

Specifications of Health Reform Proposals

Draft Specifications

Prepared for:

**Colorado Blue Ribbon Commission for Health
Reform**

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Table of Contents

A Plan for Covering Coloradans	Page 1
Colorado Health Service Program	Page 18
Better Health Care for Colorado	Page 22
Solutions for a Healthy Colorado	Page 30

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These specifications apply to the initial model and may be different from the Final Report.

Title	A Plan for Covering Coloradans
Author	Committee for Colorado Health Care Solutions

A Plan for Covering Coloradans provides coverage to Coloradans through a public program expansion and a mandatory private pool for all residents not eligible for the public program. It provides a minimum benefits package in a private pool and premium assistance based on income for those who cannot afford insurance. The private pool would be administered by a quasi-governmental entity, but subsidies would be administered through the tax system. The program would be financed through an employer assessment and a variety of taxes. Detailed specifications of the Plan are as follows:

A. Coverage

The proposal covers all residents in Colorado. For Medicaid and Child Health Plus (CHP+) programs residency is defined in according to federal standards. For the private insurance pool, the premium assistance group would be required to have lived in Colorado for at least 6 continuous months, in addition to any other requirements under current law (e.g., citizenship requirements). For all other individuals in the private insurance pool, there is no durational requirement and residency would be under current law.

The proposal combines public program expansion, employer mandate and individual responsibility to provide health coverage. The proposal expands Medicaid to adults living in poverty, expands CHP+ eligibility and combines Medicaid and CHP+ into a single program.

a. Public Program Expansion

The combined Medicaid and CHP+ expanded population would be as follows:

Figure 1
Proposed Expansion for Public Programs

#	Age or Population Group	Current Eligibility (FPL)	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%

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#	Age or Population Group	Current Eligibility (FPL)	Expansion Proposed (FPL)
6	Disabled working adults	--	300% (buy-in)
7	65+	74%	100%
8	Medically needy	--	50%
9	COBRA Premium Assistance	--	100%

The proposal would:

- 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;
- Offer Medicaid coverage to non-disabled adults without children (group 5) up to 100% FPL using state-only dollars;
- Expand eligibility to the elderly and disabled. The plan raises the eligibility limit for Coloradoans who receive Supplemental Security Income (group 6) to 100% FPL;
- Establish 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;
- 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 in-between jobs with minimal assets (group 9) whose income is below 100% of FPL (referred hereafter as the “COBRA premium assistance group”); and
- 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.

Individuals and families who appear to be presumptively eligible in government programs would be presumptively enrolled. Coverage for the elderly population eligible for Medicaid long term care services would remain unchanged.

b. Employer Mandate

Employers would be required to offer coverage or pay an assessment which can be waived for employers who provide adequate coverage for the employees.

c. Individual Mandate/Personal Responsibility and Enforcement

All other individuals, families and employers (including self-employed) would be able to buy coverage through a private sector purchasing pool which combines the current individual, small group and large group markets. This includes the following low-income population who would not be eligible for the expanded Medicaid/SCHIP program:

- Children and parents above 300 percent FPL;
- Pregnant women above 300 percent FPL;
- Disabled working adults above 300 percent FPL;
- Non-disabled childless adults above 100 percent FPL;
- COBRA premium assistance group above 100 percent FPL;
- Medically needy group above 50 percent FPL;
- Any individual with Employer Sponsored Insurance.

However, premium assistance would be available to people up to 400 percent PFL on a sliding scale, discussed further below.

Proof of insurance would be required at the time of tax filing. If there is no proof of coverage, the following assessment would apply:

- For individuals who would participate in the private insurance pool, the assessment would be equivalent to the annual premium in the least expensive plan; and
- For those who would be eligible for the public programs, they would be determined presumptively eligible based on participation in other public programs (e.g., food stamps, school-lunch programs) and automatically enrolled in Medicaid or CHP+ as applicable.

B. Covered Services, Cost Sharing and Benefit Limits

Benefits packages vary between the combined Medicaid/SCHIP program and the Private Insurance Pool.

- a. **Combined Medicaid/SCHIP program** For people enrolled under the combined Medicaid/SCHIP program the following two benefit package would apply (Figure 1):

- All people in the combined Medicaid/SCHIP expansion would be covered by the standard Medicaid benefits with one exception:
 - Children and parents in families with income between 200-300 percent FPL would receive the CHP+ Like Benefit Package. However, these families would also pay a premium and copayments, similar to the premium assistance program in the private pool.

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Figure 1
Comparison of Colorado Public and Private Health Insurance Options-Coverage, Limits and Out-of Pocket Costs

	Medicaid^a	Child Health Plus (CHP+)-Like Plan^b
Premium/Deductible	None	Premiums- Based on sliding scale same as Premium Assistance Program (Figure 3) No deductible
Max Annual Out-of-Pocket	None	5% of yearly income
Coinsurance/Copays	Limited copay for some services if enrolled in Primary Care Physician Program (PCPP). No copays if enrolled in HMO, 18 or younger, pregnant or in a nursing home.	Copays: Based on sliding scale same as Premium Assistance Program (Figure 3)
Lifetime Benefits Max Paid by Plan	No limit	No limit
Services		
Emergency Services	Covered in full-no copay	\$15 copays
Emergency Transport-Ambulance Services	Covered in full-no copay	Covered in full
Inpatient Hospital Stay	\$15/visit	Covered in full
Outpatient Ambulatory Surgery	\$3/visit	Covered in full
Lab, x-ray and Diagnostic Services	Covered in full-no copay	Covered in full
Medical Office Visit	\$2/visit	0-250%: \$5 copays 251-300% FPL: \$10 copay
Preventive Services	Covered in full-no copay	Covered in full
Maternity Care	Covered in full-no copay	Covered in full
Neurobiologically Based Mental Illness	Covered in full-no copay	0-250%: \$5 copays 251-300% FPL: \$10 copay
Other Mental Health Services	Covered in full-no copay	0-250%: \$5 copays 251-300% FPL: \$10 copay <u>Limits:</u> 45 inpatient days or 90 outpatient treatment days per benefit period. 20 outpatient visits.
Alcohol and Substance Abuse Treatment	Covered in full-no copay	0-250%: \$5 copays. 251-300% FPL: \$10 copay. 20 outpatient visits per diagnosis. No inpatient coverage.

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	Medicaid ^{a/}	Child Health Plus (CHP+)-Like Plan ^{b/}
Physical, Occupational and Speech Therapy	Covered in full-no copay	30 outpatient visits per diagnosis.
Durable Medical Equipment	Covered in full-no copay	Max \$2,000, excluding glasses contacts or hearing aids.
Prescription Drugs	\$1 generic, \$3 brand-name	Generic: No copay Name brand: \$5 copay
Vision Services	\$2/visit	Coverage of age appropriate preventive and specialty care. \$50 benefit for lenses, frames or contacts. Per visit copay: 0-250%: \$5 copay 251-300% FPL: \$10 copay
Audiological Services	Covered in full-no copay	Coverage for age appropriate preventive care, hearing aids max \$800
Transplant Services	Covered in full-no copay	Coverage for limited transplants with prior authorization
Dental Care	Excluded unless surgical	\$5 copays per procedure for fillings and extractions Covers periodic cleanings, exams, x-rays, fillings, root canals. Annual max \$500.
Podiatry Services	\$2/visit	Excluded
Skilled Nursing Facility	Long-term care-may have to pay portion of income	Covered in full
Hospice Care	Long-term care-may have to pay portion of income	Excluded
Home Health Care	Long-term care-may have to pay portion of income	Covered in full
Spinal Manipulation	Excluded	Excluded

^{a/} KaiserCommission on Medicaid and the Uninsured. Benefits by State: Colorado 2004. www.kff.org. Colorado Department of Healthcare Policy and Financing (HCPF) www.chcpf.state.co.us/HCPF/elig/Q9.asp.

^{b/} Colorado HCPF, Child Health Plan Plus, Summary of Benefits, www.cchp.org/chpweb/mainPage.cfm?PageToLoad=summaryOfBenefits.cfm. Colorado HCPF, Child Health Plan Plus, Annual Enrollment Fee and Copayments, www.cchp.org/chpweb/mainPage.cfm?pageToLoad=annualEnrollmentFeeChart.cfm. Copays have been modified based on sliding scale.

Source: Lewin analysis of A Plan for Covering Coloradans, Committee for Colorado Health Care Solutions, Appendix H and Medicaid/SCHIP benefit package

- **Private insurance pool:** Individuals not eligible for the expanded Medicaid/CHP+ program would be able to purchase from a variety of standard plans in the purchasing

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pool. There would be two plans to be available under a premium assistance program and at least two plans not available for premium assistance.¹

o Non-Premium Assistance Plans

For modeling purposes, plan benefits for people who would not be receiving premium assistance would be based on the Colorado Federal Employee Health Benefits Program (FEHBP) but would vary based on cost-sharing arrangements and deductibles. For illustrative purposes, we assume the following Plan choices:

- One plan based on a Colorado FEHBP benefit package with standard PPO cost-sharing arrangements (**Figure 2, Plan A**); and
- A less expensive high deductible, higher-cost-sharing health plan (**Figure 2, Plan B**). For illustrative modeling purposes, we assume that this least expensive plan would be the plan into which people who are not eligible for premium assistance would be auto-enrolled at the time of tax filing.

People not seeking premium assistance could also choose either of the plans offered in the premium assistance program, but would have to pay the full cost, less their employer contribution.

**Figure 2
Non-Premium Assistance Benefits, Cost Sharing and Limitations**

Benefit	Plan A Nationwide BCBS Benefit Plan (Standard)	Plan B Aetna HealthFund - All of Colorado (High Deductible Health Plan)
Medical Fund (HSA)	Not Applicable	Plan contributes to HSA on a monthly basis. In 2007, for each month member is eligible for an HSA premium pass through, plan contributes \$125 per month (Self)/\$250 (Self+Family) to HSA
Dental Fund	Not Applicable	Not Applicable
Adult Preventive Screenings and Office Visits	\$15 office visit copayment No copays for covered preventive screenings	No copays for in-network provider.
Child Preventive Care	No copays for covered services	No copays for in-network provider.

¹ Lewin would determine how to allocate people among plans based on the Health Benefits Simulations Model (HBSM) data and assumptions.

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Benefit	Plan A Nationwide BCBS Benefit Plan (Standard)	Plan B Aetna HealthFund - All of Colorado (High Deductible Health Plan)
Inpatient services	\$250 yearly deductible	Member pays 100% of allowable charges until deductible of \$2,500 (Self)/\$5,000 (Self+Family) is met - then 10% of Plan allowance.
Home and office visits	\$15 office visit copayment	Member pays 100% of allowable charges until deductible of \$2,500 (Self)/\$5,000 (Self+Family) is met - then member pays 10% of Plan allowance.
Outpatient physical, occupational, and speech therapy	\$15 for each visit 75 visit maximum per year	Member pays 100% of allowable charges until the deductible of \$2,500 (Self)/\$5,000 (Self+Family) is met - then member pays 10% of Plan allowance.
Mail service pharmacy	Up to a 90 day supply \$10 copayment for generic drugs \$35 copayment for brand name drugs	Mail Order Pharmacy, for 31-day to 90-day supply per prescription or refill: \$20 copay per generic formulary drug; \$50 copay per brand name formulary drug; and \$80 copay per non-formulary (generic or brand name) drug.
Retail pharmacy	Up to a 90 day supply 25% PPA at the time of purchase	Up to a 30-day supply per prescription or refill Once the deductible is satisfied, the following will apply: \$10 copay per generic formulary drug; \$25 copay per brand name formulary drug; and \$40 copay per non-formulary (generic or brand name) drug.
Hospital Inpatient	\$100 per admission copayment	Member pays 100% of allowable charges until deductible of \$2,500 (Self)/\$5,000 (Self+Family) is met - then 10% of Plan allowance.
Outpatient Facility Care, excluding laboratory and X-ray services	Subject to \$250 calendar year deductible	Not covered

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Benefit	Plan A Nationwide BCBS Benefit Plan (Standard)	Plan B Aetna HealthFund - All of Colorado (High Deductible Health Plan)
Outpatient Facility, physical, occupational and speech therapy	\$15 copayment per visit	Member pays 100% of allowable charges until you meet deductible of \$2,500 (Self)/\$5,000 (Self+Family) is met - then 10% of Plan allowance.
Outpatient Facility, laboratory and X-ray services	Subject to \$250 calendar year deductible	Member pays 100% of allowable charges until deductible of \$2,500 (Self)/\$5,000 (Self+Family) is met - then 10% of Plan allowance.
Outpatient Surgery	10% PPA	Member pays 100% of allowable charges until deductible of \$2,500 (Self)/\$5,000 (Self+Family) is met - then 10% of Plan allowance.
Accidental Injury — emergency room care and ambulance services	None for covered charges for services rendered within 72 hours of the accident \$50 co-pay per-trip for ambulance services	Member pays 100% of allowable charges until deductible of \$2,500 (Self)/\$5,000 (Self+Family) is met - then 10% of Plan allowance.
Medical Emergency — facility care	\$250 calendar year deductible, then 10% PPA	Member pays 100% of allowable charges until deductible of \$2,500 (Self)/\$5,000 (Self+Family) is met - then 10% of Plan allowance.
Medical Emergency — physician care	\$15 office visit copayment	Member pays 100% of allowable charges until deductible of \$2,500 (Self)/\$5,000 (Self+Family) is met - then 10% of our Plan allowance.
Outpatient professional services	\$15 office visit copayment	Member pays 100% of allowable charges until deductible of \$2,500 (Self)/\$5,000 (Self+Family) is met - then 10% of Plan allowance.
Spinal manipulations	Up to 12 spinal manipulations per year \$15 copayment	Not covered. Member is eligible for discounts through Alternative Health Program
Routine Dental Care	Benefits paid according to yearly fee schedule	Not covered

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Benefit	Plan A Nationwide BCBS Benefit Plan (Standard)	Plan B Aetna HealthFund - All of Colorado (High Deductible Health Plan)
Catastrophic Benefits	Plan pays 100% after member meets \$4000 out-of-pocket in coinsurance, copayment and deductible expenses	<u>Self Only:</u> In-network: \$4,000 annual out-of-pocket maximum. Out of-network: \$5,000 annual out-of-pocket maximum. <u>Self and Family:</u> In-network: \$8,000 annual out-of-pocket maximum . Out of-network: \$10,000 annual out-of-pocket maximum is \$10,000.

Source: The Lewin Group analysis of Federal Health Employee Benefits schedule in Colorado.

o Premium Assistance Plans

For the premium assistance program there would be two plans available with comprehensive benefits, one an HMO and the other a PPO (see **Figure 3**). The premium assistance plans would offer low deductibles, first dollar coverage for preventive services, minimal to no co-payment for chronic disease medications, and lower cost-sharing for use of safety net providers and other “high-value” providers. Copayment would be applied as specified in **Figure 3**. There would be no copayment for people with income below 100 percent of poverty and no copayment for preventive care or chronic disease management.

**Figure 3
Premium Assistance Plan Benefits, Limits and Out-of-Pocket Payments**

Covered Benefits	Benefit Limits and Out-of-Pocket Payments
Physician/Routine Office Visit	0-250%: \$5 copay 251-399%: \$10 copay
Prevention	0-250%: Covered in full 251-399%: Covered in full
Maternity Care	0-250%: Covered in full 251-399%: 90% coinsurance
Urgent Care	0-250%: \$5 copay 251-399%: \$10 copay

² This is Appendix G of the proposal.

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Covered Benefits	Benefit Limits and Out-of-Pocket Payments
Outpatient Hospital Surgical All Other Outpatient	All outpatient hospital 0-250%: Covered in full 251-399%: 90% coinsurance
Ambulance- Emergency	0-250%: covered in full 251-399%: \$25-50 copay
Hospital-Emergency	0-250%: \$15 copay 251-399%: \$25-50 copay
Inpatient Hospital	0-250%: covered in full 251-399%: 90% coinsurance
Lab and X-Ray	0-250%: Covered in full 251-399%: 90% coinsurance
Other Diagnostic (e.g. CT,MRI, PET, Nuclear)	0-250%: Covered in full 251-399%: 90% coinsurance
Transplants	0-250%: Coverage limited w/prior authorization 251-399%: 90% coinsurance for covered transplants
Family Planning	0-250%: Covered in full 251-399%: Covered in full No coverage for infertility treatment
Mental Health	Neurobiologically based MI Parity: inpatient same as hospitalization; outpatient same as medical office visit Other Mental Services Parity: inpatient same as hospitalization; outpatient same as medical office visit
Substance Abuse	Residential Same as inpatient hospital Outpatient \$5 copay
Therapies (Speech, PT, OT)	0-250%: \$5 copay 251-399%: 90% coinsurance Limited to 30 visits per year for diagnosis
Durable Medical Equipment	0-250% Covered in full Annual maximum \$2,000 251-399% 90% coinsurance Annual maximum \$2,000
Prescription Drugs	0-250% \$2 Generic \$5 brand 251-399% \$10 copay preferred generic

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Covered Benefits	Benefit Limits and Out-of-Pocket Payments
	\$15 copay preferred brand \$25 copay non-preferred All income levels No copays for chronic disease management drugs
Vision	0-250% Exam, specialty care covered Copay \$5; \$100 towards lenses, frames, or contacts 251-399% 90% coinsurance for exam, specialty care; \$50 towards lenses, frames, or contacts
Dental	0-250% Periodic cleaning, exams, xrays, fillings, extractions, root canals Annual maximum \$750 251-399% 90% coinsurance Annual maximum \$750 Dental services resulting from an accident 0-250%: Covered in full 251-399%: 90% coinsurance No annual maximum
Audiology	0-250% Hearing aids, copay \$25 Annual maximum \$1000 251-399% Hearing aids, 90% coinsurance Annual max \$1000
Skilled Nursing Facility	0-250%: Covered in full 251-399%: 90% coinsurance 100 days per year maximum
Hospice	0-250%: Covered in full 251-399%: 90% coinsurance
Home Health	0-250%: Covered in full 251-399%: 90% coinsurance
Deductibles	None for < 250% FPL \$150 per person per year for all others Not applicable to preventive care (e.g., routine physicals, immunizations, PAP tests, mammograms, and other screening and testing provided as part of the preventive care visit) or office visits (primary care, consultations, mental health and chemical dependency outpatient visits, office-based surgeries, and follow-up visits)
Maximum	5% of yearly income annual maximum

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Source: A Plan for Covering Coloradans, Committee for Colorado Health Care Solutions,
Appendix G

C. Premiums and Subsidies

Premiums would be charged to obtain coverage through the private plans pool. Premium rates for all covered units (individuals, individuals with spouses, individuals with children and families) in the pool living in the same geographic area would be the same for a specific insurer's plan (i.e., community rating).

Estimated Single and Family premiums by Age and Gender under the non-premium assistance program (see **Figure 2**, Plan A and Plan B above) are as follows:

Nationwide BCBS Benefit Plan (Plan A)			Aetna Health Fund (Plan B)		
Medical Expense PEPM by Age/Gender/Tier			Medical Expense PEPM by Age/Gender/Tier		
Contracts Effective 1/1/2009			Contracts Effective 1/1/2009		
	Monthly Medical Expense per Employee			Monthly Medical Expense per Employee	
Age/Gender	Single	Family	Age/Gender	Single	Family
<25 M	\$167	\$604	<25 M	\$170	\$615
25 - 34 M	\$204	\$881	25 - 34 M	\$208	\$897
35 - 44 M	\$270	\$1,051	35 - 44 M	\$275	\$1,071
45 - 54 M	\$454	\$1,182	45 - 54 M	\$462	\$1,205
55 - 64 M	\$771	\$1,412	55 - 64 M	\$786	\$1,439
<25 F	\$299	\$644	<25 F	\$304	\$656
25 - 34 F	\$376	\$908	25 - 34 F	\$383	\$926
35 - 44 F	\$438	\$1,007	35 - 44 F	\$446	\$1,026
45 - 54 F	\$577	\$1,190	45 - 54 F	\$588	\$1,213
55 - 64 F	\$830	\$1,461	55 - 64 F	\$846	\$1,489

Source: NovaRest Consulting

Estimated Single and Family Premiums by Age and Gender for the Premium Assistance Plan (**Figure 3** above) are as follows:

Premium Assistance Plan
Medical Expense PEPM by Age/Gender/Tier
Contracts Effective 1/1/2009

	Monthly Medical Expense per Employee	
Age/Gender	Single	Family
<25 M	\$170	\$613
25 - 34 M	\$207	\$893
35 - 44 M	\$274	\$1,066

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45 - 54 M	\$460	\$1,199
55 - 64 M	\$782	\$1,433
<25 F	\$303	\$653
25 - 34 F	\$381	\$922
35 - 44 F	\$444	\$1,021
45 - 54 F	\$585	\$1,207
55 - 64 F	\$842	\$1,482

Source: NovaRest Consulting

Employers would be required to allow workers to pay their share of premiums through a payroll deduction and would be required to establish a section 125 plan for workers. The proposal would provide premium assistance to people with income up to 400 percent of FPL from a shorter list of plans that participate in premium assistance, with the government being the payer of last resort. The premium assistance would be as follows:

- Full subsidies for individuals and families at or below 200% of FPL;
- Sliding scale up between 201-400% of FPL as follows
 - 201-250 percent FPL - 90 percent subsidy
 - 251-300 percent FPL - 80 percent subsidy
 - 301-350 percent FPL - 60 percent subsidy
 - 351-400 percent FPL - 25 percent subsidy; and
- No subsidy for any individuals or families above 400% of FPL.

Note: Subsidy levels for 251-300 percent are for illustrative purposes. The author requested that Lewin assume a sliding fee scale which is non-linear, with very little premium sharing on the lower end of the scale and larger increments of increased subsidies per increase FPL as one moves up the scale, to account for the fact that persons between 200% and 250% have almost no capacity to share in premiums.

A benchmark premium would be negotiated by the Authority for the subsidized plans. For modeling purposes, the median premium of plans participating in the premium assistance pool would be the benchmark premium. Workers in self-insured employers who offer benefits package that meet the minimum benefits package established by the Authority would also be eligible for subsidies.

Employers would define their level of contribution. If the employer contribution would not cover the full cost of the individual or family coverage, employee dollars would be applied through a payroll deduction up to a maximum out-of-pocket premium defined by income, the subsidy schedule and the benchmark premium. *For example:* for people between 201-250 percent of poverty, once the employer makes their contribution, the individual/family would be expected to pay up to 10 percent of the benchmark premium plus any amount in excess of the benchmark the plan they select costs. The government would pay the remainder.

Example: government subsidy amount for people between 201-250 percent of poverty

$$\text{Government Subsidy} = (90\% \times \text{benchmark premium}) - \text{employer contribution.}$$

D. Consumer Choice

Consumers in the private pool would be able to choose among a number of plans based on a limited set of standardized, comprehensive benefits packages and the characteristics of type of plan (e.g., HMO, PPO, etc.), price, and customer service rating. Consumers enrolled in the premium assistance programs would be able to select among just two of these plans, one an HMO, the other a PPO, both with low cost-sharing (**Figure 3**).

People who are eligible for government sponsored programs (combined Medicaid/SCHIP) would be enrolled in a managed care plan—automatic or passive enrollment would kick in if they do not select a plan. Individuals who are not eligible for the Medicaid/CHP+ program who do not select a plan would be assessed a fee by the Department of Revenue equal to the cost of the annual premium in the lowest cost plan and provided enrollment information. Individuals would not be disenrolled for non-payment of premiums but would face penalties.

E. Administration

The Department of Health Care Policy and Finance would continue to administer the newly combined Medicaid/CHP+ program. Administration of premium subsidies and penalties would be through the tax system under the Colorado Department of Revenue.

The proposal creates an independent, quasi-governmental Authority with a governance Board responsible for setting policy and standards, and an administrative structure to manage the private pool. The pool would provide participating employers with standardized information about plans and enrollment forms to set up Section 125 plans for workers.

The Authority Board would perform the following:

- Define the minimum benefit package;
- 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;
- Establish a benchmark premium for the premium assistance program
- Bring stakeholders together to develop a standardized uniform billing and payment system; and
- Convene stakeholders to select robust outcome measures and determine how accountability and incentives for delivery of high quality care is allocated.

Administrative functions of the Authority would include but not be limited to, certifying plans, assuring regional coverage and network adequacy, enrollment of individuals and groups in plans of their choosing, collecting premiums, collecting claims data from insurers and managing

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the risk adjustment process and disbursing payments to insurers, assuring public outreach and education, etc.

Health plan responsibility for claims processing and network development would continue. However, there would be a decrease in broker functions as the Authority conducts enrollment and premium collection. In addition plan underwriting function be eliminated as a result of the community-rated pool.

F. Financing

Employers would be required to offer coverage or pay an assessment which can be waived for employers who provide adequate coverage for the employees. Adequate coverage would be defined as offering health benefits that meet or exceed the minimum benefit package defined by the Authority, and contributing at least 85% of the median cost of a standard individual plan. Financing, which includes a set of new tax assessments to fully fund the proposal is as follows:

- a. **Employer Assessment:** An employer assessment that would be based on the number of full-time equivalents of workers not offered a plan meeting the benchmark benefit, multiplied by the annual per worker assessment. For illustrative purposes, the annual per worker assessment would be \$347. The amount is prorated for part-time workers. Business Groups of 1 (BG1), i.e., self-employed and the federal government would be exempt from paying the assessment.
- b. **Premium Tax:** A premium tax on insurers by redistributing a portion of the insurer's administrative costs savings through the proposal to a premium assistance fund.
- c. Savings that can be gained from the following could also be used to finance the program:
 - Any savings from Medicaid enrollees being required to use 340B drugs;
 - Any savings from adopting a formulary similar to Oregon's Medicaid formulary for the Medicaid/CHP+ newly expanded program;
 - Savings from requiring that Medicaid/CHP+ population enroll in a mandatory, capitated, statewide managed care program;
 - Implementing mandatory case management for high users/high cost individuals; and
 - Implementing a statewide nurse advice line.
- d. **Other Fund Sources:** Additional moneys to fully fund the proposal as follows:
 - A provider tax on revenues (estimated to approximate the value of average uncompensated care cost-shifting in current prices);
 - An increase in tobacco—from \$.84 up to \$2.00 per pack; and
 - An increase in alcohol taxes as follows
 - Spirits: from \$.60 to \$5.63 for a liter (or from \$2.28 to \$21.30 per gallon)

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- Wine: from \$.07 to \$.66 per liter (or from \$.32 to \$2.50 per gallon)
 - Beer: from \$.05 to \$.15 per 6-pack (or \$.08 to \$.26 per gallon)
- e. If there remains a deficit in funding, the following financing options would be modeled:
- Option 1: An increase in the income tax
 - Option 2: Property and sales taxes taking into account the higher collection costs;

The income and property tax options are not part of the proposal. Estimates are provided for informational purposes to assist the Author in assessing the level of increased taxation that would be required to fully fund the proposal using the employer assessment and an income tax increase.

With respect to any of the taxes under this section of the specifications, Colorado's Taxpayers Bill of Rights (TABOR) and the Arverschoug-Bird law which impose limits on state spending without voter approval, and other tax laws would likely have implications to the financing mechanisms analyzed in this proposal.

G. Disposition of State/Local Programs

Because plans would be required to guarantee issue using community rating, CoverColorado, the state's high risk pool would be eliminated. As discussed above the proposal combines Medicaid and CHP+ and expands these programs. Otherwise, all other public programs would remain.

H. Provider Payment Levels

For services under the newly expanded Medicaid/CHP+ program, providers would be paid as follows:

- Option 1:
 - For services under the newly expanded Medicaid/CHP+ program, providers would be paid Medicaid rates
 - Insurer plan payments in the private pool would be risk adjusted by the Authority using claims to account for health risks among enrollees in the plan.
- Option 2: Medicare rates (to approximate reimbursement rates that would fully cover the average cost of providing services). [This is not currently modeled. If modeled, summary tables of changes in state, local and federal spending would provide a comparison of the impact of Medicaid and Medicare rates].

I. Health Information Technology-Pending

The proposal recommends funding rapid development of HIT by the Colorado Department of Health and Environment to create an Office of Health Information Technology (OHIT) which would be responsible for the following:

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- Creating standards of interoperability;
- 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;
- Provide technical assistance to providers who are selecting systems.

J. Insurance Market Reforms

The proposal retains the private insurance market, but creates a pooling mechanism by combining individual, large group and small group markets through which issuers offer coverage and purchasers buy coverage, to include all insurers, individuals, and employers (except those exempt from state regulation who choose to offer self-funded coverage).

The proposals requires guaranteed issue and implements a pure community rating—plans would not be allowed to base premium rates based on any attributes related to health status or risk. Dependent adults would be eligible to be covered under their parent’s policies until 26 years old. Plans would not be allowed to develop risk-adjusted rates, but would receive risk adjusted payments from the Authority.

Title	Colorado Health Services Program – Single Payer
Author	<i>Health Care for All Colorado Coalition</i>

The Colorado Health Services (CHS) Program is a single payer plan that would provide coverage to all residents of the state, including state and local workers, and residents currently covered under Medicare, Tricare and Federal Health Benefits programs. The program would provide comprehensive health care benefits equivalent to the Colorado Medicaid benefits package to all. Consumers would have their choice of providers and hospitals within the state.

No premiums would be required but there would be some cost-sharing required. The program would be financed with savings in going to a single payer system and taxes. The CHS program would be administered by a publicly owned non-for-profit governing board. The following present detailed specifications of the CHS Program:

A. Coverage

All Colorado residents, including state and local government workers and retirees would be covered under the proposal. Residency would be defined as anyone who has resided in Colorado for 3 months or who works in the State of Colorado. During the first 2 years of the program, all Colorado residents would be determined presumptively eligible for the minimum benefit package. So, during the first 2 years of the effective date of the program, all individuals who present for services would not be required to show any evidence of coverage.

B. Covered Services

All individuals would be eligible for the Medicaid benefits package as the core benefit package (**Figure 1**). Long term care services would be covered subject to the following:

- For nursing home eligible Medicaid recipients, room and board for a nursing home stay would be covered as under current law;
- For those who are not Medicaid-eligible nursing home long-term care would only include the medical component—room and board would be excluded; and
- In the first year there will be allowance for a 25% increase in home and community-based care.

In addition, plans can provide enhanced benefits depending on the specific needs of each of the five regions. Employers would also be permitted to provide additional coverage not provided under the CHS benefit package.

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Figure 1
Colorado Health Services Benefit Schedule

	Medicaid^a
Premium/Deductible	None
Max Annual Out-of-Pocket	None
Coinsurance/Copays^{b/}	Limited copay for some services if enrolled in Primary Care Physician Program (PCPP). No copays if enrolled in HMO, 18 or younger, pregnant or in a nursing home.
Lifetime Benefits Max Paid by Plan	No limit
Services	
Emergency Services	Covered in full-no copay
Emergency Transport-Ambulance Services	Covered in full-no copay
Inpatient Hospital Stay	\$15/visit
Outpatient Ambulatory Surgery	\$3/visit
Lab, x-ray and Diagnostic Services	Covered in full-no copay
Medical Office Visit	\$2/visit
Preventive Services	Covered in full-no copay
Maternity Care	Covered in full-no copay
Neurobiologically Based Mental Illness	Covered in full-no copay
Other Mental Health Services	Covered in full-no copay
Alcohol and Substance Abuse Treatment	Covered in full-no copay
Physical, Occupational and Speech Therapy	Covered in full-no copay
Durable Medical Equipment	Covered in full-no copay
Prescription Drugs	\$1 generic, \$3 brand-name
Vision Services	\$2/visit
Audiological Services	Covered in full-no copay
Transplant Services	Covered in full-no copay

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	Medicaid ^{a/}
Dental Care	Excluded unless surgical
Podiatry Services	\$2/visit
Skilled Nursing Facility	Long-term care-may have to pay portion of income
Hospice Care	Long-term care-may have to pay portion of income
Home Health Care	Long-term care-may have to pay portion of income
Spinal Manipulation	Excluded

^{a/} KaiserCommission on Medicaid and the Uninsured. Benefits by State: Colorado 2004. www.kff.org. Colorado Department of Healthcare Policy and Financing (HCPF) www.chcpf.state.co.us/HCPF/elig/Q9.asp.

^{b/} The copays in this table would be applicable to individuals eligible for Medicaid and CHP+ under current law.

Source: Lewin summary of Colorado Medicaid benefits package

C. Cost Sharing

There would be no deductibles under this plan. Cost-sharing provisions would be as follows:

- For people who would be eligible for Medicaid and Child Health Plus (CHP+) under current law, copays would remain at current Medicaid levels. **(Figure 1)**
- For all other people under the CHS plan, services would be same as for Medicaid **(Figure 1)** but with the following copays:
 - No copays for preventive services;
 - \$5 for office visits;
 - \$15 for urgent and emergency care; and
 - \$5 generic prescriptions/\$15 brand-name prescriptions

D. Financing

The CHS plan would be financed as follows:

- Colorado would seek agreement with the federal government for matching funds for CHS plan services provided to people who would have been eligible for federal programs (i.e., Medicare, Medicaid, Tricare/CHAMPUS, and the Federal Employees Health Benefits Plan);
- All current State and Local government health spending would be transferred to the program (i.e., Medicaid, employee health benefits, worker’s compensation and other safety net program funding); and

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- The remainder of CHS program would be financed as follows:
 - All employers, including those that do not currently offer coverage and self-employed people, would pay a 4 percent employer payroll tax; and
 - Individuals and families, including self-employed people, would pay an income tax surcharge.

Note: Colorado's Taxpayers Bill of Rights (TABOR) and the Arverschoug-Bird law which impose limits on state spending without voter approval would likely have implications to the financing mechanism in the single payer proposal.

1. Provider Payment Levels

Provider payment levels would be set at the average level of reimbursement across all payors for health care services under current law.

2. Administration

The CHS program would be administered by a publicly owned non-for-profit governing board comprised of 15 members. The state would have five regional offices under the governing board for the purpose of local administration, medical directorship, outreach and oversight of programs that may be specific to each of the 5 regional needs, as follows:

- North-central and Northwest;
- South-central and Southwest;
- Southeast and East-central;
- Northeast; and
- Denver Metro

The CHS Board would provide oversight and administrative direction for the CHS. All decisions of the CHS Board will be final in regard to administration and implementation of health care within the state unless otherwise directed by the courts or state statute. The board would also be responsible for conducting initial reviews of medical malpractice claims. The Legislature cannot remove funds allocated to the trust without the consent of the people. In addition, the CHS cannot operate in a deficit and the administrative overhead of the CHS cannot exceed 5% of total expenditures.

E. HIT

The CHS program calls for a statewide, fully integrated Information Technology network that can be expanded upon with Colorado Health Regional Information Organization (COHRIO). The proposal does not provide any specific funding to put into HIT development. HIT would include electronic medical records, billing/claims adjudication, and centralized data support

Title	Better Health Care for Colorado
Author	SEIU

Better Health Care for Colorado provides a path to universal health care through a public program expansion and access to private insurance coverage with low-income subsidies through a Health Insurance Exchange. Individuals eligible for public programs would receive benefits under those programs and individuals purchase private coverage would have access to a limited core set of benefits, with premiums copays. Financing for the program would be using DSH dollars, savings in uncompensated care and other administrative savings.

A. Coverage

Public Program Expansion: The proposal extends health coverage to uninsured, low-income populations up to 300 percent of the federal poverty level (FPL) through the Medicaid and Child Health Plus (CHP+) programs under Medicaid/SCHIP SPAs and an 1115 Demonstration Waiver, as follows:

- Children up to 300% FPL – Medicaid/SCHIP SPA; and
- Parents up to 250% of FPL and childless adults up to 225% FPL – 1115 Demonstration waiver to authorize Medicaid-funded premium subsidies to purchase private insurance through an Exchange (not a traditional Medicaid benefit package or entitlement).

The following populations are excluded:

- People with ESI and the employer pays at least 20 percent of costs for single or 30 percent for families;
- People with private non-group insurance;
- People with Medicare or Medicaid coverage;
- People covered under the Federal Employee Health Benefits Program (FEHBP);
- People with state or local employee health benefits; and
- And people covered under CHAMPUS/Tricare.

Private Coverage Expansion: Under the proposal, uninsured Colorado residents who work in qualified small business (including part-time workers) would purchase private insurance coverage through an Exchange. The worker would have to have been employed in a firm with 50 or fewer workers who has not offered employer sponsored insurance coverage (ESI) for at least one year.

Residency Requirement. The residency requirement would be the same as in the Colorado Medicaid program, for children eligible for Medicaid or CHP+ and for parents and childless adults eligible for Medicaid-funded premium subsidies. Undocumented aliens who are low-

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income or who work for uninsured small businesses would be eligible to buy insurance from the Exchange, however no subsidies would be provided to purchase insurance.

B. Covered Services, Cost Sharing and Benefit Limits

Individuals who are currently eligible for Medicaid and CHP+ would receive the benefits under those programs, including pharmacy benefits and long term care. Applicable cost-sharing requirements under the Medicaid program would apply.

Parents and childless adults in the expansion population and other uninsured workers would enroll in private plans and receive a minimum benefit package described below. Private plans would be required to offer a minimum benefit plan, with cost sharing and subject to benefit limits (**Figure 1**). Copayments would be enforceable and would not exceed the following:

- Under 100 percent FPL, no copayments required;
- 100-200 percent FPL, maximum copayment of 2 percent of income; and
- 200-300 percent FPL, maximum copayment of 4 percent of income.

However, copayments could be waived as an incentive for wellness/healthy behavior. The proposal would establish a medical home and emphasize access to affordable coverage for primary care services. The minimum benefits package would also create a preferred drug list by a specialty pharmacy program.

Figure 1
Potential Colorado Benefit Design for Core, Basic Benefit, Cost Sharing and Limits^{a/}
Based on May 30, 2007 Assumptions

Covered Benefits/Services	Copayments	Limits
All Benefits		\$35,000 Annual Maximum
All Outpatient Services		\$5,000 Annual Maximum
✓ Physician Services <ul style="list-style-type: none"> ▪ Primary Care (including adult preventive services & specialist monitoring a chronic condition) ▪ Specialist Care 	\$10 \$20	
✓ Urgent Care	\$25	
✓ Outpatient Hospital <ul style="list-style-type: none"> • Surgical Services • Other Outpatient Services 	\$50 \$25	
✓ Ambulance (emergency)	\$50	
✓ Laboratory & X-Ray	\$0	
✓ Family Planning Services	\$0	
✓ Mental Health Services	Sliding scale	
✓ Therapies (consistent w/HMO benefit)	\$10	
Other Services		

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Covered Benefits/Services	Copayments	Limits
✓ Inpatient Hospital Services	\$100	\$25,000 Annual Maximum
✓ Emergency Services	\$50*	\$1,000 Annual Maximum
✓ Durable Medical Supplies/Equipment	\$50	\$1,500 Annual Maximum
✓ Prescription Drugs <i>(Medicaid FFS carve-out, if broad-based PDL is implemented)</i>	Generic-\$5 Brand-50% of cost, \$25 minimum	\$2,500 Annual Maximum

^{a/} Plans would be allowed to offer a \$25,000 maximum annual limit for all services and enhanced benefits.

Source: Better Health Care for Colorado.

The minimum benefit would establish a "floor" for benefits, a guaranteed subsidy for participants and a payment schedule for providers that varies by gender, age and potentially geographic area. Insurers could offer enhanced benefits and employers and unions could negotiate for more comprehensive coverage from selected plans; these plans would be required to extend that benefit package to all participants who choose that product on the Exchange.

In addition, the Exchange could offer different options for insurance coverage such as a more comprehensive "benchmark" benefit plan with higher participant cost sharing (like a State employee plan) or, for participants who are at high risk and would qualify for the state's high risk pool, a higher premium subsidy to enroll in CoverColorado.

In place of supplemental or wrap-around coverage the State could continue to use a portion of DSH to reimburse uncompensated care in excess of insurance coverage or, through the low-income pool, could use reinsurance or establish outlier payments for costs that exceed the annual limits.

Long term care services would continue to be provided under the Medicaid program and would not be incorporated in the new premium subsidy program.

C. Premiums and Subsidies

Premiums would be set based on the benchmark minimum benefits above. However, monthly per member per month costs for the core benefit would be targeted at \$150-\$200. Individuals who do not pay their monthly premium would be disenrolled. For specific insurance products already offered, such as CoverColorado, existing policies & procedures would apply.

Estimated Single and Family premiums by Age and Gender for the benefits package in **Figure 1**, are as follows:

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Better Health Care for Colorado
Medical Expense PEPM by Age/Gender/Tier
Contracts Effective 1/1/2009

*Monthly Medical Expense per
Employee*

Age/Gender	Single	Family
<25 M	\$143	\$517
25 - 34 M	\$175	\$753
35 - 44 M	\$231	\$899
45 - 54 M	\$388	\$1,011
55 - 64 M	\$660	\$1,208
<25 F	\$256	\$550
25 - 34 F	\$322	\$777
35 - 44 F	\$374	\$861
45 - 54 F	\$493	\$1,018
55 - 64 F	\$710	\$1,250

Source: NovaRest Consulting

Premium subsidies would be offered for low income people by eligibility group as outlined in #1, on a sliding fee scale as follows:

- Under 100 percent FPL, no premiums required;
- 100-200 percent FPL, 98 percent premium subsidy;
- 200-300 percent FPL, 96 percent premiums subsidy; and
- Above 300 percent of FPL, no premium subsidies.

In addition, premium discounts could be offered through a wellness/healthy behavior initiative, along with value-based purchasing discounts to encourage use of cost-effective protocols for specific diseases (i.e. diabetes).

Low income individuals who receive a subsidy and enroll in a higher cost plan would be responsible for any additional premiums in excess of the subsidy provided for the core, basic benefit plan, with the exception of those eligible for the State's high risk pool.

The Exchange will establish a system to administer premium subsidies and collect premiums through payroll deductions and, if not employed, through coupon payments or EFT. Alternatively, any functions now operated by the state for a Medicaid health insurance purchase arrangement or other premium collection system could be expanded to collect premiums for the expansion population.

D. Consumer Choice

Currently Medicaid and CHP+ eligible people would enroll in these programs and cannot enroll in a private plan. The Medicaid program would operate under a fully-capitated MCO

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model on a statewide basis and Primary Care Case Management (PCCM) in rural areas. The managed care program would be mandatory for all currently Medicaid eligible populations except dually-eligible. Under the expansion population, children would enroll in the Medicaid or CHP+ programs.

Parents, childless adults and uninsured workers and families would be able to buy private market products offered by a Health Insurance Exchange. Low-income workers who are eligible for a premium subsidy would have the choice to opt out of the plan to enroll in ESI using the premium assistance to pay for their employee contribution.

Plans would compete through an exchange by offering lower cost-sharing or enhanced benefits packages, for example, lower-cost benefit plan that offers primary and preventive coverage with an annual benefit limit of \$25,000 or \$35,000. The Exchange would certify plans with preference for HMOs and PPO products that incorporate care management and managed care principles.

Individuals with higher health care costs or chronic conditions would have the option to select a product with broader coverage (e.g., a benchmark plan with more comprehensive coverage and higher cost sharing like the State Employees Health Plan with broader coverage or, if eligible under the criteria required for enrollment in the state's high risk pool, CoverColorado). In these instances the annual limit would not apply, but rather the alternative plan provisions selected by the participant would provide a choice of coverage with more comprehensive benefits and higher cost sharing. As noted, a higher subsidy could be provided for those eligible for CoverColorado to eliminate any financial disincentive to enroll in that program if an individual is high risk and qualifies for the program.

E. Enrollment and Coverage Continuation

The plan would specify an initial period of 60 days to enroll once eligible, an annual open enrollment period, and a lock-in period of one year, with exceptions for good cause, such as changes in employment, income or marital status. For specific insurance products already offered, such as CoverColorado, existing policies and procedures would apply. Individuals could be disenrolled for failure to pay premiums, or denied service for failure to pay required cost sharing after a 30 day grace period.³

F. Disposition of State/Local Programs

The plan expands Medicaid and CHP+ as specified above. In addition the plan proposes to establish a high-quality, capitated Medicaid managed care program statewide. All other public programs such as Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Mental Health clinics, CoverColorado school based health services, etc, would be maintained.

³ The proposed grace period is to be comparable to that used in the individual and small group market and ESI coverage.

G. Employer Provisions

Any employer contribution for the subsidized population would be voluntary. Multiple employers could contribute to coverage on the exchange and payroll deductions could be drawn from more than one employer for employees with multiple jobs.

Employers would be required to cooperate with the Exchange to coordinate work site enrollment, payroll withholding and the establishment of a s. 125 plan to assure pre-tax treatment of employee contributions for health care. Employers could also make voluntary contributions for plan coverage.

H. Insurance Market Reforms

A modified community rating (age and gender) would apply for the basic, core insurance product on the Exchange. The Exchange could also allow rates to be established by geographic area. The rating rules that apply for CoverColorado would continue for that program.

I. Insurers' Role

Insurers would offer products to be certified for the Exchange, and would be responsible for meeting benefit requirements (minimum coverage, guarantee issue for products on the Exchange), comply with wellness/healthy behavior, disease management, and for pay for performance requirements. Insurer's roles in marketing, outreach, information sharing and other enrollment functions would be reduced as these functions would be facilitated by the Exchange.

J. Financing

The program would be financed as follows:

- DSH payments;
- Unexpended federal SCHIP allotments;
- Other uncompensated care spending;
- Administrative savings from Medicaid resulting from the plan; and
- Currently unmatched state and local funds for health care services (through financing mechanisms approved by the federal government).

K. Provider Payment Levels

For Medicaid and CHP+ services providers would be paid at the Medicaid and CHP+ payment levels. For the expansion population purchasing insurance on the Exchange, providers would be paid at Medicare or comparable market rates. The following additional pay-for-performance incentives would be provided:

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- For hospitals, future increases will be distributed on a provider specific basis depending on their “score”. For example, if the budget provides an overall 3% increase in hospital rates, individual hospital rates could range from 4.5% to zero depending on their score. Insurers in the Exchange and other insurers would be encouraged to emulate the hospital P4P program in their payment designs.
- For Medicaid MCOs – the construct is to set rates at the bottom of the rate range and create incentives for outstanding plan performance that would get a MCO to the mid-point of the rate range. For products offered through the Exchange, a portion of the subsidy will be tied to outcome performance.
- Physician P4P would be required for MCOs or PCCM vendors in Medicaid managed care and for all plans offered through the exchange.

Rate updates for Medicaid and CHP+ would continue as a function of the state budget process. For the private plans, the Exchange would review and approve rates to be offered, subject to approval of funding in the state budget process.

L. Administration

For the public program expansion (parents and childless adults) and for private plans (unsubsidized small business employees), plan selection and enrollment would be facilitated by a quasi-public entity, “the Exchange”. Medicaid and CHP+ administration would continue upon the plan effective date; however, the state could phase in to the Exchange model and could explore the extent to which other existing programs/structures could perform some of the Exchange functions. Functions of the Exchange would be as follows:

- Offer products to subsidized uninsured and non-subsidized small businesses;
- Facilitate enrollment, certify plans, administer premium subsidies, collect premiums through payroll deductions, coupon payments and EFT, ensure portability, and leverage pre-tax contributions to reduce cost.;
- Create an environment where providers would compete on price, quality, and provider networks;
- Certify plans with a preference for managed care and PPO products that incorporate care management and managed care principles, to provide a choice of insurance options, including:
 - Limited benefit health plan with first dollar coverage and annual benefit limit of \$25,000 to \$35,000;
 - A pre-paid and/or point-of-service plan;
 - A benchmark plan with more comprehensive coverage and higher participant cost sharing, such as the State Employee Health Insurance Plan;
 - State care initiatives (i.e., Colorado Indigent Care Program); and
 - If eligible, the Colorado high risk pool.

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In addition to providing access to affordable insurance for the subsidized population, the Exchange would be a platform to offer more accessible, affordable products to uninsured small businesses with streamlined administration and portability for workers. Regulation of insurers in the marketplace would continue to be the responsibility of the Division of Insurance.

To the extent possible, the Exchange would coordinate with and build on Medicaid eligibility systems for outreach, eligibility determinations and coordination of health plan enrollment for multiple family members. The Exchange would also establish new lines of coordination and communication with employers for work site sign-up, payroll withholding and s. 125 plans.

The administration of long-term care services would remain with the Medicaid program; the Exchange would not administer any long term care services. Individuals requiring long term care system would access information/service via the current, but enhanced single entry points.

M. Long-Term Care Component

The plan proposes the following LTC components:

- Develop Special Needs Plans (SNPs) and other integrated care models;
- Making consumer-directed care a central piece of the reform plan;
- Increasing the clinical threshold for nursing facility placement;
- Identifying policy tools to increasing housing options in the LTC continuum;
- Develop LTC quality initiatives;
- Provide training, particularly to Certified Nurse Assistants (CNAs), to focus on specialized services (e.g., Alzheimer's)

Title	Solutions for a Healthy Colorado
Author	Colorado State Association of Health Underwriters

Solutions for a Healthy Colorado provides coverage to all Colorado residents under a Core Limited Benefit Plan in the private sector and expands coverage under Medicaid and Child Health Plus (CHP+). People who are low income but who would not be eligible for the government programs would receive a premium subsidy. The program would be financed through a combination of program savings and taxes. Detailed specifications of the proposal are as follows:

A. Coverage

All Colorado residents, except those covered under Medicare, Tricare/CHAMPUS and Federal Employee Health Benefits, would be required to obtain coverage through a guaranteed issue Core Limited Benefit Plan. Self-employed individuals would also be required to have coverage. In addition, this proposal expands eligibility of children in Child Health Plus+ (CHP+) to 250 percent of the federal poverty level (FPL) and to parents in Medicaid up to 100 percent of FPL. There are no employer mandates.

For the expansion program, the residency requirements under current law would remain the same. For all others, an individual would be determined a resident subject to the individual mandate if they are a resident for purposes of filing Colorado state income taxes or if they have been in Colorado for at least six-month.

B. Covered Services and Cost-Sharing

Covered services under the Core Limited Benefit Plan, other out of pocket spending and limits would be as follows:

Figure 1
Core Benefits Plan Summary

	In Network	Out of Network	
Routine Office Visit	\$15 Copay	\$15 Copay	Limited to 10 visits per year \$200 max per visit
Preventive Care	\$15 Copay	\$15 Copay	Limited to 1 visit per year plus all child and adult preventative
Individual Deductible	\$100	\$200	
Mental Health and Substance Abuse	80%	60%	\$1000 annual maximum

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	In Network	Out of Network	
Emergency Benefit	\$100 copay	\$100 Copay	\$3000 annual maximum
Hospitalization Cost	80%	60%	\$3000 per day limit
Outpatient/Ambulatory Surgery	80%	60%	\$2000 annual maximum
Lab & X-Ray	80% Coinsurance	60% Coinsurance	\$2000 annual maximum
CT, MRI, Pet, Nuclear	80% Coinsurance	60% Coinsurance	\$2000 annual maximum
Prescription	\$10 Generic \$20 Preferred Brand 100%	50% Coinsurance	\$300 per month maximum
Durable Medical Equipment	80% coinsurance	60% coinsurance	\$1000 annual maximum
Annual Maximum	\$50,000 In and Out of Network		

Source: Solutions for a Healthy Colorado

Eye exams and hearing tests would be covered under routine office visits. Dental services and eyeglasses would be excluded from the Basic Core Limited Benefit package.

Individuals would be able to purchase coverage in a more comprehensive plan offered in the individual market, through their employer group plan or under CoverColorado (the state's high risk pool) if they qualify.

C. Premiums and Subsidies

The low income population who would receive a subsidy would have guaranteed issue for the Basic Core Limited Benefit package. Premiums would be set using a modified community rate—plans would be allowed to rate based on age and health status in the individual and small group markets.

Premiums would also be allowed to vary based upon coverage and enrollment (same as under current law). The following premium categories would apply for group coverage;

- Employee only, employee +spouse;
- Employee + one child;
- Employee + two children;
- Employee + three or more children;
- Employee + spouse +one child;
- Employee + spouse +two children;
- Employee + spouse + three or more children; and
- Child only.

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Lewin estimates the PMPM under the Core Limited Benefit package to be \$178 PMPM. A premium subsidy, in the form of a voucher, would be provided to individuals up to 250% of FPL. The subsidies amounts would be as follows:

- 90% of the premium for a core benefit plan to individuals between Medicaid eligibility and 150% of FPL;
- 70% subsidy to those between 150% and 200% of FPL;
- 50% for those between 200% and 250% of PFL; and
- Above 250% FPL no subsidy

Individuals would be allowed to use their subsidies to purchase insurance from their employer or towards purchase of a higher cost plan. Also, individuals who purchase coverage in a plan that is more comprehensive than the Core Limited Benefit plan would be responsible for the full premium difference between the core benefit plan and the enhanced plan they select. Premiums would be collected in the current fashion by payment directly to the entity or carrier providing the health plan.

The following are estimated premiums for Single and Family coverage by age and gender for the benefits package:

Solutions for a Healthy Colorado

Medical Expense PEPM by Age/Gender/Tier
Contracts Effective 1/1/2009

*Monthly Medical Expense per
Employee*

Two Tier

<u>Age/Gender</u>	Single	Family
<25 M	\$116	\$419
25 - 34 M	\$142	\$612
35 - 44 M	\$188	\$730
45 - 54 M	\$315	\$821
55 - 64 M	\$535	\$981
<25 F	\$208	\$447
25 - 34 F	\$261	\$631
35 - 44 F	\$304	\$699
45 - 54 F	\$401	\$827
55 - 64 F	\$576	\$1,015

Source: NovaRest Consulting

D. Consumer Choice

All licensed products providing at least the Basic Core Limited Benefit would be able to participate in the Connector by paying a fee to register with the Connector. Consumers would have a choice of plans through the Connector. The plan would provide an initial open enrollment window of either 6 or 12-month period. There would be a premium surcharge and pre-existing condition limitations for enrollment beyond the open-enrollment period.

E. Disposition of State/Local Programs

The program increases eligibility of children in CHP+ to 250% of FPL and for parents up to 100 percent of FPL. There are no changes to Medicaid, CoverColorado or other government programs.

F. Insurance Market Reforms

All health insurance carriers doing business in Colorado would be required to offer a Limited Core Benefit Plan. Low income individuals who are eligible for a subsidy would have guaranteed issue for the Basic Limited Care Benefit plan. A standardized, modified community rating would be imposed for pricing—the plan would be allowed age and health status rating flexibility. The only exception would be that health status could not be utilized as a rating or underwriting factor on the guaranteed issue core benefits plan. Health status and claims could be utilized in a +10% to -25% range in the small group market.

The plan proposes that any mandates that affects less than one percent of the insured population by contributes to more than one percent of the costs of coverage should be eliminated. It also recommends creation a safe harbor for employers by adopting rating changes which would permit employers who implement such programs to receive premium savings.

The plan proposes no changes to the large group market; however, it proposes to eliminate the following barriers:

- Requiring the purchase of life insurance when purchasing health insurance;
- Imposing a 35% penalty on individuals and businesses for coming back into the fully insured market;
- Requiring high employee participation in group coverage; and
- Excluding dedicated 1099 employees from group-sponsored health care coverage.

Insurers would continue to perform their current roles in the areas of plan administration, claim processing, network development, marketing and implementation of disease management, transparency and customer service tools.

G. Coverage Continuation

Individuals would receive a 30-day grace period for non-payment of premiums after which coverage can be discontinued.

The State Continuation for groups under 20 and COBRA for groups over 20 will continue to exist. The Connector model, in the short term would provide information and access to health insurance application/assistance. In the longer term, once this program is stabilized, there is the opportunity for the Connector to operate as a mechanism for true portability. Individual Core COBRA and Continuation Coverage would still be available and Basic Core Limited Benefits would be recognized as Creditable Coverage. Individual policies would be as they are now, not subject to these factors. Benefit plans would have guaranteed renewability and portability as long as premiums are paid.

H. Employer Provisions

Pre-tax (Section 125 POP plan) would be encouraged but not mandated. Employer contributions would not be mandated though they would be allowed.

Employers who currently have group medical plans would be required to accept premium subsidy vouchers in payment of part or all of a low wage worker's share of employer sponsored medical coverage. Employers would not be required to offer a selection of medical plans.

I. Financing

The plan would be financed as follows:

- Savings in uncompensated care;
- Employer contributions to a subsidy pool for employers who do not offer employer sponsored coverage; and
- A Nutrition Sales Tax on all consumable food items that have little or no nutritional value to finance the costs that are not covered by participant premiums, including 2% to 5% sales tax on all nutritional fountain sodas and walk-up coffee locations.

Note: Colorado's Taxpayers Bill of Rights (TABOR) and the Arverschoug-Bird law which impose limits on state spending without voter approval would likely have implications to the financing mechanism in this proposal.

J. Tax and Other Incentives

The plan presumes federal law would allow income tax deduction for the premiums paid by individuals. The plan also proposes benefits to employers for offering healthy behavior/wellness programs such smoking cessation, drug & alcohol abuse programs, in the form of tax breaks and reductions in the employer contribution to the subsidy pool.

K. Reinsurance

All insurers, except self-funded plans, would be required to pay a reinsurance premium into a reinsurance pool. The reinsurance would be as follows:

- The pool would retain 100% of each claim up to a cap amount (e.g., \$50,000);
- Between \$50,000-\$100,000 20% would be retained by the primary insurer and between \$100,000-\$200,000, 10% retained; and
- The reinsurance would cover 100% of claims above \$100,000 but no more than \$500,000 or \$1 million.

L. Mandate Enforcement Provisions

The plan proposes an income tax credit for those who have coverage and a penalty for those who do not. Colorado residents would be required to file proof of coverage with their individual tax return as well as with vehicle registration and application for drivers' license or state identification card. Individuals who do not have evidence of coverage at time of application would be referred to the Connector to obtain coverage and would have 30 days to obtain coverage.

Individuals would be denied vehicle registrations, licenses and identification cards if they do not have proof of coverage. In addition tax filers with no proof of coverage would receive a State Income Tax penalty of \$500 per person up to \$1,500 per household.

M. Provider Payment Levels

Medicaid reimbursement levels would be increased to the Medicare payment levels. Payment rates for the private sector would be 120%-150% of Medicare and would take into account quality ratings ranging from Average to Superior Quality as follows:

- Level one—125% of Medicare (entry level)
- Level two-130% of Medicare (average quality measures)
- Level three-140% of Medicare (above average quality measures)
- Level four-150% of Medicare (superior quality measures)

For out-of-network services, plans must pay providers at 120% of Medicare rate. In addition, no provider can charge the patient above the difference between the provider's reasonable and customary charge and the provider's Medicare payment level. Under this plan the maximum reimbursement a provider would receive would be 150% of the Medicare payment level

N. Administration

The plan establishes an internet-based, public/private Colorado Health Insurance Connector to provide information to consumers about government programs as well as private insurance plans. A limited agency/website would be created called the Health Care Coverage Matrix with

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These specifications apply to the initial model and may be different from the Final Report.

links to public entity programs such as Medicaid and CHIP+. In addition, through the Connector, insurance brokers would be available to provide personalized expert advice on insurance choices, including government sponsored programs. Members of the Colorado State Association of Health Underwriters who choose to participate in the program would receive training on government programs. The plan would provide increase outreach to individuals who are eligible but not enrolled in government sponsored programs.

An internet-based tool would be developed to allow consumers to compare cost and quality of health care provides. The plan proposes implementation of Health IT to reduce system inefficiencies.

A large number of administrative and regulatory barriers exist that if modified could dramatically reduce the administrative costs of health care provisioning. Creating a consistent pricing model would benefit everyone. Standardized applications, and claims paying, as well as consistent medical underwriting, where that exists, are examples. Favorable tax treatment for health insurance carriers, a major component in administrative costs, is another.

O. Medical Malpractice Reform

The plan recommends comprehensive medical malpractice reform including:

- a. Limiting non-economic damage awards;
- b. Allocating damages in proportion to degree of fault;
- c. Placing reasonable limits on punitive damages and attorney fees with a statute of limitations on claims; and
- d. Implementing stricter disciplinary rules on physicians as a means to reduce costs associated with medical errors.