COLORADO COMMISSION ON AFFORDABLE HEALTH CARE

Meeting Minutes
7-11-2016
COPIC, Founders Room

Commissioner Members

Present: John Bartholomew, Jeffrey Cain, Rebecca Cordes, Greg D'Argonne, Steve ErkenBrack, Ira Gorman, Linda Gorman, Marcy Morrison, Dorothy Perry, Cindy Sovine-Miller, Christopher Tholen, Jay Want, Larry Wolk

By Phone: Marguerite Salazar

Meeting Minutes

I) Approval of the Minutes

A) Greg motioned for approval of the Commission meeting minutes from June 13, 2016. Jeff seconded the motion and the minutes were approved unanimously.

II) Statewide Meetings

A) Lorez provided an update on the statewide stakeholder meetings held to date in Colorado Springs, Alamosa, Grand Junction, Summit County, and Adams County. The next two meetings are in Sterling and Greeley on July 20.

B) Questions and discussion from the Commission on the statewide meetings in general:

1) One of the challenges is addressing costs in the short time we have available; we have been hearing that people want things done quickly.

2) From the perspective of those in the insurance and hospital business, what are the real drivers?

(a) Communities would love to be able to take control of this themselves. But units have to change.

(b) The drivers we've been discussing are the right drivers. But I agree that it's about units, cost shift, the influence of government reimbursement on private insurance, the increase in size of the ERISA plans and the self-insured, etc. The Harvard Business Review looked at bundled payments versus capitated payments – that kind of analysis could be very helpful for this Commission.

(c) I agree with what's been said. The real issue is in the mountain communities versus Denver, because rates are going up a lot higher in the mountain towns. They're seeing 20% increases from two years ago. It's a supply and demand issue. A lot of it is a lack of hospital and physician providers. But it's not just a lack of providers; it's also a lack of need.

(d) We've talked about the health care provider shortage, but the other end of that is that providers are able to demand much higher salaries.

(e) As a provider, I've always thought there was a workforce issue, but it's also a delivery model issue. The cost of the delivery model is very high in this country. Are there other ways to design delivery models?

(f) If we look at the cost shift, we have to look at the very problem with using the term "cost." Is what we're paying for these various things appropriate?

3) In all the statewide community forums, there certainly wasn't an understanding of the complexities of these issues. There are no easy answers, but the average person does not totally understand that. Everyone you talk to has a different idea of what the solutions look like. If

there's nothing else we can do, surely we can at least emphasize and educate on the complexity of health care costs.

4) There are a lot of different ways to measure the health care system; for instance, on productivity, the U.S. does very well. It's important to convey that to stakeholders as well.
5) The expansion of eligibility drives costs too.

C) Cindy introduced Summit County Commissioner Dan Gibbs, who provided comments to the Commission because he was unable to attend the Summit County stakeholder meeting. Dan noted that the legislative session is right around the corner, and said that if the Commission wishes to pursue legislative action, it should do so quickly. Dan also shared a letter that the Summit County Commissioners wrote to Commissioner Marguerite Salazar. The letter highlighted Summit County Commissioner concerns about growing insurance rates, which are a particular challenge in mountain communities where child care costs and housing are already very expensive. The letter suggests that the Commission recommend taking the cost of living into account when looking at health care subsidies; that it explore solutions in other states; and that it look at innovative solutions for delivery to take advantage of Section 1332 waivers.

III) Local Public Health Opportunities, Lisa Van Raemdonck & John Douglas, CALPHO

A) Lisa presented on how investing in the public health system can help reduce health care costs. CALPHO's goal is for Colorado to be the healthiest state in the nation, and CALPHO believes that public health is essential for reaching this goal. She noted that public health work has to consider innovative funding models, not just great ideas. All Colorado communities have undergone an assessment to look at their priorities based on data and the needs of residents; these communities now have health improvement plans, but they do not necessarily have the ability to implement them. Lisa suggested that local public health departments are both underutilized and underfunded, emphasizing the important of public health for bringing cost savings and cost avoidance via prevention. She used asthma as an example: acute care treatment for asthma is very expensive, but prevention can be both very affordable and very effective. Lisa noted that public health has generally existed outside the traditional funding mechanisms, and that it doesn't need to look like fee for service; there are wellness trusts that pool community health dollars from hospitals, for instance. CALPHO doesn't wish to reach into the pockets of other health care institutions; it simply wants to demonstrate how much public health can help when it comes to prevention, overall health, and the burden on the health care system. Lisa's full presentation is posted here.

B) Questions and discussion from the Commission:
   1) There are so many options with public health, some contradictory. At what point does public health just leave people alone? Public health has been wrong before.
      (a) John: It's about making the healthy choice an easy choice. It's not about control; it's about offering structured health choices.
      (b) Lisa: Public health sits on the razor's edge of public good and individual choice, and that's a constant deliberation for us.
   2) If you had more money, where would you invest it?
      (a) Lisa: It has to be done on a community need basis, funding the programs that are targeting improvements that we have already identified in the community assessments.
      (b) John: When we ask what people care about, it's frequently obesity, mental health/behavioral health, opiate abuse.

C) We know our state is still below many others in immunization. Why is that?
   (a) John: It has a lot to do with the cost of immunizations.

2) Lisa: Public health's role in immunization varies from community to community. In some communities, we're the only providers of immunization; in others, we don't provide immunizations anymore because other providers have them covered.

D) Are there a few areas where should be focusing our dollars? Asthma, diabetes, unintended pregnancy prevention, obesity?
   1) Lisa and John noted that they would provide draft recommendations focusing on a few areas where the Commission could make the most impact.

IV) Topic Recommendations: Prescription Drug Costs and Drivers, Amy Downs, CHI

A) Amy offered a presentation on cost control and pharmaceutical drugs. She noted that about 2% of patients are driving 43% of Colorado's pharmaceutical spending. Amy presented a range of possible solutions, but noted that it's difficult for a sparsely populated state like Colorado to have an impact on the pharmaceutical industry. At the federal level, patents and the exclusivity of drugs, prohibitions on Medicare negotiating prices, and regulations on the (re)importation of drugs from other countries have a big impact. Many states have tried state-based solutions and they have not been successful. Amy's full presentation is posted here.

B) Questions and discussion from Commissioners:
   1) To the degree that you can aggregate more lives to get more purchasing power, does that work?
      (a) There could be an opportunity for a soft recommendation to conduct an analysis on that savings.
      (b) The state has created a preferred drug list, and that does cut back at lot of the expenditures.
      (c) To the degree that other states have been able to achieve savings, it would be good to know the degree of the savings achieved with aggregation.
      (d) Unfortunately, if you create a multi-state purchasing pool, you're not actually going to address the challenge with most spending coming from specialty drugs (11%).

C) What benchmark should we use? What should be the focus with respect to educating the public on how cost effective our system is?
   1) Colorado has the lowest annual expenditures on pharmaceuticals per month.
   2) Maybe we need to create a more structured presentation on what actually goes into drug costs. For instance, Canada has really low costs for drugs, but there are certain specialty drugs that you can't get. Lowering the cost of the drug prevents future innovation. It's important to educate on the trade-offs.

D) I thought the Commission was less interested in the individual rabbit holes for pharmaceutical spending, but more about how we are addressing it on a system level across Colorado.

E) The reason this has so much momentum is that these costs have gone up so much higher than the rest of health care costs. It appears to be an industry that isn't going to police itself. So, the rubber is going to have to meet the road with both specialty drugs and traditional drugs.

F) Commissioners discussed an idea to write a letter to the federal congressional delegation.
   1) We might see if our congressional delegation would be interested in a conversation about this now.
   2) Before we go to the delegation, it's important to know what the trade-offs are.
   3) The Commission requested that CHI articulate the trade-offs, because of course all of these policy possibilities have trade-offs.
   4) What we're trying to get around is saying that we can't do something because of trade-offs, or just trying to spread the costs – neither of those seem like a very good "recommendation."

G) Our report needs to provide some discussion and analytics and a frame of reference for the legislature. Should the report have a robust discussion about this topic, but then address the point

that these issues should be evaluated at the federal level given that Colorado is just one state and a relatively sparsely populated state at that?

H) A recommendation should clarify what would actually be gained by more transparency around pharmaceutical costs.

I) It seems like if a lot of the possible solutions have failed in other states, there isn't a lot for this Commission to do. It doesn't feel very fruitful.
   1) We could at least refresh the research/discussion on buying in bulk.
   2) It is important for the Commission to consider that this is an area where federal influence and regulation impedes a state's ability to make any kind of useful change. We have to address it, of course, but there are some things that are outside our scope of control and we shouldn't waste the Commission's time debating things that the Commission can't really control.

V) CICP Study Update, John Bartholomew, HCPF

A) John notes that HCPF is currently working to summarize all of the information it has and noted that the goal is to deliver a report the week before the next Commission meeting in August/ September.

VI) Planning Group Update, Cindy Sovine Miller

A) Advisory Committee Discussion: Cindy led a discussion around the Commission's obligation to create Advisory Committees on topics in need of more in-depth study. The mandate does not specify how many Advisory Committees to set up. There was some debate about whether the Advisory Committees were absolutely required, but ultimately, the Commission agreed that setting up at least one Advisory Committee was not optional. Questions and discussion from Commissioners:
   1) Is the goal to develop Advisory Committees on areas the Commission has or has not discussed?
      (a) It could be an area that complements an existing topic, or a new topic.
      (b) It is important to make sure that we can figure out how to set up an Advisory Committee in a meaningful way.
   2) Does it need to be established in time to inform the next report in only a few months?
      (a) The Advisory Committees only need to inform the final report. There do seem to be topics that still need to be discussed, but we need to ensure that there's buy-in from the whole Commission to discuss these additional topics.
   3) I suggest no more than three Advisory Committees going forward due to Commissioner timing and funding.
   4) Because the mandate indicates that the Advisory Committees must include non-Commission members, I suggest that we ensure a diverse group – not just from Denver but from around the state. The challenge with these groups will be coming up with any more concrete recommendations than the Commission itself has been capable of, especially given the time constraints.
   5) Public comment from Clif Croan, Enigami Systems: It would be interesting if Anschutz did some pharmaceutical development to create competition, setting up competition between the private sector and the university on patents. Could this be a topic for an Advisory Committee?
   6) Public comment from John Dethmen, HCPH: Public health could be a good topic for the Advisory Committee.
   7) Other topics for Advisory Committee consideration:
      (a) Maryland CMS – Is there potential for a workaround for rural hospitals?
      (b) Out-of-network costs
      (c) Facility growth and expansion (including workforce/personnel and freestanding ERs)
      (d) Access (including cost shift)
      (e) End-of-life care

(f) Social determinants
(g) ColoradoCare

B) November Report
1) Keystone and CHI will draft a report outline in September to present to the Commission. Thus, the August Commission meeting will need to focus on recommendations and the Commission will need to vote.
2) One Commissioner noted that to date, CHI's reports have focused on Medicaid or state employees, and suggested that the next reports go beyond those topics.

C) Additional Topics:
1) For the September meeting, Cindy suggested discussing offering the expanded Medicaid population the option to take advantage of premium tax credits and get insurance through the ACA instead.

VII) Public Comments

A) George Swan, Retired Hospital Administrator: Every hospital I've been in has been a part of a group purchasing process. It's also worth considering best practices and cost/benefit around the use and abuse of drugs, and the relationship to disease registers. Stephen Larsen has a great book on the role of drugs in best practices. I submitted an example pivot table repository to explore how you could organize all the data. I also sent an open letter to Michael Porter and Michael Green, who have made a case for bundled payments in healthcare. Michigan contracted with them to create a Social Progress Index.