

April 6, 2007

Colorado Blue Ribbon Commission for Health Care Reform
303 East 17th Avenue, Suite 400
Denver, Colorado 80203

Dear Commissioners,

Please accept the attached Colorado Health Care Reform Proposal.

Name of Proposal

Colorado Balanced Choice Health Care Reform Proposal

Proposer

Balanced Choice Health Care, Inc.

Key Author

Ivan J. Miller, Ph.D.

Address

350 Broadway, Suite 210
Boulder, Colorado 80305

Telephone

303-499-3888

Fax

303-494-3837

Email Address

IvanJM@aol.com

Authorizing signature: _____



Ivan J. Miller, Ph.D., Executive Director
Balanced Choice Health Care, Inc.

INTRODUCTION

The Balanced Choice Health Care proposal is a model for funding the uninsured and underinsured in Colorado. *It will develop via market forces into a single risk pool system that affordably funds quality health care for all Coloradans.* Our model consists of two options: a **Standard Plan** with a fixed provider reimbursement and small co-pays and an **Independent Plan** with a base amount for provider reimbursement plus a gap payment paid by the consumer to meet the provider's independently determined charges. The amount of co-pays or gap payments would be clearly and easily available to all. Balanced Choice offers the efficiency and effectiveness of single risk pool system, full choice of providers, freedom for providers to charge more than Standard Plan reimbursements, transparency, and increased consumer and provider cost awareness.

With this model, Coloradans can make informed decisions based on answers to the three questions: (1) How can I maintain and improve my health? (2) What treatments and services are necessary? (3) How much does treatment cost compared to other providers and options?

The plan will benefit families, providers, and businesses in Colorado and serve as a model for the rest of the country, perhaps even resolving the looming Medicare crisis. Balanced Choice provides:

- The efficiency and savings of a universal system,
- Improved value and cost consciousness resulting in cost containment,
- Freedom of choice for patients and providers,
- A market-balancing feature that ensures quality care in the Standard Plan,
- The uncoupling of health care from employment, and
- Quality and efficiency improvements that result from a single data repository.

(A) COMPREHENSIVENESS

(1) What problem does this proposal address?

The Colorado Balanced Choice Program (Balanced Choice) proposes a plan for assuring that all Coloradans have quality health care that is comprehensive, accessible, and affordable. The specific problems addressed by this model include

- Insufficient personal funding for health care,
- Insufficient coverage in many insurance products,
- Incomplete health care coverage for conditions such as mental health,

- Lack of insurance for 17% of Coloradans¹,
- Shortages of providers due to inadequate reimbursements,
- Health care disparities,
- Overwhelmed safety net services,
- Insufficient focus on quality,
- Excessive medical errors,
- Burdensome managed care barriers and restrictions, and
- System complexities that are confusing and burdensome for consumers and providers.

In addition, Balanced Choice addresses the following underlying problems in health care:

- Health care spending that is 33% higher than would be expected in comparisons to peer countries,²
- The hindrance of U.S. businesses in global competition due to excessive responsibility for health care,
- A fragmented, inefficient system with gaps in coverage and significant underinsurance, and
- The failure of market forces to exert a constructive influence on health care.

(2) What are the objectives of your proposal?

Balanced Choice proposes a realistic and practical transition to a single-risk-pool system that addresses the above problems. Those who do not have comprehensive health insurance would make affordable contributions, and those who do have comprehensive insurance could enroll voluntarily. The objectives of Balanced Choice are to:

- Provide universal access to comprehensive, quality, and affordable health care.
- Allow market economy principles to create choices for consumers and providers.
- Eliminate portability issues by delinking health care from employers.
- Relieve employers of responsibility for providing health insurance.
- Lower the aggregate cost for employer contributions to health care.
- Create a system that has checks and balances, contains self-correcting mechanisms, and is sustainable for taxpayers, consumers, providers, and employers.

¹ Colorado Health Institute. Issue Brief: Profile of the Uninsured in Colorado, an Update for 2005. November 2006.
Author

² McKinsey & Company. (2007). Accounting for the Cost of Health Care in the United States.

- Emphasize wellness and prevention.
- Establish a transparent system that utilizes information technology and results in quality improvement, error reduction, and improved efficiency.
- Create a system that minimizes bureaucracy and is responsive to consumers and providers.
- Empower consumers with information about health, quality, and cost.
- Respect all individuals by attending to disparity issues and creating a fair, user-friendly system.

(B) GENERAL

(1) Please describe your program in detail.

What is Balanced Choice?

Balanced Choice combines the cost-saving efficiency of traditional single payer systems with the flexibility of market-based systems. It assures affordable health care for all residents, has the lowest overall cost for health care when compared to other financing systems, and maintains a healthy marketplace for providers. Balanced Choice strives to incorporate American values and includes multiple economic and philosophical perspectives while remaining practical and feasible.

Balanced Choice is a set of ideas for health care financing that, when combined, will create a well-functioning health care system. Balanced Choice Health Care, Inc., a nonprofit organization that educates the public about health care financing ideas, is submitting this proposal. Balanced Choice Health Care, Inc., does not sell any insurance or health care products; nor does it seek ownership in any system that might use our ideas. Unless otherwise noted, “Balanced Choice” will refer to the proposed Colorado program, rather than the Balanced Choice National Health Care Program.

Who is covered?

Balanced Choice provides health care coverage for all Colorado residents except those who opt out by virtue of having an equivalent or better health care insurance policy that is purchased individually, through a Colorado employer, or through an ERISA-exempt employer. There are no waiting periods or restrictions after residency is established. Enrollment would include those previously covered by Medicaid and S-CHIP. Medicare beneficiaries may voluntarily choose to enroll through the Medicare Advantage program. It is anticipated that there

would be a gradual voluntary enrollment of those who initially opt out because the low administrative costs would make Balanced Choice less expensive than insurance products, employers would generally find Balanced Choice to be less expensive and administratively more cost-effective than most employer-sponsored plans, and workers' compensation medical expenses could be covered by Balanced Choice.

The benefit package would be equal to or greater than Medicare; it would include improvements on Medicare such as providing provide better prescription drug coverage, higher reimbursements for primary care and some specialists, mental health parity, and vision and hearing services. Consumers would pay a portion of the health care costs, but there would be no deductibles. The improvements over Medicare coverage would amount to at least an 11% increase in benefit dollars.³

Medications, lab work and imaging tests

The central unique feature of Balanced Choice is the “base and gap” payment system that establishes consumer cost-consciousness and personal responsibility. The purpose of the base and gap payment system is to encourage patients to ask two questions: (1) How necessary is this treatment or service, and (2) How much does this cost compared to other providers and options?

Balanced Choice makes a base payment for a category of service, and patients pay the difference—called the “gap”—between the base and the fee for the service. Economically speaking, the base payment is the “first dollar,” which is set by policy and the gap is the “last dollar.” Because patients pay the last dollar, they accrue any savings when they find lower fees and pay the full cost of any increase in fees. Consequently, they are cost conscious.

An example of gap payment would be when Balanced Choice paid \$100 for a medication. If one brand of this medication cost \$110, the patient would pay a gap of \$10. If another brand cost \$125, the patient would pay a gap of \$25.

For the base and gap payment system to work effectively, patients must have cost information. Consumer and provider friendly cost information will be widely available including in the physician's office and on the Internet. Patients' cost concerns should be discussed with their physicians when making medical decisions. With readily available cost information, this

³ Medpac, Medicare Advantage Benchmarks and Payments Compared with Average Medicare Fee-for-Service spending. Washington, DC, projects that in 2006 Medicare Advantage programs will receive 111% of the Medicare fee-for-service expenses per beneficiary. Balanced Choice intends to be able to add Medicare beneficiaries in a revenue neutral manner, and therefore, could at least match the 111% paid to Medicare Advantage programs. Other savings (no cost shifting for the uninsured and less provider administration) may allow for greater benefit increases.

discussion will consume far less time than is currently spent referencing insurance coverage. Plus it bypasses time-consuming negotiations with insurance companies.

The base and gap payment system will be used for medications, lab tests, and imaging tests. Patients concerned about the size of gap payments can exert a market force to lower costs. In addition, Balanced Choice is a flexible system that can use other cost containment strategies such as negotiating lower prices and DRG payments to hospitals.

The Standard and Independent Plans

In Balanced Choice, patients always have a choice between two Plans each time they select a provider. Providers can choose between Plans each time they accept a new patient. Both providers and patients can change Plans, patients can use different Plans for different providers, and providers can choose to have a mix of patients from each Plan.

The Standard Plan offers all of the services of Balanced Choice. Consumers make small co-payments, and providers agree to accept the Standard Plan rate of reimbursement.

On the Independent Plan, providers can charge more and are reimbursed through the base and gap payment system. The base payment would be less than 100% (e.g., 85 or 90%) of the Standard Plan reimbursement; patients would pay the gap between the provider's fee and the Independent Plan base payment. Independent Plan providers would be required to base their charges on a percentage of the Standard Plan rate so that consumers could compare provider charges, i.e., one Independent Plan provider might charge 110% of the Standard Plan rate and another 115%. *The freedom to set fees in the Independent Plan is important because providers have realistic fears about the government-set fees found in most single-payer systems.* This market component allows providers to charge more if patients are willing to make the gap payment.

Patients and providers can mix Plans and change Plans. A patient may see one provider on the Standard Plan and another on the Independent Plan; patients may choose to change providers at any time. Providers may also mix Plans and accept a new patient on either the Standard Plan or the Independent Plan. Providers may change a patient's Plan, but with some restrictions. If an Independent Plan patient cannot continue paying the gap payment, the provider may transfer the patient to the Standard Plan any time. If, however, providers wish to transfer Standard Plan patients to the Independent Plan, providers must give a year's notice and honor Standard Plan agreements throughout the one-year waiting period.

Maintaining quality via the Mandatory Funding Split

Balanced Choice is unlike other two-tiered systems because it has a self-correcting mechanism—the Mandatory Funding Split—that protects the Standard Plan from deteriorating into substandard care for the poor. Balanced Choice will be required to make periodic adjustments in reimbursements. It will adjust base payments so that 75% of reimbursement expenditures go to the Standard Plan--a 75/25 split with the Independent Plan. This split will ensure that reimbursements in the Standard Plan are high enough to attract quality providers. Balanced Choice will start out with a preponderance of low-income residents who probably will find the Independent Plan too expensive. As Balanced Choice coverage gradually attracts more and more higher-income enrollees, the funding split will approach a more economically sustainable 60/40 split. (Details and an explanation of why this mechanism is not inflationary are in Appendix A.) *The Mandatory Funding Split is necessary in Balanced Choice to keep the Standard Plan in balance with the Independent Plan.*

Assured affordable health care

Balanced Choice assures health care security. To encourage entry into the system, the first primary care visit each year will have no co-payment because any co-payment could be a serious barrier to low-income patients. At this first visit, the primary care provider will be required to give patients information about how to apply for assistance with copayments and gap payments. Balanced Choice procedures will consider income level and severity of medical condition in determining assistance with copayments and gap payments. Patients will receive health care according to need and will be required to take personal fiscal responsibility according to ability.

Emergency services and out of state coverage

Emergency services and intensive care are covered by the Standard Plan, rather than the Independent Plan. Enrollees who receive treatment outside of Colorado will be reimbursed at the Independent Plan base rate. There is no coverage outside of the United States.

Consumer Health Advocacy Organization (Consumer Organization)

Balanced Choice establishes an independent Consumer Health Advocacy Organization (Consumer Organization) that provides consumers with cost and quality information, encourages wellness, communicates about local issues, and acts as a watchdog on Balanced Choice. The Consumer Organization may use its funding and apply for grants to conduct research relevant to

consumer purchase of health care services. The Consumer Organization will receive 0.1% of the Trust funds and can raise additional funds through memberships and the sale of its publications. The Consumer Organization is designed to emulate Consumers Union and its publication, Consumers Reports.⁴

Choice is easy for consumers

Balanced Choice makes cost-conscious choices easy. Rather than needing to decipher complex insurance plans, consumers exercise choice each time they make a medical decision. The Balanced Choice system makes price comparison information available to patients and providers. For example, a provider will inform the patient of treatment options, benefits, and out-of-pocket costs. Based on the provider's expert advice and the patient's preferences, the patient will choose a treatment procedure.

If consumers want more options, they can contact a new provider and ask about Standard Plan openings. If available, the patient could choose to use the Standard Plan. If the provider were accepting only Independent Plan patients, the patient could inquire about gap rates and added services. Independent Plan providers would state their fees as a percentage of Standard Plan (e.g., 110% Standard Plan rate); thus knowing the base rate and the provider's fee, patients could readily calculate their out-of-pocket costs. Typical gap fees would also be available from the provider and on the Internet. Patients could decide if the value was worth the cost, or they could look for a different provider.

Guidelines for cost containment

Costs are contained in the Balanced Choice system in several ways. Standard Plan fees are set at an economical rate. Prices for medications and supplies will be negotiated with manufacturers. Cost-conscious consumers and providers will create a responsible awareness of cost throughout the health care system. Administrative costs will be lower than with current systems. The single risk pool will create a database that will be used measure quality and efficiency as well as provide the opportunity for additional cost-containing measures.

Minimizing third-party managed care

Third-party management is rarely needed with Balanced Choice because consumer cost consciousness limits overuse and contains costs. There are times that third party managed care is necessary. For example, third party oversight reduced unnecessary lengthy inpatient psychiatric

⁴ Balanced Choice is not endorsed by, supported by, or affiliated with Consumers Union.

hospitalizations. On occasions when third party managed care is used, it will be subject to guidelines that protect consumers and providers from hardship and require transparency.

Quality

Quality is maintained in a variety of ways. As a single-risk pool system with the transparency of a public system, Balanced Choice will be able to provide a repository of data to the public, to health agencies, and to academic and research institutions. Balanced Choice will be authorized to fund research and obtain grants for research on quality and efficiency. It will establish a Quality and Efficiency Implementation Committee to issue public reports and recommendations. The Consumer Organization will function as an independent source of quality information, conduct research on quality, and monitor quality within the Balanced Choice Program. The Board will hire independent consumer and provider ombudspersons who also will monitor quality. Balanced Choice includes funding for a “medical home,” or “personal case manager,” for patients with complicated health problems who require follow-up or coordination of care providers to ensure that they receive necessary care.

Funding

The Balanced Choice Trust will be financed through multiple sources that include all current state funding for health care and all available federal funds. Colorado residents will benefit from knowing that they and their Colorado family members are assured health care, even if job lay-offs should occur. The burden of cost shifting will end. Coloradans will pay a 0.5% Health Care Operations Tax when they file state income tax. The tax will begin a year prior to Balanced Choice implementation and will provide some of the necessary operating reserves. Because alcohol and tobacco contribute significantly to health care costs, taxes on alcohol and tobacco products will be increased and dedicated to the Trust.

The remaining Balanced Choice funding will come from Payroll Contributions to Health Care Premiums and from an Individual Contribution to Health Care Premiums paid through the income tax process and collected by the Colorado Department of Revenue. Coloradans who already have adequate health care coverage (either individually or through their employer) could opt out of making these contributions. ERISA exempt employers will only participate voluntarily.

Gap payments and co-payments are out-of-pocket expenses. The Standard Plan is designed so that 8% of health care costs come from out-of-pocket payments from the mix of patients who do and do not receive assistance for co-payments and gap payments.

New residents, visitors, and dependents

Visitors and first-year residents without coverage are responsible for their own medical expenses. If participating providers make a reasonable effort to collect fees from nonresidents and are unable to collect fees, Balanced Choice will reimburse the providers up to 50% of the Standard Plan fee.

In the United States, complete coverage has included dependents living out of state, e.g., college students. Balanced Choice functions as a replacement for traditional health care insurance. Therefore, the out-of-state dependents of full time employees or of Coloradans who pay a substantial Individual Health Care Contribution on their income tax will have coverage.

Exclusion of dual coverage

Balanced Choice relies on consumer cost consciousness. Insurance policies that cover the gap and co-payments will undermine consumer cost consciousness. Therefore, Balanced Choice cannot be used with any other insurance policy. However, participants can use other health care insurance for services not covered by Balanced Choice, e.g., optional cosmetic surgery. In addition, insurance would be allowed if it pays patients on a basis other than reimbursement for health care expenses (e.g., mortgage payment insurance or flat sum illness compensation).

Adverse selection is generally not an issue for Balanced Choice

To be profitable, insurance companies often establish elaborate procedures to prevent high-risk people from selecting to join their risk pool. Such adverse selection is generally not a concern for Balanced Choice because many high cost beneficiaries (uninsured, under-insured, Medicare, Medicaid, and uninsurable populations) will be included from the beginning. Balanced Choice is designed to experience the opposite of adverse selection; additional enrollees will likely come from the lower-risk pools. They will be attracted to Balanced Choice because it offers more value for the dollar.

If employers choose to discontinue buying insurance for employees, the employer and employee will cover the new enrollee's expenses through Payroll and Individual Contributions to Health Care Premiums. It is likely that many Coloradans, employees, and employers will choose

Balanced Choice over traditional insurance because Balanced Choice will be more affordable because of its lower administrative costs.

Adverse selection is an issue when interstate issues are considered. With Colorado assuring affordable health care, uninsured people with severe illnesses may migrate to Colorado; therefore residency requirements need to be established and enforced.

Consumers can opt out only if they possess adequate insurance

Coloradans may opt out of the Payroll Contributions to Health Care Premiums and Individual Contributions to Health Care Premiums only when their health insurance policies are equal to or better than Balanced Choice. The financial rationale for this standard is that otherwise, people could own a cheap inadequate policy and then enroll in Balanced Choice when they become seriously ill. Thus, they would reap the benefits of Balanced Choice without contributing their fair share.

Advantages of Balanced Choice Compared to Other Systems

Restores consumer and provider cost consciousness

When insurance or any third party pays the health care bills, neither consumers nor providers have a financial incentive to be concerned with cost savings. Deductibles merely act as an admission ticket, either causing patients to avoid treatment, or once the deductible has been met, to “stock up.” Moreover, relevant cost information has been largely unavailable. Consumers are actually prevented from becoming responsible shoppers, and costs escalate.

Third party managed care manages costs, but interferes with doctor/patient treatment decisions, while adding a layer of costly bureaucracy. Before managed care, doctors and patients said, “The cost doesn’t matter because insurance is paying the bill.” Managed care did not create cost consciousness shoppers but only made doctors and patients say, “Let’s see what the insurance will pay for?”

High-deductible, consumer-directed health care proposals have attempted to restore consumer cost consciousness, but they do it in a manner that has many weaknesses. These plans are criticized because they focus on tax deductions and mostly benefit the healthy and wealthy. Their impact on consumer cost consciousness is excessive because paying the full cost of routine health care makes consumers so cost conscious that they avoid necessary care. Consumers still have trouble obtaining pertinent cost comparison information. Once the high deductible is met, consumers lose their cost consciousness because insurance is paying the bill.

Balanced Choice's transparency, with its published prices and cost comparisons expressed as percentages of the Standard rates, make "shopping" easy. Use of gap payments, where the consumer pays the last dollar, creates cost consciousness. These two simple changes—cost information and gap (last dollar) payments—are inexpensive, non-coercive methods of empowering consumers and providers to be cost and value conscious in their health care decisions. The need for costly third party management is reduced.

Eliminating the fragmented, administratively burdensome systems

The health care insurance model does not and cannot fix the many problems in the United States health care systems (Appendix B). Multiple insurers and health care systems require high administrative costs, often including marketing, stock dividends, and other non-medical overhead expenses. Because Balanced Choice operates with a single risk pool that includes any Coloradan and operates with a single administrative system — with no marketing and no stock dividend expenses — there is more health care for less money.

Benefits for patients and providers

Coloradans are justifiably wary about government-run health care. The efficiency, security, provider choice, and universal coverage available with a government run single payer system are also available with Balanced Choice. However, Balanced Choice is market and consumer run, not government run. The Independent Plan allows for freedom of choice — for providers to set their own fees and for consumers to pay for extra services if they desire. The rate-balancing adjustments maintain quality of care in the Standard Plan.

Reduces per capita and aggregate health care costs

In Balanced Choice, consumer and employer contributions to health insurance policies are converted to contributions to Balanced Choice. Overall, the contributions to Balanced Choice will be lower than the current contributions to private insurance premiums. As Balanced Choice approaches 100% Colorado coverage, it will cover all of the uninsured and still achieve enough administrative cost savings to result in lower than current per capita or aggregate health care costs (Appendix C).

(2)(a) Who will benefit from this proposal?

Residents/Patients: Coloradans who are uninsured, underinsured, or intermittently insured will have reliable health care. Those who currently have insurance are assured affordable health care regardless of future employment, health, or marital status. Balanced Choice is simple

and user friendly. Residents are automatically enrolled unless they opt out. Financial assistance is available for those unable to make co-payments because of low income and/or high medical expenses. Those receiving disability compensation can work up to their capacity without loss of health care. Medicaid recipients will be able to find providers. Stress relief from insurmountable medical debt will improve the health of Coloradans.

Coloradans can choose providers and make treatment decisions with a health care professional without managed-care intrusion. Treatment and provider choice can be made without restrictions imposed by an incomprehensible insurance policy. Transparency in pricing and treatment options empowers patients to make responsible decisions about their own health needs. An independent Consumer Ombudsperson advocates for their interests. The Consumer Organization provides health, wellness, and quality information to all Coloradans, as well as acting as a watchdog.

Providers, Hospitals and Safety Net Providers: Health care will be compensated. Providers will experience decreased paperwork, lower administrative costs, freedom from third party managed care, and assurances of adequate compensation paid within 15 days of receipt of invoices. The existence of an Independent Plan assures that if reimbursements become inadequate, there is a market component that offers an alternative to the Standard Plan and also applies pressure on the Board to adjust rates.

Providers have an independent Provider Ombudsperson to advocate for their interests. They also have majority participation on committees that establish covered procedures and quality improvement programs.

Employers/Businesses: Participation in Balanced Choice is voluntary. However, comprehensive health care coverage is required if a business opts out of Balanced Choice. Balanced Choice not only provides a healthier work force, but it creates a fair system to which all businesses contribute and have health care as an employee benefit. The Payroll Contributions to Health Care Premiums will cost less than many businesses currently spend on insurance premiums. By taking advantage of Balanced Choice, employers remove the administrative burden of choosing, negotiating, and managing health care programs. Knowing that their health care contribution will not increase, as insurance premiums inevitably do, enables companies to compete in the global marketplace and more effectively plan for the future. Employers can also eliminate the medical contribution to workers' compensation insurance.

Funding Sources: Cities, counties, nongovernmental organizations and philanthropic groups that contributed to safety-net basic health care costs will be able to spend their money on other important concerns such as improving the quality of care, medical research, public education, reduction of environmental hazards or prevention services related to health care.

Colorado: Balanced Choice offers business the opportunity to end its responsibility for health care insurance and decrease health care costs. This would be good for the economy of Colorado because it would attract and retain businesses to the state.

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

Health insurance companies, bill collectors, bankruptcy attorneys, and personal injury attorneys might experience negative effects. Although health insurance companies could continue to do business in Colorado, they would need to compete with the administratively leaner Balanced Choice program.

Employers who previously have not provided health care would be required to provide a 4.5% payroll contribution. This contribution would be introduced over a 2-year period at 3% the first year (when employers could include the medical expenses of workers' compensation insurance) and an additional 1.5% the second year. This expense, however, occurs at near the rate of inflation, which should mitigate the hardship.

(3) How will Balanced Choice impact distinct populations?

Low-income and disabled populations will be positively affected by quality affordable health care that is available regardless of ability to pay or employment status. A person's automatic inclusion into Balanced Choice once he or she files Colorado income tax makes access to health care simple. Additionally, Balanced Choice has the flexibility to support education and training programs (e.g., to address language and/or cultural barriers); to fund medical care managers; and to create provider reimbursement incentives. Balanced Choice can obtain and fund grants to underserved population providers for facility, program, training, research, or equipment needs. The data from a single aggregate database will expose unmet needs and indicate remedies. Safety Net providers, relieved of the need to fund basic health care, can address other patient needs. The Board has the authority to create provider incentives and special programs whenever necessary. The Board and Consumer Ombudsperson will communicate with all population groups, state health agencies, and concerned organizations to identify unmet needs and remedies.

Colorado Balanced Choice recommends that residency, rather than immigration status, be the criteria for eligibility. Immigration status is a contentious political issue to be decided in the political process. For the purpose of the feasibility analysis, residency is the only requirement.

Rural and/or underserved areas: Rural communities will be positively impacted because health care costs will be paid. Balanced Choice will have the option of increasing reimbursement rates if needed to assure adequate health care services and of establishing special programs, pilot projects, and obtaining or funding grants to meet the needs of rural communities and underserved populations. (For example, a Distribution of Reusable Equipment and Materials project might be established.)

Health care service delivery can be a major problem in rural areas because of the infrequency of need for expensive equipment, the lack of local specialists, and long travel times due to distance, poor weather and road conditions, and lack of public transportation. Individual communities, which are aware of their particular needs, can communicate with the Board to obtain resources to address specific problems.

Caring for the uninsured nonresidents: Balanced Choice will share the burden of uninsured nonresidents with providers. If participating providers are unable to obtain payment from insurance or from the patient after a reasonable collection effort, Balanced Choice will compensate them up to 50% of the Standard Plan reimbursement rate.

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

The Balanced Choice Program proposal is innovative and unique, but it is based on established programs. The Independent Plan feature adds market economic forces to what can be conceptualized as a modified single payer proposal. Single payer health systems have proven to be an efficient way to provide health care in many parts of the world largely because of the ability to eliminate administrative, marketing, and profit-related expenses. Shortcomings are largely attributable to the lack of adequate funding that impacts the number of providers who enter the profession, increases waiting periods, and sometimes decreases quality or rations care. These shortcomings are addressed by Balanced Choice's Independent Plan modifications.

Balanced Choice can also be conceptualized as an improvement on Medicare. Medicare has provided health care fairly successfully for millions of Americans. Balanced Choice corrects the problems associated with Medicare such as inadequate reimbursement, an inefficient and substandard prescription drug program, and lack of adequate support for low-income clients. The

technical analysis by the Independent Consultant could evaluate costs by adding and subtracting various components from the costs of Medicare.

The base and gap payment system is new to the United States, but it has been used successfully in other countries. It is a part of the Australian public-private system. A similar system called reference pricing has successfully controlled costs of medications in Europe.⁵

Insurance companies have already recognized that restoring consumer cost consciousness is necessary and beneficial, and they are trying to simulate market forces through beneficiary cost sharing. The most common example is the tiered pharmacy benefit system. As explained in Appendix D, the cost-reducing market forces resulting from gap payments are more powerful than those created by the tiered pharmacy system.

The viability of a model in which consumers pay for additional choices and services is well established. Insurance companies offer out-of-network reimbursement at lower rates, physicians have established boutique models, and mental health professionals often establish managed-care-free practices in which patients are willing to pay out of pocket.

(5) How will the program be governed and administered?

The State of Colorado will establish the Colorado Balanced Choice Trust (Trust), which will receive dedicated funds collected by the Colorado Department of Revenue. The Trust will be governed by the Colorado Balanced Choice Program Board of Directors (Board) consisting of six people appointed by the Democratic state senators, six appointed by the Republican state senators, and three appointed by the Governor. Each Director will serve a four-year term, with half the terms expiring every two years. Members can be reappointed.

The Democratic and Republican senators and the governor will include in their appointments two (one) persons qualified as consumer advocate representatives, two (one) qualified as provider advocate representatives, and two (one) at-large representatives. At least one of each set of six would need to be from a rural area. It is hoped that qualified Directors will represent diverse viewpoints and regions of the state. The General Assembly and the Governor will provide oversight to the program.

The Board will hire an Executive Director who will be responsible for the operation of Balanced Choice. The Board of Directors will also hire a Consumer Ombudsperson and a

⁵ Kanavos, P. and U. E. Reinhardt. (2003). Reference pricing for drugs: Is it compatible with U.S. health care? *Health Affairs*, 22(3), 16–30.

Provider Ombudsperson. These Ombudspersons will be responsible for receiving complaints, gathering information and data about their respective constituencies, advocating for their constituencies, and providing periodic reports to the Board and to the public. The Board and the Ombudspersons will communicate with local communities and organizations.

(6) Will any federal or state laws or regulations need to be changed to implement this proposal?

This proposal must be implemented through state law. Because taxes are involved, TABOR would apply, and a vote of the people will be required. The success of the vote will depend on the degree to which consumers, providers and employers believe the proposal to be beneficial.

A federal Medicaid waiver will be required; however, because Medicaid services will be enhanced rather than reduced, this waiver should not be problematic.

The Medicare Advantage program (Medicare Part C) should allow for enrollment in Balanced Choice on a voluntary basis so no change in federal Medicare law is anticipated.

It is presumed that changes to ERISA are impractical at this time. Balanced Choice however, allows for ERISA (and other) employers to enroll voluntarily by making Payroll Contributions to Health Care Premiums and having employees make Individual Contributions to Health Care Premiums. It is possible that employers could enroll a portion of their employees in Balanced Choice.

The ERISA exemption creates a potential problem. Because an ERISA employer is exempted from providing information, the employer could claim exemption for all employees, yet only provide health care insurance for a portion of the employees. To achieve complete health care coverage, Balanced Choice will need to provide health care for those that are uninsured. This problem can be solved by requiring that Coloradans be responsible for both Payroll and Individual Contributions to Health Care Premiums unless they opt out by virtue of possessing equivalent or better health insurance. Because this requirement applies to the employee, not the employer, it would not be prohibited by the ERISA exemption.

Some administrative arrangements and state laws will need to change to allow the medical portion of workers' compensation to be covered by Balanced Choice. Workers' compensation does not require a co-payment from employees, and arrangements will need to be made to resolve this problem. A possible resolution would be for the workers' compensation

insurance adjuster to award lump sums to employees to pay anticipated co-payments and gap payments, but allow the employee the freedom to decide how to spend the lump sum. Such a payment system would maintain the cost consciousness essential to Balanced Choice.

(7) How will the program be implemented? How will it transition from the current system?

The success of Balanced Choice relies on adequate funding and preparation. One year prior to implementing Balanced Choice, all Colorado residents will be assessed a dedicated alcohol and tobacco tax and a 0.5% Health Care Operations Tax to provide funding for establishing the governing board, creating the infrastructure, and beginning to create the operating reserves. An anticipated surge from uninsured people who have been delaying health care may create a temporary period of higher costs. Start up costs that include education, training, transition expenses, and upgrading technology may also create a temporary period of higher costs. During the first year, Board members will select the Executive Director, create operating procedures, educate and communicate with all stakeholders in the state, and begin negotiations with medical suppliers. During the four months preceding Balanced Choice's implementation, providers and consumers will be enrolled. Two months prior to starting the system, there will be dry runs to make sure the system is operational.

C. ACCESS

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

The Balanced Choice proposal expands access to provide affordable health care to all Colorado residents. Timely access is assured because the reimbursement adjustments required by the Mandatory Funding Split would result in the participation of almost all Colorado providers. When access would benefit from medical management, providers will be reimbursed for medical home services.

(2) How does this proposal affect safety net providers?

Safety net providers will receive health care reimbursements on a fee-for-service basis, just as other providers. If their organizations have been receiving state funds, those funds will be transferred to the Trust. The need for safety net providers will continue, but on a much smaller scale, for people who cannot establish Colorado residency. These providers will benefit from the provision that they receive up to 50% of the Standard Plan reimbursement for uncollected charges for nonresidents. They can continue to solicit and accept funds from contributors for

enhancing services, providing necessary, but non-medical, services, or focusing on education, prevention, and research.

D. COVERAGE

(1) Does Balanced Choice expand health care coverage?

Balanced Choice will cover all Colorado residents who do not opt out by virtue of possessing a health insurance policy that is equivalent to or better than Balanced Choice.

(2) How will outreach and enrollment be conducted?

Participants in Medicaid and S-CHIP will be automatically enrolled immediately. All Colorado income tax filers will be automatically enrolled unless they provide evidence qualifying them to opt out. During the transition period, Balanced Choice will develop procedures for eligible residents to obtain enrollment cards (and PIN numbers for accessing personal health records should they be available) by phone, mail, Internet, or in person. Procedures will be simplified for taxpayers who filed in Colorado the previous year. Balanced Choice will establish procedures for determining residency for persons who have lived in Colorado but not filed income tax; for health care coverage for dependents who attend school or reside part of the year in other states; and for rapid enrollment to accommodate urgent health care conditions.

(3) How does your proposal define “resident?”

If uninsured residents of another state develop serious illnesses, it is reasonable to assume that they might travel to Colorado if there were no residency restrictions. On the other hand, moving to Colorado for employment should qualify people for coverage. To replace employer-based coverage, Balanced Choice needs to cover out-of-state dependents under some conditions. Therefore, residency for the purpose of enrolling in Balanced Choice, can be defined in any one of the following ways:

1. A person who has been in the state for one year.
2. A person who has resided in Colorado for less than one year can be enrolled during the initial year while working full time, if Payroll and Individual Contributions to Health Care Premiums are being made and he or she can show evidence of continuous comprehensive health insurance coverage for the year prior to moving to Colorado.

3. Dependents of a resident who is paying the Payroll and Individual Contributions to Health Care Premiums and working full time or making a substantial contribution to the Trust will be enrolled even if they live out of state (e.g., attending college).
4. A resident's dependents who reside in Colorado at least 25% of the year or who have newly resided in Colorado less than one year.

New residents who have lived in Colorado for less than one year, are employed 30 hr/wk or more, and have not opted out from Balanced Choice will be eligible for Balanced Choice but pre-existing conditions will be excluded until they establish a full year's residency.

E) AFFORDABILITY

(1) What will enrollee and/or employer premium-sharing requirements be?

Employers subject to state health insurance law will be required to pay a 4.5% Payroll Contributions to Health Care Premiums unless they provide the employee with health insurance that has equivalent or greater coverage than Balanced Choice. Employers can use Balanced Choice to cover the medical portion of workers' compensation insurance. ERISA employers may be exempt from this requirement and choose to be nonparticipating, or they may participate voluntarily. Employers will be assured that there will be no future increase in the 4.5% Payroll Contributions to Health Care Premiums, and any necessary additional funds will come from other sources. As with health insurance, employers can pay these contributions with pre-tax dollars, or use pre-tax cafeteria plans.

If employers who are exempt from state law due to ERISA or being a federal employer do not make the Payroll Contribution and do not provide a qualified insurance policy, the employee will be responsible for the Payroll Contribution. All residents who do not opt out by virtue of a comprehensive health insurance policy will be required to pay an Individual Contribution to Health Care Premium. These contributions to premiums will be collected through the Colorado income tax process, perhaps with different deductions or capped amounts.

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

There will be no deductibles. Co-payments and gap payments are an integral part of the Balanced Choice system because they encourage consumer cost consciousness. Balanced Choice will adjust rates so that 8% of the costs of Standard Plan care are paid through co-payments and gap payments. Independent Plan gap payments will fluctuate according to market conditions, and

because of the design of Balanced Choice, these payments will amount to a larger percent of the costs than the Standard Plan.

The first Standard Plan primary care visit each year will have no co-payment to assure that patients enter the health care system without financial worry. During the first primary care visit of the year, providers will inform patients of the possibility of financial assistance with co-payments and gap payments if there is a need due to low income or high medical expenses. Balanced Choice will establish procedures to assure that patients receive temporary or permanent, complete or partial assistance with co-payments and gap payments to assure that no Coloradan needs to forego necessary treatment because of an inability to pay. To simplify administration, whenever people apply for food stamps or any other public assistance in Colorado, the applicant will be given the option of having relevant information released to Balanced Choice so that it is available should they apply for assistance with co-payments or gap payments.

F) PORTABILITY

(1) Describe provisions for assuring that individuals maintain access to coverage even as life circumstances and health status change?

Balanced Choice is established to provide health care for all Coloradans who do not have adequate health insurance. If a Coloradan is disenrolled from any other health care policy, the person becomes eligible immediately for coverage under Balanced Choice. Health status will not affect coverage except for new residents. Except for those who opt out, health care is provided for everyone, regardless of employment, health, or marital status. Coloradans moving to another state can purchase coverage under the COBRA guidelines.

G) BENEFITS

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

The benefit package is adequate because it will be at the same level or better than Medicare A+B+D, with the improvements noted below in (G) Benefits, question 2. It will have appropriate limitations because in addition to those included in Medicare, a central data repository will provide information to identify and prevent misuse of the system.

A uniform benefits package will help address the needs of all populations. Important improved benefits include parity for mental health and continuous health care for those currently

receiving Medicaid, S-CHIP, or disability eligibility that is not based on means testing. If populations have been receiving greater benefits under a program that has funds transferred to the Balanced Choice, the greater benefits will be maintained. Balanced Choice will have the flexibility to adjust benefits to populations with unique needs.

(2) Identify an existing Colorado benefit package that is similar to the Balanced Choice proposal and the differences between the existing benefit package and Balanced Choice.

Balanced Choice will, at a minimum, provide the benefits in Medicare A+B+D. Balanced Choice will not be bound to follow the Sustainable Growth Rate (SGR) used by CMS and will immediately offer benefits and reimbursements that will be at least 11%⁶ greater than Medicare. Balanced Choice will be able adjust Medicare fees upwards in situations in which the Medicare reimbursement schedule is not currently adequate. Examples include providing adequate compensation to primary care professionals for evaluation, disease management, and “medical home” services. Vision and hearing care will be added. The prescription drug benefit will not have deductibles or a doughnut hole and will be subject to the same provisions for gap payment assistance as other aspects of Balanced Choice.

(H) QUALITY

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

Balanced Choice generally subscribes to the Institute of Medicine’s positions on quality.⁷ In spite of spending \$1.9 trillion a year on medical care, many people are receiving more care than they need, many are receiving less care than they need, and many are receiving the wrong kind of care. What is not measured cannot be managed. Balanced Choice creates the measures needed for quality improvement by creating a single, non-proprietary database that enables the analysis of variations in cost, quality, and utilization. Balanced Choice will provide incentives for providers to participate in an integrated health information network that would allow all providers and patients to access a patient’s electronic medical record—an expansion of the Colorado Regional Health Information Organization (CORHIO). In addition to privacy

⁶ Medpac, Medicare Advantage Benchmarks and Payments Compared with Average Medicare Fee-for-Service spending. Washington, DC, projects that in 2006 Medicare Advantage programs will receive 111% of the Medicare fee-for-service expenses per beneficiary. Balanced Choice intends to be able to add Medicare beneficiaries in a revenue versus expense neutral manner, and therefore, could at least match the 111% paid to Medicare Advantage programs. Other savings (no cost shifting for the uninsured and less provider administration) may allow for greater benefit increases.

⁷ Institute of Medicine. (2001). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, DC: National Academy Press.

protections, patients will be able to have information excluded from access by the network by personal request.

Two other proposals to the Blue Ribbon Commission for Health Care Reform have excellent and extensive recommendations for defining, measuring, and improving quality. These are the Colorado Foundation for Medical Care and Colorado Clinical Guidelines Committee (Arja P. Adair, Jr., key author, Appendix E) and the American Academy of Pediatrics et al. (James Todd, key author, Appendix C). Balanced Choice endorses these proposals as methods for defining, measuring, and improving quality and James Todd's Colorado Health Care Outcomes Measurement and Evaluation Consortium (CO-HOME) as a method for defining useful quality measures. Because Balanced Choice is a single system, it could implement these recommendations without the cumbersome process of coordinating between independent proprietary insurance companies.

Balanced Choice recognizes that even well-intentioned efforts to improve quality and achieve cost savings can divert funds from health care services. When the goal of quality improvement is achieved, the diverted funds are justified, but when inconsequential measures merely result in excessive regulation, patient care is deprived of essential funding. To prevent development of a counter-productive bureaucracy, Balanced Choice recommends the following guidelines for implementing quality improvement and efficiency measures:

- Regulation will not be implemented unless information, feedback, transparency and/or education approaches fail.
- Temporary incentives, market forces, availability and transparency of data for use by consumer groups, and non-punitive measures will be the preferred methods of regulation.
- Quality and cost reduction measures will be regularly evaluated by the Board and the public for effectiveness, unintended consequences, and need (i.e., regulation must be evidence based).
- All regulation will require approval by a Quality and Efficiency Implementation Committee (Q&EIC), a majority of whose members will be composed of providers who earn at least 75% of their professional income providing health care services.⁸ This requirement should ensure the practicality of regulations in clinical situations.

⁸ Some have expressed concern that having regulation approved by a provider-dominated committee is allowing the fox to guard the henhouse. This committee is an essential component in the Balanced Choice set of checks and

(2) How 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.)?

Balanced Choice will have the authority to implement quality and cost-savings programs that meet the guidelines described above. In so doing, it will encourage the establishment of integrated health information technology. This technology will not only allow providers to access a patient's complete medical record, but will also provide extensive epidemiological, treatment and outcome information that could be used for internal quality improvement and public education. Balanced Choice will have the authority to sponsor education or provide incentives to correct disparities in the quality or accessibility of health care. These include implementing evidence-based guidelines, and developing provider-training programs.

Adequate reimbursement for "medical home" services is necessary to enable providers to manage and direct treatment for both wellness services and the treatment of patients with complex problems. Balanced Choice will reimburse "medical home" at a level that takes into consideration case complexity.

Because the success of Balanced Choice requires that consumers make informed decisions, providing quality information is essential. For example, public health legislation requiring hospitals to report the number of hospital-acquired infections has resulted in hospitals voluntarily developing standards of care and has reduced the number of infections. The open records data pool that will be available with Balanced Choice (after privacy and confidentiality are protected) will assist agencies and consumer groups in their quality advocacy efforts.

An independent Consumer Health Advocacy Organization (Consumer Organization) will provide information to consumers regarding health care, wellness, and quality (Appendix C). Informed consumers can be an effective method for quality improvement. An example of this in the United States is that a small number of people who subscribe to *Consumers Reports* are able to have a dramatic impact on product quality via published ratings. As an independent

balances. It is unlikely to function as a unified provider veto because it will contain a broad mix of providers—physicians, nurses, hospital administrators etc. It will also have a substantial number for non-provider representatives. If it acted in a manner that was too protective of providers, the Executive Director, Consumer Organization, and the Consumer Ombudsperson will be able to publicly address the problem.

organization, the Consumer Organization will publish a magazine, maintain a website, fund research, and obtain grants as well as evaluate and critique the Balanced Choice program.

The Consumer Organization will receive 0.1% of the Trust revenues and can raise additional income from magazine subscriptions and memberships. The Consumer Organization governing board will have one member appointed by the governor, the Colorado State Senate Democrats, the Colorado State Senate Republicans, and the Executive Director of Balanced Choice. An additional four members will be elected by the membership of Consumer Organization. As an independent organization, it will provide pressure on Balanced Choice to meet the needs of consumers and act as a Balanced Choice watchdog.

(I) EFFICIENCY

In both health care and the financing of health care, the issues of efficiency and quality need to be considered concurrently. To contain the negative effects of expanding bureaucracies, guidelines for quality improvement listed in the answer to question (h) will also apply to efficiency issues.

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

Initially, as an additional program for covering the uninsured and underinsured, expenses will increase. As more employers opt to transfer health care coverage to Balanced Choice and it approaches becoming a single payer system for Coloradans, it will lower aggregate or per capita health care costs. It has been estimated that simply moving from the current fragmented health care system to the administratively leaner Balanced Choice system will save enough to provide universal coverage and achieve a substantial savings.⁹ Additional cost containing measures are listed below.

1. The Board sets the standard reimbursement for each procedure.
2. Providers may charge more than the Standard Plan rate, and since patients pay the gap, cost consciousness will contain prices on the Independent Plan.
3. Balanced Choice uses co-payments and gap payments throughout the system to encourage patients to ask two questions: (1) How necessary is this service, and (2) What is the least expensive way to obtain the appropriate service? Examples of the results of answering these questions are:

⁹ Miller, I. J. (2006). *Balanced Choice: A Common Sense Cure for the U.S. Health Care Systems*, Bloomington, ID: Authorhouse.

- A decrease in unnecessary treatments and tests,
 - The selection of cost-saving forms of treatment and medication, and
 - Creative ideas for saving money. If providers can vary gap payment fees, it allows them to offer patients new ways to save money. For example, MRI or CAT machines are expensive. If the machines could be used 20–24 hours per day, the cost per scan would decrease. Patients might agree to have scans at unconventional hours (e.g., 2:00 a.m.) to obtain a lower gap payment. As a result, fewer MRI machines would be needed, and the cost per scan would decrease.
4. Balanced Choice will negotiate prescription drug and medical equipment prices, perhaps teaming up with other states.
 5. A large unitary database and state-of-the-art information technology will enable Balanced Choice to identify ways to lower costs.
 6. Balanced Choice will be authorized to institute other cost control features that meet the guidelines specified in (h).

(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?

Balanced Choice uses market forces to provide incentives to decrease costs, increase availability, and improve quality. It uses co-payments and gap payments throughout the system to encourage patients and providers to become sensitized to cost. It makes cost information available to consumers and providers at the time that they are making health care choices.

Consumers will obtain information about quality from the provider, from the Consumer Organization, and from Balanced Choice. Providers will have the incentive to improve quality to compete for the informed consumer to maintain a full practice, and increase income through the Independent Plan. The database and quality measures in James Todd and Arja Adair's proposals, Appendix E and H, will give consumers and providers feedback.

The financial incentives in the Independent Plan assure accessibility. A primary reason for problems with access in public and managed care programs is inadequate provider reimbursement, which results in restricted provider panels. If the Standard Plan reimbursement is inadequate, providers will increasingly choose to see patients on the Independent Plan. This will

cause the Mandatory Funding Split to be out of balance, and the Board will be required to raise the Standard Plan reimbursement (Appendix A).

(3) Does this proposal address transparency in costs and quality?

Balanced Choice is public and fully transparent. It shifts information from proprietary caches to public scrutiny. The independent Consumer Ombudsperson, Provider Ombudsperson and Consumer HOA offer additional levels of transparency and scrutiny.

Consumers will have cost comparison information for use with both Plans and throughout the program. Providers will have current gap cost comparison information for medications. Independent Plan providers will be required to base their fees on a percentage of the Standard Plan reimbursement schedule, which allows consumers to compare provider fees. Laboratory and imaging services will be required to provide straightforward and published information about gap fees. Providers will compete for patients with respect to quality and cost. Independent Plan providers will need to demonstrate superior quality or service to justify the gap payments.

(4) How would your proposal impact administrative costs?

Balanced Choice achieves major savings by lowering administrative costs and containing bureaucracy. These savings are sufficient so that if Balanced Choice achieves 100% coverage in Colorado, it will result in lower than current aggregate health care costs in Colorado, while establishing universal coverage (Appendix C). Administrative costs should be no greater than Medicare or other publicly administered programs. Many of Medical Group Management Association's (MGMA) administration simplification suggestions for reducing costs are easily implemented with a single payer model. Coloradans are automatically registered with an opt-out, rather than an opt-in, system that decreases administrative costs for the system and the consumer.

Balanced Choice also has an additional billing error and fraud control measure. Balanced Choice will send patients consumer-friendly statements that describe all treatment episodes and the charges. If the patient identifies a billing error, the patient can contact the provider. The provider will be required to give a portion of the refund to the patient and the remainder to Balanced Choice. Thus, cost conscious consumers will look for billing errors. If a provider has a disproportionate number of over-billing errors, it might be grounds for investigating fraud.

(J) CONSUMER CHOICE AND EMPOWERMENT

(1) Does your proposal address consumer choice?

Providing consumers with appropriate choices is a central feature to Balanced Choice. When consumers must choose among bundled health care programs, such as picking an insurance plan, there is both too much information and too much uncertainty about future health care needs for consumers to be sure they are choosing what they really want. Even experts cannot predict the performance of an insurance company based on its marketing materials and contract. Too much choice, as in the selection of Medicare Part D plans, is overwhelming. Consumers want choices they understand. In coordination with a health care professional, consumers are actively involved in treatment decisions in Balanced Choice. The Balanced Choice proposal maximizes appropriate choices throughout the program. For instance,

- Consumers can choose the Standard Plan or the Independent Plan every time they see a new provider, and they can switch Plans at any point.
- Choices are made at the time of service, one decision at a time (e.g., choice of provider, choice of medication, or choice of lab. A provider might say, “There are three choices of medication that I could prescribe. The least expensive one might have more side effects, and the most expensive one usually has the least side effects. Which one would you like to try first?”
- Patients are provided with relevant cost information when they make choices.
- Patients can use their personal health care provider to assist them with choices.

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

- Patients may use their provider or others to guide them in making choices because cost information will be available in the provider’s office.
- Balanced Choice will adequately reimburse primary care providers for evaluation and management of patients and medical-home services, enabling primary care providers to guide patients through the system.
- Balanced Choice will encourage the development of educated and informed consumers and the Consumer Organization will provide additional consumer education and information.
- Transparency at all levels will allow consumers to become informed decision makers

(K) WELLNESS AND PREVENTION

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

In response to economic pressure, prevention services have been under funded in most insurance plans even though many programs tout their attention to prevention services. In the current fragmented health care system, economics work against prevention. Managed care companies need to focus on this quarter's profits, not the long term benefits of prevention. In addition, with beneficiaries switching plans every few years, companies cannot capture prevention savings. As a result, services such as mental health care that have demonstrated long-term prevention value are persistently under funded.

Balanced Choice is positioned to benefit economically from prevention services. It seeks long-term financial viability. As a program moving toward a single-risk-pool, it is likely to keep its participants over a number of years, thereby reaping the financial benefits of long-term prevention.

To encourage early intervention, there is no co-payment for the first primary care Standard Plan visit every year. Medical-home services, which include prevention, are fully funded. All established prevention services will be funded. Balanced Choice may sponsor education or use incentives to the extent that they demonstrate savings. It will provide mental health parity. It can use funds to research and develop long-term prevention strategies.

(L) SUSTAINABILITY

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

Balanced Choice considers four components of sustainability: (1) funding, (2) provider participation and satisfaction, which includes adequate reimbursement and freedom from bureaucracy, (3) consumer participation and satisfaction, which includes adequate quality, accessibility, and freedom from bureaucracy, and (4) employer preference.

There may be a time when our society cannot afford all health care. Costs of health care are rising because of treatment advances, and there will be a need to limit the available health care. When that day comes, difficult decisions will need to be made about what services will be funded. In Balanced Choice, these decisions will be made with complete transparency.

The first component to sustainability is funding. Balanced Choice increases efficiency by eliminating wasteful administrative costs. The program requires an initial increase in funding when it is added to the current system as a method for including the uninsured. As Balanced

Choice becomes a complete single payer system covering everyone, it will lower aggregate and per capita health care costs below current levels through its savings in decreased administrative expenses alone.¹⁰ Its additional cost-containment mechanisms have the potential to further lower health care expenses. As time progresses, both consumer cost consciousness and the ability to develop efficiencies by monitoring a unitary database will have an increasing impact on cost containment. Thus, Balanced Choice will be far more sustainable than attempts to merely add on to the current system.

Nevertheless, there will be advances in health care that will undoubtedly increase the cost of health care. For this reason, the Balanced Choice proposal recommends that as costs rise beyond the capacity of the proposed funding, the Board will request additional funding from the citizens of Colorado. At the point when the Colorado citizens decide that advances in health care are not worth additional funding, the state will need to develop ways to limit the services available. However, because of the efficiency of Balanced Choice, it will postpone longer the day of limiting services and involve fewer limitations than other systems.

The second component to sustainability is provider participation and satisfaction. If providers leave the system or specific fields of practice, shortages are created. This is happening in programs where insurance reimbursement is inadequate, public programs that are under funded, and in single-payer systems that do not maintain adequate funding.

Balanced Choice assures that provider reimbursement is adequate because of the Independent Plan option and the Mandatory Funding Split balancing mechanism (Appendix A). These features require reimbursements to be adequate to attract providers to the Standard Plan. Provider satisfaction is also increased by minimizing bureaucracy and third-party managed care intrusions.

The third component of sustainability is consumer participation and satisfaction. A health care program is not sustainable if the consumers do not consider it reasonably priced, high quality, accessible, and free of excessive bureaucracy. If consumers are not pleased, they will not continue funding the program and will look for ways out of the system.

Balanced Choice assures that consumer satisfaction and participation is sustainable because consumers have the option to use the Independent Plan. In addition, the Mandatory

¹⁰ Miller, I. J. (2006). *Balanced Choice: A Common Sense Cure for the U.S. Health Care Systems*, Bloomington, ID: Authorhouse.

Funding Split adjustments will maintain quality care and ensure adequate participation in the Standard Plan. Consumer inconvenience is considered in evaluations of administrative expense and will be minimized.

The fourth component of sustainability is attracting employers to the program. Because Balanced Choice begins by covering many high-needs and seriously ill patients, the consumers who receive health care through employers are likely to be lower cost than the ones already enrolled. These relatively healthy consumers are in the costly and fragmented insurance-driven health care system. Balanced Choice's benefit package is designed to be attractive to employers and employees so that they are willing to transfer their health care contributions; Balanced Choice is clearly less time-consuming and more efficient from their perspective. Bringing healthier people into the risk pool will move Balanced Choice toward the desirable single-risk payer pool. Sustainability will rely on maintaining a benefit package that is attractive to employers and employees so that this healthier group voluntarily transfers to and stays with Balanced Choice.

(2) Optional-- How much do you estimate this proposal will cost? How much do you estimate that this proposal will save?

Balanced Choice requires an initial increase in funding when it is added to the current system as a method to primarily cover the uninsured. As it approaches becoming a single payer system that covers everyone, it will lower aggregate and per capita health care costs below current levels through its savings in decreased administrative expenses alone (Appendix C). Its additional cost containing mechanisms have the potential to further lower health care expenses. As time progresses, both consumer cost consciousness and the ability to develop efficiencies will have an increasing impact on cost containment.

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

The funds for the new costs will come from employers who have not contributed to health care financing in the past, employers who transfer employee health care coverage to Balanced Choice, Colorado taxpayers, taxes on tobacco and alcohol, and the individuals who enroll in Balanced Choice. See Table 1— Health Care Payers in Balanced Choice.

(4) How will distribution of costs for individuals, employers, government, or others be affected by this proposal? Will each experience increased or decreased costs?

As shown in Table 1, Balanced Choice requires changes in the distribution of costs among payers. To transition from a fragmented and inefficient system to one that can lower aggregate health care costs, it is necessary to develop a method of transferring funds from the fragmented system to the efficient system. Table 1 demonstrates one way this could work. The proposed financing is based on the following principles:

1. Individuals who benefit from Balanced Choice should contribute to it.
2. As much as possible, funds that are already going to health care should be transferred to Balanced Choice.
3. It is a reality that when risk is spread across everyone, the healthy will pay for more than they use.
4. It is a reality that high-income people will pay more than low-income people; as a result, contributions will depend on payroll and income, not the number of dependents.
5. Federal laws cannot be changed by Colorado. Consequently, ERISA-exempt employers, federal employees, and Medicare beneficiaries may only be enrolled voluntarily in Balanced Choice.
6. Coloradans will not want to be forced to give up their health insurance if it is good insurance, and therefore, may want to opt out.
7. Employers and employees may want to opt out if they have contracts or agreements for comprehensive health care.
8. If employers opt into Balanced Choice, there must be an overall increase in funding sufficient to cover the costs of the new enrollees.

Table 1—Health Care Payers in Balanced Choice

Funding Source	Current Health Care Contribution	Balanced Choice Contribution	Rationale	Advantages
Taxes on tobacco and alcohol	None	Increased taxes	These products contribute to health care expenses.	These funds help create a pool for the currently uninsured.
Colorado taxpayer	No direct payment	Health Care Operations 0.5% income tax	All Coloradans benefit from universal coverage.	Affordable health care coverage regardless of health, employment, or marital status.
Individuals enrolled in Balanced Choice	Individual payments to health insurance plus out-of-pocket expenses	Individual Contribution to Health Care Premium through taxes or pretax funds. If employer is exempt, individuals must pay Payroll Contribution. Also pay out-of-pocket expenses.	The funds that individuals are contributing to health care should be transferred to the new system. Pretax systems may continue.	Affordable health care coverage regardless of health, employment, or marital status.
Individuals who opt out because of having equivalent or better health insurance	Payments to health insurance for self and dependents and out-of-pocket expenses	None to Balanced Choice and individuals maintain full responsibility for health care	Coloradans do not want to be forced to give up their health insurance if it is good insurance.	Balanced Choice is more feasible if individuals can choose whether to join or keep insurance.
Employers subject to Colorado insurance law who do not opt out	Wide variation in contribution except all are required to pay workers' compensation	4.5% Payroll Contributions to Health Care Premiums, which are pretax. Employers can voluntarily pay part of Individual Contribution to Health Care Premium with pretax dollars.	Level across employers and lower required employers' contributions	Lowered employers' overall contributions. Ends employer responsibility for health insurance. 100% participation lowers workers' comp. costs.
Employers subject to Colorado insurance law who opt out by virtue of providing health insurance equivalent to or better than Balanced Choice	Premiums for health insurance that is equivalent to or better than Balanced Choice for employee and dependents	None to Balanced Choice and employers maintain full responsibility for health care	Coloradans do not want to be forced to give up their insurance, and some labor contracts will need renegotiation before changing.	Balanced Choice is more feasible if employers and employees can choose whether to join or keep insurance.
Federal government as employer and ERISA exempt employers	Wide variation, but overall a large contribution to health insurance for employee and dependents	Current responsibility plus if not providing insurance equivalent or better than Balanced Choice, employees must upgrade insurance, purchase insurance, or pay both Payroll and Individual Contributions to Balanced Choice.	Both the federal government as employer and ERISA-exempt employers are not subject to state law and would only participate voluntarily.	If these employers participate voluntarily they may lower health care expenses, be able to fund employee health care by paying an affordable percentage of payroll, and reduce workers' comp. costs.
Medicare	Choice of regular Medicare or Medicare Advantage	Many Medicare Advantage beneficiaries will select Balanced Choice.	Medicare beneficiaries have a legal right to choose Medicare plan	Balanced Choice offers improved coverage for Medicare beneficiaries.

(5) Are there new mandates that put specific requirements on payers in your proposal? Are any existing mandates on payers eliminated under your proposal?

Yes, there is an indirect mandate, but there are also two options for being exempt from the mandate (Options 2 & 4 below). Employers offering insurance that does not meet the Balanced Choice standards will have four choices:

1. To pay for upgrading employer-purchased health care,
2. To allow employees to pay for upgrading the employer purchased health care,
3. To join the Colorado Balanced Choice Program and limit their responsibility for employee health care expenses and the medical expenses for workers' compensation coverage, or
4. To continue to purchase inadequate insurance with the knowledge that their employees would be subject to additional Payroll and Individual Health Care Premium Contributions (not a desirable choice).

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

Balanced Choice eliminates significant cost shifting. The only remaining cost shifting would result from the 50% uncompensated care for visitors and people who have not established full residency and are unable to pay health care expenses. By eliminating the cost shifting caused by caring for the uninsured, some parties, such as hospitals, may reap a windfall of increased payments. Balanced Choice will need to evaluate how eliminating cost shifting should affect reimbursement rates.

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

Yes, there are some new public funds required to begin coverage of the currently uninsured and underinsured. Employers and employees will also gradually transfer funds currently paid for private insurance to public funds that are placed in the Balanced Choice Trust. To a great extent, this transfer will be voluntary. See Table 1—Health Care Payers in Balanced Choice for details.

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

See Table 1—Health Care Payers in Balanced Choice.

***SINGLE PAGE DESCRIBING HOW YOUR PROPOSAL IS EITHER
COMPREHENSIVE OR WOULD FIT INTO A COMPREHENSIVE PROPOSAL.***

Balanced Choice will assure that all Colorado residents have comprehensive, quality, accessible, and affordable health care. In addition, Balanced Choice has realistic ways of addressing major underlying problems in health care.

Balanced Choice offers a practical and voluntary pathway for transitioning from the costly and fragmented plethora of insurance plans to a more economical and sensible single-risk pool. Employers and individuals can choose between purchasing an insurance policy that has equivalent-or-better coverage or enrolling in Balanced Choice.

Balanced Choice creates a pathway for lowering U.S. health care expenses. It is unique in using the gap payment system to restore consumer cost consciousness and market forces to health care. A flexible system, it will not only depend on cost conscious consumers to lower costs, but will also implement cost control strategies.

As a large transparent system with electronic medical records, Balanced Choice will have the ability to identify and modify areas of waste and problems in the delivery of quality care. Medical-home programs, disease management programs, and other quality-improvement or cost programs can easily be implemented as their effectiveness is demonstrated.

Balanced Choice ends the onerous third party-managed care restrictions on choice and treatment. Balanced Choice replaces the proprietary and confusing operations of managed care companies with a system that is completely transparent. Instead of restricting patient and provider choices, Balanced Choice offers both patients and providers a full range of choices.

Balanced Choice offers a plan that is more sustainable for patients, providers, employers, and taxpayers than other proposals. It contains checks and balances as well as self-correcting mechanisms that increase its long-term viability. The flexibility of a single system to respond quickly to make adjustments that prevent potential problems is a strength of Balanced Choice that contributes to its viability and sustainability. Transparency at all levels and constant communication with all stakeholders ensure that informed decisions guide policy development.

Balanced Choice creates a pathway for ending employer responsibility for health care. Although employers who previously did not contribute will be required to make a contribution based on payroll, overall employers' contributions will be lower and their administrative

responsibility for health care will be essentially eliminated. In addition, employers' expenses for the medical portion of workers' compensation insurance will be eliminated. By lowering employer health care expenses, Colorado will become more attractive to businesses.

SINGLE PAGE DESCRIBING HOW YOUR PROPOSAL WAS DEVELOPED

Ivan Miller, in cooperation with numerous colleagues, has been developing Balanced Choice Health Care over the past 13 years. His ideas originated from the conviction that there must be a better way to run a health care system than the bizarre labyrinths of managed care, the wasteful health care insurance system, or the simplistic adoption of a national Medicare plan or a traditional Canadian style single payer system — all ideas that are disliked by many Americans. A full explanation of the ideas presented in this proposal is available in *Balanced Choice: A Common Sense Cure for the U.S. Health Care Systems*. Balanced Choice Health Care, Inc., a nonprofit organization has been established to educate the public about the Balanced Choice innovations and ideas for health care financing reform.

A national base of supporters believes that Balanced Choice is the most practical and effective way to achieve meaningful health care reform. These supporters come from all parts of the country. They include liberals, conservatives, consumers, providers, and employers. Because U.S. health care reform currently is focused on state-by-state changes, Balanced Choice decided to adapt its national program to this proposal for Colorado.

Numerous national and state supporters have contributed to the writing and editing of this proposal. Many supporters are also members of Health Care for All Colorado (HCAC), and we thank them for a stimulating exchange of ideas. We all share the goal of assuring everyone affordable health care.

Arja Adair and James Todd shared their 208 Commission proposals with us. Because we can endorse most of their suggestions, we are pleased to include their proposals as supplements to our comprehensive proposal.