Appendix V—Public Comments

Comments Received May through August 31

A.J. Ehrle

Alex Ball

All Kids Covered

Arthritis Foundation

Boulder Emotional Wellness

Carol Pace

Chronic Care Collaborative

Coalition for Immigrant Health

Colorado Academy of Family Physicians, American Academy of Pediatrics, and American College of Physicians

Colorado Access

Colorado Advocacy Organizations – Joint Letter

Colorado Association of Health Plans

Colorado Center on Law and Policy

Colorado Community Health Network

Colorado Competitive Council

Colorado Consumer Health Initiative

Colorado Dental Association

Colorado Dental Organizations

Colorado Foundation for Universal Health Care

Colorado Medical Society

Colorado State Association of Health Underwriters

Debra Irvine

Delta Dental

Eagle Insurance Agency

Glenwood Insurance

Healthcare Business Strategies

JM Fay

Kyle Curley

Toni and Kreg Lyles

Miles Kessler

Northern Colorado Individual Practice Association

Robin Mills

Walt Geisel

Women's Reproductive Health

Comments Received October 7 through October 28

Adrianna Jones
Albert Nemes
Alexandra Hoffman
All Kids Covered
Amanda Bristol Swanson
Amberly Stringer
American College of Emergency Physicians, Colorado
Chapter American Health Insurance Plans
Andrea Fields
Anita Connors
Anna Davis
Anonymous
Anthem
Antonella Lyles
Aurora Coverage Assistance Network
Becky Houghton
Benjamin Ferree
Bonnie
Bonnie Davis
Boulder County
Brandt Wilkins
Brenda Miller
Brian Hughes
Britta Robinson
Bruce Church
Bryce DeHaven
Carol Pace
Carol Salter
Carol Shaw
Carolyn Carroll Flynn
Cassandra Williams
Cathy Jarrett
Center for Health Progress
Charles Becker
Children's Hospital Colorado
Colorado Access
Colorado Agricultural Aviation Association
Colorado Association of Health Plans

Colorado Center on Law and Policy
Colorado Community Health Network
Colorado Competitive Council
Colorado Consumer Health Initiative
Colorado Dental Association
Colorado Hospital Association
Colorado Land, Water & Food Alliance
Colorado Medical Society
Colorado Psychiatric Society
Colorado Rural Health Center
Colorado Society of Osteopathic Medicine
Colorado State Association of Health Underwriters
Conejos County Hospital
Connect for Health Colorado
Connor Johnson
Consumers (250+ signatures)
Counties and Commissioners Acting Together
Craig Richardville
Cynthia Hoover
Dan Weaver
Daniel Oakley
Daniel Willard
Dee Perry
Dennis Leonard
Denver Health
Denver Metro Chamber of Commerce
Derek Harris
Diane Ekstrom
Direct Health Public Benefit Corporation
Donald Miller
Eastern Plains Hospital Consortium
Edna Heimerman
Elizabeth Johnson
Elizabeth Rand
Elyse Dinnocenzo
Eric Mello
Erika
Erin Williams

Ernie Phillips
Ethan Lovell
Eugene Humbert
Evan Holloday
Frances Musser
Friday Health Plans
Gary Goodwin
Georgina Minto
Glenda Singleton
Good Business Colorado and Small Business Majority
Haxtun Hospital
Healthier Colorado
HealthOne Colorado
Hospital Chiefs of Staff
Jack Ekstrom
Jack Hamm
James Hoffman
James Rose
Jean Dudley
Jeanette Turner
Jim Abels
Joe Foecking
John Golden
John Jones
John Mason
John Tumulty
Jonathan Ward
Joseph Giudice
Joseph Quinn
Joyce Lash
Julie Cade
Kaiser Permanente
Karl Ecklund
Karl Honegger
Kathryn Burch
Katya Chorover
Kelly Miller
Kevin Burns
Kevin Ladd

Kimberly Mayton
Kirk Groves
Kurt Kool
Laureen Gutierrez
Lauren Roe
Lee Hively
Lee Sutherland
Levi
Linda Kemp
Longinos Gonzalez
Lora Krista Lafortune
Luciano Lemos-Filho
Luke Ward
Margaret Dumas
Mark Matthews
Marta Oakley
Martha Brown
Martha Crapo
Marti Stude
Mary-Sue Quinn
Matthew Mammoser
Medical Staff Presidents
Megan Smith
Melissa Jones
Melissa Shields
Michael Merrill
Michelle Klermund
Michelle Madd
Mitchell Baldwin
Monte Tucker
Nancy King
Nathan Nidiffer
National Jewish Health
National Multiple Sclerosis Society
Nick Kliebenstein
Nina Anderson
P Frerich
Pamela Assid
Parkview Medical Center—Mark Dunsmoor, Chair of the Board of Directors

Parkview Medical Center—Leslie Barnes, President/CEO
Pat Cook
Patrick Stookesberry
Peter Nemec
Pharmaceutical Research and Manufacturers of America
Phyllis Albritton
Progressive 15
Raeman Haines
Randy Umland
Ray Walters
REMI Partnership
Rich Lirtzman
Richard Allen
Robert Bucheit
Robert Clemans
Robert Jones
Robin Sweet
Rodney Koehler
Ronald Madd
RosAnn Biondo
Rozanne Nelson
Ryan Simpson
Samantha Wagar
San Luis Valley Health—Carmelo Hernandez, Chief Medical Officer
San Luis Valley Health—Christine Hettinger-Hunt, Chief Operating Officer
San Luis Valley Health—Donna Wehe, Director of Communications & Public Information Officer
Sandra Foote
Sarah Boeke
Sarah Ellis
Scott Honeycutt
Senator Ray Scott
Sheryl Glasgow
Sheryl Hobbs
Sky Ridge Medical Center
Spencer Way
St. Mary's Hospital
Steve Evans
Steve Schwettman
Steve Wesselhoff

Susan Hicks
Susan Luenser
Susan Morgenstern
Susan Richards
Susan Sadd
Suzanne Watson
Tamara Vliek
Ted and Aiko Kozikowski
Teri Cavanagh
Theresa Cuccio
Timothy Powell
Tom DeBie
Trish Weber
Trudi
UCHealth Medical Group
UCHealth
United Health Group
University of Colorado School of Medicine
Valley View Hospital
Veronica Lee
Vivian Simon
Wayne Mee
Western Healthcare Alliance
William Bertram
William Inman

Ideas for an Affordable Health Coverage Option, HB19-1004

Submitted by AJ Ehrle, AJ Ehrle Health Insurance

Ideas I had for a state option. I would be happy to answer any questions about them.

-State option only available in counties serviced by less than 3 carriers

-To service a county a carrier must offer at least bronze and silver level plans

-premiums are capped or based on age bands (ex:0-18 $150; 19-35 $300;35-50 $450;51-65 $600

- Deductible is equivalent to 10% of income, based on last Federal income tax return filed or other form of income verification

-PPO/ Any provider practicing in Colorado must accept

-Administration of all provider bills to the state plan must be paid within 45 days

-Only available through C4; paid a fee of 2% of effectuated premium

-Brokers to be paid a flat $100 annual fee for obtaining the state plan for a consumer to be paid no later than 60 days from effective date

Leave Medicaid and Medicare programs alone. I mean you could change those programs, but not as part of this.

After my presentation, I had a few changes/answers to certain problems/questions. They are as follows:

Verifications for Out of Pocket

Self employed verification: Average of the most recent 3 Federal tax returns

Employeed verification: Average of one years tax return and current paystub

Combined verification: Average of two years tax returns and other qualifying documentation

Change the age bands to 0=25, 26-35, 36-45, 46-55, 56-64. Make the 56-64 age band available throughout entire state

Make the state option available for anyone identified as being in the "family glitch"

With the reinsurance pool, most consumers will already see a decline in individual rates, except in areas where there are less than three carriers.

Dear Kim Bimestefer and Mike Conway,

What is the point of spending millions on price transparency that is supposed to encourage competition thus driving down chargemasters' pricing?

Encouraging and increasing competition cannot be accomplished with the current rules that allow more than one geographic rating zone while insurance companies are allowed to provide quotes based on residents' physical address and exclude individual plans where they provide group and self insured plans. I can be the greatest shopper of healthcare services, but I will never be rewarded for being proactive according to the current state rules. CIVHC is spending millions to increase price transparency. but I will never be rewarded for utilizing their tools. Providers are required to be more price transparent. Colorado's practice of allowing multiple geographic rating zones prevents me from being rewarded for shopping and choosing the best price as long as insurance companies are allowed to judge me on my apartment's address versus my friend's address. Why does state government allow insurers to pit rating areas against each other without passing on savings created by individual choice to the greater community? Additionally, if one statewide rating zone was implemented, insurance companies would still be allowed to cherry pick where they underwrite in the state. I propose that all insurance companies, wanting to underwrite group and self insured policies in Colorado, should be required to underwrite individual policies in all zip codes. How can Colorado's statewide population health data analytics be relevant for statewide comparison if data varies from zone to zone and address to address?

As a Colorado resident who would like to be self employed with affordable health insurance, please accept this email for your consideration as my public comments for the Proposal for Affordable Health Coverage Option.

Sincere thanks,
Alex Ball

Commissioner Michael Conway
Director Kim Bimestefer
Department of Regulatory Agencies
1560 Broadway, Suite 110
Denver, CO 80202
Via email: dora_ins_website@state.co.us; hcpf_1004AffordableOption@state.co.us

Subject: A Public Health Care Option that's Good for Kids

Dear Commissioner Conway and Director Bimestefer:

We know the state is committed to developing the best possible public health care option for Coloradans and we appreciate the thoughtful deliberation and stakeholder process driving this work. The All Kids Covered Coalition (AKC) members are participating in the stakeholder meetings and would like to take this opportunity to advocate on behalf of Colorado kids as the state begins to design the public option pursuant to HB19-1004.

All Kids Covered is a non-partisan coalition of more than 20 organizations. We advocate for sound policy to reduce the number of uninsured children in Colorado, and improve access to affordable and quality health care for Colorado's kids. We want every child in Colorado to have access to affordable health coverage and quality care. Providing health coverage for kids is a key way to ensure our children have the opportunity to grow into healthy adults who live, work, and thrive in communities across Colorado. As you continue engaging stakeholders, please consider these two requests to ensure the public option meets the unique needs of Colorado's children:

1. **Make the option available to Coloradans who earn low to moderate incomes, to allow families without proper documentation and those who fall into the family glitch to gain access to affordable coverage.** Despite Colorado's success in reducing the child uninsured rate, 4 percent of Colorado kids still lack health insurance. In fact, progress in getting every Colorado child covered stagnated this year. We believe the public option can help remove barriers that keep families and children uninsured. This is of primary importance for families without proper documentation or families who fall into the family glitch.

2. **Make the benefit package at least as generous as Colorado's Child Health Plan *Plus* (CHP+), with similar cost sharing limits, and more first dollar coverage of primary care benefits.** We believe a public health care option should be designed to work well for families, children and pregnant people. As such, we believe the benefit package offered through the public option for

   children and pregnant people should be at least as generous as CHP+. Additionally, we believe the benefit package in the public option for children and pregnant people should have similar cost sharing limits to that of CHP+ and more first dollar coverage of primary care benefits before a deductible.

In closing, AKC appreciates the dedication that is going into this work to create a public health care option in Colorado and we thank you for taking the time to consider our comments. We believe these recommendations align with the state's goal to develop a quality, affordable health care option for Coloradans.

Sincerely,

Leadership Team of All Kids Covered

(Colorado Children's Campaign, Colorado Covering Kids and Families and Colorado Consumer Health Initiative)

August 30, 2019

Colorado Insurance Commissioner Mike Conway
Division of Insurance, Colorado Department of Regulatory Agencies
1560 Broadway #110
Denver, CO 80202

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant St,
Denver, CO 80203

Submitted electronically via HCPF_1004AffordableOption@state.co.us

RE: Comments on the implementation of The Proposal for Affordable Health Coverage Option (HB 19-1004)

Dear Commissioner Conway and Director Bimestefer,

On behalf of the more than 54 million Americans and 300,000 children in the United States with doctor diagnosed arthritis, the Arthritis Foundation appreciates the opportunity to comment on the implementation of The Proposal for Affordable Health Coverage Option (HB 19-1004). Our comments will address four areas that we would like to see addressed within any implementation of a public option in the state. The four areas include nondiscriminatory formulary design, copayment caps, coinsurance, and step therapy protocols. Addressing each of these four areas will improve the affordability and accessibility of the public option.

Nondiscriminatory Formulary Design

In response to affordability concerns, in 2014 the Division of Insurance issued a bulletin advising carriers that placement of all or most drugs for a particular condition on the highest tier would be considered discriminatory, in violation of Section 1557 of the Affordable Care Act. To achieve widespread compliance, on June 1, 2018, the Division promulgated Regulation 4-2-58. Section 5 of the Regulation prohibits plans from placing more than fifty percent (50%) of the drugs used to treat a specific condition on the health benefit plan's highest cost formulary tier. The Arthritis Foundation and many other patient groups applauded this regulation by the Division.

Recently, in an effort to see how well the regulation was working, the Arthritis Foundation participated in an analysis of the tiering of prescription medications by the health plans on the Colorado exchange with several other patient groups.

Methodology

The analysis looked at seven conditions: Arthritis, Bipolar, Epilepsy, Hemophilia (includes Hemophilia A, Hemophilia B, and Von Wilebrand's Disease), Multiple Sclerosis, HIV, and Psoriasis.

The results of the analysis were shared in a letter dated March 4th from the Colorado Chronic Care Collaborative, which the Arthritis Foundation is a proud member of, the Colorado Center on Law and Policy, and the Colorado Consumer Health Initiative.

Staff with disease-specific expertise compiled the list of drugs for each condition and their available generic equivalents. The top row of each condition-specific spreadsheet comprises these drugs.

We then searched the formularies for each of the seven individual-market plans for each drug. We indicate which tier (or tiers) each drug is listed on. If a drug was not listed on the formulary, we indicate N/A. We indicate generic drugs ("gen") and their tiers in the same cell as the namebrand drug.

To assess the percent of drugs for the particular condition in the highest-cost tier, we counted the number of drugs covered for the condition (counting generics separately from name-brand equivalents) (denominator), and the number of those drugs in the top tier (numerator).
We counted drugs that appeared on multiple tiers depending on delivery systems or dosage as being listed in their lowest tier, in order to create the most conservative estimate of noncompliant plans (see questions as to how the Division handles these instances below).
While we conducted this analysis carefully, this type of formulary analysis was new to those involved in the project and some errors are possible.

Preliminary Results

After analyzing formulary design for seven chronic conditions, the analysis by the coalition concluded that there is a significant level of noncompliance with the Regulation.

Condition	***Number of plans that comply with Regulation 4-2-58's 50% requirement***
Arthritis	0 of 7
Bipolar Disorder	7 of 7
Epilepsy	7 of 7
Hemophilia A and B	0 of 7
Hemophilia – Von Willebrand's Disease	1 of 7
Hepatitis C	0 of 7
HIV	6 of 7
Multiple Sclerosis	4 of 7
Psoriasis	2 of 7

Recommendations

As the Division moves forward with implementation of The Proposal for Affordable Health Coverage Option (HB 19-1004), the Arthritis Foundation requests that the nondiscriminatory formulary design is made a key focus. In addition, the Arthritis Foundation encourages the Division to carry over key regulations to ensure that the public option benefit design that will have the effect of discouraging individuals with significant prescription needs from enrolling.

Copayment Caps

High cost-sharing is a barrier to medication access for people with chronic, disabling, and life-threatening conditions like arthritis. Cost-sharing for prescription medications should not be so burdensome that it restricts or interferes with access to necessary medications, which can lead to negative health outcomes and additional costs to the health care system as patients instead seek hospital or emergency room care. Ensuring that people with arthritis have access to affordable quality treatments and medications is a guiding principle of the Arthritis Foundation.

Accordingly, the Arthritis Foundation encourages the Division to utilize the current regulation (4-2-58 Section 6) regarding co-payment caps in the implementation of a public option. That regulation states, "the highest allowable copayment for the highest cost drug tier(s) must be no greater than 1/12th of the plan's 'individual' annual out-of-pocket maximum" and "cost-sharing arrangements that utilize coinsurance up to a capped dollar amount maximum are not considered copayments and cannot be used to meet the all-copayment structure requirement." These regulations are initial steps in ensuring that patients enrolling in the public option will not have to pick between their crucial mediations and their mortgage payments, groceries, and other vital needs.

Coinsurance

A 2017 analysis by Avalere, indicated that nationally consumers selecting "silver" plans on the individual exchange market saw a significant increase in the amount of coinsurance for specialty drugs. In 2017, 84 percent of silver plans sold charged coinsurance, up from 74 percent in 2016. On average, coinsurance also increased from 34 percent in 2016 to 37 percent for silver plans in 2017. High coinsurance can be a significant barrier for those patients that require high cost prescription medications.

The same regulation previously cited (4-2-58) ensures that patients have the option to select a copayment plans rather than coinsurance plans. Specifically, the rule, in Section 6, states that "for each of a carrier's service areas, no fewer than twenty-five (25%) percent of the plans offered for each metal level (Platinum, Gold, Silver and Bronze) must contain a copayment-only payment structure for all drug tiers. Carriers shall not apply the deductible or any coinsurance amount for these plans." The Arthritis Foundation encourages the Division to support efforts, like this rule, to increase the availability of copayment plans on the exchange and in Colorado's public option. Since many people with arthritis also suffer with chronic diseases such as diabetes or heart disease, their monthly expenditures can include several types of medications. Copayments plans offer patients the ability to better plan for the cost of their medications

In addition, within this rule, the Division requires that carriers shall clearly and appropriately name all plans that have the copayment structure to aid in the consumer plan selection process. The Arthritis Foundation encourages the Division to continue this transparency for patients in the public option.

Step Therapy

Step therapy or "fail first" is a practice used by insurers that requires patients to try and fail insurer-preferred medications before providing coverage for the physician's recommendation. As a result, more expensive effective drugs can only be prescribed if the cheaper drugs prove ineffective. When a person changes insurers, or a drug they are currently taking is moved to a non-preferred status, the person may be put through the step therapy process again and again.

If the Division allows usage of step therapy protocols to be utilized for the state's public option, the Arthritis Foundation encourages the Division to use guardrails to ensure that these protocols work well for everyone in the process.

Specifically, if the Division were to allow step therapy protocols, the Arthritis Foundation recommends that the Division permit a physician to override the step therapy process when patients are stable on a prescribed medication. In addition, the Arthritis Foundation would recommend that the Division permit a physician to override the step therapy if the physician expects the treatment to be ineffective based on the known relevant medical characteristics of the patient and the known characteristics of the drug regimen; if patient comorbidities will cause, or will likely cause, an adverse reaction by, or physical harm to, the patient; or is not in the best interest of the patient, based on medical necessity. Lastly, the Arthritis Foundation would recommend that any approval or denial to a step therapy exception request be submitted within a reasonable timeframe, such as 72 hours or 24 hours in exigent circumstances.

Conclusion

The Arthritis Foundation appreciates the opportunity to comment on the proposed implementation of the public option and looks forward to continued discussions with the Division on solutions that make implementation as smooth as possible for patients. Please contact me at sschultz@arthritis.org or 916-690-0098 with questions or for more information.

Sincerely,

Steven Schultz
State Director, Advocacy & Access

Boulder Emotional Wellness
3434 47th Street Suite 130
Boulder CO 80301

August 15, 2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant St
Denver, CO 80203

Commissioner Michael Conway
Division of Insurance
1560 Broadway #110
Denver, CO 80202

Re: Recommendations on the development and implementation of a Colorado public insurance option

Dear Director Bimestefer and Commissioner Conway,

We provide behavioral health to the Boulder larger community and about 60% of our client base is enrolled in Medicaid. As behavioral health providers, we have concerns about the implementation of a public insurance option. We fully support the idea, and we've been impacted by the last large effort to support public health, the ACC Phase II Medicaid expansion.

1) The ACC Phase II process was difficult bureaucratically for behavioral health providers in that all of us had to be "revalidated" by HCPF. When building capacity, please allow current HCPF validated practitioners to participate without another round of "validation."

2) The ACC Phase II logic of enrolling members based on <u>the physical address of their Primary Care Physician</u> created a number of problems for the behavioral health providers. PCPs are to have a single contract with a single RAE. Behavioral health providers have to manage contracts with Beacon (RAE 2,4), Colorado Access (RAE 3,5), Rocky Mountain (RAE 1) and CCHA (RAE 6,7). If the RAE model is followed again, please allow the patient's address to determine enrollment rather than patient's physician's work address. For example to serve the Boulder area (including just over County Line Road to the East) we contract with RAE 2, RAE 1 (for Ft. Collins), RAE 3/5 (for Denver metro, and RAE 6 (Boulder).

3) "Slamming" occurs, where when a member visits a clinic, they are somehow disenrolled from their RAE and put into another RAE. This causes problems when they come back to our clinic for behavioral health, as their RAE has changed without them knowing it, and our claims are denied. We have seen RAE 6 members become RAE 3 members without knowing it simply by going to a Denver clinic for medical needs.

4) There is broad variability in fee schedules between the RAEs that seems unfair and undermines participation by providers. I am not at liberty to disclose these fees schedules. Some will pay $104 for 90837 (a therapy hour). Others pay as low as $75. Some are between those amounts. We manage extern psychotherapists who will not see clients except for those enrolled in the

higher paying RAEs. This variability is hard to understand. If one RAE can pay 100% of the schedule, why won't they all?

5) Couple therapy has improved in the last decade with advances in psychobiological approaches to couple therapy. Couple therapy is increasing in demand at our clinic and is an effective therapy for the identified patient (the enrollee) and has a large ripple effect for children, peers, the children's school environment, etc. Couple therapy is unseen by Medicaid and typically billed as "family therapy" at an astonishingly low rate. There needs to be a bonafide CPT code for Couple Therapy, or the existing 90847 with a reasonable compensation. The fee could be 100% of 90837 for an hour and 150% for the typical 90 minutes session.

6) Not a single RAE was prepared to do business electronically on July 1, 2018. Whatever payer is created or contracted, they must be required to have relationships with industry clearinghouses (Change, Eligible) on day 1 so that electronic claims can be submitted and ERA payment data (electronic remittance advices) is returned. This created a massive paper jam.

7) Of the RAEs, all will reimburse for services provided by qualified non-licensed therapists (university MA program interns and pre-licensure externs) except for Colorado Access, which manages CHP+ (statewide) and RAE 3 and 5. This is a frustrating discrimination that we cannot support. For capacity's sake and for the sake of future capacity, the program you are developing must allow for practice by these pre-licensure professionals.

   Colorado Access' explains away this discrimination as "we have sufficient network capacity that we don't need the help", while allowing it. They will in fact pay for pre-licensure work by clinicians employed at a Mental Health "Center", however that designation is impossible to obtain from CPHE because it requires facilities to have beds and hold patients involuntarily.

8) Fundamentally the RAE system creates massive duplication. It seems arbitrary in that there are statewide payers like Colorado Access CHP+ program. A single statewide payer would be more efficient.

As a clinical training program we track new providers and their experiences closely. The state would do well to treat behavioral health providers respectfully, not just through fees but also bureaucratically. Young talented practitioners that can develop private practices at $120 an hour are disinterested in participating in insurance whether public or private. We do all we can to ease the process of record keeping and billing so these people maintain their enthusiasm. But we've seen many decide to not participate because the payment rates are perceived as disrespectful, particularly for the very important work of counseling couples.

We wish you all the best in this creative effort.

In regards,

[signed]

Andrew Rose, LPC
Director, Boulder Emotional Wellness

8-31-19

Please accept the below summary of personal consumer interests and concerns related to the HB 19-1004 legislation. Although there are a number of concerns and issues to keep in mind, the proposal offered at the Presentations Meeting (July 26, Keystone Policy Center) by Colorado Access seems to be worth pursuing, for all of the reasons presented, some of which are summarized here in the final section.

Thank you for the opportunity to provide Consumer Input.

Sincerely,

Carol G. Pace, MS

Consumer Input

I. **Legislative requirements** of the bill
   a. Requires competitive state option for health insurance coverage to be forwarded to the general assembly to include
      i. Identification of **affordability at different income levels**
      ii. Drill down on **Administrative** and financial costs, to minimize these
      iii. Utilization **of existing state health care infrastructure** to reduce costs and increase competition (especially in counties with monopoly or near monopoly insurance environments and non-competitive pricing)

II. Consumer interest must-haves
   a. **Lower prices** for health care, to include all costs—premiums, co-pays, deductibles, out-of-pocket
   b. **Less confusion in plans/coverage -**
   c. **Consumers Want Choice** – consumer should be able to choose public option if they find that the most suitable for their personal and family needs, providing the greatest coverage for the lowest administrative costs and attention to health care not for-profit bottom line maximization of non-Colorado companies.
   d. **Essential Benefits Covered**, no pre-existing condition denials, no lifetime caps No watered down plans for a lower price.
   e. End age-banding, preclude gender-banding, disease-banding, pre-existing condition banding, geographical area pricing. Discrimination has no place in health care.
      i.

III. Consumer interests – wish to avoid
   a. Do not wish to pay for your **broker,** that changes premiums for all of us
   b. Do not with to pay for your Taj Mahal hospital with **unnecessary embellishments** that you expect me to pay for with my insurance premiums
   c. Do not wish to ever see **surprise medical bills, e.g. bait and switch hospital tactics** with consumers that do not have adequately prepared insurance contracts to ensure the integrity of the plan

d. Do not wish to pay for your network of **free standing emergency rooms** or other facilities developed for hospital systems marketing and outreach, running up local costs of care for all

IV. Consumer Options

a. **Leave the individual market** - Close small businesses and seek employment with large employer, federal, state government that have affordable options

b. Keep income below ACA subsidized level or Medicaid coverage, to obtain affordable pricing through these negotiated rates

c. Family glitch – Family members are left without affordable insurance if only one member has employer coverage or similar subsidized doverage. Families leave members bare or put eligible **family members on Medicaid, CHP Plus**

d. Small business – **leave the state**, e.g. if La Plata County insurance is monopoly, move business across to New Mexico where more consumer-friendly options are available and being developed

V. State Options Requested or Presented during Stakeholder Meetings

a. Organizers were asked **to prepare data on other states working on similar public option** plans, and use them as bases for state option plans in Colorado – states that have done extensive work were mentioned, including New Mexico, Oregon, Washington, Vermont and others

b. **Cogent Proposal came from Colorado Access and their CHP+ program as a model for a state option health insurance.** This health care coverage is state administered and currently available statewide (eligible children and pregnant women) who have incomes too high for Medicaid coverage and earn too little to be able to afford private insurance coverage.

The Significant Advantages of this model, as presented include:

1. Utilizes existing state infrastructure for a state option proposal, per requirements of the legislation
2. Low administrative costs
3. CHP+ is a stand alone model-a private/public partnership (not confined by a purely Medicaid model, has fewer regulations and is simpler to administer, as a result). Multiple insurers currently offer this plan.
4. Established, geographically diverse Provider Networks – Providers are satisfied with this health plan, want more of this business, are enthusiastic.
5. Straightforward coverage – simplified and understandable to consumer
6. Competitive pricing of services
7. Integrated oral health and mental health- the latter being an elusive and frequently denied or questioned benefit under private insurers
8. State sets rates based on sound actuarial data
9. DOI currently licenses

CHRONIC CARE COLLABORATIVE

August 30, 2019

Division of Insurance,
Colorado Department of Regulatory Agencies
1560 Broadway #110
Denver, CO 80202

Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Re: Transparency in Public Option System Design

Dear Commissioner Conway and Director Bimestefer:

We appreciate the Division and the Department's work prioritizing robust public input to inform the initial design of Colorado's State Option for Health Care Coverage. Moving forward, we urge the Division and the Department to create a system to allow continued feedback from consumers on the State Option plan design and administration after its launch.

As we have seen during implementation of the Affordable Care Act, plan benefit design is complicated. There are many ways benefit design can adversely affect consumers, particularly consumers with chronic diseases or disabilities. Often, a consumer only learns that a plan designs limits access to necessary services after they have purchased the plan.

We have been working on such a problem regarding drug formulary design and compliance with DOI Regulation 4-2-58. The Division's openness to feedback and quick action on this issue after consumer groups identified a problem will result in better transparency for Coloradoans as they decide which plan to purchase. Furthermore, through this process we have seen that a willingness to make mid-year changes when these problems are identified is of particular value to Coloradans, who would otherwise face significant delays in receiving the plan benefits the law requires.

In light of the advantages of processes that enable robust public participation on an ongoing basis, the Division and Department could best ensure that the State Option's design and administration meet public need by establishing a system for incorporating public input in the future.

Because of the nature of plan benefit design, we anticipate that complications such as utilization management criteria, provider network issues, and parity violations may arise in the future. Like the noncompliance with DOI Regulation 4-2-58, these issues could be identified and be fixed through open communication if there is sufficient transparency so that consumers and consumer advocates are able to engage.

We believe the goal of this "public option" is to create a product that is responsive to the needs of the *public* and, therefore, should include a process for ongoing public engagement.

Sincerely,

Allie Moore

Allie Moore
Chronic Care Collaborative

Executive Director Kim Bimestefer
Health Care Policy and Financing
1570 Grant Street
Denver, Colorado 80203

Commissioner Michael Conway
Division of Insurance
1560 Broadway, Suite 110
Denver, Colorado 80202

August 13, 2019

Re: Recommendations for HB19-1004, Study of State-Based Health Coverage Option

Dear Director Bimestefer and Commissioner Conway,

The undersigned organizations appreciate this opportunity to provide our recommendations regarding the implementation of HB19-1004, to develop a proposal for a state health coverage option. The undersigned organizations are members of the Coalition for Immigrant Health, which holds the vision of a health care system that is inclusive of and responsive to our immigrant community in Colorado. Our long-term goal is to extend coverage to all Coloradans regardless of immigration status.

Colorado has made tremendous progress in establishing new insurance coverage options for Coloradans. The 2017 Colorado Health Access Survey (CHAS) reported a historic reduction in the rate of uninsured Coloradans: 6.5 percent, or half the pre-Affordable Care Act levels. The CHAS also reported that the biggest factors contributing to the number of uninsured Coloradans are cost and eligibility. These findings are also in line with the community feedback received so far in the stakeholder meetings for HB19-1004. The creation of a public option presents a unique opportunity to significantly decrease the uninsured population in our state and we must carefully consider the eligibility requirements so they don't continue to keep Coloradans from accessing coverage.

In order to continue to reduce the number of uninsured Coloradans, plans for a public option must explicitly state that eligibility does not require citizenship or legal documentation. The Colorado Health Institute estimates that about 100,000 Coloradan immigrants without proper documentation are uninsured, and their status makes them ineligible for the current health coverage options in Colorado.[1] Coloradans without documentation and recipients of Deferred Action for Childhood Arrivals (DACA) are excluded from the provisions of the Affordable Care

[1] Colorado Health Institute directly provided these data to Center for Health Progress. Attachment included with a breakdown by income.

Act and public insurance (Medicaid, Medicare). Given immigrants' documentation status, they also have limited access to jobs that offer health insurance and have lack of access to insurance. Additionally, there are explicit exclusions that severely limit their access to non-emergency medical services beyond primary care clinics. For these reasons, it is critical that we ensure that eligibility requirements are inclusive of all Colorado residents regardless of their immigration status; the health and well-being of our communities depend on it.

In considering the infrastructure that would support this public option, any application used for this process should change to accommodate these individuals. The application through the Division of Insurance for the individual market, for example, currently requires a social security number (SSN), effectively deterring those who have the financial capacity to purchase insurance but who lack an SSN. The state should omit the request for the SSN from the application or make it clear that the SSN is optional. Additionally, the state should ensure linguistic and cultural responsiveness in designing systems to ensure ease of navigation, and ensure that the new structure of insurance will not trigger public charge under the anticipated rules from the Department of Homeland Security[2].

It should go without saying that information should be protected in these systems, as they are today, and reassurance should be offered that information is not shared across systems for non-health purposes. Immigrants are living with toxic levels of stress and fear due to the current national political environment[3], and Colorado should do all it can to offer reassurance and security as immigrants participate in these crucial systems in order to thrive and support their families.

Thank you for this opportunity to comment. We look forward to continued engagement in the stakeholder process, and also appreciate you ensuring geographic diversity and appropriate supports are available (especially interpretation and translation). If you wish to ask members of the Coalition any questions, you can contact Chris Lyttle, Senior Policy Manager at Center for Health Progress (chris.lyttle@centerforhealthprogress.org; 937-546-3011).

Sincerely,
The undersigned members of the Coalition for Immigrant Health:

Center for Health Progress
Colorado Immigrant Rights Coalition
Colorado People's Alliance

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[2] Federal Register: Department of Homeland Security. Inadmissibility on Public Charge Grounds. Proposed October 2018. https://www.federalregister.gov/documents/2018/10/10/2018-21106/inadmissibility-on-public-charge-grounds

[3] Artiga, Samatha & Petry Ubri. "Living in an Immigrant Family in America: How Fear & Toxic Stress are Affecting Daily Life, Well-Being, & Health." Kaiser Family Foundation. December 31, 2017. Available at: https://www.kff.org/disparities-policy/issue-brief/living-in-an-immigrant-family-in-america-how-fear-and-toxic-stress-are-affecting-daily-life-well-being-health/

Tri-County Health Network
Colorado Organization for Latina Opportunity and Reproductive Rights
Colorado Fiscal Institute
FWD.us Colorado
Colorado Cross-Disability Coalition
Every Child Pediatrics
Cultivando
Colorado Children's Campaign
Clinica Tepeyac
Together Colorado
American Academy of Pediatrics - Colorado Chapter
Young Invincibles

August 27, 2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant St, Denver, CO 80203

Commissioner of Insurance Michael Conway
Division of Insurance
1560 Broadway #110, Denver, CO 80202

RE: Statewide Option for Affordable Health Coverage Comments

Dear Director Bimestefer and Commissioner Conway,

We appreciate the opportunity to comment on and shape the implementation of a public health insurance option as established under HB19-1004. The undersigned organizations represent a significant majority of Colorado's primary care physicians. While our organizations' members do not all exclusively practice primary care, we believe the public option offers an opportunity to not only expand access to care for Colorado's uninsured and underinsured, but to also ensure covered Coloradans get the right care, in the right place, and at an affordable price. The state option can achieve this through supporting and investing appropriately in primary care as the foundation of our health care system. We urge the State to implement a public option based on the following principles and design considerations:

1. **Eligibility:** The public option should be available to any Colorado resident who wants to buy in. This will ensure the greatest degree of competition in the marketplace and choice for patients. It will avoid overly complicated eligibility criteria, eligibility cliffs that can lead to churn between insurance products, and disruptions in care and the patient-physician relationship. This will allow for access to coverage for those such as the uninsured, undocumented, and those stretched to afford their current coverage and cost sharing.
2. **Affordability:**
    A. **Decrease Cost Sharing:** As directed by HB19-1004, the state must determine the definition of "affordable." We believe affordability should account for the cost of premiums as well as cost sharing such as deductibles, copays, and coinsurance. Patients and their families often cannot afford the treatment recommended by their physician due to cost sharing, and preventive visits in the current system become subject to cost sharing once a diagnosis is made. Including patients' likely cost share in determining affordability of the public option will ensure true access to care when it is needed.
    B. **Increase Competition:** The public option is expected to and should offer a lower premium than existing options, thus allowing a greater number of patients to afford coverage. Competing on administrative efficiencies should be a consideration as a means to reduce cost.

3. **Primary Care Orientation:** The public option should support a primary care foundation in line with forthcoming work of the Colorado Primary Care Payment Reform Collaborative established by HB19-1233.
    A. **Invest more in primary care:** The option should invest more in primary care than the current system, which has been shown to underinvest in high value primary care.
    B. **First-Dollar Coverage of Preventive and Primary Care:** Preventive services should be covered without copays or other cost sharing, including those pediatric preventive services outlined in the Bright Futures Guidelines. The State option should furthermore **offer first dollar coverage of primary care, such as for several *primary care visits* without charge to the patient, rather than just for preventive visits.** Too often, patients will come for a preventive visit and be faced with cost sharing the moment a diagnosis and treatment plan are made. Benefit design should encourage early detection and treatment, while minimizing the friction to accessing comprehensive care in the primary care setting.
    C. **Payment Reform:** It should also reimburse through alternative payment models (APM's) aligned with current models. The American Academy of Family Physicians Advanced Primary Care Alternative Payment Model formed the basis of Medicare's Primary Care First program, currently being rolled out. Primary Care First sits alongside the all-payer CPC+ Model, in which many Colorado practices participate. These models move away from fee-for-service as the dominant payment structure, incentivize value, and strengthen primary care. Health First Colorado's Accountable Care Collaborative and APM are similar such models with which the public option could align, although the originally proposed Track 2 APM would represent a further advance toward true primary care-oriented payment reform.
4. **Reimbursements:** Primary care reimbursements should be established starting at no less than 135% of Medicare, and be periodically re-evaluated and transitioned such that a larger percentage of the healthcare dollar is focused on primary care as we aim to increase the value (lower cost and better quality) for the patient. We also favor a shift to a more value-based payment system. Further consideration should be given to appropriate reimbursements for pediatric care, for which Medicare does not serve as a highly valid benchmark.
5. **Behavioral Health Coverage:** Provide integrated coverage for services to meet behavioral and social health needs. The Colorado State Innovation Model made significant strides on this front, and the gains made should be continued, such as payments for behavioral health integrated into primary care settings.
6. **Contraceptive Coverage:** Ensure coverage of comprehensive contraceptive services, consistent with Division of Insurance Bulletin No. B-4.84 that clarifies all FDA-approved contraception methods be covered without cost sharing.
7. **Navigation:** Ensure the public option is easy to enroll in, easy to understand for patients and physicians (i.e. transparent design, pricing and costs), and easy to access care through. Overly complex insurance designs often lead to difficulty for patients in

accessing care and planning for costs. Coinsurance is an example of complex cost sharing that does not send a clear price signal to patients. Physicians are increasingly asked about costs by their patients, and are frequently unable to give clear cost information because of the complexity of a specific patient's insurance coverage.

General Principles for a Public Option Proposal

In addition to the above design considerations, we believe the following general principles should apply to the public option:

1. Increase competition in health insurance markets, particularly in regions of the state with only one or two insurers offering health plans
2. Reduce the number of uninsured and underinsured Coloradans
3. Increase affordability by reducing insurance premiums and out of pocket costs
4. Reduce the total cost of care, including by investing a greater share of the premium dollar in high value primary and preventive care
5. Reduce administrative burdens to ease physician burnout, including in particular the overuse of prior authorizations such as for generic drugs
6. Facilitate quality improvement and alignment with other payers
7. Inspire physician network participation
8. Utilize uniform benefits consistent with the essential health benefit requirements under the Affordable Care Act, and that are informed by value
9. Reduce waste (overuse, underuse, misuse)

Sincerely,

John Cawley, MD, FAAFP
President
Colorado Academy of Family Physicians

Meghan Treitz, MD, FAAP
President
American Academy of Pediatrics, Colorado Chapter

Christie Reimer, MD, FACP
Interim Governor
American College of Physicians, Colorado Chapter

July 15, 2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant St
Denver, CO 80203

Commissioner Michael Conway
Division of Insurance
1560 Broadway #110
Denver, CO 80202

Re: Recommendations on the development and implementation of a Colorado public insurance option

Dear Director Bimestefer and Commissioner Conway,

We appreciate the commitment of Governor Polis, the state legislature, the Division of Insurance (DOI), and the Department of Health Care Policy and Financing (HCPF) to making comprehensive, affordable health coverage available to even more Coloradoans. This is directly aligned with the core mission of Colorado Access to empower people and communities through access to quality, affordable care.

We have decades of experience connecting low and moderate income individuals and families with health care in Colorado – by serving as a regional accountable entity (RAE) for Health First Colorado, offering Child Health Plan Plus (CHP+) coverage, operating the state managed care network for CHP+, serving as a medical assistance site, and serving as a single entry point (SEP) for long term services and supports. Colorado Access covers more than 500,000 members through Medicaid and CHP+.

We hope to work closely with DOI and HCPF to offer our expertise and knowledge to build a new public insurance option that delivers on the promise of affordable health coverage for all Coloradoans. Below we offer specific recommendations for developing and successfully implementing a public option.

Governor Polis, HPCF, and DOI have set ambitious goals to reduce premiums costs and ultimately save Coloradans money on health care; we believe the best way to ensure that the savings of a public option also accrue to the state is to build on current public sector coverage options such as Medicaid and Child Health Plan Plus. Current state investments in Medicaid and CHP+ should improve the health and wellbeing of low-income Coloradoans who may then experience changes in income or circumstances and ultimately enroll in the new public insurance option. As the state and partners invest in improving health, the long term cost savings of preventive and primary care should be contained within the public sector.

We recommend considering a public option model that is similar to the structure of CHP+: a full-risk managed care model run through contracts with insurers.

CHP+ is a successful, public-private partnership with bipartisan support. We believe this is a promising model for pursuing a public option in Colorado. A full-risk managed care model run through contracts with insurers, available to all subsidy-eligible individuals, should result in cost savings for consumers, financial stability for participating health plans, and could ultimately contribute to a successful 1332 waiver application.

800-511-5010
coaccess.com

11100 E. Bethany Dr., Aurora, CO 80014

Below, we offer some specific ways that we believe CHP+ is a promising model to consider. We note, though, that we consider CHP+ an *example* of a potential public option structure and look forward to working with HCPF and DOI to shape and implement the public option, regardless of the direction you pursue. Broadly, we believe that a successful public option will rely on standard state-generated plan and provider rates; benefits and networks that are similar to Medicaid; and limited to health plans that can support the complex and unique needs of a lower-income population. The CHP+ model is one way to achieve this without immediate disruption to the individual market.

Research shows that the CHP+ structure results in more affordable coverage than other sources. For example, CHP+ is substantially more affordable than exchange-based coverage. In 2015, the average out of pocket spending (premiums and cost-sharing) in CHP+ for children at 150 to 200 percent FPL was $50, compared to $828 on Connect for Health Colorado. For slightly higher income families with children at 200 to 250 percent FPL, out of pocket spending in CHP+ was $103 compared to $1,511 on Connect for Health Colorado.[1] The CHP benefit package is comprehensive and provides for integrated physical, behavioral and oral health services.

Colorado already has a fully functional Medicaid fee schedule for provider reimbursements, which incorporates cost-based reimbursement for hospitals and other safety net providers such as federally qualified health centers. The state could base the rates for the public option on the Medicaid fee schedule by adding a set percentage to the Medicaid rates. The Medicaid fee schedule is a well vetted, quick, and efficient way to begin setting rates for the public option. Our internal analysis finds that the current CHP+ rates are approximately 106 percent of Medicaid and about 90 percent of Medicare professional fees – compared to commercial rates or a Medicare benchmark, this could lead to substantial savings for the state and for consumers.

CHP+ is a financially sustainable market for health plans and the program has operated as a popular program in Colorado for more than two decades. The state sets the plan rates but allows any plan to participate that can meet specific state requirements. All plans offer a standard set of benefits (similar to the Medicaid benefit package) and standard cost-sharing, but can compete by adding additional benefits. The state's rate setting process for CHP+ is a good model to build from in contemplating how health plan rates and premiums should be set.

A managed care plan under a CHP-like structure would also allow plans to incorporate appropriate wellness or utilization incentives to encourage active participation in members' own health and wellness, and lower costs for the health care system by improving members' long-term heath. For example, small, positive financial incentives may encourage some healthy behaviors such as preventive screenings, routine vaccinations, obesity and diabetes prevention programs, and tobacco cessation.

Moreover, CHP+ delivers care that meets the needs of members. According to statewide CAHPS results for CHP+ managed care plans, members and families have positive perceptions of the quality of care and services. For example, average CAHPS scores show an 85.5 percent rate of getting needed care, 91.2 percent rate of getting care quickly, and a 68.1 percent rating of all health care. Colorado Access, specifically, had no rates substantially lower than the statewide average, and performed above average on getting care quickly (92.4 percent) and rating of all health care (69.1 percent).[2]

The public option should initially be offered to the subsidy-eligible population in the individual market. The individual, small and large group markets have different challenges and the people buying insurance in each market make different purchasing decisions. We believe focusing on the individual market has the greatest potential to increase access to affordable health coverage.

In 2016, nearly 30 percent of the remaining uninsured in Colorado were eligible for federal health insurance subsidies, but are not enrolled.[3] We believe the initial phase of the public option should first aim to connect lower income individuals with coverage. Later phases of implementation could focus on increasing affordability for individuals and families over 400 percent FPL, which make up approximately 11 percent of the remaining uninsured.[4]

We believe that a CHP+ model for the public option could receive Section 1332 waiver approval. As indicated in the public option statute (HB 19-1004), Colorado will likely need to apply for a Section 1332 waiver to establish and implement a public option. Guidance from the U.S. Departments of Health and Human Services and Treasury indicates that they will favor proposals that help connect individuals with private plans, rather than expansion of public programs. We believe that proposing a CHP-like public option could help Colorado achieve federal approval by building on a model of public-private partnership with long-standing bipartisan support at the state and federal levels.

Colorado Access is eager to collaborate with DOI and HCPF to further refine how the public option is designed and implemented. We have proven expertise serving the population that would likely be eligible for the public option.

If the public option focuses on subsidy-eligible individuals, much of the population eligible for the public option are likely to have incomes that are just above Medicaid or CHP+ eligibility; and their incomes are likely to fluctuate causing their eligibility to move between CHP+, Medicaid, and subsidy eligibility. Because we already serve the CHP+ and Medicaid population – and have the established infrastructure to do so – we are well positioned to work closely with DOI and HCPF to develop and implement a public option that meets the needs of the population, particularly as they move between programs.

We also understand that lower and moderate income individuals often have more complex health care needs and need health coverage that helps address nonclinical needs. Compared to higher-income counterparts, even relatively healthy low-income people are more likely to have poorer self-reported health and greater health risks; have more mental health care needs; and have greater social needs or concerns.[5] Again, because we already serve a high-needs, lower income population, we have experience managing complex health care needs and connecting our members with services to help improve their social determinants of health.

We reiterate our commitment to a successful public option that connects more Coloradoans with quality, affordable care. If you have any questions or would like any follow up information, please contact Gretchen McGinnis, senior vice president of healthcare systems and accountable care, at gretchen.mcginnis@coaccess.com or 720-744-5363.

Sincerely,

Gretchen McGinnis
Sr. Vice President of Healthcare Systems and Accountable Care
Colorado Access

[1] Medicaid and CHIP Payment and Access Commission, "Report to Congress on Medicaid and CHIP," Table 5A-4 and Table 5A-5 (March 2016). Retrieved on June 25, 2019 from https://www.macpac.gov/wp-content/uploads/2016/03/March-2016-Report-to-Congress-on-Medicaid-and-CHIP.pdf.
[2] Health Services Advisory Group for the Colorado Department of Health Care Policy and Financing, "2017-2018 External Quality Review Technical Report for Child Health Plan *Plus*," Table 4-5 (November 2018).
[3] Colorado Health Institute, "Colorado's Eligible but Not Enrolled Population Holding Steady," (June 2018). Retrieved on June 25, 2019 from https://www.coloradohealthinstitute.org/research/colorados-eligible-not-enrolled-population-holding-steady.
[4] Colorado Health Institute, "Colorado's Eligible but Not Enrolled Population Holding Steady," (June 2018). Retrieved on June 25, 2019 from https://www.coloradohealthinstitute.org/research/colorados-eligible-not-enrolled-population-holding-steady.
[5] The Commonwealth Fund, "Why Even Healthy Low-Income People Have Greater Health Risks than Higher-Income People" (September 2018). Retrieved on June 25, 2019 from https://www.commonwealthfund.org/blog/2018/healthy-low-income-people-greater-health-risks.

Executive Director Kim Bimestefer
Health Care Policy and Financing
1570 Grant Street
Denver, Colorado 80203

Commissioner Michael Conway
Division of Insurance
1560 Broadway, Suite 110
Denver, Colorado 80202

Re: Recommendations for HB19-1004, Study of State-Based Health Coverage Option

Dear Director Bimestefer and Commissioner Conway:

The undersigned organizations appreciate this opportunity to provide our recommendations regarding the implementation of HB19-1004, to develop a proposal for a state health coverage option.

HB19-1004 identified several goals for a state-based health coverage option, including increasing competition, improved quality and provides stable access to affordable health insurance. While we support all these goals, our key priority is to increase coverage affordability for all Coloradans. We believe increased affordability will help drive more market competition and encourage more individuals into the market which would help stabilize the market.

At the June 13th stakeholder meeting, the state sought, and continues to seek, feedback on three topics:

- Eligibility and population for whom the state option may be available
- Affordability considerations
- State health infrastructure

With this letter, we are providing you with our shared thoughts on each of these topics.

Eligibility and population for whom the state option may be available

The undersigned organizations believe that *all* Coloradans should be able to access the coverage option that is developed pursuant to HB19-1004. However, from our perspective, it is imperative that the new state coverage option be specifically geared toward individuals who are the most impacted by uninsurance and underinsurance. We believe that if we build a plan specifically designed to benefit people facing the greatest barriers, then the benefits of the new public option will extend to others as well.

As such, we encourage the state to include all Coloradans regardless of immigration status, individuals in the family glitch, and uninsured and underinsured individuals.

The Colorado Health Institute estimates that of the 112,000 Coloradans who were uninsured, roughly one in four, lacked proper documentation.[1] Twenty-two percent of U.S. born children in Colorado have one or more foreign-born parents.[2]

The 2017 Colorado Health Access Survey reports an historic reduction in the rate of uninsured Coloradans: 6.5 percent, or half the pre-Affordable Care Act levels. The CHAS reports that the dominant reasons for remaining uninsured are cost and eligibility. Further, 1 in 5 people report difficulty accessing care because of cost. Cost as a barrier to accessing care is the greatest barrier for people in the individual market and for those who are uninsured. Estimates show that the family glitch impacts 2-6 million people nationwide, which would translate to about 34,000-102,000 people in Colorado.

While the focus has been on the individual market, we believe continued conversations about affordable coverage for small business is also important.

Affordability considerations

With respect to determining affordability, one of the ACA's shortcomings was to determine affordability based only on the cost of insurance premiums. Coverage affordability should factor in all out of pocket spending -- deductibles, coinsurance, and co-payments – in addition to premiums. The Self-Sufficiency Standard for Colorado[3] finds that even families with less expensive employer-based coverage need to earn between 200 and 450 percent of the federal poverty level to make ends meet, depending on where they live. The generally higher premiums, deductibles and cost-sharing for individual market plans would suggest that families need to earn even higher levels of income in order to pay for health care and make ends meet.

Although the information is older, research conducted in Colorado in 2008 found the following:

- Families earning between 201% and 400% FPL have some income available to spend on health care, but cannot afford health insurance without a substantial subsidy. Only above 400% FPL can most families substantially contribute to their coverage.

When families spend more than 5% of their household income on health care, they must make substantial tradeoffs on other expenditure such as child care and housing.

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[1] Emily Johnson, "Colorado's Eligible but Not Enrolled Population Continues to Decline." Colorado Health Institute. June 29, 2017. Available at: www.coloradohealthinstitute.org/research/colorados-eligible-not-enrolled-population-continues-decline

[2] "Immigrant Health in Colorado: Population Demographics and Insurance Status." Center for Health Progress. February 2018. https://centerforhealthprogress.org/blog/publications/immigrant-demographics/

[3] Diana Pearce, "The Self-Sufficiency Standard for Colorado 2018." Prepared for the Colorado Center on Law and Policy. December 2018. https://cclponline.org/wp-content/uploads/2018/12/CO18_SSS.pdf

- Affordability will vary widely depending on numerous factors including family composition, employment status, age, and cultural values. The full report can be found here: https://cclponline.org/wp-content/uploads/2014/01/2009-4-1-Cost-of-Care-Affordability-Report1.pdf.

We are receptive to using a percentage of income as a starting point for an affordability standard. However, that standard must be based on family household income, not just individual income. Based on data from the report cited above, 5% of income should be the starting point for consideration of an affordability standard, but even that percentage may not be suitable for all families.

In considering a definition of affordability, the following considerations are of particular importance to the undersigned organizations:

- Predictability of costs for consumers. Current cost sharing structures make it difficult or impossible for consumers to plan and budget.
- To improve the value of coverage as well as encourage preventive services the state should consider requiring the state option to include first dollar coverage for high value primary care services.

State Health Infrastructure

We interpret state infrastructure to broadly mean the assets that the state holds that could be utilized to support greater efficiencies in purchasing, administration or enrollment. These assets include but are not limited to the Department of Health Care Policy and Financing, the state employee health plan, and Connect for Health Colorado.

We generally support offering the state option on Connect for Health Colorado because it offers a portal for eligibility, plan comparison and enrollment that could be leveraged. However, our support for using Connect for Health Colorado, including the public benefit corporation, *is conditioned on whether Connect for Health can be a vehicle for all Coloradans regardless of immigration status to access affordable coverage.* If not, then the state should consider other vehicles for eligibility and enrollment.

An existing piece of state infrastructure that should be re-examined under this state option process is the Division of Insurance's existing individual market health insurance application. The application currently requires a social security number (SSN) effectively deterring those who have the financial capacity to purchase insurance but who lack an SSN. The state should remove the SSN from the application or making it clear that the SSN is optional.

Data transparency and availability

As was noted during the first two stakeholder meetings, data and analysis will play a critical role in understanding the populations in greatest need and feasibility of certain policy options. We encourage the state to be transparent in releasing data and analysis that it has commissioned so that as stakeholders we can make the most informed contributions possible. We also ask that the state provide a timeline for the release of this information to facilitate timely and informed engagement in the process.

***

Thank you for this opportunity to comment. We look forward to continued engagement in the stakeholder process

Sincerely,

Colorado Consumer Health Initiative
Young Invincibles
Center for Health Progress
Colorado Cross-Disability Coalition
Chronic Care Collaborative
Tri-County Health Network
NARAL Pro-Choice Colorado
Good Business Colorado
The Consortium
AFSC Colorado
United for a New Economy
Together Colorado
Hypatia Studio LLC
Colorado Fiscal Institute
Colorado Health Network
National MS Society
One Colorado
Colorado Immigrant Rights Coalition
Women's Lobby of Colorado
Colorado Center on Law and Policy
The Bell Policy Center

July 18, 2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant St, Denver, CO 80203

Commissioner of Insurance Michael Conway
Division of Insurance
1560 Broadway #110, Denver, CO 80202

Re: Comments as part of the stakeholder process on the public option (HB19 – 1004)

Dear Director Bimestefer and Commissioner Conway,

I write today to provide feedback as part of the stakeholder process on the proposal for implementing a competitive state option for more affordable health care coverage in Colorado. The Colorado Association of Health Plans (CAHP) is a state association of health insurers that offers coverage to over three million Coloradans. CAHP's mission is promoting high quality, affordable, evidence-based health care in Colorado.

CAHP supports the goals outlined in HB19-1004: decrease health care costs for Coloradoans; increase competition, and; improve access to high-quality, affordable and efficient health care. The following letter offers a number of policy suggestions and market-based solutions to achieve those goals. Additionally, we have concerns that preliminary stakeholder discussions are trending in a direction that will result in a non-competitive marketplace, limiting choice for consumers, and de-stabilizing the small and large group health insurance markets. These outcomes are directly contrary to the goals of HB19-1004. A "public option" cannot truly reduce the price of health insurance without addressing the underlying costs of care. Further regulating premiums or simply introducing a "public" plan that does not abide by the same cost structure as commercial plans will limit choice by eliminating competition. Health insurance premiums can only be significantly lowered in one of two ways: lowering unit costs for health care services and prescription drugs and/or restructuring benefits. As such, a public-private partnership that leverages current market-based infrastructure is needed to foster competition while increasing value and decreasing costs.

We are committed to working with you to find solutions to the high cost of health insurance in Colorado and delivering affordable, high quality health coverage to every Coloradoan. Therefore, we would like to put forth market-based solutions that would help to achieve the goals outlined in HB19 – 1004.

Goal 1: Decreasing health care costs in Colorado

- ***Incentivize innovative payment models***
  Carriers are already pursuing value-based payment design which balance cost and quality and encourage plans and providers to collaborate on targeted, effective solutions to improve outcomes and drive down health care costs. Numerous private and public payers have implemented value-based payment models which can increase the use of high-value services and lower consumer out-of-pocket costs.

  Stakeholders, including carriers, have come together to address provider shortages in rural communities and in specific practice areas utilizing innovative payment models to address costs. Any plan to address health care costs could borrow from innovative payment models that are being utilized and have shown effectiveness. These types of solutions also build on what is currently working in the marketplace. For example:

- In Colorado, carriers have implemented alternative payment models and invested millions of dollars in physician practice transformation. For example, carriers have been key partners for the Colorado Beacon Community, Comprehensive Primary Care and Comprehensive Primary Care +, the Colorado Multi-payer Collaborative, and the State Innovation Model.

- The Colorado Multi-payer Patient-Centered Medical Home Pilot showcased that innovation in payment models can work, resulting in reduced use of the emergency department by approximately 9.3 percent over three years, equating to a reduction in emergency department costs by $3.50 per member per month, a drop of 11.8 percent. For patients with two or more conditions, the reduction was $6.61 per member per month, or 14.5 percent.[1]

Additionally, Colorado should aim to incentivize care in the most cost-effective environments that achieve the highest quality outcomes. CAHP supports initiatives that reward hospitals and providers for strong patient outcomes at reasonable prices (often referred to as centers of excellence).

- ***Address the sky-rocketing costs of care***
  Health insurance premiums are high because the cost for services and pharmaceuticals are high. To reduce the cost drivers in health care we suggest considering a variety of tools that could help the entire health insurance market become more competitive.

  For example, consideration of a hospital or provider medical loss ratio/patient care ratio could be an avenue to ensure that there is accountability for the prices charged for services. A reasonable standard could be created and applied that generates savings but still allows hospitals and provider groups to make a reasonable margin. An MLR standard/patient care ratio would create transparency around hospital costs and give consumers additional assurances that their premium dollar pays for the care they received. Also, expanding opportunities for local market initiatives could also bring down the high costs of care in non-competitive markets.

Goal 2: Increasing competition in the Colorado insurance market

- ***Focus on the individual market***
  The individual, small and large group markets have different challenges and therefore need tailored solutions. By focusing on the individual market where the greatest affordability and access issues exist, there is greater potential to achieve the stated goal of access to high quality health care. Affordability and access issues need to be addressed at the individual market level first and foremost, specifically at narrow populations for whom private coverage is unaffordable (i.e. those uninsured or significantly underinsured).

- ***Leverage public/private partnerships within existing infrastructure to build on what works***
  We strongly believe that leveraging the current health care system is preferable to building new infrastructure to increase competition in the health insurance marketplace. Our members are experts at working across the public and private sectors to design benefits, create high quality provider networks at cost-effective rates, negotiate lower prices with doctors and hospitals, get the best possible price for prescription drugs, cover the most effective technology to help prevent illness, and help people get better when they are sick. We should look at how we can build efficiencies and expertise within the existing health care infrastructure utilizing the plans as a foundation.

  For example, carriers already provide numerous tools to increase the availability of price information for health care services and promote its use in consumer decision-making to drive down costs. This expertise is fundamental to any

[1] https://www.commonwealthfund.org/publications/journal-article/2015/oct/difference-difference-analysis-changes-quality-utilization?redirect_source=/publications/in-the-literature/2015/oct/changes-in-quality-utilization-colorado-pcmh

well-functioning plan. Most insurance providers make price transparency tools available to their enrollees to help them choose cost-effective health care providers and services. Our members use messaging on plan portals, outreach through employers, digital communications, including email, social media, and text messaging, and postal mail to make their enrollees aware of available price transparency tools.

The coverage platforms that the commercial group markets provide are working, are stable, and are serving the vast majority of Colorado's population. Cost of care remains a very important, yet separate issue, and solutions offered should not destabilize platforms in any way that could jeopardize coverage and therefore care for millions of Coloradoans.

- ***Create a standardized plan and allow all carriers to compete***
  To increase competition in the market, we would support a standardized plan by which all insurers can choose to compete on services and price. As an example, a standardized plan could be created via an expansion of catastrophic plans or through a federal waiver to allow more flexibility in terms of benefit design to lower prices for consumers. Again, benefit design is one of the most significant ways to reduce premiums. Such plans would be particularly attractive for the people in the individual market who are struggling to afford insurance without federal subsidies. It would also provide these consumers with more choice in how they pay for their health care. Making it easier for more Coloradans to purchase coverage in the individual market would have the added benefit of making coverage more affordable for everyone by creating a more stable risk pool.

  We strongly caution against the creation of any plan that does not apply the same rules and regulations that are currently applicable to commercial carriers. Rather than increasing competition, it will reduce competition in the Colorado market and drive costs up. A plan that is created outside of the current regulatory framework could have market wide impacts on health insurance membership and risk pool dynamics.

Goal 3: Improve access to high-quality, affordable and efficient health care

We think it is important to recognize that the industry closely partnered with stakeholders and the administration on significant pieces of legislation in 2019 that, once implemented, will have positive impacts on premiums for consumers and will help to address access to health insurance. It is important to underline that the market needs to time to adjust to these new rules in order to measure the impact before introducing additional changes that could potentially de-stabilize working markets. For example:

- ***Reinsurance program***
  We are confident that the reinsurance program will address some of the key affordability issues in the individual market. In fact, the Division of Insurance released preliminary rates showing an average decrease of 18.2% from the previous year for individual market premiums.[2] Estimates suggest that the decrease in premiums will also increase enrollment in the individual market by 2.9% in 2020.[3] We should continue to build on the momentum that this program is already showing will have benefits for consumers.

- ***Out-of-network legislation***
  CAHP believes that the out-of-network legislation will address some significant drivers of cost in the current system. While it is hard to estimate the full impact on cost, we will know by January 1, 2021 how much this legislation has impacted premiums for consumers.[4]

[2] https://drive.google.com/file/d/1qKmhViImQrHRA9pyyR7vuVaDOLd_vIaU/view
[3] https://drive.google.com/file/d/1_QTfHnQvamJWeupH7AScekJe3A_jNo5H/view
[4] https://leg.colorado.gov/sites/default/files/2019a_1174_signed.pdf

- ***Defining affordability***
  We believe that affordability in healthcare means identifying solutions to lower the unit cost of health care, incentivize care that improves health and outcomes for patients, and increases patient access to information about their care to help them make informed decisions. We also believe that any policy on affordability must also address the provider and facility costs to drive long-term affordability across the broader system.

By implementing these market-based solutions, we believe that Coloradoans will have greater access to high quality, affordable, and efficient health care wherever they reside in the state.

CAHP is fully committed to working with the administration, our client employers, and other Colorado stakeholders to achieve the goals of HB19 - 1004. But we fundamentally believe that without addressing the underlying costs of health care there will be no way to achieve these goals. To do that in any meaningful way, we must lower unit costs for health care services and prescription drugs and/or create flexibility for benefit design.

We are eager to work together to make coverage more affordable and are optimistic that you will seriously consider the concepts outlined above.

Sincerely,

Amanda Massey
Executive Director
Colorado Association of Health Plans

COLORADO CENTER
on LAW & POLICY
Forging Pathways from Poverty
789 Sherman Street Suite 300 • Denver, Colorado 80203 | P) 303.573.5669 • F) 303.573.4947

August 26, 2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Commissioner Michael Conway
Division of Insurance
1560 Broadway, Suite 110
Denver, CO 80202

Re: Recommendations for HB19-1004, State Coverage Option

Dear Executive Director Bimestefer and Commissioner Conway:

The Colorado Center on Law and Policy (CCLP) submits the following comments regarding a state coverage option that will meet the requirements of HB19-1004, serve existing need in Colorado, and help address existing inequities in access to care. The nonprofit Colorado Center on Law and Policy uses research, education and policy advocacy to remove the systemic barriers that prevent Coloradans from meeting their basic needs and achieving better health.

These comments are intended to align with principles expressed in the joint letter submitted on behalf of over 20 consumer groups (joint letter), including CCLP, submitted July 22, 2019.

The state has invited feedback in three areas: eligibility and population to whom the state option will be made available; affordability considerations; and state health infrastructure that should be utilized. We expand on those three areas below and add a fourth, regarding transparency and accountability of a state option.

Eligibility and population

CCLP believes that the state coverage option should be accessible to all Coloradans, regardless of income, region, or immigration status. When individuals lack access to coverage, they are less likely to get preventative care and services for major health conditions and chronic diseases, more likely to have adverse events when they receive hospital care, and have increased mortality.[1] When those individuals receive care for which there is no compensation, hospitals may respond by raising prices, adding to financial burdens on other individuals and employers.

[1] Care Without Coverage: Too Little, Too Late. Chapter 3: Effects of Health Insurance on Health. Institute of Medicine (US) Committee on the Consequences of Uninsurance. Washington (DC): National Academies Press (US); 2002. https://www.ncbi.nlm.nih.gov/books/NBK220636/

The high cost of coverage for Coloradans ineligible for premium tax credits, particularly in the mountain corridor and Western Slope, has been a focal point of public discussion since at least 2014.[2] [3] [4] Testimony and reports by elected officials and residents of those areas clearly established the impact of high premium costs on the local economy and individual lives, despite incomes significantly above poverty.[5]

However, the greater proportion of individuals nationally and in Colorado who lack coverage have lower incomes.[6] The option should not be limited to those above 400 FLP because doing so would have the effect of increasing existing disparities. In 2017, 66 percent of the uninsured in Colorado had incomes between 100 and 399 FPL, three times the number of uninsured Coloradans with incomes of 400 FPL and above. Those lower-income households also spend a larger share of income on necessities such as housing, food and child care, leaving them particularly vulnerable to debt and bankruptcy when medical costs are encountered.

In order to ensure that a state coverage option serves the interests of Coloradans, it is also important to consider demographics and immigration status. Hispanic households have the highest uninsured rates of any racial or ethnic group[7] – despite many Colorado households' eligibility for subsidized coverage or public programs.[8] A 2018 report by the Center for Health Progress also noted that a quarter of Colorado's uninsured population, just over 100,000 individuals, were people who lacked documentation of legal status.[9] Due to recent federal actions and rhetoric,[10] households that include non-citizens may be less likely to access coverage even if some or all household members are eligible for tax credits or other assistance; by permitting access regardless of immigration status, the state has an opportunity to set a different tone and support a healthier future for Colorado communities.

Last, those who are already covered but seek an option that is more affordable in terms of premium cost or plan structure, or that potentially offers greater transparency, should have access to a state coverage option.

[2] Electa Draper, The Denver Post. *Colorado mountain towns pay highest health premiums in U.S*. February 8, 2014, updated April 27, 2016.
[3] Jordan Rau, Kaiser Health News. *The 10 Most Expensive Insurance Markets in the U.S*., February 3, 2014.
[4] *Rates on a Roller Coaster*, CHI, October 2015. https://www.coloradohealthinstitute.org/sites/default/files/migrated/downloads/2016_Rate_Analysis_3.pdf
[5] Christie Aschwanden, *The Healthiest State in the Country Has Some of the Steepest Premiums*. Nov. 13, 2017. FiveThirtyEight.https://fivethirtyeight.com/features/the-healthiest-state-in-the-country-has-some-of-the-steepest-premiums/
[6] Kaiser Family Foundation, *Key Facts About the Uninsured Population*. Dec 7, 2018. https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/
[7] *Profile: Hispanic/Latino Americans*. U.S. Department of Health and Human Services Office of Minority Health. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=64
[8] *Colorado's Eligible but Not Enrolled Population Continues to Decline*. Colorado Health Institute, June 29, 2017. https://www.coloradohealthinstitute.org/research/colorados-eligible-not-enrolled-population-continues-decline
[9] *Immigrant Health in Colorado Population Demographics and Insurance Status*. Center for Health Progress. February 2018. https://centerforhealthprogress.org/blog/publications/immigrant-demographics/
[10] Andy J. Semotiuk, *Immigrants Troubled by Trump's New Immigration Policy Restrictions.* Forbes. August 23, 2019. https://www.forbes.com/sites/andyjsemotiuk/2019/08/23/immigrants-troubled-by-trumps-new-policy-restrictions/#47f5c1163b34

Affordability considerations

As stated in the joint letter, we support a view of affordability that encompasses both premiums and cost-sharing, with the overall goal of providing affordable access to health care services. We also support plan benefit structures that allow greater access to non-acute services and provide more predictability, so that consumers can get care before problems become acute and can identify and budget for health-related expenses.

Premiums

Due to the ACA definition of affordability and the complexity of plan structures, premium levels are typically the main consideration for consumers when they shop for plans.[11] There is reason for optimism in Colorado regarding premium prices overall in the individual market because of the recently approved reinsurance plan and resulting forecasts.[12] That said, premiums pose a substantial initial hurdle to acquiring coverage and affect perceptions of affordability, and premium costs should remain an important factor in the state definition of affordability.

Cost-sharing levels and predictability of costs

Deductibles and cost-sharing are obstacles to access to treatment even for those who are able to purchase coverage, and it is essential that the state coverage option provides not just access to coverage but access to care. Current analysis of deductible affordability suggests that access to health care services is hampered by the presence of larger deductibles, with almost a third of enrollees in family plans with deductibles above $2,700 reporting that they delayed care due to costs.[13] Colorado's average deductibles are significantly higher, with bronze plans deductibles exceeding $12,000 for a family.

While not all families will exhaust their full plan deductible, those with chronic conditions, who have made a visit to the emergency department or have experienced a major health event are likely to do so. Very few have existing resources sufficient to cover those amounts,[14] and research by CCLP suggests that large numbers of Coloradans lack annual income – let alone income over a shorter period - sufficient to cover the cost.[15] Excluding Medicaid-enrolled families, close to half of working-age families in sixteen southern Colorado counties would have insufficient income to cover an average silver plan deductible over the course of three months. The situation for bronze-plan purchasers – who would not have access to cost-sharing reductions – is even more troubling.

[11] Erin Taylor, Katherine Carman, Andrea Lopez, Ashley Muchow, Parisa Roshan, Christine Ebner. *Consumer Decisionmaking in the Health Care Marketplace.* Rand Corporation, 2016. https://www.rand.org/content/dam/rand/pubs/research_reports/RR1500/RR1567/RAND_RR1567.pdf

[12] Reinsurance Program, HB1168 and 1332 State Innovation Waiver Application. Colorado Division of Insurance web page. https://www.colorado.gov/pacific/dora/reinsurance-program

[13] Paul Fronstin, Edna Dretzka. *Issue Brief: Consumer Engagement in Health Care: Findings from the 2018 EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey*, Dec. 13, 2018. P. 16, https://www.ebri.org/docs/default-source/ebri-issue-brief/ebri_ib_468_cehcs-20dec18.pdf?sfvrsn=effc3e2f_6

[14] Matthew Rae, Gary Claxton, Larry Leavitt. *Do Health Plan Enrollees Have Enough Money to Pay Cost-Sharing?* Kaiser Family Foundation,.Nov. 3, 2017. https://www.kff.org/health-costs/issue-brief/do-health-plan-enrollees-have-enough-money-to-pay-cost-sharing/

[15] Charles Brennan. *Deductible Affordability for Colorado's Working-Age Families.* Colorado Center on law & Policy. August 12, 2019.

One effect of unpredictable and high cost-sharing is avoidance or deferral of less acute care needs, which would potentially result in the same or similar negative outcomes as those described above for individuals who lack coverage altogether. Providing pre-deductible coverage for primary care or establishing cost-sharing structures in a state coverage option that allow access to non-acute services, including primary care and maintenance medications, should be a priority.

State health Infrastructure

CCLP interprets state infrastructure to mean assets held by the state that can be utilized to create efficiencies that will help lower the cost of coverage. We support use of the state exchange, Connect for Health Colorado, and its public benefit corporation, so long as those structures will allow all Coloradans – regardless of income, region or immigration status – to purchase coverage. We emphasize a point raised earlier in the joint letter, that the existing individual market health coverage application used by the Division of Insurance improperly requires a social security number (SSN), potentially allowing discrimination on the basis of national origin. That application needs immediate revision, and such information must be optional for a public coverage option offered off-exchange.

CCLP also recommends that state consider use of the Medicaid and CHP+ provider networks as a way to provide continuity of care for populations that may move between Medicaid, CHP+ and the individual market, and as a way to create a second income stream for providers with Medicaid caseloads.

Transparency and Accountability

A last consideration is the transparency of the state coverage option, both in its creation and its ongoing functions. One significant benefit of public programs such as Medicaid or CHP+ is that structures, medical necessity criteria, and financing have a high level of transparency. The public can hold those programs accountable; individuals can get information about services that are covered and can better understand the basis for providing care and challenge denials of care. It is CCLP's position that a coverage option that is made possible through state action should have a mechanism for ongoing public engagement and provide opportunity for public scrutiny of benefit design, utilization management and provider inclusion criteria, among other factors.

Thank you for the opportunity to comment. We look forward to continued discussions about the public coverage option over the coming months.

Regards,

Bethany Pray, Esq.

Executive Director Kim Bimestefer
Health Care Policy and Financing
1570 Grant Street
Denver, Colorado 80203

Commissioner Michael Conway
Division of Insurance
1560 Broadway, Suite 110
Denver, Colorado 80202

Re: Recommendations for HB19-1004, Study of State-Based Health Coverage Option

Dear Director Bimestefer and Commissioner Conway:

The Colorado Community Health Network (CCHN) appreciates the opportunity to provide our recommendations regarding the implementation of House Bill (HB) 19-1004, to develop a proposal for a state health coverage option.

CCHN is the membership association for Colorado's 21 Federally Qualified Health Centers (FQHCs), which operate more than 200 clinic sites in 42 counties and care for Coloradans from 63 of the 64 counties in the state. FQHCs are the health care home for more than 830,000 people, including 27% of Medicaid enrollees, 25% of CHP+ enrollees, and 40% of Colorado's uninsured. Over 92% of patients at Colorado FQHCs have family incomes below 200% of the Federal Poverty Level. CCHN's mission is to support FQHCs to increase access to high quality health care for people in need in Colorado.

CCHN views the public option as an opportunity for people who are currently uninsured or underinsured in Colorado to gain access to coverage that is affordable and meaningful.

Colorado's FQHCs already provide integrated primary care – including medical, behavioral, and oral health care – to 40% of the state's uninsured population. Once the public option is in place, it is likely that FQHCs will continue to be the health care home for many of the newly covered. We recognize that the task of balancing competition, quality, and access with eligibility, affordability, benefits, infrastructure, and provider reimbursement is complicated. CCHN looks forward and is committed to continuing conversations with DOI and HCPF staff about the development of the state option through all steps of the process.

Below are several principles that CCHN feels are important considerations for the public option from the perspective of CHCs, based on the administration's request of providing feedback on:

- Eligibility and population for whom the state option may be available
- Affordability considerations
- State option infrastructure

Eligibility Considerations

CCHN believes that the public option can and should provide a source of coverage for people who cannot afford or qualify for other private or public coverage programs including people who do not have proper documentation and dependents who fall into the "family glitch." CCHN

recommends that barriers to eligibility are not incorporated into the public option implementation. Examples of potential barriers include basing eligibility on citizenship or immigration status, or requiring a Social Security Number to apply. In addition, when including this population, it is important to ensure that every existing privacy protection for an enrollee's (and an enrollee's family) immigration status and personal contact information be maintained and defended.

Affordability Considerations

Affordability standards should take into consideration the affordability of the plan based on family income and family size. We strongly encourage the consideration of basing affordability on the self-sufficiency standard, as outlined in the August 12 report by the Colorado Center on Law and Policy.[1] In addition to premium costs, affordability considerations should also include all out-of-pocket costs and, in particular, deductibles, coinsurance, and co-payments. These out-of-pocket affordability standards are important not just for the financial well-being of Coloradans who may enroll in the public option, but holds particular significance for FQHCs.

High deductible insurance plans often result in patients never reaching the deductible in any given year. As a result, FQHCs, like other primary care providers, are rarely compensated by private insurance plans for the care they provide to patients. As much as possible, deductibles should be kept within a reasonable threshold to ensure that primary care providers do not have to write-off costs for patients covered by the public option. Additionally, to improve the value of coverage as well as encourage preventive services, the state should consider requiring the state option to include first dollar coverage for high value primary care services.

Second, FQHCs, as a unique result of their federal designation are required to provide access to a sliding fee scale for patients below 200 percent of the Federal Poverty Level. The sliding fee scale eligibility must only be based on the patient's income and family size, the fees must be "nominal," and the fees must not be a barrier to patients accessing care. Although the actual mechanisms are more nuanced at each FQHC, this means that if an FQHC's sliding fee for a service is lower than the private insurance out-of-pocket cost, the patient may use the clinic's sliding fee scale instead. This results in the FQHC not realizing any reimbursement from the private insurance company – it is as if the patient were uninsured. As a result, CCHN requests that all efforts be made to contain co-payments within a reasonable and affordable range for the public option. Additionally, for patients, having predicable out of pocket costs is important. Current cost sharing structures for many private insurance plans today make it difficult or impossible for consumers to plan and budget for their health care.

Ensuring there is meaningful coverage for primary care services (including essential health benefits that include integrated physical, behavioral, and oral health) should also bring additional, significant benefit to both enrollee health and the total cost of care. Evidence shows that primary care helps prevent illness and death, and is associated with a more equitable distribution of health in populations.[2]

State Option Infrastructure

CCHN encourages the state to consider all options to use existing infrastructure that will prioritize the eligibility and affordability points made above. That said, FQHCs serve nearly a

[1] https://cclponline.org/wp-content/uploads/2019/08/CCLP-Deductible-Affordability_081219_Final.pdf
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145/

third of the Medicaid population, a quarter the CHP+ population, and two out five of the state's uninsured. Building on current reimbursement structure of either Medicaid or CHP+ would ease FQHC's ability to care for, and be fairly reimbursed for, the care they are already providing to their uninsured patients. This infrastructure has the opportunity to create efficiencies in enrollment, administration, and provider reimbursement, and may be beneficial for a variety of reasons, including:

- Claims payment systems are already built and in use by thousands of providers
- Opportunities to build upon an existing network of providers
- Opportunities to explore potential public/private partnerships like CHP+ infrastructure.

CCHN looks forward to continuing to engage with the DOI and HCPF on this issue, and the benefits to Colorado overall. Coverage expansions in Colorado have historically helped support the growth of primary care capacity at FQHCs across the state – since the implementation of the ACA in Colorado, CHCs have grown to serve 29% more patients of all insurance statuses.

The public option holds great promise for FQHC patients. Please let do not hesitate to reach out with questions and discussion.

Sincerely,

Polly Anderson
Vice President, Strategy & Financing
Colorado Community Health Network
polly@cchn.org

August 30, 2019

Kim Bimestefer
Executive Director
Colorado Department of Health Care Policy and Finance

Dear Director,

As you move through the stakeholder process called for by HB19-1004 (Concerning a Proposal for Implementing a Competitive State Option for more Affordable Health Care Coverage) we want to be sure you receive input from a broad cross section of the business community.

Investors in C3 have agreed upon the following three principles which we believe are critical to making health care work for more Coloradoans:

- Proposals should not drive new or shift increased costs to employers and employees
- Proposals should minimize market disruption
- Proposals should prioritize market forces to control prices and avoid government price setting

The Proposal Should Not Drive New or Shift Increased Costs to Employers and Employees

The great majority of people with private health insurance in Colorado receive that insurance through employer sponsored health plans. Employers and employees are struggling to continue to afford this benefit and neither can absorb additional shifts of health care costs from public programs as this will negatively impact Colorado's business environment.

The Proposal Should Minimize Market Disruption

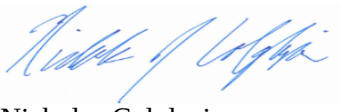
Proposals should clearly define the problems and segments of the market that are intended to be addressed, not allow markets outside of its scope to be negatively impacted and allow the state to track outcomes in an effective fashion.

The Proposal Should Prioritize Market Forces to Control Prices and Avoid Government Price Setting

Market forces rather than government price setting is more sustainable and will reduce the likelihood of employers and their employees bearing more health care costs.

As you determine the best path forward we hope you will move cautiously and in a focused, measured manner. Incorporating these principles will help ensure you consider not only the individuals you most mean to target, but employers that subsidize their employee health plans and make coverage possible for the majority of Coloradoans as well. We will remain engaged in this process and appreciate the opportunity to share these principles.

Sincerely,



Nicholas Colglazier
Colorado Competitive Council
Director
CC: Commissioner Mike Conway

Colorado Consumer Health Initiative

August 30, 2019

Executive Director Kim Bimestefer
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, Colorado 80203

Commissioner Michael Conway
Colorado Division of Insurance
1560 Broadway, Suite 110
Denver, Colorado 80202

Re: Consumer Recommendations for HB19-1004, Study of State-Based Health Coverage Option

Dear Director Bimestefer and Commissioner Conway:

The Colorado Consumer Health Initiative appreciates this opportunity to provide further comments and recommendations regarding the implementation of HB19-1004, to study and develop a proposal for a state health coverage option.

As we indicated in our previous comments, our priority with this state health option is to increase coverage affordability for all Coloradans. We believe increased affordability will help drive more market competition and encourage more individuals to enter into the market, thereby helping to stabilize the market. We continue to encourage the state to include all Coloradans regardless of immigration status, individuals in the family glitch, individuals who are caught in an affordability cliff between Medicaid and subsidized insurance, and uninsured and underinsured individuals.
With this letter, we want to share some additional thoughts and recommendations on the following: benefits covered, an affordability definition, standardized plans, and provider reimbursement rates.

Benefits Covered by the State Plan

HB19-1004 requires that, at a minimum, the state plan provide the ACA's essential health benefits (EHBs). In addition to covering EHBs, we support

the inclusion of a comprehensive dental health benefit in any plan offered as a result of this process. Poor oral health is linked to many systemic diseases and may also exacerbate existing health conditions. Oral health issues have also been linked to lost productivity through missed work and school. Moreover, those individuals who may benefit most from a state health option - individuals who are uninsured and low-wage workers - tend to have dental needs that require more comprehensive coverage. Yet, dental diseases are largely preventable, if individuals can access such services. In short, oral health plays an important role in overall health and well-being and should be part of the benefit design.

Definition of Affordability

In our previous comments, we recommended that individuals with incomes below 250% of the federal poverty level should be expected to spend no more than 5% of their income on health care costs, including both premiums and out of pocket costs. To reiterate our key principles:

- Affordability should take into account all health care costs - premiums, deductibles, copayments, and coinsurance
- Affordability should be a progressive sliding scale relative to income
- For some low wage earners, it is important to recognize that any premium may not be affordable.

Plan Standardization

One way to address consumer affordability is through plan standardization.[1] We support the adoption of standardized plans that provide first dollar, or pre-deductible, coverage, for high value services. Based on comments and presentations thus far as part of the HB1004 stakeholder process, consumer, provider, and carrier organizations all see value in standardized plans.

We have heard from consumers who are afraid to use their coverage because of their high deductible -- or even forego coverage because of the deductible. According to a recent analysis by the Colorado Center on Law and Policy

[1] Another benefit of standardized plans is reduced consumer confusion and easier decision making in the shopping experience.

(CCLP), the average deductible for an individual silver plan offered in 2017 was $3,093, more than half the average deductible of $5,798 for a bronze plan. The CCLP report concluded that:

> If a family not enrolled in Medicaid were to need a substantial amount of medical care over the course of a year, around one in four would likely need to use their savings, use credit or debt, or cut back on spending on other necessities before their insurance company would begin assuming the costs of their care.

Offering first dollar coverage with a standardized plan is one way to make health care services more accessible and affordable. Additionally, greater predictability around costs could be achieved with a standardized plan that eliminates coinsurance. Coinsurance creates uncertainty for consumers around costs because it is an extremely opaque cost sharing tool and creates perverse incentives to avoid care.

In order to meet the affordability standards, plan design could mimic the methodology for creating cost sharing reduction plans currently available for people below 250 percent of poverty such that individuals at certain income ranges get an actuarially richer benefit that helps to limit their out of pocket expenses.

Provider Reimbursement Rates

For a state health coverage option to be more affordable to Coloradans, we believe it is imperative to limit provider reimbursement rates. Current commercial rates are not practical for a state coverage option. A recent multi-state Rand report shows that Colorado commercial carriers are paying hospitals 220% to 350% of Medicare; further, studies show that hospital costs, particularly administrative costs, in Colorado are significantly higher than other states.

While we firmly believe that current reimbursement rates are not sustainable or practical for a state coverage option, we recognize that providers may not be willing to participate in carrier networks at lower mandated reimbursement rates. For this reason, we urge you to consider whether provider participation should be linked to another program, such as

the state employee plan, whether there are incentives to encourage provider participation, such as enhanced Medicaid reimbursement rates, or whether participation could be a requirement of the tax exempt status of non-profit hospitals.

Additional considerations

Because we believe the state coverage option should be available to all Coloradans, we want to note that we do not think that the state coverage option should be a high risk pool, a concept that has been mentioned in some of the stakeholder meetings. We believe this would detrimentally segment the market. Also, to the extent it is not possible to adequately meet the needs of all targeted populations with the same solution, we would suggest that the state explore allowing for alternative solutions like allowing parents and children in the family glitch to purchase CHP+ plans, or setting up a form of a Basic Health Plan.

* * *

In conclusion, we appreciate the outreach and engagement by HCPF and DOI in seeking feedback during this process to create a state health care coverage option. We urge the agencies to create mechanisms and processes for continued public engagement during implementation and operation of the state option. For the option to truly serve all Coloradans, there must be accountability and transparency to the public through the stakeholder process, during and after implementation.

Thank you for your consideration.

Sincerely,

Adela Flores-Brennan
Executive Director

BY EMAIL: HCPF_1004AffordableOption@state.co.us

August 13, 2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Commissioner Michael Conway
Department of Regulatory Agencies, Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Subject: Importance of Including Comprehensive Dental Coverage in HB19-1004 Proposal

Dear Director Bimestefer and Commissioner Conway,

The Colorado Dental Association (CDA) would like to thank the Division of Insurance and the Department of Healthcare Policy and Financing for the opportunity to comment on eligibility, affordability and infrastructure priorities for a state healthcare program pursuant to HB19-1004. The Colorado Dental Association (CDA) represents more than 70% of Colorado's dentists with a membership of over 3,000 dental professionals. The CDA is dedicated to improving the quality, availability, affordability and utilization of oral healthcare services.

Ensuring equitable patient access to dental services has been a primary focus for the CDA in recent years, as evidenced by the CDA's work to increase dental coverage in Medicaid, CHP+ and for Colorado's seniors. The CDA has also played a central role in redesigning the dental team to enable more patient-centered care and in supporting more cross-profession collaboration through medical-dental integration efforts. With these priorities in mind, the CDA believes that it is essential to include dental coverage for all Coloradans with benefits at least equivalent to those currently offered through Colorado's HealthFirst (Medicaid) program in any state plan design contemplated under HB19-1004, as dental health is a critical component of a person's overall health.

While dental health is integral to general health, it is so often overlooked in our current healthcare system. Dental disease is linked to many chronic and serious health conditions like strokes, stomach ulcers, lung disease, pneumonia, low birth weight babies, heart attacks, heart disease, hypertension and diabetes. Because of these direct links between dental and overall

health, poor dental health inevitably increases other healthcare costs, both individually and systemically. Poor dental health has adverse implications for nutrition, speaking, learning and employment, quality of life, self-esteem, social engagement and overall well-being. Adults lose nearly 100 million hours of work in the U.S. each year due to toothaches and other unplanned oral health problems. Yet, dental disease is almost entirely preventable. Safe and effective measures to prevent dental decay and gum disease are readily accessible. Prevention is key to stopping dental disease, but preventive strategies cannot be effective if we don't connect Coloradans into the dental delivery system through reliable coverage.

As demonstrated through recent state program expansions, greater dental coverage translates into more utilization of routine dental care services, which helps Coloradans stay ahead of the many overall health impacts of dental disease and provides an opportunity for significant personal and systemic cost savings. When Coloradans are covered under a dental plan they are twice as likely to get dental care and have better oral health. Children with dental coverage are three times as likely to get care than their dentally uninsured peers. In addition, recent Colorado findings show that dental coverage for parents increases the likelihood that their children get dental care.

Dental coverage is even more important for higher-risk populations like patients with chronic conditions, Coloradans with disabilities, senior adults and children. Unrecognized disease and postponed care among these high-risk populations can exacerbate other medical conditions, and ultimately lead to more extensive and costly treatment needs.

Dentists can be key partners in diagnosing and referring patients for treatment of many chronic diseases, including diabetes, hypertension, respiratory conditions, addiction, and more. Chronic conditions, which have increased prevalence among patients with disabilities and senior populations, can also drive the need for dental care – as many chronic conditions are treated by medications that adversely impact oral health. In addition, a 2012 review of dental health studies for patients with mental and intellectual disabilities indicated that these patients have higher than average rates of dental decay and are 1.7 times as likely as the average patient to have gum disease. More than 32% of patients with disabilities in the studies had current untreated dental decay (compared to 26% among all U.S. adults) and more than 80% had gum disease (47% in the general population).

Today's senior adults are also keeping more teeth for longer, and Medicare currently lacks any meaningful dental benefit, making dental coverage for all Colorado seniors essential within a state plan. At this time, most Colorado seniors cannot get the dental care they need. In 2017, the Colorado Health Institute (CHI) reported that more than half (54%) of Colorado seniors did not have dental coverage (where only 0.2% lack medical coverage). Costs associated with dental care discourage many uninsured seniors on fixed incomes from seeking treatment. CHI reports that 13% of senior adults skip dental care due to cost, more than any other health service. Seniors with dental plans are 2.5 times more likely to visit the dentist on a regular basis.

Children also require special consideration. Children with dental pain may be irritable, withdrawn, unable to concentrate or experience other behavior issues. Dental pain can affect test performance as well as school attendance, interrupting a child's ability to effectively learn and contributing to education disadvantages that can have a life-long impact. An estimated 7.8 million hours of school are lost annually by Colorado children alone due to acute dental pain and infection. Low-income and minority children are disproportionally affected, with low-income students being at least twice as likely to suffer from untreated tooth decay than their peers. Early detection and management of children's dental conditions can improve oral health, overall health and well-being, school attendance, and school performance, as well as result in substantial cost savings individually and for the many current state-funded programs that provide dental coverage to children.

But dental coverage is still out of reach for too many Coloradans. In 2017, Coloradans were more than 4 times as likely to lack dental insurance over medical insurance. Less than 7% of Coloradans lacked medical insurance, but nearly 30% lacked dental coverage. The gap in dental coverage is particularly apparent in certain populations, like seniors – where 54% lack dental coverage. These gaps in coverage underscore the vital importance of including affordable, comprehensive dental coverage for all Coloradans within the constructs of a state plan.

Colorado's HealthFirst (Medicaid) dental program provides a good minimum threshold for beginning discussion on the design and structure of a dental benefit for a state health plan. The HealthFirst program currently includes a comprehensive dental benefit for children and teens, low income adults (since 2014) and patients with disabilities. Adults have a $1,500 annual maximum on dental benefits that can be received within a state fiscal year. Children and patients with disabilities have comprehensive benefits with no annual financial cap, and there is an enhanced provider fee schedule for the DIDD (Intellectual and Developmental Disabilities) program due to the complexity of treatment and enhanced skill required for quality care for this population.

Thanks to interventions like the HealthFirst adult dental benefit, substantial gains were made toward improving Colorado's oral health metrics in recent years. Fewer Coloradans are skipping dental care because of cost concerns (down to 15.8% in 2017 from 22.9% in 2011). Dental insurance coverage is at an all-time high with the ACA's pediatric dental coverage mandate and state HealthFirst program expansions (up to 70.3% coverage in 2017 from 61.3% in 2013). Slight gains in utilization and self-reported oral health status were also reported during this period. The rate of untreated dental decay in elementary students was cut in half in a 7-year period (from 2004 to 2011).

By offering an adult dental benefit through the HealthFirst program, the state also has saved significantly on emergency dental services, emergency room visits for dental problems and concurrent medical conditions. Reports indicate a substantial reduction in emergency care related to adult dental conditions, with a state cost savings of more than $10 million in the first benefit year alone. Additional study of patient overall health outcomes and cost savings related to concurrent medical conditions is underway. This HealthFirst dental benefit has proven its

efficacy among some of the highest need populations in Colorado. The impressive gains in both dental coverage and access for some of the most vulnerable Colorado populations bodes well for continued future cost savings.

While great gains have been made under the HealthFirst program structure, there are some limitations to the current design of dental plans that can hinder participation and systems integration. These should likely be reviewed as a state plan is designed. In particular, we believe that it is critical to ensure that any dental plan contemplated in the state offering have separate deductible structure from the medical plan deductible in order to ensure meaningful coverage (should a fee-for-service payment model and cost-sharing/ deductible design similar to the current HealthFirst dental plan be considered in a state-offered plan). Deductible structures related to dental care have been a major concern with some state exchange dental plans that are embedded within a larger high deductible health plan. Under these plans, some patient's families are being required to meet a very high medical plan deductible (several thousand dollars), or even meet the plan's out of pocket maximum (that can exceed $10,000), before the plan will begin paying for any portion of – even preventive – pediatric dental care required as an Essential Health Benefit in the Affordable Care Act. These high deductibles to access pediatric dental care, as well as cost sharing barriers on preventive pediatric dental services, regularly surprise consumers and create significant barriers that prevent reasonable and expected patient access to dental care services classified as essential health benefits.

Traditionally, health plans that included dental coverage in an embedded format had either no deductible for dental (highly prevalent) or maintained a separate dental-specific deductible apart from the overall medical deductible (typically a $50 dental deductible). The practice of imposing the full medical deductible before pediatric dental care services are paid is a relatively new concept that seems to have gained traction with the proliferation of high deductible plans offered through the state exchange. Some health plans that contain embedded pediatric dental coverage still adhere to the practice of a separate dental deductible – but separate deductibles cannot be assumed as standard among health plans any longer. If a patient or family must pay several thousand dollars out-of-pocket before dental care benefits may be accessed, that obligation essentially negates the coverage (since dental coverage is typically structured as a capped benefit at an amount far less than the medical plan deductible). This design does not align with equivalent employer plan practices or the spirit of federal law regarding delivery of essential health benefits, and may have a detrimental impact on long-term oral health in Colorado. Given the impact of this deductible design on families and access to critical dental care services, some states have banned this practice altogether.

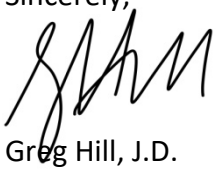
To ensure that reasonable dental coverage is accessible to patients, we believe it is vital that any state offered healthcare plan establish a separate and much lower deductible (typically a $50 dental deductible) for dental care if a deductible/cost sharing structure is utilized. In addition, the state plan should consider offering preventive dental services like exams and cleanings without a deductible or co-pay. Prevention is vitally important and reaps substantial cost savings for both patients and health plans. For this reason, both medical and dental plans have routinely incentivized preventive services by removing the cost sharing responsibility for

patients who access these services. Some innovative dental plans take additional steps in incentivizing preventive care by both removing the cost sharing and rewarding the patient with an increase to the annual maximum coverage limit for completing preventive care activities. These plans are known as "progressive maximum" dental plans. Under a progressive maximum plan, the patient may be able to increase their coverage limit from $1,500 per year to $2,500 per year, as an example, just by completing routine preventive care activities. It is ultimately in the best interest of both patient health and health plan cost containment to do everything possible to incentivize preventive dental care. Further, any cost sharing for basic dental services (such as fillings, extractions, dentures, etc.) should be as limited as possible, especially for lower-income populations. This standard is well modeled among public dental programs and stand-alone dental plans already, and should be honored in any state plan design.

Given the vital importance of dental care for general health, learning and employment, as well as social and mental health status, the CDA and its member dentists are committed to doing our part to work with state and community leaders to help ensure that all Coloradans have access to quality, comprehensive dental care under any state-offered healthcare plan.

Thank you for your consideration in addressing this important component of health. If we can be of any further help in program design and infrastructure or other questions, please don't hesitate to contact us at (303) 996-2846 • greg@cdaonline.org or (719) 522-0123 • kahlja@msn.com respectively.

Sincerely,



Greg Hill, J.D.
Executive Director, Colorado Dental Association

Jeff Kahl, DDS
President, Colorado Dental Association

cc: Lorez Meinold, Keystone Policy Center

August 15, 2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant St
Denver, CO 80203

Commissioner Michael Conway
Division of Insurance
1560 Broadway #110
Denver, CO 80202

Dear Director Bimestefer and Commissioner Conway,

We thank you for your efforts to solicit stakeholder input on development of a public option proposal as outlined in House Bill 19-1004. We, the undersigned organizations, ask that you include a comprehensive dental benefit as part of the public option framework as oral health plays a critical role in overall health and well-being.

As you may know, poor oral health is often linked to many systemic diseases and can even exacerbate existing health conditions. Oral health problems have also been linked to loss of productivity through missed work and school days. Dental caries is also the most common chronic condition of children yet largely preventable with appropriate dental care. Such challenges are especially difficult for low-income populations and the uninsured who tend to have greater dental needs that require more comprehensive benefits. Without oral health benefits individuals forgo important preventive care leading to higher costs for restorative and other major services and many often wind up receiving costly—and often non-definitive—services in emergency rooms. Prior to Colorado implementing a comprehensive adult Medicaid dental benefit the state spent $11.1 million on emergency dental services (2012) with significant savings since including a reduction in spending to just $1.2 million in the first full year of implementation (2015).

We hope the state will consider including a comprehensive dental benefit in any state public option. Thank you for considering this recommendation and please contact Helen Drexler at hdrexler@ddpco.com with any follow up questions or requests.

Sincerely,

American Academy of Pediatrics, Colorado Chapter
Center for Health Progress
Colorado Access
Colorado Children's Campaign
Colorado Dental Association
Colorado Dental Hygienists Association
Colorado Gerontological Society
Delta Dental of Colorado
Delta Dental of Colorado Foundation
Dental Lifeline Network
Denver Health
Healthier Colorado
Marillac Health
Oral Health Colorado

COLORADO FOUNDATION FOR
UNIVERSAL HEALTH CARE

August 28, 2019

Colorado Department of Health Care Policy & Finance
HCPF_1004AffordableOption@state.co.us

STATEMENT IN SUPPORT OF COMPREHENSIVE COVERAGE FOR HB19-1004

The Colorado Foundation for Universal Health Care, a non-profit 501(c)(3) organization, advocates for universal health care as a human right. We therefore support women's access to comprehensive reproductive health services without deductibles, co-pays, and other barriers to care. We support HB19-1004 and agree with NARAL and others that covered benefits should include the following:

- Well woman and obstetrical care
- All FDA approved prescription and over-the-counter birth control methods
- Abortion care (to the greatest extent possible)
- Voluntary sterilization and all required counseling, monitoring, and treatment
- Counseling, screening, and treatment for sexually transmitted infections (STIs)
- Screening and appropriate interventions for breast cancer, cervical cancer, and other reproductive health concerns
- Screening and appropriate interventions for domestic and interpersonal violence
- Folic acid supplements
- Prenatal & Postpartum care
- Breastfeeding comprehensive support, counseling, and supplies
- Additional preventive health services including mental health care

Colorado can lead the way forward with a state public option plan just as the Federal government takes punitive and discriminatory steps to restrict access to health care for all women.

Yours truly,

James R. Potter
Legislative Coordinator
Colorado Foundation for Universal Health Care
1111 Red Feather Road
Cotopaxi, Colorado 81223
Telephone: 719-942-3912
Email: JamesRaymondPotter@gmail.com

August 30, 2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Commissioner Michael Conway
Division of Insurance
1560 Broadway, Suite 110
Denver, CO 80202

BY EMAIL: HCPF_1004AffordableOption@state.co.us

RE: Recommendations for HB19-1004's State Coverage Option

Dear Executive Director Bimestefer and Commissioner Conway,

The Colorado Medical Society submits the following comments regarding HB19-1004's state coverage option to supplement our previous preliminary recommendations provided in our stakeholder presentation on July 26, 2019.

The Colorado Medical Society's Board of Directors has agreed that CMS' goal is to support a public option that increases competition in health insurance markets, reduces insurance premiums, facilitates quality improvement and administrative simplification, and inspires physician network participation. We believe that certain guiding principles should drive the development and implementation of a public option—firstly, the public option should harness innovative strategies to reduce costs by incentivizing the delivery of efficient care, delivery of high-value services, avoidance of low-value services, streamlined administration, and healthy behaviors. Furthermore, affordability can be enhanced by:

1. Increasing fair market competition
    - Increase competition in the multi-payer system utilizing current commercial payers
    - Avoid the unintended consequence of driving competition out of the market
2. Reducing costs by identifying, capturing, returning, and reinvesting savings through strong support for primary care, behavioral/mental health (including substance use disorder treatment), and all components of the medical neighborhood
3. Encouraging physician participation and reducing prices through negotiated alternative payment strategies to decrease unwarranted variations in pricing and utilization
    - Incentivize value-based care that is physician-driven; move away from fee-for-service
    - Incentivize physician participation through adequate reimbursement and reductions in administrative burden in order to ensure access
        - Physician participation in the public option must not be mandatory

- Recognizing the interest of other stakeholders in setting provider rates, it is important to highlight a number of physician concerns and thoughts:
    - Many physicians note Medicare's methodology for physician rates is significantly different from Medicare's methodology for other providers like hospitals
        - Medicare hospital rates increased roughly 50% from 2001 to 2018
        - Medicare physician rates increased just 6% from 2001 to 2018 (adjusted for inflation in practice costs, that is a 19% decline) and are scheduled to be flat into the future
    - Many also note the merits of utilizing commercial insurance rates as a benchmark given that the public option will be sold on the commercial market
    - CMS policy supports a physician's ability to set fees for their services that are reasonable and appropriate
    - Great care should be taken not to negatively impact access and quality through rate setting

4. Reducing waste (including overuse, underuse, and misuse of resources) and dramatically decreasing administrative burdens by standardizing formularies, provider contracting, prior authorization, utilization and claims management, guidelines, and cost and quality metrics across carriers
    - All guidelines, standards, and requirements should be evidence-based
    - CMS has long called for these types of changes and welcomes the opportunity to collaborate on the development of recommendations on low and high value services, quality improvement efforts, and cost control efforts
5. Incentivizing patients' healthy behaviors and encouraging more advance care planning
    - Personal accountability should be promoted
    - Social and commercial determinants of health should be acknowledged and addressed
6. Increasing transparency and use of cost and quality data, as has been done with the Hospital Value Report

Ultimately, patients need to be kept as the focus of any proposal for a state coverage option.

Thank you again for your outreach to us and your continued efforts to involve stakeholders in this process. CMS commits to continuing our active participation and welcomes the opportunity to remain constructively engaged as you work to develop a public option proposal.

Sincerely,

Debra J. Parsons, MD, FACP
President, Colorado Medical Society

As well as the undersigned organizations:
American Academy of Pediatrics, Colorado Chapter
American College of Physicians, Colorado Chapter
Colorado Child & Adolescent Psychiatric Society
Colorado Psychiatric Society
Denver Medical Society

August 23, 2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant St, Denver, CO 80203

Commissioner of Insurance Michael Conway
Division of Insurance
1560 Broadway #110, Denver, CO 80202

Re: Comments as part of the stakeholder process on the state option (HB19-1004)

Dear Director Bimestefer and Commissioner Conway,

On behalf of the Colorado State Association of Health Underwriters (CSAHU), representing hundreds of licensed agents and brokers who are engaged in the sale and service of health insurance and other ancillary products and serving employers and consumers around the country, we commend you for working towards decreasing health care costs, increasing competition, and improving access to high quality, affordable healthcare to all Coloradans, as outlined in HB19-1004.

The members of CSAHU work on a daily basis to help millions of individuals and employers of all sizes purchase, administer, and utilize health insurance coverage. CSAHU members are exceptionally well versed on the coverage options that businesses of all sizes and individual consumers, have available to them, as well as the plan choices they ultimately make. Our expansive knowledge of health insurance markets and the consumers served by these markets leads us to oppose the creation of a state option, as it is contradictory to the goals stated in HB19-1004.

Creating a government-run program through the state option would disrupt the insurance millions of Coloradans rely on. Instead of lowering costs, Coloradans would pay more in taxes to wait longer for lower quality of care. Moreover, a state option could lead to segmenting of the current market. A government-run plan would not compete fairly with private coverage due to government set pricing for provider payments vs. commercial coverage, which does not have the ability to set prices. Healthy individuals could opt to switch over to the government-sponsored plan from the ACA individual market, which would result in separate risk pools, increased market instability, and adverse selection. This would result in the increase of cost of coverage for people who have health conditions.

Under a state option, market-based plans and stable employee-sponsored plans would be eroded by the government-run program. As a result, Coloradans would see fewer and fewer options until only the state-run plan remains. In addition, access to high quality, affordable health insurance could be hindered. State option proposals assume that the buy-in will be cheaper than existing individual market coverage, mostly due to anticipated reduced medical costs. This assumption is based off of the notion that the state will negotiate lower provider reimbursement levels under the buy-in program than in commercial coverage. As a result, provider participation could diminish. Moreover, we risk losing our top physician specialists, sole practitioners, and smaller private practices to states where they can negotiate better compensation, which would be of further detriment to access of care.

CSAHU believes every Coloradan deserves access to affordable, quality health coverage and we are committed to working with you to achieve this goal. We believe the focus should be on bringing down costs, as health insurance is currently expensive because the cost of medical care is so expensive. When

the free market and public programs work together to bring down the cost of care, we can expand access to high quality care for everyone. This can be achieved by:

- Providing greater opportunities for medical care price transparency by increasing user-friendly public access to current, accurate and unbiased medical cost information, cost differentiations based on outcomes and clinical performance, quality measures including outcomes, quality designations and any disciplinary actions, adding a personal touch with the ability to talk to a live person, and consumer ratings and user experiences could all help lower costs.
- Promoting the increased use of value-based insurance design (VBID) principles. As costs continue to rise for individuals, the use of value-based insurance design is growing to help offset these costs. The premise of VBID is to reward good behavior in maintaining health by incentivizing low-cost treatments, such as preventive care, wellness, and medications that control chronic conditions at little or no cost to the consumer. VBID plans may also dis-incentivize care that is unnecessary, repetitive, or more costly than an alternative.
- Examine the ways that provider payments are made to focus on paying for quality of care, not volume, and review how the trend toward provider consolidation impacts the cost of coverage.
- Place more emphasis on wellness, including creating more incentives for employer-sponsored plans and allowing for more meaningful wellness programs for public-program beneficiaries and people seeking individual health insurance coverage. Improving wellness programs will help Coloradans achieve a greater level of health, reduce medical care utilization, reduce the use of sick time, reduce injuries, and reduce insurance claims and overall healthcare costs.

Furthermore, CSAHU worked closely with stakeholders and the administration earlier this year to establish a reinsurance program that will increase access to affordable healthcare by stabilizing the individual market and lowering premiums. The individual market is where roughly 250,000 Coloradans – often people who work for small businesses, self-employed, or independent contractors – buy their health insurance. The individual market in recent years has been plagued by insurers leaving the market and rate increases. However, a reinsurance pool will serve to protect individual market insurers from excessive claims, as money in the pool will insure high-dollar patients whose health costs exceed a certain threshold. This idea has already shown promise in states such as Alaska, where premiums dropped by more than 20% from what it could have been without a reinsurance mechanism in place. We should focus on fostering this newly established program that will pave the way for true systemic change, as opposed to creating a state option that does not address the cost of care.

Through these market-based solutions, consumer engagement and education, we can help empower consumers to make the best choices which will help to contain their costs and increase access without reducing the quality of care. We look forward to hearing from you on this important issue and working towards achieving the goals outlined in HB19-1004. CSAHU desires to be an active participant in developing and implementing the most effective state option possible should this move forward.

If you have any questions about our comment please do not hesitate to contact us at either the contact information below.

Sincerely,

Brad Niederman CSAHU Legislative Co-Chair 303-929-0055 brad@niedermaninsurance.com

Tim Hebert CSAHU Legislative Co-Chair 970-566-1111 tim@sageba.com

To Whom It May Concern:

I recently attended a stakeholder meeting hosted by the Colorado Department of Healthcare Policy and Financing regarding a "public option" for health care.
I'm grateful the state is taking time to listen to stakeholders about this, because healthcare is a primary concern of many Coloradans.
While I understand the temptation of a public option, I think it's ultimately a bad idea. I don't believe a public option will solve existing problems and would actually exacerbate them.
Colorado ranks ninth in the country for healthcare performance, including access, quality, service use and costs of care, health outcomes, and other metrics. Yet, since the introduction of Obamacare, from 2009 to 2017, average deductibles in Colorado have almost doubled and premiums have risen about 50%. Same narrative across the country.
A public option doesn't guarantee better or more accessible care. People sometimes look to Europe regarding healthcare. I lived 25 years in Europe and I saw government-run healthcare firsthand. I'm concerned the actual end goal is a single payer system which would be even worse.
When my Italian family members were hospitalized, relatives took turns ensuring that loved ones received proper care, from clean bed linens to appropriate personal hygiene. In Belgium, the mother of my Beligan friend was in rehabilitation for hip surgery. The state-run clinic provided only one small daily meal on the weekend so her daughter had to provide the additional meals. This isn't quality service, it's the bare minimum.
When I hear public option, I think of the Veterans Administration and its decades of problems. The VA's problems have been identified – lack of prompt and effective care,accountability, etc. Is this what we want for all Coloradans?
A public option creates more problems than it solves. I hope our leaders hear our voices and recommend against a public option.

Debra Irvine

DELTA DENTAL

June 26, 2019

Lorez Meinhold
Keystone Policy Center
1628 Saints John Road
Keystone, CO 80435

Re: Oral Health and the State Public Option for Healthcare

Dear Ms. Meinhold,

Thank you for the invitation at the June 13, 2019 Stakeholder Meeting for the State Public Option on Healthcare to submit comments, proposals, and other feedback related to the potential state option. As a nonprofit healthcare entity, we at Delta Dental of Colorado take very seriously our mission to improve the oral health of the communities we serve. Consequently, we feel compelled to advocate for the inclusion of comprehensive oral health benefits in any contemplated state option. We thank both the Department of Health Care Policy & Financing, and the Division of Insurance for considering the importance of oral health and its inclusion in the state option.

Oral health plays an important role in overall health and well-being. In fact, science has linked oral health to many systemic diseases including stroke,[i] lung disease,[ii] heart disease,[iii] and diabetes.[iv] Even birth defects are an increased risk with poor oral health.[v] Furthermore, poor oral health can exacerbate existing health conditions[vi] and, according to the Academy of General Dentistry, 90% of systemic diseases have oral manifestations and can be detected by looking into the mouth during routine dental check-ups.[vii] In addition to these demonstrated links to overall health, poor oral health itself is a tremendous burden on Coloradans. According to research by the Delta Dental of Colorado Foundation, on average, children miss over 58 hours of school per year due to oral health issues, and adults miss 2.5 days of work.

Clearly, given the above facts and statistics, a public option for health care in Colorado would not be complete without including oral health benefits. What might not be as clear is that those who could benefit most from a quality state public option—the low-income population and the uninsured—tends to have greater dental needs that require more comprehensive benefits. A 2014 Harris poll indicated that 50% of adults without dental insurance have foregone necessary dental care due to cost.[viii] Skipping diagnostic and preventive care (such as oral exams, prophylactic cleanings, and x-rays) leads to higher cost restorative and major services (such as fillings, crowns, root canals, extractions, and periodontal services) in the future. For the uninsured and for those whose coverage does not cover these restorative and major services, that often means a costly trip to the ER. Indeed, in 2012—prior to Colorado implementing a comprehensive adult Medicaid dental benefit—the state spent $11.1 million on emergency dental services. In 2015, the first full year that Colorado implemented a

Delta Dental of Colorado
4582 S. Ulster St., Suite 800
Denver, Colorado 80237-2567

Telephone: 303-741-9300, 1-800-233-0860
Fax: 303-741-9338
Web: deltadentalco.com

comprehensive Medicaid dental benefit, the state reduced its spend on emergency dental services to $1.2 million.[ix] A comprehensive dental benefit has proven its efficacy for low-income and uninsured populations here in Colorado before; the state should seek to build on these successes as it pursues a state public option for healthcare.

Given that Colorado provides dedicated dental benefits for its Medicaid and CHP+ populations, the state is clearly aware that dedicated dental coverage separate from medical benefits can serve the needs of its low-income populations. However, the advantages of dedicated dental coverage are not limited to those below 260% of the Federal Poverty Level. In fact, the overwhelming majority of the 249 million Americans who have dental insurance get it through a policy separate from their medical coverage. Several reasons exist for the popularity of dedicated dental plans. Among those reasons are service, value, access, and plan design, all of which stem from standalone plans' exclusive focus on oral health benefits.

Delta Dental of Colorado is proud to have served the people of Colorado for 61 years and to be its oldest and largest dental benefits provider. During that time, among the company's proudest, most defining achievements was collaborating with the state of Colorado to design, implement, and administer the original CHP+ dental benefit. That comprehensive standalone dental benefits product, designed to serve the children of families that earned too much to qualify for Medicaid but were unable to afford coverage in the private market thrived to such a degree that it was made the benchmark dental benefit for the Affordable Care Act's pediatric dental Essential Health Benefit (EHB).

Delta Dental of Colorado knows dental benefits, we know Colorado, and we know that we must fulfill our mission to improve the oral health of the communities we serve. We hope the state will consider all of the foregoing and decide to add a comprehensive dental benefit to any state public option it proposes pursuant to House Bill 19-1004. Regardless of who might administer it, when, or how it might be implemented, we would be honored to once again partner with the state to design a benefit that can improve the lives of so many Coloradans.

Thank you for your time and consideration. If you have any questions, or would like to discuss this letter or any of its contents, please contact me anytime. My telephone number is (303) 889-8662 and my email address is hdrexler@ddpco.com. I will be happy to speak with you.

Sincerely,

Helen Drexler
President and CEO
Delta Dental of Colorado

cc: Kim Bimestefer, Executive Director, HCPF
Michael Conway, Insurance Commissioner, DOI

Delta Dental of Colorado
4582 S. Ulster St., Suite 800
Denver, Colorado 80237-2567

Telephone: 303-741-9300, 1-800-233-0860
Fax: 303-741-9338
Web: deltadentalco.com

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[ii] "Healthy Gums May Lead to Healthy Lungs." American Academy of Periodontology, 1/18/11.
[iii] "Gum Disease and the Connection to Heart Disease" Harvard Health Publishing, April 2018.
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[vii] http://www.knowyourteeth.com/print/printpreview.asp?content=article&abc=p&iid=297&aid=1192
[viii] https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1114_1.ashx
[ix] Health First Colorado, Dental Program State Fiscal Year 2016 Annual Report

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Affordable Health Coverage Option, HB19-1004, Public Comment

Submitted by: Scott Bolitho, Glenwood Insurance

Hello,

I was unable to attend the last meeting through the webinar, but wanted to give some input to this from the insurance broker/consultant side.

One of the last slides says the following:

Section 1.,1a(Vii) of the bill states: "A state option for health coverage that uses existing state health care infrastructure may decrease costs for Coloradans, increase competition, and improve access to high-quality, affordable, and efficient health care."

This wording is nearly identical to what we heard from President Obama and Speaker Pelosi when the ACA was being promoted. We heard that competition would be increased, and insurance companies would be rushing to join the Exchanges across the country to sell their insurance. And because of the competition, pricing would be reduced. We all know that the exact opposite happened, and we have far fewer insurance companies, higher out of pocket costs, and premiums that have increased substantially.

In addition, if a public option is offered, you may see the private insurance companies leaving the state, since they know there is a "fail-safe" plan available. And they may not be able to compete cost-wise, so why stay in Colorado?

Thank you for the chance to give my input.

Scott Bolitho, CFP

Submitted by Helene Stout, HBS Consulting

Stakeholders meeting assignment:

Affordability:

What is affordability? What does it look like? Does it change for healthcare?

Affordability

Definition of **affordable**: able to be afforded: having a cost that is not too high products sold at **affordable** prices; an **affordable** purchase; **affordable** housing [housing that is not too expensive for people of *limited means* to manage to bear without serious detriment]

I don't think that "limited means" should be the limiting factor in the definition of affordable.

Affordable means something different to people of different means but I would like to add a value statement that I believe to be relevant.

Define inclusion:

- Affordable state option factor consideration:
  - Premium
  - Out of Pocket Expense
  - First Dollar expense (Deductible)
  - Access where and with whom you want it
  - Access when you want it
  - Access you want (not paying for services you don't need)
  - Cradle to grave concept
  - Annual increases no more than CPI
  - Healthy Incentive
- Coverage options
  - Baseline Urgent Emergent including Ambulance, Airlift Valid anywhere in the world.
  - Ala Carte coverage
    - In-patient facility
    - Out-patient facility
    - Wellness
    - Office Visits
    - Birth Control
    - Obstetrics
    - Therapies
      - PT
      - ST

- OT
- Wound Care

- Alternatives
  - Acupuncture
  - Chiropractic
  - Massage

Laboratory
Pathology
Pharmaceuticals

What is affordable:

When the total cost of accessing the healthcare system (care+insurance) does not exceed 15% of my family income.

$45,000 yr	gross annual income
4500	10% in income tax,
$40500	
2025	5% toward retirement (401k, Roth, HSA)
$37075	
$18,000	Rent
$19075	
$ *6000*	Food
$13075	
$ 3600	Car Payment
$ 9475	
$ 5000	Utilities (Water, Trash, Gas, Electric, Internet, Cell phone/Landline)
$ 4475	
$ 1200	Savings for emergency funds (other insurance homeowners, renters, auto)
$ 3275	
$ 1200	DISCRETIONARY SPENDING
$ 2075	Over 12 months is 173.00/month for health premiums and out of pocket.

1. Health premiums should be 100% tax deductible
2. Health insurance should be sold ala-carte
3. Health insurance should not be charged by age or health conditions but rather by what coverage you want.
3. Catastrophic care should only cover facility type billing.
4. All components should be priced separately and % of income pricing should be available.
5. Cradle to grave, if please are born elsewhere

Residency requirements should follow the University requirements for residency.

6. Everyone must pay something. Everyone is responsible for being healthy.
7. Healthy living premium rebate.

IE if I pay $3275/yr in premium for a catastrophic plan – but I use nothing because, I remain healthy all year – then

1. 50% (or some number) would be deposited back into my HSA, which can be used for a variety of items or just illness that is not. This

creates a forced savings for members of the population that have a hard time saving and they are your pretax premium $ healthy rebate that were earmarked for health expenses and can collect interest and grow in all those years that no health issues are experienced.

2. **OR** some amount would apply to the following years premium. Which year after year would self-limit the premium expenditure from your earned income.

******Note, could not find a solution for the issue that some people have "0 earned income" but are quite wealthy due to sale of home, investments, business dealings which directly affect their "wealth health" as such would qualify for subsidy to health premium be provided?***

I think by looking at % rather than $$ we can be fair and reasonable to <u>everyone</u> across the income spectrum not just income limited people.
Define "INCOME"

Reimbursement methodology:

- Professional 150% of Current Medicare Fee Schedules with annual CPI increase/decrease
- Facilities 200% of current Medicare fee schedules with annual CPI
    - Device outliers – to be considered separately or negotiated separately.
- Pharmaceuticals

Hello:

[Redacted]

Found out as we read alot; the state also got a waiver to treat illegals on dialysis on medicaid as its cheaper then having them go to the ER so people who have paid nothing into the system get our medicaid while we have paid into it over 30 years; get kicked off. Something is not right here.

Its not right for you to take US citizens many of whom like us; did not cause themselves to get sick off needed coverage to help illegals who have no right to be in this country much less taking coverage away from our own citizens. We frankly dont care how much they use in the ER as if they dont get there in time; they die and that makes it alot less costly then giving them medicaid needed for US citizens. Yes this sounds very selfish but we are seriouly ill for nearly 2 years and we dont have help to get alot of things done while you are helping illegals. [Redacted]

Our point is charity begins at home and thats with US citizens and legal residents here over 5 years. It does not belong to illegals or new legal immigrants not here 5 years. Please take this into consideration when you consider a public option.

Thank you for your time.

JM Fay

To Whom It May Concern,

I was told that if I have feedback about 'government-run healthcare,' I should email you.

It's great that our government is finally taking heed to the fact that multitudes are suffering and need help with healthcare costs.

I wish health insurance didn't have to exist at all, and really, it shouldn't. I want socialized medicine, and should let you know that I am speaking as someone with two master's degrees related to health information management. I've learned a lot about how US healthcare 'makes sausage,' which is really the way they make money.

Let's go fully social on medicine and forget about those already rich US healthcare entities. It's a vicious system - dangerous to all involved.

Thank you for your attention. -Kyle

--

Kyle I. Curley, MS, MLIS

Hello,
We have comments regarding the possibility for a public option for health coverage in Colorado. We are adoptive parents and know many others who have adopted or fostered kids with special needs. These kids often have long term chronic issues and our current healthcare system fails them once they reach adulthood.

Eligibility: Employer-based coverage does not work for a lot of people with chronic conditions such as mental illness, type I diabetes. Many people can work only as long as they are taking medication and seeing a provider.
Employers can let a person go at any point in time with no notice to an employee leaving them with a gap in coverage. These gaps can be extremely costly for everyone (hospitalization, incarceration, homelessness) and devastating for the person with the illness. Having **continuous** coverage is critical.
Any person can hit their head and be unable to work full-time no matter their income, age, or fitness level. Eligibility should be available to anyone with premiums based on income and perhaps higher premiums if they have considerable assets. Eligibility should be available for people starting their own business or consulting as well as for those who are employed but want to maintain continuous coverage. Any Colorado resident should be eligible rather than trying to phase in certain groups.

Affordability: Premiums and copays could be structured similar to the Medicaid Buy-In Program for Working Adults with Disabilities. I do have to say though, at the lower income levels - the jump from a $25/mo premium to $90/mo is a big leap for those that still don't make that much considering the housing prices here. It would be better if that was graduated a little more for those making under $40,000 or so.

We worry about affordability due to costs that are often inflated and predatory in the guise of "free market". Free market principles don't work well with healthcare (except for optional procedures such as lasik) since people often do not have a choice of whether they get care or not, plus it's just inhumane. For example, California sought to cap profits of the 2 huge dialysis companies. Consumers can't choose whether or not to have dialysis, and have to pick one of these companies or die. Fresenius and DaVita spent around $100 million to defeat this legislation. Unless we can rein this in and have our healthcare dollars spent on healthcare, it's hard to see how we can make this affordable. Some of this has to change to make any type of coverage work. Most options are doomed to fail when we are held hostage by for profits with exorbitant pricing that is unethical. That's a big reason our current system is failing.

Existing State Infrastructure: Using the Medicaid, state exchange, and state employee health plan infrastructure all are good places to start instead of building from scratch. We liked the ideas presented about sharing resources such as telehealth and MRI so there aren't multiple agencies building in parallel. We will have to consider what happens if people travel out of state or if there is an influx of people moving to Colorado because they have a chronic condition.
Coordination with our public health agencies that are already working on preventable chronic illness and obesity will be necessary to contain costs also.

We are extremely excited about the possibility of continuous coverage but also wary if it is feasible at the state level. Taiwan has a government payor/private provider system and has about 4x the population of Colorado. Premiums are based on income with some lotto and tobacco money. Wait times are reasonable. They also have more control over predatory costs. Modeling on systems that are working well is going to be important to identify what we can and cannot change at the state level.

Thank you,
Toni and Kreg Lyles

As a financial planner, investment advisor and insurance broker I wish to express not only the dire need for a public option in any and ALL health insurance plans, but also my unqualified support.
While a public option likely will not resolve all the issues plaguing health care in the U.S. it is a substantial step in the right direction.
Miles Kessler

Miles B. Kessler, CFP®, President
Kessler & Associates, Inc.

August 30, 2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Commissioner Michael Conway
Division of Insurance
1560 Broadway, Suite 110
Denver, CO 80202

BY EMAIL: HCPF_1004AffordableOption@state.co.us

RE: Recommendations for HB19-1004's State Coverage Option

Dear Executive Director Bimestefer and Commissioner Conway,

Northern Colorado IPA would like to submit the following comments regarding HB19-1004's state coverage option.

1. Elimination of the site of service differential in payment policy.

2. Promote use of low cost high value facilities including non-hospital owned faculties.

3. Utilize a claims processing company that pays promptly with low administrative overhead.

4. Have transparency of all payment rules and have standardization of modifiers. (no special CPT codes or modifiers unique to this product.)

5. Pay independent physicians the same as hospital employed groups for the same service to promote competition in the market.

6. The public health insurance option should have point of service claims adjudication. When a patient is scheduled for an office visit, office staff can look online for the patient's benefit plan and know what deductible needs to be collected at the time of service. The service provided is entered into the system and the claim is adjudicated and paid before the patient gets to their car. Administrative billing expenses are substantially reduced.

7. Decrease Administrative Burden – Please decrease the administrative burden to providers by standardizing formularies and reducing the number of prior authorizations required. Procedures should not require a prior authorization when the patient has the appropriate diagnosis (like Medicare policies).

8. Certified counselors should be a covered service. Medicaid covers certified counselors, but Medicare does not.

9. Since independent physicians are the most cost effective providers, consider how payment policies will impact their ability to survive and the pressure it will create to join the hospital employed physicians. If quality metrics need to submitted, please provide a portal for submission that will not require the providers to have to pay a third party to submit the reports. Please consider claims based quality metrics that can be obtained by HCPF without the provider having to pay their administrators to gather information to submit to HCPF.

Independent providers welcome the opportunity to remain constructively engaged as you work to develop a public option proposal.

Sincerely,

Jan Gillespie, MD
Executive and Medical Director
Northern Colorado IPA
Office: 970-495-0333
Cell: 970-215-2144
Email: jgillespie50@me.com

Hello,

I am a primary care provider working in a community healthcare setting in the city of Denver. I see daily how important comprehensive healthcare coverage is for people and the unfortunate consequences when people do not have it. Comprehensive coverage means preventative care as well as treatment for exiting disease. Specifically I would like to see a public option that covers not only treatments for acute and chronic illness but also annual physical exams, cancer screenings, lifestyle counseling/education, reproductive healthcare including abortion and vasectomies, mental health, substance use disorders, dental, and vision services. Our overall health is all connected so we need a system with comprehensive coverage that addresses all aspects of disease.

We also need a system that addresses preventing disease and expensive hospitalizations. 80% of disease are preventable with lifestyle changes yet, longer clinic visits focusing on behavior change, group visits and evidence based programs are difficult to get covered. Promoting healthy lifestyles by supporting these types of services means that overall health costs would decrease and a public option would become more sustainable year by year. Healthy individuals help to create healthy communities. We all do better when we all do and are better/healthier.

Thank you for considering my comments,
Robin Mills, FNP

By full cost benefit analysis I mean tax dollars spent on healthcare, through costs and savings to the public and back around to revenue for Colorado. You may have the expertise in your staff, many models are available and I'm sure many academics would love to help for getting their name listed (and included in their Vita) and maybe a publishable paper.

You probably know that this is the realm of economic hit men, and I'm sure you are aware of huge profits many wish to protect.

Personally I've long been a supporter of universal healthcare and long believed the savings, yet I would love to see whether the Full revenue side also stands up. Besides Civic Satisfaction, I'm one member of the Denver Dems Public Policy Committee.

I see that I'm a day late (and Civic Satisfaction is always a dollar short) but as a mostly technical point I hope you will consider Full cost benefit analysis. Please remember that the cost saving claims of the recent universal healthcare amendment prompted your mandate. I see you have myriad suggestions to analyze, I hope Fully.

Walt Geisel

Comments Received on Women's Reproductive Health

To the good folks at HCP&F:

The public option must support comprehensive coverage of reproductive services for women. All preventive services should not require patient cost-sharing, similar to annual exams for others. This should include a full range of services from well-woman and obstetrical care to cancer screening. Women need no-cost access to prenatal and postpartum care, with folic acid or other supplements or medications, breastfeeding support and the ability to treat gestational diabetes.

It is also critical that birth control methods (all of them) need to be provided at a low or no-cost with follow-up testing as needed for the type of birth control used.

Thank you for your consideration.

Suzanne O'Neill

To whom it may concern:

Just wanted to make sure I registered my desire to see full coverage for women's reproductive health care included in any plan; with Trump trying to deny women the health care they should be entitled to, it is even more important that our state plan pick up the slack.

Thanks for listening:

Michael & Heidi Marquardt

I support comprehensive coverage of reproductive services for women, without cost-sharing, that include the following:

- Well woman care and obstetrical care
- All FDA approved prescription and over-the-counter birth control methods
- Abortion care (to the extent allowed by the Colorado constitution)
- Voluntary sterilization and all required counseling, monitoring, and treatment

- Counseling, screening, and treatment for sexually transmitted infections (STIs)
- Screening and appropriate interventions for breast cancer, cervical cancer, and other reproductive health concerns
- Screening and appropriate interventions for domestic and interpersonal violence
- Folic acid supplements
- Prenatal & Postpartum care including mental health services
- Breastfeeding comprehensive support, counseling, and supplies
- Additional preventive health services

As the Federal government takes steps to restrict access to health care for all women, Colorado can lead the way forward.

Thank you for letting me comment.

Leroy Frankel

I wish to make a comment on what HR 1004 should include.

As a woman, I am very concerned the procedures that 1/2 of the US population depends on are written into this plan. The following are some of the very important ones..

Wellness and obstetrical care for women.

FDA approved prescription and over-the-counter birth control methods.

Abortion care to the extent allowed by the Colorado constitution. (Or we will have coat hanger deaths in the alleys.)

Voluntary sterilization and required counseling, monitoring and treatment.

Counseling, screening and treatment for STDs.

Screening and interventions for breast cancer, cervical cancer and other reproductive health issues.

Screening and appropriate interventions for domestic and interpersonal violence

Folic acid supplements.

Prenatal and postpartum care including mental health services.

Breastfeeding comprehensive support, counseling and supplies.

[Redacted]

Thank you for your serious consideration. I trust you will include women's issues in the plan.

Sincerely,

Judy Danielson

Dear planners of HB19-1004:

Colorado's healthcare option must include the following:

Well woman care and obstetrical care
All FDA approved prescription and over-the-counter birth control methods Abortion care (to the extent allowed by the Colorado constitution) Voluntary sterilization and all required counseling, monitoring, and treatment Counseling, screening, and treatment for sexually transmitted infections (STIs) Screening and appropriate interventions for breast cancer, cervical cancer, and other reproductive health concerns Screening and appropriate interventions for domestic and interpersonal violence Folic acid supplements Prenatal & Postpartum care including mental health services Breastfeeding comprehensive support, counseling, and supplies Additional preventive health services

Thank you for your consideration.

Deana Schneider

As the Federal government takes steps to reduce women to less-than-full human beings without full agency, by restricting access to health care for all women, Colorado can lead the way forward.

In America today, millions of women still struggle to survive financially and have extra health care needs that men do not. Wealthy, powerful men still decide how women will be treated.

I strongly support comprehensive coverage of reproductive services for women, without cost-sharing, that include the following:

- Well woman care and obstetrical care
- All FDA approved prescription and over-the-counter birth control methods
- Abortion care (to the extent allowed by the Colorado constitution)
- Voluntary sterilization and all required counseling, monitoring, and treatment
- Counseling, screening, and treatment for sexually transmitted infections (STIs)
- Screening and appropriate interventions for breast cancer, cervical cancer, and other reproductive health concerns
- Screening and appropriate interventions for domestic and interpersonal violence
- Folic acid supplements
- Prenatal & Postpartum care including mental health services
- Breastfeeding comprehensive support, counseling, and supplies
- Additional preventive health services

WHEN WOMEN ARE ALLOWED TO THRIVE, EVERYONE THRIVES!

LET'S MOVE INTO THE 21ST CENTURY!

THANK YOU.

Norma Shettle

I support comprehensive coverage of reproductive services

for women, without cost-sharing, that include the following

- Well woman care and obstetrical care
- All FDA approved prescription and over-the-counter birth control methods
- Abortion care (to the extent allowed by the Colorado constitution)
- Voluntary sterilization and all required counseling, monitoring, and treatment
- Counseling, screening, and treatment for sexually transmitted infections (STIs)
- Screening and appropriate interventions for breast cancer, cervical cancer, and other reproductive health concerns
- Screening and appropriate interventions for domestic and interpersonal violence

- Folic acid supplements
- Prenatal & Postpartum care including mental health services
- Breastfeeding comprehensive support, counseling, and supplies
- Additional preventive health services

Gary Mandair

I am unable to attending the hearing in Durango, but want you to know that, as a Colorado physician and University of Colorado faculty member, I support comprehensive coverage of reproductive services for women, without cost-sharing, that include the following:

Well woman care and obstetrical care
All FDA approved prescription and over-the-counter birth control methods
Abortion care (to the extent allowed by the Colorado constitution)
Voluntary sterilization and all required counseling, monitoring, and treatment
Counseling, screening, and treatment for sexually transmitted infections
Screening and appropriate interventions for breast cancer, cervical cancer, and other reproductive health concerns
Screening and appropriate interventions for domestic and interpersonal violence
Folic acid supplements
Prenatal & Postpartum care including mental health services
Breastfeeding comprehensive support, counseling, and supplies
Other preventive services as research demonstrates their efficacy.

I cannot emphasize enough the importance of comprehensive mental health care for the well being of our citizens.

Sincerely,
Evelyn Hutt, MD

To whom it may concern:

Regarding the public option health insurance plan, HB19-1004, I would like to voice my support for comprehensive coverage of reproductive services without cost sharing for women including the following:

- Well-woman care and obstetrical care
- All FDA approved prescription and over-the-counter birth control methods
- Abortion care (to the extent allowed by the Colorado constitution)
- Voluntary sterilization and all required counseling, monitoring, and treatment
- Counseling, screening, and treatment for sexually transmitted infections (STIs)
- Screening and appropriate interventions for breast cancer, cervical cancer, and other reproductive health concerns
- Screening and appropriate interventions for domestic and interpersonal violence

- Folic acid supplements
- Prenatal and postpartum care including mental health services
- Breast feeding comprehensive support, counseling, and supplies
- Additional preventive health services

Thank you,

Stacia DeLeon

Department of Healthcare Policy and Financing,

Hospitals seem to be in the crosshairs of the Polis Administration with regard to its new public option for healthcare coverage, and I cannot figure out why. Hospitals are serious about saving people money on healthcare, especially compared to many of the other players in the healthcare space. They do not deserve to be targeted by the Polis administration with a state option that threatens their budgets and staff.

In what ways is this happening? Hospitals are investing in primary care physician networks with the hope of preventing illnesses and keeping people out of hospitals in the first place. An ounce of prevention is worth a pound of cure, and hospitals know this, so they're attempting to head problems off before they get worse.

Furthermore, hospitals make major investments in community health, such as food security, transportation, housing and mental health services, all of which produce long-term savings through prevention and wellness. A healthy population is one that doesn't have to rely on the services hospitals provide nearly as much, and hospitals are seeking to attack the problem head-on.

On a completely different note, hospitals agreed to pay $40 million per year into the state's new reinsurance program, which has been credited with reducing health coverage premiums in the individual market by 20 percent. The $40 million contribution makes hospitals the largest source of state revenue for the program.

These are but a small handful of examples of the ways in which hospitals are seeking to reduce healthcare costs, which is why the initial draft of the public option was so underwhelming. The state appears to be targeting hospitals disproportionately. There are more comprehensive approaches available and I encourage the state to scrap this version and pursue them.

Signed,

Adrianna Jones

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

Please use this form to submit your comments on the draft HB19-1004 report. All comments will be logged and added as an appendix to the final report. We will accept comments until October 28.

Helpful Links:
- The draft report can be found here: http://www.colorado.gov/pacific/sites/default/files/HB19-1004%20Draft%20Report%20Colorado%20State%20Coverage%20Option%20and%20Appendix.pdf
- The bill text can be found here: https://leg.colorado.gov/sites/default/files/2019a_1004_signed.pdf
- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Albert Nemes

County (in which you reside) *

[redacted]

Organization *

Retired - 42 Years at Lockheed Martin

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No - It is another attempt by the Democrats to take over health care and cut off our options. This is not Coloradans' concerns, it is an attempt by democrats to force their healthcare agenda on us.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Don't know. Hard to understand what it really means, other than more government bureaucracy.

Does the proposal include worthwhile benefits for consumers?

Cutting off my healthcare selection options and forcing a government run healthcare program is not a worthwhile benefit for us.

Does the proposal create a product that is financially stable and sustainable?

Only time would tell. History says the government is terrible at managing programs and this will be another proof of that.

Other thoughts? Please list them here.

1. Government price controls that are needed to facilitate below-market premiums offered by a state option likely do not cover the full costs of care, and therefore the reduced reimbursements to health care providers could range from $494 million up to $1.4 billion.
2. The state option could cause a potential loss of 1,500 to 4,500 health care workers across Colorado, exacerbating the state's existing shortage of primary care physicians, nurses, and other health care providers.
3. If lost revenues from the state option are shifted to employer-provided insurance plans and other private sources, the state economy could lose between 2,900 and 8,320 jobs and $320 million to $919 million in total GDP, as a result of a more than 5% increase in the cost of health care for businesses.
4. An 80% to 100% membership loss could occur in the state's individual health insurance market as people drop private coverage in favor of the state option's below-market premiums.
5. A reduction of 2.7% to 8.3% could occur in the employer-provided insurance market.

So why do the Democrats thin this is a good deal for Colorado?

This form was created inside of State.co.us Executive Branch.

Google Forms

On a personal level, I am gravely concerned about the potentially catastrophic implications this Bill has on complex, unique healthcare services. My father, Ed, was diagnosed with Central Nervous System Lymphoma (think blood cancer but in his brain, very rare) in 2016. He lived in Richmond, Virginia and underwent many rounds of chemo. After 3 years on and off chemo, we were advised that a bone marrow transplant may be his best shot at kicking the cancer for good. The academic medical center he was getting care with in Richmond was not a Blue Cross Blue Shield Center of Distinction for Bone Marrow Transplant, however, Presbyterian St. Luke's in Denver was. This was an important part of the decision making process as it's a testament to the high quality of care and BCBS covers a greater percentage of the bill if you go to a Center of Distinction hospital.

After much deliberation, my Dad decided to move to Denver for 5 months to undergo treatment. At first, he lived in a hotel in Glendale, which is reimbursed by insurance, then the hospital for quite some time during and after the transplant, then back to the hotel, then a rehabilitation hospital. I tell you this story because a Bone Marrow Transplant is an incredibly unique, expensive, and risky service to undergo. If reimbursement to hospitals is cut, like this Bill proposes in order to subsidize premiums to consumers, niche programs like Bone Marrow Transplants will suffer. If hospitals cannot cover the cost of care, forcing them to operate at a deficit, highly qualified physicians and staff will flee Colorado for states with more supportive regulations. If we lose our talented physicians and staff, the quality of our programs will deteriorate. Then, insurance companies like Blue Cross Blue Shield will be less likely to rank our services as Centers of Distinction and patients will stop traveling to Colorado hospitals for care. In an economic sense, Colorado benefitted greatly from my Dad's decision to receive care in Colorado- we put money into the local economy including but not limited to the hotel he stayed at for over 100 days, the surrounding grocery stores and shopping, and the prescriptions he filled. Medical tourism is the current reality of American culture because when you or a loved one undergo a high risk, life altering treatment, you will travel for exceptional care! Colorado benefits greatly from medical tourism within the United States and also many who travel from other countries. If we compromise reimbursement to hospitals, we compromise our ranking as a national leader in quality healthcare.

My Dad's Bone Marrow Transplant at Presbyterian St. Luke's Medical Center saved his life. As painful and overwhelming the process was for him and our family to go through, we would do it all over again because of this outcome and the trusted treatment we received from the Colorado Blood Cancer Institute physicians. Please consider the rare specialties like blood and organ transplant as you are evaluating this Bill and the detrimental impact it will have on Colorado's ability to provide lifesaving interventions to our patients.

If you would like to learn more about my story and opposition to this Bill, feel free to reply.

Thank you,
Alexandra Hoffman

October 25, 2019

Commissioner Michael Conway
Colorado Division of Insurance
1560 Broadway, Ste 110
Denver, Colorado 80202

Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant Street
Denver, Colorado 80203

Submitted via email at: HCPF_1004AffordableOption@state.co.us

Re: Comments on the Draft Report for Colorado's State Coverage Option

Dear Commissioner Conway and Director Bimestefer:

Thank you for this opportunity to comment on the Draft Report for Colorado's State Coverage Option. We so appreciate your attention to kids' priorities and stakeholder engagement in this process. All Kids Covered (AKC) supports the creation of a State Coverage Option and is encouraged by the work that has been completed so far. We support many aspects of the report and have a few recommendations to strengthen the plan for children and families in Colorado.

All Kids Covered is a non-partisan coalition working to improve the well-being of Colorado's children through health care coverage. Since the fall of 2006, All Kids Covered has worked with policymakers, service providers, and other stakeholders to fight for comprehensive health coverage for all Colorado kids. The coalition has had dramatic success: the percent of kids without health insurance has plummeted from 14 percent in 2008 to about 4 percent in 2015, but Colorado has not seen a measurable improvement in the rate in the last few years. An estimated 62,000 of Colorado's children age 18 and younger remain uninsured. As you know, health insurance coverage improves financial security, health status, mental health, and access to care, and decreases infant, child, and adult mortality. Kids with health insurance coverage are less likely to drop-out of high school, more likely to finish college and have higher incomes as adults. **We must ensure all children in Colorado have access to high quality, affordable, continuous health insurance.**

Ensuring access to health insurance
AKC strongly supports offering state option plans both on and off the exchange and making coverage available to all Colorado residents. We specifically support the proposals to require specific outreach to families of children who use the Child Health Plan *Plus* (CHP+) for their health insurance, and dedicated efforts to reach out to individuals who speak languages other than English.

As planning moves forward, we recommend that the Department consider implementation of the plans to ensure their availability for all Colorado residents. Specifically, we request that a Social Security number not be required to enroll in coverage and that the Departments clearly articulate commitments to and assurances of data security. The State Option plan carriers and providers should be required to build strong protections with strict firewalls that prohibit sharing information across systems and agencies for **non-health purposes.** User's information should never be shared with any federal or state authorities without proper legal jurisdiction and due process.

Ensuring high quality coverage

AKC strongly supports requiring public option plans to include a greater set of high-value primary and preventive care services pre-deductible. We specifically support requiring the provision of behavioral health services pre-deductible. Pediatric dental services (a required essential health benefit) must be available pre-deductible in order to ensure access to this critical health service.

Recognizing the critical role of health care during pregnancy and childhood, we suggest that benefits for pregnant people and children be at least as generous as those in the Colorado's Child Health Plan *Plus* (CHP+), with similar cost sharing limits. In addition, in order to ensure access to services, we recommend that payment rates be set no lower than Medicaid levels for certain services that are critical during pregnancy and childhood including prenatal and postpartum care and children's preventive services.

We encourage the State to address linguistic and cultural responsiveness of providers within provider networks. For Coloradans that speak a language besides English at home, it is critical to ensure that State Option plan providers and carriers are prepared to offer meaningful translation and interpretation services.

We also support the creation of an Advisory Board. We recommend that the interests of children and families be represented on the Advisory Board by creating permanent seats for parents of children receiving coverage through the plan. In total, consumer appointments should be equal to the number of industry representatives on the Board. Consumer appointments should represent a diversity of geographies, race and ethnicities, ability, and income levels (including both subsidized and unsubsidized representation). Consumer Advisory Board members should be compensated for their time and expertise and any other costs incurred as part of their participation, including travel, lodging and any needed attendant or dependent care. Additionally, we encourage the State to give formal authority to the Advisory Board to review and make recommendations or decisions on the state option plan design, including but not limited to affordability standards, payment reform efforts, value based insurance design, quality metrics, and cost and growth benchmarks. In order to ensure these recommendations or decisions are well-informed, the Advisory Board should have access to any needed data and analysis. Therefore, we recommended funding one or more FTE to serve the Board members with project management and coordination of stakeholders as needed.

Ensuring that coverage is affordable

AKC strongly supports the use of any additional federal resources under a waiver being prioritized to increase affordability for families in the "family glitch."

However, AKC has concerns with the overall impact of the public option plan design on premium tax credits. We are concerned that the projected reduction in premium rates will also reduce the benchmark plan premium (second lowest cost silver plan), which is the plan that premium tax credits are based upon. The unintentional effect of this change will reduce the purchasing power of the subsidies for those that are eligible, especially those that qualify for cost sharing reduction plans. The Department must adjust the proposal to protect the purchasing power of the population that receives tax credits on the exchange without relying on a federal waiver.

Sincerely,

Leadership Team of All Kids Covered
(Colorado Children's Campaign, Colorado Covering Kids and Families and Colorado Consumer Health Initiative)

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

Please use this form to submit your comments on the draft HB19-1004 report. All comments will be logged and added as an appendix to the final report. We will accept comments until October 28.

Helpful Links:
- The draft report can be found here: http://www.colorado.gov/pacific/sites/default/files/HB19-1004%20Draft%20Report%20Colorado%20State%20Coverage%20Option%20and%20Appendix.pdf
- The bill text can be found here: https://leg.colorado.gov/sites/default/files/2019a_1004_signed.pdf
- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Amanda BristolSwanson

County (in which you reside) *

[redacted]

Organization *

Valley Wide Health System

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

Yes

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

I'm not sure. That depends on if providers can afford to take it.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Probably.

Does the proposal include worthwhile benefits for consumers?

Yes but only if most providers accept it.

Does the proposal create a product that is financially stable and sustainable?

Probably

Other thoughts? Please list them here.

The biggest hurdle I see is providers accepting it or not. It will pay less than private insurance and if it has more “value based” reimbursement, it may have more paperwork. These types of reimbursement models often are not meaningful in terms of how patients are actually cared for, but measure how well the EMR and check boxes are cared for. This is not a recipe for providers wanting to join. As both a physician and a market place insurance consumer, I am deeply concerned that if the pay is less and the paperwork is greater or even equal to private insurance there will be large groups of people that at can afford the insurance, but still can’t access care.

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To whom it may concern,

With regard to state rate-limiting for hospitals, I urge you to consider the following:

- Cutting reimbursement rates will only threaten the quality of care we can provide and limit access to healthcare across our state. If below-cost reimbursement rates expand even further in Colorado, providers will have no choice but to cut services, staff and possibly close their doors altogether. Ultimately, patients will have less access to quality care, not more, and our state will be the worse for it.

- We believe our patients deserve better and therefore our policymakers must do better. State officials need to slow this process down, focus on the facts and develop responsible policies that address the cost of healthcare insurance while also preventing unintended consequences – including staff and service reductions at Colorado hospitals.

- Some organizations are pressuring the administration to use Medicaid reimbursement rates, for example, which currently pay just 69 cents for every dollar of care provided. As you know, Colorado hospitals are already grappling with a major expansion of below-cost reimbursement rates, mostly due to a major expansion of the Medicaid program.

- Hospital professionals support the goal of universal healthcare coverage. To make this coverage more affordable, we work hard to find savings within our operations. We also make investments that will bring down costs, including programs that address the shortage of primary care physicians in Colorado and a $40 million per year contribution from the hospital sector to the state's new reinsurance program.

- Hospital professionals want to reduce the cost of insurance coverage, which has skyrocketed in recent years. But health insurance and healthcare are not the same thing and cutting payments to the dedicated professionals who actually provide healthcare in Colorado is not a real answer.

In short, if you or a loved one need an trauma surgeon, neuro surgeon or other highly complex surgery in the middle of the night, you don't need to worry about access to such services today. With rate-setting, you will. We all will.

Amberly Stringer

COLORADO CHAPTER
American College of Emergency Physicians
ADVANCING EMERGENCY CARE

Colorado ACEP
10465 Melody Dr., #101
Northglenn, CO 80234

(303) 255-2715
(fax) (303) 255-2704
E-mail: bburgess@estreet.com

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EXECUTIVE DIRECTOR

Barb Burgess

October 28,2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203
Submitted electronically: kim.bimestefer@state.co.us

Commissioner Michael Conway
Division of Insurance
1560 Broadway, Suite 110
Denver, CO 80202
Submitted electronically: Michael.conway@state.co.us

RE: Recommendations for HB19-1004's State Coverage Option

Dear Executive Director Bimestefer and Commissioner Conway,

I write you on behalf of the Colorado Chapter of the American College of Emergency Physicians (COACEP) who cares for all patients, 24/7/365, regardless of their ability to pay or insurance status. Emergency physicians are proud to care for all, it is both our **moral calling** and part of federal EMTALA mandate. We work in rural and urban communities, large hospitals with the latest most advanced technology as well as small hospitals and freestanding Emergency Departments (EDs) that operate with minimal technologies available.

We are currently **neutral** to the Colorado State Coverage Option as published October 7, 2019. We are eager to know more about how this will be implemented and the potential ramifications of adoption of a public option prior to making a decision, based the potential benefits

and harms to our patients and emergency care system prior to either supporting or opposing the public option.

COACEP shares your motivation to improve health care transparency, affordability, and coverage for the citizens of Colorado. **The ambiguity in the draft prohibits us from clearly understanding the final impact.** However, from our reading we want to voice the following **concerns**, which we hope you will address.

- We have been assured that the public option applies to facilities only and recommend that in the next draft **"provider rate" be clarified** as applying only to facilities and not physician professional services.
- We are concerned about the practice of rate setting and believe rate setting is a dangerous and arbitrary process which may have the unintended consequence of limiting emergency care available to Coloradans.
- Hospitals are partners in providing care, but they also operate as businesses, often with shareholders. Decreases in profits will likely cause insolvency for many low margin service lines such as high-risk OB, burn surgery, etc. **Lower reimbursement for hospitals may result in termination of service lines and closure of small hospital** and freestanding emergency departments (FSEDs) that provide critical access to Coloradans.
- COACEP is concerned that even if hospitals or services are not completely lost, that **hospitals will likely cut clinician staff**, environmental service staff or other essential personnel that are key to the efficient functioning of hospitals and provision of patient care. If this occurs patients will wait longer and experienced compromised care.
- We are concerned that if a public option is poorly implemented and coupled with recent out-of-network legislation, that sets rates for physicians providing emergency services, will be a detriment to Colorado's ability to recruit and retain highly trained emergency physicians and specialists. **This will further risk Colorado patients access to necessary care.**
- **COACEP favors market-based solutions over rate setting as proposed in this draft**.

After querying our members, there were **recurring thoughts and questions** which we ask are publicly addressed prior to moving forward. These include:

- We applaud efforts to make insurers spend more of their profits on patient care, but the draft lacks a requirement that **carriers pass savings on to their insured/patients**.
- While there is an appropriate focus on the cost savings on primary care, it is important to remember that when a patient cannot go to their primary care provider during

regular office hours, the patient calls their primary care provider's office and is redirected to the emergency room or it is after hours, or a holiday, **the delivery of primary care falls upon the emergency physician** to provide. By federal law, emergency physicians are prohibited from redirecting those patients back to their PCP.

- **How many Coloradoans will be eligible** for this program?
- Is there a requirement that **those accessing this program be Colorado citizens**?
- What is there in the draft to **prevent uninsurable, chronically ill patients from coming to Colorado** to access this program which will inevitably increase health care costs?
- What assurances are there that **participation in this program will remain voluntary to physicians**? How will **network adequacy** requirements be enforced? There is an implicit threat in the Draft that the State will compel hospitals to participate.

With consideration to all of the above Colorado ACEP urges the Colorado administration and the Colorado State Legislature to **address these questions and concerns prior to moving forward with the proposal**. Additionally, there has not been enough time since the publication of this Draft and the deadline for feedback to allow Colorado citizens the opportunity to comment. We again urge you to **slow down** this process and **flush out the details** prior to moving forward.

Respectfully submitted,

Donald Stader, MD

Donald Stader, MD, FACEP
President
Colorado Chapter, American College of Emergency Physicians

America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite Five Hundred
Washington, DC 20004

October 28, 2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Commissioner of Insurance Michael Conway
Division of Insurance
1560 Broadway, #110
Denver, CO 80202

RE: Comments Regarding the Draft Report for Colorado's State Coverage Option

Dear Director Bimestefer and Commissioner Conway:

I write today on behalf of America's Health Insurance Plans (AHIP)[1] to provide feedback on behalf of our member companies regarding the draft report for Colorado's State Coverage Option. We appreciate the opportunity to comment and look forward to working with the Department of Health Care Policy and Financing (HCPF) and the Division of Insurance (DOI) to find the best path forward to provide access to affordable health care to all Coloradans.

As the draft report recognizes, our members have the knowledge and infrastructure to achieve the best value for their enrollees. We applaud the DOI and HCPF's willingness to address plan affordability while protecting market stability. We are similarly appreciative of the draft proposal's contemplation of the incorporation of innovative, value-based payment reforms. Our members have been leaders in developing payment arrangements that align reimbursement with enhanced quality.

However, we have significant concerns regarding several other aspects of the proposal. We believe that the draft proposal will not meet the state's goals of improving affordability, access, plan choice, and competition. The implementation of a coverage option, as proposed, would actually decrease competition, innovation, and choice overall as well as reduce the total federal premium subsidies available for Colorado consumers. We appreciate the state's effort to address

[1] AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers. Our members provide a range of products to millions of consumers, including major medical coverage, disability income insurance, dental insurance, LTCI, reinsurance, pharmacy benefits, and administrative services for self-funded health plans.

affordability, and we want to work with the state to develop policy alternatives that will further bolster market stability, increase coverage rates, and improve overall affordability. To that end, we offer the following feedback on several of our concerns.

Mandated Carrier Participation Will Have an Adverse Effect on all Aspects of Colorado's Health Insurance Market

Overall competition in Colorado's individual market is strong; however, mandated participation runs the risk of destabilizing the market by making continued participation in Colorado's market less sustainable for some plans and less feasible for plans that may otherwise wish to enter. Each individual plan is in the best position to decide if its financial and market position can sustain adding a state option plan offering to its existing offerings. Our members have spent years pursuing strategies to enable them to compete in the regions in which they operate, and to address the needs of consumers within those regions. This proposal would undercut those efforts. It would require carriers to go beyond areas of traditional experience and expertise to invest in networks and services in new areas and develop strategies to address consumer needs that they may not be familiar with. All of this would entail significant costs. While the thresholds for mandated carrier participation in the state option plan have not yet been established, we are concerned this proposal may have significant unintended consequences, including reductions in market participation and significant added cost.

Additionally, we are concerned that the proposed state plan offering risks creating an unlevel playing field. Fundamentally, compelling participation — especially into new markets and regions — risks creating market disruption and the reduction of consumer choice in Colorado — exacerbating a problem which the state option proposal seeks to remedy.

Capped Reimbursement Rates Reward Volume Over Value and Risks Destabilizing the Non-State Option Markets

Adding products to the market that include price controls on health care providers poses a danger to both choice and competition in the individual market. The well-documented phenomenon of cost-shifting makes it likely that consumers of non-state option plans will bear the cost of the rate reductions mandated in the state option plans. This will likely to raise prices for consumers of those plans and threaten the viability of such plans going forward.

The combination of these factors is likely to create a textbook example of an unlevel playing field, with state option plans having the advantage of government-controlled rates, and the non-state-option plans bearing ever higher costs shifted by providers away from such plans. For consumers to benefit from choice and competition, there needs to be a level playing field for all

carriers in all markets who want to offer products to individuals and families purchasing coverage.

The market damage caused by capped reimbursement in the state option plans will not be limited to the individual market. Higher reimbursement rates charged by facilities and providers seeking to shift lost revenue will place upward pressure on premiums for small and large employer groups, and self-insured plans — where the vast majority of the state gets coverage. Any health care solution, including the state option plan, should not increase rates for those remaining in individual, small group, large group, or ERISA plans.

The state option plan discusses the need for carriers to utilize value-based payments to reward providers who achieve quality and pricing targets. AHIP supports improving quality through value-based payments. However, under a Medicare-linked capped reimbursement model, there is no room to negotiate or reward quality because the payment rate is linked to a fee-for-service methodology. A capped rate in a fee-for-service system, as this option proposes, drives up overall health care costs while at the same time leaving no room to provide the right incentives to improve quality of care or lower overall costs. This is not mere conjecture as we have seen this in other markets. For example, in the state of Montana:

> *Montana's State Employee Plan implemented a flat-fee pricing methodology for medical services at a payment rate of approximately 234% of Medicare rates for reimbursement of hospital claims and the majority of hospitals in the state contracted to accept this rate.[2] This policy initially resulted in savings for the state plan. However, in the years since the state plan implemented this reimbursement model, costs have continued to rise. Overall, 2018 resulted in a $2.3 million loss and plan expenses are expected to exceed revenues in 2020 and 2021.[3] Per member per month (PMPM) spending on medical claims in 2018* ***increased by 11.2%*** *over 2017.[4] These increases in medical cost trend for the state plan are in stark contrast to the national medical cost trend, which has remained steady at 5.7% in 2018 and 2019.[5] Additionally, the average high cost claim was approximately* ***$235,000, which is higher than the previous 6 years' average****.[6]*

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[2] NAIC Health Innovations (B) Working Group 2019 Summer National Meeting, page 35. August 3, 2019. Available at https://www.naic.org/meetings1908/cmte_b_health_inn_wg_2019_summer_nm_materials.pdf.
[3] State of Montana Employee Group Benefits Advisory Council Meeting Minutes, May 22, 2019, page 3.
[4] State of Montana Employee Group Benefits Advisory Council Meeting Minutes, March 28, 2019, page 2.
[5] "Medical cost trend: Behind the numbers 2020," page 3. June 2019. PricewaterhouseCoopers' Health Research Institute. Available at https://www.pwc.com/us/en/industries/health-industries/assets/pwc-hri-behind-the-numbers-2020.pdf.
[6] State of Montana Employee Group Benefits Advisory Council Meeting Minutes, May 22, 2019, page 3.

While more is to be learned to fully understand the Montana story, it is clear that simply capping rates has not resulted in long-term savings. Given the critical nature of assuring the lowest cost and highest quality care be available to Colorado residents, we are deeply concerned that a similar fact pattern would result from the proposed state option.

Raising the Medical Loss Ratio (MLR) Could Raise Costs and Reduce Vital Consumer Services

The Affordable Care Act (ACA) included requirements for carriers to spend 80 cents of every premium dollar in the individual market on medical care and quality improvement activities. The ACA's MLR requirements are working, and consumers have benefited from MLR rebates in instances when a carrier does not meet the required MLR threshold. Carriers are also required to meet state and federal regulatory requirements and provide important consumer services that improve customer care – nearly all of which are not counted as medical care under the MLR.

Examples of these "administrative costs" include (varies by market segment):

- Network engagement with provider recruitment and retention, negotiations with doctors, hospitals, and pharmaceutical companies, and timely payment of claims;
- Customer services, including call centers, interactive websites, mobile apps, cost transparency tools, provider directories, medical interpreters, and translation services;
- Clinical experts to ensure patients receive evidence-based care and cost-effective treatments, 24/7 nurse advice lines, and Pharmacy & Therapeutics Committees to review drug safety and use; and
- National certifications and accreditations (NCQA, URAC, etc.), quality reporting, regulatory audits and surveys, and other regulatory requirements such as rate filings, annual reports, actuarial analyses, and fraud, waste, and abuse prevention, detection, and correction.

Recognizing that, on average, only 2.7 cents of every premium dollar goes to net profit,[7] carriers would still be required to meet all their statutory obligations under a higher MLR. Premium rates must be actuarially sound and account for total health plan spending. Raising the MLR does not automatically equate to lower overhead costs, it just changes the ratio between the delivery of medical care and the amount available to provide high-quality customer service, meet accreditation and regulatory requirements, and meet state mandated solvency requirements.

[7] "Where Does Your Premium Dollar Go?" America's Health Insurance Plans. March 2, 2017. Available at https://www.ahip.org/health-care-dollar/.

Additionally, federal regulations require states to demonstrate why a lower MLR would be necessary for market stabilization, but they also require states seeking to enact a ***higher*** MLR to demonstrate the need for and impact of such a change:

> *In adopting a higher minimum loss ratio than that set forth in §158.210, a State must seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.*[8]

As drafted, we do not believe the state option meets these prerequisites. By making it more difficult for carriers to perform their required administrative functions, this proposal discourages, rather than encourages, innovation, competition, and choice. We strongly urge the state to maintain the MLR requirements outlined in the ACA.

The Underlying Drivers of Health Care Costs Need to be Adequately Addressed

Rather than capping the reimbursement rate to certain providers, the state's solutions should focus on the underlying cost drivers and market dynamics driving premium increases — prescription drug pricing, third party payments, monopolistic market behavior — including hospital acquisition of provider practices and provider consolidation, and other tactics that game the system to drive up costs. For example, recent research has shown that there is a correlation between increased provider and facility consolidation and integration and higher prices for physician and hospital services.[9] In addition, private equity firms are implementing business strategies to consolidate physician groups to generate higher revenue through market consolidation and aggressive contracting tactics.

Most importantly, this proposal ignores the single largest driver of health care costs – prescription drug prices. Nationally, prescription drugs represent the largest segment of commercial health care spending, making up more than 23% of commercial premiums.[10] These recommendations have no levers aimed at lowering the prices that drug makers set, which continue to increase year over year. There are no requirements on drugmakers to do anything under these proposals to be accountable for the prices they set. Regulating drug prices or cost-sharing through health plans or their PBM partners will not bring down prices, and in fact could increase drug prices and their impact on premiums.

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[8] 45 C.F.R. § 158.211

[9] Polyakova, Maria, M. Kate Bundorf, Daniel Kessler, and Laurence Baker. "ACA Marketplace Premiums and Competition Among Hospitals and Physician Practices." The American Journal of Managed Care, February 2018. Available at https://www.ajmc.com/journals/issue/2018/2018-vol24-n2/aca-marketplace-premiums-and-competition-among-hospitals-and-physician-practices.

[10] "Where Does Your Premium Dollar Go?" America's Health Insurance Plans. March 2, 2017. Available at https://www.ahip.org/health-care-dollar/.

There are a number of alternative approaches that could more efficiently and directly address rising health care costs. For example, Colorado has already joined with private entities to address costs. Colorado's community-based purchasing alliance will be offering plans for the first time in 2020. Additionally, the state has been promoting an employer-based purchasing alliance, an effort that is in its infancy. AHIP's members are not necessarily endorsing these approaches, but we have yet to see the full impact of these programs and would urge the state to allow time for such programs to take effect before implementing anther significant reform. We are concerned that any positive gains achieved by these programs may be jeopardized by the implementation of a state option.

To tackle access and affordability issues, we need to build upon what works in Colorado and expand choice and competition through free-market solutions. For example, we know that well-crafted reinsurance programs can help stabilize the individual market. Colorado's newly implemented reinsurance program is being credited with lowering premiums for plan year 2020 by an average of 20.2% across Colorado. We must also seek to address the drivers of unit costs and overall consumer out-of-pocket costs, which increasingly create a barrier to accessing care. We look forward to working with the state on opportunities to address these affordability concerns without compromising market stability and consumer choice. To that end, we offer the following proposed solutions to lower premiums.

These proposals are adapted from a comprehensive list of 12 proposed solutions[11] supported by our members, and are based on three tested and proven methods for driving down the costs of premiums for consumers: reducing the cost of health care, offering premium savings to consumers, and increasing enrollment and retention to balance the pool of enrollees in the insurance marketplace.

The proposals in which Colorado policymakers can play a role include:

- **Reduce Surprise Medical Billing** by protecting patients from surprise medical bills and preventing unnecessary premium increases related to out-of-network care. The Colorado Legislature recently adopted surprise medical billing legislation that has not been fully implemented. This measure will save consumers money and bring predictability to carriers and consumers when fully implemented.
- **Curb Inappropriate Third-Party Premium Payments** by limiting the list of third-party entities from which carriers must accept premium and cost-sharing payments. Colorado

[11] "12 Solutions to Lower Premiums for Hardworking Americans Who Buy Their Own Coverage." America's Health Insurance Plans. November 2018. Available at https://www.ahip.org/wp-content/uploads/2018/11/AHIP_AffordabilityWorkgroup-111518.pdf.

may also prohibit the use of copay coupons for brand-name drugs if there is a less expensive, equally effective alternative. These marketplace schemes seek to increase overall health care costs, thus increasing premiums for all.

- **Increase Drug Competition and Transparency** by requiring manufacturers to publish true R&D costs and explain price setting and price increases.
- **Create a State Premium Assistance Program** for individuals and families earning more than 400 percent of the federal poverty level.

AHIP shares your goals to make health care more affordable for Colorado residents. However, government rate setting, MLR adjustments, and mandatory participation are not solutions to address the underlying costs of health care in the state. Our members stand ready and eager to work with policymakers and other stakeholders to inform policy approaches to make coverage more affordable, but such efforts can and should be done in a way that strengthens the market and does not pose the risk of higher costs to consumers.

We appreciate this opportunity to comment and welcome the opportunity to remain engaged as this proposal is developed. Please contact Leanne Gassaway at lgassaway@ahip.org or (202) 861-6365 if you have any questions or concerns.

Sincerely,

Leanne Gassaway
SVP, State Affairs and Policy

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

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- The bill text can be found here: https://leg.colorado.gov/sites/default/files/2019a_1004_signed.pdf
- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Andrea Fields

County (in which you reside) *

[redacted]

Organization *

Self

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

No

Other thoughts? Please list them here.

The market is broken because politicians and insurance companies keep manipulating it. If you want to fix the cost of health care, stop messing around and publish costs.

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- The bill text can be found here: https://leg.colorado.gov/sites/default/files/2019a_1004_signed.pdf
- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Anita Connors

County (in which you reside) *

[redacted]

Organization *

N/A

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

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Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No.

Does the proposal include worthwhile benefits for consumers?

No.

Does the proposal create a product that is financially stable and sustainable?

No.

Other thoughts? Please list them here.

The more the government is involved in our health care, the more expensive - and of less quality is - the care.

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“The hospital I work for provides liver transplant services and Level IV neonatology services to patients from across the region. As you can imagine, the service is expensive to administer because we need highly specialized nurses and physicians, cutting edge technology and equipment, and rare medications to give our patients the very best care. I am concerned because the proposed Bill for state-run health insurance would cut reimbursement to hospitals like mine who provide critical but often times expensive services. If the new state-run plans reimburse below the cost to provide care, like Medicaid and Medicare payments, the quality of care in Colorado will be threatened. Imagine, if we cannot cover our cost to provide the liver transplant or Level IV neonatology services, Colorado hospitals may be forced to reduce staff, discontinue certain treatment options, or close services altogether because we simply cannot afford it. Highly-skilled physicians may leave our state because it is not a viable option to practice medicine here. Patients may flee Colorado to seek care in a state with more comprehensive programs. Our patients and healthcare professionals deserve responsible policies that will improve healthcare. HB 19-1004 is not the solution.”

Anna Modic Davis, MBA-HCM

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

Please use this form to submit your comments on the draft HB19-1004 report. All comments will be logged and added as an appendix to the final report. We will accept comments until October 28.

Helpful Links:
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- The bill text can be found here: https://leg.colorado.gov/sites/default/files/2019a_1004_signed.pdf
- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

[redacted]

County (in which you reside) *

[redacted]

Organization *

Self

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

No

Other thoughts? Please list them here.

Please stay out of healthcare. Government does not run anything efficiently nor effectively

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Google Forms

Anthem

October 25, 2019

Commissioner of Insurance Michael Conway
Division of Insurance
1560 Broadway #110
Denver, CO 80202

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Re: Draft Report for Colorado's State Coverage Option

Dear Commissioner Conway and Director Bimestefer,

On behalf of Anthem Blue Cross and Blue Shield (Anthem), I am writing in response to your request for comments from interested stakeholders on the Draft Report for Colorado's State Coverage Option issued by the Colorado Division of Insurance (DOI) and Department of Health Care Policy and Financing (HCPF). Anthem appreciates the opportunity to comment on this important set of policy issues.

For more than 80 years, Anthem has been committed to the Colorado market. To underscore ongoing commitment to Colorado, we are the only insurer offering individual coverage in every county across the state, and as stated in the draft report, in 2020, we will also be the only insurer that will be offering individual coverage in 22 of Colorado's counties. We share your concern that individual state residents in certain counties have limited choices and that the average premium for an individual member is over $600 per month for those without subsidies, over $300 for those with subsidies in 2019[1], and up to 40 percent higher in higher-cost regions.

<u>The Challenge of Hospital Costs and Anthem's Efforts to Address Them</u>

Importantly, the draft report focuses on hospital costs as a key and significant factor in determining premiums. In Colorado, approximately 55 percent of Anthem's individual market's benefit payments are paid to hospitals.[2]

For all market segments, hospital prices in Colorado have been driven by an environment where a handful of hospital systems dominate key regions and have significant negotiating leverage over payers. Three hospital systems now represent approximately 70 percent of Anthem's expenditures for facilities, and in several regions, hospital systems have a monopoly or near-monopoly market position that they use, as described below, to leverage higher payments across their entire system.

A large share of physicians (particularly in the critical specialty areas such as cardiology, orthopedics, and oncology) are also now employed by hospitals, increasing the price of their services. After a hospital

[1] Average premium level for all Individual insurers based on market-wide risk adjustment reporting.
[2] Anthem's Unified Rate Review Template filing for the 2020 benefit year projects that approximately 55 percent of our total expenditures for members' medical care will come from Colorado hospital providers.

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acquires a physician group, it is not unusual for the cost of a service provided by the same physicians to multiply by a large factor when services get shifted to a hospital site-of-service.

Hospitals do not just use this leverage to negotiate higher prices for services at a specific facility. Some will also require insurers to negotiate prices for their entire system across the State on an "all or nothing" basis, leveraging a monopoly position in just one region to drive prices up across the State. This puts insurers in the untenable position of either losing the provider and potentially having to pay billed charges, or withdrawing from a region and cancelling their consumers' coverage, or meeting the hospital demands and raising the cost that consumers and businesses pay across the State.

Hospital systems also use their leverage to require contract terms that further increase costs for consumers, including those that:

- Allow the health system to extend their contract terms to any acquired hospital/provider – which creates a situation where the health system can buy up other pieces of the insurer's existing network;
- Include the entire hospital system in the top tier of any tiered network, irrespective of quality;
- Prohibit changes to medical management programs without the hospital system's permission; and
- Do not require the hospital to notify the insurer of any changes to its services or locations.

Despite a challenging contracting environment, Anthem deploys a number of programs that aim to drive value and improve health outcomes. Specifically, in Colorado:

- We have 70 percent of our provider payments (and 83 percent of our in-network primary care physicians) in the commercial market tied to value, which includes shared savings, shared risk, capitation, and bundled payments that all create an incentive for efficiency and improved health outcomes;
- We have created a high-value network in our individual products called "Pathway" and a network in eight mountain communities called "Mountain Enhanced" that can result in premium savings of greater than 10 percent as compared to the broad Preferred Provider Organization network;
- We work closely with the hospitals in the mountain and rural areas to ensure patients have access to care in those regions;
- We have a number of programs aimed at ensuring patients receive the right care at the right time in the appropriate setting, including the use of targeted analyses to ensure that patients are directed to lower-cost ambulatory surgical centers instead of hospital outpatient departments, when appropriate; and,
- A related an important initiative seeks to reimburse outpatient services at a set rate regardless of the site of service that reflects the availability of lower-cost settings.

Anthem has also been actively advocating for policy changes in Colorado to help lower costs for consumers, including:

- Anthem supported the reinsurance program enacted this year that is projected to lower 2020 premiums by over 20 percent on average;
- Anthem supported the surprise billing legislation enacted this year that bans surprise medical bills and establishes a market-based reimbursement benchmark for out-of-network services provided at in-network facilities; and,

- Anthem supported the legislation enacted in 2018 that requires off-campus, hospital-owned facilities to submit claims with a National Provider Identifier separate from the hospital's provider number, which provides greater transparency into the charges from off-campus facilities and helps identify savings opportunities.

Proposed State Option is an Overly-Complicated Approach to Address Cost Drivers

While Colorado policymakers importantly focus on cost drivers, the proposed approach in the draft report—to create a new sub-market within the individual market with additional regulation—is an overly-complicated framework to try to mitigate this challenge. The following are challenges we have identified with the concept in the draft report to create a State Option market:

Mandating Insurers Participate in Market

The proposal in the draft report would mandate insurers with an (unspecified) market share to participate in the State Option market. Such a mandate:

- **Removes the flexibility for insurers to determine where they can successfully offer coverage and thereby jeopardizes the stability of that coverage:** Insurers are attracted to any market that is structured to function well and facilitate competition for the benefit of consumers. If an insurer has determined they cannot successfully offer coverage in an area, mandating that they participate does not resolve the challenges that led them to make that decision; to the contrary, it invites potential network inadequacy issues and higher prices for the insurer's consumers to the extent networks need to be adjusted.
- **Could result in the market being over-saturated with insurers unable to cover fixed costs due to limited enrollment:** If the mandate results in the market being over-saturated with too many insurers covering a pool of consumers that is too small, insurers may not enroll enough consumers to fully cover fixed administrative costs in those markets, yielding market inefficiencies and losses that would need to be addressed by higher rates.
- **Invites cross-subsidization between market segments:** In Anthem's experience in other states, mandates to participate in a specific market segment as a condition of being in another segment go hand-in-hand with an expectation that the insurer lose money in the mandated market with cross-subsidization from other markets. Such an outcome runs contrary to insurance regulation and actuarial principles that require actuarially-sound rates and that each market be able to operate on its own.
- **Does not address that some insurers are locked-out of the individual market under federal law:** The federal Health Insurance Portability and Accountability Act (HIPAA) includes a lockout provision that requires any insurer that has withdrawn from the individual market to wait five years before it reenters the market. A mandate to participate in the market therefore has the potential to either (1) violate federal law, or (2) result in the mandate inequitably falling on some insurers but not others for no other reason than prior actions.

Higher Minimum Medical Loss Ratio (MLR) for Proposed Market

Under federal law, as a result of the Affordable Care Act (ACA), there is an intentionally-established a lower 80 percent MLR requirement for the individual and small group markets to reflect the higher costs associated with serving these markets as compared to large employers (where the requirement is 85 percent). A higher MLR for the State Option within the individual market would inhibit spending on administrative costs in a number of areas that are good for consumers, such as:

- Fraud prevention;
- Enrollment efforts to expand coverage;
- Digital tools for consumers, including cost transparency tools and provider directories;
- Provider network innovations;
- Customer services, such as call centers and nurse advise lines; and,
- Pharmacy & Therapeutics Committees to review drug safety and use.

In addition, state and federal regulations limit how rates can vary within the individual market between products (e.g., rates cannot vary due to different administrative expenses or profit expectations). Having separate MLR standards within the market segment would conflict with existing rating requirements.

Additional Benefit Requirements

Anthem supports value-based benefit design and other concepts proposed in the draft report. However, standardized benefits are likely to add costs and reduce innovation. Working within the standards established by the ACA, insurers have developed and continually improve upon coverage options and innovative benefit designs to meet the needs of consumers with varying health and financial situations. This balance – between a minimum set of standards and benefit design flexibility – promotes choice and innovations that can improve health outcomes.

Based on Anthem's experience in other states, the following are examples of how standardized benefit designs create barriers to benefit innovation that is good for consumers:

- Inhibiting tiered networks for providers or pharmacies (where insurers differentiate in-network providers and use digital tools to show consumers the cost advantage associated with selecting a high-value provider) because the cost-sharing may vary in ways not allowed by the standardized benefit design; and,
- Inhibiting innovation in value-based benefit design when insurers identify new ways to lower cost-sharing for high-value benefits that are not reflected in the standardized benefit design.

Government-set Hospital Rates

Anthem opposes government rate-setting for providers' rates to reduce costs for the following reasons:

- It forces all providers to be paid the same in order to bring costs down, instead of focusing on health outcomes and quality;
- It undermines innovations that pay for value and health outcomes. For example, it is difficult to conceive how a complicated risk-sharing arrangement with a hospital system that involves shared risk for patient outcomes would work in an environment where the government is mandating a payment rate. The draft report states that insurers should move to value-based payments, but government-rate setting inhibits those innovations; and,
- The approach invites greater cost-shifting to the consumers enrolled other market segments as providers seek to make up any lost revenue from this market.

If policymakers are intent on mandating a framework around hospital rate setting, it would need to be flexible enough to mitigate the challenges noted above.

Alternative Policy Proposals to Lower Costs for Consumers

Instead of the framework outlined in the draft report that creates an overly-complicated sub-market within the individual market, we support a number of alternative public policy solutions that are more directly targeted at reducing the drivers of premium increases and healthcare costs:

Hospital Costs

- **Prohibit hospitals from requiring contract terms with insurers that drive up costs for consumers:** As stated above, hospital systems use their market power to not only drive up payment rates, but also to force contract terms that significantly drive up costs and prohibit payers from managing costs effectively. State law should be changed to:
    - Prohibit contract terms that require insurers to negotiate prices for its entire system across the State on an "all or nothing" basis;
    - Prohibit contract terms that allow the health system to extend their contract terms to any acquired hospital/provider;
    - Prohibit contract terms that require insurers to include the entire hospital system in the top tier of any tiered network, irrespective of whether the providers in their system exhibit high quality;
    - Prohibit contract terms that stop insurers from making changes to medical management programs without the hospital system's permission; and,
    - Require hospitals to notify the insurer of any changes to its services or locations.

- **Require that professional services rendered be billed on a CMS 1500 claim form.** Anthem supports a requirement that professional services be billed on a CMS 1500 claim form and are not reimbursable if they are billed on a UB-04 claim form. The 1500 form has data elements to allow for improved comparisons of costs among providers and will also help streamline payment processes.

Additional Recommendations to Improve Affordability in Individual Market

- **Requiring drug manufacturers to publish the price increases (above the Consumer Price Index) for existing drugs for the following year prior to the deadline for individual market rate filings**. Payers, employers, and governments require plans to establish rates and budgets some 18+ months in advance, while manufacturers adjust prices at any time and frequently. Legislation should be enacted that requires manufacturers to publish information related to price increases with enough lead time for that information to be factored into plans' rates and employer/government budgets.

- **Prohibit manufacturer co-pay coupons:** Because the federal government does not consider the individual exchange market a public program, drug manufacturers are allowed to promote the use of co-pay coupons for consumers. These co-pay coupons drive up costs by inhibiting carefully-designed benefit structures that encourage patients to use generics and higher-value, equally-effective drugs. Additionally, co-pay cards can negatively impact health outcomes; when a consumer uses a co-pay card, those claims may not hit our claims system, creating a loss of data that erodes our clinical programs by limiting insight into utilization metrics that

confirm clinical appropriateness and flag for safety issues. We support banning co-pay coupons in this market consistent with the existing ban in public programs.

Additional Questions

Anthem also raises the following issues in the form of questions that we would be interested in discussing with the DOI and HCPF:

- Does defining "affordability" mean that the DOI would dictate member cost-sharing for all individual market products? How does this "affordability" definition relate to actuarial soundness of rates, regulation of plan design, etc.?

- How would the State Option proposal impact the viability of the small group market to the extent that market gets smaller due to any expected migration from the small group market to the State Option individual market?

- Have the Agencies considered the need to ensure a level playing field between the State Option and the other health insurance plans offered in the individual market? Specifically, the draft report indicates federal pass-through funding via a federal 1332 waiver would be directed to the State Option plan via subsidies or additional benefits. A level playing field is important for all plans offered in the individual market, and the draft report is not clear as to whether the State Option plans may receive additional funding over and above what other plans might receive.

- How would the regulation of the State Option plan by at least three different government entities (DOI, HCPF, Connect for Health Colorado) impact insurers' ability to engage in the market and effectively plan and execute their business options? Having multiple regulatory agencies increases the potential for overlapping and inefficient regulatory authority, including varying requirements, mandates, and applicable timeframes. Successful partnership between government and business relies upon clear and predictable rules. The implementation of even small regulatory changes in the individual insurance market can be tremendously burdensome, requiring, at a minimum, sufficient lead time to plan and execute under the current rate and product filing requirements.

- How would the U.S. Department of the Treasury (Treasury) and the U.S. Department of Health and Human Services (HHS) calculate federal pass-through funding for the reinsurance program and the proposed State Option program? Federal pass through funding is a complicated set of calculations based on what premiums for second-lowest cost silver benchmark plan would have been without either of these programs. Each of these programs may have an impact on the level of federal pass-through funding for the other and additional actuarial analyses would be helpful to fully evaluate any potential implications.

Anthem appreciates this opportunity to provide comments on the draft report. Should you have any questions or wish to discuss our comments further, please contact Rebecca Weiss at (303) 764-7273, or Rebecca.Weiss@Anthem.com.

Sincerely,

Scott Kreiling
President, West Region Commercial

Anthem is a leading health benefits company dedicated to improving lives and communities, and making healthcare simpler. Through its affiliated companies, Anthem serves more than 78 million people, including over 40 million within its family of health plans. We aim to be the most innovative, valuable and inclusive partner. For more information, please visit www.antheminc.com or follow @AnthemInc on Twitter.

The proposal for a Colorado State Coverage Option is definitely a step forward in improving our health in Colorado. It is a difficult thing to do at a state by state level with carriers, pharmaceuticals, and provider systems often being controlled out of state. I like the requirement that 85% of premiums must go toward patient care. We need to take greed out of our healthcare. It is great we will have an option for coverage for those with chronic illness that are suddenly unemployed, for small business employees, and independent contractors.
One concern I continue to have is related to continuous coverage for those with mental illness. The system is still very complex for many to navigate and they can still easily find themselves with gaps in coverage if coverage does not start quickly. Medicaid has dropped my son off of coverage with no warning before, and plans on the exchange did not start immediately. It's very difficult for someone with low income to cover costs of medication and labs out of pocket. It would be helpful to have navigators or case managers that ensure these at risk individuals don't fall out of coverage.

Thank you for all the hard work in putting the proposal together and soliciting feedback from the community.
Toni Lyles

Commissioner Michael Conway
Director Kim Bimestefer
Department of Regulatory Agencies
1560 Broadway, Suite 110
Denver, CO 80202

Via email: hcpf_1004AffordableOption@state.co.us

Dear Commissioner Conway and Director Bimestefer:

I very much appreciate the opportunity to participate in and offer comments on the Draft Report for Colorado's State Coverage Option. The Draft Report includes some important measures that will help reduce health care costs and premiums, specifically by limiting the rates paid to providers.

I am a program manager of a certified Connect for Health Colorado Assistance Site and a Health Coverage Guide. Our ConnectAurora team assisted with the enrollment of over 1100 consumers in Marketplace plans last year, over 90% received financial assistance to purchase the plans. We assisted another 1600 consumers with Health First Colorado Medicaid and CHP+ enrollments. It is our honor and mission to assist consumers who struggle to enroll, maintain and use their health insurance.

While I am hopeful and pleased that the measures in the Draft Report may reduce monthly premiums for Colorado consumers, I am concerned for the subsidy eligible consumers who may not realize the savings the consumers with higher incomes may experience.

Due to the hard work of the state legislature, advocates and the Polis Administration Team, many Colorado consumers will benefit from reduced premiums in 2020 as a result of the Reinsurance program. I am pleased that many consumers may see their premiums decline by an average 18% (Wakely Report on the Colorado Individual Exchange Renewals presented to the Connect for Health Colorado Board on 10.14.19). However, many of the consumers our Health Coverage Guides serve will not see reductions in their premiums; according to the Wakely Report, they may see an average rate increase of 19%. Although the actual dollar amount of the increase may not appear large, the Second Lowest Silver Plan for 2020 also includes a higher deductible and a higher Out of Pocket Maximum. Many of the consumers receiving tax credits are continuing to experience an erosion of their purchasing power.

My concern is that these subsidy eligible consumers will experience the same result with the measures in the Draft Report. If the measures are successful in bringing down rates as estimated in the Wakely Modeling of the State Coverage Option contained in the Draft Report, premiums will decrease by 9.6% to 18.2% in the first year of implementation. While it is a good that the unsubsidized population will benefit from the decrease in premiums, it is unlikely the subsidized consumers will realize such significant reductions.

I encourage the Commissioner and the Director to consider options which will enable subsidized consumers to also benefit from the reductions in premiums. One example would be to limit the offering of one state option plan in each rating area so that the Second Lowest Silver Plan will not decrease the same level as the Lowest Silver Plan. I hope you will consider this suggestion or another that may achieve a similar result.

Again, thank you for the opportunity to respond. I look forward to continued participation in the process.

Sincerely,

Allison Summerton
Aurora Coverage Assistance Network/ ConnectAurora.org
A Connect for Health Colorado Certified Assistance Site
Aurora Mental Health Center
11059 E Bethany Drive, Aurora, 80014
303-923-6519

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- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Becky Houghton

County (in which you reside) *

[redacted]

Organization *

Colorado voter and tax payer

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

Yes

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

Yes

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Yes

Does the proposal include worthwhile benefits for consumers?

Yes

Does the proposal create a product that is financially stable and sustainable?

Yes

Other thoughts? Please list them here.

I have had to refinance my home in order to pay for insurance. I have retired from teaching because of a cancer diagnosis. I have COBRA now, but would have to pay almost $1,000 a month with a $10,000 out of pocket expense or 500.00 a month for a $16,000 out of pocket expense through Peracare starting in 2021. That is outrageous. I hope the state option will lighten the enormous burden of having to pay exorbitant rates for insurance coverage.

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- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Benjamin Ferree

County (in which you reside) *

[redacted]

Organization *

Honest Oak LLC.

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

Keep government out of health care

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

Once government got involved through the affordable care act the prices of healthcare increase significantly every year and the quality has decreased significantly. It is so bad many providers are leaving the profession because they refuse to work in a system that is so bent on decreasing care to the patient.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Sure if your goal is to use insurance company greed to further your social agenda.

Does the proposal include worthwhile benefits for consumers?

I believe the quality of healthcare for all will continue to be eroded and the cost will continue to be unaffordable. This is the plan of any socialistic government agenda. This plan will decrease the premium costs by 9%? Yeah, after they have gone up 30-40% since the ACA what a deal.

Does the proposal create a product that is financially stable and sustainable?

No it will cause the system to eventually break and lead us to the governor's eventual plan of nationalized healthcare.

Other thoughts? Please list them here.

Please actually do something that can help the people and stop trying to just further your agenda. I work in healthcare and it is sad to see how bad it has gotten since the ACA waas past. The people deserve better than this!!

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Jared, I completely opposed government run healthcare. I am annoyed enough that I have to pay for company healthcare and now have to pay over $1,300 a year for Medicare. I paid for Medicare all of my life and apparently that payment never ends. Why not think about these things instead?

Healthcare that can be purchased across state lines
Change the medical legal system - tort reform
Have someplace for people to go that do not have medical insurance versus the emergency room.
Why is Denver a sanctuary city? It ads cost to a city that could use the money for other things, eg education!!!!

I will oppose any Medicare for all program. People like me want choices.

Bonnie Davis

Have an awesome day, Bonnie

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- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Bonnie

County (in which you reside) *

[redacted]

Organization *

No

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

No

Other thoughts? Please list them here.

Stop giving things away for free that others have to pay for. Set up a charity for people that need it. I will donate.

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October 25, 2019

Colorado Division of Insurance and Department of Health Care Policy and Finance

RE: Public Comment: Proposal for Affordable Health Coverage Option

To the Colorado Division of Insurance and Department of Health Care Policy and Finance:

Boulder County submits these comments on the draft proposal for a State Option to provide affordable health insurance to Coloradans. With the enactment of House Bill 19-1004, Governor Jared Polis and Colorado's General Assembly tasked the Colorado Division of Insurance (DOI) and the Department of Health Care Policy and Financing (HCPF) with developing and submitting a proposal to the legislature for a State Option.

Boulder County, home to more than 320,000 Coloradans, is a part of Health Statistics Region 16, where 5% of people are still uninsured and 13% have individual insurance or insurance that is not offered by their employer or the state.

Boulder County applauds the state in their efforts to address the cost of care to ensure health care insurance cost reductions are sustainable in Colorado. We appreciate that the DOI and HCPF considered the cost of hospital care in other states and proposes to ensure hospital reimbursement rates in Colorado are on par with the average costs of hospital care in the nation. As the state implements the proposed State Option, Boulder County appreciates that the state is paying special attention to Colorado's rural and critical access hospitals. Boulder County also encourages the state carefully consider access to critical health care services at all hospitals as the reimbursement rates are adjusted, to ensure that access to care does not decline, and that smaller, nonprofit hospital systems are able to sustain their services.

As access to mental health services is a critical issue in Boulder County, the county is especially supportive of providing pre-deductible access to behavioral health services. And Boulder County supports the broad and equitable access to the State Option, with all Colorado residents offered the option to purchase insurance in the program.

In conclusion, Boulder County applauds the Division of Insurance and the Department of Health Care Policy and Finance in their creation of a state option that:

- Decreases health insurance costs and health care costs for Coloradans
- Ensures parity of access to behavioral health services
- Utilizes the existing structure of Connect for Health Colorado
- Is accessible to any resident of Colorado
- Puts downward pressure on the cost of care by:
    - Creating hospital reimbursement rates that are more comparable to rates in other states
    - Utilizing a value-based insurance design as supported by the Affordable Care Act

- Requiring that insurance providers utilize 85% premiums to cover health care costs for those insured

Thank you for your consideration of Boulder County's comments.

Summer Laws, MPH | Policy Analyst
Boulder County Commissioners' Office

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

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- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Brandt Wilkins

County (in which you reside) *

[redacted]

Organization *

National MS Society

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

Yes - People with MS have so many interactions with the Health Care World.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

Yes - support for rebate to consumer since our drugs average $75K/year.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Yes.

Does the proposal include worthwhile benefits for consumers?

Yes - the rebate of Pharma co-pay assistance

Does the proposal create a product that is financially stable and sustainable?

I'm not sure

Other thoughts? Please list them here.

People with MS - a chronic disease that progresses to sometime complete disability needs a plan that can live with us as the disease progresses.

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Three common sense and proven facts:

1. State created mechanisms to force (control) health care workforce labor will fail
2. Legislation Will Result in more state bureaucracies that will result in lag of care to those in need
3. Insurers who are coerced through threats of mandate, will have to raise insurance rates and fire employees, or fail

These proven effects regarding bad state-controlled health care is exceptionally bad for insurers, insured and the medical community.

Best,
Brenda Miller

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Brian Hughes

County (in which you reside) *

[redacted]

Organization *

Lightstone Counseling PLLC

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

Yes

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

Yes

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Yes

Does the proposal include worthwhile benefits for consumers?

Yes

Does the proposal create a product that is financially stable and sustainable?

Yes

Other thoughts? Please list them here.

I very much support a public option for health care. I believe it would free people up to start businesses and pursue better jobs since they would not have to worry so much about losing health insurance. This would create a more dynamic and productive economy for our state.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Britta Robinson

County (in which you reside) *

[redacted]

Organization *

SCL Health

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

I share the Administration's concern that too many Coloradans struggle daily with the pressures that come with a lack of access to affordable health care; however, the proposed draft does not provide concrete information and details that show how it will make healthcare more affordable and accessible for Coloradans.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

The State Option, as proposed, would only be available to the ~230,000 individuals who currently purchase health care coverage through the state exchange, although there are intentions to expand its applicability to small and large group coverage under the exchange; actuaries predict that the number of individuals who will actually participate is 9,600. There is no mention of the ~400,000 Coloradans who remain uninsured.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Based on the draft plan and information released at the Denver stakeholder meeting, I am unable to clearly identify any specific provisions that will result in making health care more affordable and increase access to health care.

Does the proposal include worthwhile benefits for consumers?

Due to the fact that the plan does not propose any concrete evidence of ways it will increase affordability and access of care, I do not believe it includes worthwhile benefits for consumers.

Does the proposal create a product that is financially stable and sustainable?

The plan relies on current Medicare reimbursement rates, which in Colorado equates to only $0.69 of every dollar of costs reimbursed, which fails to cover the full cost of care. Additionally, the plan only focused on hospital costs and excludes other cost factors such as physicians, pharmaceutical companies and other providers and supplies.

Other thoughts? Please list them here.

A solution to providing affordable and accessible healthcare to the residents of Colorado requires thoughtful and thorough planning and the involvement of all stakeholders who contribute to the overall cost of care. This draft plan is moving too quickly and proposing solutions that are not grounded in the goal of such legislation/action, which is ultimately to make healthcare more affordable and accessible to Coloradans.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Bruce Church

County (in which you reside) *

[redacted]

Organization *

Individual

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

NO

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

NO

Does the proposal include worthwhile benefits for consumers?

NO

Does the proposal create a product that is financially stable and sustainable?

NO

Other thoughts? Please list them here.

Don't mess with our healthcare system

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As a healthcare leader, I am concerned that this Bill…

- Does not focus on Colorado's 400,000 uninsured patients
- Has very real potential to limit Coloradan's ability to choose the health insurance plan best for them
- Introduces government price controls with mandatory hospital participation, possibly jeopardizing access to care

The range of possible outcomes include major cuts in reimbursement rates to healthcare providers – cuts that would pay hospitals well below the actual cost of providing care.

- Cutting reimbursement rates will only threaten the quality of care we can provide and limit access to healthcare across our state. If below-cost reimbursement rates expand even further in Colorado, providers will have no choice but to cut services, staff and possibly close their doors altogether. Ultimately, patients will have less access to quality care, not more, and our state will be the worse for it.

- We believe our patients deserve better and therefore our policymakers must do better. State officials need to slow this process down, focus on the facts and develop responsible policies that address the cost of healthcare insurance while also preventing unintended consequences – including staff and service reductions at Colorado hospitals.

- Some organizations are pressuring the administration to use Medicaid reimbursement rates, for example, which currently pay just 69 cents for every dollar of care provided. As you know, Colorado hospitals are already grappling with a major expansion of below-cost reimbursement rates, mostly due to a major expansion of the Medicaid program.

- Hospital professionals support the goal of universal healthcare coverage. To make this coverage more affordable, we work hard to find savings within our operations. We also make investments that will bring down costs, including programs that address the shortage of primary care physicians in Colorado and a $40 million per year contribution from the hospital sector to the state's new reinsurance program.

- Hospital professionals want to reduce the cost of insurance coverage, which has skyrocketed in recent years. But health insurance and healthcare are not the same thing and cutting payments to the dedicated professionals who actually provide healthcare in Colorado is not a real answer.

- I would be glad to discuss this legislation and my concerns further.

Bryce DeHaven

Consumer Comments

The efforts of the Division of Insurance (DOI) and the Colorado Department of Health Care Policy and Financing (HCPF) are appreciated.

I. Legislation Purpose and Requirements

Additional attention needs to be directed toward the specific requirements and stipulations of the statute where the PURPOSE of the legislation is identified:

- *Coloradans cannot afford the health care premiums and out-of-pocket expenses* (Sec III)

The bill focuses specifically on consumer AFFORDABILITY as the priority:

- *The proposal must identify the most effective implementation of a state option based on affordability to consumers. . .* (3)

The bill projects greatest success and stipulates use of EXISTING STATE INFRASTRUCTURE:

- *A state option for health care coverage that leverages existing state infrastructure. . .* (2.a)

II. Administrative Costs

Overhead and administration is an element that needs ongoing work in the Proposal to fulfill the stated purpose of AFFORDABILITY.

Why use Existing State Infrastructure?

- Public health plans do not build profit into their rates, profit for the insurance companies and profit for their shareholders, and further tie it not to their costs but to each direct health care premium dollar.
- Public health plans have achieved considerable efficiency in administration (including operations, purchasing power, providing extended benefits to consumers) with Medicare and Colorado Medicaid both boasting administrative costs in the 3% to 5% range. Private insurers have demonstrated neither an interest nor an ability to hold down administrative costs, and report that inefficiency, with administrative costs reported at 12% to 30% and higher.
- Public health plans do not spend large amounts of the patient dollar on marketing and the other expenses of competition which serve to raise, not lower, the premium and cost of health care (costs such as overbuilt facilities, Free Standing ERs on every corner in the urban centers only, redundant major equipment—all related to outdoing the competition, while not providing value across a state with a diversity of urban and rural areas, and underserved populations)

The Current Proposal modifies the ACA allowance of 20% admin and profit to 15%, or equivalent to the ACA rules regarding how those insurers must sell to large groups, making the Public Option essentially a large group market expansion—no concession to affordability at all, as the Proposal states. The insurance industry still considers any direct patient care (whether 80 or 85% of their expenditures) to be their Loss, as expenses which benefit patients are termed by the industry as their Medical Loss Ratio.

The Proposal further identifies that Administration of the Proposal will require extensive costs and activities by a host of entities, from the Insurance companies (at 15%), Connect for Health Colorado Exchange fees (5%), brokers (1.5%) and various other entities that provide redundant consumer services.

The Congressional Budget Office (CBO) identified that administrative expenses for Public Option plans were anticipated to be lower, in a report that they submitted at one point in time.

An Administrative Cap of 7% (considered the combined administrative costs of Medicare and Medicare Supplements) to 11% would seem to be an appropriate target for this Proposal. Entities not required for Public Programs such as Brokers or the Exchange should not receive compensation for triaging consumers to the Public Option and more than they receive them for directing Consumers to Medicare, the VA, CHIP or Medicaid. Their benefits will stem from more clients seeking some type of health insurance coverage, an additional expansion of the market, and Consumer Advice for those that Want It, or want to pay for it.

The Current Proposal Administrative Costs do not appear to fulfill the legislation's requirement to Leverage Existing State Infrastructure, and these need to be re-examined.

III. General

The Proposal has sometimes stark omissions of the terms Consumer and Affordability. It would be useful to have these terms mentioned more frequently in relation to all aspects of the plan. Additionally, there may be confusion about what a Community Representative is, one term used in the Proposal, as compared to switching that to Consumer, the Colorado resident who is trying to access Affordable health care coverage.

The term "emotional health" is utilized in the Proposal where it is likely that the term "behavioral health" is now more commonly attributed to a serious health care need.

The term "provider" in the Proposal needs to be substantially clarified and detailed, as the significant portion of this relates to Prices that can be charged, but by which Providers is not clear. Additionally, the state statistics of locations where there are "outlier" Medicare costs need to be carefully reviewed, as one example includes a county with less than 30,000 in population but an outlier Medicare cost in excess of 500%.

It does not appear to follow the legislation requirements for HCPF, or other state agencies, to opt out of managing the Proposed State Option. Indeed, the bill appears to require all considerations to be evaluated and not to shuffle this back over to the historically inefficient private industry. The best presentation in the public meetings was from CHIP, offering an excellent model for a State Option plan. It's unclear why this is not part of the Proposal.

Leveraging existing state options is also a call to leverage the current existing purchasing and negotiating power of a large, established public entity. This Buying Power is a significant part of producing Affordability in a health plan. This Buying power is now available with some of the large public health care programs, and absent in the private sector.

Lastly, these are some of the current Colorado headlines about the extraordinary profits being realized from Colorado consumers:

Colorado Hospitals' Profits Amongst Highest in U.S. – Denver Post 10-4-18.

Denver-area hospitals made a record $2 billion in profits in 2018. . . -Colorado Sun 9-13-19. This article goes on to say that the profit margin in the 27 metro area hospitals was at 19.3% and had gone up a full percentage point each of the last couple of years. One hospital system is identified as having a 46% profit margin.

We can do better. The State Option has good potential.

Thank you for this opportunity to provide Consumer Input.

Sincerely,

Carol Pace

My name is Carol Salter. I am the Director of Business Development for Banner Health, Northern Colorado. I reside at [REDACTED].

In the book 32407, Joe Rubenstein carefully and thoroughly details his horrific experiences while a prisoner at Auschwitz. While reading his account, my mind could not fully comprehend the atrocities he witnessed and endured. But what was most striking to me was his release. When they were finally freed, he and two other prisoners found themselves in a town near the prison. There were many people there, going about their daily lives as if unaware of what was going on a few miles from them. My mind raced, why didn't they stop what was going on? Silence implies consent. When we remain silent on things that will have a huge impact on how hospitals serve their communities, we are consenting to what is being proposed. And we know what is being proposed, a public option. Public is not perhaps the best term as it is more state driven than a public demand.

I can certain appreciate Governor Polis's intent to lower health care costs. It is a worthy goal. But do we attempt to do this at the expense of one component of health care, the hospitals? Essentially, this option imposes a price control on health insurance financed by a price control on hospitals. The proposal requires the insurance carriers to offer a government health insurance plan at a rate well below market value. Hospitals will bear the entire burden of this scheme by absorbing enormous cuts in the amounts they are reimbursed by the state. Hospitals will be forced to cut staff, from doctors to environment services employees and/or reduce services. Ultimately this public option brings health care under state control.

As a health care employee, and more specifically, an employee who representatives the five Banner hospitals in Colorado, I cannot be silent. I have seen fellow employees who have given their lives to improving the community in which they live, lose their position due to cuts already caused by the reinsurance program initiated during the last legislative session. I have seen numerous worthy community events that the hospitals at one time sponsored, go by the wayside. This public option will not improve the quality of health care, the access to health care or the betterment of the community. I would respectfully request that we give careful consideration to this state-run public option.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Carol Shaw

County (in which you reside) *

[redacted]

Organization *

Republican

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No government controlled healthcare!!!!

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

No

Other thoughts? Please list them here.

No government controlled healthcare!!!!

This form was created inside of State.co.us Executive Branch.

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Director Kim Bimestefer

Department of Health Care Policy & Financing

1570 Grant Street

Denver, CO 80203

Commissioner Mike Conway

Colorado Department of Regulatory Agencies

Division of Insurance

1560 Broadway, Suite 850

Denver, CO 80202

Director Bimestefer and Commissioner Conway:

As a Nurse Manager at UCHealth General & Trauma Surgery in Colorado Springs, I am writing to share my concerns about the “Draft Report for Colorado’s State Coverage Option,” released Oct. 7, 2019.

In my job, I meet patients and their families at an incredibly difficult time. We provide support and guidance as they make decisions ranging from end-of-life and final wishes to long-term care. More than 70 percent of my patients receive Medicaid or Medicare benefits. The rest are those who have private health insurance through their employer or those who have no coverage at all. Each patient receives my best efforts and those of my colleagues.

I am proud of UCHealth’s commitment to our community. As the largest provider of Medicaid, we are dedicated to caring for every patient who walks through our doors. We also support programs that improve health in the communities we serve, keep kids healthy, prevent distracted driving, provide healthy options for seniors, provide a free nurse advice line, free flu shots, programs to address postpartum depression, treat substance use disorders, and so much more. We’ve just started a program that will dedicate at least $100 million to treat behavioral health in a more comprehensive and integrated way.

While I applaud your desire to improve health care, I disagree with the plan’s proposal to use government rate setting to cut reimbursements for hospitals. I believe such actions will force a dramatic reduction of services provided by hospitals like the one where I work as well as reducing or eliminating our community programs.

I care about my patients and the community we share. And I worry that some hospitals will not be strong enough to weather these cuts and will be forced to permanently close. This proposal will cause serious harm to our patients, our communities, and our hospitals.

I want to note that these are my personal comments and don’t necessarily represent those of my employer.

Respectfully,

Carolyn Carroll Flynn, RN BSN CCRN-E MBAHA

Dear Sir or Madam.

My name is Cassandra Williams. I live in [REDACTED] and I am the patient safety program manager for a non-profit hospital in the heart of Denver whose mission is to serve those who are under-served and generally forgotten about by the masses. While I respect the basic premise of a public option for healthcare as proposed in HB19-1004, I urge you to consider the following when weighing the planned benefits of such a system against the risks since it will undoubtedly have greater economic implications than meet the eye.

In the context of healthcare as an ecosystem, each part of the ecosystem plays an important role in ensuring that this country continues to move in the direction of achieving the six aims of quality set forth by the Institute of Medicine over 23 years ago. Those six aims challenged the ecosystem to provide safe, effective, patient-centered, timely, efficient, and equitable care to patients and are still just as relevant today as they were all those years ago.

My stake in whether or not a public option is adopted reaches past my role as part of the healthcare workforce. I am a single mother of three children, ages 12, 8, and 4, who has been on both ends of the healthcare affordability spectrum. Before accepting a position as a government contractor and moving to Colorado from Georgia four years ago, I was among the uninsured in spite of having a Masters degree and being a military veteran. While unemployed, I could obtain Medicaid coverage for my children but could not secure medical coverage for myself. I had already lost trust in the VA medical system and had no real faith in Medicaid to ensure access to care and needed interventions for my middle daughter who requires specialized care due to her medical diagnoses. Even with private insurance through my employer, my daughter spent two whole years on the waiting list to be seen by a developmental pediatrician and evaluated for her global developmental delays.

I fear that a public option for healthcare coverage will jeopardize the already fragile healthcare ecosystem and lead hospitals and healthcare providers to cut corners to adjust for lower reimbursement without the benefit of lower operating costs. While insurance premiums and out-of-pocket costs for the healthcare consumer may decrease with a public option, costs of living for healthcare workers like myself will not decrease with a public option and neither will the costs of supplies needed to provide high quality care to patients. If hospitals are no longer able to keep their doors open due to insufficient reimbursement, the loss of jobs and billions in economic activity is just the tip of the iceberg.

Thank you for your consideration of my concerns surrounding HB19-1004.

Cassandra Williams

Dear Sir or Madam,

Please stop the implementation of HB19-1004. It will kill people by reducing their access to health care.
Reimbursing hospitals less than it costs them to provide the service will cause then to cut their services and possibly go out of business. Doctors and nurses will loose their jobs. People will have less access to health care, not more. There will be rationing of care by government bureaucrats who will decide who gets care and how much. People will die sooner. Are you trying to reduce the population?

Cathy Jarrett

October 28, 2019

Executive Director Kim Bimestefer
Colorado Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Commissioner Michael Conway
Colorado Division of Insurance
1560, Suite 110
Denver, CO 80202

Re: Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

Dear Director Bimestefer and Commissioner Conway,

Center for Health Progress appreciates the opportunity to provide public comment and recommendations regarding the Proposal for Affordable Health Coverage Option (HB19-1004).

Center for Health Progress is a Colorado-based advocacy and community organizing organization, established 22 years ago with the vision that our health care system should work for all Coloradans. So, we bring people together to ensure factors like race, income, and ZIP code don't determine a person's access to care or opportunity to live a healthy life.

It is with these values in mind that we have come to the conclusion that the State Option Draft Proposal will not serve the needs of Coloradans, primarily because it does not meaningfully expand coverage to the uninsured. According to the actuarial analysis, the State Option would only extend coverage to 4,600 to 9,200 Coloradans in its first year. Because this is only a fraction of the state's uninsured population, we strongly encourage HCPF and DOI to go back to the drawing board and develop a plan that will reach more uninsured Coloradans.

Center for Health Progress also urges HCPF and DOI to re-examine the guiding philosophy behind the State Option and its long-term goals. For example, due to TABOR, the state is currently not in a position to raise the taxes needed to create a true public option. Addressing our state's financial limitations first would allow HCPF and DOI to propose a more robust plan in the future. Furthermore, mandating the participation of both carriers and hospitals (who have expressed concern)[1] could instigate a chaotic environment and negative working dynamic from the onset. If HCPF and DOI plan to use their political capital in implementing this Proposal, why not pursue a more ambitious plan, such as a true public option, that will further expand coverage to the uninsured? The agencies should consider their long-term goals for providing affordable coverage to

[1] https://cha.com/colorado-hospital-association-response-to-states-public-option-proposal/

Coloradans and if implementing the proposed State Option will do more harm than good in the long-term.

Clearly, we see many shortcomings to the State Option Draft Proposal and believe the Proposal should undergo significant changes. However, if HCPF and DOI plan to move forward with the current framework, Center for Health Progress offers the following commentary on specific components included in the Proposal.

To begin with, Center for Health Progress supports the State Option's attempt to tackle the cost of health care. The State Option aims to adjust reimbursement rates from the current rate of approximately 289% of Medicare currently paid by insurance carriers in the individual market to 175%-225%. This is a positive development in curbing the cost of health care given that Denver-area hospitals reported a record $2 billion in profits in 2018,[2] and Colorado hospitals regularly charge patients with private insurance three or four times what Medicare pays for the same services.[3] We also support changing the Medical Loss Ratio to 85%, which will ensure that more of a consumer's premium dollar goes toward their health care. Together, these proposals will improve health care affordability, particularly for middle class families.

In addition to the cost containment components, we believe that the State Option Advisory Board will bring oversight and transparency. However, the Board must include representation from directly-impacted individuals, as well as advocates for consumers, immigrants, and the uninsured. They know what they need most for the State Option to be a health care plan that meets their needs. We are also pleased that State Option Plans will cover the Essential Health Benefits and that many services will be pre-deductible, including preventive care, primary care, and behavioral health care.

However, the most essential component of the Proposal is that State Option Plans will be available to all Colorado residents, including immigrants regardless of their documentation status. According to a 2017 analysis by the Colorado Health Institute, 441,000 Colorado adults under the age of 65 are uninsured. Of this population, 112,000, or one in four, are immigrants without documentation which makes them ineligible for current health coverage options in Colorado.[4] If HCPF and DOI aim to reduce Colorado's uninsured rate, extending coverage to immigrants without documentation is the most important place to start.

Although the State Option would allow immigrants without documentation to purchase a plan, it would not significantly reduce the number of Coloradans who are uninsured. As mentioned, the State Option would only extend coverage to 4,600 to 9,200 Coloradans in its first year. Because this is only a fraction of the state's uninsured population, we strongly encourage HCPF and DOI to reconsider the Proposal in order to reach more uninsured Coloradans, particularly immigrants who are undocumented.

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[2] https://coloradosun.com/2019/09/13/colorado-hospital-profit-margins/

[3] https://coloradosun.com/2019/05/13/colorado-hospital-prices-rand-study/

[4] https://www.coloradohealthinstitute.org/research/colorados-eligible-not-enrolled-population-continues-decline

There are several ways in which the state could reach more uninsured Coloradans including but not limited to the following:

- Require carriers to create strategies to reach uninsured populations.
- Require carriers to allocate a percentage of their profits toward subsidies for the uninsured.
- Look toward other funding sources, such as hospital community benefit money and foundation funding, to develop outreach programs to reach uninsured populations.
- Ensure that advocates for the uninsured and the uninsured themselves have the opportunity to participate on the State Option Advisory Board.
- Consider opening the state option plan up for a public and competitive bidding process by carriers.

In addition to reaching more uninsured Coloradans, we encourage HCPF and DOI to specify how they plan to ensure linguistic and cultural responsiveness. Approximately 17% of Coloradans speak a language besides English at home,[5] so it's critical that all State Option Plan documents, participating providers and insurers, and other affiliated systems and people be adequately prepared to provide high-quality translation and interpretation services. There should also be robust training for and availability of culturally-responsive care and customer service.

Furthermore, data security is increasingly important for Coloradans, and most especially for immigrants whose information can be particularly vulnerable due to documentation status. Colorado should do all it can to earn the trust of immigrants and all Coloradans by building in strong information protections with strict firewalls that prohibit sharing across systems and agencies for non-health purposes. Ideally, there would be an unequivocal guarantee that users' information will not be shared with any federal or state authorities without proper legal justification and due process.

Center for Health Progress is also concerned about how the State Option will affect premium subsidies purchased on the exchange. Because of premium subsidy calculations, multiple State Option Plans could lead to tighter clustering of premiums at a lower premium level. While this would be attractive to non-subsidized buyers, it would do little to improve and might even decrease a subsidized consumer's buying power. Low-income and middle class families could end up paying more out-of-pocket for their health insurance than they are now. An analysis published in *Health Affairs* found that the "inclusion of multiple public option plans in a rating area would substantially increase—more than doubling in some cases—the contribution to premiums that subsidized shoppers with incomes at 200 percent of poverty level must make for existing, non-public option exchange plans."[6]

There are several ways in which HCPF and DOI could remedy this problem, including but not limited to the following:

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[5] https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF

[6] https://www.healthaffairs.org/do/10.1377/hblog20190828.810494/full/

- Limit the number of State Option Plans in a rating area to one.
- Limit the number of low-cost premiums at the silver level.
- Exempt the State Option Plans for being used as benchmarks for premiums.

Ultimately, we believe that the State Option needs to undergo substantial modifications. As it stands now, the Proposal will fail to meet the needs of Coloradans, particularly the uninsured and immigrants without documentation. We hope that HCPF and DOI will consider our concerns in developing their final proposal for the General Assembly. Thank you again for the opportunity to provide public comment--we hope to continue to engage in the process moving forward. Please feel free to contact Chris Klene at chris.klene@centerforhealthprogress with any questions or requests for additional information.

Sincerely,
Chris Klene
Policy Specialist

PO Box 18877 | Denver, Colorado 80218 | **TELE** 720.583.1760 | www.centerforhealthprogress.org

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

Please use this form to submit your comments on the draft HB19-1004 report. All comments will be logged and added as an appendix to the final report. We will accept comments until October 28.

Helpful Links:
- The draft report can be found here: http://www.colorado.gov/pacific/sites/default/files/HB19-1004%20Draft%20Report%20Colorado%20State%20Coverage%20Option%20and%20Appendix.pdf
- The bill text can be found here: https://leg.colorado.gov/sites/default/files/2019a_1004_signed.pdf
- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Charles Becker

County (in which you reside) *

[redacted]

Organization *

Private citizen /Veteran.

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

In a Pigs eye, No.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No.

Does the proposal include worthwhile benefits for consumers?

No.

Does the proposal create a product that is financially stable and sustainable?

No.

Other thoughts? Please list them here.

It is plainly obvious that any bills like this comes from a collective that has a total cumulative IQ. Of less than .00000000000000000000000000001

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Google Forms

Children's Hospital Colorado
Here, it's different.™

October 28, 2019

Director Kim Bimestefer
Department of Health Care Policy & Financing
1570 Grant St.
Denver, CO 80203

Commissioner Mike Conway
Colorado Department of Regulatory Agencies, Division of Insurance
1560 Broadway, Suite 110
Denver, CO 80202

RE: **State Option Public Comment**

Dear Director Bimestefer and Commissioner Conway:

Thank you for the opportunity to provide comment on the draft report on the State Coverage Option.

Children's Hospital Colorado is one of the leading, not-for-profit pediatric healthcare providers in the country, as well as the largest provider of Medicaid services for children in Colorado. We care deeply about the health and well-being of children in our state and desire to preserve and expand their access to care. We are thankful to the sponsors of HB19-1004 for their thoughtful approach to improving access to care but have concerns with the structure proposed in the October 7th draft.

We had hoped that the option proposed by the departments would be designed to improve access to care for those who are uninsured. The actuarial analysis indicates a disappointingly low impact on the state's uninsured rate, and we believe this represents a significant missed opportunity. We urge the departments to revise their model to target high-cost geographic regions and special populations who do not today have affordable access to insurance.

We appreciate the high-level configuration of the plans' benefit structure, but also hope the departments will consider additional safeguards around children's access to care. We strongly support requiring pre-deductible coverage of high-value preventative and primary care services, including and especially behavioral health and pediatric dental services. In terms of covered services, Medicaid's longstanding Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirement is considered the gold standard for children's access to care. If companies offering state option plans are being driven to reduce costs, we hope the State will require that participating insurers ensure coverage for all medically necessary care. This is not only important as a matter of health equity, but it also is a good long-term investment in the health and well-being of Coloradans.

13123 E 16th Ave, Aurora, CO 80045
720-777-1234 | childrenscolorado.org

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University of Colorado
Anschutz Medical Campus

Looking at the larger healthcare system, there is also cause for concern about the potential for this option to destabilize the broader individual market in Colorado. We echo the concerns of consumer advocacy coalitions that the State Coverage Option may have unintended effects on federal premium tax credits. If premium rates fall, thereby reducing premiums in the second lowest cost silver plan (the benchmark plan), the purchasing power of federal subsidies for those that are eligible for support in the Connect For Health exchange could drop as well. We encourage plan re-design to address this unintended consequence.

Further, we urge the departments to consider the extent to which this new offering will displace individuals from other Exchange offerings, and how those plans will react. We have concerns that the State Option may ultimately be the only one offered, limiting families' choices and resulting in significant decreases in reimbursement for providers. If other providers limit their Medicaid or state option caseloads in response to the proposed 22 to 39 percent reimbursement cut, thereby increasing wait times for patients, how would the departments propose assisting those remaining providers and facilities that continue providing services to patients irrespective of their payer or plan? The weight of that burden may not be sustainable for safety net providers like Children's Hospital Colorado and may not serve consumers well—especially if the state option effectively crowds out other insurance options but then cannot provide sufficient access to care. If the departments are not willing to set aside the policy of state-mandated reimbursement rates, they might consider reimbursement cuts to providers in the 9 to 18 percent range, which would match the proposed discount offered to consumers, would be more equitable, and might result in less potential for market destabilization.

To partially mitigate the impact to low-income patients and the burden on safety net providers, we endorse the comments of consumer advocacy groups in support of a requirement that insurers offering the State Option must contract with all Essential Community Providers (ECPs) in their geographic region.

Other elements of the draft proposal, like the "Centers of Excellence" concept, are interesting and have significant potential to concurrently improve quality and contain costs, although more detail is needed to effectively evaluate this potential. We believe that operationalizing a center of excellence model could be a more effective way than indiscriminate rate cuts to drive cost reduction for specialized and expensive procedures. As you hone this concept, it is important to ensure that patient and family choice is protected, and that the difficulties associated with regional travel for those living in rural and frontier counties are taken into account. We applaud the departments for including this important concept, and we hope to partner with the departments as the model is refined in the coming months.

We agree with the Administration's diagnosis that healthcare costs are too high in Colorado and that too few in our state can access needed care. We do not believe the State Coverage Option as written is the best approach to tackling those worthy problems or that it aligns with the Administration's "shared sacrifice" approach to lowering the cost of healthcare. As noted above, hospitals are facing rate cuts of 22 to 39 percent but consumers are only expected to see premium

savings of 9 to 18 percent; we encourage further analysis and re-working of program design to ensure that the State Coverage Option does not represent a subsidy to health plans of the difference between those two figures. We further note that the state's actuarial analysis of the new 85 percent medical loss ratio (MLR) requirement assumes it will not have an impact on the cost of the plans offered, as the statewide MLR is already above 85 percent. Similarly, we do not see a serious attempt to control the cost of prescription drugs in the plan as currently written.

In sum, we encourage you to consider modifications to the State Coverage Option that would meaningfully lower the uninsured rate, ensure reliable access to care, and ensure that all sectors of the healthcare industry are sharing in the work of achieving the worthy goal of lowering healthcare costs for Coloradans.

Again, thank you for taking these comments under consideration. We look forward to working with you as the model evolves.

Sincerely,

Jena Hausmann
President and CEO
Children’s Hospital Colorado

October 28, 2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant St
Denver, CO 80203

Commissioner Michael Conway
Division of Insurance
1560 Broadway #110
Denver, CO 80202

Re: Draft Report for Colorado's State Coverage Option

Dear Director Bimestefer and Commissioner Conway,

We appreciate the commitment of Governor Polis, the state legislature, the Division of Insurance (DOI), and the Department of Health Care Policy and Financing (HCPF) to making comprehensive, affordable health coverage available to even more Coloradans. This is directly aligned with the core mission of Colorado Access to empower people and communities through access to quality, affordable care, and we fully support the goal of HB19-1004 (Proposal For Affordable Health Coverage Option) to expand affordable health coverage in our state.

Below we offer a few specific recommendations and questions. As HCPF and DOI refine the current draft proposal, we want to reiterate our offer to share our expertise and knowledge as a local health plan with decades of experience connecting low- and moderate-income individuals and families with health care in Colorado. Colorado Access covers more than 500,000 members through Medicaid and CHP+.

State Option Advisory Board

We are pleased to see that the proposal includes a State Option Advisory Board. This will be an important opportunity for the public and health care stakeholders to provide ongoing input on the State Option Plan. We recommend that the Advisory Board specifically include at least one seat for Regional Accountable Entities (RAEs). RAEs offer a unique perspective on the health care needs of individuals with low incomes and can help shape the development and implementation of the State Option so that it meets the needs of members, many of whom will likely move between Medicaid and the State Option Plan.

Alignment with RAEs and CHP+

Continuity of care and coverage is critical for the health of all Coloradans. Given the high degree of churn that is likely between the RAEs, the CHP+ plans and the State Option, we encourage HCPF and the DOI to establish more formal and intentional hand-offs between the programs as individuals' eligibility changes to ensure on going provision of coverage and continuity of care. Additional care coordination and/or enrollment support could help families transitioning between plans stay up-to-date with their preventive services and other high value care.

Additionally, the State Option Advisory Board – and other efforts to implement the State Option – should prioritize alignment across other health care transformation efforts. Currently, there are multiple efforts aimed

800-511-5010
coaccess.com

11100 E. Bethany Dr., Aurora, CO 80014

at bringing down health care costs and improving outcomes including the state-wide Performance Improvement Advisory Committee (PIAC), multi-payor collaborative efforts, and the primary care payment collaborative. Alignment across all these efforts will be critical to achieving the overarching goal of making health care more affordable and improving the overall health of Coloradans.

Enhanced Data and Trend Tracking

As the State Option is implemented, we recommend additional data and trend tracking to understand how the program is affecting the uninsured rate and the rate of churn between the State Option, CHP+, and Medicaid. We believe it's likely there will be substantial movement of members between these insurance options. Enhanced data on insurance rates and churn will better inform our understanding of continuity of care, benefit alignment, impact on members, and the administrative burden to the state and other stakeholders.

Comprehensive Benefits and Pre-deductible Services

We strongly support the State Option requiring coverage of the Essential Health Benefits (EHB). The EHB helps guarantee that individuals have access to comprehensive services that meet their health care needs. We also strongly support the decision to offer high-value primary and preventive care services, as well as behavioral health services, that individuals and families can access without needing to meet their deductible.

Underlying Costs of Care

To further tackle health care costs, DOI and HCPF should consider an additional focus on the underlying cost drivers and market dynamics, including prescription drug prices. Prescription drugs represent the largest segment of health care spending, making up more than 23 percent of commercial premiums, but are largely unaddressed in the current proposal.[1]

Carrier Participation

We are pleased that proposal specifically mentions keeping Medicaid, CHP+, and HCPF's other safety net programs separate from the State Option, and that the proposal is focused on leveraging the strength of the commercial market. We agree with HCPF's assessment that Medicaid operational capabilities and offerings have been customized to serve the state's most vulnerable populations in partnership with the federal government.

We are also seeking clarity about how participation in the State Option will evolve and shift in the future as there are changes to market share and new payors emerge in the market.

If we can provide additional information or share more about our perspective, please contact Gretchen McGinnis, senior vice president of healthcare systems and accountable care, at gretchen.mcginnis@coaccess.com or 720-744-5503.

Sincerely,

Gretchen McGinnis
Sr. Vice President of Healthcare Systems and Accountable Care
Colorado Access

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[1] AHIP. "Where does your health care dollar go?" (May 22, 2018) Retrieved on October 28, 2019 from https://www.ahip.org/health-care-dollar/.

Colorado Agricultural Aviation Association (CoAAA)
16489 Burghley Ct.
Platteville, CO 80651
10/28/19

Health care is one of the most important economic issues of our time, possibly nowhere more so than in rural communities, where local and regional hospitals support their service areas not just with critical medical and public health services, but as an economic driver with both direct and indirect financial impacts on the community. That is why I oppose the public option, with its price controls and cuts to hospitals like the one serving my community.

The benefit and influence of hospitals is not limited to local areas; they are crucial to the health of the entire state, literally and figuratively. Just this year, Colorado hospitals agreed to pay $40 million a year to fund the state's new reinsurance program, which is estimated to reduce individual plan premiums by 20 percent or more. This investment makes hospitals the number one source of revenue for this important program. This is just one of many ways in which hospitals take the lead on reducing health care costs.

And yet, they are now facing a public option plan which will do nothing but squeeze them financially. Expanding health insurance coverage and access to medical care is a goal all of us share but imposing a state-run insurance plan and paying for it on the backs of hospitals and healthcare providers is certainly not the way to go about it. All that will accomplish is to reduce the number of doctors and nurses available, and simultaneously reduce services at the most important health care delivery centers. Insurance is not the same thing as care, and the trade off of this plan is more people on cut-rate government insurance, but fewer hospitals, fewer doctors, and fewer health care services.

The proponents within the governors office may try and dispute the fact that the public option will result in health care job losses, but history and empirical studies back that up, and what's more those same officials even admit that they do not know what will happen, since their analysis failed to use Colorado specific data.

In closing, I support our hospitals in their stand against the public option, and ask that you would as well.

Thank you,

Jessica Freeman

Jessica Freeman

Executive Director
Colorado Agricultural Aviation Association

October 28, 2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant St, Denver, CO 80203

Commissioner of Insurance Michael Conway
Division of Insurance
1560 Broadway #110, Denver, CO 80202

Re: Draft Proposal for Colorado's State Coverage Option

Dear Director Bimestefer and Commissioner Conway,

We write today to provide feedback as part of the stakeholder process on the Draft Proposal for Colorado's State Coverage Option. The Colorado Association of Health Plans (CAHP) is a state association of health insurers that offers coverage to over three million Coloradans. CAHP's mission is promoting high quality, affordable, evidence-based health care in Colorado.

As stated previously, we fundamentally agree with the goals of HB19 – 1004, specifically decreasing health care costs for Coloradoans; increasing competition, and; improving access to high-quality, affordable and efficient health care. We appreciate the stakeholder process conducted by the Division of Insurance (DOI) and the Colorado Department of Health Care Policy and Financing (HCPF) and we recognize your efforts to reflect stakeholder feedback. We note the focus of the Draft Proposal on the individual market and the effort to utilize existing infrastructure to deliver a State Option plan. We also commend you for looking at solutions to address the cost drivers of high health insurance premiums and we appreciate the concerted focus on tackling the price of health care services.

However, CAHP has critical questions about how the Draft Plan can be delivered, given that there are no guarantees to ensure that health plans can successfully offer the State Option. Health plans are the only component in this proposal that are mandated to participate, and nothing compels hospitals or providers to contract with health plans offering the State Option.

CAHP is also very concerned the proposal will not achieve the goals of HB19 – 1004 and will instead reduce competition and choice, while increasing health care costs for employers. The Draft Report fails to allow for innovation and flexibility and will likely result in a one-size-fits-all approach to health care. After years of instability in the individual market, the Draft Report will fundamentally disrupt the health care market at a time when we are still implementing no less than 30 health care related bills from the 2019 legislative session.

The main goal of HB19 – 1004 is to increase competition, but under this proposal, carriers will be required to offer similar health care plans, benefit designs, and networks. This approach will fail to generate distinct heath plan choices, while further limiting both choice and competition in the counties that this proposal should be focused on benefiting. If the goal is to generate real competition in the areas currently lacking adequate access to affordable health insurance plan options, CAHP questions whether that goal can be achieved through this proposal.

Key concerns of health plans

The goal is decreasing health care costs, but costs are likely to shift or go up

1. **Cost shift to employers**

CAHP commends the Draft Report's effort to highlight the reality of the challenges posed by the already high, and increasing, cost of care in Colorado. Given the direct relationship between the high costs of health care and the cost of health insurance premiums, the focus on controlling the cost of care is essential to any effort to address the access and affordability challenges facing our state.

However, employers have been bearing the brunt of these high health care prices for years and we have significant concerns that the Draft Proposal will likely continue that burden. Hospitals have consistently shifted costs towards the commercial market from Medicaid and Medicare citing that government programs underpay.[1] By setting rates in the individual market in the State Option, hospitals are very likely to shift costs onto employer-sponsored markets to maintain current overall reimbursement levels.

While the DOI intends to report on and monitor these shifts, the DOI cannot monitor one-third of Colorado's market, the self-funded employer market, where it does not have authority. We are extremely concerned that the cost shift will become greater and greater as the State Option expands to different markets and the employers will bear the additional burden. CAHP believes strongly that a plan for identifying, tracking, and preventing increases in hospital cost shifting is fundamental to controlling health care costs.

Under the Draft Proposal, cost shifting is very likely to continue, further concentrate in the group markets, and then be used as a justification for the further expansion of the State Option. The result will be considerable disruption of Colorado's employer-sponsored health insurance markets. If the state intends to prevent hospitals from shifting their costs onto employers, we think it is critical that the administration look for other ways to address the cost shift now. Cost shifting needs to be prevented - not allowed to increase.

2. **Monopolistic behavior will continue**

The Draft Proposal does nothing to address the monopolistic behavior of health systems that is currently driving high prices and limited competition in Colorado. As referenced in the 2019 January Health Care

[1] Colorado Health Care Affordability and Sustainability Enterprise: Cost Shift Analysis Report January 2019. https://www.colorado.gov/pacific/sites/default/files/2019%20January%20HCPF%20Cost%20Shift%20Analysis%20Report%20Draft.pdf

Policy and Financing Cost Shift Report, in 2009 only six systems owned twenty-three hospitals, but by 2019, seven systems own forty-one hospitals.[2] At the same time, these systems are also buying up physician practices and delivering more expensive care at these hospital-owned practices.[3] The cost shift will only be more pronounced under the Draft Proposal given the consolidated market. By excluding providers from the State Option, hospital-owned practices will now have additional leverage (and incentive) to increase provider rates knowing that carriers are required to offer a State Option plan and cannot otherwise build networks. The state is therefore encouraging hospitals to shift their costs through increased reimbursements from hospital-owned providers and such increases may very well offset any savings from mandated hospital rates.

CAHP is also very concerned that without changes to network adequacy rules, most carriers would struggle to build networks for a State Option plan, particularly in the same rural areas that carriers have opted not to offer plans currently – typically due to limited provider/hospital availability and/or provider rate considerations.

3. How to achieve affordability?

CAHP fully supports the goal of ensuring that Coloradans have access to quality health insurance coverage and affordable premiums. However, the definition of "affordability" offered in the Draft Report is very subjective and does not take into account the Affordable Care Act's affordability standards set at the federal level. The unanswered question is: how will "unaffordable" premiums be offset?

Carriers are strongly concerned about how we will provide actuarially sound rates to the DOI under a new, subjective definition of affordability. As you know, current premiums and cost-sharing parameters reflect current costs for health care in Colorado. We are extremely troubled by the fact that insurers could face a situation in which it becomes difficult, if not impossible, to meet any new affordability requirements, as well as existing federal and state requirements, and submit actuarially sound rates.

Goal is increased competition, but outcome is likely less competition and innovation

1. Elimination of competitive advantages by choosing winners and losers in the market

The mandate in the Draft Report for carriers to offer State Option plans is hugely problematic for carriers. Our industry is one of Colorado's most heavily regulated industries and decisions about where and how to conduct business and what types of products to offer are the most fundamental decisions for any Colorado business. As a matter of principle, Colorado health plans are opposed to the adoption of state laws or policies to force – through statutory authority, regulatory authority, or otherwise – private health plans to do business in markets where they do not currently operate, or to offer products that they do not currently offer.

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[2]Colorado Health Care Affordability and Sustainability Enterprise: Cost Shift Analysis Report January 2019. https://www.colorado.gov/pacific/sites/default/files/2019%20January%20HCPF%20Cost%20Shift%20Analysis%20Report%20Draft.pdf

[3] Ibid.

Colorado health plans also hold significant concerns that if such mandates are adopted, they will fail to establish meaningful or sustainable competition on Colorado's individual market, while also subjecting our state's broader health care marketplace to the risk of massive disruption and unintended consequences. Rather than incentivize health plans to compete and innovate through differentiated services and product offerings, the Draft Proposal mandates where health plans must conduct their business and what products the health plans must offer.

Fundamentally, compelling participation throughout different markets and different regions is wholly anti-competitive and does not make Colorado an attractive place to do business. While we recognize the notion of the DOI and HCPF that this is a "public-private partnership" we would appreciate the opportunity to choose to be part of that partnership.

2. Lack of choice for Coloradans

Colorado has one of the most competitive state marketplaces in the country.[4] While CAHP members recognize the need for improvements - particularly in high-cost, rural areas - by forcing all carriers to offer plans in the individual market, the current diversity of the individual market will be replaced by one-size-fits-all plans.

The Draft Proposal aims to establish a new, and tightly regulated health plan product and suggests that all carriers would be required to offer the same product in terms of the covered benefits and design. However, there are fewer facilities and providers in many of the twenty counties with only one individual health plan option. Accordingly, even if there are multiple carriers offering the State Option in those counties, those plans will likely share most, if not all, of the same health care facilities and providers in their networks. Without a guarantee that providers and facilities have to contract with carriers offering the State Option in rural areas, we do not see how the State Option can succeed in the high-cost, rural areas where help is most needed.

Additionally, government intervention to determine which businesses can thrive will massively disrupt the market after years of uncertainty. Experts have widely noted that while the individual market is beginning to stabilize, "that stability could be shaken if policies keeping changing."[5] This is particularly concerning given Governor Polis' October 10 announcement of 2020 rates which showed an average decrease of 20.2% across Colorado.[6]

3. Discourage carriers to operate in Colorado

CAHP members have serious concerns about the Draft Report's proposal to increase the Medical Loss Ratio (MLR) from 80% to 85% for the State Option plans. Current insurance premiums directly reflect the underlying cost of health care goods and services. While the Draft Report suggests that there would be administrative savings from the State Option, carriers respectfully and strongly disagree with that

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[4] Connect for Health Colorado® Among the Most Competitive State Marketplaces, New Analysis Shows https://connectforhealthco.com/connect-for-health-colorado-among-the-most-competitive-state-marketplaces-new-analysis-shows/
[5] Colorado Health Institute: How Does Colorado's Health Insurance Market Compare to Other States? https://www.coloradohealthinstitute.org/blog/how-does-colorados-health-insurance-market-compare-other-states
[6] https://www.colorado.gov/governor/news/gov-polis-2020-aca-premiums-going-down-average-202

assumption. Although the state would determine reimbursement rates for hospitals, carriers would still be responsible for negotiating, constructing, credentialing, and managing the contracts with the hospitals, in addition to creating networks with other providers in order to have a viable network. Carriers are also required by law to pay state and federal taxes and fees, meet federal and state regulatory requirements, and provide consumer and administrative services – nearly all of which is not counted as medical care under the MLR. Current taxes include: Colorado's premium tax (2% of gross premiums[7]), Connect for Health Colorado assessments (3.5% of premiums for the individual market), and the federal health insurance tax.

Recognizing that on average, only 2.7 cents of every premium dollar goes to net profit, health insurance carriers would be still be required to meet all their statutory obligations under a higher medical loss ratio. Compelling carrier participation in the market, while reducing the opportunity to be financially sustainable in that market, means that carriers will have to make difficult decisions about their ability to operate in Colorado. This is especially true since the most recent report from DOI shows carriers were already operating at a loss of -4.9% in the individual market.[8]

The Draft Report notes the importance of "creating a reasonable provider reimbursement fee schedule that ensures the market functions more efficiently and that providers have the right incentives to continue to thrive."[9] As businesses and employers of Coloradans, we too, would like the opportunity to thrive in the Colorado marketplace. There are more than 23,000 Coloradans employed by, or as part of, the health insurance industry and together we contribute more than $250 million in state taxes.[10]

Considerations for the administration

There are less disruptive ways to achieve the goals of HB19 - 1004

We appreciate the effort to solve many problems at once but doing so creates many unintended consequences that are in direct opposition to the stated goals. We recommend focusing on the uninsured and underinsured populations rather than the entire state.

To achieve the goals of decreasing health care costs and increasing competition, we suggest the administration look to expand and fund programs that are already working. For example, the reinsurance program has shown that premium costs can be reduced significantly by taking the highest cost claims out of the risk pool. However, the reinsurance program is only funded in the short term. Ensuring long-term funding for reinsurance would ensure that the 20.2% premium reductions are permanent.

We are also seeing the effectiveness of community-based and employer-based purchasing alliances which are still in their infancy and are seemingly a positive mechanism to inject competition into the marketplace. We support these innovative initiatives as a means to bring down health care costs in Colorado. The administration

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[7] C.R.S. 10-3-209

[8] Division of Insurance Health Cost Report 2018. https://drive.google.com/drive/folders/0B_UoCf17OVmWfmdCd1g5bXJCZ2ZXZWdiWk1wbktpWUQwUTgwT2JiT3pMeWl1UU1zMEZOTG8

[9] HB19 – 1004 Draft Report for Colorado's State Coverage Option Appendix. https://www.colorado.gov/pacific/sites/default/files/HB19-1004%20Draft%20Report%20Colorado%20State%20Coverage%20Option%20and%20Appendix.pdf

[10] AHIP Colorado Health Insurance By the Numbers. https://www.ahip.org/wp-content/uploads/Colorado_StateDataBook_2019.pdf

has made notable changes this year which could have promising and lasting impacts for health care coverage in Colorado and we worry that these initiatives would be eliminated given the current State Option proposal.

To address affordability, Colorado could look to other states where an individual mandate coupled with state premium assistance tax credits were instituted to help the uninsured and under insured populations access coverage. [11]

We fully understand and support the goals of increasing competition and decreasing costs, but the broad, disruptive nature of the proposals in the Draft Report are not the best way to achieve those goals. Rather than trying to solve one problem, the Draft Report aims to fundamentally reshape the entire Colorado marketplace, potentially risking the gains that will be achieved by the reinsurance program, the employer purchasing collaboratives, the surprise billing prohibition and other 2019 initiatives. We think a more measured approach would be preferable for all stakeholders so that we can continue to build on what is working and fix what isn't.

Thank you for the opportunity to share our concerns and we look forward to working with you on the best approach to providing affordable, high quality health care to all Coloradans.

Sincerely,

Amanda Massey
Executive Director, Colorado Association of Health Plans

[11] California's Initiatives Will Lead to Hundreds of Thousands Gaining Health Care Coverage With Lower Premiums and New Financial Help. https://www.coveredca.com/newsroom/news-releases/2019/07/09/californias-initiatives-will-lead-to-hundreds-of-thousands-gaining-health-care-coverage-with-lower-premiums-and-new-financial-help/

COLORADO CENTER
on LAW & POLICY
Forging Pathways from Poverty
789 Sherman Street Suite 300 • Denver, Colorado 80203 | P) 303.573.5669 • F) 303.573.4947

October 28, 2019

Commissioner Michael Conway
Colorado Division of Insurance
1560 Broadway, Ste 110
Denver, Colorado 80202

Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant Street
Denver, Colorado 80203

Dear Commissioner Conway and Director Bimestefer:

Thank you for this opportunity to comment on the Draft Report for Colorado's State Coverage Option and for your attention to priorities raised by consumer advocates. Over just a few months, the State has met with stakeholders statewide, conducted detailed analysis, and put together a nuanced proposal, and we recognize the effort that has entailed.

The Colorado Center on Law and Policy (CCLP) stands with diverse communities in a shared fight against poverty. We use research, administrative advocacy, education, and litigation to help achieve our vision of a Colorado where everyone has what they need to succeed. Our comments here are submitted on CCLP's behalf and are intended to supplement comments made jointly with the Colorado Consumer Health Initiative and several other organizations.

While CCLP supports many of the components of the proposal it is essential that a state option provide savings for all Coloradans, and not just those who are ineligible for subsidies. Because of a quirk in the way subsidies are calculated under the ACA, a system that requires almost all carriers to create "state option" plans is projected to result in savings for Coloradans with above-median household income at the expense of Coloradans in low- or moderate-wage jobs. We do not believe this outcome was the intention of legislators when passing HB19-1004, of Governor Polis when signing the legislation, or of the state agencies tasked with creating the proposal, and believe adjustments can be made to shift that outcome.

In order to ensure trust in a state option, we also believe that public oversight must be meaningful. A proposed structure must have enough transparency to give Coloradans confidence that the plans are serving public need, and its advisory board must have sufficient authority that the plan will continue to evolve to meet public goals.

Below, we offer comments on the proposal, including recommendations on improving affordability across the income spectrum, ways to improve networks and allow for better continuity of care between programs and payers, and ways to improve transparency, governance and usability of a state option.

1. Plan benefits, standardized plan design and Value-Based Insurance Design (V-BID)

We strongly support inclusion of all Essential Health Benefits (EHB) and improved access to a defined set of benefits pre-deductible in a standardized format. According to a recent study, current deductibles for silver and bronze plans on the individual market are sufficiently high that only a small fraction of lower-income enrollees see a clear financial benefit from coverage[1] though there are other benefits, such as risk avoidance and provider choice, that may make coverage worthwhile. This information is consistent with CCLP's study on deductible affordability, which found that few Coloradans had sufficient resources to pay a deductible after meeting basic needs, meaning that many would have to borrow money or forgo needed care.[2] We support the state's intention to use the state option to demonstrate investment in primary care, as described by the Primary Care Collaborative created under HB19-1233.

We have no objection to increasing use of Value-Based Insurance Design (V-BID) principles in the design of the state option. However, if V-BID relies on imposition of lower or higher cost-sharing to influence enrollee use of services, it will be essential that disproportionate impact on people with disabilities and households with lower income be considered and avoided. While reducing cost is important, equal emphasis should be put on the goals of enhancing enrollee experience and improving outcomes at all income levels.

We strongly support plan standardization, which allows enrollees to know what to expect regarding benefits and cost-sharing, regardless of carrier, and the creation up-front of a system for measuring the plans' impact.

- We recommend that plan standardization be comprehensive. It should include specific pre-deductible benefits, set cost-sharing, and utilization management criteria and processes that are public and transparent to both enrollees and providers.
- To the extent that V-BID principles are included, they should be incorporated into plan standardization. Adopting V-BID approaches in all state option plans will improve measurability of outcomes and reduce burdens on providers.
- We recommend that the State Option Advisory Board be charged with making recommendations on standardized plans, approving the plan design and recommending and approving subsequent changes.
- Prior to launching the plans, the DOI and HCPF, with input from the Advisory Board, should establish how the state will measure the plan's ability to lower costs, enhance enrollee experience and improve outcomes for defined populations.

2. Broad-based availability on and off-Exchange

An option designed and overseen by the state of Colorado should be available to all its residents, regardless of income, geography, age, or eligibility for subsidies either due to immigration status or other ACA requirements. By adopting this approach, the state can avoid or reduce disparities

[1] Naomi Zewde, "Did Marketplace Coverage Really Offer Financial Protection? Financial Gains from the Affordable Care Act's Private Insurance Policies for the Previously Uninsured." Roosevelt Institute Working Paper, October 2019.
[2] Charles Brennan, "Deductible Affordability for Colorado's Working-Age Families." Colorado Center on Law and Policy, August 12, 2019. https://cclponline.org/pub_library/deductible-affordability-for-colorados-working-age-families/

created by limitations on access to coverage. We support broad availability and use of Connect for Health Colorado platforms to offer the state option on and off exchange.

3. Provider reimbursement and network adequacy

We support the state establishing reimbursement rates for hospitals and hospital-owned practices that are in line with reimbursement in other states. We believe that the range described, 175 to 225 percent of Medicare, is reasonable in light of available data. A 2008 study by Milliman found that commercial carriers typically paid 1.28 times Medicare rates.[3] A more recent study of reimbursement rates in Texas found comparisons between Medicare and commercial rates that generally align with the proposed range.[4]

At the same time, it is important that providers be willing to join networks and that a state option plan gives enrollees adequate access to specialists and hospital-based care. We anticipate that it would be difficult for multiple carriers to establish networks in a given area at the lower reimbursement rates, and offer solutions below. As stated in the joint letter with CCHI, we encourage the State to more specifically address treatment of not just rural hospitals but also other rural providers whose participation will be essential to establishing networks state-wide. In addition, we note that a significant drop in Medicaid enrollment over the past two years has left some types of providers with more uninsured patients; we would recommend that the State also consider payer mix for non-hospital providers when establishing reimbursement benchmarks.

In order to make reimbursement levels more financially manageable for participating providers, we propose certain measures that could reduce administrative burdens on providers and improve continuity of care across systems. The reduction of administrative burdens on providers can result in considerable savings to providers and the system overall. Analysts estimated that the U.S. health system spends twice as much as necessary on administrative costs, including utilization management.[5] A study of California providers found that billing and insurance-related costs accounted for one eighth of physician revenue.[6]

- We recommend that Medicaid enrolled providers be deemed to have met provider certification requirements for state option plans. Those providers will face fewer barriers to joining the state option network, and individuals who transition from Medicaid to commercial coverage can more easily maintain a relationship with their provider.

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[3] Fox W, Pickering J. Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid and Commercial Payers. Milliman; 2008. http://www.aha.org/content/00-10/081209costshift.pdf.

[4] Trudy Millard Krause, Maria Ukhanova, Frances Lee Revere, "Private Carriers' Physician Payments Compared with Medicare and Medicaid." Texas Medical Association, June 2016. https://www.texmed.org/June16Journal/

[5] James G. Kahn, "Excess Administrative Costs," in Pierre L. Young, Robert S. Saunders, and LeighAnne Olsen, eds., *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary* (Washington: National Academies Press, 2010), https://www.ncbi.nlm.nih.gov/books/NBK53942/

[6] James G. Kahn and others, "The Cost of Health Insurance Administration in California: Estimates For Insurers, Physicians, and Hospitals," *Health Affairs* 24 (6) (2005): 1629–1639, available at https://www.healthaffairs.org/doi/10.1377/hlthaff.24.6.1629.

- We recommend that state option plans be required to contract with all Essential Community Providers in their service area. Individuals who were previously Medicaid-covered or uninsured will be more likely to be able to maintain a relationship with a provider.
- State option reimbursement rates for Medicaid-enrolled providers and ECP providers should be sufficient to allow them to maintain a mixed caseload, i.e. at or above costs.
- We recommend that utilization management criteria and processes be standardized and transparent. Doing so, especially in the context of standardized plan design, will ensure greater consistency in access to benefits for enrollees, and will reduce administrative burdens on providers.

4. Impact on subsidized enrollees

The needs of the population eligible for subsidies should be a priority for the State. While some aspects of the proposal, such as pre-deductible benefits, would improve subsidized enrollees' access to health services, reduced buying power would result in higher monthly costs and potentially cause more individuals to go uninsured. The majority of Coloradans have income under 400 FPL, and approximately five times as many uninsured Coloradans have income between 139 and 400 FPL, compared to those over 400 FPL.[7] Based on data provided by Families USA, Coloradans enrolled in subsidized plans are more likely to be Latino and urban or suburban than unsubsidized individual market enrollees.[8] In 2019, at least three-quarters of Connect for Health enrollees were determined subsidy-eligible, though the number eligible could be higher because unsubsidized customers may not have investigated their eligibility for tax credits. Coloradans who receive subsidies typically have incomes below self-sufficiency, meaning that their financial resources are insufficient to meet basic needs, including housing, food, transportation, and child care, and a small increase in health care costs can have a major impact on the ability to make ends meet.[9]

Even if additional funding made available through a 1332 waiver could be targeted toward the subsidy-eligible population, that funding would likely be too little and too late. We believe the silver spread should be addressed at the outset. Addressing the silver spread would do nothing to undermine the significant benefit that the state option could provide to Coloradans with higher incomes, particularly those in the high-cost mountain region, many of whom dropped coverage through Connect for Health when premiums rose sharply in 2018.[10] In order to preserve the spread between the silver benchmark and the lowest-cost silver plan and prevent harm to the subsidized population, the State may take one of the following steps:

- Create a process to select one carrier that will offer the state option plan in all regions of the state. Billy Wynne, CEO for Direct Health PBC, has proposed such a process. This option would maintain the silver spread and increase the likelihood of an adequate network.

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[7] Based on 2017 ACS data showing uninsured rates as follows: 139-199 FPL – 14.6%; 200-299 FLP – 13.3%; 300-399 FPL – 9.0%; 400-499 – 5.9%; 500+ FPL – 2.8%

[8] Source: National Center for Coverage Innovation at Families USA (NCCI) analysis of American Community Survey (ACS) data for 2017.

[9] The Self-Sufficiency Standard For Colorado 2018. http://www.selfsufficiencystandard.org/sites/default/files/selfsuff/docs/CO18_SSS_Web.pdf

[10]. Source: National Center for Coverage Innovation at Families USA (NCCI) analysis of American Community Survey (ACS) data for 2017.

- Create a process to select one state option carrier for each geographic rating area. This option would also maintain the spread and increase the likelihood of an adequate network.
- Allow multiple carriers to create state option plans but coordinate with Connect for Health Colorado to ensure that a single silver state option is certified for purchase through the exchange. The number offered off-exchange need not be limited.
- Apply for a 1332 waiver to exempt state option plans from the benchmark process and base benchmarks on non-state-option plans only.

5. Advisory board

We support the creation of an advisory board for the state option. As stated in the joint letter, board appointments should reflect Colorado's ethnic, economic and geographic diversity and the views of subsidized and unsubsidized enrollees, as well as people with disabilities. Representation by the health industry should not be disproportionately greater than consumer representation. For more information, we refer you to the joint letter regarding processes that can increase the likelihood of an inclusive board membership.

Board members should have enough access to information that they can play a meaningful role, and be given authority to approve proposals for standardized plan design, ensuring that the products continue to serve the needs of the public. We believe that inviting robust board input into the plan will increase the plan's quality, visibility, and uptake by both enrollees and providers. Moreover, it would give the public assurance that the state option was designed and run in a way that serves public needs, and is not a state option in name only.

6. 1332 waiver

We refer you to the joint letter for our position on opportunities created by a waiver, and to questions as to the specific ACA provision that the State would seek to have waived. One waiver concept noted here would be to exempt state option plans from the benchmark process. Should a waiver be granted, we support the State's proposal that pass-through funds could be used to increase premium subsidies and lower out-of-pocket costs, address the family glitch and fund high-value benefits such as dental coverage.

Conclusion

Thank you for your consideration of our comments and recommendations. We appreciate the work of the Department of Health Care Policy and Financing and the Division of Insurance to engage Coloradans around the state, and to develop a proposal that uses public and state expertise to tackle financial and structural obstacles to better health.

Very truly yours,

Bethany Pray
Health Program Director

COLORADO
COMMUNITYHEALTHNETWORK
Access for All Colorado

Executive Director Kim Bimestefer
Health Care Policy and Financing
1570 Grant Street
Denver, Colorado 80203

Commissioner Michael Conway
Division of Insurance
1560 Broadway, Suite 110
Denver, Colorado 80202

Re: Feedback on Draft Report for Colorado's State Coverage Option

Dear Director Bimestefer and Commissioner Conway:

Thank you for the opportunity to provide feedback on the Draft Report for Colorado's State Coverage Option, dated Oct. 7, 2019.

Colorado Community Health Network (CCHN) is the membership association for Colorado's 21 Federally Qualified Health Centers (FQHCs), which operate more than 200 clinic sites in 42 counties and care for Coloradans from 63 of the 64 counties in the state. CCHN's mission is to support FQHCs to increase access to high quality health care for people in need in Colorado.

FQHCs are the health care home for more than 830,000 people, including 27 percent of Medicaid enrollees, 25 percent of CHP+ enrollees, and 40 percent of Colorado's uninsured. Over 92 percent of patients at Colorado FQHCs have family incomes below 200 percent of the Federal Poverty Level (FPL). Twenty-one percent of FQHC patients statewide are uninsured, compared to the Colorado statewide uninsured rate of 6.5 percent.

On the whole, CCHN is supportive of the draft plan and appreciative of the thoughtful process and analysis that both departments took in their approach to developing it. Many elements of the plan align with recommendations that CCHN made previously during the stakeholder process. Thank you for crafting a plan that:

- Provides access to all Colorado residents,
- Covers Essential Health Benefits including behavioral health treatment,
- Provides a greater set of high-value primary and preventive services that can be accessed pre-deductible,
- Takes total out-of-pocket costs and basic self-sufficiency standards into account for the affordability definition, and
- Protects the state budget.

CCHN also applauds the vision of modernizing the primary care system using this plan in concert with the Primary Care Collaborative (HB 19-1233) and other efforts. FQHCs are eager to continue to participate in opportunities to move more investment into primary and preventive care, and CCHN encourages further explanation in the final version of the plan of how these two initiatives can work in concert. We also appreciate efforts to set the stage for expanding the plan for other Coloradans (e.g. small group) and the potential to expand coverage (e.g. dental).

CCHN has the following specific feedback on elements of the proposal that may require further analysis or clarification:

Impact on CHC Patients
While CCHN is happy to see potential premium reductions of 9 to 18 percent, unfortunately we do not anticipate that these will help a significant number of the uninsured patients at FQHCs. The vast majority (92 percent) of FQHC patients have incomes below 200 percent FPL. For those who are ineligible for marketplace subsidies, the resulting premiums outlined in the Wakely actuarial analysis (of approximately $443 to $490 monthly) are unlikely to be low enough to purchase coverage. For example, an individual living at 150 percent of FPL and making $18,210 per year would pay between $5,316 - $5,868 annually in premiums, or 32 percent of their income.

For FQHC patients who are eligible for marketplace subsidies, CCHN encourages the state to give further consideration to methods that would reduce the likelihood of the state option devaluing premium tax credits.

CCHN supports the continued efforts to lower the costs of health care and coverage for the lowest income Coloradans who do not have other options for insurance coverage. FQHCs are proud to offer primary care to Coloradans regardless of their insurance status or ability to pay, however, having access to affordable and robust insurance coverage is a necessity and helps FQHC patients access specialty and emergency care without accruing what can often be crippling financial debt. This issue is acute due to the large and rising number of uninsured patients cared for by FQHCs.

Affordability
CCHN is appreciative of the plan's attention to affordability and the inclusion of total out-of-pocket costs and basic self-sufficiency. However, CCHN is concerned that setting hospital reimbursement could have the unintended consequence of incenting hospitals to integrate vertically (i.e. create their own primary care clinics) in an attempt to manage their budgets across service lines. It is essential that hospitals are not incentivized to develop primary care where there is adequate, high quality primary care already available. History has shown that primary care expansion by hospitals in some areas results in competition for the limited number of skilled providers and insured patients, leaving FQHCs and other safety-net providers with an unsustainable workforce and payer mix. Hospitals should instead be incentivized to partner with existing primary care providers (including FQHCs), and to develop accessible and open specialty care for patients of all insurance statuses.

Provider Participation
In planning to ensure sufficient provider participation in plans, and determining provider network standards, we wish to remind HCPF and DOI about the Essential Community Provider (ECP) provisions within 3 CCR 702-4, Regulation 4-2-53, Section 9 which are intended to ensure reasonable and timely access for low income, medically underserved individuals in their service areas. Current rules state that carriers shall demonstrate that at least 30 percent of available ECPs in each plan's service area participate in the plan's network. As a Qualified Health Plan, these standards should also apply to state option plans sold on the marketplace and we encourage the DOI to consider increasing the participation threshold to all ECPs in the area. Additionally, we encourage a similar standard for plans that are offered off Connect for Health Colorado.

CCHN further suggests that providers should be incentivized to take steps for better patient care. For example, where possible, primary care providers meeting certain criteria should be eligible for and included in preferred provider networks or higher reimbursement.

Criteria could include such things as:

- National Patient Centered Medical Home recognition, as an indicator of having in place a quality improvement infrastructure
- Offering some type of open access schedule or evening and weekend hours
- Being open to new Medicaid patients, and offering a sliding scale to uninsured patients, because patients in the State Option are likely to churn between these coverage options, and ensuring continuity of care will help keep costs down for the plan
- Public reporting of performance and access data

Value-Based Insurance Design

CCHN is interested in the innovation of using value-based insurance design to incent the best care for patients in a cost-effective way. As organizations that participate heavily with Medicaid, FQHCs are already well acquainted with these ideas and are well on the way to preparing for a value-based future that supports care coordination and quality improvements. When considering the types of behaviors to incentivize, FQHCs are interested in opportunities that would expand specialty care access for FQHC patients (including those covered by Medicaid or who are uninsured) and bolster creative and mutually beneficial partnerships between hospitals and primary care providers. FQHCs are already beginning to engage with hospitals with the Medicaid-covered population through elements of the Hospital Transformation Program (HTP) and we also encourage alignment in quality metrics between the state option's value-based incentives and HTP.

Rural and Critical Access Hospitals

The plan mentions protections for the financial well-being of rural and critical access hospitals, and acknowledgement for the differences in geographic costs of providing care. We encourage further development and clarification of these protections with the entities that will be impacted to ensure that the reimbursement for those hospitals ensures their financial well-being, and considers the different cost of living, cost of retaining talented providers, and the unique rural and frontier dynamics. Rural and Critical Access Hospitals are essential partners to FQHCs and invaluable care providers in key areas of Colorado.

Cost Savings: 1332 Waiver

The plan discusses the potential to draw down federal savings through a 1332 Waiver. CCHN is supportive of this application. For low income FQHC patients, premium and out-of-pocket costs are the primary barriers to purchasing private insurance. For FQHCs themselves, as mentioned in previous stakeholder comments, if a privately covered patient has a co-pay that is too high for them to pay, FQHCs will still see the patient and instead place them on the clinic's sliding fee scale. This is beneficial to patients who may be able to pay this lower fee, however FQHCs often do not get reimbursed at the level they should from private insurance because of this nuance. As a result, we encourage the use of the waiver savings to go toward lowering co-pays and premiums for low income individuals and families. However the savings are invested, CCHN encourages flexibility in order to take advantage of opportunities that may arise in the future.

Advisory Board
CCHN is very supportive of the creation of an advisory board to continue conversations and advise the state departments and legislature on implementation and growth of the state option. Because of the plan's intent of creating an affordable plan for Colorado consumers with an emphasis on primary care, we recommend ensuring that multiple seats are reserved for primary care providers, as well as health care consumers and consumer advocates. We also respectfully request a seat for an FQHC representative (from a FQHC or CCHN as the state association) in order to provide the nuanced experience of FQHCs to the board and this process. We encourage the State to ensure the Advisory Board has proper authority to make recommendations and/or decisions on the state option plan design such as affordability standards, value-based insurance design, alignment of quality metrics across programs, and payment reform efforts. There should also be adequate staffing for the advisory board via funding for FTE to provide project management and stakeholder outreach.

Thank you for the opportunity to comment and participate in the shaping of this innovative approach to coverage in Colorado. As you know, FQHCs provide a model of primary care which connects patients with medical, behavioral, and oral health care in an integrated setting. The result of this model is most often higher quality care for patients and efficient use of funds for payers. As health care costs across the state continue to rise, FQHCs continue to push for further investment in primary care as one method to drive overall health costs down. CCHN and FQHCs stand ready to partner on those efforts with the state and with other providers.

Sincerely,

Polly Anderson
Vice President, Strategy & Financing
Colorado Community Health Network
polly@cchn.org

October 28, 2019

Kim Bimestefer
Executive Director
Colorado Department of Health Care Policy and Finance

Michael Conway
Commissioner of Insurance
State of Colorado

Dear Executive Director Bimestefer and Commissioner Conway,

As we continue to progress through the HB19-1004 stakeholder process, the Colorado Competitive Council (C3) submits the following comments on the draft proposal.

One of C3's concerns is the mandatory participation in the program for carriers and hospitals. Requiring a company to provide services in a market doesn't spark competition or guarantee lower costs. Rather, it could do the opposite. Mandating companies to participate in markets in which they may not have the resources to serve only adds inefficiencies and costs, putting a greater burden on the system and driving costs.

C3 is also opposed to the use of government price setting. The better and more sustainable way to lower prices is to use the market as was done in Summit County recently with the addition of PEAK Health. This model showed that health care rates can be influenced by the market when communities come together.

Ultimately, the forced participation and market rate caps will have the unintended consequences of shifting costs to Colorado employees, many of whom are already struggling with the costs of providing health care for their employees. If you control rates in one segment of the market, the costs not covered don't just disappear. They will shift to different portions of the market, such as ERISA plans that are beyond the authority of the state and therefore cannot be monitored.

Thousands of Coloradans receive their health care through their employer and the unintended consequences of these regulations will further burden employers and employees with increased costs, even as employers and employees are already struggling to pay for health care.

While the goal is laudable and we appreciate and share your commitment to decreasing health care costs, the Colorado State Coverage Option does not meet our criteria for support. We hope you will work with us to address our concerns moving forward as we continue working to finding additional solutions to the cost of health care.

Thank you for taking our comments into consideration and please contact Nicholas Colglazier at Nicholas.Colglazier@ColoradoCompetes.org with any questions.

Sincerely,

Nicholas Colglazier
Colorado Competitive Council
Director

October 28, 2019
Commissioner Michael Conway
Colorado Division of Insurance
1560 Broadway, Ste 110
Denver, Colorado 80202

Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant Street
Denver, Colorado 80203

Re: Comments on the Draft Report for Colorado's State Coverage Option

Dear Commissioner Conway and Director Bimestefer:

Thank you for this opportunity to comment on the Draft Report for Colorado's State Coverage Option, your attention to consumer priorities, and your diligence in preparing the report in a very short timeline.

The undersigned organizations generally support the provisions of the proposed draft report and appreciate the ongoing stakeholder engagement; however, we do have a few questions and concerns we believe merit further clarification. We strongly believe that there is potential harm to the subsidized population in the proposed draft report. We urge the State to further analyze the impact of this proposal on Coloradans eligible for premium tax credits and identify any policy changes that mitigate the potential for harm, while still preserving choice and affordable options.

We appreciate that the draft report aims to address many areas of concern that consumer advocacy organizations, including CCHI and many of the undersigned organizations, raised during the previous comment periods. We **support** the following provisions:

Standardized Plans
We strongly support the desire to standardize the plan benefit design under the state option plans. We believe this effort will make it easier for consumers to shop and compare plans, knowing the benefits and cost-sharing will remain the same while they weigh other benefits, such as customer service, quality, and networks offered by carriers. Additionally, we fully support making high-value services available pre-deductible, especially primary care and behavioral health. We urge the state to include as many pre-deductible services as possible within the constraints of the actuarial value of the plan, as this will add value by allowing those consumers with high-deductible health plans to afford and access care they otherwise might not be able to.

Furthermore, we urge the State to consider minimizing reliance on coinsurance wherever possible. Compared to copays, coinsurance is a much harder to understand and predict what a consumer will pay out-of-pocket for any given service. Also, recognizing the critical role of health care during pregnancy and childhood, we suggest that benefits for pregnant people and children be at least as generous as Colorado's Child Health Plan *Plus* (CHP+), with similar cost-sharing limits. Finally, we also encourage the State to consider how current utilization management criteria and formulary designs will be impacted (if at all) by standardizing the plan design for the state option plans, in addition to standardizing the cost sharing requirements.

Broad Eligibility

We strongly support the provisions to make the state option plans available to all Colorado residents. However, it should be noted that we do have significant concerns about the affordability of the product for low-income individuals who are not eligible for subsidies, and for subsidized enrollees for whom subsidies are reduced due to the impact of lower premiums for the benchmark plan.

Essential Health Benefits Coverage
We believe it is imperative for the state option plans to cover all essential health benefits, and it is our assumption that the essential health benefits will cover pediatric dental.

Use of Exchange Infrastructure
Connect for Health Colorado has reached stability and sustainability. We support leveraging Connect for Health Colorado's technology and services to help facilitate the sale of and enrollment of individuals into the state option plans.

Consistency with Other Legislative Initiatives
We appreciate the State's attention in coordinating with other various legislative initiatives, specifically the primary care collaborative, to ensure that we are able to leverage the same definitions and affordability standards in supporting the development of the state option plans.

Advisory Board
We support the creation of an advisory board as part of the infrastructure surrounding the state option. We would like to ensure that multiple consumer appointments are permanent seats of the Advisory Board's structure. Specifically, we'd like to note that the consumer appointments should represent not only a diversity of geographies, ethnicities, and income levels (including both subsidized and unsubsidized representation), but also a diversity of health care perspectives, including but not limited to those with a focus on chronic disease, physical disabilities, caregivers, high- and low-utilizers. These appointments, to the extent possible, should be compensated for their time, including provisions for child and/or dependent care, parking, remote participation, and lodging, when necessary. The health care industry should be represented on the Advisory Board, but not hold a disproportionate number of seats in comparison to the consumer representatives.

Additionally, we encourage the State to consider giving some authority to the Advisory Board to review and make recommendations or decisions on the state option plan design, including but not limited to affordability standards, payment reform efforts, value-based insurance design, quality metrics, and cost and growth benchmarks. In order to ensure these recommendations or decisions are well-informed, we believe the Advisory Board should have access to data and analysis, as needed. Furthermore, we encourage the State to consider recommending funding one or more FTE to serve the Board members with project management and coordination of stakeholders as needed.

Prescription Drug Rebates
We strongly support passing through rebates from pharmaceutical manufacturers to consumers in an effort to bring down the cost of prescription drugs and coverage. We believe the best way to do this in the individual market is to count prescription drug rebates in the MLR as either an administrative cost or as a negative factor out of claims. This should be transparently reported in the carrier's rate filings.

1332 Waiver
While we are unclear exactly which provisions of the ACA will be waived under a 1332 waiver, we do support the application of a waiver in order to realize the maximum pass-through funding

available. It is imperative that the state recoup these savings to ensure the affordability needs of low-income Coloradans are met. If the state is successful in applying for a 1332 waiver, , we support the state using the funding to increase premium subsidies for low-income enrollees, reducing the out-of-pocket cost sharing for low-income consumers, and for funding an imbedded adult dental benefit.

While we are generally supportive of the proposed draft report, we do have several **areas of concern**. Further clarification on the following provisions is imperative to better understand how the proposed draft would affect health care consumers in Colorado. The following are proposed provisions that we urge the State to either reconsider or provide further clarification on:

Impact on Provider Networks
As CCHI has previously commented, we support the State setting reasonable reimbursement rates for hospitals and hospital-based providers. As we understand it, the intention in the draft proposal is to set the reimbursement rate between 175% and 225% of Medicare rates. We strongly encourage the State to clarify which entities this reimbursement rate will apply to (hospitals vs. hospital-based providers vs. non-hospital-based providers).

Additionally, we urge the State to consider the impact that this reimbursement rate will have on network adequacy and access to specialists. In order to ensure that the state option plan provides adequate, quality networks, the State needs to ensure specialist participation for both hospital-based and non-hospital-based providers, as many individuals with chronic conditions rely on their specialists as a routine source of care. Furthermore, we have concerns that hospitals could refuse to participate, leaving large areas of the state without in-network access to hospital-based and emergency services under the state option plan.

In order to mitigate some of these concerns, we suggest the following changes for further consideration. These ideas may have the added benefit of improving continuity of care for individuals who churn between Medicaid and commercial insurance.

- Allow providers that are already credentialed with the Medicaid program to be automatically credentialled with the state option plan carriers. In other words, require carriers offering the state option to accept all providers that have already been enrolled as Medicaid providers, without further credentialing requirements.
- For some providers, including existing Medicaid providers, primary care providers, behavioral health providers (especially in rural areas), midwives and obgyns, offer a minimum reimbursement guarantee to incentivize their participation. We are unable to recommend what the minimum reimbursement should be, but suggest that it be **at least** the Medicaid reimbursement rate.
- Require all carriers offering the state option plan to contract with all Essential Community Providers (ECPs) in their geographic service area, which will help supplement the potential workforce shortage in primary and preventative care.

Finally, we encourage the State to address linguistic and cultural responsiveness of providers within provider networks. For Coloradans that speak a language besides English at home, it is critical to ensure that State Option plan providers and carriers are prepared to offer translation and interpretation services.

Impact on Rural Communities
We appreciate the stated commitment to "fiercely" protect rural hospitals and providers; however, we encourage the State to provide further clarification in order to protect access to care for

residents in rural areas that currently have limited (or no) alternative access points. Additionally, rural hospitals are often the largest (or one of the largest) employers in a community, and a reduction in reimbursement rates could have drastic impacts on a community's economy, with unintended consequences resulting in an increase in poverty, unemployment rates, and/or dispersion.

Impact on Subsidies

We are generally encouraged that the overall impact on insurance premiums is predicted to be a 9-18% reduction. However, we are concerned that the reduction in premium rates will also reduce the benchmark plan premium (second lowest cost silver plan), which is the plan that premium tax credits are based upon. The unintentional effect of this change will reduce the purchasing power of the subsidies for those that are eligible, especially those that qualify for cost sharing reduction plans.

In order to mitigate this concern and help preserve the value of the premium tax credits, we suggest the following for further consideration:

- Only one carrier in every geographic rating area could offer a silver state option plan, leaving a higher priced benchmark plan, and therefore higher PTCs; any carrier could offer state option plans in the gold and bronze metal tiers, and in the silver, off-exchange metal level.
- Connect for Health Colorado or the Division of Insurance could have the authority to select a particular silver plan to offer on the exchange for the purpose of maximizing the benchmark premium price and PTCs, and all other silver plans would be offered off exchange.
- The State could apply for a waiver to exempt state option plans from the benchmark process.
- Only bronze and gold level could be state option plans.

**please note that we have not yet analyzed the impact of any of the above suggestions and urge the State to conduct additional actuarial analysis to determine if any of these are both feasible and mitigate concerns.*

Furthermore, to the extent it is not possible to adequately meet the needs of the subsidized population with the same solution as the unsubsidized populations, we suggest that the State explore allowing for multiple, alternative solutions tailored to the needs of each population. In fact, it may be necessary to customize solutions by income level, even within the subsidized population, as the affordability concerns and impacts on consumers may vary between 138% and 400% FPL.

Value Based Insurance Design

We appreciate the emphasis on creating higher value insurance products, and we also want to ensure that VBID does not lead to discriminatory practices and utilization management criteria for people with chronic conditions. VBID should be designed to support care coordination and quality improvements, and should take into account chronic disease management; it should not be employed solely as a cost saving mechanism. Furthermore, we encourage the State to consider the additional burden on providers associated with various value-based initiatives and quality metrics. To mitigate this concern, and thus incent provider participation, we suggest the State adopt the same requirements and VBID across all state option plans. Monitoring VBID design and implementation could be the role of the Advisory Board.

Commitment to Equity and Privacy

We believe the State has an opportunity to advance equity in health care through the State Option plans—both through the culturally and linguistic responsiveness addressed above, and through data security. Data security is increasingly important, especially for immigrants whose information can be particularly vulnerable due to documentation status. The State Option plan carriers and providers should be required to build strong protections with strict firewalls that prohibit sharing information across systems and agencies for **non-health purposes.** User's information should never be shared with any federal or state authorities without proper legal justification and due process.

***

In conclusion, we appreciate the outreach and engagement by HCPF and the DOI in seeking feedback during this process to create a state health care coverage option that meets the needs of all Coloradans.

Sincerely,

Colorado Consumer Health Initiative
All Families Deserve a Chance Coalition
Chronic Care Collaborative
Colorado Center on Law and Policy
Colorado Children's Campaign
Colorado Cross Disability Coalition
Colorado Fiscal Institute
One Colorado Education Fund
Stahlman Disability Consulting, LLC
Young Invincibles, Rocky Mountain

BY EMAIL: HCPF_1004AffordableOption@state.co.us

October 28, 2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Commissioner Michael Conway
Department of Regulatory Agencies, Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Subject: Dental Coverage in HB19-1004 Proposal

Dear Director Bimestefer and Commissioner Conway,

The Colorado Dental Association (CDA) would like to thank the Division of Insurance and the Department of Healthcare Policy and Financing for recognizing the key importance of dental coverage for Coloradan's health in the draft Report for Colorado's State Coverage Option on public option ("draft report") as required by House Bill 19-1004.

As reflected in our prior comments, ensuring equitable patient access to dental services has been a primary focus for the CDA for years. Dental health is a critical component of a person's overall health and fundamental to the design of systems which aim to achieve affordability and long-term cost efficiency. The CDA recognizes and respects the many important competing healthcare needs of Coloradans as well as the constraints of the current proposal, especially with regard to the impact of expanded services on affordability of premiums. Within these parameters and with an eye toward efficient, long-term systems design, the CDA continues to urge inclusion of comprehensive dental coverage for all Coloradans as it is feasible to include these services in future updates to this proposed plan – and potentially as a result of a federal Section 1332 waiver. We urge prioritizing dental benefits coverage for children, Coloradoans with disabilities and seniors, if all populations cannot be immediately served.

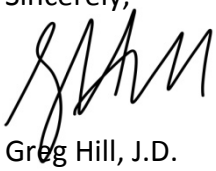
As emphasized in previous comments, the CDA urges that cost sharing be eliminated for at least preventive, if not all, dental care services for children that would have dental coverage under the Essential Health Benefits (EHB) elements of the proposed model. The draft report notes that "many services will be pre-deductible, including preventive care, primary care, and

behavioral health care," but it is not clear whether cost sharing for EHB dental services will be limited for preventive or primary care dental services – especially given the segregation of behavioral health services in this context.

Ideally, if a deductible is imposed for dental care services, the EHB dental plan included in the current proposal would also have a separate deductible structure (typically a $50 dental deductible) separate from the medical plan deductible in order to ensure meaningful coverage. Otherwise, patient families could be required to meet a much higher medical plan deductibles, or – depending on how the plan is structured – even meet the plan's out of pocket maximum, before the plan will begin paying for any portion of dental care services needed to prevent pain, infection and subsequent physical and behavioral health complications. Large deductibles to access pediatric dental care, as well as cost sharing barriers on preventive pediatric dental services, create significant barriers that prevent reasonable and expected patient access to dental care services classified as essential health benefits. In 2015, California required that all dental plans fully eliminate deductibles for all children's dental services with little to no increase in dental plan premiums.[1]

Thank you for your consideration in addressing these important components of health. If we can be of any further help in program design and infrastructure or other questions, please don't hesitate to contact us at (303) 996-2846 • greg@cdaonline.org or (719) 522-0123 • kahlja@msn.com respectively.

Sincerely,



Greg Hill, J.D.
Executive Director, Colorado Dental Association

Jeff Kahl, DDS
President, Colorado Dental Association

cc: Lorez Meinold, Keystone Policy Center

[1] http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0515_1.ashx

c|h|a
Colorado Hospital Association

Oct. 28, 2019

Director Kim Bimestefer
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Commissioner Mike Conway
Colorado Department of Regulatory Agencies
Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Dear Director Bimestefer and Commissioner Conway:

On behalf of more than 100 hospitals and health systems across Colorado, Colorado Hospital Association (CHA) appreciates the opportunity to provide feedback on the "Draft Report for Colorado's State Coverage Option," ("Polis proposal") released Oct. 7, 2019.

Colorado hospitals are proud to be a leading voice for ensuring all Coloradans have access to high-quality, affordable health care. We have done this by being steadfast advocates of coverage expansions and health care transparency; providing voluntary price reductions in competitive negotiations; focusing on providing high-quality care delivered at the right place at the right time; addressing public health crises such as the opioid epidemic; and investing in social determinants of health and community benefits that improve the overall health of Coloradans.

These efforts have paid off – Colorado ranks 9th in the country for overall health system performance and consistently ranks among the best states for measures such as physical activity, obesity, smoking, avoidable hospital use and cost, deaths from cancer, diabetes and cardiovascular disease.[1] And progress is accelerating: for the first time, individual market premiums will decrease by 20 percent on average next year, and even without the state's new reinsurance program, premium increases submitted by insurers were just 0.5 percent year-over-year – lower than both population growth or inflation, and a testament to the fact that Colorado is successfully constraining health care costs.[2]

House Bill (HB) 19-1004 offered the opportunity to examine whether Colorado could craft a "competitive state option for more affordable health care coverage," and CHA supported the legislation because it promised to bring patients, hospitals, providers, insurers, pharmaceutical manufacturers and policymakers together to discuss ways to improve the health care system, and these types of conversations are crucial to the success of any and all solutions.

Unfortunately, despite considerable stakeholder input provided during town hall-style forums hosted by the administration over the past several months, the process lacked any substantive and iterative discussions or debate of genuine solutions. As a result, the Polis proposal misses the mark because it prioritizes lower premiums at the expense of patient access and choice.

[1] https://scorecard.commonwealthfund.org/rankings/
[2] https://www.colorado.gov/pacific/dora/news/polis-administration-projects-182-average-decrease-premiums-individual-health-insurance-plans

Specifically, the Polis proposal:

- Fails to prioritize coverage and affordability for Colorado's remaining 375,000 uninsured, leaving this at-risk population even further behind.
- Fails to protect patient choice by undermining competition among insurers and health care providers.
- Fails to defend access to care by cutting hospital payments up to 40 percent.

CHA provides detailed feedback in the content below, but in general, we request that the final proposal submitted to the legislature incorporate the following changes:

- Refocus broad-scale affordability on the state's total spending on health care to support long-term, sustainable and comprehensive solutions that improve value for Coloradans.
- Consistent with legislative intent, identify ways to incentivize – not mandate – provider participation.
- Ensure all strategies contained in the proposal have actuarially sound cost savings projections and assess impact on patient choice and access to care.

We look forward to continuing to work with the Polis administration and legislators as we continue to fulfill our shared commitment to maintain and improve Coloradans' access to high-quality, affordable health care.

Sincerely,

Chris Tholen
Executive Vice President
Colorado Hospital Association

c|h|a
Colorado Hospital Association

Hospital Feedback on the Polis Proposal for a Draft State Coverage Option

The proposal fails to close the coverage gap for 375,000 Coloradans who are uninsured today.
Acknowledging less than 2 percent of Colorado's uninsured would gain coverage, the proposal ignores the uninsured and perpetuates existing inequities, leaving vulnerable Coloradans even further behind. While the uninsured rate is 6.5 percent statewide, there is significant variation across communities – from 2.6 to 14.3 percent, a more than five-fold difference that creates different challenges for different communities.[3] The state's first priority should be enabling access to affordable coverage for all Coloradans by focusing on enrolling the 60 percent of uninsured individuals already eligible for existing public coverage programs. If Colorado achieved the uninsured rate of the best-performing state (Massachusetts), an additional 213,000 people would gain coverage. Two alternative approaches to improving affordability and increasing coverage adopted in other states include funding additional subsidies and instituting a state-level individual mandate.[4]

The proposal may *increase* health insurance costs for more than half of Coloradans.
With at least $235 million in cuts to health care providers in the first year – and upwards of $1.5 billion over five years – costs will be shifted to the 53 percent of Coloradans with employer-sponsored insurance. In addition, the proposal would actually result in *decreased* federal subsidies, increasing premiums for 114,000 Coloradans currently receiving subsidies through Connect for Health Colorado. While this would undoubtedly be an unintentional side effect of well-intentioned efforts to reduce costs, this is exactly what we have seen with the creation of reinsurance under HB 19-1168: while individual market premiums will decrease by 20 percent on average for 2020, actual premiums for subsidy-eligible Coloradans will *increase* 19 percent. HB 19-1004 required the proposal to "evaluate the impact on consumers eligible for financial assistance for plans purchased on the exchange." However, this analysis has not been conducted, and neither has analysis modeling the effects of this program running concurrently with other significant policy changes currently being implemented, such as reinsurance, new surprise billing regulations that take effect in January 2020 and the Hospital Transformation Program, all of which are facing significant implementation challenges.

Forcing providers to participate ignores the General Assembly's instructions.
The legislature provided clear guidance to the Polis administration in the legislation authorizing the development of this proposal. Specifically, the administration was directed to assess "provider rates necessary to *incentivize* participation and *encourage* network adequacy and high-quality health care delivery." The legislature expressly directed the administration to focus on voluntary participation, and yet the proposal acknowledges the administration's intent to "implement measures to ensure health systems participate." This kind of unduly coercive language aims to intimidate providers into participating "voluntarily" and undermines trust in state officials, who should be focused on collaborative, win-win solutions.

[3] https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/CHAS2019InfoPackage.zip
[4] https://www.kff.org/health-reform/issue-brief/state-actions-to-improve-the-affordability-of-health-insurance-in-the-individual-market/

The proposal fails to balance cost, access and quality, and the rate setting approach will not result in significant savings.
Polis administration officials have repeatedly cited that their goal is to bring hospital payments in line with the "national average," citing RAND Corporation data for the premise that 175-225 percent of Medicare payments provides an appropriate payment.[5] However, the very chart cited by the administration shows most states' hospital payments are closer to 225-250 percent of Medicare. HCPF's own data for the same time period as the RAND study acknowledges that Colorado hospitals receive 220-240 percent of Medicare on average across all services, all hospitals.[6] Further, the RAND data includes only half of states and is not adequate to assess what "national average" would be. CHA commends the administration for setting a clear spending goal in moving to the national average; however, we also assume that the administration does not feel that "average" is an adequate goal for Colorado's health care quality or health outcomes – cost alone is an insufficient metric. As is consistently recognized through countless national and objective metrics, Colorado's health care delivery system is much better than "average," and Colorado hospitals will not be complicit in the destruction of our high-performing system.

Choosing fee-for-service rate setting over value-based care is the wrong direction for Colorado.
Rate setting inherently conflicts with other value-based concepts advanced in the proposal because it relies on the existing fee-for-service payment model. As recently noted by Massachusetts Gov. Charlie Baker, "[i]f you cap rates under the current regime, you're going to get exactly what you have now, just less."[7] HB 19-1004 required the state to "determine whether the state option plan should be a fully at-risk, managed care, fee-for-service, or accountable care collaborative plan, or a combination thereof." This is not directly addressed in the proposal, but the underpinning infrastructure doubles-down on a fee-for-service payment system inconsistent with the state's standing commitments to payment reform and value-based care.

The proposal creates perverse economic incentives and will fail to restrain overall costs.
By limiting government rate-setting to some providers and not others, the proposal incentivizes providers without price caps to charge higher rates and drive care away from price-regulated settings that may deliver higher-quality care and achieve better outcomes. Maryland, the only state with functional all-payer rate setting, acknowledged similar flaws in their model after more than 30 years when it shifted to an all-payer, all-provider regulatory model in 2014. Maryland has further acknowledged that their model is dependent on Medicaid and Medicare increasing payments to eliminate cost-shifting. To be clear, CHA does not support government rate setting in any form, but this proposal suffers from significant and irrational design flaws that will jeopardize access and quality for patients and fails to incorporate lessons learned from other states' successes and failures.

The proposal neglects the reality of shared responsibility for improving health care affordability.
Under the Polis proposal, hospitals – which comprise 40 percent of health spending – will bear 100 percent of the burden, which will be passed on to our employees and our patients. With at least $235 million in cuts to health care providers in the first year – $1.5 billion over five years – our patients may face longer wait times and fewer providers to choose from when they need care the most. The proposal

[5] https://www.rand.org/pubs/research_reports/RR3033.html
[6] https://www.colorado.gov/pacific/sites/default/files/2019%20January%20HCPF%20Cost%20Shift%20Analysis%20Report%20Draft.pdf
[7] https://www.masslive.com/news/2019/10/gov-charlie-bakers-new-health-care-plan-envisions-major-spending-increase-on-primary-and-behavioral-health-care.html

cuts reimbursements to hospitals without holding insurers, pharmaceutical manufacturers and physicians equally accountable for reducing cost. Our employees may face layoffs, hiring freezes, increased pressure to care for more patients with fewer resources and added strain on existing workforce shortages and efforts to recruit and retain talented employees. This is particularly true in rural and underserved areas of Colorado, where hospitals are often the largest employer and where downsizing will cause a cascading effect across other businesses, schools and local programs throughout the community.

The proposal fails to articulate long-term intent, and the analysis lacks sophistication. As a result, the work to-date is insufficient to proceed.

There are a number of areas in the proposal where the administration's policy objectives are shockingly vague, which could be perceived as either a lack of commitment to developing detailed policy prescriptions or an intent to be opaque and breed distrust. Without a clearly articulated intent and objective, evidence-based analysis that assesses both advantages and disadvantages, stakeholders and legislators cannot fairly evaluate the policy prescriptions. Just four key examples include:

- *Does the Polis administration intend to seek legislative authority for its proposal?*
  While HB 19-1004 was largely characterized as a "study bill" during the legislative debate, repeated statements by Polis administration officials have suggested the administration received "carte blanche" from the legislature to implement its ideas. As recently as the week of Oct. 21, officials have reportedly offered different answers to the question of whether legislation is necessary and will be sought to enact any or all of their proposal.
- *Does the Polis administration intend to collapse private insurance into the "state option?"*
  By setting rates below current market rates and forcing insurers and providers to participate, the proposal clearly intends for the "state option" to undercut its existing competition. The natural result of this is that higher-priced "competitors" will no longer be viable, ultimately eliminating competition and choice in the individual market. This approach is highly likely to threaten the viability of emerging market-based solutions that the Polis administration itself has championed, such as the Peak Health Alliance. If this is not the intent, it is an obvious consequence that should be guarded against.
- *Does the Polis administration intend for the state to intentionally manipulate insurer and provider competition by forcing providers and payers to participate?*
  The proposal lacks significant operational detail and related policy and actuarial analysis, especially regarding impacts on insurance markets, provider markets and consumer choice. By forcing some payers and providers to participate, the state will be picking winners and losers and fostering imbalances in the market. Further, the proposal may enable commercial insurers to unfairly reduce rates for vulnerable hospitals that already lack negotiating leverage and receive lower commercial payments. This is a stark, unprecedented and highly interventionist role for state government that will undoubtedly have consequences that should be carefully scrutinized.
- *Does the Polis administration intend to expand mandatory participation and rate setting to physicians and other providers, or just to hospitals?*
  The proposal repeatedly uses the term "providers" and on one occasion uses "health systems." However, public comments from administration officials regarding the proposal indicated that only hospitals will be forced to participate and subject to rate setting. The breadth of application of rate setting has wide-ranging consequences, and the proposal should be transparent and not obfuscate the administration's intent.

When compared to more than a dozen health care plans developed by leading Democrats, the Polis proposal is more extreme in several respects.
Since the 2018 elections, Democrats' focus on health care reforms has renewed and is likely to further intensify throughout the presidential election contest in 2020. As a result, there are more than a dozen public plans for large-scale health care reforms published by leading elected Democrats and presidential candidates. While these vary significantly and range from improving on the Affordable Care Act to implementing a national single-payer system, they also share many common traits. In contrast, the Polis proposal is the *only* plan that would:

- Not significantly expand coverage to the uninsured
- Force insurers and hospitals to participate
- Exclusively target hospitals for rate setting
- Fail to provide additional subsidies while supporting profitability of private insurance companies

The proposal fails to articulate how it would protect rural and other vulnerable hospitals.
A full half of Colorado hospitals are unable to cover costs with enough certainty to be considered sustainable in the long-term, and the Polis proposal is likely to disproportionately impact vulnerable hospitals that have a hard time making ends meet. In some cases, hospitals are paid less than the proposal's rate setting range of 175-225 percent of Medicare, yet it is unclear if the administration proposes to raise payments for these hospitals, which would decrease total savings. Costs associated with ensuring viability of rural and other vulnerable hospitals should not be shifted onto other hospitals. Without the pertinent details of how these hospitals are to be protected, this promise of protection falls flat.

The Polis proposal is not the only way to support struggling hospitals. In partnership with the Hickenlooper administration, CHA spearheaded an effort to pursue a global payment model for rural hospitals. That effort has been abandoned by the Polis administration, and we recommend the legislature invest in further analysis of this concept.

The Polis proposal gives joint decision-making capacity and unprecedented power to multiple unelected bureaucrats.
The proposal states that three state agencies will have responsibility for the state option (HCPF, DOI and Connect for Health Colorado). This gives enormous power to multiple unelected bureaucrats without any oversight from the legislative branch or a single board. Nowhere in the proposal is a process outlined for how the leaders of the three agencies will make decisions or who will have ultimate authority. Nowhere in the proposal is any system of checks and balances contemplated. Although the proposal would establish an "advisory board" for consumers, the group will have no real power or oversight capabilities. Instead, the state should learn from other states' models and best practices and establish an independent, nonpartisan governing board with broad representation and with oversight and authority over key decisions.[8]

While the proposal includes some promising high-level ideas, the proposal lacks evidence of their ability to lower cost or improve value.
CHA has been a long-standing supporter of the Triple Aim, which focuses on reducing cost while also improving access, quality and outcomes. There are a number of general ideas in the proposal that could

[8] https://www.urban.org/sites/default/files/publication/73841/2000516-Hospital-Rate-Setting-Revisited.pdf; https://www.mass.gov/orgs/massachusetts-health-policy-commission

improve value and which CHA might support, including identifying benefits that qualify for "first dollar" coverage; advancing primary care; increasing value-based insurance design and alternative payment models; and ensuring prescription drug rebates benefit consumers. However, neither the stakeholder process nor the draft proposal provided any actuarial analysis, savings estimates or impact assessments for these ideas, and we encourage the administration to more thoroughly develop and vet these concepts prior to the final report's release.

Our Bottom Line:
CHA does not support the Polis administration's proposal in its current form and instead offers viable policy alternatives.
Despite the administration's expressed desire for radical solutions that consolidate power with the state and eliminate choice, there are actually evidence-based solutions that have can, or already have been implemented in Colorado to address the affordability of health care and health insurance while strengthening the private market system we have today. CHA has met repeatedly during this comment period with administration officials to share our concerns, our perspectives and our solutions. We hope that the final report addresses these concerns and reflects the following alternatives:

- **Total Cost of Care (TCOC):** A squeezed balloon is often used as a metaphor to describe health care; pressure to lower costs in one area results in increased costs in another. Comprehensive solutions that look at health spending broadly are needed to effectively address affordability. Under a TCOC system, patients, hospitals, providers, insurers, pharmaceutical manufacturers and policymakers come together to set a target for total health care expenditures in order to shrink the whole balloon. Responsibility for meeting shared goals in a manner that improves quality and access rests with all stakeholders. At least six other states have turned to TCOC efforts to slow the growth of health care expenditures, led by Massachusetts, which first passed TCOC legislation in 2012 and has achieved $5.5 billion in savings since 2013.[9]
- **Community and Market-Based Solutions:** Community-led efforts such as Peak Health Alliance, Valley Health Alliance and Mountain Enhanced Network have sky-rocketed in recent years to bring down cost and improve the health of communities across Colorado. These efforts allow for unique solutions reflective of individual communities or regions. These successful efforts should not be put at risk by heavy-handed government intervention that intends to undercut competition.
- **Value-Based Care and Payments:** Health policy experts have long known that in order to lower costs in the system and improve health care outcomes, a shift from the fee-for-service system to one based on value and improved health is necessary. Both Medicare Accountable Care Organizations and Medicaid Regional Accountable Entities in Colorado have been shown to create a cost-savings over time, but there has been limited uptake of value-based arrangements to date, particularly in commercial insurance. National data suggests that only one-third of total health care payments are in "alternative payment models" (APMs) that reward value over volume, and that commercial payers lag even further behind with just 28 percent of payments in APMs.[10] An alternative Colorado should consider is how to measure and incentivize APMs and set clear targets for public and private payers to expand adoption of these value-based payments.

[9] https://www.mass.gov/news/growth-in-overall-spending-lowest-since-passage-of-2012-landmark-health-care-bill
[10] https://hcp-lan.org/2018-apm-measurement/

To whom it may concern:

Thank you for the opportunity to provide comments.

The public option, especially as presented recently by the Polis administration, is not right for Colorado, and will be particularly hard on the rural parts of the state.

Our hospitals are already struggling to stay open and provide the care that people in our communities need, and this proposal could prove to be the final straw for many of them. By cutting the reimbursement rates paid to hospitals as a way to pay for the state-offered discount health insurance program, the plan shifts all of the financial burden onto the facilities that are at the front lines of providing care to rural Coloradans.

What's more, the Polis administration is going as far as to threaten hospitals that voice concerns over how the new program will impact them, saying that they will force them to accept the changes and participate in the program, whatever the consequences. So much for an inclusive process that solicits the input from those who are closest to the healthcare issue. By saying things like "we have the tools to mandate hospital participation", the state is showing a shocking level of contempt for the people who are in the healthcare trenches day after day.

It is not as though the situation in Colorado demands such a drastic over-reaction; The Kaiser Family Foundation recently released data showing that Colorado has the fifth lowest healthcare spending per capita in the country, while also ranking among the highest in terms of quality. Healthcare costs are certainly an issue, especially here in rural Colorado – but the approach to deal with those costs put forward by the Polis administration will make matters worse, not better.

We need to distinguish between "healthcare" and "health insurance". We have good healthcare in the state; the problem is we have more expensive health insurance, due largely to issues at the federal level revolving around the ever-contentious Affordable Care Act. We will not reduce the cost of health insurance by increasing demand while restricting supply, as the public option does, and certainly not by placing all the financial risk onto hospitals.

We are grateful for the medical professionals who strive to provide the best care possible to the citizens of our community, and for the hospital in which they provide that care. If you would take a little more time and solicit input from the hospital -based professionals who know what they are talking about, we would be in a far better place than the public option threatens to leave us.

Respectfully submitted,
Mack Louden, President
The Colorado Land, Water & Food Alliance with organizational members
Colorado Women Involved in Farm Economics
Colorado Independent CattleGrowers Association
Southern Colorado Livestock Association
Meet America, Inc.
Southeast Colorado Private Property Rights Council

COLORADO
MEDICAL SOCIETY

October 25, 2019

Executive Director Kim Bimestefer
Colorado Department of Health Care Policy and Financing
1570 Grant St.
Denver, CO 80203

Commissioner Michael Conway
Division of Insurance
1560 Broadway, Suite 110
Denver, CO 80202

BY EMAIL: HCPF_1004AffordableOption@state.co.us

RE: Comments on HB19-1004 State Coverage Option Proposal

Dear Executive Director Bimestefer and Commissioner Conway,

On behalf of the more than 7,200 physician members of the Colorado Medical Society (CMS), I am writing to express our support for the HB19-1004 state coverage option proposal dated October 8, 2019. We applaud the Polis Administration for the inclusive process taken to solicit ideas regarding this proposal, we appreciate the opportunity to offer feedback, and we are grateful for your intentional collaboration with us in seeking physician insights on a final plan.

CMS has long advocated for high quality, cost-effective health care coverage for all Coloradans. The current proposal meets many of the components of the stated CMS goal for the State Option, including increasing competition in the multi-payer health insurance market, which has been a Colorado physician priority for years; reducing premiums and facilitating better health care value through mechanisms like value-based payments and the pursuit of centers of excellence; decreasing administrative costs by increasing the health plan medical loss ratio requirement and simplifying physician practice administrative burdens through the use of a standard benefit package. We recommend that there be an annual reporting requirement for each health insurer by each plan related to changes in premiums and out-of-pocket costs, network adequacy and access measures.

There are some legitimate concerns that have been raised that merit further discussion, such as the possibility of the State Option driving other health plans out of the individual market, potential cost shifting to employers, the adequacy of physician workforce, and unintended impacts of hospital rate setting on the ability of physicians to provide the care their patients need. It is more important than ever to ensure that physician clinical autonomy and quality patient care is protected. We appreciate your stated clarification that references to provider rate setting within the current proposal refer to hospitals, not physicians. The final and future versions of the report should include a definition of “provider” to avoid any confusion or misrepresentation of the state’s intent. As this process moves forward, we are interested in investigating other stakeholder concerns because we want Colorado to be the best state in which to provide and receive the safest, highest quality, and most cost-effective medical care.

In addition, we recognize and eagerly accept your call for other ideas to help reduce the total cost of care in Colorado while ensuring quality within the State Option and hopefully across the rest of the system. In a recent CMS statewide poll, 73% of physicians described health care costs today as a crisis or serious problem. Physicians reported that they are actively working with patients and making changes to their practices to address these issues, but they cannot do it alone. We believe that the proposed Advisory Board

called for in the current proposal provides a solid platform to help drive some of these necessary changes. We suggest, and are eager to make recommendations, that primary, specialty and mental health care physicians be included on this board. We recommend the following ideas and commit to collaborate actively with you and others on them:

- **Evidence-based benefit design** – We support the proposal's use of an essential benefit package and encourage further work to design health benefits that drive the provision and use of high value care. We commend the work of Mark Fendrick, MD, and the Center for Value-Based Insurance Design within the Institute for Healthcare Policy & Innovation at the University of Michigan. Simply stated, the State Option should pay for what works and utilize incentives to encourage healthy behaviors, prevention and appropriate treatment.
- **Drive the use of common, evidence-based performance measures** – Physicians have explicitly asked for the State Option to facilitate quality improvement across payers. The current array of physician quality and cost performance measures and programs are both disparate and draining as each program imposes its own set of administrative burdens on physician practices. CMS has long championed the need to standardize the use of common performance measures and the State Option proposal offers a chance to align a focus on a core set of evidence-based measures across payers.
- **Data-driven action at the point of care** – The proposal calls for enhanced transparency and use of data to drive better value and informed decision-making. Getting accurate, timely and meaningful data into the hands of physicians at the point of care is imperative. All too often today, existing information is stuck at systems levels; is prohibitively expensive; cannot be integrated into physicians' existing workflows; or is outdated, unactionable, or not clinically relevant. Colorado assets like CORHIO, QHN and the all-payer claims database at the Center for Improving Value in Health are making important advances. More must be done to get actionable data in the hands of physicians like the digitization of referrals, scaling the advanced directive registry within the Colorado Department of Health and Environment, and providing practice level reports to build out value-based payment models that target low value care and potentially avoidable complications. We recommend focusing on getting user-friendly tools to physicians that will empower them and their patients to make clinically appropriate, high quality and cost-effective decisions.
- **Accelerate use of value-based payment models** – Input from key stakeholders, including physicians, should be taken into account when developing proposals for value-based payment models that encourage high value care. Care must be taken to ensure such models fairly and accurately identify how services are categorized. Consideration should be given to models that utilize either validated approaches or piloted innovations with clear parameters to achieve high quality, cost-effective care.
- **Eliminate administrative burdens** – Administrative complexity consumes far too much time from patients, physicians and other providers–time that could be better spent on caring for patient needs, as well as promoting and sustaining health. Physicians and their back-office operations cannot shoulder the weight of hundreds of disparate administrative requirements, some of dubious value and many wasteful by redundancy. The state should seize this opportunity to standardize and streamline administrative processes, including contracting and claims management. Utilization review and prior authorization requirements should be aligned across payers to enhance access to quality, cost-effective care by waiving requirements for physicians who achieve evidence-based health care quality metrics through the use of "gold card" programs.
- **Target social determinants of health** – Much has been written on the importance of "going upstream" to address the drivers of health care costs including unhealthy behaviors. As physicians our bond is with our patients to work in partnership to achieve improved individual and population health – which will reduce overall health care spending. We support and encourage the state to explore the recent announcement by the Centers for Medicare and Medicaid Services regarding the Wellness Program Demonstration Project to design and offer wellness programs for individual market health plans that provide people with direct incentives to make healthier choices and achieve better health outcomes.

Thank you once again for the chance to share feedback and use the knowledge physicians have of quality health care and our patients needs to promote their health in the development of the State Option. Colorado Medical Society commits to remain actively engaged and will review and assess our position in the hopes of continuing to support this proposal as it works its way into and through the Colorado legislature.

Sincerely,

David S. Markenson, MD, MBA
President, Colorado Medical Society

Colorado Psychiatric Society
777 S Wadsworth Blvd, Ste 1-206
Lakewood, CO 80226
Tel: 303-692-8783
Web: www.coloradopsychiatric.org
Email: office@coloradopsychiatric.org

October 25, 2019

Dear Executive Director Bimestefer and Commissioner Conway,

The Colorado Psychiatric Society has been part of the Colorado Medical Society's process to develop feedback on HB19-1004's state coverage option and we support their submitted comments. In addition, we would like to highlight how the proposed option affects behavioral health.

The longer individuals delay care, the costlier it becomes. Covering behavioral health care, preventive care, and primary care as pre-deductible services will help Coloradans access care while reducing costs. In addition, we greatly appreciate the specific inclusion of essential health benefits, which include mental health and substance use disorder services.

We ask that consideration be given to adding a dedicated behavioral health seat to the State Option Advisory Board. This seat could be filled by any one of a number of provider types, and could represent mental health and substance use.

We strongly agree that the proposal should incentivize physician participation through adequate reimbursement and reductions in administrative burden in order to ensure access. Psychiatry is more likely to participate as regulatory burdens are decreased and parity of rates are ensured. As part of this, we support streamlining processes such as prior authorizations to reduce waste.
Finally, we agree with the report and would like to reiterate that true network adequacy is essential in order to achieve meaningful access to behavioral health care. We are happy to participate in an open dialogue with HCPF, DOI, carriers and other stakeholders.

Thank you for the continued opportunities for stakeholders to engage and provide comments.

Sincerely,

Patricia Westmoreland MD
President, Colorado Psychiatric Society

October 28, 2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant Street
Denver, Colorado 80203

Commissioner Michael Conway
Colorado Division of Insurance
1560 Broadway, Suite 110
Denver, Colorado 80202

Dear Executive Director Bimestefer and Commissioner Conway,

Thank you for the opportunity to provide feedback on behalf of our members on the draft report issued October 7. We have given the report, your public comments, and the recent meetings with our membership into consideration. As the Colorado State Office of Rural Health & Colorado Rural Health Association, representing thirty two Critical Access Hospitals and over one hundred clinics that serve 47 of our state's 64 counties, we hope you will give equal consideration to our feedback in the final iteration of the plan.

Our mission aligns with the vision of the state option plan to ensure that all Coloradans have access to comprehensive, affordable, high quality healthcare. Further, we appreciate your continued distinction between urban and rural healthcare systems, the communities they serve, and the challenges they face. Critical Access Hospitals and other rural healthcare facilities exist to provide access in the state's most geographically remote and sparsely populated areas. Their low volumes, higher acuity patients and higher Medicare/Medicaid payer mix do not enable high profit margins seen in urban areas. In Colorado, cost-based reimbursement, Medicaid Expansion and the Hospital Provider Fee, have helped keep rural hospitals financially afloat.

Congress created the Critical Access Hospital (CAH) designation in response to a string of rural hospital closures during the 1980s and early 1990s. The CAH designation is designed to reduce the financial vulnerability of rural hospitals and improve access to healthcare by keeping essential services in rural communities. To accomplish this goal, CAHs receive certain benefits, such as cost-based reimbursement for Medicare services.

However, in just a few years, rural hospitals have received tens of millions in Medicare reductions (loss of rural hospitals designations and payments, sequestration cuts, and ACA

cuts). As a result, over 120 rural hospitals across the country have closed since 2005, and the National Rural Health Association estimates an additional 673 hospitals are vulnerable or at risk of closure, representing more than one-third of rural hospitals in the U.S. As of 2018, 22 of Colorado's 32 rural hospitals were operating with negative margins, up from 11 rural hospitals the previous year.

Throughout the legislative process of HB19-1004 and the stakeholder process this summer, HCPF and DOI have been very vocal that the rate setting is intended to protect rural hospitals. The report states, "There will be a special focus through this process to ensure rural and critical access hospital and provider sustainability." However, specific solutions and considerations for rural are not outlined in the report.

Under the proposal, the state will create a reimbursement fee schedule to pay for the program, shifting all risk of the new program to healthcare providers and insurance companies. The state intends to set the rates between 175% to 225% of what Medicare charges for services. The current state average paid to hospitals across the state is 289% of Medicare, while rural Colorado hospitals are paid an average of 218% of Medicare. Even among rural regions the rates vary greatly, meaning the impact of the newly crafted plan will be felt differently across rural Colorado.

The draft plan does not provide a clear explanation for how rural hospitals will be protected. In some cases, hospitals are paid less than the proposal's rate setting range of 175-225 percent of Medicare, yet it is unclear if the administration proposes to raise payments for these hospitals. Further, the lack of details in the report and in conversations with state officials have raised concerns for our members and left us with more questions than feedback. As a result, we cannot support the draft report without answers to the following questions.

1. How does DOI and HCPF plan to "fiercely protect rural hospitals"?
2. There are some rural facilities/regions that are paid below the 175%-225% of Medicare. The report indicates this is a cap for payments, but is there a floor?
3. The sustainability of rural hospitals varies by region-does HCPF and DOI plan to differentiate their support/protection of rural by region?
4. If the plans are intended to be sold through private insurance companies, how can we ensure network adequacy in rural areas that have only one option on the exchange?
5. How does HCPF plan to monitor and enforce the ban on cost-shifting?
6. The report indicates providers may opt-in to accepting the new plan but may enforce participation in the future, will rural hospitals be forced to accept the plan(s)?

7. If the federal waiver is granted, will any of the federal dollars be used to administer the program, or is it all intended to be passed through to consumers?
8. How will premium reductions be measured? Based on what type of plan?
9. Who will be on the State Option Advisory Board and what decision-making will they have?
10. Is there concern that some or all insurance companies will pull out of the Colorado market based on this new mandate?
11. How will the State Option interact with other quality program already required by the state?
12. How can HCPF and DOI ensure there will be no market disruption if the plan may be offered to all Coloradans?
13. The State Option will offer some pre-deductible services, such as primary care. Are any other services intended to be offered without a deductible? Will this lead to higher deductibles for other types of care, such as specialty and dental?

While our members have many questions about the draft report, we also have some suggestions about how to implement this bold new plan.

1. We welcome the potential increase in rates and ask for clarification on how rates will be finally established and how you will reconcile possible increase in rates to rural hospitals with the goal of reducing premiums for enrollees. As an alternative to Critical Access Hospitals being reimbursed via a multiple of the Medicare Fee Schedule, we ask that consideration be given to a cost plus reimbursement model. We ask that you consider reimbursement at 30 basis points above cost of charge ratio.
2. We understand the need to establish adequate networks and the possibility of making participation mandatory if necessary. We urge you to do everything possible to work with the providers in the state to create a program attractive enough to encourage voluntary participation. If mandatory participation becomes a requirement, we seek clarification on whether that would become a statewide requirement or if the proposed program would selectively focus on geographic areas.
3. We request some support to encourage payers to acknowledge the total cost of care when referring patients to the urban areas instead of seeking care close to home. We are heartened by comments made by both of you that the cost of care includes all costs the patient incurs when traveling to urban areas including lost time at work, travel costs and other out of pocket expenses. We encourage you to create incentives for payers to have patients to seek care locally rather than the current trend of creating incentives to seek care in urban areas.

4. We request the final report include guidance for carriers on acceptable rates and contract terms to avoid disparate treatment between large urban systems and the small rural hospitals. In the alternative we ask that you consider whether groups of small rural hospitals can negotiate as a single entity for contracts under this plan in the hopes of leveling the playing field between the insurance company and the hospitals.
5. We request the state create a separate advisory board to assist in the development of a rural health strategy and the delivery of this program. We propose such a body be made up of representatives of frontier and rural Hospitals, the Colorado Rural Health Center, Colorado Hospital Association, commercial payers and policy makers from the state.
6. Finally, we appreciate the need to control costs under this proposal and we accept the inevitable discussion that urban hospitals should bear some burden in controlling these costs. However, we ask that you also consider the sustainability of urban providers, as we require them to serve as our partners in delivery of care.

In closing, CRHC is incredibly grateful for the robust stakeholder process throughout the drafting of this report. We look forward to the final report and hope our concerns are addressed and our suggestions are considered. If there are any resources or feedback from our rural members that could help inform the final report, please don't hesitate to reach out. We look forward to working alongside HCPF and DOI to fulfill our shared commitment of ensuring all Coloradans have access to high-quality, affordable healthcare.

Sincerely,

Michelle Mills
Chief Executive Officer
Colorado Rural Health Center

COLORADO
SOCIETY OF OSTEOPATHIC MEDICINE

142 E. ONTARIO ST., CHICAGO, IL 60611
T: (800) 621-1773, EXT. 8287
F: (312) 202-8488
CSOM@OSTEOPATHIC.ORG
WWW.COLORADODO.ORG

October 28, 2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Commissioner Michael Conway
Division of Insurance
1560 Broadway, Suite 110
Denver, CO 80202

Comment Letter Regarding HB19-1004's State Coverage Option

Dear Executive Director Bimestefer and Commissioner Conway,

As president of the Colorado Society of Osteopathic Medicine (CSOM), I have been directed by the Board of Trustees to write this letter regarding the proposed State, or Public, Option Insurance plan.

We recognize that there are certainly segments of the population in Colorado that may not qualify for Medicaid or Medicare and, as a result, can be faced with high health insurance premiums that substantially impact household budgets. Unfortunately, no plan to date has adequately addressed this gap.

Having acknowledged this, we have a significant number of concerns with the current proposal, as we understand it. The main issue is that there is a critical lack of clarity on fundamental elements of the proposal including the costs. We can't support something for which we don't know the price tag. Specifically, our concerns are outlined below:

1. We are concerned about the mechanism proposed to fund this option. Substantial rate cuts to hospitals will have a number of adverse consequences. Currently, hospitals offset the low reimbursements they get from government funded insurance by cost shifting to private payers. Your proposal will only exacerbate this practice. This a classic scenario of robbing Peter to pay Paul. We are not convinced that hospitals know how to cut costs. We are opposed to mandatory rate setting, for any provider, including hospitals. It is likely that the State Option will be forced to make it mandatory for hospitals to participate, because without adequate reimbursement, many hospitals will not participate.

2. Further, cost control measures with the State Option, will reduce costs by limiting patient access to care, delay needed elective procedures, and will result in restricted formularies. We see this with other government- controlled healthcare programs in other countries.

3. Your proposal claims to spare, if not enhance, rural facilities. How is this going to happen? Many hospitals in rural communities in Colorado are operating on very thin margins and at risk of

closure. If you apply your insurance rate cuts to rural hospitals, they will suffer directly. We oppose any potential negative impact on rural healthcare. We would like to know what strategy(ies) you offer to enhance rural healthcare in this proposal?

4. There is no estimate on administrative costs included with this proposal. Your proposal says that costs to state government will be "minimal." What does that mean? How will state government ensure that the mandates of the plan are being complied with? Administrative costs, like other costs, should be quantified.

5. How many citizens do you expect will be eligible to purchase this insurance? What are the requirements to determine patient eligibility for this plan? Will out of state individuals be able to find a way to purchase this? What about people in the country illegally?

6. How much taxpayer subsidy will there be for individuals who can't pay some, or all, of their premium? We note in your proposal that you intend to apply for a 1332 Federal Waiver that might offset some subsidies. According to the document plan you issued a month or so ago, the outcome of this application could be no award, or 69 million dollars, or 133 million dollars. It strikes us that this huge range of funding outcomes makes it impossible to legitimately consider this Federal waiver as part of the State Option proposal.

7. We agree that it is laudable to propose to advance primary care. However, it is not clear how this will be accomplished. Much of the healthcare bottleneck is due to low reimbursement, which results in poor access. A large percentage of physicians will not take new Medicare patients, and even more physicians will not take Medicaid patients. They cannot afford it. Several Medicare practices have gone bankrupt. The State Option must be prepared to adequately reimburse all physicians, including specialists.

8. We see how the plan intends to reduce reimbursement to hospitals to pay for the State Option, but what will the contribution be from insurance companies? Put another way, what will be the insurance companies' profit margin? We highly doubt that patients will see any shared savings in this plan.

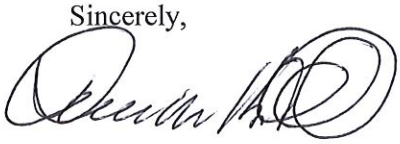
9. The State Option proposes that it will save money in the delivery of healthcare in Colorado. Our Board of Trustees is skeptical that a government mandated plan can do that without rationing, cutting services, reducing access to care, treatments and medication. One has only to look at the Veteran's Affairs and Indian Health System for examples of inefficiencies resulting in significant problems in access and delivery of healthcare to eligible beneficiaries.

10. We are disappointed, but not surprised, that the State Option does not include any mention of the importance of a stable medical malpractice environment for physicians and other clinicians. Such emphasis would likely go a long way, coupled with stable reimbursement, in enticing new providers to Colorado and voluntary participation in this proposal.

While we share the concern for so-called "gap" patients between Medicaid, Medicare and current private insurance options, this proposal presents with far too many unanswered questions. Healthcare provision and its funding is an extraordinary complex issue. Proposals that hope to substantially change the market require very careful consideration and structured expert opinion. This plan appears very rushed to meet an arbitrary deadline. The Board of Trustees of CSOM therefore cannot support the proposal in its current form. We ask that the Governor's Office and the legislature table consideration until more of these, and other, questions can be adequately addressed.

Please feel free to contact me, or the CSOM Board, with any questions.

Sincerely,



David Ross, DO

President, Colorado Society of Osteopathic Medicine
Email: drdr0682@aol.com

October 28, 2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant St, Denver, CO 80203

Commissioner of Insurance Michael Conway
Division of Insurance
1560 Broadway #110, Denver, CO 80202

Re: Comments State Option Draft (HB19-1004)

Dear Director Bimestefer and Commissioner Conway,

On behalf of the Colorado State Association of Health Underwriters (CSAHU), representing hundreds of licensed agents and brokers who are engaged in the sale and service of health insurance and other ancillary products and serving employers and consumers around the country, we applaud you for working towards decreasing health care costs, increasing competition, and improving access to high quality, affordable healthcare for all Coloradans, as outlined in HB19-1004.

The members of CSAHU work daily to help millions of individuals and employers of all sizes purchase, administer, and utilize health insurance coverage. CSAHU members are exceptionally well versed on the coverage options that businesses of all sizes and individual consumers have available to them. We guide, inform and educate so that the plan choices ultimately made are the best fit for their needs.

CSAHU would like to thank the DOI and HCPF for an open, transparent, robust stakeholder process. Traveling throughout the state to hear from various and diverse stakeholders was a key element of the process. CSAHU would like to thank you for listening to the broker community and truly taking brokers' feedback into account as you drafted the State Option proposal. We thank you for recognizing the valuable role brokers play in the market in assisting businesses and consumers with plan choices, enrollment, service, and navigating their healthcare options. CSAHU thanks you for including broker commissions in the State Option proposal. We also agree that brokers should be included and have a valuable role to play on the State Option Advisory Board.

The cost evaluation of the healthcare system that DOI and HCPF conducted is commendable. CSAHU has spent a lot of time reviewing the State Option draft proposal and while we appreciate the work of the DOI and HCFP, we have several unanswered questions. CSAHU is dedicated to working with the DOI and HCPF as well as all other stakeholders as the State Option proposal proceeds forward. CSAHU remains committed to always being engaged as we continue to digest the State Option proposal.

Here are just a few of our questions and concerns:

- The State Option draft proposal aims to decrease costs for consumers; a goal CSAHU shares. How will the State Option ensure premium affordability? How will affordability be defined and monitored?
- CSAHU has concerns about cost shifting to the individual, small, large, and self-funded marketplaces.
- The State Option assumes carriers, providers, and hospitals will participate in the State Option. What if they don't? How can the State require their participation?

- Carriers that are currently in the individual market will have the State Option risk in their current risk pool. How will this work for Aetna, Humana, & UHC? How is a risk pool sustainable with only 3 plans?
- We are concerned carriers may decide to exit the market or choose not to enter the market in Colorado.
- In the last several years, we have seen market consolidation with hospitals and providers. With this consolidation, CSAHU has concerns that there could be less consumer choice in providers which could increase wait times and increase health care costs.
- If the goals are to bring down the cost of care, why can't the strategies outlined in the draft to reduce the cost of care (rate setting and PBM rebates), be applied to the current system, where everyone is currently insured, instead of creating a State Option?

CSAHU would advocate:

- A broker that currently enrolls consumers in individual plans, preferably a member from CSAHU's leadership team, be included on the advisory board.
- Broker commissions will always be included at a reasonable level.
- Advocate plan choice by offering plans in various metallic levels including at least one HSA plan.

CSAHU believes every Coloradan deserves access to affordable, quality health coverage and we are committed to working with you to achieve this goal. We believe the focus should be on bringing down costs, as health insurance is currently expensive because the cost of medical care is expensive. When the free market and public programs work together to bring down the cost of care, we can expand access to high quality care for everyone. This can be achieved by:

- Providing greater opportunities for medical care price transparency by increasing user-friendly public access to current, accurate and unbiased medical cost information, cost differentiations based on outcomes and clinical performance, quality measures including outcomes, quality designations and any disciplinary actions, adding a personal touch with the ability to talk to a live person, and consumer ratings and user experiences could all help lower costs.
- Promoting the increased use of value-based insurance design (VBID) principles. As costs continue to rise for individuals, the use of value-based insurance design is growing to help offset these costs. The premise of VBID is to reward good behavior in maintaining health by incentivizing low-cost treatments, such as preventive care, wellness, and medications that control chronic conditions at little or no cost to the consumer. VBID plans may also dis-incentivize care that is unnecessary, repetitive, or more costly than an alternative.
- Examine the ways that provider payments are made to focus on paying for quality of care, not volume, and review how the trend toward provider consolidation impacts the cost of coverage.
- Place more emphasis on wellness, including creating more incentives for employer-sponsored plans and allowing for more meaningful wellness programs for public-program beneficiaries and people seeking individual health insurance coverage. Improving wellness programs will help Coloradans achieve a greater level of health, reduce medical care utilization, reduce the use of sick time, reduce injuries, and reduce insurance claims and overall healthcare costs.

Furthermore, CSAHU worked closely with stakeholders and the administration earlier this year to establish a reinsurance program that will increase access to affordable healthcare by stabilizing the individual market and lowering premiums, on average, 20% for 2020. The individual market is where

roughly 250,000 Coloradans buy their health insurance. We should focus on fostering the reinsurance program and securing permanent funding.

Through these market-based solutions, consumer engagement and education, we can help empower consumers to make the best choices which will help to contain their costs and increase access without reducing the quality of care. We look forward to hearing from you on this important issue and working towards achieving the goals outlined in HB19-1004. CSAHU remains committed to be an active participant in developing and implementing the most effective state option.

If you have any questions about our comments, please do not hesitate to reach out to either of the contacts listed below.

Sincerely,

Brad Niederman CSAHU Legislative Co-Chair 303-929-0055 brad@niedermaninsurance.com

Tim Hebert CSAHU Legislative Co-Chair 970-566-1111 tim@sageba.com

Oct. 28 2019

Director Kim Bimestefer
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Commissioner Mike Conway
Colorado Department of Regulatory Agencies
Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Director Bimestefer and Commissioner Conway:

I am proud to submit comments on behalf of San Luis Valley Health Conejos County Hospital for the "Draft Report for Colorado's State Coverage Option," released on Oct. 7, 2019. We agree that our state needs to take proactive steps to address health care access and affordability to ensure that Coloradans have access to the care they need and can afford it when they do seek care. Unfortunately, we are concerned that this proposal, as drafted, would have serious ramifications for our community, our local hospital and our state as a whole.

Specifically, we don't believe this proposal will help enough Coloradans and may actually jeopardize access to care and affordability for those who are already covered. With nearly 400,000 Coloradans currently uninsured, we are disappointed that this new option doesn't prioritize those individuals. We are also concerned that it will increase health insurance costs for many Coloradans, as costs will be shifted to the nearly half of Coloradans who have employer-sponsored insurance. Finally, we believe that the government rate setting for hospitals that funds this proposal could be incredibly detrimental to hospitals across our state.

Conejos County Hospital, our local hospital, is a vital part of our community. It is one of the largest employers in our community and provides significant community benefit beyond the traditional patient care offered within the hospital. While the draft proposal doesn't examine the financial impact to hospitals, we must assume that this type of government rate setting for hospitals will be significant – especially since hospitals cuts are the only funding mechanism for these significantly reduced health care plans.

The proposal purports to protect rural hospitals, but doesn't give any specific details about how that will happen. Our hospital, like most in rural Colorado, works incredibly hard to make ends meet in order to ensure access to care in our community. Without the benefit of the detail, this is too risky to our local hospital.

Please consider the impact this proposal could have on communities like ours, on hospitals like ours and on access to affordable care for patients like me, my family, friends and neighbors. We agree that there is still more work to do to improve our health care system, but this proposal as drafted is not the solution.

Sincerely,

Kelly Gallegos RN, BSN
Administrator
San Luis Valley Health Conejos County Hospital

CONNECT for HEALTH COLORADO®

4600 South Ulster Street | Suite 300
Denver, CO 80237

October 23rd, 2019

BY ELECTRONIC DELIVERY

Colorado Division of Insurance,
Colorado Department of Health Care Policy and Financing

Re: Draft Report for Colorado's State Public Option

Dear Commissioner Conway and Executive Director Bimestefer:

The staff of Connect for Health Colorado, the state-based health insurance marketplace (SBM) for Colorado, greatly appreciates the opportunity provided by the Colorado Division of Insurance (DOI) and Department of Health Care Policy and Financing (HCPF) to comment on the "Draft Report for Colorado's State Public Option." As part of our mission to increase access, affordability and choice, we support the state's efforts to create solutions that decrease the cost of health coverage, while increasing choice and access to quality, affordable coverage.

We are confident we have developed the expertise to support a public-private partnership outlined in the draft. For the past seven years, we have worked closely with carriers and with state agencies to meet the needs of consumers shopping for their own health insurance. As such, we are committed to ensuring consumers have access to a reliable and easy-to-use platform to apply and shop for health insurance on the individual market. We are pleased that a state option would allow consumers to apply for the advance payment of the premium tax credit and cost-sharing reductions to reduce the costs of health insurance.

We commend HCPF and the DOI on their work to develop a meaningful proposal that was informed by a diverse group of stakeholders, including consumers. We look forward to continued partnership as we seek ways to make health care more affordable in Colorado.

Sincerely,

Connect for Health Colorado Staff

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

Please use this form to submit your comments on the draft HB19-1004 report. All comments will be logged and added as an appendix to the final report. We will accept comments until October 28.

Helpful Links:
- The draft report can be found here: http://www.colorado.gov/pacific/sites/default/files/HB19-1004%20Draft%20Report%20Colorado%20State%20Coverage%20Option%20and%20Appendix.pdf
- The bill text can be found here: https://leg.colorado.gov/sites/default/files/2019a_1004_signed.pdf
- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Connor Johnson

County (in which you reside) *

[redacted]

Organization *

Leapforce

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

No

Other thoughts? Please list them here.

This form was created inside of State.co.us Executive Branch.

Google Forms

October 28, 2019

Commissioner Michael Conway
Colorado Division of Insurance
1560 Broadway, Ste 110
Denver, Colorado 80202

Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant Street
Denver, Colorado 80203

Re: public support for Draft Report for Colorado's State Coverage Option.

Dear Commissioner Conway and Director Bimestefer,

Thank you for the opportunity to comment on the Draft Report for Colorado's State Coverage Option. We appreciate your attention and commitment to consumer priorities in developing this proposal. It is with this in mind that the Colorado Consumer Health Initiative submits the following signatures of over 250 Colorado consumers who support the following principles.

We believe the State Coverage Option should:

- offer affordable, transparent, and accountable new coverage options to save consumer money on their health insurance premiums;
- control the underlying costs of health care by limiting rates paid to certain providers and offering standard high-value plans; and
- increase affordability, competition, and innovation in Colorado's health insurance market--while reducing costs across the state.

We believe this is a unique opportunity to create a new, competitive, and affordable insurance option for consumers, and ***urge you to keep these values in mind while finalizing the draft proposal***.

Thank you,

Debra Jean Baker
Maro Zagoras
Susan Zager
Candyce Hanus
James Hansen
Deborah Abrams
Tracy Henderson
Gill Jen
Jennifer Gaskin

Elizabeth Latham
Todd Andersen
Michael Boyd
Alexandra Feinstein
Paulette Mullin
Antonia Rios
Karen Brott
Mark Wiley
Terry Bitzel
Rita Stafford
Mick DeNudt
Ren Willis
Kris Ring
Susie Gardner Jones
Cherri De'Shon
Sara Brownlee
Frederic B Silva
Lorry Schmitz
Michael Hayes
Lori Bailey
Arfnublet Karntschaffe
Julian Flores
Carol Wright
Erin Cormany
Chris Rabren
Deborhah Dreith Calloway
Ludwina Trevino
Jerry P. Archuleta
Jeffrey Clark
Pau Scho
Jose Loera
R Elena Mendez
Travis Burns
Lezlie Ringland
Janine S Cutlip
Vicki Bright
John Monosmith
Andy Floyd
Lenora Rowley
Stacey Young
Russ Nesiba
Renee Martinez
Allen Butcher
Elise Hamburger Zakroff
Sharon McKim
Josh Wells
Alula Kahsay
Charlene Howard

Dave Campos
Paula Talley
Brian Halvorsen
Shawn Roy
Deb Diemer
Diane Stapleton
Brandon Musser
Timothy Kyle
Michael Edgington
Andrea Mulkey
Sylvia Flores
Kim Johnston
Rachel Hunt
Jeanetta Griffin
Marty Seidel
Lelia Odom
Tanira J. Boddie
Robert Baca
Peter Vallegos
Virginia Albin
Greta Thomsen
Mollie Evans
Candice Combs Hensley
Megan McArthur-Federico
Angela Villalovos
Michelle Lowe Dannar
Sidney Augen
Maureen Lyon
Lisa Bowthorpe
Barbara Farr
Evie Van Auken
Andrea Shundich
Amy Lameris
Carolyn McDowell Dickinson
Elizabeth Franz
Brandi Benavidez
Melissa Allen
Elizabeth Chi Tran
Cornisha Dockins
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Jaine Roosa
Joy Weber
Kelly Zeller
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Teryl Fabry
Joann M Armijo
Juana Calzada
Diane Parker

Lupita Vagancias
Erykha Puchi
Patsy Banuelos
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Crystal Pacheco
Bea Neves
Merrily Williams Zamora
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Tina Halbig
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Trudie Miles-Rafferty
Lowana Lu Baldon Burch
Allison Hilf
Christine Leland
Liz Weyant-Sutherland
Pat Rowan
Ellen Aknin
Tanya Rich
Gypsy Blanchette-Goodhue
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David Gomez
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Mimi Damicone
Gail Finlay
Sandra Cadwell
Suni Daze Ogle
Jan Kifer
Ron Simpson
Kim G Leach
Cory Mowery
Barb Jeschke Banks
Ake'le Biglow Gabari
Savra Frounfelker
Kyle Phillips
John Dando
Patty Munk Goldhammer
Paula Houston
Colleen Clark
Margie Gonzales
Ren Willis
Terri Lynn
Jim Naslund
Jeff Brown
Kimberly Bailey
Martha Lewis
Leigh Lyon
Cynthia Hufford Wadle
Kelly Zeller
Laurie Ritchie
Gail Finlay
Sylvia J Harris-Miles
Ashley Becker
Caroline Life
Annette Brooks
Kainoa Gardon
Lara Brenner
Andrea Botvin Duchovnay
Debra Turner
Gypsy Blanchette-Goodhue
Michael Edgington
Jasmine Dailey
Greg VanHoosier-Carey
Kimberly Botello
Ron Simpson
Jeff S Miller

Bruce Anderson
Krista Murphy
Sharon Adams
Emily Wright
Cindy Koke
Rosa Sanchez
Kasie Oliver Mejia
Dylan Snow
Wendy Vernon
Joseph Harper
Karen Mullen
Michael Miller
Rebecca Slattery
Valerie Laster
Tammy Pino-Pereyra
Scheel Monica Rodriguez
Jessica Macklen
Christy Lee Gardner
Donna Cowan
Danielle Hardin
Chris Klene
David Reynolds
Kathleen Aikin
Shelly Perry
Robert Robertson
Chr Rab
Cathy Porteous
Renee Natole
Jessica Smith
Linda Gann
Kimberly Miller
Pau Hou

CCAT

Counties & Commissioners Acting Together

Counties and individual commissioners across Colorado working to provide a unified, nonpartisan and independent voice at the statehouse. Collectively, CCAT represents all regions of the state and the diversity of issues facing every corner of Colorado.

October 28, 2019

DELIVERED VIA EMAIL

TO: Commissioner Michael Conway , Colorado Division of Insurance
Director Kim Bimestefer, Department of Health Care Policy and Financing
Ms. Elisabeth Arenalus. Office of Governor Jared Polis

Re: Comments on the Draft Report for Colorado's State Coverage Option

Counties and Commissioners Acting Together (CCAT) applauds the Polis Administration's efforts to take on the critical issue of high cost health care as residents in both rural and mountain towns often pay dramatically more for the same plans offered in the Front Range. Meanwhile citizens in 14 Colorado counties only have one insurance carrier option on the state exchange. This cannot remain the status quo.

Thank you for the opportunity to comment on the Draft Report for Colorado's State Coverage Option. CCAT actively supported HB 19-1004, Proposal for Affordable Health Coverage Option, to explore health insurance coverage models that may increase affordability and expand consumer options across Colorado. During deliberation on the bill CCAT cautioned lawmakers to relook at the proposal before "going live" as an offering in Colorado's insurance market. This was due to concerns the program could be set up in a manner as to create unintended consequences or have adverse impacts.

CCAT feels further conversation is needed on the potential impact of this proposal in rural and mountain communities. The stated commitment to protect rural hospitals and providers is appreciated; however, additional detail is needed as to how this commitment will be realized. Additionally, CCAT is concerned about impacts to Coloradans who are currently eligible for premium tax credits.

To this end CCAT would like to submit the following questions and concerns and request further clarification on some provisions of the plan. We welcome the chance to continue discussions on this front and intend continued involvement in future stakeholder opportunities, including any needed legislation in the upcoming 2020 session.

Impact on Rural and Specialty Hospitals

Depending on the individual hospital and location/region of the state, a cap on hospital rates could result in significant negative impact on their overall financial operations. Such an outcome is particularly concerning for critical access, specialty hospitals and the ability to expand hospital-based service in rural areas. Would the State consider a tiered / stair-step reimbursement for different classes of hospitals? Will the rate vary by procedure? Certain hospitals may need to make process improvements / adjustments over time to be able to sustain lower reimbursement rates. What assistance could be offered in that regard under this proposal?

♦♦♦♦♦

Additionally, rural hospitals are often one of the largest employers in a community. What assurances are in place that a reduction in reimbursement would not result in a decreased work force that adversely impacts a community's economy and unemployment rates.

Provider Participation-Network Adequacy, Access to Care

What is meant by the State making provider participation "mandatory if necessary"? Under what legal authority can the State take such action? Would such an approach result in provider pushback and thus make negotiations difficult or divisive? Anecdotally, CCAT has heard numerous providers express concerns with the State Medicaid program's existing practices and a mandate to participate would seem to create additional barriers for this newly created, quasi-public program.

How will the State Plan ensure adequate, quality networks are in place to ensure access to care for residents in rural areas that currently have limited or no alternative access points? How will the plan prevent large areas of the state from being without in-network access to hospital-based and emergency services? CCAT suggests further analysis on the impact capping hospital reimbursement rates may have on network adequacy and access to specialists in rural Colorado.

Impact on Low Income Coloradoans (Health Care Subsidies)

CCAT is thrilled that the overall impact on insurance premiums is predicted to be a 9-18% reduction and supports offering a state option plan to all Colorado residents. However, doing so may impact overall affordability for low-income individuals who are not eligible for subsidies, and for individuals whose subsidies are reduced or eliminated due to the impact of lower premiums for the benchmark plan.

Declining premium rates may result in the commensurate reduction in purchasing power of the subsidies for those that are eligible, especially those that qualify for cost sharing reduction plans. How is this plan going to be structured to ensure such a shift does not occur? Can the reduced premium costs can be maintained over time – are they sustainable?

Utilization

How does this plan address utilization, starting at the primary care / specialist level? Could savings from hospital costs be redirected to primary care providers to incent them at a higher reimbursement level if they can demonstrate that they are actively managing their patient population and meeting certain quality and outcomes criteria over time? Could they be reimbursed a portion of savings by redirecting care to lower cost settings? Could covered members on the plan be incentivized for utilizing a lower cost of care setting when appropriate?

CCAT supports a greater emphasis on quality and cost transparency as part of the program. Will the program provide data tools for enrollees and providers in advance of having a procedure?

Centers of Excellence

CCAT is intrigued by this initiative to promote quality health coverage. Currently the organization does not have a formal opinion on the proposal but offers the following questions:

Will this be limited to Colorado based providers?

Will Centers of Excellence and the services provided therein be automatically deemed in-network and the range of procedures deemed covered benefits? Or, will this be discretionary by health plan and thus put

the consumer in the position of paying at the out-of-network benefit/provider level? Likewise, depending on location, consumers may be required to travel a far distance thus limiting choice to a Center of Excellence may create additional obstacles to care.

How will this impact hospital revenues depending on the frequency of the services being performed that would be directed elsewhere? Should this be taken into consideration when establishing a reimbursement schedule. If an individual hospital's revenue is disproportionately impacted as they are not a Center of Excellence, should they be reimbursed at a different / higher percent of Medicare for other services?

Conclusion

CCAT is excited about the potential of a State Option program to be the first of its kind in the country and beneficial to thousands of Coloradoans. Realizing this goal will require questions and concerns be addressed and, perhaps, the program built out on a region-by-region, hospital-by-hospital basis. This may take time and effort but having these conversations is critical to the long-term success.

To this end we appreciate the outreach and engagement by HCPF and the DOI in seeking feedback during this process to create a state health care coverage option that meets the needs of all Coloradans.

CCAT MEMBERSHIP

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Guyleen Castriotta, Broomfield

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Hilary Cooper, San Miguel
Lance Waring, San Miguel
Kris Holstrom, San Miguel
Thomas Davison, Summit
Elisabeth Lawrence, Summit
Karn Stiegelmeier, Summit
** Denotes individual Commissioner member*

♦♦♦♦♦

www.coloradoccat.org

For more information on these or other CCAT issues, please contact Aponte & Busam Public Affairs
Ruth Aponte (303) 907-1980 ♦ Dave DeNovellis (303) 359-8268

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

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- We will accept comments in all languages!

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Craig Richardville

County (in which you reside) *

[redacted]

Organization *

SCL Health

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

I share the Administration's concern that too many Coloradans struggle daily with the pressures that come with a lack of access to affordable health care; however, the proposed draft does not provide concrete information and details that show how it will make healthcare more affordable and accessible for Coloradans.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

The State Option, as proposed, would only be available to the ~230,000 individuals who currently purchase health care coverage through the state exchange, although there are intentions to expand its applicability to small and large group coverage under the exchange; actuaries predict that the number of individuals who will actually participate is 9,600. There is no mention of the ~400,000 Coloradans who remain uninsured.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Based on the draft plan and information released at the Denver stakeholder meeting, I am unable to clearly identify any specific provisions that will result in making health care more affordable and increase access to health care.

Does the proposal include worthwhile benefits for consumers?

Due to the fact that the plan does not propose any concrete evidence of ways it will increase affordability and access of care, I do not believe it includes worthwhile benefits for consumers.

Does the proposal create a product that is financially stable and sustainable?

The plan relies on current Medicare reimbursement rates, which in Colorado equates to only $0.69 of every dollar of costs reimbursed, which fails to cover the full cost of care. Additionally, the plan only focused on hospital costs and excludes other cost factors such as physicians, pharmaceutical companies and other providers and supplies.

Other thoughts? Please list them here.

There are too many unanswered questions with the draft plan. The plan lacks detail and the process is moving too fast for SCL Health to take a formal position on the draft. Additionally, we are actively working to implement more than 15 substantial pieces of legislation from the 2019 session (i.e., reinsurance program and hospital transformation project).

● The proposal does not further SCL Health's mission of improving the health of the people and communities we serve, especially the poor and vulnerable.

● SCL Health is committed to working closely with Governor Polis and his administration to continue to address access and affordability issues for the betterment of healthcare across Colorado.

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TO: Colorado Democrats and Jared Polis:

I am completely opposed to your latest plan to institute government-run healthcare in Colorado. This is Socialism. People come to America to get away from Socialism. Please stop trying to make Socialists out of United States citizens.

Sincerely,

Cynthia A Hoover

Commissioner Conway and Director Bimestefer,

I work at one of Colorado's health care systems, and I see first-hand the amazing work our dedicated employees perform. Physicians, nurses and staff care for significant numbers of Medicaid and uninsured patients. They provide programs that improve health in the communities we serve, keep kids healthy, prevent distracted driving, provide healthy options for seniors, provide a free nurse advice line, free flu shots, programs to address postpartum depression, treat substance use disorders, and so much more. Our clinical teams literally save lives each and every day.

This proposal for a state option will put these community programs and clinical care at risk. Having government bureaucrats set reimbursement rates - far below what other insurance plans pay - is dangerous. Slashing payments to hospitals will force them to cut programs, cut community benefits, and reduce access to high-cost care. Most concerning - some hospitals in our state will not be able to withstand these cuts, and will close.

I believe the state is also underestimating the impact to the broader insurance market. We will begin to see small employers stop offering insurance to their employees - instead providing a stipend for employees to purchase the public option. Then large employers will start doing the same. Fewer and fewer people will be in the commercial insurance market, which means the number of plans shouldering the burden for Medicaid, Medicare, self-pay and public option underpayments will also decrease. Premiums will skyrocket, and our state will see additional cuts to access. More hospitals will close, and patients will lost their trusted doctors and facilities.

Quite simply - this is the wrong path for our state. This public option proposal is dangerous, and will have significant, unintended consequences. This is a big step toward single-payer health care - something Colorado voters have soundly defeated.

I encourage Commissioner Conway, Director Bimestefer and the state legislature to NOT approve this proposal. I encourage you to start over - look at addressing costs including drug costs and Medicaid losses, and work collaboratively with providers to push savings on to everyone who has health care insurance in Colorado.

Sincerely,

Dan Weaver
[REDACTED]
And these are my personal opinions, so I'm not listing my employer here. My opinions don't necessarily reflect those of my employer.

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

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- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Daniel Oakley

County (in which you reside) *

[redacted]

Organization *

retired

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

NO

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

NO

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

NO

Does the proposal include worthwhile benefits for consumers?

NO

Does the proposal create a product that is financially stable and sustainable?

NO!!!!!!

Other thoughts? Please list them here.

NO to socialism

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Daniel J. Willard

County (in which you reside) *

[redacted]

Organization *

Mr.

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

No

Other thoughts? Please list them here.

Govt. has demonstrated inability to run anything. Health insurance will be no different.

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As a Board member of Boulder Community Health (BCH), an independent not-for-profit healthcare organization in Boulder County, I have the opportunity to engage with a highly respected healthcare organization striving to meet the health needs of our expanding and aging community. While BCH shares the state's goal of making health care more affordable for patients and employers, the proposal creates other challenges that may not have been thoroughly considered.

The state's solution does not recognize that some Colorado hospitals truly prioritize mission over margin. Organizations like BCH could find our ability to continue developing new services that address our communities' changing needs undermined by being forced to accept insurance reimbursement that doesn't come close to covering our costs.

The draft plan indicates the state is "hopeful" that hospitals will voluntarily participate in the state option plan. The proposal and repeated public statements, however, acknowledge that the state will forcibly compel providers to participate if necessary. Because BCH's locally governed, non-profit organization makes its investment decisions based on community need rather than potential profitability, BCH has had an average operating margin of only 1.6% over the past five years. Non-profit hospitals like BCH that are clearly investing in their communities should not be constrained from expanding or improving services by being forced to accept insurance reimbursement that doesn't come close to covering our costs.

While the state promises the proposed public insurance option will protect rural and critical access hospitals, institutions that are absolutely vital to their communities, it has not provided any insight into how that will be accomplished. The state also doesn't acknowledge the 21 urban hospitals whose sustainability may be put at risk through these substantially lower reimbursement rates.

BCH and other Boulder County non-profit hospitals need reasonable reimbursement that supports the mission of providing quality health care that responds to our communities' needs and values.

Respectively submitted,

Dee J. Perry

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Dennis Leonard

County (in which you reside) *

[redacted]

Organization *

AME, Inc

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

no, there is no documentable evidence that this government management will health reduces costs without lowering care. Government price controls that are needed to facilitate below-market premiums offered by a state option will not cover the full costs of care, and therefore the reduced reimbursements to health care providers in Colorado could range from $494 million up to $1.4 billion.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No, the Colorado program from the obamacare health exchanges failed. They were unworkable and costs spiraled up by 3rd year. I lost 3 employees.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

no cause it won't be done that way

Does the proposal include worthwhile benefits for consumers?

in the 1st year maybe, after that costs will go up and coverage and doctor availability will go down. This is true in any system in the world if you would study them. There is no reason to believe Colorado politicians can do it differently.

Does the proposal create a product that is financially stable and sustainable?

NOT Possible . Never has in the history of the world. Make all the legislators go into the system and see how they really feel.

Other thoughts? Please list them here.

will medicare also be destroyed?

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DENVER HEALTH™
est. 1860
FOR LIFE'S JOURNEY

October 28, 2019

Director Kim Bimestefer
Department of Health Care Policy & Financing
1570 Grant Street
Denver CO 80203

Commissioner Mike Conway
Colorado Department of Regulatory Agencies
Division of Insurance
1560 Broadway Suite 110
Denver, CO 80202

Director Bimestefer and Commissioner Conway:

Denver Health and Hospital Authority appreciates the opportunity to provide feedback on the "Draft Report for Colorado's State Coverage Option," released on Oct. 7, 2019. We value and support the shared goal of providing all residents of Colorado affordable health care coverage. Denver Health believes that a Public Option plan may be a viable path forward to addressing the current access and affordability challenges in the healthcare environment in Colorado and we welcome the opportunity to participate in further conversations.

Denver Health was founded in 1860 as City Hospital to serve the health care needs of the rapidly developing city of Denver. Since then, we have grown alongside the community to become a complete health care system, proudly providing care for all residents -- at every point in their lives. Believing that healthy people are the foundation of a vibrant community, Denver Health delivers preventative, primary and acute care services, with a strong commitment to making our community a healthy place to live, work and raise a family. As a comprehensive, integrated organization, we provide inpatient hospital care, comprehensive primary care services through our network of federally qualified health centers, specialty outpatient services and emergency care and we serve as the medical arm of the Denver public health department, all without regard to the ability to pay. This integration promotes continuity of care for each patient and assures health care that is delivered in the most efficient, cost-effective setting.

We care for thirty-three percent of Denver's adult and child population; seeing nearly 930,000 total patient visits a year and, in particular, serving the needs of special populations such as the poor, uninsured, pregnant teens, individuals involved in the justice system, persons addicted to alcohol and other substances, victims of violence and the homeless. As Colorado's primary safety-net institution, Denver Health has provided billions of dollars in uncompensated care and serves as a model for other safety net institutions across the nation.

In addition, Denver Health is an insurance carrier, both on and off the public exchange. The Denver Health Medical Plan, Inc. (DHMP) is a local, nonprofit health insurance company

established in 1997 to provide quality, accessible and affordable health insurance. We provide health insurance coverage to over 100,000 members in the Denver Metro Area, including employer group, Medicare, Child Health Plan Plus (CHP+), health care exchange and Medicaid products. Denver Health and Hospital Authority has the unique advantage of providing its comments from the view of an integrated healthcare system inclusive of an urban safety net hospital, network of community clinics, provider of public health services for the City and county of Denver and as an insurance provider. In reviewing the State's draft Public Option proposal, we have identified a number of questions and issues that we believe need further discussion, as outlined in the attachment. However, we are confident that these questions can be addressed and reasonable solutions identified through intentional dialogue. We would welcome the opportunity to sit down and discuss these.

Support of the goal – providing affordable insurance coverage

Denver Health supported House Bill 19-1004 because it offered the community the opportunity to bring patients, hospitals, providers, insurers, pharmaceutical manufacturers and policymakers together to discuss ways to improve the health care system and create a system that works for all of us who are invested in the success of a healthy Colorado. Today's health care system is ripe for change and improvement – issues of affordability, access to care and the costs of health insurance impact every segment of our society. Recognizing that while all institutions serve some number of vulnerable patients, at Denver Health, the vast majority of people we serve are the sickest, the poorest, and the most vulnerable, with more than 80% of all patients uninsured, Medicaid or Medicare. We fully support Colorado's goal of finding a sustainable path forward that will allow for an affordable healthcare system, but due to the health status, life complexity and tremendous needs of many of our patients, we depend on our public partners to understand and support our institutional viability, so that we may continue to meet the needs of our patients. Our comments and questions are posed within the context of continued commitment to finding solutions that work for all Coloradans while ensuring Denver Health remains viable and able to deliver critically necessary services to our vulnerable patients.

We support Colorado's creation of this Public Option draft plan as a means of addressing affordability and the ability to access coverage for all Coloradoans. Ideally we would like to see a plan that would encourage competition between carriers and support the healthcare delivery system as a whole in becoming competitive and efficient; a Public Option plan that would reward innovation and allow for partnerships with all of those willing to partner with us. When the final report on the Public Option is issued, we strongly request a much more robust actuarial analysis to support some of the assumptions that are being made, as well as consideration of the points included in this comment letter. Nevertheless, we are committed to working with the State, the Legislature and other stakeholders to ensure a Public Option is crafted that enhances Colorado's healthcare market viability. We have identified a number of questions and details that need further discussion; we are confident that this can be addressed and manageable solutions identified. We ask for the opportunity to continue to be part of the conversation.

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Denver Health appreciates the opportunity to comment on the draft plan. We look forward to continuing to be part of the stakeholder process and look forward to working with HCPF and the DOI as Colorado continues to work toward affordable healthcare for all.

Sincerely,

Robin D. Wittenstein, Ed.D, FACHE
Chief Executive Officer

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Supplemental items for continued discussion on Public Option

Payer Mix Considerations and Safety Net Hospitals

As is well known, Denver Health is here to serve all those that need healthcare, regardless of their ability to pay. This requires constant commitment to delivering high-quality, cost-effective care; which Denver Health has demonstrated, even with a payer mix that is predominantly un- and underinsured. As we continue to work to fulfill our mission every day, we want to be sure that the Public Option plan is a sound proposal that recognizes the challenges of a safety net institution -- delivering care with limited resources to segments of the population that experience significant health issues and challenges, as well as a variety of social and economic factors that complicate their health status. The major method being proposed to reduce health care costs, and thus health insurance premiums, is rate setting for hospitals. We are not opposed to rate setting, but the proposed ranges must be sufficient to cover the costs of care and allow safety net institutions, such as Denver Health, to continue to deliver on our mission of serving those in greatest need, even when there is no reimbursement. If we exclude our own employee health care utilization, Denver Health's commercially insured population is less than 15% (based on gross charges). As a safety net institution on the frontline of serving vulnerable patients with complex health care needs, we acknowledge that costs can be prohibitive for patients who need care and are fully committed to working with the State to develop solutions to reduce those costs. However, we are also well aware of the fact that maintaining our financial viability in the face of stagnant revenues, increasing salary and benefit costs and spiraling drug costs can only be made worse with inadequate recognition of the challenges of our payer mix. We applaud the State's desire to protect rural and critical access hospitals, but would strongly urge that all safety net institutions be considered – the impact that would occur if Denver Health were unable to meet the needs of its patient population would be considerable.

The effectiveness of our overall approach to delivering high-quality care in a more cost effective manner, focusing on primary care, prevention and social risk factors, has allowed Denver Health to achieve lower inpatient hospitalization and ED utilization rates for our members. This has resulted in significant savings to the State through our Medicaid Choice insurance plan. The reimbursement levels selected for Denver Health, and all safety net institutions, must be sufficient to allow us to continue our long-term approach to shifting care to the most appropriate setting possible, with the necessary support services in that setting.

This will require consideration about how to account for the difference in service mix at our federally qualified health centers (FQHC) – because our patients are generally sicker, poorer and face a variety of social risk factors, we have added a variety of supportive services to these FQHCs. These range from additional pharmaceutical support, to social workers and patient navigators to additional outreach workers. These services are consistent with the intent of the FQHCs and are a large part of the reason why Denver Health is able to achieve lower hospitalization and Emergency Department utilization rates among a higher risk population. Reimbursing these services at a lower

percentage of Medicare may not recognize the value of these additional services and put them at risk. We ask that an analysis of the FQHC role in this Public Option be completed and appropriate reimbursement guidelines, including possible treatment as non-hospital based or reimbursement set as a percentage of the Medicare FQHC rates, be considered.

Mandatory Participation

As it currently stands, the Public Option includes mandatory participation by carriers. However, we would ask for some consideration or guidelines that limit mandatory participation to plans that are large enough to make this possible. The Denver Health Medical Plan (DHMP) offers health plans on and off the exchange, serving a unique role for specific high risk patient populations; specifically those with HIV, hepatitis and ESRD. We have approximately 900 enrollees in our Elevate plan who predominantly receive their care at Denver Health. These are high-risk, high-cost and high-need individuals who receive comprehensive primary and specialty care as needed. The Elevate plan has such a high risk membership that, based on the federal government's risk adjustment methodology, our plan has one of the highest acuity measures in the country. While this plan is critical in meeting the needs of this population, we are not in a position to be able to offer a plan option across the entire state. We ask that you consider the size of the carriers that are required to participate in offering a Public Option in the marketplace. For the financial welfare of the DHMP, and to be able to continue to offer our high risk product, we would ask the state create a threshold that carriers only have to participate if that carrier's market share is 10% or higher statewide, unless the opportunity exists for a Public Option plan to be offered within specific geographic regions and not across the entire state. It would be impossible for the DHMP to offer a statewide Public Option product, without a complete disruption to the way our network is built. As one of the smallest plans in the state, and one that traditionally uses a closed model for care we are unable to see a path forward if we are mandated to participate as a carrier.

Contracting Opportunities

In order for our institution to continue to work toward its mission we should be allow to contract with carriers who are offering the Public Option product. We understand that this is a change from current contracting practices which allow carriers to select who participates in their plans (either through their own choice or based on pressure from participating providers). However, ensuring that providers who have had a historical commitment to caring for vulnerable populations are not further disadvantaged by exclusion from networks, now that these patients may become insured, is critical.

Impacting the overall cost structure

Hospital care makes up between 35-50% of health care spend. The Public Option plan proposes rate setting as a means of controlling health care costs and, thus, health insurance costs. However that leaves 50-65% of health care spending untouched. Drug costs, in particular, have continued to increase year over year. Putting the entire burden of reducing health care costs/premiums on hospitals is not only unfair, but will not effectively restructure the entire health ecosystem to work

towards this goal. And hospitals, which are large economic engines for their communities, could be placed at risk.

Need for innovation

We are interested in working with the State to ensure that innovation and flexibility will continue to be rewarded. The move towards value based and alternative payment methods, while slow, has the potential to provide the right incentives and flexibility for change that can drive efficiency and innovation. The Public Option, as currently drafted, is the same fee for service system, only at a lower price point. We believe that rewarding those who are willing to accept risk and foster innovation is a more effective way of driving change while protecting high-quality delivery systems. As we have proposed before, Denver Health is willing to enter into full risk, capitated models.

Drug rebate proposal

The draft report includes a provision related to requiring prescription drug rebates to be passed through to the member. There is little detail about how the proposed rebate pass through would work, and which rebates they are talking about. The plan says that "all prescription drug rebates…" must be used to reduce the price of individual policies. Currently, and presumably in the future, carriers price their products based on expected costs of the health care used by members; MLR calculations ensure that 80% (85% under this proposed plan) of the premium dollar must be used for health care expense or members receive rebates. Drug rebates are an offset to the health care costs and are therefore already factored into calculations of premium price points; this is effectively already reducing the cost of individual policies across the members. To the degree that DHMP receives any rebates, (these are limited for our plan due to 340b pricing which is not eligible for rebates), we pass those rebates on to our members by building them into our premium pricing, maintaining at least the minimum MLR spend. However, to the degree that fees or incentives are paid to our PBM, we have no visibility into those. We appreciate the clarification that we received that the intent of this section is not to try and associated rebates with specific individual policies, but rather to ensure members benefit from any rebates or manufacturer incentives that may exist. To the extent this is factored into premium pricing already, no additional reductions should be required. Without detail about how this would be implemented and through what mechanisms potential fees and/or manufacturer incentives would be identified and accounted for, we are concerned about the administrative burden and costs. We also would like assurance that other Federal rebate programs, specifically 340b, will not be impacted as part of Colorado's Public Option. This is an area where the expertise of the Division of Insurance can be especially helpful.

Continued high rates of uninsured

The development of a Public Option plan as one means of addressing issues of coverage and costs is a good first step. Continuing to work on other initiatives to insure the currently uninsured population has the opportunity to acquire health insurance and access necessary care is also important. We have almost 400,000 uninsured in Colorado, and while the Public Option plan may provide an opportunity to cover some of those lives, the initial estimate was that only 4600-9200 additional Coloradans will be covered through this plan. We respectfully suggest that finding ways

to move those who are currently eligible for insurance into appropriate coverage should also be a major focus of the State and could have a significant impact. A concerted enrollment campaign that would go hand-in-hand with the rollout of the Public Option should be part of the implementation plan. We also believe that understanding the reality of those that cannot access insurance for whatever reason remains critical – these individuals must have a reliable safety net to meet healthcare needs when they arise. What is important to the success of a functional and affordable healthcare system in Colorado is the protection of the safety net, and the protection of rural and critical access hospitals. Denver Health is already contracted with the State to enroll individuals into Medicaid; we would be interested in discussing how to leverage our expertise to develop and implement additional enrollment programs. We also caution that the Departments and the Polis Administration must be prepared for potential market instability or other unintended consequences as the Colorado Public Option rolls out; especially if the uptake in those participating the Public Option is greater than expected among the currently insured population.

Additional Outstanding Questions/Issues

A number of questions need additional consideration and/or analysis in order for us to fully understand the impact and potential unintended consequences of this plan, such as:

1. The draft plan references value based insurance design and Centers of Excellence as two means of reducing health care costs, yet there is very little detail about what either of these two mean or how they would be implemented. Who decides on the VBID components? The Centers of Excellent concept, while potentially a viable idea, also needs further discussion, especially for institutions that have more limited resources to invest in specific services. While we understand that Centers of Excellence will be those that deliver high-quality, cost-efficient services, the development and maintenance of such can often require resources that may be more limited in safety net hospitals.
2. The actuarial report was very preliminary and mentions repeatedly that additional analysis is required. It also clearly discounts the financial impact of VBIS and Centers of Excellence, which are held out as part of the way health care costs and premiums will be reduced. How will this be reconciled? If high-risk patients join a public option, will the carrier be required to pass any risk adjustment dollars onto the provider? For our Elevate plan, these dollars are what allow us to provide the full range of services needed for these patients. If, instead, the hospital is reimbursed at a percentage of Medicare without any adjustment for the acuity of the patient, we could easily realize a significant loss on the care provided to these patients and/or be forced to stop providing the services. We need to have a clear understanding of whether the risk adjustment methodology will differ from the current QHP issuer program and whether carriers offering Public Option plans will be required to pass any risk adjustment dollars on to the providers caring for the patients. Again, this is a discussion point that Denver Health would be very interested in participating in and in helping to develop solutions that are reasonable for all.

By email: Director Bimestefer, Commissioner Conway and HCPF_1004AffordableOption@state.co.us

October 25, 2019

Director Kim Bimestefer and Commissioner Conway:

Today we write on behalf of the Denver Metro Chamber and its 3,000 members to express concerns with the proposal for Colorado's State Coverage Option. Our organization represents almost 400,000 employees across the state. We work every day to ensure more Coloradans can get to work in great jobs at great companies through advocacy, education, leadership training, small business resources and economic development.

In our 152-year history we've seen how well our market works – it responds to demand, it innovates and it advances with technology. Our experience has been that many of the challenges we face are best addressed through market-based solutions. Health care is no exception to this, and Coloradans agree. In 2016, more than 80 percent of Colorado voters opposed a state-run health insurance program, indicating a lack of support for an increased role of government in health care.

For example, we oppose mandatory participation in the program for carriers and hospitals because we believe requiring a company to compete in a market (whether based on geography or niche) that they aren't equipped to serve (whether lacking the expertise or resources) only adds costs and inefficiencies, costing our companies and employees more money. And, frankly, employers and their employees across our state are struggling to pay for health care already. We've seen that market pressure can positively influence rates faster than any other strategy – which was proven in Summit County with the launch of PEAK Health.

Last legislative session we saw major reforms to our health care system, including the introduction of a reinsurance program, estimated to reduce individual-plan premiums between 10 and 25 percent, and a law to end surprise billing, affecting about one-third of private-insurance customers. We will continue to work with legislators to explore additional market strategies that could help even more.

We appreciate and share your commitment to decreasing health care costs in Colorado but cannot allow our smallest businesses and their employees to continue to be expected to carry the burden of the unintended consequences from regulations like this.

Thank you for your consideration of our concerns. Please reach out to Laura Giocomo Rizzo at Laura.Rizzo@denverchamber.org with any questions.

Sincerely,

Kelly J. Brough

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

Please use this form to submit your comments on the draft HB19-1004 report. All comments will be logged and added as an appendix to the final report. We will accept comments until October 28.

Helpful Links:
- The draft report can be found here: http://www.colorado.gov/pacific/sites/default/files/HB19-1004%20Draft%20Report%20Colorado%20State%20Coverage%20Option%20and%20Appendix.pdf
- The bill text can be found here: https://leg.colorado.gov/sites/default/files/2019a_1004_signed.pdf
- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Derek Harris

County (in which you reside) *

[redacted]

Organization *

Self

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No: increasing government and/or insurance company involvement in healthcare transactions always causes the cost to increase. Reduce government and insurance company involvement in routine and preventive care to lower the cost of healthcare.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No: it will reduce the availability and quality of healthcare options, especially for the most vulnerable.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No: it's a bad idea.

Does the proposal include worthwhile benefits for consumers?

No: it will increase government control at the expense of the most vulnerable consumers.

Does the proposal create a product that is financially stable and sustainable?

No: providers will reject being forced to provide care at a loss, and we will lose provider options.

Other thoughts? Please list them here.

Pass a bill that prevents insurance companies from getting involved in all healthcare transactions below $1000. Insurance companies add ~40% cost to every transaction that they get involved in.

This form was created inside of State.co.us Executive Branch.

Google Forms

I am against the public option for a many reasons, but notably because it seems like a punitive measure against hospitals. It's frustrating to me that the Polis administration has repeatedly ignored facts that get in the way of its political agenda. Case in point:

- Data from the Kaiser Family Foundation shows that Colorado already has the fifth-lowest healthcare spending per capita in the nation.

- Colorado is consistently ranked as one of the highest quality states for healthcare in the country.

- This year, hospitals agreed to pay $40 million per year into the state's new reinsurance program, which has been credited with reducing health coverage premiums in the individual market by 20 percent.

- The reinsurance program, along with other reforms created collaboratively with the administration and others like patient protections for out-of-network billing have already resulted in a predicted 20% reduction in premiums for individual healthcare coverage.

Our system isn't perfect and we should be looking for sensible and responsible ways to improve on cost and quality. But we already have lower-cost and higher quality care than most other states and we shouldn't threaten all that by rushing through a state option that cuts hospital budgets and staff.

That's exactly what a public option would do. It would undermine progress we've already made and further push hospitals to cut budgets, potentially reduce staff, and eliminate programs. This isn't the solution we need or deserve when it comes to reducing healthcare costs for Coloradans.

We can absolutely do better than this, and looking at the bullet points above, I can't fathom how the administration arrived at the plan it did to create a public option. It won't solve the problems it purports to, and will undo much of the good already accomplished.

Sincerely,

Diane Ekstrom

Direct Health PBC
Health Care is a Public Good

October 18, 2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Commissioner Mike Conway
Division of Insurance
1560 Broadway, Suite 110
Denver, CO 80202

Re: Comments on the Draft Report for Colorado's State Coverage Option

Dear Executive Director Bimestefer and Commissioner Conway:

Direct Health PBC (Direct Health) appreciates this opportunity to submit comments regarding the Draft Report for Colorado's State Coverage Option (the Draft Report) under HB19-1004. We believe that the State Option program presents a profound opportunity for Colorado to reduce health care costs, expand coverage to those in need, and reorient commercial insurance markets toward a higher standard of public interest and patient care. In doing so, the State Option could revitalize the universal coverage movement at a time it is defending against policies that have increased the number of uninsured nationwide for the first time since 2014.

Direct Health is a Colorado-based public benefit corporation (PBC) established to partner with states in implementing new coverage option programs. In doing so, we bring together operational expertise and private capital to create insurance solutions that meet the needs of local communities.

As a PBC, we are required by Colorado law to prioritize our mission as highly as shareholder return. We believe this PBC structure, which combines the entrepreneurialism and access to capital of the private market with the transparency and inclusive, community interest of a public program, is ideally suited to deliver the State Option in Colorado.

The Draft Report provides a strong foundation for the State Option program. The state has executed a tremendous degree of analysis and collected extensive stakeholder input to develop the Report in an short period of time. We support the overall direction you have established for improving the value of health care in Colorado.

These preliminary comments focus on a few key recommendations we have for improving upon the Draft Report to optimize the success of the State Option. We intend to follow up on this submission with more robust data and refined recommendations prior to the close of the comment window.

5275 S University Blvd, Greenwood Village, CO 80121 | billy@directhealthpbc.com | 202-309-0796

Our essential thesis is simple. The public demands and deserves a new type of health insurance option that will drive enhanced value while maintaining overall market stability. Furthermore, because the carrier selected to issue the State Option will occupy a privileged position in the market, one that includes the state rightly leveraging its buying power to drive down prices, it owes a considerable responsibility to all Colorado communities in return.

We are concerned that the mandatory, multi-carrier approach to implementing the State Option will not achieve the affordability gains identified in the Draft Report. It is unclear how hospital reimbursement regulation could be effectuated on a multicarrier basis, especially with uniform affordability gains for all plans, as the Draft Report assumes. Furthermore, the federal advanced premium tax credit (APTC) implications of the multi-carrier approach decrease the buying power of subsidized consumers, as explained below.

We likewise see no authority or support in HB19-1004, other Colorado law, or the comments received from stakeholders thus far for mandating carrier participation. Due to the principles outlined above, we firmly believe that State Option carriers should be eager to serve in this important, public-interested role, rather than mandated to do so.

In addition to numerous areas of strong alignment, the core recommendations we present here that intend to build on the promising foundation laid by the Draft Report include:

1. The State Option should be delivered by a single carrier committed to offering one plan at each metallic tier statewide for three years, selected via a competitive bidding process; and
2. The selected carrier should be mission-driven and uphold the public interest via enhanced transparency and commitment to assisting vulnerable populations.

1. The State Option Should Consist of One, Statewide Carrier Offering One Plan at Each Metallic Tier

We believe that the State Option should be issued by a single carrier that is required to operate statewide, selected via a public, competitive process, and obligated to remain in all counties as the State Option for a minimum of three years.

We appreciate the merits of the state's proposal to require all carriers with a certain degree of market penetration to offer the State Option but believe that a single carrier approach will be more successful at improving affordability, expanding choice of plans throughout the state, and designed in a way that protects and promotes market stability, with necessary guardrails to ensure a competitive market.

a. Selecting a Single Carrier is Superior to a Multiple Carrier Approach in Decreasing Costs for Middle Class Households

For households with income between 138 and 400 percent of the federal poverty level, who represent 76 percent of the Exchange market in 2019, a single carrier approach to implementing the State Option will improve affordability to a much greater degree than the multiple carrier approach posed in the Draft Report. This is primarily due to the variance in APTC value the multiple and single carrier approaches create and the corresponding impact on the buying power of subsidized consumers.

In brief, requiring multiple carriers to offer State Option plans would likely increase the real, out-of-pocket contributions subsidized consumers are required to make to the lowest cost Bronze or Silver plan available to them (we project a modest decrease for the lowest cost Gold plan) relative to a non-State Option baseline.

Selecting a single carrier to offer one State Option plan at each tier has a dramatically different effect. If would reduce the real, out-of-pocket contribution these subsidized consumers make to the premium of the lowest cost option available to them by approximately 40 percent for the Bronze tier, 33 percent for the Silver tier, and 26 percent for the Gold tier.

To evaluate this impact, we used the average monthly premium baseline of $542 included in the Draft Plan for 2022 and adjusted it to determine the cost of the lowest and second lowest options at each metal tier, using the ratio between average premium and lowest cost plans that exists in the 2019 market.[1] We then discounted the premium of the lowest cost plan by 14 percent (the median point of the Draft Plan's State Option discount range of 9-18 percent) for the single carrier scenario. For the multiple carrier scenario, we discounted both the lowest and second lowest cost plan premiums by this amount. Our core findings, which are consistent with work published by Wynne and Anderson in a September *Health Affairs* blog[2] are presented here.

Metallic Tier	**Multiple State Option Carriers**		**Single State Option Carrier**	
	Net Change in Annual Premium Contribution for Subsidized Buyer	*Percentage Variation from Baseline*	*Net Change in Annual Premium Contribution for Subsidized Buyer*	*Percentage Variation from Baseline*
Bronze	+$67	+5.8%	-$458	-39.6%
Silver	+$7	+0.5%	-$517	-32.7%
Gold	-$125	-4.9%	-$650	-25.7%

As explored more in the next section, using the same data analyzed above, the cost of non-State Option plans stays relatively flat under the single carrier scenario, with net premiums increasing 2 to 4.4 percent. In other words, non-State Option plans remain as affordable as they are now under the single carrier approach.

Under the multiple carrier approach, net premiums for non-State Option plans *go up by 22.8-49.8 percent* for middle class families, rendering them essentially unaffordable relative to the State Option alternatives.

b. A Single Carrier Approach Does Not Require a Federal Waiver

A core plank of the state's strategy in pursuing the multiple carrier approach appears to be generation of pass through funding via a federal waiver that the state could then use to address affordability or finance new benefits. While we wholeheartedly support this intention, we are concerned by the uncertainty

[1] Data drawn from https://www.valuepenguin.com/best-cheap-health-insurance-colorado and https://www.hixcompare.org/.
[2] https://www.healthaffairs.org/do/10.1377/hblog20190828.810494/full/

regarding approval of such a waiver and the degree to which any pass through funds would be available once subsidized consumers are "kept whole" by "resubsidizing" their purchasing power to a level it would have been under the single carrier approach.

A single carrier State Option strategy does not require a federal waiver to generate substantial improvements to premium affordability for subsidized (and non-subsidized) consumers.

c. Selecting a Single Carrier is Superior to a Multiple Carrier Approach in Maintaining Market Stability while Improving Competition

Due to the fact the multi-carrier approach will make non-State Option plans relatively unaffordable and the assumptions the Draft Plan makes regarding existing plans leveraging their existing provider networks to offer State Options with identical premium discounts, we think it is safe to assume that *the non-State Option market would quickly become obsolete under the multiple carrier approach.*

Under the single carrier approach, the existing, non-State Option market would still present affordable choices to consumers and thus remain stable for the foreseeable future. With the right protections in place, introducing a single State Option plan for each tier that would capture a reasonable, minority market share is much less disruptive for carriers and providers than an approach that essentially converts the entire individual market into the State Option. We welcome the opportunity to work with the state to implement additional guardrails to prevent market disruption and ensure competitiveness.

The single carrier approach also aligns with HB19-1004's emphasis on competition, which is intended to introduce a new, dependable alternative to existing choices, especially in non- or nominally competitive areas. The single carrier strategy would create a new State Option alternative to existing carriers, including in the 22 counties that currently have only one carrier present.

The multiple carrier approach, on the other hand, especially with the mandate for all carriers to participate, eliminates incentives for new plans to enter the market and could jeopardize the availability of the choices consumers currently have.

d. Selecting a Single Carrier is Superior to a Multiple Carrier Approach in Maximizing the Probability of a Successful, Dependable State Coverage Option Program

In contrast to requiring carriers to (perhaps begrudgingly) offer State Option plans, selecting a single carrier to deliver the Option, one that willingly entered and won a competitive bidding process to do so, will bolster the financial viability of the program, empowering that carrier to institute mission-driven initiatives that depart from existing industry practices.

The economic viability of Colorado's individual market varies widely across the state. This variability is a key reason that there are currently 22 counties with only one carrier present. By requiring the State Option carrier to operate statewide, in every county, the program will leverage the financial benefits of operating in more competitive, densely populated parts of the state in order to maintain a viable, dependable presence in less competitive, sparsely populated parts of the state.

Otherwise, the State Option market will look similar to the one we have today, with a clustering of plan options in the metropolitan areas and only a few, or one, carriers in rural regions.

The single carrier approach is also a more realistic context for establishing a provider network that complies with the state's reimbursement framework and achieving the premium reduction goals identified in the Draft Report. We question whether every plan with specified market penetration will be able meet the state's reimbursement criteria and how the state will collaborate will all carriers on their respective networks and provider reimbursement strategies to achieve the stated premium reduction goals.

2. The State Option Carrier Should be Mission-Driven and Uphold the Public Interest via Enhanced Transparency and Commitment to Assisting Uninsured and Underinsured Populations

Any State Option carrier should be required to operate in a consumer-driven, transparent way, including the Draft Report's proposals to public reimbursement rates, cover high-value services like primary care and mental health pre-deductible, and protect rural providers and they communities they serve. We believe the State Option could go further, however, in advancing transparency and consumer protection while prioritizing the unmet health needs of populations that face barriers to coverage and care.

a. The State Option Should Meet a Higher Standard of Transparency and Consumer Protection

While the Draft Report takes strong steps in this direction, we recommend more robust, specific requirements be imposed on the State Option carrier in return for its selection under the competitive bidding process. These include:

i. Publishing negotiated provider reimbursement rates and submitting all related data to Colorado's all-payor claims database;
ii. Maintaining a public cost-sharing or copay calculator so that enrollees can easily understand their financial responsibility before initiating a medical service;
iii. Disclosing the data underlying the carrier's medical loss ratio calculations for the State Option plans;
iv. Providing enrollees untrammeled access to their personal health information and other records maintained by the carrier;
v. Conducting public comment processes to solicit input regarding major coverage decisions; and
vi. Establishing a Consumer Advisory Board for input regarding grievances and other enrollee concerns.

b. The State Option Should Prioritize Delivering Coverage to the Un- and Underinsured

Per a recent survey, over 100,000 Coloradans are eligible for premium subsidies in the individual market but are not enrolled. Well over 100,000 additional Coloradans are ineligible for ACA-based subsidies for a variety of reasons, including the "family glitch" or lack of required documentation.[3]

[3] See, e.g., www.coloradohealthinstitute.org/research/colorados-eligible-notenrolled-populationcontinues-decline

While the affordability gains generated by the State Option should help resolve the persistent challenge of un- and underinsurance in Colorado to some degree, the selected carrier should be required to present specific strategies and a clear commitment to expanding access to insurance and care to individuals throughout the state who currently face barriers to these services.

Interested carriers should be challenged to engage with communities at the local level to understand their needs and propose innovative solutions to address them. In tandem with this requirement, the state should take concrete steps to alleviate barriers to enrollment wherever possible, including by reforming individual market enrollment processes outside of the Exchange.

Expanding coverage to these populations would likely strengthen the overall risk profile of the individual market in Colorado, reduce uncompensated care for providers, and satisfy a moral obligation that should be inherent to the State Option program.

3. Conclusion

Thank you very much for your consideration of these recommendations. We believe the Colorado legislature took an historic step in passing HB19-1004. Direct Health PBC stands ready to partner with the state to deliver a State Option that is truly dedicated to the public interest, improves health outcomes, and increases affordability for all Coloradans.

Sincerely,

Billy Wynne
Founder & CEO
Direct Health PBC

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

Please use this form to submit your comments on the draft HB19-1004 report. All comments will be logged and added as an appendix to the final report. We will accept comments until October 28.

Helpful Links:
- The draft report can be found here: http://www.colorado.gov/pacific/sites/default/files/HB19-1004%20Draft%20Report%20Colorado%20State%20Coverage%20Option%20and%20Appendix.pdf
- The bill text can be found here: https://leg.colorado.gov/sites/default/files/2019a_1004_signed.pdf
- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

DONALD R. MILLER

County (in which you reside) *

[redacted]

Organization *

PRIVATE CITIZEN/TAXPAYER

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

IN NO WAY! SIMILAR TO THE ACA TELLING US "NO INCREASE IN PREMIUMS" AND "YOU CAN KEEP YOUR CURRENT HEALTH INSURANCE". ALL BUNK AND NOT TO BE TRUSTED!!

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

KEEP GOVERNMENT - AT ALL LEVELS - OUT OF OUR HEALTH INSURANCE PROGRAMS!

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

KEEP GOVERNMENT - AT ALL LEVELS - OUT OF OUR HEALTH INSURANCE PROGRAMS!

Does the proposal include worthwhile benefits for consumers?

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Does the proposal create a product that is financially stable and sustainable?

KEEP GOVERNMENT - AT ALL LEVELS - OUT OF OUR HEALTH INSURANCE PROGRAMS!

Other thoughts? Please list them here.

KEEP GOVERNMENT - AT ALL LEVELS - OUT OF OUR HEALTH INSURANCE PROGRAMS!

This form was created inside of State.co.us Executive Branch.

Google Forms

EPHC
HEALTH TOGETHER

October 28, 2019

Director Kim Bimestefer
Healthcare Policy & Financing
1570 Grant Street
Denver, CO 80203

Commissioner Mike Conway
Colorado Department of Regulatory Agencies
Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Re: Comments regarding Draft Report for Colorado's State Coverage Option

Via: Electronic Mail: HCPF_1004AffordableOption@state.co.us

Dear Director Bimestefer and Commissioner Conway:

The Eastern Plains Health Consortium consists of eight independent critical access hospitals and one hospital system serving the Eastern Plains of Colorado (see Appendix A for the list of hospitals and CEO contacts for each member). We appreciate the opportunity to provide feedback on the Draft Report for Colorado's State Coverage Option (Draft Report), dated October 7, 2019.

We commend the Polis Administration and you for taking this bold step and endeavoring to address many of the vexing problems facing Coloradoans as they seek to gain access to high quality, low cost healthcare. While there are many items in the Draft Report where we have questions and concerns we appreciate the effort taken to invite public input throughout the process. We urge you to continue this philosophy as you craft the final recommendation and shepherd this effort through the General Assembly and hopefully through implementation of a successful program. We believe it is important to take the time to develop a thoughtful program that limits unintended consequences. We are frustrated with the recent reinsurance program, while admirable in its goals resulted in burdening rural hospitals with an unexpected obligation resulting in reduction or elimination in already desperately thin operating margins.

We agree with the Colorado Hospital Association (CHA) that the final plan should provide solutions that:

- Focus on Colorado's uninsured and underinsured populations;
- Protects Consumer choice to competitive insurance markets; and

- Safeguards access to high quality care through sufficient payments for all providers.

We are encouraged by several statements made through the process and during the public comment period and in the draft report about the need to protect rural and critical access hospitals. We appreciate your commitment to help these hospitals not only to survive, but to thrive in the future.

After review of the Draft Report we offer the following comments:

- Rate Setting. We appreciate the need to control costs under this proposal. We accept the inevitable discussion that hospitals and our related services should bear some burden in controlling these costs. We urge you to ensure that all facets of the healthcare system carry an equal burden in controlling costs. This includes payers, pharmaceuticals and medical supply and equipment providers.
    - We understand the methodology you used in arriving at the range of 175% - 225% of Medicare fee schedules as base rates for the proposed program. We ask that these rates be validated to ensure that they in fact are "national averages" as you present in the Draft Report. Having said that, you are aware that these rates are significantly higher than average payment rates being reported for small critical access hospitals, including our members. We welcome the potential increase in rates and ask for clarification on how rates will be finally established and how you will reconcile possible increase in rates to rural hospitals with the goal of reducing premiums for enrollees.
        - As an alternative to Critical Access Hospitals being reimbursed via a multiple of the Medicare Fee Schedule, we ask that consideration be given to a cost plus reimbursement model.
    - Payers (insurance companies and government benefit programs)
        - Payers regularly unleash a barrage of rules and requirements upon hospitals causing increased administrative complexity and confusion. These include overly complex and inconsistent rules for billing, pre-authorization requirements and enrollment verification. We request that any final version of this proposal or its implementing regulations include at least an acknowledgement that much of the increase in administrative costs in hospitals is brought about by external forces, often with the implied (if not express) purpose of limiting access to care by creating administrative complexity. This is particularly troublesome for small rural

hospitals who lack the administrative capacity to deal with these challenges.

- We also request some support to encourage payers to acknowledge the total cost of care when referring patients to the urban areas instead of seeking care close to home. We are heartened by comments made by both of you that the cost of care includes all costs the patient incurs when traveling to urban areas including lost time at work, travel costs and other out of pocket expenses. We encourage you to create incentives for payers to have patients to seek care locally rather than the current trend of creating incentives to seek care in urban areas. Recently Anthem and United Health have adopted policies where hospital-based services will be routinely denied. This essentially would require all rural residents covered by these plans to travel to the city for outpatient care. While both have stated a willingness to consider geographic location, neither have implemented in practice on a consistent basis. We specifically call out CEBT and CTSI, two quasi-public entities who overtly encourage their enrollees (public employees) to seek care outside of their local area. This includes hospital care and pharmaceutical care.
- While we welcome the role of the Commercial Insurance Companies outlined in the Draft Report, we request some check on these entities as they "negotiate" rates with small critical access hospitals. As we've discussed the disparity in market power is extraordinary and Insurance Companies at times use a "take it or leave it" approach when contracting with small hospitals. We request the Final State Option include guidance for Insurance Companies on acceptable rates and contract terms to avoid disparate treatment between large urban systems and the small rural hospitals. In the alternative we ask that you consider whether groups of small rural hospitals (such as EPHC) can negotiate as a single entity for contracts under this plan in the hopes of leveling the playing field between the insurance company and the hospitals.

- Suppliers
  - Pharmaceutical companies often impose extraordinary costs for badly needed medications. Often reimbursement for these costs do not cover our costs causing hospitals of all sizes to make the decision on whether to

offer life-saving medications to our patients knowing full well we will not be paid in full for that cost.

- Medical Supply & Equipment providers are also often unwilling to offer competitive pricing for small rural hospitals due to our lack of market power. As with pharmaceuticals, we often are forced to make decisions on whether to offer care knowing full well the cost of supplies and equipment exceeds our reimbursement.

- Provider Participation. We understand the need to establish adequate networks and the possibility of making participation mandatory if necessary. We urge you to do everything possible to work with the providers in the state to create a program attractive enough to encourage voluntary participation. If mandatory participation becomes a requirement, we seek clarification on whether that would become a statewide requirement or if the proposed program would selectively focus on geographic areas?
- Rural Hospital Support. We are grateful for the specific acknowledgment that rural and other safety net hospitals require special attention. It goes without saying that without the critical access hospitals serving remote areas of the state, and large safety net hospitals like Denver Health and Colorado Children's, access to care for marginalized populations including rural, low income, minority and disabled populations who rely on care from these safety net providers is endangered.
    - We've outlined above steps we ask you consider to help support rural hospitals in the relationship with the insurance companies charged with administering the proposed program. Similarly any leverage you can provide in allowing rural hospitals to negotiate with pharmaceutical companies and other medical supply and device providers is welcome.
    - We encourage a plan design that would allow for an increased number of services to be provided pre-deductible. As you have both agreed, often rural hospitals are forced to accept limited payment from our patients because they have not yet met their deductible. However, if these same patients are referred to the urban facilities, the deductible is often met and the urban providers are able to bill the insurance company resulting in increased collections.
        - On a related topic, we ask that you consider a system where the insurance companies are responsible for collecting copays and deductibles under this plan. That would significantly simplify the administrative burden for small hospitals and improve our cash flow.

- As referenced above, we request that the proposed program provide opportunities for rural hospitals to work together in contracting and purchasing. We also welcome the opportunity to work with you on developing Centers of Excellence in rural areas that allow us to improve services and refer patients to one another for appropriate services rather than refer to the city. Additionally, we are intrigued by the idea that when patients are referred to the city such a referral is done under a "bundled payment" methodology, where rural hospitals share in the revenue for the management of the patient and create incentives for those patients to be returned home for convalescent care and follow up by local providers.
- Finally we ask, perhaps as a tangential effort, the state evaluate the creation of a separate advisory board to assist in the development of a rural health strategy. We propose such a body be made up of representatives of Frontier and Rural Hospitals, the Colorado Hospital Association and the Colorado Rural Health Center, Commercial payers and policy makers from the state.
    - Included in this strategy is consideration given to the breadth of services most rural hospitals provide including long term care, home health, hospice, transportation and primary care. Often rural hospitals are penalized financially for offering such services, but are forced to offer them because no one else will. With shrinking reserves and unsustainable margins we hunger for innovative reimbursement models that will help us to meet our collective goal of thriving in this new market place. We believe that improved care results from encouraging hospitals to offer a broad range of services to promote wellness and health rather than the current "sick care" model where we are reimbursed under a fee for service model.
    - We suggest there also be focus on establishing policies across all payers to support systems to keep care local. Numerous studies suggest that patients will respond to treatment more favorably when care is provided close to home. Additionally, the overall cost of care can be reduced by eliminating the need for travel, time away from work and the general disruption created by the need to travel.

Thank you again for the opportunity to comment. We remain committed to working with you to come to a mutually agreeable solution for all.

With Warm Regards, on behalf of the Eastern Plains Health Consortium,

Trampas Hutches

Trampas Hutches
CEO Melissa Memorial Hospital
Board Chair, Eastern Plains Health Consortium

Cc: Eastern Plains Health Consortium Board
Chris Tholen, Colorado Hospital Association
Michelle Mills, Colorado Rural Health Center

EPHC
HEALTH TOGETHER

Appendix "A"

Consortium Member	Member Contact / EPHC Role	Phone Number	Email Address
Melissa Memorial Hospital	Trampas Hutches, Board Chair	(970) 854-2241	Trampas.Hutches@bannerhealth.com
Weisbrod Memorial Hospital	Charlene Korrell, Chair Elect	(719) 438-5401	char.korrell@kchd.org
Lincoln Community Hospital	Kevin Stansbury, Immediate Past Chair	(719) 743-2162	kstansbury@lchnh.com
Haxtun Hospital District	Dewane Pace, Board Member	(970) 774-6301	dpace@haxtunhealth.org
Keefe Memorial Hospital	Stella Worley, Board Member	(719) 767-5661	sworley@keefemh.org
Kit Carson County District Hospital	Kelly Duke, Board Member	(719) 346-5311	KDuke@kcchsd.org
Sedgwick County Hospital	Nick Goshe, Board Member	(970) 474-3323	ngoshe@schealth.org
Yuma District Hospital	Beth Saxton, Board Member	(970) 848-4676	bsaxton@yumahospital.org
Banner Health	Hoyt Skabelund, Board Member	(575) 749-2486	Hoyt.skabelund@bannerhealth.com
Vertical Strategies	Melissa Bosworth, EPHC Executive Director	303.506.4428	Melissa@easternplainshealth.org
Vertical Strategies	Megan Little, EPHC Associate Executive Director	989.522.2814	Megan@easternplainshealth.org
Vertical Strategies	Felipe Tendick-Matesanz, EPHC Support Staff	312.752.8637	felipe@easternplainshealth.org

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Hugo, Colorado 80821
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October 28, 2019

Director Kim Bimestefer
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Commissioner Mike Conway
Colorado Department of Regulatory Agencies
Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Re: Comments regarding Draft Report for Colorado's State Coverage Option

Via: Electronic Mail: HCPF_1004AffordableOption@state.co.us

Director Bimestefer and Commissioner Conway:

Thank you for the dialogue you've hosted over the past several weeks to get input on Colorado's State Coverage Option. I appreciate your openness and your commitment to addressing the challenges of health care in general and rural healthcare in particular.

Included in this packet are comments provided by community members and leaders from Lincoln Community Hospital & Care Center. We agree that our state needs to take proactive steps to address health care access and affordability to ensure that Coloradans have access to the care they need and can afford it when they do seek care. Unfortunately, we are concerned that this proposal, as drafted, would have serious ramifications for our community, our local hospital and our state as a whole.

Specifically, we don't believe this proposal will help enough Coloradans and may actually jeopardize access to care and affordability for those who are already covered. With nearly 400,000 Coloradans currently uninsured, we are disappointed that this new option doesn't prioritize those individuals. We are also concerned that it will increase health insurance costs for many Coloradans, as costs will be shifted to the nearly half of Coloradans who have employer-sponsored insurance. Finally, we believe that the government rate setting for hospitals that funds this proposal could be incredibly detrimental to hospitals across our state.

Our local hospital, Lincoln Community Hospital, is a vital part of our community. It is one of the largest employers in our region and provides significant community benefit beyond the traditional patient care offered within the hospital. While the draft proposal doesn't examine the financial impact to hospitals, we must assume that this type of government rate setting for hospitals will be significant – especially since hospitals cuts are the only funding mechanism for these significantly reduced health care plans.

The proposal purports to protect rural hospitals, but doesn't give any specific details about how that will happen. Our hospital, like most in rural Colorado, works incredibly hard to

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make ends meet in order to ensure access to care in our community. We look forward to learning more about the details of the support the program will have for our local facility. As detailed in the attached letter from the Eastern Plains Health Consortium, we encourage you to continue the dialogue with that organization on how to best work with rural facilities like ours to ensure we are thriving.

Please consider the impact this proposal could have on communities like ours, on hospitals like ours and on access to affordable care for patients like me, my family, friends and neighbors. We agree that there is still more work to do to improve our health care system, and we encourage you to consider the observations of stakeholders like the Colorado Hospital Association and the Eastern Plains Health Consortium.

Sincerely,

Kevin M. Stansbury
CEO

Lincoln Community Hospital and Care Center

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October 25, 2019

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Department of Health Care Policy & Financing
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Denver, CO 80203

Commissioner Mike Conway
Colorado Department of Regulatory Agencies
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Sincerely,

Steve Burgess
Lincoln County Commissioner

Lincoln Community Hospital and Care Center

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October 25, 2019

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Department of Health Care Policy & Financing
1570 Grant Street
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Sincerely,

Erika Saffer
Chief Operating Officer/Nursing Home Administrator
Lincoln Community Hospital & Care Center

Lincoln Community Hospital and Care Center

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Sincerely,

Lucas Koch
Maintenance Director/Safety Officer
Lincoln Community Hospital & Care Center

Lincoln Community Hospital and Care Center

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Sincerely,

Linda Messer, MLT

Linda Messer, MLT-ASCP
Director of Outpatient Services
Lincoln Community Hospital & Care Center

Lincoln Community Hospital and Care Center

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Sincerely,

Jacquelyn Rapp
Executive Assistant
Lincoln Community Hospital & Care Center

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

Please use this form to submit your comments on the draft HB19-1004 report. All comments will be logged and added as an appendix to the final report. We will accept comments until October 28.

Helpful Links:
- The draft report can be found here: http://www.colorado.gov/pacific/sites/default/files/HB19-1004%20Draft%20Report%20Colorado%20State%20Coverage%20Option%20and%20Appendix.pdf
- The bill text can be found here: https://leg.colorado.gov/sites/default/files/2019a_1004_signed.pdf
- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Edna Heimerman

County (in which you reside) *

[redacted]

Organization *

none

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

no

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

no

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

no

Does the proposal include worthwhile benefits for consumers?

no

Does the proposal create a product that is financially stable and sustainable?

no

Other thoughts? Please list them here.

leave our healyj care alone

This form was created inside of State.co.us Executive Branch.

Google Forms

Please support Jared Polis' proposal. I live in [REDACTED]. I am self employed and my only choice has been Kaiser Permanente.

I have to pay nearly $700 per month for individual coverage, which, in spite of being better than nothing, doesn't cover much of anything. It is basically catastrophic coverage only, in spite of the high cost.

I am having a very difficult time paying for this. I do not have a spouse with any coverage possibility for me to be covered. I know there are lots of people like me who live in Colorado. I think more choices could bring more competition and help make it more affordable for us.

Thank you.
Elizabeth Johnson

Liz

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Elizabeth Rand

County (in which you reside) *

[redacted]

Organization *

N/A (retired)

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

No

Other thoughts? Please list them here.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Elyse Dinnocenzo

County (in which you reside) *

[redacted]

Organization *

Principle Land Planning, LLC

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

I believe it will help regulate and decrease costs.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

I believe it will.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

I am concerned that the existing infrastructure may not be adequate yet.

Does the proposal include worthwhile benefits for consumers?

Absolutely.

Does the proposal create a product that is financially stable and sustainable?

I believe it is. If other states can have universal healthcare for their residents, I think we can make this option work just as well.

Other thoughts? Please list them here.

Thank you for making healthcare reform and its associated costs a priority for Colorado.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Eric Mello

County (in which you reside) *

[redacted]

Organization *

SCL Health

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

We all want affordable healthcare. This plan does not specifically demonstrate how it is going to accomplish affordable health care for Coloradans. It only provides an option for “All Colorado residents who buy their own individual health insurance can purchase a State Option plan”. This is a small part of the Colorado population which already has coverage.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

I do not believe this option addresses the actual high healthcare costs. It is an insurance option which only impacts a small percentage of the Colorado population paying their own insurance without addressing the larger uninsured population. The plan gives vague references to “Centers of Excellence” which once again only addresses a small part of the cost which is hospital facilities and not physician costs, pharmaceutical costs, medical device manufacture costs.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

After reading the proposed plan I do not see any concrete way that it will meaningfully reduce costs through existing infrastructure. A family might see a reduction $60 - $180 in premium savings and the addition of several layers of bureaucracy to receive medical services.

Does the proposal include worthwhile benefits for consumers?

The plan is based on speculation and does not address what “All Essential Health Benefits will be covered” entails. With the addition of only 9-18% savings I would say that it does not include worthwhile benefits.

Does the proposal create a product that is financially stable and sustainable?

Once again the plan does not address the main medical cost pain points which are pharmaceutical costs, medical devices, physician costs. These are the big-ticket costs on a medical bill. It then puts the state in the insurance business which ads a layer of bureaucracy forms and inconvenience to the user driving up dissatisfaction. These factors combine for an unstable model that will not be sustainable and will eventually lead to tax payer investment to keep it afloat.

Other thoughts? Please list them here.

Up until four years ago I was paying out of pocket for my family’s medical insurance. My high deductible premiums were somewhat stable until around 2009. At that point my expenditures went from around $400 a month for the family of five to $1000+ in 2015 when I got a new job with medical coverage. The increased competition in the market by the federal government did not result in savings it resulted in a 53% increased burden on me and my family. If you want to be innovators address the costs that the insurance companies have to address go after the costs of pharmaceuticals, physician reimbursement, and medical device manufacturers selling services and products in the state of Colorado.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Erika

County (in which you reside) *

[redacted]

Organization *

Physician Assistant

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

Absolutely not

Other thoughts? Please list them here.

Government run healthcare would be a disaster. Those with private insurance would be responsible for greater costs than currently exist. Employers would have to cut employees to pay for this. Clinics and hospitals would not be able to sustain accessibility

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Erin Williams

County (in which you reside) *

[redacted]

Organization *

RNDC Distributing Company

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

Yes, but it has to be a plan that actually covers something real. Putting out another plan with an insane deductible that no normal family can afford will be a waste of time and energy. Coloradans want real health care coverage, not another $5,000 deductible before we pay for anything plan.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

Giving more options to the residents of our state who have very few public options seems like a good idea.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Well, you haven't really written up how that would work only that it should be looked into so I don't know.

Does the proposal include worthwhile benefits for consumers?

I think having more options for healthcare is always worthwhile.

Does the proposal create a product that is financially stable and sustainable?

Once again you haven't laid out all the ideas so I don't know. But I look forward to hearing about it and think it is a worthwhile endeavor.

Other thoughts? Please list them here.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

ERNIE PHILLIPS

County (in which you reside) *

[redacted]

Organization *

RETIREMENT

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

NO

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

NO

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

NO

Does the proposal include worthwhile benefits for consumers?

NO

Does the proposal create a product that is financially stable and sustainable?

NO

Other thoughts? Please list them here.

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On Tuesday, October 8th, the Colorado Department of Health Care Policy and Finance (HCPF) and the Colorado Department of Insurance (DOI) jointly presented a draft proposal for introducing a Public Option to the individual health care insurance exchange. Here is my review of the proposal and suggestions regarding what else the State of Colorado might consider.

Proposal Review:

Stepping back -- what does the public option do near-term and long-term?

Based on the draft proposal, the public option begins as a coverage expansion. Persons who wouldn't buy individual coverage today, or who would buy it and not use it might buy and use coverage if a public option were available.

- Individuals below 400% of the Federal Poverty Level (FPL) could be persuaded at the margin to buy and use health care insurance.

- More likely, uninsured persons above 400% of the FPL, if provided financial assistance under a Medicaid 1332 Waiver, would be persuaded to buy insurance.

- Persons with individual insurance today might choose the public option and, at the margin, be less likely to forego care for financial reasons.

Longer-term, it's much harder to draw conclusions about the availability of a public option. In principle, it should catalyze greater efficiency (and, perhaps, lower levels of profitability) amongst hospitals and payors, therein making health care more affordable for a significant number of Coloradoans.

Details and Critique:

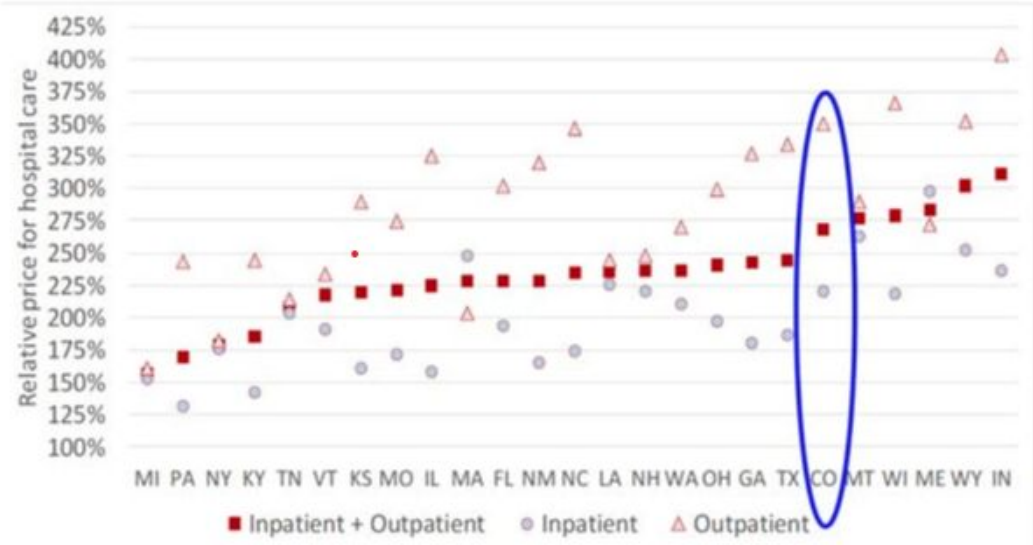
The State of Colorado (the "State"), plans to use the existing individual market framework to deliver the Public Option. This makes a ton of sense, as does the State's decision not to use the Medicaid framework. As elucidated by Department of Insurance (DOI) Commissioner, Mike Conway, the State will rely on existing payors to underwrite the public option risk and Colorado's state-based exchange in order to keep admin costs low. (Currently, it's estimated that 3.5% of premiums support exchange operations.) What's more, by making the Public Option available on the exchange (as well as off), persons receiving financial assistance (e.g. through advance premium tax credits) can continue to do so. Finally, as a happy consequence of this decision, brokers will remain an important part of the distribution channel, which should 1) lead to a better buying decision and 2) keep the broker community satisfied. Overall, by simply mandating that payors offer the public option and avoiding changes that might be considered disruptive, the State ought to be able to ensure a successful launch of the public option while keeping State financial obligations and risk to a minimum.

The State has proposed that <u>hospital</u> inpatient and outpatient reimbursement be set at 175%-225% of Medicare. This proposal merits some discussion.

This level of reimbursement does appear to represent a "sweet spot" for hospital reimbursement for a number of reasons.

- Hospitals today are in a strong financial position -- most make money, and most boast strong balance sheets. While each hospital is unique, the average hospital has achieved this financial status largely through a mix of very profitable private insurance (much of which is purchased through large employers), reasonably profitable Medicare (which, by definition reimburses at ~100% of Medicare) and unprofitable/loss-making Medicaid and uncompensated care. While a discussion of case-mix-index is a rabbit hole for another day, offering hospitals <u>new</u>, non-elderly business at 2x Medicare, while not disrupting hospitals' existing mix should be a net <u>positive</u> for hospitals over the near- (and probably intermediate) term.

- The State's choice of 175%-225% of Medicare appears well-founded in comparison to the average reimbursements hospitals enjoy nationwide. Many hospitals appear to be doing just fine at this level of reimbursement, and Colorado hospitals, as some of the most expensive, would certainly continue to enjoy an all-payor average well in excess of this figure, even if the Public Option were wildly successful. Here's a slide from the State's presentation:



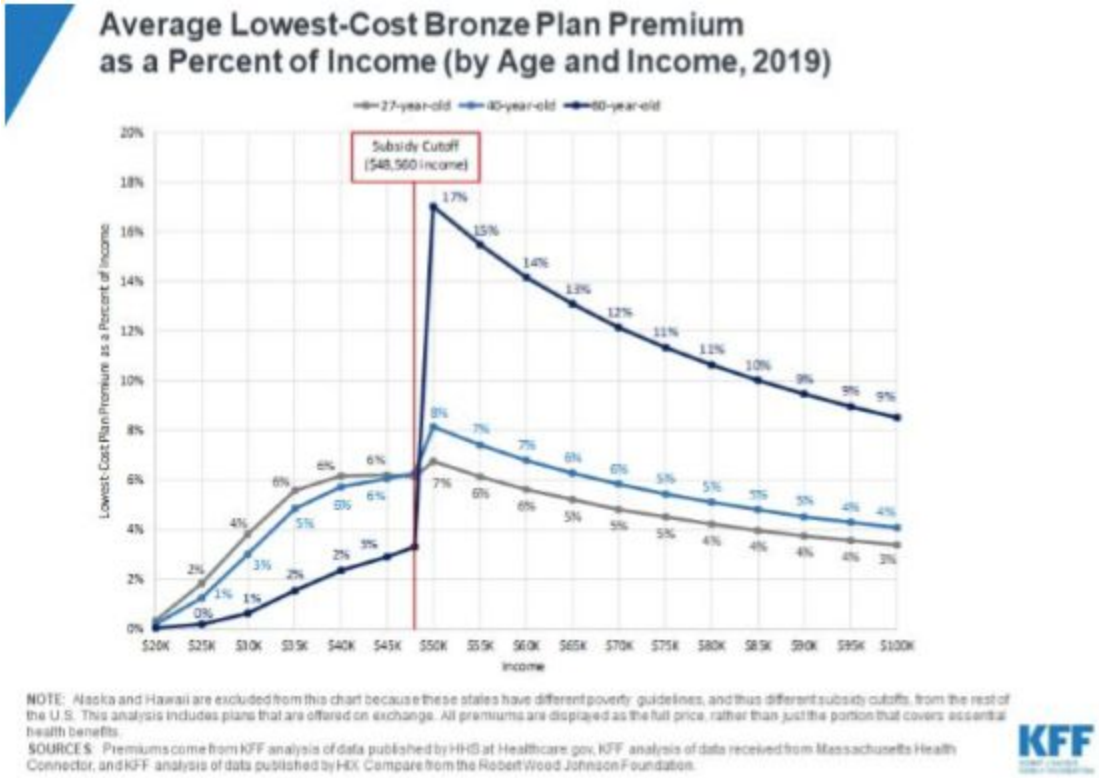
As is evident from a survey of States with all-payor claims databases, states operating significantly above 225% of Medicare represent reimbursement outliers.

The State has not proposed that physician (a.k.a. “professional”) reimbursement rates be set at a particular percentage of Medicare, nor has the State proposed that pharmacy benefits be impacted.

The State has suggested that Payors will negotiate hospital rates that average 175%-225% of Medicare, and that enforcement will take place via Payors’ rate filings and the review thereof. At least as far as the State’s October 8th presentation to stakeholders is concerned, Payors will be the State’s heavies when it comes to provider compliance. A hospital provider negotiating with Anthem for example must not only consider the direct consequences of balking at being in network for the Public Option, but the indirect consequences such a decision might have on the remainder of its business with Anthem, not to mention its social currency with the State. As a reminder, Payors wishing to offer individual policies must also offer the Public Option in order to do so.

The State commissioned Wakely Consulting Group, LLC (Wakely) to conduct an actuarial analysis of the effects of the Public Option draft proposal. The analysis seems reasonable, albeit conservative when it comes to assumptions around the number of individuals that would switch to the Public Option and the effects of achieving pass through savings under the Medicaid 1332 Waiver and passing these savings along to consumers. For this reason, Wakely’s conclusion that Coloradoans might save 9-18% on monthly premiums through the Public Option could prove conservative over time.

The State is going to request a Medicaid 1332 Waiver in order to redirect a portion of the Public Option savings achieved to what’s known as the “Subsidy Cliff”. Currently, under the Affordable Care Act, persons above 400% of the FPL are not eligible for financial assistance to purchase individual health insurance. As a consequence, these individuals (particularly those close to 400% of the FPL) find health care to be much less affordable. Here’s the graph:



As one can see, the effect is particularly pronounced for those who are older but not yet eligible for Medicare (represented in this graph by the 60 year olds). Presumably -- b/c the HCPF and DOI folks working on this have demonstrated both a comprehensive understanding of the failings of our health care system, as well as a high degree of compassion -- it is likely that the pre-Medicare elderly will receive the bulk of the financial assistance under this 1332 Waiver. This remains to be seen, however.

Timelines (and Implications):

According to the draft proposal, the Public Option would not be available to consumers until January 1, 2022 (with an open enrollment period held in the fall of 2021). This is, unfortunately, realistic, since the State is requesting a 1332 Waiver and since the individual market is on a January 1st renewal cycle (with rate filings due roughly six months prior and open enrollment taking place roughly 3 months prior). Given the lengthy process involved in standing up the Public Option, the State should get started on the small group Public Option in an overlapping fashion (see Suggestions provided later in this document). The goal should be to get the small group Public Option operational roughly a year later (i.e. on January 1, 2023).

Suggestions:

Hospital Input Costs; Assist with Input Transparency and Demand Disclosure. At the State's presentation, I asked about initiative designed to get at one of the true culprits behind high costs of care. Specifically, I asked whether the State was pursuing strategies intended to reduce input costs and increase transparency around these figures. While hospitals aren't terribly good at disclosing these dynamics, sufficient information is available to draw a pretty good picture.

By some, it's perceived that GPOs do a pretty good job of reducing the prices hospitals pay for a variety of medical supplies and devices. These include commodity items like gowns and gloves, and physician preference items like implantable defibrillators and knee prosthetics. Different GPOs embrace different business models, but the idea is the same -- aggregate purchasing power and extract a lower price from device manufacturers. Unfortunately, with the amount of horizontal hospital consolidation that's gone on, GPOs really don't have much to add to what multi-hospital systems (a.k.a. IDN's) can demand directly from manufacturers, especially when it comes to physician preference items. Instead, they provide a little added juice where possible, as well as the ability of smaller customers to coat-tail.

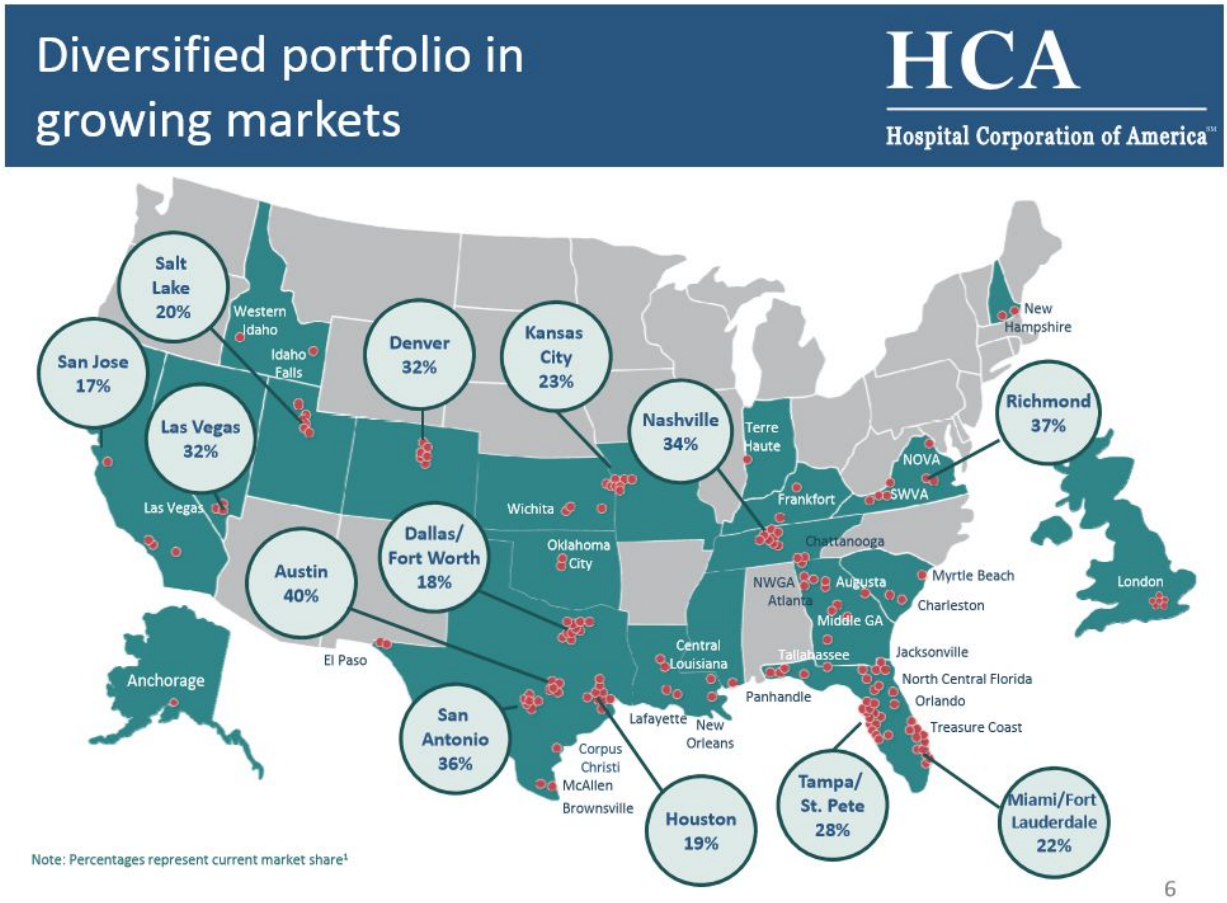
In contrast, hospitals with significant market share -- either in terms of service area or service line -- truly have the market power. Here are some data on DRG 470 (joint replacement) from CMS's Inpatient Prospective Payment System database (FY '17).

DRG Definition	Provider Name	City	State	Discharges	Average Covered Charges	Average Total Payments	Average Medicare Payments
470 - MAJOR JOINT REPLACEMENT	HOSPITAL FOR SPECIAL SURGERY	NEW YORK	NY	4,255	$70,572.01	$21,217.73	$14,447.55
470 - MAJOR JOINT REPLACEMENT	NEW ENGLAND BAPTIST HOSPITAL	BOSTON	MA	2,390	$24,854.62	$15,523.33	$13,101.59
470 - MAJOR JOINT REPLACEMENT	EVANSTON HOSPITAL	EVANSTON	IL	1,482	$56,508.61	$16,284.30	$12,607.97
470 - MAJOR JOINT REPLACEMENT	MAYO CLINIC HOSPITAL ROCHESTER	ROCHESTER	MN	1,464	$33,920.36	$20,514.73	$16,412.94
470 - MAJOR JOINT REPLACEMENT	CHRISTIANA CARE HEALTH SERVICES, INC.	NEWARK	DE	1,461	$32,179.37	$15,379.07	$10,949.81
470 - MAJOR JOINT REPLACEMENT	NYU LANGONE HOSPITALS	NEW YORK	NY	1,400	$130,292.56	$25,621.53	$19,750.88
470 - MAJOR JOINT REPLACEMENT	CHRIST HOSPITAL	CINCINNATI	OH	1,391	$50,491.58	$14,211.05	$10,714.51
470 - MAJOR JOINT REPLACEMENT	HOAG ORTHOPEDIC INSTITUTE	IRVINE	CA	1,382	$64,603.06	$15,332.12	$11,480.97
470 - MAJOR JOINT REPLACEMENT	MOUNT CARMEL NEW ALBANY SURGICAL HOSPITAL	NEW ALBANY	OH	1,339	$47,568.03	$12,271.27	$9,711.83
470 - MAJOR JOINT REPLACEMENT	NEW HANOVER REGIONAL MEDICAL CENTER	WILMINGTON	NC	1,326	$46,923.40	$15,225.40	$13,141.21
470 - MAJOR JOINT REPLACEMENT	BEAUMONT HOSPITAL, ROYAL OAK	ROYAL OAK	MI	1,314	$34,016.95	$14,464.21	$11,641.87
470 - MAJOR JOINT REPLACEMENT	MORRISTOWN MEDICAL CENTER	MORRISTOWN	NJ	1,269	$55,464.96	$16,728.73	$13,870.98
470 - MAJOR JOINT REPLACEMENT	SWEDISH MEDICAL CENTER	SEATTLE	WA	1,260	$72,884.42	$17,813.00	$12,129.65
470 - MAJOR JOINT REPLACEMENT	VIRTUA WEST JERSEY HOSPITALS VOORHEES	VOORHEES	NJ	1,260	$74,269.57	$13,344.68	$9,852.34
470 - MAJOR JOINT REPLACEMENT	ST FRANCIS HOSPITAL & MEDICAL CENTER	HARTFORD	CT	1,183	$41,788.01	$18,231.22	$13,130.12
470 - MAJOR JOINT REPLACEMENT	CENTURA HEALTH-PORTER ADVENTIST HOSPITAL	DENVER	CO	697	$66,363.68	$14,135.52	$10,755.11
470 - MAJOR JOINT REPLACEMENT	ROSE MEDICAL CENTER	DENVER	CO	306	$104,982.37	$15,216.97	$11,479.63
470 - MAJOR JOINT REPLACEMENT	SAINT JOSEPH HOSPITAL	DENVER	CO	224	$78,660.00	$17,607.97	$13,459.75
470 - MAJOR JOINT REPLACEMENT	PRESBYTERIAN ST LUKES MEDICAL CENTER	DENVER	CO	76	$124,296.87	$18,617.20	$13,240.50
470 - MAJOR JOINT REPLACEMENT	DENVER HEALTH MEDICAL CENTER	DENVER	CO	20	$46,816.65	$22,295.30	$19,361.10
470 - MAJOR JOINT REPLACEMENT	SWEDISH MEDICAL CENTER	ENGLEWOOD	CO	228	$92,254.74	$14,812.82	$10,850.83

It's pretty clear, for example, how important the Hospital for Special Surgery (HSS) is to the New York market (and to knee and hip implant manufacturers generally). What's more, large volume centers like HSS tend to be places where surgeons are trained, and surgeons tend to stick with the devices upon which they are trained. It should be no surprise, therefore, that HSS gets some of the best deals on implants, despite the fact that their net patient service revenues are annualizing at only about $1bn annually as of Q1 2018[1]. HCA, in contrast, with over $50bn in

[1] https://www.crainsnewyork.com/assets/pdf/CN115603521.PDF

annualized revenues [2], faces a considerable amount of geographic and service line dispersion. To be fair, the company has some markets where it commands significant market share, but price negotiations -- whether held directly with vendors or through GPOs -- rely on the intersection between compliance and volumes. As a consequence, HCA doesn't fare as well. You can see from the selected Denver data that HCA's Swedish Medical Center is of only moderate importance to the local market. What's more, depending on the perceived market power of the local physician groups, it again may be difficult for HCA to convince physicians to standardize on only one or two manufacturers.



The point to all this is that the State would do well to encourage (or demand) greater transparency of specific input costs as well as cost to charge ratios at a greater level of aggregation. By doing so, the State would make it much more difficult for manufacturers to price discriminate behind closed doors (input prices vary as dramatically as do hospital gross- and net charges). Depending on antitrust limitations, the State ought to consider developing a true buying group available to rural and critical access hospitals.

[2] https://investor.hcahealthcare.com/press-release/hca-reports-second-quarter-2019-results

To put some numbers behind this, you can see from the chart that a typical hospital might take in $12,000, on average, for a Medicare-reimbursed simple joint replacement procedure. The State is proposing reimbursing hospitals for Public Option beneficiaries at ~200% of Medicare, or maybe $24,000 per case (in contrast to the 289% [$35K/case] currently enjoyed in the individual market. Honestly, this is plenty of money under either scenario. At the best prices enjoyed in the industry for joint prosthetics (<$3,000 per unit), the implant is <13% of the case's reimbursement while, at average prices (say, ~$5,000 per unit), the implant is only ~21% of the reimbursement rate. Still, if the State gives hospitals the tools to drive to better and less variable input pricing, the transition to 175%-225% of Medicare will be smoother.

It is worth mentioning that, while hospitals may not know exactly what one another are paying, they are fairly effective, in aggregate, at affecting pricing trends in the device world. The most costly devices (pacemakers, ICDs, spine hardware, knees, hips) typically see net price reductions in the 2-3% range, on average. It's fairly easy to confirm this, as many large device companies disclose trends on their conference calls. This begs an important question -- where do the savings go? As described at length in the State's presentation on the Public Option, they certainly aren't being passed on to customers; hospital net pricing reliably remains on an upswing.

Finally, I'd mention that the device companies can take it (i.e. added price pressure). Zimmer-Biomet, which is a relatively pure-play manufacturer of orthopedic devices, reported a 71% gross margin in the second quarter of this year[3]. I like to look at this another way. Zimmer-Biomet, on average, marked up the cost of making one of these implants by a factor of 3.5x. Masimo, which is a pure-play manufacturer of non-invasive monitoring devices, reported a gross margin of 67% (i.e. they only marked up the cost of their products by a factor of 3x[4].

Take Transparency Further and Demand Contract Level Disclosure from Payors and Hospitals for the Urban Markets. By far the most impactful way to introduce competition is to demand that hospitals disclose, up front, what they will charge a customer and that customer's plan. Up until now, efforts to reform our health-care system have focused on differences in what hospitals charge for a particular Diagnosis-related Group (DRG), which is typically a procedure or service bundled within an inpatient stay. That's certainly laudable at a societal level, but customers need added information in order to estimate what they'll pay out of pocket, based on their payor and plan design. Thus, by disclosing net charges by plan filed with the Department of Insurance (DOI) and, even better, providing an online tool within which a Coloradoan can estimate total charges for the inpatient stay and follow up care, we can finally get competitive traction in the hospital market. However, there's more to the story. Even if customers don't immediately embrace the new data, competing hospitals will gain access to one another's fee structures and should use this information to compete for share.

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[3] https://investor.zimmerbiomet.com/news-and-events/news/2019/07-26-2019-110123929

[4] http://masimocorp.gcs-web.com/news-releases/news-release-details/masimo-reports-second-quarter-2019-financial-results

Obviously, there are caveats to this initiative:

1. The data will likely only affect elective procedures, and regulators will have to monitor potential compensatory stratagems in emergent care.
2. The data will be most impactful in urban areas where a resident can choose between a number of hospitals in a relatively small geographic area.
3. The State might have to loosen the direct and indirect ties between physicians and hospitals. Hospitals maintain what are known as admitting privileges, and they use these to influence physician behaviors, especially in areas where physicians are performing evaluations and procedures in both inpatient and outpatient settings. Patients and physicians need greater flexibility in choosing where they'll do business.
4. The State will have to find a "plain english (or spanish)" solution such that a layman can navigate the portal or app without getting frustrated.

Pharmaceutical Costs -- Get Tough and Fair on Cost Sharing. From an expense and dissatisfaction point of view, retail drugs are the most important to tackle when it comes to reform. The State's Public Option proposal is fairly quiet on the subject but for mandating that 100% of rebates be passed on to beneficiaries. While it's understandable that the State doesn't truly get after the problem (drugs are only about 14% of the bill, and the industry isn't going to play ball with just one state worth <1% of net revenues), there are ways in which the State can improve the customer's experience. Options the state might consider include the following:

- For products sold in the individual market, outlaw the use of co-insurance when it comes to the pharmacy benefit. While a payor can design a benefit that simply has a high co-payment in lieu of a co-insurance threshold, 1) at least the beneficiary knows his or her obligation before heading to the pharmacy and 2) extraordinarily high co-pays may act as a deterrent when a beneficiary is comparison shopping for a plan.
- Mandate that 100% of rebates be returned to beneficiaries in the form of <u>pharmaceutical</u> benefit cost reductions. Because pharmaceutical spending has been one of the fastest growing categories in health spending, payors have used pharmaceutical rebates to cross-subsidize other categories of care. By keeping the pharmaceutical benefit in its lane, there will be less of a temptation to cost shift in the form of co-payment inflation.
- Mandate that annual deductibles and out-of-pocket maximums be combined across benefit sub-classes. Folks can only afford what they can afford.
- Eliminate the use of step-therapy. This will eliminate the game playing that goes on from both sides and ensure that patients receive the therapy that is most appropriate. Put guard rails in place such that the <u>appropriate</u> amount of documentation is required in order for a patient to be put on a high-priced therapy.

Use 1332 Waiver Pass Through Savings to Address the Older Middle Class and the Family Glitch.

The Social Security Act of 1965 set general Medicare eligibility at age 65, with no early buy-in. Unfortunately, health issues such as cancer and heart disease don't adhere to such a discrete schedule. As a result, persons aged 55-64 use a lot of health care (and don't necessarily have a lot of savings or income). Thus, they are particularly vulnerable when it comes to health care affordability. As is elucidated in the graph on page 4, pre-Medicare elderly slightly above the threshold of 400% of the FPL essentially fall through the cracks when it comes to our health care safety net. The ACA established a maximum ratings band of 3:1 when it was passed, but the group between 400% and 500% of the FPL could benefit from some added assistance. I'd also note that, while persons between 200% and 400% do get financial assistance, it's not as significant as for those below 200%. As a consequence, uninsured rates for this population run above the state average. I'd recommend that the State use 1332 pass through savings to help with premiums for these groups and/or, set up a narrower ratings band (e.g. 2:1) for pre-Medicare elderly persons falling into these groups.

In its draft proposal, the State includes the following characterization of what's known as the "Family Glitch":

Under the Affordable Care act, individuals are eligible for tax credits to help pay for their health insurance premiums on Connect for Health Colorado if they are not offered "affordable" health insurance through their employers. Unfortunately, for a family, coverage through an employer is considered affordable when the coverage is affordable for the individual worker themself even if the coverage offered to their family is unaffordable

The State then goes on to suggest that it doesn't have the financing to fix this today, but that 1332 Waiver savings might be used to do so. I include this recommendation only to reinforce what it appears the State already has in mind.

According to the Wakely actuarial estimates $70-130mm might be saved with the Public Option as proposed. Again, these estimates seem to be based on conservative assumptions as far as I can tell.

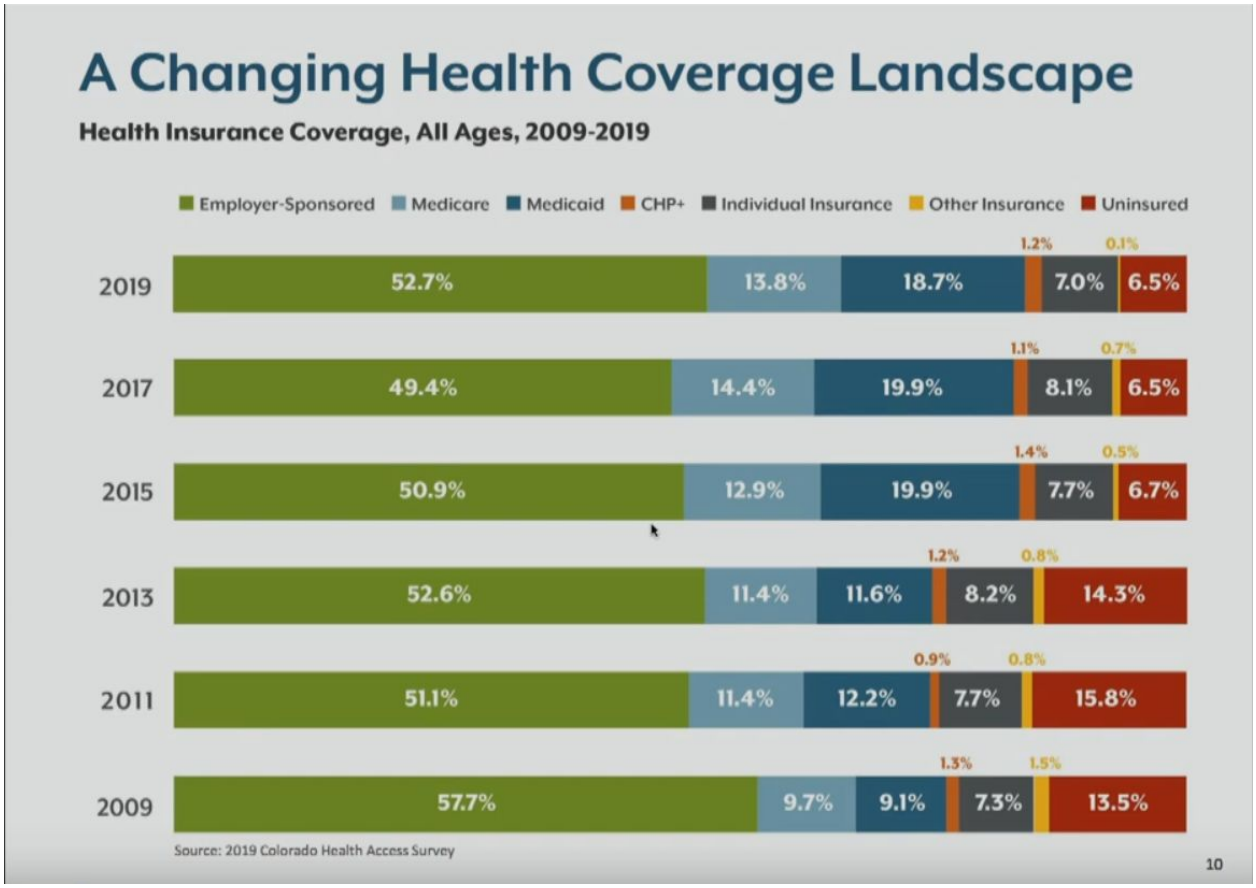
Individual and Small Group Public Option: Catalyze Switching and Prop Up SHOP

According to the Colorado Health Institute, 6.5% of Coloradoans remain uninsured[5]. That's 365,000 people compared with the roughly 142,000 covered through Connect For Health Colorado, the State's health insurance exchange. The obvious question is why these individuals are still falling through the cracks.

First, it's important to recognize that the insured population didn't change much post the implementation of the ACA, but for one population - the newly Medicaid eligible (a.k.a. the

[5] https://www.coloradohealthinstitute.org/research/CHAS

expansion population). Here's the CHI slide on that topic (note, the ACA's main effects began in 2014, and the expansion population is a portion of the red [pre-] and dark blue [post-] bars):



Extending subsidies to certain populations above 400% of the FPL and fixing the Family Glitch ought to address some of these individuals, but it appears that outreach and <u>material</u> changes in affordability might be necessary to move the needle.

As evidence, take the numbers provided by the State in its presentation on the Public Option draft proposal. Specifically, the State's actuarial consultant suggested that savings of 9-18% could be achieved by adopting the proposal, which is good. That said, savings of this magnitude translate into only a reduction from monthly premiums of approximately $542 to between $443 and $490.

Table 1: Difference between 2022 Baseline Average ACA Premiums and the State Option by Reimbursement Scenario

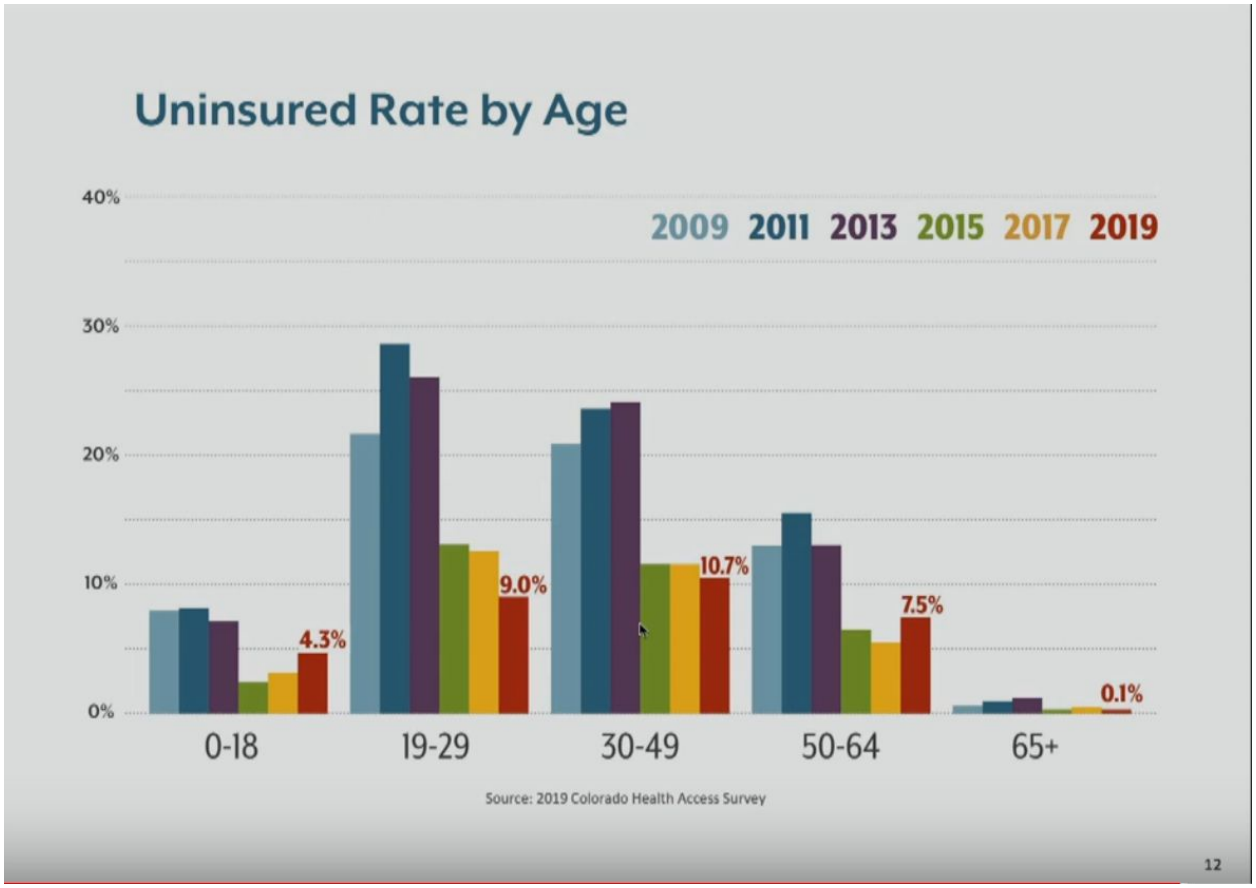
	Baseline (~289% of Medicare)	State Option - 175% of Medicare	State Option - 200% of Medicare	State Option - 225% of Medicare
Estimated 2022 ACA Premium	$541.79	$443.22	$466.40	$489.64
Difference to Baseline		-18.2%	-13.9%	-9.6%

For those finding it difficult to buy health insurance, $443 or $490 per month is still a lot of money. To wit, here's the quote from the focus group research the State conducted:

9. **Most warn that costs will need to be significantly lower to consider a public option plan.** Many mention that they would consider monthly premiums of $100-$200, but not anything higher. And, they would like premiums to be at least 30% less than what is currently available or else coverage could still be out of reach.

In order for reductions of 30% (or more) to be achieved, the State has to work hard in the early years of the availability of the Public Option to switch existing customers from currently-available plans, and to use this windfall to drive further penetration of the uninsured population. As a reminder, hospitals -- the group most affected by the success of the Public Option early on -- are a fixed cost business. Even if they face a little reimbursement pressure, new paying customers that supplant charity care represent a windfall that should easily eclipse any headwinds.

The second avenue that might be able to have an impact is improving the Small Business Health Options Program (SHOP) exchange. We know that most Coloradoans in the workforce are employed - the U.S. Bureau of Labor Statistics had the Colorado unemployment rate at 2.8% in August. We also know that most of the uninsured population is part of the labor force (again, courtesy of CHI):



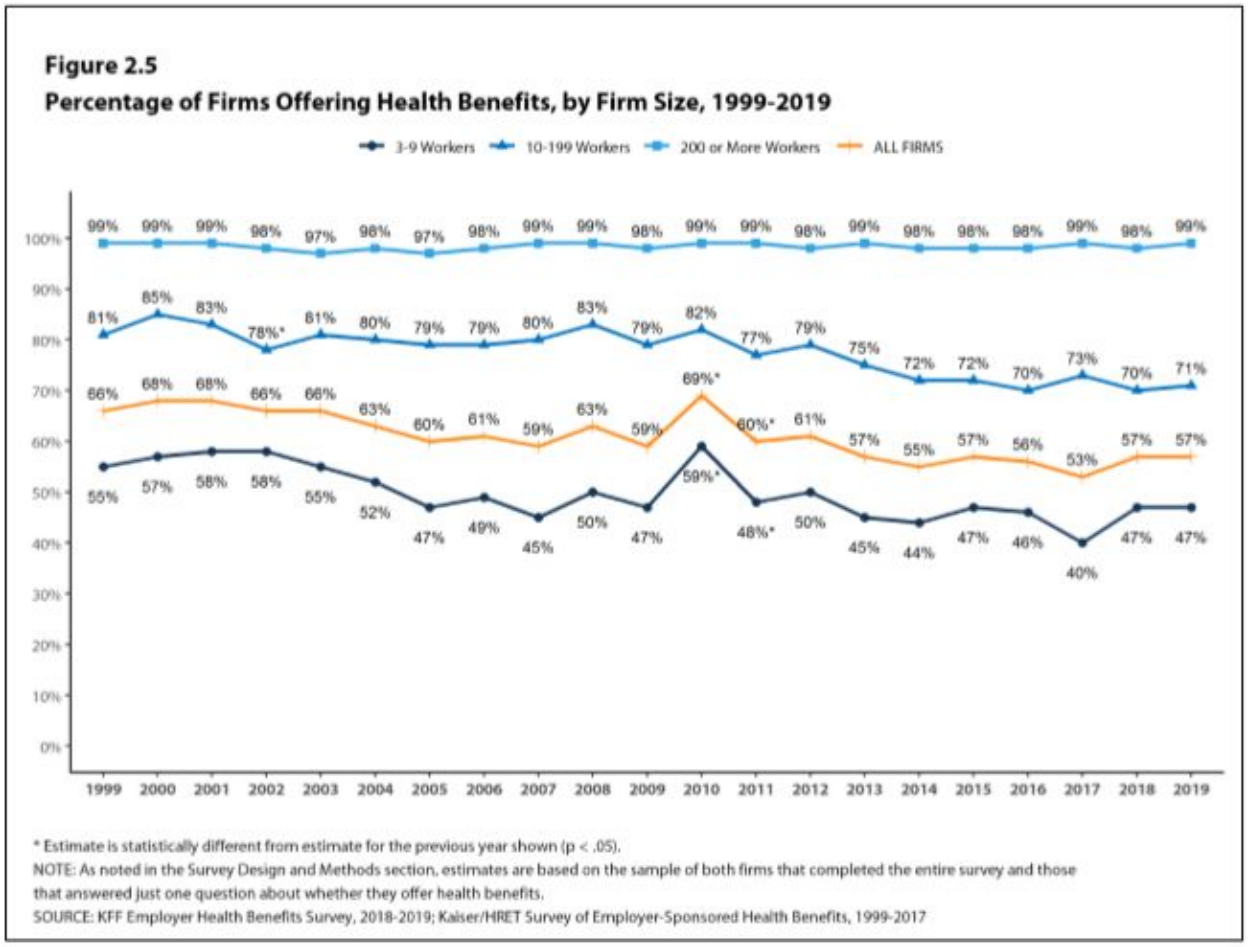
Finally, we know that offer rates and take up rates amongst large employers are quite high (nationally at 99% and 78%, respectively, according to Kaiser Health Family foundation surveys).

Thus, it's logical to infer that a substantial portion of the uninsured population might be addressed by making health care insurance significantly more affordable for those employed by firms with between 2 and 99 employees (i.e. the small group market).

Since the financial crisis of 2008, the offer rate amongst employers with both <10 workers and 10-199 workers has declined with little-to-no sign of recovery. This has transpired despite the achievement of the lowest rate of unemployment in 50 years. Given the importance of health care coverage to combined Salaries, Wages and Benefits, this means that the jobs we have created over the past 10 years are, on balance, of lower quality. According to the United States Census Bureau, approximately 11.5% of paid employees in Colorado work for firms with less than 10 employees, and approximately 24.1% work for firms with between 10 and 99 employees (2012 data -- unfortunately the most recent). The Federal Bureau of Labor Statistics pegs Colorado's non-farm payroll at 2.8mm persons as of August 2019[6], which suggests that somewhere around 588,000 persons in the addressable small group market are either obtaining

[6] https://www.bls.gov/eag/eag.co.htm

individual coverage or foregoing coverage altogether[7] (as a reminder there are 142K persons enrolled through C4HC). As health care benefits become more expensive, they become a more important part of being able to offer a competitive package to employees at the same time as small employers are finding it more difficult to offer coverage. The State of Colorado needs to move forward quickly and with purpose to help level the playing field when it comes to health benefits.



[7] Assumes an offer rate of 65%, eligibility rate of 82% and take-up rate of 75%.

Figure 3.2

Eligibility, Take-Up Rate, and Coverage In Firms Offering Health Benefits, by Firm Size, Region, and Industry, 2017

	Percentage of Workers Eligible for Health Benefits Offered by Their Employer	Percentage of Eligible Workers Who Participate In Their Employers' Plan (Take-Up Rate)	Percentage of Workers Covered by Their Employers' Health Benefits
FIRM SIZE			
3-24 Workers	84%*	78%	66%
25-49 Workers	81	73	59
50-199 Workers	81	74*	60
200-999 Workers	78	78	61
1,000-4,999 Workers	82	80	65
5,000 or More Workers	77	79	61
All Small Firms (3-199 Workers)	**82%**	**75%***	**62%**
All Large Firms (200 or More Workers)	**78%**	**79%***	**62%**
REGION			
Northeast	78%	77%	60%
Midwest	76	76	58
South	81	79	64
West	81	79	64
INDUSTRY			
Agriculture/Mining/Construction	84%	74%	62%
Manufacturing	93*	79	74*
Transportation/Communications/Utilities	87*	87*	76*
Wholesale	91*	85*	77*
Retail	54*	63*	34*
Finance	95*	82*	78*
Service	77	75*	57*
State/Local Government	88*	89*	79*
Health Care	79	79	62
ALL FIRMS	**79%**	**78%**	**62%**

* Estimate for eligibility, take-up rate, or coverage is statistically different from all other firms not in the indicated size, region, or industry category ($p < .05$).

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2017

What is SHOP? SHOP is a program initially made available by the ACA. It was intended to be an avenue by which small employers could contribute to standardized, qualifying health insurance for their employees in a turnkey fashion. ACA proponents also envisioned it as a chassis for larger employers over time. Unfortunately, SHOP is complicated, it's undergone changes and added limitations since the ACA was passed, and it's an indirect way of obtaining coverage if you are an employee (i.e. your employer has to qualify and go through the process of offering it). As a consequence, where the Congressional Budget Office (CBO) originally estimated that 4 million firms would be eligible to participate, leading to $37bn in outlays over ten years, this figure has dropped to a de minimis amount in CBO's most recent scoring. Today, SHOP is only available to firms with fewer than 25 full-time equivalent employees, paying an average of less than $53,000 per full time equivalent employee (2017). Employers qualifying can claim a tax credit of up to 50% of premiums paid through SHOP (on a sliding scale).

Admittedly, salvaging SHOP may not be the most efficient way to improve offer rates amongst smaller employers. Still, if the State wants to reduce year-to-year churn and the percentage of uninsured, revisiting SHOP may be the quickest. Specifically, the State could consider:

- Retooling the C4HC portal to permit small business owners to compare various financial scenarios online (and maximize their employees' ability to afford coverage).
- Working with payors in the state to expand the number of options available in the SHOP exchange.
- Initiating the same steps for SHOP as have been initiated for the individual exchange prior to when the individual Public Option goes live.
- Revisit geographic rating areas such that newfound savings find their way to higher-cost geographies with an abundance of small firms. There is a good review of this topic on the State web portal.[8]

Provide Incentives for ACO Adoption, Update the Website. One of the most Gordian of knots in health care is care coordination. For good reason, we have what are known as Stark laws that prevent physicians from referring patients to facilities in which they have a financial interest. What's more, we have a payment system for just about every category of care you can think of (there's even something called a long-term, acute care hospital or LTACH, which is usually just a wing within the hospital that houses complex patients for extended periods; it gets reimbursed differently than an acute care hospital). For this reason, providers tend to operate in silos where they are incentivized to optimize their own operations and disregard the financial or clinical performance in the post-acute setting. If the State is going to partner with payors in order to develop and manage networks that will serve the needs of Public Option beneficiaries, they have a golden opportunity to launch and/or develop high performance Accountable Care Organizations (ACOs) contemporaneously. ACOs are effectively integrated organizations of various shapes and sizes organized to provide similar or superior outcomes at a reduced total cost of care. Indeed, the State (or the payors) could get creative with performance objectives and financial arrangements for the Public Option population, such that those networks meeting certain goals (levels of integration, cost containment/reduction, meeting outcomes thresholds) receive preferential treatment.

- A simple example might be to adopt something like the Medicare Stars construct, where high performing plans get financial bonus.
- Another, softer approach might be to move towards an Amazon model, where plans receive a "Colorado's Choice" designation and be listed first, or where plans can be sorted by popularity or verified buyer rating.

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8 https://www.colorado.gov/pacific/sites/default/files/8%20-%20DOI%20-%20Colorado%20Single%20Geographic%20Rating%20Area%20Study%20Powerpoint.pdf

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

Please use this form to submit your comments on the draft HB19-1004 report. All comments will be logged and added as an appendix to the final report. We will accept comments until October 28.

Helpful Links:
- The draft report can be found here: http://www.colorado.gov/pacific/sites/default/files/HB19-1004%20Draft%20Report%20Colorado%20State%20Coverage%20Option%20and%20Appendix.pdf
- The bill text can be found here: https://leg.colorado.gov/sites/default/files/2019a_1004_signed.pdf
- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Eugene Humbert

County (in which you reside) *

[redacted]

Organization *

None

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

Not at all

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

NO!!

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

NO

Does the proposal include worthwhile benefits for consumers?

Absolutely NOT!!

Does the proposal create a product that is financially stable and sustainable?

Again, absolutely NOT

Other thoughts? Please list them here.

Please stop trying to californicate Colorado

This form was created inside of State.co.us Executive Branch.

Google Forms

TO: **Report for Colorado's State Coverage Option (**HB19-1004)
hcpf_1004affordableoption@state.co.us

FROM: Evon Holladay, Coloradan from Arapahoe County
Eholladay303@gmail.com

DATE: October 26, 2019

RE: Comments on draft Report of Colorado's State Coverage Option

Sincerest thanks to both the Colorado legislature for HB19-1004 and the Colorado Division of Insurance (DOI), the Department of Health Care Policy and Financing (HCPF), and the Lieutenant Governor who have led the creation of this report. It will provide a solid basis for leading the US by creating a State Coverage Option for Coloradans to obtain affordable health insurance coverage.

As a current Connect for Health Colorado (C4HCO) customer and former vice president in a national healthcare organization who currently serves on Colorado's Office of eHealth Innovation (OeHi) Consumer Engagement Workgroup and the Colorado Dental Board, my comments are focused on ensuring that the final report reflects the greatest opportunity to achieve the most affordable, consumer-oriented, highest quality, geographically diverse, and sustainable State Coverage Option possible.

I understand the temptation to only commit to price reductions that model what has been tried in the past, but making healthcare affordable, sustainable, equitable and accessible will require defined actions that continue to force changes into a system that is wed to the current models of high-priced care with poor health outcomes. My comments and references reflect well researched defined actions that should be considered for inclusion into the final report.

Evon Holladay

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1. Does the proposal address Coloradans' concerns about health care affordability?

a. Draft Report Table 1 (page 3) How much will the State Option save Coloradans?

Coloradans will see at least 9-18% savings on monthly premiums.

● Additional savings on out-of-pocket costs will be achieved through a federal waiver that may bring an additional $69-$133million of savings to consumers.

● This is the impact of adjusting reimbursements to 175%-225% of Medicare from the current rate of approximately 289% of Medicare being paid by insurance carriers in the individual market.

Comments: this is an example of choosing an existing model, instead of maximizing cost savings. Based on the actuarial analysis the 9-18% cost savings is due to adjusting only facility services reimbursements to 175%-225% of Medicare from the current rate of approximately 289% of Medicare. (Draft Report page 25) Reimbursement reductions are "applied to facility services (like the current Affordable Care Act)…*Professional and prescription drug reimbursement will not be impacted under the State Option*." ….(Draft Report page 32) "Approximately *50% of total claims* are facility."

Industry standard administrative fees of ten percent of claims are also built in into the cost…(Draft Report page 31) "Calculation of the Change in Premiums: The impact of premium changes due to a change in claims has been calculated as the *estimated change in claims times 90%*. *This is due to the presence of fixed administrative costs* …(Draft Report page 32) "Assuming 50% of administrative expenses are variable and 50% are fixed. …As rates decrease, the amount of variable administrative expenses included in the rates also decreases."

I recommend adding language to ensure that the expectation is set that these rates continue to be reduced. A six percent increase is already built in–almost double inflation. Affordability is not sustainable with these rates and administrative fees.

Recommended final report additions *(in italics)*:

- *Initial pricing of 175-225% of Medicare rates for facility services will remain and be expanded to include the same reductions in all healthcare pricing such as professional and prescription drug reimbursement. Parity in all healthcare pricing to 175-225% of Medicare's regionally adjusted prices must be achieved no later than 2023 (defined date).*
- *Initial pricing adjustments of reimbursements to 175-225% of Medicare rates will continue to move toward Medicare rates. Reductions in adjustments to 110% or less of Medicare's regionally adjusted prices must be achieved by 2026 (defined date).*
- *Annual insurance carrier reporting on fixed and variable administrative fees included in the Colorado coverage option premium – both rates and total spend – will be established with the launch of the state coverage option. As rates decrease, the amount of variable administrative expenses included in the rates should also decrease. The goal will be to reduce the total administrative spend from the current ten percent of total claim value with all reductions passed thru to reduced premium rates.*

Rationale/References – High spending is being driven by all healthcare prices – not just facility charges

1. US House Ways and Means September 2019 report on international drug pricing[1] findings:
   - U.S. drug prices are nearly 4Xs higher than average international prices with prices ranging from 0.6 to 67Xs the price for the same drug in the US.
   - The U.S. could save $49 billion annually on Medicare Part D alone by using average drug prices for comparator countries.
2. A 2018 study[2] published in the Journal of the American Medicine Association (JAMA) found: "The health care spending gap with other countries appears to be driven by the high prices the U.S. pays for health care services — particularly doctors, pharmaceuticals, and administration.
3. Numerous research studies have confirmed that high healthcare spending is being driven by all US healthcare prices[3,4] not just facility charges. US prices are higher than average when compared to High Income Countries (HIC) and vary significantly across the country. [5,6] Even with contracts, prices can vary as much as 20-fold for the same service in the same region[7]
4. Medicare Advantage plans, the insurance industry offering to Medicare recipients – a model for this Colorado coverage option - "nominally pays only 100–105 percent of traditional Medicare rates"[8]
5. The Peak Health Alliance initiative that was introduced in Summit County for 2020 plan year resulted in lower negotiated reimbursement rates for *facilities and providers*. Plan premiums are 20-25% lower as a result.[9]

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b. Draft Report Table 1 (page 3) Why will the State Option be more affordable?

- "Providers will be reimbursed at a rate benchmarked to Medicare rates that continues to allow for profitable delivery of services, and there will be a special focus through this process to ensure rural and critical access hospital and provider sustainability"

Comment: keeping providers and facilities 'profitable' using the current pricing model does not make healthcare more affordable. It continues to build in the status quo. Rather the goal must be to look at new models of care that improve health outcomes, where providers and all hospitals, critical access and otherwise, *are paid based on value (defined below).* The current fee for service model results in wide variation and poor health outcomes[10]. For rural hospitals, this would include expanding focus on prevention in clinics and partnership with community resources, and the use of telemedicine for delivery of subspecialty services such as oncology. It also may mean the evolution of a hospital to a clinic with emergency and rapid transport capabilities.

Recommended final report action:

The above comment of profitability of delivery of services should be moved to align with an evolved goal of value (see #4 below) – combining the goal of Centers of Excellence and Value-Based Insurance Design or VBID, with the creation of incentives for providers and consumers to avoid low-value care and seek high-value care.

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d. Draft Report Table 1 (page 3) Why will the State Option be more affordable?
"All prescription drug rebates and other compensation paid by manufacturers to insurance carriers must be used to reduce the price of individual policies."

Comment: this action must be kept, but it will not result in improved affordability in that premium year. As previously noted, drug price reductions must be included in the reduction of Medicare reimbursement rates. Reducing prices for consumers up front aligns with findings from the Colorado's Office of eHealth Innovation (OeHi) Commission, Consumer Engagement top three findings[11] that consumers need to know final costs upfront. They want less confusion. Requiring rebates and other compensation to insurance carriers to be applied to premium reductions for the next year is the right thing to do. However, it is too delayed to achieve the goal of addressing Coloradans' concern about affordability.

Recommended final report additions *(in italics)*:
"*In addition to reducing prescription drug pricing, initially to 175 to 225% of Medicare regionally adjusted rates,* all prescription drug rebates and other compensation paid by manufacturers to insurance carriers must be used to reduce the price of individual policies."

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2. Does the proposal create a product that reaches Coloradans struggling with high health care costs?
3. Does the proposal create a state option that utilizes existing infrastructure in a meaningful way?

a. Draft Report Table 1 (page 3): Who will administer the State Option?

- Every carrier in the state over a certain size will be required to offer this option, to spread both the opportunity and the risk.

Comment: requiring insurance carriers of a certain size to offer a state option is commendable. However, many do not have an existing network infrastructure that reaches across the state. This will lead to consumers driving long distances or out-of-network care which drives "*surprise medical bills*". This report should align coverage options with existing carrier networks and set the expectation that networks should be innovative – aligning with primary care models and telemedicine.

Recommended final report addition *(in italics)*:
- Every carrier in the state over a certain size will be required to offer this option, to spread both the opportunity and the risk.
  - *Carriers with a statewide network shall be required to participate statewide. Carriers with local or regional networks shall be required to participate for just that area*
  - *Carriers should include innovative approaches to provide the most comprehensive network. This includes inclusion of the Primary Care Collaborative or use of telemedicine especially for subspecialty care.*

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4. Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way *to create maximum value*?

Comment: This question should really be focused on the end result of value – with value defined as *reducing waste, and improving healthcare delivery quality and population health outcomes*. The move to high deductible plans incents consumers to stay away, rather than utilize healthcare as a partner in disease prevention, or managing symptoms when prevention is not possible. Centers for Disease Control estimates that 90 percent of US healthcare spend is for people with chronic and mental health conditions. The opportunity to reduce high cost care – by partnering with Coloradans is what is needed to truly reduce cost and a create sustainable coverage option.

Recommended final report addition *(in italics)*:
c. Create Combined Key Component: ***How will the plans ensure highest value – addressing waste while improving healthcare quality, and population health outcomes?***

This would replace:

(delete) ~~**Draft Report Table 1 (page 4) How will the plans improve the quality of health care?**~~

The following would be highlighted under this new Key Component on value:

The State Option will incorporate innovative designs such as:

- **Advancing primary care in Colorado *for prevention and chronic disease management to improve health outcomes*.** The State Option will support the Primary Care Collaborative, investing in a primary care system that manages *prevention,* chronic conditions, coordinates across providers, and supports the physical and emotional health and wellbeing of all enrollees.
- ***Use Value-Based Insurance Design to reduce waste*.** A new way of thinking about benefit design, known as Value-Based Insurance Design or VBID, creates incentives for providers and patients to *reduce waste by* avoiding low-value care and seek high-value care. VBID would create financial disincentives for patients or doctors to seek low value care through increased out-of-pocket costs and lower reimbursements. VIBD will be informed by Centers of Excellence.
- ***Establish Centers of Excellence to maximize value and improve healthcare quality*.** Insurance carriers will collaborate with the state, *care providers, and* hospitals to refine and implement Centers of Excellence. They will build high-performing networks and utilize value-based payments to reward providers *and facilities* who achieve quality and pricing targets.
    - *(move from why affordable)* "Providers will be reimbursed at a rate benchmarked to Medicare rates that continues to allow for incentives for value that enable profitable delivery of quality services, with a special focus through this process to ensure rural and critical access hospital and provider sustainability as new models such as telemedicine (e.g. for subspecialties, radiology, etc.) are deployed to enable the best outcomes. It also may mean the evolution of a hospital to a clinic with rapid transport.
    - Centers of Excellence will establish a state body to assess quality/value of diagnostic/treatment options – *building on the existing model of Choose Wisely - a model that brings medical specialists together to identify tests or procedures commonly used in their field whose necessity should be questioned or discussed*
        - *Starting with a review of already reviewed tests and procedures*
        - *Expanding to include:*
            - *Evaluation of new diagnostics and treatments.*
            - *Examining growth in hospital beds, free standing emergency services, technological innovation as they add significant cost and confusion, adding to poor outcomes.*

Rationale/References

The June 2019 Colorado OeHI Consumer Engagement discovery phase[ibid] findings identified lack of information on 1) coverage, 2) care cost vs value, 3) options for services and wellness options, as the major barriers for Coloradans to make informed health decisions. This state option has the opportunity – if not obligation – to incorporate innovation that reduces confusion and cost.

The Institute of Medicine (now the National Academy of Medicine) estimates waste accounts for 30 to 40% of healthcare expenditures – most often in the form of low value services. Estimates are that 30% of care Americans receive does not help or even harms patients[12,13,14,15]. Over a third of Medicare patients receive some low value care in a given year. This underscores the need to assure every service benefits the person, not the institution, physician or product manufacturers bottom line.

5. Does the proposal include worthwhile benefits for consumers?

Comment 1: this state option does not remove the current Health Savings Account (HSA) premium penalty. As a C4HCO customer, I currently have to choose between a non-HSA plan OR a 10-15% higher premium for a plan that allows me to contribute to an HSA. Both have high deductibles over $6500 per person – so in effect both are catastrophic coverage.

What can be done to eliminate this penalty in purchasing an HSA qualified plan? Even if additional "Many services will be pre-deductible, including preventive care, primary care, and behavioral health care." Consumers should be encouraged to save for medical expenditures. An HSA provides this additional incentive via the tax benefit.

Comment 2: While this report defines an initial design, it does not include anything to reduce insurance complexity. Variation in healthcare payment schemes adds major cost - consuming eight percent of US total health care spending compared to three percent in other HIC[16,17]. Much of US spending is on administrative tasks to pay for care rather the provision of care.

As noted above, OeHI's Consumer Engagement work has identified that consumers want to understand their coverage so they can make informed choices. Multiple choices and complex schemes significantly reduce population health and result in wasted spending – especially if consumers stay away and end up with emergency care - the most expensive level of care.

What can be done to reduce insurance complexity for consumers and providers?
Creating standardized health plan options starting points might include:

- Establishing a spending floor which is available to everyone and a ceiling for healthcare services that are not considered essential - above which individuals must personally pay.

6. Does the proposal create a product that is financially stable and sustainable?

Comment: per above, true long term (not just year-over-year) financial stability will only happen as value is increased through waste reduction, and improved healthcare delivery quality and health outcomes. The above comments focus on what is needed to engage consumers in their health while incenting insurance carriers and healthcare providers to move to new models that reduce cost and complexity.

7. Other thoughts?

Comment 1: there are several 'aspirational' statements in this report. While important to note, the delivery costs – whether a reduction, addition, or shifting (to the consumer, carrier or even care provider) - are not factored into the actuarial analysis. This is misleading. These items should be noted as directional and that cost increases or savings have not been accounted for.

Some examples:

- **Image 1 – comment that administrative costs are reduced** - even the image does not show a reduction. See above recommendation in feedback on affordability on administrative cost reporting and reduction.
- **The State Option will define more benefits that can be used pre-deductible.**
- **See comment on "*How will the plans ensure highest value*"**

Comment 2: "Health is defined by the World Health Organization (WHO) as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Achieving health depends more on an array of social factors such as income, education, community, environment, and behaviors than on the healthcare system. Healthcare delivery determines only 10-15% of health outcomes. We are the only HIC that spends more on the health care than on social care.

The National Academy of Medicine's assessment of why we are not achieving the health outcomes of other HIC was: "A major reason lies in the fact that the foci of our attention, our resources and our incentives are too narrow….our investments are primarily directed to biomedical (medical diagnostics and treatment)."

High spending on medical treatment results in proportionally small investment in disease prevention and addressing social factors like income, education, community, environment, and behaviors – which determines most of health outcomes. Expensive sick care has reduced the health of the population.

The report should reflect this reality, and even suggest that a portion of savings should be reinvested to align with emerging models such as Robert Wood Johnson Foundation's New Action Framework[18] - a distillation of real-world lessons learned, coupled with extensive empirical research on catalyzing social change to achieve outcomes of improved population health, well-being, and equity.

Recommended final report addition *(in italics)*:
Recognizing that health is created where Coloradans live, work and play, we recommend examining ways to redistribute a portion of the state option savings to address social determinants of health.

Thank you for this foundational report. I know every effort has been made to put forth a report that addresses the critical need to reduce the high cost of health insurance as a result of high cost of care. As a former healthcare insider, I understand the many forces that seek to ensure carriers and care providers change in as small of increments as possible. Unfortunately, all Coloradans lose if policymakers do not use this state option as a building block to new models of consumer engagement, care delivery, and payment reform.

Please feel free to contact me regarding my comments.

Sincerest regards,
Evon Holladay
Eholladay303@gmail.com
720-480-8489

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We don’t want socialized,government run healthcare. It doesn’t work, never has & never will !! We strongly disagree & oppose interference with our health care system. Fix our streets and infrastructure that really need it, especially in Southern Colorado Springs: Security, Widefield & Fountain area where the streets are horrible.

Frances Musser

October 16, 2019

Michael Conway, Commissioner
Division of Insurance
1560 Broadway #110, Denver, CO 80203

Kim Bimestefer, Executive Director
Department of Health Care Policy and Financing
1570 Grant St, Denver, CO 80203

Re: Draft Proposal for Colorado's State Coverage Option

Dear Commissioner Conway and Director Bimestefer,

I write today to provide feedback as part of the stakeholder process on the Draft Proposal for Colorado's State Coverage Option. Friday Health Plans is a small, Colorado-based health insurer, and we are highly focused on the ACA individual and small group markets. We are supportive of any initiative that lowers health care costs and increases access to health care for Colorado.

We appreciate the ambition, scope and detail of this proposal. The focus on lowering facility costs is correct and is the single most important thing we can all do to improve affordability of health care in the state today. We agree that more of our uninsured population will choose to buy health insurance if we continue to lower premiums. Friday Health Plans' main concern is the increased medical loss ratio floor. However, we are interested in seeing this health reform initiative succeed. Please take our comments in the spirit intended, as supportive and constructive.

We have several areas of interest, which we outline below:

1. **Statewide launch**. In Friday's view, there are several rating areas in the state where both carrier competition and provider competition appear to be working, particularly in the Front Range rating areas of 1, 2, and 3. On the other hand, limited competition and even monopolistic behavior is evident in certain smaller cities and rural areas. We believe that these areas should be the initial focus of the state option, as they will have the highest impact and the lowest disruption risk. Moreover, if the state were to target

the 22 counties where only one option is available to ACA consumers, Friday would be very interested in offering a competitive alternative based on the state option. If it's helpful to the state, we could be even more explicit in our commitment to expanding our rural service areas.

2. **Enhanced benefit design**. Friday agrees with the state approach. In fact, we began offering enhanced primary care benefits in 2018. Consumers like this, we know it's good health care, and we believe that enhanced primary care benefits will ultimately lower the cost of care. We will continue to innovate in this area regardless of state action, and we only ask that the state option does nothing to limit our ability to offer better primary care (and mental health) benefits in the future. Regarding the pass through of all pharmacy rebates, we also agree with the state approach, and since 2018, we have largely engineered rebates out of our benefit, formulary, and PBM contracts. Ultimately, we've concluded that there is no truly equitable way to correctly pass through pharmacy rebates to members other than by avoiding them altogether. Again, our only ask of the state is that we don't make the design of the state option benefit so rigid that innovation becomes even more difficult.

3. **Provider rate setting.**
    a. **Issues for urban areas**. We support the approach that the state is taking, and we believe that in high cost areas, 175% - 225% would represent a significant savings to consumers. In urban areas, 175% - 225% looks roughly similar to the commercial rates that we are able to negotiate with competitive health systems, so additional detail and analysis would be required to determine a market approach. As Friday Health Plans gains scale in urban areas, we are optimistic that we could negotiate even lower commercial rates, assuming that the state doesn't unintentionally create a floor through this state option.
    b. **Supporting vulnerable rural hospitals**. We are concerned that certain rural hospitals which are financially vulnerable would be pushed out of business by this lower commercial rate, so we would be interested in working with the state to identify vulnerable facilities and develop strategies to reasonably protect them. We would also be interested in working with the state to analyze any potential changes in network adequacy rules.

4. **Increased Medical Loss Ratio Floor**. We are concerned that the increase in MLR floor to 85% could be a disaster for an innovative health plan like Friday. Because the ACA individual business is the majority of our insured book, there is no other line of business to absorb the expected losses. While the draft proposal suggests that administrative savings could fund this increase in MLR, it is not obvious to us how that will happen. While the state will set rates for facility contracts, we will still need to negotiate, configure, credential and manage those facility contracts in addition to all of the other providers necessary to have a viable network. Taken a step further, when we look ahead to significant decreases in premiums, we wonder whether a decreased MLR floor,

as low as 75%, might be warranted. Especially for companies like Friday that have been successful in offering low premium products to catastrophic and bronze consumers, our administrative ratio tends to be relatively high despite our efficient operation.

We appreciate the opportunity to participate in this process and share our unique view of the many opportunities and risks in this proposal. We are impressed by the level of innovation and the focus on lowering facility costs in the state. We look forward to continuing dialogue with the state and other stakeholders as we innovate together to make Colorado a leader in health care and health insurance.

Sincerely,

David Pinkert
President and Co-founder
Friday Health Plans, Inc.

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

Please use this form to submit your comments on the draft HB19-1004 report. All comments will be logged and added as an appendix to the final report. We will accept comments until October 28.

Helpful Links:
- The draft report can be found here: http://www.colorado.gov/pacific/sites/default/files/HB19-1004%20Draft%20Report%20Colorado%20State%20Coverage%20Option%20and%20Appendix.pdf
- The bill text can be found here: https://leg.colorado.gov/sites/default/files/2019a_1004_signed.pdf
- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Gary Goodwin

County (in which you reside) *

[redacted]

Organization *

Individual voter and taxpayer

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

No

Other thoughts? Please list them here.

What makes you think you can devise a state healthcare system that will work when other states have found it a failure. Why not learn from other's failures. I do not believe that you people are any smarter than the others...even if you think you are! This looks like another boondoggle that will cost tax payers a ton of dollars. You have not let that stop you yet...but the Colorado taxpayers are about to have their fill of you and your minions! Vote NO on CC!!

This form was created inside of State.co.us Executive Branch.

Google Forms

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

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- The bill text can be found here: https://leg.colorado.gov/sites/default/files/2019a_1004_signed.pdf
- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Georgina Minto

County (in which you reside) *

[redacted]

Organization *

Me

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

NO

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

no

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

no

Does the proposal include worthwhile benefits for consumers?

no

Does the proposal create a product that is financially stable and sustainable?

no

Other thoughts? Please list them here.

Requiring insurance companies to pay out 85% of the premiums will cause all the major carriers to pull out of Colorado. Then we will be left with no insurance at all.

This form was created inside of State.co.us Executive Branch.

Google Forms

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

Please use this form to submit your comments on the draft HB19-1004 report. All comments will be logged and added as an appendix to the final report. We will accept comments until October 28.

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- The bill text can be found here: https://leg.colorado.gov/sites/default/files/2019a_1004_signed.pdf
- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
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If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Glenda Singleton

County (in which you reside) *

[redacted]

Organization *

G Singleton MD

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

NO

Does the proposal create a product that is financially stable and sustainable?

No NO

Other thoughts? Please list them here.

Dear Sirs,

I am writing to strongly object to the proposal for the “State option”. This is not a well thought out plan and the unintended consequences to our state health care and healthcare system will be immense.

I propose we do not need a new “State option” with legions of new tax and legal and administrative costs.

The state has Medicaid in place and this could much more easily be expanded.
To serve additional patients, there could be a program to buy into Medicaid if they have a lower income level vs buying traditional insurance with a higher premium. Cost planning could be implemented in a tiered level, rather than creating a whole new entity.

One of the reasons costs have gone up for health insurance and care, is the hospitals for example, are charging more to cover care that is underfunded in some of the programs already in place. This state option would just continue this cost shifting and result in further price increases, without promoting any overall decrease in the cost of healthcare.

Sincerely,
G Singleton MD

This form was created inside of State.co.us Executive Branch.

Google Forms

October 28, 2019
Colorado Division of Insurance
1560 Broadway #110
Denver, CO 80202

RE: Public Comments on State Option Draft Proposal

To Whom it May Concern:

Good Business Colorado and Small Business Majority appreciate the opportunity to provide comments on the draft report for the State Option for Health Care Coverage. We appreciate your detailed attention to the needs of Colorado residents, and the short timeline for constructing this proposal, as we believe this will benefit Colorado's small businesses.

Good Business Colorado and Small Business Majority are committed to promoting a sustainable, inclusive and equitable economy through entrepreneurship. Together, we are dedicated to elevating the voices of our state's business leaders and entrepreneurs to advance our economy and shared prosperity. Our networks include close to 2,500 of Colorado's employers, and our businesses provide services in nearly every sector of the economy.

Access to affordable, quality health benefits is one key issue facing our networks. Recent polling from Small Business Majority shows that nearly half of small business owners view the rising cost of healthcare as a threat to their business. Additionally, a majority of business owners support cost containment measures such as reinsurance and, most notably, the ability to buy into a state or public option plan. Further, Good Business Colorado is currently surveying our nearly 200 business members regarding their policy priorities. Healthcare policy and access to a state plan is currently one of the largest policy priorities identified by members.

We broadly support the Division of Insurance's recommendations for the State Option, and appreciate the level of stakeholder engagement that went into developing the recommendations. We do have questions that should be clarified prior to full implementation of the proposal.

We support the following provisions:

Small Group Plans
Providing benefits to employees is one of the largest administrative and financial challenges facing businesses in Colorado. Healthcare, in particular, has been singled out as the primary cost driver for many of the state's small and mid-sized firms. As a result, many businesses do not have the means to offer health benefits to their employees. Including small group plans in the State Option proposal provides an affordable vehicle for employers to remain competitive, and recruit and retain high-quality employees. We ask that the Division of Insurance provide a concrete timeline for rolling out small group plans, and actively work to educate the business community of the details of those plans. Although this public comment is not referencing any specific legislation, when corresponding legislation is introduced, a timeline for program expansion to include small business plans should be codified in policy proposals.

Standardized Plans

The complexity of purchasing and administering health benefits is often prohibitive for small business owners. Standardized plans provide a quality vehicle for plan comparison while businesses consider other important variables such as customer service, quality and networks. Additionally, we are pleased to see the draft proposal's inclusion of pre-deductible high-value services, such as primary care and behavioral health. We urge the state to include as many pre-deductible services as possible, as these services are often cost-prohibitive, yet critical for preventative care.

Use of Exchange Infrastructure

Connect for Health Colorado is a valued partner to Colorado's businesses. Offering the plan through the exchange provides business owners with information, services, technical assistance and ease of access that is critical for ensuring businesses and their employees choose the right plan.

Broad Eligibility

We believe it is the state's duty to support an infrastructure for a healthy workforce. Colorado's residents are among the best educated and skilled in the nation, and their continued health is critical for ensuring our businesses can grow their operations. The cost of healthcare can also be a determining factor in industry development and new employers choosing to locate their workforce in Colorado.

Prescription Drug Rebates

One of the primary drivers of cost increases in health benefits for businesses has been prescription drug costs. Polling from Small Business Majority shows that more than 8 in 10 small business owners say their prescription drug copays have increased in recent years, and they're being forced to manage these increasing costs by either shifting some of the higher costs to their employees or absorbing them themselves. We strongly support passing through rebates from pharmaceutical manufacturers to consumers in an effort to bring down costs.

Advisory Board

We strongly support the creation of an advisory board to provide input into the creation and oversight of the state option. As representatives of businesses that are heavily impacted by the high cost of healthcare, we would request the appointment of a small business advocate to the advisory board. Specifically, we would ask that this representative come from an organization with a mission dedicated to supporting small business interests, and advancing affordable, accessible healthcare options for all Colorado businesses. Additionally, the planning, implementation and education needed to expand inclusion to small plan options should be specified as a component of the Advisory Board responsibilities.

We have concerns about the following aspects of the proposal:

Impact on Provider Networks

Good Business Colorado and Small Business Majority generally support state efforts to set reasonable reimbursement rates for hospitals, and hospital based providers. We strongly encourage the state to provide clarity on which entities the reimbursement rates will apply to, and to consider the impact the reimbursement rates will have on networks and access to specialists. Because rural Coloradan businesses struggle with healthcare access and costs, it is important that policy proposals do not allow hospitals to refuse participation, therefore leaving areas of the state without in-network access to hospital-based and emergency services under the state plan option.

Impact on Premium Assistance

We are pleased to see an anticipated 9-18% reduction in insurance premiums for individual plans. However, we have concerns that the reduction in premium rates will also reduce the benchmark plan premium, which is the plan that premium tax credits are based upon. The unintended consequence of this change could reduce the purchasing power of the subsidies for those that are eligible.

Again, we appreciate the time and effort the Division of Insurance put into the development of this draft proposal. We look forward to a finalized proposal that will support the needs of Colorado businesses of all sizes.

Sincerely,

Hunter Railey
Colorado Director
Small Business Majority
hrailey@smallbusinessmajority.org

Karen Moldovan
Director of Policy
Good Business Colorado
karen@goodbusinessco.org

October 17, 2019

Colorado Department of Health Care Policy & Financing
1570 Grant St.
Denver, CO 80203

We are encouraged by the recent dialogue in our state regarding the cost of healthcare. We are dedicated to doing what we can to help provide high quality healthcare at a reasonable cost to those we serve. We are a small critical access hospital (rural) in an underserved Healthcare Provider Shortage Area (HPSA) of Northeastern Colorado. We struggle with negative operating margins and are concerned about our sustainability. While we are dedicated to being as efficient as possible, any additional cuts to revenue could be devastating to our survival. A closure of our hospital would have a devastating effect on our community and those we serve.

We believe the factors driving the cost of healthcare are:

1.) Pharmaceuticals, 2.) Insurance, and 3.) Healthcare Providers.

As a healthcare provider we know that the cost to provide care is high. We face rising costs of supplies (including pharmaceuticals), paying salaries to healthcare professionals that are competitive, shrinking reimbursements, and a regulatory burden that is equal to that of larger healthcare entities. We improve the quality and quantity of life of those we serve. This is truly a higher calling and many of our Team work in our facilities for this reason alone.

Our position on the state's current proposal is "hopeful but concerned".

Concerns:

- Our dealings with insurance companies to date have not been favorable. The premium reductions to consumers will certainly come at a cost to hospitals, further reducing our reimbursement.
- $750K Cost to the State to oversee this program. Doesn't this just add more cost to the system?
- $69.7M - $133.6M savings – "50% of claims are facility". Further reduction of reimbursement?

Hopefuls:

- Ensure rural and Critical Access Hospitals are reimbursed adequately.
- Variation of more than 400% across Colorado for the same service (we represent the low end)
- Rx rebates must be passed through to members and used to reduce premiums
    - (would prefer to see the PBMs eliminated but this is a good start)
- Utilize new DOI authority to address provider behavior

Desires:

- Pharmaceutical costs addressed, PBMs eliminated (like Michigan is doing)
- Regulatory burden for Rural Hospitals lightened
- Details provided for how Rural Hospitals are protected

We welcome further dialogue to reduce healthcare costs to patients,

Dewane Pace, MBA, FACHE
Chief Executive Officer
Haxtun Hospital District

HEALTHIER™ COLORADO

October 28, 2019
Commissioner Michael Conway
Colorado Division of Insurance
1560 Broadway, Ste 110
Denver, Colorado 80202

Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant Street
Denver, Colorado 80203

Re: Comments on the Draft Report for Colorado's State Coverage Option

Dear Commissioner Conway and Director Bimestefer:

Thank you for the opportunity to comment on the draft report for Colorado's State Coverage Option and your attention to the priorities of Coloradans. We also want to express appreciation for your extensive travel around the state to solicit input on the draft proposal. We appreciate the truly statewide approach you've taken in engaging stakeholders throughout this entire process.

Overall, we are happy that the draft report seeks to address many areas of concern that everyday Coloradans experience when trying to afford their premiums, out of pocket costs, and obtain quality health insurance coverage. This draft proposal is a great place to start and takes significant steps in creating more competition, lowering costs, and ensuring more Coloradans can afford coverage on the individual market. We wanted to highlight a few areas of agreement, as well as provide some comments on areas where we would like to see further clarification and/or see the draft plan changed.

Broad Eligibility and Essential Health Benefits Coverage - We believe it is important to provide all Coloradans the opportunity to purchase the state option plan, while also providing them the opportunity to compare various insurance plans and coverage. We also believe it is crucial for the state option to cover all essential health benefits, including pediatric services like oral and vision care.

Standardized Plans - We are supportive of the standardization of the plan benefit design under the state option proposal. We know that this will make it easier for Coloradans to shop and compare plans, and will allow them to focus on provider network, premiums, benefits and quality, while not having to make complex tradeoffs among cost sharing differences. Additionally, we are in support of making high-value services available pre-deductible to consumers such as primary care and behavioral health. We urge the state to include as many pre-deductible services as possible within the constraints of the actuarial value of the plan, as this will add value by allowing those consumers with high-deductible health plans to afford and access care they might not be able to now.

In addition to standardizing cost sharing requirements, we urge the state to consider how current utilization management criteria and formulary designs will be impacted by standardizing the plan design for the state option plans.

Use of Exchange Infrastructure - We are in support of utilizing and leveraging the exchange's pre-existing technology and infrastructure to assist in the facilitation of the sale and enrollment of individuals into the state option plans. Because of the "no wrong door approach" of Connect for Health Colorado and Peak, using the exchange will ensure that participants are routed to the appropriate coverage option.

Public-Private Partnership - We support this aspect of the plan and see the establishment of a public-private partnership upholding the original intent of HB19-1004. If the state plan is managed and run properly, we will ensure we minimize catastrophic disruption in the current market. We will also benefit from the existing administrative structure that the private market has already built. Additionally, asking carriers to take on the burden of underwriting the risk of these new plan offerings also ensures that the state, and by extension the state budget, will not be responsible for bearing the risk of this new state option.

Prescription Drug Rebates - We support passing on rebates from pharmaceutical manufacturers to bring down costs of prescription drugs for consumers. We believe the best way to do this in the individual market is either pass these rebates directly to consumers or ensure they are being utilized to lower their respective premiums.

1332 Waiver and Ensuring Dental Coverage - If the state is successful in applying for a 1332 waiver and drawing down federal dollars, we support the state using the funding to increase premium subsidies for enrollees, increasing subsidies for people who need them the most, reducing the out-of-pocket cost sharing for consumers, and for funding an imbedded adult dental benefit. We believe that dental coverage is a crucial element in addressing overall health issues for Coloradans. We also know there is an inherent link between oral health and overall health that is important to consider when providing dental coverage.

Impact on Rural Communities - We appreciate and applaud the draft plan's stated commitment to protecting rural hospitals and providers, but we urge the state to provide clarification and concrete steps for ensuring access in rural communities is not detrimentally impacted by this new state option. Rural hospitals are often a unique member of rural communities, not only providing needed care, but also acting as a major employer and economic driver of the region. Many of Colorado's rural areas are already struggling with economic hardship and we urge the state to consider potential impact on poverty rates and the local tax base when making decisions involving rural hospitals and providers.

Value Based Insurance Design - We appreciate the emphasis on creating higher value insurance products, but we also want to ensure that VBID does not lead to discriminatory practices and utilization management criteria for people with disabilities, people who are medically complex, and/or people living with chronic conditions. While we are supportive of the goals of VBID, we also strongly believe that VBID should be used to increase quality of care and outcomes for patients, not solely as a means to

achieve cost savings. Providers must not be incentivized to turn away patients who are more expensive and/or more complex to treat. In addition, VBID that is based on individual outcomes without a pay bump or incentive for treating complex patients, is necessary for ensuring that everyone - not just those who are young and healthy - can get the care they need. To the extent possible, the state option should look to the VBID work that is already happening at HCPF and use the lessons they've learned to inform VBID.

Advisory Board - We support the creation of an advisory board as part of the infrastructure surrounding the state option. We would like to ensure that multiple consumer appointments are permanent seats of the advisory board's structure. Specifically, we'd like to note that the consumer appointments should represent not only a diversity of geographies, ethnicities, and income levels, but also a diversity of health care perspectives, including but not limited to those with a focus on chronic disease, people with disabilities, caregivers, high- and low-utilizers. These appointments, to the extent possible, should be compensated for their time, including provisions for child and/or dependent care, parking, remote participation, and lodging, when necessary. The healthcare industry should be represented on the advisory board, but not hold a disproportionate number of seats in comparison to the consumer representatives.

Additionally, we encourage the State to consider giving some authority to the advisory board to review and make recommendations or decisions on the state option plan design, including but not limited to affordability standards, value-based insurance design, and quality metrics. In order to ensure these recommendations or decisions are well-informed, we believe the advisory board should have access to data and analysis, as needed. Furthermore, we encourage the State to consider recommending funding one or more FTE to serve the Board members with project management and coordination of stakeholders as needed.

Reimbursement Rates - As we understand it, the intention in the draft proposal is to set reimbursement rates in this plan for hospitals between 175% and 225% of Medicare rates. While we appreciate a clearly articulated range, we worry that giving a range will cause hospitals to automatically set their rates at the high end of the range. We believe that choosing a mid-level benchmark rate may be a more productive way to approach this process.

We also have some reservations about the process for determining these rates. We would like to see a process that puts the final decision on rates in the hands of a neutral, non-political arbiter that has the power to make the rates binding. This process could include the following steps:

- A mid-level rate benchmark or goal could be set by DOI that would be based on actuarial analysis, location of hospital and the community they serve (e.g. rural, urban, or frontier), and payer mix for that particular hospital or grouping of hospitals. The mid-level benchmark should not be lower than current Medicaid reimbursement rates.
- Once DOI sets the mid-level goal reimbursement rate, providers and carriers would go into their negotiations with that mid-level goal in mind when negotiating their rates.
- After negotiations conclude, and reimbursement rates for individual providers and hospitals are agreed upon by carriers and providers, the rates will be submitted to DOI in a similar manner to the annual carrier rate review. If a facility or provider negotiates a state option plan rate that is substantially higher than the median of all their negotiated rates or the median of like facilities (as

specified above), they would go before a neutral arbiter (see below section for recommendation on who that arbiter could be) to provide data showing the need for the higher rate in order to maintain services.

- The neutral arbiter would then have the authority to make a decision based on the information provided by DOI and the hospital in question to either accept their negotiated rate or the arbiter could set the reimbursement rate for that plan year between the benchmark rate and the negotiated rate.
- This process can occur on an annual basis with each hospital that falls outside the mid-level goal reimbursement rate that is set by DOI.

Neutral Arbiter for Rate Review Process - The current proposal does a good job of increasing competition by requiring carrier participation. We believe we can increase competition further by setting up a rate review process in a neutral space that is removed from the political sphere and cannot be lobbied on. We believe that a neutral arbiter should be the final decision maker on rates for a few reasons.

There has been a pattern over the last several years of various health care industry players battling one another in the legislative and political space. This includes pouring large amounts of money into lobbying against one another and the ultimate outcome of all of this is that consumers lose because we mitigate one issue, but often inadvertently create stress in another part of the system. We believe that the final decision around rates for the state option should, to the extent possible, be moved out of the political and legislative realm where there are multiple factors at play when a decision is made. We want the process to be as fair as possible while also remaining above the political fray. Having the final decision-maker on rates be an entity that cannot be lobbied will increase the likelihood that consumers' considerations are considered on an equal footing as the industry.

One option for a neutral entity that cannot be lobbied could be an administrative law judge that resides in either the Office of Administrative Courts (where the rest of the state's ALJs currently reside) or in the Attorney General's office. The benefits provided by this kind of entity include: they cannot be lobbied, ALJs would provide a neutral framework to make decisions from, and therefore, we remove the issue from the political sphere. We are open to other entities who could serve as the neutral arbiter, but where this individual resides and how they are appointed/hired would matter. We want the state option to exist in perpetuity and therefore make it sustainable in a shifting political landscape. We would recommend giving a neutral arbiter the following authority:

Network Adequacy - In addition to thinking about the best process for determining reimbursement rates, we urge the State to consider the impact that this reimbursement rate will have on network adequacy and access to specialists, particularly in rural areas. In order to ensure that the state option provides adequate, quality networks, the State needs to ensure specialist participation for both hospital based and non-hospital based providers, as many individuals with chronic conditions rely on their specialists as a routine source of care. In order to mitigate some of these concerns, we suggest the following changes for further consideration. These ideas may have the added benefit of improving continuity of care for individuals who churn between Medicaid and commercial insurance.

- Allow providers that are already credentialed with the Medicaid program to be automatically credentialled with the state option plan carriers. In other words, require carriers offering the state option to accept all providers that have already been enrolled as Medicaid providers, without further credentialing requirements.
- For some providers, including existing Medicaid providers, primary care providers, and behavioral health providers (especially in rural areas), offer a minimum reimbursement guarantee to incentivize their participation. We are unable to recommend what the minimum reimbursement should be, but suggest that it be **at least** the Medicaid reimbursement rate.
- Require all carriers offering the state option plan to contract with all Essential Community Providers (ECPs) in their geographic service area, which will help supplement the potential workforce shortage in primary and preventative care.

We encourage the State to clarify which entities this reimbursement rate will apply to (hospitals vs. hospital based providers vs. non-hospital based providers).

Industry Participation - It is clear from this draft plan that the carriers will be forced to participate in the state option plans. In addition to carriers, we also need to ensure that there is adequate participation from hospitals and providers. Within the current proposal, we do not see any information on how to acquire adequate participation from hospitals and providers, which is a crucial aspect in the potential success of the state option plans. We would like further clarification on how the State will ensure that hospital and provider participation is adequate enough for the plan to be successful and sustainable.

Cost Shift Analysis - We appreciate that the draft proposal mentions paying special attention to potential cost shifting that could occur when this plan is implemented. We encourage the State to formalize this review process on an annual basis.

Additionally, in order to ensure that the state option plans are not causing harm or have unintended consequences to the market or consumers, we request the state option be analyzed after it has been implemented and running for several years. This analysis should assess whether or not the state option plan is continuing to accomplish the goals of lowering costs, increasing competition, and ensuring quality care and coverage for Coloradans.

In conclusion, we appreciate the outreach and engagement by HCPF and the DOI in seeking feedback during this process to create a state health care coverage option that meets the needs of all Coloradans.

Sincerely,
Healthier Colorado

The Medical Center of Aurora
North Suburban Medical Center
Presbyterian/St. Luke's Medical Center &
Rocky Mountain Hospital for Children
Rose Medical Center
Sky Ridge Medical Center
Spalding Rehabilitation Hospital
Swedish Medical Center

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Administrative Offices
4900 South Monaco Street
Suite 380
Denver, Colorado 80237
303.788.2500 Phone
303.779.4993 Fax
www.HealthONECares.com

Via E-mail to: HCPF_1004AffordableOption@state.co.us

Commissioner Michael Conway
Division of Insurance
Colorado Department of Regulatory Agencies
1560 Broadway #110
Denver, CO 80202

Executive Director Kim Bimestefer
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

RE: Comments on "DRAFT Report for Colorado's State Coverage Option"

Dear Commissioner Conway and Director Bimestefer:

As a means of introduction, HCA Healthcare is one of the nation's leading providers of healthcare services, comprising of 184 hospitals and approximately 2,000 sites of care in 21 states and the United Kingdom. Our care in Colorado is provided under the HealthONE name. HealthONE is the largest healthcare system in the metro Denver area with more than 11,000 employees. As part of the HealthONE system of care, The Medical Center of Aurora, North Suburban Medical Center, Presbyterian/St. Luke's Medical Center, Rocky Mountain Hospital for Children, Rose Medical Center, Sky Ridge Medical Center, Swedish Medical Center, and Spalding Rehabilitation Hospital work together to provide a higher level of care for Denver area communities. In addition, our family of services includes seven hospital free-standing emergency departments and numerous ambulatory surgery centers, CareNow Urgent Care and occupational medicine clinics, physician practices, imaging centers, and AIRLIFE-DENVER, which provides critical care air and ground transportation across a 10-state region. As the #7 corporate philanthropist in the metro area, and the only hospital system in the top 10, HealthONE contributed more than $1.5 million in 2018 and supports over 150 organizations through cash and in-kind donations.

HealthONE /HCA Healthcare, Inc. ("HealthONE") believes that every Coloradan should have access to affordable, high quality coverage. That is why HealthONE, and the hospital industry's associations — the Federation of American Hospitals and American Hospital Association — supported the Affordable Care Act ("ACA") when it was enacted in 2010. The ACA aimed to deliver health care to Colorado through two primary mechanisms: 1) the creation of a competitive health insurance marketplace and 2) expansion of the Medicaid program. While millions of newly insured Americans now have access to affordable insurance, for a variety of reasons, the ACA has not yet met its full intent. Like the Federation and AHA, HealthONE continues to believe that there are clear fixes that can be made to the individual marketplace — such as reinsurance, increased subsidies, and increasing education and enrollment — that would be effective and result in an increased number of Coloradans having more affordable, predictable coverage.

The proposed State Coverage Option ("Public Option"), however, is not the answer. Numerous studies have found that a public option/government run insurance system would ultimately adversely impact tens of millions of Americans that currently have employer sponsored coverage that they like and want to keep.[1] Further, a fully implemented Public Option could force more than half of all rural hospitals to close which would reduce access to healthcare and create tremendous disruption and uncertainty.[2] Ultimately, a Public Option would result in a one-size-fits-all government health care system where Coloradans will pay more to wait longer for worse care.

HealthONE appreciates the opportunity to comment to the Colorado Division of Insurance (the "Division") and the Department of Health Care Policy & Financing ("HCPF") on the *DRAFT Report for Colorado's State Coverage Option* ("Draft Proposal"), published on October 7, 2019. In addition to the substantial, adverse impact a Public Option would have on Coloradans (see above), HealthONE also strongly objects to the Draft Proposal for three overarching reasons: (1) implementation of the Draft Proposal is not permitted under Colorado law; (2) the analysis and assumptions underlying the Draft Proposal are both materially and fatally flawed; and (3) the Draft Proposal risks disrupting existing competitive markets to the detriment of Coloradans.

OVERVIEW

The core feature of the Draft Proposal is a radical and dangerous rate-setting proposal that would limit in-network hospital reimbursement based on the inadequate Medicare reimbursement rate and threaten network adequacy and competition in currently competitive markets.

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[1] Lane Koenig, PhD, Asha Saavoss, Samuel Soltoff, Berna Demiralp ,PhD, Jing Xu, PhD, KNG Consulting, "Impact of Medicare-X Choice on Coverage, Healthcare Use, and Hospitals, March 12, 2019; Lane Koenig, PhD, Asha Saavoss, Berna Demiralp, PhD, Joel Nair, Julia Sheriff, "The Impact of Medicare for America on the Employer Market and Health Spending," October, 2019.

[2] Jeff Goldsmith, Jeff Leibach, Navigant Consulting, "The Potential Impact of a Medicare Public Option on U.S. Rural Hospitals and Communities: A Scenario Analysis," August 2019.

First, Colorado law does not permit the Division or HCPF to set negotiated provider rates. Without such legislative authority, the Draft Proposal cannot be implemented and does not meet the requirements for a waiver under section 1332 of the Affordable Care Act ("Section 1332"). Moreover, to the extent that the proposal interferes with the performance of existing contractual obligations by altering network provider rates, the proposal would be unconstitutional.[3]

Second, the draft rate-setting proposal, including the supporting actuarial analysis, significantly errs in estimating any savings from the proposal and fails to appropriately evaluate the access to high-quality, affordable health care under the proposed Public Option. The savings estimate is based on the assumption that current hospital reimbursement rates on the individual market are approximately 289% of Medicare rates. This figure, however, is derived from a study of hospital reimbursement rates *for employer-sponsored coverage* and included no data on reimbursement rates for individual market coverage on or off the exchange. Without any market data concerning network hospital rates on the individual market, the actuarial analysis' conclusions are wholly unsupported and unreliable. In fact, based on the data presented, it is impossible to determine whether the Draft Proposal would decrease or increase premiums and whether it would produce any savings or would increase government spending.

Finally, at present, the competition on Colorado's health benefits exchange, Connect for Health Colorado, and the off-exchange individual market is providing Coloradans with robust and affordable options in most Colorado markets. At present, over 89% of Coloradans live in counties where they can choose from between 30 and 75 plan options offered on Colorado's health benefits exchange, Connect for Health Colorado.[4] Over half of Coloradans live in counties with six or more carriers offering coverage on the exchange, and 88% live in counties with between three and seven carriers offering exchange coverage.[5] The vibrant competition in these markets is working to provide Coloradans with robust and cost-effective health care coverage options, and it is critical that any state option not disrupt these markets. The Draft Proposal, however, does not include any initiatives designed to preserve existing competition that benefits so many Coloradans. Instead, the Draft Proposal hinges almost entirely on a statewide rate-setting proposal for Colorado hospitals without any county-by-county analysis of the expected impacts on competition.[6]

In short, because of the legal and analytical deficiencies of the Draft Proposal, HealthONE urges the Division and HCPF to withdraw the Draft Proposal.

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[3] U.S. Const. Art. I, § 10; Colo. Const. Art. II, § 11

[4] Based on our analysis of 2020 exchange offerings by Colorado county (Colorado Department of Regulatory Agencies, Division of Insurance, 2020 Individual Medical Plan Counts – by Rating Area / County and On / Off-Exchange, *at* https://drive.google.com/open?id=1Z1a01d0nl13htGWefhJca0JXQtc7zDpq) and county population estimates for 2017 (Colorado Department of Local Affairs, Current Population Estimates, Counties, 2010 – Current, *at* https://drive.google.com/uc?export=download&id=1IuFZCD7KCdS3HpJ6BVxGkk4RoUW5f0GS).

[5] *Ibid.*

[6] Although the Draft Proposal includes various components other than a limit on network hospital rates—including, value-based insurance design ("VBID"), an adjustment to the medical-loss ratio ("MLR"), and Centers of Excellence—those other components are not expected to have any material effect on premiums or savings per the Draft Proposal's actuarial analysis and are not discussed further in these comments.

DISCUSSION

I. Colorado Law Does Not Authorize Rate Setting for Contracted Hospitals or Mandate Market Participation for Carriers.

As a threshold matter, the Draft Proposal cannot be implemented because neither H.B. 19-1004 nor any other Colorado law permits the Division or HCPF to set contracted provider rates for health insured products offered on or off the Exchange. The Draft Proposal identifies no legislation that would authorize rate-setting by the Division or HCPF, but appears to suggest that the Division has authority to ensure that individual market plans only reimburse hospitals at between 175% and 225% of Medicare fee-for-service rates. In fact, the Division has no authority to limit network provider reimbursement rates. To the contrary, the Division's authority to review and disapprove "rates" is limited to issuer rates, not negotiated provider rates. *See* Colo. Rev. Stat. § 10-16-107.

Likewise, Colorado law does not permit the Division or HCPF to require insurers to participate in the Public Option. The Draft Proposal indicates that certain, unspecified insurance carriers will be required to offer Public Option coverage. The Draft Proposal does not offer a clear proposal for determining which carriers would be required to participate, but suggests it may be based on the size of the carrier (based on "market share or membership") or the carrier's participation in a "major market (individual, small group, or large group)." Aside from the wholesale lack of clarity as to how carriers could be required to participate or the criteria for determining which carriers would be so required, the Draft Proposal fails to identify any legal authority for such a mandate.

Under H.B. 19-1004, the Draft Proposal is required to include "an identified statutory or rule change necessary to implement the proposed state option."[7] The Draft Proposal identifies no such legislative or regulatory changes despite the absence of legal authority described above. Without further legislation, the Draft Proposal cannot be implemented.[8] Similarly, without further legislation, no waiver under Section 1332 may be granted.[9]

Finally, to the extent that the proposal interferes with the performance of existing contractual obligations by altering network provider rates, the proposal may impair obligations of

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[7] Colo. Rev. Stat. § 25.5-1-129(6).

[8] HealthONE /HCA Healthcare further notes that, under Article V, section 17 of the Colorado Constitution, "[n]o law shall be passed except by bill." As such, H.B. 19-1004 did not and could not delegate legislative authority to the Division and HCPF, and additional legislation authorizing key features of the state option proposal would be necessary in order to implement the proposal.

[9] Under Section 1332, a state seeking a waiver must enact a "law that provides for State actions under a [Section 1332 waiver], including the implementation of the Sate plan." 42 U.S.C. § 18052(b)(2). Colorado law, however, does not permit the Division or HCPF to limit contracted provider rates or to require carrier to participate in the state option, as explained above. Without such legislation, Colorado cannot provide the necessary assurances to submit an application for a Section 1332 waiver, and no such waiver would be granted. Colo. Rev. Stat. § 25.5-1-129(6).

contract in violation of the United States Constitution and the Constitution of the State of Colorado.[10]

II. The Actuarial Analysis Relies on Erroneous Assumptions, Overstates any Premium Savings and Underestimates the Federal and State Budgetary Impact

Both the Draft Proposal and actuarial analysis repeatedly note the erroneous assumption that "insurance carriers in the individual market" currently pay contracted hospitals "approximately 289% of Medicare," and this erroneous assumption provides the basis for all of the purported savings under the Draft Proposal.[11] The average price used to calculate savings under the Draft Proposal is based on analyses of both in-network and out-of-network claims under *employer-sponsored* coverage that explicitly "*excluded . . . nongroup plans*."[12] The cited studies, therefore, reached no conclusions about the rates paid by insurance carriers in the individual market, despite representations in the Draft Proposal to the contrary. ***Without any data from the individual market, it is impossible to ascertain whether the proposed rates could be supported in the individual market or whether the Draft Proposal would produce any savings or additional expenditures.***

In short, the entire analysis suggesting that Coloradans would save at least 9 to 18% on premiums is infected by a fundamental error, and it is entirely possible that the Draft Proposal would ***raise premiums*** in at least some currently competitive markets, which would in turn increase spending by the Federal government in the form of premium tax credits. In addition, any increase in premiums would render coverage less affordable rather than more affordable for

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[10] U.S. Const. Art. I, § 10; Colo. Const. Art. II, § 11.

[11] Draft Proposal at p.3; *see also id.* at p.12, p.26 tbl.1, p.27 tbl.2 & tbl.3, p.29.

[12] RAND Corporation, *Prices Paid to Hospitals by Private Health Plans are High Relative to Medicare and Vary Widely: Findings from an Employer-Led Transparency Initiative*, p.15 (2019), *at* https://www.rand.org/content/dam/rand/pubs/research_reports/RR3000/RR3033/RAND_RR3033.pdf (emphasis added) ("RAND Study"). There are two sources cited in the Draft Proposal and actuarial analysis, but both are based only on employer-sponsored coverage claims data. First, the Draft Proposal cites to the 2019 RAND Study (Draft Proposal at pp.9, 12), but the RAND study only analyzed employer-sponsored coverage data. *See* RAND Study at p.15 ("The study design also excluded Medicaid plans, nongroup plans, and Affordable Care Act Exchange plans."); *see also id.* at p.vii ("Our approach was to gather claims data . . . for enrollees in employer-sponsored health benefits."), pp.8 – 9 (describing data). The Draft Proposal and actuarial analysis also cite to a report from the Colorado Center for Improving Value in Health Care ("CIVHC"). *See* Draft Proposal at pp.12, 29, 34. But the CIVHC report is itself based on the same RAND Study that focused only on hospital claims for employer-sponsored coverage. *See* CIVHC, Regional Price Information as a Percent of Medicare Now Available, *at* https://www.civhc.org/2019/09/05/regional-price-information-as-a-percent-of-medicare-now-available/ ("The data is based on [the 2019] RAND [Study]."); CIVHC, Medicare Reference-Based Price Report, *at* https://www.civhc.org/get-data/public-data/interactive-data/reference-pricing/ ("This report is based on [the 2019] RAND [Study] analysis."); *see also* CIVHC, CO Medicare Reference Price Data, *at* https://www.civhc.org/get-data/public-data/interactive-data/reference-pricing/ (noting that "[f]or more information on the data sources, methods, and results, please access the [RAND Study]" and specifying that the data reflects prices paid "by Private Employer-Sponsored Health Plans"). It is also notable that the RAND Study reported prices that "represent a mixture of negotiated contracted rates paid to in-network providers and allowed amounts for services provided by out-of-network providers. Rand Study at 15. Thus, it is impossible to reach any conclusions concerning in-network hospital rates for individual market services based on the RAND study.

Colorado residents, fundamentally undercutting the intent behind the H.B. 19-1004 and the Public Option.

The actuarial analysis also contains additional errors that significantly undercut the conclusion that the Draft Proposal would produce premium savings and would not have an adverse budgetary impact. Once these errors are corrected, it is likely that a sound analysis would model increased federal spending under the Draft Proposal, a result that would render the proposal ineligible for a waiver under Section 1332 and preclude pass-through payment of premium tax credits.[13]

First, the analysis assumes that new enrollees would have 73% relative morbidity compared to the currently insured individual market population.[14] This assumption is not supported by the cited study, and there is no basis for applying this 73% figure to assess likely premiums and expenditures under the Public Option. The actuarial analysis relies on a lone footnote in a 2017 Council of Economic Advisers Issue Brief ("CEA Issue Brief") as the basis for assuming 73% relative morbidity for newly insured individuals, but the CEA Issue Brief focuses on the individuals that *leave* the health insurance market, not previously uninsured individuals who newly enroll in coverage.[15] In contrast, it stands to reason that currently uninsured individuals have deferred medical care and may have claims costs that equal or exceed claims costs for currently insured individuals.[16] Furthermore, the Draft Proposal notes that Medicare and Medicaid enrollees and other beneficiaries of public coverage options would be eligible to participate in the proposed Public Option.[17] The Medicare-eligible population has higher morbidity than the population currently covered by the individual insurance market. The actuarial analysis contains no discussion of the premium impact of expanding eligibility to these groups, and it stands to reason that the broad eligibility proposed may increase premiums and federal spending.

Second, the actuarial analysis wholly fails to address any potential "woodwork" or "welcome-mat" effect in which uninsured individuals that are currently eligible for but not enrolled in Medicaid or premium tax credits on the exchange take up such coverage after seeking to enroll

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[13] Under Section 1332(b)(1)(D), a waiver request cannot be granted if the Secretary determines the proposal would "increase the Federal deficit." 42 U.S.C. § 18052(b)(1)((D).

[14] Draft Proposal at pp.26, 31.

[15] CEA Issue Brief, Understanding Recent Developments in the Individual Health Insurance Market (Jan. 2017), *at* https://obamawhitehouse.archives.gov/sites/default/files/page/files/201701_individual_health_insurance_market_cea_issue_brief.pdf. With respect to the 73% figure, the CEA Issue Brief only notes in a footnote that "a reasonable estimate is that claims costs for individuals who leave the market when premiums rise are around 73 percent of claims costs for enrollees who remain." *Id.* at p.6 n.7.

[16] See, e.g., Government Accountability Office, Health Insurance Exchanges: Claims Costs and Federal and State Policies Drove Issuer Participation, Premiums, and Plan Design (Jan. 2019), at https://urldefense.proofpoint.com/v2/url?u=https-3A__www.gao.gov_assets_700_696603.pdf&d=DwIGaQ&c=9fZnZOgPWmHmvevlab4V4DSjtBMjorSlbQYfK_MauDg&r=pyH4SB3Cx38Fym0BDTLfA5HctTocjzsg3s6w9G5YUy4&m=we3DkuigGrgmTOE9c6Nh1qeWQ5TWYUt-gDhX6mot054&s=7uw5gWz5MorOt4SJHGVu_0k3QLR3TfQQmapDOA0C9Eo&e=.

[17] Draft Proposal at p.10.

in coverage through the new Public Option. This woodwork effect was observed during the roll-out of the ACA when Medicaid enrollment increased among previously eligible but non-covered populations in both expansion and non-expansion states.[18] Any woodwork effect that increases Medicaid enrollment would result in increased state and federal spending, and any woodwork effect that increases subsidized exchange enrollment would result in increased federal spending in the form of premium tax credits.

Third, the actuarial analysis assumes without support that there would be no change in employer coverage as a result of the availability of the Public Option. This assumption is particularly untenable in light of the June 13, 2019 final rule on health reimbursement accounts ("HRAs") issued by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.[19] Under that rule, which became effective on August 19, 2019, employers are permitted to offer coverage through an HRA that is integrated with individual market coverage purchased by the employee.[20] Despite this significant change in federal rules, the actuarial analysis does not consider any impact that the Public Option might have on an employer's decision to offer coverage through an HRA that is integrated with a state option plan or other individual market coverage.

Finally, the actuarial analysis assumes that "[i]ssuers will offer plans that adhere to the State Option requirements using their current provider networks and infrastructure."[21] This assumption, however, has no evidentiary support. Current payer-provider managed care agreements establish rates based on arms-length negotiations that reflect complex market factors. Modifying these rates requires a contractual amendment negotiated by the parties, and there is no evidence indicating that hospitals in the many-varied markets of Colorado would agree to the proposed rates. Thus, contrary to the actuarial analysis' assumptions, carriers could not use their current hospital networks to offer state option plans. In fact, there's no basis to believe that an issuer could satisfy its network adequacy obligations, including the requirement to offer an "adequate number of accessible acute care hospital services within a reasonable distance, travel time, or both" and to "include essential community providers in the carrier's network" for state option plans.[22] Even if the RAND Study of employer-sponsored coverage was at all relevant, it would not support the adequacy of the proposed Public Option rates because (1) the study indicates

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[18] *See, e.g.*, Medicaid and CHIP Payment and Access Commission (MACPAC), Medicaid Enrollment Changes Following the ACA, *at* https://www.macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/.

[19] Health Reimbursement Arrangements and Other Account-Based Group Health Plans, 84 Fed. Reg. 28,888 (June 20, 2019).

[20] *Ibid.*

[21] Draft Proposal at p.24.

[22] Colo. Rev. Stat. § 10-16-704. H.B. 19-1004 requires the Division and HCPF to evaluate "provider rates necessary to incentivize participation and encourage network adequacy and high-quality health care delivery." Colo. Rev. Stat. § 10-125.5-1-129(4)(b). Without any data on network hospital rates on the individual market in each rating area, the Draft Proposal fails to satisfy this requirement. In addition, there is no discussion of any non-hospital rates; instead, non-facility providers are excluded from any rate impact and non-hospital facilities are not discussed at all.

significant variation in rates for hospitals within a state, suggesting that a statewide rate is simply not supportable; (2) any interstate variation observed in the study does not suggest that the variation is inappropriate or that lower rates are sustainable in Colorado; and (3) the study is based on scant data outside of Colorado (e.g., claims for as few as 102 inpatient services in some states) and any interstate differences in contracted rates may not even be statistically significant.[23]

Without a sound and reliable actuarial analysis, it is impossible to properly evaluate the potentially significant risks and destabilizing impacts of the rate-setting proposal. Moreover, because of the foundational and pervasive data and analysis errors in the Draft Proposal's actuarial analysis, the Draft Proposal is not supported by the necessary actuarial research required under H.B. 19-1004. For this reason alone, the Draft Report should not be finalized with any rate-setting components.

III. <u>The Draft Proposal Would Disrupt Competitive Markets</u>

H.B. 19-1004 explicitly and correctly focused on access and affordability issues facing those Coloradans that "have access to only a single insurance carrier participating in the Colorado health benefit exchange."[24] The Draft Proposal, however, applies statewide—including in markets that are highly competitive and currently provide Coloradans with choice and low premium prices. For example, in the Denver rating area, there are currently seven carriers offering individual market coverage, both on and off the exchange.[25] In the Denver rating area, there are 109 plans with competitive premiums that are 17.9% lower than 2019 premiums.[26] These include 20 gold plans, 49 silver plans, and 34 bronze plans.[27] Furthermore, Denver is a market that is becoming *more* rather than less competitive at present. Oscar Insurance Company entered the Colorado insurance market for the first time this year to offer ten individual market plans in 2020, thus increasing the number of carriers in the Denver rating area from six to seven.[28] In addition, two carriers expanded

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[23] The detailed data accompanying the RAND Study explicitly notes that "[d]ifferences in prices among states have not been tested for statistical significance." RAND Study, Detailed Data, *available at* https://www.rand.org/content/dam/rand/pubs/research_reports/RR3000/RR3033/RAND_RR3033.data.zip. By way of example, the RAND Study only reflects claims data for 102 inpatient services in Washington, 116 in North Carolina, 135 in Georgia, 136 in Wisconsin, 194 in Pennsylvania, 441 in New York, and 478 in Tennessee. The population covered by employer-sponsored plans in each of these states exceeds that of Colorado, but the RAND Study included data for 45,765 inpatient services in Colorado (more than double that of any other state in the study). Given the enormous range of data quality in the study, it is impossible to reach any conclusion based on interstate comparisons.

[24] Colo. Rev. Stat. § 25.5-1-129(1)(a)(IV).

[25] Colorado Department of Regulatory Agencies, Division of Insurance, 2020 Individual Medical Plan Counts – by Rating Area / County and On / Off-Exchange, *at* https://drive.google.com/open?id=1Z1a01d0nl13htGWefhJca0JXQtc7zDpq.

[26] Colorado Department of Regulatory Agencies, Division of Insurance, 2020 Individual Medical Plans Average Premium changes – by County and Rating Area, *at* https://drive.google.com/file/d/1jy3LsG3CluyUqycxgQBUSsaztlc_-KwP/view.

[27] *Ibid.*

[28] *Compare* Colorado Department of Regulatory Agencies, Division of Insurance, 2020 Individual Medical Plan Counts – by Rating Area / County and On / Off-Exchange, *at* https://drive.google.com/open?id=1Z1a01d0nl13htGWefhJca0JXQtc7zDpq *with* Colorado Department of

their 2020 exchange offerings compared to 2019, with Anthem (HMO Colorado, Inc.) and Bright Health Insurance Company offering two more plans each on the exchange for 2020.[29] In contrast, there are 22 Colorado counties that will only have a single insurance carrier participating in the Colorado health benefits exchange in 2020, which reflects a decrease in competition in certain parts of the state compared to 2019.[30] Thus, while some markets in Colorado are becoming more competitive, others suffer from inadequate carrier competition.

Despite these extraordinary market differences, the Draft Proposal uses statewide averages and a statewide rate proposal without any consideration of the differential impact of the proposed Public Option in highly competitive markets compared to markets with low competition. The Draft Proposal does not analyze the expected impact of rate-setting on competition, network composition, consumer choice, and premiums in different markets. The Draft Proposal and actuarial analysis also fail to consider any potential adverse impact on competitive markets flowing from the proposed requirement that large carriers offer the Public Option on a statewide basis. This aspect of the proposal could result in smaller carriers declining to expand in order to avoid the statewide participation mandate, diminishing competition in markets that would otherwise see new entrants or expanded offerings. The Draft Proposal does not include the threshold that would be used to determine which carriers are subject to this mandate, and without a proposed threshold, it is impossible to adequately evaluate the likely impact of the statewide mandate. A reliable modeling of these impacts and a full understanding of the adverse impact for the many Coloradans that reside in competitive markets is a necessary prerequisite to meaningful discussion of the risks and benefits of the proposal.

The rate-setting proposal undergirding the Draft Proposal also threatens to disrupt the movement toward alternative payment models and value-based care in competitive markets. The 2019 RAND Study of hospital rates for employer-sponsored coverage expressly excluded "non-claims-based payments to providers, such as risk-sharing payments and pay-for-performance bonuses."[31] The Draft Proposal contains no analysis of the impact of rate-setting on the use of alternative payment models that share risk or incentivize value-based care. If Colorado takes the radical step of establishing hospital reimbursement rates for commercial coverage based on a set methodology (*i.e.*, a multiplier of estimated Medicare rates), payers and providers would have less latitude to experiment with alternative payment models that have the capacity to improve quality and value for Coloradans. This is true even if the Public Option includes Value-Based Insurance Design features or a Centers of Excellence model because the Public Option would limit payers

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Regulatory Agencies, Division of Insurance, 2019 Individual and Small Group Medical Plan Counts – by Rating Area/County and On/Off-Exchange, *at* https://drive.google.com/open?id=1UZjEWb1YQ1UxWJg4y4kr-URyirpOKQK1.

[29] *Ibid.*

[30] Colorado Department of Regulatory Agencies, Division of Insurance, 2020 Individual Medical Plan Counts – by Rating Area / County and On / Off-Exchange, *at* https://drive.google.com/open?id=1Z1a01d0nl13htGWefhJca0JXQtc7zDpq.

[31] RAND Study at p.17. The exclusion of this data from the RAND Study analysis indicates another flaw in the actuarial analysis. Without understanding the full range of provider payments (claims-based and otherwise), it is impossible to model the likely premium impact of the rate-setting proposal or the likelihood that an adequate hospital network could be sustained in each Colorado market at the proposed rates.

and providers to the state-established model, foreclosing market-based alternatives that would otherwise emerge in a competitive marketplace.

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HealthONE/HCA Healthcare appreciates the opportunity to submit these comments. If you have any questions, please contact Melissa Osse, Vice President, Government Relations, 303-584-8089.

Oct. 28, 2019

Director Kim Bimestefer
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Commissioner Mike Conway
Colorado Department of Regulatory Agencies
Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Director Bimestefer and Commissioner Conway,

As leaders of the medical staffs at many of Colorado's hospitals, representing more than 5,000 providers across the state, we are jointly sharing our significant concerns about the Draft Report for Colorado's State Coverage Option.

Our physicians and advanced practice providers care for a substantial number of Colorado's Medicaid and uninsured patients, and we are dedicated to the communities we serve. We are focused on reducing health care costs and improving overall value, and we believe that all sectors of the health care economy must do their part to reduce prices. However, we have serious concerns that, as currently drafted, this proposal will negatively impact patient care throughout our state, increase premiums for those not enrolled in the public option plan, reduce access to care, and force some hospitals to permanently close their doors.

Our primary concerns include:

1. Government-mandated rate setting will reduce competition among providers and reduce competition among insurance plans. This competition is essential to drive down health care costs as multiple studies have shown, and harming competition could increase prices.
2. Cutting reimbursement rates will likely force hospitals and health care systems to cut services and reduce their support for research, education and community benefits. Some hospitals, unable to withstand these cuts, will likely be forced to close.
3. Introducing a new insurance plan, with artificially-lowered premiums, will disrupt the private insurance market, reducing competition and increasing premiums for employers and insurance plan members. These problems will be amplified when the State expands the public option into the commercial market, as the Division of Insurance and Department of Health Care Policy & Financing have said they plan to do.
4. The state's plan for reduced reimbursements does not seem to take into account the unique characteristics of hospitals, including those that provide residency and fellowship programs, care for disproportioned numbers of Medicaid and Medicare patients, and those that operate as critical access hospitals.
5. We also expect that this plan will harm our ability to recruit nationally recognized talent and innovative researchers, and increase the out-migration of providers who are able to move to states with more favorable health care regulations.

We recommend that the state NOT move forward with this proposal to establish a state option. Instead, a plan should be designed to extend coverage to the 400,000 uninsured people in Colorado; allow competitive reimbursement rates that will increase, rather than decrease,

competition in our state; provide a solution that will reduce expenses for providers, allowing them to pass those savings on to insurance plans and patients; support education and research which will drive health care in future generations; increase innovation and population-based strategies to improve the overall health of our state; and most importantly, ensure that patients are able to continue enjoying the high quality health care that Colorado offers.

We encourage the state to partner with providers and work collaboratively to develop a proposal that can be an example to other states while providing superior care for all of our patients.

Sincerely,

Bill Neff, MD
Chief Medical Officer
UCHealth

James Campain, MD
Chief of Staff
UCHealth Greeley Hospital

James Hoyt, MD
Chief of Staff
UCHealth Medical Center of the Rockies

Chris Fleener, MD
Chief of Staff
UCHealth Poudre Valley Hospital

David Steinbruner, MD
Chief of Staff
UCHealth Memorial Hospital Central

James Duffey, MD
Chief of Staff
UCHealth Grandview Hospital

Jean S. Kutner, MD, MSPH
Chief Medical Officer
University of Colorado Hospital

Thomas Downes, MD
Chief Medical Officer
UCHealth Northern Colorado Region

Colleen Conry, MD
Medical Staff President
University of Colorado Hospital

Jose Melendez, MD
Chief Medical Officer
UCHealth Southern Colorado Region

RE: Polis Hospital Rip-off

Why is the target squarely on hospitals to bear the brunt of the Polis Administration's poorly conceived public option healthcare plan? Hospitals are and alwaays have been committed to saving people money on healthcare. These are the good people who take care of our most vulnerable and serve all of us when we're at our most vulnerable. They do not deserve to be targeted by the Polis administration with a state option that threatens their budgets and staff.

Hospitals are investing in primary care physician networks with the hope of preventing illnesses and keeping people out of hospitals in the first place. Who else is doing this? What other sector involved in the health care debate is making strides toward lowering costs while driving innovation? Pharma? Insurance? Doubtful.

In addition, hospitals are active in our communities through charitable giving and other initiatives that address issues like food security, transportation, housing and mental health services, all of which produce long-term savings through prevention and wellness. Again, this is a sector of healthcare working to get at the root of the problem, not score political points.

Finally, hospitals came to the table and agreed to pay $40 million per year into the state's new reinsurance program, which has been credited with reducing health coverage premiums in the individual market by 20 percent. The $40 million contribution makes hospitals the largest source of state revenue for the program.

Despite that contribution, here's the Polis administration putting the bulk of the costs of a public option on the shoulders of hospitals. How much is enough? This public option is deeply flawed, and I do not support it as written. I hope and believe the Polis Administration must go back to the drawing board and come up with something better.

Jack R. Ekstrom
Principal
PolicyWorks America

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

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- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Jack Hamm

County (in which you reside) *

[redacted]

Organization *

private citizen

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No. Government programs have never been less expensive than those offered by private industry, UNLESS the availability of full and complete care is reduced. We do not want reduced quality and quantity of care, which would be determined by workers outside of the medical profession..

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

It might as long as the health services are limited, or capped, which is not off benefit to anyone.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Apparently, but I'm not convinced.

Does the proposal include worthwhile benefits for consumers?

No. I believe the quality of medical care will suffer severely.

Does the proposal create a product that is financially stable and sustainable?

No, not without additional income from taxes or other sources.

Other thoughts? Please list them here.

This is a bad idea.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

James Hoffman

County (in which you reside) *

[redacted]

Organization *

Self

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No. Neighborhood clinics and better use of EMTs and first responder training with technology for rural areas would help though! Also incorporate student medical loans into the training and practice of medicine.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No. Raises costs for private insurance patients.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Does the proposal include worthwhile benefits for consumers?

no

Does the proposal create a product that is financially stable and sustainable?

Absolutely not

Other thoughts? Please list them here.

Democrats caused severe damage to the best healthcare delivery system on the world and now want to finish the job. Socialism has failed multiple times, let's not reinvent the square wheel!

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To: Who will listen, I have been working for an auto/home/life insurance company 28 years and my healthcare has climbed 10 -15% every year. Now paying 650.00 a month and my company pays the other 650.00 a month 1,300.00 times 12 months $15,600.00 and no medical claims. 1/3 of my paycheck is paying healthcare costs. A family with one son that is in 8th grade. Not a family with 4 or five kids and no insurance. Thanks for reading.....
Mr. Rose

James C Rose

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Jean Dudley

County (in which you reside) *

[redacted]

Organization *

None

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

No

Other thoughts? Please list them here.

Stop trying to be in everyone's lives. It is not the governements place. You are employed by us not the other way around, ACT LIKE IT.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Jeanette Turner

County (in which you reside) *

[redacted]

Organization *

Individual

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

NO- it limits our freedom!

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No- help is already available, don't take away our freedom for private healthcare choices!

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No- adds big government control

Does the proposal include worthwhile benefits for consumers?

No- I want my freedom to choose my own options for my healthcare

Does the proposal create a product that is financially stable and sustainable?

No- it's just more government control!

Other thoughts? Please list them here.

Stop trying to control our lives as citizens with Big Government programs!! Keep America free and a country where we choose our own healthcare!

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

JIM ABELS

County (in which you reside) *

[redacted]

Organization *

INDEPENDENT

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

NO

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

NO

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

NO

Does the proposal include worthwhile benefits for consumers?

NO

Does the proposal create a product that is financially stable and sustainable?

NO

Other thoughts? Please list them here.

SOCIALISM DOES NOT WORK, LOOK AT HISTORY

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Director Kim Bimestefer
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Commissioner Mike Conway
Colorado Department of Regulatory Agencies
Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Director Bimestefer and Commissioner Conway:

My name is Joe Foecking, and I am the director of rehabilitation at UCHealth Memorial Hospital. I'm writing to say that the proposed Public Option plan is a study in what **not** to do to help uninsured Coloradans access care.

Under the draft proposal, 2 percent of Colorado's uninsured would gain coverage and costs would be shifted to the 53 percent of Coloradans who have health care coverage from their employers. As those costs increase, fewer people will be able to afford those premiums, resulting in fewer people being insured in the long run.

Is it the state's intent to eliminate private insurance and have people opt into the state's public option? While there is a national discussion underway about eliminating private insurance companies, I don't believe the American people want to surrender their private insurance for a plan run by the government.

A plan like this puts the kibosh on creativity and any market-based solutions that may be derived from robust discussion. A plan like this should be guarded against.

This plan is explosive and damaging to Coloradans and their communities. Health care providers will go elsewhere, hospitals will close, jobs will be lost and the overall health of Colorado will suffer.

Please reconsider this reckless proposal.

Joe Foecking
[REDACTED]
[REDACTED]

These are my personal opinions and they do not necessarily represent those of my employer.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

John Golden

County (in which you reside) *

CO

Organization *

Mr.

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

No

Other thoughts? Please list them here.

Government run services have never worked (USPS, California Bullet Train, etc. etc.)

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

John J0nes

County (in which you reside) *

[redacted]

Organization *

MNA

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

Not at all!!!!!!!!!

Does the proposal create a product that is financially stable and sustainable?

Ha not governmenet run

Other thoughts? Please list them here.

Defeat this proposal

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To Whom It May Concern:

Government-operated insurance programs have been tried and failed before, here in Colorado and across the country. Evidence shows the outcome is less competition, less personalized care and, often, significant costs spread across other insurance pools and taxpayers.

Unfortunately, the State's proposal threatens to destabilize Colorado's health care system to create marginal, and questionable, savings for a handful of residents. In reality, the plan would burden our state's health care providers, restrict access to quality care and services, and force private insurers out of the market, limiting competition and creating more one-size-fits-all coverage.

Colorado's health care system is on the right track. A record number of residents are insured, and more are using their coverage to get the care they need, when and where they need it. A record 93.5% of Coloradans have health insurance, and that rate has remained steady over the past two years, even after the individual mandate was removed.

I urge you to slow down and do it right. We need to have an informed discussion on a change that will greatly impact the state's economy. We don't want to unintentionally take a step back.

Sincerely,

John Mason

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

John Tumulty

County (in which you reside) *

[redacted]

Organization *

Personal comments - no real organzation

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No. This proposal uses government rate setting to establish an arbitrary reimbursement rate. This proposal will likely have the opposite effect of addressing health care affordability - it will destabilize the insurance market, increasing premiums for those of us with employer-sponsored insurance. Further, we will likely see hospitals cutting expensive services rather than lose money on them. Our state will see less competition among insurance companies and hospitals - which is especially concerning since this has been proven to lower health care costs.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No. This proposal is unlikely to attract uninsured people, which means Colorado will still have a significant number of residents with no insurance whatsoever. And by setting and artificially low reimbursement rate, premiums paid by everyone else will increase. The state's reinsurance program is already helping Coloradoans struggling with the highest health care costs. (a program which is funded primarily with a fee on hospitals.) The state should focus on what is already working, while branching out to address prescription drug costs.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No. This proposal threatens the infrastructure and expertise in our state - with the potential impact of facilities reducing the services they provide, and driving some highly-qualified experts to leave Colorado and go to another state.

Does the proposal include worthwhile benefits for consumers?

No. As stated above, this proposal may force providers to cut services, cut staff, or raise prices on consumers with traditional insurance plans.

Does the proposal create a product that is financially stable and sustainable?

No. Chronically under-funding providers is dangerous and unsustainable. Medicaid reimburses hospitals just 69% of actual costs (even with the hospital provider fee). Medicare reimburses hospitals at around 70%. Now the public option will also slash reimbursements. A smaller and smaller number of patients are carrying the increasing burden (cost shift) of these under-reimbursements. This is unsustainable and dangerous - the wrong option for Colorado.

Other thoughts? Please list them here.

The state's data has shown prescription drug prices are a significant problem. This is a burden both for patients and for providers - because hospitals are also suffering from losses due to high drug prices. Addressing this problem - and either lowering drug prices or establishing a rebate program - will help patients. But more importantly, a proper solution to drug prices will also help hospitals and providers reduce their expenses, allowing them to lower their own prices.

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Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

Please use this form to submit your comments on the draft HB19-1004 report. All comments will be logged and added as an appendix to the final report. We will accept comments until October 28.

Helpful Links:
- The draft report can be found here: http://www.colorado.gov/pacific/sites/default/files/HB19-1004%20Draft%20Report%20Colorado%20State%20Coverage%20Option%20and%20Appendix.pdf
- The bill text can be found here: https://leg.colorado.gov/sites/default/files/2019a_1004_signed.pdf
- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

JONATHAN WARD

County (in which you reside) *

[redacted]

Organization *

Retired President of Rocky Mountain Cardiology, Fellow of the American College of Physicians and Cardiology

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

YES, partially

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

YES, ? availability to the rural community

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

YES

Does the proposal include worthwhile benefits for consumers?

YES

Does the proposal create a product that is financially stable and sustainable?

YES if efficient and appropriate care

Other thoughts? Please list them here.

Emphasize preventative care to reduce costs, Provide benefit to employers/employees, Minimize additional costs in the way of copay, deductible

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- The bill text can be found here: https://leg.colorado.gov/sites/default/files/2019a_1004_signed.pdf
- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Joseph M. Giudice, Jr.

County (in which you reside) *

[redacted]

Organization *

Retired Teacher

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

We teachers have great health care and should be exempt from a state run health care program!

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

It should be optional not required!

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

It should be optional not required!

Does the proposal include worthwhile benefits for consumers?

It depends on the cost after the second year!

Does the proposal create a product that is financially stable and sustainable?

It depends on what happens the second tear!

Other thoughts? Please list them here.

It needs to be truly affordable, optional, and should not absorb existing free market, successful insurance programs we currently have!

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- The bill text can be found here: https://leg.colorado.gov/sites/default/files/2019a_1004_signed.pdf
- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Joseph Quinn

County (in which you reside) *

[redacted]

Organization *

Private citizen

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

NO

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

NO

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

NO

Does the proposal include worthwhile benefits for consumers?

NO

Does the proposal create a product that is financially stable and sustainable?

NO

Other thoughts? Please list them here.

the last time Democrats screwed up my healthcare my premiums doubled and my deductibles tripled. STAY OUT OF PRIVATE BUSINESSES OUR TAX DOLLARS ARE NOT YOUR PERSONAL CHARITY TO GIVE AWAY AND CHARGE ME MORE!

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- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Joyce Lash

County (in which you reside) *

[redacted]

Organization *

none

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No, it makes healthcare less available in full to Coloradoans

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No, government run healthcare means less healthcare

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

No, it is unsustainable

Other thoughts? Please list them here.

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To whom it may concern,

I am a client at the Neurofeedback Clinic Of Northern Colorado. I have [REDACTED] .. All of these conditions have improved in my life dramatically.

An amazing beginning has been made in this treatment and my therapist expects me to need another year of Neurofeedback.

So far I have been changed into a person capable of functioning in my life in a way I never could do before I began this Neurofeedback treatment in August 2018.

I am no longer burdened with anxiety, shame, or fear. I have been lifted literally from darkness to light. I am able to think clearly and in a way impossible for me before Neurofeedback. In fact, one of my best friends says that it was very difficult to converse with me because my thoughts were so tangential. I am calmer and even my driving skills are more attentive.

My therapist plans to work on deep trauma and abandonment issues that affect my decision-making in the coming year. The calming of abandonment issues will greatly help my brain to recover from the hoarding addiction. Being free from the stranglehold of owning more possessions than I have room for will open up my ability to have friends, family, and maintenance people in my home.

Without the completion of my Neurofeedback all these parts of healing in my brain will not be integrated together. My brain's changes will remain fragmented.

I am asking that you continue to support the contract you have had for the past few years with the NFCNC. This treatment has helped me immeasurably and I want to be able to finish the treatment. Please continue to allow the NFCNC keep the reimbursement rate they negotiated with you so they can break even and continue to treat the 150 to 200 patients on [REDACTED].

Also, all of the therapists are receiving Neurofeedback themselves because it IS so effective. Please do not cut off this amazing therapy from these [REDACTED] clients. It is more effective than any other treatment known today.

Thank you so much for your consideration of these people and their improving lives and relationships. Their communities, families, friends, and employers will thank you.

Sincerely,

Julie Cade

KAISER PERMANENTE®

October 25, 2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant St.
Denver, CO 80203

Commissioner Michael Conway
Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Sent via email to hcpf_1004affordableoption@state.co.us

Re: Draft Report for Colorado's State Coverage Option

Dear Director Bimestefer and Commissioner Conway:

Thank you for the opportunity to comment on the *Draft Report for Colorado's State Coverage Option* (the "Report"). As the largest issuer serving Colorado's individual market, Kaiser Permanente appreciates the Department of Health Care Policy and Financing and Division of Insurance (collectively, the "Agencies'") ongoing commitment to stabilize Colorado's individual market. We are concerned that the Report's recommendations would reverse Colorado's market stability gains and undermine competition and consumer choice across all of Colorado's commercial markets. As drafted, the Report compels issuer participation in a new system providing minimal premium reductions to a relatively small number of Colorado consumers at the expense of significant reimbursement cuts to Colorado's rural hospitals. It focuses on unit prices instead of total costs, and does not factor in quality and value.

At its core, the public option seeks to achieve premium reductions through artificial price controls; Kaiser Permanente opposes government-led approaches to capping or setting reimbursement rates without addressing the underlying costs of health care. The proposal also compels statewide coverage, antithetical to Kaiser Permanente's integrated model of coverage and care that serves more Coloradans in the individual market than any other carrier statewide.

The public option proposal, as discussed below, is unlikely to achieve its premium reduction goals for most Coloradans and could eventually significantly disrupt coverage for state residents – including those who currently carry employer-sponsored insurance. Rather than potentially jeopardizing consumer choice and access to coverage and care, we recommend that the Agencies build upon existing, proven approaches (such as Colorado's reinsurance program, consumer-directed subsidies and an individual mandate) to expand access to affordable coverage for more

Coloradans. Kaiser Permanente is committed to working on and providing alternative solutions that advance the State's agenda to reduce costs, without relying on government-set rates.

Kaiser Permanente commissioned the actuarial firm Milliman to review the impact of a public option on Colorado's health care market and consumers.[1] Based upon that work and our experience in the Colorado individual market, we are concerned that the Report's premium savings estimates may be overstated, particularly for urban areas. For the reasons explained below, Kaiser Permanente finds Milliman's analysis more compelling than the analysis in the Report, but we welcome further discussion on the relative merits of the competing analyses. Our primary concerns about the analysis in the Report, as contrasted with the analysis performed by Milliman, are as follows:

- First, the Report apparently assumes a uniform level of facility reimbursement across the state at 289 percent of Medicare. Milliman, based on its methodology, notes that facility reimbursements materially vary by geographic region.[2] It is not disputed that there are generally lower baseline reimbursement rates for urban markets where more providers and issuers already compete for individual market consumers versus less-competitive rural markets. Because the Report's conclusion about the uniform level of facility reimbursement does not reflect any geographical weighting, we believe that number is simply not an accurate reflection of the market. Milliman's premium reduction projections reflect geographic differences and the relative percentage of the population in the different areas.

- Second, the Report evaluates the hypothetical public option's performance against a statewide average individual market premium, whereas Milliman compares the public option against actual facility reimbursement rates under the current second lowest-cost silver plan ("SLCS") offered through Connect for Health Colorado. In the highly price-sensitive individual market, participants often choose one of the lower-priced plans, and issuers are therefore incentivized to limit facility payments to achieve a lower price point. Kaiser Permanente believes projections should therefore compare the public option's performance against premiums and products a vast majority of individuals actually purchase. SLCS is the better measurement for this behavior than a statewide average due to the fact that it is the basis for federal subsidies available to (and actual buying power of) subsidy-eligible consumers in a price-sensitive market. More than half of Colorado's individual market consumers receive subsidies; modeling changes to SLCS rates therefore

[1] *Evaluation of a Colorado Public Option*, Milliman (Oct 21, 2019) (attached).
[2] The commercial employer group reimbursement rates assumption is based on Milliman analysis of the IBM Marketscan® database, proprietary Milliman claims databases, and publicly available data sources. The assumption that the provider reimbursement underlying plans available on CFHC is better than standard commercial employer group reimbursement in certain counties is based on Milliman experience and work with previous, similar studies in other states. *Id.* at 19.

better estimates probable premium savings to current and potential individual market participants. While a single, publicly-available individual market reimbursement value (potentially between the analyses) is unavailable, we believe Milliman's geographic weighting and SLCS-based framework more closely reflects the actual value.

Below, we discuss in more detail Kaiser Permanente's specific concerns with the Report, referencing Milliman's findings where applicable.

- **Few Colorado consumers would benefit from the public option, and any benefit comes at the expense of rural hospitals.**

The Agencies' stated primary objective for a public option is to provide more Colorado consumers with lower-cost individual market coverage. The proposal presumes to accomplish this by limiting what private insurers would reimburse Colorado's hospitals. Milliman concluded that "the competitive advantage obtained by a public option is borne entirely by the provider community."[3] Limiting facility reimbursements to between 175-225 percent of Medicare fee-for-service rates, the Report projects, will generate monthly premium reductions of at least 9 to 18 percent.[4] Based upon the Milliman analysis, Kaiser Permanente believes these premium reductions are overly optimistic. Further, Milliman concludes that the benefit of any premium reductions under the public option would apply to a relatively small number of Colorado's individual market consumers, who reside outside the state's major urban areas. Overall, Milliman concludes that the public option will provide little to no price relief for urban consumers, even at very low percentages of Medicare.[5] The competitive market in urban areas has generally succeeded at keeping rates lower. The public option can only succeed in reducing premiums for rural customers by imposing an effective assessment on rural hospitals in the form of reimbursements capped at very low percentages of Medicare rates compared to current reimbursement levels.

While customers in the state's rural areas – with higher reimbursement rates due to lower or non-existent hospital competition and limited coverage options – would benefit from greater price relief, it is important to consider the broader impact of introduction of a public option. Any price relief attributable to rural consumers would be at the cost of lower reimbursements to providers that are already financially stressed.[6] Further, the state's existing reinsurance program features differentiated coinsurance rates designed to provide the state's rural consumers with additional, premium relief. We recommend that the Agencies evaluate the success of the reinsurance program at reducing the cost of coverage before introducing a new, unproven approach that could threaten the financial viability of the state's rural providers.

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[3] *Colorado Public Option: Evaluating Potential Implications, Milliman (Oct. 18, 2019) at 3 (attached)*.at 3.
[4] *Draft Report for Colorado's State Coverage Option*, Colorado Division of Insurance and the Colorado Dep't of Health Care Policy & Financing (Oct. 7, 2019) at 3.
[5] *See supra* n.2 at 3.
[6] *See Id.*at 4.

- **The proposal does not meaningfully reduce underlying costs of care.**

At its core, the public option achieves premium reductions through artificial price controls, without addressing the underlying costs of health care. The Report does not address issues such as rising pharmaceutical prices, costly benefits mandates and third-party payment mechanisms that drive increases in insurance premiums. The Report's recommendations instead attempt to impose additional restrictions on issuers by increasing the minimum medical loss ratio ("MLR") from 80 to 85 percent. This proposal may discourage participation in the individual market, which features administrative challenges given its high turnover and acquisition costs, combined with significant member engagement and higher-than-typical risk profile.

- **Maintaining current coverage could become more expensive following introduction of a public option.**

The Report apparently requires all carriers above a market share threshold (to-be-determined) in Colorado's commercial markets to offer the public option in order "to spread both the opportunity and the risk."[7] To the extent that the Report's plan reduces premiums, Colorado's rural individual market consumers could lose any effective alternative to public option coverage. Milliman concludes that many subsidized Colorado consumers will see no reduction in total coverage costs under the public option plan, and would pay substantially more to remain in the same plan.[8] This is largely because the Affordable Care Act's advanced premium tax credit ("APTC") subsidy, pegged to the second-lowest cost silver plan in a given market, diminishes as premiums artificially decrease due to the presence of the public option in that market. To the extent the subsidy decreases, total out-of-pocket costs for Colorado consumers who wish to keep their current coverage – or any form of individual market coverage that is not the public option – increases. Overall, Milliman concludes that many subsidized enrollees would pay more to maintain current coverage.[9]

- **Costs may rise across Colorado's commercial insurance markets to benefit a small number of consumers.**

Colorado's individual market covers just over 200,000 lives statewide, or 4 percent of the state's entire population.[10] The cost for providing premium relief to a small selection of these consumers, however, could increase costs and jeopardize current coverage for the nearly 3 million Coloradans receiving coverage through their employers. If the public option succeeds in lowering rates, hospitals, particularly rural facilities, would be forced to make up financial losses sustained

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[7] *Supra* n.4 at 3.
[8] *Supra* n. 3 at 3.
[9] *Id.*
[10] *Supra* n. 1 at 13.

through reduced individual market reimbursements, from other payers – particularly group and self-funded payers. Health costs on self-insured Colorado employers will increase, because the proposal only regulates contracting between hospitals and fully-insured plans. Because states lack significant tools to regulate self-insured employers, any such action may offer little marginal benefit.

- **Other alternatives better promote market stability in Colorado without imposing government-set rates.**

Colorado policymakers can build upon existing reforms to stabilize Colorado's individual market without the risks of imposing broader market disruption and limiting consumer choice. Kaiser Permanente recommends:

Improvements to Reinsurance

The Agencies could expand and improve upon Colorado's new reinsurance program, to extend the benefits to more Coloradans. First, reinsurance could better mitigate the overlap between the reinsurance program and federal risk adjustment to improve program efficiency. A promising option is to replace the traditional reinsurance structure, which potentially biases toward high-risk carriers, with a flat per-member-per-month or flat percentage market subsidy made payable to issuers, which would then be used to reduce premiums. Under a traditional reinsurance structure, the overlap between reinsurance and risk adjustment should continually be monitored, as any change in parameters may have a significant impact on the level of overlap, and dampening factors should be applied to address any determined overlap. Second, if maintaining a traditional reinsurance program, equalizing coinsurance rates across urban and rural areas could offer Colorado's urban consumers meaningful premium relief.

Direct Subsidies to Consumers

Colorado could direct new subsidies to help currently APTC-ineligible consumers better afford coverage. This approach would not require significant changes to existing exchange operations and would not require a Section 1332 waiver for implementation. The state could target relief to individuals, families and small business owners currently lacking federal premium assistance available to other Colorado consumers.

Individual Mandate

Other states, such as California, New Jersey and Washington, D.C., have pursued state-level individual mandate policies that replicate the ACA's federal requirement to stabilize the risk pool.

Such an approach could encourage more issuers to offer individual market coverage in more places across Colorado.

- **The report's prescription drug recommendations require further clarity.**

The Report recommends requiring "all prescription drug rebates and compensation paid by manufacturers to insurance carriers" to be used to "reduce the price of individual policies." Very few additional details about this proposal were provided in the Report.

Kaiser Permanente appreciates what the Agencies are trying to accomplish by requiring use of rebates to lower premiums. We currently recognize price concessions from manufacturers in our premiums and cost-sharing. Depending on how the Agencies intend to implement this recommendation, it could create significant operational challenges, disrupt plans' ability to use drug discounts to lower cost-sharing, and lead to burdensome new reporting requirements in addition to what we must already report to the All Payer Claims Database. Health plans should instead retain flexibility over rebate use, which could lead to more plan choices that better meet patients' variant health care and financial needs.

With this context in mind, we request that the Agencies provide more details about this recommendation and encourage them work closely with insurance carriers and pharmacy benefit managers to ensure any new requirements do not create an undue burden.

Thank you for your time and consideration. Please do not hesitate to contact us if you have any questions or require additional information. We look forward to discussing how proven approaches to market stabilization can expand access to affordable coverage and care to more Coloradans.

Sincerely,

Mike Ramseier
President
Kaiser Foundation Health Plan of Colorado

Margaret Ferguson, MD, MBA
President and Executive Medical Director
Colorado Permanente Medical Group

Colorado Public Option: Evaluating potential implications

Commissioned by Kaiser Permanente

Fritz Busch, FSA, MAAA
Paul Houchens, FSA, MAAA

October 21, 2019

Kaiser Permanente (Kaiser) engaged Milliman to assist in analyzing various aspects of the potential introduction of a Public Option in Colorado. In determining the scope, methodology and assumptions for our analysis, we relied in part on the text of Colorado HB19-1004 which laid out the public policy objectives and analysis requirements of a state-sponsored proposal that outlines the most effective implementation of Public Option in Colorado. One of those objectives was to estimate premium rates under a Public Option and the required provider reimbursement levels required underlying those rates.[1]

A major variable in any Public Option scenario is provider reimbursement. Any changes in professional and / or facility reimbursement have significant cost implications. Since the text of the bill did not define "provider," we assumed a broad definition of the word. Given that broadest possible definition of the word "provider," our analysis assumed changes in both professional and facility reimbursement.

On October 7, 2019 and concurrently with finalizing our report, the Colorado Department of Regulatory Agencies and the Colorado Department of Health Care Policy and Financing released their joint report on a Public Option (the joint report).[2] *The analysis in the joint report assumes that only facility reimbursement will be reduced in order to achieve the desired rate impacts. By contrast, our analysis assumes that both professional and facility reimbursement levels would be modified in order to obtain the needed premium rates for the Public Option to be competitive.*

Despite this key difference, we present our analysis in full, under our original assumption, using a provider reimbursement structure that includes changes to both facility and professional providers. While this difference is significant, the overall conclusions drawn related to market impacts are still directionally consistent. Where they are not comparable, however, is in terms of premium rate impact. To facilitate cleaner comparisons between our report and the joint report, we have calculated two scenarios that assume only facility reimbursement is affected in addition to our original four scenarios that assume both facility and professional are affected.

MILLIMAN AND JOINT REPORT PROVIDER REIMBURSEMENT ASSUMPTIONS

- In order to achieve meaningfully lower consumer-facing prices in the individual market for non-subsidized consumers, a Public Option includes mandated reimbursement for facility and professional providers (or for just facilities alone, as in the joint report) that is lower than what underlies current Connect for Health Colorado (CFHC) participating plan offerings. In particular, the *provider payment level for a Public Option would need to be lower than payment levels underlying the current second-lowest-cost silver (SLCS) plan on Connect for Health Colorado (CFHC).*

- There are significantly different reimbursement-related assumptions made between the analyses in our report versus the joint report, specifically:

  - The joint report assumes that facility reimbursement is at a uniform percentage of Medicare across the entire state. Our analysis, based on Milliman research, assumes that there are material variations by geographical region.

  - The joint report assumes a reimbursement level as a percentage of Medicare of 289%[3], which is much higher than what we assume currently underlies premium rates on CFHC, and in particular, for the second lowest cost silver plan.

In Figure 1 we detail these assumptions for current reimbursement for five representative counties compared to the state-wide assumption used in the joint report.

FIGURE 1: COMPARISON OF ASSUMED PREVAILING REIMBURSMENT MILLIMAN VS. STATE REPORT ANALSYSIS

	MILLIMAN REIMBURSEMENT ASSUMPTIONS BY CLAIM TYPE AND COUNTY, PERCENTAGE OF MEDCIARE BASIS			
County	**INPATIENT**	**OUTPATIENT**	**PROFESSIONAL**	**TOTAL**
Boulder	142%	142%	120%	134%
Denver	130%	167%	116%	138%
Larimer	208%	246%	120%	189%
Mesa	214%	241%	140%	196%
Gunnison	216%	345%	180%	250%
State Report	289%	289%	NA	NA

[1] https://leg.colorado.gov/sites/default/files/documents/2019A/bills/2019a_1004_01.pdf Section1 (4)(a) & (b)
[2] Colorado Department of Regulatory Agencies & Colorado Department of Health Care Policy and Financing (October 7, 2019). DRAFT Report for Colorado's State Coverage Option. Retrieved October 17, 2019, from http://www.colorado.gov/pacific/sites/default/files/HB19-1004%20Draft%20Report%20Colorado%20State%20Coverage%20Option%20and%20Appendix.pdf.
[3] Ibid.

As Figure 1 shows, our research indicates that significantly lower reimbursement currently exists in highly populated and competitive counties such as Boulder and Denver. Reimbursement is higher in rural counties for facilities, but is generally still lower than 289%. *The difference in overall reimbursement and the material variations by geography lead to very different projections of premium savings coming from a Public Option.*

MILLIMAN AND JOINT REPORT PUBLIC OPTION PREMIUM SAVINGS IMPACTS FROM PROVIDER REIMBURSEMENT ASSUMPTIONS

- The impacts of provider reimbursement assumptions on the estimated premium savings of a Public Option relative to the SLCS are illustrated in Figure 2 below[4].

FIGURE 2: COMPARISON OF PREMIUM SAVINGS FROM PUBLIC OPTION

	MILLIMAN ANALYSIS						JOINT REPORT	
	FACILITY AND PROFESSIONAL AT MEDICARE %				FACILITY ONLY AT MEDICARE %		FACILITY ONLY AT MEDICARE %	
County	SCENARIO A 180% OF MEDICARE	SCENARIO B 150% OF MEDICARE	SCENARIO C 120% OF MEDICARE	SCENARIO D 100% OF MEDICARE	SCENARIO E 225% OF MEDICARE	SCENARIO F 175% OF MEDICARE	225% OF MEDICARE	175% OF MEDICARE
Boulder	21.7%	5.6%	-9.6%	-19.1%	25.7%	9.5%	NA	NA
Denver	22.8%	5.8%	-10.2%	-20.3%	25.9%	8.5%	NA	NA
Larimer	-4.9%	-18.1%	-30.8%	-39.0%	-1.5%	-15.2%	NA	NA
Mesa	-8.1%	-20.1%	-31.6%	-39.0%	-1.4%	-15.6%	NA	NA
Gunnison	-25.0%	-35.1%	-44.6%	-50.7%	-12.4%	-22.8%	NA	NA
Composite	**12.9%**	**-2.5%**	**-17.0%**	**-26.3%**	**16.8%**	**1.0%**	**-9.6%**	**-18.2%**

Scenarios A through D shown in Figure 2 assume that both professional and facility reimbursement are at the percent of Medicare level indicated. In high-density population areas such as Denver and Boulder, which are competitive markets with five or six carriers offering coverage on CFHC, we estimate current reimbursement for the SLCS to be much lower than in rural counties, which leads to smaller premium savings and, under scenarios A & B, premium rates actually above the current SLCS. *Thus our analysis indicates that a Public Option may bring little to no price relief to a large portion of Colorado consumers (those residing in urban areas) even when reimbursement as low as 120% of Medicare applies to both facility and professional providers.*

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In summary, we find that the ability of the Public Option to provide lower prices for Coloradans purchasing coverage on CFHC, particularly the unsubsidized, is highly dependent on three factors:

- the actual level of reimbursement that currently exists for the SLCS,
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- Current carriers (or potential new entrants) may not be able to obtain the same reimbursement terms on non-Public Option offerings as those related to Public Option plans, making a private carrier's CFHC non-Public Option offerings uncompetitive (and possibly irrelevant). This is particularly true after considering the effect of federal premium subsidies on a consumer's net premium. Depending on the degree of price advantage held by a Public Option, individual carriers may be forced to participate in the Public Option program or simply exit the individual ACA-compliant market, thereby accomplishing the opposite effect intended and actually decreasing carrier competition and consumer choice. The leveraged impact of the introduction of a lower priced Public Option on post-subsidy premiums is illustrated in Figure 3 for a single 40-year-old with income equivalent to 150% Federal Poverty Level (FPL).

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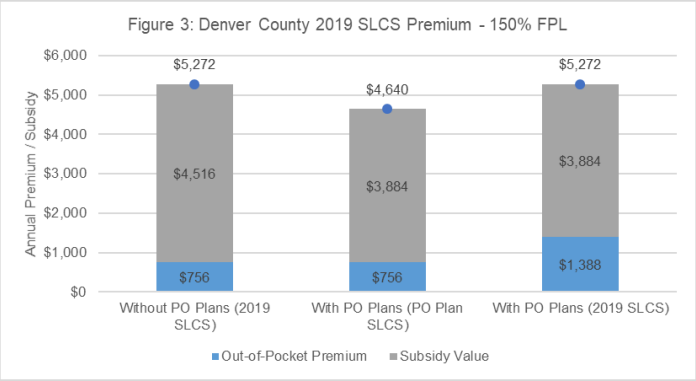

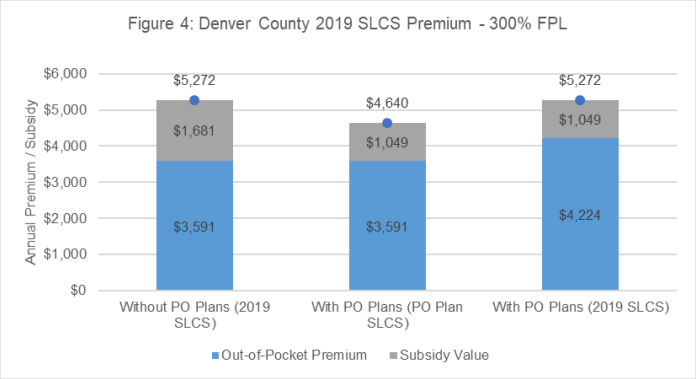

In this example, the introduction of Public Option plan causes the gross annual premium for a 40 year old for the SLCS plan to decrease by 12% ($5,272 to $4,640). The person can switch to the Public Option (middle column), with the net out-of-pocket annual premium remaining at $756. However, to the extent the person wanted to stay on the same plan (right column), then the annual out-of-pocket premium increases from $756 to $1,388, an *84% increase*. This effect is the result of the premium subsidy value decreasing from $4,516 to $3,884, which in turn is a result of the Public Option becoming the SLCS.

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Therefore, under a Public Option, a subsidized person will see no reduction in out-of-pocket premiums and must pay substantially higher out-of-pocket premiums to remain in their same plan.

The market dynamics illustrated in Figures 3 and 4 are magnified in regions where there is potentially a larger spread between existing plans and Public Option premiums. As Figure 2 illustrates, estimated current provider reimbursement in rural areas is higher relative to urban areas; therefore, it is projected that a Public Option (assuming uniform, statewide reimbursement levels are implemented) would have a larger price advantage to existing CFHC plans in rural areas and, therefore, a heavy post-subsidy leveraging effect on out-of-pocket premiums. Corresponding out-of-pocket increases for 150% of FPL and 300% of FPL for high cost rural areas are 218% and 46%, assuming those consumers want to keep their current plan.

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- Just over 50% of Coloradans receive their healthcare coverage through employer-sponsored plans. This is the largest single share of healthcare coverage by market (Medicaid is second, covering approximately 21% of the State of Colorado's population). Depending on reimbursement level and geography, a Public Option could have premium rates that employers currently offering traditional group coverage might find attractive.

  Assuming eligibility for a Public Option would include employees currently covered under employer-sponsored plans, significant migration to the Public Option might occur under certain scenarios. Along with attractive prices, the availability of tax-favored vehicles, such as the Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) and the Integrated Individual Health Reimbursement Arrangement (IIHRA) allows employers to fund premium payments for individual health insurance coverage. That could make an employer's decision to fund coverage on CFHC in lieu of a traditional plan much easier. This migration from group segments (small group, large group insured, and self-funded) could increase if product features such as an adequate provider network are satisfactory to employers.

EFFECTS ON COLORADO'S PROVIDER COMMUNITY

- A potentially large membership movement from both the individual and group markets to a Public Option with materially lower provider reimbursement is possible, depending on the Public Option's price. Because of the size of employer group segment (50% of Coloradans), small percentage movements in this segment can have large impacts on Public Option enrollment. The movement of members to a Public Option is anticipated to have at least two effects.

  First, because the cost of the competitive advantage obtained by a Public Option is borne entirely by the provider community, movement to it will reduce provider revenue for each individual purchaser or employee who chooses it.

  Figure 5 illustrates the interplay between lower premium rates, higher enrollment, and reduced provider reimbursement. In short, the relationship becomes nonlinear as each effect compounds the other. For example, under the 150% of Medicare scenario, enrollment is modest at approximately 250,000 and a reduction in provider revenue is seen of slightly above $63 million. However, under the 120% of Medicare scenario, enrollment nearly doubles in the Public Option, but provider revenue losses increase nearly ninefold (from a loss of $63 million to $578 million).

  Second, in response to revenue pressures, providers could react in a variety of ways and most likely in a combination of ways. These potential reactions include (but are not limited to):

- Choosing not to contract with the Public Option, depending on the level of reimbursement. This could cause network adequacy challenges and result in access issues for Public Option enrollees.

- Changing patient mix, accepting fewer patients with lower reimbursement coverage, such as Medicaid patients. This will cause access issues for the affected populations.

- Contracting with the Public Option but attempting to increase revenues on other commercial contracts they may have with payers (cost shifting). Figure 5 shows the impact to commercial contracts under various reimbursement levels (in the "Cost Shift to Commercial Group" line) if providers were able to shift *all* of the costs of the Public Option revenue loss to those contracts.

- **FIGURE 5: ESTIMATED PUBLIC OPTION MEMBERSHIP, PROVIDER REVENUE IMPACT, AND COST SHIFTING**

	LEVEL OF PROVIDER REIMBURSEMENT FOR PUBLIC OPTION			
SCENARIO	**SCENARIOS A 180%OF MEDICARE**	**SCENARIOS B 150% OF MEDICARE**	**SCENARIO C 120% OF MEDICARE**	**SCENARIO D 100% OF MEDICARE**
PUBLIC OPTION MEMBERSHIP	31,200	249,600	466,000	619,900
PROVIDER REVENUE CHANGE $ (MILLIONS)	$116	-$63	-$578	-$1,115
PROVIDER REVENUE CHANGE %	0.4%	-0.2%	-1.9%	-3.7%
COST SHIFT TO COMMERCIAL GROUP	-0.8%	0.5%	4.3%	8.7%

As an example, if providers under a Public Option were to accept 120% of Medicare state-wide *and* attempted to recoup all the lost revenue of the 466,000 enrollees by cost shifting to commercial payer contracts, they would need to increase reimbursement levels by 4.3% on the remaining commercial group coverage to be made whole.

Providers could also respond to lower revenues by changing patient mix. One example of this might be by accepting fewer Medicaid patients. Finally, providers could employ a combination of the various strategies mentioned above, improving their efficiency, increasing patient volume, and / or merging with another provider. In extreme cases, physicians may also choose to retire and exit private practice, or close their independent practices and work for a health system.

UNIQUE CONSIDERATIONS FOR RURAL COUNTIES

- HB19-1004 notes specifically the lack of carrier choice in the individual market in 14 Colorado counties. These counties also typically have much higher premium rates due to a combination of lower provider competition (i.e., a single hospital or health system serves the area) and minimal carrier competition.[5] One of the purposes stated for considering a Public Option in the bill is to address these specific issues. As shown in Figure 3 above, rural areas could see significant premium rate relief under a Public Option. However, this price relief comes at the cost of reduced reimbursement to providers (professional and facility) that may be already financially stressed.[6,7]

- Additional financial stress of lower provider reimbursement may induce provider consolidation or even closing of facilities.[8] These actions may exacerbate access issues for rural patients.

- Finally, overall carrier competition in the State of Colorado, as noted above, may not be enhanced with a Public Option. If a private carrier is competing against a Public Option that has a competitive advantage (legislatively mandated lower reimbursement) that it may not be able to match, it may not make business sense to continue offering coverage in that county. The exit of that carrier would leave the county with a single carrier again,[9] but this time it would be the Public Option, which given its lower reimbursement, may or may not have been successful at contracting an adequate network.

OTHER POLICY OPTIONS

Our review of various policy alternatives finds that there are other available options that could be more efficient means to reducing prices in the individual market, particularly for those above 400% FPL. Although a Public Option could set eligibility standards that would allow current employer group members to enroll and employers might benefit from moving employees to the Public Option, current reform strategies, including a Public Option, are largely targeted at the *unsubsidized, individual market*. The individual market is only about 3.8% of Colorado's 2019 health benefits marketplace and the unsubsidized portion is even smaller (approximately 105,000 persons or less than 2% of the State of Colorado's total population). Geographically, the current market challenges lie predominantly in rural regions that are not densely populated, and have limited carrier and healthcare delivery system competition.

[5] See Appendix B of the full report for rates by geographic region and carrier counts.
[6] National Rural Health Association. Advocacy: NRHA Save Rural Hospitals Action Center. Retrieved October 9, 2019, from https://www.ruralhealthweb.org/advocate/save-rural-hospitals.
[7] U.S. Senate Committee on Finance (May 24, 2018). Statement of Konnie Martin: "Rural Health Care in America: Challenges and Opportunities." Retrieved October 9, 2019, from https://www.finance.senate.gov/imo/media/doc/24MAY2018MartinSTMNT.pdf.
[8] Ingold, J. (July 4, 2017). In Colorado's drumbeat of medical mergers, rural hospitals often trade independence for better care. Denver Post. Retrieved October 9, 2019, from https://www.denverpost.com/2017/07/04/colorado-rural-hospitals-merge-with-big-city-health-economic-concerns/.
[9] Colorado currently has 14 one-carrier counties. Please see Appendix B for more information.

Thus, it is important to consider the potentially broad ramifications of an ambitious proposal that is intended to primarily benefit a relatively small sub-segment of the population.

Hence, the discussion of more targeted and efficient solutions to improve Colorado's individual health insurance market relative to a Public Option may include:

- *A state-based program that extends subsidies based on income beyond the federal limit of 400% FPL*. This would not require a 1332 Waiver and could be built off of existing CFHC infrastructure. It can be designed to achieve the same effect as a reinsurance program or Public Option in terms of net premium decreases. Finally, it can eliminate the subsidy cliff that exists at 400% FPL.

  If implemented in lieu of an existing reinsurance program, state-based subsidies eliminate the structural weaknesses that may be inherent in reinsurance programs (such as high-cost carriers receiving disproportionate shares of program funding and duplicative payment by the federal risk adjustment). State-based subsidies could also complement a reinsurance program, achieving even greater out-of-pocket premium rate reductions for targeted populations.

- *A per member per month (PMPM) or flat percentage market subsidy.* These types of market subsidies (received by carriers) can achieve the same price reductions as a Public Option (or reinsurance program), but reduce or eliminate the potential high-cost carrier bias and overpayment issue (double payment by risk adjustment and reinsurance) that are both inherent to a reinsurance program. A market subsidy is much easier to implement than a Public Option and can build off the existing reinsurance infrastructure. Like state-based subsidies, these options can be implemented in lieu of a reinsurance program or as a complementary program.

- *Enhancing the reinsurance program*. A Public Option would be a large investment for the State of Colorado, with both business and insurance risks associated with it. For example, a stand-alone, risk-bearing Public Option entity would have significant startup costs, ongoing and likely increasing capital needs, and other associated expenses. Moreover, it is not entirely clear that a Public Option would achieve the desired policy ends without significant drawbacks. These same funds could be used more efficiently and with less risk to the State of Colorado by simply increasing the funding and, therefore, the rate impact of Colorado's reinsurance program.

  These policy options also come with the additional advantage that there is either no need of a 1332 Waiver to reclaim savings (state-based subsidies) or a low risk of not getting an application approved (reinsurance or market subsidy). Yet these policy options can have virtually the same effects on consumer premiums as a Public Option, without the potential detrimental effect on consumer choice.

  The full report can be found at: http://www.milliman.com/insight/2019/Evaluation-of-a-Colorado-Public-Option/

CAVEATS AND LIMITATIONS

The services provided for this report were performed under the Consulting Services Agreement between Milliman Inc. (Milliman) and the Kaiser Foundation Health Plan dated August 1, 2019. Kaiser Permanente is the organization's trade name.

The information contained in this report has been prepared for the Kaiser Permanente to provide data and analysis related to the evaluation of potential health benefits market impacts from the introduction of a Public Option in Colorado. The data and information presented may not be appropriate for any other purpose.

It is our understanding that the information contained in this report could be released publicly in summary form. Any distribution of the summary information should be done so in conjunction with access to the full report. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for Kaiser Foundation Health Plan by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about the premium rates, insurance market population estimates, trend rates, and other assumptions.

Milliman has relied upon certain data and information that is publicly available from the Connect for Health Colorado, Colorado Insurance Commissioner, and the Centers for Medicare and Medicaid Services (CMS). Additionally, we relied on statutory financial statement information downloaded from S&P Global Market Intelligence (formerly SNL Financial). Milliman has relied upon these third parties for the accuracy of the data and accepted it without audit. To the extent that the data provided are not accurate, the estimates provided in this report would need to be modified to reflect revised information.

It should be noted that there is significant uncertainty surrounding future enrollment and premiums in health benefits programs, particularly the individual market. Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

Contact:

Fritz Busch, FSA, MAAA
fritz.busch@milliman.com

Paul Houchens, FSA, MAAA
paul.houchens@milliman.com

MILLIMAN REPORT

Evaluation of a Colorado Public Option

Prepared for the Kaiser Permanente

October 21, 2019

Fritz Busch, Consulting Actuary, FSA, MAAA
Paul Houchens, Principle and Consulting Actuary, FSA, MAAA

Milliman

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APPENDIX A: LEGISLATIVE BACKGROUND FOR PUBLIC OPTION STUDY IN COLORADO

APPENDIX B: CARRIER PARTICIPATION HISTORY AND COLORADO RATE INCREASE

1. EXECUTIVE SUMMARY

Kaiser Permanente (Kaiser) engaged Milliman to assist in analyzing various aspects of the potential introduction of a Public Option in Colorado. In determining the scope, methodology and assumptions for our analysis, we relied in part on the text of Colorado HB19-1004 which laid out the public policy objectives and analysis requirements of a state-sponsored proposal that outlines the most effective implementation of Public Option in Colorado. One of those objectives was to estimate premium rates under a Public Option and the required provider reimbursement levels required underlying those rates.[1]

A major variable in any Public Option scenario is provider reimbursement. Any changes in professional and / or facility reimbursement have significant cost implications. Since the text of the bill did not define "provider," we assumed a broad definition of the word. Given that broadest possible definition of the word "provider," our analysis assumed changes in both professional and facility reimbursement.

On October 7, 2019 and concurrently with finalizing our report, the Colorado Department of Regulatory Agencies and the Colorado Department of Health Care Policy and Financing released their joint report on a Public Option (the joint report).[2] *The analysis in the joint report assumes that only facility reimbursement will be reduced in order to achieve the desired rate impacts. By contrast, our analysis assumes that both professional and facility reimbursement levels would be modified in order to obtain the needed premium rates for the Public Option to be competitive.*

Despite this key difference, we present our analysis in full, under our original assumption, using a provider reimbursement structure that includes changes to both facility and professional providers. While this difference is significant, the overall conclusions drawn related to market impacts are still directionally consistent. Where they are not comparable, however, is in terms of premium rate impact. To facilitate cleaner comparisons between our report and the joint report, we have calculated two scenarios that assume only facility reimbursement is affected in addition to our original four scenarios that assume both facility and professional are affected.

MILLIMAN AND JOINT REPORT PROVIDER REIMBURSEMENT ASSUMPTIONS

- In order to achieve meaningfully lower consumer-facing prices in the individual market for non-subsidized consumer, a Public Option includes mandated reimbursement for facility and professional providers (or for just facilities alone, as in the joint report) that is lower than what underlies current Connect for Health Colorado (CFHC) participating plan offerings. In particular, the *provider payment level for a Public Option would need to be lower than payment levels underlying the current second-lowest-cost silver (SLCS) plan on Connect for Health Colorado (CFHC).*

- There are significantly different reimbursement-related assumptions made between the analyses in our report versus the joint report, specifically:

  - The joint report assumes that facility reimbursement is at a uniform percentage of Medicare across the entire state. Our analysis, based on Milliman research, assumes that there are material variations by geographical region.

  - The joint report assumes a reimbursement level as a percentage of Medicare of 289%[3], which is much higher than what we assume currently underlies premium rates on CFHC, and in particular, for the second lowest cost silver plan.

In Figure 1 we detail these assumptions for current reimbursement for five representative counties compared to the state-wide assumption used in the joint report.

FIGURE 1: COMPARISON OF ASSUMED PREVAILING REIMBURSMENT LEVELS IN MILLIMAN VS. STATE REPORT ANALYSIS

	MILLIMAN REIMBURSEMENT ASSUMPTIONS BY CLAIM TYPE AND COUNTY, PERCENTAGE OF MEDCIARE BASIS			
County	**INPATIENT**	**OUTPATIENT**	**PROFESSIONAL**	**TOTAL**
Boulder	142%	142%	120%	134%
Denver	130%	167%	116%	138%
Larimer	208%	246%	120%	189%

[1] https://leg.colorado.gov/sites/default/files/documents/2019A/bills/2019a_1004_01.pdf Section1 (4)(a) & (b)

[2] Colorado Department of Regulatory Agencies & Colorado Department of Health Care Policy and Financing (October 7, 2019). DRAFT Report for Colorado's State Coverage Option. Retrieved October 17, 2019, from http://www.colorado.gov/pacific/sites/default/files/HB19-1004%20Draft%20Report%20Colorado%20State%20Coverage%20Option%20and%20Appendix.pdf.

[3] Ibid.

Mesa	214%	241%	140%	196%
Gunnison	216%	345%	180%	250%
State Report	289%	289%	NA	NA

As Figure 1 shows, our research indicates that significantly lower reimbursement currently exists in highly populated and competitive counties such as Boulder and Denver. Reimbursement is higher in rural counties for facilities, but is generally still lower than 289%. *The difference in overall reimbursement and the material variations by geography lead to very different projections of premium savings coming from a Public Option.*

MILLIMAN AND JOINT REPORT PUBLIC OPTION PREMIUM SAVINGS IMPACTS FROM PROVIDER REIMBURSEMENT ASSUMPTIONS

- The impacts of provider reimbursement assumptions on the estimated premium savings of a Public Option relative to the SLCS are illustrated in Figure 2 below[4].

FIGURE 2: COMPARISON OF PREMIUM SAVINGS FROM PUBLIC OPTION

	MILLIMAN ANALYSIS						JOINT REPORT	
	FACILITY AND PROFESSIONAL AT MEDICARE %				FACILITY ONLY AT MEDICARE %		FACILITY ONLY AT MEDICARE %	
County	**SCENARIO A 180% OF MEDICARE**	**SCENARIO B 150% OF MEDICARE**	**SCENARIO C 120% OF MEDICARE**	**SCENARIO D 100% OF MEDICARE**	**SCENARIO E 225% OF MEDICARE**	**SCENARIO F 175% OF MEDICARE**	**225% OF MEDICARE**	**175% OF MEDICARE**
Boulder	21.7%	5.6%	-9.6%	-19.1%	25.7%	9.5%	NA	NA
Denver	22.8%	5.8%	-10.2%	-20.3%	25.9%	8.5%	NA	NA
Larimer	-4.9%	-18.1%	-30.8%	-39.0%	-1.5%	-15.2%	NA	NA
Mesa	-8.1%	-20.1%	-31.6%	-39.0%	-1.4%	-15.6%	NA	NA
Gunnison	-25.0%	-35.1%	-44.6%	-50.7%	-12.4%	-22.8%	NA	NA
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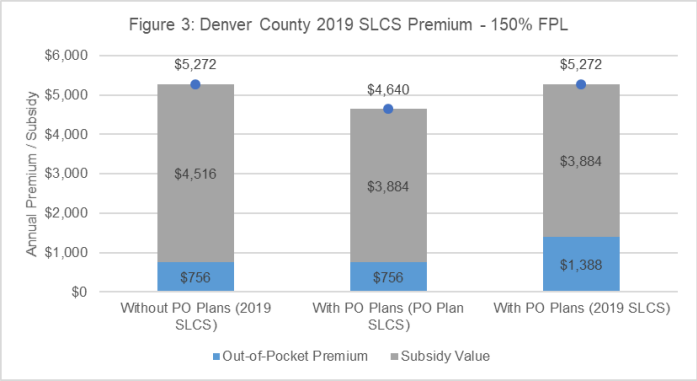
- Current carriers (or potential new entrants) may not be able to obtain the same reimbursement terms on non-Public Option offerings as those related to Public Option plans, making a private carrier's CFHC non-Public Option offerings uncompetitive (and possibly irrelevant). This is particularly true after considering the effect of federal premium subsidies on a consumer's net premium. Depending on the degree of price advantage held by a Public Option, individual carriers may be forced to participate in the Public Option program or simply exit the individual ACA-compliant market, thereby accomplishing the opposite effect intended and actually decreasing carrier competition and consumer choice. The leveraged impact of the introduction of a lower priced Public Option on post-subsidy premiums is illustrated in Figure 3 for a single 40-year-old with income equivalent to 150% Federal Poverty Level (FPL).



In this example, the introduction of Public Option plan causes the gross annual premium for a 40 year old for the SLCS plan to decrease by 12% ($5,272 to $4,640). The person can switch to the Public Option (middle column), with the net out-of-pocket annual premium remaining at $756. However, to the extent the person wanted to stay on the same plan (right column), then the annual out-of-pocket premium increases from $756 to $1,388, an *84% increase*. This effect is the result of the premium subsidy value decreasing from $4,516 to $3,884, which in turn is a result of the Public Option becoming the SLCS.

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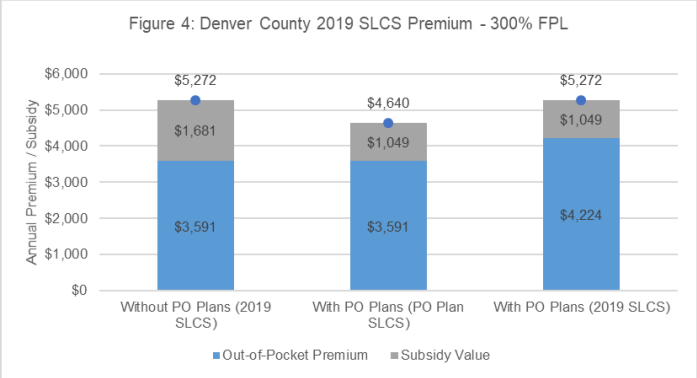

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- We assume that a Public Option would be a qualified health plan (QHP) offered on CFHC. Given the price sensitivity of individual consumers and their acclimation to narrow network products already common on CFHC, the movement to a lower-priced Public Option would make the most economic sense. A large share of the individual market would likely switch to a Public Option under several of the price scenarios we modeled, especially given the leveraged post-subsidy rate increases consumers would experience if they do not switch.

- Just over 50% of Coloradans receive their healthcare coverage through employer-sponsored plans. This is the largest single share of healthcare coverage by market (Medicaid is second, covering approximately 21% of the State of Colorado's population). Depending on reimbursement level and geography, a Public Option could have premium rates that employers currently offering traditional group coverage might find attractive.

  Assuming eligibility for a Public Option would include employees currently covered under employer-sponsored plans, significant migration to the Public Option might occur under certain scenarios. Along with attractive prices, the availability of tax-favored vehicles, such as the Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) and the Integrated Individual Health Reimbursement Arrangement (IIHRA) allows employers to fund premium payments for individual health insurance coverage. That could make an employer's decision to fund coverage on CFHC in lieu of a traditional plan much easier. This migration from group segments (small group, large group insured, and self-funded) could increase if product features such as an adequate provider network are satisfactory to employers.

EFFECTS ON COLORADO'S PROVIDER COMMUNITY

- A potentially large membership movement from both the individual and group markets to a Public Option with materially lower provider reimbursement is possible, depending on the Public Option's price. Because of the size of employer group segment (50% of Coloradans), small percentage movements in this segment can have large impacts on Public Option enrollment. The movement of members to a Public Option is anticipated to have at least two effects.

  First, because the cost of the competitive advantage obtained by a Public Option is borne entirely by the provider community, movement to it will reduce provider revenue for each individual purchaser or employee who chooses it.

  Figure 5 illustrates the interplay between lower premium rates, higher enrollment, and reduced provider reimbursement. In short, the relationship becomes nonlinear as each effect compounds the other. For example, under the 150% of Medicare scenario, enrollment is modest at approximately 250,000 and a reduction in provider revenue is seen of slightly above $63 million. However, under the 120% of Medicare scenario, enrollment nearly doubles in the Public Option, but provider revenue losses increase nearly ninefold (from a loss of $63 million to $578 million).

  Second, in response to revenue pressures, providers could react in a variety of ways and most likely in a combination of ways. These potential reactions include (but are not limited to):

  - Choosing not to contract with the Public Option, depending on the level of reimbursement. This could cause network adequacy challenges and result in access issues for Public Option enrollees.

  - Changing patient mix, accepting fewer patients with lower reimbursement coverage, such as Medicaid patients. This will cause access issues for the affected populations.

  - Contracting with the Public Option but attempting to increase revenues on other commercial contracts they may have with payers (cost shifting). Figure 5 shows the impact to commercial contracts under various reimbursement levels (in the "Cost Shift to Commercial Group" line) if providers were able to shift *all* of the costs of the Public Option revenue loss to those contracts.

FIGURE 5: ESTIMATED PUBLIC OPTION MEMBERSHIP, PROVIDER REVENUE IMPACT, AND COST SHIFTING

	LEVEL OF PROVIDER REIMBURSEMENT FOR PUBLIC OPTION			
SCENARIO	**SCENARIOS A** 180%/175% OF MEDICARE	**SCENARIOS B** 150% OF MEDICARE	**SCENARIO (C)** 120% OF MEDICARE	**SCENARIO (D)** 100% OF MEDICARE
PUBLIC OPTION MEMBERSHIP	31,200	249,600	466,000	619,900
PROVIDER REVENUE CHANGE $ (MILLIONS)	$116	-$63	-$578	-$1,115
PROVIDER REVENUE CHANGE %	0.4%	-0.2%	-1.9%	-3.7%
COST SHIFT TO COMMERCIAL GROUP	-0.8%	0.5%	4.3%	8.7%

As an example, if providers under a Public Option were to accept 120% of Medicare state-wide *and* attempted to recoup all the lost revenue of the 466,000 enrollees by cost shifting to commercial payer contracts, they would need to increase reimbursement levels by 4.3% on the remaining commercial group coverage to be made whole.

Providers could also respond to lower revenues by changing patient mix. One example of this might be by accepting fewer Medicaid patients. Finally, providers could employ a combination of the various strategies mentioned above, improving their efficiency, increasing patient volume, and / or merging with another provider. In extreme cases, physicians may also choose to retire and exit private practice, or close their independent practices and work for a health system.

UNIQUE CONSIDERATIONS FOR RURAL COUNTIES

- HB19-1004 notes specifically the lack of carrier choice in the individual market in 14 Colorado counties. These counties also typically have much higher premium rates due to a combination of lower provider competition (i.e., a single hospital or health system serves the area) and minimal carrier competition.[5] One of the purposes stated for considering a Public Option in the bill is to address these specific issues. As shown in Figure 3 above, rural areas could see significant premium rate relief under a Public Option. However, this price relief comes at the cost of reduced reimbursement to providers (professional and facility) that may be already financially stressed.[6,7]

- Additional financial stress of lower provider reimbursement may induce provider consolidation or even closing of facilities.[8] These actions may exacerbate access issues for rural patients.

- Finally, overall carrier competition in the State of Colorado, as noted above, may not be enhanced with a Public Option. If a private carrier is competing against a Public Option that has a competitive advantage (legislatively mandated lower reimbursement) that it may not be able to match, it may not make business sense to continue offering coverage in that county. The exit of that carrier would leave the county with a single carrier again,[9] but this time it would be the Public Option, which given its lower reimbursement, may or may not have been successful at contracting an adequate network.

OTHER POLICY OPTIONS

Our review of various policy alternatives finds that there are other available options that could be more efficient means to reducing prices in the individual market, particularly for those above 400% FPL. Although a Public Option could set eligibility standards that would allow current employer group members to enroll and employers might benefit from moving employees to the Public Option, current reform strategies, including a Public Option, are largely targeted at the *unsubsidized, individual market*. The individual market is only about 3.8% of Colorado's 2019 health benefits marketplace and the unsubsidized portion is even smaller (approximately 105,000 persons or less than 2% of the State of Colorado's total population). Geographically, the current market challenges lie predominantly in rural regions that are not densely populated, and have limited carrier and healthcare delivery system competition.

[5] See Appendix B of the full report for rates by geographic region and carrier counts.

[6] National Rural Health Association. Advocacy: NRHA Save Rural Hospitals Action Center. Retrieved October 9, 2019, from https://www.ruralhealthweb.org/advocate/save-rural-hospitals.

[7] U.S. Senate Committee on Finance (May 24, 2018). Statement of Konnie Martin: "Rural Health Care in America: Challenges and Opportunities." Retrieved October 9, 2019, from https://www.finance.senate.gov/imo/media/doc/24MAY2018MartinSTMNT.pdf.

[8] Ingold, J. (July 4, 2017). In Colorado's drumbeat of medical mergers, rural hospitals often trade independence for better care. Denver Post. Retrieved October 9, 2019, from https://www.denverpost.com/2017/07/04/colorado-rural-hospitals-merge-with-big-city-health-economic-concerns/.

[9] Colorado currently has 14 one-carrier counties. Please see Appendix B for more information.

Thus, it is important to consider the potentially broad ramifications of an ambitious proposal that is intended to primarily benefit a relatively small sub-segment of the population.

Hence, the discussion of more targeted and efficient solutions to improve Colorado's individual health insurance market relative to a Public Option may include:

- *A state-based program that extends subsidies based on income beyond the federal limit of 400% FPL*. This would not require a 1332 Waiver and could be built off of existing CFHC infrastructure. It can be designed to achieve the same effect as a reinsurance program or Public Option in terms of net premium decreases. Finally, it can eliminate the subsidy cliff that exists at 400% FPL.

  If implemented in lieu of an existing reinsurance program, state-based subsidies eliminate the structural weaknesses that may be inherent in reinsurance programs (such as high-cost carriers receiving disproportionate shares of program funding and duplicative payment by the federal risk adjustment). State-based subsidies could also complement a reinsurance program, achieving even greater out-of-pocket premium rate reductions for targeted populations.

- *A per member per month (PMPM) or flat percentage market subsidy.* These types of market subsidies (received by carriers) can achieve the same price reductions as a Public Option (or reinsurance program), but reduce or eliminate the potential high-cost carrier bias and overpayment issue (double payment by risk adjustment and reinsurance) that are both inherent to a reinsurance program. A market subsidy is much easier to implement than a Public Option and can build off the existing reinsurance infrastructure. Like state-based subsidies, these options can be implemented in lieu of a reinsurance program or as a complementary program.

- *Enhancing the reinsurance program*. A Public Option would be a large investment for the State of Colorado, with both business and insurance risks associated with it. For example, a stand-alone, risk-bearing Public Option entity would have significant startup costs, ongoing and likely increasing capital needs, and other associated expenses. Moreover, it is not entirely clear that a Public Option would achieve the desired policy ends without significant drawbacks. These same funds could be used more efficiently and with less risk to the State of Colorado by simply increasing the funding and, therefore, the rate impact of Colorado's reinsurance program.

  These policy options also come with the additional advantage that there is either no need of a 1332 Waiver to reclaim savings (state-based subsidies) or a low risk of not getting an application approved (reinsurance or market subsidy). Yet these policy options can have virtually the same effects on consumer premiums as a Public Option, without the potential detrimental effect on consumer choice.

2. INTRODUCTION AND BACKGROUND

Kaiser Permanente (Kaiser) has engaged Milliman to assist in analyzing various aspects of the potential introduction of a Public Option in Colorado as well as other possible state reform strategies. Based upon legislation passed and the study mandate described therein,[10] the State of Colorado is interested in understanding whether a Public Option could remediate dysfunctions found in the individual market, most notably 1) the lack of carrier competition in rural areas, and 2) high prices (even after the implementation of the reinsurance program in 2020).[11] Specifically, in the unsubsidized portion of the individual market, high prices are a particularly acute problem as these consumers are paying the full premium, without any federal premium assistance.

A Public Option, depending on its structure and competitive advantages, could have significant impacts to the individual business of current or prospective carriers in Colorado. Moreover, a Public Option, depending on how eligibility for the program is set, could have secondary effects on other markets, such as the commercial employer-sponsored markets, that may be unintended and undesirable.

The introduction of a Public Option will also affect provider reimbursement and may cause providers to counteract revenue reductions by shifting costs to other payers (e.g., employer-sponsored coverage). It is likely that the Public Option could be backed by a mandated reimbursement level that is significantly lower than prevailing commercial market rates. Coupled with broad eligibility, a hypercompetitive price, and the availability of health reimbursement arrangements (HRAs)—vehicles for paying health insurance premiums with pretax wages—the Public Option could ultimately see significant enrollment that would drive provider revenue down.

Finally, a Public Option could have impacts on the amount of federal premium subsidies available to Colorado residents if offered through Connect for Health Colorado (CFHC). It is possible that the reduced federal outlays for premium subsidies could be returned to the state in the form of pass-through funding from a 1332 Waiver.

However, a Public Option is not the only mechanism for achieving the state's policy ends. There are various other avenues to address these issues, each with its own set of trade-offs that should be considered in the context of evaluating a Public Option.

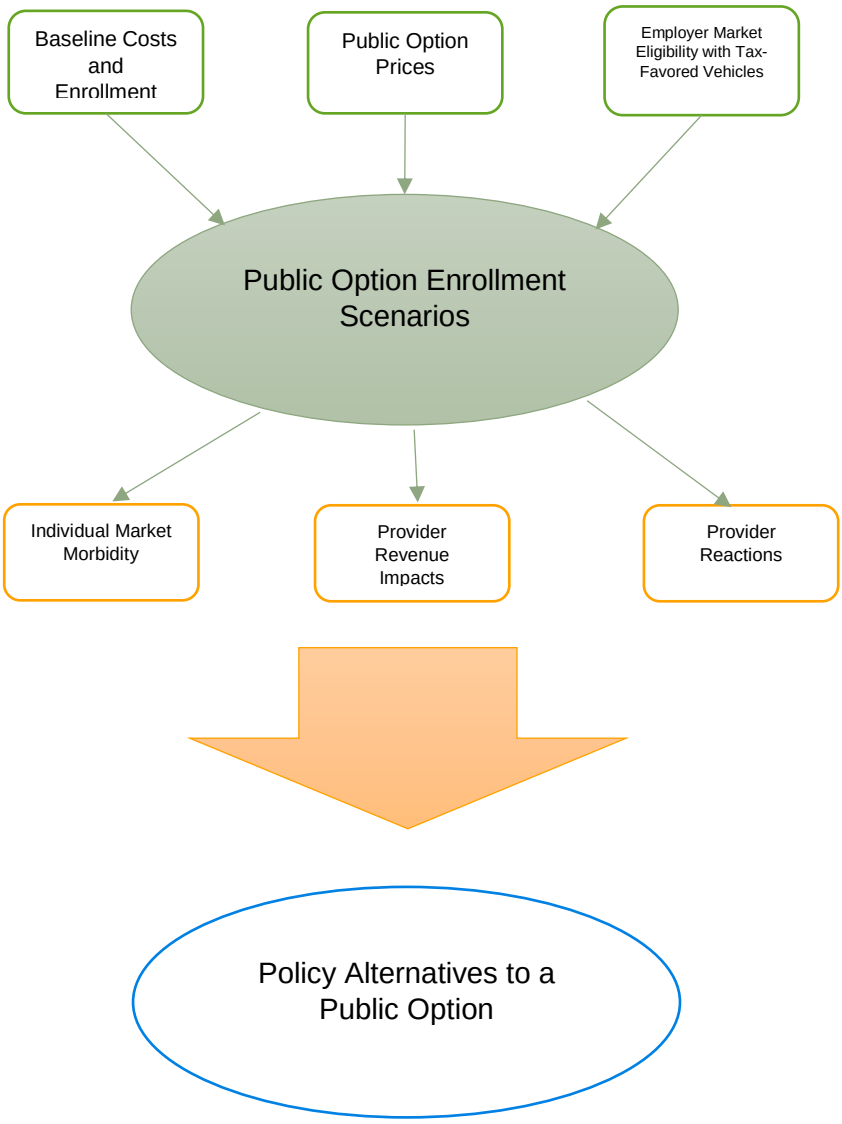
Our report is structured to discuss each of these key features of a Public Option as well as possible alternatives and is outlined below:

- **Establish a baseline scenario for enrollment and costs by market for Colorado in 2019.** This will be used to model two key Public Option features: price and enrollment.
- **Model price scenarios**. Using cost indexes from the baseline analysis and assumptions of reimbursement *levels relative to Medicare, we establish four Public Option price scenarios.*
- **Understand employer market dynamics related to health benefit offerings.** We assume that current members of employer plans would be eligible for Public Option coverage. Therefore, employers' attitudes toward health benefits and any tax-related consequences of health benefits decisions, along with Public Option prices, will have a significant influence on Public Option take-up rates in this large segment of Colorado's health benefits landscape.
- **Model Public Option enrollment scenarios.** Using pricing scenarios and various take-up assumptions from the individual and employer markets, we model four enrollment scenarios that are correlated with price (i.e., higher Public Option price means lower overall enrollment and vice versa).
- **Model impact to provider reimbursement and the potential for cost shifting.** Higher enrollment in the Public Option will put downward pressure on provider revenues. Providers will have various responses to this, including cost shifting to commercial payers. We also model the varying effects of morbidity on the individual pool that may occur as a result of insurance market migration induced by the Public Option.
- **Discuss policy alternatives to Public Option.** Given the various dynamics modeled, alternatives to the Public Option are explored.

[10] See Appendix A for a summary of the key components of the Public Option Study Bill.
[11] See Appendix B for a rate increase history and a carrier participation history.

A diagram of the analysis flow is shown in Figure 6.

FIGURE 6: PUBLIC OPTION IMPACTS ANALYSIS FLOW



3. PUBLIC OPTION[12] HISTORY AND CURRENT STATE-BASED ACTIVITY

The birth of the public option idea traces its development to a California state policy proposal in 2001 through 2002. The goal of the California's "Health Care Options Project," not entirely unlike the goals articulated in the Colorado HB19-004, was to examine options for expanding healthcare coverage in California. The project put forth nine different proposals, including the CHOICE[13] program, which would have created a state-operated insurance option for workers and their dependents, subject to an income-based premium and funded by an assessment on employers for each employee who did not select employer-sponsored coverage.[14] The hope of this proposal, which ultimately was not implemented, was to drive down premiums and lower healthcare costs through an additional competitive option sponsored by the state government.

> Historically, a public option, in its various forms, has sought to utilize government purchasing power in an attempt to increase carrier competition and lower consumer prices.

The public option next emerged as part of the 2008 presidential campaign.[15] A Medicare-based public option that would have utilized a federally run framework was proposed, while John Edwards put forth a health platform that emphasized a state-based public option.[16] As a key element of the healthcare discussion, a *federally run* public option was included in the early versions of the Patient Protection and Affordable Care Act (ACA) and became one of its more controversial elements.[17] The public option was viewed by proponents as a way to increase coverage, limit the growth in healthcare costs, and promote competition by expanding the number of options available to exchange participants.[18] Critics were wary of the ability of the private market to compete with a government-sponsored plan, and worried that this would lead to *reduced competition and innovation* and ultimately higher prices and unsustainable government expenditures.[19] In the end, a lack of support from moderate Democrats led to the removal of a public option from the final version of the ACA, and the public option was again sidelined.[20] Instead, the law contained funding for consumer operated and oriented plans (CO-OPs), which were taxpayer-funded corporations[21] whose goal was to put patients first and focus on ACA-compliant coverage, in essence a privately adminstered but publicly funded option.[22]

At the state level, there has been a much wider variety of activity. The state of Washington passed a public option (Cascade Care) in May 2019, under which the state will select insurers to administer a health plan according to terms established by the state. Cascade Care will have state-determined benefit designs and maximum provider reimbursement levels.

Among states that have not passed legislation, bills for Medicaid buy-in (a form of public option) have been proposed in Maine, Massachusetts, New Jersey, and Oregon. Additionally, Colorado has established a task force to study the issue. Connecticut considered a Washington-style public option, but this bill was opposed by health insurance industry

[12] Note that, when capitalized, "Public Option" will refer specifically to Colorado's proposed program. Without capitalization, it is used generically.
[13] The authors of this proposal did not provide a definition for this acronym, though it appears to have been a reference to Medicare+CHOICE, the name by which the current Medicare Advantage program was known at the time.
[14] Health Access (2002). Health Care Options Project: Nine Options for Health Care Reform in California. Retrieved October 9, 2019, from https://health-access.org/health-care-options-project/.
[15] Health Affairs (June 2010). The Origins and Demise of the Public Option. Retrieved October 9, 2019, from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0363.
[16] Collins, S.R. & Kriss, J.L. (January 2008). Envisioning the Future: The 2008 Presidential Candidates' Health Reform Proposals. Commonwealth Fund. Retrieved October 9, 2019, from https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2008_jan_the_publics_views_on_health_care_reform_in_the_2008_presidential_election_collins_envisioningfuture2008prescandhltreformprop_1092_pdf.pdf.
[17] Washington Post. 8 questions about health-care reform. Retrieved October 9, 2019, from https://www.washingtonpost.com/wp-srv/special/politics/8-questions/.
[18] Reich, R.B. (June 24, 2009). Why we need a public health-care plan. Wall Street Journal. Retrieved October 9, 2019, from https://www.wsj.com/articles/SB124580516633344953.
[19] Cannon, M.F. (August 6, 2009). Fannie Med? Why a "public option" is hazardous to your health. Policy Analysis. Retrieved October 9, 2019, from https://www.cato.org/sites/cato.org/files/pubs/pdf/pa642.pdf.
[20] Health Affairs, Origins and Demise of the Public Option, op cit.
[21] The U.S. Department of Health and Human Services (HHS) awarded $2.4 billion in funding to 23 CO-OPs. Please see https://www.hsgac.senate.gov/imo/media/doc/Majority%20Staff%20Report%20-%20Failure%20of%20the%20Affordable%20Care%20Act%20Health%20Insurance%20CO-OPs.pdf for more information.
[22] Planet Money (September 28, 2009). Podcast: Looking at health care co-ops. NPR. Retrieved October 9, 2019, from https://www.npr.org/sections/money/2009/09/podcast_a_closer_look_at_healt.html.

interests. California, Iowa, Maine, Maryland, Minnesota, Nevada, Wisconsin, and Wyoming have also considered or are considering public option proposals.

OTHER STATE HEALTHCARE REFORM ACTIVITY

As additional background, we note that states have been active with a number of proposals to improve individual market conditions. *All of these proposals share a goal common to the proposed Colorado Public Option, namely that of bringing price relief to the unsubsidized individual market.*

Since 2017, the most popular reform has been the state-based reinsurance program. Under Section 1332 of the ACA, a state can use a state innovation waiver (Section 1332 Waiver) to implement market reforms, to the extent the waiver maintains federal deficit neutrality and does not harm the ACA's insurance coverage improvements. Additionally, to the extent the Section 1332 Waiver reduces federal premium assistance expenditures, a state can receive "pass-through" funding from the federal government for its innovation. As of September 2019, 12 states, including Colorado, have received approval for reinsurance programs via a Section 1332 Waiver, leveraging a variety of funding sources.[23]

The nullification of the individual mandate penalty in 2019 as part of the Tax Cuts and Jobs Act of 2017 led to discussion (and in some cases passage) of state-level health insurance coverage mandates. Massachusetts has had an individual mandate since before the passage of the ACA.[24] California,[25] New Jersey,[26] Rhode Island,[27] Vermont,[28] and Washington, D.C[29].,, have all passed laws establishing their own mandates, with New Jersey and Rhode Island using their mandates to fund their 1332 Waivers. Maryland considered a mandate, but that provision was dropped from a state reform bill.[30]

Another approach that has made some headway is enrollment facilitation via tax returns or means-based programs. Under this reform, states can enroll individuals in Medicaid or proactively reach out to exchange-eligible individuals, simplifying the process of enrolling in health coverage. To date, Maryland has the only program that includes exchange markets,[31] while Louisiana and South Carolina have more limited programs that address likely Medicaid-eligible populations.[32,33]

States have also taken action regarding association health plans (AHP). While federal action on AHPs has met legal opposition, several states have sought to exploit a loophole in the effective rate review program requirements of the Centers for Medicare and Medicaid Services (CMS) that allow for certain self-insured associations to bypass federal restrictions, including Georgia, Iowa, Kansas, Nebraska, and Tennessee. These plans are effectively exempt from many of the ACA's market reforms. AHPs impact the individual market by allowing sole proprietors (many of whom are currently on the individual market and not eligible for subsidies) to qualify for less expensive group coverage under the AHP.

California has taken a wider variety of healthcare reform approaches in the last two years than most other states. While the widely publicized efforts to create a single-payer system have yet to bear fruit, California has expanded subsidies (extending them to households with income up to 600% FPL and increasing the value for households with income at or under 400% FPL), created an individual mandate, and consolidated prescription drug purchasing in a single state agency.[34]

[23] SHADAC. Resource: State-Based Reinsurance Programs via 1332 State Innovation Waivers. Retrieved October 9, 2019, from https://www.shadac.org/publications/resource-state-based-reinsurance-programs-1332-state-innovation-waivers.
[24] The full text of the Massachusetts law is available at https://malegislature.gov/Laws/SessionLaws/Acts/2006/Chapter58.
[25] The full text of the California law is available at http://www.dof.ca.gov/Budget/Trailer_Bill_Language/documents/HBEXIndividualMandateandStateHealthCareSubsidies.pdf.
[26] The full text of the New Jersey law is available at https://www.njleg.state.nj.us/2018/Bills/AL18/31_.PDF.
[27] The full text of the Rhode Island law is available at http://webserver.rilin.state.ri.us/BillText/BillText19/HouseText19/H5151Aaa.pdf.
[28] The full text of the Vermont law is available at https://legislature.vermont.gov/Documents/2020/Docs/ACTS/ACT063/ACT063%20As%20Enacted.pdf.
[29] The full text of the Washington, D.C., law is available at https://code.dccouncil.us/dc/council/laws/22-168.html#%C2%A75002(b).
[30] Witte, B. (May 13, 2019). Maryland gov signs 1st-in-nation measure to help uninsured. Minneapolis StarTribune. Retrieved October 9, 2019, from http://www.startribune.com/maryland-gov-signs-1st-in-nation-measure-to-help-uninsured/509857412/
[31] Ibid.
[32] Commonwealth Fund. Louisiana: Streamlining Enrollment With Express Lane Eligibility. Retrieved October 9, 2019, from https://www.commonwealthfund.org/publications/newsletter-article/louisiana-streamlining-enrollment-express-lane-eligibility.
[33] South Carolina Health and Human Services (October 4, 2012). SCDHHS meets promise to insure more poor children through 'Express Lane' eligibility. Press release. Retrieved October 9, 2019, from https://www.scdhhs.gov/press-release/scdhhs-meets-promise-insure-more-poor-children-through-express-lane-eligibility.
[34] Quinn, M. (July 11, 2019). California takes Obamacare to a new level as the law's fate looms. *Governing*. Retrieved October 9, 2019, from https://www.governing.com/topics/health-human-services/gov-california-newsom-obamacare-subsidies-mandate.html.

4. STATE HEALTH BENEFITS PROFILE

In order to better evaluate potential impacts a Public Option would have in Colorado, it is helpful to first establish a baseline for context and comparisons. This section of our report provides an overview of Colorado's health benefits market landscape in 2019. Much of the information presented is used for further analysis, as well as to support assumptions and conclusions. We provide estimates of health benefits enrollment by market in 2019, and further enrollment analyses by age group and household income. Estimates for provider reimbursement (total non-prescription drug claims dollars) are developed by market segment. Finally, we provide an estimate of the 2019 federal premium assistance provided through Connect for Health Colorado (CFHC).

ENROLLMENT BY HEALTH BENEFITS MARKET

Figure 7 provides a summary of the estimated number of Coloradans by health benefits coverage source in 2019. The estimates are developed from a combination of insurer financial information, publicly available reports on Medicaid and Medicare enrollment, and the American Community Survey (ACS). Please see the Methodologies section of this report for further details.

FIGURE 7: COLORADO, ESTIMATED 2019 HEALTH BENEFITS COVERAGE LANDSCAPE

MARKET	PERSONS	% OF POPULATION
Individual	217,000	3.8%
Small Group	299,000	5.2%
Large Group	679,000	11.7%
Self-Funded	1,936,000	33.5%
Employer Group Subtotal	**2,915,000**	**50.4%**
Medicaid	1,199,000	20.7%
Medicare	741,000	12.8%
Duals	83,000	1.4%
Other	155,000	2.7%
Uninsured	476,000	8.2%
Total	**5,786,000**	**100.0%**

Notes:
1. *Values have been rounded to the nearest thousand.*
2. *Employer group subtotal includes small group, large group, and self-funded populations.*
3. *Medicaid enrollment includes CHIP.*
4. *"Other" coverage represents TRICARE, Veterans Health Administration (VHA), and other public healthcare programs.*
5. *"Duals" coverage reflects persons with both Medicaid and Medicare coverage.*
6. *Medicare values reflect traditional and Medicare Advantage enrollment.*

As shown in Figure 7, the employer group market (small group, large group, and self-funded employers) is the source of health benefits for approximately 50% of Colorado's population. However, we estimate only 4% of Coloradans are purchasing coverage in the individual market in 2019. Enrollment in the individual market is estimated to have declined by nearly 50,000 persons since 2017. This may be attributable to a combination of factors, including:

- Significant premium rate increases that have adversely impacted persons not qualifying for federal premium assistance, particularly in 2017 and 2018.[35]
- Improving economy and associated job growth that has resulted in greater access to employer group health benefits and less need for individual market health benefits. The July 2019 unemployment rate was 2.9%,[36] which is at or near record low levels.[37]

[35] McMahon, X. (July 14, 2017). Colorado health insurance companies seek 27 percent premium spike. *CPR News*. Retrieved October 9, 2019, from https://www.cpr.org/2017/07/14/colorado-health-insurance-companies-seek-27-percent-premium-spike/.
[36] Colorado Department of Labor and Employment (August 16, 2019). Colorado Employment Situation, July 2019. Retrieved October 9, 2019, from https://www.colorado.gov/pacific/cdle/news/colorado-employment-situation-july-2019.
[37] U.S. Bureau of Labor Statistics. Colorado Economy at a Glance, Retrieved October 9, 2019, from https://www.bls.gov/eag/eag.co.htm.

- The individual mandate penalty became $0 for 2019, potentially providing less incentive for some consumers to purchase health benefits.

Figure 8 provides estimated 2019 enrollment in each health benefits market by age group.

FIGURE 8: COLORADO, ESTIMATED 2019 HEALTH BENEFITS MARKET ENROLLMENT BY AGE GROUP

MARKET	0 TO 17	18 TO 25	26 TO 34	35 TO 44	45 TO 54	55 TO 64	65+	TOTAL
INDIVIDUAL	26,000	16,000	40,000	35,000	37,000	60,000	3,000	217,000
EMPLOYER GROUP	618,000	355,000	475,000	508,000	491,000	444,000	24,000	2,915,000
MEDICAID	555,000	149,000	160,000	139,000	102,000	94,000	-	1,199,000
MEDICARE	4,000	4,000	4,000	6,000	11,000	27,000	685,000	741,000
DUALS	2,000	1,000	2,000	4,000	7,000	12,000	55,000	83,000
OTHER	39,000	24,000	28,000	20,000	17,000	25,000	2,000	155,000
UNINSURED	63,000	86,000	105,000	86,000	71,000	60,000	5,000	476,000
TOTAL	**1,307,000**	**635,000**	**814,000**	**798,000**	**736,000**	**722,000**	**774,000**	**5,786,000**

Notes:

1. *Values have been rounded to the nearest thousand.*
2. *"Employer" coverage includes small group, large group, and self-funded populations.*
3. *Medicaid enrollment includes CHIP.*
4. *"Other" coverage represents TRICARE, Veterans Health Administration (VHA), and other public healthcare programs.*
5. *"Duals" coverage reflects persons with both Medicaid and Medicare coverage.*

For working age adults, 18 to 64 years old, employer coverage provides health benefits to approximately 61% of the population (2.3 million out of 3.7 million), while individual market coverage is only purchased by 5% of the population (188,000 out of 3.7 million). *In considering potential health benefits policy changes, policies that have a minor impact to the employer market may have a corresponding significant impact to the individual market.* For example, if 10% of the employer market shifted to individual market coverage due to a Public Option, this would increase the size of the individual market from 217,000 to approximately 509,000, a nearly 135% increase in market enrollment. More specifically, if there is systematic bias in terms of which 10% of the employer group market (e.g., a less healthy 10%) moves over to the individual market, it could have a material effect on overall rates in the individual market due to increased morbidity. More discussion on the morbidity impact of moving populations can be found in Section 8 of this report below.

Comparing the individual and employer markets, it is noticeable that the age of consumers in the individual market is significantly older on average. Persons age 45 or older represent approximately 46% of individual market consumers (100,000 out of 217,000), while in the employer group market, this age group represents approximately only one-third of enrollment (1.0 million out of 2.9 million). Age mix differences are a contributing factor to the individual market's higher estimated per capita claims cost relative to the employer group health benefits market (as shown in Figure 8).

Public programs represent a much greater share of health benefits coverage for children (Medicaid) and the elderly (Medicare). Over 40% of children residing in Colorado are estimated to be enrolled in Medicaid, including the Children's Health Insurance Program (CHIP).

We estimate a 2019 uninsured rate for the total Colorado population of 8.2%. The uninsured rate is estimated to be greatest for the 18- to 25-year-old population (approximately 13%), while approximately 9% for adults ages 45 to 64.

The uninsured population represents an important segment of the Colorado market with regard to a potential Public Option. Policy makers would like to see this segment reduced[38] and the lower premiums associated with a Public Option could be an important tool in this effort. We estimate that the overall morbidity of the uninsured is favorable to the current individual and employer group markets and thus their entrance into the individual pool could lower rates all else equal (see Section 8 for more discussion of the impact of morbidity on this analysis).

Figure 9 examines the estimated distribution of health benefits coverage by income level, measured as a percentage of FPL.

[38] University of Pennsylvania (February 6, 2018). State Efforts to Close the Health Coverage Gap. Retrieved October 9, 2019, from https://ldi.upenn.edu/brief/state-efforts-close-health-coverage-gap.

FIGURE 9: COLORADO ESTIMATED 2019 HEALTH BENEFITS ENROLLMENT BY INCOME LEVEL (PERCENTAGE OF FPL)

MARKET	<139%	139% TO 250%	251% TO 400%	401% TO 500%	500%+	TOTAL
INDIVIDUAL	1,000	70,000	47,000	48,000	50,000	217,000
EMPLOYER GROUP	104,000	400,000	632,000	432,000	1,347,000	2,915,000
MEDICAID	606,000	349,000	152,000	42,000	50,000	1,199,000
MEDICARE	128,000	161,000	165,000	73,000	214,000	741,000
DUALS	52,000	15,000	7,000	2,000	6,000	83,000
OTHER	27,000	30,000	35,000	22,000	42,000	155,000
UNINSURED	165,000	110,000	113,000	25,000	62,000	476,000
TOTAL	**1,083,000**	**1,136,000**	**1,151,000**	**645,000**	**1,771,000**	**5,786,000**

Notes:
1. Values have been rounded to the nearest thousand.
2. "Employer" coverage includes small group, large group, and self-funded populations.
3. Medicaid enrollment includes CHIP.
4. "Other" coverage represents TRICARE, Veterans Health Administration (VHA), and other public healthcare programs.
5. "Duals" coverage reflects persons with both Medicaid and Medicare coverage.

Within the full individual market (ACA-compliant and non-ACA-compliant), we estimate 98,000 persons (45% of market enrollment) have household income above 400% FPL and, therefore, do not qualify for federal premium assistance. Thirty-three percent of individual market enrollees are estimated to have income at or below 250% FPL, allowing qualification for both federal premium assistance and cost-sharing reductions through CFHC (to the extent silver-level coverage is purchased). Note, the individual market cohort with income below 139% FPL is assumed to reflect lawfully present individuals who are eligible for federal premium assistance.

Relative to the individual market, the employer market is estimated to have a higher proportion of persons with household incomes above 400% FPL (61% vs. 45%) and significantly fewer persons with incomes below 250% FPL (17% vs. 33%). As discussed in more detail in Section 7, large employers have continued to offer health benefits at high rates even after the introduction of premium assistance through CFHC beginning in 2014. While the ACA's employer mandate likely has had some effect on the continuation of employer-sponsored coverage, this is also attributable to the significant proportion of employees who do not have access to federal premium assistance in CFHC, based on having household incomes above 400% FPL. Particularly for higher-income employees, this results in employer-sponsored coverage continuing to be perceived as an important benefit offered by employers.

For each health benefits coverage segment in the State of Colorado, Figure 10 provides detail on claims expenses as follows:

- Per capita allowed claims (the cost of all covered services, including both insurer paid expenses and member cost sharing)
- Proportion medical cost (the percentage of allowed claims attributable to medical costs, excluding pharmacy and long-term services and supports (LTSS)
- Per capita allowed medical cost
- Aggregate medical cost, shown in billions of dollars

Note, costs for the uninsured population do not reflect uncompensated care delivered by providers and exclude any indirect payments for the delivery of uncompensated care. Based on national-level information, we have assumed approximately 80% of provider care to the uninsured population is uncompensated.[39]

The information provided in Figure 10 establishes a baseline view of 2019 provider revenue in Colorado. Projected revenue under Public Option enrollment scenarios will be compared to these baseline values later in this report.

[39] Kaiser Family Foundation (May 30, 2014). Uncompensated Care for the Uninsured in 2013: A Detailed Examination. Retrieved March 4, 2019, from https://www.kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/.

FIGURE 10: COLORADO, ESTIMATED 2019 HEALTH BENEFITS COVERAGE, ENROLLMENT AND CLAIMS EXPENSE

	PERSONS	PER CAPITA ALLOWED CLAIMS	PROPORTION MEDICAL COST	PER CAPITA ALLOWED MEDICAL COST	AGGREGATE MEDICAL COST ($ BILLIONS)
Individual	217,000	$7,911	80%	$6,329	$1.4
Small Group	299,000	$6,063	80%	$4,851	$1.5
Large Group	679,000	$6,335	80%	$5,068	$3.4
Self-Funded	1,936,000	$6,272	80%	$5,018	$9.7
Employer Group Subtotal	**2,914,000**	**$6,265**	**80%**	**$5,012**	**$14.6**
Medicaid	1,199,000	$4,365	95%	$4,146	$5.0
Medicare	741,000	$10,879	80%	$8,703	$6.4
Duals	83,000	$48,115	35%	$16,840	$1.4
Other	155,000	$6,335	80%	$5,068	$0.8
Uninsured	476,000	$1,038	80%	$830	$0.4
Total	**5,786,000**	**$6,696**		**$5,182**	**$30.0**

Notes:
1. Values have been rounded.
2. Estimates for the individual, small group, and large group markets developed from 2017 medical loss ratio submissions trend to 2019 and Connect for Health's 2019 open enrollment report presentation. Individual market claims expense estimated by 2019 premium estimates, an assumed market loss ratio of 80%, and actuarial value estimates.
3. Estimates for public health benefits programs were estimated based on publicly available CMS data.
4. Percentage of claims by insurer estimates developed from CMS risk adjustment transfer reports and actuarial judgment. The estimate for the individual market includes cost-sharing reduction plan design enhancements.
5. Medicaid per capita costs include supplemental payments and are net of pharmacy rebates.

On a composite basis, we estimate approximately $30 billion in healthcare medical claims cost in 2019, with the individual market generating $1.4 billion or approximately 3% of the total. As shown in Figure 10, the per capita allowed claims costs for the individual market ($7,900) is higher than the employer group health benefits composite ($6,300). This difference is attributable to the following factors:

- As shown in Figure 10 above, the individual market is composed of a greater proportion of adults age 45 and over (46% of enrollees) and significantly fewer children (12% of enrollees) relative to the employer group market (33% of enrollees age 45 and over, and 21% of enrollees' children). As healthcare costs increase with age, the higher age mix in the individual market results in higher per capita claims expenses.

- For a given age, we estimate that the average morbidity (illness burden) in the individual market is approximately 15% to 20% higher relative to the same age in the employer group health benefits market. This is likely driven by the lower average household income[40] of the individual market and adverse selection among consumers (the greater likelihood that persons with greater healthcare needs will purchase coverage).

- All else equal, a non-biased, balanced cross-section of migration from the employer group market could improve overall rates in the individual markets. However, as we discuss in greater detail in Section 7, anti-selective behavior by large employers offering HRAs that result in the movement of sicker individuals could have a detrimental effect on individual morbidity and, therefore, overall premium rates.

- Offsetting age mix and morbidity to some degree, we estimate that current provider reimbursement in the individual market is less, on average, relative to employer group coverage. Narrow network strategies that contribute to lower provider reimbursement are employed by insurers operating in the individual market far more often than in the employer group health benefits market.

- The employer group market is estimated to have approximately $15 billion in aggregate allowed medical costs, reflecting nearly 49% of medical cost expenditures.

[40] Summary Health Statistics, National Health Interview Survey 2017. Retrieved August 29, 2019, from http://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2017_SHS_Table_A-11.pdf.

INDIVIDUAL MARKET DETAIL

This section provides additional information related to enrollment, premiums, federal premium assistance, and benefit design selections for Colorado's individual market. For CFHC, Figure 11 provides additional detail is provided on persons purchasing coverage with an advanced premium tax credit (APTC) relative to those not receiving federal premium assistance (non-APTC).

FIGURE 11: COLORADO, 2019 INDIVIDUAL HEALTH BENEFITS MARKET PROFILE

SEGMENT	PERSONS	ANNUAL PER CAPITA PREMIUM	AGGREGATE PREMIUM ($ MILLIONS)	ANNUAL PER CAPITA APTC	AGGREGATE APTC ($ MILLIONS)
CONNECT FOR HEALTH COLORADO (EXCHANGE)	141,000	$7,775	$ 1,096.0	NA	NA
APTC	112,000	8,300	933.2	$6,700	$ 752.6
NON-APTC	29,000	5,700	162.8	NA	NA
OFF-EXCHANGE	55,000	6,000	389.3	NA	NA
GRANDFATHERED	21,000	6,550	140.6	NA	NA
TOTAL	**217,000**	**7,200**	**$ 1,565.6**	**NA**	**NA**

Notes:
1. Person estimates have been rounded to the nearest thousand. With the exception of aggregate premium and federal premium assistance, other values have been rounded to the nearest multiple of 25.
2. Estimates developed from August 2019 effectuated enrollment reports released by CMS and prior year insurer financial experience. Actual values are certain to vary from the estimates illustrated.

Individual market enrollment is estimated to relatively stable in 2019, with an estimated enrollment decrease from 2018 of 5,000 persons (222,000 to 217,000). Based on effectuated enrollment patterns in 2018 (the number of people paying premiums through the year) and open enrollment selection differences between 2018 and 2019, we estimate an average monthly CFHC enrollment of 141,000 persons in 2019, accounting for 65% of individual market enrollment.

Approximately 80% of consumers purchasing coverage through CFHC receive federal premium assistance. For 2019, we estimate the average annual financial assistance received by APTC-eligible consumers is $6,700, resulting in approximately $750 million in aggregate federal APTC expenditures. As individual market premiums have increased significantly in the last two years, this has resulted in greater levels of premium assistance being provided to Coloradans. From 2018 to 2019, we estimate that federal premium assistance expenditures increased by approximately $136 million ($616 million to $752 million). We believe this increase is largely attributable to the Colorado Department of Insurance permitting insurers to load for CSRs only on silver exchange coverage.[41] In the next section of this report, we model premium rates in the individual market that decrease significantly under a Public Option, depending on underlying provider reimbursement levels and morbidity improvements. This scenario would also result in a corresponding decrease in federal premium assistance expenditures.

SUMMARY

Colorado's individual market provides health benefits to persons without access to employer group or public program coverage. As Colorado has a robust employer group market and public programs, the number of persons covered by the individual market is estimated to represent only 4% of state residents. However, market enrollment may increase materially in periods of higher unemployment (similar to expectations for Medicaid enrollment).[42]

Federal premium assistance is estimated to be responsible for more than half of Connect for Health premium payment in 2019, with 80% of Connect for Health enrollees receiving APTCs. It is important to understand that for many consumers purchasing coverage in Connect for Health, out-of-pocket premiums are capped at levels far below the full premium rate, with the APTC making up the difference. The estimated average annual APTC value of $6,700 per capita is estimated to cover more than 80% of premium for subsidy-eligible enrollees and approximately 50% of total

[41] Colorado Department of Regulatory Agencies (October 4, 2018). Division of Insurance releases state's 2019 health insurance plans and premiums. Retrieved October 9, 2019, from https://www.colorado.gov/pacific/dora/news/division-insurance-releases-states-2019-health-insurance-plans-and-premiums.
[42] Kaiser Family Foundation (December 2011). Medicaid and the Uninsured: Changes in Health benefits Coverage in the Great Recession, 2007-2010. Retrieved March 4, 2019, from https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8264.pdf (registration required).

ACA-compliant premiums (across subsidized and nonsubsidized enrollees). Therefore, State of Colorado initiatives, such as a Public Option, that have the effect of reducing individual ACA-compliant rates, have the indirect effect of reducing federal subsidies to the State of Colorado as well.

Among the uninsured population of approximately 476,000, we estimate less than 20% have incomes above 400% FPL and, therefore, do not qualify for federal premium assistance. In evaluating the impact of a potential Public Option on the state's uninsured rate, this higher-income population would receive the direct benefits of lower market premium rates.

5. PUBLIC OPTION RATE DEVELOPMENT SCENARIOS

We model the potential premiums and cost sharing based on the assumptions of provider reimbursement (as a percentage of Medicare) that a Public Option might obtain. The four scenarios assume underlying composite reimbursement (across professional and facility costs) of 100%, 120%, 150% and 180% of Medicare.

We start with plan designs for the lowest and second-lowest-cost silver (LCS and SLCS) and the lowest-cost bronze (LCB) plans in five Colorado counties for 2019. We chose counties that have a range of current underlying provider reimbursement and carrier participation as a Public Option will have disproportionate impacts based on these characteristics. Although open enrollment from these counties accounted for only 33% of total 2019 Connect for Colorado Health (CFHC) open enrollment,[43] we believe a composite of them to be a reasonable estimate for statewide impacts.

ASSUMPTIONS

Public Option assumptions

- **Provider reimbursement:** We assume, regardless of the form the Public Option might ultimately take, that the underlying provider reimbursement for Public Option plans, in order to be a viable competitive offering and provide significant savings to consumers, would need to be equal to or lower than what is currently obtained by the SLCS carrier on CFHC.

  To estimate the current level of reimbursement underlying the SLCS in each county (and hence the maximum level of reimbursement that the Public Option could have to achieve savings, all else equal), we started with provider reimbursement assumptions that are appropriate for the commercial employer group segment in Colorado. This assumption is based on Milliman analysis of the IBM Marketscan® database, proprietary Milliman claims databases, and publicly available data sources. We estimate that current provider reimbursement for non-prescription drug costs for the commercial employer group segment in 2019 ranges across the five Colorado counties from approximately 190% of Medicare to 250% of Medicare for facility and professional services combined. This is shown in line (A) in Figure 12 below.

  We further assume that the provider reimbursement underlying plans available on CFHC is better than standard commercial employer group reimbursement in certain counties. This is an assumption based on our experience and work with previous, similar studies in other states. We further assume that the degree of this favorability varies by county. Specifically, in rural counties where there is likely only one main health system, the incremental improvement in reimbursement for plans available on CFHC over employer group reimbursement is likely very small to non-existent (e.g., Gunnison County). However, in urban counties, such as Denver and Boulder, this incremental improvement could be material, as systems compete for CFHC membership. The assumed reimbursement for CFHC plans is shown in line (B) in Figure 12.

  Finally, we assume the Public Option will need to negotiate provider reimbursement rates that are not just lower than the average exchange reimbursement but also lower than the reimbursement of the carrier with the SLCS (and possibly LCS) rate in a county. It is likely that this reimbursement is lower than the average CFHC reimbursement, hence why that carrier is the SLCS.[44] However, in counties with only one or two carriers, these market dynamics would not hold and, therefore, no additional decrement is made (Gunnison) or a very small decrement is made (Mesa and Larimer).

  The final reimbursement that is assumed for the current SLCS plan is found in line (C) in Figure 12. This is the maximum reimbursement we assume a Public Option can pay providers in order to accomplish the policy goal of lowering gross (prior to application of federal premium subsidies) prices on CFHC.

[43] CFHC. By the Numbers: Open Enrollment Report, Plan Year 2019. Retrieved October 10, 2019, from https://s3.amazonaws.com/c4-media/wp-content/uploads/2019/03/C4HC_OpenEnrollmentReport_WebVersion.pdf.
[44] Other factors impacting premium rates may include underlying medical management efficiency, administrative costs, and degree of pricing conservatism.

FIGURE 12: ASSUMED REIMBURSEMENTS BY COUNTY IN BASELINE SCENARIO

		BOULDER (5 CARRIERS)	DENVER (6 CARRIERS)	LARIMER (3 CARRIERS)	MESA (3 CARRIERS)	GUNNISON (1 CARRIER)
(A)	ESTIMATED COMMERCIAL REIMBURSEMENT	191%	197%	234%	229%	250%
(B)	ESTIMATED CFHC AVERAGE REIMBURSEMENT	149%	154%	199%	206%	250%
(C)	ESTIMATED SLCS CARRIER REIMBURSEMENT	134%	138%	189%	196%	250%

- **Qualified health plan (QHP) status:** We assume that the Public Option would be a QHP and offer its plans through CFHC. Both of these conditions would need to hold in order for the improvement in the cost of the SLCS (if any) to result in potential federal pass-through funding under a 1332 waiver.

- **Reinsurance:** We assume that, as a part of the ACA-compliant individual market, the Public Option would be eligible for payments under the state's reinsurance program that starts in 2020. We also assumed a uniform impact of the reinsurance program across regions and carriers.

- **Provider tolerance:** We discuss provider reactions to lower reimbursement in Section 9 but we note here that, while a 100% of Medicare scenario is modeled, this reimbursement level may not be feasible given the provider reactions and final reimbursement agreed to in Washington under Cascade Care.[45]

Modeling assumptions and methodologies

- **Model:** The Milliman Managed Care Rating Model (MCRM) was used to estimate underlying costs by inpatient, outpatient, and professional categories at current estimated provider reimbursement levels and under four different percentages of Medicare reimbursement: 100%, 120%, 150%, and 180%.

- **Demographics**: Demographic assumptions are based on CFHC's 2019 open enrollment statistics as reported in the State-Level Public Use File.[46] The average assumed age is 42 years old.[47]

- **Prescription drug costs:** We assumed no change in prescription drug (Rx) costs for Public Option plans.

- **Administrative expenses:** We assumed that administrative expenses, taxes, and profit built into CFHC plans are on average approximately 18% of current premiums. We further assume that the fixed portion of these expenses is approximately $55 per member per month (PMPM) and variable expenses are 5% of premium.[48]

  Note, these are industry average loads for administration and, therefore, represent the assumption that the Public Option will have no advantage or disadvantage in pricing due to administrative efficiency.

MODELING RESULTS

The average rate impact across the LCB, LCS, and SLCS by county and scenario is summarized in Figure 13.

[45] Cascade Care originally targeted 100% of Medicare reimbursement but ended up at 160%.
[46] CMS. 2019 Marketplace Open Enrollment Period Public Use Files. Retrieved October 10, 2019, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2019_Open_Enrollment.html.
[47] Note that a per capita premium using a population distribution with an average age of 42 will not be consistent with Connect for Health prices for a person 42 years old due to the nonlinear nature of the ACA age curve.
[48] Assumptions are reasonable pricing assumptions that likely produce an 80% or greater medical loss ratio (MLR) and do not reflect any specific carrier or the actual experience in the Colorado market.

FIGURE 13: ESTIMATED PRICE IMPACT OF MEDICARE REIMBURSEMENT ON CY2020 PREMIUM RATES BY COUNTY

County	180% OF MEDICARE	150% OF MEDICARE	120% OF MEDICARE	100% OF MEDICARE
Boulder	21.7%	5.6%	-9.6%	-19.1%
Denver	22.8%	5.8%	-10.2%	-20.3%
Larimer	-4.9%	-18.1%	-30.8%	-39.0%
Mesa	-8.1%	-20.1%	-31.6%	-39.0%
Gunnison	-25.0%	-35.1%	-44.6%	-50.7%
Composite	12.9%	-2.5%	-17.0%	-26.3%

Key observations from Figure 13 include:

- Within a reimbursement scenario (looking down the columns), premium rate impacts of each of the Medicare reimbursement scenarios vary by region based on our estimates of underlying SLCS reimbursement in that county (Figure 12).

Alternatively, a Public Option could contract with mandated reimbursement levels that are not uniform across the State of Colorado but vary by region. This would produce more uniform savings across regions. For example, the Public Option could contract at a 120% of Medicare in Denver County (to obtain a 12% premium savings) and 180% in Gunnison (to obtain a 15% savings).

- The overall impact on premium rates of Medicare reimbursement levels is dampened due to reimbursement changes not affecting pharmacy costs or fixed administrative expenses. We estimate pharmacy costs represent approximately 20% of incurred health care expenses for individual market coverage.

- In addition to these reimbursement impacts, we estimate that the Public Option rates may benefit from up to a 2% additional reduction due to improved morbidity in an individual market that contains the Public Option offering. The impact of morbidity improvement is not included in the values presented in Figure 13. Please see Section 8 for more discussion of morbidity impacts.

Summary

Individual rates for Public Option plans could be lower than 2020 levels in high-cost counties by 10% to 45% depending on the reimbursement levels that the Public Option obtains. In more urban counties, where there are more carriers and reimbursement is already at lower levels, the introduction of the Public Option is less likely to produce lower-priced options until very low Medicare reimbursement levels are assumed. Thus, the Public Option may be more valuable to non-subsidized consumers in rural counties where costs are high and carrier participation is lowest.

6. IMPACT TO INDIVIDUAL NON-PUBLIC OPTION PLANS

Our modeling assumes the Public Option, regardless of which form it takes, will be offered on Connect for Health Colorado (CFHC) and compete directly against existing QHPs currently offered by private carriers. Depending on the premium rate reduction resulting from the mandated reimbursement level associated with a Public Option, we believe market dynamics may render non-Public Option plans in the individual market unviable for many carriers.

The likelihood of this occurring is greatest in rating areas where underlying provider reimbursement is highest relative to Medicare (or other benchmarks), which is more likely to occur in rural markets from our experience. The market dynamics created by a Public Option that is priced lower than current carrier offerings are attributable to the ACA's premium subsidy structure, which exposes all consumers in the market (regardless of subsidy eligibility and income levels) to the full premium differential between the plan selected and the benchmark silver plan (SLCS).

To illustrate these effects, Figures 15 to 17 illustrate the change in net premium for a single, 40-year-old in Denver County in 2019 at varying household income levels under three purchasing scenarios:

1. The actual 2019 SLCS or subsidy benchmark premium available with a monthly premium of $439.35 or a $5,272 annual premium is purchased.

2. The Public Option plan becomes the subsidy benchmark plan and is purchased by the consumer.

3. The same plan that was purchased in scenario 1 (when it was the SLCS) is purchased but it is offered alongside a Public Option plan that has become the SLCS and, therefore, the subsidy benchmark plan.

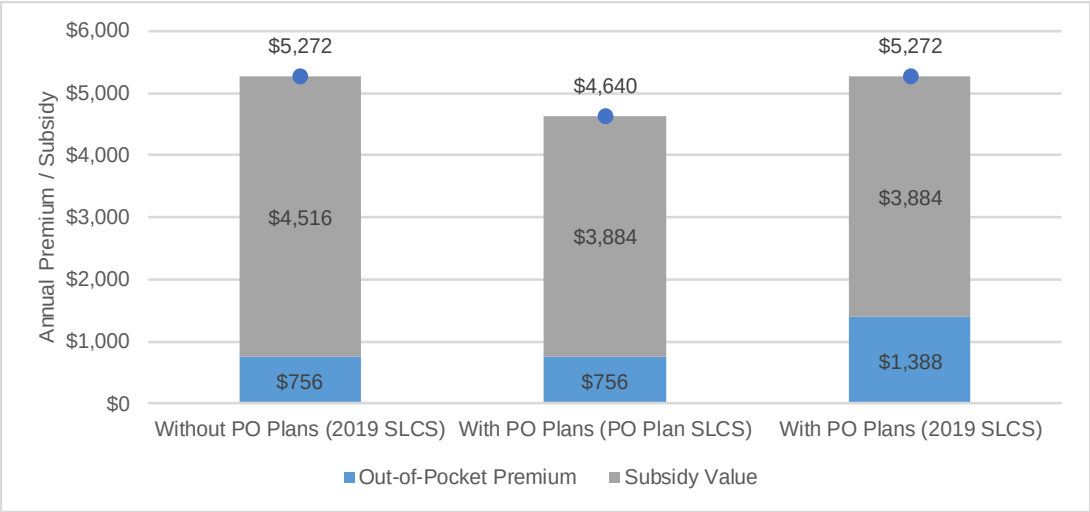
For the provider reimbursement reduction impact on Public Option gross premiums, we assume a premium rate decrease of 12%, reflecting percentage of Medicare reimbursement requirements between 120% and 150%. While we only reflect a single Public Option scenario in Figures 15 to 17, the conclusions made for it will hold true in all cases where the Public Option establishes a price advantage relative to existing QHPs.

- **Consumer 1, Income 150% FPL**: For low income consumers (generally income below 250% FPL), the out-of-pocket cost or net premium for the subsidy benchmark plan will not change, as it will remain capped at the maximum percentage of household income. However, to the extent a consumer wanted to remain in a non-Public Option plan, they would be required to pay the additional premium equal to the full differential between the Public Option plan and the non-Public Option plan. Figure 15 illustrates out-of-pocket premiums for the three purchasing scenarios described above for a single 40-year-old residing in Denver County with household income of 150% FPL.

  - The annual net premium for the subsidy benchmark plan is $756 under both scenarios 1 and 2. However, when the silver Public Option plan becomes the SLCS, the federal government's subsidy decreases from $4,516 to $3,884, as the subsidy value is equal to the difference between the total premium and the maximum the person must pay for the SLCS ($756).

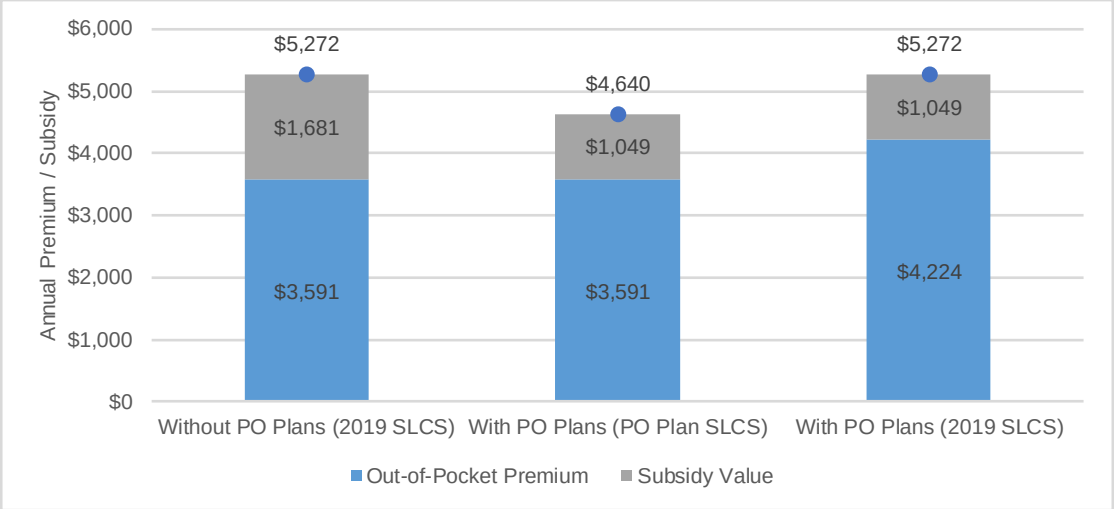
  - However, the cost to the consumer of the former subsidy benchmark plan under scenario 3 increases to $1,388, an 84% premium increase. To the extent the Public Option plan was even less expensive relative to the actual 2019 SLCS (a 12% premium differential is reflected in the illustrated modeling), the out-of-pocket premium change in this scenario would be even greater, as the value of federal premium assistance would be reduced further. Given the price sensitivity of low-income consumers, we estimate the non-Public Option plans that had a material price disadvantage would attract very little market share. As shown in Figure 10 above, we estimate 33% of individual market consumers have income below 250% FPL and would likely shift to Public Option plan coverage.

FIGURE 14: DENVER COUNTY, SINGLE 40-YEAR-OLD, HOUSEHOLD INCOME 150% FPL, PREMIUM RATE IMPACT FROM INTRODUCTION OF PUBLIC OPTION PLANS 12% BELOW CURRENT SLCS



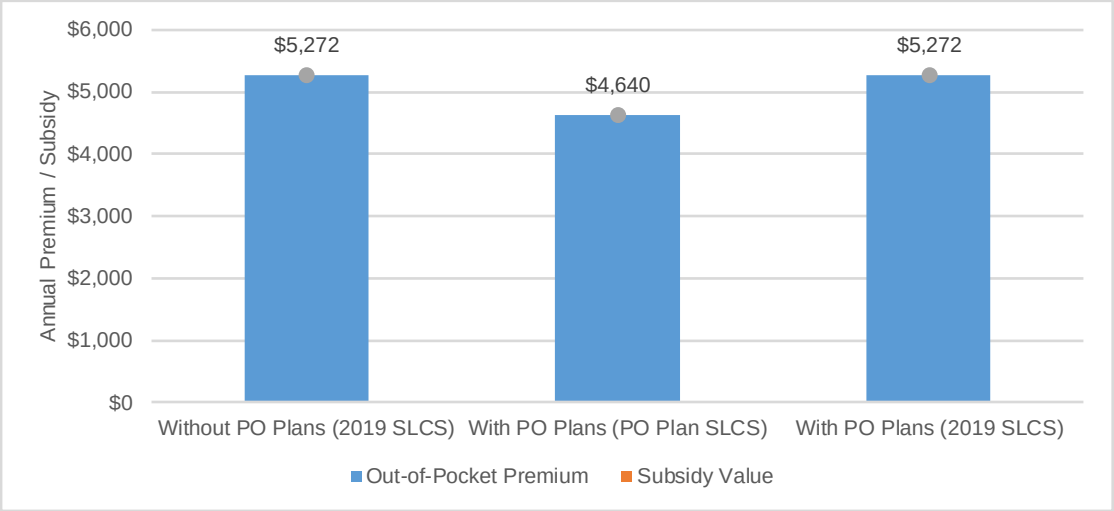
- **Consumer 2, 300% FPL:** For many middle-income consumers (between 250% FPL and 400% FPL) qualifying for lower amounts of federal premium assistance, market dynamics created by the Public Option may be similar to those experienced by consumers with income below 250% FPL. In Figure 15, a consumer with income at 300% FPL currently pays an annual net premium of $3,591 for the subsidy benchmark plan, receiving a premium subsidy value of $1,681 (reflecting a total premium of $5,272).
  - With the introduction of the Public Option plan, the annual premium for the subsidy benchmark plan drops from $5,272 to $4,640, reducing the subsidy value from $1,681 to $1,049. Note that, for some consumers at this income level, particularly young adults, a Public Option may reduce the subsidy value to $0. In these cases, the consumers would experience an out-of-pocket decrease for the SLCS plan, sharing in the premium savings with the federal government.
  - To the extent the consumer wanted to remain in the non-Public Option plan, that person would be required to pay a $4,224 annual out-of-pocket premium, approximately an 18% net premium increase.

FIGURE 15: STATE OF COLORADO, DENVER COUNTY, SINGLE 40-YEAR-OLD, HOUSEHOLD INCOME 300% FPL, PREMIUM RATE IMPACT FROM INTRODUCTION OF PUBLIC OPTION PLANS 12% BELOW CURRENT SLCS



- **Consumer 3, 500% FPL:** For consumers with income above 400% FPL, the change in cost for the subsidy benchmark plan should equal the premium rate difference between the Public Option and non-Public Option plans. These consumers can benefit from the lower Public Option premium or choose to continue their current plans at no additional cost.

FIGURE 16: STATE OF COLORADO, DENVER COUNTY, SINGLE 40-YEAR-OLD, HOUSEHOLD INCOME 500% FPL, PREMIUM RATE IMPACT FROM INTRODUCTION OF PUBLIC OPTION PLANS 12% BELOW CURRENT SLCS



The price sensitivity of individual market consumers is supported by CMS research on consumer price sensitivity. CMS reported 64% of individuals selecting a marketplace plan chose the LCS or SLCS plan in a metallic tier in 2014, with this figure reported at 47% for the 2015 coverage year.[49]

As discussed above, the premium rate differential between Public Option and non-Public Option plan options will likely vary across the state. Particularly in rural areas, existing provider reimbursement for CFHC coverage may be comparable to employer group market reimbursement, creating significant premium differential between Public Option and non-Public Option plan options. In urban areas, where a narrow network strategy is more feasible, existing provider reimbursement for marketplace coverage may be significantly less than employer group health benefits, reducing the premium differentials between the Public Option and non-Public Option plan options.

To the extent material network access differences exist between the Public Option plans offered through CFHC and non-Public Option plans offered both inside and outside of CFHC (with presumably broader provider access), it may be possible that a portion of the market will elect to remain enrolled in a non-Public Option plan. This may occur more frequently in urban areas where carriers have already likely developed narrow networks for plans offered through CFHC.

[49] HHS (October 30, 2015). Health Plan Choice and Premiums in the 2016 Health Insurance Marketplace. Retrieved October 10, 2019, from https://aspe.hhs.gov/basic-report/health-plan-choice-and-premiums-2016-health-insurance-marketplace.

7. EMPLOYER GROUP HEALTH BENEFITS MARKET DYNAMICS

With the Public Option creating a potential material premium rate decrease as a result of reduced provider reimbursement and improved morbidity of the risk pool (as well as the State's existing reinsurance program), premium rates for Public Option coverage may be lower relative to comparable benefit plans in the employer group health benefits market. The reduction in premium rates due to provider reimbursement requirements and morbidity improvements may offset the current estimated morbidity difference (15% to 20%) between individual and employer group health benefits markets. Therefore, at face value, Public Option plan premium rates may be less than employer group health benefits rates for comparable plan designs.

However, there are many other factors that employers may consider when assessing whether the lower-cost Public Option plan available on Connect for Health Colorado (CFHC) could be a viable alternative to traditional employer group health benefits. This section provides a summary of why offering employer group health benefits coverage is common among large employers, as well as an examination of how the potentially lower cost of Public Option plans, and changes in regulations governing HRAs, may result in the Public Option plan being viewed by some employers as a superior alternative to offering traditional employer group health benefits.

REASONS EMPLOYERS OFFER HEALTH BENEFITS

Motivations to offer health benefits vary by employer, particularly by size of firm (small group versus large group). However, generally, the following reasons have been broadly applicable since the introduction of employer-based health benefits coverage:

- **Attract and retain employees**. Health benefits are a major part of an employer's compensation strategy. A survey conducted by America's Health Insurance Plans (AHIP) found 56% of workers view health benefits as a key factor in remaining at their current jobs.[50]

- **Employee population health**. A health benefits plan may be used by an employer to reduce employee absenteeism and increase productivity.[51]

- **Tax exclusion**. Employer group health benefits are excluded from state and federal income for employees and payroll taxes for both employers and employees.[52] Therefore, particularly for high-wage earners, employer group health benefits represent a very tax-efficient means of employee compensation.

Additional factors that are now considered after implementation of the ACA and federal premium assistance in the exchanges include:

- **Lack of eligibility for federal premium assistance**. As illustrated in Figure 10 above, approximately 62% of Coloradans covered by an employer group health benefits plan have income above 400% FPL and, therefore, are not eligible for premium assistance. In the absence of eligibility for other types of coverage, it would be necessary to pay the full premium rate for individual market coverage with after-tax wages.

- **For employers in the large group market segment, the ACA's employer mandate**. Under the ACA, an applicable large employer, defined as 50 or more full-time employees (and full-time equivalents), must offer minimum essential health benefits coverage or pay a penalty of approximately $2,300 per full-time employee in 2019 (the first 30 full-time employees are exempted).[53] Additionally, the employer mandate penalties are not tax-deductible.

[50] AHIP (February 6, 2018). The Value of Employer-Provided Coverage. Retrieved October 10, 2019, from https://www.ahip.org/esi-survey/.
[51] Lofland, J.H. & Frick, K.D. (January 2006). Effect of health benefits on workplace absenteeism in the U.S. workforce. *Journal of Occupational and Environmental Medicine*. Retrieved March 4, 2019, from https://journals.lww.com/joem/Abstract/2006/01000/Effect_of_Health_Insurance_on_Workplace.2.aspx.
[52] IRS. Employee Benefits. Retrieved March 4, 2019, from https://www.irs.gov/businesses/small-businesses-self-employed/employee-benefits.
[53] IRS. Employer Shared Responsibility Provisions. Retrieved March 4, 2019, from https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions.

Based on Medical Expenditure Panel Survey (MEPS) data,[54] nearly all large employers in the state of Colorado (with 50 or more employees) offer health benefits. This observation has not changed with the introduction of CFHC and the availability of federal premium assistance beginning in 2014.
Small employers, however, offer traditional employer group coverage at far lower rates. MEPS data indicates that only 28% of Colorado state private sector establishments with fewer than 50 employees offered health benefits in 2017.[55] Some small employers contribute to the cost of individual exchange coverage for their employees, even though up until the passage of the 21st Century Cures Act and the establishment of the Qualified Small Employer Health Reimbursement Arrangement (QSEHRA), this was against the law and subject to fines of up $36,500 per year per employee.[56]

FACTORS EMPLOYERS CONSIDER WHEN OFFERING SPECIFIC COVERAGE

In a study sponsored by the U.S. Department of Labor,[57] the RAND Corporation found employers primarily select a health plan based on cost, defined by two measures:

- Provider discounts (including pharmacy costs)
- Administrative costs

These findings suggest that an employer may be open to alternatives to traditional employer group health benefits to the extent it results in cost savings to the organization. According to the U.S. Bureau of Labor Statistics, approximately 8% of 2018 compensation for civilian employees was related to health benefits.[58] Therefore, to the extent significantly more affordable options become available, it may allow an employer to materially reduce its employee benefit costs.

The RAND study also found that network adequacy was a major consideration for employers. To date, employers have been reluctant to offer narrow provider networks in employee health plan offerings. For example, the 2018 Kaiser Family Foundation Employer Health Benefits Survey indicated that only 6% of firms with 50 or more workers offered a narrow network plan.[59] The survey reported only 8% of employers had eliminated a hospital from their networks in the last year to achieve cost savings.[60]

A major contingency influencing employer take-up of Public Option plans, then, is the extent to which adequate networks can be built by participating Public Option carriers or by the stand-alone Public Option entity, especially considering the significant reductions in reimbursement underlying Public Option coverage compared to the reimbursement of coverage available on CFHC.

QSEHRA AND INTEGRATED INDIVIDUAL HRA AS ALTERNATIVES TO TRADITIONAL COVERAGE

Some employers have used health reimbursement arrangements (HRAs) as a means to supplement employer group health benefits coverage for their employees.[61] The following are key aspects of traditional HRAs, prior to recent legislative and regulatory developments:[62]

- An HRA must be funded solely by an employer
- Contributions made by an employer are excluded from an employee's gross income
- Reimbursements for qualified medical expenses from HRA funds are tax-free to the employee
- An employer may elect to carry over unused funds in the HRA to the following year(s)
- There is no limit on the amount of money an employer can contribute to the accounts
- The HRA must be offered in conjunction with other employer-provided health benefits

[54] HHS. Medical Expenditure Panel Survey. Retrieved October 6, 2019, from https://meps.ahrq.gov/.
[55] AHRQ. Table II.A.2: Percent of Private-Sector Establishments That Offer Health Insurance by Firm Size and State: United States, 2017. Retrieved October 10, 2019, from https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2017/tiia2.htm.
[56] Ibid.
[57] Mattke, S., Van Busum, K.R., & Martsolf, G. (2013). Final Report: Evaluation of Tools and Metrics to Support Employer Selection of Health Plans, Section 8.2. Retrieved March 4, 2019, from https://www.dol.gov/sites/default/files/ebsa/researchers/analysis/health-and-welfare/evaluation-of-tools-and-metrics-to-support-employer-selection-of-health-plans.pdf.
[58] U.S. Bureau of Labor Statistics (December 14, 2018). Employer costs for employee compensation news release text. Retrieved March 4, 2019, from https://www.bls.gov/news.release/ecec.nr0.htm.
[59] Kaiser Family Foundation (October 3, 2018). 2018 Employer Health Benefits Survey, Figure 14.6. Retrieved March 4, 2019, from https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-section-14-employer-practices-and-health-plan-networks/.
[60] Ibid.
[61] The 2018 Kaiser Family Foundation Employer Health Benefits Survey indicates 7% of employers (sponsoring an employer group health plan) offer a high-deductible health plan with an HRA. Please see https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-8-high-deductible-health-plans-with-savings-option/ for more information.
[62] More information about HRAs from the IRS is available at https://taxmap.irs.gov/taxmap/pubs/p969-003.htm.

Prior to plan years beginning in 2020, federal regulation required HRAs to be offered in conjunction with a traditional employer group health plan. Following the passage of the ACA, the U.S Department of Labor ruled that offering employees cash specifically for the purchase of individual health insurance constituted an annual limit on health benefits, and thus would violate the prohibition on dollar-based annual coverage limits under the ACA. However, recent legislative and regulatory developments have modified the requirement for integrated group coverage for employers. These changes create alternatives to traditional group coverage with equivalent tax benefits for both employer and employee, while also fulfilling the ACA's employer mandate for large employers.

Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)

The 21st Century Cures Act (Cures Act), enacted on December 13, 2016, created the Qualified Small Employer Health Reimbursement Arrangement (QSEHRA).[63] A QSEHRA allows an eligible small employer to reimburse an employee's medical expenses, including premiums for individual health benefits policies, so long as certain requirements are met:

- As with any HRA, the arrangement is funded solely by an eligible employer (an employee cannot make voluntary salary reduction contributions toward a QSEHRA).
- The amount of payments and reimbursements in the benefit year cannot exceed $5,150 for single coverage, or $10,450 for family coverage (2019 limits). Reimbursement limits are indexed each year.[64]
- The arrangement is generally provided on the same terms to all eligible employees of the eligible employer. Employers can vary contributions using the relevant ACA individual market age and family rating practices.
- The small employer must not offer a traditional group health plan to any of its employees.
- The employee must be covered by minimum essential coverage (which would include individual coverage, but would not include coverage under a short-term limited duration insurance plan).

Additionally, QSEHRA amounts can be supplemented by APTCs under certain conditions:

- The employee's net premium for self-only coverage for the SLCS after the self-only QSEHRA contribution must be above the APTC affordability threshold (9.78% of household income in 2020). The affordability threshold is indexed each year.
- For example, an employee with household income of $25,000 would not be eligible for an APTC to the extent that the post-QSEHRA out-of-pocket annual premium for the SLCS was less than approximately $2,500.
- If individual market coverage is deemed unaffordable with the QSEHRA, then the enrollee can receive an APTC. The normal APTC amount calculated based on the employee's household income as a percentage of FPL is reduced by the funds available within the QSEHRA.

Individual Integrated Health Reimbursement Arrangement (IIHRA)

In June 2019, the U.S. Departments of the Treasury, Health and Human Services (HHS), and Labor finalized new regulations to expand the usability of health reimbursement arrangements (HRAs). The proposed rule permits any employer to offer an HRA that can be used to purchase individual health insurance. An employer's group health plan must meet several conditions for the Individual Integrated HRA to qualify:[65]

- Individual employees (and their dependents) must be covered by an individual health benefits plan that meets minimum essential coverage requirements (i.e., IIHRA funds cannot be used for short-term limited duration coverage).

[63] IRS. Notice 2017-67: Qualified Small Employer Health Reimbursement Arrangements. Retrieved March 4, 2019, from https://www.irs.gov/pub/irs-drop/n-17-67.pdf.
[64] IRS. Rev. Proc. 2018-57: Tax Forms and Instructions. Retrieved March 4, 2019, from https://www.irs.gov/pub/irs-drop/rp-18-57.pdf.
[65] The full text of the final rule is available at https://www.federalregister.gov/documents/2019/06/20/2019-12571/health-reimbursement-arrangements-and-other-account-based-group-health-plans.

- Employees who are offered an IIHRA cannot be offered a traditional group health plan (and thus cannot be offered alongside an Excepted Benefits HRA).
- Employees in the same "employee class[66]" are offered an HRA on the “same terms.” Amounts can vary by employee age and family composition.
- Employees would have to be able to opt out of HRA coverage at least annually.
- Employees must substantiate coverage prior to receiving HRA reimbursements.

Unlike the QSEHRA, the employer can have a traditional group health plan along with an HRA offering, so long as no class of employees has access to both options at the same time. Therefore, employers could offer different reimbursement amounts or even different types of coverage to different classes of employees. Under the proposed rules, the following are examples of potential employer benefit offering scenarios:

- Full-time employees could be offered a traditional group plan and part-time employees an IIHRA, so long as the number of part-time employees meets the minimum class size requirement
- An IIHRA with one set of funding amounts could be offered to offices in one ACA rating area and with another set of funding amounts to offices in another ACA rating area

Although these offerings to various classes cannot be discriminatory, it is possible that large employers could establish business classes, such that certain groups of higher-cost individuals or groups of employees were offered HRAs, thereby removing them from employers’ risk pools (and lowering their costs) and moving them into the individual market risk pool.

In general, IIHRAs offer employers more segmenting flexibility than QSEHRAs. However, variations in contributions for age and family size are more of a mixed bag. QSEHRAs can vary contributions according to the exact age and family size combination of each employee, but only according to ACA rate variations that apply, while IIHRAs can apply any nondiscriminatory variation by family size, but can only account for the age of the employee. Additionally, IIHRAs do not have annual contribution maximums, unlike QSEHRAs.

Another key difference between IIHRAs and QSEHRAs relates to the determination of affordability. Affordability of a QSEHRA is determined relative to the second-lowest-cost silver plan, while affordability for an IIHRA would be evaluated against the lowest-cost silver plan instead. This difference can be significant in certain markets. Additionally, an individual who has access to a QSEHRA can still receive a supplementary APTC if coverage is unaffordable, while the employee must decline an unaffordable IIHRA to be eligible for APTC.

Overall, these new regulatory developments, along with the potential for lower-priced Public Option plans with broad eligibility, have the potential to change the employer health benefit landscape in the State of Colorado. By providing large employers (fully insured or self-funded) a legal and tax-efficient vehicle to make cash contributions toward individual market health benefits, it is possible that some employers will elect to forgo traditional group health benefit plan offerings, especially if Public Option plan coverage costs are less relative to traditional employer group coverage.

SUMMARY

Employer group health benefits is an important part of Colorado’s healthcare landscape and most employees are satisfied with their coverage under traditional health plans.[67] However, because cost is a critical consideration for employers, they could view lower-cost Public Option plans as a viable option provided they offer:

- A similar ability to attract and retain employees as current employer group health plans

[66] Classes include full-time employees (EEs), part-time EEs, salaried EEs, non-salaried EEs, EEs whose primary site of employment is in the same rating area, seasonal EEs, EEs covered by a collective bargaining agreement, EEs who have not satisfied a waiting period for coverage, non-resident aliens with no US-based income, and EEs who are provided by a staffing agency that is the actual employer. Combinations of the above classes are also acceptable. However, employers must meet minimum class sizes for classes offered IIHRAs if the employer offers an IIHRA to one class and a traditional group health plan to another class.
[67] AHIP, op cit.

- A contribution strategy that is similar to the current employer group health plan subsidy, funding an equivalent (or better) level of benefits
- Employee access to a similar level of benefits relative to the current employer group health plan available to them
- A tax-equivalent vehicle for funding costs
- Compliance with the ACA's employer mandate for large employers
- Adequate network breadth and provider access similar to the employees' current employer group health plan[68]

We summarize these considerations in Figure 17 and we discuss how these dynamics influence estimates of employer group take-up rates into Public Option plans in the next section.

FIGURE 17: SUMMARY OF EMPLOYER MOTIVATIONS TO MOVE TO INDIVIDUAL MARKET VIA HRA

CONSIDERATION	LARGE EMPLOYER	SMALL EMPLOYER	COMMENTS
ATTRACT AND RETAIN	+/-	+/-	Contingent upon public perception of Public Option plans, likely to vary significantly by employer
LOWER PRICE	+	+	Will vary by area
NETWORK ADEQUACY	+/-	+/-	Contingent on Public Option carrier's ability to contract
BENEFIT RICHNESS	-	+	No platinum-level benefits on CFHC for some large employers
RATING RULES (3:1 AGE LIMITS)	-	NA	Age rating limits on CFHC a disadvantage for large groups with disproportionate share of younger employees
TAX BENEFITS	+/-	+/-	Both QSEHRA and IIHRA offer tax advantages
FULFILL EMPLOYER MANDATE	+/-	NA	Mandate does not apply to employers under 50 lives

Note: A "+" indicates a factor that could motivate an employer to shift employees to the Public Option, "-" is a factor that may prevent shifting to the Public Option, and "+/-" represents an undetermined or neutral consideration.

[68] Larger employers tend to value broad networks. See Kaiser Family Foundation (October 3, 2018). 2018 Employer Health Benefits Survey, Figure 14.6. at https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-section-14-employer-practices-and-health-plan-networks/.

8. PUBLIC OPTION PLAN TAKE-UP RATES AND IMPACT TO PROVIDER REIMBURSEMENT

BACKGROUND

We modeled the potential impact of various Public Option plan take-up rates by commercial market segment (employer group, individual, and uninsured) to quantify the impact on the medical (non-pharmacy) revenues of Colorado providers. The reduction in provider revenue is a result of persons shifting from higher provider reimbursement market segments (e.g., the employer group market) to the lower reimbursement Public Option plans, partially offset by reductions to uncompensated care from decreases to the uninsured population. Therefore, changes in provider revenue are directly correlated with Public Option plan take-up.

Based on these projected movements and the resulting provider revenue reduction, we calculated the "cost-shift" percentage, which represents the incremental provider reimbursement increase to the employer group market that could result in a complete offset to the revenue loss caused by shifts to various percentages of Medicare reimbursement under the Public Option plans. Note that we believe it unlikely that cost shifting could occur in public health benefits programs (Medicare, Medicaid) due to the assumption that provider reimbursement is largely tied to Medicare or state Medicaid fee schedules.

We emphasize that while cost shifting to the employer group market is one possible response by providers, there are other strategies that may be used by them to compensate for revenue reductions. Moreover, market dynamics between payers and providers may only allow varying amounts of this cost shift to actually occur. Further discussion of provider responses to lower reimbursement under Public Option plans is found in Section 9 below.

PUBLIC OPTION PLAN TAKE-UP RATES

As each health benefits market segment has different demographic profiles, motivations, and purchasing habits, the market dynamics that influence overall take up rates are discussed below.

Individual market

As mentioned earlier, individual health benefits purchasers are primarily price-driven. Therefore, we assume that, for comparable benefits and reasonable network access, consumers will readily switch to Public Option plans. Exchange consumers generally are likely acclimated to narrow networks in the current exchange markets. To the extent that plans experience provider contracting difficulties under the Public Option due to lower reimbursement, consumers may be more accepting of provider access limitations, particularly if there are significant premium cost differences between Public Option plans and non-Public Option plans.

We assume no changes to the ACA's premium subsidy structure. It is anticipated that Public Option plans will become the "subsidy benchmark plan" or SLCS, as well as the LCS offered through Connect for Health Colorado (CFHC) in each geographic area. As illustrated in Section 6 of this report, while subsidy-eligible consumers could continue to purchase non-Public Option plans, consumers will be exposed to the plan's full premium difference relative to the Public Option plan. Therefore, to the extent a Public Option is introduced with meaningful price advantages relative to existing carriers, we estimate significant Public Option plan take-up during the first year it is offered.

Fully insured small groups

Only an estimated 27.6% of Colorado state private sector establishments with fewer than 50 employees currently offer health benefits to their employees.[69] Small employer groups that currently either offer transitional small group plans or ACA-compliant plans may have some incentive to move to Public Option plans due to lower price. Small employers, like individuals, are also price-sensitive and, assuming that both silver and gold level of benefits would be available under Public Option plans, small groups could receive a level of benefits comparable to their current plans and at potentially lower prices. Small employers may also be less averse to narrow networks, which are common on exchanges and could be a part of Public Option plans due to contracting challenges.

Given the past history of small employers contributing funds toward the cost of exchange coverage even when illegal, it is reasonable to assume that this practice will continue and expand with the introduction of QSEHRAs and, likely to

[69] AHRQ. Table II.A.2, op cit.

a smaller degree, the IIHRA introduced by the Trump administration (both would be available to small employers). These HRAs provide legal avenues for employers to establish alternative means of coverage for their employees on the individual market by making contributions both legal and tax-favored. Small employers *not* currently offering health benefits could now also use an HRA to reenter the employee health benefits market and adopt defined contribution approaches to health benefits offerings that are affordable for them. This may result in a reduction in Colorado's uninsured population.

For these reasons, the Public Option plan take-up assumptions for small groups are less than for individuals but more than the for the large group market. While employees of at least some of the employers not offering coverage are already purchasing coverage in the individual market, Public Option plan enrollment may occur from a portion of the approximately 70% of small employers that do not offer any coverage at all and are not captured in the small group enrollment numbers shown in Figure 8 above. We account for this potential enrollment by having slightly higher migration assumptions than we otherwise would.

The migration of fully insured small groups to the individual market could have a favorable impact to Public Option plan rates, given that the morbidity level in the small group market is estimated to be 15% to 20% lower relative to the individual market. If small employers with ACA-compliant coverage move employees into Public Option plans on CFHC, they will most likely move their entire groups. First, if a QSEHRA were used, the small employer could not offer traditional group benefits to any employee. Second, there is little motivation to move only certain employees to Public Option plans (such as the less healthy) via an IIHRA because health status rating is not permitted in the ACA-compliant small group market.

However, small employers that fund their current group health plans through self-funded or level-funded[70] arrangements might be motivated to offer an HRA to certain classes of employees to remove them from the group's risk pool, thereby directly reaping the benefits of improved overall medical costs. Self-funded small groups are considered in the self-insured market discussion below.

Large group fully insured and self-insured

Consistent with the previous section on employer group health benefits dynamics, we would generally assume no take-up from the large group employer market (either fully insured or self-insured) into Public Option plans in the absence of the IIHRA, for the following reasons:

- Large employers appear to have greater motivation to provide traditional employer group coverage and employees are generally satisfied with that offering.
- The termination of a group health plan would lessen the perceived ability for many employers to attract and retain employee talent. Even with the availability of the IIHRA to large employers, employee recruitment and retention will be a primary factor in maintaining traditional group coverage.

However, rules related to the IIHRA are finalized and these HRAs are now available to large employers. This means that they could opt to establish what amounts to a defined contribution approach to their health benefit plans. They could legally contribute to an employee's IIHRA to purchase a potentially lower-cost Public Option plan on CFHC. Moreover, if Public Option plans offer adequate networks and comparable benefits, there may be less risk of employee dissatisfaction.

For these reasons, we project in three of our four scenarios at least some take-up into Public Option plans by the large group segment and in both the medium and high scenarios for the self-insured segment, with take-up rates greater for the fully insured large group segment relative to the self-funded segment. Based on insurer financial data, the average fully insured large employer has approximately 180 insured employees, while self-funded groups have an average of more than 1,000 employees covered. Therefore, at the low end of the fully insured large group market, employer behavior under a Public Option may have more parallels with small employers, given that the IIHRA is now available to subsidize the purchase of individual market coverage.

Note, while not inherently considered in our modeling, we would anticipate that any employer migration to a defined contribution approach through an IIHRA would gradually occur over several years (5+ years).[71] Before terminating

[70] Level-funded products are a form of self-funding for small groups. Small employers who purchase them are contained in the self-funded lines of Figures 8 and 11.
[71] A defined contribution reflects an employer contributing a set amount of money (e.g., percentage of salary) towards a health benefits benefit. The contribution is not tied directly towards the cost of the benefit.

traditional employer group health benefits coverage, Public Option plans would need to have a favorable public perception in terms of provider access, ease of enrollment, and premium payment, as well as benefit design choices.

Uninsured

The impact of a Public Option on the uninsured population will most likely vary significantly by income level. In Section 4 of this report above, we provide estimates of the uninsured population by income level. Approximately 60% of uninsured Coloradans have incomes below 250% FPL, with the remaining 40% split almost evenly between the 251% FPL to 400% FPL and 400%+ FPL cohorts. In assessing the potential reduction to the statewide uninsured rate from the Public Option, consideration should be given to out-of-pocket premium rate impact to each income cohort and the relative size of the uninsured population within each income cohort. These effects are similar in nature to the out-of-pocket premium changes estimated for persons currently in the individual market with the same respective household incomes.

Household income below 250% FPL, premium rate savings retained by federal government

Lower-income households purchasing health benefits coverage in CFHC are currently receiving significant federal premium assistance. The value of the premium assistance caps out-of-pocket premium expenditures at a specified percentage of household income.

- We estimate that premium rates for Public Option plans will remain above the out-of-pocket premium limits, with out-of-pocket premiums for the vast majority of households at these lower income levels not changing.
- However, as previously discussed, the federal government will accrue savings from a reduction in premium subsidy costs.

Household income between 250% FPL and 400% FPL, premium rate savings shared between consumers and federal government

Consumers at this higher income level are still eligible for federal premium assistance for coverage purchased through CFHC. However, the value of premium assistance is significantly lower relative to lower income levels.

- Depending on the magnitude of premium rates decreases associated with the Public Option, some consumers in this income cohort will no longer receive premium assistance, as the cost of the SLCS plan may be below the limit specified by the ACA's premium subsidy formula.
- However, despite not being eligible for premium assistance for this reason, these consumers may have a lower out-of-pocket premium rate as the full premium rate of the Public Option plan may be less than the current subsidized premium for a non-Public Option plan. This is most likely to occur for young adults in this income cohort.
- As the federal government will no longer be providing premium assistance or providing a lower subsidy amount per capita, it will share in the Public Option plan premium savings with consumers in this income cohort.
- For some consumers in this income cohort, particularly adults approaching age 65, the premium rate for the SLCS plan will still be high enough to trigger federal premium subsidy payments. The federal government will accrue the full savings from the Public Option plans for these consumers.

The out-of-pocket premium rate changes for this income cohort will be mixed, with some consumers (particularly younger adults with higher incomes currently receiving limited premium subsidies) realizing direct premium rate savings from Public Option plans, while other consumers (older adults, particularly those with lower incomes) may not experience reductions in out-of-pocket premium rates. While we estimate that lower out-of-pocket premium rates for some consumers in this income cohort will reduce the state's uninsured rate, the impact will be muted relative to the population with income above 400% FPL that is currently not eligible for premium assistance.

Household income above 400% FPL, premium rate savings retained by consumers

The impact to consumer premium rates as a result of the introduction of Public Option plans is most straightforward for the income cohort above 400% FPL. These consumers do not qualify for premium assistance under the ACA and will realize the full premium rate reduction from the introduction of the Public Option plans.

IMPACT TO PROVIDER REIMBURSEMENT: PUBLIC OPTION MIGRATION SCENARIOS

Based on assumptions about general market dynamics resulting from the Public Option described in the above discussion, we modeled four market shift scenarios, as shown in Figure 18. These percentages, applied to baseline enrollment estimates, represent the portion of each market segment that is estimated to transition to a Public Option plan under the Public Option. These estimates reflect long-term (3-5 years) migration impacts. While we believe the majority of migration to Public Option plans in the individual market will occur immediately upon implementation, migration from the employer market (if it occurs) is more likely to happen gradually over the course of several years.

FIGURE 18: ASSUMPTIONS OF MIGRATION TO PUBLIC OPTION PLANS BY MARKET SEGMENT AND UNINSURED

SCENARIO	INDIVIDUAL	SMALL GROUP	FULLY INSURED LARGE GROUP	SELF-INSURED LARGE GROUP	UNINSURED
BASELINE ENROLLMENT	217,000	299,000	679,000	1,936,000	476,000
SCENARIOS A: LOW ENROLLMENT SHIFT – 180% OF MEDICARE	10%	0%	0%	0%	2%
SCENARIO B: MEDIUM ENROLLMENT SHIFT – 150% OF MEDICARE	30%	10%	5%	5%	5%
SCENARIO C: HIGH ENROLLMENT SHIFT – 120% OF MEDICARE	85%	15%	10%	7%	7%
SCENARIO D: EXTRA HIGH ENROLLMENT SHIFT – 100% OF MEDICARE	100%	20%	15%	10%	10%

Figure 19 illustrates the baseline 2019 medical revenue—excluding prescription drugs and long-term services and supports (LTSS)—for each market segment, prior to any migration that is assumed to be caused by the introduction of Public Option plans (the development of these estimates is provided in Figure 11 of this report above). Additionally, we provide the estimated payment index for each market, which reflects the estimated relative provider reimbursement compared to the employer group markets (shown as 100%). For example, the payment index for the individual market is 82%, which indicates the estimated provider reimbursement in the market is approximately 18% less than the employer group markets. We exclude prescription drugs for all segments because these costs are not affected by Medicare fee-for-service reimbursement. We also estimate the portion of Medicaid and Medicare costs attributable to LTSS (nursing facility and waiver services) and exclude those costs, as well.

Uninsured revenue is assumed to be the portion of revenue actually collected by providers directly from the patient.

FIGURE 19: COLORADO ESTIMATED 2019 PAYMENT INDEX, MEDICAL MEMBERSHIP, AND ALLOWED CLAIMS DISTRIBUTIONS BY MARKET SEGMENT

MARKET SEGMENT	PERSONS	ASSUMED PAYMENT INDEX	ESTIMATED PROVIDER MEDICAL REVENUE ($ BILLIONS)	PERCENTAGE OF TOTAL MEDICAL REVENUE
INDIVIDUAL	217,000	82%	$1.4	4.7%
SMALL GROUP	299,000	100%	$1.5	5.0%
LARGE GROUP	679,000	100%	$3.4	11.3%
SELF-FUNDED	1,936,000	100%	$9.7	32.3%
MEDICAID	1,199,000	40%	$5.0	16.7%
MEDICARE	741,000	47%	$6.4	21.3%
DUALS	83,000	47%	$1.4	4.7%
OTHER	155,000	100%	$0.8	2.7%
UNINSURED	476,000	26%	$0.4	1.3%
TOTAL	5,785,000	74%	$30.0	100.0%

Based on the interaction of the market enrollment shifts illustrated in Figure 19 above and the estimated provider reimbursement levels in each market, we modeled the net change in provider revenue under the Public Option for the four take-up scenarios. Additionally, we modeled the necessary cost shift (increase in provider reimbursement) to the residual employer group market to completely offset the provider revenue loss under the Public Option. For example, if the provider revenue reduction were estimated at $300 million prior to cost shifting, we assumed the employer group market would absorb a $300 million provider revenue increase to result in provider revenue neutrality under the Public Option.

As noted in Section 9, cost shifting is one of many possible provider responses to the Public Option. The cost shift estimates reflected in the four scenarios reflect providers only cost shifting in response to the Public Option. Therefore, cost shifting estimates illustrated in the four scenarios should be considered maximum estimates to employer group reimbursement. Particularly under the high and extra-high take-up scenarios, it is unlikely the employer market would be able to absorb the full cost increase and thus providers would need to take other actions to offset the reductions and may not be able to offset 100% of the reduction.

Public Option at 180% of Medicare: Low take-up scenario

Figure 20 illustrates the estimated Public Option plan enrollment and associated provider revenue impacts under the low take-up scenario. Figure 20 provides the following information for the commercial markets (employer group and individual) and the uninsured population:

- **Baseline membership in each market:** The 2019 estimated enrollment by market, taken from Figure 8.
- **Percentage of market enrolling in Public Option plans:** This reflects the estimated proportion of baseline enrollment in each market assumed to migrate to Public Option plans.
- **Market enrollment shifting to Public Option plans:** This reflects the estimated number of individuals in each market assumed to migrate to Public Option plans, calculated as the baseline membership in each market multiplied by the percentage of market shifting to Public Option plans.
- **Cumulative Public Option plan membership:** From left to right, these values represent the cumulative Public Option membership as membership from each market migrates. In Figure 20, under the Individual column, enrollment of 21,700 is shown, which reflects 10% of the baseline enrollment of 217,000 shifting to Public Option plans. For this scenario we assume that 0% of the small group market baseline enrollment of 299,000 will shift to Public Option

plans. This enrollment is added to the individual market Public Option plan enrollment, resulting in a cumulative enrollment value of 21,700 for Public Option plans in this scenario. For other scenarios where the percentage of small group market shifting to the Public Option is not zero, this will be a different value, higher than the previous one. The Public Option plan enrollment migration estimates continue from left to right in Figure 20. As the cumulative Public Option plan enrollment changes from 21,700 to 31,200 for the uninsured population, this indicates an assumption of 9,500 currently uninsured persons purchasing Public Option plans. The 9,500 value is 2% of the total uninsured population but equivalent to approximately 10% of the uninsured population with income above 400% FPL (as shown in Figure 10 above).

- **Cumulative total medical revenue impact:** Based on the market migration and estimated provider reimbursement relativities, this line item represents the cumulative aggregate provider medical revenue under the Public Option. In a manner identical to the Cumulative Public Option Membership line item, the values represent the cumulative effect of Public Option plan migration by market. For example, we estimate a provider medical revenue *decrease* of $34 million from individual market migration. We assume previously uninsured persons purchasing Public Option plans will increase provider medical revenue by $150 million (through a combination of additional services and higher reimbursement), resulting in a final cumulative provider revenue increase of $116 million.

- **Cumulative total medical revenue impact, % of total baseline revenue:** In addition to illustrating the provider revenue impact in millions of dollars, we also give the provider revenue change as a percentage of the baseline medical revenue estimate of $30.0 billion. The cumulative $116 million net provider revenue increase represents a 0.4% increase in provider revenue relative to the aggregate baseline value. In other scenarios, this will be a reduction in revenue and hence a negative percentage.

- **Remaining employer group only medical revenue base ($ millions):** Based on the cumulative migration to Public Option plans across each market, this value represents the remaining residual provider revenue base derived from the employer group market. For the Individual column, the value of $14.6 billion is equal to the baseline value for the Employer Group illustrated in Figure 11. The value is the same under the small group column because no small group membership is assumed to move to the Public Option in this scenario. However, other scenarios reflect reductions in provider medical revenue resulting from small group migration to Public Option plans.

- **Remaining employer group only medical revenue base, % of total baseline revenue:** These values represent the estimated residual provider revenue derived from patients in the employer group market relative to the total baseline medical revenue estimate of $30 billion. Based on cumulative Public Option plan migration across markets, providers' medical revenue derived from patients in the employer group market is estimated to be reduced in all other scenarios.

- **Cost shift for budget neutrality:** Finally, we illustrate the increase in revenue associated with patients with employer group coverage that would completely offset the reduction in revenue resulting from Public Option plan migration.

FIGURE 20: CUMULATIVE ENROLLMENT AND PROVIDER REVENUE IMPACTS: 180% OF MEDICARE AND LOW PUBLIC OPTION ENROLLMENT

TOTAL MEDICAL REVENUE BASELINE (ALL COMMERCIAL AND GOVERNMENT MARKETS)	$30.0 BILLION				
MARKET	Individual	Small Group	Fully Insured Large Group	Self-Insured Large Group	Uninsured
BASELINE ENROLLMENT	217,000	299,000	679,000	1,936,000	476,000
PERCENTAGE OF MARKET SHIFTING TO PUBLIC OPTION	10%	0%	0%	0%	2%
MARKET ENROLLMENT SHIFTING TO PUBLIC OPTION	21,700	-	-	-	9,500
CUMULATIVE PUBLIC OPTION MEMBERSHIP	21,700	21,700	21,700	21,700	31,200
(A) CUMULATIVE TOTAL MEDICAL REVENUE IMPACT ($ MILLIONS)	-$34	-$34	-$34	-$34	$116
% OF TOTAL BASELINE REVENUE	-0.1%	-0.1%	-0.1%	-0.1%	0.4%
(B) REMAINING EMPLOYER GROUP ONLY MEDICAL REVENUE BASE ($ MILLIONS)	$14,600	$14,600	$14,600	$14,600	$14,600
% OF TOTAL BASELINE REVENUE	48.7%	48.7%	48.7%	48.7%	48.7%
(C) = (A) / (B) PROVIDER REVENUE NEUTRAL COST SHIFT	0.2%	0.2%	0.2%	0.2%	-0.8%

Public Option at 150% of Medicare: Medium take-up scenario

Figure 21 illustrates the estimated Public Option plan enrollment and associated provider revenue impacts under the 150% of Medicare reimbursement level and medium Public Option take-up scenario. Under this scenario, there are almost 250,000 members in Public Option plans. Provider revenue declines by $373 million from shifts to Public Option plans but is offset by approximately $310 million when additional uninsured enter the market. The net provider medical revenue loss of $63 million is then shifted to the remaining employer group market revenue base of approximately $13.8 billion, resulting in a cost shift of 0.5%.

FIGURE 21: CUMULATIVE ENROLLMENT AND PROVIDER REVENUE IMPACTS: 150% OF MEDICARE AND MEDIUM PUBLIC OPTION ENROLLMENT

TOTAL MEDICAL REVENUE BASELINE (ALL COMMERCIAL AND GOVERNMENT MARKETS)	$30.0 BILLION				
MARKET	Individual	Small Group	Fully Insured Large Group	Self-Insured Large Group	Uninsured
BASELINE ENROLLMENT	217,000	299,000	679,000	1,936,000	476,000
PERCENTAGE OF MARKET SHIFTING TO PUBLIC OPTION	30%	10%	5%	5%	5%
MARKET ENROLLMENT SHIFTING TO PUBLIC OPTION	65,100	29,900	34,000	96,800	23,800
CUMULATIVE PUBLIC OPTION MEMBERSHIP	65,100	95,000	129,000	225,800	249,600
(A) CUMULATIVE TOTAL MEDICAL REVENUE IMPACT ($ MILLIONS)	-$140	-$182	-$232	-$373	-$63
% OF TOTAL BASELINE REVENUE	-0.5%	-0.6%	-0.8%	-1.2%	-0.2%
(B) REMAINING EMPLOYER GROUP ONLY MEDICAL REVENUE BASE ($ MILLIONS)	$14,600	$14,500	$14,300	$13,800	$13,800
% OF TOTAL BASELINE REVENUE	48.7%	48.2%	47.7%	46.0%	46.0%
(C) = (A) / (B) COST SHIFT FOR REVENUE NEUTRALITY	1.0%	1.3%	1.6%	2.7%	0.5%

Public Option at 120% of Medicare: High take-up scenario

Figure 22 illustrates the estimated Public Option plan enrollment and associated provider revenue impacts under the high take-up scenario. Under this scenario, Public Option prices are even lower and almost 500,000 persons migrate to Public Option plans. Provider revenue declines by $919 million from shifts to Public Option plans, but is offset by approximately $341 million from previously uninsured persons purchasing coverage. The net loss of $578 million in provider revenue is then shifted to the remaining employer group market revenue base of $13.4 billion. Note that the employer group revenue base for the high scenario is smaller than the medium scenario. The combination of the smaller residual employer group revenue base and larger provider revenue reduction from Public Option plan migration, creates a compounding effect on the cost shift percentage. Thus the ultimate cost shift for revenue neutrality is 4.3%

FIGURE 22: CUMULATIVE ENROLLMENT AND PROVIDER REVENUE IMPACTS: 120% OF MEDICARE AND HIGH PUBLIC OPTION ENROLLMENT

TOTAL MEDICAL REVENUE BASELINE (ALL COMMERCIAL AND GOVERNMENT MARKETS)	$30.0 BILLION				
MARKET	Individual	Small Group	Fully Insured Large Group	Self-Insured Large Group	Uninsured
BASELINE ENROLLMENT	217,000	299,000	679,000	1,936,000	476,000
PERCENTAGE OF MARKET SHIFTING TO PUBLIC OPTION	85%	15%	10%	7%	7%
MARKET ENROLLMENT SHIFTING TO PUBLIC OPTION	184,500	44,800	67,900	135,500	33,300
CUMULATIVE PUBLIC OPTION MEMBERSHIP	184,500	229,300	297,200	432,700	466,000
(A) CUMULATIVE TOTAL MEDICAL REVENUE IMPACT ($ MILLIONS)	-$383	-$477	-$625	-$919	-$578
% OF TOTAL BASELINE REVENUE	-1.3%	-1.6%	-2.1%	-3.1%	-1.9%
(B) REMAINING EMPLOYER GROUP ONLY MEDICAL REVENUE BASE ($ MILLIONS)	$14,600	$14,400	$14,000	$13,400	$13,400
% OF TOTAL BASELINE REVENUE	48.7%	48.0%	46.8%	44.6%	44.6%
(C) = (A) / (B) COST SHIFT FOR REVENUE NEUTRALITY	2.6%	3.3%	4.5%	6.9%	4.3%

Public Option at 100% of Medicare: Extra-high take-up scenario

Analysis similar to the previous paragraphs can be done on the final scenario shown in Figure 23. For clarity, we note, a 100% of Medicare scenario may not be realistic. We display it here because other public options (such as Washington State's Cascade Care program) started with this assumption. Analysis done by the REMI Partnership[72] appears to assume this level of reimbursement, as well.

FIGURE 23: CUMULATIVE ENROLLMENT AND PROVIDER REVENUE IMPACTS: 100% OF MEDICARE AND VERY HIGH PUBLIC OPTION ENROLLMENT

TOTAL MEDICAL REVENUE BASELINE (ALL COMMERCIAL AND GOVERNMENT MARKETS)	$30.0 BILLION				
MARKET	Individual	Small Group	Fully Insured Large Group	Self-Insured Large Group	Uninsured
BASELINE ENROLLMENT	217,000	299,000	679,000	1,936,000	476,000
PERCENTAGE OF MARKET SHIFTING TO PUBLIC OPTION PLANS	100%	20%	15%	10%	10%
MARKET ENROLLMENT SHIFTING TO PUBLIC OPTION	217,000	59,800	101,900	193,600	47,600
CUMULATIVE PUBLIC OPTION MEMBERSHIP	217,000	276,800	378,700	572,300	619,900
(A) CUMULATIVE TOTAL MEDICAL REVENUE IMPACT ($ MILLIONS)	-$578	-$731	-$1,003	-$1,514	-$1,115
% OF TOTAL BASELINE REVENUE	-1.9%	-2.4%	-3.3%	-5.1%	-3.7%
(B) REMAINING EMPLOYER GROUP ONLY MEDICAL REVENUE BASE ($ MILLIONS)	$14,600	$14,300	$13,800	$12,800	$12,800
% OF TOTAL BASELINE REVENUE	48.7%	47.8%	46.0%	42.8%	42.8%
(C) = (A) / (B) COST SHIFT FOR REVENUE NEUTRALITY	4.0%	5.1%	7.3%	11.8%	8.7%

INDIVIDUAL MARKET MORBIDITY CHANGES

The premium changes shown above in Section 5 isolate the impact of reimbursement and do not include any potential morbidity effects of migration from small group and large group markets or from the uninsured into the Public Option. It is reasonable to assume that employers may have interest in allowing employees access to the potentially lower costs of a Public Option through tax-enabling vehicles, such as the IIHRA and the QSHERA, described earlier. Employer group markets tend to be healthier than the individual market because employees have to maintain reasonable health status in order to work and because carriers typically enforce a minimum percentage of employees who must be enrolled in the plan. This helps ensure a balanced cross-section of risk in each employer group.

[72] REMI Partnership, op cit.

By contrast, the individual market is the market of last resort and individual consumers may choose to enroll when they anticipate the need for services. The uninsured also tend to be healthier than those in the individual insured market, particularly at higher incomes because, for the reverse reason, they will choose to "self-insure" when they are healthy.

We estimate the favorable effects of these dynamics for the employer group market and the uninsured population by normalizing composite per capita allowed amounts derived from Figure 11 above for differences in estimated provider reimbursement levels and age differences, thereby isolating differences in morbidity between markets. We then calculate the impact of migration from employer group markets and the uninsured over to individual (using the migration scenarios outlined in Figure 18 of this report above). The results of this analysis are summarized in Figure 24.

FIGURE 24: CUMULATIVE MORBIDITY IMPACT OF EMPLOYER GROUP AND UNINSURED MIGRATION TO INDIVIDUAL SEGMENT

MIGRATION / REIMUBURSEMENT SCENARIO	BASELINE INDIVIDUAL MARKET	AFTER SMALL GROUP MIGRATION	AFTER LARGE GROUP MIGRATION	AFTER SELF-INSURED MIGRATION	AFTER UNINSURED MIGRATION
SCENARIOS A: LOW ENROLLMENT SHIFT – 180% OF MEDICARE	0.0%	0.0%	0.0%	0.0%	-1.3%
SCENARIO B: MEDIUM ENROLLMENT SHIFT – 150% OF MEDICARE	0.0%	-2.6%	-3.0%	-3.9%	-3.9%
SCENARIO C: HIGH ENROLLMENT SHIFT – 120% OF MEDICARE	0.0%	-1.6%	-2.2%	-3.1%	-3.2%
SCENARIO D: EXTRA HIGH ENROLLMENT SHIFT – 100% OF MEDICARE	0.0%	-1.8%	-2.4%	-3.3%	-3.4%

Figure 24 illustrates that by adding members to the individual market from employer group markets and the uninsured population, the acuity of the individual market is reduced in all scenarios relative to the baseline.

However, these estimates should be dampened as we anticipate there could be some anti-selective behavior on the part of large groups related to IIHRA offerings. It is conceivable, although against regulations, that employers would seek to make HRA offerings to certain classes of employees that are higher-cost, thereby moving them out of the traditional employer group health plan and improving the employer's risk pool while worsening the individual pool. Offsetting this to some degree is the additional premium that will be realized as younger uninsured individuals enter the market. Because of the 3:1 age restriction on premiums in the ACA, younger people are paying more than their expected claims costs will be. All in, we estimate the net effect of the anti-selective behavior and the improved premium yield due to a younger age to reduce the favorable impact shown above by approximately 50%.

Based on these considerations, we estimate that the individual market could see a range of improvement in overall morbidity and claims costs of between 0% and 2%. Unlike the impact of reimbursement changes, which would be immediate upon implementation of a Public Option, the impact of morbidity improvements in the individual market would occur over time, as actual migration takes place over several years.

Summary

Depending on network adequacy and the price, Public Option plans could see a wide range of take-up rates. The scenarios modeled are intended to illustrate potential ranges and impacts to provider revenue. To the extent Public Option plans have a material advantage relative to other plans offered in the individual market, it is reasonable to assume that a very large portion of the individual business will switch to Public Option plans. There is greater uncertainty

with Public Option migration, as it likely depends on perceived network adequacy of the Public Option and the adoption of defined contribution strategies for health benefits through tax-favored vehicles that fulfill the employer mandate.

With regard to the uninsured population, the Public Option is estimated to reduce the uninsured population by 10% in the extra-high scenario. Because a Public Option will have limited to no impact on the out-of-pocket premium for the SLCS plan, insurance take-up rates are unlikely to change materially for households with income under 400% FPL (accounting for more than 80% of the estimated uninsured population). This results in a stand-alone Public Option (without additional state-based subsidies) reducing the State of Colorado's uninsured rate only from 8.2% to 7.4%.

9. RESPONSE BY PROVIDERS

Depending on the number of enrollees covered by Public Option plans, providers will experience varying levels of reduced reimbursement. Providers' reactions will also vary accordingly. Moreover, those reactions may vary by geographical area as well. However, the most likely reactions may be:

Do not accept Public Option plan patients

The success of the Public Option depends on the willingness of providers to accept lower reimbursement levels because consumers' coverage is less useful if they lack access to providers. The Public Option's below-market reimbursement could discourage providers from contracting with carriers that are seeking to build out a network for a Public Option plan offering (under a contracted approach), or from contracting with the Public Option stand-alone entity. Depending on a particular provider's reimbursement mix from other payers, both Public Option plans and private, some may choose to contract and some may not.

While contracting at lower than market reimbursement rates could be challenging for insurers in urban areas, it may be an even greater challenge in rural areas. In a 2019 10-state survey of marketplace administrators and insurers, the Urban Institute reported narrow networks (which typically include lower reimbursement) were difficult to establish in rural areas due to a limited number of existing providers and the resulting negotiating leverage retained by them.[73] In addition, state network adequacy requirements would still apply to Public Option plans, and an inability to negotiate contracts with a sufficient number of providers may prevent Public Option plans from being offered in rural and / or high-cost areas. Yet these areas are one of the main focuses of HB19-004.

The breadth and quality of the networks associated with the Public Option's plans, based on the acceptance or lack of acceptance of the relatively lower reimbursement, will have other downstream impacts. As previously discussed in this report, an employer's strategy of terminating its traditional employer group health plan and funding IIHRAs for employees to purchase Public Option plans would likely be preconditioned upon there being reasonable provider access available through Public Option plan networks. To the extent provider access in Public Option plans is publicly perceived as limited, lower take-up rates for Public Option plans from persons currently enrolled in employer group plans would be anticipated.

Shift costs to other markets when possible

In order to offset the reduction in reimbursement from enrollment in the Public Option, a provider may attempt to negotiate higher reimbursement levels for other markets, particularly the employer group market. To the extent cost shifting occurs, higher underlying provider reimbursement rates will need to be absorbed in those markets, and all else equal, premiums will increase in the markets to which costs are shifted. This dynamic was quantified in Section 8 of this report.

Change the payer mix

The provider may assess its mix of patients among employer group, Connect for Colorado Health (CFHC) coverage (specifically Public Option plans), Medicaid, and Medicare. To the extent reimbursement associated with health benefits purchased through the CFHC is reduced, the provider could elect to accept fewer Medicaid, Medicare, or Public Option patients (and increase the number of employer group patients if possible), offsetting the Public Option reimbursement reduction. This option may not be possible in rural areas where provider access is limited. However, where it is possible to do this, it could cause access issues for vulnerable populations, such as low-income and elderly under both Medicaid and Medicare programs.

Other responses by providers could include:

Increase efficiency. To the extent a provider can reduce underlying expenses associated with the delivery of healthcare services, the provider may be able to mitigate some of the margin decrease experienced from reduced reimbursement levels.

Increase volume. Particularly under fee-for-service reimbursement, a provider may elect to deliver more services per patient or add patients (if the provider currently has excess capacity). Adding patients could reduce visit times or otherwise compromise quality of care.

[73] Holahan, J., Blumberg, L.J., Wengle, E., & Elmendorf, C. (January 2019). What's Behind 2018 and 2019 Marketplace Insurer Participation and Pricing Decisions? Robert Wood Johnson Foundation. Retrieved February 14, 2019, from https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2019/rwjf451264 (PDF download).

Accept lower reimbursement. To the extent a provider's underlying expenses are not reduced, lower reimbursement will result in lower margins for the provider.
Pursue consolidation with other providers. Small physician practices may join large medical groups or become hospital employees to take advantage of typically higher negotiated commercial rates. Hospital mergers may occur to increase negotiating leverage, economies of scale, or population health management capabilities.

Exit market. A provider could exit the market (retire, move to a different state, etc.)

Additionally, it may be possible that a provider reacts to reduced reimbursement rates with a combination of behaviors. For example, healthcare delivery efficiency may be increased, and higher employer group reimbursements could be negotiated (cost shifting) while accepting slightly lower margins.

10. SECTION 1332 WAIVERS

Section 1332 of the ACA permits a state to apply for a waiver to "pursue innovative strategies for providing their residents with access to high quality, affordable health benefits while retaining the basic protections of the ACA."[74] In November 2018, CMS issued guidance describing several "waiver concepts," including state-specific premium assistance proposals.[75] In order for a waiver to be approved, the state's application must meet the following criteria, known as "guardrails":

- Health benefits coverage (coverage): The waiver must provide coverage to a comparable number of residents of the state as would be provided coverage absent the waiver.
- Health benefits affordability and comprehensiveness: The waiver would provide access to coverage that is as affordable and comprehensive as would be accessible absent the waiver.
- Deficit neutrality: The waiver would not increase the federal deficit.

To the extent a waiver generates savings to the federal government, a state may receive federal pass-through funding based on the difference between federal expenditures with and without the waiver.

Our modeling shows that the Public Option could potentially reduce premium rates relative to the current 2020 plans by material amounts, depending on provider reimbursement and geographic region. This will reduce premium rates for consumers not qualifying for premium assistance. Additionally, it will reduce federal outlays for premium tax credits for the nearly 80% of the population purchasing Connect for Health Colorado (CFHC) coverage with premium assistance. Figure 25 illustrates how pass-through funding under a section 1332 Waiver may be generated by the Public Option based on current federal premium assistance being received by three households.

FIGURE 25: ILLUSTRATION OF POTENTIAL SECTION 1332 WAIVER PASS-THROUGH FUNDING UNDER THE PUBLIC OPTION

	PREMIUM AND SUBSIDIES WITHOUT THE PUBLIC OPTION			PREMIUM AND SUBSIDIES WITH THE PUBLIC OPTION			PUBLIC OPTION IMPACT	
Household	Full Premium	Premium Subsidy	Net Premium	Full Premium	Premium Subsidy	Net Premium	Consumer Savings	Federal Government Savings
A	$500	$300	$200	$300	$100	$200	$0	$200
B	$500	$100	$400	$300	$0	$300	$100	$100
C	$500	$0	$500	$300	$0	$300	$200	$0

Household A. Consumers qualifying for premium assistance with value greater than the premium reduction resulting from the introduction of Public Option plans are unlikely to see reductions in net premium cost (federal government retains 100% of premium savings, which becomes pass-through funding under the 1332 Waiver). Consumers with household incomes under 250% FPL with be represented by Household A. As illustrated in Section 4, consumers in this income cohort are estimated to reflect approximately 33% of the population currently purchasing coverage in the individual market.

Household B. For consumers qualifying for limited premium assistance, such as Household B, premium savings will be shared by the consumers and the federal government. Household B does not qualify for premium assistance after the introduction of the Public Option plans, but experiences a $100 reduction in monthly net premiums (federal government retains 50% of premium savings, which become pass-through funding under the 1332 Waiver). Consumers with household incomes between 250% FPL and 400% FPL are most likely to be represented by Household B. As illustrated in Section 4, consumers in this income cohort are estimated to reflect approximately 22% of the population currently purchasing coverage in the individual market.

Household C. Higher-income consumers who did not qualify for premium assistance prior to the implementation of the Public Option plans will realize the full premium savings from the reinsurance program (consumer retains 100% of

[74] CMS. Section 1332: State Innovation Waivers. Retrieved October 10, 2019, from https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/section_1332_state_innovation_waivers-.html.
[75] CMS (November 29, 2018). Fact Sheet: State Empowerment and Relief Waiver Concepts. Retrieved October 9, 2019, from https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Fact-Sheet.pdf.

premium savings, no pass-through funding available). Consumers with household incomes above 400% FPL are most likely to be represented by Household C. As illustrated in Section 4, consumers in this income cohort are estimated to reflect approximately 45% of the population currently purchasing coverage in the individual market.

By requiring lower than market reimbursement for private individual market coverage, the implementation of Public Option plans is estimated to reduce premium rates through what is, in essence, a provider assessment. This subsidy to the individual market will reduce premiums by reducing claims expenses in a similar manner as a state-based reinsurance program. One important difference between these two options, however, is that a reinsurance program reduces an insurer's expenses *after* the direct provider payment is made. However, the Public Option reduces both carrier (whether a stand-alone or a contracted entity) and consumer claims expenses at the point of service.[76] As a result, it will also reduce consumers' claims expenses when services are subject to a deductible and / or coinsurance.

To the extent the State of Colorado seeks a 1332 Waiver for the Public Option, approval may result in the return of federal pass-through savings to the state.

Summary

The implementation of Public Option plans is anticipated to result in significant premium rate reductions to the subsidy benchmark plans offered in CFHC in rural areas and, under some scenarios, urban areas as well. These premium rate savings will be fully realized by consumers who do not currently qualify for subsidy assistance and partially by consumers who qualify for only limited premium assistance. However, the federal government will realize the entire amount of savings for low-income consumers.

A 1332 Waiver may be one policy option that would allow Colorado's healthcare delivery system to retain federal premium assistance savings. Because no public option has been submitted to CMS for approval under a Section 1332 Waiver, some initial conversations with CMS regarding a 1332 Waiver submission based on the Public Option may be helpful.

[76] Note that, for provider-owned insurers, while the Public Option plans may reduce claims expenses on paper from the view of the insurance entity, participation as a Public Option plan does not reduce the actual cost to deliver healthcare services. Therefore, with respect to the parent company, offering a Public Option plan may result in an overall system net revenue reduction.

11. OVERVIEW OF POLICY OPTIONS

As noted in Section 3, many of the historical and most recent state reform activities, including the public option, have the following in common:

1. The reforms attempt to reduce premiums, and the most recent initiatives focus on the individual market and then primarily on the unsubsidized portion of that market (persons with household incomes above 400% FPL).

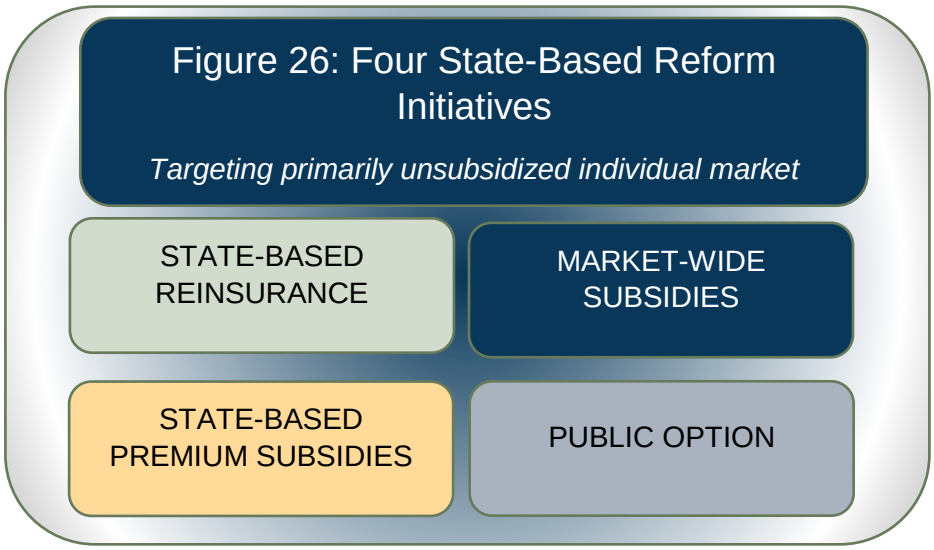
2. A secondary goal is to increase consumers' choice of insurance carrier and / or increase market competition by encouraging more carriers to enter, particularly in regions that have only one carrier.

The enabling legislation for Colorado's Public Option study (see Appendix A) cites very similar motivations. The assembled public data in Appendix B reinforces the State of Colorado's concerns related to affordability and carrier participation. Appendix B illustrates that the individual market in Colorado has seen both increasing prices (approximately a 90% SLCS cumulative rate increase from 2014 to 2019) and a decreasing number of participating carriers (the average number of carriers offering coverage per county has decreased from 6.6 in 2014 to 2.4 in 2019). A Public Option, regardless of the form it takes, attempts to address both of these policy goals *directly* but is just one of several alternatives that are intended to address similar challenges.

The Public Option addresses both affordability and carrier participation directly…

To that end, we have identified four reform initiatives, shown in the graphic in Figure 26, that could (or do currently) address one or both of these concerns, affordability and carrier participation. This section describes the details as well as the advantages and disadvantages of each initiative. Note, we review reinsurance as a policy "option," albeit one that is already exercised in Colorado, because it will be important to understand the potential benefits or drawbacks of this option as it is reviewed by policy makers annually, as well as part of the waiver renewal with CMS after five years. It is also important to consider a Public Option in light of what has been (or will be accomplished) by the reinsurance program starting in 2020.

Our evaluation of benefits and drawbacks is done primarily from a public policy perspective but we also articulate various features of each option that could be challenging for private market carriers.



STATE-BASED REINSURANCE

As noted earlier, 13 states have now been approved for state-based reinsurance waivers or the related concept of an invisible high-risk pool, the most recent being Delaware, Montana, and Rhode Island in August 2019.[77] State-based reinsurance programs make the state (or a state-sponsored entity) the risk-bearing entity for claims above a certain threshold and likewise reduce risk for carriers, both incumbent and those entering the market.

Reinsurance waivers are popular because they are relatively straightforward conceptually, have limited implementation risk, have been approved by CMS in a timely fashion, and carriers seem to be comfortable with the idea and the impact of the programs. The demonstration of compliance with the 1332 Waiver guardrail requirements is relatively simple, as evidenced by the number of approved waiver applications. Reinsurance has both market subsidy and true insurance elements, meaning that the total market-wide subsidy (which reduces gross premiums of all carriers) is "allocated" across carriers and benefit plans via the reinsurance element.

Because the reinsurance program reduces the premium for the SLCS, it generates federal "pass-through" funding that helps offset program costs. In effect, CMS reimburses the state for the reduction in costs for the subsidized portion of the market, leaving the state with a net cost of reinsurance for the unsubsidized populations. *Thus, the net benefits of the program accrue largely (but not entirely) to those over 400% FPL.*

Attachment points, carrier coinsurance percentage, and the total per member reinsurance payout cap can be set to fulfill policy and budget goals. For example, Colorado has set varying attachment points by region to bring a greater reinsurance impact to high-cost rural parts of the state and a smaller reinsurance impact to lower-cost urban parts of the state.[78]

BENEFITS AND DRAWBACKS OF A STATE-BASED REINSURANCE PROGRAM

Because Colorado has already been approved by CMS for a state-based reinsurance program under a 1332 Waiver, it is important to understand how the reinsurance program has attained some of the same goals or benefits of a Public Option, potentially making the Public Option (regardless of actual form) marginally less valuable. Moreover, it is important to consider how the Public Option would interact with the reinsurance program, which we discuss further below. Finally, a firm understanding of reinsurance mechanics relative to other policy options can help shape future policy modifications as the Colorado reinsurance program comes up for renewal with CMS and the State of Colorado potentially considers other reform options.

Benefits

Along with the fact that reinsurance waivers are currently the only successfully approved waiver affecting the individual market[79] (which should not be discounted), reinsurance has the following additional strategic advantages:

1. **Reduced claims expense volatility:** The insurance element of reinsurance reduces claims expense volatility for all carriers. However, this protection could be more valuable for smaller carriers and new carriers, either of which will likely have smaller individual market membership.

2. **May encourage private competition:** The insurance protection noted above might provide additional incentive for new carriers to enter the market or existing smaller carriers to stay, thereby improving private plan competition. The ACA's transitional reinsurance program, which is similar to most current state-based reinsurance programs, was a part of the "3Rs" package of stabilization mechanisms, which were intended to provide some protections to encourage additional carriers to enter the ACA's insurance marketplaces. This aspect of a state-based reinsurance program is important as it is aligned with one of the State of Colorado's primary objectives with its Public Option (e.g., introducing more carrier choices and competition, particularly in rural and / or one-carrier counties).

3. **Ease of compliance:** The demonstration of a reinsurance program's 1332 Waiver guardrail compliance is straightforward.

[77] CMS, Section 1332: State Innovation Waivers, op cit.
[78] CMS (July 31, 2019). Colorado: State Innovation Waiver under Section 1332 of the PPACA. Press release. Retrieved October 10, 2019, from https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/CO-Fact-Sheet-.pdf.
[79] Hawaii's waiver allowed it to no longer operate a Small Business Health Options Program (SHOP). For more information, please see: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Hawaii-1332-Waiver-Fact-Sheet-12-30-16-FINAL.pdf.

a. Comprehensiveness. The reinsurance program makes no changes to covered benefits.

b. Coverage. As the reinsurance program reduces out-of-pocket premium rates for persons not qualifying for federal premium assistance, health insurance enrollment is projected to be flat or increase relative to the market without the waiver.

c. Affordability. The market subsidy introduced by the reinsurance program creates more affordable coverage relative to the market without the waiver.

d. Federal deficit neutrality. The federal deficit neutrality requirement is reasonably straightforward as well, but does involve the projection of multiple elements, such as premium tax credits (PTCs), enrollment, and market morbidity changes.

4. **Increases subsidized individual's purchasing power on higher-cost plans:** Because reinsurance will have a tendency to benefit higher-cost carriers (see the first discussion point below under Drawbacks), those carriers may reduce their rates more than the carrier that currently offers the SLCS. This will narrow the gap between higher-cost plans and lower-cost plans, making the former marginally more attractive after federal subsidies (as well as on an unsubsidized basis). This phenomenon is illustrated in Figure 27 with a hypothetical $400 gross premium for the SLCS, an assumed market-wide reinsurance impact of -18%, and the assumption that carriers will price in their expected returns from the reinsurance program.

FIGURE 27: SAMPLE ILLUSTRATION, IMPACT OF REINSURANCE PROGRAM ON CONSUMER NET PREMIUMS

Silver Rank	1st LCS	2nd LCS	3rd LCS	4th LCS
PRE- REINSURANCE PRICE	$380	$400	$450	$500
SUBSIDY	$300	$300	$300	$300
NET CONSUMER PREMIUM	$80	$100	$150	$200
NET PREMIUM RELATIVE TO THE SLCS	-$20	$0	$50	$100
REINSURANCE BENEFIT ASSUMED IN PRICING	12%	15%	18%	21%
POST-REINSURANCE PRICE	$334	$340	$369	$395
SUBSIDY	$240	$240	$240	$240
NET CONSUMER PREMIUM	$94	$100	$129	$155
NET PREMIUM RELATIVE TO THE SLCS	-$6	0	$29	$55
PERCENTAGE CHANGE IN NET PREMIUM	18%	0%	-14%	-23%
CHANGE IN NET PREMIUM DIFFERENTIAL RELATIVE TO THE SLCS	$14	$0	-$21	-$45

Note, the LCS plan saw an increase in net consumer premiums after reinsurance of 18% ($80 to $94) and a deterioration of its position relative to the SLCS plan of $14 (the $20 net premium price advantage was reduced to $6). Conversely, both the third-ranked and fourth-ranked silver plans improved on both of these measures. These phenomena continue, but are less dramatic, even if carriers do *not* make different assumptions about the impact of reinsurance.

5. **Ease of expansion:** Colorado's reinsurance program is effective for the 2020 coverage year and is projected to reduce premiums approximately 16%.[80] Because the state is exploring potentially additional price relief in

[80] CMS (July 31, 2019), op cit.

the form of the Public Option, it could also consider using funds that would otherwise be put into a Public Option to simply increase the price relief of the current reinsurance program.

Drawbacks

Despite the advantages noted above, reinsurance programs have drawbacks that should be considered strategically by both the State of Colorado and carriers.

1. **Potential bias:** Parameter-based reinsurance programs will allocate funds based on a carrier's incurred claims above a certain threshold. Carriers that consistently attract higher-risk and, therefore, higher-cost claimants serve to benefit from a reinsurance program more so than carriers attracting lower-risk claimants. This bias may be seen as a strategic advantage by some carriers as the disproportionate benefits likely accrue to carriers that have broader networks, loosely managed degrees of healthcare management, or more generous out-of-network benefits. Critics of this aspect would argue that it simply compensates for a carrier's strategic weaknesses and helps perpetuate the carrier's inefficiencies.

   The practical implication to this bias, the effect of which has been explored above in the context of a consumer advantage, is that a carrier will likely price to its expected reinsurance payout, thereby improving its pricing disproportionately relative to lower-cost carriers.

   Condition-based reinsurance programs, such as the invisible high-risk pools operated by Alaska and Maine under 1332 Waivers, require the ceding of a reinsured premium to the high-risk pool (or a substantial portion of it). This additional requirement may reduce the impact of carrier bias as carriers would be required to "pay" to receive the benefits of the program. The inherent bias in reinsurance programs favoring higher-cost carriers would be reduced due to this requirement. However, the ceded premiums are likely to only fund a small portion of overall reinsurance program payouts.

2. **Pricing risk:** Although smaller and / or newer insurers to the market may benefit from the insurance element of a reinsurance program, some pricing risk is introduced as carriers must estimate the claims impact from the reinsurance program in developing premium rates. Smaller insurers whose experience is less credible and new insurers who have no claims experience may have to price conservatively in this regard, which will disadvantage them pricewise relative to larger carriers that have credible experience or large enough blocks of business where pricing risk is smaller.

3. **Overpayment:** An important aspect of a claims-based reinsurance program is that members who qualify for reinsurance may also be compensated as high-risk under the federal risk adjustment program. Carriers with high-cost claimants are effectively paid twice, once under each program. If all the high-risk, and therefore likely the high-claims, individuals were distributed evenly across carriers, this would not be an issue. However, this certainly is not the case in many if not most markets. Cursory reviews of the CMS risk adjustment reports (which indicate material variances in risk adjustment transfer payments among carriers), along with membership data from medical loss ratio (MLR) reporting, prove this point.

   Without some correction, the double reimbursement only serves to magnify the favorable bias to high-risk and / or low-efficiency carriers, noted above. For example, recognizing this overpayment as a significant issue, Maryland added a "dampening" factor of 70% to payments under the risk adjustment program for claims that were also reinsured.[81] It can also be corrected for with a state-based risk adjustment program that is calibrated using post-reinsurance payout, state-specific claims data.

4. **Pass-through funding inefficiency:** Another side effect of the potential bias issue noted above is that it is entirely possible that the effect of a reinsurance program will not result in the maximum reduction to the SLCS plan, and hence, will not maximize federal pass-through funding under a 1332 Waiver. This could occur because it is more likely that the carrier that has the SLCS plan does not cover as many high-cost claimants (or does not project that it will do so) and therefore, will likely receive less benefit from the program.[82] Hence, it will not lower its rates as much as other carriers that project disproportionately higher benefits from the program. This will reduce federal pass-through funds and put more pressure on state-based funding sources.

[81] The full text of the Maryland Health Benefit Exchange resolution is available at https://www.marylandhbe.com/wp-content/uploads/2018/11/MHBE-Board-Resolution-Interaction-Between-Risk-Adjustment-and-Reinsurance_Programs.pdf.
[82] Note that a carrier could be more efficient with medical management, have better unit-cost contracts with providers, have lower administrative costs, or a combination of these in order to position itself as offering the second-lowest-cost silver plan.

5. **OOP pocket premium impacts:** The out-of-pocket (OOP) premium benefits will accrue to both the "lightly subsidized" (i.e., those with incomes between 300% FPL and 400% FPL, generally young adults) and the wholly unsubsidized (those with incomes over 400% FPL). This may not necessarily be a disadvantage depending on how the State of Colorado defines affordability. For example, if Colorado defines affordability as out-of-pocket premiums less than or equal to 9.86% of income, then the lightly subsidized would not require a price reduction. Yet under a reinsurance program, this is precisely what could happen. Figure 28 illustrates these dynamics.

FIGURE 28: REINSURANCE IMPACT TO CONSUMER OUT-OF-POCKET PREMIUMS BY SUBSIDY LEVEL

	Base Market Case			Reinsurance Scenario		
Subsidy Level	**Heavy**	**Light**	**None**	**Heavy**	**Light**	**None**
2019 FPL %	150%	350%	401%	150%	350%	401%
Income (thousands)	$18.2	$42.5	$48.6	$18.2	$42.5	$48.6
Gross Premium	$400	$400	$400	$320	$320	$320
2019 % of Income Cap	4.15%	9.86%	NA	4.15%	9.86%	NA
Federal Subsidy $s	$337	$51	$0	$257	$0	$0
State Subsidy	NA	NA	NA	NA	NA	NA
Net Premium	$63	$349	$400	$63	$320	$320
Consumer Savings (State's Net Funding)				$0	-$29	-$80
Federal Savings (Pass-Through Funding)				-$80	-$51	$0
Gross Premium Savings (Total Funding)				-$80	-$80	-$80

Note, the lightly subsidized individual receives a $29 reduction in premium even though the pre-reinsurance premium was considered "affordable" according to the ACA's premium assistance structure. This phenomenon (the already-subsidized receiving the benefits of a reform initiative) is consistent across several of the four reform scenarios.

6. **CMS pass-through determination risk:** Because a reinsurance program requires a 1332 Waiver, the pass-through funding is subject to recalculation by CMS each year. This determination may vary significantly from amounts calculated by the State of Colorado and its actuaries.[83] State-based programs that do not involve a 1332 Waiver, such as a Public Option or state-based subsidies, do not involve this risk, and therefore , may be favorable from the State of Colarado's perspective.

7. **Decreases subsidized individuals' purchasing power on lower-cost plans:** As described above in the advantages for reinsurance programs, reinsurance will likely not result in uniform impacts across carriers and it can alter the competitive positions of carriers somewhat artificially (i.e., not necessarily related to any change in the true value of the plan), particularly on a net basis (after federal subsidy). As the price for the SLCS drops, higher-cost plans improve competitively on a net basis. Conversely, lower-cost plans will become less competitive. This includes the LCS and most bronze plans (see Figure 27 above, specifically the 1st LCS column).

Market-wide subsidies are simply state funds that are allocated to each carrier proportionally. The proportionality is typically implemented in one of two ways: allocating either 1) a flat per member per month (PMPM) payable for each market enrollee, or 2) a flat percentage of claims or premium. In either case, the allocation of funds is *not* based on the existence of a high claims threshold, which is what reduces (in the case of a percentage allocation) or eliminates (in the case of a flat PMPM) the carrier bias and removes the double-counting issues present in a

MARKET-WIDE SUBSIDIES

[83] See https://www.shadac.org/publications/resource-state-based-reinsurance-programs-1332-state-innovation-waivers for more information on pass-through estimates vs. approved amounts.

reinsurance program. Each carrier and plan receives the same PMPM or percentage claims or premium reduction from the program regardless of risk or high claims.

A market-wide subsidy takes its form by attempting to remedy some of the drawbacks of the state-based reinsurance previously discussed. Specifically, the potential bias toward high-risk carriers and the overpayment due to the presence of risk adjustment are both addressed via a market-wide subsidy program. To date, no state has proposed this idea, officially or otherwise. However, the reinsurance challenges that it solves are real and other solutions have been proposed. For example, the reinsurance double-counting can be solved with a state-based risk adjustment program that is calibrated using post-reinsurance payout, state-specific claims data. As we mentioned previously, Maryland addressed this with a dampening factor on the risk-adjustment payouts for reinsured claims.

Note, a percentage of claims subsidy would still favor higher-cost carriers; however, the fixed percentage eliminates the differential pricing that might occur among carriers estimating claims expense reductions from the program, as all market participants would reflect the exact same percentage in rate development. The flat PMPM subsidy will tend to actually favor lower-cost carriers, as the fixed PMPM will result in a larger percentage reduction to claims expense relative to high-cost carriers.

Variations of the idea include varying market subsidy amounts for geographic areas that are higher-cost or lower-cost. An additional variation, albeit more complicated, is to define a preset level of affordability as a percentage of income, in a region (effectively extending the federal percentage of income premium caps), and then set regionally based subsidies to reach this predetermined level of affordability on that region's SLCS plan. This variation directly addresses the affordability challenges that Colorado sees in its rural counties.

Benefits

1. **Eliminates bias and overpayment:** The key benefit to the market-wide subsidy approach is the elimination of the potential favorable bias toward high-risk, high-cost carriers, as well as the overpayment due to risk adjustment.

2. **Eliminates pass-through funding inefficiency:** The market subsidy approach also eliminates the pass-through funding inefficiency challenge because all plans (including the current or pending SLCS plan) will receive the same amount of price relief with certainty.

3. **Reduces pass-through funding uncertainty:** Because the amount of the reduction to the SLCS plan is known with certainty, the amount of pass-through funding as determined by CMS will have less uncertainty associated with it.

4. **Interaction with current reinsurance program:** A market subsidy program could be implemented as supplemental price relief for the market, in addition to the relief already brought by the reinsurance program, or it could be implemented in lieu of reinsurance in future years.

5. **Guardrail compliance:** Other advantages related to reinsurance hold here as well, namely the ease of demonstrating compliance with guardrails.

Drawbacks

Despite solving several of the downsides of reinsurance, the market subsidy approach removes several key advantages to a reinsurance program, namely:

1. **Eliminates insurance protection:** Claims volatility will be higher for carriers relative to a reinsurance program, all else equal, and smaller carriers or new carriers in the market will be affected to a greater degree than larger carriers by this loss of protection.

2. **Impacts private competition:** The elimination of the insurance protection and lower claims volatility brought with a reinsurance program may deter smaller companies or new entrants from participating in the individual market, particularly in rural areas where populations and hence membership are already small and claims can be volatile.

3. **Less choice for subsidized enrollees:** To the extent that a pure reinsurance program likely narrows the gap between lower-cost and higher-cost plans and facilitates more affordable choices for those receiving subsidies on higher-cost plans, this benefit is eliminated under a market subsidy approach. Each carrier (high-cost or low-cost) would receive the same amount under a PMPM approach or the same percentage under a percentage of claims or premium approach. Conversely, lower-cost plans including the LCS and many bronze plans would no longer be affected negatively, as under a reinsurance program.
4. **Funding requirement uncertainty:** To the extent a fixed PMPM or percentage of claims or premium market subsidy is provided by a state, the cost of these subsides will vary based on future claims expense and market enrollment. Because of financial resource constraints, a state may need to reduce the level of funding provided if enrollment or claims expense is higher than expected.

STATE-BASED PREMIUM SUBSIDIES

State-based premium subsidies can be additional state-funded subsidies for those who already receive federal subsidies, subsidies for higher-income levels that currently do not receive any federal subsidies at all (i.e., persons with income above 400% FPL), or both. A prime example of state-based premium subsidies is California's introduction of state-based subsides for the 2020 coverage year. Beginning in 2020, the following new state-based premium subsidies will be available to persons purchasing coverage through Covered California:[84]

- Extension of PTCs for households with income up to 600% FPL
- Additional $15 subsidy for the average household that previously qualified for federal PTC
- For persons with household incomes under 138% FPL, out-of-pocket premiums are reduced to $1 per member per month

As demonstrated by California, state-based premium subsidies do not require a 1332 Waiver as the State of Colorado would not be waiving any provision of the ACA, only expanding on the existing subsidy structure established by the ACA.[85] This means there is no federal application or approval process and no federal pass-through funding involved. The target demographic to which Colorado funds are applied can be broad or reflect only the nonsubsidized or lightly subsidized segments (hereafter referred to as just the "unsubsidized segment") of the individual market.

State-based premium subsidy programs can bypass CMS and directly reduce premiums for unsubsidized individuals and / or enhance subsidies for the existing eligible population.

In fact, state-based subsidies are a more direct method of addressing affordability concerns for the unsubsidized segment than a reinsurance model. In the reinsurance model, the total program costs are used to reduce gross premium rates for the *entire market*. The federal government then reimburses the State of Colorado for the portion of the program costs applicable to the *subsidized segment*, leaving Colorado with a net cost of reinsurance applicable to just the *unsubsidized segment*.

Figure 29 illustrates this dynamic, without regard to age variation among members. Note, the state's required funding (**in bold**) is identical by design in order to highlight the direct path (i.e., no federal government pass-through funding) to a similar end that is offered by the state-based premium subsidies approach.

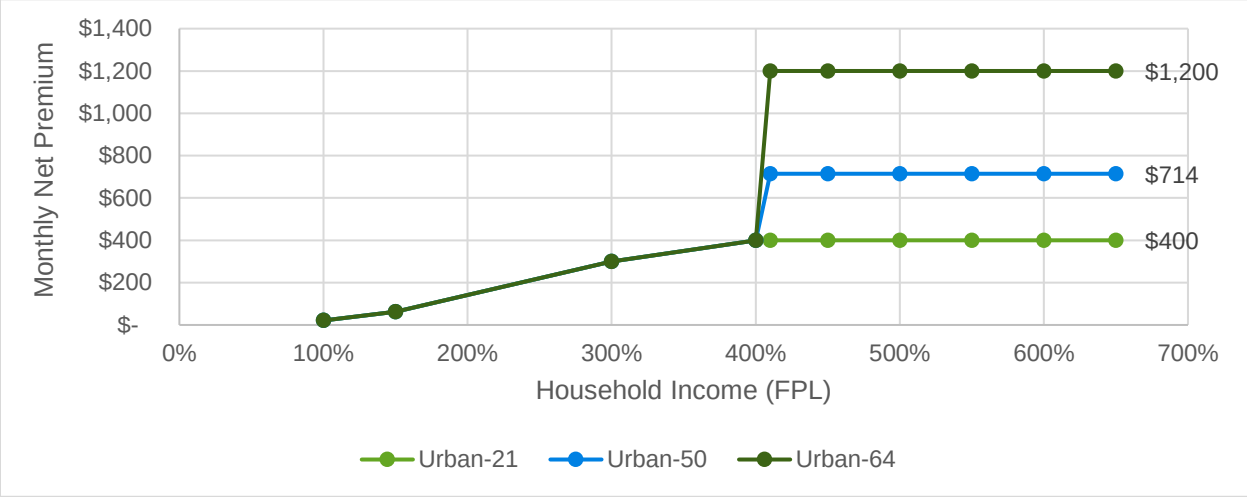
[84] Covered California. Projected Impacts of State Laws Affecting Health Care Consumers and Covered California in 2020. Retrieved October 10, 2019, from https://www.coveredca.com/news/pdfs/State_Subsidy_and_Mandate_Fact_Sheet.pdf.
[85] CMS has proposed a version of state-based subsidies that would seek to waive all federal subsidies due to a state, with those funds then redistributed at the state's discretion. Obviously, this would require a waiver.

FIGURE 29: HOW REINSURANCE AND STATE-BASED SUBSIDIES CAN HAVE THE SAME NET EFFECT

	Base Market Case			20% Reinsurance Scenario			State-Based Premium Subsidies		
Subsidy Level	Heavy	Light	None	Heavy	Light	None	Heavy	Light	None
2019 FPL %	150%	350%	400%	150%	350%	400%	150%	350%	400%
Income	$18.2k	$42.5k	$48.6k	$18.2k	$42.5k	$48.6k	$18.2k	$42.5k	$48.6k
Gross Premium	$400	$400	$400	$320	$320	$320	$400	$400	$400
2019 Federal % of Income Cap	4.15%	9.86%	NA	4.15%	9.86%	NA	4.15%	9.86%	NA
Federal Subsidy $s	$337	$51	$0	$257	$0	$0	$337	$51	$0
State Subsidy	NA	NA	NA	NA	NA	NA	$0	$29	$80
Net Premium	$63	$349	$400	$63	$320	$320	$63	$320	$320
Consumer Savings (State Funding)				**$0**	**-$29**	**-$80**	**$0**	**-$29**	**-$80**
Federal Savings (Pass-Through Funding)				-$80	-$51	$0	$0	$0	$0
Total Gross Premium Savings				-$80	-$80	-$80	$0	$0	$0

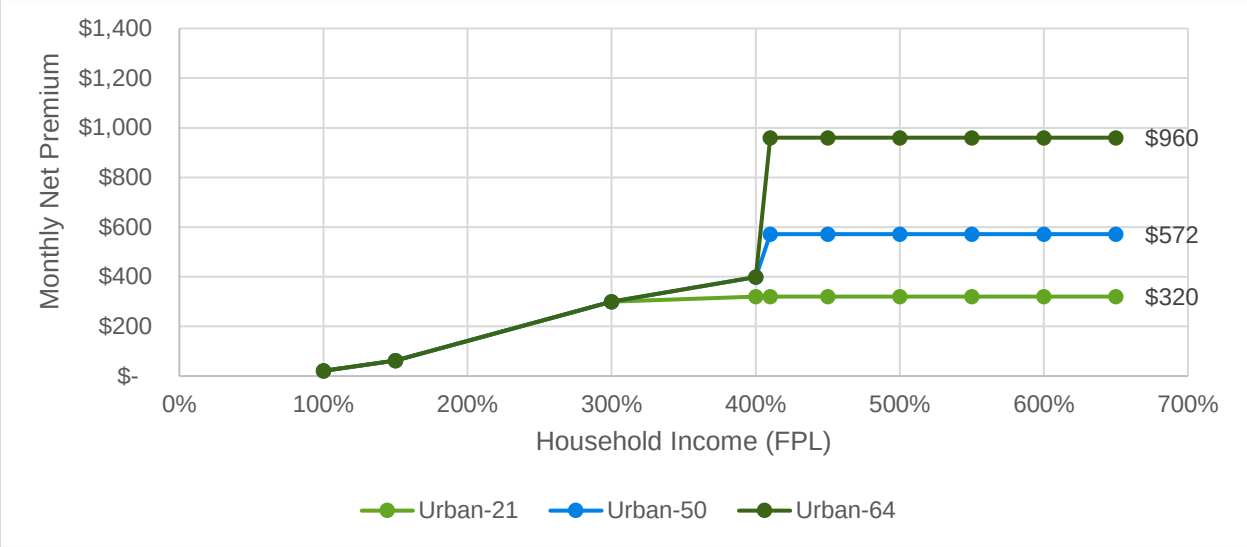
Figures 30 to 32 illustrate the general impact of state-based subsidies versus a reinsurance program when age *and* household income (FPL) are considered. We use a hypothetical age 21 gross premium (prior to the application of federal subsidies) of $400, identical to Figure 29 above. The net premiums (after application of federal subsidies) are then shown by three ages (21, 50, and 64) and by FPL.

FIGURE 30: NET CONSUMER PREMIUMS, BASE SCENARIO (NO REINSURANCE PROGRAM)



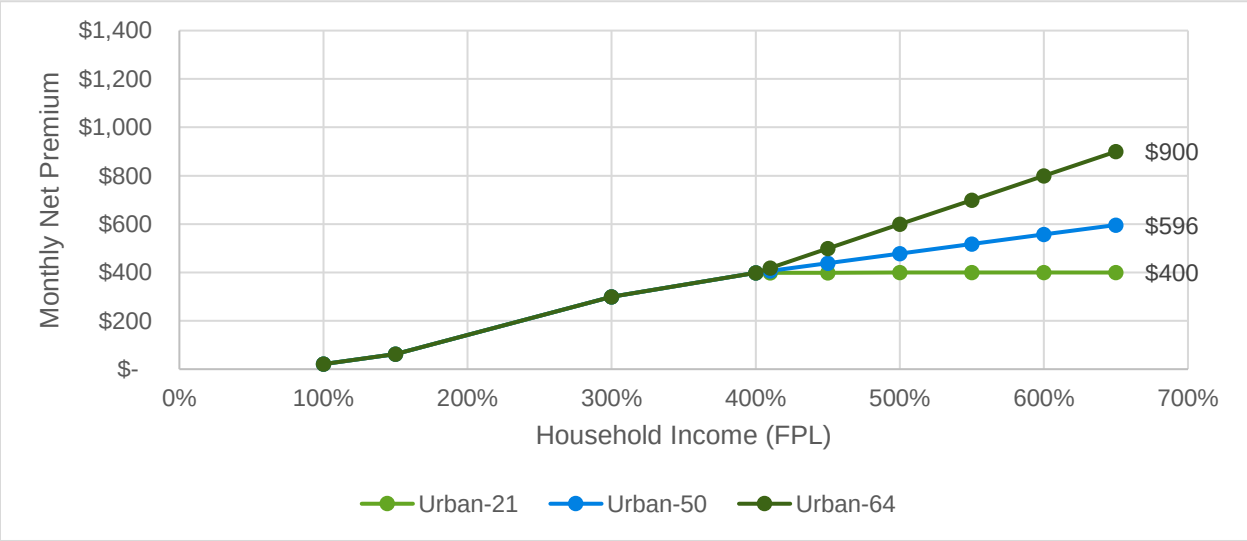
Note, the dramatic increase in the consumer's net premium at just over 400% FPL for the two older ages, otherwise known as the "subsidy cliff." Colorado's reinsurance program will mitigate, but not eliminate, the subsidy cliff by lower prices, as the graph in Figure 31 shows (again, using a hypothetical but realistic 20% reinsurance impact target).

FIGURE 31: NET CONSUMER PREMIUMS, REINSURANCE SCENARIO



With the use of state-based subsidies, greater premium relief for older enrollees above 400% FPL is achieved, as well as the elimination of the subsidy cliff at just over 400% of FPL.[86] The state-based subsidy structure used in the graph in Figure 32 extends subsidies to enrollees who are currently *not* receiving federal subsidies up to 650% FPL. The premium at that point is just slightly lower ($900) than in the case of reinsurance in Figure 31 ($960), thereby greatly reducing the subsidy cliff for the 64-year-old.

FIGURE 32: NET CONSUMER PREMIUM, STATE-BASED SUBSIDIES TO 650% FPL



State-based subsidies obviously require a mechanism for administration, as the federal exchange platform only accommodates the federal subsidy structure. Because Colorado already has a state-based exchange, this hurdle is already cleared, other than the incremental cost of incorporating the new subsidies on the existing platform.

[86] Note that there is a smaller cliff, affecting substantially fewer people once subsidies go to zero at 650% FPL.

Benefits

1. **Eliminates structural weaknesses of reinsurance programs:** With state-based premium subsidies, many of the disadvantages of reinsurance programs and some of the disadvantages of market subsidies (both flat and percentage of claims) are eliminated. This includes potential carrier bias, overpayment, and subsidy inefficiency.

2. **Eliminates need for a 1332 Waiver and related costs:** Because the state would not have to waive any provisions of the ACA in order to simply supplement already available federal subsidies, state-based premium subsidies eliminate the risks of non-approval of a waiver, pass-through funding determination risk, and any related costs and regulatory hurdles related to the waiver application.

3. **State retains program control:** With complete control of the supplemental state-based subsidies, the State of Colorado can design a program based on state-determined affordability levels. In the example above, the state determined a percentage of income affordability cap for income levels above 400% FPL that continues the pattern established by federal subsidies (increasing percentage of income as income rises). The example above also assumes that those receiving small federal subsidies would not receive any additional state-based subsidies, a drawback of a reinsurance program in most states that may be unavoidable. Other subsidy structures could also be considered by a state.

4. **Could be implemented in addition to, or in lieu of, a state-based reinsurance program:** Similar to other policy options, state-based subsidies can be implemented in lieu of a reinsurance program, as Figure 32 indicates, or the state could retain its reinsurance program and simply use any additional available funds to extend subsidies and / or supplement current subsidies.

Drawbacks

1. **Requires modifications to the state-based exchange:** As mentioned earlier, CFHC would need to modify its subsidy structure from the ACA's parameters, which may require an initial investment.

2. **Funding requirement uncertainty:** With a reinsurance program, a state could modify the attachment point or coinsurance rate to match reinsurance payouts to insurers' expenses. However, with state-based premium subsidies, it would likely be difficult to modify consumer premium assistance amounts during the coverage year. To the extent a recession occurred that reduced employer-sponsored coverage, additional Coloradans might seek coverage in the individual market, resulting in additional state expenditures for subsidies in a declining tax revenue environment.

PUBLIC OPTION

The preceding discussion of the other policy options is intended to put context around the evaluation of a Public Option in the State of Colorado in terms of its ability to address the issues of affordability and introducing competition and choice to the Individual market. As we have seen, each of these policy options address at a minimum the affordability challenges *directly* and, in certain cases, such as reinsurance, the issue of additional competition *indirectly*. A Public Option attempts to address the two core challenges of affordability and increased competition directly but does so in a way that introduces different considerations, and hence, our evaluation framework will change slightly.

VARIATIONS OF PUBLIC OPTIONS

The Colorado legislation enabling the study of a Public Option appears to have at least two variations in mind. One variation is a newly created, stand-alone, risk-bearing entity. The second is an approach similar to the state of Washington's, whereby the state contracts with existing carriers to offer Public Option plans. Because each variation has key features that drive differing advantages, disadvantages and market dynamics, we consider each separately. However, under either construct, the following would likely apply:

- First, a Public Option all but guarantees, by definition and design, to produce an offering that is lower in price than current offerings. This is because it has a strategic advantage that most likely cannot be matched by incumbent private carriers: provider reimbursement that is significantly lower than what is generally currently negotiable by

carriers. This lower "cost of goods sold" is mandated by legislative fiat and the authority of the State of Colorado government is used to enforce and maintain this advantage.

This could be a significant concern for private carriers as, all else equal, they will have a difficult time competing, particularly on the CFHC where the presence of subsidies leverages competitive price advantages. Moreover, this should be a significant concern to the Colorado as private carriers that are currently offering in the market may decide to exit due to the lack of competitiveness. It may also be possible that providers agree to lower rates for non-Public Options plans after the Public Option is implemented, reflecting the new market benchmarks for provider reimbursement.

- Second, a Public Option could be offered anywhere in the State of Colorado, including current one-carrier counties. Under the stand-alone approach, the Public Option would contract its own network. Presumably Colorado would be able to compel a sufficient number of providers (hospitals and physicians) to accept its reimbursement terms. In the contracted approach, carriers could build on existing networks but would re-contract at the mandated reimbursement levels.

While these two facets of a Public Option provide the distinct advantage of solving each of the policy objections (affordability and competition) both directly and with certainty, the means of establishing these advantages may have various negative side effects, which are discussed further below.

Contracted carriers

This approach was utilized by the Washington state for its' recently passed public option program "Cascade Care."[87] In this approach Washington utilizes existing carriers to offer a set of public option plans that are built on a legislatively mandated reimbursement level, presumably much more favorable than current market rates that underlie other private carriers' offerings. Private carriers that are approved to offer these plans and that agree to do so would attempt to contract a network of providers who agree to take the state-mandated reimbursement. All else equal, this would drive a significantly lower premium relative to existing exchange plans, depending on the level of reimbursement (100% of Medicare, 150%, etc.). The contracted approach would require carriers, as terms of their participation in the program, to offer plans in all geographic areas the state requires or all areas that are feasible for the carrier, given its geographic service area.

Benefits of the contracted carrier approach

1. **More cooperative with less crowd-out:** By engaging with carriers to solve the affordability and carrier choice issues, particularly in one-carrier counties, a state will likely be building on existing relationships rather than introducing the state (or other public entity) as a competitor to carriers and potentially creating adversarial relationships. As noted earlier, a stand-alone risk-bearing entity as a Public Option runs the risk of discouraging private carriers from offering coverage on exchanges or in the individual market overall.

2. **Marginal enrollment impacts:** Existing carriers in the individual market and in the small group and large group markets may benefit from becoming "approved" Public Option offerings. By capturing enrollment that might otherwise have been lost by not offering coverage in the individual market or lost to a stand-alone version of the Public Option, a carrier can spread fixed costs and other investments across a broader membership base.

3. **Harness existing infrastructure and industry expertise:** The HB19-1004 bill seeks to build on "existing infrastructure" and it could be argued that a certain material portion of that infrastructure is contained within the private carrier market. This would include operational capabilities such as enrollment and billing, medical management, and claims payment. Intangible assets, such as brand awareness, provider relationships, and industry expertise, are easily harnessed with a contracted approach.

4. **Network contracting:** A significant challenge, depending on the level of mandated reimbursement chosen for a Public Option, will be the contracting of a broad enough network that accepts the lower reimbursement. Private carriers may have a higher likelihood of building such a network than a stand-alone state entity.

[87] Jenkins, A. (May 16, 2019). Will Washington state's new 'public option' plan reduce health care costs? NPR. Retrieved October 10, 2019, from https://www.npr.org/sections/health-shots/2019/05/16/723843559/will-washington-states-new-public-option-plan-reduce-heath-care-costs.

5. **More likely to preserve value and innovation:** To the extent that private carriers improve value and innovate to acquire and maintain membership, this dynamic may be lost or diminished if private carriers are not a direct part of the Public Option solution.

6. **Solvency concerns are minimal:** As current carriers are going concerns and constantly financially monitored both internally and externally, capital requirements should be of minimal concern. Any additional membership due to the Public Option offering will not likely impact carriers, as 1) much of that membership will be from existing books of business, and 2) any new membership coming from the uninsured will be relatively small compared to total books of business.

7. **Reduces claims costs at the point of service:** Because reimbursement is lower at the time services are rendered to a patient, the patient will in many cases have lower cost sharing if claims are subject to the deductible and coinsurance.

Drawbacks of the contracted carrier approach

1. **FFS-based reimbursement metric:** Not all carriers reimburse on a purely fee-for-service (FFS) basis, and requiring a carrier to verify that the underlying reimbursement is at the required percentage of Medicare may be difficult or impossible to do. This requirement may exclude or severely disadvantage certain carriers, such as integrated delivery systems. For example, it may be more difficult for a carrier to engage a provider in a value-based contract or shared savings arrangement where reimbursement is not entirely on a FFS basis.

2. **Network contracting:** Carriers' industry expertise and provider relationships, while valuable assets for private carriers, may not be sufficient to create a network for a Public Option, particularly at lower reimbursement levels, such as 120% of Medicare or lower.

3. **Provider cost shifting:** Lower reimbursement from the Public Option is almost certainly going to result in an attempt by providers to cost shift to the commercial market segment. The degree of that shift will depend on the level of reimbursement that the Public Option is built around and the breadth of the eligibility criteria for enrollment in the Public Option.

Stand-alone state-sponsored entity

The second approach that is contemplated is the "stand-alone, risk-bearing entity" approach, which would essentially create a state-sponsored insurer. Similar to the contracted carrer approach, the state would endow this Public Option with significantly lower reimbursement than what underlies currently offered plans. It could be offered statewide or could be offered only in counties that currently have limited carrier choices, such as the 14 one-carrier counties.

A state-sponsored carrier would need to perform all of the functions of a private market insurer or have those functions contracted out to a third-party administrator. This would include the critical function of network contracting. Moreover, being a risk-bearing entity, the Public Option would need to raise and hold capital and surplus to remain solvent (or be backed by the state with sufficient funds as needed). If the Public Option were to fall below the risk-based capital standard for authorized control, it is not entirely clear how the State of Colorado would mitigate what could be perceived as a conflict of interest.

Proponents of the Public Option contend that a publicly sponsored entity would provide consumers with at least one additional choice of carrier and introduce more competition in the market. However, there is not universal agreement around the idea that carrier competition, at least by itself, reduces premium rates. In a May 2019 report, the Colorado Health Institute noted that higher premiums were not simply a function of fewer carriers, but also of reduced hospital system competition.[88] This would imply that introducing a Public Option would not, by itself, bring meaningful competition because the Public Option would be subject to the same hospital system pricing power as current insurers. Because being a part of the Public Option's network would likely require lower reimbursement, the system's pricing power might translate into simply not participating in the Public Option.

[88] Colorado Health Institute (May 14, 2019). The Competition Conundrum. Retrieved October 10, 2019, from https://www.coloradohealthinstitute.org/research/competition-conundrum.

Benefits of the stand-alone entity approach

1. **Direct resolution to issues of carrier choice and consumer affordability:** Of all the policy options, the stand-alone approach to a Public Option might be the single solution that solves both of the primary policy goals outlined in the legislation directly, rather than indirectly. Reinsurance is an example of indirectly attempting to improve carrier choices by creating market conditions that are conducive to more carriers but does not guarantee that any carriers will actually enter the market or increase their presence.

2. **State control:** The State of Colorado, or a state-sponsored entity, would retain direct control of Public Option operations, including network contracting, administrative expenses, service regions, and benefit plans offered.

3. **Reduces claims costs at the point of service:** Both stand-alone and contracted carrier approaches will in many cases have lower patient cost sharing if claims are subject to the deductible and coinsurance as a result of lower provider reimbursement.

Drawbacks of the stand-alone entity approach

1. **Provider cost shifting:** As in the case of the contracted carrier approach, a stand-alone option would likely cause varying degrees of provider cost shifting to commercial markets, driving up prices in that market, all else equal.

2. **Crowd-out:** Rather than improving carrier competition, a Public Option might cause carrier exits due to a private carrier's inability to match legislatively mandated reimbursement levels that can only be accessed by the Public Option. Without the possibility of being able to match this strategic advantage, carriers would quickly see their membership migrate to the Public Option, assuming the Public Option had similar value-added features such as customer service and network adequacy.

3. **Inability to spread fixed costs and amortize investments:** Depending on the Public Option's overall value to consumers, membership in the Public Option could be quite low. Our modeling shows that the Public Option may not have a significant price advantage in high-density population areas even under a 150% of Medicare scenario. Modeling of enrollment and premium scenarios for the Public Option can be found in Section 8 of this report.

   In order to accumulate enough membership to make a stand-alone Public Option viable, it may need to be made available to a broad population base, specifically small group and large group segments, and likely at a very competitive price in order to overcome the inertia elements of those markets. (See Sections 7 and 8 of this report above for broader discussions of employer market segment dynamics and tax-favored vehicles that may enable employer group migration to a Public Option.)

4. **Large up-front implementation requirements:** Implementing a stand-alone entity will practically be the equivalent of starting a new carrier from the ground up. Although much of the execution of that can be outsourced to third-parties, it nonetheless will be expensive and the value proposition of the resulting offering may not be any better than what is currently available, save for the artificially lower price due to mandated price controls.

   Critics might argue that the cost of such an endeavor might be better spent on increasing funding for the existing reinsurance program, instituting state-based subsidies to directly reduce out-of-pocket premium expenses, or improving access to primary care or some other care delivery innovation or improvement.

5. **Solvency concerns:** Smaller insurers (which the Public Option would almost certainly be considered, under any scenario) and newly established ones are far more likely to be thinly capitalized and to ultimately run into solvency problems. This is especially true if membership materializes at higher levels than expected. This happened to several of the previous generation of "Public Options," namely the CO-OPs. While the CO-OPs offered competitively priced premiums, it caused a flood of membership that ultimately proved to be underpriced.[89] For the Public Option to attract material enrollment, it will most likely need a reimbursement advantage that cannot be matched by other carriers. To the extent the Public Option's premium rates are

[89] U.S. Senate (March 10, 2016). Failure of the Affordable Care Act Health Insurance CO-OPs. Retrieved October 10, 2019, from https://www.hsgac.senate.gov/imo/media/doc/Majority%20Staff%20Report%20-%20Failure%20of%20the%20Affordable%20Care%20Act%20Health%20Insurance%20CO-OPs.pdf.

aggressive in relation to its underlying provider reimbursement, the potential for solvency concerns or additional outside capital will be greater.

We close this section with a summary table that compares the four policy options discussed above.

FIGURE 33: COMPARISON OF FOUR POLICY OPTIONS

	REINSURANCE	MARKET SUBSIDY ($ OR %)	STATE-BASED SUBSIDIES	PUBLIC OPTION
ADDRESSES SUBSIDY CLIFF	No	No	Yes	No
CARRIER BIAS IN PROGRAM BENEFITS	Yes	No / Yes	No	No
REQUIRES 1332 WAIVER	Yes*	Yes*	No	No
PROGRAM BENEFICIARIES**	U & L	U & L	U (State discretion)	U & L
EFFECTS ON CARRIER PARTICIPATION	Indirect	No	No	Yes
OVERPAYMENT DUE TO RISK ADJUSTMENT	Yes	No	No	No
EFFECTS ON PROVIDER REIMBURSEMENT	No	No	No	Yes
STATE ADMINISTRATIVE BURDEN	Low	Low	Low	High (Stand Alone) / Medium (Contracted

* A waiver is required to request and receive federal pass-through funding.

** "U" = Currently receiving no federal subsidies; "L" = Currently receiving small (light) federal subsidies

12. RATE IMPACT ANALYSIS ADDENDUM

During the finalizing of this report, the Colorado Department of Regulatory Agencies and the Colorado Department of Healthcare Policy and Financing released their report "DRAFT Report Colorado's State Coverage Option" (the joint report)[90].

The State Report analysis assumes provider reimbursement changes needed to obtain the second lowest cost silver plan position in a particular county would only affect facilities (both inpatient and outpatient) but professional reimbursement would stay at current levels. Moreover, the State Report assumes a single reimbursement percentage for facility currently exists across the entire state of Colorado (289% of Medicare). Our analysis, by contrast, assumes that facility and professional reimbursement would be affected and *that reimbursement currently varies materially by geographical region.*

To facilitate comparisons of rate impacts between reports, we have recalculated our rate impacts under the assumption of facility-only reimbursement changes and adopted 175% and 225% of Medicare scenarios[91] both consistent with the State Report. However, as this assumption materially changes the evaluation of the effectiveness of a Public Option in Colorado, we continue to assume geographical variation in underlying provider reimbursement.
Figure 34 shows these results:

FIGURE 34: COMPARISON OF PRICE IMPACT OF REIMBRUSEMENT ASSUMPTIONS ON PUBLIC OPTION PREMIUM RATES

	MILLIMAN ANALYSIS						JOINT REPORT	
	FACILITY AND PROFESSIONAL AT MEDICARE %				FACILITY ONLY AT MEDICARE %		FACILITY ONLY AT MEDICARE %	
County	SCENARIO A 180% OF MEDICARE	SCENARIO B 150% OF MEDICARE	SCENARIO C 120% OF MEDICARE	SCENARIO D 100% OF MEDICARE	SCENARIO E 225% OF MEDICARE	SCENARIO F 175% OF MEDICARE	225% OF MEDICARE	175% OF MEDICARE
Boulder	21.7%	5.6%	-9.6%	-19.1%	25.7%	9.5%	NA	NA
Denver	22.8%	5.8%	-10.2%	-20.3%	25.9%	8.5%	NA	NA
Larimer	-4.9%	-18.1%	-30.8%	-39.0%	-1.5%	-15.2%	NA	NA
Mesa	-8.1%	-20.1%	-31.6%	-39.0%	-1.4%	-15.6%	NA	NA
Gunnison	-25.0%	-35.1%	-44.6%	-50.7%	-12.4%	-22.8%	NA	NA
Composite	**12.9%**	**-2.5%**	**-17.0%**	**-26.3%**	**16.8%**	**1.0%**	**-9.6%**	**-18.2%**

As can be seen from Figure 34, our estimates of premium changes are not as favorable as what is shown in the State Report. This difference stems primarily from differing assumptions of reimbursement that currently underlie plans available on Connect for Health Colorado (CFHC) and in particular, the reimbursement that underlies the second lowest cost silver plan in each region. We isolated our assumptions related to facility-only reimbursement and compared those with the 289%[92] of Medicare assumption used in the State Report in Figure 35.

FIGURE 35: COMPARISON OF REIMBURSMENT ASSUMPTIONS IN MILLIMAN REPORT VERSUS STATE REPORT ANALSYSIS

	MILLIMAN REPORT REIMBURSEMENT ASSUMPTIONS BY CLAIM TYPE AND COUNTY – PERCENT OF MEDCIARE BASIS			
County	INPATIENT	OUTPATIENT	PROFESSIONAL	TOTAL
Boulder	142%	142%	120%	134%
Denver	130%	167%	116%	138%
Larimer	208%	246%	120%	189%
Mesa	214%	241%	140%	196%
Gunnison	216%	345%	180%	250%

[90] http://www.colorado.gov/pacific/sites/default/files/HB19-1004%20Draft%20Report%20Colorado%20State%20Coverage%20Option%20and%20Appendix.pdf
[91] Ibid. The state's report also included a 200% of Medicare scenario that we did not model.
[92] Ibid Pg. 29

State Report	289%	289%	NA	NA

As Figure 35 displays, our research would indicate significantly lower reimbursement currently exists in highly populated and competitive counties such Boulder and Denver but that reimbursement is higher in rural counties. This geographical variation drives different rate impacts of a Public Option by county.

13. DATA RELIANCE AND LIMITATIONS

The services provided for this report were performed under the Consulting Services Agreement between Milliman Inc. (Milliman) and the Kaiser Foundation Health Plan dated August 1, 2019. Kaiser Permanente is the organization's trade name.

The information contained in this report has been prepared for the Kaiser Foundation Health Plan to provide data and information related to the evaluation of potential health benefits market impacts from the introduction of a Public Option in Colorado. The data and information presented may not be appropriate for any other purpose.

It is our understanding that the information contained in this report could be released publicly in summary form once it is finalized. Any distribution of the summary information should be done so in conjunction with access to the full report. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for Kaiser Foundation Health Plan by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about the premium rates, insurance market population estimates, trend rates, and other assumptions.

Milliman has relied upon certain data and information that is publicly available from the Connect for Health Colorado, Colorado Insurance Commissioner, and the Centers for Medicare and Medicaid Services (CMS). Additionally, we relied on statutory financial statement information downloaded from S&P Global Market Intelligence (formerly SNL Financial). Milliman has relied upon these third parties for the accuracy of the data and accepted it without audit. To the extent that the data provided are not accurate, the estimates provided in this report would need to be modified to reflect revised information.

It should be noted that there is significant uncertainty surrounding future enrollment and premiums in health benefits programs, particularly the individual market. Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

14. METHODOLOGIES

In preparing this report, we relied on data, information, and assumptions based on public data sources. Data sources utilized in our analysis include, but are not limited to, the following:

- Health plan financial information downloaded from S&P Global Market Intelligence
- Health insurer rate review information available at https://ratereview.healthcare.gov/
- Insurer rate filing information
- Medical Loss Ratio Reporting Form data, 2015 through 2017
- Current and historical Medical Expenditure Panel Survey data
- HHS Marketplace Open Enrollment reports
- Reports released by the federal government related to premium stabilization programs, APTC amounts, and effectuated marketplace coverage
- CFHC premium and enrollment information
- U.S. Bureau of Labor Statistics employment statistics
- Proprietary provider reimbursement levels for health benefits coverage offered through CFHC provided by participating health insurers

We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of the assignment.

It should be noted there is significant uncertainty surrounding future enrollment and premiums in health benefits programs, particularly the individual market. Uncertainty arises from the inability to predict individual behavior, as well as the inability to predict the business decisions of carriers in the market, as well as state and federal legislators and regulators. Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

The actuarial analyses presented in this report solely reflect the estimated incremental impacts from the introduction of a Public Option in Colorado. Other state or federal policy changes may impact actual amounts presented in this report. This report does not constitute an actuarial certification for a 1332 Waiver.

We specifically note that our projections of enrollment and premium rates in the individual market assume that federal funding of cost-sharing reduction (CSR) subsidies remains terminated, and that the individual mandate penalty remains $0. To the extent that judicial, legislative, or regulatory changes are made to the ACA, the values presented in this report may be impacted by a significant degree.

APPENDICES

APPENDIX A: Legislative Background for Public Option Study in Colorado

In the spring of 2019, the Colorado legislature passed House Bill 19-1004 (HB19-1004) which was ultimately signed into law by Governor Polis. This bill tasked the Colorado Department of Regulatory Agencies (DORA) to develop a proposal that considers the feasibility and costs of implementing a state option for healthcare coverage that:

- Leverages existing state healthcare infrastructure
- Increases competition and improves quality
- Provides stable access to affordable health insurance

The preamble to the bill notes what appears to be the impetus for this task: high prices and reduced carrier choice in at least 14 Colorado counties on the individual market. The specific aspects of the study are to include:

- *Conducting actuarial research to identify the potential cost of premiums and cost sharing to pay claims in a plan that is, at a minimum, a plan compliant with the ACA's essential health benefits (EHBs)*
- *Evaluate provider rates necessary to incentivize participation and encourage network adequacy and high-quality healthcare delivery*
- *Evaluate eligibility criteria for individuals and small businesses to participate*
- *Determine the impact, if any, on the state budget*
- *Determine the impact on the stability of the individual market, the small group market, and the Colorado health benefit exchange*
- *Evaluate the impact on consumers eligible for financial assistance for plans purchased on the exchange*
- *Determine whether a state option plan should be offered on or off the exchange*
- *Determine whether the state option plan should be a fully at-risk, managed care, fee-for-service plan, or an accountable care collaborative plan, or a combination thereof*
- *Determine whether the state option should be offered through the state department, and identify the expected impact, if any, to the Colorado Medical Assistance program*
- *Identify the expected impact, if any, to the children's basic health plan*
- *Investigate funding options, including but not limited to state funds and federal funds secured through available waivers*
- *Evaluate the feasibility, legality, and scope of any necessary federal waivers*
- *Review information relating to any pilot program that may be operated by the state personnel director pursuant to Section 24-50-620, as enacted in Senate bill 19-1004*
- *Create a statewide definition of affordability for consumers*

APPENDIX B: ACA Individual Market Rate Increase History and Carrier Participation

ACA Carriers by County 2014 to 2019							
		2014	2015	2016	2017	2018	2019
Average Carriers per County		6.63	6.73	3.58	2.34	2.36	2.41
Total Carrier Counties*		424	431	229	150	151	154
Count of 1-Carrier Counties		0	0	0	14	14	14

Colorado Second-Lowest Silver Plan Rates (21 Year-Old) and Increase 2014 to 2019										
		2014	2015	2016	2017	2018	2019	Est. 2020	Annualized Increase 2014 to 2019	Cumulative Increase 2014 to 2019
Rating Area 1	Premium	$197.60	$161.30	$219.57	$247.07	$310.90	$364.60	$301.59	13%	85%
	Rate Increase		-18.4%	36.1%	12.5%	25.8%	17.3%	-17.3%		
Rating Area 2	Premium	$192.22	$152.13	$202.99	$240.52	$318.84	$360.97	$305.21	13%	88%
	Rate Increase		-20.9%	33.4%	18.5%	32.6%	13.2%	-15.4%		
Rating Area 3	Premium	$196.59	$161.65	$189.71	$238.75	$297.98	$343.78	$285.28	12%	75%
	Rate Increase		-17.8%	17.4%	25.8%	24.8%	15.4%	-17.0%		
Rating Area 4	Premium	$187.72	$175.93	$230.55	$282.73	$341.98	$401.06	$323.32	16%	114%
	Rate Increase		-6.3%	31.0%	22.6%	21.0%	17.3%	-19.4%		
Rating Area 5	Premium	$228.81	$229.23	$291.96	$388.93	$457.17	$447.62	$359.55	14%	96%
	Rate Increase		0.2%	27.4%	33.2%	17.5%	-2.1%	-19.7%		
Rating Area 6	Premium	$187.72	$176.76	$230.55	$282.73	$341.98	$398.70	$323.32	16%	112%
	Rate Increase		-5.8%	30.4%	22.6%	21.0%	16.6%	-18.9%		
Rating Area 7	Premium	$237.12	$220.08	$255.17	$289.01	$347.15	$361.51	$296.15	9%	52%
	Rate Increase		-7.2%	15.9%	13.3%	20.1%	4.1%	-18.1%		
Rating Area 8	Premium	$239.31	$162.79	$214.48	$289.01	$348.64	$461.72	$375.85	14%	93%
	Rate Increase		-32.0%	31.8%	34.7%	20.6%	32.4%	-18.6%		
Rating Area 9	Premium	$267.02	$195.00	$271.06	$321.12	$425.69	$538.04	$438.34	15%	101%
	Rate Increase		-27.0%	39.0%	18.5%	32.6%	26.4%	-18.5%		
State Average	Premium	$214.90	$181.65	$234.00	$286.65	$354.48	$408.67	$334.29	14%	90%
	Rate Increase		-15%	29%	22%	24%	15%	-18%		

Sources: 2014-2019 rates are from Colorado state exchange at http://connectforhealthco.com/. 2020 rates are calculated from information contained in Colorado's 1332 Waiver application

*** Sum total across all counties of carriers in each county.**

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

CONTACT

Fritz Busch
Fritz Busch@milliman.com

Paul Houchens
Paul.Houchens@milliman.com

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October 17, 2019

RE: Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

To Whom It May Concern:

Health care is a hot-button issue. There is emphasis by Democrats and Republicans to find a solution, yet the options seem to fall flat. Cost and access remain the major concerns, yet "Medicare for all" isn't the solution and a public option is troubling for multiple reasons.

Regardless of what politicians call it — any top-down, government-run health care insurance system would threaten access, quality, and affordability for all Americans. Higher taxes or increases in premiums would make this problem worse.

Proposals that eliminate private insurance coverage could gut billions from our health care system. There is no doubt that cuts of this scale will act as a catalyst to diminishing access to types of care that have already exhibited decreases in the last decade such as local oncology treatment.

The closure of hospitals and clinics that could take place under the "Medicare for All" buy-in and the public option also would put an incredible strain on physicians. The skyrocketing number of patients also would result in a diminished quality of care.

Independent analyses conducted by both the Urban Institute and the Mercatus Center at George Mason University estimate that should a Medicare buy-in or public option program ultimately lead to "Medicare for all," it would cost taxpayers approximately $32 trillion over 10 years.

We need to remain focused on strengthening health care in America, not undermining it by scrapping a system that has taken years to build in favor of one that will deliver lower-quality care, reduced access, and longer wait times — all at higher cost.

Sincerely,

Karl Ecklund
Small Business Owner
Frisco, Colorado

Good afternoon,

I am very concerned that after reading the draft of this plan that my state government is confused and don't realize that health insurance and healthcare are not the same thing. This is a fact that is often conflated in the public debate about the future of healthcare in this country, and in our Centennial State. When my government addresses the problem of rising healthcare costs by proposing a public option, I think they're missing the root of the debate entirely.

The cost of health insurance has been rising too fast in recent years because of years of turmoil and uncertainty at the federal level over the fate of the Affordable Care Act, which overhauled the way the federal government regulates private health insurance. The inability of our federal elected officials to get on the same page and come up with something that addresses the underlying causes of these rising costs is frustrating, no matter which party you belong to.

But attacking hospitals when you're angry about skyrocketing insurance premiums and deductibles won't help anyone. Under the public option proposed by Governor Polis, state officials will force insurance companies to sell their "state option" at below-market prices. Then, the Polis administration will cap how much hospitals will be reimbursed for treating patients, without regard for the real cost of treatment in each case. Under these one-size-fits-all price controls, hospital budgets will be hit the hardest.

This approach is flawed from the jump and will have the unintended side effect of diminishing access for patients and driving down quality. Neither of these outcomes are desirable, and worse, I have serious doubts that a public option will actually lower health insurance costs for the majority of Coloradans. I am opposed to the public option because of the way it's constructed and I urge the administration to start again on a new plan – one that does a better job of addressing root causes.

Please start-over by focusing on a plan that will address the foundational problems inherent in this over-regulated industry.

Best regards,

Karl Honegger

My name is Kathryn Burch. I live at [REDACTED], am a CO native and work as a Medical Staff Quality Program Manager with St. Joseph Hospital.

I came to healthcare after caring for my terminally ill mother. She underwent several rounds of chemotherapy for colon cancer and often had reactions and would need to ride in an ambulance to the ER, each time getting a hefty bill. One week of shots to increase her white blood cells and prevent life threatening infection were $1000 out of pocket. This was after Medicare paid their portion. Three years of copays were crippling to their finances. Although she was covered by Medicare, my parents had to file bankruptcy after exhausting their life savings to battle her cancer. Having Medicare did not protect them from losing everything they worked so hard for.

If you're trying to solve the issue of soaring premiums, deductibles and out-of-pocket expenses then creating a public option that mimics Medicare will fall short of that goal. There are too many unanswered questions with the draft plan. The plan lacks detail and the process is moving too fast for SCL Health to take a formal position on the draft. Additionally, we are actively working to implement more than 15 substantial pieces of legislation from the 2019 session (i.e., reinsurance program and hospital transformation project).

Medicare reimbursement rates fall short of making providers and hospitals whole for the services they provide. Before joining SCL I worked for Denver Health facilitating referrals for Medicare members to outside specialists. It was commonplace for those patients to wait >6 months for appointments. If they had private insurance they would have gotten in sooner.

I believe that Coloradans deserve to have access to affordable, quality care. However, offering a program that does not fully reimburse those that provide care will drive down quality, further impede access and could ultimately cause providers and hospitals to close their doors. The proposal does not further SCL Health's mission of improving the health of the people and communities we serve, especially the poor and vulnerable.

Our healthcare system is complex and requires a complex solution. A solution that does not cause good, hard-working people to choose between a roof over their head and healthcare. A solution that provides timely access and great quality care. SCL Health is committed to working closely with Governor Polis and his administration to continue to address access and affordability issues for the betterment of healthcare across Colorado. The proposed Public Option Plan will not provide those solutions. Thank you.

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

Please use this form to submit your comments on the draft HB19-1004 report. All comments will be logged and added as an appendix to the final report. We will accept comments until October 28.

Helpful Links:
- The draft report can be found here: http://www.colorado.gov/pacific/sites/default/files/HB19-1004%20Draft%20Report%20Colorado%20State%20Coverage%20Option%20and%20Appendix.pdf
- The bill text can be found here: https://leg.colorado.gov/sites/default/files/2019a_1004_signed.pdf
- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Katya Chorover

County (in which you reside) *

[redacted]

Organization *

None

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

Yes

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

Yes!

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Yes

Does the proposal include worthwhile benefits for consumers?

Not sure

Does the proposal create a product that is financially stable and sustainable?

Yes

Other thoughts? Please list them here.

I have lived in Washington, a state with an amazing state supported health care option, and I strongly encourage Colorado to take on this challenge and make this happen here! This gives CO an opportunity to become a national leader in the ongoing challenge of providing health care, which should be a human right, to the citizens. As a nation and as a state, we have the chance to remove the insurance companies and their motives for putting profits above caring for patients, and do what is right for the people. Thank you for making an effort in this direction! Even if it's not perfect, this is a great start.

This form was created inside of State.co.us Executive Branch.

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Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

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- The bill text can be found here: https://leg.colorado.gov/sites/default/files/2019a_1004_signed.pdf
- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Kelly Miller

County (in which you reside) *

[redacted]

Organization *

none

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No, government healthcare is not the answer. Affordability should be attained by competition between insurers and providers, equitable cost-sharing across the globe for R&D for new drugs, and no more ridiculous charges at hospitals for toiletries, etc. Perhaps if we weren't paying for healthcare for people who aren't even citizens that would help, too.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

That's a loaded question and provides no real information by answering it.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No, you're stealing the resources built by capitalism. That's theft.

Does the proposal include worthwhile benefits for consumers?

No, not for my family. We like our doctors and plan want to keep them. Costs will be shifted to consumers, once again, to make up for government programs not paying the full cost of the services. So my healthcare costs will go up, more doctors will move away or retire because they can't make ends meet, and the quality of care will go down without enough providers. Let the market balance out supply and demand. Get out of the way.

Does the proposal create a product that is financially stable and sustainable?

No, and you've already overspent with all your laws you passed last year. It's irresponsible to even consider this.

Other thoughts? Please list them here.

Government has no business in our healthcare.

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To Whom It May Concern:

Government-operated insurance programs have been tried and failed before, here in Colorado and across the country. Evidence shows the outcome is less competition, less personalized care and, often, significant costs spread across other insurance pools and taxpayers.

Under the ACA, Colorado created a public co-op similar to the plan now under consideration. The program was unable to cover costs, despite a 25 percent premium increase. It was dismantled, which left 83,000 Coloradans without coverage and taxpayers with a $72 million federal debt.

In 2016, 79% of Coloradans voted against Amendment 69, which would have created a state-run universal health care system. Analysis by the Colorado Health Institute found the plan would have run at an annual deficit that would have grown to nearly $8 billion within a decade.

Across the country, government-operated insurance programs have had consistently bad results. Insurers have left the market, costs have exceeded expectations, and many residents have been left without coverage.

I urge you to slow down and do it right. We need to remain focused on strengthening health care in America and do better with the existing system. Thanks to the Governor, Summit County just this year was recognized as an area to have costs reduced. We don't want to unintentionally take a step back by rushing in a new program.

Sincerely,

Kevin Burns

Former Mayor of Dillon, Colorado

To whom it may concern:

I want to express my opposition to Colorado's public option for state-run health insurance. I cannot fathom how this will increase quality of care. I feel that all of the arguments for the public option are tailor-made specifically to exclude any of the downside – namely quality care. I would love to hear the rationale of how cutting reimbursement rates below the actual cost of providing the care is going to improve care and quality.

I am a registered voter and consider this issue very important. I do not support this issue and will not support the politicians in favor of this measure.

Thank you,

Kevin Ladd

Dear ( )

Recently the administration of our Governor Jared Polis unveiled a plan for radically transforming Colorado's health care sector. The plan would create a so-called public option – a state-run insurance program that offers lower premiums and lower reimbursement rates than commercial insurance carriers.

While everyone agrees and recent research by the non-profit Colorado Consumer Health Initiative and the Health Care Value Hub of Altarum found cost is a top reason residents do not have health insurance. Colorado's uninsured rate of 6.5% is below the national uninsured rate of about 8.8% according to the most recent data from the Colorado Health Institute. It is clear most residents of Colorado are interested in improving the quality of health care and seeing a reduction in the cost, not a reduction in access to health care services or the closing of facilities.

As a health care professional for forty years, I have experience in small community facilities, as well as large major medical centers and teaching hospitals. I have worked as a nursing assistant, a critical care nurse and a bedside case manager. I too want to see a reduction in the cost of insurance coverage, which has skyrocketed in recent years. However, health insurance and health care are not the same thing and cutting payments to the dedicated professionals who actually provide health care in Colorado is not a real answer.

Low prices imposed on physicians and hospitals cannot prevent health care costs from rising. Hospitals employ physicians, nurses, rehabilitation therapists and highly educated health care professionals who should be reimbursed for their expertise. Further, I am concerned how this proposed approach will affect research and innovation.

Cutting reimbursement rates will only threaten the quality of care we can provide and limit access to health care across our state. If below-cost reimbursement rates expand even further in Colorado, providers will have no choice but to cut services, staff and possibly close their

doors altogether. Ultimately, patients will have less access to quality care, not more, and our state will be the worse for it.

The presently proposed Colorado State Option will have effects throughout the health care system that clearly have not been anticipated by the rush to roll out an ill conceived program that was a campaign promise made by our Governor. That is why I ask you to keep what works in our Colorado health care system, fix what's broken and deliver a better experience for all Coloradoans.

Instead of introducing more government intrusion into the markets, we must strengthen and protect our existing safety-net programs and address the drivers of costs by fostering a competitive and dynamic private insurance market in which plans and providers compete on the basis of cost and quality — not a system that makes promises that can't be kept and leaves taxpayers to clean up the mess. I would like to see our state focus on the pharmaceutical and medical equipment industries, as well as the practices of commercial insurance companies.

We believe our patients deserve better and therefore our policymakers must do better. State officials need to slow this process down, focus on the facts and develop responsible policies that address the cost of health care insurance while also preventing unintended consequences – including staff and service reductions at Colorado hospitals.

Thank you for the opportunity to share my personal and professional perspective on the Governors Colorado State Option proposal.

Very respectfully,

Kimberly S. Mayton, RN, BSN, MHA
Division Director – Case Management
HealthONE – HCA Healthcare Continental Division

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

KIRK M GROVES

County (in which you reside) *

[redacted]

Organization *

n/a

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

yes

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

yes

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

yes

Does the proposal include worthwhile benefits for consumers?

yes

Does the proposal create a product that is financially stable and sustainable?

yes

Other thoughts? Please list them here.

lower health care costs please

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Kurt Kool

County (in which you reside) *

[redacted]

Organization *

My Family

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

No

Other thoughts? Please list them here.

I strongly oppose the Democrats' proposed "state option" that would force healthcare providers to absorb massive cuts, reducing access to care and increase healthcare costs for Coloradans on private health insurance plans. I do not support this socialist agenda!

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Laureen Gutierrez

County (in which you reside) *

[redacted]

Organization *

Private Citizen 5th Generation Native CO

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No, it's a takeover of our personal care liberties.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

NO, it will increase costs overall.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

NO.

Does the proposal create a product that is financially stable and sustainable?

Hell no.

Other thoughts? Please list them here.

This is a control issue, not health care. Polis is a dreamer who is out of step with reality. Unfortunately, tax payers will pay for his pipe dreams and good intentions gone awry.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Lauren Roe

County (in which you reside) *

[redacted]

Organization *

None

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No. It just says they promise to look into it. It doesn't say anything about rates or rate locks.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No. When it costs $2200/mo for 2 people to get health insurance and they still have a $7k individual deductible you're almost asking people to file for bankruptcy at that point. This proposal doesn't mention ANYTHING about rate control.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

The proposal is just an document that says they're going to try their best to talk about the rising cost of healthcare. It doesn't say anything about what will be done.

Does the proposal include worthwhile benefits for consumers?

No.

Does the proposal create a product that is financially stable and sustainable?

The proposal is just an document that says they're going to try their best to talk about the rising cost of healthcare. It doesn't say anything about what will be done.

Other thoughts? Please list them here.

The problem with healthcare is that anywhere can charge anything they want for any code. There is no universal charge and no oversight. If you want to fix the cost of healthcare, you need to start with that. There needs to be a statewide universal charge for every ICD code so that the prices can't be inflated artificially.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Lee Hively

County (in which you reside) *

[redacted]

Organization *

self

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

NO NO NO

Other thoughts? Please list them here.

State government has NO business meddling with my healthcare.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

lee sutherland

County (in which you reside) *

[redacted]

Organization *

lee sutherland

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

The proposal cuts to the heart of the matter and will mandate accountability for unlimited price increases by increasingly profitable and increasingly large health monopolies.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

This will open the door to fighting back at health care profit increases that prevent access for many Colorado citizens.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

The proposal is innovative and will signal an end to unlimited monopoly growth and cost increases for the largest health care providers.

Does the proposal include worthwhile benefits for consumers?

The proposal will benefit most Coloradoans.

Does the proposal create a product that is financially stable and sustainable?

The proposal will work for better access for all Coloradoans by reducing costs, and this will make a more sustainable health care system even if it means the large monopolies face existential revenue issues.

Other thoughts? Please list them here.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Levi

County (in which you reside) *

[redacted]

Organization *

Simplekey

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

NO

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

NO

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

NO

Does the proposal include worthwhile benefits for consumers?

NO

Does the proposal create a product that is financially stable and sustainable?

NO

Other thoughts? Please list them here.

We need to fully privatize the health care industry to see meaningful help for Coloradians. In other words move the government OUT of health care.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Linda Kemp

County (in which you reside) *

[redacted]

Organization *

Resident

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Does the proposal include worthwhile benefits for consumers?

Does the proposal create a product that is financially stable and sustainable?

Not at all

Other thoughts? Please list them here.

We do not support the bill and are extremely concerned about the cost to taxpayers and to the state overall. We do not believe it will ultimately serve the people for whom it was intended.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Longinos Gonzalez

County (in which you reside) *

[redacted]

Organization *

Private Citizen

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No. Costs are being absorbed by the medical/insurance company or the companies' members/patients who aren't on this new system because you are capping costs at below what is needed to pay for the services. You are spreading the cost to others similar to a new tax, where costs go down for some and up for most to pay for this new unfunded State mandate.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

It will bring services to some but at a greater cost to others.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

NO

Does the proposal include worthwhile benefits for consumers?

For some consumers yes, for many, many others, it increases their costs and likely the costs to the companies that must implement this unfunded mandate.

Does the proposal create a product that is financially stable and sustainable?

NO. The proposed legislation would fix reimbursement below the full cost of care that must be made up and paid for by others. That is not sustainable.

Other thoughts? Please list them here.

I have done research and this is a poor bill for the following reasons: the proposed legislation would fix reimbursement below the full cost of care, so it is not sustainable as it could force out providers; A study by REMI Partnership estimates that because of the plan's government price controls, health care providers throughout the state could be forced to cut services, reduce health care jobs, and/or raise the prices offered through other insurance plans. Patients may lose access to the care they need, and rural hospitals with unstable finances could be especially impacted. Some hospitals may be forced to close. The REMI Partnership study also estimates that the State's economy could lose thousands of jobs; finally, I did not see a notice for the 14 public listening sessions here in El Paso County/Colorado Springs. Did you host one here or were we skipped over?

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Lora KristaLafortune

County (in which you reside) *

[redacted]

Organization *

Radiation Improvement Specialists

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

No

Other thoughts? Please list them here.

I am not in favor of this in any way

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Luciano Lemos-Filho

County (in which you reside) *

[redacted]

Organization *

Self

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

Absolutely not.

Other thoughts? Please list them here.

The proposal currently is very vague, but we know who it will target: patients, doctors and hospitals. There is an implied threat that hospitals who don't agree to participate will be forced to do so; and that goes for doctors also. That is called a monopoly and will lead to years of litigation; and by the way the people have defeated a single payer system. The plan: create a public option and if no one wants to enter in a deal with the government, force them to. No other state has tried this. This is another attempt to create a monopolistic low quality system. The State should cover the uninsured with the state option and to pay for it levy a tax on insurance companies and pharmaceutical companies who are the true winners of this proposal and of the current mess that is our healthcare. Patients, doctors, and hospitals will lose by being forced to take payments below fair market value for quality work. Quality of healthcare in Colorado will suffer when heavily indebted new doctors leave, or never come in the first place, for more friendly states. This proposal let's large corporate interests keep their profits on the backs of doctors patients and hospitals.

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Dear Department of Healthcare and Policy,

The state option for healthcare, as proposed by the Polis Administration, would take the state in the wrong direction and undo some of the progress that has been made in this state. I'm not entirely certain how the administration came to the conclusions it did, but it strikes me as unnecessarily targeting one segment of healthcare (hospitals), while letting virtually everyone else off the hook.

And why? Hospitals have shown a willingness to work with all sorts of parties to come up with creative solutions that bring down healthcare costs across the board. Just this year, healthcare professionals joined with legislators and the Polis administration to pass a new reinsurance program and patient protections for out-of-network billing, among other reforms. These reforms are already showing real promise, including a predicted 20% reduction in premiums for individual healthcare coverage. The state option would disrupt all of the progress that's already been made. Instead of rushing the state option through, the Polis administration needs to slow down and give other important programs the time they need to work.

It's alarming to me that just this legislative session, our leadership asked the administration to study what a public option might look like. After a series of meetings that were poorly publicized, with agendas that were nearly impossible to find online, and hosted with a tone of dismissiveness and condescension, less than six months after the conclusion of the legislative session we have the proposed plan. This was released a day before its first regulatory hearing, and the public now only has 17 days to respond to it.

Why the hurry? And why the laser focus on hospitals to shoulder the cost? Something doesn't smell right, and given the reasons above, I am not in support of a public option in Colorado

With Much Thought,

Luke Ward

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

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- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Margaret Dumas

County (in which you reside) *

[redacted]

Organization *

Personal

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No. It only perpetrates political gain for those presently in power.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

absolutely not

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

Of course not. This seems to be present Government policy, no sustainability.

Other thoughts? Please list them here.

Free enterprise has always been this Nations excelling quality. Now Government wants it gone.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Mark K Matthews MD

County (in which you reside) *

[redacted]

Organization *

Individual

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

Not meaningfully

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

Partially

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

It adds to the complexity of an already fragmented system.

Does the proposal include worthwhile benefits for consumers?

The essential health care benefits are worthwhile

Does the proposal create a product that is financially stable and sustainable?

Time will tell

Other thoughts? Please list them here.

On October 1 of this year my granddaughter, Cecilia, was born. Will she be another generation that has to navigate the current dysfunctional health care system or will she benefit from us putting in the necessary effort to establish a health care system that is focused on being just, compassionate, and affordable rather than profit driven? Will her health benefits be determined by the religious affiliation of her employer?

This opportunity to create a Colorado public option is likely a once in a lifetime event. I believe that its ultimate goal should be to achieve universal coverage with controlled costs, and high quality.

The state already administers the Medicaid program but Medicaid only raises people from the ranks of the uninsured to the ranks of the underinsured. A public option that builds on an enhanced Medicaid program can change this situation. Funding would need to be increased by applying for a block grant from the Federal government that truly helps to cover costs (costs cannot be controlled without a budget), increase state taxes on products that adversely affect health, charge private insurance companies a fee to sell their products in the state (with the promise of no cost shifting), and a sliding scale premium for people who want to buy into the program.

A well run Enhanced Medicaid program could eventually cover the majority of Coloradans but meanwhile there is a choice.

I fear that the proposed State Option will do little to change to overall health care landscape and that my granddaughter will be facing the same issues that past and current generations have faced.

Respectfully,
Mark K Matthews, MD FACP

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Marta Oakley

County (in which you reside) *

[redacted]

Organization *

retired

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

no

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

no

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

absolutely NO

Does the proposal include worthwhile benefits for consumers?

NO

Does the proposal create a product that is financially stable and sustainable?

absolutely NO

Other thoughts? Please list them here.

no to socialism!

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Martha Brown

County (in which you reside) *

[redacted]

Organization *

None

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No because Bureaucrats do not solve problems but create dependency.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

No

Other thoughts? Please list them here.

Do not create another healthcare crisis. Let Coloradans keep their plans.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Martha Crapo

County (in which you reside) *

[redacted]

Organization *

Home Maker

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No - there is no government run or mandated health care that will address the problem. The problem is with the cost of medical and prescription drugs. Work on solutions to drive down costs instead of creating a bureaucracy that will drive costs up, create terrible inefficiencies, reduce the quality of card and availability of care.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No. As stated above, the problem is the cost of care. Work on solutions to make health care competitive, make prescription drug pricing reasonable and have a system to help the indigent. Absolutely no dollars should be spent on people who are not citizens.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Not sure.

Does the proposal include worthwhile benefits for consumers?

NO - ultimately we will all lose!

Does the proposal create a product that is financially stable and sustainable?

No - this proposal reduce payments to health card workers and will drive the quality and availability down. This will ultimately cause a hardship on hard working citizens, people who have worked hard for a living so they could provide for themselves and their families. Let's get back to a program that rewards hard work, initiative, self direction and perseverance. Create a system that will help those who are really needy but NO to government pricing! NO to government run healthcare!

Other thoughts? Please list them here.

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Thank you for the opportunity to comment on the October 7, 2019 Draft Report for Colorado's State Option. I believe everyone can agree on the need to reduce the costs of health insurance and healthcare services.

My major concern with the proposed plan is the effect it will have on the ability of rural hospitals to continue to provide a safety net for the communities they serve. It is not uncommon for hospitals in rural areas to step in and provide care when other options are not available.

In my role as a Board member of SCL St. Mary's Regional Hospital in Grand Junction I have seen many examples of how the Hospital acts as a safety net. At the October Board meeting we learned that the home health agency in Grand Junction that provides services to Medicaid patients is closing. This means that St. Mary's and Community Hospital will continue to provide expensive acute care resources because of a lack of in home community services. Both hospitals are currently engaged in conversations with other home health agencies to determine how to work with them to solve the problem.

Another example of St. Mary's involvement in partnering to solve community resource issues involves the Mind Springs Mental Health Facility. St. Mary's made a substantial donation to increase the number of beds available for mental health patients from the Western Slope. In my opinion, these examples demonstrate that the Hospital is trying to lower overall costs by helping patients receive the right care, at the right time in the right place. In fact, Kim Bimestefer, at a recent public forum in Grand Junction, congratulated both Community and St. Mary's for their efforts to control costs over the past several years.

I believe that the current draft of the State Option will result in significant burdens especially for rural safety net hospitals. These hospitals are much more to a community than an acute care facility. Some people criticize hospitals for making a profit. Since hospitals do not have shareholders who receive dividends or stock, they pay these earnings to the community as described in the examples above.

I ask that you pause and partner with all stakeholders to lower costs by working on a plan to align provider and consumer incentives. In my work as a Clinical Social Worker in a large city hospital, as Director of a Cancer Center, as Hospital Administrator and now as hospital Board Member I have seen what can be accomplished when we address problems by aligning incentives. If I can be a part of that process, I am willing to serve because I believe we can make substantive changes which affect the health of the population as well as the affordability of insurance.

Sincerely,

Marti Stude
706 Perry Ridge Rd
Carbondale, CO 81623
314-304-5269 (c)
marti.stude@gmail.com

Good Afternoon,

I am firmly against government run healthcare.
We own our own business and must pay extremely high premiums already in order to secure quality healthcare with options.

We cannot afford to pay even more to cover those who do not want to pay for their own health insurance on their own or through their employer.
You are forcing a socialist agenda down the throats of hard-working Colorado citizens. We do not want it and we cannot afford it.

Please stop trying to turn this state into a socialist haven. You will turn it into the California of today where the middle-and-upper class residents are leaving in droves because they can no longer afford to live there. The nonstop taxation, liberal policies, unlimited illegal immigration, the homeless crisis that is everywhere you go, and the take-over of the educational system is not acceptable.

STOP TRYING TO CRAM MORE GOVERNMENT PROGRAMS DOWN OUR THROATS BFORE YOU RUIN THIS STATE AND DRIVE THE WORKING-CLASS OUT!

Sincerely,

Mary-Sue Quinn

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Matthew Mammoser

County (in which you reside) *

[redacted]

Organization *

Taxpayer

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No, the issue with healthcare affordability is the government involving themselves in the transaction.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No, the unintended consequences will make it worse.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No government program utilizes anything with any expertise or rational meaning in the first place.

Does the proposal include worthwhile benefits for consumers?

No, it's a scam.

Does the proposal create a product that is financially stable and sustainable?

No government program is ever stable or sustainable over the long run.

Other thoughts? Please list them here.

Government is the cause of healthcare, education and financial issues in this country and states.

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October 21, 2019

Dr. David Markenson
President, Colorado Medical Society
7351 E. Lowry Blvd, Suite 110
Denver, CO 80230-6083

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Commissioner Michael Conway
Division of Insurance
1560 Broadway, Suite 110
Denver, CO 80202

RE: Recommendations for HB19-1004's State Coverage Option

Dear Dr. Markenson, Executive Director Bimestefer and Commissioner Conway,

As the Medical Staff Presidents of large hospitals in metro Denver, we represent over 3,000 physicians and allied health professionals. We work in solo practice, small and large private practices, and corporate-employed physician groups. We work in inpatient and outpatient settings and practice across all specialties.

We are writing to voice our concerns about the Colorado State Coverage Option as published October 7, 2019. While we share your motivation to improve health care transparency, affordability, and coverage for the citizens of Colorado, we disagree with the strategy you propose.

- Rate setting is a dangerous and arbitrary process which will ultimately limit the care available to Coloradans. This is the opposite of a market-based solution and will only serve to decrease competition in the insurance market. We understand that the current proposal only covers hospital reimbursement, but this will immediately affect physicians who are employed by or under contract with hospital. We have no doubt that reducing physician reimbursement is on the horizon, as happened in Maryland.
- Rate setting for hospitals will fall disproportionately on large, urban hospitals and may result in eliminating resource-intense, low-margin service lines, including organ transplantation, high risk obstetrics, burn care and critical care, as well as, programs and services for rural facilities in underserved areas. These service lines are essential to the high level of care we want to provide for Coloradans. Abandoning these services would result in job losses for some of the most highly trained physicians, nurses and technologists in our community.
- With the stated intention of expanding the State Option to small- and large-group markets, the long-term plan appears to be to replace the current commercial insurance market and incentivize employers to transition their employees into the State Option. This is a back-door strategy to implement Medicare for all, which voters have already recognized as not good for Colorado.
- If healthcare networks and therefore the physicians in those networks, decline to participate in the State Option, there is an implicit threat in the Draft that the State will compel us to accept the State Option. Good solutions do not require threats. Patients, physicians and the entire healthcare community will

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freely participate in a successful plan because they want to, not because they have to. We encourage you to devise such a plan.

- The sum of the current Draft will increase the out-migration of providers who are young in their practice and able to move to states with more favorable healthcare climates. It will decrease the ability of Colorado practices to recruit and retain talented new physicians of all specialties to the state. And, ultimately, it will decrease availability and quality of health care providers across Colorado in the long term.

We recommend that the Colorado State Legislature NOT move forward with the proposal as drafted and consider the following suggestions:

- Narrow the scope of the plan to cover the 6.5% uninsured Coloradans.
- Scale up the State Option to the individual market only after successful implementation for the uninsured.
- Set provider rates benchmarked to Medicare that account for the low cost basis of the current Medicare RVU reimbursement rate (1997 dollars).
- Devise a mechanism to pay for resource-intense, low-margin services, and to identify and support Centers of Clinical Excellence.
- The Draft is silent on health behaviors, which are an enormous component of healthcare cost. Simply put, taking pills is easier than exercise and eating right – but it is also more expensive. Consider taxing and/or removing subsidies for industries that produce unhealthy products. And, conversely, create benefits to incentivize healthy behavior.
- Give a minimum of 30 days to the voters of Colorado to comment on any future legislative proposals of this magnitude.

We want to partner with you in your efforts to reform health care delivery in Colorado so that our physician members will be engaged and the plan succeeds.

Signed,

DocuSigned by:
Mark J Kozlowski
67AC3F33971B48C...
Mark Kozlowski, M.D.
Chair HealthONE Presidents Council

DocuSigned by:
Mary L. Warner MD
2D5AA24B037E4D0...
Mary Warner, M.D.
Medical Staff President, Swedish Medical Center

DocuSigned by:
Neide Fehrenbacher, M.D.
DAF6B6FF89274A8...
Neide Fehrenbacher, M.D.
Medical Staff President, Lutheran Medical Center

DocuSigned by:
Johnny Cheng, D.O.
F3E46C94D10E48F...
Johnny Cheng, D.O.
Medical Staff President, North Suburban Medical Center

DocuSigned by:
JC
FC0EF6585E1DF84B...
Jeffrey Lewis, M.D.
Medical Staff President, Rose Medical Center

Director Kim Bimestefer
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Commissioner Mike Conway
Colorado Department of Regulatory Agencies
Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Director Bimestefer and Commissioner Conway:

As a Registration Educator at University of Colorado Hospital in Aurora, I am writing to share my concerns about the "Draft Report for Colorado's State Coverage Option," released Oct. 7, 2019.

In my job, I meet patients and their families at an incredibly difficult time. We provide support and guidance as they make decisions ranging from end-of-life and final wishes to long-term care. More than 70 percent of the patients I work with are receiving either Medicaid or Medicare benefits. The rest are wither those who have private health insurance through their employer or those who have no coverage at all. At UCHealth, I am proud that each patient receives my best efforts and those of my colleagues, regardless of their income, insurance status, or ability to pay for care.

I am proud of UCHealth's commitment to our community. As the largest provider of Medicaid, we are dedicated to caring for every patient who walks through our doors. We also support programs that improve health in the communities we serve, keep kids healthy, prevent distracted driving, provide healthy food options for seniors, provide a free nurse advice line, free flu shots, programs to address postpartum depression, treat substance use disorders, and so much more. We've just started a program that will dedicate at least $100 million to treat behavioral health in a more comprehensive and integrated way.

While I applaud your desire to improve health care, I disagree with the plan's proposal to use government rate setting to cut reimbursements for hospitals. I believe such actions will force a dramatic reduction of services provided by hospitals like mine, as well as reducing or eliminating our community programs. Our largest payer is Medicaid, which is already reimbursing at a rate of .69c per dollar, and further reimbursement cuts will demand that as a hospital system we re-allocate budget funding to cover this greater gap in payment reimbursements. In times of crisis our patients should not be worried about the cost of care and I feel that further cuts to hospital reimbursements could have a negative impact on our top priority, the patients.

I care about my patients and the community we share. I am concerned that some hospitals will not be financially solvent enough to weather these cuts and will be forced to permanently close, especially in rural areas where healthcare resources are already stretched thin. I strongly believe that this proposal will cause serious harm to our patients, our communities, and our hospitals.

Please note that these are my personal comments and views, which don't necessarily represent those of my employer.

Respectfully,

Megan Smith
[REDACTED]
[REDACTED]

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Melissa Jones

County (in which you reside) *

[redacted]

Organization *

Consumer advisory board Colorado coalition for the homeless

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

Yes

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

Yes

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Yes

Does the proposal include worthwhile benefits for consumers?

Yes

Does the proposal create a product that is financially stable and sustainable?

Yes

Other thoughts? Please list them here.

Affordable health care in some cases can prevent homelessness that I've seen due to outrageous cost of healthcare

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To Whom It May Concern:

My name is Melissa Shields. I live in [REDACTED] and I am an Oncology Certified Registered Nurse at Sky Ridge Medical Center.

I am submitting comments about my opposition to the State Option, which proposes to establish a public option for health insurance that would reimburse hospitals and healthcare providers at lower rates.

I'd like to start off by providing some background. In Colorado, the percentage of patients insured by Medicare or Medicaid increased from 20% in 2008 to 34% in 2017. That means that one-third of insurance payments for healthcare services in the State of Colorado are reimbursed at only $0.69 for every $1. The remaining $0.31 does not just disappear. These lost costs are, in effect, picked up by reimbursements from commercial insurance plans. In other words, hospitals and healthcare providers rely on reimbursements from commercial insurance plans to stay afloat to continue to provide vital and high-quality services to the community. The reimbursement constraints in this bill would force healthcare providers and hospitals to accept payments do not cover the cost of care. They will face pressure to cut services or close their doors, effectively cutting off access to healthcare to those who need it most – our patients.

I am a Registered Nurse. But I am also a wife, a friend, and daughter. I have hugged a young cancer patient knowing that was the last time I would see them alive. I have held and kissed the new baby of my best friend who tried for 4 years to get pregnant and then ended up having a high-risk, complicated & scary pregnancy. I have seen my father undergo brain surgery and rehab to treat a hemorrhagic stroke. I have stayed awake for 36 hours to stay with my husband as he prepared to undergo an emergency appendectomy. How can that happen if the lights are off and the doors closed and locked?

Like you, I want everyone to have affordable health insurance and access to high-quality care. But, doctors, nurses and hospitals did not cause these problems. So, they should not be punished. The State Option is well-intentioned, but it is the wrong way to go.

Thank you for your time and consideration.

Melissa Shields, RN, BSN, OCN, ONN-CG

Michael C. Merrill
[REDACTED]
Retired CO. state employee
[REDACTED]
Q 1. Yes
Q 2. Yes
Q 3. Yes
Q 4. Yes
Other thoughts—

I am a retired state employee and my wife and I currently have PERACare with Anthem & 2020 health insurance carrier.

I have contacted the PERACare representative, Ms. [REDACTED] Linhart and asked if they have worked with others to develop a long term health care plan for PERA. I specifically included; the old "208 Commission" Health Care Benefit Managers-Brokers, Connect for Colorado, ACA, "HB 88." Ms. Linhart response was "healthcare committee is made up of staff & consultants and her."

With recent news & Governor Polis remarks (Denver Post, 10/10/19), I was interested in whether or not PERA, with 600,000 state citizens, employees & retirees were part of the "HB 19-1004" Plan?

Thank you for your time and consideration

Sincerely,
Michael C. Merrill

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

Please use this form to submit your comments on the draft HB19-1004 report. All comments will be logged and added as an appendix to the final report. We will accept comments until October 28.

Helpful Links:
- The draft report can be found here: http://www.colorado.gov/pacific/sites/default/files/HB19-1004%20Draft%20Report%20Colorado%20State%20Coverage%20Option%20and%20Appendix.pdf
- The bill text can be found here: https://leg.colorado.gov/sites/default/files/2019a_1004_signed.pdf
- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

michelle klermund

County (in which you reside) *

[redacted]

Organization *

Myself

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

Medicare for all

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

Medicare for all

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Medicare for all

Does the proposal include worthwhile benefits for consumers?

Medicare for all

Does the proposal create a product that is financially stable and sustainable?

Medicare for all

Other thoughts? Please list them here.

Medicare for all

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To WHom It may Concern,

I am opposed to the ACPF_1004 Affordable Option. It would put at risk a health care system that is already worse after the ObamaCare introduction. Our premiums have doubled and our coverage is much less and even difficult to get now.

Do NOT pass ACPF_1004 Affordable Option!

Michelle Madd

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Mitchell Baldwin

County (in which you reside) *

[redacted]

Organization *

None

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

Not when the government gets involved (if you like your doctor you can keep your doctor) How well did that work out? Obamacare promised insurance would be affordable. Anybody with half a brain knew that was a lie. You can't drop millions of uninsurable people in a system and expect costs to drops. Sounds like you are promising pie in the sky economics again. You are trying to fix the wreck Obamacare caused. I don't think you can.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

Promises promises just like Obamacare.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Define minimal costs to taxpayers. That's all we need is another layer of bureaucrats telling insurance companies how 2 behave. You can do that now.

Does the proposal include worthwhile benefits for consumers?

Promises promises.

Does the proposal create a product that is financially stable and sustainable?

No. What happens to rates and services should insurance companies quit the system? Who Pays?

Other thoughts? Please list them here.

I personally think you are nuts for attempting this. All you are doing is putting price controls on existing carriers. Why do you need a whole new program to that? You said it only requires minimal dollars for state staffing. How much is minimal? Minimal to you probably means millions for staffing and growing the size of government. Save the expense and tell carriers to reduce premiums by 10%. When you pass this as I know you will, and insurance carriers pull out, WHO is on the hook for this NEW program???? Taxpayers who else. Has anyone computed the cost to taxpayers when insurance carriers leave the system? You said some counties only have one carrier. What happens if they leave? Is the state taxpayer on the hook for care? Your program sounds like a sure way to get insurance companies to leave.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Monte D Tucker

County (in which you reside) *

[redacted]

Organization *

N/A

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

Never

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

The opposite

Does the proposal include worthwhile benefits for consumers?

It will break the bank

Does the proposal create a product that is financially stable and sustainable?

It will break the bank

Other thoughts? Please list them here.

As usual, liberals do not see the outcome that will occur from this measure. The consequences will be disastrous and devastating and will do precisely the opposite of what the liberals good intentions are meant to do.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Nancy King

County (in which you reside) *

[redacted]

Organization *

Colorado Rural Health Center

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Does the proposal include worthwhile benefits for consumers?

Does the proposal create a product that is financially stable and sustainable?

Other thoughts? Please list them here.

I am very concerned about hospital rate setting and how it will impact rural hospitals across our state. It is more expensive to provide critical access to hospital services in rural areas, and this plan does not account for differences between rural and urban hospitals. How does DOI and HCPF plan to “fiercely protect rural hospitals”? There are some rural facilities/regions that are paid below the 175%-225% of Medicare. The report indicates this is a cap for payments, but is there a floor? The sustainability of rural hospitals varies by region-does HCPF and DOI plan to differentiate their support/protection of rural by region? If the plans are intended to be sold through private insurance companies, how can we ensure network adequacy in rural areas that have only one option on the exchange?

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Madam Chair and members of the committee,

I am Nathan Nidiffer and I am from Colorado Springs where I work as healthcare finance professional.

The Air Force moved my wife and two children to Colorado Springs in 2007 where we immediately fell in love with the outdoors, sense of community, and small town feel. Since moving here, we have seen Colorado grow by over 600,000 residents and the demand for all types of healthcare to meet our growing population's needs.

We can all agree healthcare costs are rising and we need to find a way to control these costs without undue harm to our residents. I absolutely agree with this…this is not my concern. My concern is with Senate Bill 1 are the consequences a single payer system will bring to our individual communities and State.

Imposing a single payer system that requires healthcare providers to accept reimbursements that are lower than what it costs to deliver that care is not financially sustainable. If Senate Bill 1 passes it will lead to less healthcare professionals moving to Colorado and those here to consider moving away from Colorado where similar payment models do not exist. This will exacerbate our statewide shortage of healthcare providers, which according to the US Department of Health and Human Services is at 264 – this will be magnified in our rural areas where 1.1 million Coloradans are directly impacted by the shortage.

Hospitals will be unable to cover the cost of care and will have to divest themselves of needed services to be able to continue to deliver even the most basic healthcare to the communities they serve. Ultimately, this will result in even less access to healthcare for our growing population and lower quality of care because of our lack of physicians - not to mention the impact of lost employment and revenue in a profession that accounts for over 71,000 jobs and $18 billion in economic activity to Colorado annually.

We need to meet the healthcare needs for all of our Coloradans, but Senate Bill 1 will not deliver this. Instead it will result in less access to care and decreased quality…this is not what Coloradans need or deserve.

Nathan Nidiffer
nidiffer@gmail.com
719-640-9896

National Jewish Health®
Breathing Science is Life.®

Michael Salem M.D., FACS
President and CEO

1400 Jackson Street
Denver, CO 80206
Tel: 303.398.1031
Fax: 303.270.2165
salemm@njhealth.org

Oct. 28, 2019

Director Kim Bimestefer
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Commissioner Mike Conway
Colorado Department of Regulatory Agencies
Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Dear Director Bimestefer and Commissioner Conway:

We appreciate the opportunity to provide feedback on the "Draft Report for Colorado's State Coverage Option," released on Oct. 7, 2019.

National Jewish Health is the #1 Respiratory Care hospital in the nation and we have been proud to be a part of Colorado for 121 years. We provide a unique patient care experience (and provide a great deal of time for each patient and their families with their provider) in respiratory, cardiac, immune and related disorders for adults and children. We have always been an organization that serves all patients on a first-come, first-serve basis. We have no restrictions on the number of Medicaid or uninsured patients we see. Many patients come to the institution having had a number of medical opinions previously; with serious unsolved medical issues; misdiagnoses; tertiary and quaternary medical problems; and, in many cases, a lack of education about their acute or chronic illnesses. We do all we can to keep patients from being hospitalized and work closely with Saint Joseph Hospital, a part of the SCL Health system, and a high quality/low cost provider.

We offer many services that are beyond essential hospital care, but are needed by our community. For example, we run an on-site, free school for up to 90 chronically ill children – the Morgridge Academy. This school serves Colorado children in kindergarten through 8th grade. The school serves the medical needs of the children while providing a solid education for children who are unable to succeed in their neighborhood schools due to their illnesses. While we receive some funding from the state for designated facility schools, the bulk of the cost is willingly borne by National Jewish Health. We also invest substantially in and conduct extensive biomedical research to ensure that we advance science and medicine to bring leading edge treatments and solutions to our patients and others around the world - a critical part of our mission.

We see over 130,000 patients each year. We know how important it is for people to get the health care they need at the time they need it. We have been a steadfast advocate for the expansion of health care coverage and access.

We have watched the conversation around the proposed public option legislation and the stakeholder process used to develop a plan required by House Bill 19-1004. Despite considerable input from the Colorado Hospital Association on behalf of all hospitals, including us, and input from many individual hospitals, community members and others, the process seems to have lacked substantive discussion about genuine solutions. As hospitals shared during the stakeholder process, we believe a state public option should:

- Prioritize coverage and affordability for Colorado's remaining uninsured
- Protect patient choice through competitive insurance markets
- Safeguard access to high-quality care through sufficient payments for providers and hospitals

Because the proposal does not include details in its actuarial analysis about the impact on hospitals like ours, it places the responsibility for that analysis on us. The proposal does not consider the unique issues of caring for the chronically ill or the patients that have failed treatment elsewhere. These patients require a higher level of clinical support, the costs of which are not reimbursed by Medicare and cannot be financially supported at the rates proposed in House Bill 19-1004.

We believe the current proposal will have significant negative impact on our organization. We operate on small margins and invest any income back into care and research to meet the needs of our patients. We do believe that the proposed plan is unworkable as it penalizes the very organizations that provide the care. We also believe that that the financial burden imposed by the proposed plan will be unsustainable and will ultimately lead to reimbursement reductions that our hospital cannot bear. And, we believe that reducing services or reducing the health care workforce – which are likely outcomes of this measure – are not in the best interest of Colorado.

This proposal is not an acceptable solution for our community or our hospitals, which is why we believe revisions must be made to this proposal before it is finalized. We urge you to look closely at the options provided by CHA.

We look forward to working with you and your staff on this and other issues as we all seek to maintain and improve Coloradan's access to high-quality, affordable health care.

Sincerely,

Michael Salem, M.D.

National
Multiple Sclerosis
Society

October 25, 2019

Commissioner Michael Conway

Colorado Division of Insurance

1560 Broadway, Ste 110

Denver, Colorado 80202

Director Kim Bimestefer

Department of Health Care Policy and Financing

1570 Grant Street

Denver, Colorado 80203

Re: Comments on the Draft Report for Colorado's State Coverage Option

Dear Commissioner Conway and Director Bimestefer:

The National Multiple Sclerosis Society (Society) thanks you for this opportunity to comment on the Draft Report for Colorado's State Coverage Option. Multiple sclerosis (MS) is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Symptoms range from numbness and tingling to blindness and paralysis. The progress, severity and specific symptoms of MS in any one person cannot yet be predicted. Nearly one million people are living with MS in the United States, more than twice the original estimate. Since 2014, the Affordable Care Act (ACA) health insurance marketplace has been an extremely important avenue to affordable, quality coverage for uninsured people living with MS.

1100 New York Ave NW Suite 440E Washington D.C. 2005 tel +1 202 408 1500 fax +1 202 408 0696 www.nationalMSsociety.org/advocacy

National
Multiple Sclerosis
Society

Affordable plans ensure patients can access needed care in a timely manner from an experienced provider without undue financial burden. For people with MS, access to high quality, affordable health care services and early and consistent control of disease activity plays a key role in preventing accumulation of disability and allows people with MS to remain active in their communities. Therefore, we commend the work done to increase choice and competition in the insurance market, and offer an additional insurance option for people living with MS who are uninsured, struggle to afford coverage, or are ineligible for ACA subsidies and therefore spend a significant proportion on their income on premiums and out of pocket costs.

Areas of Consensus

Standardized Plans

We support the desire to standardize the plan benefit design under the state option plans. We believe this effort will make it easier for consumers to shop and compare plans, knowing the benefits and cost-sharing will remain the same while they weigh other benefits, such as comprehensiveness of coverage, quality, and networks offered by carriers. The Society supports measures to require health plan transparency to allow consumers to select the most appropriate plan to ensure their physical health and financial security.

Additionally, we urge the State to consider how current prescription drug utilization management criteria and formulary designs will be impacted (if at all) by standardizing the plan design for the state option plans, in addition to standardizing cost sharing requirements. People with MS report high and rapidly escalating medication prices, increasing out-of-pocket costs, confusing and inconsistent formularies, and complex payer approval processes such as prior authorization and step therapy requirements that stand in the way of getting the treatments they need in a timely manner. For those with diseases such as MS, which may be severe or debilitating, delaying treatment can be a serious outcome.

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Broad Eligibility

We strongly support the provisions to make the state option plans available to all Colorado residents. However, it should be noted that we do have concerns about the affordability of the product for low-income individuals who are not eligible for subsidies, and for subsidized enrollees for whom subsidies are reduced due to the impact of lower premiums for the benchmark plan.

Essential Health Benefits Coverage

We believe it is imperative for the state option plans to cover all essential health benefits. In addition to being affordable, healthcare must be adequate, meaning that healthcare coverage should cover treatments patients need including all the services in the essential health benefits package.

Use of Exchange Infrastructure

Connect for Health Colorado has reached stability and sustainability. We support leveraging Connect for Health Colorado's technology and services to help facilitate the sale of and enrollment of individuals into the state option plans.

Advisory Board

We support the creation of an advisory board as part of the infrastructure surrounding the state option. We would like to ensure that multiple consumer appointments are permanent seats of the Advisory Board's structure. Specifically, we'd like to note that the consumer appointments should represent not only a diversity of geographies, ethnicities, and income levels (including both subsidized and unsubsidized representation), but also a diversity of health care perspectives, including but not limited to those with a focus on chronic disease, physical disabilities, and caregivers. There should be equal representation of the health care industry and patient advocates.

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Society

Prescription Drug Rebates

We support passing through rebates from pharmaceutical manufacturers to consumers to bring down the cost of prescription drugs and coverage. This should be transparently reported in the carrier's rate filings.

1332 Waiver

If the state is successful in applying for a 1332 waiver and drawing down federal dollars, we support the state using the funding to increase premium subsidies for low-income enrollees and reducing the out-of-pocket cost sharing for low-income consumers.

Areas of Concern and Clarification

Impact on Provider Networks

We urge the State to consider the impact that the proposed reimbursement rates will have on network adequacy and access to specialists. In order to ensure that the state option plan provides adequate, quality networks, the State needs to ensure specialist participation for both hospital based and non-hospital based providers, as many individuals living with MS rely on their specialists as a routine source of care. Network inadequacy raises particular concerns for people living with MS and others with specialized and complex healthcare needs. People living with MS may require care from neurology, rehabilitation, radiology, mental health and other specialists, as well as treatments, services and products from pharmacies, durable medical equipment providers, home care agencies and more to live their best lives.

Impact on Rural Communities

We encourage the State to provide further clarification in order to protect access to care for residents in rural areas that currently have limited (or no) alternative access points.

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Impact on Subsidies

We are pleased that the overall impact on insurance premiums is predicted to be a 9-18% reduction. However, we are concerned that the reduction in premium rates will also reduce the benchmark plan premium (second lowest cost silver plan), which is the plan that premium tax credits are based upon. The unintentional effect of this change will reduce the purchasing power of the subsidies for those that are eligible, especially those that qualify for cost sharing reduction plans. Furthermore, to the extent it is not possible to adequately meet the needs of the subsidized population with the same solution as the unsubsidized populations, we suggest that the State explore allowing for multiple, alternative solutions tailored to the needs of each population.

Value-Based Insurance Design (VBID)

We appreciate the emphasis on creating higher value insurance products; however, we caution against utilizing value-based insurance design as simply a cost-savings mechanism. True VBID should aim to increase health care quality while decreasing costs by promoting cost-efficient health care services that are in line with the patient's goals and treatment plans. The Society believes that true value is realized in health care when individuals with MS are at the center of their healthcare decision making and can access the treatments that are prescribed in consultation with their healthcare providers in a shared decision-making process. As MS presents differently in each individual, every person's response to a MS disease-modifying therapy will vary. In fact, it is critically important that payers, payment models and delivery systems recognize that despite similarities in their indications and usage, these medications are not therapeutically interchangeable. As such, it is critical to ensure that VBID does not lead to discriminatory practices and utilization management criteria for people living with MS. VBID should be designed based on evidence-based criteria that support care coordination and quality improvements and improve adherence.

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In conclusion, the Society strongly appreciates the outreach and engagement by HCPF and the DOI in seeking feedback during this process to create a state health care coverage option that meets the needs of people living with MS. For further information, please contact Jessalyn Hampton, Sr. Manager of Advocacy, at Jessalyn.hampton@nmss.org or 303-698-5431.

Respectfully,

The National Multiple Sclerosis Society

1100 New York Ave NW Suite 440E Washington D.C. 2005 tel +1 202 408 1500 fax +1 202 408 0696 www.nationalMSsociety.org/advocacy

Colorado already has a shortage of doctors and nurses. I fear that a public option for healthcare coverage will make this problem worse. Why? Because when you mandate what type of reimbursement healthcare professionals can get for the services they offer, irrespective of what those services actually cost, you're going to dissuade people from either going into the profession, or to seek opportunities outside of Colorado.

As special a place as Colorado is, and it is, it's not special enough to defy basic economic principles. You can't enact a command and control style of price setting for an entire sector of the economy and not expect there to be serious repercussions. If medical institutions can't cover their expenses thanks to a public healthcare option, they're necessarily going to make cuts. How that exactly will work is unknown. We don't know, and more importantly, the Polis administration doesn't know either, but they'd prefer to handwave that concern away.

What really bothers me is that officials in the administration seem to have no concern over this. The governor's top healthcare advisor, Kim Bimestefer, remarked that Coloradans have "way too much access" to healthcare in some areas, including cancer treatments, heart surgery and orthopedic surgery. "An abundance of providers in healthcare doesn't drive costs down, it often drives costs up," she says.

In what universe does more choice drive costs up? That simply makes no sense and feels like a blithe statement one makes when they don't want to engage a concern seriously. This is a serious issue and deserves our full attention. I hope the Polis administration slows down their agenda and works with more stakeholders before anything is offered for decision from either the public or the legislature because as it stands, the current plan for a public option has too many holes to be taken seriously.

Nick Kliebenstein

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Nina Anderson

County (in which you reside) *

[redacted]

Organization *

Self

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No, absolutely nothing! affordability requires a root cause solution! This is nothing but government arrogance! A group of legislators thinking they can do better than the private market that is choked full of a lot of much smarter people.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

See above.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Does the proposal include worthwhile benefits for consumers?

no, it does NOTHING to address access to care especially in rural Colorado

Does the proposal create a product that is financially stable and sustainable?

no - it is an INSURANCE - insurance does NOT address financially stability or root cause of rising costs.

Other thoughts? Please list them here.

The Proposal is another unsustainable insurance that lack creativity and does NOTHING to further improvements to care for Coloradans. There was clear lack of listening on the listening tour and it is abundantly clear you decided what was to be done prior to rolling out the inadequate model in this draft legislation. The age old model of insurance does NOTHING to address access to care. I specifically shared the DPC (Direct Primary Care model during the tour. It is a monthly paid membership that provides just that - Direct access to a primary care physician! Under the current model the physician negotiates pricing for services and prescriptions at predictable rates. There are other models such as physician concierge that should have been reviewed also. While I do not know the details of their business model neither do you because you did nothing to LISTEN!!! What a waste of energy, effort, and tax payer dollars! Disgusting!

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Do not go forward with goverment run health care.

P Frerich

Pamela A. Assid, DNP, RN, CNS, CEN, CPEN, NEA-BC
[REDACTED]
[REDACTED]
[REDACTED]

To Whom It May Concern:

Thank you for the opportunity to review the draft report for Colorado's state coverage option. I appreciate our Governor, DOI and HCPF working to address concerns by our state's citizens relative to the costs associated with healthcare.

As I reviewed the draft report, I have concerns where more clarity and consideration needs to be applied before moving forward on creating legislation on the state coverage option:

- Colorado has approximately 400,000 uninsured citizens. There is nothing in this draft proposal that focuses on attaining coverage for these citizens or ensuring they have health insurance options;
- The rate setting approach does not take into consideration if there is payment variation by facility, service, community or any other factors. This has significant potential to limit all of Colorado citizens' options with choosing health insurance coverage.
- There is no explanation of how the Centers of Excellence quality improvement will work or potential impact to Colorado citizens on hospital or physician choice.
- Ensuring Colorado citizens in rural communities have access to healthcare is important but there is no specifics provided on how this will be accomplished.
- There is nothing relative to safe guarding the sustainability of urban hospitals which may be at risk with the rate setting approach presented.
- There is little discussion for the funding that would be required to implement the state coverage option. When Amendment 69 was proposed in 2018, the funding alone would have bankrupted our state and not supported access to quality healthcare in our state.

While Colorado hospitals and physicians have worked to streamline care and minimize costs (currently at the 10th and 7th lowest in the country according to Kaiser Family Foundation and Centers for Medicare and Medicaid Services), the costs of health insurance are challenging and rise at levels disproportionate to costs associated with health care. Based on information from the U.S. Medical Expenditure Panel Survey, health insurance costs in the form of premiums have risen 54-60% over the past decade; in the same time period, deductibles have risen even more dramatically, 105-108%.

A Colorado Statewide Hospitals Survey, conducted in April 2019, indicates many Coloradoans (67%) believe our current state healthcare system is meeting their needs. They want a focus on maintaining quality of healthcare (82%) but definitely want help controlling costs (82%). This draft report does not address how to maintain the current state healthcare system, ensure maintenance on quality of care or address costs of healthcare insurance. This is what I would like a state coverage option to focus on and ensure we can continue to be innovative and cost conscious in Colorado.

As someone who provides health care as well as being a consumer of health care, I urge the individuals and committees to listen to feedback from Colorado citizens on what we desire. We do desire assistance with controlling health insurance costs, ensuring those who provide our healthcare are focused on both quality as well as being cost conscious, and allow us to maintain choice with coverage options.

Thank you,

Pamela Assid, DNP, RN, CNS, CEN, CPEN, NEA-BC

October 23, 2019

Director Kim Bimestefer
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Commissioner Mike Conway
Colorado Department of Regulatory Agencies
Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Director Bimestefer and Commissioner Conway:

I am grateful for the opportunity to submit comments on behalf of Parkview Medical Center for the "Draft Report for Colorado's State Coverage Option," released on October 7, 2019. We agree our state needs to take proactive steps to address health care access and affordability to ensure Coloradans have access to the care they need and can afford it when they do seek care. However, we are concerned that this proposal, as drafted, would have serious ramifications for our community, our hospital and our state.

Specifically, we do not believe this proposal will help enough Coloradans and may actually jeopardize access to care and affordability for those who are already covered. With nearly 400,000 Coloradans currently uninsured, we are disappointed that this new option does not prioritize those individuals. We are also concerned it will increase health insurance costs for many Coloradans, as costs will be shifted to those Coloradans who currently have employer-sponsored insurance. Finally, we believe the government rate setting for hospitals that fund this proposal could be incredibly detrimental to hospitals across our state.

Parkview Medical Center, our local hospital, is a vital part of our community. It is the largest employer in Pueblo County and provides significant community benefit beyond the traditional patient care offered within the hospital. While the draft proposal does not specifically examine the financial impact to hospitals, we must assume this type of government rate setting for hospitals will be significant – especially since hospital cuts are the only funding mechanism for these significantly reduced health care plans. We are hopeful that during the formal comment period, the state will take a more in-depth look at the feedback provided and make many changes to the proposal before it is finalized.

Please consider the impact this proposal could have on communities like ours, on hospitals like ours, and on access to affordable care for patients like me, my family, friends and neighbors. We agree there is still more work to do to improve our health care system, but this proposal, as drafted, is not the solution. Thank you for your consideration.

Sincerely,

Mark Dunsmoor
Chair, Board of Directors
Parkview Medical Center

parkview
MEDICAL CENTER

October 23, 2019

Director Kim Bimestefer
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Commissioner Mike Conway
Colorado Department of Regulatory Agencies
Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Director Bimestefer and Commissioner Conway:

Parkview Medical Center appreciates the opportunity to provide feedback on the "Draft Report for Colorado's State Coverage Option," released on October 7, 2019.

Our hospital is proud to provide a variety of health care services for the areas we serve. We currently provide over 90% of the care provided in our community. As the largest employer in Pueblo with 3,200 employees, the economic impact our employees and families have is significant. We offer a number of services outside the essential hospital care every day. We have been a steadfast advocate for the expansion of health care coverage and access.

We believe a state public option should:

- Prioritize coverage and affordability for Colorado's remaining uninsured
- Protect patient choice through competitive insurance markets
- Safeguards access to high-quality care through sufficient payments for providers and hospitals

This proposal fails on all of these priorities. Our organization believes the proposal submitted is flawed and not ready for implementation due to several reasons:

1. There was discussion about a phase in or variation by facility/community but there is not specificity in the report related to this.
2. The report discusses Centers of Excellence but does not contain an explanation of how that would work and what impact this would have on patient choice of hospitals or physicians.
3. The report promises to protect rural and critical access hospitals, but it does not provide any insight into the mechanisms that will be used to accomplish that goal.
4. The report does not acknowledge that there are many independent urban hospitals whose sustainability may also be at risk.

Because the proposal does not include details in the actuarial analysis about the impact on hospitals like ours, it put the responsibility for that analysis on us. Without the changes above, we believe the impact to our organization for those patients in the individual market will be significant, with an impact between $1.0 million - $2.0 million. This is not a sustainable reduction our hospital can bear, meaning we will likely have to assess services and staffing. This is not an acceptable solution for our community or our hospital, which is why we believe revisions must be made to this proposal before it is finalized.

We look forward to working with you on this and other issues as we all look to maintain and improve Coloradan's access to high-quality, affordable health care.

Sincerely,

Leslie Barnes

Leslie Barnes
President/CEO

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

Please use this form to submit your comments on the draft HB19-1004 report. All comments will be logged and added as an appendix to the final report. We will accept comments until October 28.

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- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

pat cook

County (in which you reside) *

[redacted]

Organization *

na

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

no- we need to do better with transparency -especially with specialist, dental care, emergency care that is not emergent, and prevention care such as flu shots, substance abuse etc.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

maybe- community education of what the program really is needs work. Folks think because they have "medicaid" they have an unlimited budget. That would be first thing fixed so the claims are real time and timely. Once you spent your allotment for the year- you would have a UM review for next layer of approval. It could be disease regulated on the chronic side. Other challenge is getting the primary care doctors comfortable enough to practice. Other thing that needs addressed is torts, law suits etc. That needs to be curbed down to very little as that is a big ticket item that keeps driving costs .

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

no- it does not give a good, informatic of the process. We need to make sure the information that comes forward is constant across the state. If we had one system and not splintered- it could save money. It cannot be that disaster from Colorado Springs again. Training of the project was not reliable. Feedback from processors was not factual and had to make appeals not needed due to that...

Does the proposal include worthwhile benefits for consumers?

somewhat- after all the information is gathered, it needs to re sent to all the same groups for feedback. Need to make sure mental/behavioral health is available and not stimy to 6 visits. Not everyone is cookie cutter and fixed so to speak in 6 visits. Also, need to talk about telemedicine- privacy, functionality and risks. It is also important to discuss provider types- many folks only want a MD type person for services.

Does the proposal create a product that is financially stable and sustainable?

possibly- right now we are spending too much on medicaid because it is not means tested on cash assets. That needs to be looked at- the person tells me often they keep income in the appropriate lane just to be on medicaid.
Children should not have to be re-qualified every month- that is a big waste. That goes for our other programs . Counties spend a great deal of administrative time and wages redoing and reevaluating the lowest income when their life is static. That is not where financial abuse of the program propagates.

Other thoughts? Please list them here.

in process, there is a small faction of folks who do not get any medicare at 64/months. We need to clean that up so they are not without. Some of these are PERA employees who threw their state program in the trash when the ACA came and then found out they have nothing at 65. We also need to figure out immigrants and dependents. OAP is told to be available to folks on arrival. It is not. I would like to see this program only if you have worked and paid into state taxes for at least 5 years and citizen. It is abused program.
We also need to figure out all the migrant homeless. So, for those folks the FQ programs try to take many.

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please no to any kind of government run programs, they have all been devastating failures especially healthcare, example aca aka obama care

Patrick Stookesberry

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

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- We will accept comments in all languages!

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Peter Nemec

County (in which you reside) *

CO

Organization *

citizen

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

no

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

no

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

no

Does the proposal include worthwhile benefits for consumers?

only a few

Does the proposal create a product that is financially stable and sustainable?

no

Other thoughts? Please list them here.

The premise of high cost of health care only affects 14 county's in Colorado is incorrect. In addition, health care is a personal responsibility.

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PhRMA

October 25, 2019

VIA ELECTRONIC SUBMISSION

Colorado Division of Insurance
ATTN: Commissioner Mike Conway
1560 Broadway, Suite 850
Denver, CO 80202

Re: State of Colorado State Coverage Option

Dear Commissioner Conway:

We are writing on behalf of PhRMA, the Pharmaceutical Research and Manufacturers of America, a trade association of 35 biopharmaceutical companies that are devoted to discovering and developing medicines that enable patients to live longer, healthier, and more productive lives. Since 2000, PhRMA member companies have invested more than $900 billion in the search for new treatments and cures, including an estimated $79.6 billion in 2018 alone.[1] We appreciate the opportunity to submit comments on the Colorado Draft Report State Coverage Option, released on 9/30/19.

PhRMA appreciates the tremendous time and resources that the Colorado Division of Insurance, part of the Department of Regulatory Agencies and the Department of Health Care Policy and Financing, devoted to formulating the report that outlines core features the agencies believe will support a successful State Option in Colorado.

While we appreciate your goal of using manufacturer rebates to lower patient costs through reduced plan premiums, this is essentially the status quo. We strongly urge you to instead require plans to share rebates directly with patients at the point of sale. The pharmaceutical industry provides more than $166B in rebates (as of 2018) to the federal and state government. A Milliman study showed that providing access to discounted medicine prices at the point of sale could save certain commercially insured patients with high deductibles and coinsurance from $145 to more than $800 per year. In addition, this analysis showed that sharing negotiated rebates with patients would have a minimal

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[1] Pharmaceutical Research and Manufacturers of America (PhRMA). *PhRMA Annual Membership Survey, 1996-2018.* Washington, DC: PhRMA; 2019.

impact on premiums because it would only increase health plan costs, on average, about 1 percent or less. The analysis looked at patients across seven states, including Colorado, with high deductibles and coinsurance and showed sharing negotiated rebates with asthma and diabetic patients in Colorado would have minimal impact on premiums and could save patients up to $1,000 annually[2].

It is critical not to lose sight of the importance of access to innovative therapies for patients. As patient groups have already submitted in writing and as described in the Draft Report, patient advocates make the point that they must have access to a robust formulary design that offers as many treatment options as possible. The groups also emphasized that the plan should not indiscriminately choose treatment options that are simply the most affordable, because one size does not fit all and what works for one patient may not work for another patient with the same diagnosis. The healthcare provider must be the ultimate decision maker for the best treatment options for their patient, taking into consideration the patient's comorbidities, previous health history, prior reactions and side effects to other medicines, etc.

Thank you for the opportunity to submit comments and to continue dialogue on this issue as the Department of Insurance finalizes the report for submission by November 15, 2019. We are happy to have any additional follow up discussions with you and your staff regarding sharing the savings with patients.

Sincerely,

Dana Malick
Deputy VP, State Govt Affairs, PhRMA
dmalick@phrma.org

Sharon A. Lamberton, MS, RN
Deputy VP, State Policy, PhRMA
slamberton@phrma.org

[2] Milliman Analysis commissioned by PhRMA. *"Point of Sale Rebate Analysis in the Commercial Market: Sharing rebates may lower patient costs and likely has minimal impact on premiums."* Bunger, Gomberg, Hunter and Petroske. Washington, DC; October 2017.

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Phyllis Albritton

County (in which you reside) *

[redacted]

Organization *

Colorado Safety Net Collaborative

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

Potentially, but it will only be clear when the prices that include the premium, the deductible and the copayments are available for review.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

We do not know. See below for our thoughts on who is struggling with high health care costs.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Potentially.

Does the proposal include worthwhile benefits for consumers?

Potentially. Not enough information is available to discern this.

Does the proposal create a product that is financially stable and sustainable?

Potentially, especially if the state reinsurance mechanism is utilized.

Other thoughts? Please list them here.

Colorado Safety Net Collaborative (CSNC) Comments on

HB19-1004, CO State Coverage Option

The Colorado Safety Net Collaborative (CSNC) appreciates the opportunity to comment on HB19-1004, Proposal for an Affordable Health Coverage Option.

The CSNC is comprised of safety net clinics that are NOT Federally Qualified Health Centers. These clinics serve people across the state that are Medicaid members as well as the uninsured.

Historically, insurance coverage has improved. When the Affordable Care Act was passed in 2010 and primarily implemented by January 1, 2014, safety
net clinics celebrated better access to care for the people we serve. Many more people were able to access insurance in Colorado through Medicaid expansion, the Connect for Health Colorado insurance exchange and federal insurance subsidies.

However, our experience has been a reversal with increasing numbers of uninsured patients visiting our clinics.

Currently, more uninsured are coming to safety net clinics.

From 2014 to 2016, safety net clinics experienced declines in the number of uninsured patients visiting our clinics. Since that time, however, the number of uninsured patients visiting our clinics is on the rise.

Since 2016, safety net clinics that collect this data have seen a 30% year over year increase for the past 3 years.

To help explain the financial situation families find themselves in, here is a scenario: Even with subsidies, families and individuals with debt, housing costs and other bills can find insurance costs difficult to manage. A family of four buying insurance on the Connect for Health Insurance Exchange in the Denver
Metro area at 200% of the federal poverty level still requires the family to pay at a minimum $5000 a year for coverage with a $12,000 deductible and $15,800 out of pocket maximum.

More work needs to be done to understand why safety net clinics are having this experience. While there is no research available on the reasons why there is an increasing number of

uninsured people coming to safety net clinics, there are some possible explanations that we are considering:
1. There are more uninsured people. There is no penalty for not having insurance and the insurance available may be deemed by a family to be unaffordable.

2. People who used to be insured may not be able to survive with high health insurance costs and choose to go bare in an attempt to maintain their middle class status. Research from the Bell Policy Center outlines how hard that is in Colorado. Research from the Bell Policy Center outlines how hard it is for middle class families today.
http://www.bellpolicy.org/2018/07/12/colorado-middle-class-families/
As one of the country's only state-specific studies on middle class makeup and health, "Colorado's Middle Class Families: Characteristics and Cost Pressures" shows the share of families classified as middle income has declined since 2000 and at a rate higher than the majority of the country.

3. People are actually insured, but cannot afford the deductible, coinsurance and out-of-pocket maximums. In this case, there are more uninsured visitors because people coming to our clinics are actually insured but cannot afford to use their insurance and so they visit safety net clinics.

4. More uninsured people know where safety net clinics are than in the past. This seems unlikely as many of these clinics have been created by their communities and in existence for many years.

Policymakers should investigate this growing number of uninsured patients
We would welcome participating in further research to determine what is happening in Colorado and why safety net clinics are seeing more uninsured people. As it was in pre-Affordable Care Act days, rising numbers of uninsured may impact prices for those who are insured as that cost of care is managed by hospitals, doctors and others in the health care system.

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October 28, 2019

I am writing to submit comments on the drafted state option proposal for health insurance, and the damage it will do to hospitals throughout the state. Hospitals are the backbone of our healthcare system; and more than that, they are a cornerstone of many rural communities in the state in which a hospital still exists. They provide both emergency and routine medical care to people who live far from the state's more populous metro areas, administer preventative healthcare services, serve as a base for doctors and other medical professionals serving rural areas, and are an economic bulwark for the towns, counties, and regions in which they are located. Rural hospitals and the admirable people who work in them take seriously their calling, and their responsibility for saving people money. It is unconscionable that they should be the targets of the state government, on the receiving end of a proposal that will threaten their budgets and their staff. When you go after rural hospitals, as you are with the public option plan, you are effectively going after the people who live in the communities they serve.

Hospitals, especially in rural areas, are not just healthcare warehouses, or medical treatment factories. They are fundamental to the overall public health of the community. For example, they invest in primary care physician networks, with the goal of preventing illness and avoiding long hospital stays. They make investments in community food security programs, outpatient housing, and other community health needs. And they are crucial in providing mental health services which are becoming so critical in rural areas.

Their investment doesn't stop at their local community either; last year, Colorado's hospitals paid $40 million into the state's brand-new re-insurance program, which has reduced health insurance premiums in the individual market by 20%, making them the programs largest single source of revenue.

It makes no sense then, why the state would pursue a program that would punish hospitals. We have heard that there would be protection for rural hospitals, but we would like to see it in print and urge you to scrap the presented state option and come back to the table with a more reasoned, and reasonable, approach.

Yours Truly,

Catherine J. Shull
Executive Director

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Raeman Haines

County (in which you reside) *

[redacted]

Organization *

Independent

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

No

Other thoughts? Please list them here.

This is in need Government control plain and simple . A step to total control and Communism

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Randy L Umland

County (in which you reside) *

[redacted]

Organization *

N/A

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

no

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

no

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

no

Does the proposal include worthwhile benefits for consumers?

Absolutely NOT

Does the proposal create a product that is financially stable and sustainable?

Absolutely NOT

Other thoughts? Please list them here.

This will bankrupt this state

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Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Ray Robert Walters

County (in which you reside) *

[redacted]

Organization *

Private

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

No

Other thoughts? Please list them here.

No state run health care

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Public Comment Submitted to Colorado Department of Health Care Policy and Financing and the Division of Insurance

DATE: October 28, 2019
RE: **Public comment regarding the *Draft Report for Colorado's State Coverage Option***

Dear Executive Director Bimestefer and Commissioner Conway,

On behalf of the REMI Partnership please find the following public comments concerning the draft proposal to establish a state health insurance option in Colorado.

The REMI Partnership represents Colorado Association of REALTORS®, the Colorado Bankers Association, Colorado Concern, Common Sense Policy Roundtable, and Denver South Economic Development Partnership. Our mission is to provide Colorado lawmakers, policymakers, business leaders, and citizens with greater insight into the economic impact of public policy decisions that face the state and surrounding regions.

To fully promote a thorough public understanding of the proposal, we strongly encourage the Administration to provide additional information to the public and engage in an actuarial analysis that will provide answers to the following questions:

- What would be the net change in revenue going to medical providers, by category of provider, as a result of people migrating to the state option?
    - How would the state option impact the underlying costs of delivering care?
    - Would there be any impacts on health care quality or access to services as a result of any change in revenue to medical providers?
    - Would there be an impact on health care jobs across the state?

- What would the projected enrollment in the state option plan be?
    - Along with those that were previously uninsured, what existing coverage would state option enrollees be migrating from?
    - What would be the estimated enrollment if the state also chose to offer a state option plan in the small and large group markets, as has been indicated could be mandated in future years?

- How would the state option impact different regions of the state?
    - Would there be a single statewide reimbursement rate, or would prices be set by region, by procedure?
    - How would the proposed benchmarked prices compare to the underlying costs of delivering services across different regions of the state?
    - How would the proposed benchmark prices compare to the actual costs associated with delivering the care?
    - How did the proposal arrive at reimbursement rate benchmarked at 175% to 225% of Medicare?

- What is the operational plan for the state to set the state option premium reimbursement rates across the state?
    - What is the underlying data set that the state will be using?
    - Are there any good examples of where this has been done before?
    - What are the likely uses and impacts of the estimated federal premium tax credit savings?

- If hospital profit margins have been suggested to be too high, what barriers currently exist to allow for consumers to choose lower cost alternatives?
    - What are the barriers for competing hospitals to open or to lower prices and attract some of that profitable business?
    - What is limiting consumer's access to information that can help make more informed decisions about the costs of their care?
    - Are there other health care system innovations that could address the rising costs of delivering care that don't require the state government to intervene in this way?

We recognize the need and urgency of the Administration's effort to improve health care accessibility and affordability. These are essential components of the discussion, and we share in your concerns regarding the growing costs for consumers and businesses related to health care. Equally important is the idea of 'do no harm'. Coloradans have worked hard to build a health care system that is one of the top in the nation and we believe in the foundational principles of how free markets work, through transparency, free exchange, and a level playing field.

As a partnership, we are committed to helping voters and public officials fully understand policy decisions and impacts of those decisions. To that end, the REMI Partnership released a study, "Anticipating a State Option for Health Care: Will Businesses Face Higher Costs or Will Quality and Access be Cut?" on September 10th, several weeks prior to the release of the current state option proposal.

The study highlighted the potential unintended consequences and economic impacts of a state option based on if different levels of price-controls were implemented. Our study examined consequences across all economic sectors. The full study is available on the REMI Partnership website: www.remipartnership.org. Our study was based on the actuarial findings of a proposed state option in Washington state which found premiums could be reduced by 24% to 42%. The current draft proposal suggests the target range for a Colorado state option would be between 9% to 18%. While the magnitude of the impacts we identified in our study will change, the underlying drivers of those impacts have not. To better gauge the potential impacts of this new plan, the REMI Partnership will be updating our analysis following the November 15th release of the final state proposal.

We believe it will have a significant impact on both the state's health care system, as well as the entire Colorado economy. We encourage the administration to slow down, invite all stakeholders to the table, and work with Coloradans to better understand the true impact of changing the health care marketplace. There are other policy tools that can address fundamental issues that are driving the high costs of healthcare.

This approach does not solve the problem of high costs, it merely ensures that medical providers will be left with the difficult choice between finding ways to reduce costs that may adversely impact quality or bypassing costs on to the remaining private insurance market. We appreciate the administration's verbal commitment to protecting Colorado's communities and preventing cost-shifting onto employers but do not

see how these efforts are compatible with a proposal that includes statewide benchmarked payments to Medicare, well below current market rates. Legislating lower prices does not make costs disappear, it simply shifts those costs somewhere else. The impact of this inevitable shift is left unanswered by this proposal and it is of the utmost importance.

We encourage the administration to slow down and work with us to better understand the true impacts of fundamentally changing the health care marketplace. We invite your suggestions, feedback and questions on our work. Please contact CSPR Director of Policy and Research Chris Brown at chris@csprco.org with your input. We would appreciate your suggestions by December 2nd so that we may issue a timely analysis.

Thank you for your consideration of our comments and we look forward to continued opportunities to engage on this important topic.

Sincerely,

The REMI Partnership

This bill might create lower premiums for some people in Colorado.

However I think it will do irreparable damage to community hospitals like ours in Boulder, Boulder Community Health.

While the draft plan indicates the state is “hopeful” that hospitals will voluntarily participate, their proposal and repeated public statements acknowledge that the state will forcibly compel providers to participate if necessary. Because BCH’s locally governed, non-profit organization makes its investment decisions based on community need rather than potential profitability, BCH has had an average operating margin of only 1.6% over the past five years. Non-profit hospitals like BCH that are clearly investing in their communities should not be constrained from expanding or improving services by being forced to accept insurance reimbursement that doesn’t come close to covering our costs.

While the state promises their proposed public insurance option will protect rural and critical access hospitals – institutions that are absolutely vital to their communities – it has not provided any insight into how that will be accomplished. The state also doesn’t acknowledge the 21 urban hospitals WHOSE SUSTSAINABILTY MAY BE PUT AT RISK through these substantially lower reimbursement rates.

BCH and other Boulder County non-profit hospitals need reasonable reimbursement that supports the mission of providing health care that responds to local needs and reflects local Boulder values.

Thank you.

Richard Lirtzman

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Richard Pierce Allen

County (in which you reside) *

[redacted]

Organization *

Retired resident

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

No

Other thoughts? Please list them here.

Residents defeated Single Payor three years ago; no Socialized Medical!

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Robert Bucheit

County (in which you reside) *

[redacted]

Organization *

Retired

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

No

Other thoughts? Please list them here.

The state of Colorado does not need HB19-1004.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Robert Clemans

County (in which you reside) *

[redacted]

Organization *

Myself

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

NO!

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

NO!

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

NO!

Does the proposal include worthwhile benefits for consumers?

NO. Not in the long run for the greatest number.

Does the proposal create a product that is financially stable and sustainable?

No. The model will collapse on itself in short order.

Other thoughts? Please list them here.

Government price controls that are needed to facilitate below-market premiums offered by a state option will not cover the full costs of care. Therefore, health care providers will loose from $494 million to $1.4 billion.
Because Colorado health care providers will be losing money, they will have to lay off 1,500 to 4,500 health care workers across Colorado. That will exacerbate Colorado's existing shortage of primary care physicians, nurses, and other health care providers.
Lost revenues from the state option will cause at least a 5% increase in employer-provided insurance plans and other private sources. The state economy could lose between 2,900 and 8,320 jobs and $320 million to $919 million in total GDP.
An 80% to 100% membership loss could occur in the state's individual health insurance market as people drop private coverage in favor of the state option's below-market premiums.
A reduction of 2.7% to 8.3% will likely occur in the employer-provided insurance market. This will cause corporate and private health care cost to soar leaving employers with no choice but to lay off workers.
I think the whole health care system will collapse. It will not be able to deliver even good healthcare to large portions of our population. Will have even more people than today with little or no healthcare.
The socialized medicine is not the answer.
We need a private solution to healthcare. The Heritage Foundation has an excellent plan for delivering high quality healthcare to the widest population. As always, charity will be needed for a few of our less fortunate.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Robert Jones

County (in which you reside) *

[redacted]

Organization *

General Contractor

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

no

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

no

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

no

Does the proposal include worthwhile benefits for consumers?

no

Does the proposal create a product that is financially stable and sustainable?

no

Other thoughts? Please list them here.

leave my insurance alone-I don't want State mandated insurance

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Robin Sweet

County (in which you reside) *

[redacted]

Organization *

no organization - personal comment

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

Absolutely not. These artificial price controls will only affect a small percentage of people in our state. And by the state's own estimate - fewer than 9,000 of the almost 400,000 uninsured people in our state will sign up for this. In fact - the proposal will do more harm than good. For those of us with insurance through our work - our premiums will increase because of this! Cutting payments to hospitals will result in higher premiums for the rest of us.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No. This will result in hospitals cutting services, or refusing to take care of certain types of patients (like those on Medicaid). Premiums will increase for the majority of Coloradans. And most concerning - people in rural parts of our state who are already struggling with limited access to doctors and hospitals will see even this limited access reduce. Hospitals will be forced to close. Outreach clinics and specialized services will be reduced as hospitals struggle with these significant cuts.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Utilizes existing infrastructure in a meaningful way? Absolutely not! This is like a bully in the 4th grade - refusing to listen to anyone, refusing to be collaborative, and just threatening everyone until he gets his way.

Does the proposal include worthwhile benefits for consumers?

HCPF and DOI are being disingenuous as they try to sell this poorly conceived plan to the public. They're using inaccurate information, and making false claims. They're trying to fund a lower-priced insurance plan solely on the backs of hospitals without realizing the broader implications of a collapse of the commercial insurance market.

Does the proposal create a product that is financially stable and sustainable?

This is a recipe for disaster - namely, the collapse of the commercial insurance market. Small employers will stop providing health insurance - instead sending their employees to the exchange with a stipend. Then large employers will do the same. Soon - very few people will be left to cover the costs for Medicaid and Medicare underpayments, and the losses hospitals carry.

Other thoughts? Please list them here.

I'm a registered Democrat. I vote. And I voted for Polis. But I am extremely disappointed in our Democratic elected officials that they would support such a dangerous proposal. Colorado voters rejected single-payer health care by a wide margin. I don't appreciate the state's backdoor attempt to circumvent the will of voters, and if the Polis administration supports this proposal, I may do the unthinkable - I might vote for Republicans.

Instead of this - I encourage the state to take a much broader look at health care costs. Address prescription drug prices. Fix nursing home care. Help hospitals reduce their costs on things like drug prices and personnel, and then make sure those savings are passed on to people through lower premiums.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Rodney Koehler

County (in which you reside) *

[redacted]

Organization *

The Medical Center of Autora

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No not even close

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

Absolutely not. You will decrease access to care with this. Hospitals will decrease services that are necessary and you will decrease access

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

No you will put hospitals out of business

Other thoughts? Please list them here.

A Medicare for all only pays 85 cents per dollar of cost. High cost procedures will go away and hospitals will decrease staffing to survive. Because of this access to healthcare will decrease. Government healthcare Medicare for all will be a disaster. You non healthcare politicians really should listen to providers.

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To Whom It May Concern,

I would like to express my strong opposition to HB 1004. This bill would be devastating to our state in several respects:

1. It would put rural areas in Colorado at risk by decreasing the choices in healthcare which residents in these areas now enjoy.

2. It would mean job losses for both doctors and nurses, as well as other health care professionals

3. It would decrease the quality of care all Coloradans now receive and greatly increase waiting times to get appointments.

It has also come to the public's attention that the Governor's office skipped dense, Republican population centers during their stakeholder engagement about this issue, which is unacceptable. One of the Governor's spokespersons actually said "If you look at some of the opportunities that we can all look to, we have in some areas way too much access [to healthcare]." How can too much access to healthcare possibly be a bad thing?

Thank you,

Ronald Madd

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

RosAnn Biondo

County (in which you reside) *

[redacted]

Organization *

None

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

YES

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

YES

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

YES

Does the proposal include worthwhile benefits for consumers?

YES

Does the proposal create a product that is financially stable and sustainable?

YES

Other thoughts? Please list them here.

YES on this it is about time to cut the greed of medical providers in any arena thank you

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Rozanne Nelson

County (in which you reside) *

[redacted]

Organization *

N/A

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

No

Other thoughts? Please list them here.

The government getting involved in our healthcare system in ANY way is simply a very bad idea!!!

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Dear Ms. Bimestefer and Mr. Conway,

As a healthcare leader, I am concerned that this Bill…

- Does not focus on Colorado's 400,000 uninsured patients
- Has very real potential to limit Coloradan's ability to choose the health insurance plan best for them
- Introduces government price controls with mandatory hospital participation, possibly jeopardizing access to care

The range of possible outcomes include major cuts in reimbursement rates to healthcare providers – cuts that would pay hospitals well below the actual cost of providing care.

- Cutting reimbursement rates will only threaten the quality of care we can provide and limit access to healthcare across our state. If below-cost reimbursement rates expand even further in Colorado, providers will have no choice but to cut services, staff and possibly close their doors altogether. Ultimately, patients will have less access to quality care, not more, and our state will be the worse for it.

- We believe our patients deserve better and therefore our policymakers must do better. State officials need to slow this process down, focus on the facts and develop responsible policies that address the cost of healthcare insurance while also preventing unintended consequences – including staff and service reductions at Colorado hospitals.

- Some organizations are pressuring the administration to use Medicaid reimbursement rates, for example, which currently pay just 69 cents for every dollar of care provided. As you know, Colorado hospitals are already grappling with a major expansion of below-cost reimbursement rates, mostly due to a major expansion of the Medicaid program.

- Hospital professionals support the goal of universal healthcare coverage. To make this coverage more affordable, we work hard to find savings within our operations. We also make investments that will bring down costs, including programs that address the shortage of primary care physicians in Colorado and a $40 million per year contribution from the hospital sector to the state's new reinsurance program.

- Hospital professionals want to reduce the cost of insurance coverage, which has skyrocketed in recent years. But health insurance and healthcare are not the same thing and cutting payments to the dedicated professionals who actually provide healthcare in Colorado is not a real answer.

As a healthcare leader, I look forward to working with you on this and other issues as we all look to maintain and improve access to high-quality, affordable health care.

Sincerely,

Ryan S. Simpson, FACHE

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Samantha Wagar

County (in which you reside) *

[redacted]

Organization *

SLV Health

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

In my opinion, no. Many consumers may still view the state option as an added expense to their personal cost of health care. The overall intentions of the proposal are to address the cost of healthcare, but don't necessarily take into account the reasons why healthcare pricing has increased so much. Administrative complexities with private payers, such as prior authorization (which by the way we are seeing an increase in services requiring prior authorization as well as increases in denials), has resulted in providers having to spend more of their resources to try to get paid on things that should have been covered. Across multiple payers, it is not uncommon for up to 6 attempts to be made for a denial to be over-turned and in some cases this requires physician re-work and additional work to justify the rationale behind their clinical thinking. This has increased the overhead for providers just to get paid and be able to continue to provide service to their community. I don't disagree that costs are high, but I think there should be more done to address the multiple reasons care costs so much.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

As long as payers agree to offer the plan and/or this is mandated and available on the exchange, then I don't see why it would not increase access to insurance.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

I think so.

Does the proposal include worthwhile benefits for consumers?

From the foundation, yes. Without seeing a more detailed plan proposal, it is hard to say if there is real value for consumers.

Does the proposal create a product that is financially stable and sustainable?

Other thoughts? Please list them here.

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Oct. 25, 2019

Director Kim Bimestefer
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Commissioner Mike Conway
Colorado Department of Regulatory Agencies
Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Director Bimestefer and Commissioner Conway:

I appreciate the opportunity to provide feedback on the "Draft Report for Colorado's State Coverage Option," released on Oct. 7, 2019.

This proposal fails on all of these priorities. Our organization believes that the proposal submitted is flawed and not ready for prime time:

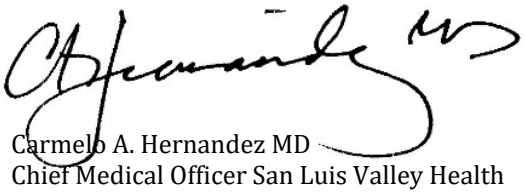
1. The proposal cuts reimbursements to hospitals without holding insurers, pharmaceutical manufacturers, and physicians equally accountable for reducing cost. Our employees may face layoffs, hiring freezes, increased pressure to care for more patients with fewer resources, and added strain on existing workforce shortages and efforts to recruit and retain talented employees. This is particularly true in rural and underserved areas of Colorado, where hospitals are often the largest employer and where downsizing will cause a cascading effect across other businesses, schools, and local programs throughout the community.
2. A full half of Colorado hospitals are unable to cover costs with enough certainty to be considered sustainable in the long-term, and the Polis proposal is likely to disproportionately impact vulnerable hospitals that have a hard time making ends meet. In some cases, hospitals are paid less than the proposal's rate setting range of 175-225 percent of Medicare, yet it is unclear if the administration proposes to raise payments for these hospitals, which would decrease total savings. Costs associated with ensuring viability of rural and other vulnerable hospitals should not be shifted onto other hospitals. Without the pertinent details of how these hospitals are to be protected, this promise of protection falls flat.
3. Rate setting inherently conflicts with other value-based concepts advanced in the proposal because it relies on the existing fee-for-service payment model. As recently noted by Massachusetts Gov. Charlie Baker, "[i]f you cap rates under the current regime, you're going to get exactly what you have now, just less."[1] HB 19-1004 required the state to "determine whether the state option plan should be a fully at-risk, managed care, fee-for-service, or accountable care collaborative plan, or a combination thereof." This is not directly addressed in the proposal, but the underpinning infrastructure doubles-down on a fee-for-service payment system inconsistent with the state's standing commitments to payment reform and value-based care.

Because the proposal doesn't include details in the actuarial analysis about the impact on hospitals like mine, it put the responsibility for that analysis on us. Without the changes above, I believe the impact to our organization will be significant. This is not a sustainable reduction that our hospital can bear, meaning we will likely have to reduce services. This is not an acceptable solution for our community or our hospital, which is why I believe revisions must be made to this proposal before it is finalized.

[1] https://www.masslive.com/news/2019/10/gov-charlie-bakers-new-health-care-plan-envisions-major-spending-increase-on-primary-and-behavioral-health-care.html

I look forward to working with you on this and other issues as we all look to maintain and improve Coloradan's access to high-quality, affordable health care.

Sincerely,



Carmelo A. Hernandez MD
Chief Medical Officer San Luis Valley Health

October 28, 2019

Director Kim Bimestefer
Department of Health Care Policy & Financing Agencies
1570 Grant Street
Denver, CO 80203

Commissioner Mike Conway
Colorado Department of Regulatory
Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Dear Director Bimestefer and Commissioner Conway:

I am proud to submit comments on behalf of San Luis Valley Health for the "Draft Report for Colorado's State Coverage Option," released on Oct. 7, 2019. We agree that our state needs to take proactive steps to address health care access and affordability to ensure that Coloradans have access to the care they need and can afford it when they do seek care. Unfortunately, we are concerned that this proposal, as drafted, would have serious ramifications for our community, our local hospital and our state as a whole.

Specifically, we don't believe this proposal will help enough Coloradans and may actually jeopardize access to care and affordability for those who are already covered. With nearly 400,000 Coloradans currently uninsured, we are disappointed that this new option doesn't prioritize those individuals. We are also concerned that it will increase health insurance costs for many Coloradans, as costs will be shifted to the nearly half of Coloradans who have employer-sponsored insurance. Finally, we believe that the government rate setting for hospitals that funds this proposal could be incredibly detrimental to hospitals across our state.

San Luis Valley Health, that includes two hospitals serving rural populations in south, central Colorado, is vital to this region of the state. It is the largest employer in our region and provides significant community benefit beyond the traditional patient care offered within the hospital. While the draft proposal doesn't examine the financial impact to hospitals, we must assume that this type of government rate setting for hospitals will be significant – especially since hospital cuts are the only funding mechanism for these significantly reduced health care plans. It does not adequately address the administrative health plan complexities that are credited as the most significant driver of health care waste.

The proposal purports to protect rural hospitals, but doesn't give any specific details about how that will happen. Our hospitals, like most in rural Colorado, have demands that far exceed resource needs. Five of the six counties served by San Luis Valley Health are designated as a Medically Underserved Area and as Health Professional Shortage Areas, and have some of the highest Medicaid populations in the state. The challenges are daunting when providing health care in a low income, medically underserved area. Without the benefit of the detail, this is too risky to our local hospital, its financial and mission stability, and importantly the patients we serve.

As an active participant in the stakeholder process used to develop a plan required by House Bill 19-1004, we are left to believe that considerable input from our organization and others was

106 Blanca Avenue
Alamosa CO 81101
Phone: 719-587-1209
Fax: 719-587-6339

not incorporated into this draft proposal. We are hopeful that during this formal comment period, the state will take a more in-depth look at the feedback provided and make many changes to the proposal before it is finalized.

Please consider the impact this proposal could have on communities like ours, on hospitals like ours and on access to affordable care for patients like me, my family, friends and neighbors. We agree that there is still more work to do to improve our health care system, but this proposal as drafted is not the solution.

Sincerely,

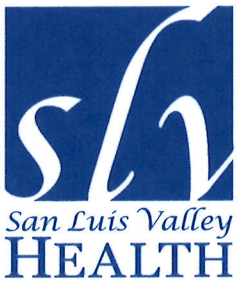
Christine Hettinger-Hunt

Christine Hettinger-Hunt
Chief Operating Officer

October 28, 2019

Director Kim Bimestefer
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Commissioner Mike Conway
Colorado DORA
Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202



Dear Director Bimestefer and Commissioner Conway:

House Bill (HB) 19-1004 has offered the opportunity to examine whether Colorado could craft a "competitive state option for more affordable health care coverage." I sit on the Connect for Health Colorado state advisory board as a representative from the San Luis Valley and have been following this discussion carefully. I'm also the former regional C4HCO HUB coordinator and health coverage guide. My former position here at SLV Health was the Patient Access Manager, and I fully understand the challenges facing our population and their needs. I remember how painful it was that the federal funding for the public option (Colorado HealthOP) in 2014 was not extended, which caused the plan to fail*.

It comes down to this: Yes, the people of the state of Colorado deserve more options for more affordable health care coverage. But, who is going to pay for this and how do the various players remain sustainable, from rural hospitals, to large insurance companies?

The current proposal leaves many unanswered questions and could quite possibly do more harm than good. While the outcome of a public option is well-intended, this proposed option fails to prioritize coverage and affordability for the uninsured and under-insured.

I am writing this letter to urge you to re-focus the legislation to ensure long-term, sustainable solutions. Be aware of unintended consequences and unfunded mandates.

If you have any questions or would like to contact me, please do not hesitate.
Sincerely,

Donna Wehe

Donna Wehe
Director of Communications & Public Information Officer, Donna.Wehe@slvrmc.org

*Ninety percent of Colorado's exchange enrollees picked nonprofit health plans in 2015: 40 percent chose Colorado HealthOP, the ACA-created CO-OP, 35 percent selected Kaiser Permanente, and 15 percent went with Rocky Mountain Health Plans. Kaiser got 46 percent of exchange enrollees in 2014, and auto-enrollment likely helped their retention, despite the fact that Colorado HealthOP offered the lowest rates in all but one of the rating areas in Colorado for 2015.
Source: https://www.healthinsurance.org/colorado-state-health-insurance-exchange/

106 Blanca Avenue
Alamosa CO 81101
Phone: 719-587-1209
Fax: 719-587-6339

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

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- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Sandra Foote

County (in which you reside) *

[redacted]

Organization *

Self

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

Only those that are entitled. The rest of us will pay more for less while ending with rationing.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No. It adds to us struggling with high health care cost.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No. Just adds more wasteful bureaucracy, experts without any real world experience but lots of moral narcissism, control by Marxist not the people and finishes with the same problems as ACA. Not affordable, no care and an act from the beginning.

Does the proposal include worthwhile benefits for consumers?

Citizens , working people, small business owners, young entrepreneurs and retires that saved receive zero benefits.

Does the proposal create a product that is financially stable and sustainable?

No. It is based on taxing everything that moves and will ensure anyone who can will move where you can't tax them out of existence.

Other thoughts? Please list them here.

You'd be ashamed of what you are doing to Colorado but that requires a conscious, integrity and honesty traits lacking in the current party controlling Colorado.
Stop the give always, follow the rule of law , let people choose and let the free market and personal responsibility decide health care Care is not the same as coverage. Something your dictatorial experts have yet to figure out.
Promote, support and encourage health care professionals current, past and future by decreasing regulations, providing adequate compensation for care givers not experts and administrators and decrease useless, destructive, time wasting and foolish regulations. Cut bureaucracy not add additional layers.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Sarah Boeke

County (in which you reside) *

CO

Organization *

Sarah Banjak and Assoc., inc

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

Yes

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

Yes

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Yez

Does the proposal include worthwhile benefits for consumers?

Yes

Does the proposal create a product that is financially stable and sustainable?

Yes

Other thoughts? Please list them here.

I am self employed with 2 kids, both with type 1 diabetes. I currently get insurance through the marketplace, but it is the lowest quality of the plans out there. What I mean by that is I currently have Cigna, but not 'normal' Cigna, it's Connect Cigna. Normal Cigna can go to the Barbara Davis Center which is the region's leader in T1D care. Connect Cigna cannot. I pay $1611 per month in premiums and an additional $14,900 out of pocket for my kids' insulin, devices glucometer strips, etc. That's over $34,000/year just in 'covered' medical costs. But wait, I ALSO pay for MD visits out of pocket as cash patients so my kids can been treated at the Barbara Davis Center. I am close to $40,000 out of pocket per year to keep my kids alive. There's got to be a better way.
Thank you Governor Polis for putting this team together to come up with a plan. I look forward to Colorado being a leader in healthcare reform.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Sarah Ellis

County (in which you reside) *

[redacted]

Organization *

SCL Health

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

I appreciate the state's efforts to address healthcare costs in Colorado. I understand the need and frustration on behalf of consumers and as a consumer myself.

However, I do not believe that the public option draft proposal as it stands will further this important goal. It leaves too many unanswered questions, lacks crucial detail and is moving too fast. In addition, I question how it will impact other substantial pieces of healthcare legislation from the 2019 session that have yet to be fully implemented.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

The State Option, as proposed, would only be available to about 230,000 individuals who currently purchase healthcare coverage through the state exchange, although there are intentions to expand it. Still, actuaries predict that the number of individuals who will actually participate is 9,600. There is no mention of the nearly 400,000 Coloradans who remain uninsured.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Based on the draft plan and information previously released, it is difficult to clearly identify any specific provision that will result in making health care more affordable and increase access to care.

Does the proposal include worthwhile benefits for consumers?

Without any concrete evidence of benefit, It is my belief that this proposal does not further our mission to improve the health of the people and the communities that we serve, including the poor and vulnerable.

Does the proposal create a product that is financially stable and sustainable?

The plan relies on current Medicare reimbursement rates, which in Colorado equates to only $0.69 of every dollar of costs, which fails to cover the full cost of care. Additionally, the plan only focused on hospital costs and excludes other cost factors such as physicians, pharmaceutical companies and other providers and suppliers. Like any other business, healthcare grapples with the higher costs of doing business. Costs of supplies, technology and staffing continue to rise in all industries, including healthcare. I don't believe that any business can sustain a model where costs outpace collections, as we would be required to do under this proposal.

Other thoughts? Please list them here.

Collectively, hospitals in Colorado have been working diligently to lower costs. The system I work for, SCL Health, has in fact lowered theirs by 3% and continues to strive for higher quality and more affordable, accessible health care.

But we're not just a business. We are providing lifesaving treatments to all, often without any reimbursement, and give back to the community in myriad ways.
I don't work in direct patient care but I see some of the most compassionate people you'll ever meet doing their best every day and providing the highest level of care to patients. Our case managers are working desperately every day to find appropriate places for people who don't need to be in a hospital but have been brought there with nowhere else to go. These people aren't just caring for sick people, they also care for and support patients families throughout an illness or even loss of their loved ones.

There are good reasons why we have a shortage of caregivers and hiring and keeping those wonderful people is a part of everyone's healthcare cost.

Our system, SCL Health, is committed to working closely with Gov. Polis and his administration to continue to address access and affordability issues for the health of all Coloradans.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Scott Honeycutt

County (in which you reside) *

[redacted]

Organization *

Self employed

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

Not sure

Does the proposal create a product that is financially stable and sustainable?

No

Other thoughts? Please list them here.

The government needs to focus on roads. Don't tell people what they can and can't afford.

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October 26, 2019

RE: Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

To Whom It May Concern:

Affordable health care is and should remain a top priority. But solutions should not jeopardize residents' access to quality of care or the coverage they rely on.

A record number of residents are insured, and more are using their coverage to get the care they need, when and where they need it. A record 93.5% of Coloradans have health insurance, and that rate has remained steady over the past two years, even after the individual mandate was removed.

In 2019, 81.1% of Coloradans visited a general doctor at least once, up more than 10 points from 2017. Nearly three quarters (73.6%) visited a dentist, which is up from the two-thirds rate that's prevailed for nearly a decade. Additionally, Coloradans enjoy the fifth-lowest health spending per capita, even as cost of living has increased. Colorado's health care system consistently ranks among the top in the country for innovation and excellence, and several of the nation's best hospitals located here.

The proposed state-operated public option will create marginal savings for a small portion of residents and a negative impact on most. The true costs far outweigh the benefits. The State's proposal seeks to make insurance more affordable for the individual market—which is less than 10% of residents. The proposal estimates a public option would provide coverage to about 9,200 uninsured individuals. That is less than 0.2% of the state's population.

Government-operated insurance programs have been tried and failed before, here in Colorado and across the country. Evidence shows the outcome is less competition, less personalized care and, often, significant costs spread across other insurance pools and taxpayers. I encourage the administration to slow down and facilitate greater public scrutiny of this critical proposal.

Sincerely,

Ray Scott
Colorado State Senate representing District 7

NO, NO, NO! I travel the world and I speak to everyone about their gov. run healthcare. I have been told some get great care when they are dying, but no care in early diagnosis if there is any care.
Countries boast they only spend 11% in their total budget for healthcare, that is because they stop spending at 11% not because of reduced prices or proper care given. I lost my healthcare plan under Obama and 2 of my favorite doctors who wouldn't work under Obamacare. My costs spiraled up by thousands of dollars with huge deductables. Stop the lies, there is nothing good about Gov. health care, especially when Swedes and Dains pay 67% income tax for poor services. We do not want the Gov. in charge of the large budget item, it will only get worse!!!!!

Sheryl Glasgow

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Sheryl Hobbs

County (in which you reside) *

[redacted]

Organization *

Citizen

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

If it is a Democrat-backed proposal, it will not be financially stable or sustainable.

Other thoughts? Please list them here.

I am not an advocate for any changes in the current healthcare plan that are based on providing healthcare or healthcare insurance for non-citizens.

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October 25, 2019

Director Kim Bimestefer
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Commissioner Mike Conway
Colorado Department of Regulatory Agencies
Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Director Bimestefer and Commissioner Conway:

I appreciate the opportunity to provide feedback on the "Draft Report for Colorado's State Coverage Option," released on Oct. 7, 2019. As a member of the start-up team at Sky Ridge Medical Center, I am proud of the incredible, live-saving services our hospital provides to our community and how much we have paid in taxes over the past 16 years to fund critical resources. While not a clinician, I have the honor to work with community leaders, our neighbors, patients and families in my role as VP, Marketing & Public Affairs. I am proud of the legacy we have created in community outreach and health education as well as the free and low-cost screenings we host on our campus.

I have been personally touched by the extraordinary care we provide during my husband's 14-month battle with cancer. While I lost him, I don't want other families to face such tragedy. And my fear is that this proposed public option may do just that.

I believe we can all agree that our state needs to take proactive steps to address health care access and affordability to ensure that Coloradans have access to the care they need and can afford it when they do seek care. I am concerned that this proposal, as drafted, would have serious ramifications for our community, our hospital and our state as a whole.

My fear is that this proposal may jeopardize access to care and affordability for those who are already covered. With nearly 400,000 Coloradans currently uninsured, my colleagues are disappointed that this new option doesn't prioritize those individuals. We are also concerned that it will increase health insurance costs for many Coloradans, as costs will be shifted to the nearly half of Coloradans who have employer-sponsored insurance, like us. Finally, we believe that the government rate setting for hospitals that funds this proposal could be incredibly detrimental to hospitals across our state.

Sky Ridge is a vital part of our community. As one of the largest employers in Douglas County, we provide significant community benefit beyond the traditional patient care offered within the hospital. While the draft proposal doesn't examine the financial impact to hospitals, we must assume that we will be negatively impacted. Please consider the impact this proposal could have on communities like ours, on hospitals like Sky Ridge and on access to affordable care for patients like me, my family, friends and neighbors. We agree that there is still more work to do to improve our health care system, but this proposal as drafted is not the solution. Thank you for your consideration.

Sincerely,
Linda Watson
VP, Marketing and Public Affairs

To whom it may concern:
My name is Spencer Way. I'm from [REDACTED] and I work in administration at Littleton Adventist Hospital.
My office is adjacent to the surgery waiting area. I heard parents in the hallway calling friends and family to provide updates about their children in surgery after the STEM shooting in Highlands Ranch. I see nurses come in on their only day off for staff meeting on cost reduction, surgeons volunteer to change practice habits and schedules to create access and lower cost and I meet with clinicians who are bent and bowed by the pressure to do the right thing in the face of constantly shrinking resources and support on daily basis.
I believe we have a responsibility to lower the cost of care and create healthcare that every person in this country can access. But the State Option, a public option, unintentionally accomplishes the opposite.
This is a funding reduction for the front lines of healthcare. Forcing providers to accept below cost reimbursement threatens our ability serve everyone.
Economics in this case are simple. When we reduce the resources available to provide a service, the service will in turn be reduced. The connection between access and quality has been studied time and time again and the link is clear. When we reduce services, limit access or constrain the ability for people to seek care, the quality of care declines despite the best efforts of the clinicians I support every day.
I deeply appreciate the intention of the State Option but we can and we must do better.

Spencer Way

SCL Health
ST. MARY'S

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

Terri Chinn, CFO
Mesa County
St. Mary's Hospital
2635 N. 7th Street
P.O. Box 1628
Grand Junction, CO 82502-1628
terri.chinn@sclhealth.org

Does the proposal address Coloradans' concerns about health care affordability?
I share the Administration's concern that too many Coloradans struggle daily with the pressures that come with a lack of access to affordable health care; however, the proposed draft does not provide concrete information and details that show how it will make healthcare more affordable and accessible for Coloradans.

Does the proposal create a product that reaches Coloradans struggling with high healthcare costs?
The State Option, as proposed, would only be available to the ~230,000 individuals who currently purchase health care coverage through the state exchange, although there are intentions to expand its applicability to small and large group coverage under the exchange; actuaries predict that the number of individuals who will actually participate is 9,600. There is no mention of the ~400,000 Coloradans who remain uninsured.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?
Based on the draft plan and information released at the Denver stakeholder meeting, I am unable to clearly identify any specific provisions that will result in making health care more affordable and increase access to health care.

Does the proposal include worthwhile benefits for consumers?
Due to the fact that the plan does not propose any concrete evidence of ways it will increase affordability and access of care, I do not believe it includes worthwhile benefits for consumers.

Does the proposal create a product that is financially stable and sustainable?
The plan relies on current Medicare reimbursement rates, which in Colorado equates to only $0.69 of every dollar of costs reimbursed, which fails to cover the full cost of care. Additionally, the plan only focused on hospital costs and excludes other cost factors such as physicians, pharmaceutical companies and other providers and supplies.

Other thoughts? Please list them here.
I live and work in Western Colorado. I am deeply concerned that the current proposal will ultimately put the rural safety net hospitals out of business. Not having access to this basic level of care may make living and working in rural Colorado much more difficult. This could have a significant unforeseen impact on the economy of a huge geographic portion of the state. While I think that we need to reduce the cost of healthcare, **I disagree with the current proposal which was hastily constructed and targets healthcare providers**.

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

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Helpful Links:
- The draft report can be found here: http://www.colorado.gov/pacific/sites/default/files/HB19-1004%20Draft%20Report%20Colorado%20State%20Coverage%20Option%20and%20Appendix.pdf
- The bill text can be found here: https://leg.colorado.gov/sites/default/files/2019a_1004_signed.pdf
- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Steve Evans

County (in which you reside) *

[redacted]

Organization *

MAGA

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

NO

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

NO

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

NO

Does the proposal include worthwhile benefits for consumers?

NO

Does the proposal create a product that is financially stable and sustainable?

NO

Other thoughts? Please list them here.

NO more socialism

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Name *

Steve Schwettman

County (in which you reside) *

[redacted]

Organization *

none

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

Yes

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

Yes

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Yes

Does the proposal include worthwhile benefits for consumers?

Yes

Does the proposal create a product that is financially stable and sustainable?

Yes

Other thoughts? Please list them here.

I HOPE that this legislation will finally address the Family Glitch as stated. I don't feel that this legislation as presented, does enough to eliminate intentional inefficiencies created by third party profiteers and pharmaceutical companies.

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My name is Steve Wesselhoff. I have called Colorado home for three years, but I promise I moved here as soon as I could. I am a Doctor of Physical Therapy at UCHealth Memorial Hospital in Colorado Springs. There I have the opportunity to help patients after strokes and traumatic brain injuries to walk for the first time after their medical event. The title Doctor of Physical Therapy comes with a $140,000 price tag and a salary not commiserate with the debt required to receive the designation. My wife is a social worker who works three jobs to help pay for our 1,200 square foot home in the only market area we can afford in the Southern Denver Metro area.

I think this bill has lost track of the real problem that we have in this state. Our actual cost of healthcare provided is the 5th lowest of any state and cost of hospital care the 10th lowest. So where has this rhetoric of excessive healthcare costs in Colorado developed from? That I cannot say specifically. However, I can say how a bill proposed like the State Option will impact the 71,000 Colorado residents employed by healthcare organizations. This bill will lead to reduced salary and benefits for the bedside clinicians who choose healthcare clearly not for the money, but to provide a service to patients. I don't think it is too much to ask for me and the other Colorado residents who work in healthcare to make a living sufficient to sustain their livelihood. This bill will force the already shrinking middle class constituents' you senators represent into either financial insolvency or to leave their passion of healthcare to pursue less socially impactful professions. A hospital can only only reduce overhead costs to a certain degree, the next step is cutting of their labor force.

In a more objective analysis of this bill, what we are essentially proposing with the State Option is a price ceiling on the reimbursement for healthcare. This type of government intervention has been used many times and in an economic sense it has historically led to overall market failure. It will drive down the total supply of healthcare services available in the market for the over 5.5 million people in which you serve. Additionally, this may cause healthcare tourism to other states in liklihood that the State Option has a detriment to the quality of care provided in Colorado.

In summary, I oppose the State Option as it will severely reduce the services which will be available for the population of Colorado and force the middle-class healthcare providers to seek a different a career path then helping patients.

Sincerely,

Steve Wesselhoff PT, DPT

I am writing today to oppose the public option for the following reasons:

- Some organizations are pressuring the administration to use Medicaid reimbursement rates, for example, which currently pay just 69 cents for every dollar of care provided. As you know, Colorado hospitals are already grappling with a major expansion of below-cost reimbursement rates, mostly due to a major expansion of the Medicaid program.

- Hospital professionals support the goal of universal healthcare coverage. To make this coverage more affordable, we work hard to find savings within our operations. We also make investments that will bring down costs, including programs that address the shortage of primary care physicians in Colorado and a $40 million per year contribution from the hospital sector to the state's new reinsurance program.

- Hospital professionals want to reduce the cost of insurance coverage, which has skyrocketed in recent years. But health insurance and healthcare are not the same thing and cutting payments to the dedicated professionals who actually provide healthcare in Colorado is not a real answer.

- Cutting reimbursement rates will only threaten the quality of care we can provide and limit access to healthcare across our state. If below-cost reimbursement rates expand even further in Colorado, providers will have no choice but to cut services, staff and possibly close their doors altogether. Ultimately, patients will have less access to quality care, not more, and our state will be the worse for it.

- We believe our patients deserve better and therefore our policymakers must do better. State officials need to slow this process down, focus on the facts and develop responsible policies that address the cost of healthcare insurance while also preventing unintended consequences – including staff and service reductions at Colorado hospitals.

- We are concerned that physicians will leave our state if this is passed as proposed.

Thank you for considering these points.

Susan Hicks RN

I do not want the Colorado state legislature and governor to establish a healthcare public option.

It does not represent true competition. It would erode the quantity and quality of healthcare services that medical professionals and facilities are financially able to provide. In addition, it would divert Colorado taxpayer dollars from currently-provided services and from road repair/improvements.

Private firms forced to compete with a government-run business do not have the financial resources to match the funding that the government can make available to keep viable what is otherwise a money-loosing enterprise.

Please share my comment with the committees in charge of this bill.

Thank you,

Susan Luenser

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Susan MORGENSTERN

County (in which you reside) *

[redacted]

Organization *

Republican

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

Absolutely not

Does the proposal create a product that is financially stable and sustainable?

No

Other thoughts? Please list them here.

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My name is Susan Richards. I have more than 30 years of work experience in Hospital reimbursement and Hospital Administration. I am also an individual that has cerebral palsy. I am STRONGLY OPPOSED to this proposal. My opposition is based on the following:

- *The mechanism for paying for this single payer system has not been clearly identified. There is no way around it. Our taxes will go up.*

- *The State of Colorado has NOT demostrated any level of competency in managing CO Medicaid, "Health First". Health First's recepient eligiblity files are a mess and not updated timely. Health First's claims processing system is broken and claims for Hospital emergency services are not getting paid. When asked, when the system will be fixed, the response is, "I don't know". Health First's management of access to behavioral health services is an embarrassment and is putting our community at risk. Before taking on an entire State run system, demonstrate competency by fixing what is broken now.*

- *As an individual with cerebral palsy with ongoing needs for medical services. I want to be able to choose my own private coverage to maximize my health and manage my own healthcare costs. We are very fortunate in Colorado to have high callibre healthcare: excellent physicians, nurses and other healthcare providers, as well as, healthcare facilities. Moving to a single payer State run system and reducing reimburesment will drive all of the excellent providers out of our State.*

In closing, this is a very bad idea.

As you consider the public option for healthcare coverage, I ask you to also consider the process that led to its creation. Despite claiming to receive input from people all across the state, I'm forced to ask how transparent or inclusive that process actually was. From meetings that were announced on short notice, to agendas published very shortly in advance of occurring, to websites that were nearly impossible to find and navigate – the entire process felt like window dressing.

A truly robust process that allows for real comment, collaboration, and creative solutions would have been far preferable, and you don't even have to look far or long ago to see such an outcome. Just earlier this year, healthcare professionals joined with legislators and the Polis administration to pass a new reinsurance program and patient protections for out-of-network billing, among other reforms.

These reforms are already showing real promise, including a predicted 20% reduction in premiums for individual healthcare coverage. The state option would only serve to disrupt all of the progress that's already been made.

With something like this, why the rush of getting a poorly-thought out state option in front of the public a mere one day before its first hearing, and a small 17-day comment period for feedback? You all need to slow down and give other important programs the time they need to work, or, even better, follow the lead of a program like this, and come up with better, more creative and more collaborative solutions than a public option that overburdens hospitals without addressing underlying problems with the system.

Susan Saad

State medicare for all!

Suzanne Watson

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Tamara Vliek

County (in which you reside) *

[redacted]

Organization *

SCL Health St. Mary's Medical Center

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

I do share the Administration's concern that too many Coloradans struggle daily with the pressures that come with a lack of access to affordable health care; however, the proposed draft does not provide concrete information and details that show how it will make healthcare more affordable and accessible for Coloradans.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

The State Option, as proposed, would only be available to the ~230,000 individuals who currently purchase health care coverage through the state exchange, although there are intentions to expand its applicability to small and large group coverage under the exchange; actuaries predict that the number of individuals who will actually participate is 9,600. There is no mention of the ~400,000 Coloradans who remain uninsured.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

Based on the draft plan and information released at the Denver stakeholder meeting, I am unable to clearly identify any specific provisions that will result in making health care more affordable and increase access to health care.

Does the proposal include worthwhile benefits for consumers?

Due to the fact that the plan does not propose any concrete evidence of ways it will increase affordability and access of care, I do not believe it includes worthwhile benefits for consumers.

Does the proposal create a product that is financially stable and sustainable?

The plan relies on current Medicare reimbursement rates, which in Colorado equates to only $0.69 of every dollar of costs reimbursed, which fails to cover the full cost of care. Additionally, the plan only focused on hospital costs and excludes other cost factors such as physicians, pharmaceutical companies and other providers and supplies.

Other thoughts? Please list them here.

I am not only an consumer of healthcare, but also work for SCL Health St. Mary's in Grand Junction for over 15 years. If this plan is initiated as is, it could have dreadful impact , such as a reduction in services we provide for the entire Western Slope and even worse, a reduction in workforce and loss of jobs. This proposal must be adjusted with revisions, before it is finalized. Thank you.

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My wife, our family, friends and myself donot support government run/supervised healthcare.

We here in Colorado are doing very well with our healthcare program and prefer to stay with what we presently have. We've seen time and time again when the government gets involved with the people's healthcare, the programs they presently have go downhill and the government programs put in place of what we have are nowhere near as good. So, please stay out of our healthcare.

We the people are much wiser than you who were voted into office think we are. Just about every Coloradan I've discussed this government attempt to intervene in our Healthcare, 'throughout' our great state feels exactly as my wife and I. Once again - please stay out of our healthcare. We did not vote you Legislators into office to get involved in Coloradans Healthcare.

Respectfully, Ted and Aiko Kozikowski

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Teri Cavanagh

County (in which you reside) *

[redacted]

Organization *

SCL Health St. Mary's Medical Center

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No. It falls far short of fundamental cost drivers.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No. It reaches less than 5% of Coloradans with health insurance while disregarding the vastly larger numbers of uninsured.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No. The plan is based on a flawed federal reimbursement system that fails to cover the actual cost of care. Its shortfalls will undoubtedly fall back on Colorado taxpayers, thus inadvertently increasing the cost of care coverage.

Does the proposal include worthwhile benefits for consumers?

No. The benefits are limited and promise to raise the cost of care to all.

Does the proposal create a product that is financially stable and sustainable?

Absolutely not. The Medicare reimbursement rate covers just 2/3 of the actual cost of care. This shortfall will cause insurance costs to rise - the opposite effect of its intent.

Other thoughts? Please list them here.

The legislative work to rein in healthcare costs is commendable and truly the work of the people of Colorado. The “Public Option” as written however, falls far short of addressing key issues to achieve that result. With a basic premise that ties hospital reimbursement to Medicare rates (just 2/3 the actual cost of care) the plan immediately presents an unsustainable model and promises to put shortfalls back on Colorado taxpayers. The legal and practical complexities presented by the CMS system are well documented and do not provide a stable framework for any new legislation. By not addressing primary cost drivers such as out-of-pocket expenses and insurance deductibles it fails to deal with core cost issues, while at the same time, is not clear about it will compel insurance companies and providers to participate. This leads to the question of intent. For over a decade before I entered the healthcare industry I was a private business owner. I served on the Board of the Grand Junction Economic Partnership and am a committed supporter of economic development. While my company paid substantially to gain the well-intended promises offered by federal healthcare reform, that legislation created quite the opposite effect, driving costs up and limiting choice. The citizens of Colorado soundly defeated the tenants of universal health at the ballot box, yet this legislation finds is footing on the same basic pillars. Most importantly, the legislation does not ensure that cost savings will be passed on to individuals. It impacts only a tiny fraction of Coloradans with insurance while disregarding a vastly larger number of individuals who are uninsured. It fails to address fundamental issues tied to the rising cost of care such as acuity, over-utilization, and many others. I have only recently become employed by the healthcare industry, but my experience as a private business owner informs my understanding that the “Public Option” is not good for Colorado. As a life-long advocate for economic development, I can also attest to the fact that a negative impact to the hospitals in western Colorado will unquestioningly lead to a negative economic impact to our entire region. I urge you to slow down, consider the full breadth of negative consequences this legislation will have on a great number of Coloradans, especially when compared to the very limited benefits hopes to deliver.

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Cutting reimbursement rates will only threaten the quality of care we can provide and limit access to healthcare across our state. If below-cost reimbursement rates expand even further in Colorado, providers will have no choice but to cut services, staff and possibly close their doors altogether. Ultimately, patients will have less access to quality care, not more, and our state will be the worse for it.

We believe our patients deserve better and therefore our policymakers must do better. State officials need to slow this process down, focus on the facts and develop responsible policies that address the cost of healthcare insurance while also preventing unintended consequences – including staff and service reductions at Colorado hospitals.

As a NICU RN I am concerned that one of the services that could be cut is NICU services. We provide a great service to our communities. If NICU's were forced to close and there were only a few NICU's most babies would need to be transported. The transportation alone puts the infant at significant risk, so the ones that are transported out are already critical, but if babies that could in the past taken care of at the facility where they are born are transferred out there could be a significant increase in morbidities which in turn would raise healthcare costs.

Theresa Cuccio

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Name *

Timothy T Powell

County (in which you reside) *

[redacted]

Organization *

Creative Assurance LLC

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

No

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

No

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

No

Does the proposal include worthwhile benefits for consumers?

No

Does the proposal create a product that is financially stable and sustainable?

No

Other thoughts? Please list them here.

I do not want state run healthcare as I prefer my own choice on whom I see and when. The state option has too many unknowns and will impact conducted and the industry negatively.

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Tom DeBie

County (in which you reside) *

[redacted]

Organization *

None

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

The proposal is broad and does not address the affordability of healthcare. It will provide an option to purchase health insurance that it appears is similar to the already available state run marketplace. The affordability of healthcare can be addressed with value based pricing and certificate of need. Prices with hospitals need to be locked in throughout the state and this can be done with percentage of Medicare. New contracts would need to be negotiated with providers either directly through the state or through the insurance providers. The ACA provided low income families with an option to receive health insurance that would normally be a write off for providers. However, with an increase in individuals covered, providers received additional cash flow. The cash flow did not decrease services charged by the provider but instead went to reserves of the organization or additional hospitals being built. Competition between hospitals does not decrease the costs in the healthcare industry and instead increases the cost. Hospitals have set fixed prices to be run and if hospitals in the area are below capacity then costs will increase rather than decrease. The state should pass a certificate of need for hospitals to analyze if a hospital is necessitated in a geographic area before it is built.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

The proposal could create a product that reaches lower income families struggling with the costs of high healthcare if the state would help them with the premiums through a credit on the premiums or if the costs were negotiated to a value based pricing model with the providers.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

The options will work with the existing structure. However, if it is not mandated that everyone purchase health insurance, then you will only have the individuals that are currently sick signing up for health coverage. The premiums will then be to high for individuals to afford unless there are credits provided by the state.

Does the proposal include worthwhile benefits for consumers?

Everyone should have healthcare coverage as a right rather than as a privilege. Therefore the state and the federal government should seek any way to provide coverage for everyone. The proposal provides a possible option that may be a viable product.

Does the proposal create a product that is financially stable and sustainable?

The product will more likely than not be financially stable and sustainable without funding through the state or the federal government to make the premiums affordable to low income families.

Other thoughts? Please list them here.

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I would like to suggest that the State Board of Pharmacy publish a one page, weekly update, on new generic drugs which become available as alternatives to more expensive, commonly prescribed medications. Plus, they could also publish price alerts if there is a sudden, significant price increase on a medication. This information could be emailed to all physicians registered with the State Board of Medicine. This was done monthly in GJ in past years, by a physician in the IPA.

Second recommendation is to help more physicians practice independently, rather than being employed by hospitals, as the rising number of employed physicians increases overall health care costs. However, value based care reporting is one obstacle, along with electronic record cost, to Indepent Physician groups. Maybe a central entity could be a collection source for a group of Independent practices, to help reduce overhead?

Trish Weber, MD

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Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Trudi

County (in which you reside) *

[redacted]

Organization *

N/A

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

Not even a little bit. This will DESTROY the health care industry in Colorado. Government-run programs NEVER save anyone money but cost much much more over the long run.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

Maybe a few. However, it will cause trouble for many more people than it helps, as almost all government programs do. There are many more ways to address the health care issue than implementing a government controlled public option. This program will limit coverage for everyone overall because there will be too many people and too few providers. This will cause long waits, denial of care, and bureaucratic red tape. Do you honestly believe the VA system is good for our veterans? It is a prime example of how government-run health care operates, which is to say, POORLY.

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

"Meaningful way"??? What does that even mean? Efficient? Cost effective? NO NO NO!! It will NOT be cost effective or efficient. Because it will administered and controlled by the government, It will be grossly inefficient and incompetent and encumbered by bureaucratic red tape, pointless regulations, and a one-size-fits-all mentality.

Does the proposal include worthwhile benefits for consumers?

If by consumers you mean those who enjoy being taken care of by government, then of course they will benefit. Overall benefits will be limited, however, as case loads increase because there will not be the providers or the facilities to handle the demand. All facilities will resemble Medicaid clinics, where there is ALWAYS a long waiting line, short visits with the doctor, and a severe limitation on the quality of care patients receive.

Does the proposal create a product that is financially stable and sustainable?

You're kidding, right? "Financially stable and sustainable"??? Since when has ANY government-run program been financially stable and sustainable. Your estimates of the cost of this program are woefully understated, and your promised benefits are grossly overstated. The quality of health care for even basic treatments will be significantly lowered. There is no way government can do anything better than the private sector. Socialized medicine does not work in England, Canada, Cuba, or anywhere else.

Other thoughts? Please list them here.

I know it is hard for progressives to accept, but the government does not belong in this area of our lives. Obamacare has been an abysmal failure in spite of all the grandiose promises that were made regarding our doctors, our plans, and our premiums. PLEASE PLEASE PLEASE do not meddle in areas where you have no experience or expertise!!! Allow competition between hospitals and health clinics, encourage people to take more responsibility for their own care and payment for that care. We do not need insurance or government to pay for every little thing. You want all of us to pay for "reproductive health care," i.e., abortion on demand up to and beyond the moment of birth. That is unacceptable!!! Prices should be readily available to everyone so they shop around for the best deal as they do for other products. Too much government, too much dependence on health insurance has skewed the relationship between cost and price in this industry. You want people to be dependent on government from cradle to grave, whereas society would benefit much more from a populace that is self-reliant and self-sufficient as much as possible. This effort is not at all about providing people with quality health care; it is all about keeping people under the thumb of the government so they can be commanded and controlled by nameless, faceless unelected bureaucrats who crave power.

This form was created inside of State.co.us Executive Branch.

Google Forms

October 25, 2019

Director Kim Bimestefer
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Commissioner Mike Conway
Colorado Department of Regulatory Agencies
Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Director Kim Bimestefer and Commissioner Mike Conway,

As a physician and the CEO of one of our state's largest and most comprehensive medical groups, I want to share my significant concerns about the Draft Report for Colorado's State Coverage Option.

UCHealth Medical Group employs more than 1,000 physicians and advanced practice providers, and we are proud of the excellent quality, safety and outcomes we provide our patients. We practice at community hospitals and locations across Colorado. Importantly, I believe we are at the forefront of many initiatives to address population health and to improve the overall health of the communities we serve. Our initiatives to reduce readmissions, address chronic health conditions, lead care coordination, reduce unnecessary utilization and improve quality are reducing the overall costs of health care.

I and our medical group providers have serious concerns that this public option will have devastating unintended consequences and will threaten the important work we have already undertaken to lower costs, improve quality, and deliver patient care in safer and more innovative ways. Importantly, we believe the public option must maintain the patient's choice in the care they receive, reduce the uninsured rate in our state, maintain or increase competition among insurance providers, and reimburse health care services at rates that are competitive with commercial payers.

Further, we believe that one of the best ways for the state to reduce overall health care prices is to help providers address their expenses by easing regulations, encouraging health care delivery innovations, and reducing the rising costs of drugs. Importantly, drug price increases are one of the largest drivers of increasing provider expenses and are growing much faster than the cost of hospital care itself.

In addition, we believe that creating "centers of excellence" may disrupt continuity of care. Patients, especially those with complex health care needs, need coordinated care and communication among providers using a single, advanced medical record with access to all tests, radiology images, treatment plans, etc. A "centers of excellence" model that restricts patients' choice and forces them to visit certain providers or facilities could lead to poor outcomes and increased prices as some tests, imaging or visits are repeated at multiple locations. Patients deserve the ability to receive care close to home and to have a choice in where they receive their health care.

UCHealth Medical Group is focused on reducing health care prices, but this goal must be shared by insurance companies, other physician groups, hospitals, drug manufacturers, nursing homes and others. Unfortunately, this proposal may do more harm than good, and we believe it is a risk our state cannot afford to take.

Sincerely,

Michael T. Randle, MD, FACP
President and Chief Executive Officer
UCHealth Medical Group
michael.randle@uchealth.org

uchealth

Oct. 25, 2019

Director Kim Bimestefer
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Commissioner Mike Conway
Colorado Department of Regulatory Agencies
Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Director Kim Bimestefer and Commissioner Mike Conway,

On behalf of UCHealth, I want to share feedback on the Draft Report for Colorado's State Coverage Option.

UCHealth is Colorado's largest provider of Medicaid services, and we provided more than $350 million in uncompensated care last year alone as part of our $933 million in total community benefits. Medicare and Medicaid, which reimburse hospitals far less than the actual cost of care, make up almost 70% of our patient care. As a nonprofit organization, we are committed to these patient populations and to the communities we serve, though it is important to recognize that we lose hundreds of millions of dollars each year in unreimbursed and under-reimbursed care.

UCHealth supported the development of Colorado's reinsurance program, funded substantially through a fee on hospitals. Further, we agree that health care spending must be reduced, and that all sectors – including health care providers, insurance companies, drug manufacturers, long term care facilities, home nursing programs and others – must do their part to reduce prices.

As UCHealth and other providers shared during the stakeholder process to develop the plan required by House Bill 19-1004, we believe the state option should prioritize coverage and affordability for our state's uninsured, protect patient choice through competitive insurance markets, and ensure access to high-quality care through competitive reimbursements to hospitals and physicians.

Unfortunately, the proposal does not achieve these goals. It will not produce a product that is financially stable and sustainable, nor will it provide worthwhile and long-term benefits for consumers. Our most serious concerns include:

1. Government price controls that may reimburse hospitals less than the actual cost of care will destabilize the private insurance market and stifle competition in our state. Providers will be forced to reduce services or cut jobs, reducing access to high-quality care for Colorado residents. Providers may also be forced to shift losses to the remaining commercial insurance plans, which would increase health care prices and premiums for businesses and members. Some hospitals in our state will not be able to withstand these losses and will be forced to close.
2. While we oppose rate setting, an additional concern is that the proposal provides very little information on how those rates would be set. Medicare base rates vary based on hospital characteristics including teaching status, Disproportionate Share Hospital status, sole community hospital and rural referral center. Since we have both the state's only adult academic medical center and the largest number of Medicaid patients in the state, UCHealth has a particular interest in how specific hospital characteristics will affect rate setting. Reimbursement rates must take hospitals' status and circumstances into consideration and compete fairly with commercial insurance rates.

uchealth

3. The proposal's nonspecific reference to creating "centers of excellence" lacks detail. However, any attempt to limit care and direct patients to specific locations could have a detrimental impact on continuity of care for patients. Health care costs might actually increase as communication among various facilities and providers grows more difficult, and diagnostic tests may be unnecessarily duplicated. Most importantly, patients and their physicians should decide where they seek care, not the state. Patient choice, and the ability for people to receive care close to home, must continue to be priorities.
4. The proposal fails to establish an independent, nonpartisan governing board with representation from hospitals that would have oversight and decision-making authority. In the current proposal, though hospitals will predominately shoulder the cost of the program, they have no participation or involvement in those decisions.
5. The current proposal references, with no details, that rural and critical access hospitals may be protected. However, exempting dozens of providers from this plan will only force a smaller number of facilities to shoulder the full costs. The plan should not provide special or preferential treatment to select providers.
6. No providers should be forced or required to participate in a program that may be detrimental to patient care, may reduce competition, or be a financial liability.

This proposal does not include a final actuarial analysis, so hospitals are left to themselves to determine how serious the implications might be. In the initial years, we expect substantial losses each year because of the government-mandated rate setting. If the commercial insurance market begins to collapse as we fear, these costs would multiply 10-fold. To mitigate these losses, we would expect to both reduce staff and cut services. Some community benefit programs would be reduced and funding for important research and education initiatives could be put in jeopardy as we would need to focus resources on serving the underserved including Medicare and Medicaid patients. This would have a detrimental impact on the patients and communities we serve.

Ultimately, this is a dangerous proposal that may lead to significant unintended consequences on the State of Colorado, providers and patients. Revisions must be made to this proposal to address these and other concerns to protect patients.

Sincerely,

Elizabeth B. Concordia

Elizabeth B. Concordia
President and Chief Executive Officer
UCHealth

OFFICE OF THE PRESIDENT AND CHIEF EXECUTIVE OFFICER

Mail Stop F-417 • Leprino Building • 12401 E. 17th Ave. • Aurora, CO 80045 • p: 720.848.4024 • f: 720.848.5548 • uchealth.org

UNITEDHEALTH GROUP®

Richard J. Migliori, M.D.
Office of the Chief Executive
9900 Bren Road East | MN008-T904
Minnetonka, MN 55343

October 28, 2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant St, Denver, CO 80203

Commissioner of Insurance Michael Conway
Division of Insurance
1560 Broadway #110, Denver, CO 80202

Director Bimestefer and Commissioner Conway,

UnitedHealth Group (UHG) appreciates the opportunity to provide feedback on the Colorado Division of Insurance (DOI) and Department of Health Care Policy and Financing (HCPF) draft framework for the implementation of a Public Option (PO) insurance product.

UHG is a mission-driven organization dedicated to helping people live healthier lives and making our nation's health care system work better for everyone through two distinct business platforms – UnitedHealthcare, our health benefits business, and Optum, our health services business. We, along with our 320,000 employees, are honored to serve the health care needs of 143 million people worldwide, funding and arranging health care on behalf of individuals, employers, and federal and state governments.

In Colorado, our 4,100 employees serve over 1.3 million Coloradans in UnitedHealthcare's and Rocky Mountain Health Plans' insurance coverage offerings, and increasingly work to improve and enhance their health care experiences via Optum's care delivery and health services businesses.

For nearly twenty years, UHG has publicly advocated for policies to achieve universal coverage. We believe efforts to expand access to health care in the United States should protect and preserve the stability and choice of existing, successful coverage platforms – leveraging what is working today – to cover individuals who remain uninsured. Employer-Sponsored Insurance, Medicaid, and Medicare Advantage are providing cost-effective, consumer-responsive, innovative health care benefits, with proven results and high member satisfaction.

In this vein, UHG shares the goals underlying the Proposal, to achieve universal coverage via addressing the pressing health care access and affordability challenges that too many Coloradans currently face. We recommend that the DOI and HCPF consider alternative policies to increase access to coverage, lower costs, and improve the consumer experience. As currently drafted, UHG holds strong concerns that the Proposal would drive unintentional negative impacts on Colorado's health care system and for Colorado residents.

Statewide Participation Mandate
Under the proposal, the mechanism to ensure availability of POs will be to require insurers that offer plans in a major market (individual, small group, or large group), above a market share or membership size (to be determined), offer the PO on a statewide basis. This participation mandate will increase administrative and financial burdens on insurers that currently do not offer individual market products. For example, insurers will have to develop provider networks, add operational staff, and invest in marketing materials – with minimal infrastructure to support the long term financial sustainability of the program.

UHG holds strong concerns that requiring carrier participation may not increase competition – a stated goal of the Proposal – yet creates the risk of significant unintended negative consequences for Colorado's health system. With PO plans being required to offer richer benefits with lower medical benefit cost structures, we can expect that other Exchange offerings will become less attractive and insurers may cease to offer them. The likely exit of plan options from the market will disrupt enrollees in those plans, and ultimately diminish choice. A statewide participation mandate could also have the result of increasing instability in the market and reducing choice, if insurers decide that complying with the participation mandate is too onerous and withdraw from a market – for example if the participation mandate is tied to offering products in the small group market, certain insurers may cease to offer such coverage because offering a PO creates barriers to entry. Plans that participate regionally today do so because of their ability to develop competitively-priced networks and meet network adequacy standards in those regions. A statewide mandate will likely stifle the ability for regional plans to continue operation.

An example of mandated carrier participation limiting competition has already played out in Washington State where participation in the School Employee Benefits Board (SEBB) health insurance program is conditioned on offering products in the individual marketplace. Two carriers that historically participated in offering coverage to school districts chose not to bid or withdrew from the procurement process in early 2019 after the mandate was legislated, creating disruption and fewer options for members. This also did not result in increasing carrier participation on the marketplace.

We also expect the Proposal may cause market conditions that would limit innovation in plan design. For example, UHC has recently launched a new product, the Colorado Doctors Plan, which offers an innovative benefit design and enhanced affordability. The Colorado Doctors Plan offering is the result of UHC's efforts to reimagine what health care coverage and benefits are and should offer to our consumers. This new product offering places the patient-provider relationship at the core of the benefit design, and is the result of UHC leaning in to form new, innovative, and value-focused partnerships with leading Colorado health systems and providers to deliver deeper, yet more affordable, health care coverage to Coloradans. UHG holds significant concerns that the establishment of a PO in the Colorado market could significantly limit the incentives for health insurers and providers to innovate and establish new relationships aimed at achieving meaningful and sustainable increases in health care coverage and affordability.

In addition, led by the efforts of UnitedHealthcare and Rocky Mountain Health Plans, UnitedHealth Group is a leader in Colorado's statewide health system. We are committed to continuing our leadership role in working to improve this system to deliver more accessible and affordable health care coverage throughout the state. Rocky Mountain Health Plans offers an innovative, effective Medicaid managed care plan in six Colorado counties, which consistently exceeds stringent state quality targets and currently operates at a two percent net savings in total cost to Colorado taxpayers, pursuant to actuarial analysis completed by HCPF. Additionally, in recent months, UHC and RMHP have both taken

on significant efforts to partner at the state and local levels – via Summit County's newly formed Peak Health Alliance – to bring new, more accessible, and more affordable health coverage offerings to Coloradans living in some of the highest cost regions of the state. It has been estimated that combined with the new reinsurance program set to take effect in 2020, this new coverage model could reduce individual plan rates nearly 40 percent in Summit County, compared to existing rates. The establishment of a PO, however, could create significant uncertainty for the viability of new coverage models such as the Peak Health Alliance, particularly if the PO limits the ability for a community-based purchasing cooperative to negotiate meaningful discounts for their communities. Indeed, the PO could drive cost shifting impacts that result in increased rates, decreased affordability, and destabilization in the group market, such that the savings offered by Peak's new coverage model are put at risk.

If the final Proposal contains a participation mandate, it will be important that it be implemented uniformly – no insurer should be made exempt because of their existing footprint, the structure of their organization (e.g. group model HMO), or their status as a not-for-profit. To compel certain insurers and not others to offer PO plans will create an uneven playing field that will reduce competition in the state.

Crowd Out

We agree with the DOI and HCPF expectation – included in the Proposal – that the PO will eventually de-stabilize the small group market and large group market. As a result, the agencies expect individuals currently enrolled in employer-sponsored coverage to enroll in the individual market or group market PO. By crowding out the private provision of health care coverage in favor of a government health care option, or health care that is so tightly regulated by state government, the responsibilities and market incentives for private health plans to continue offering private health insurance products will be significantly disrupted and diminished. The state may have little financial responsibility for the increased use of Federal tax credits under the Proposal, but the shift of costs from government programs will ultimately cause an impact.

UHG holds strong concerns regarding the potential risk of significant destabilization of the group health insurance marketplace posed by crowd out and believes it is essential that the final proposal include firm guardrails to protect the integrity of Colorado's well-functioning small and large group markets. DOI and HCPF could look to the minimum essential coverage (MEC) and affordability rules that serve a similar purpose in the individual market today. For example, to avoid the Crowd-Out challenge, the agencies could include a guardrail that Coloradans who are offered employer-sponsored coverage that meets MEC and affordability rules would be ineligible to receive Advanced Premium Tax Credits to purchase individual market coverage, or could be ineligible to participate in or purchase a Public Option plan.

Medical Loss Ratio

We would request that the DOI and HCPF provide additional information for the requirement that PO plans maintain an 85% medical loss ratio (MLR option). While the State presented that a five percent savings could be achieved from government-set hospital reimbursement rates, the administrative burden for carriers will not substantially change under the proposed plan. Carriers would still be required to negotiate contracts with providers and hospitals and the necessary administration may be even higher without the required participation of providers in the state option plan, thereby increasing financial instability for carriers attempting to participate in the PO. We are further concerned that DOI and HCPF have not contemplated that MLRs for PO plans may exceed 100% – in fact the average MLR was 114.52% in 2015 and 100.49% in 2016 in the individual market. Instability in the individual market has continued.

While premiums have slowly decreased nationally in 2019 and for 2020, Coloradans are well aware of the instability in the individual market, which served as the genesis for the creation of the state's regional reinsurance program. The legislature's call for the agencies to bring forth a PO proposal is further acknowledgement that the individual market in Colorado is unstable. A PO proposal that builds on the current structure of the individual market without solving for the inherent challenges in the market's construct will exacerbate the MLR challenges for carriers rather than improve them. We would also request clarity from DOI and HCPF regarding how the PO would be treated in the federal risk adjustment program for the individual market. With higher MLR requirements, the PO product would hold a different level of risk than other Qualified Health Plans offered by carriers in the market. This dynamic should be carefully considered in any changes to MLR requirements and spreading of risk across both the PO and the individual market writ large in Colorado. To that end, we recommend that the DOI and HCPF allow insurers to withdraw from the PO market if they are unable to achieve reasonable MLRs without penalty for participation in other areas of the Colorado insurance market.

Cost Shift

We agree with the DOI and HCPF that hospitals are likely to cost-shift onto other commercial populations as a result of this Proposal. Researchers have documented hospital cost shifting practices[1] and hospital inpatient and outpatient price increases continue to rise.[2]

The DOI and HCPF acknowledge that their Proposal will negatively impact hospitals' revenues, causing them to engage in cost-shift that will negatively impact individuals in small group and large group coverage. In other words, the Proposal will increase health care costs for the 237,050 people with small group coverage[3] and millions more Coloradans with large group coverage to help a portion of the 170,000 Exchange enrollees who pay premiums.[4] We believe that there are better alternatives to achieving universal coverage and lowering health care costs than by improving choice for a smaller set of individuals while causing continual price increases to a majority of Coloradans.

We are further concerned about the uncertainty regarding how hospital participation and rate-setting will be implemented. We expect hospitals to vigorously oppose this Proposal, and are not optimistic that they will agree to the proposed reduced rates voluntarily.

Unintended Consequences of Rate Setting

The DOI and HCPF Proposal includes benchmarking the provider fee schedule to a level between 175-225% of Medicare, which is significantly lower than the current average of 289% of Medicare, as a means to lower the overall cost of purchasing health care services for those purchasing a PO plan. In many instances, leveraging a blunt, one-size-fits-all approach to benchmarking rates will serve as a floor for the cost of services, rather than a ceiling, will likely lead to unintended consequences and not achieve the goal of lowering the cost of care. Benchmarking rate also runs contrary to the Proposals stated goal to leverage value-based care arrangements as a means increasing the efficiencies, quality, and cost of care. Benchmarked rates will create challenges for carriers in developing flexible, value-based payment arrangements with providers participating in the PO network due to the mandated benchmark price. In addition, because the benchmark serves as a guideline for a pricing floor, providers, particularly in higher cost rural regions of the state, may be required by their pricing structure

[1] https://www.nber.org/papers/w24304
[2] https://www.healthcostinstitute.org/research/annual-reports/entry/2017-health-care-cost-and-utilization-report
[3] https://www.kff.org/other/state-indicator/market-share-and-enrollment-of-largest-three-insurers-small-group-market/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[4] https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

to negotiate higher rates to cover their costs, creating increased hospital rates in some localized areas like we see today. This phenomenon will also likely contribute to the cost shift to commercial markets as providers seek to make up losses for participating in the PO by increasing their fee schedules for commercial products.

While UHG holds strong concerns regarding a number of central elements of the Public Option Proposal and the risks that potential unintended consequences pose to Colorado's health system, we welcome the opportunity for constructive discussion and collaboration as part of this comment process. UHG shares the Administration's goal of advancing Colorado to universal coverage, and developing new and innovative solutions to deliver more affordable and more accessible heath care to Coloradans across the state. We look forward to discussing potential strategies for how Colorado could better leverage its existing high value and highly functioning health care coverage platforms, namely employer-sponsored insurance, in place of further consideration of a proposal that risks undercutting and destabilizing that platform and therefore, the health insurance benefits for the 2.5 million plus Coloradans who are insured via their employer.

Sincerely,

Richard J. Migliori, M.D.
Executive Vice President and Chief Medical Officer
UnitedHealth Group

University of Colorado Medicine

13199 E. Montview Blvd. | Aurora, CO 80045
P: 303.493.7000 | F: 303.493.7001

October 28, 2019

Executive Director Kim Bimestefer
Department of Health Care Policy and Financing
1570 Grant St
Denver, CO 80203

Commissioner Michael Conway
Division of Insurance
1560 Broadway #110
Denver, CO 80202

RE: Draft Report for Colorado's State Coverage Option

Dear Director Bimestefer and Commissioner Conway,

I write as the President of CU Medicine, the largest independent physician and advanced provider practice in Colorado, to encourage continued consideration of options to provide affordable and effective health care. With 2,212 physicians and 1,132 advanced practice providers who practice at multiple hospital systems, including University of Colorado Hospital (operated by UCHealth), Children's Hospital Colorado, Denver Health, and the Rocky Mountain VA Medical Center, we can offer a perspective of the comprehensive health care needs of Coloradans. Among our patients are more than 150,000 Medicaid beneficiaries. Our practice occupies a vital place in the health system of our state because we represent the faculty members of the University of Colorado School of Medicine. We have the primary role in Colorado of training the next generation of physicians, physician assistants, and physical therapists. At the same time, our faculty are improving the quality of care by engaging in a wide-ranging medical research program.

We applaud and support a robust and open dialog and we encourage efforts to remodel the health care system to deliver improved outcomes at lower cost to all Coloradans. The Draft Report offers an opportunity to continue efforts to identify the best approaches to achieve our shared goal. While we are an independent practice not employed or controlled by any health care system, our operations are critically connected to and affected by changes in the health care market. As a result and in response to the solicitation of public comment, I offer these thoughts about the proposal.

Our practice is based in one of the most economically, ethnically, and racially diverse communities in the state. We would hope that any state option proposal would prioritize covering the ~6% of Coloradans who still lack health insurance coverage. This proposal is focused on offering alternative insurance options to currently insured residents, but it does not specifically target ways to decrease the number of uninsured state residents. The lack of affordable coverage for them leaves them vulnerable and does not address the systemic issue of how the current model causes cost-shifting from patients with insurance to cover the costs of those who do not have insurance.

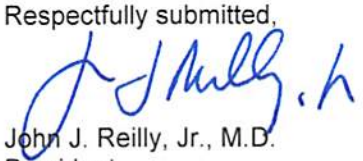
In addition, our providers receive referrals of patients with the most complicated conditions and the most acute care needs. Our practice accepts ~7,000 transfers a year from other hospitals throughout the region and we staff many clinical programs that cannot be found elsewhere in Colorado. We are particularly interested in the "Center of Excellence" concept advanced in the report. To support such a concept and to establish value in health care, it is essential to gather and make available objective safety and outcome data. Several of our programs, including organ transplantation, bone marrow transplantation, and cardiac surgery, participate in outcome data reporting to national organizations. These programs are highly ranked nationally and amongst the best in the state. We would welcome the opportunity to partner with HCPF to establish a statewide system of safety and outcome data reporting that could be used to determine the value and quality of care and to inform decisions about creating Centers of Excellence. Without establishing this resource, the Draft Report does not make clear how officials would make such determinations.

The Draft Report states that a central goal of the state option is "[i]ncreasing competition in the state among health insurance carriers to put downward pressure on health insurance premiums." As the report correctly notes, many Colorado residents are in areas where only one insurance option is available. Consideration should be given to requiring that insurance companies offering products in our state offer them in all counties.

By serving on the boards of four hospital systems in Colorado, I am familiar with the financial structures of the existing system and the potential impact of changes in these structures. In reviewing this proposal, I am concerned that the proposed rate-setting for hospitals, if extended across the entire marketplace as envisioned, will force many hospitals into economic distress. While setting prices is one potential lever in addressing health care costs, there are other factors that should be considered. We advocate that the state consider reimbursement models that recognize the importance of making comprehensive and effective primary care available to all and that take advantage of new technologies to deliver care in innovative ways. Lowering the overall cost of health care cannot be achieved without effective measures to improve individual and population health. By focusing specifically on reimbursement rates, the state option may create short-term financial relief for payers while jeopardizing the long-term viability of health care providers without improving the quality of health for our population. I would strongly urge an approach that supports the health promotion and disease-prevention efforts that we need to both improve the health of Coloradans and to achieve sustained control of costs.

On behalf of our faculty, I reiterate our commitment to work with you to develop innovative approaches to the missions of improving health in Colorado while reducing the cost of health care. Thank you for the opportunity to comment on the Draft Plan.

Respectfully submitted,



John J. Reilly, Jr., M.D.
President
University of Colorado Medicine

October 25, 2019

Director Kim Bimestefer
Dept. of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Commissioner Mike Conway
Colorado Dept. of Regulatory Agencies
Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Director Bimestefer and Commissioner Conway:

I am proud to submit comments on behalf of Valley View Hospital Association for the "Draft Report for Colorado's State Coverage Option," released on Oct. 7, 2019. As a hospital, we agree that our state needs to take proactive steps to address health care access and affordability to ensure that Coloradans have access to the care they need and can afford it when they do seek care. Unfortunately, we are concerned that this proposal, as drafted, would have serious ramifications for our community, our local hospital, and our state as a whole.

Specifically, we do not believe this proposal will help enough Coloradans and may actually jeopardize access to care and affordability for those who are already covered. With nearly 400,000 Coloradans currently uninsured, we are disappointed that this new option doesn't prioritize those individuals. We are also concerned that it will increase health insurance costs for many Coloradans, as costs will be shifted to the nearly half of Coloradans who have employer-sponsored insurance. Finally, we believe that the government rate setting for hospitals that funds this proposal could be incredibly detrimental to hospitals across our state.

Valley View Hospital, our local hospital, is a vital part of our community. It is the largest employer in our community and provides significant community benefit beyond the traditional patient care offered within the hospital. While the draft proposal doesn't examine the financial impact to hospitals, we must assume that this type of government rate setting for hospitals will be significant – especially since hospitals cuts are the only funding mechanism for these significantly reduced health care plans.

The proposal purports to protect rural hospitals, but does not give any specific details about how that will happen. Our hospital, like most in rural Colorado, works incredibly hard to make ends meet in order to ensure access to care in our community. Without the benefit of the detail, this is too risky to our local hospital.

Please consider the impact this proposal could have on communities like ours, on hospitals like ours, and on access to affordable care for patients like me, my family, friends, and neighbors. We agree that there is still more work to do to improve our health care system, but this proposal as drafted is not the solution.

Sincerely,

Brian Murphy, MD

vvh.org
People Care.
That's Valley View.

Brian Murphy, MD
CHIEF EXECUTIVE OFFICER
Valley View Hospital
1906 Blake Avenue
Glenwood Springs, CO 81601
Brian.Murphy@vvh.org
TEL 970.384.6600

To whom it may concern,

Our system isn't perfect and we should be looking for sensible and responsible ways to improve on cost and quality. This much everyone already agrees on. What not everyone agrees on, but which is verifiably true, is that we already have lower-cost and higher quality care than most other states and we shouldn't threaten all that by rushing through a state option that cuts hospital budgets and staff.
It's disappointing that the Polis administration has repeatedly ignored facts that get in the way of its political agenda. Data from the Kaiser Family Foundation shows that Colorado already has the fifth-lowest healthcare spending per capita in the nation. We are also consistently ranked as one of the highest quality states for healthcare in the country.

So why is a public option that threatens the very people who administer the care being rushed through without critical public involvement or feedback? We should absolutely look for ways to bring down costs, but not at the expense of our quality and access. Why isn't the administration looking at other segments of healthcare and seemingly taking aim solely at hospitals? This doesn't add up to me, and I'm wondering whose benefit the current plan actually serves.

Hospitals, whether they are for-profit or non-profit, cannot continue to operate if their expenses are not covered. They are at the forefront of care and already make tremendous strides in saving people money. Why isn't the government being more holistic in attacking this problem? Again, something doesn't add up here, and I'm disappointed in our leadership for its myopia and truculence on this issue. I do not support the public option as presented by the Polis Administration, and strongly urge it to reconsider.

Sincerely,

Veronica Lee

Emergency Department Technician

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

Please use this form to submit your comments on the draft HB19-1004 report. All comments will be logged and added as an appendix to the final report. We will accept comments until October 28.

Helpful Links:
- The draft report can be found here: http://www.colorado.gov/pacific/sites/default/files/HB19-1004%20Draft%20Report%20Colorado%20State%20Coverage%20Option%20and%20Appendix.pdf
- The bill text can be found here: https://leg.colorado.gov/sites/default/files/2019a_1004_signed.pdf
- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

Vivian Simon

County (in which you reside) *

[redacted]

Organization *

Fremont County SEP

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

I believe it addresses some of the concerns but the Plan Details Premium rates listed on page 159 I believe are still too high. Most of the individuals we encounter that are looking for help with medical costs & bills, insurance coverage, etc. still can't afford that much each month. Both age groups 36-50 & 51-65 don't have $450 or $600 to spare each month. It may not seem like a lot to those with higher incomes but for individuals that don't qualify for Medicaid but yet don't have much more that the cut off income amounts still can't afford the premiums listed. Will there be any possibility to lower those monthly costs for premiums? Even individuals that have some sort of private or employer insurance coverage are skipping needed care due to the cost of premiums and deductibles. I feel that premiums are still too expensive with this proposed plan.

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

Only some - see above answer

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

It seems to.

Does the proposal include worthwhile benefits for consumers?

the premiums, deductibles & co-pays need to be kept low otherwise individuals will still not consistently seek care.

Does the proposal create a product that is financially stable and sustainable?

unsure

Other thoughts? Please list them here.

I am still concerned about the monthly costs to individuals. I feel that they are still going to skip care or choose not to seek coverage due to the costs of the premiums, deductibles & co-pays as listed in the plan.

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Keep your hands off my health care.Keep the government out of health care.

Wayne Mee

Western Healthcare Alliance
30 YEARS OF COLLABORATION
715 Horizon Drive, Suite 485
Grand Junction, CO 81506
888 · 828 · 0011 | wha1.org

STATE OF COLORADO
DIVISION OF INSURANCE
NOV 01 2019
RECEIVED

Oct. 28, 2019

Director Kim Bimestefer
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Commissioner Mike Conway
Colorado Department of Regulatory Agencies
Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Director Bimestefer and Commissioner Conway:

On behalf of Western Healthcare Alliance (WHA), please accept this submission of comments for the "Draft Report for Colorado's State Coverage Option," released on Oct. 7, 2019.

We agree that our state needs to take proactive steps to address health care access and affordability to ensure that Coloradans have access to the care they need and can afford it when they do seek care. In rural Colorado, we've been addressing this problem since 1989.

We are concerned that the State's Coverage Option as drafted, would have serious ramifications for our rural hospitals and the communities they serve. Specifically,

- The proposal's use of rate setting directly conflicts with the successful efforts we have made thus far to transition from a fee-for-service payment system towards one that focuses on value and payment for keeping patients healthy.
- Rural hospitals face a constant challenge of not only attracting providers but retaining them in areas that have limited resources. The proposal cuts reimbursements to hospitals without holding insurers, pharmaceutical manufacturers and physicians equally accountable for reducing cost. Our rural hospitals could face layoffs, hiring freezes, and even more pressure to do more with less meaning an additional strain on the existing workforce.

WHA is made up of 30 rural hospital and healthcare organizations in Colorado who collaborate to ensure local access to healthcare, while increasing operational efficiencies and lowering the overall cost. They do this through collaboration and sharing of resources. There are networks like ours serving rural communities across the United States, but Colorado's Network is unique. Our members also own 2 companies. One of those is the Community Care Alliance, a company dedicated to creating sustainable solutions that ensure healthier populations, as we shift towards a reimbursement model focused on value.

Since the Community Care Alliance's inception in 2015, WHA members have been learning how to coordinate care in their Accountable Care Organization, the Western ACO. It has approximately 15,000 attributed beneficiaries in 12 rural communities throughout the Western Slope. They are ensuring not only healthcare savings for CMS (12 million dollars in 3 years), but better care for patients by preventing unnecessary emergency room visits and addressing social determinants of care such as adequate housing and transportation.

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Our rural hospitals are vital members of their communities. They often are the largest employer in their county and provide significant community benefit beyond the traditional patient care offered within the hospital. While the draft proposal doesn't examine the financial impact to hospitals, we must assume that this type of government rate setting for hospitals will be significant – especially since hospital cuts are the only funding mechanism for these significantly reduced health care plans. And though the proposal proports to protect rural hospitals, it does not provide any specific details about how that will happen, which leaves them feeling more threatened and vulnerable. Our WHA members work hard to make ends meet in order to ensure access to care in our community. Without the benefit of the details, we are fearful that there will be dire consequences for rural Colorado.

As an active participant in the stakeholder process used to develop a plan required by House Bill 19-1004, we are left to believe that considerable input from our organization and others was not incorporated into this draft proposal. We are hopeful that during this formal comment period, the state will take a more in-depth look at the feedback provided and make many changes to the proposal before it is finalized.

Please consider the impact this proposal could have on rural communities like ours, on hospitals like ours and on access to affordable care for patients like me, my family, friends and neighbors. Rural hospitals are closing at an unprecedented rate but not in Colorado. We believe we are finding solutions and through collaboration, are keeping rural hospitals open, therefore taking care of our rural residents. We agree that there is still more work to do to improve our health care system, but this proposal, as drafted, is not the solution.

Sincerely,

Angelina Salazar, CEO
Western Healthcare Alliance

I am writing to express my concern for the proposed public option that the Polis Administration is considering. While I fully support affordable coverage for all Coloradans, lower reimbursement for care provided would be detrimental to the individuals and organizations providing care.

My facility, like all healthcare facilities, is staffed by educated professionals whom have committed their lives to education, staying current in the latest practice trends, and working countless hours to serve those in need of our services. These individuals own homes, have families, and pay taxes to our State and local jurisdictions.

My facility is committed to providing cutting-edge technology to the patients we serve. Advancing technology allows us to provide better care to patients and to improve outcomes, decrease suffering, and get our patients back to their lives sooner. As you are well, technology is very expensive and my facility commits large amounts capital to acquire and maintain this technology.

Poor reimbursement for the care we provide will directly impact the personnel who provide the care and the quality of care we are able to provide. We will not be able to sustain current staffing levels and will lose qualified professionals to other states with better reimbursement. We will not be able to purchase or maintain the technology that our patients deserve. In the end, the quality of care will decline, outcomes will decline, and our ability to practice the best medicine will be drastically interrupted. Colorado will no longer draw patients from surrounding states who come to the Denver-metro area for advanced care.

Thank you for considering my opinion.

Respectfully,

Will Bertram, MBA, RN, BSN, CNOR

Official Comment on HB19-1004: A Proposal for an Affordable Health Care Coverage Option

Please use this form to submit your comments on the draft HB19-1004 report. All comments will be logged and added as an appendix to the final report. We will accept comments until October 28.

Helpful Links:
- The draft report can be found here: http://www.colorado.gov/pacific/sites/default/files/HB19-1004%20Draft%20Report%20Colorado%20State%20Coverage%20Option%20and%20Appendix.pdf
- The bill text can be found here: https://leg.colorado.gov/sites/default/files/2019a_1004_signed.pdf
- Si prefiere ver este formulario en español: https://docs.google.com/forms/d/e/1FAIpQLSdM7YtxX_Thi_yjXOFWdItBXjtTMGQ4aqGn0NdTcWmna0BQOA/viewform?usp=sf_link
- We will accept comments in all languages!

If you wish to submit a comment in the form of a letter, please send your document to hcpf_1004affordableoption@state.co.us. We will accept comments in all languages. Please include your name, county, organization (if applicable), and email address with all submissions.

Thanks so much for your continued interest in HB19-1004. We appreciate your comments.

Name *

William J. Inman

County (in which you reside) *

[redacted]

Organization *

disabled

Email Address *

[redacted]

Does the proposal address Coloradans' concerns about health care affordability?

no

Does the proposal create a product that reaches Coloradans struggling with high health care costs?

no

Does the proposal create a state option that utilizes existing infrastructure and expertise in a meaningful way?

no

Does the proposal include worthwhile benefits for consumers?

no

Does the proposal create a product that is financially stable and sustainable?

no

Other thoughts? Please list them here.

I think the free enterprise system is the best way: not government run.

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