Blue Ribbon Commission on Health Care Reform

Key Author Answers to Commissioner Questions

May 14, 2007

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Note: Questions and answers regarding Comprehensive Health Care Plan for Colorado, proposal #4, will be distributed to Commissioners on Tuesday, May 15th.

Better Health Care for Colorado/Proposal #2

1. **Do subsidies apply to catastrophic coverage as well- if not what provisions exist for lower income people with chronic conditions, LTC needs who may not qualify for base Medicaid program?**

   Yes, subsidies would pay for catastrophic coverage and care for chronic conditions. The Exchange would certify and offer products and consumers would have a choice with coverage provided in numerous ways. Plans on the Exchange could compete by reducing copayments and cost sharing and by offering enhanced benefit packages.

   - ❖ The vast majority of individuals covered by the expansion could be served by a basic benefit plan that provides access to primary care and prevention.
     - A basic benefit plan with first dollar coverage of primary and acute care, services comparable to core benefits in many employer-sponsored insurance plans, and an annual benefit limit would allow the State to cover more people at a lower cost per person. Alternatively, the State could consider reinsurance in place of annual limits.
     - Many of the uninsured are young and relatively healthy.
     - Actuarial data shows that annual medical claims are moderate for most consumers. For instance, the percent of people with high health care costs shows that annual medical claims are less than $10,000 for 95% of the population and less than $50,000 for 99.5% of the population.[1]
   - ❖ Our proposal provides choices to consumers for insurance coverage, including the State's high risk pool (with higher premium subsidies) for those eligible for CoverColorado, and a benchmark plan with more comprehensive coverage and higher cost sharing for those with greater health care needs.
     - For persons with disabilities, the state could explore initiatives to improve outreach and expedite eligibility determinations for those who may be eligible but not enrolled in the existing program.
   - ❖ All insurance products offered on the Exchange would be required to utilize managed care approaches with a "medical home," care coordination, standards to support quality and consumer direction, disease management, and incentives for wellness and healthy behaviors.
   - ❖ Although the solicitation focuses on access to health care for the uninsured, our proposal provides a three-pronged approach to address the uninsured, the elderly, and the existing Medicaid-eligible population. In particular, our proposal builds a more sustainable platform for reform by improving long term care and by strengthening

[1] Medstat 2003 Commercial Population Continuance Table. http://dhfs.wisconsin.gov/healthywisconsin/092606/HealthyWisconsin%20-%20Structure%20Part%202_26Sep06.pdf, slide 11. September 26, 2006.

Medicaid coverage of primary and acute care, including disease management for those with chronic care needs.

- Our proposal strengthens long term care by reducing nursing home utilization and using the savings to invest in expanded access to quality long term care in the community. Also, by implementing a home and community-based care "spend down," consumers can access coordinated and integrated home and community based care and avoid more costly and restrictive nursing home care.

- Of the proposals under consideration by the Commission, only three incorporate recommendations on long term care. Of these, our proposal provides the most comprehensive plan to improve the access, quality and affordability of long term care services. We recommend specific changes in the areas of eligibility, reimbursement, housing, developing a nursing facility right sizing strategy, enhancing the care delivery system, and developing a quality management program.

- Our proposal also creates more targeted interventions for those with chronic disease within the Medicaid program through managed care approaches to enhance disease management and improve access to primary and preventive care.

2. How do you account for potential cost shifting which may occur, for example due to increased ER usage, when you use enforceable cost sharing even for low income persons?

Our proposal would reduce ER usage by providing significant subsidies to low-income uninsured to ensure that access to health insurance is affordable, that cost sharing is reasonable, and that consumers have incentives and education to access care in a more managed and cost-effective environment. Our proposal would also change the delivery system to ensure that primary and preventive care is managed, cost-effective and accessible. Taken together, these initiatives will reduce cost shifting.

Benefits, subsidies, copayments, and other cost sharing would be designed to encourage participation, to prevent crowd-out, and to ensure coverage of the maximum number of Colorado's uninsured citizens within available funding. To address these important goals, cost sharing by federal poverty level (FPL) would be structured as follows:

- Limited copayments only for uninsured with income under 100% of the FPL.

- Copayments and premium payments on a sliding scale based on income up to a maximum of 5% of income for uninsured with income of 100% to 200% FPL.

- Cost sharing could potentially exceed 5% of income for higher income uninsured.

In particular, the reform plan would:

❖ Focus on expanding access to primary, acute, preventive care and non-institutional long term care. By improving access to care in appropriate settings, the proposal will change the delivery system to create an alternative to reduce the reliance on ERs and

inpatient hospitals as the main point of access to provide non-emergency care for the uninsured and nursing facilities for long term care.

- ❖ Utilize copayments to control inappropriate use and to promote access to services in the most appropriate setting. Copayments would range from $10 for primary care office visits, to $50 for non-emergency use of the ER, to $100 for an inpatient hospital admission. As allowed under the federal Deficit Reduction Act, copayments would be enforceable for non-emergency use of an ER. Enforceable copayments, however, are feasible under our proposal because primary and preventive care will be available in a convenient and accessible setting and consumers will be informed, educated, and have incentives to access care in a more cost-effective setting.

- ❖ Waive copayments and required cost sharing through a wellness/healthy behavior incentive to encourage primary and preventive care. In addition, copayments for ER use would also be waived for emergency use of an ER.

3. If no individual mandate and exchange is guarantee issue, community rated - what protects against risk of adverse selection? P. 21.

- ❖ We believe that Colorado's current individual insurance market is largely driven by adverse selection in that those who purchase insurance today tend to be those who have health needs. Younger, healthier individuals are not purchasing insurance.

- ❖ This proposal goes a long way toward mitigating the impact of the current issues of adverse selection by bringing together the combined market forces of a very large new population of insureds, making insurance more affordable by providing subsidies and offering an adequate choice of products in a way that would spread the risk associated with adverse selection across the products insurers will offer.

- ❖ This proposal creates a large new market of individuals to purchase health insurance. In the initial phase, more than 490,000 (64%) of low-income uninsured Coloradans would be able to take advantage of Medicaid-funded subsidies to purchase insurance, including:

    - 139,000 children up to 300% FPL
    - 179,000 parents up to 250% FPL
    - 175,000 childless adults up to 225% FPL

- ❖ Experience in other states suggests that when affordable health insurance products are made available, take-up rates are good and a significant number of individuals will decide to purchase insurance. A report recently issued by the Kaiser Foundation indicates that take up rates can be as high as 90% for individuals whose employers cover more than 90% of the costs of insurance and the individual's contribution is less than 10%; however take up rates steadily decline as the individuals' required contribution increases. When the individual's required contribution approached half the cost of the insurance, the take up rates dropped to less than 70%. We would anticipate the same result in Colorado.

- ❖ Experience in other states, such as Minnesota, Rhode Island and Wisconsin, suggest that extending Medicaid coverage to children and parents as a means to cover more

of the low-income uninsured is an effective strategy. The uninsured rates in these states are 9% to 10%, compared with 16% to 17% nationally and 17% to 18% in Colorado.

- ❖ Additionally, two key features of the Exchange will also promote participation and develop a more balanced pool of new covered lives, thereby reducing the risk of adverse selection, even in the absence of an individual mandate:

    - Individuals will have a choice of products and will be able to select a plan that best meets their health needs. We anticipate that relatively healthy individuals (including "young invincibles") would choose a lower-cost basic benefit plan that offers primary and preventive coverage with an annual benefit limit of $25,000 or $35,000. Individuals with chronic conditions or other health needs would likely select a product with broader coverage, such as a benchmark or a catastrophic coverage plan through the state's high risk pool, CoverColorado. Even if those individuals selected the basic benefit plan, coverage would be limited to the annual cap, so the risk of adverse selection would be mitigated.

    - The Exchange will interface with employers to offer work site enrollment, collect the employer's contribution toward premiums and establish payroll withholding to make it easier for employees to pay their share of premium costs. Coordination with employers will also help to encourage participation of a "natural" pool of workers with a mix of population and health characteristics in the Exchange.

- ❖ A number of states have both guaranteed issue and community rating. These states still have high rates of uninsured and the risk of significant adverse selection because products are not affordable enough to draw in the younger, healthier population.

  Washington State, New Jersey, New York and Pennsylvania all have some combination of guaranteed issue and community rating in the individual and small group markets. The uninsured rates in those states remain close to the uninsured rate for the nation, and only slightly better than Colorado's current uninsured rate.

- ❖ Our proposal creates a platform to reduce the uninsured rate in Colorado to 4%.

An individual mandate would go even further to address concerns regarding adverse selection. While our proposal does not preclude the State from moving toward a mandate, we do not support an individual mandate without access and affordability. Colorado's insurance market and health care delivery system are not adequately positioned for a mandate at this time; affordable health insurance products are not universally accessible for all residents and the capacity of the health care system to deliver care, particularly in rural areas, is not sufficient.

Our proposal lays the foundation for a mandate by ensuring adequate access to affordable coverage for low-income individuals, by enhancing provider rates to support adequate networks and quality care, and by providing a platform for small businesses and remaining uninsured to purchase affordable coverage for their employees. In establishing a mandate, the state would need to develop the appropriate criteria and shared responsibility for individuals, employers, health care providers, insurers, and state,

federal and local units of government to ensure the infrastructure to support, fund, monitor and enforce a mandate.

4. **Currently, physicians must try to accommodate different standards from different payers in Pay for Performance programs. What standards would be used in the Pay for Performance for Providers in your proposal?**

   We recommend that a broad group of stakeholders be established to determine the specific standards for physician pay-for-performance (P4P) development based on the following three principles:

   - P4P program will draw on existing data available to the insurer/program so as to not to increase the burden on physicians.
   - P4P program will be consistent across all products sold through the Exchange and Medicaid managed care plans.
   - Wherever possible the P4P program will rely on measures that have been demonstrated in other states to improve quality, including those measures currently used by other carriers' P4P programs

   Our proposal also recommends pay for performance standards for hospitals and long term care providers to encourage accountability and quality care. In developing these standards we also recommend using broad stakeholder input, measurable standards, and minimizing the administrative burden on providers.

5. **Would your HIFA waiver proposal include using Medicaid funds to allow recipients to purchase private insurance products to achieve broader reach and coverage?**

   Our proposal would not use a HIFA waiver that typically reduces benefits and increases cost sharing of the existing Medicaid population to expand coverage. Instead, our proposal would use a federal Medicaid section 1115 research and demonstration waiver to allow the state to:

   - Significantly expand coverage to the uninsured (including childless adults).
   - Leverage federal Medicaid funding and non-traditional financing arrangements to provide premium subsidies to the uninsured.
   - Ensure flexibility to reform the delivery system (managed care, care management, medical home and long term care), with savings explicitly available to implement reform and coverage expansion.
   - Coordinate with employer-sponsored insurance (ESI), including opt out to ESI, core benefits and cost sharing like ESI, workplace sign-up and payroll withholding.

6. **How would your Medicaid premiums be funded?**

Premium subsidies would be funded by state and federal Medicaid funds, cost sharing from enrollees, tax savings from using pre-tax contributions to fund insurance coverage, and employer contributions.

Funding could also be dedicated from monies now used to cover the uninsured to:

- ❖ Reallocate some or all of Colorado's Medicaid disproportionate share hospital (DSH) funds already spent on the uninsured.

- ❖ Maximize unexpended federal SCHIP allocations.

- ❖ Leverage financing mechanisms approved in comprehensive reform waivers for unmatched state and local health care spending for the uninsured.

- ❖ Create efficiencies in the Medicaid program, including long term care and access to primary and acute care.

  Improve cost-effective access to long term care *[See page 11 of "Better Health Care for Colorado" for a comprehensive list of recommendations]*

  - *Development of Special Needs Plans and Other Integrated Models*. Leverage provisions of the Deficit Reduction Act (DRA) that established Special Needs Plans (SNPs) to integrate Medicare and Medicaid primary care, acute care, prescription drug, behavioral health and long term care services for dual eligibles to meet the important 3 H's of long term care - keeping the individual healthy, happy and at home. In addition, develop other integrated models that ensure access to well-coordinated and high quality long term care.

  - *Consumer Directed Care.* Empower current enrollees, especially baby boomers, to control their health and support program. Make consumer directed care more accessible as a central part of the plan to give consumers a fuller range of health care options. [A CMS-sponsored study found that consumer directed care is less costly than other forms of home care and higher satisfaction rates may postpone nursing facility placements.]

  - *Adjusting Eligibility and Utilization.* Modify long term care reimbursement to encourage appropriate treatment in the least restrictive setting possible to rebalance long term care by right sizing incentives to create a higher quality and more home-like environment in nursing home facilities and by adopting tiered reimbursement for facilities that provide comprehensive health benefits. Increase the threshold for clinical placement into a nursing home facility to ensure that the most restrictive setting (institutional care) is reserved for those with the highest acuity levels.

  - *Commitment to Affordable Housing as a Long Term Care Priority.* Support the transition of individuals from nursing homes to the community by addressing a significant barrier – the difficulty in obtaining housing for lower income seniors. Pursue policy tools like housing set asides or priority placements and the integration of housing experts into the program to address this issue.

- *Quality Management***.** Improve quality by establishing a LTC Quality Management Committee, benchmarks and performance standards, a quality management strategy, a formal backup system, a training program, and a public authority.

- *Staff Training***.** Focus on specialized units (i.e., for Alzheimer's disease), specialized training and consistency in staffing, and transition certified nursing assistants to provide assisted living and consumer directed care.

Strengthen Medicaid and the Health Care System *[See page 12 of "Better Health Care for Colorado" for a comprehensive list of recommendations]*

- *Expand Managed Care Options and Strategies.* Create an efficient and more cost-effective delivery system by strengthening managed care through full risk capitation and PCCM alternatives (primarily in rural areas).

- *Link Hospital Pay to Performance.* Develop a performance-based hospital system to ensure quality and accountability.

- *Improve Pharmacy Benefits Management.* Implement proven strategies to increase efficiency through a preferred drug list, participation in a multi-state purchasing pool and implementation for a specialty pharmacy program to negotiate lower prices, secure supplemental rebates and improve care coordination.

7. Please demonstrate how your proposal would contain health care costs.

The proposal would contain health care costs by reforming the delivery of health care to the uninsured, by improving long term care, and by strengthening the existing Medicaid program. In particular, our proposal would:

❖ Reduce uncompensated care, cost shifting to other payers, and inefficiencies in the current delivery system by providing access to affordable health insurance for the uninsured that leverages market competition, consumer choice and empowerment, managed care principles, incentives for prevention and wellness, and Medicaid-funded subsidies to reduce costs.

❖ Improve long term care by addressing the need for better integration and infrastructure for home and community based services to assure cost-effective care in the least restrictive setting for more Coloradans and reduce future funding requirements for long term care.

❖ Create savings from efficiencies in the current Medicaid program that build a more sustainable framework for reform through initiatives to:

- Improve health care delivery and the overall health status of consumers through care coordination and management to reduce costly ER and inpatient hospital services, P4P, and disease management to reduce long term cost pressures on the program.

- Establish incentives through P4P for hospitals to contain health care costs by reducing re-admission rates, pharmacy errors and hospital acquired infections.

- Leverage pharmacy purchasing strategies to garner savings through a preferred drug list (PDL), a multi-state purchasing pool, and a specialty pharmacy program.

Solutions for a Healthy Colorado/Proposal #5

1. Does your proposal address issues of the underinsured – please explain?

The term "underinsured" is not defined by the 208 RFP and is not commonly used in the health insurance industry, so the term could be interpreted differently by different individuals. If we are to consider the population that is between Medicaid eligibility and financial stability (300% of FPL ?) and may move in and out of insured status periodically as being "underinsured", then, our proposal addresses this population. The creation of an individual mandate coupled with a guaranteed issue, core benefit plan that is subsidized for low income Colorado residents, assures that those populations most likely to become underinsured are guaranteed affordable coverage regardless of their income status.

2. Your proposal caps provider reimbursement in a range of 125% - 150% of Medicare. Currently some physicians charge far more. How will you dissuade exceptionally talented physicians who can command far greater reimbursement that 150% of Medicare from leaving Colorado to practice in a state where they would make far more money?

While there may be a few physicians that receive reimbursement at a much higher rate than 150% of Medicare, our primary concern is making insurance coverage affordable and sustainable to the general population in Colorado. Some of the physicians that currently receive this higher reimbursement rate rarely participate in provider networks; thus they are either balance billing their patients for the difference, or their practice is built on a "private pay" model.

Should there prove to be a particular specialty that would necessitate payment at a higher than 150% of Medicare rate, we believe that accommodation should be made to do so. The reimbursement levels given in our proposal are primarily intended for illustrative purpose. In the case where it would be in the greater good for the general populace to have a particular group of physicians receive a higher rate, the governing board overseeing the implementation of the 208 recommendations should consider such an accommodation. Any accommodation should still be tied to a percentage of Medicare reimbursement so as to avoid further cost-shifting due to government program under payment and funding.

If it can not be shown that the general population would suffer, then no accommodation should be made. It is our belief that all stakeholders will need to make concessions if we are truly serious about reforming our current healthcare system. Our proposal provides a new paradigm for networks by basing compensation on quality of care. This model benefits consumers, insurers and in the long run, medical providers by supporting greater transparency.

3. How do you propose to enforce an individual mandate?

The reality of enforcing an individual mandate is extremely problematic. We believe that complete universal coverage may never be accomplished and therefore a reasonable percentage of the population being covered should be the goal. As stated in our proposal, we believe an individual mandate should be encouraged by creating a **tax incentive** for those who do have coverage and enforced by a Colorado state income **tax penalty** for those residents who do not provide proof of coverage along with their Colorado state income tax return. Those not filing a return will generally be eligible for state assistance programs. Those eligible for assistance will be able to enroll in the limited coverage core benefit plans and will receive subsidy on a sliding scale based on income level. Colorado residents applying for or renewing any state license would also be required to provide proof of health coverage before renewal.

4. Please demonstrate how your proposal will contain health care costs.

The CSAHU proposal primarily contains health care costs be eliminating the ever increasing effects of cost-shifting from the Medicare/Medicaid population to the privately insured sector. The effects of this cost-shifting would be capped at today's level by linking provider reimbursement to the current Medicare Reimbursement Schedule.

Should Medicare devise a new reimbursement scheme in the future, we would recommend a similar linkage be devised.

The other areas that need to be addressed to contain costs are:

- the effect of an aging population leading to increased health care demand
- the cost-shifting from the uninsured to the insured population
- new technologies adding to the cost of care
- limiting coverage for various conditions and/or treatments.

As far as the increased demand caused by an aging population, prevention might be the best remedy. Through the use of an expanded schedule of covered preventive care items, it is our hope that some reduction in emergent/critical care can be achieved. Further use of targeted wellness programs, public education and disease management would also be required. Unfortunately, however, the demographics of our state and nation pose a particular concern that cannot be fully contained.

Requiring all Coloradans to have basic/core health benefit coverage should eliminate/reduce the effects of cost-shifting to the rest of the insured/covered population.

The coverage and reimbursement of new technologies and treatments should be linked to the efficiency of those new treatments as compared to the technology it is replacing. The use of evidenced based outcomes, where applicable, should be part of the review process before a health plan should be required to pay for new technology.

Finally, there may come a time when health care funding may need to make difficult decisions as to what conditions and/or treatments should be covered by a health plan.

While not mentioned specifically in our proposal, we feel that Colorado (and the nation) needs to consider the implementation of some sort of review mechanism that weighs the appropriateness of care based upon the potential outcome. We do not mean to suggest that care should be rationed, but a societal recognition that funding for health care is a limited resource. The resource should be matched with outcome potential.

5. What features of this proposal are designed to strengthen the insurance industry in Colorado and why will this make coverage more accessible and affordable?

Any time the pool of covered lives increases, greater predictability and stability is created. By imposing an individual coverage mandate, greater stability will be created. If a standardized minimum level of core benefits is mandated, carriers will compete on the basis of cost, network and service. This competition, within a more predictable marketplace, that minimizes adverse selection will lower costs. This more stable market along with the state sponsored subsidy for low income residents will serve to make coverage more accessible and affordable.

6. Your proposal addresses access through Medicaid reimbursement rates but not with accessibility to rural Colorado. Could you touch on how your proposal would address this population?

There are many issues with providing access to care, particularly in rural Colorado. One of the issues is attracting and retaining providers in low population density areas. In discussing this question with Mike Gillen, a long time administrator for the Sterling Regional Hospital in Northeastern Colorado, there are several programs that have been successful in bringing providers to rural areas. These programs include "sharing" relationships of certain specialists by several communities and attracting "part-time" doctors into these areas to relieve the 7 day a week work load of existing doctors.

The main issue in attracting and retaining doctors to rural areas, is financial reward. As stated in our proposal, we believe the greatest barrier to access is the cost of health care coverage. A significant percentage of the individuals living in rural Colorado are low income workers. Any provider who must treat a large percentage of individuals that are either Medicaid eligible or have no health care coverage will struggle financially. By increasing Medicaid Reimbursement levels and mandating a core benefit package that is subsidized for low wage workers, providers will receive fair and consistent compensation for working in rural Colorado.

Another issue facing rural Colorado is the lack of health plan availability. Health plans must meet network adequacy laws before plans can be offered in certain parts of the state; many plans cannot attract the providers to meet this requirement. By setting the non-contracted provider reimbursement rate at 120% (or whatever level is deemed appropriate) of the Medicare Reimbursement Schedule, it is our hope that the provider community in rural areas will seek to join more networks. Thus, the carriers will be able to meet network adequacy requirements and be able to offer their plans in more areas of

the state. This will provide rural Colorado with more options for health insurance/coverage accessibility.

A Phased Approach to Achieving Universal Health Coverage in Colorado/Proposal #6

Kaiser Permanente Colorado is pleased to respond to the Blue Ribbon Commission for Health Care Reform's questions on our submission.

Successful reform requires a public/private partnership that maximizes the value of state and private programs by increasing efficiencies and reducing duplication. For beneficiaries, it requires choice balanced with personal responsibility.

By using a phased approach that develops voter support for additional state funds and obtains additional federal funds; covers an increasing number of people with increasingly comprehensive benefits; and provides choices of plans with transparent results on quality, cost, access, and service, we can be good stewards of both public and private investment in health care.

1. Please provide more detail about adding cost sharing to Medicaid, including LTC, using DRA flexibility.

We believe that cost sharing, properly applied, can encourage patients/parents to act responsibly in seeking care. The Deficit Reduction Act allows both monthly premiums and co-insurance/co-payment. Although monthly premiums are allowable under DRA for select categories, the administrative burdens associated with premium collection should be assessed, as well as consideration of who would be responsible for premium collection. It is unlikely assessing premiums for this population would be worth the effort.

We propose requiring providers or health plans, depending on their structure and relationship with providers, to collect cost-sharing at the point of service for most care provided to both Medicaid and CHP+ beneficiaries (there may be services, such as preventive services, that do not require cost-sharing). For example:

	Exempt groups[2]	Income < 100% FPL (less than $20,650 for a family of four)	Income 100% - 150% of FPL ($20,650--$30,975)	Income 151-200% of FPL (over $30,975--$41,300)	Income 200- 300% of FPL ($41,300 - $61,950)
Medical services (inpatient and outpatient)	$0	$0	Up to $5, and can be varied by type of service (e.g., $0 for preventive, $2 for acute)	Up to $10, and plans can vary by type of service (e.g., $0 for preventive, $2 for acute)	Up to $10, and can be varied by type of service (e.g., $0 for preventive, $2 for acute)
Institutional services[3]	$0	$0	Up to25% of payment for 1st day of care per admission	Up to 33% of payment for 1st day of care per admission	Up to 50% of payment for 1st day of care per admission
Prescription drugs	Up to $5 for non-formulary brand drugs where a generic equivalent is available	Up to $5 for non-formulary brand drugs where a generic equivalent is available	Up to $10 for non-formulary brand drugs where a generic equivalent is available	Up to $15 for non-formulary brand drugs where a generic equivalent is available	Up to $15 for non-formulary brand drugs where a generic equivalent is available
Non-emergency care in an ER	Up to $15, if other care is available	Up to $15, if other care is available	Up to $25, if other care is available	Up to $50, if other care is available	Up to $50, if other care is available
Aggregate cap	Up to 5% of monthly income	Up to 5% of monthly income	Up to 5% of monthly income	Up to 5% of monthly income	Up to 5% of monthly income

We propose giving Medicaid/CHP+ health plans the option to develop value based plan designs that identify groups of patients that would benefit most from a given treatment and reduce cost sharing, perhaps to zero, for that group for those services. An example is

[2] Children under 18 who are also under 100% of FPL, pregnant women for pregnancy –related services, individuals receive hospice care, residents of nursing facilities or intermediate facilities for the mentally retarded, certain inpatients in hospitals and other medical institutions defined by federal regulation, children in foster care or adoption assistance programs.

[3] Institutional services are nursing facility/long-term care services

diabetics where compliance with testing and treatment improves with lower or no cost-sharing.

There are other opportunities in the Deficit Reduction Act that need exploration, including the long term care partnership and transfer of assets sections.

2. Please describe in more detail plans for extending coverage to additional populations over time. What is your assessment of the feasibility of these expansions?

Our first choice would be to cover all age groups with comprehensive benefits, but our assessment is that it is not probable that the voters would approve new taxes in the magnitude required to do so, especially for a new program. Therefore, we propose steps, with children first. "Start small with the small ones."

We believe that streamlining public programs, significantly expanding the use of managed care, requiring medical homes for those on the statewide indemnity plan, and adding personal responsibility to Medicaid and CHP+ through cost-sharing will generate significant savings enabling expansion to more persons. Implementing other interventions to the long-term care portion of Medicaid, such as proposed by SEIU in their submission, will generate more savings, again increasing funds available for expansion to more people.

Then, by adding at least coverage for prevention and early intervention to many/most, we can begin improving everyone's health and prevent illness. This should fundamentally transform affordability.

As populations are added, we should be able to demonstrate the value of coverage, generating more voter support to add more people and to enhance benefits.

We suggest that the evaluation firm be asked to determine the optimal answer to the following set of givens and variables:

- Federal funds currently available
- State funds currently available
- Savings from interventions in public programs
- Costs to expand CHP+/Medicaid to all lower income children from birth through 18
- Estimate of additional federal funds available from this expansion
- Costs to develop the individual mandate and guaranteed issue systems
- Total costs of a limited benefit package for the following age groups:
    - Children 0 – 18;
    - Adults 19 – 29;
    - Adults 30 – 39;
    - Adults 40 – 49;
    - Adults 50 – 59;
    - Adults 60 – 64;
    - Adults 65 and older not qualifying for Medicare.
- Total costs of a plan with limited front-end benefits, a deductible ($0, $2,000 and $10,000) and then comprehensive coverage for the above age groups.
- Estimate of savings resulting from universal coverage of prevention and early intervention services (which result in reduced disease and more cost-effective treatment).
- Realistic estimate of additional funds available through voter-approved new taxes. An assessment should be made whether it is better to approach the voters once for the comprehensive program or whether it is better to start with some populations and more limited benefits and return to the voters once the system has shown positive results.

Once there is a realistic estimate of additional funds, potential savings and additional costs for various options, the evaluation firm can model how comprehensive the benefit package can be and how many people can be covered. Most likely there will be a choice: do we do something for all, or do we do everything for some. In our view, it is better to have everyone have a limited benefit package that covers prevention and early intervention and at least some treatment. Having Colorado known as providing prevention for all would be wonderful.

3. Colorado never achieved full managed care penetration in Medicaid and CHP+, how will we get there?

Full managed care penetration requires both attracting managed care plans and enrolling all eligible beneficiaries. Attracting qualified managed care plans requires a true public/private partnership between the plans and HCPF. If there are actuarially sound rates, a focus on cost-effective quality care, and reasonable administrative requirements, and if the plans can expect that to continue year after year, we do not anticipate difficulty in attracting plans. If plans don't participate, the state would need to understand the reasons why and make adjustments to strengthen the partnership.

Outreach and enrollment efforts would focus on reaching parents at two critical touch points: schools, and where children receive care. Providers would be encouraged to

provide information on coverage options to parents, and HCPF staff would work with school districts to drive application for coverage (or demonstrating proof of commercial coverage) at enrollment. In order to ensure that beneficiaries in public programs select a managed care plan (where available), beneficiaries would be required to select a managed care plan at the time of application or renewal (as is done successfully in CHP+ today), and fee-for-service would be eliminated for providers in the managed care coverage area.

4. The proposed benefits packages include choice of basic care and high deductible. Please discuss how your program addresses problems of underinsurance?

The benefits proposed for guaranteed issue in the individual market are designed to meet most of the outpatient needs, supporting the goal of improving health by providing preventive services and early intervention of illness and health risks. In addition, we propose a plan or plans that cover outpatient needs and comprehensive services with a deductible. We expect these two plans to be affordable.

While the problem of underinsurance would not be solved until all phases are complete, it would reduce the problem, first for children. It would also solve the lack of coverage for prevention and early intervention, having significant, positive impact on downstream costs and quality.

5. What enforcement mechanism would be used to enforce the individual mandate and ensure participation?

Upon the filing of annual state income tax, a person must demonstrate continuous medical coverage for the tax year. If there is a lapse in coverage, a special tax is charged, in excess of the average premium. They would also be denied their personal exemption from state income tax for the year they did not maintain coverage.

An office would be created to assess and provide financial assistance for insured individuals who face sudden financial hardship, but are not eligible for the low-income plans. Any tax penalty revenue could be applied to this office.

The state agency would contact each person who has recently lost group or individual plan coverage, and request documentation of replacement coverage. The Office will assist people in finding coverage, if they do not have replacement coverage.

Carriers will notify the Office in the event of any termination,

The state could also limit access to other state services until individuals could demonstrate health coverage, such as to secure a business license, a drivers license or state ID.

6. Why can't a HIFA waiver apply to all private insurance products, instead of HMOs only?

It could, but we believe that for public programs HMOs are organized to have the best chance to assure beneficiaries receive recommended preventive services and have efficient, coordinated care. This was well demonstrated in "Impact of a Decline in Colorado Medicaid Managed Care Enrollment on Access and Quality of Preventive Primary Care Services," Pediatrics 2005; 116; 1474-1479:

TABLE 2. HEDIS-Reported Immunization Rates for Medicaid Enrollees According to Type of Medicaid Programs

	1999,% (95% CI)	2001, % (95% CI)	2002, %*	2003, % of the 2 Participating HMOs
4:3:2:1:1 (2 y of age)				
HMO (total)	44.6 (47.6–41.6)	41.8 (44.1–39.5)	25.3	51.0 and 65.2
Kaiser Permanente	72.9 (85.1–60.7)	66.2 (72.8–59.6)	NP	NP
PCPP	41.9 (46.5–37.2)	45.7 (50.7–40.8)	33.3 [A]	55.5
UFFS	20.9 (24.7–17.1)	33.8 (38.5–29.1)	21.7 [B]	31.4
Total Colorado	38.6 (40.8–36.4)	41.1 (43.0–39.2)	26.4	50.8
2 MMR (adolescent)				
HMO (total)	70.2 (NA) [A]	45.8 (48.9–42.8)	NA	NA
Kaiser Permanente	81.8 (NA) [A]	76.9 (85.5–68.3)	NA	NA
PCPP	54.0 (NA)	58.9 (63.8–54.0)	57.2 [A]	53.3
UFFS	29.7 (NA) [B]	37.2 (42.0–32.4)	44.0 [B]	33.6
Total Colorado	55.8 (NA)	46.8 (49.1–44.6)	50.6	43.4

* In 2002, CIs were not provided; however, a notation was made if the group mean was significantly above ([A]), or below ([B]) the overall total Colorado mean. This information was not provided for 2003. NA indicates data not available; NP, the HMO was nonparticipating in that year.

In addition, by contracting almost exclusively with managed care on a capitation basis, the state has predictable expenditures and a greatly reduced load on their claims system.

7. Please explain how you propose to fund an expansion of public programs.

Expanding public programs will rely on savings, cost-sharing with participants, and additional state and federal funds. We believe that public program interventions described above in #2 will generate significant savings that can be used to expand the program to more people. Beyond that, additional state funds will probably be required and hence additional federal funds should be available. The source of additional state funds is a political decision, dependent on the voters. We recommend that the public funding source or sources be broad-based, not disproportionately impact only one sector, and not increase the cost of health care.

8. Please demonstrate how your proposal will contain health care costs.

Our proposal would contain health care costs in the following ways:

- By achieving near universal coverage, the hidden cost imposed by caring for the uninsured would reduce charges by hospitals.

- The redesign of the care delivery system, using health information technology and evidence based guidelines will result in far more cost-effective care provided to patients with less wasted resources.

- Disease state management will be encouraged. Studies show that 1% of the people use 30% of all health care resources. If we can assure that those people are provided with care that is truly cost effective, we can achieve significant savings. Incentives are included to encourage people to make healthy choices and to access preventive care. This will reduce the number of people with chronic diseases such as diabetes and heart disease.

- Streamlining CHP+ and Medicaid will help reduce costs.

- Carrier transparency, accountability and competition based on price, quality and service will improve the value of the health care system and manage costs.

- Benefit design that encourages individuals and providers to use resources efficiently and wisely will help reduce costs.

9. How will your phased approach to expanding coverage, building on existing funding opportunities and focusing on managed care principles and choice provide a platform for comprehensive health care reform in the future?

We envision an end state that achieves the Commission's goals of improved health, access, quality, and value; one that emphasizes personal responsibility and choice, where care is coordinated, culturally sensitive, and cost effective; one where an individual's health record is seamlessly delivered when and where needed; one where open disclosure of plan and provider performance provides incentive for positive individual and organizational choices; one that is politically and financially sustainable. In short, we envision one that meets the diverse needs of the people of Colorado.

Achieving this vision requires commitment from all the stakeholders. If that commitment, including the commitment of Colorado's taxpayers, is available now, then we can move quickly. However, we believe it is more likely that we must earn the trust of all the stakeholders by building on the success of each phase. As citizens begin to see positive changes—few individuals lacking coverage, improved quality, better information and delivery systems, reduced growth in health care costs, and positive personal health changes through healthy eating and active living—their commitment to a healthy future for all Coloradans will provide the investment to make this vision a reality.

Connecting Care and Health for Colorado/Proposal #7

1. Benefit levels comparable to Medicaid and SCHIP- which? P. 25.

Connecting Care & Health for Colorado creates a public program that serves all Colorado residents at or below 300% FPL with a full benefit package appropriate for the target low-income population. From the consumer's perspective the benefit package offered is the same for all and improves upon the existing Medicaid package. From the administrative perspective, the program will be paid for by several different funding streams such as Medicaid and SCHIP.

Pgs. 5-6: "We recommend that public programs cover full implementation of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), preventive dental care, vision and hearing services, mental health and substance abuse services (including early childhood mental health), screening for all children to age 21, screening for cancer and other chronic disease, rehabilitative services, non-emergent medical transportation, and appropriate interpretation and translation services."

Pg. 25: "For people with incomes below 300% of poverty with an offer of employer-sponsored coverage, the consultant should evaluate the best means of providing benefits comparable to Medicaid and SCHIP. The consultant should determine whether it is cost-effective and feasible for the person to enroll in their employer's plan with public programs "wrapping around" to provide benefits that are not covered and to pay excess cost-sharing, or whether it is better for such individuals to obtain all of their coverage through the public program. The consultant should weigh the extent to which employer-dollars for health care could be lost, administrative costs, and the likelihood that individuals will be left underinsured."

To clarify, what was meant by the reference to both Medicaid and SCHIP on page 25 is that while the benefit package is the same for all on public programs, cost-sharing levels may vary based on federal rules. We want to make sure people who have employer-sponsored insurance, will still get the benefits they are entitled to if they are eligible for public programs (listed on pg. 5-6, referenced above). We ask the consultant to look at the cost estimates and feasibility of public programs acting as a wrap-around (e.g. vision, dental, hearing, mental health, cost-sharing wrap) to employer-sponsored insurance.

2. Your proposal requires the guaranteed issue of health insurance for individuals without an individual mandate. Why would someone purchase insurance while (s)he is healthy, when (s)he could simply wait until (s)he contracted an illness or otherwise needed it?

In order to remedy this problem, we did indeed propose an individual mandate to get more healthy people into the market to increase the size of the risk pool and therefore spread risk more broadly and evenly. This will help to reduce premiums for older and sicker populations.

Pg. 8: "We support mandating all residents of Colorado to obtain health insurance. However, we cannot recommend an individual mandate if other provisions contained within the proposal are not also adopted. Coverage must be accessible and truly affordable, leaving consumers to pay no more than 5% of their incomes for premiums, cost-sharing or other out-of-pocket health costs."

Pg. 34: "The Coalition recommends an individual mandate to secure universal participation in Colorado's health care system. In aggregate, the effect of covering all Coloradans will be that individuals now purchasing health insurance will spend less, while people with moderate income who do not now have coverage would be required to purchase affordable, comprehensive coverage. Individuals who are older or have more health care needs will pay less for coverage than they do now in the private market."

3. This proposal would impose guaranteed issue, community rating and a mandatory standard relatively "rich" benefit package for all Coloradoans. Shouldn't individuals be encouraged, through reasonable cost-sharing incentives, to select insurance products that best meet their needs and that provide incentives for cost-effective utilization?

Connecting Care and Health for Colorado provides all Coloradans with a meaningful package of benefits to increase risk-sharing between sick and healthy people. In this system, healthy people contribute toward the medical costs of people with health problems, rather than self-selecting into bare-bones plans and exacerbating adverse risk selection. Spreading risk across populations is the practical purpose of all types of insurance, and one of our proposal's goals is to restore this function to the Colorado health insurance market.

People are given choices under our plan. We propose three tiers of coverage in order to 1) set a floor package of benefits to avoid underinsurance (the high costs of limited access), 2) allow for consumer choice, and 3) make it easier for consumers to compare products across carriers. We proposed that the content of this baseline or bottom tier be decided by the *Health Care Quality and Cost Advisory Committee* of consumers, carriers, and providers in a transparent and inclusive process that makes sense to all the stakeholders.

Cost-effective utilization decisions will take place at the level of the health care provider. Primary care case management, chronic care case management, family advocate systems, and health care home models, all of which are recommended in this proposal, result in more efficient and appropriate utilization of services.[4]

[4] National studies show that 20 percent of people, mostly those with active disease, generate 80 percent of health care costs. Managing critical and chronic conditions by providing care that is consistent with best practice guidelines saves costs. See, for example, Goetzel, "Return on Investment in Disease Management, Health Care Financing Review", 2005 at http://www.cms.hhs.gov/HealthCareFinancingReview/PastArticles/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=3&sortOrder=descending&itemID=CMS1196851&intNumPerPage=10.

Connecting Care and Health for Colorado does allow for cost-sharing as long as total out-of-pocket expenses (both premiums and cost-sharing) do not exceed 5% of an individual's income. We chose 5% because it is the maximum allowable level of cost-sharing for SCHIP. Our proposal strives to provide security for Coloradans. Insurance products should provide adequate benefits that protect individuals should they fall ill, and cost-sharing structures that protect families from financial ruin. If total out-of-pocket expenses exceed 5%, the insurance coverage is no longer "affordable" for low-income families.[5] In our proposal we used the SCHIP standard for all income groups. However, we would like to suggest that the total percentage of income could be higher for people in higher income brackets, and would ask that the consultant model appropriate cost-sharing levels for these populations.

Increasingly, health plans (in both the individual and employer market) offer "thinner" coverage, with higher deductibles, and higher for services such as hospital care and prescription drugs. Increases in cost-sharing continue in spite of the fact that experts in the field – including insurance company executives – generally concur that such increases will not result in a significant reduction in premiums or overall health care costs. Moreover, increases in cost-sharing have a detrimental effect on the health and well-being of workers. A sizable body of research indicates that increases in cost-sharing reduce access to necessary care.[6]

Families whose medical expenditures total 10 percent or more of their income or whose plans include deductibles greater than 5 percent of income – the underinsured – are at particular risk. For underinsured families, medical bills have a profound effect on financial security. Nearly half (46%) of underinsured families report being contacted by a collection agency regarding medical bills in the last year, and more than one-third (35%) have taken drastic measures, such as re-mortgaging a home or running up credit card debt, to pay medical bills.[7] Our proposal seeks to stop this trend by ensuring benefits are there when necessary, and that using these services doesn't invite economic ruin.

4. Demonstrate how health care quality and efficiency at the provisioning level are achieved in this proposal?

We propose several delivery models and tools in order to ensure quality and efficiency at the level of actual service delivery:

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[5] Studies show that when states have increased out-of-pocket requirements for beneficiaries in public coverage programs, enrollment has declined and many people have not obtained care that they needed due to cost (Samantha Artiga and Molly O'Malley, "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences". Washington, DC: Kaiser Commission on Medicaid and the Uninsured, May 2005.

[6] Martin Chalkey and Ray Robinson, *Theory and Evidence on Cost Sharing in Health Care: An Economic Perspective* (London: Office of Health Economics, 1997); Joseph P. Newhouse, *Free for All? Lessons from the RAND Health Insurance Experiment* (Boston: Harvard University Press, 1996 reprint).

[7] Cathy Schoen, Michelle M. Doty, Sara R. Collins, and Alyssa L. Holmgren, "Insured but Not Protected: How Many Adults Are Underinsured?" *Health Affairs* Web Exclusive (June 14, 2005): W5-289 to W5-302.

Pg. 27: "Chronic care case management. Case managers could coordinate care for people with various chronic conditions, preventing duplication by providers and connecting patients with necessary services to avoid medical complications that lead to expensive hospital visits."

Pg. 27: "Examination of the quality measurement model currently used by Rocky Mountain Health Care, quality measures for long-term care currently used in Texas and Minnesota, and national best practices in order to develop a measurement system for primary care case management and other subsidized care…"

Pg. 29: "We propose primary care case management as the delivery system for subsidized health care. This will give enrollees a health care home, encourage greater use of primary care, and ensure the coordination of primary and specialty care.

Pg. 29: "We also propose an expansion of the family health advocate system. Many people are not aware of their rights to health care services or have difficulty navigating through referral and health care payment problems. Family health advocates will assist people in obtaining needed services."

We also propose:

- Increasing the scope of practice of nurse practitioners to increase their capacity to serve, especially throughout rural Colorado;
- Disseminating best practice treatment guidelines to providers to increasingly provide adequate, appropriate care;
- Setting a fixed medical loss ratio that ensures that insurance carriers spend a high percentage of premium dollars on health care claims (we propose the consultant help determine what a reasonable medical loss ratio would be); and
- Increasing provider reimbursement rates to expand access to primary care.

We believe these strategies will increase primary care and prevention overall, which will reduce the use of expensive, overburdened emergency rooms for preventable health care conditions and result in better quality and efficiency at the point of service.

5. How would you fund your proposal's expansions of Medicaid and CHP+?

We propose funding public program expansions in part with federal reimbursements from Medicaid and SCHIP. Additional federal matching dollars would be drawn down by increasing the income eligibility level for Medicaid and SCHIP to 300% FPL. We also recommend exploring additional opportunities available to states to maximize federal matching funds of which Colorado currently is not taking advantage. We propose employers contribute financially to the expansion through an employer assessment. Finally state funds most likely will be needed beyond the employer assessment to make up the State's match. Currently there are 3 major existing state funding streams for health care (Amendment 35 tobacco tax, Referendum C, and Tobacco Master Settlement). We recommend protecting these funding streams from being used for other

programs. Additionally, we understand that the State may have to raise new public funds, which would require a vote of the people due to TABOR. Potential new funding sources could include raising the tobacco excise tax again or raising other "sin taxes" on things like alcohol and snacks and sodas. Other sources could include a broad tax on those that benefit from the comprehensive health care system such as health care providers. Those providers that see Medicaid and CHP+ patients would see some return on their tax payments in the form of increased reimbursement rates. Those who do not currently see Medicaid/CHP+ patients may be encouraged to do so, given higher reimbursement rates and the desire to take advantage of the return on their tax "investment".

6. Your proposal includes the creation of several commissions/committees to oversee your plan. Could you please address the effect of these potential cost drivers to overall affordability and efficiency of the plan?

The governance and administrative structure that we propose is designed specifically to increase quality and efficiency over time. We propose the creation of the following:

- Stakeholder Oversight Commission
- Health Care Quality & Cost Advisory Commission
- Rural Health Advisory Committee
- Health Disparities Advisory Committee
- Office of the Ombudsman
- System Navigator Office

While it is true that there will be some initial costs to creating this system, we believe that it will more than pay for itself over time. The advisory committee on cost and quality will identify quality initiatives and cost-containment strategies. The advisory committees on rural issues and health disparities will identify access issues and identify targeted strategies to reduce geographic, ethnic and racial disparities among Colorado residents. The navigator and ombudsman functions will help consumers appropriately access the system and resolve conflicts. Overall there will be increased coordination, reduced duplication of efforts, increased transparency, and frequent monitoring and evaluation, with the end goal of creating a healthier Colorado while reducing health care spending over the long term.

In other words, we believe that our proposed system of governance and administration will not cost that much relative to the important role it will play in bringing overall spending down and creating a more efficient system. It is a net positive. It is worth mentioning that creating new advisory bodies to help inform the implementation process is consistent with other recent comprehensive state expansions.

Maine: Dirigo Health set up an Advisory Council on Health Systems Development to create a State Health Plan every two years. The State Health Plan estimates costs, evaluates resource allocation, sets efficiency and spending reduction goals, oversees Certificate of Needs, sets statewide budget for CON projects, and works with hospitals and providers to set voluntary spending targets.

Vermont: Catamount Health created the "Blueprint for Health" — a statewide chronic care management program overseen by the Blueprint Executive Committee. The Vermont Rural Health Alliance was recently initiated to work with the Blueprint to address rural health needs.

Massachusetts: Massachusetts Health Reform established a Quality and Cost Council to set benchmarks for quality improvement and cost containment, to collect data, and to publish its findings on its website. It also created a statewide Racial/Ethnic Health Disparities Council to track disparities data and create pay for performance benchmarks.

An Individual Based Insurance System Combining Free Market Principles with an Appropriate Role for Government/Proposal #9

Submitted by David Laverty, Chairperson of the South Metro Denver Chamber Healthcare Taskforce on behalf of the South Metro Denver Chamber of Commerce

1. How does the program account for the risk of adverse selection where there is not an enforcement mechanism requiring people to purchase maintenance tier coverage, individual policies are guarantee issue and community rated, and "At any time, the consumer could change a policy instead of accepting the employer's choice of carrier." P. 15

   In the current healthcare market, there is considerable risk of adverse selection which can be accelerated with guarantee issue and community rating. Removing rating increases for age and pre-existing conditions can expose an insurance company to substantial upside risk under the current system due to high dollar claims from catastrophic conditions, such as cancer, heart disease and major car accidents.

   Giving consumers the ability to change insurance providers at any time should not increase the risk of adverse selection and saddle the provider with high risk. The $100K cap on claims mitigates the risk of adverse selection. Since 10% of the population incurs approximately 90% of the healthcare costs, this new system would remove the largest risk to insurance providers. The potential risk of significant numbers of company policyholders filing high dollar claims has been eliminated due to the 100K cap. With a considerably lower risk threshold, the provider can operate under the framework of guarantee issue and community rating, yet earn a profit resulting from competitive advantage in a fair marketplace.

   Moving health insurance towards a system similar to auto insurance will benefit many stakeholders. With auto insurance, each person is required by law to carry insurance or risk potential fines up to $1,000. Although auto insurance and health insurance cover different scenarios, where auto insurance is focused on liability and health insurance on maintaining quality of life, similarities exist pertaining to implementation.

   When a person attempts to obtain healthcare services without insurance, then the state would enroll this uninsured person in the voucher system. Thus, the state would issue vouchers for the following year so these people could purchase insurance. If this person did not qualify for ongoing assistance, then a financial reconciliation would occur with the submission of a state tax return. The state would penalize the person financially for the voucher costs incurred during the prior year.

If this person submitted a tax return with an annual income under 250% of the Federal Poverty Level, then they would remain in the voucher system and receive either a partial or full subsidy for their insurance. At the time of reconciliation, the state would mail a letter to these voucher recipients (with incomes above 250% FPL) stating continued non-compliance with the mandatory insurance law could lead to fines up to $1,000.

2. How do people with chronic diseases get to the catastrophic care limit ($100,000) if the trigger for entry is on a per incident basis? (p. 16) What if someone has two events in one year – which together total more than $100,000 in cost- or a chronic illness with several hospitalizations in one year, does that count as one "incident" . Please provide more detail about how this program works for people with chronic illness/disabilities.

   When a person is diagnosed with a disease or suffers an injury, the maintenance policy would cover that medical incident up to the $100K cap, most often without a time limitation. For example, a person becomes ill with cancer and receives treatment, yet has a reoccurrence three years later. The cumulative billing totals would continue along with any future treatment connected with the incident. If the illness reoccurrence causes the total to exceed $100K, then the catastrophic tier would cover the bills beyond $100K even though the second event occurred three years later.

   There may need to be exceptions when a person is regarded as cured and the reoccurrence occurs after a lengthy passage of time. For example, a person is diagnosed with a form of cancer at 25 years old and a similar form returns 30 years later. Thus, the reoccurrence may need to be considered a new incident. Pertaining to several hospitalizations in one year, as long as the hospitalizations were connected to the original incident, then the treatment would count as one incident.

   When there are multiple incidents resulting from one diagnosis, such as both congestive heart problems along with kidney failure from diabetes, the billing totals would be considered cumulative since there is reasonable scientific evidence that the two incidents are medically connected. It is our hope that combining multiple incidents from an original diagnosis could occur and keep the catastrophic pool financially viable. However, we certainly realize that separating the incidents may be another option worthy of study.

   If a person has two separate unrelated incidents during one year, then the treatment costs of each incident as well as follow-up costs would accumulate separately. Once the costs connected to an incident exceeded $100K, then the additional costs related to the one incident would be paid from the catastrophic pool.

As for chronic conditions, the same rationale would apply. For example, a person is diagnosed with diabetes and begins treatment to monitor the illness. However, the catastrophic threshold is not triggered until 10 years later, then the group pooling would begin once the cumulative bills exceeded $100K without regard to time constraints.

Regarding disabilities, the ongoing medical costs from a disability would accumulate and be covered once the cumulative totals exceeded $100K despite frequent treatments or passage of time. Loss of income or living expenses would need to be covered from alternate sources including disability insurance, long-term care insurance or Medicaid.

3. Vouchers for those currently in Medicaid-dollar amount at least at mid-point of average policy. P. 19. What protections, if any, are in place for low income (and higher needs) participants who may not be able to pay co-payments and deductibles in the average policy, particularly if the policy is individually owned and co-payments and deductibles apply per individual in a family (rather than on a family basis).

   One of our proposal's main components relies upon the forces of competition to aggressively drive down insurance prices. In the current non-competitive market, prices, co-payments, and deductibles remain higher than the prices and out-of-pocket expenses in a more competitive market. By having a voucher system cover at least 80% of available individual policies among the menu options for a person in the voucher program, our assumption is that companies will provide insurance products with low co-payments and deductibles in order to earn the business of people paying for insurance products with vouchers.

   Again, with the upside risk of high dollar claims capped at $100K, the underwriting risk for all insurance providers will be much lower than with the present system. Insurance providers will certainly gain competitive advantage by offering products with low out-of-pocket expenses.

4. The proposal says that if there are continuing needs Medicare kicks in (p. 17) – but Medicaid, not Medicare covers Long Term Care- how is that accounted for in the Medicaid voucher system?

   Thank you for the correction. By applying for and receiving a Medicaid waiver, the State of Colorado would be responsible for financially backing services previously covered by the Medicaid program. The state would provide vouchers for the purchase of any services related to this person's long-term care needs. Vouchers equal to the dollar amount that a Medicaid recipient received from the federal government would now be provided by the state. In addition, long-term care insurance could be added to the basic maintenance plan available to all Colorado residents or potentially be considered among the menu options of an expanded version of the maintenance plan.

5. Many reform proposals and, in fact, the federal government look to strengthen the employer-sponsored insurance market. This proposal drastically reduces the role of employers in making health coverage available to employees. Why?

   Our group believes strengthening the employer-sponsored insurance market would accelerate many problems with the current healthcare situation. Insurance needs for the diversity of individuals at one place of employment vary drastically. The concerns of young parents in their 20s, singles in their 30s or 40s, and empty-nest couples approaching retirement are considerably different. Incomes, personal savings, health issues, and risk tolerances are as diverse as the people themselves. When an employer decides which insurance provider to use for group coverage, there is no way to account for all employee concerns and still purchase a group policy at price levels which keep the business competitive. The individual is not only removed from the purchase decision, yet often has little influence on the choices of covered benefits.

   With auto insurance, there is a clear connection between driving behavior and individual insurance rates. When a person makes poor driving choices, financial consequences through higher insurance rates quickly follow. At the present time, the individual knows their employer covers their insurance rates and is not often financially accountable for poor lifestyle choices. We would like to see the same connection exist in health insurance as in car insurance where healthy lifestyle choices could translate to a positive financial benefit for the consumer. If a greater number of people focused on the key health metrics of blood pressure, cholesterol, non-smoking, and other metrics listed in our proposal, then the overall costs of healthcare from a reduction in high dollar catastrophic incidents will significantly occur.

   Consumer buying behavior is a powerful force. When consumers are fully engaged in any market, the company is forced to design products that address the consumer's needs or face competitive disadvantage. In today's health insurance world, the consumer has little involvement in the purchase decisions. The physician may recommend an MRI, yet the procedure's cost can range from $500 to $4,000 depending upon the negotiated reimbursement rates provided by the insurance provider. If the consumer managed the process and could see a direct financial benefit from a cost effective decision, then the overall quantity of over-priced MRIs would drastically decrease. At the present time, healthcare has evolved into a fight between insurers and providers for financial control. By giving the consumer an equal seat at the table, healthcare costs will decrease, quality will increase, and we will all enjoy greater healthcare value.

6. The proposal claims that health care costs will be contained through increased competition, yet nowhere in the proposal is this claim validated or demonstrated. Please provide information to substantiate this claim.

The approach to healthcare in our proposal is unique. We cannot provide specific examples of where this approach has been applied in other US states or countries. However, we have provided two strong arguments for these ideas based upon materials from two credible sources, Dr. Michael Porter, of Harvard University, who is widely considered the top expert on business competitive strategy, and a report by the United States Federal Trade Commission and the Antitrust Division of the Department of Justice

Competition the Cure for Healthcare

http://hbswk.hbs.edu/item/5452.html

Michael E. Porter is the Bishop William Lawrence University Professor at Harvard Business School. In 2001, Harvard Business School and Harvard University jointly created the Institute for Strategy and Competitiveness, to further Professor Porter's work. He is a leading authority on competitive strategy and the competitiveness and economic development of nations, states, and regions.

- American healthcare is broken structurally, rewarding the wrong actions and punishing the patient.
- Competition correctly placed in healthcare can reduce cost, improve physician performance, and create better results for patients.

Roger Thompson is editor of the *Harvard Business School Alumni Bulletin.*

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Roger Thompson: What went wrong with the American model? On paper it looks ideal. It's private, it's competitive, yet it doesn't seem to work.

Michael E. Porter: The United States has a system with the wrong kind of competition, on the wrong things. Instead, we have a zero-sum competition to restrict services, assemble bargaining power, shift the cost to others, or grab more of the revenue versus other actors in the system.

Zero-sum competition does not create value; it can actually destroy value by adding administrative costs and leads to structures involving health plans and providers and other actors, which are misaligned with patient value. In a world of zero-sum competition, for example, providers will consolidate into provider groups to gain clout against insurers. But, as we point out in our book, the provider group doesn't create any value. Value is not created by breadth of services, but excellence in particular medical conditions.

Zero-sum competition was a natural evolution given the historical roots of the field. In some ways, the field of healthcare is stuck in the past. Health plans think of themselves as insurance companies because that is what they started out doing. Providers are organized around the old functional structure of specialties, rather than integrated care organizations. It is a lot like the distinction between functional structures and business unit structures in management thinking, except that healthcare is still stuck in the functional model.

These forms of competition and organization have also been institutionalized in medical education and in physician certification. Nobody deliberately set out to create this mess, but unfortunately, we are left with how to deal with it.

Q: What are the key steps? Where do we begin?

A: One of the most hopeful things we discovered in the course of this research is that the revolution, if you will, has already started. The U.S. [healthcare] system can be reformed from the bottom up. Any hospital, physician practice, health plan, or employer can take positive steps in the direction of value-based competition today and be better off, even if nobody else changes. They will be more efficient, achieve better customer satisfaction, and the physicians involved will feel more pride in what they are doing. We included many examples in the book, such as the Cleveland Clinic, M. D. Anderson Cancer Center, and Dartmouth Hitchcock Medical Center, which are moving toward results measurement and integrated practice unit structures.

Reforming the U.S. system does not require a top down, big bang, government-led regulatory change. That having been said, the government can actually help a lot through modifying and extending key policies, particularly in the area of results information and removing restrictive and unnecessary impediments to competition. The corporate practice of medicine law is a perfect example. The law makes it difficult for doctors to be employed by corporations, which makes no sense today because we want doctors and hospitals to work seamlessly as an integrated practice. Another example is physician certification by state, which means that when the Cleveland Clinic wants to offer a national second-opinion service, they have to scramble around within their staff physicians to find doctors that have certifications in all the states even though the Clinic is a preeminent medical center. There are a striking number of other examples such as this, which actually work against delivering value to patients.

So government does have a key role to play, but luckily, we do not have to wait for government.

In other countries such as the United Kingdom or Germany, government is far more directly involved in delivering healthcare. In these countries, change will be highly political. But in the United States, and this is one of our great strengths as a

country, we tend to be more fluid and flexible. Once Americans understand the problem, we can make considerable headway.

Q: You must have seen the recent report about the massive differences in Medicare costs from state to state, and even within states, with no apparent difference in care. How do you explain those differences?

A: The recent findings are just the latest in a body of important work by John Wennberg and his colleagues at Dartmouth. Those findings were an inspiration for our work. Indeed, they were the last piece of the puzzle for us in truly understanding the problem. We have known for a long time that U.S. healthcare is high cost. What everyone assumed was that U.S. healthcare was very high quality, which at least made the high cost understandable.

What Wennberg did, as did others, was to show that U.S. healthcare is not high quality. Indeed, there is every possible quality problem you can imagine: incorrect diagnoses, drug errors, unnecessary complications, and failed treatments. Also, there are huge differences in quality across providers and across geography.

For us, this framed the problem. How could we have a high-cost system that also has poor quality, where providers differ so much in value, but these differences persisted? In a world of normal competition, that cannot happen. The high quality players grow and thrive, and the poor quality players go out of business or fix their problems. So finally, the right question became, why is competition failing? And that led us to the distinction between zero-sum competition and positive-sum competition, and the central importance of value.

Q: Why isn't high quality, value-driven healthcare more expensive?

A: Healthcare is not like buying a car. If you want leather seats in a car, this costs more because leather costs more than plastic. If you want a TV set with a bigger screen and more features, that is more expensive; it takes more circuits, more material, and so on. Healthcare is very different, especially today when we already treat virtually every medical condition in some way. Most of the time, the best quality healthcare is also the lowest cost care. The reason is that the lowest costs arise when the patient stays healthy, or gets healthy faster.

If you get the diagnosis right, you save a lot of wasted and unnecessary treatment, and costs go down. If you avoid making mistakes, costs go down. If excellent surgery allows the patient to go home sooner, costs go down. If you actually cure the disease, the patient does not need to have any more office visits or drugs. And so on, as we discuss extensively in the book. Of all the fields we have worked in, this is the field where the notion that quality is free is the most powerful.

One of the central themes of our book is that the way to drive down costs in healthcare is to drive up quality. That is the dynamic we have to harness. And in

order to drive up quality, there is only one way that will work: We have to measure results. And in order to use results to drive quality, we have to create competition on results at the medical-condition level.

Q: How would health plans change? What new roles would they take on?

A: Health plans have eroded the trust of many of their subscribers during the era of gate keeping, denial of claims, and network restrictions. As a result, some believe we ought to get rid of health plans and move to a single-payer system where the government is the payer. We disagree, because health plans have important value-adding roles in the system.

Why do we need health plans? We need them to integrate across all of an individual's health needs. Some make the case that an integrated provider system can play the role of integrator. We reject that idea because it is crucial to have competition at the provider and medical condition levels.

So a value-based system keeps the health plan separate from the provider, and providers compete at the medical condition level. The health plan is also indispensable in aggregating information. We think the health plan is the logical place in the system at which to aggregate medical records. Right now, the medical record resides with providers, and one provider can request the record from another. That is a very cumbersome and inefficient system, which creates delay and duplication.

Health plans should also inform and advise members about where to seek care, and help to navigate the care cycle. Many health plans, among them Harvard Pilgrim and Aetna, are starting to move in these directions. Health plans must become health organizations, rather than see themselves as payers or insurance companies.

Q: Could health plans help push along the movement toward electronic patient records?

A: Health plans have an important role in encouraging medical records because it will help them drive higher value in the system. Health plans can create incentives and standards to rapidly disseminate electronic medical records to all the actors in the system. There is a critical need for standardization of data and protocols so that records can be aggregated. In Massachusetts, for example, Blue Cross Blue Shield has invested heavily in a pilot program to develop a medical records platform that could be shared.

But as we emphasize in our book, IT is not the solution to the problem of healthcare delivery, but an enabler. Automating current care delivery processes will have limited benefits. Conversely, there is much that can be done to radically improve value without fully electronic records.

Q: I was startled reading that in your book.

A: Individuals who are young and healthy may not think insurance is necessary. But the whole logic of insurance is that everybody needs to pay every year so that they contribute enough to pay their costs if they get sick. It is the same principle as in auto insurance. You do not buy car insurance the day before you are going to have an accident. Universal and mandatory insurance should go together, with subsidies for those who need them.

We also need to get away from the idea that either you have enough money to buy insurance, or it should be free. Individuals should contribute to the cost of their insurance to the extent that they can. This will also reduce the cost of moving to universal coverage.

I want to emphasize, however, that universal insurance is not a solution. Universal insurance enables the solution. The only solution to the healthcare problems in America is to dramatically improve the value we are getting for the money we are spending.

Q: People who have bad health habits, who smoke, drink excessively, don't exercise, they're overweight, how do you factor that in what they should be paying for insurance?

A: This is a controversial issue, but a crucial one. Historically, individuals have not been responsible for behavior that affects their health and healthcare. But healthcare is a co-produced product. The doctor and the patient produce healthcare together. If the patient does not participate, it limits what the doctor can accomplish.

We are moving to a system where the individual must be engaged, or face the consequences. More employers are asking employees to participate in health risk screening and disease management, or bear higher premiums for their health insurance.

Excerpts from a Report by the Federal Trade Commission and the Antitrust Division of the Department of Justice on Healthcare Competitiveness.

http://www.usdoj.gov/atr/public/health_care/204694/exec_sum.htm

EXECUTIVE SUMMARY

Health care is a vital service that daily touches the lives of millions of Americans at significant and vulnerable times: birth, illness, and death. In recent decades, technology, pharmaceuticals, and know-how have substantially improved how care is delivered and the prospects for recovery. American markets for innovation in pharmaceuticals and medical devices are second to none. The miracles of

modern medicine have become almost commonplace. At its best, American health care is the *best* in the world.

Notwithstanding these extraordinary achievements, the cost, quality, and accessibility of American health care have become major legislative and policy issues. Substantial increases in the cost of health care have placed considerable stress on federal, state, and household budgets, as well as the employment-based health insurance system. Health care quality varies widely, even after controlling for cost, source of payment, and patient preferences. Many Americans lack health insurance coverage at some point during any given year. The costs of providing uncompensated care are a substantial burden for many health care providers, other consumers, and tax payers.

This Report examines the role of competition in addressing these challenges. The proper role of competition in health care markets has long been debated. For much of our history, federal and state regulators, judges, and academic commentators saw health care as a "special" good to which normal economic forces did not apply. Skepticism about the role of competition in health care continues.

This Report by the Federal Trade Commission (Commission) and the Antitrust Division of the Department of Justice (Division) (together, the Agencies) represents our response to such skepticism. In the past few decades, competition has profoundly altered the institutional and structural arrangements through which health care is financed and delivered. Competition law and policy have played an important and beneficial role in this transformation. Imperfections in the health care system have impeded competition from reaching its full potential. These imperfections are discussed in this Report.

The Agencies based this Report on 27 days of Joint Hearings from February through October, 2003; a Commission-sponsored workshop in September, 2002; and independent research. The Hearings broadly examined the state of the health care marketplace and the role of competition, antitrust, and consumer protection in satisfying the preferences of Americans for high-quality, cost-effective health care. The Hearings gathered testimony from approximately 250 panelists, including representatives of various provider groups, insurers, employers, lawyers, patient advocates, and leading scholars on subjects ranging from antitrust and economics to health care quality and informed consent. The Hearings and Workshop elicited 62 written submissions from interested parties. Almost 6,000 pages of transcripts of the Hearings and Workshop and all written submissions are available on the Commission website.

The Report addresses two basic questions. First, what is the current role of competition in health care, and how can it be enhanced to increase consumer welfare? Second, how has, and how should, antitrust enforcement work to protect existing and potential competition in health care?

A key recommendation from this report:

Recommendation 1: Private payors, governments, and providers should continue experiments to improve incentives for providers to lower costs and enhance quality and for consumers to seek lower prices and better quality.

> ***a) Private payors, governments, and providers should improve measures of price and quality.***

As noted above, health care pricing can be obscure and complex. Increased transparency in pricing is needed to implement strategies that encourage providers to lower costs and consumers to evaluate prices. Achievement of this goal will likely require addressing the issue of cross-subsidization, which encourages providers to use pricing that does not reveal the degree to which the well-insured may be subsidizing the indigent, and more profitable services may be subsidizing less well-compensated care.

A great deal of work already has been done on measuring quality. Quality measures exist for a considerable number of conditions and treatments. The Agencies encourage further work in this area. The Agencies suggest that particular attention be paid to the criticism that report cards and other performance measures discourage providers from treating sicker patients. If it is not addressed, this criticism could undermine the perceived validity and reliability of information about quality.

> ***b) Private payors, governments, and providers should furnish more information on prices and quality to consumers in ways that they find useful and relevant, and continue to experiment with financing structures that will give consumers greater incentives to use such information.***

Information must be reliable and understandable if consumers are to use it in selecting health plans and providers. Research to date indicates that many consumers have not used the price and quality information they have received to make decisions about health plans and providers. Additional research into the types of price and quality information that consumers would use for those decisions appears to be necessary. Further experiments with varying co- payments and deductibles based on price-and quality-related factors such as the "tier" of service that consumers choose can help give consumers greater responsibility for their choices. Such responsibility will also likely increase consumer incentives to use available information on price and quality.

> ***c) Private payors, governments, and providers should experiment further with payment methods for aligning providers' incentives with consumers' interests in lower prices, quality improvements, and innovation.***

Payment methods that give incentives for providers to lower costs, improve quality, and innovate could be powerful forces for improving competition in health care markets. Although payors have experimented with some payment methods that provide incentives to lower costs, no payment method has yet emerged that more fully aligns providers' incentives with the interests of consumers in lower prices, quality improvements, and innovation. At present, for example, most payments to providers have no connection with the quality of care provided.

A focus on the degree to which providers' incentives are compatible with consumers' interests is important. Compatible incentives and interests are more likely to yield better results; incompatible incentives and interests are more likely to have unintended consequences that can lead to worse results. Initiatives that address the use of payment methods to align providers' incentives with consumers' interests are necessary. These experiments should be carefully analyzed to evaluate their consequences, both intended and unintended.

Healthy Colorado Now/Proposal #10

The proposers of the *Healthy Colorado Now* plan would like to thank the Commissioners for selecting this plan for further consideration. The proposers appreciate the opportunity to respond to questions and clarify essential components in their proposal.

We have proposed a model that will set the stage for the evolution of a fundamentally changed system of health care that emphasizes and expands the role of prevention, technology, and patient empowerment. It is our intent to start with a model of care for those currently uninsured, and grow that system of care to create the necessary systems change desired.

1. **How do you account for those who are not employed?**

There are approximately 100,000 people (four percent of the population) unemployed on any given day in Colorado. Some of the unemployed are on COBRA, some have pension benefit guarantee, or state continuation. If the unemployed are not covered by another mechanism they may buy into the PRO-CO plan, and may qualify for the sliding scale premium assistance component of the plan based on their income.

The *Healthy Colorado Now* plan looks at income at any given time. Persons may see an enrollment specialist to enroll in PRO-CO and apply for subsidies when they become unemployed, or when they seek care at the point of service.

The point-of-service option allows persons without coverage to enroll when they come for health services. This option is similar to CICP. When a person without income needs medical services such as hospitalization, they undergo a financial screening at their point of service. PRO-CO has the same option for enrollment at that point in time, as well as at any place in Colorado making the value statewide.

The overarching principle is income. If unemployed persons do not have any income, they have the option to enroll in PRO-CO, and receive premium assistance on a sliding scale. The *Healthy Colorado Now* plan uses 250 to 500 percent of FPL as a range for the sliding scale premium assistance option. However, the proposers established this range as a starting point to create a model. Those points are considered to be adjustable either way for affordability, etc.

2. **How do you account for the risk of adverse selection in PROCO?**

The *Healthy Colorado Now* plan requires that every individual carry coverage and that all insurers in the non-ERISA market guarantee issue and base premiums on community rating; therefore, there will be little pressure for adverse selection. Community rating and guaranteed issue will fundamentally change the market and eliminate adverse selection. The only reason for an individual or employer to choose PRO-CO over a private plan will be cost and performance of PRO-CO, and for those eligible for a subsidy to receive the subsidy based on their lower income.

3. **Not sure whether modified or pure community rating- please clarify. (p. 5, p. 32).**

The proposers of *Healthy Colorado Now* prefer pure community rating, but would consider using smoking as a valid, evidence-based reason to consider a modified version. The proposers would request our plan be modeled both ways.

4. **Yearly and lifetime spending cap- what are limits? What happens when exceeded, particularly yearly.**

The proposers of *Healthy Colorado Now* do not have the resources to perform actuarial analysis to determine the optimal fixed cap. The goal of setting caps was to achieve a high value but affordable insurance package. The proposers discussed a yearly cap of $250,000, and a lifetime of $500,000, but are not certain what cap would achieve an affordable price point. The proposers of *Healthy Colorado Now* welcome modeling to show how many people of the 770,000 uninsured in Colorado would go over a yearly cap of $250,000, or a lifetime cap of $500,000.

For those who go over their yearly caps, risks would largely accrue to providers which are currently at risk for the payments in the present system. The proposers anticipate exhaustion of the annual cap will occur very rarely (The experience of Cover Colorado is that only .04 percent of their clients hit their lifetime maximum over a three year period[8]). Given providers' current risk for uninsured care, this model would dramatically decrease their overall risk exposure because everyone will be covered for at least a guaranteed payment up to the predetermined cap.

Additionally, individuals may buy supplemental coverage to cover them beyond their cap. Individuals who exhaust their lifetime caps would likely qualify for Medicare based on disability or potentially Medicaid depending on their income. Yet another option would be for PRO-CO to employ a reinsurance mechanism to insure those who exhaust their cap. The proposers would appreciate if the plan were modeled with and without this option.

5. **What enforcement mechanism would be used to enforce the individual mandate and ensure participation?**

Evidence of insurance would be required with yearly tax filings. For all those who are employed, employers would be responsible for ensuring employee and employer contributions are withheld. A financial penalty would be assessed for non-compliant employers and self-employed individuals, and for unemployed individuals who fail to continue to maintain the documentation required to keep coverage current (to maintain coverage, unemployed individuals would need to file a form with an enrollment specialist documenting their status, testifying to their current income, and arranging for their share of the sliding scale payment depending on their income while unemployed). An

[8] According to information pulled from Cover Colorado claims data over the last three years.

appropriate penalty would be assessed to non-compliant employers or individual. The proposers request the modeler's assistance in determining the appropriate penalty amount.

Individuals that do not carry coverage will be required to pay a percentage of what their total costs should have been (up to 100 percent) through their state income tax. If an individual came to their point of service and they are shown that they have not paid in, they will owe the state the back-portion for the time they did not contribute. The proposers believe penalties should be assessed through the state income tax mechanism which is already in place and provides for verification and enforcement protocols.

6. **This proposal is based on a "pay or play" model in which employers that do not offer health insurance pay a penalty. Many small businesses cannot afford to offer health insurance. Would a pay or play approach help or hinder small businesses in their ability to operate in the State?**

The proposers of *Healthy Colorado Now* are proposing a uniform amount of money, or percentage, based on payroll. All employers will be treated equally under this plan. The proposers do not anticipate this would hinder small businesses from starting up or staying in business in Colorado as it will eliminate the unfair advantages small businesses suffer when they cannot afford to provide health insurance to employees. In fact, most businesses would benefit from a healthier workforce and from the cost stabilization that would occur with fixing their future health care costs. Businesses would see less absenteeism and higher productivity as people with health coverage take better care of themselves and show up to work more frequently.

7. **Guarantee issue has been shown to increase insurance rates. Demonstrate how affordability for the lower income demographic can be achieved in this proposal.**

The effect of guaranteed issue on rates has only been documented in the current fragmented, unstandardized insurance environment, with large numbers of individuals remaining uninsured. The proposers of the *Healthy Colorado Now* plan anticipate that guaranteed issue in an environment of universal coverage would not add cost, but would result in a net decrease in cost by eliminating the cost shift for the uninsured. Furthermore, most of the uninsured are young and relatively lower cost to cover than the average Medicaid or Medicare beneficiary. Affordability would again be achieved by providing an income based subsidy for low-income individuals.

8. **How would you fund expansions of Medicaid and CHP+ in your proposal?**

Colorado Indigent Care Plan (CICP) funds and Disproportionate Share Hospital (DSH) funds could be redirected into expansion of Medicaid as they will be less necessary if not completely unnecessary in this model. Further, the proposers of *Healthy Colorado Now* believe it is essential to evaluate every possible way to maximize federal contributions

for Medicaid and CHP+ because maximizing federal match opportunities is an under-utilized methodology that could potentially bring new money in to the system. An on-going analysis is needed to determine which additional or supplemental revenue streams would be available for expansions.

9. Please demonstrate how your proposal contains health care costs.

First, cost containment can only be obtained by having reasonable administrative costs. Efficient administration is essential. It may prove beneficial to use and adapt an existing administrative system such as the Colorado Compensation Insurance Authority, as suggested in our proposal. Utilizing an administrative structure currently in operation will meet our goal of keeping administrative costs under 10 percent.

Also, the *Healthy Colorado Now* plan does an excellent and innovative job addressing health care costs. Behind the question about costs is the question about sustainability; which is an extremely difficult thing to measure. *Healthy Colorado Now* incorporates current research to control costs and ensure sustainability. These benefits will likely not be appreciated for several years and will certainly require initial investment. These are outlined in the proposal under section L. Sustainability and are summarized below:

- Evaluate new technology and make coverage decisions based on the value of this technology.
- Use the state's group purchasing power to negotiate lower prices with pharmaceutical firms and develop one formulary that will be used by PRO-CO.
- Establish, continually review, and update a standard benefit package based on proven, evidence-based medicine.
- Coordinate all care to minimize waste caused by the current fragmented health care system.
- Define criteria for a medical home and incentivize providers to utilize the medical home model.
- Aggressively monitor outcomes to ensure that the care provided is of high value.
- Ensure that the funds available to PRO-CO are continually evaluated and used appropriately.
- Optimize and improve wellness programs and incentives in the program and wherever possible, link to currently available state and local wellness programs with proven efficacy (smoking cessation, weight loss, stress reduction, nutrition, exercise and fitness).
- Monitor health spending and resource utilization in Colorado.

- Define and evaluate quality standards in clinical practice, medical home standards and patient care.

The proposers know that all of these pieces are incredibly important, and the cost savings will be shown down the road, but it will take some time. The *Healthy Colorado Now* Plan takes the long view on health care costs. By incentivizing prevention and wellness, reducing redundancy through health information technology such as electronic medical records, offering case and care management, and standard benefits, the plan will show significant cost savings.

The *Healthy Colorado Now* vision will fundamentally change health care in Colorado. The proposers' vision is a plan that immediately covers all Coloradans in a structure that can leverage change within the existing system and put in place a new model with the capacity grow and evolve into a completely new system that will dramatically improve and revolutionize the organization and provision of care in Colorado. This plan considers and engages all stakeholders in changing the health care system in Colorado which will save money and create a healthier state.

Community of Caring/Proposal #11

1. **Is your program based on concept that safety net providers provide care for most in the state – how will this be integrated with current private, non safety net provider system?**

   Currently, safety net providers are an integral part of the overall health care system in our state. Last year Community Health Centers – just one type of safety net provider - served 1 in 12 Coloradans and nearly 1 in 4 uninsured. The safety net has a long history of working closely in communities across the state with public and private hospitals, private physicians, specialists and other non safety net providers.

   Under the Community of Caring proposal, we envision building upon this successful model. The ***Health Insurance Partnership*** will contract with high quality health plans, including safety net oriented plans that have contracts with a variety of health care providers in the state. Many individuals will continue to rely on safety net providers because of their expertise in caring for low income, special needs, rural and other underserved populations. Even with statewide insurance coverage, safety net providers will be necessary to provide:

   - A health care home for rural and underserved Coloradans;
   - Capacity and workforce support to meet the health care needs of our state;
   - Care in areas of the state where historically underserved populations live; and
   - Experienced staff and leadership who have already successfully integrated quality initiatives including the chronic care and health care home models in their operations.

   As we consider providing coverage to an additional 770,000 Coloradans, the safety net is critical to assuring adequate statewide capacity so that we can provide a high quality, accessible health care home to all.

2. **Modified or pure community rating? Please clarify.**

   Our proposal does not require one specific approach. The ***Community of Caring*** proposal recommends one purchasing pool for the public and private sectors. Pure community rating is advantageous in our approach because a larger pool will lower risk for insurers and rates for individuals and employers. See pages 9 and 10 of our proposal for further information about this topic.

3. Please discuss how aspects of this proposal are similar to or different from the Colorado Family Care (HIFA) waiver proposal discussed in 2005.

Our proposal was developed and is responsive to the goals and principles in the Request for Proposal from the Blue Ribbon Commission on Health Care Reform. While our proposal includes some of the ideas put forth in Colorado Family Care proposal, our plan is more comprehensive and includes everyone in the state. The Colorado Family Care proposal was confined solely to the Medicaid and CHP+ programs. The Colorado Family Care proposal recommended one coverage pool for Medicaid and CHP+ children and families. Under that plan, families and children losing eligibility for public sector programs became uninsured. Our approach allows families to retain coverage as they move in and out of public sector programs and employment situations. The ***Health Insurance Partnership*** allows for blending the funding from employer, individual and public contributions to provide seamless, continuous coverage.

Our proposal reorients the health care system by:

1. Creating a ***Community of Caring Collaborative*** to:
    a. Promote a culture of health, wellness and prevention;
    b. Develop quality standards for the ***Health Insurance Partnership***;
    c. Develop programs that address health care workforce needs; and
    d. Facilitate community change and be an incubator for health innovation.

2. Creating a ***Health Insurance Partnership*** to:
    a. Provide universal, continuous and affordable coverage to all Coloradans;
    b. Combine and leverage the purchasing power of the public and private markets; and
    c. Enhance portability for Coloradans as they move through employment situations and on and off eligibility for public health insurance.

3. Creating the ***Colorado Health Benefit Package*** to ensure that all Coloradans have access to adequate health care benefits regardless of their payer source.

4. Creating a ***Safety Net Stabilization Program*** to recognize and provide a funding stream for providers that serve a disproportionate share of low-income and special needs Coloradans.

We must create a new context for prosperity in Colorado – one that includes the health of its people as the centerpiece of our community. We propose to:

- Provide health coverage for every Coloradan;
- Create a public-private partnership to lead a focused community discourse on a culture of health care for Colorado; and
- Leverage health care funds from all sources.

Our proposal recognizes the mobility in our society, especially those under 300% of the federal poverty level, in which families move between Medicaid, S-CHIP,

uninsured and privately insured – often within one year. Our proposal promotes access, coverage, portability, continuity of care and coverage, transparency in cost and quality, consumer choice and empowerment, with a particular emphasis on wellness and prevention and maximizes existing capacity and strengthens our health care workforce.

4. **This proposal would significantly revamp the state's insurance market, would impose mandatory guaranteed issue and community rating of insurance products and would require employers to contribute a significant amount towards the cost of health insurance. Would these new requirements potentially incentivize employers and insurers to leave the state and leave more Coloradoans without access to coverage?**

   Our proposal is built on the principal of a shared responsibility for health care between individuals, employers and government. In our current system, employers provide a disproportionate share of health care funding; this burden is particularly heavy on small employers, many of whom would like to contribute toward the cost of health insurance for their employees but are priced out of the market because of cost shifting and adverse selection that is currently built into the system.

   Our proposal shares the responsibility for covering all Coloradans by:

   - Providing subsidies to small businesses and individuals with low-income to help with the cost of coverage;
   - Reinforcing individual choice, continuity of coverage, portability and consistent rating across populations and years through guarantee issue and community rating; and
   - Employing one purchasing pool to:
     - Leverage the purchasing power of the public and private markets to maximize efficiencies; maximize existing public and private funding streams; reform purchasing while maintaining the Medicaid program;
     - Provide transparency in financing, evaluation, cost, coverage and quality;
     - Ensure rate stability and mitigate fluctuations in rates from year to year by having a extremely large base to spread risk;
     - Eliminate cost-shifting by covering all Coloradans and basing rates for all payers on a reasonable rate scale; and
     - Simplify administrative systems.

   Under current federal law, broad discretion is provided to states to expand Medicaid eligibility to 200% of the federal poverty level and beyond to children and families without a waiver. Covering lower income individuals through currently available federal funds further reduces the financial burden on businesses. By reducing overall health care costs through these various strategies, Colorado will continue to be seen as a business-friendly state with a healthy workforce.

5. How can consumer empowerment be achieved if government buys and standardizes all coverage?

Consumer empowerment is about empowering people to take charge of their own health and well being - not just about purchasing health insurance. The ***Community of Caring*** proposal is focused on reorienting the health discussion to create a new context for prosperity in Colorado – one that includes the health of its people as the centerpiece.

Under our proposal, the ***Health Insurance Partnership*** an independent partnership made up of public, private and business representatives – not the government – will oversee health coverage in our state. See pages 7 and 8 for a detailed description of the composition and charge of the Partnership.

Consumer choice and empowerment, in the context of health insurance, becomes a reality only when consumers have a choice of health plans and providers and useful information to inform their decision. This proposal would establish a broad menu of coverage options to insure the health needs of Coloradans. The ***Community of Caring*** also creates an environment where consumers are central to the decision making, inform the process and technology becomes a tool that works.

Our proposal supports and engages consumers in meaningful participation and collaboration. Through the ***Community of Caring Collaborative*** and the ***Health Insurance Partnership***, Colorado will solidify its commitment to:

- Individual ownership of health insurance;
- Individual selection of health plans and benefits;
- Wellness and prevention;
- Focusing on quality outcomes and encouraging high quality disease care which incorporates self management and clinical information systems and support;
- Technology, personal health records and electronic information exchange;
- Transparency of cost and quality data; and
- Evidence-based care.

6. How would you fund the proposal's expansions to Medicaid and CHP+?

Until we can have a statewide discussion about the full range of costs and benefits of creating healthy communities, insuring all Coloradans, removing negative incentive from the system and consolidating health care purchasing and rating, we cannot estimate the full costs of the proposal.

However, under current federal law, broad discretion is provided to states to expand Medicaid eligibility to 200% of the federal poverty level and beyond to children and

families without a waiver. Covering lower income individuals through currently available federal funds further reduces the financial burden on businesses and leverages all sources of funds, including employer and individual contributions. Increasing Medicaid eligibility levels for children and families adds room under the limited S-CHIP allocation to provide coverage to other individuals not currently covered.

The Blue Ribbon Commission for Health Care Reform is contracting with The Lewin Group to conduct a financial analysis of the impact of the selected proposals. The full costs and financing requirements will not be available until this work is complete, however, we look forward to working with the Commission and The Lewin Group on this important work.

7. Demonstrate how your proposal would contain health care costs.

We are proposing a comprehensive approach to coverage and financing and a broad community-based approach to prevention, wellness and developing systems for health that will contain costs. While there will be additional funds necessary to cover all Coloradans up front, over the long term providing access to quality health care for all Coloradans will save money.

Currently, we are using our dollars inefficiently to provide care to the uninsured, typically in high-cost settings. For example, in 2003 the cost of uncompensated care in Colorado reached 1.1 billion dollars.[9] Redirecting those resources to more appropriate use of cost-effective services will pay off over time. A comprehensive proposal that focuses on wellness, prevention, coverage and access to care will contain costs in the long run.

Additionally, the ***Health Insurance Partnership*** will contain costs by:

- Offering the ***Colorado Health Benefits Package*** to ensure health coverage of primary and preventive care to reduce expenditures on specialists, pharmaceuticals and unnecessary emergency room visits and hospitalizations;
- Treating people with behavioral health problems before they enter the criminal justice system, lose their jobs or become homeless;
- Competitively negotiating contracts with private health plans which will reduce administrative costs by creating a purchasing entity for both the public and private markets;
- Implementing quality standards for health insurers and health care providers based on guidelines from the ***Community of Caring Collaborative;***
- Educating and empowering Coloradans to make informed choices about their health insurance coverage;

[9] Department of Health Care Policy and Financing. Supplemental/Budget Amendment Request. (February 15, 2006)

- Utilizing existing resources within the system and maximizing federal funding which eliminates the "hidden tax" on health care that the insured pay to cover the costs of the uninsured; and
- Participating with the ***Community of Caring Collaborative*** to measure and monitor health plan performance, focusing on continuous improvement consistent with evidence-based medicine and to integrate best practices in wellness and prevention and encouraging high-quality team-based approach to chronic disease care.

The ***Community of Caring Collaborative*** will include all stakeholders in the design and implementation of strategies that help contain costs, including:

- Supporting state-of-the-art patient education by building and supporting community resources and technologies that provide transparent, accessible information for Coloradans to make decisions;
- Providing consumers with incentives for prevention and wellness and for self-management of chronic illness. Incentives in this case are not intended to reference financial incentives- but lifestyle incentives and community support;
- Integrating and supporting all aspects of technology, including acceptance of electronic medical records and promotion of interoperability;
- Developing and administering the ***Safety Net Stabilization Program*** including setting certification criteria for provider participation;
- Strengthening the health care workforce by recruiting and retaining qualified health care providers, particularly in rural and underserved areas;
- Supporting and managing quality initiatives that improve efficiencies and cut waste in the delivery system while delivering better health outcomes for patients; and
- Encouraging innovations that we have yet to envision.

A Plan for Covering Coloradans/Proposal #12

1. **Affordability review-- assumes variations, adjustments in benefits package? Please describe, and with particular attention to high needs, and LTC participants.**
   [*clarification was requested on this question, which resulted in the following restated question:*]
   How could you establish a structure that assures affordability, especially if it is dependent on annual appropriation of state funds? (see pg 19, paragraph 1 of proposal).

The challenge of assuring affordability is complex and our response to the Commission's question will address at least six relevant and important aspects—(1) the analytic process proposed to determine projected premium costs and affordability, (2) our proposal's approach to benefit design, (3) issues related to high cost cases, (3) the effect of emerging medical technology on affordability, (4) end of life issues and (6) long term care.

The structure we establish for assuring that health coverage is affordable for all Coloradoans hinges on a series of objective analyses commissioned by the Authority Board and decisions made by the Authority based on those analyses, as described on p. 19 of our proposal. It begins with defining a basic benefit package, a list of essential health care services which all plans must cover, along with a list of procedures or benefits that are excluded from coverage. This process aims at defining the "minimum health services that should generally and uniformly be available in order to assure adequate health status and protection of the population from disease"[10] and that meet any other criteria or standard adopted by the Board or legislature. Next, estimates of service utilization will need to be made. The analysis will have to account for the fact that insurance coverage increases the average use of health care services among those who have been without insurance, with a leveling off after the initial "pent-up demand". Costs of services will then need to be projected. Once a set of benefit plans are designed and utilization and service costs projected, estimates of the total cost of individual and family coverage may be made and a "benchmark premium" for the premium assistance plans established.

A separate analysis to determine how much an individual or family can be expected to contribute towards the cost of coverage (the affordability matrix) will be periodically commissioned by the Board. Methods for conducting such analyses have been established.[11] This affordability matrix, coupled with the benchmark premium, will define the income related premium assistance schedule. Estimates of the income distributions and employer premium contributions of the population predicted to enroll in

[10] Pepper Commission (1990). A Call for Action—US Bipartisan Commission on Comprehensive Health Care. Washington, D.C.: US Govt Printing Office.
[11] Glazner J. (2000) Prices and Affordability of Health Insurance for Colorado's Uninsured Population. Denver, CO: The Colorado Coalition for the Medically Underserved.

the premium assistance program must then be made before total required funding can be estimated.

This series of objective analyses and criteria-based decisions will determine the funding necessary for adequate assistance levels, which we propose be part of the governor's submission to the legislature. It will be "the job of the legislature to adjust revenue sources as necessary to provide adequate funding to maintain the guarantee of affordable coverage" (proposal, p. 19, #1).

We realize that the best data to make accurate projections of total costs will come from experience in the early years of implementation. Therefore, a staged implementation beginning with the lower income groups is recommended. Affordability studies may only be indicated every five years, with consumer price index adjustments in intervening years.

The questioner may be asking if the affordability assurance process we have proposed includes an option for the Authority to change the basic benefit design if faced with an inadequate budget appropriation. The answer is that while we recognize that the Board will have to make carefully balanced decisions on benefits that take into account estimated costs and available revenues, we would strongly discourage adjustments in the benefits package below the comprehensive standard package. The recent "melt-down" of the Oregon Health Plan (OHP) demonstrates the risk of relying on reductions in benefits rather than sources of sustainable funding to support expansions in public insurance.[12] Enrollment in OHP dropped precipitously, by 40% in 4 months, after major cuts in benefits and modest increases in cost-sharing were implemented.

Approaches to basic benefit design can be based on *promotion of access* to encourage early diagnosis, yield better long-term outcomes and potentially lower costs. Benefit design can also be based on *protection of assets* as exemplified by high-deductible, high-cost sharing plans that merely protect people from the costs of treating catastrophic illness. Our proposal recommends an approach strongly focused on promotion of access to primary care, but also protecting from catastrophe, within limits. Our proposal does not preclude a different choice of benefit design depending on the income levels of those covered by the plan; i.e. the design could focus primarily on the goal of protection of assets for the non-subsidized plans. On the other hand, we propose that the list of services defined by the basic benefit package be available with low cost-sharing (low deductibles and co-pays) and that there be first dollar coverage for preventive services in the two plans for which premium assistance is available. Our committee feels strongly that those with lower income levels should not be forced to have less-than-adequate access to routine care because they cannot afford full coverage. The remaining standardized plans adopted by the authority would be allowed higher cost sharing to assure they are affordable to those in higher income groups.

[12] Oberlander J. Health reform interrupted: The unraveling of the Oregon Health Plan. Health Affairs 26(1): w96-105, Dec 2006.

With respect to particularly high-cost cases which account for a notably disproportionate share of total health care expenditures, we propose that when very high needs become evident the initiation of intensive, patient-centered care coordination in order to insure that appropriate interventions are pursued, futile care is avoided and good health outcomes at reasonable costs are enhanced (CoverColorado is currently testing such an approach). We also suggest that the Authority Board create limitations on hospitalization, procedures and tests using evidence-based approaches to begin to impact the well documented overuse and misuse of services.

One of the reasons that our proposal did not bring the population traditionally served by Medicaid into the purchasing pool was that we believed that the special needs of the poor and disabled require different, enhanced benefit plans. Those with the highest needs may eventually become eligible for the Medicaid under one of our proposed eligibility expansions or buy-ins for that program. They would then be eligible for the fuller range of services provided by Medicaid (such as home and community based services, nursing facility care, increased assistance for durable medical equipment, transportation, training, and respite care), helping to support their independence and in some cases, their participation in the job market.

Another important issue is the rapid advancement of medical technology. High-cost interventions will increasingly become available, and it may not be possible for all people to have access to all or unlimited quantities of interventions. The Health Authority is likely to be faced with difficult choices in determining, not just the "floor", but also the "ceiling" of coverage in the sponsored plans, but it is our expectation that they will make those choices not from a political or purely financial standpoint, but with a full range of information from experts in medical ethics, outcomes research, and public policy.

We believe the improved management of end-of-life care is one of the most important health care reforms necessary to both assist families and the elderly and to contain costs. We have therefore proposed that providers (and/or a special service in the community) be compensated for assisting people in navigating care in high needs situations, and end of life; that hospice and palliative care at least equivalent to Medicare's coverage be included in the basic benefit package; that advance directives be required upon admission to nursing facility or home-based care; and we promote the rapid deployment of interoperable electronic medical records which will allow for portability of advance directives, treatment histories, medications, allergies and goals of care.

Although our committee did not have time to develop a full proposal on the issue of long-term care, we recommend that the 208 Commission carefully consider the Coordinated Care Pilot Program and other recommendations that are in final stages of development by the Colorado Long Term Care Advisory Committee established under Senate Bill 05-173.

2. What will be the biggest challenges/risks to implementing your proposal?

(Challenges that will be faced in any reform effort are italicized.)

Building public support—

- *Helping the public understand the complex issues involved in health care reform as well as tradeoffs inherent in meaningful reform.*
- *Building public support and buy-in across all stakeholders—demonstrating to each why there is something to gain*. This is particularly true for lower wage employers not currently offering health coverage and those in employment sectors that might be displaced by, or need to adjust their work to, the reforms. We must also convince providers and health plans to support the power and authority we propose to give the independent public authority.
- *Moving to a societal value of shared responsibility for health care coverage (individuals, employers, insurers, providers, government)*.

With respect to the insurance reform part of our proposal—

- The analytic challenge of developing an unbiased method for testing and correcting for adverse selection between plans.
- *Developing a process for defining covered benefits that is equitable, addresses emerging technologies and is fiscally responsible.*
- *Predicting total costs during the early implementation stage of the reform due to lack of data on possible adverse selection, the difficulty of estimating the effects of "pent-up demand" and health care utilization over the long term for newly covered populations, the level of employer contribution available to offset premium assistance, and the effect of cost containment strategies*.
- Creating a truly independent, objective Health Authority.
- Creating prices, products and services through the Purchasing Pool which are so attractive that self-funded plans will want to join.
- Addressing the risk of adverse selection caused by firms changing back and forth between self-insuring and participating in the pool as the health status of their employees' changes.

With respect to individual and employer mandates—

- Establishing employer assessments for those employers that do not provide coverage that capture a substantial proportion of the cost of insuring their workers without running afoul of ERISA or generating serious opposition by employer groups.
- Defining a fair affordability standard.
- Assuring high compliance with the individual mandate. In states with compulsory automobile insurance, 15% of people violate the law.
- Getting everyone signed up for a plan, establishing a simple and acceptable process for automatically enrolling those who can not demonstrate coverage, and establishing methods to maintain accurate rosters of subsidized enrollees so as not to pay premiums for those who are no longer in the state.

With respect to financing and containing costs—

- *Assuring that, whenever possible, funding of the health care system is based on objective cost projections and not political exigencies.*
- *Putting enough resources into the transition, and planning it well enough, to assure its success (e.g., we don't want a repeat of the CBMS experience).*
- *Health care costs that are already spiraling, due to many factors, many of which are beyond state control.*

With respect to the clinical components of our proposal—

- Creating and executing detailed implementation plans (e.g., disease state management, clinical information sharing, assuring the quality and managing the liability associated with the advice line).

With respect to portability—

- Our proposal significantly enhances the portability of health coverage because everyone continues to be covered despite changes in their life situations. It may, however, be necessary for individuals to change plans or providers when they transition between 1) Medicaid/SCHIP eligibility, 2) participation in the private market through the purchasing pool and/or 3) coverage in an employer's self-insured benefit plan. However, the Authority and the Department of Health Care Policy and Financing may be able to set up systems that would make the transition between public insurance and the subsidized plans in the pool largely seamless, leaving only those transitioning in or out of employer-based self-insured plans subject to disruptions in coverage.

3. Demonstrate how individual and small group policies will cost less than ERISA plans, as this proposal claims, and how a single pool has any greater integrity than the current system of risk pooling, if large group employers are not included.

Our proposal combines not only individual and small group markets, but also the large group market and all state employees into the purchasing pool. The only private plans not sold through the purchasing pool would be self-insured plans, otherwise known as ERISA plans.

In the current market there is only a patch work of risk pooling with many employers and individuals priced out because they are defined as higher risk based on the imprecise predictors insurers have at their disposal. The risk of a few high cost cases is substantial for smaller carriers in the current markets, and they must compensate by charging more and retaining larger reserves. Insurers are forced to plan for the worst that can happen and this adds a substantial amount to premiums. In our proposal, insurers would end up with more covered lives, more predictable risk, and assurance of risk adjustment, lowering the amount that needs to be added to premiums. Furthermore, the size of the pool will stabilize the year to year variation in premiums. By proposing real risk pooling we create a market with a high degree of "integrity".

We estimate that 69% of all persons covered by employer-based insurance in Colorado are currently in ERISA plans.[13] Seventeen percent are covered in the large-group commercial market and the remaining 14% are in the small group market. Adding together all Coloradans with private health coverage, we estimate that at least 40% are in the commercial market or are state employees and would be pooled in our reform proposal. Such a substantial number of covered lives, when coupled with standardization of benefit designs to help prevent adverse selection, and risk adjusted payments to account for adverse selection when it occurs, will considerably stabilize the commercial market and prevent risk fragmentation.

This questioner raises an important issue, which is the potential for large employers, particularly those with young, healthy workforces, to leave the commercial market (and the pool) and self-insure. Why would large groups want to be in the new large purchasing pool? The most important driver is cost. While we don't state that equivalent policies offered through the pool will be less expensive than the total health benefit costs that a large company would face through self-insurance, we believe that premium costs will be very competitive. The reason is two fold: First, our pooling design significantly reduces the administrative costs of carriers. Marketing, underwriting, churning enrollments and costs of administering multiple benefit packages in fragmented markets will all be substantially less. Second, costs will also be lower due to proposed cost-control mechanisms within the pool, particularly the plan to attract managed care plans with network provider integration into the market. California provides an example of the relationship between availability of managed care and large employers electing self-

[13] America's Health Insurance Plans, Health Insurance Overview and Economic Impact in the States, December 2005. www.ahipresearch.org/statedata.html.

insurance. California has a high penetration rate for HMOs and the lowest proportion of employer-based covered lives in self-insured plans of the 50 states (49%).

There are also other reasons that human resource managers in firms currently self-insuring will be attracted to the large purchasing pool we propose:

- Predictability: premiums will be more stable from year to year
- Simplicity: they get out of the business of having to choose and manage health benefits
- Consistency: their employees receive the same standard benefits as everyone else, and now have access to enhanced services such as intensive care coordination when employees have high needs
- Participation in the premium assistance program: In particular, firms that employ large numbers of low income workers will be selecting the pool in order to take advantage of the assistance program.

Two types of employers may still decide to choose self-insurance. Large firms that operate in multiple states and have system wide benefit packages may continue to choose self-insurance for consistency and simplicity within their own system, and possibly for cost. Employers with generally healthy employees (who are not income eligible for premium assistance) may also opt for self-insurance. While our proposal does not challenge the right of firms to self-insure for employee health coverage, there are some indications that a small number of "self-insured" plans may fall into the category of insurance and therefore fall under state regulatory authority. Our committee believes it would be beneficial to the success of any reform effort to encourage the Colorado Department of Insurance to monitor this closely and pursue regulation of self-funded arrangements that fall into the category of insurance if this trend appeared to compromise goals of reform. If employers truly had to retain risk for providing employee benefits in order to avoid state insurance regulation, fewer would opt out of the insured market.

4. How would your proposal create funds for Medicaid and CHP+ expansions?

On page 10 of our proposal and in Appendix I, we list the new sources of funding that will be required to raise the dollars needed for the state match for expansion of Medicaid along with costs of operating the Authority and the premium assistance program.

Our proposal seeks funding from the following sources. Each has combined effects of increasing revenues and either redressing current inequalities or aligning incentives to support health:

- An employer assessment for employers who do not offer a minimum level of health care coverage to their employees and families—we believe this assessment must be well below the actual cost of coverage to avoid an ERISA challenge but we do not rule out more aggressive strategies to increase revenues from this source. This assessment levels the playing field between employers.
- A premium assessment on insurers—the thinking being that some of the administrative cost savings that the pooling mechanism provides could be turned over to the premium assistance fund.
- An assessment on hospital and physician/group practice revenues. This would lead to an increase in fees and therefore a one time rebasing of the cost of premiums in the commercial market and costs of claims among self-insured firms. We see this as capturing uncompensated care costs for the uninsured population who will be brought into coverage by our reform plan. It keeps health care related dollars within the health care system, is likely ERISA compliant and levels the playing field between providers who currently provide high levels of uncompensated care with those who don't.
- We also identify new alcohol and tobacco taxes and assessments on certain luxury goods and services as feasible options. The former have the additional benefit of reducing use and abuse of products with health-averse impacts—impacts that are disproportionately borne by the population eligible for Medicaid. Alcohol taxes have not been raised in Colorado since 1976 for beer and 1981 for wine. The $31 million in revenue collected annually from state excise taxes falls far short of covering the cost of alcohol-related health care costs in Colorado. Tax on beer and wine is currently $.08 and $.28 per gallon, respectively. Simply adjusting for inflation would have raised these taxes to $.29 and $.62, respectively. Colorado also has room to go in raising tobacco taxes. At $.84 per pack, our excise tax is currently 19% below the average for states.[14]

These new revenue sources would fund the Medicaid/SCHIP expansions as well as the Authority and the premium assistance program.

A limited amount of additional funding for the Medicaid/SCHIP expansion would be freed up from certain dollars from Amendment 35 and Referendum C pertaining to public

[14] http://tobaccofreekids.org/research/factsheets/pdf/0097.pdf

assistance expansion efforts. We also note that funding for CoverColorado will no longer be necessary. These dollars could be redirected to fund our coverage initiatives.

Finally, a new bill introduced in Congress in April 2007 by Senators Feingold and Graham entitled "The State-based Health Care Reform Act" would create significant funding for pilot programs in a few states to increase health coverage. If this bill passes, the timing of Colorado's 208 Commission process puts our state in an ideal position to compete for these funds. Our proposal meets the minimum requirements proposed in the legislation (the coverage initiative must identify a set of minimum benefits for every covered individual which must be comparable to health insurance offered to Federal employees and must include a mechanism to guarantee that the insurance is affordable).

5. Demonstrate how your proposal would contain health care costs.

We believe that cost-containment can only be fully realized through major restructuring of the systems of financing health care and of delivering health care. Short of major federal reform however, the state is limited in what it can do. We have proposed an aggressive but practical approach to restructuring systems:

- Reorganization of health insurance market—
  by merging all commercial health insurance markets into a single purchasing pool under the organization of a new quasi-governmental Authority and combining the two major state programs, Medicaid and CHP Plus--
    - Our market restructuring can be expected to immediately reduce average private insurance premiums due to economies of scale from enlargement of the risk pool and reductions in marketing and underwriting costs.
    - Because individuals will be selecting their plans in the purchasing pool, there will likely be less churning of enrollment in plans, and this will further reduce premium costs.
    - Standardization of benefit packages, forms, billing and payment processes could substantially reduce administrative costs at the point of service. We note that billing-related expenditures alone accounted for 20% of private health care expenditures in a California study (proposal, p. 12).
    - Consumers will be able to truly compare products based on quality and price under our proposal. The purchasing pool will vastly simplify and clarify comparisons between plans for consumers. Benefit packages will be standardized, and information will be collected and reported by the Authority on plan customer service ratings and network quality indicators.
    - Our proposal promotes evidence-based benefit designs to control costs:
        - Availability of higher cost-sharing plans for those in higher income levels who can afford it.
        - Low or no cost-sharing for evidence-based preventive services such as vaccines, prenatal care, cervical cancer screening and tobacco cessation services.
        - Embracing evidence-based pharmacy benefit design that includes cost-effectiveness considerations: e.g., we propose requiring

Medicaid and subsidized plan to have formularies based on cost-effectiveness data. Other states have saved tens of millions of dollars per year using Medicaid preferred drug lists. Governor Ritter got the ball rolling this year with an executive order to implement a preferred drug list.

- Incentives for patients to use physicians, hospitals and networks that are identified as "high performance" providers, meaning their care meets Board established criteria for high quality at low cost.

- Health care delivery system redesign.
  Fundamentally, we believe that delivery models must align the incentives of health care providers to optimize health while controlling costs. We leverage the reorganized and consolidated insurance system under the Colorado Department of Health Care Policy and Financing (public) and the Colorado Health Insurance Purchasing Authority (private) to do this.
  - Managed care delivery models with financial or other types of integration of physicians and hospitals (e.g. group and staff model HMOs like Kaiser-Permanente and Denver Health) with incentives to increase quality and control costs, such as pre-paid contracts, are a key strategy that our proposal supports in both the public and private systems. We cite strong evidence that in regions where there is competition among HMOs, consumer prices are lower: e.g., group model HMOs in highly competitive markets have premiums 11% lower than those in other markets.[15] Even in regions with low penetration of managed care, vertically integrated systems are less expensive. Where such conditions exist in the state, our proposal would invite a competitive bidding process in both Medicaid and the purchasing pool subsidized plans to contract with plans.
  - Support for primary care
    - A requirement for medical home enrollment in public and private plans. A medical home is a primary care practice that provides people with accessible, continuous, and coordinated care. Medical homes are associated with better health and lower overall costs of care, as well as a reduction in disparities in health.[16] Plans will offer management fees to clinicians who serve as personal physicians and incentive payments to physicians in practices that provide medical home services.
    - A telephone nurse/physician advice line available state-wide, which is helpful to all and especially useful for those for whom a medical home is not available or established. Denver Health has

[15] Stanton MW, Rutherford MK. Reducing costs in the healthcare system: learning from what has been done. Rockville (MD): Agency for Healthcare Research and Quality; 2002. Research in Action. Issue 9. AHRQ Pub. No. 02-0046.
[16] Starfield B; Shi L. The medical home, access to care, and insurance: a review of evidence. Pediatrics 113(5):1493-1498, 2004.

evaluated their telephone advice line. They found that patients frequently chose a lower level of care if they talked to a nurse.[17]

- Compensating providers (or providing services in each community) for assisting patients in care management such as end-of-life care and care for chronic disease and other high needs.

- Integrated health information systems and electronic medical records/systems with interoperability and decision support. There is a potential for investment in health information technologies that include networks of electronic medical records (EMRs) to be cost-saving to both providers and payers[18] (for instance, by reducing redundant medical and radiology tests by up to 20%, reducing billing errors, preventing fraud, increasing evidence-based care and improving referral processes and care transitions[19]). The challenges are that health information technology is generally necessary but not sufficient to reap these savings (cost savings also requires changes in how providers practice), that it takes time and high initial investments to implement, and that the benefit does not necessarily accrue to the providers that bear the burden of the cost investment. That is why our proposal calls for the creation of a state Office of Health Information Technology department, funding options, and pay-for-performance schemes to help smaller providers select, afford and exploit the efficiencies and quality improvements possible with EMRs.
- Identifying the small proportion of cases that cost the most and providing carefully constructed wrap-around advanced multi-disciplinary case management with the targets of optimizing treatment and enhancing health incomes.
- Pay-for-performance at both the HMO/integrated system level and the individual provider level has great potential to improve quality and may have some potential to reduce costs, however there are many limitations in current approaches that need to be addressed. Our proposal charges the Authority with convening experts and stakeholders to evaluate and select robust performance measures that are focused on efficiency, coordinated care and health outcomes.

- Accessing additional federal funding.
  Finally, we save state dollars by drawing down federal dollars whenever possible:
  - Expanding Medicaid and SCHIP eligibility
  - Maximizing the use of 340B drugs pricing. The federal 340B Drug Pricing Program provides access to reduced price prescription drugs to nearly 200 health care facilities certified as "covered entities" by the U.S. Department of Health and Human Services (HHS) in Colorado. These clinics, centers

[17] Personal communication, Patricia Gabow, MD, CEO, Denver Health, 5/13, 2007.
[18] Health Information Technology: Can HIT lower costs and improve quality? RAND Research Highlights: 2005, accessed at http://www.rand.org/pubs/research_briefs/RB9136/index1.html.
[19] Oregon Health Policy Commission Report to the 73rd Legislative Assembly: Electronic Health Records & Data Connectivity. March 2005

and hospitals in turn serve thousands of Medicaid patients as well as other government-funded populations (prisoners, mental health and indigent patients). Requiring these patients to use accessible 340B pharmacies would save the state millions of dollars. For example, in 2005, Denver Health's Medicaid Managed Care program saved $5.7 million dollars using this approach. Adding negotiation of supplemental cash rebates and competitive bidding of pharmacy services would save millions more dollars for the state Medicaid program[20].

Although we realize that this question addresses health care cost containment, there are two additional points that our committee believes are important to make. The first is that, in some cases, it may be to Coloradans' advantage to consider the impact of cost containment across more systems than the health care system when making decisions as to what type of health care to provide, as in the case of providing early intervention in mental illness and substance use disorders. The indirect costs associated with mental health and substance use disorders affect an array of state social service systems, the criminal justice system, the public safety system and losses to the state workforce.

The second point is that our committee considered a wide variety of prevention and wellness initiatives, but tried to keep in mind that while it is tempting to think of all prevention/early intervention health services as cost-saving, many are significantly health-saving, but not cost-saving. Therefore, our committee believes that the following elements of our plan relate directly to **prevention, early intervention, and wellness**, but that not all will be cost-saving measures:

- Coverage for all, which will help stimulate patients into accessing care early
- Financial assistance for those with lower incomes, so that they will be more likely to seek care
- Comprehensive benefits packages for all, which include (along with all other services), zero co-pays for the most evidence-based preventive services, first dollar coverage for prevention and early detection services, prescription coverage, and treatment for mental illness and substance use disorders
- Special assistance for those with diagnoses that are likely to lead to a need for extensive care, through minimal or no co-pays for chronic disease care and medications, intensive multidisciplinary care coordination, and assistance in managing care at home
- Promotion of the use of clinical guidelines by providers

While we believe that the rising rate of obesity is likely to contribute significant cost and health burden in the future, we were unable to quickly identify evidence-based practices within the health system that would make a significant impact. This is an area that will require further consideration. We also considered many other possible ways to promote wellness (discounts for healthy behaviors or products leading to activity, penalties for

[20] See Office of Program Policy Analysis and Government Accountability an office of the Florida Legislature, Report No. 03-27, April 2003

unhealthy behaviors, etc.), but in the end decided not to include them in our proposal due to lack of evidence of effectiveness and the challenges in preventing abuse of the incentives.

Colorado Health Services Program/Proposal #16

1. Do you envision any changes or reductions (besides increased availability of home based care) to Long Term Care programs and services? Please describe.

We envision no reductions to long term care services. Numerous studies have demonstrated the cost effectiveness of outpatient long term care services. In fact, we envision home health services as a team member in the medical home model. This is especially effective in the management of chronic disease states such as congestive heart failure or high risk pregnancy and in prevention of malnutrition; avoidable falls, etc., in the elderly. These interventions have been shown to decrease hospitalizations, severity of illness if hospitalization occurs along with shorter lengths of stay.

Other long term care services, such as inpatient psychiatric care for severe mental illness, hospice, rehabilitation, etc., are intended to be covered services. Nursing home services are also covered with the exception of room and board, which would be means tested just as it is now.

2. Your proposal provides that all physicians would be reimbursed at the same rates. Currently some physicians charge far more than their colleagues. How would your proposal dissuade talented physicians who can command far greater reimbursement than their peers from leaving Colorado to practice in a state where they would make more money?

First, all physicians would be reimbursed the same for the same procedures or the same level office visit. Under our present system, there are physicians who charge more than others, but they rarely receive that. Currently, physician reimbursement is fixed to the allowable payment by Medicare and Medicaid and is also determined by the contracts that those physicians have with the insurance companies. In reality, currently a doctor can charge whatever he wants but he is not going to get it and physicians are not leaving the state today as a result.

It is our intent that physician reimbursement under this plan remains specialty and regionally competitive with their peers, although serious consideration needs to be given to providing a more fair and equitable reimbursement scheme between the cognitive and procedural specialties.

The plan does allow for physicians to provide services that are not covered benefits and to charge patients individually what the market will allow for those services. We recognize that some individuals will be willing to pay out-of-pocket for boutique or concierge medicine and this proposal allows for that.

3. How does this proposal promote personal responsibility, cost-conscious decision making and a sustainable fiscal base?

The program is sustainable on several levels because everyone has access to a Medical Home where preventive medicine is emphasized and savings are seen in prevention and proper treatment of chronic disease states. Because everyone has access to a primary care provider, the Medical Home can be used instead of the emergency room for most care and the driving cost of delayed care can be drastically reduced.

With the use of centralized data gathering, utilization, safety data, quality, outcomes and practice patterns can be tracked and patient or physician outliers can be identified. This can help to identify fraud but also can be used for incentives such as pay-for-performance rewards for providers or reductions in premiums for patients who demonstrate compliance or healthy lifestyles.

Because the amount that is contributed to the system is placed on an individual's state income tax forms, they do become aware of the amount that they are personally contributing. Rewards such as reductions in their individual premiums can be applied as discussed above.

Other sustainability issues include a cap on administrative expenses, a program that cannot operate in a deficient, if it does experience excess funds that money must stay within the program, the program has legal authority to pursue value purchasing, and because decision making of the board is transparent, consumers help to guide the program, making it truly "consumer driven".

4. Demonstrate how having a single governing board for managing a health care system achieves the principle of increasing personal responsibility and consumer empowerment?

This program exposes the philosophical differences between social and personal responsibility. There is only so much that an individual can do to affect their own health and offering such things as a reduction in premiums to reward healthy lifestyle choices is one way to encourage that (in fact, unless we are lucky enough to die in our sleep, every one us will eventually develop a chronic disease which will be very expensive to manage). The RAND studies of the past demonstrated that increasing "personal responsibility" in the form of copays and deductibles not only discouraged the use of unnecessary care but also discouraged the use of necessary care. The disparities between the use of "necessary" and "unnecessary" care is also magnified in the most vulnerable populations. As a result, increasing "personal financial responsibility" and "empowering" consumers to make health care choices based upon their own personal income only works when individuals have the resources to do so. It favors the wealthy and creates huge disparities, not only in access but also in the way that providers deliver care.

Having a single system levels the field for all (providers and consumers) on at least what is considered basic care and having a single governing board which must

function in a transparent manner truly gives consumers a platform to have their input into what benefits are being offered and how their money is being spent.

5. Demonstrate how your proposal contains health costs.

A. By having a single administrative process which is not-for-profit, several studies have demonstrated that we can save about 20% in health care expenditures.
B. Because everyone has access to a Medical Home, savings can be seen on numerous fronts. Diminished use of emergency rooms for non-emergent problems, prevention services (immunization, education, family planning, prenatal and childhood care, etc.) to head off chronic disease states before they become expensive, detecting cancer when it is easily treatable, when chronic disease states are present, proper follow up can prevent expensive hospitalizations or more expensive interventions due to delayed care.
C. Use of a statewide, centralized, fully-integrated health information technology network to track outcomes, practice patterns, and utilization. This information can then be used to improve quality, safety, and outcomes which save lives and money.
D. Because coverage is continuous, malpractice awards no longer have to address medical expenses, thus lowering malpractice premiums. For the same reason, savings will also be seen in auto and workers compensation premiums for individuals and business.
E. With the board having the legal authority to set limits on spending and benefits, health care inflation can be better managed.
F. Having a single drug formulary allows the program to encourage the use of generic medications and allows pharmaceutical companies to compete for contracts with the CHS.
G. Because of all of the above and the fact that cost-shifting is essentially removed, the health premiums that business and individuals have to pay can be contained.

FAIR Health Care/Proposal #21

Free-markets, Affordability, and Individual Rights

May 14, 2007

Brian T. Schwartz · WhoOwnsYou.org

The answers to Commission questions refer to specific reforms in the proposal. For completeness of this document, their definitions and acronyms are reproduced below:

Benefits Mandates Reform (BMR)

The Colorado legislature should repeal any and all benefits mandates related to health insurance. A mandated benefit, as defined by the Council for Affordable Health Insurance (2007), is legislation "requiring that a health insurance policy or health plan cover (or offer to cover) specific providers, procedures or benefits." Such mandates drive up the costs of insurance premiums, thereby causing some people to drop insurance or not purchase it. Benefits Mandate Reform, or "BMR" in this proposal, seeks to repeal benefits mandates that the state currently places on insurance policies.

According to the Council for Affordable Health Insurance, Colorado currently has 37 mandated benefits. For the list, see their "Trends in State Mandated Benefits, 2006," on-line at http://www.cahi.org/cahi_contents/resources/pdf/TrendsEndsMay2006.pdf.

Small Group Reform (SGR)

Small Group Reform, or "SGR" in this proposal, seeks to phase out the state's distinction of a "small group of one." While federal rules impose "guaranteed issue" on small-group insurance – i.e., require insurance providers to offer insurance to everyone in the category who applies – Colorado also imposes "guaranteed issue" on the "small [or business] group of one," meaning the self-employed who qualify. The state thus creates a perverse incentive that encourages some people to avoid purchasing health insurance until after they develop health problems. This drives up insurance costs for other small-group participants. Phasing out the category of the "small group of one" will encourage more of the self-employed to seek lower-cost, long-term, individual insurance in conjunction with a tax-exempt Health Savings Account.

Medicaid Reform (MCR)

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)
MCR2: Utilize new state-level authority granted by the 2006 Deficit Reduction Act (DRA)
The National Center for Policy Analysis summarizes what the Deficit Reduction Act allows states to do regarding Medicaid (Goodman *et al* 2006). They include

(**MCR2a**) Tailor benefit packages to certain eligible Medicaid populations, as long as the benefits are at least as generous as a Blue Cross Blue Shield plan currently offered to federal workers.

(**MCR2b**) Charge premiums and copayments for beneficiaries whose incomes are over 150 percent of the federal poverty level; however, certain mandatory populations (pregnant women and children) will still be exempt from cost-sharing.

(**MCR2c**) Increase the "look back" period to five years to discourage seniors from transferring assets in order to quality for Medicaid.
(**MCR2d**) Allow states to offer more home care through community-based services as an alternative to costly nursing home care without requiring a waiver.

MCR3: Allow Medicaid to compete with charities by establishing a dollar-for-dollar tax deduction for donations to qualified Colorado Health Charities.

1. Please describe how this program promotes efficiency and addresses the problems of the under insured.

My proposal addresses efficiency in Section (*i*), starting on page 25, and answers the following:

1. Does your proposal decrease or contain health care costs?
2. To what extent does your proposal use incentives for providers, consumers, plans or others to reward behavior that minimizes costs and maximizes access and quality in the health care services?
3. Does this proposal address transparency of costs and quality? If so, please explain.
4. How would your proposal impact administrative costs?

To summarize; benefits mandates, guaranteed issue for the "business group of one," the lack of cost-sharing in Medicaid, Medicaid long-term care abuse, and Medicaid's status as a monopoly charity all increase the costs of health care. My proposals address these issues and will decrease costs of health insurance and health care. The decreased costs will make health insurance more affordable to the under insured. I will further address how my proposal specifically promotes efficiency in the following sections on Benefits Mandates Reform (BMR), Small Group Reform (SGR), and Medicaid reform.

Benefits Mandates Reform (BMR)

Mandated benefits increase the cost of insurance from between 20 to 50%, and have been shown to be responsible for 20% to 25% of the uninsured. Current mandates prohibit insurance companies from selling low-cost plans, which hence discourages them to minimize costs. Mandates force consumers to purchase more expensive policies than they would freely choose – this increases premium costs.

Mandated benefits also distort the insurance market toward prepaid health care plans, which discourage consumers from being frugal and thoughtful consumers because someone else is paying the bill. Without benefits mandates, consumers will be more likely to purchase less comprehensive plans and use the cost-savings to self-insure, perhaps with a tax deductible Health Savings Account. As the RAND Health Insurance

Experiment shows, cost-sharing increases transparency of costs hence significantly reduces consumer spending at negligible impact on their health.

> In a large-scale, multiyear experiment, participants who paid for a share of their health care used fewer health services than a comparison group given free care.
>
> - Cost sharing reduced the use of both highly effective and less effective services in roughly equal proportions. Cost sharing did not significantly affect the quality of care received by participants.
> - Cost sharing in general had no adverse effects on participant health, but there were exceptions [just 4 out of 30 conditions]: free care led to improvements in hypertension, dental health [seeing a dentist], vision ["marginal"], and selected serious symptoms. These improvements were concentrated among the sickest and poorest patients.
> - Cost sharing also had some beneficial effects. Participants in cost sharing plans (higher deductible) worried less about their health and had fewer restricted-activity days (including time spent in seeking medical care).
> (source: http://www.rand.org/pubs/research_briefs/RB9174/index1.html)

Small Group Reform (SGR)

Guaranteed issue for the "business group of one" creates a moral hazard by allowing qualified individuals to wait until they are sick to purchase insurance. This increases costs by keeping healthy individuals out of the risk pool.

Medicaid Reform:

Excerpt from Appendix D of the FAIR proposal:

> Medicaid increases health care costs for those not enrolled. *The Puget Sound Business Journal* reports that "employers pay hundreds of dollars more for each employee because Medicaid and Medicare underpay hospitals and doctors. In 2004, according to the study, Washington employers together paid more than $1 billion in health care costs to cover government payment shortfalls incurred by hospitals and physicians. The study, by the actuarial firm Milliman Inc., concluded that nearly 9 percent of what employers pay in insurance premiums a year goes to subsidizing Medicaid and Medicare rather than to covering employee medical expenses" (Neurath 2006).
>
> Medicaid also increases drug prices for those with private insurance. A study by the National Bureau of Economic Research (Duggan and Morton 2004) found that "a ten percentage-point increase in the MMS [Medicaid Market Share] is associated with a ten percent increase in the average price of a prescription. This result is robust to the inclusion of controls for a drug's therapeutic class, the existence of generic competition, the number of brand competitors, and the years since the drug entered the market. We also demonstrate that the Medicaid rules increase a firm's incentive to introduce new versions of a drug at higher prices and find empirical evidence in support of this for drugs that do not face generic competition. Taken together, our findings suggest that government procurement can have an important effect on equilibrium prices in the private sector."
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> References:
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> Neurath, Peter, "Study: Medicare, Medicaid payments drive up employee insurance costs," *Puget Sound Business Journal*, http://tinyurl.com/2vnvzr, May 31, 2006

Duggan, Mark, and Fiona Scott Morton, "The Distortionary Effects of Government Procurement: Evidence from Medicaid Prescription Drug Purchasing," NBER Working Paper no. 10930, http://www.nber.org/papers/10930, November 2004.

Increasing cost-sharing for Medicaid enrollees can mitigate how Medicaid increases health care costs. Parts of my proposal that increase cost sharing include:

MCR1: Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs)

MCR2: Utilize new state-level authority granted by the 2006 Deficit Reduction Act (DRA)

The National Center for Policy Analysis summarizes what the Deficit Reduction Act allows states to do regarding Medicaid (Goodman *et al* 2006, http://www.ncpa.org/pub/st/st288). They include:

> (**MCR2a**) Tailor benefit packages to certain eligible Medicaid populations, as long as the benefits are at least as generous as a Blue Cross Blue Shield plan currently offered to federal workers.
> (**MCR2b**) Charge premiums and copayments for beneficiaries whose incomes are over 150 percent of the federal poverty level; however, certain mandatory populations (pregnant women and children) will still be exempt from cost-sharing.

Medicaid's fee-for-service plan is effectively prepaid health care, which encourages thoughtless over-consumption and increases costs of private insurance plans. The FAIR proposal suggests that Colorado emulate South Carolina and Florida by converting Medicaid to a voucher-based program for private insurance with Health Opportunity Accounts that enrollees can use for out-of-pocket health care expenditures. As I mentioned above, cost-sharing increases efficiency by reducing expenditures with negligible effect on health outcomes.

Converting Medicaid to a voucher-based program for private insurance can reduce the number of frequent emergency room users. Empirical studies have shown cost-sharing to reduce emergency room use. In *Covering America: Real Remedies for the Uninsured*, Tom Miller notes that "that increased cost sharing could discourage patients from inappropriately using hospitals' emergency departments" Miller sites a study in the *New England Journal of Medicine* (O'Grady, Manning, Newhouse, and Brook. "The Impact of Cost Sharing on Emergency Department Use." August 22, 1985, p 484–90) finding that a "25-percent level of cost sharing deterred emergency department utilization for less serious conditions but did not deter utilization for more serious conditions." A more recent study in the same journal (Selby, Fireman, and Swain. "Effect of Copayments on Use of the Emergency Department in a Health Maintenance Organization," March 7, 1996) concluded that "a small co-payment resulted in a 15 percent reduction in emergency department utilization but did not affect conditions classified as 'always an emergency'." (source: http://www.cato.org/research/articles/miller-coveringamerica.pdf)

The success of Colorado's Consumer-Directed Attendant Support (CDAS) program also provides evidence that putting Medicaid recipients in charge of their health care spending has satisfies enrollees and contains costs. Under CDAS, started in 2002, severely disabled Medicaid patients have the ability to choose their own caregivers and choose how to spend money on equipment to help them with their disabilities. John Andrews (*Wall Street Journal*, 2005) reports that,

> CDAS, our state's experiment with Consumer-Directed Attendant Support for the severely disabled, got started in 2002. The wheelchair-bound Linda Storey was one of its first four clients. The program now has 146 participants, each newly empowered to hire and fire their own caregivers. Quality of care and patient satisfaction are up, costs are down, and legislators approved offering the option for 33,000 Medicaid recipients statewide in 2006.
>
> If there is more alleluia and less blues in the Storeys' music these days, CDAS is a big reason. "It gives you your life back," Mrs. Storey told me. "I'm in control of my health now." Under a federal waiver obtained by Colorado officials, she selects the health aides who come to her house, bypassing the provider agencies otherwise required under Medicaid rules for home- and community-based services.
>
> ...[W]ith Medicaid expenses surging faster than almost every other budget line in almost every state, such savings are welcome news to policy makers. Taxpayers in Colorado have seen their share of Medicaid--matched dollar for dollar with federal funds--increase almost 33% since 2001. Another 22% jump is predicted by 2010.
>
> Absent a tax increase here (one on the November ballot is trailing in opinion polls), the Medicaid spiral will continue squeezing all other priorities except K-12 education.
>
> The first two years of Colorado's CDAS pilot program, by contrast, showed average monthly spending at 21% under budget ($3,925 per client allocated, $3,131 expended). While the sample is tiny, the vector is positive for once. To Medicaid administrators like Aggie Berens and Viki Manley, that brings unaccustomed praise--and proud smiles."

(MCR2c) Increase the "look back" period to five years to discourage seniors from transferring assets in order to quality for Medicaid.

In *The Wall Street Journal*, Stephen Moses (2005), President of the Center for Long-Term Care Reform, writes:

> According to the National Council on the Aging, 81% of America's 13.2 million householders aged 62 and over own their own homes, and 74% own their homes free and clear. Altogether, seniors possess nearly $2 trillion worth of home equity. Yet, by the time they apply for Medicaid, few own their homes. Are they giving the homes away to their grown-up children or other relatives? Such a transfer of assets carries no legal penalty as long as it is done at least three years and a day before applying for Medicaid.
>
> That's just one of hundreds of eligibility "loopholes" that allow individuals, especially those advised by Medicaid planning attorneys, to qualify for Medicaid long-term care benefits without spending down their own wealth for care. If you doubt this, try an Internet search for

"Medicaid planning" and read some of the sales pitches on the more than six million hits. You'll learn how to purchase non-countable assets, buy and give away a string of luxury cars without penalty, hide wealth in exempt annuities, sell your ailing parent a "life-care contract," even buy a farm or business -- all for the express purpose of "impoverishing" yourself or a loved one artificially and qualifying for Medicaid long-term care benefits.

Extending the look back period can discourage such abuse and reduce Medicaid costs because, as I wrote in Appendix D of the FAIR proposal,

> Medicaid also crowds out long-term care. A National Bureau of Economic Research study by Jeffrey Brown and Amy Finkelstein found that "the provision of even incomplete public insurance can substantially crowd out private insurance demand. We examine the interaction of the public Medicaid program with the private market for long-term care insurance and estimate that Medicaid can explain the lack of private insurance purchases for at least two-thirds and as much as 90 percent of the wealth distribution, even if comprehensive, actuarially fair private policies were available" (http://www.nber.org/papers/w10989).

(MCR2d) Allow states to offer more home care through community-based services as an alternative to costly nursing home care without requiring a waiver.

John Goodman and his colleagues at the National Center for Policy analysis explain how this measure can reduce costs and better serve Medicaid enrollees"

> Medicaid encourages institutional care over home care. Although many state programs are changing, they could increase their use of less-expensive home care.[1] Home care often costs only half as much as a nursing home. [2] In some high-cost areas, the cost savings from home care may be even greater. For instance, home care in Washington, D.C., costs less than one-third as much as nursing home care. In Manhattan, a year of home care costs only about one-fifth as much as a year-long stay in a nursing home. [2] Home providers offer a range of medical services, including occupational or physical therapy.
>
> Ohio, Oregon, Washington and Wisconsin expanded home- and community-based care to help control rapidly increasing institutional care expenditures. These states were able to serve more people while controlling the growth in overall long-term care spending. Between 1982 and 1992 the combined total of nursing home beds in the three states declined 1.3 percent, while total nursing facility beds nationwide increased 20.5 percent. [3]
>
> Ohio's Commission to Reform Medicaid has proposed rewarding families who choose lower-cost options that save the state money, such as care in the home or community. This would allow an elderly parent living with family members to receive a few hours of home or personal care per week that could delay their entry into a nursing home. The financial incentive could be to exclude some assets from eligibility tests or shield them from cost recovery. [4]
>
> Sources
>
> "Opportunities for State Medicaid Reform," http://www.ncpa.org/pub/st/st288/st288i.html

[1] Enid Kassner, "Medicaid and Long-Term Services and Supports for Older People Fact Sheet," AARP Public Policy Institute, http://assets.aarp.org/rgcenter/il/fs90r_hcbltc.pdf, February 2005.

[2] For a pamphlet comparing the annual cost of home care and nursing home care across the country, see "Can You Afford the Cost of Long-Term Care?" U.S. Office of Personnel Management. Available at http://arc.publicdebt.treas.gov/files/pdf/fscombined.pdf. Access verified June 19, 2006.

[3] "Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs," U.S. Government Accountability Office, Report No. 152298, http://archive.gao.gov/t2pbat2/152298.pdf, August 1994.

[4] Ohio Commission to Reform Medicaid, "Transforming Ohio Medicaid: Improving Health Quality and Value," State of Ohio, January 2005.

MCR3: Allow Medicaid to compete with charities by establishing a dollar-for-dollar tax deduction for donations to qualified Colorado Health Charities.

Given the evidence that Medicaid increases health care costs (along with other undesirable consequences catalogued above), very few taxpayers would choose to donate to such a charity if they had the choice. Making Medicaid compete for funds will give administrators incentive to support those in need in a cost-effective manner. However, federal matching funds for Medicaid will still discourage frugal spending. This may be offset if the matching funds can be used for the tax refund to those who choose to donate to non-government charities.

2. Over 50% of health care in Colorado is now provided through a "free market" model. Why are so many Coloradoans uninsured and unable to afford coverage?

This question reflects two important distinctions that need to be made before productive discourse on health care policy may take place. The first distinction is the difference between the provision of "health care" and the provision of "health insurance." The second distinction is between types of markets: markets for goods and services can have varying degrees of freedom determined by the amount of legislation that prohibits voluntary exchanges between buyers and sellers.

Distinction I: Health care vs. Health Insurance

The 50% figure mentioned in the question prompted me to look up some figures about health insurance and the uninsured. According to the Kaiser Family Foundation, Colorado's Distribution of Insurance Status is as follows:

Medicaid: 9.5% Medicare: 8.5%

Employer: 58.6% Individual: 7.1% Uninsured: 16.4%

(source: http://www.kff.org/mfs/medicaid.jsp?r1=CO&r2=US)

In 2002, the US Census Bureau noted that "Spells without health insurance, measured on a monthly basis, tend to be short in duration -- about three-quarters (74.7 percent) were over within one year." http://www.census.gov/hhes/www/hlthins/hlthin02/hlth02asc.html. In 2003 the Congressional Budget Office issued a report, available on-line, "How many people lack health insurance and for how long?" According to this report, 45% of spells without insurance end within four months, 26% are between five and twelve months, 13% endure between thirteen months and two years, and only 16% last more than two years.

Also noteworthy is that a recent study concluded that a significant percentage of the uninsured can in fact afford insurance. In "Is Health Insurance Affordable for the Uninsured"," a 2002 paper for the National Bureau of Economic Research, the authors find that "depending on the definition, health insurance was affordable to between one-quarter and three-quarters of the uninsured in 2000." (http://www.nber.org/papers/W9281) In "The Uninsured and the Affordability of Health Insurance Coverage," a 2007 article in the peer-reviewed journal *Health Affairs*, the authors found that "twenty-five percent of uninsured Americans are eligible for public coverage" and that "20 percent can afford coverage."

In Appendix D of my proposal (p. 39), I show that in the case of Medicaid, having this type of health *insurance* does not guarantee that enrollees receive adequate health *care*. Here is a relevant excerpt:
* * *

In "Medicaid's Unseen Costs," Michael Cannon (2005) summarizes

> Medicaid patients often see their physician choices narrow even when payments to physicians rise. From 1998 to 2003 states increased physician payments by twice the rate of inflation. Yet Medicaid patients still saw their choice of providers drop. The share of doctors accepting all new Medicaid patients fell from 48.1 percent to 39.4 percent from 1999 to 2002. In contrast, far more doctors accepted all new private fee-for-service (FFS) and preferred provider organization (PPO) patients, Medicare patients, non-Medicaid health maintenance organization (HMO) patients, and uninsured, self-pay, and charity patients (see Figure 2). The share of doctors accepting no new Medicaid patients increased from 26.4 percent to 30.5 percent over the same period, yet far fewer doctors refused to see patients with the other types of coverage. As Oregon's Medicaid bureaucracy acknowledged in 2001, "Having coverage does not always guarantee access."...[A]dults who are eligible for Medicaid but have private coverage have fewer unmet medical needs than eligible adults who are enrolled in the program.

In some cases uninsured women had better access to health care than those on Medicaid. Salganicoff (2002) reports that more often than uninsured women, women on Medicaid attributed "difficulty getting care to lack of doctors or clinics" (14%) and could not see a new doctor because the doctor was not taking new patients (23%).

Doctors are not accepting new Medicaid patients because reimbursement costs are too low and paperwork is too high. John S. O'Shea, M.D (2007) summarizes:

> About one-fifth of physicians (21 percent) reported accepting no new Medicaid patients in 2004-05, a rate six times higher than for Medicare patients and five times higher than for

> privately insured patients. Low physician participation in Medicaid has been shown to reduce enrollees' access to medical care (Cunningham 2005). The most important reasons given by physicians for not accepting Medicaid patients are inadequate or delayed reimbursement and the growing burden of Medicaid administration and paperwork (Cunningham 2006).

Dr. O'Shea (2007) also reports that "Medicaid patients with NSTSE ACS [a form of heart attack] were less likely to receive evidence-based therapies and had worse outcomes (including increased mortality rates) than patients who had private insurance as the primary payer."

A study of more than 400 health clinics further shows that Medicaid enrollees are being short-changed: "Private insurance gives patients a far better chance of getting appointments within a week of treatment than does Medicaid or no insurance, according to the study of 430 clinics in nine U.S. cities. Most clinics inquired about patients' insurance status but not their conditions, the researchers found" (Tanner 2005).

* * *

Having health insurance does not guarantee access to medical care in other countries as well. Consider this excerpt from Appendix A (p. 36) of the FAIR proposal:

* * *

According to a Commonwealth Fund report, only one in twenty patients (5%) in the United States had to wait more than four months for elective (non-emergency surgery). Yet, this happens at least four times more often in the Australia, New Zealand, Canada, and Britain (23%, 26%, 27%, and 36% respectively). Physicians in the United States see only about two-thirds the number of patients than those in Canada or the United Kingdom, but they more likely to spend over 20 minutes with a patient (30%) than in the above-mentioned countries (12%, 15%, 20%, 5% respectively) (Goodman 2005)

Compared to the United Kingdom and Canada, patients in the United States are significantly more likely to receive high-tech treatment. John C. Goodman (2005), cites studies showing that "the use of coronary bypass surgery in the United States is slightly more than three times higher per capita than in Canada and almost five times higher than in Britain. The rate of coronary angioplasty in the United States is almost five times higher than in Canada and almost eight times higher than in Britain. The rate of renal dialysis in the United States is almost double that of Canada and almost three times that of Britain. Britain was the co-developer with the United States of kidney dialysis in the 1960s, yet Britain consistently has had one of the lowest dialysis rates in Europe." The United States also has significantly more, more than twice as many in all but one case, per-capita CT scanners, MRI units, and lithotripsy units."

* * *

Distinction II: the not-so-free market in health care.

While there is a *market* for health care and health insurance, it is certainly not a "free market." That is, government legislation significantly sets rules concerning who can legally provide medical services or insurance, and what kind of products and services can be legally sold. Also, the examples of crowd-out below show Medicaid operates as a competitor to private heath insurance -- and an unfair one because it is funded through compulsory taxes rather than voluntary donations or purchases.

For example, in his article, "Health Care Regulation: A $169 Billion Hidden Tax," Chris Conover of Duke University's Center for Health Policy, Law and Management writes that " that health services regulation imposes an annual cost of $256 billion per year (with a range of $28 billion to $657 billion), suggesting that health services regulations could increase estimates of overall regulatory costs by more than 25 percent…. The high cost of health services regulation is responsible for more than seven million Americans lacking health insurance, or one in six of the average daily uninsured."

The following examples show how Colorado and the United States lacks a free-market in health care:

[1] Consider again the section of my proposal (p. 14) that I quoted in section 1:

Economic analysis and robust empirical findings demonstrate that benefits mandates increase the costs of insurance premiums.

According to an analysis of benefits mandates by the Council for Affordable Health Insurance (CAHI) for 2007, Colorado imposes 46 health-insurance mandates. A CAHI document states, "Based on our analysis presented in this paper, mandated benefits currently increase the cost of basic health coverage from a little less than 20% to more than 50%, depending on the state" (Bunce 2007). Furthermore, costs of benefits mandates are considerably higher than gains. One study finds that, nationally, benefits mandates probably cost nearly double what they're worth (Conover 2004, p. 12). An older study defines "benefit" more broadly than does this proposal finds that between 20 percent and 25 percent of "uninsured Americans lacks coverage because of benefit mandates." Furthermore, the study finds, mandates drive down wages, drive up the cost of insurance premiums, and harm smaller employers particularly severely (Jenson 1999, p. *i*).

References:

Bunce, Victoria Craig, J.P. Wieske, and Vlasta Prikazsky, "Health Insurance Mandates in the States 2007," Council for Affordable Health Insurance, http://www.cahi.org/cahi_contents/resources/pdf/MandatesInTheStates2007.pdf, 2007.

Conover, Christopher J., "Health Care Regulation: A $169 Billion Hidden Tax," Policy Analysis, No. 527, The Cato Institute, http://www.cato.org/pubs/pas/pa527.pdf, October 4, 2004.

Jenson, Gail A., and Michael A. Morrisey, "Mandated Benefit Laws and Employer-Sponsored Health Insurance," Health Insurance Association of America, http://membership.hiaa.org/pdfs/jensenrpt.pdf, 1999.

Turner, Grace-Marie and Melinda L. Schriver, "Uninsured Rates Rise Dramatically in States With Strictest Health Insurance Regulations," Galen Institute, http://www.galen.org/statehealth.asp?docID=179, 1998.

[2] The tax-exempt status of employer-provided insurance reduces competition and has converted true insurance into pre-paid health care. Insulated from costs, patients over-consume and drive up prices - while costs of uninsured procedures such as cosmetic surgery and corrective eye surgery have decreases compared to the Consumer Price Index. (Google "NCPA - Brief Analysis 437, Why Are Health Costs Rising?" and "Insulation vs. Insurance")

[3] Nearly 9 percent of what employers pay in annual insurance premiums subsidizes Medicaid and Medicare instead of covering employee medical expenses. (Google "Medicare, Medicaid payments drive up employee insurance costs").

[4] Medicaid crowds out the free-market: (from page 41 of the FAIR proposal)

Government-run charities and pre-paid health programs also crowd out for-profit insurance companies and discourage employers of low-income workers from providing coverage. Cannon (2005) summarizes research by the Robert Wood Johnson Foundation (Davidson 2004):

> Medicaid encourages employers of low-income workers not to offer coverage and encourages low-income workers not to enroll in private coverage. Researchers at the Robert Wood Johnson Foundation surveyed 22 leading studies on whether "free" government coverage crowds out private coverage and concluded that such crowd-out "seems inevitable." More than half of those studies found that expansions of public coverage were accompanied by reductions in private coverage. Some even found that enrollment growth in public programs was completely offset by reductions in private coverage.

Medicaid also crowds out long-term care. A National Bureau of Economic Research study by Jeffrey Brown and Amy Finkelstein found that "the provision of even incomplete public insurance can substantially crowd out private insurance demand. We examine the interaction of the public Medicaid program with the private market for long-term care insurance and estimate that Medicaid can explain the lack of private insurance purchases for at least two-thirds and as much as 90 percent of the wealth distribution, even if comprehensive, actuarially fair private policies were available" (Brown 2004).

Results of recent studies call into question whether Medicaid is functioning as a safety net or as competition to private insurance companies. For example, the *USA Today* reports that "many workers choose Medicaid over insurance offered by their employers because it is less expensive" (Cauchon 2005). The effect of a 1996 law limiting Medicaid eligibility for immigrants further illustrates how Medicaid discourages consumers from seeking private insurance. Economist George Borjas of Harvard writes

that "as the Medicaid cutbacks took effect, the proportion of those immigrants covered by some type of health insurance should have declined." However, Borjas found that "the expected decline in health insurance coverage rates did not materialize. If anything, health insurance coverage rates actually rose slightly in this group."

As historian David Beito described in *From Mutual Aid to the Welfare State* (Appendix D, D.3), government programs and legislation drove out private charities, fraternal societies, and lodges that provided communities with a true safety net. It is time to reverse this injustice.

[5] Medicaid increases costs for those not enrolled (from FAIR proposal, p. 42)

Medicaid increases health care costs for those not enrolled. *The Puget Sound Business Journal* reports that "employers pay hundreds of dollars more for each employee because Medicaid and Medicare underpay hospitals and doctors. In 2004, according to the study, Washington employers together paid more than $1 billion in health care costs to cover government payment shortfalls incurred by hospitals and physicians. The study, by the actuarial firm Milliman Inc., concluded that nearly 9 percent of what employers pay in insurance premiums a year goes to subsidizing Medicaid and Medicare rather than to covering employee medical expenses" (Neurath 2006).

Medicaid also increases drug prices for those with private insurance. A study by the National Bureau of Economic Research (Duggan and Morton 2004) found that "a ten percentage-point increase in the MMS [Medicaid Market Share] is associated with a ten percent increase in the average price of a prescription. This result is robust to the inclusion of controls for a drug's therapeutic class, the existence of generic competition, the number of brand competitors, and the years since the drug entered the market. We also demonstrate that the Medicaid rules increase a firm's incentive to introduce new versions of a drug at higher prices and find empirical evidence in support of this for drugs that do not face generic competition. Taken together, our findings suggest that government procurement can have an important effect on equilibrium prices in the private sector."

[6] Amy Finkelstein of the National Bureau of Economic Research found that “Medicare was associated with a 23 percent increase in total hospital expenditures (for all ages) between 1965 and 1970, with even larger effects if her analysis is extended through 1975″ (Google "Medicare and Its Impact").

3. "This proposal requires a much higher educational level regarding managing one’s health care coverage than the vast majority of people possess. How would a transition be managed to make this sort of system feasible or practical?"

I thought this question pertained to Medicaid vouchers for private insurance & Health Opportunity Accounts (HOAs). My proposal cited Medicaid's Cash and Counseling programs, South Carolina's Medicaid counseling program, and Colorado's

Consumer-Directed Attendant Support (CDAS) as examples of how to smoothly transition from a program that discourages consumers from being knowledgeable to a consumer-driven system that promotes and fosters wise health care choices.

Converting Medicaid to a voucher-based program for private insurance and, if applicable, Health Savings Accounts, may be phased in as an option for Medicaid recipients. That is, the new program would not be a mandatory assignment. For details, see Tom Miller, "Medicaid Opt-Out for Other Private Insurance Coverage" in *Covering America: Real Remedies for the Uninsured*, p. 55. (http://www.cato.org/research/articles/miller-coveringamerica.pdf)

However, the Commissioner who asked the question elaborated: "No - my observation wasn't specifically tied to Medicaid. The proposal requires a great deal more understanding of personal health matters than is possessed by the general public. In order for the public to handle heath care coverage that requires more financial involvement and personal responsibility they will need a much higher degree of understanding. If the public was just thrown into the structure described in the proposal, there would be chaos. As a practical matter, how to we get there from here."

The Commissioner's concern is true to the extent that people currently lack choice and responsibility in providing for their own health care, which includes self-insuring, purchasing insurance, and making wise life-style choices. I am happy to see this question, as Section 2 of Senate Bill 06-208 identifies as one of the Commission's "personal health responsibility" as one of its "goals and objectives." (see http://tinyurl.com/yxlhb2)

A segment of Colorado's population that clearly lacks the understanding of personal health matters required to taking responsibility for their own health care: children. Generally speaking, their parents choose their insurance plan and doctors, and schedule appointments. They also provide food, shelter, and clothing. As the children mature to adolescents and adults, parents (we hope) gradually shift these responsibilities to their children so they too can become self-responsible adults.

Yet, we all have met "adults" whose parents could not let go. For example, the college student whose mother still helps her with homework, pays all of her bills and manages her finances. Or the 30-something bachelor whose mother brings over dinner and does his laundry, and his father manages his retirement account. These are codependent relationships, where parents do not let the child grow up because their sense of worth and importance derives only from being a parent. To the extent that their parents keep making choices for them, these adults never have an incentive to take responsibility for their own lives. But it is this personal responsibility, ability to choose, and self-determination gives each of us identity, values, and makes possible a meaningful life.

In many cases government policies have the same effect on citizens that over-protective parents do on their children. The largely government-run education system

drastically limits school choice to all but those who can afford non-government schools. We have, for the most part, a "single payer" education system. The implicit message in the lack of school choice is that parents are not responsible for educating their children, or even to budget for it when choosing to become parents. Yet, parents are generally more satisfied when able to choose their schools.

University of Wisconsin professor John Witte, the official evaluator of the Milwaukee choice program, commented on school choice research: "There's one very consistent finding: Parental involvement is very positive, and parental satisfaction is very positive…parents are happier. The people using vouchers are mostly black and Hispanic and very poor…they deserve the same kind of options that middle-class white people have."

References:
Parental Satisfaction with School Choice, Institute for Justice, www.ij.org/pdf_folder/school_choice/parental_satisfaction.pdf, 2004
School Choice: 2006 Progress Report, http://www.heritage.org/Research/Education/bg1970.cfm

Consumers already have choices in life insurance and car insurance, and there are on-line services that compare plans. To the extent that Coloradans are not informed health care consumers, their ignorance can be attributed to existing government policies. For example, the federal tax-exemption for employer-paid premiums limits consumer choice by providing a large incentive for consumers to be insured through their employer. Consider my case: I am an engineer at a small company. Except for a Flexible Spending Account, could make no choices about my health insurance policy. If there were no tax exemption, I'd choose to accept a higher salary and purchase insurance on my own, as I do for my car. As it is, I do not even know – and have little incentive to find out – how much my premiums cost.

In health care, Health Savings Accounts, Medicaid Cash and Counseling programs, and Colorado's Consumer-Driven Attendant Support (CDAS) programs empower consumers to make responsible and informed decisions about their medical care. As Milton Friedman says, "Nobody spends somebody else's money as wisely or as frugally as he spends his own." The FAIR proposal describes the success of both Cash and Counseling and CDAS on page 15. Both have a counseling component to assist Medicaid enrollees in making informed health care choices, and I return to these below.

The Commissioner's writes that if "the public was just thrown into the structure described in the proposal, there would be chaos." This implies that my proposal suggests radical changes from the current system, whereas these changes are meant to be incremental and are modeled on existing policies. Below I address each suggestion of my proposal.

BMR: Benefits Mandates Reform:

Eliminating benefits mandates will make it legal for insurance companies to offer

lower-cost policies, and hence give consumers more choices. Yet, there is little reason to fear that consumers lack the ability to make correct choices.

In 2004 the Colorado legislature lifted the prohibition of selling "mandate-lite" policies to small businesses. According to the Colorado Commission on Mandated Insurance Benefits (Feb. 2, 2007, http://www.dora.state.co.us/insurance/meet/MHB/SB07-78.pdf), this allowed consumers to purchase insurance with coverage of "mammography and prostate cancer screenings, services for non-biologically based mental illness, general anesthesia for children undergoing dental procedures, and...alcoholism treatment." I have yet to see reports of problems related to mandate-lite policies that can be attributed to consumer ignorance.

The RAND Health Insurance Experiment, which I describe in Appendix C of my proposal, also demonstrates that individuals with high-deductible low-premium plans (such as those that qualify for Health Savings Accounts) are both wise and frugal consumers. RAND summarizes the key findings:

> In a large-scale, multiyear experiment, participants who paid for a share of their health care used fewer health services than a comparison group given free care.
>
> - Cost sharing reduced the use of both highly effective and less effective services in roughly equal proportions. Cost sharing did not significantly affect the quality of care received by participants.
> - Cost sharing in general had no adverse effects on participant health, but there were exceptions [just 4 out of 30 conditions]: free care led to improvements in hypertension, dental health [seeing a dentist], vision ["marginal"], and selected serious symptoms. These improvements were concentrated among the sickest and poorest patients.
> - Cost sharing also had some beneficial effects. Participants in cost sharing plans (higher deductible) worried less about their health and had fewer restricted-activity days (including time spent in seeking medical care).
>
> (source: http://www.rand.org/pubs/research_briefs/RB9174/index1.html)

Eliminating mandated benefits will allow insurance companies to offer a broader range of insurance policies to customers in the individual and employer-based markets. Without mandated benefits, for example, an insurance company can offer one or more lower-cost plans that lack some or all of the previously mandated-benefits. This gives consumers more choices, and as the Commissioner's question points out, choosing the best plan for them will require them to become more familiar with their health care needs. For example, some consumers would be better off purchasing a lower-cost policy and, if applicable, saving the money saved on premiums in a Health Savings Account.

To envision how consumers will become more education, it is useful to look at what resources are currently available for assistance in choosing the best plan. The market has provided services to help consumers become educated about health care decisions. In his book, *The Cure*, Dr. David Gratzer explains

> Many insurance companies aren't just selling health savings accounts, they're offering companion services, like information websites. At the Cigna site, for example, members can

> estimate annual costs, compare drug prices, and get comparisons of hospitals (showing quality ratings for certain procedures as well as the cost and length of the stay). Other companies offer "health coaches," so that a health professional can guide patients along, helping them navigate the choppy waters of health care. Companies outside the insurance industry are also getting involved. Websites such as DestinationRx.com and PharmacyChecker.com let patients search for their medication and compare prices as different online pharmacies. (p. 71)

For people with health insurance through their employer, their most accessible source for guidance may be in the Human Resources department, or with whoever it is in the company that works with the insurance company. They can provide pamphlets for available polices, contact information for customer service, and on-line resources such as those mentioned in the quote above.

For example, my insurance is through United Health Care, and I can access information about my plan at myUHC.com. The site includes a section called "Check Your Symptoms, a "Treatment Cost Estimator" section, a section titled "How to Choose Your Health Care," and a Spanish language option. A web search on "how to choose a health insurance policy" returns several useful pages, including:

- http://www.ahrq.gov/consumer/insuranc.htm
  The United States Department of Health and Human Services: Checkup on Health Insurance Choices

  Today, there are more types of health insurance, and more choices, than ever before. The information presented here will help you choose a plan that is right for you. You may be buying health insurance for the first time, or you may already have health insurance but want to consider changing plans. Married or single, children or no children, this information will help you to find out how to choose a health insurance plan that best meets your needs and your pocketbook.

- ColoHealth.com:

  Choose the Health Insurance Plan That's Right For You:
  http://www.colohealth.com/choose-plan.htm
  Consumer's Guide to Buying Health Insurance:
  http://www.colohealth.com/consumer-guide.htm

- How to Choose a Health Insurance Plan,
  http://www.ehow.com/how_138961_choose-health-insurance.html,

- Assurant Health's Buyers' Guide: allows you to compare plans for individual and small businesses
  http://www.assuranthealth.com/corp/ah/HealthPlans/BGComparePlans.htm

With the above employer-based and on-line services already in place, the expanded range of options created by eliminating benefits mandates are incremental changes that these information providers can easily accommodate.

Small Group Reform (SGR)

Small Group Reform seeks to phase out the state's distinction of a "small group of one."... Colorado also imposes "guaranteed issue" on the "small [or business] group of one," meaning the self-employed who qualify. The state thus creates a perverse incentive that encourages some people to avoid purchasing health insurance until after they develop health problems. This drives up insurance costs for other small-group participants. Phasing out the category of the "small group of one" will encourage more of the self-employed to seek lower-cost, long-term, individual insurance in conjunction with a tax-exempt Health Savings Account. (From FAIR, page 5.)

This reform would encourage would-be free-riders to purchase insurance before they need it, just as individuals do when not insured through their employer.

Medicaid Reform

Converting Medicaid to a voucher-based program for private insurance and self-insurance through Health Opportunity Accounts (HOAs) will give Medicaid enrollees more choice and responsibility for their own medical care. Enrollees will certainly want to learn how to make wise decisions, and a responsible way to transition Medicaid to this type of system is to provide counseling on these matters - as South Carolina has done. On page 21 of the FAIR proposal I quote South Carolina Governor Mark Sanford.

> Critical to the success of this effort will be the agency utilizing enrollment counselors during the eligibility process. These counselors will help explain the menu of options that will be available to recipients. In fact, the agency's role will evolve from primary claims processor to more education and coordination. The agency's role will help the beneficiary become a wise shopper for health care, a real market place participant. The beneficiary will be able to define what quality health care means to him, and through his purchasing power, influence the kinds of services that are available to him (http://www.heartland.org/Article.cfm?artId=17762).

Similar programs include Cash and Counseling and Colorado's Consumer-Directed Attendant Support (CDAS). I described these on page 15 of the FAIR proposal:

* * *

HOAs are not the first Medicaid programs that involve a cash allowance to recipients. Cash and Counseling Programs were first established in Arkansas, Florida, and New Jersey in 1998, and have been expanded to a dozen more states in 2004. As described on the program's website (CashandCounseling.org), the program

> provides a flexible monthly allowance to recipients of Medicaid personal care services or home and community based services. Participants use an individualized budget to make choices about the services they receive and they are able to make sure these services address their own specific needs. In the Cash & Counseling program, the participant, instead of an agency, decides who to hire and what services they would like to receive. Participants also have the option of using their budget to purchase labor saving devises or to make home modifications to help them live independently. In addition, this innovative program offers counseling and fiscal assistance to help consumers manage their allowance and responsibilities by themselves or with the aid of a representative.

James Frogue summarizes the preliminary data on Medicaid participant's satisfaction with Cash and Counseling: "Satisfaction rates among beneficiaries are extraordinarily high. Mathematica Policy Research, Inc., the evaluation contractor chosen to study Cash and Counseling, released an interim memorandum in April 2002 based on a survey of 231 of the initial participants in Florida's Consumer Directed Care. Mathematica found that 99 percent of beneficiaries were 'satisfied with their relationship with their caregivers' and that, of those that were satisfied, '96 percent described themselves as "very satisfied".' Studies of participant satisfaction rates in the Arkansas and New Jersey experiments found virtually identical results." (http://www.heritage.org/Research/HealthCare/BG1618.cfm)

The success of Colorado's Consumer-Directed Attendant Support (CDAS) program also provides evidence that putting Medicaid recipients in charge of their health care spending has positive outcomes. Under CDAS, started in 2002, severely disabled Medicaid patients have the ability to choose their own caregivers and choose how to spend money on equipment to help them with their disabilities. John Andrews (*Wall Street Journal*, 2005) reports that,

> CDAS, our state's experiment with Consumer-Directed Attendant Support for the severely disabled, got started in 2002. The wheelchair-bound Linda Storey was one of its first four clients. The program now has 146 participants, each newly empowered to hire and fire their own caregivers. Quality of care and patient satisfaction are up, costs are down, and legislators approved offering the option for 33,000 Medicaid recipients statewide in 2006.
>
> If there is more alleluia and less blues in the Storeys' music these days, CDAS is a big reason. "It gives you your life back," Mrs. Storey told me. "I'm in control of my health now." Under a federal waiver obtained by Colorado officials, she selects the health aides who come to her house, bypassing the provider agencies otherwise required under Medicaid rules for home- and community-based services.
>
> ...[W]ith Medicaid expenses surging faster than almost every other budget line in almost every state, such savings are welcome news to policy makers. Taxpayers in Colorado have seen their share of Medicaid--matched dollar for dollar with federal funds--increase almost 33% since 2001. Another 22% jump is predicted by 2010.
>
> Absent a tax increase here (one on the November ballot is trailing in opinion polls), the Medicaid spiral will continue squeezing all other priorities except K-12 education.
>
> The first two years of Colorado's CDAS pilot program, by contrast, showed average monthly spending at 21% under budget ($3,925 per client allocated, $3,131 expended). While the sample is tiny, the vector is positive for once. To Medicaid administrators like Aggie Berens and Viki Manley, that brings unaccustomed praise--and proud smiles."

* * *

Empowering consumers to spend their own money on health care provides incentives for wise and thoughtful spending. This gives health care providers incentives to lower costs and improve the quality of their services.

4. Your proposal addresses expanding access by making it more affordable with a Medicaid voucher plan but how would your proposal address the access issue pertaining to rural Coloradoans? How will access be addressed in his proposal with respects to lack of providers in rural areas which is a part of reforming healthcare for rural Colorado?

My proposal primarily addresses insurance regulations and Medicaid reform. If implemented, these reforms will decrease the cost of insurance policies and encourage responsible health care consumption. This will result in more people having access to affordable insurance and medical care. However, it does not address your concern with providers in rural areas.

My understanding is that medical licensing requirements limits competition among doctors and nurse practitioners, and hence their supply. It is conceivable that easing these requirements would increase the number of providers in rural areas. For example, on April 1, 2007, the Associated Press reported that "In one of the most far-reaching attempts at the state level to make health care more accessible and affordable to everyone, Gov. Ed Rendell is seeking to lower barriers in Pennsylvania laws and regulations that prevent a wide range of nonphysician health professionals from providing basic types of care. From nurse practitioners and nurse midwives to dental hygienists and pharmacists, the Rendell administration wants to reshape health care practices in Pennsylvania to help provide lower-cost preventive care."

I also found this 2004 a study in the journal *Medical Care Research and Review* (Vol. 61, No. 3, 332-351) that

> reports results of the 2-year follow-up phase of a randomized study comparing outcomes of patients assigned to a nurse practitioner or a physician primary care practice. In the sample of 406 adults, no differences were found between the groups in health status, disease-specific physiologic measures, satisfaction or use of specialist, emergency room or inpatient services. Physician patients averaged more primary care visits than nurse practitioner patients. The results are consistent with the 6-month findings and with a growing body of evidence that the quality of primary care delivered by nurse practitioners is equivalent to that by physicians.

In 2004, the United States Department of Justice and Federal Trade Commission wrote in *Improving Health Care: A Dose of Competition*:

> State licensing boards composed primarily of physicians determine, apply, and enforce the requirements for physicians to practice within a particular state. Various state licensing boards have taken steps to restrict allied health professionals and telemedicine. Some states have limited or no reciprocity for licensing physicians and allied health professionals already licensed by another state. The Report discusses the anticompetitive potential of such restrictions, as well as their rationales. (see http://www.usdoj.gov/atr/public/health_care/204694.htm)

I considered including this in the proposal, but since I became aware of the issue just a few days before the due date, I did not have time to adequately research the ways in which the current state of CO licensing laws impact rural Coloradoans.

Zoning laws may be another impediment to attracting doctors and other providers to rural areas. For example, on April 20 of this year the *Steamboat Pilot* reported that

"linkage policies" can restrict hospital expansion: "Linkage would require residential and commercial developers to compensate the city, either by a fee or by construction of affordable homes, for a percentage of the market-rate housing units or employees created by their new development." The article begins "Yampa Valley Medical Center's top executive said Thursday that city policies intended to fund affordable housing, if approved in their current form, would significantly limit future expansion and services at the hospital."
(http://www2.steamboatpilot.com/news/2007/apr/20/hospital_questions_housing_fees)

Some cities have prohibited the large stores such as Wal-Mart from opening, either though zoning laws or outright refusal. Regardless of one's feelings about Wal-Mart, they are providing low-cost health care. MSNBC reported in April that

> Wal-Mart Stores Inc. plans to open as many as 400 in-store health clinics over two to three years and could raise the total to 2,000 within seven years...Wal-Mart said it would contract with local hospitals and other organizations to operate the walk-in clinics, which lease space from Wal-Mart and are run as separate businesses. It currently has 76 such clinics, which typically provide a limited number of basic health services at a lower cost than hospital emergency rooms or doctor's offices and do not require an appointment."
> (http://www.msnbc.msn.com/id/18292564)

If results of government-run health care in other countries are any indication, such programs will not alleviate the problems in rural areas. This is documented in *Twenty Myths about Single-Payer Health Insurance: International Evidence on the Effects of National Health Insurance in Countries around the World* by John C. Goodman and Devon M. Herrick (http://www.debate-central.org/topics/2002/book2.pdf). Myth #17 (p. 76 - 80) provides evidence against the notion that "Single-payer health insurance would benefit residents of rural areas" by citing studies in Canada, Britain, New Zealand, and Australia that compare access to health care in rural and urban areas.

5. How would your proposal address individuals who can afford insurance but choose not to obtain it knowing that they can access medical care in an emergency through the emergency room and generate cost-shift of those expenses to other people?

This is a common and legitimate concern in health care policy. A coworker asked me the same question just a couple of days before receiving this one, and researching it was on my list of aspects of health care policy I wanted to learn.

Central to this issue is federal legislation known as EMTALA, the Emergency Medical Treatment and Active Labor Act, passed in 1986. Details of the legislation can be found at http://www.emtala.com/law/index.html. It states that in

> the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition ... exists.

It is reasonable to predict that some people might abuse this law as suggested in the question. That is, they forgo purchasing insurance because federal regulations require hospitals to treat them. As I noted in question 2, a significant percentage of the uninsured can in fact afford insurance. In "Is Health Insurance Affordable for the Uninsured," a 2002 paper for the National Bureau of Economic Research, M. Kate Bundorf and Mark V. Pauly find that "depending on the definition, health insurance was affordable to between one-quarter and three-quarters of the uninsured in 2000." (http://www.nber.org/papers/W9281)

In *Covering America: Real Remedies for the Uninsured*, Tom Miller summarizes EMTALA's effect:

> As an unfunded federal mandate imposed on hospitals, EMTALA has created free-rider problems. First, managed care organizations cut back on emergency care coverage, and then their insured patients bypassed their health plans' contractual restrictions on access to emergency departments and arrived there for "free treatment" anyway. By the late-1990s, EMTALA essentially mandated access to 24-hour, just-in-time, emergency care at levels well above what many insured individuals were willing to pay for in their managed care plan contracts.With hospital emergency departments already disproportionately serving patients covered by Medicaid and those who are uninsured, increasingly unable to "make up their losses on volume," and finding their proportion of paying insured patients declining, EMTALA's unrestricted entitlement for utilization up to ER capacity provided strong incentives for hospitals to constrain, rather than expand, their emergency department capabilities. As too many patients lined up for federal free lunches in the ER, overcrowding, queuing, and declining quality of care hurt the uninsured most.

However, I was surprised to find a study concluding that those in this population are not frequent users of emergency facilities. In a 2004 study, "Characteristics of Occasional and Frequent Emergency Department Users: Do Insurance Coverage and Access to Care Matter?" in the peer-reviewed journal *Medical Care*, authors Zuckerman and Shen concluded:

> The uninsured do not use more ED visits than the insured population as is sometimes argued. Instead, the publicly insured are overrepresented among ED users. Frequent ED users do not appear to use the ED as a substitute for their primary care but, in fact, are a less healthy population who need and use more care overall.

They summarized their results:

> People in fair/poor health are 3.64 times more likely than others to be frequent ED users as compared with nonusers. The uninsured and the privately insured adults have the same risk of being frequent users, but publicly insured adults are 2.08 times more likely to be frequent users. Adults who made 3 or more visits to doctors are 5.29 times more likely to be frequent ED users than those who made no such visits.

If these results are accurate, the high rates of emergency facility use by "publicly insured adults" suggest that converting Medicaid to a voucher-based program for private insurance can reduce the number of frequent emergency room users. Empirical studies have shown cost-sharing to reduce emergency room use. In *Covering America: Real Remedies for the Uninsured*, Tom Miller notes that "that increased cost sharing could discourage patients from inappropriately using hospitals' emergency departments" Miller

sites a study in the *New England Journal of Medicine* (O'Grady, Manning, Newhouse, and Brook. "The Impact of Cost Sharing on Emergency Department Use." August 22, 1985, p 484–90) finding that a "25-percent level of cost sharing deterred emergency department utilization for less serious conditions but did not deter utilization for more serious conditions." A more recent study in the same journal (Selby, Fireman, and Swain. "Effect of Copayments on Use of the Emergency Department in a Health Maintenance Organization," March 7, 1996) concluded that "a small co-payment resulted in a 15 percent reduction in emergency department utilization but did not affect conditions classified as 'always an emergency'." (source: http://www.cato.org/research/articles/miller-coveringamerica.pdf)

Other research suggests that cost-shifting caused by the uninsured is not a crisis. In a recent piece in the *Los Angeles Times*, Michael Tanner and Michael Cannon of the Cato Institute write that "some suggest that when people without health insurance receive treatment, the cost of their care is passed along to the rest of us. This is undeniably true. Yet, it is a manageable problem. According to Jack Hadley and John Holahan of the left-leaning Urban Institute, uncompensated care for the uninsured amounts to less than 3% of total healthcare spending — a real cost, no doubt, but hardly a crisis." (*LA Times*: http://tinyurl.com/3cyftx, study: http://tinyurl.com/395lh5)

In any case, the implementation of the FAIR proposals will reduce the costs of insurance, as described in section (i), p. 25-29 of the proposal:

- Eliminating mandates would make it legal to sell low-cost policies.
- Phasing out guaranteed issue for the business group of one will encourage this population to purchase insurance before they need it, and hence reduce the odds that they abuse the EMTALA law.
- Converting Medicaid to a voucher-based system allows insurance companies to compete for Medicaid enrollees while Health Opportunity Accounts encourage responsible consumption.
- Enacting the Medicaid reforms allowed by the 2006 Deficit Reduction Act will also reduce costs.
- Allowing Medicaid to compete for tax-dollars will provide administrators incentives to transform Medicaid into an efficient charitable organization that no longer imposes costs on those who fund it (as described in Appendix D of the FAIR proposal and in the answer to question 2, above.)

All of these will make insurance more affordable and contribute to decreasing the number of uninsured, and hence, the number of free-riders.

Some may suggest mandatory health insurance as a solution to this problem. Yet, as shown above, the uninsured do not abuse emergency room access, and they do not impose a large cost. To the extent that they do impost costs, requiring that everyone purchases insurance does not eliminate this unfair cost-shifting imposed by free-riders, it just obscures it.

This occurs for two reasons. First, requiring everyone to purchase insurance increases demand for it, and hence increases prices. Second, it somewhat eliminates the option of self-insurance in so far as the previously uninsured who are compelled to purchase insurance by a comprehensive plan as opposed to a high-deductible plan that qualifies for a Health Savings Account. As the RAND Health Insurance Experiment showed, consumers with such prepaid plans utilize significantly more medical resources than those with high-deductible plans, with negligible benefit for the large costs imposed. Lastly, such a policy would punish the innocent instead of the free-riders. Resources would be better spent on tracking down those who do not pay by, for example, garnishing their wages, instead of reducing the liberties of those who end up paying the bill.

6. Did you mean to get rid of insurance pricing regulation, plan regulations and issue regulation as well as just the benefit mandates? Would the state still be able to audit companies for financial stability? Would it be able to require people to restrict their purchases to only those companies that pass state vetting or would it operate more on the Underwriters Lab model?

My proposal concerns the elimination of benefits mandates and phasing out guaranteed issue for the "business group of one." I suppose the former can be classified as a plan regulation, while latter change concerns a type of "issue regulation."

I considered addressing community rating and rate banding, which are types of pricing regulations. I found a few studies* showing adverse effects of these regulations on insurance markets and increasing the number of uninsured. Yet, due to constraints of time, the length of the proposal, and that the problems these state-level regulations are aimed to solve may be rooted in federal policies, I chose not to pursue this path.

As for auditing companies for financial stability and state vetting, I did not consider this aspect of reform. However, I have researched the role of non-government certification agencies such as Underwriters Laboratories (electronics), AAA (hotel and restaurant ratings), Good Housekeeping, Morningstar Inc. (investment ratings), Dun & Bradstreet (business credit), the American Dental Association, and Consumer Reports.

If I were to look further, I'd start with a paper by economist Daniel Klein at George Mason University, "Trust for Hire: Voluntary Remedies for Quality and Safety," and the references therein (http://lsb.scu.edu/~dklein/papers/trust.html). I would also look at private companies such as A.M. Best, which track insurance companies' ability to pay claims.

* Studies:

Meier, Conrad F., "How Eight States Destroyed Their Individual Insurance Markets," Heartland Institute, http://tinyurl.com/23xwad, 2004.

Park, Edwin, :Lessons From New Hampshire: Senate Health Bill Could Drive Up Health Insurance Premiums For Many Small Businesses," Center on Budget and Policy Priorities, http://www.cbpp.org/4-26-06health.pdf, 2006.

Turner, Grace-Marie and Melinda L. Schriver, "Uninsured Rates Rise Dramatically in States With Strictest Health Insurance Regulations," Galen Institute, http://www.galen.org/statehealth.asp?docID=179, 1998.