

Name of Proposal: **Connecting Care & Health for Colorado**

Proposer or Team: **Colorado Consumer Health Initiative**

Lead Contact Person: **Kelly Shanahan, CCHI Policy Director**

Address: **1536 Wynkoop St, Suite 101  
Denver, CO 80202**

Telephone: **(303) 839-1261 office  
(970) 219-7588 cell  
(303) 839-1263 fax**

Email Address: **kelly@cohealthinitiative.org**

Signatures of those authorizing the submission of the proposal:

---

**Denise “Dede” de Percin  
Executive Director  
Colorado Consumer Health Initiative**

## 2. Narrative

### A) Comprehensiveness

#### (1) What problem does this proposal address?

This proposal addresses the problems of the uninsured, the underinsured and the high cost of health care to individuals and businesses in Colorado. Currently, there are approximately 770,000 uninsured Coloradans, representing 17% of the State's population compared to the national average of 15%. The rising cost of health insurance is a major factor. The cost of insurance has skyrocketed in the last few years – between 2000-2006, family health insurance premiums rose 5.5 times faster than median earnings in Colorado. On average, health care premiums rose by 82.2%, while median earnings rose by only 15%.<sup>1</sup> These price hikes have caused few Colorado small businesses to offer employer-sponsored insurance. They have also caused greater levels of under-insurance. Many Coloradans who have insurance find that their out-of-pocket expenses are barriers to receiving care and/or that their benefit packages and policy limits do not adequately meet their health care needs.

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

The Coalition brought together by Colorado Consumer Health Initiative established a set of goals that would alleviate the problems described above.

1. Affordable health care for all. This proposal seeks health insurance affordability for all individuals. It aims to make coverage universally available.
2. Accessible health insurance and health care. All Coloradans would have access to insurance and services regardless of income, health status and employment under this proposal.
3. Comprehensive benefits. The proposal strengthens benefits so that everyone would be adequately covered. Meaningful, standardized benefit packages will be available in both public programs and the private market.
4. Efficient and high-quality care. The proposal improves quality and efficiency in the health care system in ways that would effectively contain long-term health costs.

### B) General (1) Please describe your proposal in detail.

To achieve its established goals, the proposal brings together Colorado's public programs and the private insurance market to reach Coloradans who are currently unable to access either. The

---

<sup>1</sup> Jones, Kim. *Premiums Versus Paychecks: A Growing Burden for Colorado's Workers*. Washington: Families USA, December 2006.

proposal would improve health care affordability, accessibility, and quality for all consumers in our State. Our proposal includes:

- Broad spreading of risk by moving to guaranteed issue and community rating across non-group and small group markets.
- Expansions of public programs for children, parents and adults without adequate employer health benefits, up to 300% FPL and support for employer-sponsored insurance when it is offered to persons under 300% FPL.
- Coverage available on a pre-tax basis for persons at all income levels.
- A standardized benefit package for private insurance, including a minimum benefit requirement.
- Improved efficiency and reduced cost by eliminating money spent on underwriting and reducing administrative expenditures of carriers.
- Stronger delivery systems and reduced cost-shifting by expanding coverage, raising Medicaid rates, and creating incentives to expand access to providers in underserved areas.
- Required financial contributions and shared responsibility from all stakeholders, including individuals, employers and insurers.

#### Building on Public Programs

Medicaid and SCHIP are important foundations of health care coverage in Colorado. Our Coalition believes that expansion of these existing programs to serve more low- and moderate-income Coloradans, people with disabilities and senior citizens is the crucial first step of reform. Our proposal covers children, parents and adults to 300% FPL, or \$51,510 annual income for a family of three in 2007, based on gross income. The Coalition asks the consultant to study the impact of removing the asset test as part of the eligibility criteria.

- The proposal covers children through an expansion of the State Children's Health Insurance Program (SCHIP) or a combined expansion of SCHIP and Medicaid. We request that the Commission's consultant determine if adequate SCHIP funding will be available to finance the expansion (pending federal legislation), or if we must expand both SCHIP and Medicaid.
- We would increase the income eligibility for parents from 60% of poverty (only \$10,302 annually for a family of three) to 300% of poverty by expanding Medicaid.

- We would cover other uninsured Coloradans up to 300% of poverty (\$30,630 for an individual) who are not eligible for Medicaid or SCHIP by creating a Medicaid look-alike program. Benefits, enrollment and outreach, and reimbursement rates for providers would be the same in this program as in Medicaid.

We advise the Commission to support existing employer-sponsored insurance for people below 300% poverty by considering the following:

- Preserving employer-sponsored insurance for Medicaid-eligible workers if that coverage meets specific guidelines related to benefits and affordability. The Coalition asks the Commission's consultant to evaluate the cost-effectiveness of providing premium assistance for individuals below 300% FPL when the employer's benefit meets a standard, and/or premium assistance with a wrap-around benefit if the employer offer has fewer benefits than Medicaid.
- Examining alternative ways to retain employers' contributions for coverage that will protect low-income consumers' access to comprehensive benefits.

We recommend that individuals below 200% of poverty pay no premiums or cost-sharing. We ask that the Commission's consultant evaluate what percentage of annual income families and adults above 200% of poverty may reasonably contribute toward premiums and cost-sharing, with an out-of-pocket maximum at the SCHIP level of 5% of income. No cost-sharing should be imposed for preventive care services.

The Coalition also addresses the specific needs of seniors and disabled Coloradans by proposing the following expansions:

- Extend Medicaid eligibility up to 300% of poverty for seniors and disabled individuals. This may be accomplished through a variety of mechanisms with federal matching dollars:
  - Raise guidelines to 100% of poverty, then disregard income that is 100-300% of poverty.
  - If the above is not financially feasible, expand QMB (Medicare Savings Program) to 300% of poverty by disregarding income that is 120-300% of poverty.
- Establish a Medically Needy program under Medicaid to cover people who earn more than 300% of poverty (or another feasible level), but who have very high medical expenses. After an individual spends enough on medical care that her income falls below the medically needy

income limit established by Colorado, the remainder of medical care will be covered by Medicaid.

- Establish a Medicaid Buy-In for Working Individuals with Disabilities up to 450% of poverty under the Ticket to Work and Work Improvement Act.
- For children who are so severely disabled that they would qualify to reside in an institution, provide Medicaid services regardless of family income. Currently, Colorado serves a limited number of such children through its children's home and community based services waiver. Explore ways of expanding the number of children served under the waiver, and if the need is still greater than the available slots, at least provide basic Medicaid services to children on the waiver waiting list by using the TEFRA option.

We recommend adopting Primary Care Case Management (PCCM) for delivery of services to enrollees in Colorado's public programs. PCCM links patients to a primary care provider who coordinates their care. This will promote health care homes and preventive care. It also considers the needs of rural Coloradans (explored in further depth later) in areas with few managed care organizations to provide coverage. However, we recognize that not all individuals will appoint physicians to be their primary care provider, and the PCCM program must provide flexibility as to the type of primary care provider enrollees elect. We also recognize that special provisions must be made for homeless individuals and seasonal and migrant workers for whom a single, fixed health care home often times is not a practical service delivery model.

In order for Medicaid, SCHIP and the Medicaid look-alike program to provide access to providers and services, provider reimbursement rates must be increased. We request that the Commission's consultant examine what reimbursement rates are necessary to attract an adequate level of providers, observing provider reimbursement rates in the private sector and mechanisms to increase reimbursement rates over time (such as indexing to inflation). The consultant should model the cost and effect on provider participation of several reimbursement rate alternatives.

### Comprehensive Benefits

All persons in Colorado should be entitled to a reasonably comprehensive package of benefits. We propose the promotion of meaningful coverage through the following measures:

- Add to the benefits currently covered by SCHIP and Medicaid. We recommend that public programs cover full implementation of Early and Periodic Screening, Diagnosis, and

Treatment (EPSDT), preventive dental care, vision and hearing services, mental health and substance abuse services (including early childhood mental health), screening for all children to age 21, screening for cancer and other chronic disease, rehabilitative services, non-emergent medical transportation, and appropriate interpretation and translation services.

- A new Health Care Quality and Cost Advisory Committee (discussed later) and the Division of Insurance (DOI) should develop a standard plan for private insurance coverage that sets a baseline level of benefits. This plan must include all state-mandated benefits, as well as preventive care and screenings, acute, specialty, rehabilitative, mental health and pharmaceutical services. The Quality and Cost Advisory Committee and DOI shall study typical employer-sponsored insurance offerings, and consider community needs in developing standards. We recommend the creation of two to three additional plans that include a richer package of benefits (for example, offering dental and vision coverage), but are standardized across carriers to allow consumers to comparison shop with greater ease. Reinsurance would be available only for standardized products.

Our proposal would enrich benefits for populations with special needs, including people who are disabled, institutionalized, mentally ill, or have incurred brain injuries.

- We propose that Colorado study ways to streamline its many home-and-community-based-care waivers, consolidating them where appropriate. In some cases, services are offered to one population based on its diagnosis that we believe could also benefit other populations. We seek to provide services that are appropriate to assist with functional and medical needs and not based on diagnoses.
- We propose improving benefits offered under the Medicaid state plan for mental health, and expanding benefits beyond treatment only for biologically-based mental diseases.
- We recommend that the State apply for a Money-Follows-the-Person demonstration grant should the opportunity arise. We understand that the federal government is not currently accepting applications, however, they may open new grant cycles in the future.
- We ask the consultants to explore the development of level-of-care criteria for Medicaid that will allow people with cognitive impairments (e.g. Alzheimer's) to receive services.

### Private Market Reforms

We recommend reform of Colorado's insurance market to increase affordability of and access to coverage for all Coloradans.

- We propose instituting guaranteed issue with all carriers for all products, prohibiting insurers from denying individual/group coverage based on health status or claims history. Guaranteed issue would eliminate the need for CoverColorado (State's high-risk pool).
- However, guaranteed issue does not suffice to give all individuals access to coverage. We recommend community rating to accompany guaranteed issue. Using health status, medical claims history, gender, and occupation to rate premiums should be prohibited. The Coalition feels that pure community rating best provides access to affordable coverage; however, we would compromise to accept adjusted community rating that allows variation based solely on geography and age. In no case should variation be greater than 2:1. We ask the Commission's consultants to study the economic impact on the insurance industry, premium rates, and the small group market of pure community rating, and adjusted community rating.
- Our proposal merges the small group and individual markets to create a larger risk pool.
- We recommend allowing young adults to retain dependent coverage through their parents' health insurance plans until the age of twenty-six. This keeps young, healthy people, who are otherwise likely to be uninsured as students or in their first jobs, in the insurance market.
- We propose imposing medical loss ratios on health insurance companies, requiring that they spend an established portion of premiums on health care claims. This limits the amount insurers may retain for administration, marketing, and profit. We request that the consultant study a reasonable medical loss ratio for private insurers in Colorado, taking into account their current loss ratios, the loss ratio of Medicaid, and the loss ratios of other states. Medical loss ratios must be accompanied by increased rate regulation and greater public accountability regarding premium increases.

We propose the creation of a reinsurance pool to spread more equitably the risk of high cost claims, help stabilize the insurance market as rate reforms are enacted, and reduce the cost of insurance for businesses, families, and individuals in Colorado. We ask the consultant to recommend: an appropriate stop-loss level to stabilize the market as community rating and minimum loss ratios are implemented; the level of responsibility insurers should maintain for claims that they cede to the pool to still provide incentives to deliver cost-effective care; appropriate premiums for insurers who cede risk; the amount of funding, outside of premiums

and assessments paid by insurers in the reinsurance pool, that would be needed to stabilize premiums and reduce catastrophic risk for insurers. Health insurance carriers and third-party administrators would be assessed, regardless of whether they actually cede losses to the pool, to cover high cost claims. In addition, we request that the consultant examine the costs and benefits of publicly financed reinsurance to lower premiums further for some or all small businesses and suggest possible funding sources for this.

The proposal promotes employer participation and individual responsibility in the system.

- We recommend an assessment on employers to fund public expansions. All employers would be assessed, with tax credits available to employers who offer health coverage. We ask that the consultant model the impact that varying the percentage of the payroll and exemptions on a portion of payroll (e.g. the first \$10,000/ FTE or payroll above the Social Security withholding limit) would have on revenue and the number of affected employers.
- The proposal requires employers to offer health benefits through Section 125 cafeteria plans, thereby allowing employees to purchase health insurance with pre-tax dollars.
- We support mandating all residents of Colorado to obtain health insurance. However, we cannot recommend an individual mandate if other provisions contained within the proposal are not also adopted. Coverage must be accessible and truly affordable, leaving consumers to pay no more than 5% of their incomes for premiums, cost-sharing or other out-of-pocket health costs. Limitations on the amount of money insurers may retain for costs other than health claims (administration, marketing and profit) must also be in place to implement an individual mandate.

We propose strengthening protections for consumers to ensure that adequate protocol exists for individuals to appeal insurance company decisions and file grievances. We recommend the creation of an external ombudsman (discussed later) to oversee and promote the integrity of these processes in both the private market and public programs. We propose a strong consumer-based appeals system possibly based on existing models such as the Colorado bill introduced in 2006 or the NAIC model currently under review.

### Improving Health Care Quality and Efficiency

Creating a more efficient, higher quality health care system goes hand-in-hand with saving money and reducing projected health care costs. We propose the establishment of a Health Care

Quality and Cost Advisory Committee (as part of a proposed Stakeholder Oversight Commission discussed later) to oversee quality and efficiency initiatives designed to achieve a healthier population and better serve health care consumers, while reducing systemic expenditures. The role of the Advisory Committee would be to evaluate the effectiveness and oversee implementation of the following policy ideas:

- Expanding the scope of practice for various types of providers.
- The development of standards and best practices for health care providers statewide. Review various options to promote adherence to these standards, such as public reporting and other financial incentives.
- Advancing health information technology (HIT) with appropriate consumer protections.
- Promoting health care homes.
- Providing health care system navigators to consumers.
- Investigating strategies to lower prescription drug costs while preserving consumer rights to access necessary medication.
- Guide process for creating the minimum package of benefits, with consumer representation.

In addition to establishing an entity to oversee the health care quality agenda, we recommend the creation of additional advisory committees to address rural health access and reduce health disparities among racial and ethnic minorities (also as part of the Stakeholder Oversight Commission discussed later).

- The *Health Disparities Advisory Committee* would investigate and adopt measures to eliminate health disparities in public programs and the private market, including:
  - Data collection, monitoring, and public reporting on racial and ethnic, language status, and income-based health disparities on an ongoing basis. We propose requiring private insurers as well as public programs to collect this type of data.
  - Cultural competency training for provider licensure.
  - Providing individuals with access to appropriate linguistic and signing services.
  - Creating minimum standards for culturally and linguistically competent health services.
- We propose the establishment of a coalition of rural stakeholders to form the *Rural Health Advisory Committee*. Its role would be to:
  - Represent rural health care consumers in the legislative process.
  - Inform and oversee strategic planning on provider needs in the area.

- Integrate community health services for greater effectiveness.
- Develop creative, cost-effective ways of increasing access.

Our proposal also puts forward ideas that will increase health system efficiency to reduce health care costs. We propose more rigorous regional planning to ensure appropriate placement of health care facilities, including hospitals, federally-qualified health centers, and community health and mental health clinics. Currently, hospitals and other facilities are moving out of urban areas. Furthermore, we must address the severe rural deficit (see section C).

#### Increasing System-wide Integration, Transparency and Sustainability

In order to ensure that these reforms are implemented appropriately, that there is appropriate data collection and evaluation, that the system is transparent to all stakeholders, and that there is ongoing dialogue about the effectiveness of these reforms, the Coalition proposes the following structural additions to the current health care system:

- The creation of a permanent *Stakeholder Oversight Commission* within state government and driven by stakeholders that is charged with global oversight of the system and reporting to the Governor and a new Joint Legislative Committee on Health Care Reform. The Commission would coordinate and monitor programs and policies that address cross-cutting issues such as quality, cost, health disparities, and rural needs. To this end, the Commission would staff and manage the following previously-mentioned advisory committees: 1) Health Care Quality and Cost, 2) Rural Health, and 3) Health Disparities. In addition, the Commission would have the authority to create other advisory committees as is deemed necessary (e.g. business, insurance, vulnerable populations, etc.).
- The creation of a new *Joint Legislative Committee on Health Care Reform* with equal representation from both political parties and both legislative bodies to oversee the work of the Stakeholder Oversight Commission.
- The creation of a special health team at the Colorado Office of the State Auditor who would be responsible for conducting audits and independent reviews on an ongoing basis and reporting findings to the Stakeholder Oversight Commission.
- Mandated meaningful consumer representation for all new and existing health-related advisory bodies within state government. Consumer defined as someone who has no financial interest in the outcome of health care.

*Please see Appendix A for a schematic and more in-depth description of this governance model.*

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

The current health care system is fragmented and inefficient. Yet, this proposal, if implemented, can restructure Colorado's system to provide seamless, cost-effective health care to both children and adults. With public and private reforms, this proposal includes provisions that would benefit all of Colorado's residents, making it a win-win proposal.

This proposal will help lower health care costs for families as well as for the State. In 2005, health insurance premiums for families who had insurance through their private employers, on average, were \$934 higher due to the cost of health care for the uninsured. In addition to higher premiums, there are additional systemic economic and social costs of uninsurance that Coloradans have to bear, including: lost health and longevity, developmental and educational losses for children, lost workforce productivity, increased financial stresses for health care providers and institutions, and increased financial risk for families with one or more uninsured members. This proposal provides coverage to the uninsured thereby lowering premiums and minimizing the social, financial, and systemic impact of the uninsured on the State.

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

Low-income Coloradans: Our proposal addresses Colorado's low-income population through the expansion of public programs for all individuals and families living at or below 300% FPL. This would eliminate the stair-step system currently in place with different income eligibility rates for children ages 0-5, children 6-18, adult parents, non-parent adults, the elderly, and the disabled. It would ensure that all members of a family at or below 300% FPL have the same access to health care. It would ensure that all low-income Coloradans, regardless of family status, age, or disability are covered.

Disabled Individuals: In addition to increasing the income level at which disabled persons are eligible for Medicaid to 300 percent FPL, we propose examining Colorado's 13 Home and Community Based Care waivers to determine which ones might be streamlined or consolidated, extending all benefits currently offered under each affected waiver to the consolidated waiver groups. For example, the following waivers might be consolidated: PLWA (Persons Living with

Aids); MI (Mental illness); and EBD (Elderly, Blind, and Disabled). We also propose several other Medicaid expansions building upon federal programs and leveraging a federal match:

- Allow families of disabled children with income above 300% poverty to buy into Medicaid through a Medically Needy Medicaid expansion or the Family Opportunity Act.
- Establish a Medicaid Buy-In for Working Individuals with Disabilities up to 450% of poverty under the Ticket to Work and Work Improvement Act.
- Expand the home-and-community-based services waiver program that covers severely-disabled, institutionalized children and implement the TEFRA option.

Rural Communities: Our proposal addresses barriers to care in rural Colorado.

We recommend several strategies to increase the number of providers practicing in rural Colorado including expansion of the scope of practice for mid-level providers, and recruitment programs to provide incentives for students in rural areas to pursue medical careers.

- Increase provider reimbursement rates for public programs.
- Enrich both public and private benefit packages to cover more adequately transportation costs and interpretation services.
- Strengthen the ever-critical emergency medical services (EMS) infrastructure in rural areas.
- Provide greater funding and promote the growth of mobile health services.
- Expand the State's telemedicine capabilities and create a State nurse hotline.

Racial and Ethnic minorities: Racial and ethnic minorities continue to experience disparities in health care access, treatment, and outcomes. Our proposal seeks to address disparities in access by expanding coverage, but also addresses issues related to disparities as to treatment and outcomes. To this end, we propose the creation of a Health Disparities Advisory Committee that would investigate and adopt measures to eliminate health disparities, including data collection, monitoring, and public reporting of racial and ethnic, language status, gender, sexual orientation and income-based health disparities. The advisory committee would oversee the coordination of services and programs that have an impact on racial and ethnic minorities, such as the following:

- The implementation of a Patient Navigator program to help people navigate the system, as well as a Community Health Worker program to conduct culturally appropriate outreach and education within communities.

- Cultural competency training for providers, health workers, and advocates.
- Reimbursement and integration into mainstream service delivery of culturally-traditional and other alternative services.
- Incentives to diversify the health care workforce to better reflect Colorado’s changing demographics.
- Opportunities for meaningful community input.

Immigrant populations: The Coalition believes firmly that all Colorado residents (residents defined as anyone who has lived in the State for 30 days or more) should have access to health services. We understand that there are statutory limitations, both federal and State, on how public funds may be used for immigrant populations in the United States without proper documentation; however, accidents and illness do not take into account a person’s legal status. Many undocumented immigrants end up in hospital emergency rooms – the most expensive way to receive care – instead of receiving less costly preventive and primary care services. As it stands, the citizens of Colorado are paying for the health care of this population. From a public health perspective it is imperative to ensure that all residents have access to early medical intervention, particularly to prevent the spread of communicable disease. The potential for significant public health threats is directly impacted by the availability of early treatment for all residents. In the mathematical functions that demonstrate the growth of an epidemic, the documentation status of the victims has no bearing and thousands of lives can be saved by a rapid, direct, and universal response. For these reasons, we propose creating a system that allows access to more appropriate and cost-effective health care services for *all* Colorado residents, including immigrants. This would mean that immigrant residents at or below 300% FPL would be eligible for the public program. From the State’s perspective, how services for this person are paid for will depend upon the requirements of state and federal funding. The State should make appropriate changes in state law to accommodate this goal. The State should also consider what other states have done with waivers, private funds, and assessments/fees/taxes to finance care for these populations. We believe that, ultimately, this will result in systematic cost-savings since emergency room usage will decrease as will the related cost-shifting.

In addition, to facilitate more timely and efficient care (e.g. accurate diagnosis the first time), we propose that language services (interpretation and translation) be accessible and

reimbursable. In many cases, providers should be required to provide translation services. We recommend the State implement a certification/qualification system for health care interpreters and translators drawing upon national standards (e.g. National Association of Health Care Interpreting). We also recommend that hospitals and large clinics have a Limited English Proficiency (LEP) policy with sufficient resources in place, and for small provider clinics that do not have the capacity, the State will provide a statewide interpretation/translation service (accessible online and via telephone).

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

States have a long track record of signing up low-income populations for public coverage. Similar proposals have been modeled in a number of other states including New York, Connecticut, Illinois, Massachusetts, and others. In general, research findings have suggested that this type of approach to reform will expand coverage, reduce cost-shifting, and increase federal matching payments while providing a modest reduction in spending by employers and individuals who currently purchase insurance. Proposals of this type are also expected to yield net benefits in terms of economic growth.

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

We recommend building upon the current health care administration system by adding broader oversight and evaluation and greater integration. We recommend that this system set in place appropriate checks and balances to ensure accountability and transparency, and that it be insulated as much as possible from partisan politics. To this end, we propose these reforms be governed and administered as follows:

1. The Department of Health Care Policy & Financing (HCPF) would administer the public program expansion.
2. The Division of Insurance (DOI) would implement and regulate the private market reforms.
3. A permanent ‘Stakeholder Oversight Commission’ would be created within state government to oversee broad implementation of system reforms, reporting to the Governor and a new Joint Legislative Committee on Health Care Reform.
4. A Joint Legislative Committee on Health Care Reform would be created to recommend Commission appointments and oversee Commission work.

5. A special health team would be permanently staffed at the Office of the State Auditor to be responsible for conducting regular independent reviews and reporting to the Commission.
6. Meaningful consumer representation would be mandated for all new and existing health-related advisory bodies within state government.

(Please see Appendix A for a schematic and in-depth description of this proposed structure.)

Commission Responsibilities: The Stakeholder Oversight Commission would supervise implementation of Colorado’s health care reforms in their entirety across both the public and private spheres. The Commission would be allotted sufficient staff and resources to carry out several program functions and advisory responsibilities.

- *Program Functions:* We recommend the creation of two offices within the Commission – a System Navigator Office and an Ombudsman Office. The system navigator office would conduct public outreach and health care access assistance to Colorado residents. Responsibilities would include supervision and management of the patient navigator, family advocacy, and community health worker programs, as well as linguistic services. The Ombudsman Office would resolve conflicts between stakeholders.
- *Advisory Responsibilities:* The Commission would monitor the transition and progress toward achieving the 208 mission of covering all Coloradans and reducing overall health care costs. The Commission would ensure that appropriate mechanisms for data collection, both qualitative and quantitative, exist within state agencies to enable evaluation of progress over time. The Commission would coordinate and monitor programs and policies that address cross-cutting issues, staffing and managing the following previously-mentioned advisory committees: 1) Health Care Quality and Cost, 2) Rural Health, and 3) Health Disparities. Other advisory committees would be created as deemed necessary (e.g. business, insurance, vulnerable populations, etc). Finally the Commission would ensure that affordability standards are met in implementation and enforcement of the individual mandate, and oversee the Division of Insurance in its promotion of the standardized insurance products, as well as best practices and intake questions for providers (which would be developed by the Healthcare Quality & Cost Advisory Committee).

Responsibilities of Advisory Committees:

- *Health Care Quality & Cost:* The advisory committee would oversee quality and efficiency initiatives designed to achieve a healthier population and better serve health care consumers, while bringing down systemic expenditures. (See sections B.1 and I.1 for more detail.)
- *Rural Health:* The advisory committee would be responsible for building greater capacity in rural areas. It would maintain the voice of consumers in areas with limited access to providers, empowering them to recommend legislation, inform and oversee strategic planning on provider needs in the area, integrate needs of the community health services, and work on creative, cost-effective ways of increasing access.
- *Health Disparities:* This advisory committee would investigate barriers to access and adopt measures to eliminate health disparities, including data collection, monitoring, and public reporting of racial and ethnic, language status, gender, sexual orientation, and income-based health disparities. The advisory committee would oversee the coordination of services and programs that have an impact on these populations.

Our position is that the Stakeholder Oversight Commission must maintain a high degree of independence from any one particular elected official or political party in order to minimize undue influence and maintain objectivity. *Please see Appendix A for a more in-depth description of how we believe this is possible.*

**(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?**

Colorado will need to enact new laws and/or regulations to:

- Set standards (including standards for benefits, cost-sharing, and cost efficiency) for employer sponsored coverage that will qualify for premium assistance;
- Establish a publicly financed program similar to Medicaid for the childless adult population;
- Change rate rules for small group and individual health insurance, establish minimum medical loss ratios, and require guaranteed issuance of policies;
- Require licensed insurers as well as public programs to use uniform screening procedures for children’s health;
- Expand providers’ scope of practice;
- Make family advocacy programs more widely available;

- Establish an employer assessment and a tax credit for employers who offer coverage meeting certain thresholds;
- Establish a tax penalty for individuals who have access to affordable coverage yet who do not purchase or maintain such coverage. Affordability standards should be noted in law and further defined by regulation;
- Provide for reinsurance of a guaranteed issue, standard product.

The Medicaid/SCHIP expansions will not require any change in federal law. Colorado will need to change appropriate state law and file amendments to its state Medicaid plan to implement the proposed expansions and use primary care case management as the delivery system. More specifically, in changing related statute and making state plan amendments, Colorado should increase income eligibility guidelines and disregard some income of applicants. This is permissible under Section 1902 (a)(10), (r)(2) and (e)(3) and Section 1931 of the Social Security Act. Similarly, Colorado can enrich its Medicaid benefit package by amending its state plan. To improve long term care services, we suggest amendments to Colorado’s existing Medicaid home-and-community-based care waivers and a consolidation of those waivers where reasonable and appropriate.

An assessment on employers that helps to finance public health programs does not violate ERISA. According to an ERISA legal expert, states may allow employers to provide health coverage instead of paying an assessment (e.g., by providing an equivalent tax credit to employers who offer coverage) as long as this is a real choice: “As long as a tax law can avoid being characterized as a coverage mandate, allowing an employer to offer coverage instead of paying the assessment does not ‘dictate’ an ERISA health plan administrator’s choices by requiring alteration of the plan’s terms to comply with the law.”<sup>2</sup> Colorado must be careful, however, not to structure an assessment in a way that would single out one employer or that would cause multi-state employers to significantly alter their record-keeping systems.

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

---

<sup>2</sup> *Patricia A. Butler, JD, DrPH*, ERISA Update: Federal Court of Appeals Agrees ERISA Preempts Maryland’s “Fair Share Act” (Prepared for AcademyHealth and the National Academy for State Health Policy, February 2007, <http://www.statecoverage.net/SCINASHP2.pdf>)

The program would be implemented over a three-to-five-year time period. Upon adoption of the proposal, Colorado would begin filing Medicaid/SCHIP state plan amendments, drafting rules for a Medicaid/SCHIP primary care case management system, and proposing a Medicaid/SCHIP provider reimbursement increase that is designed to improve access to providers. Public program expansions would be implemented as soon as Colorado receives approval of the relevant state plan amendments. If funding does not permit Colorado to immediately expand public coverage for all populations up to 300% of poverty, this would be done in increments over the three years. However, we strongly recommend immediate implementation if possible since that would simplify outreach tasks and minimize confusion about eligibility.

Affordable private insurance policies must be made available before the individual mandate goes into effect, meaning that premiums, deductibles, and cost-sharing cannot exceed 5 % of total income. The Stakeholder Oversight Commission would oversee implementation and ensure that this affordability standard is met. Thus, the Commission must set precise standards for what is considered available, affordable insurance. At the end of the year that Colorado's rate reforms go into effect and insurers offer benefit packages that meet the standards, individuals who do not enroll in health insurance will be subject to a tax penalty.

Within two years, Colorado should develop level-of-care criteria for long-term care that better allow people with cognitive impairments to gain access to treatment covered by Medicaid.

### **C) Access**

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

This proposal identifies ways to improve access to health care providers for all Coloradans. First, we propose an increase in provider rates. A higher reimbursement rate would attract a greater number of providers throughout the State. Currently, Colorado provides a Medicaid reimbursement rate that is 60% of the Medicare rate. In order to ensure appropriate payment levels, we recommend:

- We request that the Commission's consultant to examine what reimbursement rates are necessary to retain an adequate level of providers, observing provider reimbursement rates in the private sector and mechanisms to increase reimbursement rates over time (such as indexing to inflation). The consultant should model the cost and effect on provider participation of several reimbursement rate alternatives. We would especially target certain

in-demand services where provider networks are currently inadequate, such as primary care, occupational therapy, physical therapy, home-care, and mental health.

- Colorado’s Medicaid program and the Medicaid look-alike program should reimburse a wider array of state-licensed health care providers, such as private duty nurses, nurse midwives, and others who may extend care to people at home and in the community.

Second, our proposal includes regional planning activities to ensure appropriate placement of health care facilities. This targets a current problem of hospitals and other facilities moving out of urban areas. Third, we propose changes to the system to improve health care access in rural areas. In order to enhance providers in rural areas, we propose:

- The creation of a state advisory committee to build greater capacity in rural areas. The *Rural Health Advisory Committee* would maintain the voice of consumers, propose legislation, inform and oversee strategic planning on providers in the area, integrate needs of community health services, and work on creative, cost-effective methods of increasing access.
- Support the Community Health Center and Rural Health Center systems (including Community Mental Health Centers), and study the possibility of funding other providers with enhanced rates for operating in a rural setting. We also propose provider reimbursement for interpreter services and for transportation to care.
- Continued support of the Emergency Medical Service program, and a plan to enhance its current volunteer-based structure. We suggest greater education and training of people committed to serving rural areas.
- Supporting students and others living in rural areas to pursue health care professions.
- Continued work on creative solutions for providing care in rural areas. These include mobile care vans, mobile dental screenings, telemedicine, and creating a state nurse triage hotline.

Fourth, we propose taking steps to eliminate health disparities among racial and ethnic communities. Working to end health disparities remains central to our proposal for health reform. However, we specifically propose:

- The creation of a *Health Disparities Advisory Committee* to oversee initiatives and legislation to reduce health disparities.
- Improved interpretation services. All providers should receive reimbursement for the provision of interpreters. A certification system for health care interpreters should be

established. We recommend that hospitals be required to provide adequate interpreter services, and that the State create a reserve of people available to provide medical translation.

- Cultural competency training. We propose that a cultural competency curriculum be developed for all providers and health workers.
- Patient navigators and community health workers. A case manager or advocate may help individuals navigate the health system, as well as promote wellness and prevention in a culturally appropriate manner.
- Enhanced workforce. Create incentives for individuals from culturally diverse communities to enter health care professions.
- Evaluation. We propose data collection on community needs and evaluation of health disparities. This will lead to better monitoring and quality initiatives to reduce disparities.

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

This proposal will not affect Disproportionate Share Hospital (DSH) dollars. By increasing the provider rates, we are attempting to strengthen and support all safety net providers.

## **D) Coverage**

### **(1) Does your proposal “expand health care coverage?” (Senate Bill 06-208) How?**

Our proposal expands health care coverage in several ways.

- We recommend raising Medicaid and SCHIP eligibility levels to 300% of poverty (\$51,510 annual income for a family of three in 2007) to provide coverage to a greater number of low-to-moderate-income Coloradans. Sixty-four percent of the uninsured in Colorado have income below 200% poverty (\$34,340 for a family of three)<sup>3</sup>. We ask that the consultant evaluate how many children, parents, working adults, seniors and disabled individuals will be covered under the expanded Medicaid program we have proposed.
- We propose significant reforms to the private insurance market that would allow more Coloradans to obtain affordable insurance. Guaranteed issue would end the insurance industry’s practice of denying coverage to individuals with greater health needs. Community rating would prevent insurers from rating premiums at exorbitantly high rates based on health

---

<sup>3</sup> State Health Facts, *Kaiser Family Foundation*, available online at [http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&category=Health+Coverage+%26+Uninsured&subcategory=Nonelderly+Uninsured&topic=Distribution+by+FPL&link\\_category=&link\\_subcategory=&link\\_topic=&welcome=0&area=Colorado&notes=show&printerfriendly=0#pagetopic1](http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&category=Health+Coverage+%26+Uninsured&subcategory=Nonelderly+Uninsured&topic=Distribution+by+FPL&link_category=&link_subcategory=&link_topic=&welcome=0&area=Colorado&notes=show&printerfriendly=0#pagetopic1), accessed March 26, 2007.

status, medical claims history, gender and occupation. We recommend merging the small group and individual markets, and allowing young adults to remain on their family's coverage as dependents until age 26. We propose the creation of a reinsurance pool for all state-licensed carriers to stabilize premiums, as well as exploration of a subsidized reinsurance pool for small employers. All of these measures aim to increase the accessibility and affordability of private insurance. We request that the consultant estimate how many Coloradans would gain coverage as a result.

- Our proposal promotes employer participation in providing health benefits. All employers will have to contribute a reasonable amount to employee coverage, or pay an assessment. We will also require employers to offer Section 125 cafeteria plans, allowing employees to purchase health care benefits with pre-tax dollars.
- Finally, we recommend imposing a mandate that all Coloradans obtain health insurance. In order for the mandate to apply, meaningful benefits (See section G) at an affordable price must be available. Requiring everyone to obtain insurance will undoubtedly expand coverage.

## **(2) How will outreach and enrollment be conducted?**

As we are proposing a significant program expansion for all Coloradans with incomes at or below 300% FPL, outreach and enrollment will be very important. We propose the following in order to facilitate speedy, efficient eligibility determination and program enrollment:

- Program eligibility determination guidelines should allow for continuous 12-month eligibility, presumptive eligibility, self-declaration of income, and no enrollment fee.
- Outreach and Enrollment should take place at decentralized enrollment sites, with an expanded role of Community Based Organizations to also enroll individuals and families in public programs. We must expand the number of participating organizations, formalize their relationship and communication with the System Navigator Office at the Stakeholder Oversight Commission and the state Medicaid agency (HCPF) and provide them with training and financial assistance.
- Financial assistance should be available to applicants for enrollment costs (e.g. language services, transportation, and purchasing required identification documents such as birth certificates).

- We should create an express-lane eligibility system in which one application enrolls people into multiple public programs (e.g. school lunch, WIC). Additionally, an E-application should be available online that is linked to the enrollment system, allowing individuals and families to begin the process of inputting their information by way of a web portal.
- Community health workers, or *promotoras*, to educate racial and ethnic minorities about the availability of public insurance and how to seek enrollment.

In the private market, we propose outreach and public education about the new standardized products that will be available.

- We propose that the *Health Care Quality & Cost Advisory Committee* create a set of marketing guidelines for private carriers of both the subsidized and standardized products. These guidelines will include intake questions for insurance companies to screen for Medicaid eligibility and provide appropriate referrals, so carriers do not sell Medicaid-eligible individuals private health insurance. The marketing guidelines should also include resources describing the health care reform law (including the individual mandate), how families may make affordable choices, and consumer appeal and grievance rights. The Division of Insurance (DOI) will require plans to follow the guidelines.
- We recommend that DOI conduct a public relations campaign about the new, standardized products that are available. They should create a “shopper’s guide” that is available as both an online and paper-based tool.

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

Our proposal defines “resident” as anyone who resides in Colorado for a minimum of 30 days.

**E) Affordability**

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

There are no employer premium requirements, however, employers would be required to allow employees to purchase insurance with pre-tax dollars, and will also be subject to a payroll tax if they do not contribute a reasonable share to employee health benefits (the level of the assessment and *reasonable* employer contribution would be determined by the Commission’s consultant). Employers may receive a credit against their payroll tax liability for eligible health expenses made on behalf of their employees.

Exact employee premium requirements have not been determined (also subject to the consultant's modeling). However, persons below 200% FPL would be eligible for full premium subsidy, either through the public plans, or, if cost-effective, through a premium assistance program with their employer [see section g (2), page 24 for explanation]. For people between 200-300% FPL, premiums and cost-sharing would be based on a sliding scale, and limited to the SCHIP standard (not more than 5% of income). For people above 300% FPL who are mandated to purchase coverage, premiums and cost-sharing would be no greater than 5% of income.

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

Cost-sharing for low income households below 200% FPL would be limited to the Medicaid standard regardless of Medicaid eligibility (e.g. parents and non-parent adults would be subject to the same cost-sharing rules). For people earning between 200-300% FPL, we suggest an out-of-pocket maximum of 5% of income for all costs.

There would be no cost-sharing for preventative services and cost sharing would be waived or reduced for people with chronic illnesses participating in a care management protocol (in order to improve compliance with clinical guidelines and to avoid adding financial burden for those with chronic diseases).

**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.**

Our proposal builds on our current system of health insurance which is a mix of public programs and private market options. While achieving seamless portability across any system with multiple entities can be difficult, we offer recommendations that assure individuals maintain access to coverage even if their circumstances and health status change.

- We propose establishing a standardized minimum package of benefits that would include all state-mandated benefits, preventive care and screenings, acute, pharmaceutical and mental health services. Guaranteeing a baseline of meaningful coverage in the private market that everyone should have would provide people with continuous, high-quality coverage even if they change jobs or insurance carriers, lose employer insurance, or come off family coverage.

- We recommend guaranteed issuance of all insurance policies and community rating. If both reforms were implemented, individuals would not be denied access to insurance or penalized with high premiums for a change in their health status.

## **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 benefits we propose for the Medicaid/SCHIP populations add services in areas where community organizations have noted significant gaps in coverage. We expect that better preventive care will save health care dollars in the long run. For example, failure to treat a cavity may eventually cause serious infections and exacerbate problems such as diabetes.<sup>4</sup>

People with incomes up to 300% of poverty would have access to long-term care, among other benefits that are covered by Medicaid. The Medicaid population would have better access to home- and community-based services when existing waiver programs are consolidated, where appropriate, and include a similar array of possible services congruent with needs. This would enable people to get services based on their individual needs and level of care rather than based on their diagnosis.

Limited English speaking populations currently face barriers in getting health care both because of difficulty in navigating the system, and because interpreters are often not provided, particularly by providers who see small numbers of patients speaking a given language. We propose that all hospitals have a Limited English Proficiency policy in place, and the creation of a state-supported interpretation/translation service, accessible online and via telephone, for patients using providers that do not otherwise provide interpreters.

Primary care case management and family advocacy would assure that people get appropriate amounts of service. For those using private insurance, the standardization of policies would help consumers and employers better purchase the amounts of coverage they need.

### **(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.**

---

<sup>4</sup> Payne, January W. "Dental Care Challenge: Open Wider." *Washington Post*, March 27 2007.

Medicaid and SCHIP populations would receive the following benefits in addition to their current services: preventive dental care; vision and hearing services; family advocates to assist people who are chronically ill, have limited English, or have other special needs in navigating the health care system; improved transportation to medical care; cancer screening; access to medical interpreters as needed (discussed further below); and full implementation of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, including access to early childhood mental health services and substance abuse services. Home and community-based waiver services would be consolidated where appropriate so that all populations requiring this level of care will be able to obtain an array of services based on their functional and medical needs instead of being based on their primary diagnoses. As opportunities become available, Colorado would remove enrollment caps from home- and community-based care waiver programs and would apply for grants to implement money-follows-the person initiatives.

Childless adults who have incomes below 300% of poverty and enroll in the state-sponsored program will receive most of the same benefits as Medicaid and SCHIP enrollees with the following exceptions: (1) they will not need EPSDT or other children's services, and (2) they will not need most long-term care services as they will qualify for Medicaid should they become significantly disabled.

For people with incomes below 300% of poverty with an offer of employer-sponsored coverage, the consultant should evaluate the best means of providing benefits comparable to Medicaid and SCHIP. The consultant should determine whether it is cost-effective and feasible for the person to enroll in their employer's plan with public programs "wrapping around" to provide benefits that are not covered and to pay excess cost-sharing, or whether it is better for such individuals to obtain all of their coverage through the public program. The consultant should weigh the extent to which employer-dollars for health care could be lost, administrative costs, and the likelihood that individuals will be left underinsured. People with income below 300% of poverty does not have disposable income after meeting basic needs, and cannot afford to obtain services for which there is no coverage.<sup>5</sup> The Commission should determine what

---

<sup>5</sup> This was the result of an affordability study in Massachusetts, "Mandating Health Care Insurance: What is Truly Affordable for Massachusetts Families?" Boston: Greater Boston Interfaith Organization, 2007. Colorado could gather similar information to verify that the findings hold true in Colorado as well.

limited sliding scale premiums and cost-sharing are reasonable, but at a minimum, people with incomes below 300% of poverty should not be charged for preventive care.

Regarding long term care, a task force should be convened to explore long-term care partnership programs that exempt certain assets from consideration by Medicaid if people purchase private, long-term care policies. The task force will study whether such partnerships are beneficial to consumers and whether they are cost-effective.

For the population above 300% (covered by private health insurance), we recommend that Colorado develop a standard plan for private insurance, including coverage of all mandated services, preventive care and screenings, acute, and pharmaceutical and mental health services, so that consumers may more easily evaluate policies being offered by various carriers. Currently, Colorado's mandated benefits for state-regulated private insurance address discrete problems where there may otherwise be coverage gaps, but they do not set forth a standard coverage policy that includes an appropriate range of primary, specialty, and acute care. Colorado could develop several tiers of standardized coverage offering richer benefits from which enrollees could choose (for example, a minimum or bronze, silver, and gold level benefits). Furthermore, we propose that the State continue its existing mandates and, in addition, develop a uniform health screening program for all children under age 21. This will be helpful to families and will also ensure that any health problems are identified.

## **H) Quality**

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

We propose the creation of a *Health Care Quality and Cost Advisory Committee* to oversee quality initiatives, which aim to achieve a healthier population, better serve health care consumers, and reduce health care spending over the long term. There should be community input at every level of the system. Over a period of years, an investment in primary and preventive care will reduce health care spending – but we do not expect this to happen overnight. We believe more work would be required of the Blue Ribbon Commission and the proposed Health Care Quality and Cost Advisory Committee to define quality. Components should include:

- People should have a health care home.

- People should be trained to manage effectively their health conditions, and this training should extend to people with developmental disabilities, people with limited English, and people with mental health issues as well as the broader community.
- People should have appropriate choices between institutional and home and community-based care.
- Screening, prevention, and early intervention are of utmost importance

The role of the *Health Care Quality and Cost Advisory Committee* would be to evaluate the effectiveness and oversee the implementation of the following policy ideas:

- Chronic care case management. Case managers could coordinate care for people with various chronic conditions, preventing duplication by providers and connecting patients with necessary services to avoid medical complications that lead to expensive hospital visits.
- Expanding the scope of practice for various types of providers. For example, we recommend expanding the scope of practice of licensed practical nurses to deliver community care, home birth midwives and visiting nurses.
- Development of standards and best practices for health care providers statewide. Review various options to promote adherence to these standards, such as public reporting, and other financial incentives for adhering to treatment protocols or reducing medical errors as long as these do not create perverse incentives for providers.
- Examination of the quality measurement model currently used by Rocky Mountain Health Care, quality measures for long-term care currently used in Texas and Minnesota, and national best practices in order to develop a measurement system for primary care case management and other subsidized care, the advisory committee should.
- Advancing health information technology (HIT) with adequate consumer privacy protections. Consumers should be provided with access to their own health information. To this end, the committee would support the work of the Colorado Regional Health Information Organization's (CORHIO) in their efforts to facilitate better information-sharing, with appropriate consumer protections, between hospitals and other health facilities.
- Implementation of the recently-passed House Bill 06-1045 concerning public reporting of hospital-acquired infections.
- Promoting health care homes. The proposal relies on primary care case management for delivery of services in the public programs, which will encourage individuals to see a

primary care provider for prevention and referrals for specialized care. Health care homes must allow individuals direct access to mental health care services.

- Greater training to primary care providers about issues of mental health, substance abuse, assault, and neglect. The advisory committee should create a standard set of intake questions for health care providers. All state-subsidized plans would be required to use the questions, and the Department of Insurance would encourage their use by insurers more widely.
- Growing the family advocate system, providing health care system navigators to consumers.
- We recommend investigating strategies to lower prescription drug costs while preserving consumer rights to access necessary medication. The advisory committee should explore:
  - Appropriate bulk purchasing by utilizing a preferred purchasing list that allows for buying in bulk the most costly drugs. However, it should not require a prescribing list that dictates what a provider can prescribe.
  - The State shall investigate flexible pricing and reimbursement strategies such as actual acquisition cost, State Supplemental Manufacturer Rebate Programs, reference-based pricing, etc. The State shall determine which pricing and reimbursement program offers the best prices and rebates to garner the significant savings for the State.
  - Encouragement and better utilization of Federal 340B drug pricing for community mental health clinics. This avoids a retail mark-up and allows purchasers to negotiate sub-ceiling prices.
  - The feasibility of a Charitable Drug Program allowing the return and reuse of unused medications by entities such as drug manufacturers, pharmacies, nursing homes, assisted living centers, charitable clinics, health care facilities, or government programs. These groups may donate prescription drugs to a drug repository program to accept and dispense prescription drugs donated for the purpose of being dispensed to individuals who meet the medically indigent eligibility standards.
  - Maximum State Allowable Generic Pricing program, giving Colorado more support to examine and potentially overhaul its generic pricing system. The Commission should look at Michigan and Indiana’s initiatives for guidance.

We recommend establishing a *Health Disparities Advisory Committee* to look specifically at the cultural and linguistic competency of services as part of its measurement of quality, use a community-based participatory research model to study disparities, and collect data on ethnic

and racial disparities in care. The Health Disparities Advisory Committee would investigate and adopt measures to eliminate health disparities. Such measures include:

- Data collection, monitoring and public reporting on racial and ethnic, language status and income-based health disparities on an ongoing basis. We propose requiring private insurers to collect this type of data as well.
- Cultural competency training for provider licensure.
- Providing individuals with access to appropriate linguistic services.
- Creating minimum standards for culturally and linguistically competent health services.

**(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, rural areas, etc.?)**

We propose primary care case management as the delivery system for subsidized health care. This will give enrollees a health care home, encourage greater use of primary care, and ensure the coordination of primary and specialty care. Consumers will still have direct access to their mental health providers. However, to ensure that primary care providers also screen for mental health problems and help refer people to appropriate services, the Health Care Quality and Cost Advisory Committee will develop and disseminate a screening tool. We propose a training program for primary care case managers on mental health, substance abuse, assault, and neglect, including community treatment resources.

We also propose an expansion of the family health advocate system. Many people are not aware of their rights to health care services or have difficulty navigating through referral and health care payment problems. Family health advocates will assist people in obtaining needed services.

Our proposal calls for a uniform health screening program for children, to be used by both public and commercial state-licensed health insurers. This will improve early identification of health and developmental problems for children.

We propose three training initiatives:

- Training consumers to seek preventive care services. Community health workers will be used as health promoters.

- Training providers to better serve culturally diverse populations. In addition, primary care providers will be trained on issues of mental health, substance abuse, assault, and neglect;
- Recruitment of culturally diverse communities into the health professions, and may also include some workforce incentives.

We recommend that consumers have better access to their own health information. With appropriate protections for consumer privacy, Colorado should use information technology to facilitate better information-sharing between hospitals, clinics, and other health facilities. The Colorado Regional Health Information Organization (CORHIO) should be supported in their efforts to facilitate the development of an effective statewide system.

Because of enhancements in benefit packages, low-income mental health consumers would be able to obtain drugs that improve the quality of their lives; families would receive appropriate vision and dental services; and seniors and people with disabilities would be able to receive a broader range of long-term care services in their homes and communities that better address their needs.

## **I) Efficiency**

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

Our proposal calls for the creation of a Health Care Quality and Cost Advisory Committee to oversee quality initiatives, and tactics to reduce health care spending. The advisory committee will direct implementation of appropriate policies, including:

- Expanded scope of practice for providers: We propose expanding the practice of licensed practical nurses, midwives and visiting nurses, with a goal of reducing provider costs and improving access.
- Prescription drug pricing: We propose obtaining better drug prices in Colorado through bulk purchasing, wider use of federal 340B drug pricing, and exploration of other initiatives.

Preventive care: The Coalition promotes preventive care as a means to a healthier population and lower health care costs overall. We recommend primary care case management and no cost-sharing for preventive services in Medicaid and the Medicaid look-alike program. By providing all Coloradans with affordable coverage and meaningful benefits, we estimate that many people will seek necessary care, rather than waiting for a major condition to develop.

**(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.**

To promote quality among providers, we propose that the Quality and Cost Advisory Committee review quality measurement models, including the model currently used by the Rocky Mountain HMO, for effectiveness and equity. We recommend that the Quality and Cost Advisory Committee be responsible for establishing best practices and standards of care for providers. The Commission should consider a range of options to encourage best practices and adherence to standards of care, including public reporting of quality measures, bonus payments for participation in quality initiatives, technical assistance to providers not meeting quality goals, and, eventually, financial incentives for adherence to widely accepted treatment protocols.

To encourage positive health outcomes for consumers, we promote health care homes. We suggest using a system of primary care case management for service delivery in the public expansion programs. This system will encourage individuals to see a primary care provider for prevention services and referrals for specialized care. Through health care homes, we would like to expand training and education on preventive care services to all individuals. It is important to note that we recognize special provisions must be made for homeless individuals and migrant workers for whom a fixed health care home is often not a practical service delivery model.

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

As stated above, the proposed quality and cost advisory committee will oversee certain programs aimed at improving quality and transparency. These include:

- **Health Information Technology:** We support providing consumers with access to their own health information, and to provider outcomes data. With consumer protections, we encourage better information-sharing between hospitals and other facilities. We support the Colorado Regional Health Information Organization (CORHIO) in their efforts to facilitate the development of an effective statewide system.
- **Education and training:** We support greater training of primary care providers about issues such as mental health, substance abuse, assault and neglect. The quality and cost advisory committee should create a standard set of intake questions for health care providers. All public health expansion plans would require these standards, and the Division of Insurance would encourage their use by insurers.

- Family advocate system: We propose an expansion of the current system to provide greater access to family health advocates to aid individuals in navigating the health care system.

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

Our proposal limits administrative costs of insurers by establishing medical loss ratios. Medical loss ratios require that insurers spend a certain portion of premiums collected on medical care, while limiting the amount that can be used for administration, profit, and marketing. We request that the Commission study reasonable medical loss ratio levels for Colorado insurers.

To further efficiency in the private insurance system, we propose greater rate regulation. Each year, insurers should be required to report premium increases through a public hearing process.

**J) Consumer choice and empowerment**

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

One of the main goals of our proposal is to ensure high quality, comprehensive health coverage for all Coloradans. Our proposal requires a robust benefit package for all public health expansions (Medicaid, SCHIP and Medicaid look-alike programs for people up to 300% FPL). We also require standardized benefits for products in the private insurance market. The set of standardized packages would include: a “minimum” coverage option with basic benefits (including inpatient and outpatient care, all state mandates, mental health benefits, preventative care and screenings), and other “tiers” of health insurance. For instance, benefits at the “gold”, “silver” and “bronze” levels would be available for people purchasing in the private market. This system would continue to allow consumer choice, but also allow comparison of the cost and value of health options across carriers.

For seniors and people with disabilities, our proposal expands eligibility and access for people seeking home and community-based long term care services. This policy will result in providing greater choice in long term care settings.

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

Our plan promotes a system of primary care case management for access to health services provided through public health expansions. This system will encourage preventative care. We encourage the use of health care homes as a foundation to expand training and education on healthy behavior. We recommend expanding the family advocate systems that are in place to provide assistance navigating the health care system. In addition, we support the creation of a

system to allow consumers to gain access to their own health information. This system could also include data comparing outcomes and information on providers and facilities to help consumers make informed choices.

## **L) Sustainability**

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

Our proposal consists of a public program expansion up to 300% FPL for all populations, significant private market reforms, an employer assessment and an individual responsibility provision with strong affordability protections. In combination, we believe these reforms would cover all Coloradans at a meaningful benefit level, and address special needs populations, resulting in a healthier population, less inappropriate emergency room use, and less cost shifting to the currently insured. Sustainability of the public program expansion would be very much tied to funding sources. We believe that it is possible to fund much of the public expansion without using State general fund dollars. Several ideas about how to do this would be described later in this section. Our private market reforms and reinsurance program would increase the stability of private market premiums. The employer assessment would support and incentivize employers to offer health insurance coverage.

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

We have not conducted a cost analysis, therefore we cannot provide the Commission with a concrete number in cost or in savings. However, any cost analysis must look at system wide and longer-term savings. As coverage is expanded to the uninsured, the State will achieve savings as people have cost-effective early prevention, screening and intervention services, and total uncompensated care costs are reduced.

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

All stakeholders will contribute toward new costs. Individuals who were not previously insured are mandated to purchase coverage and will pay premiums. Individuals in public programs above 200% poverty will pay sliding scale premiums and cost-sharing. The State and federal governments will contribute to the public programs and health care infrastructure. Employers will either continue to provide coverage, or pay an assessment. Insurers will participate in the reinsurance pool, paying premiums and assessments. Providers may also be assessed a fee.

**(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?**

The Coalition recommends an individual mandate to secure universal participation in Colorado's health care system. In aggregate, the effect of covering all Coloradans will be that individuals now purchasing health insurance will spend less, while people with moderate income who do not now have coverage would be required to purchase affordable, comprehensive coverage. Individuals who are older or have more health care needs will pay less for coverage than they do now in the private market.

Employers who do not now provide coverage or other health benefits would be subject to an assessment, while employers that currently insure their workers would likely see an aggregate reduction in spending due to reduced cost-shifting. This provision would not require employers to increase spending if they now provide their workers with an adequate level of health benefits or coverage.

State spending would increase to pay for Medicaid and SCHIP expansion, a new public program for low-income individuals ineligible for Medicaid, as well as increased Medicaid reimbursement rates. Federal investment in Colorado would increase due to increased Medicaid spending and increased use of pre-tax dollars to purchase insurance.

**(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.**

Employers would be subject to a new payroll assessment, in an amount to be determined by modeling, to help finance publicly subsidized coverage. There would also be a new (non-refundable) tax credit for employer health spending. We ask the consultant to model the impact that varying the percentage of the payroll and exemptions on a portion of payroll (e.g. the first \$10,000/ FTE or payroll above the Social Security withholding limit) would have on revenue and the number of affected employers.

Individuals with incomes above 300% FPL would be subject to a new mandate to purchase insurance, provided that affordable insurance meeting minimum standards was available. Premiums and out-of-pocket spending (including deductibles and co-payments) should not exceed 5% of income. This progressive affordability standard should include allowances for extraordinary expenses and an exemption process for financial hardship.

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

Two major sources of cost-shifting, underpayment by Medicaid and reduction in the cost of uncompensated care would be virtually eliminated. By increasing Medicaid provider rates, this proposal seeks to prevent providers from shifting costs to private payors. This rate increase is especially important with the expansions of Medicaid and SCHIP, and the creation of a Medicaid-like program to cover uninsured adults. Additionally, the public expansions will greatly increase the number of low-income people who have comprehensive health coverage, thereby reducing the costs of uncompensated care and premiums for the currently uninsured.

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

Some new public funds will be required. However, it is important to note that as coverage is expanded to the uninsured, the State will achieve savings as people seek cost-effective early prevention, screening and intervention services, and total uncompensated care costs are reduced. As a result, we do expect that the need for public funds would be less than would initially appear.

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

The Coalition suggests three guiding principles to the 208 Blue Ribbon Commission with regard to funding health care reform in Colorado.

1. Protect, as the foundation, major existing State funding streams for health care (Amendment 35 tobacco tax, Referendum C, and Tobacco Master Settlement).
2. Minimize the State's reliance on general funds wherever possible.
3. Leverage federal funds wherever possible.

We understand, however, that the State may have to raise new public funds, which would require a vote of the people due to TABOR. Potential new funding sources could include raising the tobacco excise tax again or raising other sin taxes on things like alcohol and snacks and sodas. Other sources could include a broad tax on those that benefit from the comprehensive health care system such as health care providers. Those providers that see Medicaid and CHP+ patients would see some return on their tax payments in the form of increased reimbursement rates. Those who do not currently see Medicaid/CHP+ patients may be encouraged to do so given higher reimbursement rates and the desire to take advantage of the return on their tax "investment".

With the guidance and expertise of Don Vancil, former HCPF Financing Specialist and current consultant, the Coalition has compiled a list of ideas regarding how to leverage additional federal funds. We would be happy to share these ideas with the Commission at your request.

### **3. A single page describing how your proposal is either comprehensive or would fit into a comprehensive proposal.**

Our proposal stands independently to meet our goals of providing accessible, affordable, comprehensive, high-quality health care to all Coloradans while reducing market inefficiencies and bringing down long-term costs. It strengthens the major components of our current system, while promoting the participation of all stakeholders.

*Public expansions.* We cover all people under 300% FPL through Medicaid and SCHIP for children and parents, and a Medicaid look-alike program for other adults. We also target some of our most vulnerable members by providing greater access for seniors and disabled individuals.

*Private insurance.* We propose insurance reform to spread risk, increase access, affordability and efficiency. Guaranteed issue will make insurance accessible to all, and community rating help make it affordable. By merging the individual and small group markets, we create a larger risk pool to reduce premiums. We propose creating a mandatory reinsurance pool for all Colorado carriers to reinsure the highest-cost claims. We recommend a minimum level benefits, and greater standardization of insurance products to allow consumers to make easier choices about health care. These standards would apply in all markets, to create portability of insurance. Our proposal imposes an individual mandate to obtain insurance, with affordability protections.

*Employers.* We support employer-sponsored insurance as one of the pillars of coverage in our State. Our proposal discourages erosion of employer-based health benefits by requiring that employees who are eligible for public programs take insurance offered by employers, if it meets certain criteria. We also propose an assessment on all employers to cover public expansions, with a non-refundable tax credit available for employers who provide health coverage.

*Quality.* Our proposal strengthens the health care delivery system and improves health care quality. We recommend increasing provider rates to improve access. Our proposal creates a Health Care Quality and Cost Advisory Committee to oversee quality initiatives. We also propose the establishment of a Rural Health Advisory Committee and Health Disparities Advisory Committee to improve access.

#### **4. (Optional) A single page describing how your proposal was developed.**

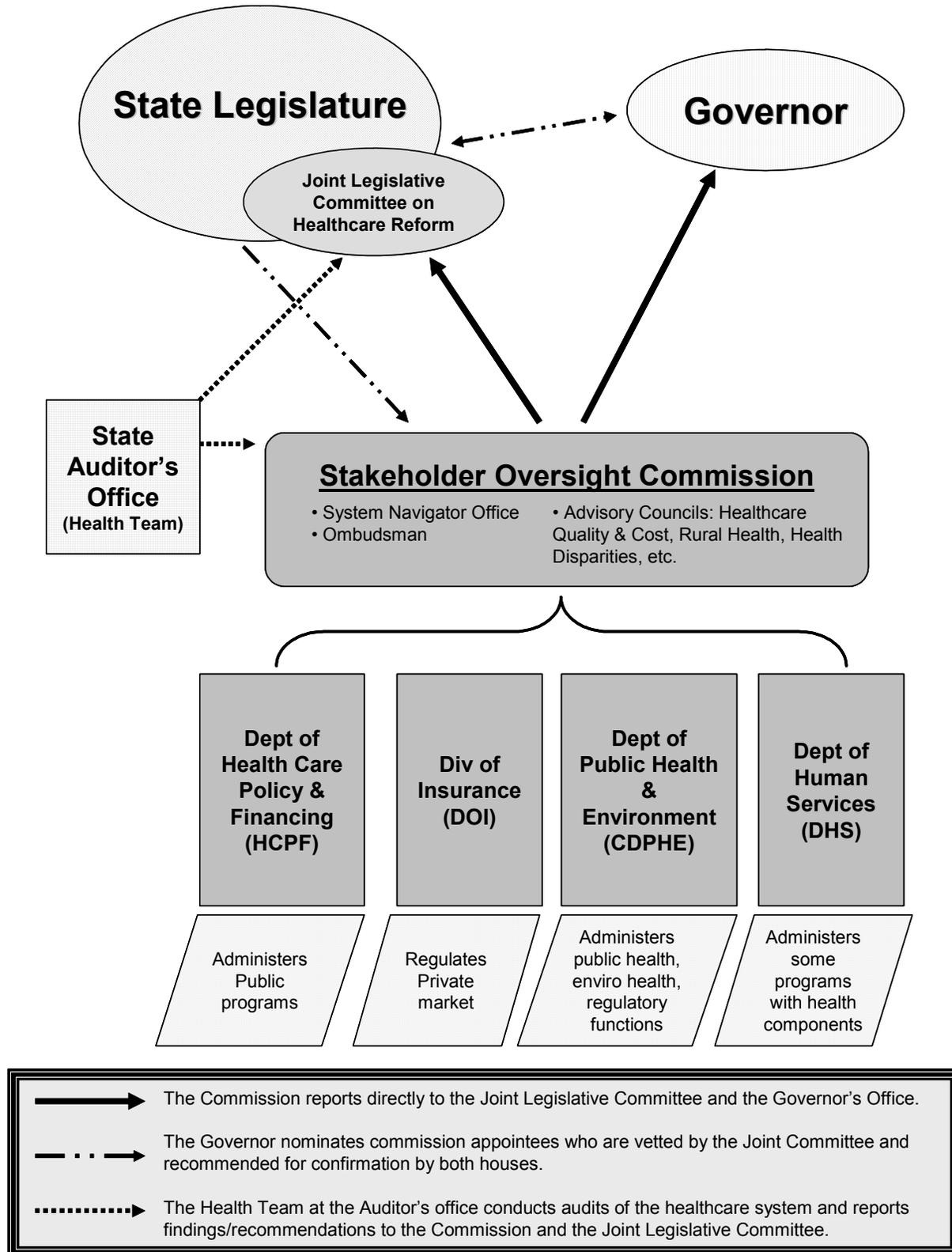
The Colorado Consumer Health Initiative is a statewide, unified membership organization comprised of organizational and individual health care consumer advocates (please see Appendix B for a listing of our membership). CCHI acts as a unified representative of its members and partners at the legislature and in the community to influence and shape effective health care policy to ensure barrier-free access to quality affordable health care for all Coloradans. CCHI makes its critical policy decisions through consensus of its membership.

In January we invited all of our members to discuss how, if at all, CCHI should participate in the Blue Ribbon Commission process. A core group of members agreed to form a 208 work group to develop a comprehensive proposal. This work group, consisting of board, staff and approximately 20 active members, has met every Friday for the past 2 months to author this proposal. We have received technical assistance from Families USA in Washington DC and Community Catalyst in Boston, Massachusetts, two national health policy organizations.

We began by systematically looking at major reform ideas around the country. We identified 6 major questions we needed to answer in order to build a proposal from the ground up, tackling a new question each week. In addition, the work group formed six ad hoc groups to address specific issues in separate smaller meetings. Those ad hoc groups were: 1) longterm care & disability, 2) eliminating health disparities, 3) rural health issues, 4) data, evaluation and governance, 5) funding sources, and 6) Medicaid/CHP+ access and enrollment.

While it has been difficult at times working with so many people in order to craft this proposal, we are proud of how collaborative the process has been. There is a great deal of expertise within our membership and we believe that is reflected in this document. Thank you for this opportunity. We look forward to working with the Commission in the future on such a worthy and important cause.

**Appendix A: Proposed structure for governance and administration of health reforms.**



## **Appendix A continued...**

### **Stakeholder Oversight Commission**

*Commissioners:* We recommend a 24-member Commission with 10 members representing various consumer groups, 5 providers, 4 business leaders, 3 insurance representatives, and 2 health care experts. The reason for this specific breakdown is as follows: There are different types of consumers with different experiences accessing the system whose perspectives are very important (e.g. public program participants, individuals with private insurance, elderly and disabled longterm care consumers, families, etc.). For this reason we recommend that consumers are the largest represented group on the Commission. The second largest group should be providers given that this includes various types of clinicians, hospitals, clinics and nursing homes. We recommend 4 business leaders from small and large businesses, both rural and urban. Finally we recommend 3 insurance company representatives and 2 general health care experts.

Commissioners are appointed for staggered 3 year terms, serving a maximum of 2 terms or 6 years. The appointment process is as follows: The governor's office develops a list of nominees in consultation with the legislative leadership (defined as both majority and minority). This list is processed and vetted by the Joint Legislative Committee on Health Care Reform. Finally, the Joint Committee votes and makes recommendations to both the House and the Senate for confirmation.

*Staff:* Once appointed, we recommend the Stakeholder Oversight Commission conduct a search and nominate an executive director and an ombudsperson to be reviewed and confirmed by the Joint Legislative Committee. Additional staff would be chosen by the executive director in consultation with a staff oversight committee consisting of the Commission's executive committee and other self-selecting members of the Commission.

*Governance:* The Commission would report directly to the Joint Legislative Committee on Health Care Reform and the Governor. We recommend the Commission operate by supermajority (2/3 approval) and be subject to the Sunshine Act (with possible exception of staff oversight). Responsibilities of the Commission would be both functional and advisory in nature (please refer to B.5 of the proposal for a description).

**Appendix A continued...**

**Joint Legislative Committee on Health Care Reform**

We recommend the creation of a new standing legislative committee to supervise system-wide health care reform. The committee would consist of 12 members with equal numbers from the House and Senate, and equal numbers from the majority and minority parties. The joint committee would have a chair and vice-chair not of the same party who would rotate annually. The committee would operate by supermajority.

**Appendix B: CCHI Membership List**



## 2007 MEMBERS

The Colorado Consumer Health Initiative, with the active support of our members and partners, is a unified, statewide organization of consumers and partners, working for barrier-free access to quality, affordable healthcare

*As a result of our efforts, thousands of Coloradans have gained access to health care.*

---

**MEMBERS:**

<p>9 to 5 National Association of Working Women</p> <p>AARP Colorado</p> <p>All Families Deserve a Chance (AFDC) Coalition</p> <p>Allied Jewish Apartments</p> <p>Alzheimer's Association, Rocky Mountain Chapter</p> <p>American Diabetes Association</p> <p>American Heart Association</p> <p>American Lung Association of Colorado</p> <p>Arc of Arapahoe and Douglas County</p> <p>Arc of Aurora</p> <p>Arc of Denver</p> <p>Autism Society of Colorado</p> <p>Bell Policy Center</p> <p>Center for African American Health</p> <p>Center for Systems Integration</p> <p>Colorado Organization for Latina Opportunity &amp; Reproductive Rights (COLOR)</p> <p>Colorado AIDS Project</p> <p>Colorado Center on Law and Policy</p> <p>Colorado Children's Campaign</p> <p>Colorado Citizen's for Accountability</p> <p>Colorado Coalition for the Homeless</p> <p>Colorado Coalition for the Medically Undeserved (CCMU)</p> <p>Colorado Developmental Disabilities Council</p>	<p>Colorado Health Charities</p> <p>Colorado Progressive Coalition</p> <p>Colorado Rural Health Center</p> <p>Colorado Women's Agenda</p> <p>Colorado Women's Health Care Coalition</p> <p>Colorado Women's Lobby</p> <p>Community Health Charities of Colorado</p> <p>Congregation Emmanuel</p> <p>Denver Urban Ministries (DenUM)</p> <p>Empower Colorado</p> <p>Family Voices Colorado</p> <p>The GLBT Community Center of Colorado</p> <p>Health Care for All Colorado</p> <p>Hep C Connection</p> <p>Hunger for Justice</p> <p>Interfaith Hospitality Network of Greater Denver</p> <p>Kid Connects</p> <p>The Legal Center for People with Disabilities and Older People</p> <p>Lupus Foundation of Colorado</p> <p>Lutheran Advocacy Ministry</p> <p>Mental Health Association of Colorado</p> <p>Metro CareRing</p> <p>National Alliance on Mental Illness</p> <p>National Association of Social Workers, Colorado Chapter</p> <p>National MS Society</p> <p>Parent to Parent of Colorado</p>	<p>Pikes Peak Partnership</p> <p>Project SOL-Survivor Outreach to Latinas with Breast Cancer (UCHSC)</p> <p>Rocky Mountain Farmers Union</p> <p>Rocky Mountain Residences</p> <p>Rocky Mountain Stroke Association</p> <p>Service Employees International Union</p> <p>Women's Resource Center of Durango</p>
--	---	---

BARRIER FREE ACCESS TO QUALITY HEALTH CARE