f. To create a single statewide malpractice pool for all participating providers and institutions.
    - i. The CHS under the direction of the Governing Board shall establish a Disciplinary and Litigation Board under the domain of

the malpractice pool to make judgments and discipline providers or health delivery systems who have failed to comply with or have violated state regulations.

- ii. In the event of a patient or group of patients who wish to bring litigation against a provider, provider group, or delivery system, they must first present their case to the Disciplinary and Litigation Board to determine whether that provider or providers in question have violated the rules, regulations, or guidelines established by the CHS before the case may go to court or be settled.
  - 1. The Disciplinary and Litigation Board must then render an opinion and it's opinion must be admissible as evidence in a court of law.
- iii. Suits brought against Pharmaceutical and Durable Medical Goods vendors.
  - 1. All pharmaceuticals and durable medical goods must be carefully reviewed and scrutinized by the Pharmacy and Durable Medical Goods committee and in conformance with the federal Food & Drug Administration (FDA). Once pharmaceutical or durable medical goods is approved, it is assumed to be safe and efficacious.
  - 2. All potential litigation against the manufacturers or distributors of pharmaceuticals or suppliers of durable medical goods must first be presented to the Disciplinary and Litigation Board before proceeding to the courts.
  - 3. The Disciplinary and Litigation Board must then render an opinion and it's opinion must be admissible as evidence to the courts.
- iv. Awards and judgments are subject to the provisions as outlined under the most current state statutes.
- g. To provide funding to help implement a statewide network of electronic medical records and electronic billing as outlined previously.
- h. To provide a statewide emergency medical response program for man-made and natural disasters.
- i. To pursue grants and funding for pre- and post-graduate education of health care professionals.
- j. To provide funds, education, and support of health care and dietary related concerns of all public assistance programs and public schools.
- k. To provide administrative oversight for any other health related program or state agency that the State Legislature deems appropriate to fall under the direction of the CHS.

**Section 305. Patients Rights.**

- (1) The CHS shall do everything within its power to protect the rights and privacy of the patients that it serves in accordance with all current state and federal statutes.

- (2) With the development of the electronic medical records, patients have the right and option of keeping any portion of their medical records separate from the electronic medical records.
- (3) Patients have the right to access their medical records upon demand.

**Section 306.** Compensation.

- (1) Compensation of the Secretary of the CHS, regional directors, members of the Governing Board, and subsequent employees shall be compensated in accordance with the current pay scale for state employees and as deemed professionally appropriate by the State Legislature and reviewed in accordance with all other state employees.

#### **TITLE IV – ADDITIONAL PROVISIONS**

**Section 401.** Intent.

- (1) It is the intent of this Act to provide universal access to health care for all individuals within the State of Colorado, to promote and improve the health of all its residents, and to contain costs to make the delivery of this care affordable.
- (2) Should legislation of this kind be enacted on a federal level, it is the intent of this Act to become a part of a nationwide system.

**Section 402.** Incorporation of other federal programs.

- (1) This Act empowers the CHS to contract with the federal government to provide health services to entities such as but not limited to the Department of Veterans Affairs and the Indian Health Services as long as such contracts are not detrimental to the good of the overall system.

**Section 403.** Public health and prevention.

- (1) It is the intent of this Act that the emphasis of the CHS at all times is to stress the importance of good public health through treatment and prevention of diseases.

#### **TITLE V – EFFECTIVE DATE**

**Section 501.** Effective Date

- (1) Except as otherwise specifically outline, this Act shall take effect on July 1, 2008.

## **Background of the Colorado Draft Bill for Single Payer Health Care**

*The enclosed bill was written to follow a single payer model and to tailor it specifically for the state of Colorado. Understandably, there is a lot of fear generated over the idea of a single payer system. This paper and this bill were written to address and to help alleviate those fears.*

To most Americans, a single payer system at its best translates into a giant Medicare-type bureaucracy and at its worse into socialized medicine. A single payer system could be either one of those, but this proposal is neither.

In its purest sense, "single payer" is just that -- one entity that oversees the financing of health care. There are numerous countries around the world that follow this model, yet they all do it differently and independently with their own unique solutions. In fact, right here in the United States, we have several different single payer models -- all of which have their own virtues and short comings. These programs include: Medicare, Medicaid, the Indian Health Services, the Veterans Administration, and the military. In fact, the military is truly socialized medicine.

We have before us the unique opportunity to review what is good and what is bad in single payer systems, to assimilate that information, and to forge a truly sound, just, viable, and sustainable health care system. This program can achieve that.

There are four basic components to any health care system:

coverage and benefits.

financing.

delivery of care and infrastructure.

governance.

The problem with our current health care system is that it is so fragmented and there are so many different players involved with the regulation and the financing that there is absolutely no way to effectively contain cost or reduce the burden of administrative overhead.

The balloon analogy of market pressure is probably the simplest but most effective way to describe trying to control cost within this fragmented system. When you squeeze on one end, it just bulges out on the other. Effective cost containment is nearly impossible, so what happens is essentially effective cost-shifting.

In contrast, this proposal will enable us to universalize and integrate all four basic elements of our health care system in such a way that it will provide equal and universal access and protect patient choice while maintaining the autonomy of physicians and hospitals in an atmosphere of cost containment and quality. All of this can be achieved while also being accountable to the people.

Let's examine the four basic areas in-depth.

### 1. Coverage and benefits.

If you read the enclosed bill, Title 1 is fairly straightforward. It provides universal and equal access to the system with the benefits as outlined in Section 102. Although there is good evidence and support behind the reasoning to eliminate deductibles and co-payments, it is a minor point and certainly open for discussion. With the recent debates over immigration, another point is eligibility. How long should one be a resident of the state before being eligible? It's worth noting that we already are paying for the uninsured as it is under the current system.

### 2. Financing.

In the enclosed bill, Title II creates a trust whose funds are separate from the general state budget. This insulates those funds and prevents the legislature from using them (or abusing them) as a political football. They must be used for health care. The funding of this trust is well outlined in Section 201. Of course, the role of the 208 Commission consultants will be to calculate the financial feasibility of this proposal. Worth mentioning, the economists that I have conferred with have calculated that we can easily pay for this program and have a sustainable mechanism for future cost containment if we were to do the following:

Administer a state payroll deduction of approximately 8 percent to go into the trust, in which some or all could be contributed by the employer.

Place into the trust all current federal and state money that currently goes to Medicare, Medicaid, Veterans Administration, etc., along with the current money being spent on health care for city, county, and state employees.

Initiate a 0.25-0.5 percent sales tax to be put into the trust.

Increase the duties on alcohol and tobacco (to offset the increase in health care expenditures due to their detrimental effects on health) and place those in the trust.

With the savings that would be derived by eliminating excessive profit-taking, dramatically reducing administrative bureaucracy, and promoting preventive medicine, we can easily pay for this program and have a sustainable mechanism for future cost containment -- a cost containment mechanism which is now impossible to achieve.

Of course, critics will be quick to point out that this will cause an increase in taxes -- and they're right.

However, for the first time in history, we will be creating a system in which a small increase in taxes will be offset by a huge financial savings for all collectively and individually (for example, a family of four now pays on average nearly \$9,000 a year in insurance premiums) and will remove the oppressive burden of health care financing from the business sector.

Critics have also pointed out that, in the era of big government reduction and keeping business in the private sector as much as possible (which has been a mandate of the electorate), initiating a program of this magnitude will only serve to expand government bureaucracy, insulate the public from "personal responsibility," and suppress innovation.

Actually, this program will be a "consumer-driven" system in the truest sense and foster innovation, not suppress it.

Along with that, the health care system will once again become a true service industry to the people.

Imagine with me for just a moment having privatized, profit-driven fire and police departments. The result -- millions who cannot afford coverage, racial inequality, innocent people dying everyday, businesses reducing their work force to maintain the capital to keep up their protection money, private departments refusing to upkeep their infrastructure in poor, unprofitable neighborhoods, thus shifting that burden to government. Sound familiar?

We have to remember that medicine is a *service* industry, and that promoting profit-taking as a driver of the system is a gross perversion of -- and not the answer to -- what medicine is all about.

### 3. Delivery of care and infrastructure.

One of the great positive aspects of this proposal is that physicians, hospitals, pharmacists, and durable medical goods vendors will stay in the private sector.

Physicians and hospitals will be reimbursed at the same rate for the same procedures no matter who walks through their door -- despite geography, population, rural versus urban, or wealth. It will actually allow providers to start

competing in the areas that they are supposed to excel in -- patient satisfaction, quality measures, and outcomes.

In contrast, under the current mechanisms of reimbursement, we do have competition, but it is what I refer to as "competitive avoidance". It is a perverted twist of the free market system that we as Americans pride ourselves in. Physicians and hospitals are constantly concerned about quality of care issues, but those concerns unfortunately are directed at those who can pay for those services and not necessarily at those who need them. This works well when you are marketing widgets, but not when you are fighting disease and trying to save lives. As a result, providers find themselves maneuvering toward contracts and neighborhoods to increase their exposure to patients who pay well while "competitively avoiding" those who don't. The policy of emphasizing consumer-directed health care and high deductible plans while trying to expand already poorly-reimbursed government programs, such as Medicaid, will only work to exacerbate this perversion of our so-called free market.

Regarding infrastructure, this bill addresses both the over- and underutilization of infrastructure. Clinics and hospitals many times strive to invest in infrastructure such as CT or MRI machines not because of need, but because of image, convenience, or profit. As a result, an excess of highly-reimbursed infrastructure frequently develops. Under normal market conditions, one would expect this to drive down the cost. However, just the opposite occurs. As our ability to do more in medicine increases, so does the cost of the technology. In order to pay for that technology, we must increase its utilization. This, in turn, increases the demand and expectations from the public, which begins to view these various hi-tech procedures as standard of care. Many times this cycle occurs without good data to support it. By having a single governing board (which we shall discuss shortly), we can apply sound science and geographic need to hi-tech procedures to prevent its over-utilization simply for the sake of profit without limiting necessary access. This will equate to a huge savings within the system.

Another place that requires reform is in the way that physicians practice medicine. By centralizing billing and reporting, clinical data and outcomes can be truly objective and used to change clinical practice in a way that is more cost effective and beneficial to the community. A single governing board that is accountable to the people will also be able to discuss the truly thorny ethical issues within a democratic platform and help provide general guidelines to physicians that will not only benefit individual patients, but society as a whole.

Under our current system, insurance companies use clinical data to protect their profit margins, pharmaceutical companies use it to promote their sales, physicians use it protect their practices, and the government uses it to save tax dollars. And all of these special interests many times become diametrically opposed to one another. The real loser ends up being the consumer -- caught somewhere in the middle. The standards of care need to be the standards of

care for everyone. Sound science with consensus needs to drive the system. Profit must take a back seat. The only way to achieve that is by moving to a single payer system.

The bill also provides for a single statewide formulary. The advantages to this are numerous. It will cause pharmaceutical manufacturers to compete against each other and to prove not only clinical but fiscal benefit of new drugs to the community. With the state purchasing medications in bulk for 4.5 million lives, the savings will be enormous. It also will help physicians in their prescribing patterns by choosing medications based on efficacy as well as cost and removing the pressure to prescribe based on marketing. It will also eliminate the overhead and administrative burden currently placed on physician practices trying to keep up with as many as 27 formularies or more and all their different regulations, which does nothing but increase the cost of doing business in medicine and frustrates the consumer. By standardizing prescribing options, it also allows medical students the opportunity to understand the symbiotic relationship between cost and efficacy, and hopefully that concept will remain with them through out their career.

With the system acting as a central clearinghouse, it will allow huge savings through bulk buying and will allow the distribution of those medications through local pharmacies. This, in turn, will keep the money within the Colorado economy and maintain the continuity of care and personal attention of local pharmacists that are so desperately needed, especially with the elderly.

#### 4. Governance and administration.

The final area to cover is described in Title III of the enclosed bill. It is here that the crux of this program lies and where this and other reform proposals distinctly separate. In the bill, the governing board of the Colorado Health Services (CHS) is comprised of representatives from across the state who are either directly or, in this proposal, indirectly (through appointment by the elected state senators) accountable to the people. A similar comparison would be the Board of Regents for the state's universities. There are several reasons why this board is so important and why its configuration must be so carefully guarded. We've already mentioned its role in overseeing utilization of infrastructure, a statewide formulary, and addressing ethical issues.

But the primary reason is to give consumers a voice and a choice in their health care. In our current system, consumers have limited, if any, impact. High deductible plans and health savings accounts do not guarantee consumer control or choice or even, in fact, access. Health savings account consumers may have limited personal control of their own health care spending, depending on their own health status and disposable income. But, ultimately, consumers have no control over health care inflation. The system is too complicated. There are too

many variables and too many players with self-interest. Consumers and the providers who practice equitable medicine do not have a free market.

The only free market that exists in health care today is the way that the insurance and pharmaceutical industries do business -- and their business is to make a profit, not fix the health care industry. I'm not attacking them or blaming them -- this is America, the bastion of capitalism. But, until we remove the profit motive from at least the financing of health care, we will not be able to fix the system. Applying the rules of Wall Street economics to the financing of health care is like trying to get an ostrich to fly. On the surface, it appears that it should work. After all, it is a bird, it has feathers, and it has wings. But no matter how hard you try or how fast you make that ostrich run, it just ain't gonna fly.

So what does all that have to do with a governing board? Simply this -- for the first time, consumers will actually have a say in how much is spent and how it is spent. There will be a mechanism available for all interested parties to have input -- including consumers -- to discuss benefits, budgets, and ethical issues on a democratic platform. This is truly consumer-driven health care.

But what about personal fiscal responsibility? This is a question of two opposing philosophies. Either way, the consumers' pocketbooks will be directly affected. But, only one philosophy allows the consumer's choice to make a difference.

In the philosophy to tweak the current system, consumers are directly affected by increases in annual insurance premiums and ever-rising personal deductibles while still paying taxes to support Medicare and Medicaid -- all in an environment of out-of-control health care inflation in which the consumers have minimal, if any, impact. In other words, they can't do anything about it.

In the alternate philosophy, which is the basis for this proposed bill, consumers do have a voice and they choose as a community through a vote or through the governing board to increase their own taxes or restructure their own benefits, which, in effect, is true consumer-directed health care.

Let's expand on these two very different philosophical approaches to reform. Society -- and, more specifically, the Senate Bill 208 Commission -- must grapple with choosing one of these two paths:

Do we continue down the road of tweaking our so-called market-driven system? If so, society must understand that there will always be a small group of people who will receive everything that health care can provide, a larger segment of the population who has poor or no access to it, and the rest of middle class America who are somewhere in the middle and will continue to struggle in a system driven by a motivation of profit and cost-shifting. It's worth noting that, as health care inflation continues to spiral, more middle class

Americans will fall into the segment who has poor or no access to the system.

Or, do we muster the courage necessary to embark in a new direction in which we all share in the burden of cost and responsibility and all patients are treated equally and have access to a minimum standard of acceptable care? The more one understands health care, the more one understands you cannot have it both ways.

That's why this Blue Ribbon Health Care Reform Commission is so important. Its role is not to pick one option and say "we're done". Rather, its role is to give several options with their pluses, minuses, and financial (not political) feasibility to the Legislature and, in effect, to society to debate. That's why it is also so important that a single payer model be a part of the options presented and why this bill written specifically for Colorado is such a good platform for beginning the discussion.

As far as this proposal goes, another primary reason why the governing board and its configuration is so important is to protect the interests of the people. By providing for a member from each state senatorial district appointed by that district's senator, the board members are insulated to a certain degree from any single interest that could unduly threaten or influence the board. It also gives equal representation across the state. With the board convening on a quarterly basis, it provides the platform of accountability to the people and the transparency so necessary to keep the system sustainable.

There are some who may argue that this makes the board too large and unwieldy. Certainly, the size of the representative regions and the size of the board are open to debate. But, the concept of having the system accountable to the people must remain intact to ensure its success.

In conclusion, these are the arguments and the thought processes behind the major points of the enclosed bill. I hope that the Commission finds them useful and gives serious consideration to the single payer concept as a viable option in our search for the answer to our current health care dilemma.

If I can be of any assistance to the board in answering questions on this or any other proposal, I am happy to avail my expertise to your service.

For the good of our state and in your service,

C. Rocky White, MD

