

Blue Ribbon Commission on Health Care Reform
- Dissenting Opinion -
Mark Simon
December 12, 2007

Introduction

(NOTE: The modeling data is based upon the 11/28/07 Lewin Presentation. The author reserves the right to modify this data as well as data dependent commentary based upon any new data that might be provided in the future. Further, this is a draft and revisions may occur up to the 20th of December.)

The Blue Ribbon Commission for Health Care Reform has undertaken an extremely difficult set of tasks concerning an incredibly complex subject while under extreme time constraints. Due to this, the commission has been unable to treat every issue with the degree of attention that it might have under other circumstances. As a result, the commission may not have addressed all issues with the appropriate degree of depth, may have excluded some ideas that deserved further consideration, and has almost certainly missed some opportunities to craft the health care debate.

The recommendations as developed by the Commission reflect certain philosophical imperatives, including "Because most Coloradans have insurance, we should build on the strengths of the current system, keeping and broadening what works to minimize dislocation for those who already have good coverage, while making important changes to better meet the needs of those who currently lack affordable health coverage." This is putting band aids on an elephant that is hemorrhaging in buckets!

The specific, dissenting commentary herein, and my dissenting position generally, are based on both the Commission's final recommendations and the 5th proposal developed by the Commission. While the Commission does not recommend the 5th proposal as a "preferred" option, it's final recommendations are based largely on the document. The 5th proposal contains far more detail and therefore provides a much clearer picture of what was intended by the recommendations and the underlying cost.

This dissenting opinion is based upon some key areas of disagreement with the Commission's final recommendations, as well as, the Fifth Proposal. This disagreement is by no means total. But there are areas of concern, especially in the areas of insurance reform, consumer interests, and the health care available for vulnerable populations, and those issues form the core of this dissent.

While I consider many of the Commission's recommendations to be sound, there are significant omissions and general philosophical issues which have inspired and necessitated this dissent. I also wish to be clear, in the problems I identify, there are solutions that were not pursued or adopted by the Commission, that in my opinion would be more effective, or at minimum do less harm, particularly for consumers and the taxpayers.

A general observation is that the fifth proposal and the recommendation that derive from it represent a significantly complex system. These provisions are likely to lead to a health care system that will be complicated and expensive to implement and may be even more difficult for Colorado citizens to navigate through and use. This

will be especially true for the uninsured population that has little previous experience with even the current Health insurance system. The amount of education, support, and maintenance that will be required will be significant.

Specific points of concern are listed below:

Fiscal Issues and Concerns

- The Commission's final recommendations reduce costs to employers, fully compensates providers for everyone they see (except for those left out of this reform [e.g. undocumented residents] or underinsured), and gives the insurance industry 221,600 new/subsidy clients, of which 117,400 are currently uninsured. Unfortunately, in this newest effort at cost shifting, the consumer and taxpayer are required to pay for it all. For many consumers it will appear as though special interests have figured out a way to open the taxpayer coffers for self enrichment and corporate risk management.
Coverage does NOT equal access!
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- \$553.7 MILLION tax dollars in new money will go to insurance companies, of which \$283.5 Million is for individuals that are currently uninsured. The recommendations/proposal will also remove a significant proportion of the high risks/high costs from the commercial risk pool and would transfer them to Medicaid or other high risk pools. In return, there is no requirement, oversight, or incentive for the insurance industry to operate at a level of greater efficiency or produce higher quality outcomes for the consumer!
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- \$77 MILLION in new administrative costs for insurance companies. According to the McKinsey Global Institute's January 2007 report on National Health Care Costs, 64% of all private payor administrative costs are spent on health risk underwriting, sales, and marketing.
- The redirection of \$630.7 million dollars of public funds to the insurance industry will simply not improve health care quality. During the public hearings it was raised several times that the recently retired CEO of United Health Care, a major insurer, received a retirement package of \$1.3 BILLION dollars!
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- \$2.6886 BILLION in increased Medicaid expenditures, which doubles the current budget will be incurred by adding 347,000 parents and childless adults alone (out of 472,700 eligible), as well as, some additional populations (at additional expense). This doubles the Medicaid budget that was already growing. The Commission's recommendations further require a three-month waiting period for these expansion populations. This waiting period effectively denies care to vulnerable people for that entire period. This provision, alone, will impact more than 10,000 people. Generally the federal government does not allow wait periods.
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- \$240 MILLION in payments to providers for previously uncompensated care, plus \$166 MILLION in administrative savings, without requiring them to decrease per-patient charges, see those without ability to pay, any increase in quality standards, or anything else for that matter; that it goes to patient care and not the bottom line. The Proposal does not fully compensate providers, at least in Medicaid. The Commission has included an increase for doctors and proposes a review of other provider rates.
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- \$987 MILLION in increased health care spending in Colorado, yet the Single-payer proposal modeled clearly indicates that there is currently sufficient money in the system to provide all Colorado residents with access for all medically necessary care as well as increasing the home care budget to meet the rising demand.
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- \$334 MILLION in reduced costs to employers, which it is claimed will then result in increased wages in an equal amount, but there is no way to verify that it actually occurs.

- \$75 million in increased family out of pocket spending, when one “backs out” of the modeling which shows \$14.9 MILLION in decreased family spending. This includes \$89.9 million in decreased family spending shifted to Medicaid, by eliminating the waiver waiting lists in Medicaid. (NOTE: The figure for family out of pocket spending is low due to the caps in the recommended “Minimum Benefit Plan”, and the current design for medically needy or catastrophic care. Under the current recommendation some citizens in Colorado will still risk facing bankruptcy.)

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- The Commission recommendations support the adoption of a Health Information Technology network in Colorado (which is a good recommendation). However, the Commission does not recommend a viable method of funding and incentivizing this effort. No method of funding is defined in the final recommendations and the fifth proposal only advocates an effort to “support and incentivize (the) use of health information technology through tax credits, uniform standards, and data sharing”. Funding HIT through tax credits alone will be a fundamentally insufficient incentive for this type of extensive program development.

Negative Aspects of The Commission’s Recommendations or Processes

Insurance Reform

- The Recommendations have no mandates for any of the other players in the health care system EXCEPT CONSUMERS AND TAXPAYERS who must also finance the new system
- The mandate to purchase insurance has severe penalties but no “carrot” to provide incentives for people to go ahead and do the right thing. It will cost you a years worth of premium for those who file without proof of coverage and will be contacted for assistance in enrolling in coverage. Those who are eligible for fully-subsidized public coverage programs will be automatically enrolled. So if you are poor you have NO choice about which plan you will be enrolled in, but if wealthy we are going to give you “assistance to pick a plan. (I would comment I do not object to mandates, but only if they apply to all stakeholders and are applied in a fair manner)
- The Recommendations contain NO true insurance reform. While it proposes requiring all insurers to offer a Minimum Benefit Plan, guaranteed issue, community rated with adjusters for geography and age, it only requires insurers to be “actuarially sound” in the individual market.
- In practical terms, this means that the industry can make or waste just as much as they currently do.
 - The insurers underwriting costs will drop significantly as a result of no longer having to do health status rating.
 - They will be able to charge elderly significantly increased premiums.
 - And while using standard claims attachment requirements, eligibility and coverage verification systems, standard electronic ID cards, etc. will save providers they will still have to invest much time and staff resources to deal with multiple insurers, all with different (negotiated) rates, treatment protocols (which also impacts continuity of care for patients), billing and prior authorization procedures, etc. all of which drive provider costs.

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- o This will result in an diminishment of the Small Group market (which has a number of mandated benefits, e.g. mammograms, prostate exams, etc.) as individuals are shifted to the individual market (almost no mandated benefits).
- Negative aspects of a governmental entity to act as an “Connector” to facilitate connecting consumers and insurers and to administer an insurance subsidy program (Also see Positive Aspects of the Commission’s Recommendations)
 - o There will be no subsidy for any insured employee’s share of employer sponsored insurance (only uninsured employees to 300% of FPL). It will be mandatory for an insured employee to continue to purchase coverage, without a subsidy, regardless of potential financial hardship
 - o If you are in the subsidy program and under 300% of FPL you cannot have a Health Savings Account, even if you come in with one, and even though it may reduce the premium (and therefore the subsidy).
- For childless adults, parents and children, below 205% of FPL, they would get a benefit package through Medicaid (with the recommended merger of CHP+ and Medicaid) that was a CHP+ “look alike” benefit plan, with a Medicaid “wrap around” if their needs increased. There is no mechanism in the Recommendations to access the “wrap around” benefits.
- The subsidy for those 205% - 300%, we would provide a subsidy (more money to insurers) of 80% - 100% of the cost of the premium, for a CHP+ “look alike” benefit plan (205-300 Subsidy Plan)
- The subsidy structure for those 300% - 400% FPL would be a premium subsidy (more money to insurers) for any portion of the premium over 9% of income (the 9% Income Subsidy Program) for the Minimum Benefit Plan only. While you can “buy-up” to a more comprehensive plan, the subsidy would still only be for the Minimum Benefit Plan. The Recommendations are silent on whether the premiums for the “buy-up” would be limited or not.
- Those over 400% of FPL for whom the premium and whose premium is more than 9% of income (most likely elderly who do not receive Medicare, since they can be charged more for premiums) are exempt from the mandate. This provision perpetuates the uninsured status of this group, and may add to it, at a point in time where they are likely to need it most.
- Also see the section on Cover Colorado below.
- In terms of private market insurance reform, the Commission did not substantively address the issue of insurance rate review. In practice, with one recent exception, institutionalized rate review has not been effective. That exception occurred in late October 2007 when the current Insurance Commissioner ordered rating modification that created a \$72.5 million consumer savings in workmen’s compensation. All of this in spite of industry objections. Excluding this exception, rates have continued to rise even in the face of past legislation designed to limit those increases. It is not clear from the Commission’s recommendations that the “Connector” concept or the “Improving Value in Health Care Authority” does anything substantive with respect to insurance rate review.

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Several suggestions that could significantly reform the current insurance market were either ignored or insufficiently explored. Some of these suggestions are included below:

- **Medical loss ratios**, where insurers are required to spend a minimum amount of premiums collected on medical care.
- **Excess profit taxes**, with potential incentives for insurers to reduce administrative costs. In Medicaid/Medicare, administrative costs are 3%-3.5% of each dollar, in the commercial market administrative costs represent 25% of each dollar, cite source, be clear not from the modeler, yet their overall performance is comparable.
- There was only brief discussion of **merging the individual market and the small group market**. There was no discussion concerning merging the large group market into either of the others. With the implementation of the Recommendations, one must also ask what happens to the current mandates in the small group market? Are they carried over to individual market or with a migration to individual coverage are they going to be lost? With a recommended premium of \$199...
- There was little discussion regarding any **workers compensation reform**, other than the 24 hour coverage concept, which did encounter significant resistance. They would not even consider recommending going after employers who do not buy workers comp and shift the costs of their work related injuries and illnesses.
- The proposal could result in a reduction of the minimum benefits insurers are required to offer under the small group plans.
- An idea was proposed to **sell Pinnacle Assurance**, a state owned workers compensation provider. The sale of Pinnacle could potentially result in hundreds of millions of dollars in revenue for the state of Colorado was given little attention.
- **Does not require the Insurance Commissioner to collect their own "unbiased data"** for use in the rate-making process.

Employer Considerations

- There is a 6 month waiting period to change from employer sponsored coverage to individual coverage in order to receive a subsidy. This is a draconian and unfair provision which will drive up the number of uninsured, underinsured, and at risk of financial hardship as a result of medical costs. It was intended to keep insured employees from dropping coverage and going to publicly subsidized programs, has no penalty to discourage employers from dropping coverage. If there really would be a large migration, I also think that we will see a large number of people dropping coverage just prior to this taking effect. And what do we do about new hires? That is not addressed.
- If a resident's employer unilaterally drops coverage, depending on the criteria "for involuntary loss of coverage", that individual may have no recourse. In the Commission's effort to avoid any employer mandates, it refused to even consider a financial penalty for employers who drop coverage. Such penalty was an option which the modelers recommended as an effective strategy to get employers to keep coverage (but that was an employer mandate). Unless an individual drops coverage for at least 6 months, they receive no assistance, even though it may create significant financial distress. Deleted: Lewin
- The ONLY mandate we require of employers in the entire proposal/recommendations is that they establish Section 125 plans (which is a very nominal cost to employers) so their employees can pay premiums with pre-tax dollars. The Commission was so opposed to ANY employer mandate that they even refused to propose a nickel per hour assessment for employers who do not offer employee coverage. It was suggested that for small employers a mandate to provide coverage would harm them, and the solution offered was to provide small employers, based on the company's earnings would have subsidies available. This would have a greater benefit than giving the individual employees a subsidy and increased income (maybe, if the employer actually passes their health care savings to the employees instead of adding it to the bottom line) as for the employer the premiums are tax deductible, for individuals they are not.

- The recommendations will encourage employers to stop offering coverage because everyone is mandated to have it (there are claims that this mandate will result in employers increasing wages). Premiums are tax deductible for employers but not employees, creating a double whammy for workers. The tax benefits of a Section 125 plan, that withholds and pays premiums for employees with pre-tax income are simply not comparable or commensurate with the tax benefit employers accrue in paying health insurance premiums. As a result, if the employer does not buy their employees health insurance and decide to pay out the savings in increased wages, the after tax-effects will result in a decrease net to the employee. Deleted:
- There is also a 6 month waiting period before the employee can buy individual coverage with a subsidy. This is intended to act as a disincentive to employees from migrating away from employer coverage to less costly publicly subsidized programs and employers from dropping coverage, who may not experience any hardship, but has a great potential to harm employees, who's only recourse may be to quit. If such an employee either has a pre-existing condition or becomes ill during that six month period, they contribute to the current problem of more uninsured people forced to use emergency rooms. Deleted: to

Medical and Provider Considerations

- The recommendations do not even mention prescription drug reforms, and any attempt at raising the issue was promptly dismissed. This includes pricing, availability, preferred drug lists, polypharmacopia (multiple medications) reviews, etc.. There recently has been a preferred drug list implemented in Medicaid, and there is evidence that preferred drug lists can harm higher needs vulnerable populations, but do fine for those with low needs, yet the Commission declined to discuss a preferred drug list for those not in Medicaid.
- The recommendations do not require any real reform or contribution from providers. In addition an excess profit tax was also suggested, but discussion of this provision was not entertained. Deleted: no quality measures, or dealing with issues such as medical mistakes and the cost of those, as well as
- Reimbursement for physicians up to 75% of Medicare rates (also see positive aspects of the Commission's recommendations), when existing reimbursement is lower, with eventual goal of 100% of Medicare; possibly vary rates by specialty. We need to know the appropriate percentage of Medicare we need to pay in order to attract an adequate number of providers to serve all the new Medicaid/CHP+ clients, rather than simply pick a number from the air. There does not seem to be any data or studies on that point. We do not have a sufficient number of providers to serve the current client base. It does no good to expand Medicaid/CHP+ if there are no providers, it would be a meaningless benefit. Deleted: es
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- They assure that providers will be paid for nearly everyone who comes through the door, significantly reducing uncompensated/undercompensated (e.g. Colorado Indigent Care Program) care, but the recommendations do nothing to improve patient safety, service delivery, etc. It also potentially increases rates in Medicaid (which I agree we need to do to get adequate provider participation, but it still increases provider revenues even more at taxpayer's expense). It will reduce cost shifting by \$92 million and the modeler assumes that 40% of reduced cost-shifting is passed back to health plans and consumers. We are also reducing administrative costs to providers estimated to be \$166 million per year, but there is no provision made to ensure that any of it goes to patient care and not the bottom line. Deleted: reduce rates, cost-shift is reduced by
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- Moves hundreds of millions of dollars from the safety net providers to other providers, including for-profit entities.
- The recommendations create no requirements for provider education (doctors are one only a few licensed professionals that do not have a continuing education requirement)
- There is no requirement to try to better coordinate and share use of high cost medical technology. \$1 million dollar machines should be used 24/7, not 8 to 5 at every hospital.
- There was no discussion about any form of medical malpractice reform.
- All discussion about non-traditional western medicine care, including chiropractic, acupuncture, holistic healing, etc. was promptly cut off.

Long Term Care Considerations

- The recommendations do not include any long term care for many people with disabilities and elderly (other than a single reference to looking at previous work on the subject), Nursing Facility Transitions, etc. LTC accounts for 70% of Medicaid's budget and its omission hides significant costs in the modeling results. This represents a critical omission in terms of care quality and reducing state and consumer costs. LTC is the major emerging health care issue in this country and in Colorado with the impending aging of the baby boomers, nor the need to grow a stable workforce to meet that demand. It is unfortunate that the commission did not go further than recommending a comprehensive study of long term care. Colorado is facing a population demographic shift that is far more significant than most states. The impact that the baby boom generation will have on the long term care infrastructure in Colorado demands immediate consideration and planning, if we are to avoid or ameliorate the fiscal consequences.

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Consumer Considerations

- A general observation is that there appears to be a number of areas where the transition of care is not likely to be seamless. There are a number of hand-over points where that transition could become more difficult from the point of view of the user. Specifically, transitions to and from Medicaid, employer based coverage, CoverColorado, and basic plan coverage to Medically Needy/Catastrophic care. These transitions may require a more complex application process and will require some education in the use of the "Connector".
- The Commission refused to even entertain making a strong recommendation that no resources currently serving vulnerable populations be shifted to expanding eligibility for less needy/vulnerable populations, and that any future cuts in funding affect vulnerable populations last. The only recommendation made on this matter is "...do not fund expansion through reduction of services to current Medicaid and CHP+ eligibles ". The lack of such recommendation sends a message to the disabled and low income elderly that there is indeed an intention to cut their life sustaining services in order to serve others who are healthier and wealthier.
- One primary focus of the Commission in the development of the 5th Proposal was to keep the premium below \$199/mo for the premium for the Minimum Benefit Plan for healthy and primarily low needs individuals. The recommended "Minimum Benefit Plan" benefit package will result in a large number of underinsured, and will not ensure that

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people actually have access to necessary medical care. Making an inadequate product affordable is not helping the problem!

- The Commission does not cap “out of pocket” costs, only out of pocket costs for premiums. This does not include co-pays, deductibles, non-covered benefits. The standard used for premium out of pocket costs is at the high end that a number of studies recommend for total out of pocket costs. The Minimum Benefit Plan recommended will mean significant out of pocket costs for anyone with any sort of health problem. Deleted: basic
- The Commission elected to use Federal Poverty Level as it's standard for affordability even though there was evidence provided to the Commission that FPL is not an adequate affordability standard, particularly for health care.
- While the recommendation is to provide a taxpayer subsidy for those between 300% and 400% of FPL, the subsidy is only for the Minimum Benefit Plan. The amount of the subsidy is based ONLY on the Minimum Benefit Package, but the individual can buy something else, at their own expense. Any additional coverage is wholly at the expense of the consumer and insurers may charge whatever they want for it. This will likely perpetuate to our multi-tier health care system of the have's and have-not's. And at 400% of FPL there is a “cliff effect”, where the subsidy goes from 80% of premium to a maximum income expenditure for premiums of 9% of income to those with income to 400% of FPL to NO SUBSIDY. This could be addressed by using a sliding scale to determine subsidy level. Deleted: under
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- If employer coverage is available that is equivalent to the minimum package for the subsidy program, and 205% - 300% of FPL, the individual must buy employer coverage. The employee would get a subsidy for their share of premium, based on income.
- If under 200% do you go to Medicaid or the employer's plan (assuming it meets or exceeds the minimum plan requirement for those in the subsidy program [or do we use the Medicaid benefit package as the minimum] with a 100% subsidy for the employees share (see above paragraph)?
- There are other features that will contribute to or leave existing populations uninsured or at risk of financial hardship as a result of medical care costs, e.g. proposed Minimum Benefit Plan, in the Fifth proposal. As the impacts could not be modeled, it skews the results. Deleted: benefits package
- The Commission does not adequately and fairly address the “asset test” that currently applies only to PWD's. Such a recommendation opens up the state to a lawsuit under the americans with disabilities act. It is proposed to be set at \$100,000 for Medicaid, CHIP+ kids, parents and for childless adults, but is kept at \$2,000 for people with disabilities and elderly. This is FORCED POVERTY. As an example:
 - A primary wage earner for a family, sustains a catastrophic injury, obtains a settlement for \$300k (the cap in CO under tort reform), invested in Government bonds would result in a rate of return of about \$15k/yr, or 75% of FPL for a family of 4. But if the individual needs medical or attendant care wjich is only provided to disabled Medicaid recipients, they will have to spend the \$300,000 in order to get “coverage” from Medicaid program for people with disabilities (and is the benefits needed are likely not provided through the 200-300 Subsidy Plan, Minimum Benefit Plan package or the reformed Medicaid/CHP+ program for childless adults, parents, children). This forces them into government subsidy programs for housing subsidies, food stamps, utility assistance, cash assistance, etc., likely for life, significantly increasing the costs to the taxpayer. Deleted: k
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- The modeler appears to be unable to model much of the issues affecting PWDs (among others), ranging from Long Term Care to the impact of having Consumer Directed Attendant Services as a statewide program (the pilot program, with 150 clients saved the state \$600,000 in direct costs and \$6 MILLION in indirect costs last year alone). As a result, since this population includes the 2 groups (disabled and elderly) that consume the VAST MAJORITY of medical care (70% of Medicaid, who is the single largest purchaser of health care, is spent on Long Term Care), it brings their entire evaluation into question. The modeler was also unable to model the cost savings in the criminal justice system (likely in the hundreds of millions of dollars) if adequate community based mental health services were provided. **They indicate their inability to model this is due to lack of data and time.** Deleted: Lewin

- A critical omission in data modeling the fifth proposal and the final commission recommendations concerns start up and implementation costs. For example, there is no discussion about the design, development, and implementation costs associated with the creation of the "Connector". In addition, initial costs associated with any of the five proposals essentially remains unknown. It will be critical for the Legislature to understand what these start up and implementation costs might be, as well as, an estimate for the ramp-up time involved. This would be a critical consideration for a state that is statutorily and constitutionally limited in the amount of revenue it can receive

- Additionally in the modeling process, the Commission pursued recommendations that would reduce costs in the modeling process. In part by shifting individuals to underinsured and "those at risk of financial hardship as a result of medical care costs" (from Senate Bill 06-208) which cannot be modeled e.g. the basic plan modeled in the 5th proposal and the inadequate benefits/caps, individual suffering due to lack of appropriate and adequate necessary care, etc. **The cost is the cost, is the cost. You can hide it anyway you want, but it is still a cost, hidden or not!**

- The only efforts to address the issue of "portability" is that since people own their policy it is completely portable. The optional continuous coverage plan may address some portability issues but it is only being considered for further study as opposed to an approved recommendation. In addition, any individual that buys into the continous portable coverage plan must remain in that program for many years. Other than this option, portability is relatively unaddressed. In addition, the proposal does not address how a portable plan is paid for during periods of unemployment, particularly if it is not a subsidy eligible plan, etc. What does an individual do if they are on employer sponsored coverage and need continuity of care, etc.? Deleted: It
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- The Commission does not address the issue of undocumented persons (about 95,000 people), most of which are illegal immigrants. This population also includes homeless persons and people living off the "grid", etc. This was done to address a perceived concern that if this provision was included, a small but vocal group might distract attention from the rest of the proposal. We need to keep this population from becoming a public health risk, ending up in the ER (which is where they go now, at the highest cost delivery method), and giving birth to \$4 million premature babies. The Commission decided to leave it as is, they get ER, delivery and 2 months of post partum care, and anything the health clinics can afford to provide. In addition, a further barrier is created regarding required documentation. This may deny health care access to individuals who would otherwise be eligible, but cannot access it due to documentation restrictions. Deleted: The

- The recommendations contain no exceptions for religious exemptions, in spite of that issue being raised by the public.

- The insurance Minimum Benefit Plan package, modeled in the Fifth proposal has a \$50,000 annual limit, with interim caps of \$25,000 inpatient, \$1000 Emergency Room. This means if an individual ends up in the ER, and runs up a bill of \$48,000 without being admitted as an inpatient, they would be liable for \$47,000. Worse yet, in the case of a catastrophic injury or illness they will likely be forced into bankruptcy. The Commission's position was that they should have bought a better policy.

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- The recommendations eliminate patient co-payments for preventive care and reduce patient co-payments for chronic care management services. If an individual continues to have low needs they have no co-pays, but if their level of need increases their co-pays go up.

- In it's final recommendations the Commission recommended that the standard for minimum benefits for the "Minimum Benefit Plan", be passed to some future group, the "Improving Value in Health Care Authority". That group could also potentially change the benefits standard for the "Minimum Benefit Plan" at any time during a "periodic review". Citizens need to know what their benefits will be in order to make informed decisions about whether or not they support this reform.

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- The revamped "Cover Colorado" risk pool where most high needs individuals over 300% of poverty and not eligible for at least an 80% subsidy will have to go. The determination will be based on a yet to be defined list of conditions, and if you have one you cannot buy coverage in the individual health insurance market. No choice, no option to buy in the individual market if one chooses to.
- If one is 205% - 300% of FPL, you would buy your coverage through the "205-300 Subsidy Program", but the 205-300 Subsidy Plan, based on CHP+ would be inadequate for many high needs individuals due to limits on mental health, durable medical equipment (wheelchairs, ventilators, feeding pumps, etc.) therapies, dental care, etc. You can "buy-up" to a more comprehensive plan, but the Recommendations are silent on whether the premiums for the "buy-up" would be limited or not.
- If you have a high cost rare or other condition that is not on the Cover Colorado list and you are above 300% FPL, you can buy coverage in the individual market, including a Minimum Benefit Plan that may not meet your needs, but the Recommendations are silent on whether the premiums for the "buy-up" would be limited or not. For those between 300% and 400% who receive a subsidy, there is no subsidy for the "buy-up" to a more comprehensive plan, again the Recommendations are silent on whether the premiums for the "buy-up" would be limited or not. This increases the likelihood that it will be unaffordable for those with high needs who end up in the individual market because they are not eligible for Cover Colorado. The amount of the subsidy is based upon the Minimum Benefit Plan, but the individual can "buy-up" to a more comprehensive plan, but the Recommendations are silent on whether the premiums for the "buy-up" would be limited or not.
- Cover Colorado will be available only to people in the individual insurance market and not in the Medicaid, CHP+ or 205-300 Subsidy Program. Rates for people purchasing through Cover Colorado will be the same as if they were not in Cover Colorado pool (i.e. no 50% rate up). People in Cover Colorado could buy a Minimum Benefit Plan. A more comprehensive benefits package through Cover Colorado, could cost far more or less than in the individual market, (which we must assume it may be given the population), and the state will subsidize the premium for the "buy-up" to bring it to 100% of the individual market (and the cost of that subsidy does not appear to have been included in the modeling numbers). If the person does not purchase comprehensive coverage as they currently do not need one but subsequently do, or cannot afford to buy

comprehensive coverage, too bad, even though this is where we will dump all the high needs individuals who do not qualify for Medicaid or the premium subsidy program as they are over 300% FPL, and even though they may have little spendable income after paying all disability related ancillary costs.

- In the 5th proposal as modeled, Cover Colorado would operate at a \$95 million deficit and could also be subject to cuts if the State falls on hard times making things worse for those who need it.
- There was only a very brief discussion as to whether the current mechanism to fund shortfalls in the Cover Colorado, an assessment on insurers, should be continued. As a result it was omitted from the Recommendations.
- There was a brief discussion regarding end of life care issue, it was decided it would be discussed in an ad-hoc committee that was never scheduled, and was just inserted at the end of the process.
- The Medicaid buy-in recommendation (also see positive aspects of the Commission's recommendations), while it will help people with disabilities to return to work and become contributory, once they exceed 450% of FPL (please remember that this population will likely have many ancillary disability related costs not covered/provided by another source) they will have to pay a premium approximately five times what a non-disabled individual would pay for insurance. This is especially true if they need attendant care.
- The Commission promotes enrollment in managed care systems for all kids, parents and childless adults in Medicaid. This recommendation is a matter of some concern since Colorado's experiment at Medicaid managed care has historically proved to be less than successful, and has been demonstrated to be more costly than traditional fee for service.
- The recommendations omit pursuing savings to Medicaid by requiring the insurer to pay first where the individual has commercial insurance in addition to Medicaid, and then appeal if they think Medicaid should pay ("pay and chase").
- Much of the proposed Medicaid expansions rely on additional federal funds, in spite of the fact that the current administration is reducing funds available to the states (\$28 Billion over the next 5 years)
- The Commission does not address non-discrimination in health care, accessibility to individually appropriate health care for people with disabilities.
- The Commission does not require the "Ombudsman/Advocacy" program (see positive aspects of the Commission's Recommendations) to be insulated from the vagaries of the political process. In specific, the political influence of the Executive branch, legislative leadership, etc. This provision would be most effective if it was a non-governmental consumer-controlled entity.
- Consumer education recommendations are inadequate. At minimum we should mandate consumer education classes as a condition of high school graduation. Changing attitudes about consumerism in health care will be intergenerational (one statistic we were provided was that 98% of Americans find shopping for health care "crass").
- The Commission does not address the needs of any Coloradoan who may get health benefits through any ERISA or another federal program. While it is true we have little to

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no control over programs preempted by federal law, it does not address that group, Deleted: those people even in terms of their utilization of health care systems in Colorado.

- Prevention and wellness measures will be critical to reducing health care costs by reducing demand. The ultimate success of this program will only be as good as the availability of access. In the fifth proposal, almost 97,500 undocumented residents, legal non-citizens, and opt-out populations will be unable to take advantage these types of programs and will continue to cost the state because of preventable health problems. It is important to remember in this provision that individuals with disabilities or chronic conditions must be accommodated for. My concern is that without specific consideration these populations that cannot achieve the prevention and wellness results available to the general population may be unintentionally discriminated against.

Positive Aspects of The Commission's Recommendations or Processes

The following is a list of Commission recommendations that represent positive steps forward in addressing State-wide health care concern, coverage, or access. *My comments are in italics.*

The addition of Buy-in, Medically-Needy, and Medically Correctable programs in Medicaid will allow us to assist some of the most vulnerable people in our state, and assure access to medical care for those who genuine are in need or those who lose everything as a result of medical care needs. Deleted: Spend Down

- The increase to 205% of FPL for adults and 250% for children with respect to Medicaid eligibility will allow some PWD's (Persons With Disability) who have been above the current (approx) 74% of FPL standard used now, to have access to necessary medical care. In the long term this will reduce costs by reducing reliance on acute care utilization, e.g. emergency room care. Deleted: 0 Deleted: for

- The increase in funding to eliminate waiting lists for children with various disabilities, *(but does not address future growth, nor is there a buy in using the new deficit reduction act option to have families with money pay into the system).*

- Reimbursement for physicians to 75% of Medicare rates (also see negative aspects), Deleted: (80?) when existing reimbursement is lower, with eventual goal of 100% of Medicare; possibly vary rates by specialty. We need to know at what percentage of Medicare rates we need to pay in order to attract an adequate number of providers (of all types) to actually serve all the new Medicaid/CHP+ clients, not to mention we don't have enough to serve the current ones. The problem here is that there is little benefit in expanding Medicaid/CHP+ if there are no providers. It would provide no discernable benefit.

- Reducing the administrative burden on providers. However, the recommendations are inadequate and were developed by an outside insurance/provider group, absent consumer input. (also see negative aspects)
- Promote consumer choice and direction in the health care system.
- Increase price and quality transparency, including making the various provider licensing authority records open to the public and included in quality comparator information provided to consumers .

- Provide consumers with evidence-based medical information at the point of service to aid in decision-making through patient-centered care. Adopt population-specific care guidelines and performance measures, where they exist, based on existing national and evidence-based guidelines and measures. It is critical to recognize the importance of patient safety and best care for each patient. It is important to remember that evidence based medicine cannot be applied to distinct populations or those with complex needs, as there is little or no information on those populations.
- Increase use of prevention and chronic care management
- Eliminate patient co-payments for preventive care
- Encourage individual responsibility for health, wellness and preventive behavior.
- Increase funding for local public health agencies in Colorado to perform functions such as preventing disease and injury, assessing community health, and promoting healthy behavior.
- Provide a medical home for all Coloradans (*but we do need adequate providers*).
- Enhance the provision, coordination and integration of patient-centered care, including “healthy handoffs.”
- Reimburse providers for care coordination and case management, particularly in the Medicaid/CHP+ and CoverColorado programs.
- Pay providers based on quality. (*Quality measures must be designed so as not to provide discouragement for providers to take patients that may have negative impact on providers “quality incentives”, such as frail elderly, disabled*)
- Support the adoption of health information technology, including the creation of a statewide health information network, focusing on interoperability and the creation of an electronic health record for every Coloradoan, with protections for patient privacy.
- Ensure that information on insurer and provider price and quality is available to all Coloradans and that it is easily accessible through a single entry point (e.g. Web site).
- Create a multi-stakeholder “Improving Value in Health Care Authority” in order to fundamentally realign incentives to in the Colorado health care system: The purpose of this Authority is to reduce costs and improve outcomes. To do so, this provision must have
 - Rule-making authority to implement recommendations regarding administrative simplification and health care transparency
 - An Ombudsman and Advocacy Program
 - Authority to study and make recommendations to the Governor, state legislature, and rule-making agencies,
 - Authority to assess and report on the effectiveness of reforms, including their impact on vulnerable populations and safety net health care providers.
- Conduct a comprehensive review of current Colorado long-term care information as a supplement to any review of the Commission reports, such as the SB 173 report , the report of the Developmental Disability Interim Committee, the Medicaid Redesign Project (SB 06-128), and the National Clearinghouse for Long-

Term Care Information. *(This is woefully inadequate though, for a program that consumes 70% of the Medicaid budget.)*

- Restructure and combine public programs (Medicaid and the Child Health Plan Plus) for parents, childless adults and children (excluding the aged, disabled and foster care eligibles). *(If adequately funded)*.
 - For all non-CHP+ Medicaid enrollees, ensure that physicians are reimbursed at least 75% of Medicare.
- Improve benefits and case management for the disabled and elderly in Medicaid by encouraging enrollment of the aged and disabled into integrated delivery systems that have incentives to manage and coordinate care. Promote care delivery in a consumer-directed, culturally competent manner to promoting cost-efficiency and consumer satisfaction. Providing care coordination and targeted case management services. Providing dental coverage up to \$1,000 per year. Exploring potential for further reforms to Medicaid, particularly for those who are disabled (see the Appendix section of the 208 *Commission Recommendations*).
- Improve delivery of services to vulnerable populations.
 - Create a Medicaid buy-in program for working disabled individuals.
 - Create a medically-correctable fund for those who can return to work or avoid institutionalization through a one-time expense.
 - Increase number of people served by the home- and community-based programs equal to the number of people on the current waiting list for these services.¹
 - Provide mental health parity in the Minimum Benefit Plan (Recommendation 21).
 - Establish a Medically-Needy or other catastrophic care program for those between 300% and 400% FPL to address the issue of people who have health insurance but do not have coverage for catastrophic events (fund at \$18 million in state funds). *(The eligibility thresholds and criteria are not delineated. In the second iteration of the fifth proposal a [more comprehensive] catastrophic fund was modeled at an estimated \$325.6 million. This estimate may be insufficient when compared to costs for far less vulnerable populations. During public comment, the commission heard testimony from several individuals with high incomes and "gold plated" health insurance coverage that still became bankrupt as the result of a catastrophic event).*
- Expand eligibility in the combined Medicaid/CHP+ program to cover more uninsured low-income Coloradans. *(But only if adequately funded and not at the expense of more vulnerable populations)*
- Ease barriers to enrollment in public programs
- Enhance access to needed medical care, especially in rural Colorado where provider shortages are common
 - Continue to pay all qualified safety net providers enhanced reimbursement for serving Medicaid patients

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¹ Including the Children's HCBS waiver program, the Child Autism waiver program, the Adult Comprehensive waiver program, the Adult SLS waiver program, the Early Intervention waiver program, the CES waiver program and the Family support waiver program.

- Expand telemedicine benefits for Medicaid and CHP+ enrollees, especially in rural areas. *(This recommendation should also include anyone who has difficulty in accessing the doctor's office or that has a condition that does not require a face to face visit with the doctor. This also omits the concepts of using automated telephone based patient status monitoring systems)*
- Develop and expand mechanisms to recruit and retain health care workers who will provide services in underserved areas of Colorado, such as state-based loan repayment, loan forgiveness programs, tax credits, and other approaches.
- Create a Consumer Advocacy Program
 - Create a program that is independent and consumer-directed
 - Provide system navigators to guide people through the system
 - Resolve problems
 - Provide assistance with eligibility and benefit denials *(and they should also provide representation in appeals)*
 - Help qualify people on Medicaid for Medicare
 - Help people qualify for SSI
- Continue to explore the feasibility of allowing employers to offer 24-hour Coverage

General Comments on Criticisms and Process

I want to be clear that my criticisms below are not intended in anyway to reflect on the Commission staff. I believe they did their best efforts to accomplish a huge task and are to be commended, but they were impaired by others. E.g. inspection of the time stamps imbedded in electronic documents show the vast majority were send out shortly after being received by staff, but may were provided hours before meetings.

I came into this process believing there was something between total free market system and single payer. Having been in Medicaid for a number of years, I have strong objections to government running health care. I have come to the conclusion that if there is the desire to truly and significantly change the current health care system (as opposed to a band-aid approach), Single-payer is the only option that may politically feasible, if there is enough ground swell of public support and strong advocates for it in public policy makers. I am concerned that special interests who currently profit from the current system will do everything they can to obstruct real reform. If we are gong to add approximately 500,000 people to Medicaid, Colorado may as well move to single payer plan, as we will be well on the way.

Unfortunately, I feel that we have missed a unique opportunity to do something that will truly benefit the people of Colorado. This could have been alleviated to some degree had the commission been more representative of Colorado's actual population. Only three commissioners were consumer representatives or advocates. None of the commissioners were uninsured or underinsured and only one a Medicare or Medicaid recipient. This composition may have skewed the final result.

There were also procedural difficulties. The process the commission followed changed relatively frequently with respect to materials, meeting format, and presentational order, etc. This made it very difficult to adequately prepare and

follow the process. On several occasions we were asked to participate in a "straw poll" to get a sense of where we were on an issue or series of issues. In some instances that "straw poll" became a binding vote. This occurred in the final selection of the 4 proposals selected for modeling, the selection of "key questions" that guided the development of the 5th proposal, as well as, at other key points in the process. It is worth noting, that of the 4 proposals submitted to the Commission selected for modeling, 3 were developed by organizations with representatives on the Commission, and as has been stated in public forums, lending the appearance of favoritism.

Simply because I participated in the process, and tried to make the best of it, I have been told that it was presumed that I was in consensus with the Commission; that I agreed with much of the recommendations. That is not the case. I made a commitment to my appointing authority to follow through in the process and seek the best result possible, which I did. That does not mean I agree with the final recommendations.

Many issues that deserved more exploration and many ideas that had real merit were consigned to a repository that the Commission identified as "the parking lot". The implication was that these issues would be reviewed at a later point in the proceedings. In a great many cases that re-review did not occur. Unfortunately, many of these parking lot ideas and issues deserved far greater examination than they received. I am of the opinion that part of the Commission's charge was to gather data on various ideas regarding health care reform. As a result, I believe the 5th proposal should have been as encompassing of all ideas not addressed in the other 4 proposals modeled, as possible

In spite of the Commission's decision to wholly comply with the spirit and intent, the violations of the Sunshine Act became too numerous to keep track of and there were numerous public complaints about it as well. Meeting announcements were not timely posted, there was no list of interested persons kept and notice provided, etc. While it did improve slightly near the end of the process, we were frequently provided with materials (frequently voluminous) just prior to, or at meetings, which we were then expected to make decisions based upon.

I made numerous requests for accommodations as a result of my disability and other persons with disabilities from the public, in order to maximize public participation, which were largely not provided.

Public input, while solicited, could have received greater attention and inclusion. There has never been any consolidation or summary of public comments and testimony. Some public testimony was discounted or labeled as "not indicative of the general population of Colorado, that most of the people who attended have an agenda". The most egregious example is when the Commission held "listening sessions" regarding the proposal solicitation criteria it had developed, the issue that "transparency and accountability" had been omitted from the criteria was noted by several people. Those suggestions were not added. It is my estimate, having attended numerous hearings across the state, is that on average, about 30% of those who testified were part of an organized effort, the rest were spontaneous.

On several occasions the Commission received presentations that seemed to have a bias to special interests, on a few occasions the Commission heard from a representative from the insurance industry for technical advice, but such opportunity was never provided for any other interest groups. On several occasions over a period of several months I requested a presentation on the issues of long term care,

as it is 70% of the Medicaid budget which never occurred. The result, the only recommendations at all on long term care is one short paragraph suggesting a review of the past work on the issue. Other Commissioners made requests for presentations also, on issues they felt they or other Commissioners needed more education on. E.g. one of the primary reasons for the lack of recommendations for substantial worker's compensation reform was due to the lack of knowledge about the workers compensation system by every single Commissioner, but one, myself.

Many issues were put off for "later", with representations it was due to the short time frame given by the legislature. This became an almost blanket reason for everything not discussed.

While some of the Task Force reports/recommendations were included in the recommendations, the Vulnerable Populations Task Force report, in specific, received insufficient attention and review, and neither of the Task Force chairs were even in the room at the time. Consumers were woefully under represented on the other Advisory Task Forces.

The Final Recommendations state "We will elaborate upon the rationale behind of specifics of these recommendations for the Commission's final report to the Colorado General Assembly, due Jan. 31, 2008.", so the details are not available for those writing a dissenting opinion, which is due 1 day after the first draft of the final report will be distributed. There have been repeated attempts to limit the content of the dissenting opinion(s), and it was decided that the drafts of dissenting opinions would have to be based on the Commission's recommendations (without the benefit of the details yet to be provided), not the final report, "due to time constraints". As a result, there may be issues that I have misunderstood as a result of the lack of details.

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