



Colorado Commission on Affordable Health Care

2015 Report to the Colorado General
Assembly and Colorado Governor

November 15, 2015

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Letter from the Chairman

November 15, 2015

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Gov. Hickenlooper, Sen. Lundberg, and Reps. McCann and Primavera,

Health care costs have been dramatically rising for the past two decades, in Colorado and across our nation. Despite the progress made on expanding access to health care as well as improving quality, rising costs are creating challenges for families, businesses, and public agencies alike. Recognizing this problem — not only for everyday Coloradans, but also for our state's fiscal health — the Colorado General Assembly passed Senate Bill 14-187 and created the Colorado Commission on Affordable Health Care.

Our mission from Day 1 has been to study this enduring problem, explore the root causes of rising health costs in Colorado, and lay a framework for the important work we have to do in 2016. Our work complements the progress of past commissions and work, while also deliberately focusing on cost containment.

In considering this matter it is important to note the complexity of the topic and the fact that obvious potential actions may in fact not address any particular topic, or even make things worse. This is also important to acknowledge that health care represents one-sixth of our economy, and this is another clarion call for diligence and appropriate care.

This report — the result of more than a year's worth of outreach, research, and expert testimony — lays out the challenges Colorado faces today on health care spending, the primary drivers of rising health costs, and several topics we will continue to grapple with in our second year. In many ways this nonpartisan, comprehensive, and evidence-based analysis of the major drivers of health care costs is a landmark resource for policymakers and others across the Centennial State. However, this is only one step toward our goal of true cost containment.

We still have work to do to study the effectiveness of strategies for controlling health care costs and propose collaborative solutions to address this problem. These challenges remain for our second year of work, and we look forward to collaborating with the Colorado General Assembly and the Governor's Office to ensure we can accomplish our legislative mandate. Your perspectives are essential to our ongoing work.

Please do not hesitate to provide us with any feedback.

Sincerely,

A handwritten signature in black ink, appearing to read "W. Lindsay III". The signature is fluid and cursive, with a small flourish at the end.

William N. Lindsay III
Chairman, Colorado Commission on Affordable Health Care

DRAFT

I. Health Care in Colorado

Health care spending has been rising as a share of household income for decades, and is projected to keep rising. This growing expense squeezes families, particularly those struggling to make ends meet.

Issues of health care costs and spending are sometimes used interchangeably by policymakers, but have distinct meanings. While much of the data analysis focuses on spending, the work of the Commission will focus primarily on cost — the price of that service, or the cost or price of all of the services an individual uses annually. This focus on cost will not be to the exclusion of a focus on spending. The increased attention to health care costs likely reflects the recent trend of health insurance premiums — the most visible indicator of health care costs — growing at a much faster rate than workers' earnings.

Finding ways to stabilize health care costs — a highly visible topic of discussion for individuals and families, employers, state policymakers, providers, and the media — is essential for our state, now and for decades to come.

Improving efficiency and reducing costs in health care in Colorado will require extraordinary public leadership and a commitment from the public and private sectors. Leaders from all sectors will need to work collaboratively to advocate for systemic changes that improve the affordability of essential health services for all Coloradans.

Total national spending on health care services and supplies — that is, by all people and entities in the United States, governmental and nongovernmental — increased from 4.6 percent of gross domestic product (GDP) in calendar year 1960 to 9.5 percent in 1985 and to 16.4 percent, about one-sixth of the economy, in 2013.¹

Most of the population under 65 is privately insured under an employer's plan or by themselves. federal and state health care provision and spending comes from programs such as Medicare (for those above 65 and certain people with disabilities), Medicaid and the Children's Health Insurance Program (for those below a defined income level), and the Veterans Health

Legislative Charge — Senate Bill 14-187

The Mission of the Commission is to ensure that Coloradans have access to affordable health care in Colorado.

The Commission shall focus its recommendations on evidence-based cost-control, access, and quality improvement initiatives and the cost-effective expenditure of limited state moneys to improve the health of the state's population.

Powers and Duties of the Commission:

- Identify, examine and report on cost drivers for Colorado businesses, individuals, Medicaid, and the uninsured.
- Data Analysis on evidence based initiatives designed to reduce health care costs while maintaining or improving access to and quality of care.
- Analyze the impact of increased availability of information.
- Review, analyze and seek public input on state regulations impacting delivery and payment system innovations.
- Analyze impact of out-of-pocket costs and high deductible plans.
- Examine access to care and its impact on health costs.
- Review reports and studies for potential information.
- Report outcomes of the 208 Commission

¹ Congressional Budget Office, The 2015 Long-Term Budget Outlook.
<http://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50250/50250-breakout-Chapter2-2.pdf>

Administration. There are a variety of payment and delivery methodologies within these private and public systems. Without changes in the health system as a whole, achieving cost sustainability or stability will be out of reach for most Coloradans.

Work

State governments have a unique opportunity to transform the current health care system into one that provides higher-quality care at lower costs. Recognizing this, state policymakers established the Colorado Commission on Affordable Health Care (Commission). The Commission was created to identify how Colorado might use its authorities and policy levers to guide this transformation and to make recommendations for actionable reforms that will reduce the principal drivers of health spending in Colorado.

The Commission is comprised of individuals representing diverse Colorado constituencies or geographic areas as well as professionals with deep subject-matter expertise on health. These experts bring the experience, understanding, and analytic capacity to delve in to this difficult topic. They also have the ability to provide the leadership across multiple sectors and constituencies necessary to arrive at and move forward with recommendations to control health care costs. A roster of the Commission's members can be found in [the appendix](#) of this report.

Shared Framework and Approach

This report provides a basic overview of the drivers of health care spending growth in Colorado. It also serves as an analytical starting point for the Commission's work on health care cost containment.

Numerous commissions, task forces, and blue ribbon panels have tackled issues surrounding health care in Colorado. Although those entities have made important progress, the Commission is focused on health care costs — for individuals, families, businesses, and public agencies. This focus not only ensures that the Commission's work is not duplicative of earlier efforts, but also focuses this critical and enduring issue for Coloradans.

The Commission's final recommendations will encourage initiatives to control health care costs and maximize value, achieving the best outcomes at the lowest cost. The Commission also will make recommendations that impact the total cost of care — now and in the future. The Commission's final report and recommendations, due at the end of June 2017 will address public systems as well as offer metrics to measure short and long-term success. In its analysis, the Commission is looking at health care spending and costs from the beginning to the end of

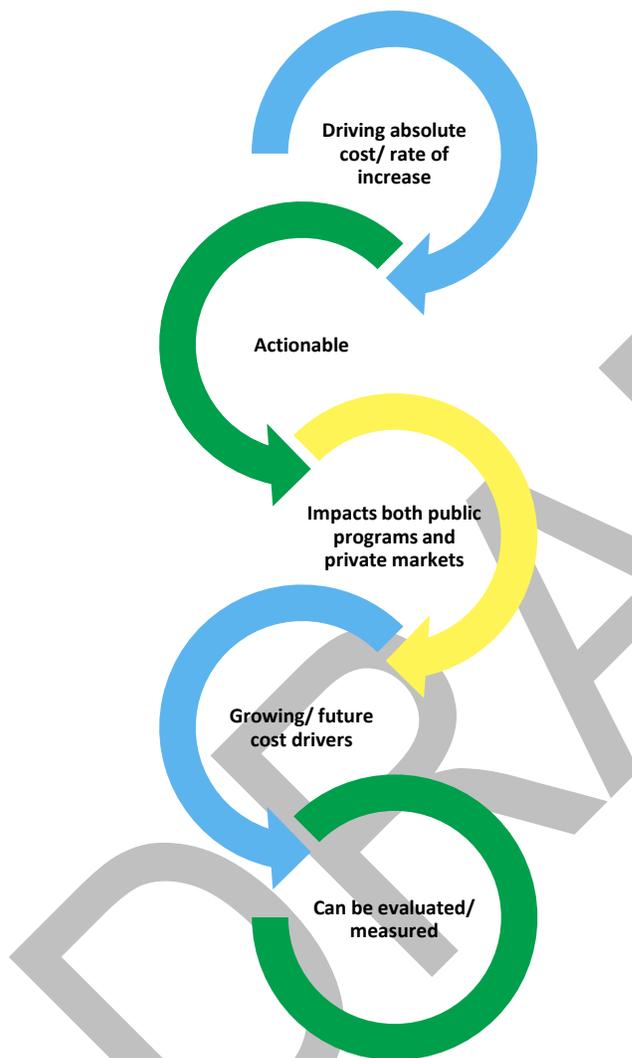
Legislative Charge (continued)

Collect and review data including:

- Rate Review Process Data from DOI
- Payment information from HCPF
- The impact of Medicaid Expansion
- Evaluate the impact of a Global Medicaid Waiver
- Review information on pricing transparency: Adequacy, composition and distribution of physician and health care networks; Drug Formularies; Co-Insurance, copayments and deductibles; and Health plan availability
- Make recommendations entities that should continue to study health cost drivers
- Make recommendations to the Congressional Delegation about needed changes in federal law

life. The Commission created the following framework to identify and prioritize recommendations.

Commission's Framework to Identify and Prioritize Recommendations



Though the goal of the Commission is to reduce health care costs, the Commission will work to ideally ensure that cost reductions do not come at the expense of access and quality, but at a minimum point out the possible tradeoffs.

The Commission recognizes that it must look at the health drivers that impact the total cost of care. There are not simple solutions given the interplay of public and private systems and multiple payers.

The analysis of the fundamental drivers of health care spending will help inform the Commission's selection and prioritization of recommendations. Thus far the Commission has reviewed analyses of state spending on personal health care by type of service, payer, and disease as well as reviewed work and recommendations of the 208 Commission. Additionally, the Commission has looked at Colorado compared to national data and has not found much in the way of Colorado-specific details.

From this analysis, the

Commission has determined key topic areas for further discussion:

- Transparency
- Workforce
- Social Determinants
- Incentive Mechanisms
- Regulatory Costs
- Administrative Costs
- Payment & Delivery Reform
- Market Competitiveness
- Technology

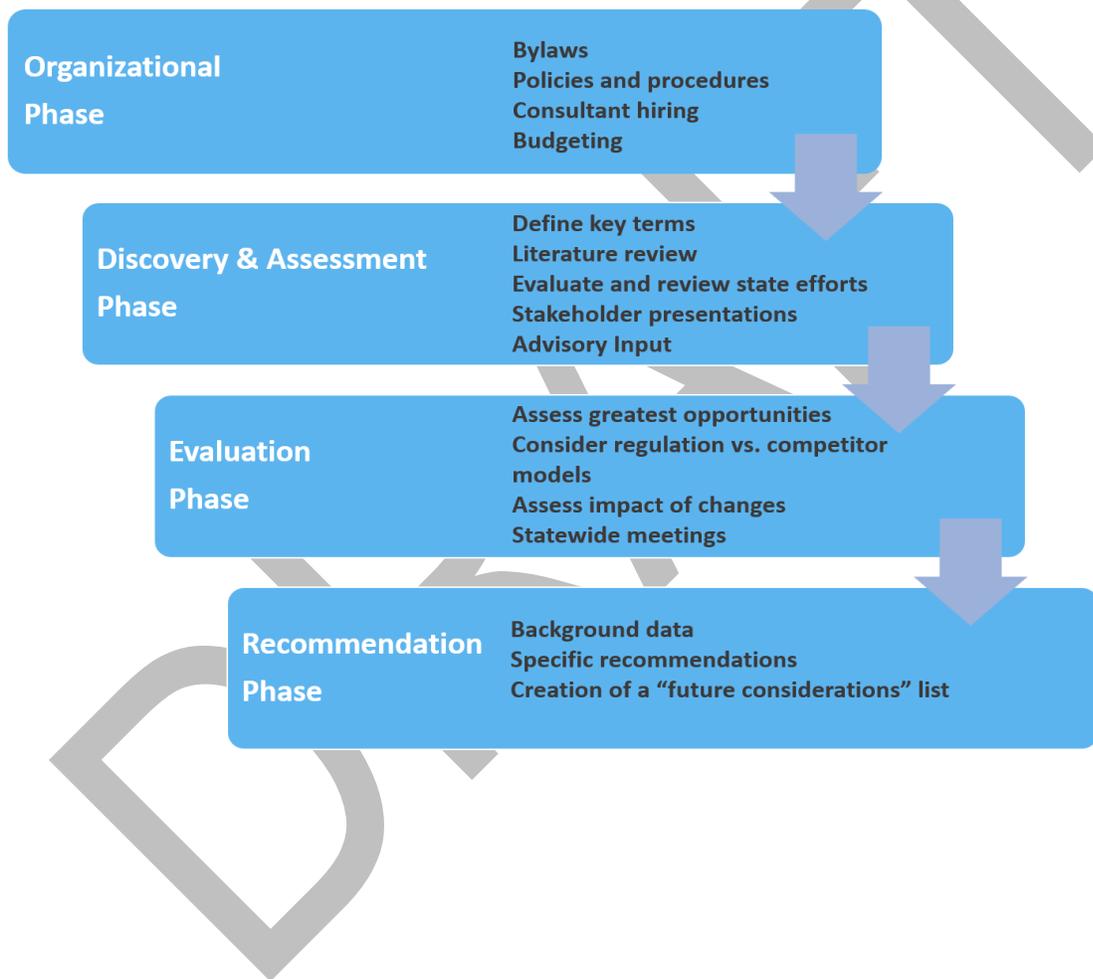
The drivers of health care spending growth are complex and multi-faceted. Just as no single driver is responsible for our high and rising health care costs, no single policy solution will be

adequate to meet this challenge. The Commission must take the time to carefully evaluate the data and evidence to understand the effects of any of its final policy recommendations.

Timeline of Work

There are four phases to the work of the Commission. The Commission completed the Organizational Phase which included the establishment of governing and decision-making policies, and is in the midst of the Discovery & Assessment Phase.

The remainder of the Commission’s work will focus on developing recommendations for the Colorado General Assembly and Governor’s Office based on further analysis of the information gathered to-date, additional research and comparative models, and input from key stakeholders and members of the public and professional community across Colorado.



IV. Stakeholder Engagement

Statewide input forms the bedrock of the Commission's work.

The Commission's meetings are broadcast via ReadyTalk, a user friendly and reliable technology, so that the public and Commissioner participation is not limited by the location of the meetings in Denver. All Commission meetings are noticed a week prior on the website and through an interested party listserv and all meetings have several opportunities for public comment.

Following its first year of work, analyzing the fundamental drivers of health care spending and hearing from experts, the Commission will create mechanisms to gather statewide feedback on multiple relevant topics. The Commission distributed a questionnaire to health care stakeholders and received a series of responses from ClinicNet, Colorado Academy of Family Physicians, Colorado Association of Health Plans and AHIP, Colorado Business Group on Health, Colorado Coalition for the Medically Underserved, Colorado Community Health Network, Colorado Foundation for Universal Health Care, Colorado Hospital Association, Colorado Medical Society, Colorado Nursing Association, Colorado Telehealth Network, COPIC, Health Care for All, LiveWell, and PhRMA.

The questionnaire and responses can be found in the appendices. The Commissioners are reviewing the submitted questionnaires and will invite stakeholders to provide additional information and perspective as the Commission moves through its deliberations.

In an effort to build on this expert input, the Commission will conduct nine statewide community meetings in early 2016 to gather reactions and feedback on its work and recommendations. These meetings will be held in Arapahoe County, Greeley, Colorado Springs, Alamosa, La Junta, Grand Junction, Summit County, Denver, and Adams County. These meetings will not only provide vital input to Commission's work and recommendations to-date, but also build support for and community ownership of its eventual recommendations.

This buy-in is essential to the Commission's long-term success and its ability to meet its legislatively mandated goals. These mechanisms include a questionnaire to key communities and stakeholders, an electronic survey, working with key organizations and individuals that have community standing and presence to do outreach, as well as using the new Commission website to solicit feedback, www.colorado.gov/cocostcommission.

V. Health Care Spending in Colorado

Spending on health care in the United States has increased dramatically over the past two decades, and Colorado's health care spending has mirrored that trend.

At the request of the Commission, the Colorado Health Institute (CHI) drew on a number of resources to gather data and provide an analysis of spending on personal health care in Colorado over the past two decades.

CHI provided analytical reports to the Commission that delved into spending by a number of different criteria, including:

- Spending by types of service, such as hospital care, physician care, pharmaceutical and other durable medical products, home health care and many more.
- Spending by types of payer, such as commercial insurance, public insurance programs and out-of-pocket expenditures.
- Spending by age group.
- Spending on a per-capita basis over the years.

The information in this chapter is based on those analyses. The data shine a spotlight on where each health dollar is going in Colorado, providing a foundational understanding as policymakers target their efforts to rein in costs and spending in both private and public sector markets.

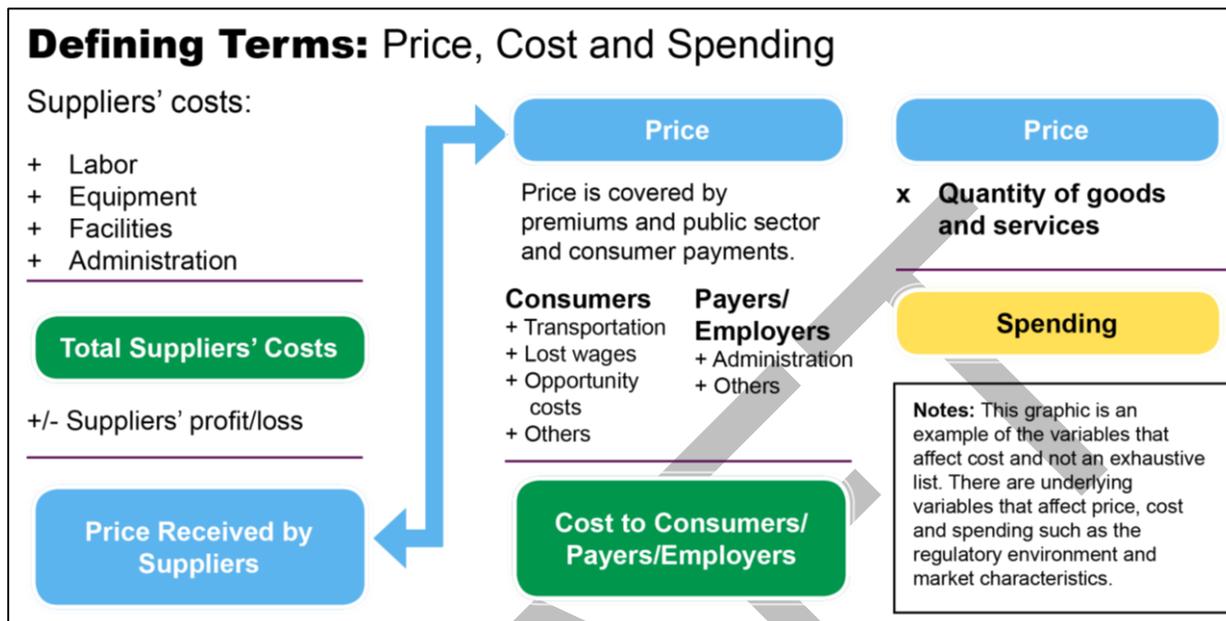
This data in partnership with literature reviews and stakeholder input will focus the work of the Commission on areas of greatest cost by service, payer, disease or condition, and age. The data that follow are based upon 2009-2013 data, which is the latest available.

Defining Cost, Price, and Spending

The Commission's Research Committee spent time to reach agreement on how to define the basic terms — price, cost, and spending — related to the work of the Commission and its mission to analyze health care costs and make policy recommendations on how to lower those costs. (See [Figure 1.](#))

- **Cost:** The resources it takes for health care suppliers to produce goods or services, including labor, equipment, facilities and administration.
- **Price:** Amount received by health care suppliers in exchange for their goods or services. When prices are higher than suppliers' costs, profits are generated; when prices are lower than suppliers' costs, losses occur. These prices are paid by insurance premiums, public sector programs, and consumers.
- **Spending:** The price of the goods or services multiplied by the quantity purchased. This means that both price and quantity impact total spending.

Figure 1.



Delving into these definitions reveals nuances. For instance, consumers face additional “costs” besides what they pay for premiums or their out-of-pocket share. These include, among others, transportation, lost wages, and the opportunity to spend their time and money on other goods or services. Payers and employers also face additional costs, including administration.

Because there are little data on the cost of different products and services, the Commission has focused its analysis on the spending side of the equation.

Understanding the relationship between price and quantity, meanwhile, is crucial to the policy discussion. Although the price of a specialty drug may be \$10,000 a dose, if only a few Coloradans use it, cutting the price would do little to reduce health care spending here. On the other hand, the price of a doctor’s office visit might be \$100, but it is a service purchased millions of times a year in Colorado.

$$\text{Price} \times \text{Quantity} = \text{Spending}$$

It is important to note that the price may not always cover suppliers’ costs. When the price does not cover costs, suppliers will lose money. They will have to cross subsidize from other profitable service lines or take on debt to stay in business. However, when the price exceeds costs, suppliers will make a profit. Prices that are “administered,” or set by payers without using the market demand to set prices may or may not cover costs.

Health Spending in Colorado: Research Analysis

Personal health care expenditures in Colorado reached an estimated \$36.3 billion in 2013. That's an increase of 327 percent over the past two decades, compared to 216 percent in the United States. And spending in Colorado has more than doubled from 2000, when it stood at \$16.3 billion. Since 2000, cumulative inflation in Colorado has been much lower at 33.3 percent.²

Personal health care expenditures, unlike total health care expenditures, do not include items such as research, structures, equipment, government public health activities, program administration, and the net cost of private health insurance. It accounts for roughly 80 percent of all health care spending.

CHI based its analyses on personal health care expenditures because the data from the U.S. Centers for Medicare & Medicaid Services are the only data that are available at the state level.

While personal health care expenditures have increased significantly in Colorado, however, residents of many other states are spending more.

Colorado's per capita personal health care spending of \$5,994 in 2009 was the nation's seventh lowest. Utah was the lowest at \$5,031 and most of the other states with relatively low spending were also in the Intermountain West.

The District of Columbia had the highest per capita spending of \$10,349, followed by Massachusetts at \$9,278.

Expenditures by Types of Services

Hospital care accounts for the greatest share of personal health care spending in Colorado. It was an estimated \$13.5 billion in 2013. This means that 37 cents of each dollar spent on personal health care in Colorado went for hospital care in 2013. (See [Figures 2](#) and [3](#)). Physician and clinical services came in second at \$9.6 billion in 2013.

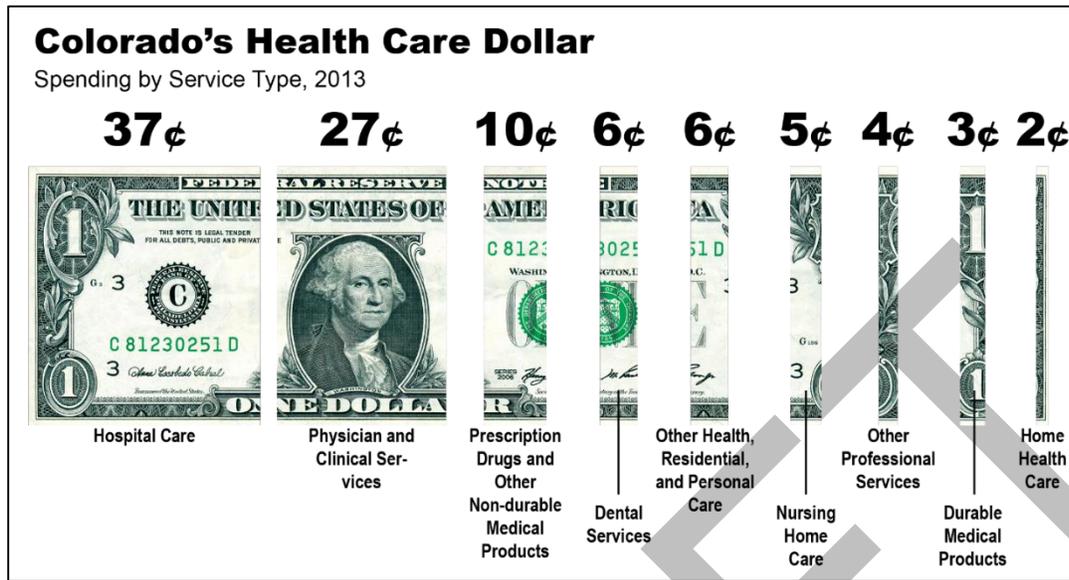
These two categories have been the top expenditures over the past two decades, and together account for nearly two-thirds of annual personal health care spending in Colorado.

The prescription drugs and other non-durable category was third at \$3.8 billion.

On the other end of the spectrum, home health care expenditures were \$866 million, or two cents of every dollar.

² U.S. Bureau of Labor Statistics

Figure 2.

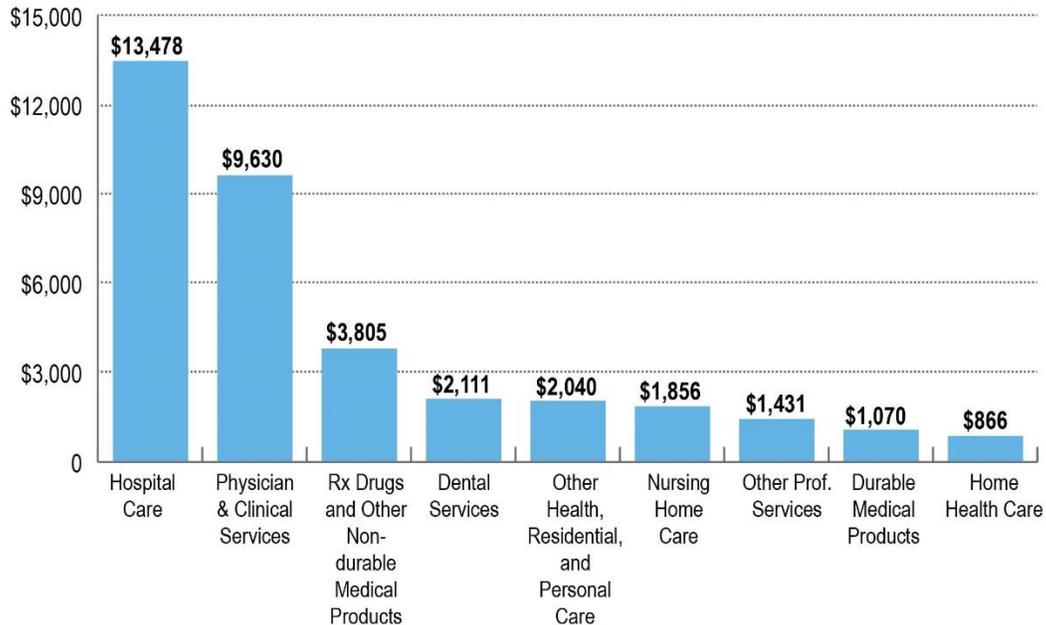


Source: National Health Expenditure Accounts, CMS, Office of the Actuary, 2011 and 2014

Figure 3.

Spending on Health Care Services in Colorado, 2013

In millions of dollars



Source: National Health Expenditure Accounts, CMS, Office of the Actuary, 2011 and 2014

Growth in Expenditures by Types of Services

While spending on personal health care services increased dramatically between 1991 and 2013, the state population grew by 56 percent during this time frame. But population growth alone does not explain all of the increase in personal health care spending.

Spending per person has increased nearly 175 percent over the past two decades. In 1991, personal health spending for each Coloradan was \$2,511. By 2013, per capita spending was \$6,893. While the nominal increase in per capita personal health spending was 175 percent during this time frame, Colorado's per capita GDP grew in nominal terms by 132 percent. To put these numbers in context, cumulative inflation was 84 percent.

Comparing three time periods — 2000 to 2005; 2005-2010; and 2010 to 2013 — finds that the lowest annual growth rate occurred between 2010 and 2013, when it was 3.6 percent. The highest was between 2000 and 2005, when it was 5.7 percent. (See [Figure 4](#).)

Figure 4.

	2000-2005	2005-2010	2010-2013
Average Annual Growth in Total Nominal Personal Health Care Services, Colorado	5.7%	4.5%	3.6%
Average Annual Inflation, Colorado	2.0%	2.2%	2.8%

Source: CHI estimates using data from the National Health Expenditure Accounts, CenCMS, 2011 and 2014.

There is not consensus on the reasons for the slowdown in growth in recent years. However, likely factors include:

- A weak economy, leading to reduced demand for services of all sorts.
- [Early or preliminary payment reform efforts implemented by the federal government that changed the way in which Medicare compensated hospitals for hospital re-admissions.](#)
- [Increases in hospitals' productivity for certain conditions and movement to outpatient care.](#)
- Changes made by health care providers' practice behavior in anticipation of the Affordable Care Act and other reforms.
- [The increased prevalence of high deductible plans, which lead to higher cost sharing and put pressures on consumers to reduce their consumption of health care services.](#)

Overall personal health care spending grew by 327 percent since 1991, but some services experienced faster growth than others. (See [Figure 5](#)).

The home health category, for instance, posted the fastest growth. It increased 584 percent, from \$127 million in 1991 to \$866 million in 2013. However, it's important to note that home health care is still the smallest category of spending, despite this rapid growth. This growth reflects a shift away from more expensive institutional-based care.

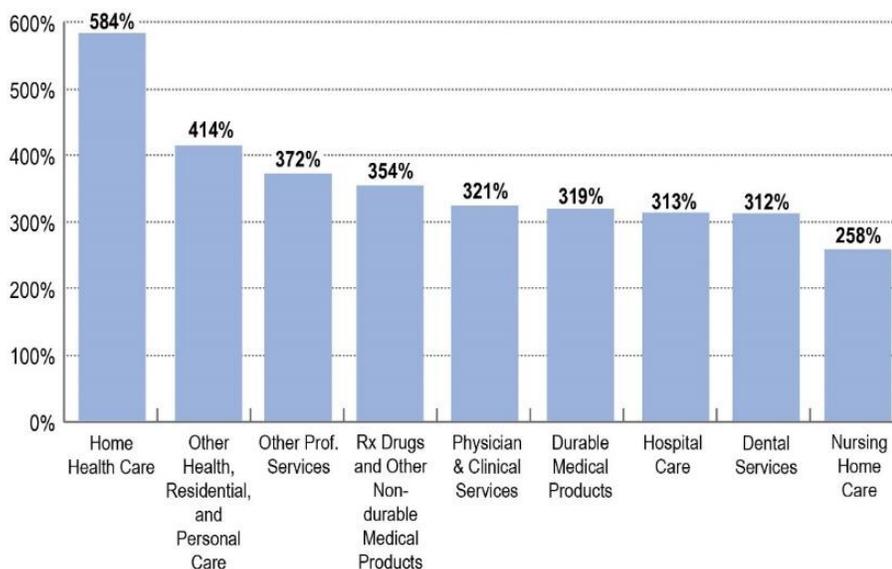
Spending on the category called "other health, residential and personal care" increased by 414 percent, the second-highest growth rate, reaching an estimated \$2.1 billion in 2013.

The biggest expenditure categories — hospital services and physician and clinical services — grew at a slower clip, with hospital services climbing 313 percent from \$3.3 billion in 1991 to an estimated \$13.5 billion in 2013. The physician and clinical services category grew 321 percent from \$2.3 billion in 1991 to an estimated \$9.6 billion in 2013.

Meanwhile, spending on nursing home care increased by 258 percent, making it the slowest growing category. This trend reflects the U.S. Supreme Court’s 1999 ruling that people with disabilities must reside in the community instead of institutions when certain conditions are met. This also explains the increase in home health and personal health services over the same timeframe. [This illustrates how reducing utilization in one area of the health care economy can increase utilization in others.](#)

Figure 5.

Growth in Spending on Health Care Services in Colorado, 1991-2013



Source: National Health Expenditure Accounts, CMS, Office of the Actuary, 2011 and 2014

Expenditures by Payer

Commercial insurance is Colorado’s largest type of payer, accounting for 41 cents of each expenditure dollar in 2013. (See [Figure 6.](#)) More than 60 percent of Coloradans were commercially insured in 2013, according to the Colorado Health Access Survey (CHAS), either by employer-sponsored insurance (52.6 percent) or through the individual market (8.2 percent).³

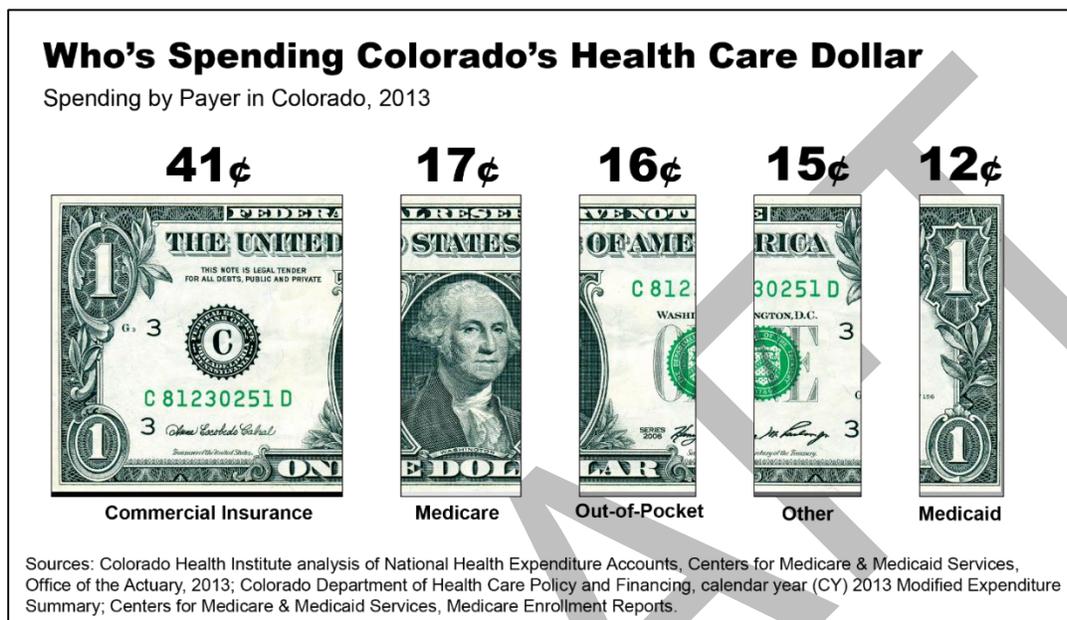
Medicare, the public insurance program for seniors and the disabled that is funded with federal dollars, was Colorado’s next biggest payer. It accounted for 17 cents of each expenditure dollar in 2013, but covered 11.4 percent of the population.

³ Colorado Health Access Survey 2015. Colorado Health Institute website. http://coloradohealthinstitute.org/uploads/downloads/2015_CHAS_for_Web_.pdf. Accessed Oct. 2, 2015.

Out-of-pocket spending by consumers came in third at 16 cents of every dollar.

And Medicaid, the federal-state public insurance program for those with the lowest incomes, was fourth at 12 cents of each dollar in 2013 when Medicaid covered 11.6 percent of the population.

Figure 6.



These 2013 estimates reflect spending before many insurance reforms and policy changes associated with the federal Affordable Care Act, also referred to as Obamacare, were implemented on January 1, 2014. These changes, including Medicaid expansion, launch of the health insurance marketplace, availability of subsidies in the individual market and the prohibition against denying coverage based on pre-existing conditions or historical claims experience.

The addition of a Medicare prescription drug benefit in 2006 (Medicare Part D) accelerated Medicare expenditures for pharmaceutical drugs, according to national estimates. Some analysis shows that after the implementation of Medicare Part D some other health care expenditures declined for some Medicare beneficiaries who did not have prescription drug coverage previously. Nonetheless, as the Baby Boom generation ages, total Medicare spending will grow even more in the coming years.

Asked to analyze changes in what the state and federal governments spend on Medicaid medical services in Colorado over the past decade, CHI found that total medical services premiums grew by 142 percent, from \$1.9 billion in fiscal year (FY) 2003-04 to \$4.6 billion in FY 2013-14.⁴

⁴ Based on data from the Nov. 1, 2014, Executive Budget Request submitted to the General Assembly by the Colorado Department of Health Care Policy and Financing. "Medicaid medical services premiums" are those funds expended by the state and federal governments to cover Medicaid enrollees' physical health services.

Spending by Disease or Condition

While Colorado-specific data for spending by disease or condition are not available, the Commission reviewed national data. Based on other analyses conducted by CHI, we do not expect that the relative magnitude of spending by disease is substantially different in Colorado than the rest of the country.

Circulatory conditions, the largest category at \$235 billion, accounted for more than 13 percent of national health care spending in 2010. (See [Figure 7.](#)) Ill-defined conditions, those not easily diagnosed by a physician, and musculoskeletal conditions made up more than 10 percent each of national health care spending.

Infectious diseases, meanwhile, were the third-smallest category of health care spending at \$58 billion. Pregnancy and childbirth were the lowest at \$38 billion.

Figure 7. Medical Services Expenditures by Disease and Condition, U.S., 2010

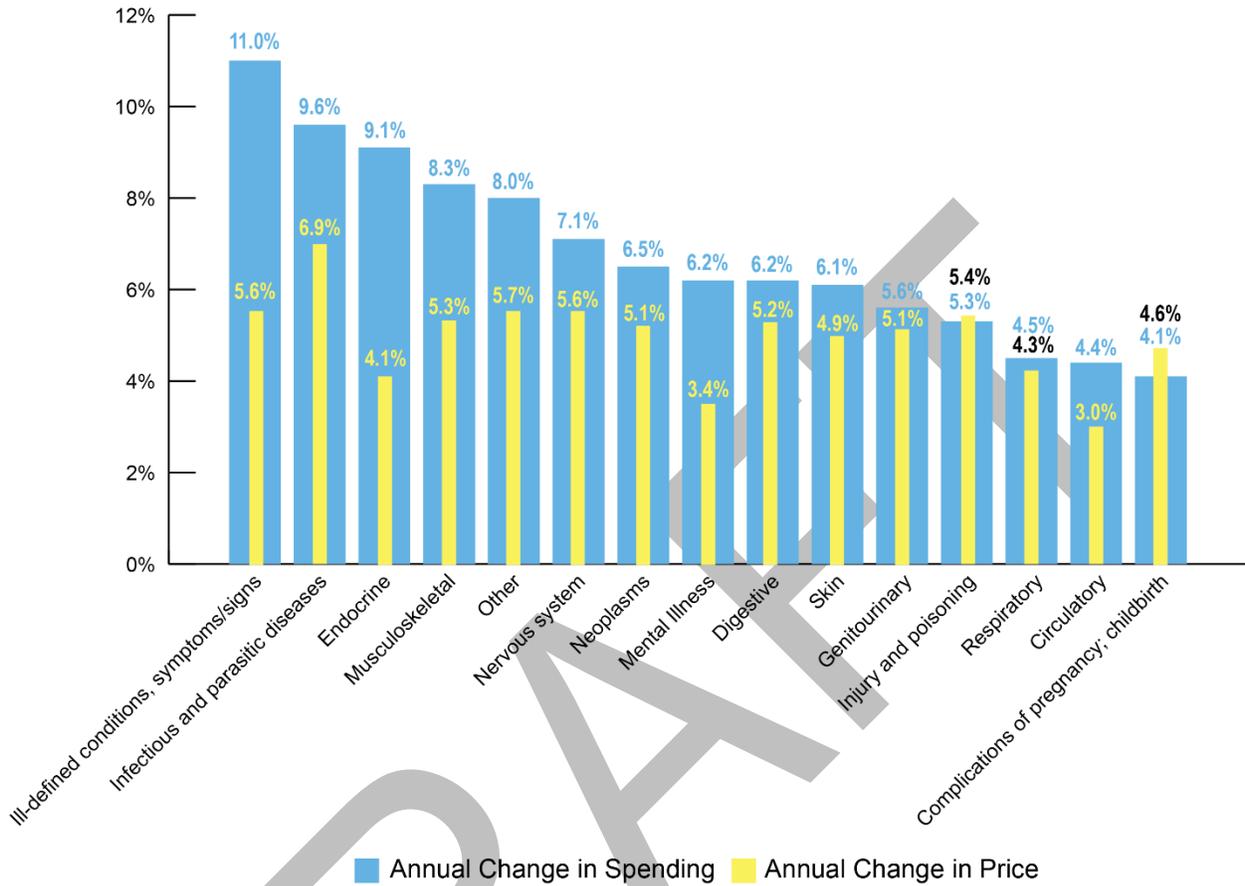
Condition	Annual spending
Circulatory	\$235 billion
Ill-defined conditions	\$207 billion
Musculoskeletal	\$170 billion
Respiratory	\$144 billion
Endocrine	\$126 billion
Nervous system	\$120 billion
Neoplasms	\$116 billion
Genitourinary	\$111 billion
Injury and poisoning	\$110 billion
Digestive	\$102 billion
Mental illness	\$79 billion
Other	\$70 billion
Infectious and parasitic diseases	\$58 billion
Skin	\$38 billion
Pregnancy and childbirth	\$38 billion

Prices and spending by condition have grown at uneven rates. (See [Figure 8.](#)) For example, spending for circulatory diseases increased by 11 percent annually, but the average prices paid, or reimbursement rates, went up by 5.6 percent annually. This most likely means that the remaining increase in spending growth for circulatory diseases has been driven by higher use or intensity of services, not by unit increases in reimbursement or price increases.

On the other hand, spending on childbirth complications increased by 4.1 percent, while the prices, or rates paid, went up 4.6 percent. This most likely means that higher prices were the major driver of increased spending in this area rather than increased demand.

Figure 8.

Average Annual Compound Growth Rates in Spending and Prices by Disease and Condition, U.S., 2000-2010



Spending by Age

Health care spending increases with age.

CHI estimated that spending for adults aged 85 and above was about \$31,600 on a per capita basis in 2013, nine times more than children ages 18 and under. (See [Figure 9](#)).

When analyzing the rate at which per capita spending increases, essentially telling us when spending on health care really heads higher, the largest percentage increase – 107 percent — was between the group aged 65 to 84 and the 85+ age group.

But the 85-plus age group accounts for just a small share of Colorado’s population — and its overall health care spending.

Nearly one-third of all health care spending was posted by the 45- to 64-year age group in 2013. (See [Figure 10](#)). Next up was the 65- to 84-year age group at \$8.7 billion.

Figure 9.

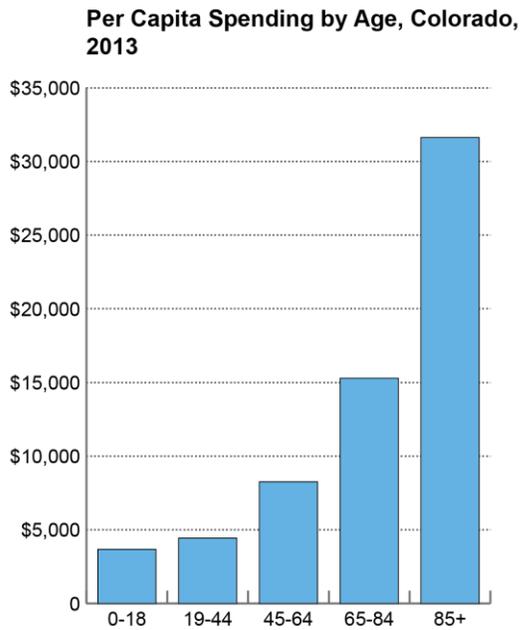
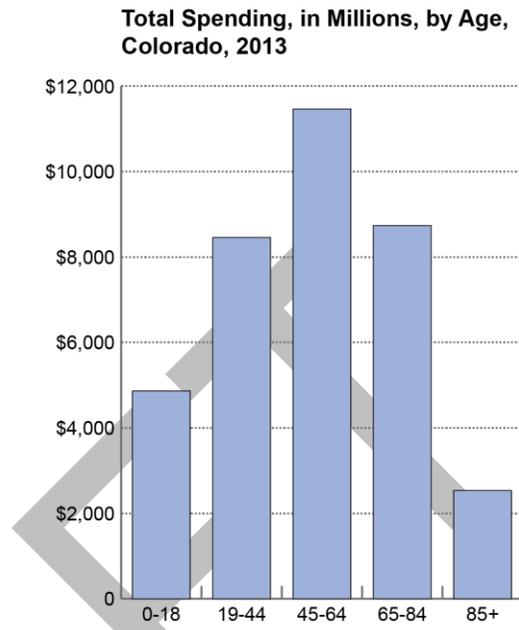


Figure 10.



Per capita expenditures illustrate average spending across a population, but don't account for the variation among populations. It is important to note that these variations can be large. For example, according to the Medical Expenditure Panel Survey, among those individuals in the United States 65 and older, the top five percent of spenders account for \$65,600 in per capita spending, the lowest 50 percent of spenders account for \$1,689 in per capita spending.⁵

⁵ Paschchenko and Porapakkarn, "Medical Spending in the U.S.: Fact from the Medical Expenditure Panel Survey Dataset," July 15, 2015. Available at: https://mpr.aub.uni-muenchen.de/65630/1/MPRA_paper_65630.pdf

VI. The Colorado Framework

Colorado, in many ways, has been a national leader in working to rein in health care costs and spending. It has seen many efforts, some small and some sweeping, to tackle this challenge.

Although there are many programs underway in Colorado to address health care spending, this is a survey of several programs in Colorado that have shown proven savings. These programs hold lessons for policymakers moving forward.

Accountable Care Collaborative

Lead Organization: Colorado Department of Health Care Policy and Financing (HCPF)

Time Frame: It began in 2011 and is ongoing.

Funding Source: Medicaid

Big Ideas: Seven Regional Care Collaborative Organizations (RCCOs) are responsible for coordinating care, developing networks, referring patients and reporting data. Medicaid clients assigned to the RCCOs are connected with a primary care medical home where they build a relationship with a provider. Payments are made on a fee-for-service basis, with participating RCCOs and providers getting a base payment plus incentive payments if they reach the program's targets.

Intended Results: Improve member health, improve the experience of members and providers, and contain costs. Key performance indicators include reducing emergency department use, cutting hospital readmissions within 30 days of discharge, using less high-cost imaging, and increasing well-child visits.

Actual Results: There have been no savings from children. Participating adults at first used more emergency department care and imaging services and had higher hospital readmissions, but use decreased after six months of enrollment, suggesting a pent-up demand for services among newly insured clients.

Savings: Net savings totaled between \$29 million and \$33 million in FY 2013-14. This is between 0.5 percent and 1 percent of total spending on Medicaid medical services premiums.

21st Century Care

Lead Organization: Denver Health

Time Frame: Between 2012 and 2015

Funding Source: Federal Health Care Innovation Challenge Grant from the Centers for Medicare & Medicaid Services (CMS)

Big Ideas: Establish a team-based, patient-centered medical home for 130,000 patients at Denver Health. The patients were placed into four tiers of services based on need. Services ranged from simple assistance, such as text message appointment reminders, to more complicated arrangements, such as integrated behavioral health services, complex care coordination, and care transition support, and specialized, high-risk clinics.

Intended Results: Over the three-year grant period, Denver Health intends to save money by reducing in-patient and emergency department use; offering this enhanced access to care for 15,000 patients; improving overall population health for Denver Health patients; reducing total cost of care by 2.5 percent relative to the overall trend; and reducing CMS spending by \$12.8 million relative to the overall trend.

Actual Results: Preliminary results exceeded the access goal of 15,000 people. Among adult high-risk patients, inpatient use dropped between FY 2011-12 and FY 2013-14. Access to

primary care services for adults increased slightly during this time frame as reported by the Healthcare Effectiveness Data and Information Set (HEDIS).⁶

Savings: Medicaid claims expenditures dropped an estimated 2.7 percent during the first 11 months of the program, according to an analysis conducted by Milliman.⁷

Bridges to Care

Lead Organization: Metro Community Provider Network

Time Frame: Between 2013 and 2015

Funding Source: Healthcare Innovation Challenge Grant from the Centers for Medicare and Medicaid Innovation (CMMI)

Big Ideas: Patients in two Aurora ZIP codes with more than three hospital visits in a six-month period were identified and enrolled in a home visit program that provided intensive care coordination, education and mental health services for eight weeks after a hospital admission or emergency room discharge.

Intended Result: Better and more cost-effective care for frail seniors and people with disabilities.

Actual Results: All users reduced the number of emergency department and hospital admissions. Mid- to high-utilizers saw the greatest decline. More than nine of 10 patients (94 percent) were successfully linked to primary care providers within 60 days after graduating from the program and 89 percent of those who lacked a primary care physician before the class had one after the class was over.

Finally, 24 percent of the uninsured participants had health insurance by graduation.

Savings: \$1.1 million over a six-month period.⁸

Colorado Beacon Consortium (CBC)

Lead Organization: Rocky Mountain Health Plans (lead), Quality Health Network, Mesa County Physicians Independent Practice Association, and St. Mary's Hospital

Time Frame: Between 2010 and 2012

Funding Source: U.S. Department of Health and Human Services

Big Ideas: Use data to improve medical care in the Grand Junction area by investing in Quality Health Network's existing health information exchange, allowing it to add new data sources, develop a regional data platform, and deploy high-value applications for community-wide interoperability.

Intended Results: Improve quality of care for patients with asthma, diabetes, and heart disease. Reduce unnecessary emergency department visits and hospital admissions. Reduce health risks associated with obesity and depression. Strengthen a secure health information exchange at the community level.

Actual Results: Increase in tobacco counseling, decrease in patients with high cholesterol. Quality Health Network has added three hospital system interfaces and two reference laboratory system interfaces, upgraded or improved four hospital systems, and successfully linked to more than 30 electronic medical record systems used by 150 providers.

⁶ [Colorado Medicaid HEDIS 2014 Results, Statewide Aggregate Report, December 2014.](#)

⁷ Personal correspondence with Tracy Johnson, PhD, Investigator, Denver Health

⁸ Bridges to Care Program Evaluation Final Report. Prepared for Metro Community Providers Network by Smith and Lehman Consulting. December 19, 2014.

Savings: At least \$3.1 million in hospital readmission spending for Medicaid adults and dual eligible patients (those eligible for both Medicare and Medicaid). Colorado Medicaid awarded \$2.2 million in shared savings to CBC participants. Beacon practices, though, had mixed results, with a slight trend toward lower costs for providers 2011, but higher costs in 2012. The results were inconclusive.⁹

Colorado's Blue Ribbon Commission for Healthcare Reform

Recommendations from Colorado's Blue Ribbon Commission for Healthcare Reform laid the groundwork for health reform in Colorado.

Passed by the General Assembly in 2006, it was known as the 208 Commission because it was created by Senate Bill 06-208.¹⁰ It was charged with identifying strategies to expand health care coverage and reduce health care costs for Coloradans. Its final report went to lawmakers in January 2008.¹¹

Many of the 208 Commission's 32 recommendations have been put into practice, either through state action or federal law, notably the Affordable Care Act.

This section classifies each of the recommendations as implemented, partially implemented or not implemented. The classification is based on legislation that has been passed since the 208 Commission ended. (In some cases, sub-recommendations have different classifications, which are noted.)

The numbers on the main recommendations refer to the original sequence of the commission's final report. The final report was not supported by all of the members of 208 Commission and included two minority reports.

Implemented

1. Slow the rate of growth of employer and private health insurance premiums by covering the uninsured and increasing Medicaid provider reimbursement rates as a means of minimizing cost-shifting. **Partially implemented.**
 - a. Reduce uncompensated care by covering at least 85 percent of the uninsured in Colorado. **Partially implemented.**
 - b. Reduce cost-shifting by increasing Medicaid provider reimbursements. **Partially implemented.**
2. Reduce employee health insurance premium costs. **Not implemented.**
 - a. Require Colorado employers to establish at least a Section 125 premium-only plan that allows employees to purchase health insurance with pre-tax dollars. **Not implemented.**
 - b. Provide sliding scale subsidies for uninsured low-income workers below 400 percent of federal poverty level (FPL; i.e., annual income of about \$80,000 for a family of four)

⁹ Colorado Beacon Consortium Fact Sheet. Office of the National Coordinator for Health Information Technology. October 25, 2012. <http://www.healthit.gov/sites/default/files/beacon-factsheet-colorado.pdf>

¹⁰ State of Colorado website. Blue Ribbon Commission for Healthcare Reform page.

<http://www.colorado.gov/208commission/>

¹¹ State of Colorado website. Final Report.

<http://www.colorado.gov/cs/Satellite/BlueRibbon/RIBB/1201542097631>

- to purchase their employer's plan. **Not implemented.**
3. Reduce administrative costs. **Partially implemented.**
 - a. Require health insurers and encourage all payers in Colorado to use standard claims attachment requirements, eligibility and coverage verification systems, electronic ID cards and prior authorization procedures; and uniform insurance application forms. Adopt nationally-recognized standards that have been accepted by industry groups but not yet implemented. **Partially implemented.**
 - b. Combine administrative functions of public health insurance programs (such as Medicaid, CHP+, premium subsidy program, CoverColorado). **Partially implemented.**
 - c. Review regulatory requirements on third-party payers and providers with the goal of reducing administrative burden. **Not implemented.**
 4. Increase use of prevention and chronic care management. **Partially implemented.**
 - a. Where allowed by federal law, allow health insurance premiums to be reduced for enrollees who engage in healthy behaviors. **Partially implemented.**
 - b. Eliminate patient copayments for preventive care and reduce patient copayments for chronic care management services. **Partially implemented.**
 - c. Encourage employers to provide workplace wellness programs. **Partially implemented.**
 - d. Encourage individual responsibility for health, wellness and preventive behavior. **Implemented.**
 - e. Increase funding for local public health agencies in Colorado to perform such functions as preventing disease and injury, assessing community health and promoting healthy behavior. **Partially implemented.**
 5. Conduct a comprehensive review of current Colorado and national long-term care information to understand challenges and opportunities and identify appropriate strategies for reform. **Implemented.**
 6. Improve end-of-life care. **Partially implemented.**
 - a. Develop strategies to foster clinically, ethically and culturally appropriate end-of-life care, including palliative and hospice care, based upon best scientific evidence. **Partially implemented.**
 - b. Ask patients, upon entry to a nursing home, home health agency or other critical point of access, to complete an advanced directive. **Partially implemented.**
 7. Commission an independent study to explore ways to minimize barriers to such mid-level providers as advanced practice nurses, dental hygienists and others from practicing to the fullest extent of their licensure and training. **Implemented.**
 8. Provide a medical home for all Coloradans. **Partially implemented.**
 - a. Enhance the provision, coordination and integration of patient-centered care, including "healthy handoffs." **Implemented.**
 - b. Reimburse providers for care coordination and case management, particularly in the Medicaid/CHP+ and CoverColorado programs. **Partially implemented.**
 - c. Provide targeted case management services for Medicaid patients. **Partially implemented.**
 9. Support the adoption of health information technology. **Implemented.**
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- a) Support the creation of a statewide health information network, focusing on interoperability and building upon regional efforts already in place for sharing data among providers. **Implemented.**
- b) Support the creation of an electronic health record for every Coloradan, with interoperability across health plans and hospitals systems and protections for patient privacy. **Implemented.**

10. Support the provision of evidence-based medicine. **Partially implemented.**

- a. Adopt population-specific care guidelines and performance measures, where they exist, based on existing national evidence-based guidelines and measures, recognizing the importance of patient safety and best care for each patient. **Partially implemented.**
- b. Develop a statewide system aggregating data from all payer plans, public and private. **Implemented.**

11. Pay providers based on quality. **Partially implemented.**

- a. Pay providers based on their use of care guidelines, performance on quality measures, coordination of patient care and use of health information technology. **Partially implemented.**

12. Ensure that information on insurer and provider price and quality is available to all Coloradans and that it is easily accessible through a single entry point (e.g., a Web site). **Partially implemented.**

- a. Make information on insurer and provider price and quality available to all Coloradans and that it is easily accessible through a single entry point. **Partially implemented.**
- b. Require the Colorado Division of Insurance (DOI) to report annually to the legislature regarding financial information on licensed carriers and public programs, including medical loss ratios, administrative costs, etc., by line of business; require Medicaid, CHP+, CoverColorado and other public programs to provide DOI with this information; and require brokers to report their compensation to their clients. **Not implemented.**

13. Promote consumer choice and direction in the health care system. **Partially implemented.**

- a. Provide a choice of Minimum Benefit Plans, including a Health Savings Account option, for all consumers purchasing in the individual insurance market. **Implemented.**
- b. Create a Connector for individuals and employees. **Implemented.**
- c. Increase price and quality transparency. **Partially implemented.**
- d. Provide consumers with evidence-based medical information at the point of service to aid in decision-making through patient-centered care. **Partially implemented.**

14. Examine and expand the efforts of Colorado communities that have been proven over the years to enhance quality and lower cost. **Partially implemented.**

15. Create a multi-stakeholder “Improving Value in Health Care Authority.” **Partially implemented.**

Before implementing the coverage expansions identified in Section 2, the state should establish an Improving Value in Health Care Authority to fundamentally realign incentives in the Colorado health care system to reduce costs and improve outcomes, and identify other means of containing systemic cost drivers. **Implemented.**

- a. Give the Authority rule-making authority to implement the Commission's recommendations regarding administrative simplification, health care transparency, design of the Minimum Benefit Package and the Consumer Advocacy Program. **Partially implemented.**
- b. Direct the Authority to study and make recommendations to the governor, state legislature and rule-making agencies regarding prevention, end-of-life care, medical homes, health information technology, evidence-based medicine, and provider reimbursement. **Partially implemented.**
- c. Direct the Authority to oversee development of a statewide system aggregating data from all payer plans, public and private, building upon regional systems, or efforts already taking place for sharing data among providers. **Implemented.**
- d. The Authority also should be responsible for assessing and reporting on the effectiveness of reforms, especially their impact on vulnerable populations and safety net health care providers. **Partially implemented.**
- e. Establish the Authority before embarking on the improvements to coverage and access. **Implemented.**

16. Require every legal resident of Colorado to have at least a Minimum Benefit Plan, with provisions to make the mandate enforceable. **Implemented.**

- a. Require purchase of a Minimum Benefit plan (average monthly premium of approximately \$200 for an individual). **Implemented.**
- b. Design and periodically review the Minimum Benefit Plan through the "Improving Value Authority." **Not Applicable.**
- c. Provide an affordability exemption or consider another mechanism for addressing affordability, such as extending the premium subsidy program to a higher income level. Assuring affordability should include consideration of both premium and out-of-pocket costs. **Implemented.**
- d. Enforce through tax penalty; automatically enroll those who are eligible into fully-subsidized public coverage programs. **Partially implemented.**

17. Implement measures to encourage employees to participate in employer-sponsored coverage. **Not implemented.**

- a. Require Colorado employers to establish premium-only Section 125 plans that allow employees to purchase health insurance with pre-tax dollars. **Not implemented.**
- b. Provide subsidies for uninsured low-income workers below 400 percent FPL (approximately \$80,000 annual income for a family of four) to purchase their employer's plan. **Not implemented.**
- c. Enforce waiting periods (minimum periods of being uninsured) for eligibility for the premium subsidy program, to discourage employers and employees from dropping employer coverage to enroll in public programs; create exceptions for involuntary loss of coverage, COBRA coverage, or qualifying events, such as marriage or birth. **Not implemented.**

18. Assist individuals and small businesses and their employees in offering and enrolling in health coverage through creation of a "Connector." **Implemented.**

19. Maximize access to/enrollment in private coverage for working lower-income Coloradans who are not offered coverage at the workplace. **Implemented.**

- a. Provide premium subsidies to workers who are not offered coverage at the workplace

who earn less than 300 percent FPL (approximately \$60,000 annual income for a family of four) for purchase of private health insurance equivalent to CHP+ benefit package.

Implemented.

- b. Provide premium subsidies to individuals and families who earn between 300-400 percent FPL (between \$60,000 - \$80,000 annual income for a family of four) such that their premium cost of the Minimum Benefit Plan is no more than 9 percent of their income. (The same subsidy would be available to workers with access to coverage at the workplace.) **Implemented.**
- c. To facilitate enrollment and reduce fraud, use auto enrollment strategies that use existing state data to determine subsidy eligibility (e.g., tax, wage, and nutrition program information). **Implemented.**

20. Require all health insurance carriers operating in Colorado to offer a Minimum Benefit Plan in the individual market. **Partially implemented.**

- a. Require all health carriers offering health insurance in Colorado to offer a Minimum Benefit Plan in the individual market, with an emphasis on value-based and consumer-directed benefit design. **Partially implemented.**

21. Guarantee access to affordable coverage for Coloradans with health conditions (implement in conjunction with Recommendation 16). **Implemented.**

- a. Require health insurance companies to issue coverage (guarantee issue) to any individual or family who applies for individual health insurance and who is not eligible for the restructured CoverColorado program due to a high-cost pre-existing condition ("qualified applicant"). **Implemented.**
- b. Allow health insurance companies to set premiums for these individuals and families based on their age and geographic location; disallow the consideration of past and current health conditions. **Implemented.**
- c. Restructure CoverColorado to cover those who apply for coverage, have a specified high-cost health condition as defined by the newly expanded program, and are not eligible for Medicaid, CHP+ or a premium subsidy. **Not applicable under the ACA.**

22. Merge Medicaid and CHP+ into one program for all parents, childless adults and children (excluding the aged, disabled and foster care eligibles). **Partially implemented.**

- a. Pay health plans at actuarially-sound rates and providers at least CHP+ rates in the new program. **Not implemented.**
- b. For all other Medicaid enrollees, ensure that physicians are reimbursed at least 75 percent of Medicare rates. **Partially implemented.**
- c. Provide the CHP+ benefit and cost-sharing package, including dental, to enrollees in the new program. Provide access to a Medicaid supplemental package, including early and periodic screening, diagnosis and testing (EPSDT) for children, for those who need Medicaid services. **Not Implemented.**
- d. Provide dental coverage up to \$1,000 per covered person per year. **Implemented.**
- e. Require enrollment in managed care, where available.

23. Improve benefits and case management for the disabled and elderly in Medicaid. **Implemented.**

- a. Encourage enrollment of the aged and disabled into integrated delivery systems that have incentives to manage and coordinate care. **Implemented.**

- b. Promote care delivery in a consumer-directed, culturally competent manner to promote cost-efficiency and consumer satisfaction. **Implemented.**
- c. Increase the number of people served by the home- and community-based programs equal to the number of people on the current waiting list for these services. **Implemented.**
- d. Explore potential for further reforms to Medicaid, particularly for those who are disabled. **Implemented.**

24. Improve delivery of services to vulnerable populations. *Partially implemented.*

- a. Create a Medicaid buy-in program for working disabled individuals. **Implemented.**
- b. Create a Medically-Correctable fund for those who can return to work or avoid institutionalization through a one-time expense. **Not implemented.**
- c. Increase number of people served by the home- and community-based programs equal to the number of people on the current waiting list for these services. **Partially implemented.**
- d. Provide mental health parity in the Minimum Benefit Plan. **Implemented.**
- e. Establish a Medically-Needy or other catastrophic care program for those between 300-500 percent FPL (\$30,000 to \$50,000 annual income for an individual) to address the issue of people who have health insurance but do not have coverage for catastrophic events (fund at \$18 million in state funds). **Not implemented.**

25. Expand eligibility in the combined Medicaid/CHP+ program to cover more uninsured low-income Coloradans. *Partially implemented.*

- a. Expand Medicaid/CHP+ to cover all uninsured legal residents of Colorado under 205 percent FPL (approximately \$42,000 annual income for a family of four). **Partially implemented.**
- b. Expand CHP+ to cover children in families earning up to 250 percent FPL (approximately \$51,000 annual income for a family of four). **Implemented.**
- c. Provide assistance with premiums and co-payments to low-income, elderly Medicare enrollees up to 205 percent FPL (approximately \$21,000 annual income for an individual). **Implemented.**
- d. Restrict the expansion to adults with less than \$100,000 in assets, excluding car, home, qualified retirement and educational accounts, and disability-related assets. **Not implemented.**
- e. Work with the federal government to ensure federal funding for low-income childless adults; do not fund expansion through reduction of services to current Medicaid and CHP+ eligible people. **Implemented.**

26. Ease barriers to enrollment in public programs. *Partially implemented.*

- a. Use automatic enrollment strategies to increase enrollment, reduce fraud and lower administrative costs; pursue presumptive eligibility where possible. **Partially implemented.**
- b. Provide one-year continuous eligibility to childless adults, parents, and children in the newly merged Medicaid/CHP+ program. **Partially implemented.**

27. Enhance access to needed medical care, especially in rural Colorado where provider shortages are common. *Partially implemented.*

- a. Continue to pay all qualified safety net providers enhanced reimbursement for serving Medicaid patients. **Partially implemented.**

- b. Explore ways to minimize barriers to such mid-level providers as advanced practice nurses, dental hygienists and others from practicing to the fullest extent of their licensure and training. **Implemented.**
- c. Promote and build upon the existing statewide nurse advice line. **Partially implemented.**
- d. Expand telemedicine benefits for Medicaid and CHP+ enrollees, especially in rural areas. **Partially implemented.**
- e. Develop and expand mechanisms to recruit and retain health care workers who will provide services in underserved areas of Colorado, such as state-based loan repayment, loan forgiveness programs, taxcredits, and other approaches. **Implemented.**

28. Create a Consumer Advocacy Program including an Ombudsman Program. *Partially implemented.*

- a. Create a program that is independent and consumer-directed to guide people through the system, resolve problems, provide assistance with eligibility and benefit denials, help qualify people on Medicare for Medicaid, and help people qualify for SSI. **Partially implemented.**

29. Continue to explore the feasibility of giving Coloradans the option to enroll in coverage that will stay with them regardless of life changes, such as the Optional Continuous Coverage Portable Plan that the Commission modeled. *Not implemented.*

30. Continue to explore the feasibility of allowing employers to offer 24-hour coverage (e.g., all of an employee's health needs, including health and workers compensation claims, are covered by a single insurer). *Not implemented.*

31. Adopt these recommendations as a comprehensive, integrated package but do so in stages, increasing efficiency and assuring access before expanding coverage. *Partially implemented.*

Notable Spending Control Initiatives in Other States

Innovative work is going on across the nation when it comes to health care. This list is a small sample of innovations occurring nationally, with an emphasis on initiatives that have generated the most savings. It includes a diverse array of ideas for both public and private coverage.

California

Entity: California Public Employees' Retirement System (CalPERS)

Initiative: Reference pricing for hip and knee replacements. Procedures are fully covered up to the price that most providers charge, but patients pay the difference if they choose a more expensive provider.

Findings: CalPERS in 2011 saved an estimated \$2.8 million, or 0.26 percent of its total health care spending, for its Anthem enrollees. The limited savings resulted from the fact that few CalPERS enrollees have hip or knee replacements each year — between 450 and 500 — and these procedures account for only about 0.75 percent of CalPERS's total spending.¹²

Massachusetts

¹² <http://www.hschange.org/CONTENT/1397/#ib2>

Entity: Blue Cross Blue Shield Massachusetts

Initiative: Alternative Quality Contract (AQC). The five-year AQC provides rewards to 11 participating physician groups for controlling spending and improving the quality of care delivered to a designated panel of patients. Providers receive a global budget for the entire continuum of care.

Findings: AQC patients with a primary care provider saved two percent in the first year and 10 percent by the fourth year compared with a control group. The positive results are because providers used lower cost methods of care and patients used less care.¹³

Arkansas

Entity: Arkansas Medicaid

Initiative: Bundled payments for five episodes of care: perinatal; attention deficit hyperactivity disorder; upper respiratory infection; total joint replacement for both hips and knees; and congestive heart failure. Providers share in both savings and excess costs. It is coupled with a medical home model.

Findings: 73 percent of Medicaid providers Principle Accountable Providers and 60 percent of Blue Cross Blue Shield Principle Accountable Providers either improved their costs or remained in a commendable or acceptable cost range.¹⁴

Maryland

Entity: State of Maryland

Initiative: Maryland operates the nation's only all-payer hospital rate regulation system. In this system, all third-party purchasers pay the same rate for hospital services. This is made possible by a Medicare waiver.

Findings: The system has limited the growth of per-admission costs, but it has also created pressure to increase the volume of services.¹⁵

Illinois

Entity: Illinois Department of Healthcare and Family Services

Initiative: Illinois Medicaid Redetermination Project. Independent consultants were brought in to verify income, residency, and identity eligibility for all Medicaid applicants.

Findings: Around 100,000 people were deemed ineligible, though the state will not save as much money as it had hoped because many of them were not using services.¹⁶

Indiana

Entity: Indiana Medicaid

¹³ <https://www.bluecrossma.com/visitor/pdf/avalere-lessons-from-aqc.pdf>

¹⁴ <http://www.achi.net/Content/Documents/ResourceRenderer.ashx?ID=276>

¹⁵ <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2014-Fact-sheets-items/2014-01-10.html>

¹⁶ <https://www.illinoispolicy.org/more-than-100000-medicaid-enrollees-found-ineligible-for-the-program/>

Initiative: The Healthy Indiana Plan replaced traditional Medicaid in Indiana for all non-disabled adults between the ages of 19 and 64 with consumer-directed health plan options in 2008.

Findings: Since 2008, emergency room use has been seven percent less compared with traditional Medicaid¹⁷, preventive care use is similar to commercially-insured customers and more members choose generic drugs compared with the commercially-insured.¹⁸

VII. Next Steps

The Commission has covered a great deal of ground since its inception. From assessing the progress Colorado has made to looking ahead at the most promising avenues for reform, 2015 has been a watershed year for the Commission. That said, the Commission still has a great deal of work to do to meet its legislative mandate.

The health care arena continues to change at a very rapid pace across the nation and statewide that the need for recommendations related to cost reduction are timelier now than ever.

In many ways, 2016 is the year the Commission moves beyond studies and seeks direct input of all Coloradans. The Commission will build off the information received in the questionnaire and plans to engage more constituents by conducting nine statewide community meetings in the spring of 2016. The Commission's statewide outreach meetings and listening sessions will provide valuable and irreplaceable guidance as its work enters the homestretch. The values and priorities of everyday Coloradans and health care professionals working on the front lines of these issues will guide the Commission's work and final report.

Alongside these outreach efforts, the Commission will continue its work on the identified topic areas. The Commission and its staff will continue to research not only the challenges facing Colorado families, businesses, and agencies, but also solutions identified through public feedback and the Commission's work.

The Commission's ability to realize these plans and meet the promise of Senate Bill 14-187 will depend on additional funding. The Commission's work, as outlined in this report, is already bearing fruit. The General Assembly's commitment to Senate Bill 14-187 and the Commission, will determine the scope and depth of its final recommendations.

¹⁷ Further research needs to be conducted to determine the extent to which co-pays have been collected and impacted utilization.

¹⁸

<https://myshare.in.gov/ISDH/LHDResource/Conference%20Materials/2015%20Public%20Health%20Nursing%20Conference%20Materials/2015%20PHN%20Conference%20Presentations/HIP%202.0.pdf>

Appendix A: Membership of the Commission

Commissioners

<i>Name</i>	<i>City</i>	<i>Area of expertise</i>
Elisabeth Arenales	Denver	From an organization representing consumers and understands consumers with chronic medical conditions
Jeffrey J. Cain, M.D., FAAFP	Denver	Health care provider who is not employed by a hospital and who is a physician recommended by a statewide society or association whose membership includes at least one-third of the doctors of medicine or osteopathy licensed in the state
Rebecca Cordes	Denver	Represents large, self-insured Colorado businesses
Greg D'Argonne	Littleton	Expertise in health care payment and delivery
Steve ErkenBrack	Grand Junction	Represents carriers offering health plans in the state
Ira Gorman, PT, Ph.D	Evergreen	Health care provider who is not employed by a hospital and is not a physician
Linda Gorman	Greenwood Village	Health care economist
Bill Lindsay (Chair/Planning Committee Chair)	Centennial	Represents licensed health insurance producers
Marcy Morrison	Manitou Springs	From an organization representing consumers
Dorothy Perry, PhD	Pueblo	Expertise in public health and the provision of health care to populations with low incomes and significant health care needs
Cindy Sovine-Miller (Vice-Chair)	Lakewood	represents small Colorado businesses
Christopher Gordon Tholen	Centennial	represents hospitals and recommended by a statewide association of hospitals

Ex officio members

Susan Birch, MBA, BSN, RN		Executive Director, Colorado Department of Health Care Policy and Financing
Julie Krow		Deputy Executive Director for Community Partnerships, Colorado Department of Human Services
Marguerite Salazar		Commissioner of Insurance, Colorado Department of Regulatory Agencies
Jay Want, M.D.		The Colorado All Payer Claims Database
Larry Wolk, M.D., MPH		Executive Director, Colorado Department of Public Health and Environment

Appendix B: Methods for Colorado Spending Analysis 2009 – 2013

Colorado-specific data for spending on personal health care by type of service are available only through 2009, while national data are available through 2013.

In order to estimate Colorado spending between 2010 and 2013, CHI compared the extent to which Colorado per capita spending for each type of service exceeded or was below national per capita spending for the same service lines between 2007 and 2009. CHI then applied that difference to the national growth rate for each year between 2010 and 2013 to arrive at a Colorado growth rate.

For example, between 2007 and 2009, per capita spending in Colorado for physician and clinical services was 90.9 percent relative to the growth in national per capita spending. In estimating 2010 Colorado expenditures we applied 90.9 percent to the national growth rate of 2.5 percent to arrive at a Colorado growth rate of 2.2 percent.

After estimating per capita growth rates for each service line for each year, CHI multiplied by the Colorado population to arrive at total state spending.

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