

(a) COMPREHENSIVENESS

(1) What problem does this proposal address?

In many ways, America has an exceptional health care system, with caring providers, modern facilities, advanced technology, and dynamic research projects that are discovering so many new interventions that it's hard to keep track of them all.

Yet at the same time, Coloradans express great concern over the parts of our health care system that are not working. Historically, efforts have been made to “tweak” the system, but the health care system is tremendously complex, and small changes are not creating the changes that people realize need to be made.

For that reason, we have reached the point in our state where it is critical to tackle comprehensive health care reform – reform that will change not just one or two parts of the system, but because those parts are inextricably linked to one other, reform that makes multiple, linked changes intended to address the following problems:

- A. Spiraling health care costs, resulting in the inability to afford health care, which affects the middle class as well as those with low incomes
- B. Over 768,000 people living in Colorado without health insurance, most of whom do not have the financial reserves to protect them in case of moderate to major health expenses
- C. Unnecessary administrative costs which divert dollars from care
- D. An insurance system which has drifted away from its original goal of assuring that we are protected when we get sick
- E. A health care delivery and payment system that is not always aligned towards the most appropriate interventions nor the most coordinated care, causing fragmentation and restricting the actions most likely to lead to the highest efficiencies and the best health outcomes
- F. Barriers to achieving health information technologies and other measures that could be increasing the quality and safety of care

(2) What are the objectives of your proposal?

- A. Create a fair system in which everyone is covered by affordable health insurance
- B. Retain what works best in the current system but change what does not work well
- C. Contain the growth of health care costs

(b) GENERAL

(1) Please describe your proposal in detail.

Introduction

It is our belief that transformation at a national level is required in order to create the highest performance American health care system, one that is affordable and accessible to all. However, there is much that can be accomplished at a state level, and progress at the state level can inform national efforts. It is in this spirit that this proposal is submitted. It aims to address the core issues detailed above by introducing significant changes in many aspects of our current approach to health care in Colorado. The proposed changes emanate from both the Guiding Principles of the Blue Ribbon Commission for Health Care Reform and an additional set of principles developed by our committee in the course of its work:

Our Guiding Principles

- 1) Health care is a right, not a privilege, and all essential health care services should be affordable for all Coloradoans.
- 2) Although a single payer system may be the solution that would contain costs most effectively, there are tradeoffs in moving from the current U.S. system to a single-payer system, which could cause significant disruption and employment shifts. At the current time, it may be unrealistic to think that we can eliminate the current separation between the public and private systems, particularly at the state level, but it is critical that we improve and administratively simplify each system.
- 3) Because the current upward spiral in health care costs is unsustainable, compromises will be required on everyone's part to bring costs under control.
- 4) Though the problem is complex, our goal is to design a system that is easy to understand, administer, and implement.
- 5) Significant change is required and a comprehensive vision and long-term commitment is vital. Change efforts must consider impacts across other systems as well as in health care.
- 6) The most promising way to address both coverage for all and reduced cost is likely in the restructuring of the system at the national level. Our state should bring strong pressure at the federal level to push for a national system that would assure coverage for all and address access, cost and quality.

Although our group developed guidelines as we deliberated, we would recommend that a more formal process be used when a final health care plan is being chosen for Colorado, one which carefully develops an approved ethical framework for future decision. The justification

for such a foundation has been developed by the Center for Bioethics and Humanities at the CU Health Sciences Center, and is included as Appendix A.

Goals of our Plan

- 1) Provide access to health insurance for all Colorado residents
- 2) Spread risk more evenly
- 3) Maximize federal matching funds
- 4) Reduce government, provider and issuer administrative costs
- 5) Target changes with the potential to improve health outcomes and contain costs

Key Elements of Our Proposal

Insurance Reform Measures

Designed to enhance fairness, reduce cost, and stabilize the private market (through risk pooling)

- 1) Retain the private insurance market, but change it through the creation of a pooling mechanism through which issuers offer coverage and purchasers buy coverage, to include all issuers, individuals, and employers (except those exempt from state regulation who choose to offer self-funded coverage)
- 2) Create an independent, quasi-governmental Authority with a governance board responsible for setting policy and standards, and an administrative structure to manage the pool.
- 3) Provide assistance in purchasing health insurance for those who cannot afford the full cost

Revenue Enhancing Mechanisms

Designed to assure shared responsibility and adequate funding

- 1) Expand eligibility for Medicaid and Child Health Plan Plus to take advantage of federal matching funds
- 2) Set a reasonable employer assessment with a waiver for employers who provide adequate insurance coverage to their workers
- 3) Set an expectation that everyone will purchase coverage, with assistance for those unable to afford the full cost
- 4) Capture funding made available by the changes
- 5) Create new assessments to make up the difference in required revenue levels

Quality and Cost Control Mechanisms

- 1) Create incentives to further integrate care
- 2) Promote rapid development of Health Information Technology
- 3) Align incentives for and reward quality
- 4) Standardize forms and billing and payment systems
- 5) Create a comprehensive benefit package as the minimum for coverage
- 6) Promote “medical homes” and patient-centered care
- 7) Improve management of high-cost conditions and chronic disease

Our reform proposal is based on the premise that, if the approach is to improve our current system, attaining health coverage for all is a shared responsibility of individuals, employers, providers, insurers and the state. The state’s responsibility is to assure that affordable health insurance is available to everyone by creating funding for those for whom financial contribution is not possible, to simplify administrative processes, and to assure survival of the safety net. The employer’s responsibility is to contribute to coverage for their workers and families. The provider’s responsibility is to design and deliver integrated systems of care, which are efficient and effective. The insurer’s responsibility is to reduce administrative cost by simplifying offerings. The insurers and providers also have responsibility to provide the transparency and the innovation that will foster competition based on quality, satisfaction and cost. The individual’s responsibility is to enroll in and pay a fair share of the premium of an affordable health plan for themselves and their family.

Insurance Reform Measures

Improving affordability is key to expanding health care coverage to all Coloradoans. The first component of our coverage strategy is to simplify the private insurance market, make it more competitive and create a means to make private insurance premiums affordable for individuals and families.

Creation of a Single Health Insurance Market

Currently, private health insurance is offered in several different “markets”, primarily the individual market, the small-group market and the large-group market (see Appendix D). Each of these groups has different characteristics that have resulted in insurers treating them differently in terms of marketing, pricing and underwriting. We propose to eliminate these differences by

combining all of these groups into one “market” in the form of a selling and purchasing pool. The following paragraphs describe this pooling concept.

Private insurers wishing to issue policies in the state of Colorado will have to provide them in the pool. Insurers will be required to guarantee issue and renewal of coverage and will be restricted from basing their premium rates on any attributes related to health status or risk (i.e., pure community rating would be required). Requiring insurers to issue coverage and set premiums without regard to health status assures that those who need coverage the most can get it, but without other protections, these rules can lead to healthy people leaving the market and higher quality plans attracting sicker enrollees (adverse selection). To protect the private market and individual health plans from adverse selection, all Coloradans will be expected to have insurance (see below) and the private insurance pool will administer a “risk equalization” mechanism for participating plans. An insurer must charge the same premium to all enrollees of a given health plan, whether or not they have preexisting conditions, but the insurance pool authority will use claims data to adjust payments to the plans to account for differences in the average risk of their enrollment pool. “Risk adjusted” payment is an incentive for health plans to compete solely on efficiency and quality and not on recruiting healthier enrollees.

Any individual or employer seeking health insurance through the private market will go to the pool to get it. Self-employed individuals and workers whose employers do not offer coverage may enroll themselves and their families in the pool. Employers will combine their contributions with that of their employees and pay that to the pool. The insurance pool will provide portability of coverage when people move between jobs and allow dependent young adults to be covered under their parent’s policies until they are 26 years old. In order to expand the size of the pool and realize some economies of scale, we are proposing that classified state employees be included in the pool.

To make the process of comparing and selecting plans simpler for consumers, there will be a limited set of standardized benefit packages, perhaps six to ten, from which to choose. All packages will have to cover a comprehensive list of essential services but may vary based on the characteristics of their provider networks (e.g., HMOs, PPOs) and the co-payments and deductibles allowed. Consumers will be able to compare products by price, the provider network and customer service ratings.

All employers will be required to allow workers to pay their share of premiums through a payroll deduction and establish Section 125 plans to allow employees to shelter their payments from taxation. The pool administrators will provide participating employers with information, a standard plan document, and enrollment forms to set up their own premium-only Section 125 plans for their employees.

With guaranteed issue/renewal, community rating, one large purchasing pool, standardized benefit designs, and a risk equalization mechanism for private health plans, there will no longer be a need for the state's high-risk plan, CoverColorado.

Creation of an Independent Public Authority with a Governing Board

The pool will be administered by a new public authority called the Colorado Health Insurance Purchasing Authority. We recommend that an independent board—the Authority Board—be created to govern the purchasing pool and the premium assistance program. The Authority Board will:

- define the minimum benefit package (see section (g))
- define and periodically update the set of standard benefit packages based on evidence of effectiveness and cost-effectiveness
- define and certify “high-value” providers
- define the requirements for participation of plans in a premium subsidy program
- define and periodically update an affordability standard below which individuals will be eligible for premium assistance described in the following section.

See section (b)(5) for complete description of the Authority Board and its responsibilities.

Provide Assistance in Purchasing Health Insurance for Those Unable to Afford It

Low to middle income individuals and families will be able to participate in a premium assistance program. The Board will define two benefit packages (similar to CHP Plus) that insurance carriers can offer those who elect and are eligible for premium assistance. Both will have low deductibles, first dollar coverage for preventive services, minimal or no co-payments for chronic disease medications, and lower cost-sharing for use of safety net providers and other “high-value” providers. At least one plan will be an HMO (subject to geographic availability). The Authority and insurers will negotiate a benchmark premium for the subsidized plans. These plans will also be available at full cost to those not eligible for subsidies.

Based on available data on affordability (Glazner, 2000) (Dubay, Holahan, & Cook, 2007), our recommendation would be to provide full premium subsidies at family incomes at or below 200% of the federal poverty level (FPL) and slide up to full cost above 400% FPL. The value of the premium subsidy would be a function of income and family size. The net cost of a premium for low to middle income individuals and families would be the difference between the premium subsidy (plus the employers contribution if offered) and the benchmark premium.

Pool administrators will enroll individuals in the plan they choose and determine their eligibility for premium assistance. The Authority will collect payments from individuals and employers, combine them with subsidies from a premium assistance fund if enrollees are deemed eligible, and pay the insurance plans their premium, adjusted up or down based on the plan's risk pool.

Insurance plans will have to meet standards established by the Authority to offer subsidized insurance to assure that public funds are directed to high value plans. We recommend inclusion of safety net providers, evidence of integration of provider networks (e.g., information sharing technologies, large multi-specialty groups, hospital-physician alliances) and of cost and quality management (e.g., use of formularies, disease-state management guidelines, performance measurement and feedback) be requirements for these plans. These standards would be gradually phased in to include all plans in the pool.

Employers offering health coverage that are self-insured will have the option of paying their contribution to the pool on behalf of their income eligible workers who choose to enroll in one of the pool's subsidized plans. Alternatively, if the health plan benefit package offered by the self-insured firm meets minimum criteria established by the board, employees may apply for a premium assistance through the purchasing pool. While provision of premium assistance for self-funded employer sponsored insurance will require considerable administrative support and subsidies, it will reduce crowd-out and therefore generate savings in the Medicaid programs and not providing it would be unfair and potentially self-defeating.

Revenue Enhancing Mechanisms

Expand Eligibility for Medicaid and Child Health Plan Plus

Our plan will expand and administratively simplify Colorado's Medicaid and State Children's Health Insurance programs (SCHIP; Colorado's program is titled CHP Plus). Such an

expansion would provide comprehensive health benefits to the lowest income and most vulnerable Coloradoans. A key reason for expanding coverage through these public programs is to take advantage of federal matching funds that will maximize the effectiveness of Colorado’s contribution to health care for these groups. (See Appendices B and C for background on public coverage).

Table 1: Proposed Expansion of Eligibility for Public Programs Based on Income (FPL)

#	Age or Population Group	Current Eligibility	Expansion Proposed (FPL)
1	Children ages 0-5 years	133% (Medicaid) 200% (CHP Plus)	300%
2	Children ages 6-19 years	100% (Medicaid) 200% (CHP Plus)	300%
3	Pregnant Women and New Mothers	133% (Medicaid) 200% (CHP Plus)	300%
4	Parents of eligible children	60%	300%
5	Non-disabled adults without children	--	100%
6	Disabled working adults	--	300% buy-in
7	65+	74%	100%
8	Medically needy	--	50%
9	COBRA Premium Assistance	--	100%
10	Severely disabled children	--	HCBS waiver eligibility

FPL: Federal Poverty Level

CHP Plus: Colorado’s Children’s Health Insurance Program, Child Health Plan Plus

HCBS: Colorado Medicaid Home and Community Based Services

We recommend combining Medicaid and SCHIP (CHP Plus) into one program and streamlining the application and renewal process for families. Combining SCHIP with Medicaid has been shown to dramatically increase the level of enrollment in SCHIP (RAND Corporation, 2005). Currently, Medicaid has different income eligibility rules for family members depending on age (see Table 1, groups 1-4). In a family of three, a 5-year old child might be eligible for Medicaid, the 7 year old for CHP Plus, but the mom can’t enroll in either program. Parents are more likely to enroll their children if they are able to enroll themselves (Schneider, Elias, & Garfield, 2002). Therefore our plan focuses on entire families rather than only children. Our proposal will:

- remove the income eligibility “steps” for families (groups 1-4) by increasing eligibility for kids and their parents to 300% of the federal poverty level (FPL), phased in over two years. Families below 200% FPL will be covered with the Medicaid benefit package. Those between 200% and 300% FPL will be given a CHP-like benefit package.

- offer Medicaid coverage to non-disabled adults without children (group 5) up to 100% FPL using state-only dollars unless a waiver is approved by the federal Center for Medicare and Medicaid Services to cover these individuals under the federal program. Because poverty is associated with a whole constellation of needs, we believe this group is best covered by the comprehensive wrap around services of Medicaid.
- expand eligibility to the elderly and disabled by:
 - Raising the eligibility limit for Coloradoans who receive Supplemental Security Income (group 6) to 100% FPL; and
 - Establishing a Medicaid sliding fee “buy-in” for working people with disabilities (group 7) up to 300% FPL through the federal Ticket to Work and Work Incentives Improvement Act of 1999. Ticket to Work will allow them to receive access to critical personal assistance and other health and employment services.
- add a medically needy program under Medicaid which will allow children up to age 21, parents, disabled and elderly persons whose incomes are above Medicaid eligibility standards to obtain Medicaid coverage if high medical expenses drop their income to less than 50% of the FPL.
- seek federal matching funds to pay COBRA premiums for people between jobs with minimal assets (group 9) whose income is below 100% of FPL. (Due to data limitations this provision was not modeled by The Lewin Group).
- Expand coverage to all severely disabled children who qualify under Colorado’s Children’s Home and Community Based Services and Children with Extensive Support waivers (group 10). (Due to data limitations this provision was not modeled).

To assure access to services under this expansion, health care provider participation in Medicaid will need to increase. Current low Medicaid reimbursement rates in Colorado are a major barrier to participation. For modeling purposes, we propose increasing payment rates to Medicare levels.

Set a Reasonable Employer Assessment

In order to “even the playing field” for employers who offer coverage, to provide an incentive to sponsor coverage for those who don’t, to reduce incentives for “crowd-out”, to fund the subsidized premiums to those in the pool who do not have access to employer based insurance and to reach near universal coverage, employers must either offer coverage or pay an assessment. Given current case law regarding the Employer Retirement Income Security Act (ERISA) and the complexity of ERISA itself, we believe that the fee should be low enough that it does not unduly burden employers who now offer benefits, but spend relatively little on them. This group is most likely to challenge fees that are too high. Setting an appropriate fee should depend on the characteristics of employers in Colorado, taking into account their unique

situation, particularly with respect to the amounts they spend on benefits and the characteristics of their workforce. Fee setting should therefore be assigned to the Authority Board. For the purposes of the analysis by The Lewin Group, we propose that the assessment be \$347 per year per full-time equivalent worker not offered coverage meeting or exceeding the minimum benefit standard (see Section (g)(1)). Employers must contribute at least 85% of the median premium cost of a standard individual plan to be eligible for a waiver. All employers would be required to set up “Section 125 plans” so that workers could purchase health insurance with pre-tax dollars. Business groups of one and the federal government will be exempted.

Set an Expectation that Everyone Will Purchase Coverage

The combination of expansion of Medicaid/CHP Plus, insurance reforms, the group purchasing pool, premium subsidies and an employer mandate will raise coverage rates considerably, but will not lead to coverage for all. The only way to do that will be to combine these strategies with a requirement for all individuals and families to have a defined level of coverage meeting or exceeding the minimum benefit standard, phased in over two years for all residents. We hesitated to recommend an individual mandate because of our respect for individual liberties; however, we recognized that not requiring insurance would raise the risk of adverse selection. Also, experience has shown that premium subsidies would have to be very large to raise coverage levels substantially if coverage was voluntary (Reschovsky & Hadley, 2001).

Facilitated enrollment mechanisms will be used to presumptively identify and enroll those eligible for public programs—for instance, participation in other public programs such as food stamps or school lunch programs will automatically enroll individuals in Medicaid/CHP as applicable. Automatic enrollment mechanisms could be phased in for those who do not voluntarily enroll. Evidence of insurance will be required as part of the state income tax filing process. Individuals and families who are not insured but appear to be eligible for Medicaid will be presumptively enrolled. Individuals and dependents who are not insured and do not appear to be eligible for Medicaid will be assessed a fee by the Department of Revenue equal to the cost of the annual premium in the least expensive pool plan, or if they appear to be eligible for premium assistance, the individual or household’s portion of the annual premium, and provided plan selection and enrollment information.

Create New Assessments to Make Up the Difference

New sources of funding will be required for the expansions of Medicaid, the operations of the Authority and the Premium Assistance Fund. For the purposes of modeling, we propose:

- an employer assessment as described above.
- a premium assessment on insurers. This would redistribute a portion of insurer's administrative costs savings under the proposal to the premium assistance fund.
- a health services (provider) assessment designed to recover a portion of the increase in reimbursement due to decreased uncompensated care under the proposal.
- Increases in alcohol and tobacco taxes.

Quality and Cost Control Mechanisms

Create Incentives to Further Integrate Care

Controlling costs, protecting patient's safety and enhancing the quality of care for all require coordination of care across the continuum and the alignment of incentives among patients, physicians, hospitals and other components of the health care system. We recommend that the Health Care Policy and Financing Department and the new Health Insurance Purchasing Authority in Colorado support the growth and development of vertically integrated health care delivery arrangements. The state should vigorously pursue strategies to support the reestablishment of Medicaid managed care plans in the state. That starts with paying actuarially sound rates to ensure plans and providers participate. The state must ensure adequate financing for safety net providers including allowing public safety net managed care providers to seek federal financial support through Medicaid financing mechanisms such as Certification of Public Expenditure. We recommend moving Medicaid enrollees into managed care organizations with integrated provider networks where available, through automatic "default" or "passive" enrollment. The state should explore ways to support the development of regional integrated models of care in major metropolitan areas utilizing safety net providers (community health centers, public/non-profit hospitals, public health departments, and school-based clinics) similar to Denver Health. Managed care contracts should have built in incentives for cost reduction and quality improvement—i.e., a base capitation rate with incentive payments to networks or providers for improvements in quality indicators. The Lewin Group did not model the effects of promoting managed care in the cost analysis.

Promote Rapid Development of Health Information Technology

Current fragmentation in care causes inefficiencies and increases costs and errors. Providing incentives for more efficient care will require data, information systems including electronic health records (EHRs) and processes for sharing information. However, the adoption of health information technology in ambulatory care environment has been slowed by the considerable capital investment required, needs for technical assistance and distrust of technology. Rapid deployment of health information technology will require state action. We propose that the Colorado Department of Health and Environment be funded to create an Office of Health Information Technology (OHIT) whose responsibilities are to 1) create standards of interoperability, 2) solicit bids for and certify a limited number of EHR product licenses that include essential elements such as stability, technical support services, registry functionality, tracking and reminder systems, evidence-based decision support and interoperability and 3) provide technical assistance to providers who are selecting systems. The infrastructure for information exchange is being developed in Colorado (Colorado Regional Health Information Organization) but to be fully functional, all providers will need electronic health systems to communicate with each other. We recommend that the state identify opportunities to foster growth of information infrastructure such as offering grants through the OHIT, or providing tax credits, for implementing OHIT-certified electronic health record systems.

The state could remove barriers to the use of data to drive performance. Multiple reporting obligations are a burden for physicians. We suggest that coordination between payers be required. The state health insurance purchasing pool will provide a venue for coordination within the private market.

Aligning Incentives For and Rewarding Quality

There are currently both public and private initiatives in Colorado to improve quality and value in health care delivery by adopting clinical guidelines and holding physicians and hospitals accountable for delivering care according to guidelines through performance reporting and other incentives¹. The Authority Board will be charged with convening these and other stakeholders to select robust outcome measures, preferably related directly to patient-oriented outcomes rather than process measures wherever possible, and determining how accountability is allocated.

¹ Kaiser-Permanente, Pacificare, Anthem BCBS, Colorado Business Group on Health, Colorado Clinical Guidelines Collaborative, Colorado Foundation for Medical Care, COPIC Insurance Company are examples.

Incentives would likely include both enhanced capitation rates and higher fee for service rates where appropriate.

Standardize Forms and Billing and Payment Systems

Insurance related costs burden physicians and hospitals. Billing-related administration costs were estimated to account for 20% of private health care expenditures in California (Kahn, Kronick, Kreger, & Gans, 2005). The lack of coordination in credentialing, contract negotiation, and measuring quality is also costly. We envision the Authority bringing all stakeholders together to create a single viable, simple billing and payment system, standardize forms and codes, and require insurers to streamline and simplify processes to lower administrative burden for providers. Electronic claims must be utilized by all insurers and providers.

Utilize a Preferred Drug List for Medicaid and Capture 340b Drug Pricing

Pharmaceutical costs have been a substantial part of health care expenditure inflation. We recommend the adoption of an evidence-based preferred drug list for Medicaid and for the subsidized health plans. High quality evidence on effectiveness and cost-effectiveness will be needed. The state should consider contracting with Oregon's Center for Evidence-based Policy to use the Oregon Health Plans list like several other states have done. Our plan would also maximize use of federally qualified health center and disproportionate share hospital pharmacies and require Medicaid enrollees to purchase their prescriptions at 340B in order to capture federal drug pricing.

Create a Comprehensive Evidence-Based Benefit Package as the Minimum for Coverage

The list of standard benefits will be determined and periodically updated by the Board based on preponderance of best available evidence of effectiveness. We propose that in general, all plans will cover prevention and early detection services, office visits, hospitalizations, ambulatory procedures, emergency care, diagnostic services, contraception and maternity care, physical, occupational and speech therapy, prescription drugs, mental health services, substance abuse treatment, limited dental, vision, hearing and podiatry care, home and hospice care and medical supplies and equipment. We suggest that over the initial two years, the Authority Board, using evidence-based medicine, create some limitation on hospitalization, procedures and tests so that we begin to impact on the overuse and misuse of services, which have been well documented.

Medical Homes and Patient Centered Care

A “medical home” is an approach to providing primary care which is comprehensive, continuous, coordinated, accessible and patient-centered. When care is patient-centered, considering patients’ preferences and values, and coordinated within a designated primary care “medical home”, unneeded, unwanted and duplicative services can be reduced. Patients often lack information about the risks as well as benefits of alternative treatment choices. They often receive little instruction or support to manage their care at home and are frequently left out of end-of-life care decisions. Patient-centered care in a “medical home” ensures that patients collaborate in making clinical decisions, are provided the tools they need for self-care, and experience coordinated and efficient transitions in care. There are actions the state can take to support initiatives that embrace these fundamental changes to the care delivery system. We recommend that enrollees in both the public programs and private plans through the pool be enrolled in primary care medical homes. Payment incentives to encourage and support physician practices that take such patient-centered care approaches should be piloted and adopted if shown to be cost-effective. We also recommend that certain information and decision processes be required and documented. For instance, documentation of advance directives should be required at or prior to the time of admission to a nursing home. For those without access to a medical home we recommend the development of a statewide 1-800 consumer nurse/doctor line available “24/7”.

Addressing High-Cost Care and the Increasing Prevalence of Chronic Disease

The cost containing recommendations we have made, to the degree that they address inefficiencies and waste, will deliver one time savings in health care expenditures. But the two major cost-drivers that have contributed to increases in health care spending are: (1) a rise in treated disease prevalence (63% of increase), caused by changes in population factors (e.g., obesity), changing treatment thresholds (treating diseases that were not treated in the past) and innovation; and (2) a rise in spending for treated cases, caused by technological innovation (37%), (Thorpe, 2005). Absent massive restructuring of administration of the health care enterprise, we believe that the most promising methods of containing costs are, (1) increased management of high-cost cases and end-of life care, including eschewing services considered to be futile; and (2) reducing obesity, which has been identified as one of the two major

contributors to increase Medicare costs. These two items address two well-documented sources of high medical costs across the health care system. Addressing these would be long-term efforts.

Given that 10% of all patients account for 70% of health care costs, finding more effective ways to manage care for those with chronic and serious illness is critical in containing costs. There are proven approaches for management of high-cost complex cases and addressing high end-of-life expenditures. HMOs or other organizations responsible for the overall health of their enrollees can more easily adopt programs for high-cost case management. Some models of this have been found to be effective in reducing costs (Villagra & Ahmed, 2004; Crosson & Magvig, 2004).

More than half of all adult Medicaid enrollees have a chronic or disabling condition (Williams, 2004) We propose that the Medicaid program contract with and provide reimbursement to agencies that develop case management programs designed for Medicaid's disabled and chronically ill populations, similar to their current asthma program. Reimbursement could be tied to demonstrated cost savings. Similarly, we recommend that in the Purchasing Pool, high-cost patients and patients with certain chronic diseases are identified and enrolled in case management programs. In addition, organizing care around the "Chronic Disease Model" has been effective at improving care processes and short-term outcomes with certain chronic conditions and is a key attribute of a medical home. There are current efforts underway in community health centers and in private clinics in Colorado to implement this model. Incentives such as pay-for-performance or reimbursement for group, e-mail and phone visits, if found to be cost-effective, would support these efforts.

Obesity is clearly a growing problem and appears to be intractable. It is likely that a combination of efforts focused on radical transformations in individual behavior that will be impossible to achieve without simultaneous policy, social and cultural change. We did not come up with a strategy to address this problem in the context of state health care reform, believing the greatest impact will come from investing in public health initiatives. For instance, there was strong interest in our group in efforts to modify the school environment and curriculum to address the epidemic of childhood obesity and we noted that recent research has found that the most important factor in preventing obesity is the presence of a full-service grocery store in the neighborhood (Powell, Ault, Chaloupka, O'Malley, & Johnston, 2006). States and municipalities

have measures at their command to provide incentives for such interventions. Certainly, investigation into other possible mechanisms for reducing obesity is important.

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

Who Benefits: All state residents will benefit from the guarantee of affordable health care coverage and the assurance that they will be able to continue coverage if/when their health declines or their employment status changes. They will also benefit from a more conscious, rational, transparent system of care that aims to improve quality, reduce costs, and maximize Coloradans' share of federal tax revenue. Those whose incomes are not adequate to be able to afford the full cost of health care coverage (which now reaches into the middle class) but who do not currently qualify for government programs will benefit because they will receive assistance in purchasing coverage, and will have access to comprehensive benefits including preventive care. Businesses will benefit by the creation of a more even playing field and possibly from more affordable coverage. Insurers and providers will benefit from less administrative burden, less cost shifting, and for providers, significantly more patients with coverage and higher Medicaid reimbursement. Other key benefits include: time and resources saved from simplification of plans and forms (consumer, employer, plans, providers); health, quality of life and resources gained from access to comprehensive benefits (families, communities, state government); and those with the most complex/high cost health care problems and their families will benefit from assistance in coordinating their care.

Those for whom changes may be either a benefit or a detriment: There will be adjustments in the allocation of resources throughout the system, resulting in different economic impacts on different people and organizations. This proposal has the potential to reduce some jobs in some sectors, particularly the insurance industry and provider billing staff, although it is anticipated to increase jobs in others (employees of the pool, care managers, staff of the Colorado Health Insurance Purchasing Authority), for which the skill sets of insurance employees would be valuable. Individuals who have not accepted insurance when it's offered in the past will eventually be expected to take it and to pay their fair share (with assistance for those who cannot afford the full cost) and may experience increased costs. Others who have suffered from ill health and paid significantly more for their insurance or for out-of-pocket expenses will

find that their costs will decline. Those businesses who have not contributed to their employees' coverage will be expected to offer insurance or pay a fee, yet other small businesses whose insurance was very expensive and who had to spend significant amounts of time researching their options will have access to a simpler system, and will likely be able to offer more affordable insurance. While this proposal has advantages for insurance companies (maintaining the private market, having lower administrative costs due to less complexity in plans and forms, no medical underwriting, and an increased market of covered lives), they will have less opportunity to create diverse products. And although under this proposal providers will likely find it important to move more quickly towards technology, such as the use of electronic health records with immediate access to decision support based on clinical guidelines, and may have to remit an assessment on collected fees, they will benefit from receiving reimbursement for functions that are critical for both health and cost control, such as prevention and care management and from the simplification of plans and forms.

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

The most important difference is that all residents, regardless of their income, ethnicity, or health status, will have access to comprehensive coverage at affordable rates.

Low income and lower middle income: Premium assistance will be provided for those unable to afford the full cost of coverage, significantly decreasing both the number of uninsured and the chance that care will be inappropriately delayed.

Rural: Residents in rural areas, as throughout Colorado, will benefit from the creation of the statewide 1-800 consumer nurse/doctor line. Since the availability of providers and medical homes is limited in rural areas, the nurse/doctor line will assist residents in determining when it is important to seek care. While this proposal does not specify mechanisms for other changes specifically designed to benefit rural areas, we have included a list of possibilities that could be considered in Appendix D3.

Ethnic minorities: Coverage for all is the single most important element to enhance access for minorities, but having coverage available will not insure that it is purchased or used. Hispanics in particular are disproportionately represented among the uninsured: “although about 20% of the state’s total population identified themselves as Hispanic in 2005, Hispanics

accounted for more than 40% of the state's uninsured population in 2005" (Colorado Health Institute, 2006a) (Colorado Health Institute, 2006b). Since even the concept of health care coverage has cultural implications, culturally sensitive and effective outreach and enrollment will be essential for the success of this proposal. Over 300,000 Hispanics would be entering the health care coverage system under this proposal, and although not directly addressed in this proposal, the state should also seriously consider enhanced efforts to increase diversity in health care providers and to assure additional cultural competence training for all providers. Minorities other than Hispanics make up a much smaller proportion of the uninsured, but several culturally sensitive approaches would need to be developed to meet the needs of diverse cultures. Of those who are uninsured, those who identified themselves as non-Hispanic Black accounted for 3%, non-Hispanic Asian 2%, non-Hispanic multiracial 1%, and non-Hispanic American Indian 1%. (Colorado Health Institute, 2006a) (Colorado Health Institute, 2006b). See Appendix D2.

People with Disabilities: Those who are disabled and currently are eligible for Medicaid will continue to have comprehensive benefits, and will be protected from the "bare bones" policies and inappropriate cost sharing being proposed by some policymakers. One of the worst gaps in health care coverage in Colorado, coverage for those who are on the Aid to Needy Disabled program awaiting determination on eligibility for SSI (Supplemental Security Income), will now become covered. Our plan raises the Medicaid eligibility limit for disabled and elderly Coloradoans who receive SSI from 74% to 100% FPL and establishes a Medicaid sliding fee scale buy-in for working people with disabilities up to 300% FPL, so that those with disabilities can be on the Medicaid plan, which offers enhanced benefits, rather than going into our standard plan for those who are receiving assistance. This plan adds a Medically Needy Program under Medicaid, which allows children up to age 21 and their parents, as well as disabled and elderly persons whose incomes are above Medicaid eligibility standards to obtain Medicaid coverage if high medical expenses drop their income to less than 51% FPL (this is a federal limit; to raise it would require a federal waiver). Our plan also calls for increased funding to provide services to all severely disabled children who qualify for Colorado's Children's Home and Community Based Services Program and Children with Extensive Support waivers, eliminating waiting lists for these critical services. Finally, the inclusion of preventive care and treatment for mental illness and substance use disorders at affordable rates will contribute to early identification and treatment of a variety of disorders, and can reasonably be expected to decrease disabilities in the future.

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

Please attach.

Among the core elements of our approach to covering all Coloradoans, the private insurance market strategy we propose has never been implemented in the US. Organizing the entire private insurance market (with the exception of self-insured plans, which are governed by federal law) within a purchasing pool, and providing premium subsidies to low- and middle-income individuals and families in the context of an individual mandate is an unusual approach and we believe it is suitable for Colorado's particular needs. Vermont has taken a similar approach but without an individual mandate. In general, premium assistance program demonstrations without mandates have found that the subsidies must be very high (>60%) to induce the uninsured to take up insurance (Yondorf, Tobler, & Oliver, 2004). Voluntary purchasing pools without premium subsidies have not been shown to increase coverage (Burton, Friedenzohn, & Martinez-Vidal, 2007),(RAND Corporation, 2005),(Wicks, 2002).

Employer responsibility legislation has been implemented in four states, two cities and a county (Families USA, 2006). A concern is that these laws may violate the federal ERISA law. Most ERISA experts believe that state laws can work around ERISA constraints (Butler, 2006). We discuss this in section (b)(1) and in next section.

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

Governance: Colorado Health Insurance Purchasing Authority Board: The workings of a health care system are extraordinarily complex, and significant changes have wide-ranging impact. Ideally, those changes would be made only after careful analysis by a neutral, expert board. We propose that a new board be established, whose purpose would be to formulate policy ensuring that all people in Colorado have adequate, affordable health care coverage provided in the most cost effective manner possible. In particular, the Authority Board would:

- 1) Commission a periodic study to project the cost of coverage, review what people in Colorado in various circumstances can truly afford, set an affordability standard (what the individual or family would be expected to contribute towards the cost of their coverage), then set the levels at which assistance will be provided to them. This objective analysis will determine the funding necessary for adequate assistance levels, which will be entered into the state budget prior to legislative deliberations. It will be expected that the revenues required to fully fund premium assistance will fluctuate, and it will be the job of the legislature to adjust revenue sources as necessary to provide adequate funding to maintain the guarantee of affordable coverage.

- 2) Adopt principles for designing benefits focused on aligning incentives for consumers to seek and providers to deliver appropriate, effective care
- 3) Determine the minimum standard of benefits by which every person in Colorado who is not covered by a self-funded plan would be covered; determine the titles and contents of a limited number of “set” benefit packages, into which all plans must fall; and determine the two (one PPO and one HMO, where an HMO exists) benefit packages that will be provided to those who do not qualify for the Medicaid/CHP+ plan but who will receive assistance in paying for health care coverage.
- 4) Define and certify “high-value” providers
- 5) Define the requirements for participation of plans in a premium subsidy program
- 6) Create a mechanism for assessing whether plans are experiencing adverse selection (a higher proportion of people with high health care needs choosing their plan) within the pool, and a fair mechanism for risk adjustment.
- 7) Define minimum quality and cost containment elements (e.g., integrated care, data reporting, etc.) that must be met in order for carriers to qualify to serve those whose coverage is subsidized by public funds.
- 8) Provide empirical cost analysis to inform the determination of provider reimbursement in the Medicaid/CHP+ pool.
- 9) Promulgate minimum standards and/or rules and regulations regarding such things as network adequacy, standardization of forms, unified billing and payment systems, and performance measures and standards for plans and provider networks.
- 10) Determine that rate-setting is sound, adopting regulations as necessary.
- 11) Periodically study the fiscal viability of the entire market and make recommendations for changes.
- 13) Perform other governance roles as appropriate.

The intent is to create a board that is neutral, fair, has expertise, and is not subject to ever-changing political climates or pressure from special interests but will consider the impact of changes for the benefit of all. Carefully modeled after the Federal Reserve Board, it would be an independent state entity that does not receive funding from the state legislature. It, along with the entire administrative structure for the Authority, would be funded through one or more of the options we’ve proposed for funding all the reforms in this proposal (see Section (b) (1)).

There will be 7 board members, appointed for 10.5 years each, with staggered terms so that a new member is appointed every one and a half years. Members must be committed to the purpose statement and to carrying out their duties as stated. Members will be appointed by the Governor and confirmed by the Senate, but the board would then function mostly independently, although it will be required to report periodically to the legislature. Members would need to have

combined expertise in health economics, health coverage options and their impact, health care systems (public and private, nonprofit and profit), health care administration, health care provision, consumer and special needs populations advocacy, and envisioning and creating innovative futures. Members would not be able to be removed from office due to their views. Members would be paid a reasonable and appropriate amount for serving based on time required and comparable compensation for other similar boards. The Chair and Vice Chair would be chosen by the Governor from among the sitting members, and confirmed by the Senate, serving four-year terms. Funding would need to cover an adequately sized staff, hired by and answerable directly to the Authority Board, to perform research and analysis. The staff of the Board will be separate from the staff performing the administrative functions of the pool.

Administration: The Department of Health Care Policy and Finance would continue to administer what will now be the combined Medicaid/CHP+ Program, and the Medical Services Board will continue to oversee Medicaid. The Authority Board would have the responsibility for creating the policy, regulation and direction for the new purchasing pool, and for hiring an Administrator, who would then set up the administrative structure to run the purchasing pool. Administrative functions would include but not be limited to negotiating rates with the carriers in the pool, certifying plans, assuring regional coverage and network adequacy, enrollment of individuals and groups in plans of their choosing, accepting and disbursing premium payments, managing the assistance program (including determination of eligibility for premium assistance), collecting claims data from insurers and managing the risk adjustment process, assuring public outreach and education, etc.

(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?

We believe that merging CHP Plus and raising Medicaid eligibility levels for the categorical and optional groups in our proposal will not require a federal Medicaid waiver, although we would defer to HCPF. We propose to seek a federal waiver to cover childless adults under the Medicaid program, but fund coverage with state-only dollars if a waiver is not approved. We have outlined changes in the regulation of the health insurance markets, the creation of a new quasi-governmental agency, the Health Insurance Purchasing Authority, a new

governance board, The Authority Board and proposed financing methods and these will require new statutes and may require a popular vote.

We are optimistic that our employer assessment and the obligation to set up Section 125 plans will survive an ERISA challenge. Maryland's law has been successfully challenged in court by a large employer association, but the law was structured in such a way as to attract legal challenges. We have structured employer fees such that they will not impose an undue burden on any employer. As noted most ERISA experts believe employer assessments are feasible under ERISA.

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

We propose a two year phase-in of the expansion of Medicaid/CHP during which time the Health Insurance Purchasing Authority and Board will lay the ground work for the restructuring of the private insurance market and the creation of the purchasing pool mechanism. The private market will be pooled at the end of year two as will the employer assessment. There will then be a one-year phase in of the individual requirement.

(c) ACCESS

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

Yes. The greatest barrier to access is the inability to afford coverage, and this proposal assures that everyone in the state has affordable coverage, significantly improving access to the 768,000 people who are currently uninsured in Colorado as well as to those whose income qualifies them to receive assistance in paying for coverage, and will be more likely to access necessary care instead of delaying it. The proposal also limits "underinsurance" by establishing a comprehensive minimum benefit design and assuring that high cost-sharing plans are purchased only by those most likely to have the means to afford them (400% FPL+), making it less likely that those who live in low or lower middle income families will put off necessary care.

However, the existence of affordable coverage does not assure that people will know about it, enroll in/purchase it, use it, or that the right kind of providers will be available when and where they need them. We discuss our strategies for informing the public about the changes and some of the methods for increasing the likelihood that they will use the program under section

(d) (2) Outreach and Enrollment, below. The likelihood that people will enroll in/purchase insurance increases with both the availability of premium assistance for those living in families up to 400% FPL and a phase-in expectation that if 95% of the population is not enrolled by the end of the first 12 months, those not enrolled will be required to enroll or will automatically be enrolled and charged the appropriate amount for their coverage. Incentives for using the coverage are discussed in section (g) (1) Benefits, below. A problem in some parts of the state is that some providers do not accept patients with public coverage such as Medicaid, CHP+ or Medicare. Our proposal increases Medicaid provider reimbursement.

The major remaining issue is to assure that people will have access to the type of provider that they need when they need it. Due to the dispersion of health care providers, those who live in rural areas face particular challenges in accessing care. For both access issues and to encourage the appropriate use of care (both utilizing the appropriate level of the care system when needed and engaging in “watchful waiting” when not needed), our proposal creates incentives for enrollment in “medical homes” and includes the development of a statewide 24/7 1-800 nurse/doctor line that anyone can call to describe symptoms and ask for direction. Although not a part of this proposal, other ideas for enhancing access across the state, particularly in rural areas, are listed in Appendix D3.

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

This program will benefit safety net providers by assuring that nearly every person they serve will have health insurance. Safety net institutions are chronically underfunded and currently rely heavily on Medicaid, CHP+, and other federal and state funding to support their care for the uninsured. Medicaid alone can provide over 1/3 (37%) of operating revenues for safety net providers, and the Kaiser Family Foundation notes that increasing the number of patients served who are insured will strengthen the financial viability of the safety net (Kaiser Family Foundation, 2007). Safety net providers are likely to be well positioned to continue to be the major providers of care for those receiving assistance because of their expertise in wrapping special services (case management, culturally competent care, etc.) around those with the greatest needs and because their structure fits well with managed care. Although safety net providers around the state vary, some have been the leaders in developing the most integrated models of care and quality/efficiency initiatives, and others are moving in that direction. These

elements will provide an advantage in becoming providers of choice for those eligible for the combined Medicaid/CHP+, which will now serve families up to 300% of FPL. Safety net providers are experienced in minimizing costs, and may provide examples for other systems of care in realizing efficiencies. Also, safety net providers will be included in the networks participating in the subsidized health plans in the purchasing pool.

(d) COVERAGE

(1) Does your proposal “expand health care coverage?” How?

Yes, this proposal significantly expands health care coverage. One of its major goals is to assure that every resident has affordable health care coverage. People with low or lower-middle incomes who now have high cost-sharing insurance coverage and become eligible from premium assistance will have lower cost-sharing plans, leaving them open to less risk financially. In addition, more residents with disabilities will have access to Medicaid, which is the most appropriate health care benefits package for those with special needs because of its extensive coverage.

Also, because the new “standard” benefit package will now include parity for mental illness, coverage for substance use disorders, and limited oral health, vision, and hearing aid coverage, all residents will also benefit from expanded health care coverage.

(2) How will outreach and enrollment be conducted?

When the goal is coverage for all people, a shift in both attitude and practicality occurs – instead of keeping ineligible people out of the system, it is now important to bring everyone into the system, and to do it in the most administratively efficient way possible.

For the general population, the following measures will be essential, and should be managed at the state level. A coordinated effort between the Department of Health Care, Policy, and Finance (HCPF) and the administration of the Authority could create outreach and services for all Coloradans that, while meeting the needs of both the Medicaid/CHP+ recipients and those purchasing insurance from the pool, would appear seamless to the consumer:

- Major media campaign for public awareness (with targeted messages to specific populations)
- 1-800 customer service line

- Simple, easy to understand website for customers
- An office in each significant population area for people to receive in-person assistance in choosing their plan and signing up for coverage, if they choose

For those receiving assistance in paying for coverage, the following changes should be made in order to create administrative efficiency:

- Create joint/single simplified application process for Medicaid, CHP+, and perhaps the state-only assistance program too, if it is deemed to be more efficient
- Community-based enrollment centers (overseen by the state rather than by counties) with CBMS access
- Allow application by mail
- Adequate staffing for quick processing
- Eliminate unnecessary verification
- Provide presumptive eligibility for pregnant women and children of Medicaid mothers
- Allow continuous eligibility for 12 months
- Do passive re-enrollment
- Targeted outreach and marketing to specific populations

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

A resident would be a person living in Colorado. Eligibility for the Medicaid/CHP+ plan would continue to be determined by federal and state requirements. In the new purchasing pool, a resident would not be eligible for premium assistance until they had lived here for six continuous months, and then as allowable by law.

(e) AFFORDABILITY

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

Introduction

One of the most critical elements of creating a coverage system for all is to objectively determine how much a person or family can reasonably contribute to the cost of their own coverage. Estimates of that amount vary, and justification for estimates are rarely cited in the literature. One of the figures commonly cited is that families should be able to afford 5% of their income. However, a careful study of the expenditures of low-income families in Colorado in 2000 found that those with incomes below 185% of FPL had no disposable income left to spend

on health insurance, those with incomes between 185%-250% had little or no funds available, and those between 250%-350% FPL, even with a noticeable increase in household income, still cannot afford the full cost of coverage without a partial subsidy. (Glazner, 2000) If a straight 5% of income is applied, a family of 4 would need to spend \$86/mo if their income is at 100% of '06-'07 FPL and \$172/mo at 200% FPL, whereas the Glazner study indicates that families below 185% have no disposable income to spend on health care costs, and those up to 250% have little or none.

Some studies rely on looking at what families already spend, but find disproportionate (significantly higher) spending on the part of lower income families, and do not take into account what sacrifices the families may be making in order to make those expenditures.

A recent process completed by the Greater Boston Interfaith Organization in order to determine whether the mandate that “as of July 1, 2007, individuals over 18 years old must obtain and maintain ‘creditable’ coverage so long as it is deemed ‘affordable’ under the schedule set by the Commonwealth Connector Board” found that “even with the most conservative approach in defining what people can afford based on their monthly income and essential expenses, almost half of all people in the 100-300% range and about 40% of the 300-500% cohort cannot afford the amount expected of them to purchase health insurance.” (Greater Boston Interfaith Organization, 2007)

Because of the critical nature of this question, this proposal tasks the Authority Board with doing carefully constructed periodic studies to objectively determine the true levels that families should be expected to contribute to their own health care costs.

Enrollee: For those individuals or families with income less than 400% FPL who purchase insurance through the new pool, there will be sliding fee scale premium assistance, to be set by the Authority Board based on their determination of affordability. Our proposal is that those living in families whose incomes are < 200% FPL are unlikely to have to pay premiums or deductibles, although they will have co-payments. Those whose income is 201-399% FPL will have premiums based on a sliding scale, and either co-payments, or a coinsurance requirement (depending on the health plan), but will have little or no deductible. For purposes of modeling, we propose the following premium subsidy schedule: Full (100%) subsidies for individuals and families at or below 200% FPL; from 201-250%, 90% subsidy; from 251-300%, 80% subsidy; from 301-350%, 60% subsidy; and from 351-400%, 25% subsidy. Because we anticipate that the

Authority Board would be setting both the standard benefit levels and the total cost-sharing amounts, our committee was reluctant to present an ideal benefit plan. However, in order to get a sense of what the Authority Board might consider and for use in modeling, we have included an example of a benefit plan in Appendix G, which can be compared with current Colorado benefit plans in Appendix H.

Employer: For modeling purposes, we propose that the minimum employer premium contribution required in order for the assessment to be waived be 85% of the median cost of a standard individual plan in the Health Insurance Purchasing Pool.

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

This proposal does not change the co-payments or cost sharing for the Medicaid and CHP+ plans.

In the new pool, the cost sharing arrangements of those whose income is above 400% is determined by which plan the enrollee selects.

Cost sharing for those whose income falls below 400% and are receiving assistance in paying for health insurance will be required to enroll in one of two plans selected by the Authority, which will have low cost-sharing arrangements by design. Again, an example of a possible plan that might be considered by the Authority Board is included in Appendix H. In that plan, copayments for those whose incomes are at or under the poverty level are waived except for a small copayment for emergency services. Copayments for those with incomes between 101 and 250% FPL could range from \$3-\$15 for most services and up to \$25 for those between whose incomes are between 251 and 399% FPL. In addition, there will be little or no cost-sharing for those services, such as preventive care and chronic disease management, deemed to be particularly important for health outcomes and cost containment.

(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.

This plan assures that everyone will have access to affordable coverage no matter what their life circumstance is; that those under 400% of FPL will receive assistance in paying for

coverage, and that health status and age will no longer be reasons for denials or increased costs of coverage. The creation of the new pool provides the option of portability (which includes not only continuous coverage, but the ability to stay with the same plan and the same provider) for anyone who is not in the Medicaid/CHP+ pool or in an employer's self-funded program, although the amount that the enrollee will pay may vary to some extent as life circumstances change. The plan also makes the transition between Medicaid and CHP+ more seamless, which is important because families at that level of income often move back and forth between programs as eligibility levels shift.

(g) BENEFITS

(1) Please describe how and why you believe the benefits under your proposal are adequate, have appropriate limitations and address distinct populations.

In the new pool, the Authority Board will set both the minimum benefit levels and the ceilings for coverage, but the Board's charge will be to set minimums that provide comprehensive coverage for all enrollees (in contrast to only either limited core benefits or catastrophic coverage), which would be similar to the state's current standard or CHP+ plan, with the addition of parity for identification and treatment of mental illness and substance use disorders, complex/chronic care management, and limited benefits for oral health, vision, and hearing aids. However, this is not meant to imply that all available care, regardless of efficacy, would be included. The Authority Board's goal will be to assure that all receive essential health care, but they will also carefully consider ceilings on care – not to prohibit necessary, efficacious care, but to make difficult choices when efficacy or appropriateness is in question.

The differences between plans that will allow enrollees choice will mainly consist of level of cost-sharing (for those not receiving assistance from the state, who will be limited to low cost-sharing plans), cost, type of plan (HMO or PPO), carriers' ability to provide quality service and adequate networks, and a limited number of plans that add some expanded benefits to the minimum comprehensive plan. These plans will be approved by the Authority Board, and the titles and benefits will be the exactly the same from carrier to carrier.

Our proposal continues to provide for an enhanced benefits package to those eligible for Medicaid because of the increased likelihood that those who qualify will need more wraparound services (expanded services) than the general population.

The challenge for the Authority Board is that there are very difficult choices to be made in coverage in order to keep health care affordable to all. The Authority Board will face challenging ethical dilemmas, and must retain the authority to make policy decisions on whether and how to cover high-cost interventions, particularly if their effectiveness is in question.

(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.

The benefit package that the Authority Board might consider for use for those receiving premium assistance (see Appendix G), is a hybrid of the CHP+ and state’s Standard plans, adapted to acknowledge the different incomes of the enrollees (co-payments vary by income), and to add the benefits necessary to address key cost drivers (case management for high-cost cases) and provide comprehensive coverage. The benefit package uses zero copayments as a method of encouraging participants to receive targeted preventive and chronic disease management care, covers mental illness and substance use disorder at parity with other illnesses, and includes limited dental, vision, and hearing aid coverage.

In addition to the benefit package offered to those getting premium assistance, the Authority will adopt perhaps 6-10 additional standardized benefit packages to be offered in the purchasing pool. To simplify analysis, we selected two plans for modeling from among those offered to federal employees in Colorado in 2007 under the Federal Employee Health Benefits Program—a standard PPO option and a high deductible plan with an Health Savings Account. Mental illness and substance use coverage at parity as well as limited dental, vision, and hearing coverage were added to meet our proposed minimum benefit criteria.

(h) QUALITY

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

The Institute of Medicine broadly defines quality as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge” (Davis et al., 2007). Inherent in that definition is appreciation for the fact that knowledge is constantly evolving. We set up mechanisms in the

Health Insurance Purchasing Authority to convene stakeholders to adopt and continuously update quality standards and establish incentives for plans and providers to meet them.

(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, and rural areas, etc.?)

This proposal will promote quality through a diverse set of strategies that directly address the IOM definitions above (we outline our strategies in Table 1, Appendix F). We propose two major approaches to creating a system that follows these basic rules of quality healthcare. The first approach is to reengineer the system of insurance in the state such that financial incentives are more properly aligned with achieving these basic rules of quality health care. These strategies are inherent in the risk pooling process proposed here. They include support for primary care and medical homes, case management of complex cases, promoting integrated systems of care, value-based benefit designs, evidence-based formularies, preserving patient choice and supporting decision making, and supporting continuous healing relationships. The second approach is to promote several key elements of quality that are not inherent to the new coverage proposal but cannot be adequately achieved without state intervention. The primary example is the need to promote rapid deployment of Health Information Technology—tools critical not only for quality improvement programs, but also the clinical integration of care.

(i) EFFICIENCY

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

The proposal uses the following strategies to contain health care costs, but we believe that it is likely not possible to decrease total health care costs without both moving to a single payer system and achieving meaningful effort to redesign the delivery system.

We believe that *reducing* health care costs is not realistic, given the march of technology and medical research. Also, it is even less likely if, at the same time, one wishes to provide increased access to care for the uninsured. This will increase total expenditures, even if the newly insured have access to primary and preventive care in “medical homes” and therefore

avoid more expensive care. Our proposal should, however, substantially reduce administrative costs, thereby assuring that any increases in expenditures go directly to patient care.

We also know there is evidence that savings by squeezing duplication and waste can be achieved while improving health outcomes, quality of care, and access to care (Davis et al., 2007), but this will require major restructuring, not just of the insurance market, but also the care delivery systems. Our proposal stresses the importance of integrated health care delivery models and recommends changes to support their further development. HMOs, particularly in a competitive market, have been shown to reduce costs (Agency for Health Care Research & Quality, 2004). Integrated health information systems and electronic medical records are key tools for “virtually” integrating clinical care. Investment in these technologies can be expected to reduce costs associated with redundant tests, unnecessary or inappropriate procedures, and avoidable errors. We control pharmaceutical expenses with Medicaid preferred drug lists and subsidized plan formularies based on evidence of effectiveness and maximization of 340B qualified health center drugs. We propose wrap-around case management services that come to bear whenever a high-cost case is identified, and support medical home enrollment and reimbursement for clinical activities needed for chronic disease management.

(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.

Our plan recommends value-driven benefit designs that provide first dollar coverage for prevention services, minimal or no co-payments for chronic disease care and medications, which align patients and provider incentives to access these services. At the health system level, we stress the importance of managed care organizations and vertically integrated systems of care—such systems align the financial incentives of hospitals and physicians and create coordination across the continuum of care, which maximizes quality and minimizes cost. We propose incentive payments to plans that meet national quality standards, establish expectations for plans to create similar performance incentives for networks and providers and propose incentives for consumers to seek care from “high-value” providers.

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

The purchasing pool we create standardizes the benefit packages that can be issued by health plans, allowing consumers to compare plans by price, networks and, when good ones are developed, quality measures.

(4) How would your proposal impact administrative costs?

Marketing, underwriting, multiple complex benefit designs, churning enrollments, and market fragmentation are major contributors to high overhead in the small group and individual markets (Davis et al., 2007), where administrative costs range from 15% to 40%. Our purchasing pool plan and market reforms will substantially reduce all these costs. To make sure those savings are turned into lower premiums, plans will be required to publicly report percentage of premiums spent on medical services (medical loss ratios). The added ease of comparing plans with standard benefit designs in the pool, electronic enrollment, support in setting up Section 125 plans and savings in broker fees may also reduce administration costs for small employers.

Standardization of electronic billing and payment processes, forms, codes and contracts, and data reporting will all lower administrative burden for providers.

(j) CONSUMER CHOICE AND EMPOWERMENT

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

Consumers who receive premium assistance will be guaranteed a choice between at least two low cost-sharing health care plan options, and within those options, adequate provider pool choices, to the extent that they exist or can be generated. These consumers will be encouraged to purchase a “high value” plan with slightly lower premium payments, and health plans will be expected to include safety net clinics in their provider panels for this population.

Consumers in the pool (everyone but those in self-funded plans) will have the level of choice most consumers say they want: a limited number of benefit plans (6-10) that provide enough choices to allow options (and easy comparability between carrier’s plans offering those benefit packages), but not so many that it is difficult or impossible to make informed choices. Choices available to the consumer will include cost-sharing options, provider panels, premium cost, and quality of carrier service. Since plans will be competing for customers based in part on

their provider panels, it is anticipated that choice of providers will be provided, though it is likely that some plans will have greater choice than others.

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

The administration of the Authority would have the responsibility for outreach, enrollment, and education for the participants in the new pool, as detailed in question (d) (2).

(k) WELLNESS AND PREVENTION

(1) How does your proposal address wellness and prevention?

Preventive services shown to be cost effective, such as vaccines, prenatal care, cervical cancer screening, and tobacco cessation counseling, will be promoted using strategies approved by the Authority Board such as first dollar coverage and zero copays . Providing full coverage for the screening and treatment of mental illness and substance abuse will also promote wellness and may even reduce costs (Holder & Blose, 1986).

(l) SUSTAINABILITY

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

The proposal is sustainable if adequate, ongoing funding mechanisms are approved. Just as public education, public safety, and Medicare rely on ongoing sources of funding, the public will need to approve dedicated, ongoing sources of funding to assure health care for all. The specific options for financing are discussed in questions (7) and (8), below.

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

See “Technical Assessment of Health Care Reform Proposals, Interim Report”, The Lewin Group, November 1, 2007.

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

In order for health care reform that truly assures everyone access to affordable coverage, everyone will need to compromise some so that no part of the system is overwhelmed. In order

for our proposal to work, shared responsibility must be assumed by individuals (all will be required to pay for a portion of their care, with the exception of those whose income is less than 200% FPL), and employers (who will be expected to provide coverage or to pay a fee). Other options for raising the funding to support this proposal include having health insurance carriers assume shared responsibility through payment of an assessment, which may be a recapturing of what they have saved through administrative simplification, and placing an assessment on the fees collected by health care providers. Finally, higher taxes could be placed on the purchase of products with health-adverse impacts (e.g., alcohol, tobacco). The graphic in Appendix I illustrates the choices.

(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? Please explain.

Please see the answer to Question (B) (2), above, regarding who will benefit and who will be negatively effected.

(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.

The private insurance market will be reorganized into a single purchasing pool and third party payers (called “insurers” in our proposal) will operate under new rules including guaranteed issue and pure community rating. Our proposal creates a new Health Insurance Authority Board charged with setting minimum benefit standards and standardizing all benefit packages in the private market. Coverage mandates would be based on best available evidence standards.

(6) (Optional) How will your proposal impact cost-shifting? Please explain.

We believe the combination of public expansions, private market reforms, affordability standards and the expectations we place on employers and individuals will lead to high levels of health insurance coverage and consequently low levels of uncompensated care. We also propose increasing Medicaid reimbursements, which will further reduce cost-shifting onto privately insured.

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

Yes. While we have achieved administrative simplification, targeted interventions likely to result in improved health and cost containment, and spread risk so that those in poor health are not penalized, we have also provided subsidized coverage to nearly 770,000 uninsured people in order to assure coverage for all, created a new care coordination system for those with complex health care needs, and initiated a statewide nurse/doctor line.

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

Please see the answer to (1) (3), above.

Describe how your proposal is either comprehensive or would fit into a comprehensive proposal:

Our proposal is comprehensive (see Appendix J) because it assure coverage for all, creates a fair mechanism that expects people to pay for their coverage but assists them when it is beyond their ability to afford, and assures that those least likely to be able to pay more later are covered by low-cost sharing plans. It provides mechanisms for administrative simplification, speeding up the adoption of health information technology, and the coverage and provision of health care services targeted to achieve the greatest health outcomes and at the same time contain costs.

(For description of how this proposal was created, see the Final Appendix)