

COLORADO COMMISSION ON AFFORDABLE HEALTH CARE

1-11-2016
COPIC, Mile High Room

Meeting Minutes

Commissioners present: Bill Lindsay (Chair), Cindy Sovine Miller (Vice Chair), Elisabeth Arenales (phone), John Bartholomew, Jeffrey Cain, Rebecca Cordes, Greg D'Argonne (phone), Steve ErkenBrack, Ira Gorman, Linda Gorman, Marcy Morrison, Dorothy Perry, Marguerite Salazar, Jay Want

Meeting notes:

I) Approval of the Minutes

- A) Motion for approval from Bill Lindsay, seconded by Cindy Sovine-Miller.
- B) Minutes from December 21, 2015 were approved with no corrections or changes.

II) Election of Officers

- A) According to the bylaws, the Commission requires 100 percent of voting members to be present to make a vote. All voting members were not currently present at this time.
- B) Suggestion to amend the bylaws so there is not a need to have 100 percent of members present
 - 1) Suggestion opposed
- C) Motion to move the election to a paper ballot
 - 1) This process will be noticed at the next Commission meeting
 - 2) Motion unanimously approved

III) Competition vs. Regulation discussion

- A) Commissioners were provided a memo on market forces vs. regulation. The memo posed questions to the Commission to provoke discussion on where they should rely on the market to help address issues (like high health care prices in rural areas) verses making changes through regulation.
- B) Discussion:
 - 1) What really accounts for the cost of care in markets like Summit Co.? Do we know the reasons costs are higher there?
 - (a) The Department of Insurance sees 50-75 percent differences in some of the high cost areas of the state. There are things like premium costs and the cost of working in certain areas – like real estate, affecting pricing. There has been discussion about geographic ratings in an area, but that is only one factor that goes into the pricing. This doesn't address the underlying issues of the high cost of care.
 - (b) Why isn't Summit Co. a higher reimbursement area than other areas across the state?
 - (i) It's not just a phenomenon in Summit Co. and it's not just a matter of people being greedy. Communities have to choose between competition and economies of scale. With regards to rating area issue, this is not a new issue. We might want to begin by looking at lessons learned in the past; see what was shown in past studies and history since then (i.e., Pueblo).
 - 2) There are other areas with market failure; might be useful to use similar index across the state to decrease costs. This would be an example of regulation helping with costs.

- (a) Nobody from the economist world talks about market forces *or* regulation. This framework isn't particularly useful from this perspective. Regulation can cause enormous cost increases as well.
- (b) Markets are not interested in efficiency or efficacy, they are there to give people what they want and are willing to pay for.
- 3) Regulatory process has to be in place because, from my experience, it is hard to get information from companies and need to use carrot and stick approach to get information from insurers to constituents.
- 4) This really isn't an either/or situation, we are talking about markets. Would disagree that this is an issue driven entirely by the ACA. This issue predated ACA and will continue. The framework is a good one because these are major issues.
- 5) There is no reason health care is a more important good than any other good people buy (housing, food, etc.). People make tradeoffs and decide what is most important to them. The question is, who's going to pay for it?
- 6) There are many levels, one is are we talking about cost of insurance or the underlying cost of healthcare? The underlying cost of healthcare is one of the drivers between Colorado regions in terms of cost.
- 7) Need some mixture of competition and market forces. Entirely one or another may not work in this context. There are also things we cannot change in the context of Colorado. The question is, we already have a patchwork that creates problems, especially in mountain communities and eastern plains because of demographics in those communities. We have Medicaid that underpays providers and we have commercial insurance. We've institutionalized the cost shift to private insurance without discussion of Medicare and Medicaid. Is it worth a discussion of how market forces and regulation can work together in certain regions of Colorado? Maryland has an interesting program that we will hear more about at the next Commission meeting.
 - (a) In Maryland an important part was an incentive for hospitals to be paid for keeping folks out of the hospital. It's a different way of looking at how to reimburse hospitals (population health).
 - (b) Does any other state use the Maryland model? Sometimes what works in one state may not work in another.
 - (i) Unsure of another state that uses this model and it is probably due to politics because it is a very significant amount of money.
 - (ii) Also requires Medicaid waivers and for Medicare to pay more per episode. Other states may have tried and were declined due to CMS concerns over fiscal costs.
- 8) Difference between increased costs due to pricing and increased cost because of practice models. There are other factors including our upcoming discussion of social determinants of health. It's hard to look at just prices as one factor of many.
- 9) If you do this by increasing Medicare rates, are you getting an absolute cost reduction or are you just shifting costs to tax payers? It seems it is just shifting costs, not reducing the cost of actual care.
 - (a) Doing this on a fee for service basis is not the answer, you have to say everyone is in the pool here and deal with a different way of compensating. Need to align financial incentives so hospitals want to use their services efficiently; this is a key component to the Maryland model.
- C) Commissioners to continue thinking about this topic for the presentation from Maryland Hospital Association at February's Commission meeting. Commissioners should think about questions to bring forward and if this is something the Commission would like to weigh in on – is this something where a pilot would make sense in Colorado?

D) Public Comment

- 1) Kathy Chandler Henry, Eagle Co. Commissioner: Appreciate discussion and the Commission's radar on what's happening to folks in mountain communities. Eagle, Summit, Pitkin, Garfield and Grand counties are working together to look for solutions. It is a crisis in our counties; we hear daily from constituents who have to choose between mortgage payments and health insurance. Hear many horror stories from folks who have to drop their insurance. We need something to happen soon. We would be willing to be a pilot program, to help with research and do whatever is necessary to help with this issue.
- 2) George Swan, retired hospital administrator: Whether it's market or regulation you can't do job without data, particularly at the county level. One thing I've argued for in pivot tables is data at county levels where they can create community health assessments to inform decisions about local circumstances. It helps to have context into what other counties and states are doing. This continues argument for pivot tables. Last week US News and World Report on health care index – sent report for Commission's input - there is all kinds of data available to help make decisions.
- 3) Rachel Richards, Pitkin Co. Commissioner: Agree with Commissioner Henry's comments. We realize how difficult this is for everyone. This is a crisis in our area. It is a tough population to serve. We understand issues with competition and economies of scale; we are challenged by this as well. In our community we have started a nonprofit working with the five major self-insured employers to try to bend the cost curve and are working with the hospital to develop pathways of care for treatment of the most common issues. We are working on both ends but it's not helping people in immediate crisis. It's particularly hard for people who are pre-Medicare (ages 55-65). Many folks are dropping policies and paying the fines. Folks on group policies don't feel it the same as those who are on individual, private policies.
- 4) Dan Gibbs, Summit Co. Commissioner: There is urgency, to say the least. Constituents are calling daily and the business community is up in arms over prices they see. Senate Bill 200 that created the Exchange says to consider the unique needs of Colorado as it pertains to access and affordability. This is the only group that is talking about the needs of rural communities relative to prices and affordability. You have a tough challenge and urge you not to wait until final recommendations in 2017 to make one on this issue. There are lots of legislators who want to work with us on this issue. Urge you to add urgency to this issue.
 - (a) When did this start to become a crisis?
 - (i) For Summit Co. it became noticeable when we started seeing national articles that reflected we were part of this region that had the highest health insurance in the nation. We heard from constituents before that, but media attention helped grow awareness. We started working together regionally at that time to figure out a way to work together. Health care is not affordable in any way in Summit Co. since the health op has left.

IV) Recommendations and Parking Lot discussion

- A) The recommendations document will move its way into the recommendations section of the Commission's June report. Encourage Commissioners to take a close look at the document and make sure they are comfortable with what is included. Any changes to the document should be sent in writing.
- B) Relative to payment and delivery reform, where is the literature on bundled payment methodology? Although there is mention included of a state employee plan pilot to look at outcomes, there is objection to using state employees as human subjects in an experiment. It would need to be clear it is an experiment and let people choose to participate voluntarily. Other commissioners want the pilot to be broadened across the system – not just state employees.

- C) Primary care funding should be moved out of the parking lot and into a recommendation. Needs additional research.
- D) Access to specialists is increasingly problematic across payers. The Commission has had discussion about primary vs. specialty care and looked at studies; these aren't captured in the document.
- E) Can we be clear about Value Based payment models? They are evolving rapidly. The Commission is encouraging experimentation without picking a particular model.
- F) The ACA has brought about transparency that created a lot of the conversation on geographic rating.
- G) Would like section on strengths and weaknesses of health care data; including the age of the data.
 - 1) Staff will put together wording on this point.
- H) Public Comment:
 - 1) George Swan: Happy to see item on "broad use of pivot tables by DOI." Public Health should take the lead on this and should be included in that statement.
 - 2) Ryan Biehle, Colorado Academy of Family Physicians: Wanted to follow-up on questions from Rhode Island presentation at the December meeting. Rhode Island does not have any gatekeeper models for their patients. There were also questions around primary care spending target and how it related to decrease in expenditures in relation to other factors affecting primary care spending. There are a myriad of factors including shifting markets into ERISA. In conjunction with increase in primary care spending, they did see some important declines in emergency department usage. I also spoke with Rhode Island insurance commissioner, who said they did need more information around this. The primary care spending target has informed many of their discussions around transformation work within practices and has been a useful performance measure in how plans are performing.

V) Transparency in Pharmacy discussion, Rep. Joann Ginal

- A) Rep. Joann Ginal provided a presentation on pharmaceutical drug pricing issues and a bill planned to be introduced in the upcoming legislative session. There have been very serious concerns on the skyrocketing prices of pharmaceutical drugs, as well as out-of-pocket premiums. Would like to bring transparency to consumers and private payers on pharmaceutical drug pricing and am bringing forward bill that would have drug companies report to the Commission on costs associated with the drug for the Commission to analyze. We view this as a first step in creating a more affordable health care system in the future. A copy of the draft bill can be found on the Commission [website](#).
- B) Commission discussion:
 - 1) Something that has been in the headlines are pharmaceutical entrepreneurs who come in and buy specialty drugs then increase the prices. How do you see this bill helping with these types of outliers?
 - (a) It's interesting that people see it as a new trend but these drugs used to be known as orphan drugs and now with research and development they are finding these drugs can help with more diseases. If we can bring down the costs of this it would help patients tremendously to be able to afford them.
 - 2) Something to think about is funding for the Commission and making sure we have resources to continue as our mission may be expanded.
 - (a) We do hope to be able to extend the funding and think the Commission does an excellent job looking at these issues.
 - 3) Is there any analysis of how much this would cost drug companies? It is expensive to provide this type of data. Concern that Colorado is a small market and this may make some companies walk away from the Colorado market.
 - (a) The legislation would apply to about 20 drugs right now. We believe that most of them already have the required data to report.

- 4) Have you visited with the pharmaceutical companies or had data prepared for you to assist with language of the bill? You've limited the number to \$50K, what was the reaction from the companies if you can share with us?
 - (a) There has been legislative research done and there is a draft of the bill you have seen. We have had two stakeholder meetings, the response from the companies was opposition in that we shouldn't just look at the drug aspect and should look at the entire picture including insurance companies and hospital costs. My thought was, where do you start? Even insurance companies are regulated to some degree. Really want to get at why the costs of drugs are getting so high.
- 5) Challenge for the Commission is that pharmaceuticals is an area we've identified to look at and address but we are having trouble how we address and make an impact. We don't have expertise to put together the questionnaire put in the bill, let alone the ability to evaluate their responses. We could think about how to address this. We appreciate your interest in Commission and support.

VI) Updates and Business

A) Planning Committee

- 1) The committee is creating a schedule for the rest of the Commission's tenure with current spending from now until September, which we will try to get to Commissioners before the February meeting. We have a good chance of getting additional funding to continue through June 2017, but want to be prepared if that is not a possibility and want to prioritize where our time will be best spent.
- 2) Sent out stakeholder survey and got back very thoughtful comments from a myriad of sectors. We want to schedule those respondents to talk to the Commission about their perspectives about what is changing and how the Commission can make a difference in those areas.
- 3) Have an assortment of speakers on the February agenda which include the Maryland Hospital Association, market concentrations, and Colorado Association of Health Plans, and would like to have more discussion on palliative care. Commissioners should think about this topic and what recommendations to make in this area.

B) Commission SMART presentation to the Joint Health Committee

- 1) [Power point](#) provided to Commissioners on the SMART presentation provided by Bill and Cindy to the Joint Committees on Health on January 8th.
- 2) The presentation was well timed, it was clear many of the legislators were not aware of the work of the Commission. Much of the discussion was spent on upcoming issues and the issues the Commission has talked about. The Commission was scheduled for 30 minutes, but the presentation ended up taking over an hour. There were lots of questions around price opposed to cost. There still needs to be a lot of education around why prices are going up.
- 3) Overall, legislators were complementary and appreciative of the time and work of the Commission. There were a lot of pointed questions and unfortunately several of the questions have nothing to do with the Commission's legislative charge. There were detailed questions and discussion around the ACA and administrative costs of insurance companies. There was discussion about the physical therapy bill and our response to those questions. There was also a lot of discussion around pharmacy costs and what can be done about it. There will be individuals who are disappointed if the Commission doesn't address their favorite issue, but we also need to be disciplined around the 23 points the Commission has been tasked with. There was a real interest expressed in engaging with the Commission and hope for the opportunity for the rest of the Commissioners to really engage with the Committee in the future.
- 4) Discussion:

- (a) Would it be helpful to send agendas to the legislators so they can see the work we are going to tackle?
 - (i) We have recently added all the legislators to our interested persons list which sends them directly to our agenda. We can include a link to the website and paste the agenda in the body of the email.
- (b) Were there questions about the definitions we came up with on cost vs. price?
 - (i) That discussion was really more directed towards the pharmaceutical discussion.
- C) Other business:
 - 1) The Commission's February meeting will run late due to a large agenda
 - (a) Request to see if Commissioners could meet earlier instead of going later at the next Commission meeting. Email to be sent to Commissioners to gauge their availability.

VII) Public Comment

- A) George Swan: As I understand, outpatient drugs have a wholesale cost component they cannot charge more than. Struck by point made in draft bill that said purpose of legislation is to make pharmaceutical pricing as transparent as in other sectors of the health care industry. But as we know, all sectors of the industry need more transparency. I believe there is a real loss of value in regard to the hospital cost reports; they kind of go to cost of care. I did send a pivot table to the Commission I developed from California that has 440 hospitals and all their cost reports are uploaded every year.

Meeting adjourned at 3:00pm