Blue Ribbon Commission for Health Care Reform

Final Report to the Colorado General Assembly

January 31, 2008

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Statement of Transmittal

Pursuant to its charge in SB 06-208, the Blue Ribbon Commission for Health Care Reform submits this report to the Colorado General Assembly as of January 31, 2008.

As directed by the statute, the report includes unbiased economic analysis, feasibility and technical assessment of five proposals for comprehensive health reform, and specific recommendations for action.

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Acknowledgments

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- The private foundations, corporations and individual donors that recognized the crucial importance of the Commission's work, providing generous support that allowed us to complete our work.
- The volunteer members of our Advisory Task Forces, who donated significant amounts of time to provide invaluable input on the proposals being considered by the Commission.
- The hundreds of Coloradans who took the time to attend Commission meetings and community meetings, sharing their views and opening our eyes to the real struggles our state's citizens face.
- The authors of the 31 proposals submitted to the Commission.
- The Colorado Foundation for Families and Children, which served as the fiscal sponsor and organizational home for the Commission.
- Commission staff:
  - Anita Wesley, MA, Project Coordinator - managed overall operations for the Commission including Commission staff and consultant contracts, development and fundraising of the Commission budget, and community outreach.
  - Sarah Schulte, MHSA, Technical Advisor - analyzed the 31 health care reform proposals submitted to the Commission, assisted with development of the Commission’s health care reform proposal (Proposal 5), supported development of the Commission’s recommendations to the General Assembly and, with Edie Sonn, developed this report.
  - Tracy Johnson, Ph.D, Technical Advisor - managed the selection of an independent evaluator to assess cost and coverage implications of proposals; provided technical oversight and facilitated communications among the evaluator, proposers and the Commission; ensured the technical accuracy of data used by the Commission; provided technical assistance to the Commission, media and interested parties; and presented cost and coverage findings to legislators, business leaders, providers and other audiences.
  - Edie Sonn, MPP, Communications Counsel - provided communications and outreach strategy and support, including media relations, stakeholder outreach and materials development, and, with Sarah Schulte, developed this report.
  - Marta Oko-Riebau, Project Assistant - supported the Commission’s operational, financial, materials management, meeting planning and communications activities and maintained the Commission’s Web site.
  - Jana Mathieson, MSW, and Chelsea Vigil, Outreach Consultants - supported the Commission’s community outreach and communications efforts, including public meetings, advisory task forces and Commission presentations.

Executive Summary

Introduction

The Colorado General Assembly created the Blue Ribbon Commission for Health Care Reform in 2006, charging it with identifying strategies to expand health care coverage and reduce health care costs for Coloradans.

Legislators took this action because Colorado, like most other states, faces urgent and interconnected problems regarding health care. The cost of health insurance is escalating rapidly. That contributes to growing numbers of Coloradans without insurance – an estimated 792,000 currently. All Coloradans pay for the uninsured, as premiums rise still more to cover the cost of care provided to those who cannot pay. The cycle feeds on itself, and in the absence of action will only worsen over time.

The package of recommendations in this report will reduce the number of uninsured Coloradans by an estimated 88 percent, extending coverage to 694,500 individuals who currently do not have insurance. We make it easier for people to get and keep coverage, whether through their workplace, as individuals or through public programs. We improve the delivery of services for vulnerable populations. We encourage and reward prevention and personal responsibility. We preserve and enhance consumer choice. We strengthen the safety net. We identify administrative streamlining measures that could save an estimated $167 million.

By extending insurance coverage to more Coloradans, we aim to minimize the "hidden tax" of uncompensated care, stabilize rising costs and improve Coloradans' health.

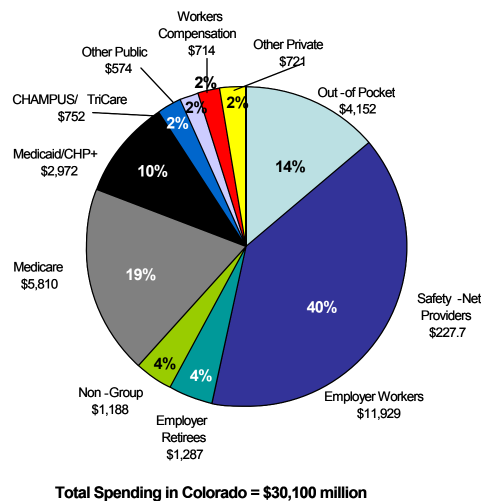
This document lays out a vision for change – a roadmap to health reform.

Highlights of the problem

The rising cost of care and coverage

- According to a report commissioned by the Commission and conducted by The Lewin Group, Colorado spends more than $30 billion annually on health care, in both public programs and private spending.

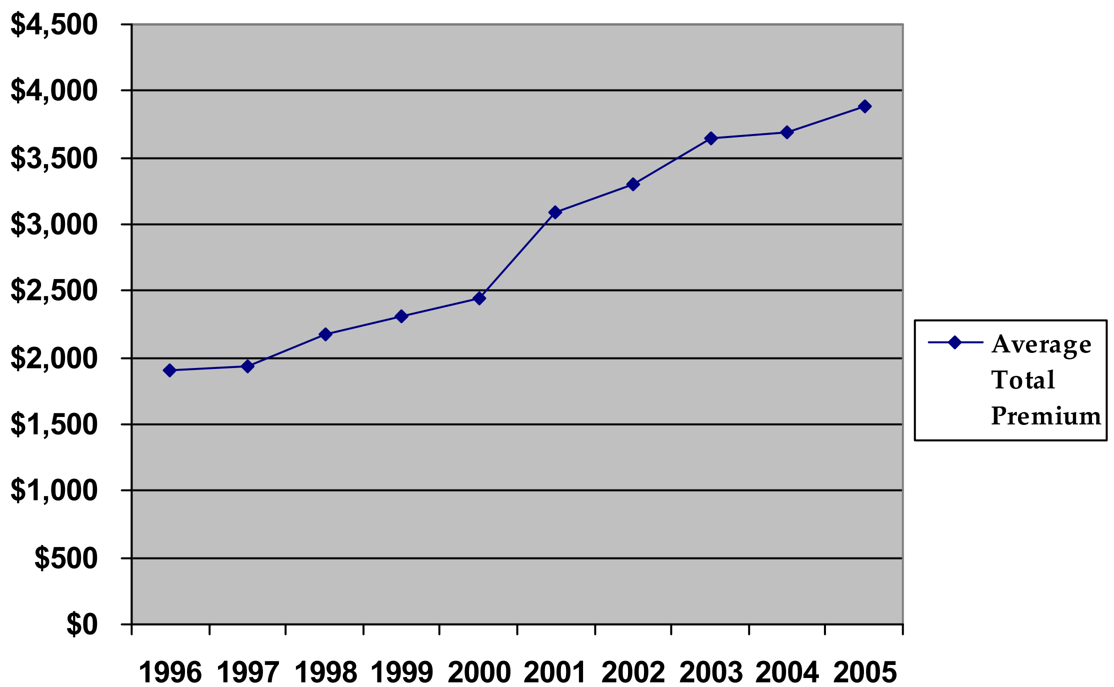
Figure 1: Health Spending in Colorado by Source of Funding



- About $1.25 billion will be spent on Colorado's uninsured in 2007-08. The uninsured pay for about half of their care out-of-pocket; the remainder is uncompensated care from doctors and hospitals, and care provided by safety net providers, workers compensation and veterans' benefits.

- Health insurance premiums have risen dramatically in recent years, outpacing overall inflation and growth in wages. As Figure 2 below shows, total premiums for employer-sponsored insurance (combined employer and employee shares) have more than doubled in Colorado between 1996 and 2005.

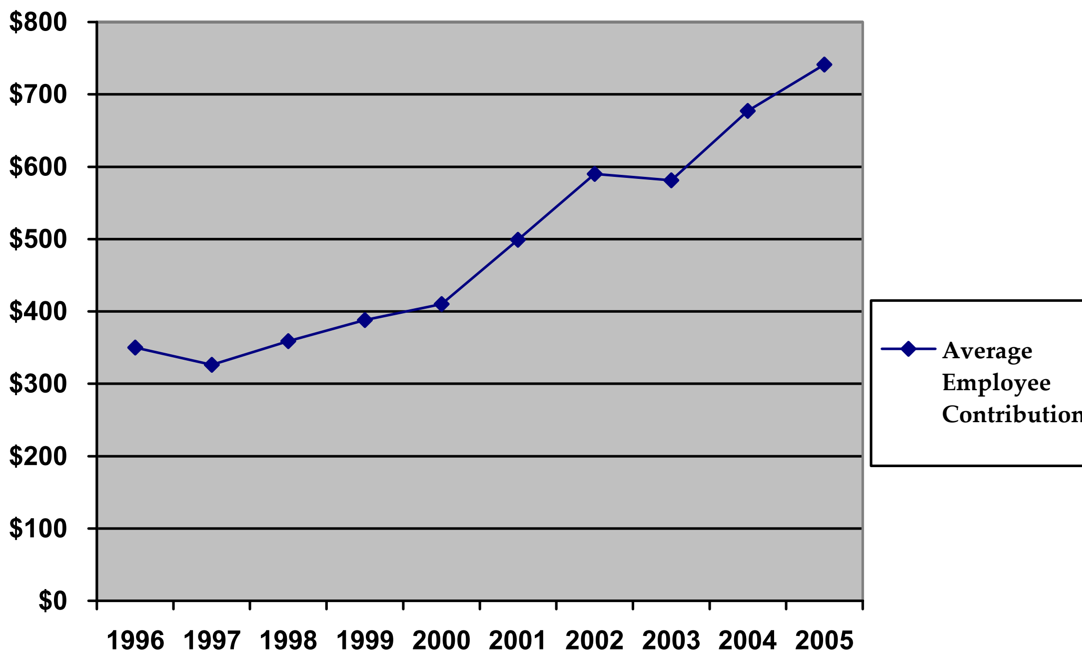
- **Figure 2: Average Total Premium per Enrolled Employee for Single Coverage at Private-Sector Establishments Offering Health Insurance: Colorado**[1]



[1] Agency for Healthcare Research and Quality. Average total single premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and State (Table II.C.1), years 1996-2005: 1996 (Revised March 2000), Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC. <http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.jsp> (December 18, 2007)

- As premiums rise, employees are asked to pay more. As shown in Figure 3, the average total employee contribution for single coverage in Colorado increased by more than 100 percent between 1996 and 2005.

Figure 3: Average Total Employee Contribution per Enrolled Employee for Single Coverage at Private-Sector Establishments Offering Health Insurance: Colorado[2]



- A key contributor to these rising expenditures is the cost of caring for the uninsured. When people without insurance do not pay for some or all of the care they receive, providers must try to recoup their own costs by charging insurance companies more – who, in turn, pass those increases along to their members. This hidden tax is estimated to account for $934 of the average $12,000 annual family insurance premium in Colorado.[3]
- Calculations by Len Nichols of the New America Foundation, presented to the Commission in July, indicate that, due to rising premiums, the share of median family income going to health insurance more than doubled from 7.7 percent in 1987 to 19 percent in 2005.

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[2] Agency for Healthcare Research and Quality. Average total employee contribution (in dollars) per enrolled employee for single coverage at private-sector establishments that offer health insurance by firm size and State (Colorado) (Table II.C.2), years 1996-2005: Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC. <http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.jsp> (December 02, 2007)

[3] "The Added Cost of Care for the Uninsured in Colorado," Families USA, June 2005.

Growing numbers of uninsured

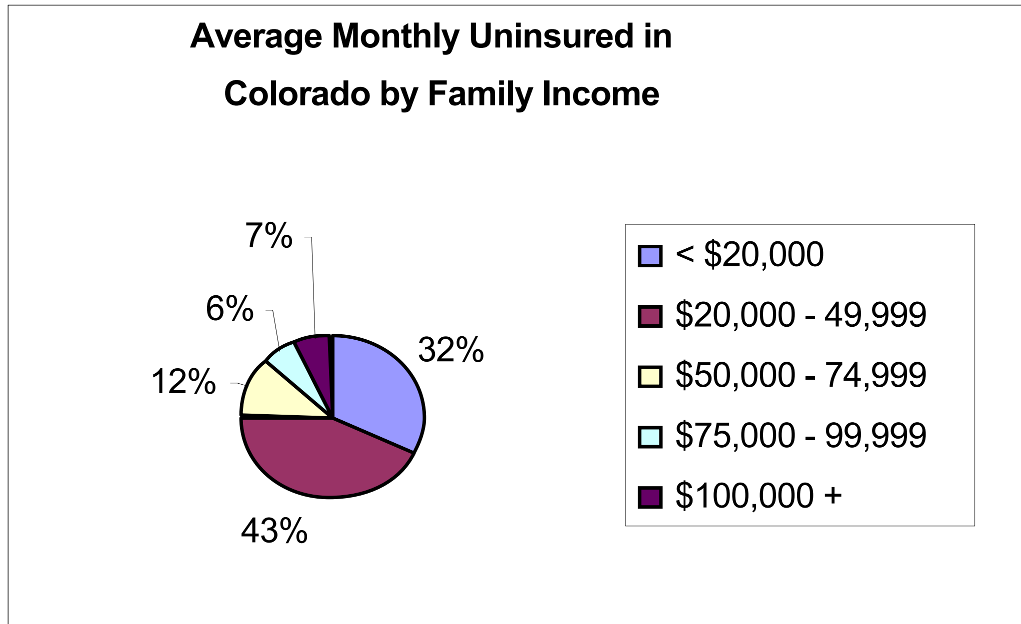
- These rising costs and resulting unaffordability of insurance have resulted in approximately 792,000 Coloradans, or **about 17 percent of our population, being uninsured in any given month in 2007, according to the Lewin Group's report.**
- In the absence of interventions, this number is likely to grow. Employer coverage, in particular, is eroding every year in Colorado, and is particularly problematic for small employers.
    - An Agency for Healthcare Research and Quality survey finds that the proportion of Colorado employers offering insurance to their workers declined from 66.5 percent in 2001 to 54 percent in 2005. The same survey shows a decline in the percentage of Colorado employees enrolling in offered coverage: from about 69 percent in 1996 to 59 percent in 2005.
    - Recent data from the Agency for Healthcare Research and Quality show that only 41 percent of Colorado businesses with fewer than 50 employees offer coverage.

Who are the uninsured?

The Lewin Group's analysis reveals important details:

- Seventy percent of the uninsured are in the workforce or are the dependent of a worker.
    - Approximately 37.5 percent of Colorado's uninsured work for firms that do not offer health coverage to their employees.
    - Approximately 21 percent are ineligible for their employer's coverage.
    - About 11 percent of uninsured workers and dependents are eligible for but do not take the coverage offered by their employer.
- The uninsured are found in all income groups (see Figure 4). Rising costs mean that more middle-income families find health insurance premiums unaffordable.
    - About 32 percent of the uninsured live in households that earn $20,000 or less annually.
    - Approximately 75 percent live in a household with an annual income of $50,000 or less.
    - Approximately 13 percent are in households that earn $75,000 or more annually; 6.5 percent earn more than $100,000 annually.

• **Figure 4: Average Monthly Uninsured in Colorado by Family Income**[4]



- Young adults are more likely than any other age group to lack insurance: about 40 percent of the uninsured are between the ages of 19 and 34.
- Close to 20 percent of the uninsured are children.
- Nearly 11 percent of the uninsured are eligible for public programs (Medicaid and the Child Health Plan Plus) but not enrolled; most of these are children.
- Approximately 21 percent of the uninsured are not citizens of the United States (either legal non-citizens or undocumented).

What do these facts tell us about what needs to be done?

- Many Coloradans can't afford health coverage without some type of assistance.
- The uninsured are a heterogeneous group. If we wish to cover Colorado's uninsured, we must employ a variety of strategies.
- We must look for ways to stabilize rising costs. For example, if we extend health coverage to more people, we can minimize the cost shift from uncompensated care that represents a "hidden tax" and contributes to escalating health insurance premiums. If we bring more healthy people into the insurance pool, we can lower the risk and thereby stabilize costs for everyone.

Highlights of the Commission's Work

With these issues as the impetus for its work, the Commission began meeting in November 2006 to fulfill its charge to extend coverage and reduce health care costs in Colorado.

[4] Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

The Commission requested proposals for comprehensive health reform from interested parties statewide and received 31 responses – far more than have most other states that have used this approach, indicating the level of engagement on this issue in Colorado.

The Commission selected four proposals for technical "modeling" analysis by an independent vendor, The Lewin Group. These proposals represented a range of approaches to health reform and were designed to offer lawmakers information on a variety of options. The Commission subsequently developed a fifth proposal of its own and subjected it to the same type of evaluation as the other four proposals.

In addition, the Commission worked diligently to receive input from the public and from stakeholder groups, conducting 24 public meetings statewide and convening four Advisory Task Forces to provide focused input from business, providers, rural communities and vulnerable populations.

Philosophy Underlying the Commission's Recommendations

The Commission now submits a package of 32 recommendations for comprehensive health reform to the General Assembly.

It is important to note the unprecedented nature of this accomplishment. The fact that such a diverse group – representing a broad array of backgrounds, ideologies and interests – was able to come to agreement on these recommendations signals that real reform is, indeed, achievable.

Three of the 27 commissioners dissent from these recommendations and have prepared two minority reports. Those reports may be found in Chapter 10 of this document.

This package of recommendations is informed by Lewin's baseline analysis of current health care costs and coverage in Colorado, the modeling results of all five proposals, input received at community meetings and feedback from the Commission's Advisory Task Forces.

It also draws heavily from the Commission's fifth proposal. The estimated cost and coverage impacts of that proposal are instructive for understanding the potential impacts of this approach.

In developing its recommendations, the Commission made careful choices about how to balance competing priorities in order to best accomplish its charge of expanding access and reducing costs.

The Commission's 32 recommendations reflect certain philosophical imperatives:

- Everyone – individuals, employers, providers, insurers and the government – has a role to play in addressing Colorado's health care needs. All have a share in the responsibility; all will share in the benefits.
- "One size fits all" doesn't work in health care. People have differing income levels and health care needs, and health status can change in an instant. Communities' needs vary greatly, depending on geographic location, demographic makeup and numerous other

factors. We need a range of interventions that respond to a variety of individual and community situations.

- Some people simply cannot afford private insurance coverage. Those people should have access to public coverage or subsidies for basic health care needs.
- Safety net providers such as community clinics and hospitals play an essential role in caring for those on public programs and those without any health coverage. If we expand public programs to include more people, and as we recognize that non-citizens will continue to need care even if they do not have coverage, we must preserve and enhance safety net providers' ability to serve these populations.
- We recognize that vulnerable populations must be protected in any reform of the system. We can not jeopardize their safety or reduce or compromise current levels of services as reform moves forward.
- Individuals should have meaningful choices and options that give them control over their own care and coverage decisions.
- Government, employers and insurers should promote and encourage healthy lifestyles and preventive care. Individuals, however, have responsibility for their own health and wellness.
- Because most Coloradans have insurance, we should build on the strengths of the current system, keeping and broadening what works to minimize dislocation for those who already have good coverage, while making important changes to better meet the needs of those who currently lack affordable health coverage.
- In order to accomplish our goals, we must maximize the federal funding available to Colorado – for example, through public program expansions that will enable us to draw down the maximum federal match, and through applications for federal waivers that will enable us to try new approaches to better meet the needs of Colorado's vulnerable populations.

Key features of this package include:

- Require all legal residents of Colorado to have minimum insurance coverage ("individual mandate'). Make the mandate feasible by:
    - Expanding eligibility for public programs
    - Providing sliding-scale subsidies for low-income workers to purchase private coverage
    - Reforming the individual insurance market by requiring health plans to cover everyone who is not eligible for a restructured Cover Colorado program due to a high-cost pre-existing condition
    - Enforce the mandate through the income tax system.
- Require employers to offer pre-tax premium-only plans to facilitate employee purchase of health coverage.
- Create a "Connector" to assist individuals and small employers to understand and choose among insurance options

- Restructure, combine and expand eligibility for Medicaid and the Child Health Plan Plus (CHP+)
- Reduce administrative costs by streamlining processes and combining functions.
- Promote consumer choice and direction and encourage cost-consciousness by improving access to cost and quality information.
- Implement measures to enhance quality and improve coordination of care.
- Encourage individual responsibility for health, wellness and preventive behavior.
- Improve delivery of services to vulnerable and underserved populations through program expansions, reimbursement for telemedicine and other mechanisms.
- Fund safety net providers and public health delivery systems appropriately.

All 32 recommendations are summarized on the following pages; full details are available in Chapter 7 of this report.

Summary of the Commission's Recommendations

Introduction: Important Considerations

What follows is not merely a laundry list of recommendations. It is a comprehensive, integrated package that will only succeed in achieving the goal of expanding coverage and containing costs if viewed as a whole and implemented in the appropriate stages.

Certain essential building blocks among these recommendations must be put in place before others if those latter elements are to be successful. Therefore, the Commission has proposed a series of stages for the implementation of its recommendations. For example, the requirement for all Coloradans to have insurance works only if other measures are enacted to make coverage accessible and affordable, such as expanding public programs, creating subsidies for lower-income people to purchase private insurance and reforming the individual insurance market. Similarly, efforts to expand enrollment in public programs must be preceded by efforts to improve efficiency and increase provider participation in those programs.

Further, where flexibility exists, strategies that 1) serve vulnerable and poorest populations and 2) fix elements of the health care system that are ineffective, should be pursued before other health care reform strategies.

Readers will find specific suggestions about implementation staging in Chapter 7.

It is imperative that cost containment efforts be instituted at the outset. The Commission provides recommendations to reduce administrative costs, and also believes that minimizing the cost shift from uncompensated care will help to stabilize costs. Yet, many other factors, including the proliferation of medical technology, medical errors, medical waste due to inefficiency and other issues, contribute to rising costs. Addressing these issues requires ongoing, coordinated effort among a variety of stakeholders. The Commission believes that the Improving Value in Health Care Authority included in these recommendations can serve this role, and urges that its creation be one of the first steps in the implementation of these reforms.

Taken together, our package of recommendations offers a bold yet realistic approach to providing high quality, affordable health care to all Coloradans.

Summary of Recommendations

Part 1: Reduce Health Care Costs, while Enhancing Quality of Care

1) Slow the rate of growth of employer and private health insurance premiums by covering the uninsured and increasing Medicaid provider reimbursement rates as a means of minimizing cost-shifting.
    a. Reduce uncompensated care by covering at least 85 percent of the uninsured in Colorado, by means of the recommendations in Part 2 (below).
    b. Reduce cost-shifting by increasing Medicaid provider reimbursements (see Recommendation 22).

2) Reduce employee health insurance premium costs.
    a. Require Colorado employers to establish at least a Section 125 premium-only plan that allows employees to purchase health insurance with pre-tax dollars (see Recommendation 17a).
    b. Provide sliding scale subsidies for uninsured low-income workers below 400 percent of federal poverty level (FPL; i.e., annual income of about $80,000 for a family of four) to purchase their employer's plan (see Recommendations 17b, 19a and 19b).

3) Reduce administrative costs.
    a. Require health insurers and encourage all payers in Colorado to use standard claims attachment requirements, eligibility and coverage verification systems, electronic ID cards and prior authorization procedures; and uniform insurance application forms. Adopt nationally-recognized standards that have been accepted by industry groups but not yet implemented.
    b. Combine administrative functions of public health insurance programs (such as Medicaid, CHP+, premium subsidy program, CoverColorado).
    c. Review regulatory requirements on third-party payers and providers with the goal of reducing administrative burden.

4) Increase use of prevention and chronic care management.
    a. Where allowed by federal law, allow health insurance premiums to be reduced for enrollees who engage in healthy behaviors.
    b. Eliminate patient copayments for preventive care and reduce patient copayments for chronic care management services.
    c. Encourage employers to provide workplace wellness programs.
    d. Encourage individual responsibility for health, wellness and preventive behavior.
    e. Increase funding for local public health agencies in Colorado to perform such functions as preventing disease and injury, assessing community health and promoting healthy behavior.

5) Conduct a comprehensive review of current Colorado and national long-term care information to understand challenges and opportunities and identify appropriate strategies for reform. Resources include the SB 173 report, the report of the Developmental Disabilities Interim Committee, the SB 128 Medicaid Redesign Project and the National Clearinghouse for Long-Term Care Information.

6) Improve end-of-life care.
    a. Develop strategies to foster clinically, ethically and culturally appropriate end-of-life care, including palliative and hospice care, based upon best scientific evidence.
    b. Ask patients, upon entry to a nursing home, home health agency or other critical point of access, to complete an advanced directive.

Recommendations (continued)

Reduce Health Care Costs, while Enhancing Quality of Care (continued)

7) Commission an independent study to explore ways to minimize barriers to such mid-level providers as advanced practice nurses, dental hygienists and others from practicing to the fullest extent of their licensure and training.

8) Provide a medical home for all Coloradans.
    a. Enhance the provision, coordination and integration of patient-centered care, including "healthy handoffs."
    b. Reimburse providers for care coordination and case management, particularly in the Medicaid/CHP+ and CoverColorado programs.
    c. Provide targeted case management services for Medicaid patients.

9) Support the adoption of health information technology.
    a. Support the creation of a statewide health information network, focusing on interoperability and building upon regional efforts already in place for sharing data among providers.
    b. Support the creation of an electronic health record for every Coloradan, with interoperability across health plans and hospitals systems and protections for patient privacy.

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

11) Pay providers based on quality.
    a. Pay providers based on their use of care guidelines, performance on quality measures, coordination of patient care and use of health information technology.

12) Ensure that information on insurer and provider price and quality is available to all Coloradans and that it is easily accessible through a single entry point (e.g., a Web site).
    a. Make information on insurer and provider price and quality available to all Coloradans and that it is easily accessible through a single entry point.
    b. Require the Colorado Division of Insurance (DOI) to report annually to the legislature regarding financial information on licensed carriers and public programs, including medical loss ratios, administrative costs, etc, by line of business; require Medicaid, CHP+, CoverColorado and other public programs to provide DOI with this information; and require brokers to report their compensation to their clients.

13) Promote consumer choice and direction in the health care system.
    a. Provide a choice of Minimum Benefit Plans, including a Health Savings Account option, for all consumers purchasing in the individual insurance market (see Recommendation 20).
    b. Create a Connector for individuals and employees (see Recommendation 18).
    c. Increase price and quality transparency (see Recommendation 12).
    d. Provide consumers with evidence-based medical information at the point of service to aid in decision-making through patient-centered care.

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

Recommendations (continued)

Reduce Health Care Costs, while Enhancing Quality of Care (continued)

15) Create a multi-stakeholder "Improving Value in Health Care Authority."
    a. Before implementing the coverage expansions identified in Section 2, the state should establish an Improving Value in Health Care Authority to fundamentally realign incentives in the Colorado health care system to reduce costs and improve outcomes, and identify other means of containing systemic cost drivers.
    b. Give the Authority rule-making authority to implement the Commission's recommendations regarding administrative simplification (Recommendation 3), health care transparency (Recommendation 12), design of the Minimum Benefit Package (Recommendation 16b) and the Consumer Advocacy Program (Recommendation 28).
    c. Direct the Authority to study and make recommendations to the governor, state legislature and rule-making agencies regarding prevention (Recommendation 4), end-of-life care (Recommendation 6), medical homes (Recommendation 8), health information technology (Recommendation 9), evidence-based medicine (Recommendation 10) and provider reimbursement (Recommendation 11).
    d. Direct the Authority to oversee development of a statewide system aggregating data from all payer plans, public and private, building upon regional systems or efforts already taking place for sharing data among providers (Recommendation 10b).
    e. The Authority also should be responsible for assessing and reporting on the effectiveness of reforms, especially their impact on vulnerable populations and safety net health care providers.
    f. Establish the Authority before embarking on the improvements to coverage and access described in Part 2.

Part 2: Improve Access to Care, with Mechanisms to Provide Choices

16) Require every legal resident of Colorado to have at least a Minimum Benefit Plan, with provisions to make the mandate enforceable.
    a. Require purchase of a Minimum Benefit plan (average monthly premium of approximately $200 for an individual).
    b. Design and periodically review the Minimum Benefit Plan through the "Improving Value Authority."
    c. Provide an affordability exemption or consider another mechanism for addressing affordability, such as extending the premium subsidy program to a higher income level. Assuring affordability should include consideration of both premium and out-of-pocket costs.
    d. Enforce through tax penalty; automatically enroll those who are eligible into fully-subsidized public coverage programs.

17) Implement measures to encourage employees to participate in employer-sponsored coverage.
    a. Require Colorado employers to establish premium-only Section 125 plans that allow employees to purchase health insurance with pre-tax dollars.
    b. Provide subsidies for uninsured low-income workers below 400 percent FPL (approximately $80,000 annual income for a family of four) to purchase their employer's plan.
    c. Enforce waiting periods (minimum periods of being uninsured) for eligibility for the premium subsidy program, to discourage employers and employees from dropping employer coverage to enroll in public programs; create exceptions for involuntary loss of coverage, COBRA coverage, or qualifying events, such as marriage or birth.

Recommendations (continued)

Improve Access to Care, with Mechanisms to Provide Choices (continued)

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

19) Maximize access to/enrollment in private coverage for working lower-income Coloradans who are not offered coverage at the workplace.
    a. Provide premium subsidies to workers who are not offered coverage at the workplace who earn less than 300 percent FPL (approximately $60,000 annual income for a family of four) for purchase of private health insurance equivalent to CHP+ benefit package.
    b. Provide premium subsidies to individuals and families who earn between 300-400 percent FPL (between $60,000-$80,000 annual income for a family of four) such that their premium cost of the Minimum Benefit Plan is no more than 9 percent of their income. (The same subsidy would be available to workers with access to coverage at the workplace.)
    c. To facilitate enrollment and reduce fraud, use auto enrollment strategies that use existing state data to determine subsidy eligibility (e.g., tax, wage, and nutrition program information).

20) Require all health insurance carriers operating in Colorado to offer a Minimum Benefit Plan in the individual market
    a. Require all health carriers offering health insurance in Colorado to offer a Minimum Benefit Plan in the individual market, with an emphasis on value-based and consumer-directed benefit design. (Note: The Commission is not dictating specifics of the Minimum Benefit Plan.)

21) Guarantee access to affordable coverage for Coloradans with health conditions (implement in conjunction with Recommendation 16).
    a. Require health insurance companies to issue coverage (guarantee issue) to any individual or family who applies for individual health insurance and who is not eligible for the restructured CoverColorado program due to a high-cost pre-existing condition ("qualified applicant").
    b. Allow health insurance companies to set premiums for these individuals and families based on their age and geographic location; disallow the consideration of past and current health conditions.
    c. Restructure CoverColorado to cover those who apply for coverage, have a specified high-cost health condition as defined by the newly expanded program, and are not eligible for Medicaid, CHP+ or a premium subsidy. Finance CoverColorado to ensure that premiums are equal to the standard rates in the individual market.

22) Merge Medicaid and CHP+ into one program for all parents, childless adults and children (excluding the aged, disabled and foster care eligibles).
    a. Pay health plans at actuarially-sound rates and providers at least CHP+ rates in the new program.
    b. For all other Medicaid enrollees, ensure that physicians are reimbursed at least 75 percent of Medicare rates.
    c. Provide the CHP+ benefit and cost-sharing package, including dental, to enrollees in the new program. Provide access to a Medicaid supplemental package, including early and periodic screening, diagnosis and testing (EPSDT) for children, for those who need Medicaid services.
    d. Provide dental coverage up to $1,000 per covered person per year.
    e. Require enrollment in managed care, where available.

Recommendations (continued)

Improve Access to Care, with Mechanisms to Provide Choices (continued)

23) Improve benefits and case management for the disabled and elderly in Medicaid.
    a. Encourage enrollment of the aged and disabled into integrated delivery systems that have incentives to manage and coordinate care.
    b. Promote care delivery in a consumer-directed, culturally competent manner to promote cost-efficiency and consumer satisfaction.
    c. Increase the number of people served by the home- and community-based programs equal to the number of people on the current waiting list for these services (see Recommendation 24c).
    d. Explore potential for further reforms to Medicaid, particularly for those who are disabled (see Appendix 10).

24) Improve delivery of services to vulnerable populations.
    a. Create a Medicaid buy-in program for working disabled individuals.
    b. Create a Medically-Correctable fund for those who can return to work or avoid institutionalization through a one-time expense.
    c. Increase number of people served by the home- and community-based programs equal to the number of people on the current waiting list for these services.
    d. Provide mental health parity in the Minimum Benefit Plan (Recommendation 20).
    e. Establish a Medically-Needy or other catastrophic care program for those between 300-500 percent FPL ($30,000-$50,000 annual income for an individual) to address the issue of people who have health insurance but do not have coverage for catastrophic events (fund at $18 million in state funds).

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

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

Recommendations (continued)

Improve Access to Care, with Mechanisms to Provide Choices (continued)

27) Enhance access to needed medical care, especially in rural Colorado where provider shortages are common.
    a. Continue to pay all qualified safety net providers enhanced reimbursement for serving Medicaid patients.
    b. Explore ways to minimize barriers to such mid-level providers as advanced practice nurses, dental hygienists and others from practicing to the fullest extent of their licensure and training.
    c. Promote and build upon the existing statewide nurse advice line.
    d. Expand telemedicine benefits for Medicaid and CHP+ enrollees, especially in rural areas.
    e. Develop and expand mechanisms to recruit and retain health care workers who will provide services in underserved areas of Colorado, such as state-based loan repayment, loan forgiveness programs, tax credits and other approaches.

28) Create a Consumer Advocacy Program including an Ombudsman Program.
    a. Create a program that is independent and consumer-directed to guide people through the system, resolve problems, provide assistance with eligibility and benefit denials, help qualify people on Medicare for Medicaid and help people qualify for SSI.

29) Continue to explore the feasibility of giving Coloradans the option to enroll in coverage that will stay with them regardless of life changes, such as the Optional Continuous Coverage Portable Plan that the Commission modeled.

30) Continue to explore the feasibility of allowing employers to offer 24-hour coverage (e.g., all of an employee's health needs, including health and workers compensation claims, are covered by a single insurer).

PART 3

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

PART 4

32) **Dissolve the Commission once its final report is made to the General Assembly January 31, 2008.**

Chapter 1: Background – The Nature of the Problem

Colorado, in common with other states, faces twin problems: rising costs for both health care and health coverage, and an associated increase in the number of residents without health insurance.

In order to understand these trends, it is important to look at the key components of the health care system, understanding how they contribute to the problems we face as well as how they might contribute to solutions.

Employer-Sponsored Coverage

Ever since World War II, when wage controls drove employers to seek other ways of attracting workers, the workplace has been the primary source of health coverage in America. The tax code and other federal laws have since reinforced this system.

For many Coloradans, this system works – about 58 percent of Coloradans are insured through their employers.[5] Yet, the vast majority of Colorado's uninsured – about 70 percent – are workers or dependents of workers.

A recent survey by the Agency for Healthcare Research and Quality finds that the percent of Colorado businesses offering insurance to their workers declined from 66.5 percent in 2001 to 54.1 percent in 2005.[6] The problem is particularly pronounced for small businesses. A Colorado Health Institute analysis found that employees in small- and mid-sized companies were nearly twice as likely to be uninsured as those who worked for large employers.[7] Other recent data show that just 41 percent of Colorado businesses with fewer than 50 employees offer coverage.[8] This is especially troubling given the significant role small businesses play in Colorado's economy, with approximately one-half of Colorado workers employed by firms with fewer than 50 employees.[9]

Finally, many part-time and low-wage workers do not qualify for insurance offered by their employers.

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[5] The Lewin Group. "Appendix A: Characteristics of the Uninsured in Colorado" in "Cost and Coverage Impacts of Five Proposals to Reform the Health Care System in Colorado." Prepared for the Colorado Blue Ribbon Commission for Health Care Reform. January 2008. See Appendix 4 of this report.

[6] Agency for Healthcare Research and Quality. Percent of private-sector establishments that offer health insurance by firm size and State (Table II.A.2), years 1996-2005:. Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC. <http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.jsp> (December 18, 2007)

[7] "Profile of the Uninsured in Colorado, 2004," Colorado Health Institute, January 2006.

[8] Agency for Healthcare Research and Quality. Percent of private-sector establishments that offer health insurance by firm size and State (Table II.A.2), years 1996-2005: Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC. <http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.jsp> (December 18, 2007

[9] Colorado Dept. of Labor and Employment Labor Market Information, http://lmigateway.coworkforce.com/lmigateway/analyzer/seltime.asp?paramx=&blnFirstGeog=True, accessed Dec. 7, 2007.

Despite these difficulties, though, there are good reasons to maintain employer-sponsored coverage. Many employers view providing health coverage as a crucial way to attract and retain employees, and more than half of Coloradans are covered by employer-sponsored insurance. Employer-sponsored insurance is an important tool for providing private, affordable coverage for Colorado's workers and their families.

Public Coverage

Another important mechanism is public coverage through such programs as Medicaid and the Child Health Plan Plus (CHP+). These programs provide an important safety net, with benefits that are especially designed to meet the needs of low-income and disabled people. Yet Medicaid and CHP+ in Colorado cover just 21 percent of the state's population under 200 percent of poverty (i.e., about $20,000 annual income for a family of four) -- the third lowest percentage in the country -- compared with the national average of 31 percent.[10]

This can be attributed to the fact that Colorado's eligibility ceilings are low – Medicaid in Colorado covers only the poorest of the poor, leaving large numbers of low-income workers ineligible. And, eligibility rules (for Medicaid, especially) are complicated; individuals' eligibility status can change monthly.

These issues are exacerbated by low reimbursements that have discouraged physicians from participating in Medicaid. Limited provider participation in these programs has meant that even those who have coverage through public programs may not have timely, convenient or effective access to care.

Individual Coverage

The individual (non-group) insurance market is an option for those who do not have access to employer-sponsored insurance and do not qualify for public coverage. However, because individual policies are priced according to risk, people with health conditions can find themselves faced with prohibitively expensive premiums and limited coverage, or even excluded from coverage altogether.

Colorado's high-risk plan, CoverColorado, is available to anyone who has been turned down for private insurance. However, its premiums are prohibitively expensive.

Action at the State vs. Federal Level

Federal laws shape much of the health care landscape. The tax code enables employer-provided premiums to be deductible for the business and not taxed for the individual. Insurance purchased by the self-employed or on the individual market is generally not a deductible expense. Federal law limits states' ability to regulate employee benefits. Public

[10] Medicaid Coverage Rates for the Nonelderly by Federal Poverty Level (FPL), states (2005-2006), U.S. (2006), statehealthfacts.org.

programs such as Medicaid that send federal dollars to the states impose restrictions on how those dollars can be used.[11]

While these and other limits make health reform at the state level challenging, inaction at the federal level makes it imperative. Comprehensive health reform has been stymied in Congress on many occasions. Despite the prominence of health care in the platforms of all candidates for the 2008 presidential election, it is difficult to imagine that sweeping changes will be made soon in Washington.

The Need for Action

The cost of health coverage has risen dramatically in recent years, outpacing growth in wages. Both employers and employees are paying more for health insurance.

- The federal Agency for Healthcare Research and Quality recently calculated that employers' share of health premiums for employee-only coverage rose by 48 percent and their share of family coverage rose by 58 percent between 2000 and 2005. Employees paid 61 percent more for their share of the average employee-only insurance premium and 60 percent more for family coverage in 2005 compared with 2000.[12]
- Families USA calculates that family health premiums rose 82 percent in Colorado between 2000 and 2006, while wages increased by just 15 percent – a more than fivefold difference.[13]
- Rising premiums mean that families are spending an ever-growing share of their income on health insurance. Len Nichols of the New America Foundation calculates that the share of median family income going to health insurance more than doubled from 7.7 percent in 1987 to 19 percent in 2005.[14]

As these rising costs contribute to greater numbers of uninsured, all Coloradans pay the price.

- We pay with our public health. When people lack health coverage, they tend to go without such basic care as annual checkups, immunizations, etc. Little problems can escalate to big problems; infectious diseases can spread, especially among children and the elderly; everyone can be compromised.
- We pay through our own health insurance premiums. A study commissioned by Families USA found that $934 of the average $12,000 annual family health insurance premium in Colorado in 2005 was the cost of caring for the uninsured.[15] When people without insurance do not pay for some or all of the care they receive, providers must try to recoup their own costs by charging insurance companies more – who, in turn, pass those increases along to their members. This phenomenon is known as the "cost shift," and is a hidden tax that contributes to rising insurance costs for everyone.

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[11] NOTE: This report does not address Medicare because that program is not subject to state control of any kind.

[12] "News and Numbers from AHRQ," posted on MedScape, Oct. 2, 2007; calculations based on Medical Expenditure Panel Survey.

[13] "Premiums versus Paychecks," Families USA, December 2006.

[14] "Health Reform: Why Here, Why Now and Some Big Choices," Len M. Nichols Ph.D., presentation to the Blue Ribbon Commission for Health Care Reform, July 19, 2007; calculation based on data from Kaiser Family Foundation, Agency for Healthcare Research and Quality, and Current Population Survey. Figures reflect premium cost only, do not include copayments, deductibles, prescriptions and other out-of-pocket costs.

[15] "The Added Cost of Care for the Uninsured in Colorado," Families USA, June 2005.

Chapter 2: Objectives, Scope and Funding of the Commission

The Colorado General Assembly created the Blue Ribbon Commission for Health Care Reform (also known as the 208 Commission; referred to in this document as "the Commission") in 2006. As directed by its enabling legislation, SB 06-208, the Commission's purpose is:

> … studying and establishing health care reform models to expand health care coverage and to decrease health care costs for Colorado residents. The Commission shall be authorized to examine options for expanding affordable health coverage for all Colorado residents in both the public and private sector markets, with special attention given to the uninsured, underinsured, and those at risk of financial hardship due to medical expenses.

The Commission's charge included:

- Soliciting comprehensive reform proposals from interested parties;
- Selecting between three and five proposals for in-depth technical assessment by an independent contractor;
- Holding statewide informational meetings at least once in each congressional district for the purpose of receiving public comments
- Presenting a final report to the General Assembly including an unbiased economic analysis, feasibility and technical assessment of the favorable and unfavorable considerations of the various reform options, and specific recommendations.

SB 06-208 called for the Commission to present its report to the General Assembly by Nov. 30, 2007. Subsequent legislation, HB 07-1360, extended that deadline until Jan. 31, 2008.

SB 06-208 configured the Commission with 24 members, providing representation to consumers, health insurance purchasers, providers, business leaders and health care experts. Members were appointed by majority and minority leadership in the Colorado House of Representatives and Colorado Senate, and by then-Governor Owens. HB 07-1360 allowed Governor Ritter to make three additional appointees, bringing the total number of commissioners to 27.

The General Assembly appropriated $100,000 to fund the Commission's activities, with one-half of that sum being "matching" funds that would be released only when an equivalent amount of private money was raised. The Commission's total budget was $1.16 million, with over $1 million coming from the private sector. Of those private funds, 83 percent ($970,000) came as grants from nonprofit foundations and 8 percent ($90,000) came from corporations. The state's allotment represented less than 9 percent of the total budget.

Chapter 3: Overview of Commission Activities

November, 2006

First meeting of Commission
External Speakers/Presenters
Rep. Andrew Romanoff; Speaker, Colorado House of Representatives
Rep. Anne McGihon; House sponsor, SB 208

December, 2006

Commission elects officers
Chair: William N. Lindsay III - President, Employee Benefits, Lockton Companies;
Vice-Chair: Mark Wallace, MD - Executive Director, Weld County Dept. of Public Health & Environment; President, North Colorado Health Alliance
Commission establishes committees
Communications and Outreach
Evaluation Firm Selection
Health Reform Proposals
Operations
External Speakers/Presenters
Governor-elect Bill Ritter, Jr.
Colorado Health Institute - overview of health coverage in Colorado

January, 2007

Commission develops guiding principles
External Speakers/Presenters
Martha King, National Conference of State Legislatures - lessons from other states
Lori Weigel, Public Opinion Strategies - survey data re: public attitudes toward health reform
Leo Tokar, Kaiser Permanente - health care cost drivers
Kathleen Stoll, Families USA - perspectives on health reform
Nina Owcharenko, Heritage Foundation - perspectives on health reform

February, 2007

Commission solicits written comments on request for proposals for comprehensive health reform

March, 2007

Commission releases request for proposals for comprehensive health reform
Commission solicits bids for technical analysis of health reform proposals
Commission conducts statewide meetings to solicit feedback on health reform criteria
External Speakers/Presenters
William Jessee, Medical Group Management Assn. - reducing health care costs through administrative simplification
Enrique Martinez-Vidal, Academy Health - state coverage initiatives
Tamra Ward, Denver Metro Chamber of Commerce - statewide polling on health care

April, 2007	**Commission receives 31 responses to its request for health reform proposals** **External Speakers/Presenters** Clark Bouton, Colorado Progressive Coalition - initial findings from CPC health reform forums
May, 2007	**Commission selects evaluation vendor: The Lewin Group, Falls Church, VA** **Commission selects four proposals for evaluation** **Commission conducts five community meetings around the state** **Commission requests nominations for Advisory Task Forces** (Business, Provider, Rural, Vulnerable Populations)
June, 2007	**Commission selects Task Force participants** **The Lewin Group presents baseline analysis of health coverage and costs** **Evaluation of four proposals begins** **External Speakers/Presenters** Devon Herrick, National Center for Policy Analysis - consumer-driven health care
July, 2007	**Task Forces begin meeting** **Evaluation of four proposals continues** **Commission begins developing fifth proposal** **External Speakers/Presenters** Len Nichols, New America Foundation - Health reform: Why now, why here
August, 2007	**Evaluation of four proposals complete** **Task Forces report reactions to four proposals**
September, 2007	**Commission finalizes fifth proposal** **Evaluation of fifth proposal begins**
October, 2007	**Commission conducts 14 community meetings statewide** **Evaluation of fifth proposal continues** **Commission begins developing final recommendations** **Task Forces present final reports to Commission**
November, 2007	**Evaluation of fifth proposal complete** **Commission approves final recommendations**
December, 2007	**Lewin submits final report to Commission**

Guiding Principles

The foundation of the Commission's work is the "Guiding Principles" adopted by the Commission in January 2007. Operational guideposts which themselves build upon the Commission's charge to reduce costs and expand access, these principles framed the Commission's request for health care reform proposals, development of its own proposal and the recommendations in this report.

- Protect and improve the health status of all Coloradans.
- Expand coverage of essential health care services for all Coloradans, with an emphasis on the uninsured and underinsured.
- Align incentives to provide high-quality, cost-effective and coordinated care.
- Support a system that is financially viable, sustainable and fair.
- Provide opportunities for meaningful choice and encourage personal responsibility.
- Emphasize wellness, prevention, health education and consumer empowerment.

Chapter 4: Public Participation

The Commission took seriously its charge to solicit input from the public, creating numerous opportunities for Coloradans to comment and offer suggestions:

- All meetings of the Commission and its committees were open to the public, and included designated opportunities for public comment. Written comments submitted at those meetings were shared with commissioners, and meeting minutes included summaries of oral comments from the public.
- The Commission also solicited written comments on its website and in meetings, and shared those with commissioners.
- Between March and October, commissioners conducted 24 community meetings at locations throughout Colorado, traveling to each congressional district multiple times.
- The Commission created four Advisory Task Forces to provide focused feedback on all five proposals.
- Commissioners made more than 100 presentations about the Commission's activities to community and stakeholder groups, using each as an opportunity to encourage questions and comments.

Commissioners reviewed and discussed input from the community meetings and the Task Forces. The committee developing the Commission's fifth proposal also requested feedback from the Task Forces about specific ideas under consideration. The Final Report Committee explicitly considered the Task Force reports and the themes that emerged from community meetings in developing its recommendations.

Blue Ribbon Commission for Health Care Reform
Community Meetings Schedule

March 22-24

Locations: Alamosa, Aurora, Colorado Springs, Grand Junction, Greeley

Attendance: More than 200

Question posed:

- Input on criteria for health reform proposals: Comprehensiveness, Access, Coverage, Affordability, Portability, Benefits, Quality, Efficiency, Consumer Choice and Empowerment, Wellness and Prevention, and Sustainability.

May 10-12

Locations: Durango, Fort Collins, Glenwood Springs, Pueblo, Wheat Ridge

Attendance: Approximately 300

Questions posed:

- What are the one or two most important features that you feel must be included in any Colorado health care reform?
- What is the most important principle that should be considered in any reform effort?

October 4-13

Locations: Boulder, Canon City, Colorado Springs, Craig, Denver, Durango, Fort Collins, Golden, Grand Junction, Greeley, Lamar, Parker, Pueblo, Silverthorne

Attendance: More than 1,100

Questions posed:

- What should be the respective roles of individuals, employers, health care providers, health plans and government in assuring access to health care?
- Please discuss anything that you think the Commission should pay particular attention to in the five proposals being evaluated – OR anything that you think is missing from the conversation that would make a difference to you as the Commission moves forward with recommendations for health reform.

Community Meetings

As shown on the preceding page, each series of community meetings was framed around a specific set of questions. In addition to or instead of responses to those specific questions, many attendees shared personal stories about their experiences with the health care system and their own viewpoints about what the Commission should do.

Most attendees at the community meetings were consumers; a number of providers and some elected officials also attended. A handful of speakers provided business or insurance viewpoints.

Certain key themes emerged from all meetings. These include:

- There was a strong sentiment that we can do better. Many comments indicated that everyone – all individuals, all sectors – has a role to play in fixing the system.
- Concern about the cost of care recurred throughout the meetings.
- Many attendees expressed a strong desire for simplicity, regardless of the eventual system adopted.
- Some participants called for an explicit acknowledgment that hard choices must be made and discussed the need for some type of limitation on benefits.
- At the same time, though, many participants expressed concerns about limited benefit packages and underinsurance.
- In many communities, a sizable percentage of attendees advocated for a single-payer system.
- Some attendees advocated for the preservation of individual choice and free-market approaches, such as increased access to health savings accounts (HSAs) and continued ability to select catastrophic/major medical coverage only.
- Numerous attendees, both consumers and providers, noted that coverage does not equal access. There were many comments about the need for ways to attract and retain providers to public programs, protect safety net providers and provide reasonable access in rural areas. Suggestions included increased use of advanced practice nurses and alternative providers.
- A number of participants stressed the need for increased funding for Medicaid services for the disabled, in order to reduce waiting lists and expand eligibility for home and community-based services.
- Those on public programs noted the difficulty of navigating the system and called for simplifications.
- Many attendees called for integrating behavioral and physical health coverage, providing more funding for mental health and substance abuse, and incorporating dental with medical coverage.
- Concerns about long-term care – especially access to home care – featured prominently.

- Numerous participants urged commissioners to focus on health, wellness and preventive care, and noted the importance of incorporating public health efforts into reform approaches.
- Reaction to the individual mandate (i.e., requirement for all Coloradans to have insurance) was mixed; those who supported it generally did so with a caution that it include ways to make insurance affordable.

Task Forces

Four Advisory Task Forces (Business, Provider, Rural and Vulnerable Populations) were established in June 2007 to help the Commission understand the positive or problematic impacts of the approaches to reform in the four proposals selected for modeling as well as the Commission's 5th proposal.

These groups were selected to ensure that specific, important perspectives were provided to help shape the Commission's views. Each Task Force was asked to focus on the impact of each proposal on the population represented by their membership.

The Commission asked the Advisory Task Forces to address the following questions:

(1) What are the impacts, both positive and problematic, of each proposal on the constituency represented by your task force?
(2) From the perspective of your task force, what, if any, challenges would be faced in implementation of these proposals?

The Advisory Task Forces met July –September 2007 and consisted of 15 non-Commission members each, with the exception of the Vulnerable Populations Task Force, which had 20 members. Each task force was led by two co-chairs, one a member of the Blue Ribbon Commission and one a community task force member. The Commission chairman appointed the co-Chairs of each task force, with the appointments ratified by the full Commission.

The co-chairs of the task forces communicated with each other about their progress and recommendations and exchanged perspectives for the consideration of the other task forces. The Advisory Task Forces provided a presentations of their analysis of the proposals to the Commission at its September 24 meeting.

See Chapter 8 for a list of the Task Force recommendations, indicating which of these were included in the final Commission recommendations. We also encourage readers to refer to the complete reports of the Task Forces in Appendix 6.

Chapter 5: Baseline Analysis of Health Coverage and Costs in Colorado

The Commission contracted with The Lewin Group of Falls Church, Va., to perform technical evaluation ("modeling") of the selected health reform proposals

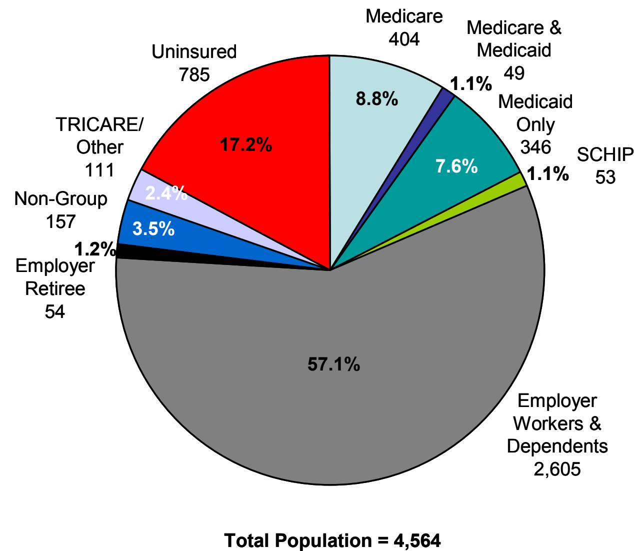
Lewin first analyzed the current landscape of health coverage and costs in Colorado, seeking to develop the most timely and accurate pictures of the insured and uninsured and the nature of health spending in Colorado. Highlights of these findings are presented below. However, readers are strongly encouraged to review the complete analyses of current uninsured and health care spending in Colorado, which are available in Appendix 4.

These analyses were essential to the Commission's work. In addition to providing a baseline from which to estimate coverage and cost impacts of each reform proposal, this information illustrated vividly the very specific problems the Commission should address in its recommendations.

The Uninsured in Colorado

Lewin estimates that approximately 785,000 Coloradans – or about 17 percent of the state's population – were estimated to lack health coverage in any given month in 2004-2006 (see Figure 5). By 2008, Lewin estimates that the number of uninsured will grow to nearly 792,000.[16]

- **Figure 5: Colorado Residents by Average Monthly Primary Source of Health Insurance 2004-2006 (thousands)[17]**



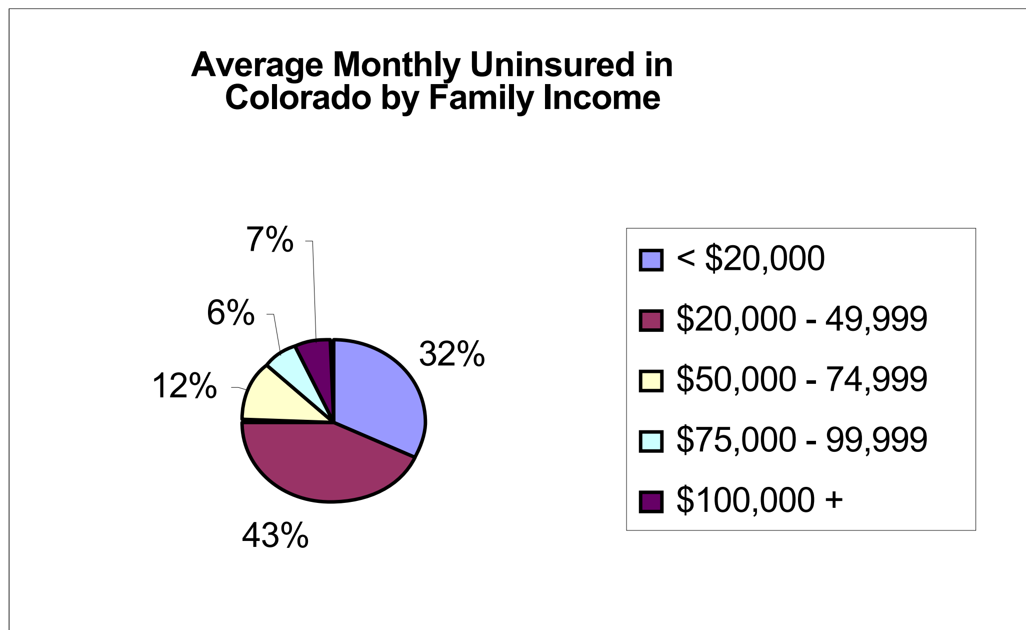
[16] The Lewin Group. "Appendix A: Characteristics of the Uninsured in Colorado" in "Cost and Coverage Impacts of Five Proposals to Reform the Health Care System in Colorado." Prepared for the Colorado Blue Ribbon Commission for Health Care Reform. January 2008. See Appendix 4 of this report..

[17] Ibid. Primary payer is determined on the basis of prevailing coordination of benefits practices now in use.

Digging deeper, Lewin's analysis of Colorado's uninsured population reveals important details, including:

- Seventy percent of the uninsured are in the workforce (or are the dependent of a worker).
    - About 11 percent of uninsured workers and dependents are eligible for but do not take the coverage offered by their employer.
    - Approximately 21 percent are ineligible for their employers' coverage.
    - Approximately 37.5 percent of Colorado's uninsured work for firms that do not offer health coverage to their employees.

Figure 6: Average Monthly Uninsured in Colorado by Family Income[18]



- The uninsured are found in all income groups.
    - About 32 percent of the uninsured live in households that earn $20,000 or less annually.
    - Approximately 75 percent live in a household with an annual income of $50,000 or less.
    - Approximately 13 percent are in households that earn $75,000 or more annually; 6.5 percent earn more than $100,000 annually.

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[18] Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Table 1: 2007 Federal Poverty Level Definitions Eligibility for public programs such as Medicaid and the Child Health Plan Plus is determined by income according to federal poverty level (FPL) guidelines. This chart provides a basic overview of those definitions.	**Family Size 1**	**Family Size 2**	**Family Size 4**
Annual income: 100% FPL	$10,210	$13,690	$20,650
Annual income: 200% FPL	$20,420	$27,380	$41,300
Annual income: 250% FPL	$25,525	$34,225	$51,625
Annual income: 300% FPL	$30,630	$41,070	$61,950
Annual income: 400% FPL	$40,840	$54,760	$82,600

- Young adults are more likely than any other age group to lack insurance: about 40 percent of the uninsured are between the ages of 19 and 34.
- Close to 20 percent of the uninsured are children.
- About 10 percent are eligible for public programs (Medicaid and the Child Health Plan Plus) but not enrolled.
- Approximately 21 percent of the uninsured are not citizens of the United States (either legal non-citizens or undocumented).

(For additional detail, see Lewin's complete analysis, "Characteristics of the Uninsured in Colorado," in Appendix 4.)

These findings have significant implications for policymakers, and shaped the Commission's final recommendations.

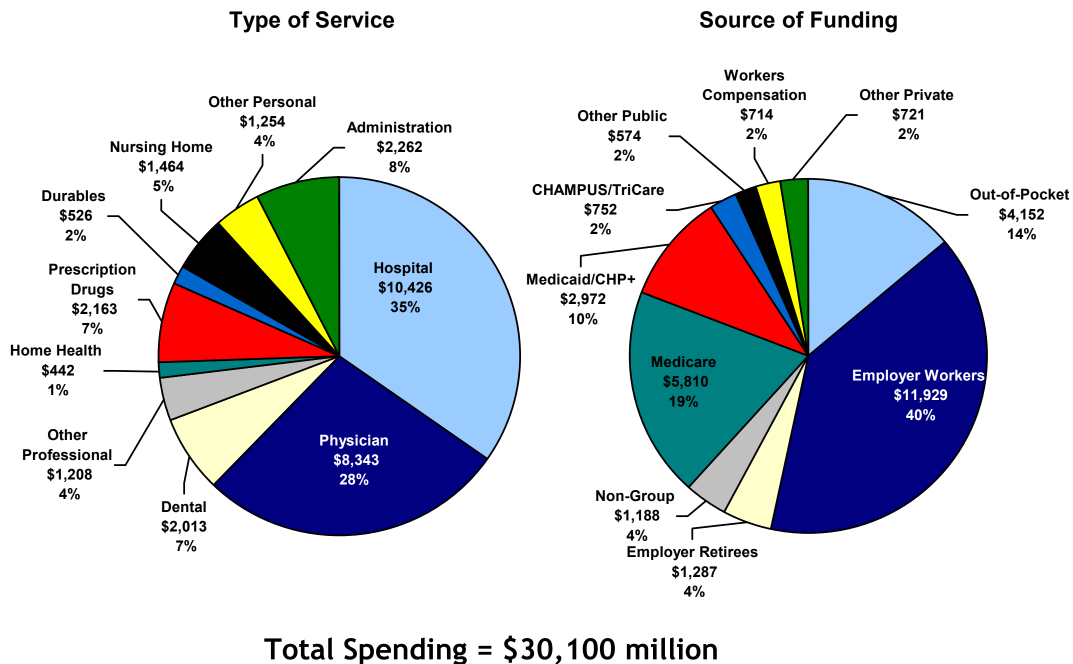
Health Spending in Colorado

Lewin estimates that, in 2007-2008, total spending on health care in Colorado will total approximately $30.1 billion.[19] This includes both public sector (e.g., Medicaid, Child Health Plan Plus, etc.) and private sector (e.g., health insurance premiums, copayments, etc.) spending.

[19] The Lewin Group. "Appendix B: Health Spending in Colorado" in "Cost and Coverage Impacts of Five Proposals to Reform the Health Care System in Colorado." Prepared for the Colorado Blue Ribbon Commission for Health Care Reform. January 2008. See Appendix 4 of this report.

Figure 7 below breaks down total annual spending by type of service and source of funding.

- **Figure 7: FY 2007-2008 Estimated Spending in Colorado by Type of Service and Source of Funding (millions)** [20]



Total Spending = $30,100 million

An estimated $1.25 billion will be spent on Colorado's uninsured in 2007-08. The uninsured pay for about half of their care out-of-pocket; the remainder is uncompensated care from doctors and hospitals, and care provided by safety net providers, workers compensation and veterans' benefits.[21]

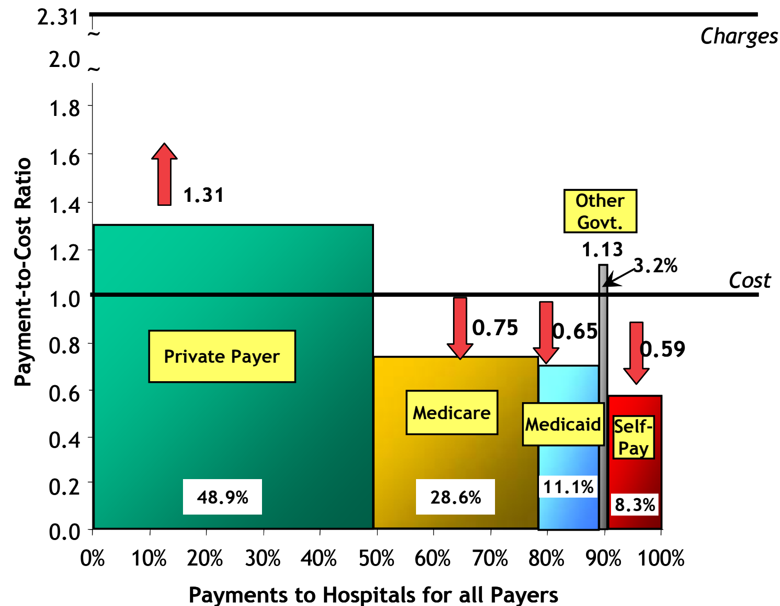
Impact of the Cost Shift

Lewin's analysis reveals that we all pay for the uninsured through the "cost shift." That is, when hospitals and other providers care for people without insurance who do not have the means to pay for their care, and when they care for enrollees in public programs (e.g., Medicaid, Child Health Plan Plus, etc.) at lower rates, providers must try to recoup the costs they have incurred by increasing the rates they negotiate with insurance companies. Insurers, in turn, pass those increases along to consumers in the form of higher premiums. Figure 8 illustrates this dynamic for Colorado hospitals.

[20] The Lewin Group. Note that percentages may not add to 100 percent because of rounding. Also, the segments "Employer Workers" and "Employer Retirees" on the "Source of Funding" chart include both employer and the employee shares of the premium.)

[21] Ibid

• **Figure 8: Summary Comparison of Hospital Payment Levels in Colorado**[22]



The chart illustrates the difference between what hospital services cost and what is paid to them. Uninsured/self-paying populations pay 59 percent of the cost of the care provided to them; Medicaid covers 65 percent of the cost of care; Medicare covers 75 percent of the cost. Because they all pay less than cost, those with private insurance end up paying 131 percent of costs.[23]

Using data provided by the Colorado Hospital Association, Lewin estimates FY 2007-2008 uncompensated charity care (that is, excluding bad debt from insured individuals) provided by Colorado hospitals, on a cost basis, to be $375.2 million. When physicians and other providers are included, the total rises to $777.1 million in uncompensated charity care.[24]

Lewin estimates that about 40 percent of the hospital shortfall is passed along to payers through the cost shift.[25] (Readers are encouraged to refer to Part III of Chapter 11, “Cost and Coverage Impacts of Five Proposals to Reform the Colorado Health Care System,” for additional analysis of this and other health spending considerations.)

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[22] The Lewin Group analysis of Colorado Hospital Association data. “Other Government” refers to CHAMPUS.

[23] “Charges” are the prices a hospital sets for its services. As the graphic shows, charges are considerably higher than payments received, due to negotiated rates with insurance plans, uncompensated care, under-payment from public programs, etc.

[24] The Lewin Group. “Appendix B: Health Spending in Colorado” in “Cost and Coverage Impacts of Five Proposals to Reform the Health Care System in Colorado.” Prepared for the Colorado Blue Ribbon Commission for Health Care Reform. January 2008. See Appendix 4 of this report.

[25] Ibid.

Chapter 6: Health Reform Proposals

Submitted Proposals

In response to its March request for comprehensive health reform proposals, the Commission received 31 proposals. We believe that this volume is significantly greater than that experienced by other states. Twenty-eight submissions met the requirements of the Solicitation for Health Care Reform Proposals. Of those 28, 23 were considered "comprehensive" (the others addressed such discrete issues as telemedicine, prescription reform, quality assurance and end-of-life care). Common strategies found in many of the proposals are shown on the next page. For a complete list of proposals submitted to the Commission, see Appendix 2.

Selected Proposals

Commissioners reviewed all proposals and, over the course of three meetings in May, narrowed them down, first to an interim list of 11 and then to a final selection of four.

Because SB 06-208 limits the Commission to evaluating no more than five proposals, commissioners decided to analyze just four of those submitted, wishing to leave ourselves the option of developing a fifth proposal after seeing the evaluations of the others.

The four proposals selected for evaluation were:

- **Better Health Care for Colorado**, submitted by the Service Employees International Union
- **Solutions for a Healthy Colorado**, submitted by the Colorado State Association of Health Underwriters
- **A Plan for Covering Coloradans**, submitted by the Committee for Colorado Health Care Solutions
- **Colorado Health Services Program**, submitted by the Health Care for All Colorado Coalition

In choosing this slate, commissioners sought to illustrate a range of philosophical beliefs about health reform. We wanted to understand the potential impacts of such disparate strategies as individual mandates, employer mandates and single-payer. Accordingly, we grouped the submitted proposals according to these and other categories and then chose among them. Commissioners were limited by the proposals that were submitted. For example, only one true "free market" proposal was submitted, and commissioners did not believe that it represented comprehensive reform.

During the selection process, commissioners recognized that each of the 31 proposals contained important and intriguing ideas. We established a "parking lot" of such ideas from the proposals that were not selected for evaluation, for reference in developing the fifth proposal and the final recommendations.

From June–August 2007, The Lewin Group conducted at least three rounds of modeling analysis on each of the four selected proposals, briefing commissioners on each stage of findings.

Summary of Common Health Care Reform Strategies Submitted to the Commission

Access Strategies

- Increase use of Medicaid managed care (3 proposals)
- Increase Medicaid provider reimbursement (5 proposals)
- Preserve the safety net for those not covered by new programs (2 proposals)

Coverage Strategies

- Expand Medicaid and CHP+ (5 proposals)
- Replace Medicaid with voucher system (3 proposals)
- Subsidize purchase of private insurance (8 proposals)
- Require employers to offer health insurance to their workers or pay a fee (4 proposals)
- Require Coloradoans to have health insurance (11 proposals)
- Reform the individual insurance market (6 proposals)
- Create single-payer system that covers everyone (6 proposals)

Benefit Strategies

- Employ a limited benefit package (4 proposals)
- Employ a comprehensive benefit package (13 proposals)

Quality Strategies

- Increase use of health information technology (12 proposals)
- Increase use of evidence-based medicine (8 proposals)
- Pay providers based on outcomes (9 proposals)
- Publish cost and quality information for insurers and providers (10 proposals)
- Increase use of case management (2 proposals)

Cost-Reduction Strategies

- Increase purchasing power by pooling multiple purchasers (3 proposals)
- Reduce administrative costs by creating a single-payer system (6 proposals)
- Increase use of home and community-based services in Medicaid (2 proposals)

Prevention Promotion Strategies

- Provide incentives for healthy behaviors and use of preventive care (7 proposals)
- Require coverage of preventive care (15 proposals)

Fifth Proposal

The Commission began developing its own fifth proposal in July, establishing a committee (whose meetings all commissioners were encouraged to attend) to spearhead the process. The Fifth Proposal Committee drafted recommendations, which were then discussed and voted upon by the full Commission.

In developing the fifth proposal, the committee referred to the modeling results of the four selected proposals and the "parking lot" of ideas from all proposals submitted to the Commission. Commissioners also submitted their own ideas for consideration, and the Advisory Task Forces were asked to provide specific input on some of the ideas being considered for inclusion in the proposal.

The Lewin Group analyzed the fifth proposal using the same assumptions as those applied to the other four that were evaluated.

Elements and Analyses of Five Proposals

Overviews of key elements in all five evaluated proposals are provided on the following pages, followed by comparison tables providing side-by-side highlights of their associated impacts on health care costs and coverage. (NOTE: These are high-level summaries. Detailed specifications for each proposal are available in Appendix 4. The Lewin Group's complete analysis of all proposals is available in Appendix 4. Readers are strongly encouraged to review that analysis, which provides essential detail for an adequate understanding of each proposal.)

Better Health Care for Colorado: Submitted by the Service Employees International Union

Key elements

- No requirements for individuals to purchase or employers to provide insurance
- Expands CHP+ to 300 percent FPL (approximately $60,000 annual household income for a family of four)
- Provides private insurance coverage for "working poor" adults
  - Choice of plans offered through health insurance exchange (i.e., a "one stop shop" that offers information, guidance and education to help consumers make informed choices)
  - Offers subsidies for private insurance purchase to parents and childless adults up to 300 percent FPL
  - Individuals may use subsidy to purchase employer-sponsored insurance
- Uninsured workers who earn above 300 percent FPL and small businesses that do not offer health insurance can purchase coverage through the exchange without a subsidy
- All plans offered through the exchange must provide at least a "core" minimum benefits package; options with more generous benefits and higher out-of-pocket costs can be offered
  - Annual benefit maximum = $35,000
  - Monthly premium cannot exceed $150-$250 depending on income
  - Modified community rating for the minimum benefit package
  - No deductible
- Medicaid reform
  - Medicaid managed care; Primary Care Case Management in rural areas
  - Pay-for-performance for Medicaid hospitals and Medicaid long-term care facilities
  - Consumer-directed home care for Medicaid recipients
- Long-term care reforms
  - Increased access to home and community-based services for people with disabilities and seniors
  - Achieve cost savings through placing recipients in least restrictive settings
  - Improves home and community-based workforce to meet growing needs of consumers

Solutions for a Healthy Colorado: Submitted by the Colorado State Association of Health Underwriters

Key elements

- All Coloradans required to have insurance. Those with insurance would get income tax credit; those without would pay tax penalty.
- Core limited benefit plan for individual insurance
    - All carriers must offer core benefit plan
    - Annual benefit maximum of $50,000
    - Guaranteed issue for core benefit plan only
    - Limited health status rating
- Subsidies for individuals and families up to 250 percent FPL (approximately $25,000 annual income for an individual, $51,000 annual household income for a family of four)
- Expands CHP+
    - Covers children up to 250 percent FPL ($51,000 annual household income for a family of four)
- Expands Medicaid
    - Covers parents up to 100 percent FPL (approximately $21,000 annual income for a family of four)
- In addition to employer-sponsored plans, individuals will have a choice of plans offered through health insurance connector
- Any benefit mandate that affects less than 1 percent of the population and contributes more than 1 percent of the cost of claims would be eliminated
- Establishes reinsurance pool to cover cost of high-dollar claims (up to $1 million)
- Uniform/standardized payments to providers
- Requires reasonable cost transparency for government subsidized care
- Reforms medical malpractice laws, including limits on non-economic damages

A Plan for Covering Coloradans: Submitted by the Committee for Colorado Health Care Solutions

Key elements

- All Coloradans required to have insurance or pay assessment through income tax filing if they do not
- All employers required to either contribute to employee coverage or pay assessment
- Merges individual, small and large group purchasers into a single pool for all private health insurance
  - Private market purchasing pool is administered by a quasi-governmental authority and governed by an independent board
  - Requires guaranteed issue, pure community rating for plans offered through the pool
  - Premium subsidies for those up to 400 percent FPL (up to $80,000 annual household income for a family of four)
  - Comprehensive minimum benefit package (includes medical, surgical, mental health, substance abuse, home/hospice care, dental, prescription drugs and protection against catastrophic costs)
  - Limited number of standardized benefit designs to allow consumers to compare plans
- Expands public programs for disabled (buy-in for those up to 300 percent FPL or approximately $30,000 annual income for an individual), elderly (up to 100 percent FPL, or approximately $10,000 annual income for an individual), medically needy (50 percent FPL or approximately $5,000 annual income for an individual), children and parents (up to 300 percent FPL or approximately $60,000 annual household income for a family of four) and childless adults (up to 100 percent FPL or approximately $10,000 annual income for an individual); merges Medicaid and CHP+

Colorado Health Services Program: Submitted by the Health Care for All Colorado Coalition

Key elements

- Single-payer program governed and administered like a public trust
  - Governing board sets annual budget and determines provider rates
  - Create Colorado Health Trust insulated from general state budget
  - Index funding to rate of growth (e.g., GDP)
- Funded through income tax and payroll deductions and transfer to CHSP trust fund all federal and state funds designated for health care
  - Employers may pay for employees
- Covers everyone who has lived in the state at least three months, including those enrolled in federal programs such as Medicare, TRICARE, FEHBP, etc.
- Basic benefit package for all based on current Medicaid benefits
  - Cover primary care, hospitalization, lab, emergency, auto and workers' comp, mental health, substance abuse, dental and other benefits; eventually add long-term care
  - Long-term care (room and board excluded for higher income)
  - Minimal co-pays assessed for services
- Statewide patient health information network for cost, utilization and quality information
  - Use data to reward providers for high-quality care and identify and fund training needs

Fifth Proposal: Developed by the Blue Ribbon Commission for Health Care Reform

Key elements

- Individual mandate – all Coloradans must have insurance or pay assessment through income tax filing if they do not
- Employers required to offer payroll deduction/pre-tax plans to help employees to purchase insurance themselves
- "Connector" for individuals and small employers to purchase insurance
- Reform individual insurance market
  - Guaranteed issue and modified community rating (premiums can vary by age, geography)
  - Equivalent coverage for mental and physical health
  - Expand and reform CoverColorado to cover more people with chronic conditions
- Sliding scale subsidies up to 400 percent FPL (approximately $80,000 annual household income for a family of four)
  - Subsidies for purchase of basic benefit plan or equivalent employer-sponsored plan for those over 300 percent FPL (approximately $60,000 annual household income for a family of four)
  - Catastrophic care fund for those eligible for subsidy
- Combine and expand Medicaid/CHP+
  - Cover children up to 250 percent FPL (approximately $51,000 annual income for a family of four)
  - Cover parents and childless adults up to 205 percent FPL (approximately $42,000 annual income for a family of four)
  - Buy-in program for disabled
  - "Medically Needy" and "Medically Correctable" programs
  - Increase funding for home and community-based service waiver programs
- Optional "Continuous Coverage Portable Plan" similar to Medicare
- 24-hour coverage option for employers (e.g., all of an employee's health needs, including health and workers compensation claims, are covered by a single insurer)
- Reduce administrative costs by streamlining and simplifying procedures for providers (e.g., standardized claims attachments for all payers, magnetized ID cards with coverage information, etc.)

Figure 9 illustrates how each reform proposal affects the breakdown of insured/uninsured.

- **Figure 9: Source of Coverage for Coloradans in 2007-08 Under Each Proposal**

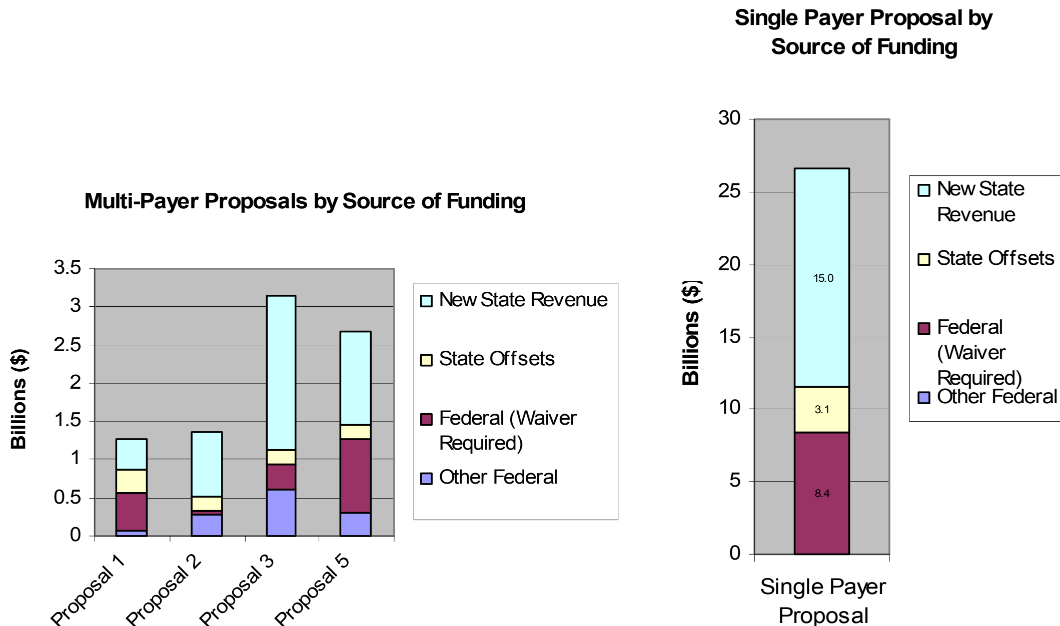
Table 2 and Figure 10 below depict the cost breakdown of each proposal in different formats. Both illustrate the public cost (state and federal) for each proposal, potential offsets from existing revenue streams and new revenues that will required for each proposal.

- **Table 2: Program Costs and Revenues**

Funding Sources	Better Health Care for Colorado (Proposal 1)	Solutions for a Healthy Colorado (Proposal 2)	A Plan for Covering Coloradans (Proposal 3)	Colorado Health Services Program (Proposal 4)	Proposal 5
State Offsets*	$31 m	$179 m	$191 m	$3.128 b	$179 m
New State Revenue	$389 m	$853 m	$2.014 b	$15.025 b	$1.232 b
Federal (Waiver Required)	$486 m	$54 m	$334 m	$8.425 b	$967 m
Other Federal	$74 m	$280 m	$607 m	$0	$302 m
Total State and Federal	$980 m	$1.366 b	$3.146 b	$26.578 b	$2.68 b

* Offsets are existing state revenue streams, e.g., tobacco tax revenues, etc.

- **Figure 10: Proposals by Source of Funding**



As part of the modeling process, Lewin required that all five proposals identify mechanisms to finance their suggested reforms. Those suggested funding mechanisms and their estimated impact are shown below **for informational purposes only; the Commission makes no recommendations about financing.**

For a more detailed examination of the financing specified for each proposal, please see the complete text of each proposal in Appendix 3.

- **Table 3: Sample Financing Strategies for Health Reform**

Sample Financing Strategies	
Strategy	**Revenue**
Tobacco tax increase (from $.84 to $2/pack)	$210 million
Alcohol tax increase Spirits from $.60 to $5.63/liter Wine from $.07 to $.66/liter Beer from $.05 to $.15/six-pack	$126 million
"Snack" tax:	
Low-nutrition foods, sodas, walk-up coffee (65%)	$522 million
Low-nutrition foods, sodas (5%)	$41 million
Premium tax (5.8%)	$240 million
Provider tax (3.1%)	$688 million
Employer payroll tax (6%)	$6.5 billion
Increase state income tax:	
By .6 percentage points	$571 million
By .8 percentage points	$854.4 million
By 8.1 percentage points	$8.2 billion
Employer "pay or play" assessment of $347 per non-covered FTE	$179 million

Chapter 7: Recommendations to the General Assembly

Introduction

Lewin's baseline analysis of health coverage and spending in Colorado, highlighted in Chapter 5, provided powerful information to the Commission about where to target policy interventions. For example:

- Most of the uninsured work. About 37.5 percent of Colorado's uninsured are workers and dependents associated with firms that do not offer coverage to any of their workforce; close to 21 percent of the uninsured are ineligible for the coverage offered by their employers. While individual, non-group coverage is available to such individuals, many choose not to buy it – and many others cannot afford it because of health conditions. *What can be done to encourage employers to facilitate access to insurance for their workers, and to make individual coverage more accessible and affordable?*
- At the same time, approximately 11 percent of Colorado's uninsured are eligible for employer-sponsored coverage but decline it. And, viewing the uninsured population another way, about 13 percent have incomes greater than $75,000 annually; 6.5 percent of the uninsured earn more than $100,000 a year. *How can we bring these Coloradans into the insurance pool?*
- Approximately 24 percent of Colorado's uninsured live below the federal poverty level (i.e., they are in households earning less than $20,000 annually for a family of four). But, under current Colorado law, adults without children are not eligible for Medicaid unless they are aged and disabled, and then only at even lower income limits; parents of children enrolled in Medicaid can qualify for the program only if they earn less than 61 percent of the federal poverty level, or less than about $13,200 annually. *What can we do to simplify and expand public coverage in our state to meet the needs of the most vulnerable among us? In light of low reimbursements to providers who participate in Medicaid and CHP+, how can we raise those payments and encourage provider participation, in order to handle greater numbers of enrollees in these programs?*

These trends carry implications for costs as well as for coverage. When we bring more healthy people into the insurance pool, it lowers the risk and thus the costs for everyone else. When we extend health coverage to more people, we aim to minimize the cost shift from uncompensated care that contributes to escalating health insurance premiums.

As the Commission debated how best to address these issues in its recommendations, certain imperatives emerged:

- Everyone – individuals, employers, providers, insurers and the government – has a role to play in addressing Colorado's health care needs. All have a share in the responsibility; all will share in the benefits.
- "One size fits all" doesn't work in health care. People have differing income levels and health care needs, and health status can change in an instant. Communities' needs vary greatly, depending on geographic location, demographic makeup and numerous other

factors. We need a range of interventions that respond to a variety of individual and community situations.

- Some people simply cannot afford private insurance coverage. Those people ought to have access to public coverage for basic health care needs.
- We recognize that vulnerable populations must be protected in any reform of the system. We can not jeopardize their safety or reduce or compromise current levels of services as reform moves forward.
- Safety net providers such as community clinics and hospitals play an essential role in caring for those on public programs and those without any health coverage. If we expand public programs to include more people, and as we recognize that non-citizens will continue to need care even if they do not have coverage, we must preserve safety net providers' ability to serve these populations.
- Individuals should have meaningful choices and options that give them control over their own care and coverage decisions.
- Government, through the public health system and public insurance programs, can promote and encourage healthy lifestyles and preventive care. Individuals, however, have responsibility for their own health and wellness.
- We seek to build on the strengths of the current system, keeping and broadening what works to minimize dislocation for those who already have good coverage, while making important changes to better meet the needs of those who currently lack affordable health coverage.
- In order to accomplish our goals, we must maximize the federal funding available to Colorado – for example, through public program expansions that will enable us to draw down the maximum federal match, and through applications for federal waivers that will enable us to try new approaches to better meet the needs of Colorado's vulnerable populations.

In developing the 32 recommendations that follow, the Commission made careful choices about how to balance competing priorities in order to best accomplish its charge of expanding access and reducing costs. These recommendations draw upon the Commission's "Guiding Principles" (described in Chapter 2), the analysis of all five proposals, learnings from other states and health policy experts, the counsel of the Commission's Advisory Task Forces and the input received from the public at meetings statewide. They fulfill the Commission's statutory charge to study and establish health care reform models that expand health care coverage and decrease health care costs for Colorado residents.

As a reflection of the Commission's twin charges, these recommendations fall largely into two groupings:

- Strategies for reducing health care costs, while enhancing quality of care
- Strategies for increasing access to care, stressing consumer choice

What follows is not merely a laundry list of recommendations. It is a comprehensive, integrated package that will only succeed in achieving the goal of expanding coverage and containing costs if viewed as a whole and implemented in the appropriate stages.

Certain essential building blocks among these recommendations must be put in place before others if those latter elements are to be successful. Therefore, the Commission has proposed a series of stages for the implementation of its recommendations. For example, the requirement for all Coloradans to have insurance works only if other measures are enacted to make coverage accessible and affordable, such as expanding public programs, creating subsidies for lower-income people to purchase private insurance and reforming the individual insurance market. Similarly, efforts to expand enrollment in public programs must be preceded by efforts to improve efficiency and increase provider participation in those programs.

Further, where flexibility exists, strategies that 1) serve vulnerable and poorest populations and 2) fix elements of the health care system that are ineffective, should be pursued before other health care reform strategies.

Readers will find specific suggestions about implementation staging in Chapter 7.

It is imperative that cost containment efforts be instituted at the outset. The Commission provides recommendations to reduce administrative costs, and also believes that minimizing the cost shift from uncompensated care will help to stabilize costs. Yet many other factors, including the proliferation of medical technology, medical errors, medical waste due to inefficiency and other issues, contribute to rising costs. Addressing these issues requires ongoing, coordinated effort among a variety of stakeholders. The Commission believes that the Improving Value in Health Care Authority included in these recommendations can serve this role, and urges that its creation be one of the first steps in the implementation of these reforms.

Taken together, our package of recommendations offers a bold yet realistic approach to providing high-quality, affordable health care to all Coloradans.

PART 1: Reduce Health Care Costs, while Enhancing Quality of Care

1) Slow the rate of growth of employer and private health insurance premiums by covering the uninsured and increasing Medicaid provider reimbursement rates as a means of minimizing cost-shifting.

Rationale

According to one study, 8 percent of the cost of health insurance premiums in Colorado is due to cost-shifting.[26] Earlier discussion in this report described that, on average, hospitals charge privately insured and private-pay patients 131 percent of their actual costs to make up for the fact that care provided to uninsured and publicly insured patients is reimbursed at 59-75 percent of cost. The Commission believes, therefore, that its recommendations to cover the uninsured and improve Medicaid reimbursement rates could significantly reduce the rate of growth of health insurance premiums that employers, employees and individuals pay in Colorado.

Recommendations

a) **Reduce uncompensated care by covering at least 85 percent of the uninsured in Colorado.** The recommendations in Part 3 cover 88 percent of the uninsured in Colorado, thereby significantly reducing the number of uninsured patients seen by Colorado health care providers. The recommendations do not cover 100 percent of the uninsured in Colorado because not all Coloradans would be included in the health care reform strategies proposed. For example, only legal residents of Colorado would be subject to the individual mandate and would eligible for new subsidy programs. In addition, 40 percent of these newly insured Coloradans would be covered by employer or private health insurance.

b) **Reduce cost-shifting by increasing Medicaid provider reimbursements (see Recommendation 22).** The recommendations in Part 2 suggest that Medicaid provider reimbursements for providers who serve adults and children be increased at least to the rates used by the Child Health Plan Plus program (approximately 80 percent of Medicare for physicians and 65 percent of billed charges for hospitals[27]), and to at least 75 percent of Medicare for physicians who serve aged and disabled Medicaid enrollees. The Lewin Group analysis assumes that this increase in provider reimbursement rates will reduce cost-shifting from publicly to privately insured Coloradans and is especially important as the number of publicly insured Coloradans grows. For further discussion of the need for and implementation of these rate increases, see Recommendation 22.

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[26] Families USA. Paying a Premium: The Added Cost of Care for the Uninsured. June 2005.

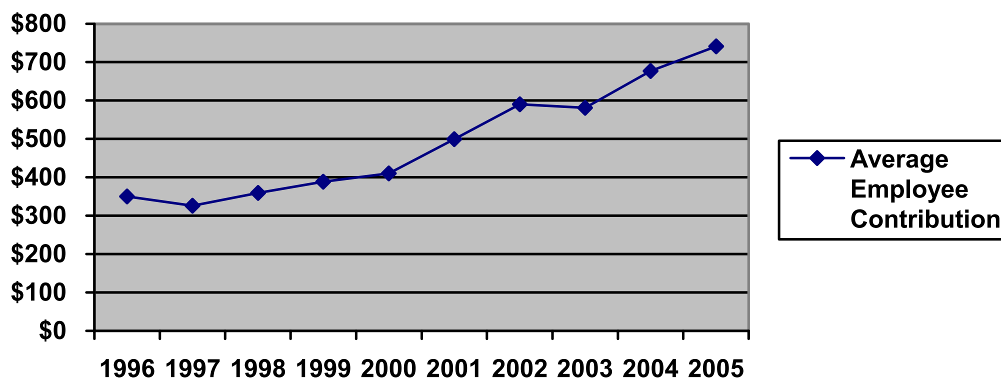
[27] These reimbursements are used in the CHP+ managed fee-for-service network.

2) Reduce employee health insurance premium costs.

Rationale

Despite the number of people covered by employer plans in Colorado, a growing number of employees are declining their employer-sponsored insurance due to the rising cost. The figure below shows that the average total employee contribution for single coverage in Colorado increased by more than 100 percent between 1996 and 2004:

- **Figure 11: Average annual total employee contribution per enrolled employee for single coverage at private-sector establishments that offer health insurance: Colorado[28]**



Recommendations

To increase affordability of employer health coverage, the Commission is recommending that Colorado implement two strategies: require that all Colorado employers offer their employees the opportunity to purchase health insurance with pre-tax dollars; and provide subsidies for low-income uninsured workers to purchase their employer's health plan.

a) **Require Colorado employers to establish at least a Section 125 premium-only plan that allows employees to purchase health insurance with pre-tax dollars** (see Recommendation 17a). For employees with access to employer coverage, the ability to purchase coverage on a pre-tax basis can reduce the effective cost of coverage, with the amount depending on the employee's tax rate. The Lewin Group estimates that Coloradans would save $372.9 million on their federal taxes through the use of 125 plans. This recommendation also was endorsed by the Commission's Business Advisory Task Force as a reasonable way to increase affordability of coverage for Colorado employees.

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[28] Agency for Healthcare Research and Quality. Average total employee contribution (in dollars) per enrolled employee for single coverage at private-sector establishments that offer health insurance by firm size and State (Colorado) (Table II.C.2), years 1996-2005: Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC. <http://www.meps.ahrq.gov/mepsnet/IC/MEPSnetIC.jsp> (December 02, 2007)

b) **Provide sliding scale subsidies for uninsured low-income workers below 400 percent FPL to purchase their employer's plan** (see Recommendation 17b). Providing premium assistance to low-income workers was included in almost half of the health care reform proposals received by the Commission. Premium subsidies for low-income uninsured workers allow individuals and their families to enroll in private, employer-based coverage. The Commission recommends that employees who earn less than 300 percent of poverty (i.e., about $60,000 annual income for a family of four) be given subsidies equal to 80-100 percent of their employer's total premium, minus their employer's contribution to their coverage.[29] For employees earning up to 400 percent of poverty (approximately $80,000 annual income for a family of four), the Commission recommends that they be eligible for a subsidy that would reduce the cost of the Minimum Benefit Plan (see Recommendation 17 for a description of the Minimum Benefit Plan) to no more than 9 percent of their annual income—a subsidy that could be used to purchase their employer's health plan. According to The Lewin Group, such subsidy programs would allow 19,700 low- and middle-income uninsured workers in Colorado to enroll in their employer's plan.[30]

3) Reduce administrative costs.

Rationale

With at least 36 licensed health insurance companies in Colorado, each offering a number of different benefit plans, the administrative burden on physicians and other providers to seek reimbursement for their health care services can be significant. To reduce these costs, the Commission recommends that Colorado require health plans to standardize functions that affect physicians and other providers.

Recommendations

a) **Require health insurers and encourage all payers in Colorado to use standard claims attachment requirements, eligibility and coverage verification systems, electronic ID cards and prior authorization procedures, and uniform insurance application forms**. This recommendation builds on a recommendation of the Commission's Provider Advisory Task Force to "standardize claims and payment process across health plans to . . . minimize administrative costs." The Commission recommends that Colorado move quickly to adopt nationally recognized standards that have been accepted by industry groups but not yet implemented. The Lewin Group estimates that standardizing health plan administrative claims and processes will reduce administrative costs for Colorado providers by $166 million annually.

b) Combine administrative functions of public health insurance programs. Where possible, the Commission recommends that Colorado combine administrative functions, such as eligibility determination, marketing, plan and provider contracting, and claims payments for its public

[29] The Commission recommends a 100 percent subsidy for those up to 250 percent of FPL, and an 80 percent subsidy for those up to 300 percent of FPL. The Commission also recommends that the subsidy be available only for employer plans that are comprehensive and equal to the coverage provided in the CHP+ benefit package.

[30] To further facilitate enrollment in employer coverage, the Commission recommends that qualifying for a subsidy be a qualifying event for enrollment in employer coverage.

health insurance programs, such as the new premium subsidy program, the new Connector and Restructured CoverColorado.

c) **Review regulatory requirements on third-party payers and providers with the goal of reducing administrative burden.** State insurance regulation may be outdated and in need of reform, especially in light of the Commission recommendations to encourage enrollment in private health insurance in Colorado. The Commission recommends that the state undertake a review of all existing insurance law and regulations to evaluate options for reducing unnecessary administrative burden on insurance companies and providers doing business in Colorado.

4) Increase use of prevention and chronic care management.

Rationale

Promoting prevention and wellness was one of the recommendations most often heard by the Commission as it solicited health care reform proposals, received recommendations from advisory task forces and conducted public hearings. More than one-half of the proposals received by the Commission proposed methods for increasing use of preventive care or incentivizing personal wellness. Each of the four advisory task forces of the Commission—Business, Provider, Rural and Vulnerable Populations — recommended strategies for increasing prevention and wellness in employer, medical and community settings. Citizens across the state who attended the Commission's public hearings said that they wanted people to take ownership of their own health by living healthy lifestyles and seeking out preventive care.

Recommendations

a) **Where allowed by federal law, allow health insurance premiums to be reduced for enrollees who engage in healthy behaviors**. A strategy recommended in several of the health care reform proposals it received, the Commission recommends that heath insurance premiums be reduced for enrollees who engage in healthy behaviors. Although federal law places restrictions on the extent to which such discounts can be given, the Commission believes that those who engage in behaviors that improve health should pay less for their health insurance. For example, employers cannot give discounts to those who have better health status (e.g. lower weight or lower cholesterol), but can give discounts to employees who participate in educational programs to promote health and prevent disease, such as tobacco cessation programs.

b) **Eliminate patient copayments for preventive care and reduce patient copayments for chronic care management services** as defined by nationally recognized, Colorado-vetted uniform guidelines, such as those developed by the Colorado Clinical Guidelines Collaborative. The Commission's Vulnerable Populations Advisory Task Force recommends that copayments for evidence-based preventive care be eliminated. The Commission builds on this recommendation by recommending the elimination of copayments for evidence-based preventive care and the reduction of copayments for chronic care management.

c) **Encourage employers to provide workplace wellness programs**. The Commission's Business Advisory Task Force states in its report to the Commission that Colorado "businesses are willing to play a role in employee education around healthy lifestyles." The Commission recommends that Colorado employers, including the State of Colorado, be encouraged to provide workplace wellness programs for their employees.

d) **Encourage individual responsibility for health, wellness and preventive behavior**. The Commission heard from proposal authors, task force members and the public that personal responsibility is an essential component of health care reform. At public hearings across the state, citizens testified that people need to take ownership for their own health. The Commission's Vulnerable Populations Advisory Task Force recommends that Colorado focus on incentivizing consumers to engage in healthy behaviors and use appropriate preventive care. And more than 25 percent of health care reform proposals received by the Commission included incentives for consumers to engage in healthy behaviors and use appropriate preventive health care services.

e) **Increase funding for local public health agencies in Colorado to perform such functions as preventing disease and injury, assessing community health and promoting healthy behavior**. The Rural Advisory Task Force agreed on the importance of wellness and prevention for health care reform. It recommends that funding for public health be increased to assure that Colorado local health departments and nursing services have adequate funding to prevent disease and, therefore, contain health care costs, especially in rural Colorado.

5) Conduct a comprehensive review of current Colorado and national long-term care information to understand challenges and opportunities and identify appropriate strategies for reform.

Rationale

The importance of long-term care cannot be overlooked given its potential fiscal impact on the state's Medicaid budget and is of paramount significance to Coloradans with severe chronic conditions. For example, the Colorado Medicaid program spends more than $600 million per year on nursing home services.[31] The Commission had very limited time and expertise, and the complexity of this matter made it impossible for the Commission to specifically and adequately address this topic. In addition, the Commission received just one proposal that addressed long-term care in any detail. While this proposal was selected for modeling (Proposal 1), it was difficult to model due to data access barriers and the highly conceptual nature of the proposal itself.

However, many other groups have studied long-term care in Colorado and nationally. Reports such as that from the Senate Bill 03-173 Commission, the Developmental Disabilities Interim Committee, the SB 128 Medicaid Redesign Project and the National Clearinghouse for Long-Term Care Information are valuable resources. The Commission recommends these reports be reviewed for consideration and action in conjunction with health care reform as it relates to long-term care.

[31] The Lewin Group. "Appendix B: Health Spending in Colorado" in "Cost and Coverage Impacts of Five Proposals to Reform the Health Care System in Colorado." Prepared for the Colorado Blue Ribbon Commission for Health Care Reform. January 2008. See Appendix 4 of this report..

Recommendation

a) **Conduct a comprehensive review of current Colorado and national long-term care resources** as a supplement to any review of the Commission reports with the goal of:

- Requiring consumer control, governance and accountability by those served
- Serving all persons needing long-term care services
- Ensuring the highest possible quality of care is provided in the least restrictive setting available
- Protecting the fiscal integrity of the long-term care system

6) Improve end-of-life care.

Rationale

Similarly to long-term care, the Commission believes that improvements in end-of-life care, particularly palliative and hospice care, are essential to giving Colorado's aging population more control of the type and amount of health care they receive. The Commission also received a proposal that identified strategies for improving end-of-life care, such as launching a public awareness campaign about hospice, dying and death; guaranteeing the option for arranging for death outside of hospital or other institution; and amending the Colorado Statutes for physician licensure to include a requirement for palliative and end-of-life treatment and care. [32]

Recommendations

a) **Develop strategies to foster clinically, ethically and culturally appropriate end-of-life care, including palliative and hospice care, based upon best scientific evidence**.

b) **Ask patients, upon entry to a nursing home, home health or other critical point of access, to complete an advanced directive**. There would be no requirement to complete an advanced directive, patients would be fully informed, there would be no outside pressure to complete the form and revocation rights would be clear and simple.

7) Commission an independent study to explore ways to minimize barriers to such midlevel providers as advanced practice nurses, dental hygienists and others from practicing to the fullest extent of their licensure and training.

Rationale

The Commission recognizes that an adequate supply of providers is critical to adequately serving the needs of Colorado's rural communities – and that greater access to providers statewide will be necessary as we expand health coverage, especially to underserved populations.

[32] "The Option to Die in PEACE (Patient Ethical Alternative Care Elective)" proposal. Please see the Commission's website www.colorado.gov/208commission for the full text of this proposal.

The Rural Advisory Task Force recommended the expansion of scope of practice for non-physician health care professionals, noting that "midlevel providers can substantively improve health care access in rural areas." At the same time, the Commission also heard from advanced practice nurses that rules imposed by insurance plans pose a bigger barrier than scope of practice laws to their ability to practice to the full scope of their licensure. The Provider Advisory Task Force cautioned that efforts to expand licensure and scope of practice must balance the need to maximize provider capacity with measures to assure quality.

Recommendations

a) **Commission an independent study to explore ways to minimize barriers to such midlevel providers as advanced practice nurses, dental hygienists and others from practicing to the fullest extent of their licensure and training.** The Commission recommends that Colorado examine ways in which non-physician providers can appropriately provide needed access to care in underserved areas of the state.

8) Provide a medical home for all Coloradans.

> Resources must be committed to re-engineer an aligned, cohesive, and coordinated system that supports a primary care-based "healthcare home" as the cornerstone of care.
>
> --The Provider Advisory Task Force of the Blue Ribbon Commission for Health Care Reform

Rationale

The next set of recommendations addresses such issues as medical homes, health information technology, evidence-based medicine and provider reimbursement based on quality, health care transparency and consumer choice. These recommendations together attempt to address what the Provider Advisory Task Force termed a "lack of systemness" in Colorado's health care system. The Commission agrees with the Provider Advisory Task Force that system-wide changes must happen in health care delivery in Colorado to improve quality and "flatten the trend" of health care spending growth. Many health care reform proposals recommended these changes as well. More than one-third of the proposals received by the Commission recommended systematic changes to Colorado's health care system, such as increasing use of information technology and promoting transparency of health care costs and quality.

"Systemness" begins with every Coloradan having a medical home. "Medical home" is a source of usual care, such as a physician or a clinic, selected by a patient. The medical home functions as the central point for coordinating care around the patient's needs and preferences. The medical home also coordinates among various team members, which include the patient, family members, specialists, other healthcare services and non-clinical services.[33] With a

[33] Adopted from the National Quality Forum

medical home in place, other system improvements, such as health information technology and evidence-based medicine, become more effective.[34]

Recommendations

a) **Provide a medical home for all Coloradans, and enhance the provision, coordination and integration of patient-centered care, including "healthy handoffs**." Patient-centered care is an important element of the medical home. The Lewin Group analysis assumes that increased access to primary care results in savings due to reductions in avoidable emergency room visits and hospitalizations.[35]

b) **Reimburse providers for care coordination and case management, particularly in the Medicaid/CHP+ and CoverColorado programs**. The Commission believes that medical homes are particularly important for vulnerable populations, such as those served by Medicaid and CoverColorado. The Commission recommends that providers in these programs (Medicaid and the restructured CoverColorado program) be reimbursed for providing care coordination and case management to their high-needs patients.

c) **Provide targeted case management services for Medicaid patients.** Targeted case management is a benefit that pays for social worker services so that medical providers can have access to supports that help their patients with housing, food and other non-medical needs.

9) Support the adoption of health information technology.

Rationale

Another important aspect of creating an integrated health care system in Colorado is the expansion of the use of health information technology, particularly electronic health records and interoperable state health information networks. More than 40 percent of health reform proposals received by the Commission suggested expanding and implementing health information technology to improve the cost and quality of health care delivered in Colorado. In addition, three of the four advisory task forces of the Commission (Business, Provider and Vulnerable Populations) recommended increased use of health information technology to support medical homes, seamless care, reduction of medical errors, and elimination of duplication of services.

Recommendations

a) **Support the creation of a statewide health information network, focusing on interoperability.** Several proposals received by the Commission recommended expanding health care providers' ability to communicate patient information electronically by creating a

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[34] The Commission received a specific proposal on ways that the current medical home concept (established in Colorado law) should be expanded.

[35] While The Lewin Group assumes savings due to use of preventive care services in more appropriate settings, these savings are offset by the overall increase in utilization by the previously uninsured. The Lewin Group relies on the RAND cost-sharing study and other studies that suggest that uninsured individuals delay or forgo care and, as a result, use fewer services than do insured people.

statewide health information network. The Commission agrees with the Provider Advisory Task Force that these efforts should build on existing local and state efforts in Colorado such as the North Colorado Health Alliance, the Community Health Partnership in El Paso and Teller counties and the Mesa County collaborative initiative. The Commission also concurs with several proposals that suggested building upon the statewide efforts of the Colorado Health Information Exchange (COHIE) and the Colorado Regional Health Information Organization (CORHIO).

b) **Support the creation of an electronic health record for every Coloradan, with interoperability across health plans and hospitals systems and protections for patient privacy**. The Provider Advisory Task Force recommends that "every primary care practitioner must have the tools necessary to track, measure, and coordinate care." The Commission believes that to accomplish this goal as well as to implement the statewide health information network above, every Coloradan should have an electronic health record that helps patients and providers document and share, with protections for privacy, patient health care information. Such electronic medical records may reduce duplication and medical errors and enhance care coordination among providers.

10) Support the provision of evidence-based medicine[36].

Rationale

Nearly 30 percent of the health care reform proposals received by the Commission recommend expanding the use of evidence-based medicine in the state as a method for increasing quality and reducing cost of health care. Strategies described in the proposals include developing care guidelines, using performance measures and collecting better data on cost and quality of care. The goal of these strategies is to try to apply scientific knowledge about best care more systemically and expeditiously to clinical practice.

Recommendations

a) **Adopt population-specific care guidelines and performance measures, where they exist, based on existing national, evidence-based guidelines and measures, recognizing the importance of patient safety and best care for each patient**. This recommendation attempts to reconcile two inclinations that are sometimes in opposition: to create care guidelines that are consistent with those developed by national organizations such as the American Academy of Pediatrics and other practice societies, while simultaneously being appropriate to Colorado providers and patients. Several proposals recommended that guidelines in Colorado continue to be developed in the manner established by the Colorado Clinical Guidelines Collaborative, which has worked with 50 Colorado health care organizations to develop eight clinical guidelines regarding care for such conditions as asthma, cancer, diabetes, and depression. The Commission recommends the continuation, support and expansion of this process for guideline development, recognizing that there is not strong evidence-based information for all

[36] Evidence-based medicine is defined as "A set of principles and methods intended to ensure that, to the greatest extent possible, population-based policies and individual medical decisions are consistent with the evidence of effectiveness and benefit." From Tunis, Sean. "Reflections on Science, Judgment and Value in Evidence-Based Decision Making: A Conversation with David Eddy," Health Affairs Web Exclusive. June 19, 2007. pp 500-515.

conditions and populations, particularly for patients with multiple chronic conditions. The Commission further recommends that all payers use these guidelines.

b) **Develop a statewide system aggregating data from all payer plans, public and private**. The first step to providing consumers better data about the cost and quality of care is to collect data that allows consumers and purchasers to draw statistically significant conclusions about the cost and quality of the care delivered by individual health care providers. To reach this goal, the Commission agrees with the Provider Advisory Task Force, as well as with the two quality-focused proposals submitted to the Commission by health care quality experts, that the establishment of an all-payer retrospective claims database is the first step toward a system that would measure the efficacy and efficiency of care. Such a database also could grow into a system that will help providers make prospective and point-of-care decisions.

11) Pay providers based on quality.

Rationale

Although reimbursement is not the only factor that influences provider behavior, it is an important one. Nearly one-third (32 percent) of proposals received by the Commission recommended paying health care providers based on their performance. Ideas submitted to the Commission included rewarding providers who implement best practices, score high on performance measures and coordinate care for patients. The Commission believes that changing reimbursement methodologies for health care providers is an important element of creating a health care "system" for Colorado patients.

Recommendations

a) **Pay providers based on their use of care guidelines, performance on quality measures, coordination of patient care and use of health information technology**. This recommendation builds on the Commission's previous recommendations to implement health information technology, evidence-based medicine and medical homes in Colorado. Reimbursing providers for engaging in these practices ensures that provider incentives are aligned to create better quality and cost outcomes for patients.

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

Rationale

One of the characteristics of an efficient market is adequate information. Health care has never operated in this fashion. Consumers know something about the cost of their coverage (though not necessarily the full cost, if their employer contributes). But they do not know the real cost of the care provided to them. Nor, as a rule, do they know much about the quality of the care they are about to receive.

Availability of such information is essential to driving down costs and improving quality. Such transparency will enable consumers and employer purchasers to "vote with their feet,"

encouraging health plans and providers to continue the steps they already are taking to manage costs and improve quality of care. The Commission recognizes and applauds existing quality reporting efforts, such as the Colorado Dept. of Public Health and Environment/Colorado Hospital Association report card on hospital quality, the Colorado Business Group on Health's report card and others. We note, however, the need for increased availability of such information and additional reporting efforts. For example, consumers should have access to the precise total costs for specific services provided by health care providers.

Recommendations

a) **Ensure that information on insurer and provider price and quality is available to all Coloradans and that it is easily accessible through a single entry point** (e.g., a Web site). More than one-third of proposals received by the Commission recommended increasing the transparency of health care cost and quality data by publishing better consumer information. This recommendation builds on the prior recommendations to increase use of heath information technology and evidence-based medicine, which will increase the amount of statistically-reliable information that can be reported to consumers and purchasers on the cost and quality of insurance products and health care services. The Commission recommends that a central "point of entry" Web site be created through which consumers can readily gain access to report cards such as (but not limited to) those described above.

b) **Require the Colorado Division of Insurance (DOI) to report annually to the legislature regarding financial information on licensed carriers and public coverage programs;** information should include medical loss ratios, administrative costs, etc, by line of business. In addition, Medicaid, CHP+, CoverColorado and other public coverage programs should be required to provide DOI with this information. Finally, brokers should be required to report their compensation to their clients.

13) Promote consumer choice and direction in the health care system.

> (Health care reform should) decrease complexity of health care plans and provide consumer education in acceptable mediums. (It should) provide tools that enable consumers to make informed choices.
>
> --Vulnerable Populations Advisory Task Force of the Blue Ribbon Commission for Health Care Reform

Rationale

The final link in the chain of creating a more integrated and efficient health care system in Colorado is to assure that, in addition to greater access to better information, consumers have choice and control in their health care decisions. The Commission believes that consumers should have choices regarding their health insurance — especially in light of a requirement to buy insurance — and that they should have accurate information with which to make informed choices.

Recommendations

a) **Provide a choice of Minimum Benefit Plans, including a Health Savings Account option, for all consumers purchasing in the individual insurance market** (see Recommendation 20). While the Commission recommends that all health insurance carriers in the state be required to offer the Minimum Benefit Plan in the individual market, the Commission also believes that the Minimum Benefit Plan should have variations that allow for Health Savings Accounts and different types of provider networks. The Minimum Benefit Plan should allow insurers to vary the benefit plan to include a Health Savings Account (HSA) option or to reflect an insurer's provider network, such as an HMO or a PPO, thus providing consumers a choice of plans. A standardized plan also enables purchasers of insurance in Colorado to compare prices among various insurance companies.

b) **Create a Connector for individuals and employees** (see Recommendation 18). This entity would offer a choice of benefit packages with easily comparable price and quality information. Benefits of a Connector for individuals and small businesses include encouraging competition among health plans and facilitating a choice of benefit plans.

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

d) **Provide consumers with evidence-based medical information at the point of service to aid in decision-making through patient-centered care**. In conjunction with the Commission's recommendations on medical homes (Recommendation 8) and evidence-based medicine (Recommendation 10), the Commission recommends that consumers be given evidence-based medical information at the point of service to aid them in decision-making. The Commission believes that improved information from medical providers to patients regarding medical decisions is a powerful mechanism for improving cost and quality of health care in Colorado.

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

Rationale

Colorado has several examples of high-quality, cost-effective regional health care partnerships:

Mesa County and the Western Slope. The 2006 study "The Care of Patients with Severe Chronic Illness: A Report of the Medicare Program by the Dartmouth Atlas Project," determined that Mesa County provides the most cost-effective delivery of Medicare services for chronically ill Medicare beneficiaries in the nation, cutting the need for hospitalizations from more than 19 days to 6.5 days, and reducing overall per capita spending from $60,000 to $21,000. The Colorado Department of Health Care Policy and Financing has determined that the Medicaid program in place in Western Colorado has vastly superior quality measurements (immunizing twice as many children, having 95 percent of pregnant women in prenatal care programs, etc.).

Health Access Pueblo (HAP). Health Access Pueblo is a collaborative effort among local organizations and leaders to provide health care coverage (not insurance) for Pueblo's working uninsured, slated to begin enrolling participants in January 2008. HAP's model calls for contributions from employers, employees and the community to cover the cost of care provided to individuals who currently are working and lack insurance.

Community Health Partnership. The Community Health Partnership in El Paso and Teller counties combines public and private providers, as well as the business and faith communities, to improve the integration of health and human services in the Pikes Peak region. Key initiatives include a mutual patient tracking system that facilitates coordination of care and use of preventive care, minimizing inappropriate use of emergency departments; and a prescription program that dispenses more than $200,000 worth of medications monthly, helping income-qualified residents manage chronic disease and behavioral illnesses. The program is supported by substantial membership dues and grants, and has leveraged $7 million in private and foundation funding for its region.

Recommendations

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

15) Create a multi-stakeholder "Improving Value in Health Care Authority"

Rationale

The prior recommendations to improve quality and reduce cost of health care in Colorado need to be studied, and sometimes implemented, by an organization that can work across the health care system to create a vision and consensus for improving Colorado's health care system. The Commission recommends, therefore, that Colorado create a permanent Improving Value in Health Care Authority to facilitate and/or implement the Commission's recommendations regarding such issues as reduction of administrative costs, improved preventive care and expansion of consumer information and choice.

Recommendations

a) **Before implementing the coverage expansions identified in Section 2, the state should establish an Improving Value in Health Care Authority to fundamentally realign incentives**

in the Colorado health care system to reduce costs and improve outcomes, and identify other means of containing systemic cost drivers. This multi-stakeholder group would address ways to redesign health insurance benefits, preventive care, provider reimbursement, medical records and consumer information, in order to fundamentally realign incentives in the system to reduce costs and improve outcomes. The Authority would also examine systemic factors that contribute to rising health care costs – such as the proliferation of medical technology, medical errors, medical waste due to inefficiency, etc. – and identify and encourage the adoption of strategies for containing them. Without such a critical look at these issues, the other recommendations of the Commission will be inadequate to address the health care reform needed for patients and providers in Colorado.

b) **Give the Authority rule-making authority to implement the Commission's recommendations regarding administrative simplification (Recommendation 3), health care transparency (Recommendation 12), design of the Minimum Benefit Package (Recommendation 16b), and the Consumer Advocacy Program (Recommendation 28)**.

c) **Direct the Authority to study and make recommendations to the governor, state legislature and rule-making agencies regarding prevention (Recommendation 4), end-of-life care (Recommendation 6), medical homes (Recommendation 8), health information technology (Recommendation 9), evidence-based medicine (Recommendation 10) and provider reimbursement (Recommendation 11)**.

d) **Direct the Authority to develop a statewide system aggregating data from all payers, public and private, as described in Recommendation 10b**. A retrospective claims database is the first step toward a system that would measure the efficacy and efficiency of medical care. The Commission recommends that the Authority develop this statewide database for assessing the cost and quality of care provided in Colorado.

e) **The Authority also should be responsible for assessing and reporting on the effectiveness of reforms, especially their impact on vulnerable populations and safety net health care providers**. The Commission recommends that the effectiveness of health care reforms be assessed against the criteria developed by the Commission for evaluation of health care reform proposals.[37] The Commission also agrees with the recommendation of the Vulnerable Populations Advisory Task Force that health reform efforts should be evaluated to determine their impact on the uninsured and vulnerable populations.

f) **Establish the Authority before embarking on the improvements to coverage and access described in Part 2**.

[37] The criteria are comprehensiveness, access, coverage, affordability, portability, benefits, quality, efficiency, consumer choice and empowerment, wellness and prevention, and sustainability

PART 2: Improve Access to Care, with Mechanisms to Provide Choices

The estimates below assume that **all** the Commission's recommendations are implemented. The estimates are highly-interdependent. The numbers would change if the package of recommendations were changed. For example, if only one program were implemented, the number of uninsured it would cover would change significantly.

- **Table 4: Summary of new programs and estimated number of uninsured covered under Commission Recommendations as modeled by Lewin in Proposal 5**

Program	Number of Uninsured Covered (ESTIMATED)
Expansion of Medicaid/CHP+ to 205% for childless adults and parents	297,000
Individual mandate	152,600[38]
Premium subsidies for coverage for low-income uninsured workers without access to employer coverage	91,600
Auto enrollment and one-year eligibility for Medicaid and CHP	67,500
Expansion of Medicaid/CHP+ eligibility to legal non-citizens who are currently not eligible	38,600
Premium subsidies for employer coverage for low-income uninsured workers	19,700
Expansion of CHP+ to 250% for children	13,900
Restructured CoverColorado	10,400
Medicaid Buy-In for working disabled	1,900

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

Rationale

The requirement to have health insurance (known as an "individual mandate") is a cornerstone of the Commission's vision for reforming Colorado's health care system. Coupled with the provision of affordable coverage and effective enforcement, the requirement assures that almost all residents of Colorado will come into the health coverage pool and builds on Colorado's existing health care system.

Eleven (11) of the health care reform proposals submitted to the Commission included an individual mandate as a key strategy for covering the uninsured, making an individual mandate the most common strategy proposed to the Commission for reducing the number of uninsured in Colorado. Subsequent analysis by The Lewin Group also showed that this strategy could significantly increase the number of Coloradans who have insurance. The implementation of an enforceable mandate increases the number of Coloradans who will purchase individual and employer coverage as well as the number of families who will enroll in public programs. Lewin estimates that the effect of an

[38] The Lewin Group estimates that 152,600 Coloradans would purchase employer or other private insurance, without a public subsidy, as the result of an individual mandate. The number of uninsured covered as a result of an individual mandate varies by proposal and depends upon other elements of health care reform, such as public program expansion, provision of subsidies for private insurance, and reforms in the individual health insurance market.

individual mandate, implemented in combination with the Commission's other recommendations, would be an additional 45,700 uninsured Coloradans purchasing their employer's health insurance and an additional 106,900 uninsured Coloradans purchasing individual private coverage, without premium subsidies.[39]

In addition to reducing the number of uninsured Coloradans, an individual mandate is designed to stabilize the premiums paid by those who currently are insured. This "cost shift" is created when hospitals and other providers increase their rates to private insurance companies in order to cover the cost of care provided free or at reduced rates to the uninsured. Colorado health care providers gave $777 million in uncompensated care in 2007.[40] The elimination of free care to the uninsured, therefore, is predicted to reduce stabilize the rates that hospitals and other providers would charge to insurance companies, thereby impacting the rates paid by employers, employees and individuals for health insurance. The Business Advisory Task Force also supports the individual mandate for this reason.

Recommendations

a) **Require purchase of a Minimum Benefit Plan (average monthly premium of approximately $200 for an individual).** Twenty percent of the proposals received by the Commission suggested using leaner health insurance packages—with high deductibles, annual caps, or limited benefits—as a mechanism for assuring affordability for the uninsured. While this strategy has the negative consequence of potentially not meeting everyone's needs — i.e., some enrollees will need health care services not covered by a minimum benefit plan— the Commission felt that a minimum benefit package was essential for assuring availability of an affordable product.[41] For example, minimum benefit plans evaluated by the Commission reduced premiums by 15-27 percent.[42]

b) **Design and periodically review the Minimum Benefit Plan through the Improving Value Authority.** Ensure that the process to create the minimum benefit package is transparent, participatory, equitable, compassionate, sensitive to value, flexible, responsive and designed by a multi-stakeholder group. The Commission further recommends that its recommendations regarding preventive care (Recommendation 4) and mental health parity (Recommendation 24d) be considered when designing this benefit package. (See also Recommendation 15 for further discussion of the Improving Value Authority.)

c) **Provide an affordability exemption or consider another mechanism for addressing affordability, such as extending the premium subsidy program to a higher income level.**

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[39] These coverage estimates are based on The Lewin Group's analysis of the Commission's fifth proposal; the specific program design choices of this proposal affect the size of these estimates. See The Lewin Group. "Appendix G: The Commission Proposal for Health Reform" in "Cost and Coverage Impacts of Five Proposals to Reform the Colorado Health Care System.." January 2008. See Appendix 4 of this report.

[40] The Lewin Group. "Appendix B: Health Spending in Colorado" in "Cost and Coverage Impacts of Five Proposals to Reform the Health Care System in Colorado." Prepared for the Colorado Blue Ribbon Commission for Health Care Reform. January 2008. See Appendix 4 of this report.

[41] For those up to 300 percent of FPL who receive a subsidy, a more comprehensive benefit package will be subsidized.

[42] The Lewin Group. "Cost and Coverage Impacts of Four Health Proposals to Reform the Colorado Health Care System, Slide 14: /summary of Benefits under a Typical Commercial Plan and Under the Four Health Reform Proposals." Presentation to the Commission, August 23, 2007.

Assuring affordability should include consideration of both premium and out-of-pocket costs, such as co-pays and deductibles.

d) **Enforce the mandate through a tax penalty and enroll those who are eligible for fully subsidized coverage in that coverage. A mandate without meaningful enforcement is, in practice, not a mandate. The Commission recommends that the individual mandate be enforced through a** tax penalty equal to one year's worth of premium (minus any subsidies for which the filer is eligible). Those who file without proof of coverage will be contacted for assistance in enrolling in coverage and those who are eligible for fully-subsidized public coverage programs will be enrolled automatically.

17) Implement measures to encourage employees to participate in employer-sponsored coverage.

Rationale

Employer-based health plans currently cover approximately 60 percent of Coloradans.[43] Despite the number of people covered by such plans, a growing number of employees are declining their employer-sponsored insurance due to the rising cost, as noted earlier in this report. By encouraging enrollment in employer-based health insurance, the Commission hopes to retain employers as an important private sector partner in assuring health care coverage for all Coloradans.

Note that the Commission's recommendations regarding employers in Colorado do not include a mandate for employers to offer coverage to their workers. Although seven health care reform proposals submitted to the Commission included a requirement for employers to either cover their workers or pay an assessment, the Commission ultimately agreed with the Business Advisory Task Force, as well as with input received during public hearings, that an employer mandate could have a negative impact on business development in the state and be particularly harmful to small businesses. As an alternative, the Commission is recommending a series of strategies aimed at making employer coverage more affordable for employees, therefore increasing voluntary enrollment in this important health insurance option.

The Commission is not recommending changes to employer group insurance laws

Recommendations

a) **Require Colorado employers to establish premium-only Section 125 plans that allow employees to purchase health insurance with pre-tax dollars.** This recommendation was endorsed by the Commission's Business Advisory Task Force.[44] For employees with access to employer coverage, the ability to purchase coverage on a pre-tax basis can reduce the cost of coverage, the amount depending on the employee's tax rate. The Lewin Group further

[43] The Lewin Group. "Appendix A: Characteristics of the Uninsured in Colorado" in "Cost and Coverage Impacts of Five Proposals to Reform the Health Care System in Colorado." Prepared for the Colorado Blue Ribbon Commission for Health Care Reform. January 2008. See Appendix 4 of this report.

[44] The Business Task Force recommendations ask that the Commission recommendations exempt businesses with 10 or fewer employees from Section 125 plan requirements. When the Commission decided to only require premium-only Section 125 plans, the two co-chairs of the Business Task Force told the Commission that they believed that the Task Force would support the requirement for all business to implement the less burdensome premium-only plans.

estimates that Coloradans would save $372.9 million on their federal taxes through the use of 125 plans. Employers also could have the option to extend this pre-tax benefit to employees who are not eligible for the group plan but have established a "voluntary" individual plan with the Connector (see Recommendation 18).

b) **Provide subsidies for uninsured low-income workers below 400 percent FPL (i.e., about $60,000 annual income for a family of four) to purchase their employer's plan**. (See Recommendation 19 for subsidies for those who do not have access to employer coverage.) This strategy of providing premium assistance to low-income workers was included in almost half of the health care reform proposals received by the Commission. While the Business Advisory Task Force expressed concern that premiums for employer coverage will increase their health insurance costs, the Commission believes that providing premium subsidies for low-income workers allow families to enroll in private, employer-based coverage is an important strategy for encouraging workers to comply with the individual mandate without undue financial burden. The Commission recommends that employees under 300 percent of FPL be given sliding scale subsidies equal to 80-100 percent of their employer's total premium, minus their employer's contribution to their coverage. For employees between 300 percent and 400 percent of FPL, subsidies would ensure that employees did not pay more than 9 percent of their income to purchase coverage equal to the Minimum Benefit Plan. Finally, the Commission recommends that subsidy checks be sent straight to employees, to avoid placing a new administrative burden on employers of processing subsidy payments. According to The Lewin Group, such a program would allow 19,700 low-income uninsured workers to enroll themselves and their families in their employer's plan.[45]

c) **Enforce waiting periods (minimum periods of being uninsured) for eligibility for the premium subsidy program, to discourage employers and employees from dropping employer coverage to enroll in public programs**. Create exceptions for involuntary loss of coverage, COBRA coverage, or such qualifying events as marriage or birth. Later in this document we discuss recommended expansions of public coverage. While these expansions are designed to assure coverage for the lowest-income Coloradans without access to employer-based coverage, there is a risk that eligible workers will drop their employer's coverage to take the new, cheaper public coverage. To discourage this "crowd-out" effect, the Commission recommends that each of its new public programs, including the subsidy program discussed above and the public program expansions discussed later, require that enrollees be uninsured for three to six months, depending on the program.

   This policy has the negative consequence of treating similarly situated individuals differently—an uninsured worker at a firm that offers coverage will be eligible for a subsidy while the insured worker will not. However, the Commission believes that this disparity is the necessary price for ensuring that public funds are not used to cover those who already have insurance. In fact, federal programs often require policies such as this to assure that enrolled individuals, like children in CHP+, are not dropping their employer coverage to enroll in public coverage. The Lewin Group analysis shows that the Commission's recommendations to require waiting periods, as well as to require those who are eligible for a subsidy and who have access to purchase employer coverage to buy it, results in public dollars covering the

[45] To further facilitate enrollment in employer coverage, the Commission recommends that qualifying for a subsidy be a qualifying event for enrollment in employer coverage.

uninsured, instead of those who already have coverage. For example, Lewin estimated that the one proposal that did not require waiting periods would spend almost two-thirds of its program funds to subsidize coverage for Coloradans who already had insurance.

Commission strategies for increasing employer-based health insurance coverage include:

- Require employers to offer pre-tax purchase of health insurance to their employees
- Offer subsidies to low- and moderate- income uninsured employees to purchase their employer's plan, or, if not offered employer coverage, private health insurance
- Require a waiting period for receipt of public subsidy to discourage employees from dropping their current coverage

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

Rationale

The Commission believes that its recommendations will lead to more than 200,000 previously uninsured Coloradans purchasing non-group health insurance coverage, either with or without a subsidy. Many of these individuals and families will need assistance understanding the nature of the individual mandate and choosing among the options now available to them. The Connector also can provide a mechanism for small businesses to offer health benefits to part-time and contract workers. The Rural Advisory Task Force advised the Commission that a Connector would be an important mechanism for rural areas of the state, where access to health insurance can be limited.

Recommendation

a) **Assist individuals and small businesses and their employees in offering and enrolling in health coverage through creation of a "Connector."** This entity would offer a choice of benefit packages with easily comparable price and quality information, certify health plans, and facilitate employer and employee contributions. The Connector would build on the availability of Section 125 plans for employees and would offer three to four standard benefit plans with options for different levels of cost-sharing and provider networks.

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

Rationale

Although Colorado currently has public programs that provide health insurance coverage to some of the poorest Coloradans, many families earn too much to qualify for these programs and are not offered employer coverage. For these individuals and families, purchasing a health insurance policy on their own can be financially burdensome. For example, families and individuals who earn between 205-300 percent of the poverty level (between $40,000 and

$60,000 annual household income for a family of four) cannot afford a private family insurance policy that would cost $12,700 per year or 20-30 percent of their gross income.[46]

Yet, private coverage may be more appropriate for these families than public programs. They may be able to contribute toward the cost of their coverage and may prefer health insurance policies similar to those offered by employers.

Almost one-half of the health care reform proposals received by the Commission recommended premium assistance to low-income families who do not qualify for public programs. Further, The Lewin Group estimates substantial subsidies (80-100 percent of premium cost) to this population would cover 111,300 uninsured Coloradans, or about 14 percent of Colorado's uninsured[47].

Recommendations

a) **Provide premium subsidies to workers who are not offered coverage at the workplace who earn less than 300 percent FPL (approximately $60,000 annual income for a family of four) for purchase of private health insurance equivalent to CHP+ benefit package**. The Commission recommends that eligible families receive a sliding-scale subsidy between 80-100 percent of the premium cost. The Commission considered leaner subsidies. However, evaluation demonstrated that lower subsidies lead to lower enrollment rates, thus covering fewer of the currently uninsured. In addition, the Commission considered subsidizing a leaner benefit package, such as the Minimum Benefit Plan, instead of the CHP+ benefit package. Evaluation results indicated, however, that using the Minimum Benefit Plan would contribute to uncompensated care because low-income families would not be able to pay for uncovered services. Instead, the Commission recommends use of the CHP+ package, a benefit package modeled not on Medicaid, but on the Colorado Small Group Standard Plan, which Lewin's analysis showed resulted in less uncompensated care.

The Commission did not resolve the issue of whether federal Medicaid dollars ought to be used to subsidize voluntary enrollment in an employer sponsored plan where such a plan is available to those earning under 200% FPL. Nor did the Commission resolve the issue of how such an enrollment scheme would impact Recommendation #26 which is to provide a Medicaid benefits package to those under 200% FPL. There are substantial public policy issues raised by this discussion. Issues of concern include: (1) the use of federal Medicaid dollars for the purchase of a non-Medicaid insurance policy; (2) the use of those same dollars for a potentially lesser benefits package and the consequences to enrollees who exceed their policy limits or are unable to afford out of pocket costs; and (3) the administrative and accounting burdens associated with transferring those dollars. These issues raise fundamental questions concerning the stability and core purpose of the Medicaid program. Possible advantages of a voluntary employer subsidy program were discussed and include: (1) the

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[46] The Lewin Group. "Appendix B: Health Spending in Colorado" in "Cost and Coverage Impacts of Five Proposals to Reform the Health Care System in Colorado." Prepared for the Colorado Blue Ribbon Commission for Health Care Reform. January 2008. See Appendix 4 of this report.

[47] This estimate comes from The Lewin Group's analysis of Proposal 5, and assumes that the other recommendations of the Commission, e.g. Medicaid and CHP+ expansions, are implemented. See The Lewin Group. "Appendix G: The Commission Proposal for Health Reform" in "Cost and Coverage Impacts of Five Proposals to Reform the Colorado Health Care System." January 2008. See Appendix 4 of this report

federal match which might be available to support the program; (2) capturing employer contributions towards health insurance coverage and reducing crowd out; and, (3) maximizing consumer choice.

b) **Provide premium subsidies to individuals and families who earn between 300-400 percent FPL ($60,000-$80,000 annual income for a family of four) such that their premium cost of the Minimum Benefit Plan is no more than 9 percent of their income.** (The same subsidy would be available to workers with access to coverage at the workplace.)

c) **To facilitate enrollment and reduce fraud, use auto enrollment strategies that use existing state data to determine subsidy eligibility** (e.g. tax, wage and nutrition program information).

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

Rationale

Purchasing a health insurance policy can be a confusing and time-consuming task, particularly for individuals and families who purchase coverage without the assistance of an employer. In addition, uninsured Coloradans who are required to buy insurance under the individual mandate recommended by the Commission will need to understand what insurance to buy to comply with the new state law.

Recommendations

a) **Require all health insurance companies in Colorado to offer a Minimum Benefit Plan in the individual market, with an emphasis on value-based and consumer-directed benefit design**. The Minimum Benefit Plan, similar in concept to the existing Standard and Basic Plans in Colorado's small group market, could be varied by insurers to include a Health Savings Account (HSA) option or to reflect an insurer's provider network, such as a health maintenance organization (HMO) or preferred provider organization (PPO). A standardized plan will enable all purchasers of insurance in Colorado to understand the minimum coverage they must buy to comply with the individual mandate, as well as to compare prices among various insurance companies.

b) **The Commission is not dictating specifically what the Minimum Benefit Plan should cover.** Instead, the Commission recommends that the Improving Value in Health Care Authority (discussed earlier in these recommendations) develop the Minimum Benefit Plan annually, emphasizing value-based and consumer-directed benefit design. However, we recommend that this benefit package include first-dollar coverage of preventive services, prescription drug coverage and parity between physical and mental health benefits (see Recommendation 16b).

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

Rationale

Rising health insurance premiums are particularly difficult for Coloradans who do not have access to an employer health plan because employers often contribute toward the premium cost and employee premiums (by statute for those employed by small businesses) are not based on the employee's health status. According to the Lewin baseline cost analysis, Colorado employers contributed 82 percent on average to employee premium costs for individuals and 73 percent for family coverage.[48] Individuals and families without employer coverage must bear the full cost of premiums and subsequent increases. In the worst cases, individuals and families cannot buy health insurance at all because of a pre-existing medical condition.

Recommendations

The following recommendations address changes to the individual health insurance market and CoverColorado, but assume that laws and regulations in the small group and large group markets would not change.

a) **Require health insurance companies to issue coverage (guarantee issue) to any individual or family who applies for individual health insurance and who is not eligible for the restructured CoverColorado program due to a high-cost pre-existing condition ("qualified applicant").** Nearly 30 percent of the proposals received by the Commission recommended some form of guarantee issue in the individual market. The Commission recommends that insurance companies be required to sell health insurance policies to anyone who applies (and is not eligible for the restructured CoverColorado program, discussed in Recommendation 21c).

b) **Allow health insurance companies to set premiums for these individuals and families based on their age and geographic location; disallow the consideration of past and current health conditions.** More than 30 percent of the proposals received by the Commission recommended elimination of health status rating in the individual market**.** Further, insurance companies should be allowed to set rates for qualified applicants based on their age and geographic location but not their health status, even if the covered person later develops a high-cost health condition. The negative consequence of this policy could be that healthy individuals and families actually could experience somewhat higher rates under these new rules. When married with the mandate for all Coloradans to have coverage, however, which should bring many young, healthy, formerly uninsured people into the individual market, there may not be much of an impact on rates.

c) **Restructure CoverColorado to cover those who apply for coverage, have a specified high-cost health condition as defined by the newly expanded program, and are not eligible for Medicaid, CHP+ or a premium subsidy. Finance CoverColorado to ensure that premiums are equal to the standard rates in the individual market.** The Commission recognizes that if the state were to require insurance companies to cover applicants with high-cost, pre-existing conditions, whom they can currently deny, this would raise costs to the insurance company

[48] The Lewin Group. "Appendix B: Health Spending in Colorado" in "Cost and Coverage Impacts of Five Proposals to Reform the Health Care System in Colorado." Prepared for the Colorado Blue Ribbon Commission for Health Care Reform. January 2008. See Appendix 4 of this report.

and consequently premiums for all of their policyholders. This is not what the Commission is recommending. Instead, to address this concern, the Commission recommends that the new insurance rules be accompanied by an expansion of CoverColorado, Colorado's existing insurance program for high-cost individuals. Under its new mission and rules, CoverColorado would enroll all individuals who apply for individual coverage and who also have a health condition on a list of high-cost conditions. This list of high-cost health conditions would be developed with the goal of enrolling the highest-cost individuals in CoverColorado. By expanding CoverColorado and enrolling those with high-cost, chronic conditions, the Commission believes that the remaining "healthy" individuals who purchase insurance will benefit from more affordable premiums. The Lewin Group estimates that, by expanding CoverColorado in this manner, 24,100 high-needs individuals would be enrolled in CoverColorado. As a result, premiums in the individual market would be reduced. For a 40-year-old male, the family premium for the Minimum Benefit Plan would be reduced by 41 percent.[49] The CoverColorado program, in turn, would offer subsidized premium rates, equivalent to those offered to the "healthy" population. The Commission believes that the new CoverColorado program, coupled with the new insurance rules, will ensure affordable rates for both the healthy and high-cost individuals who, lacking access to employer coverage, must buy private coverage on their own.

Commission strategies for increasing affordability of individual health insurance coverage include:

- Allow individuals with high-cost pre-existing conditions who cannot get individual coverage to enroll in CoverColorado; subsidize CoverColorado so that premiums are the same as in the individual market
- Require individual market insurance companies to issue policies to any applicant not eligible for CoverColorado due to a high-cost pre-existing condition; prohibit insurance companies from using health status to set premiums in the individual market

22) Restructure and combine public programs (Medicaid and the Child Health Plan Plus) for parents, childless adults and children (excluding the aged, disabled and foster care eligibles).

Rationale

The Commission believes that Medicaid and CHP+ are the best vehicles for covering the lowest-income Coloradans. Yet, Colorado should not continue to enroll low-income families in poorly performing public programs that make it difficult for individuals and families to receive the care they need and for providers to be compensated adequately for their services.

[49] The Lewin Group. "Appendix G: The Commission Proposal for Health Reform" in "Cost and Coverage Impacts of Five Proposals to Reform the Colorado Health Care System." January 2008. See Appendix 4 of this report

Before expanding public coverage, then (as discussed in Recommendation 25 below), we should reform it to reflect the best practices for assuring access and quality. [50]

CHP+ also uses a managed care delivery system but has enjoyed a more stable relationship with managed care plans, often attributed to its emphasis on a commercial benefit package and actuarially-defined rates. The Commission, therefore, recommends using CHP+ as the basis for fundamental Medicaid reforms.

Recommendations

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

b) **Provide the CHP+ benefit and cost-sharing package, including dental, to enrollees in the new program. Provide access to a Medicaid supplemental package, including early and periodic screening, diagnosis and testing (EPSDT) for children, for those who need Medicaid services.**

c) **Pay health plans at actuarially sound rates and providers at least CHP+ rates in the new program**.

d) **For all other Medicaid enrollees, ensure that physicians are reimbursed at least 75 percent of Medicare rates.** Increasing provider and plan reimbursements in this manner was included in almost 40 percent of the proposals received by the Commission. While the Commission recognizes that even this reimbursement level may not be optimal, we believe that this increase will attract more providers and improve access to care in the newly expanded program.

e) **Provide dental coverage up to $1,000 per covered person per year.** Currently, Colorado's Medicaid program does not include adult dental benefits. Yet, oral health is part of physical health, and dental problems, when left untreated, can lead to serious and expensive complications.

f) **Require enrollment in managed care, where available**.

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

Rationale

While healthy adults and children constitute the majority of Medicaid and CHP+ enrollees, the disabled and elderly account for approximately 68 percent of the costs in the Medicaid and

[50] For example, access indicators for children in the unassigned Medicaid program are much lower than for children enrolled under the various managed care options. In 2004, the best Medicaid managed care plan performed at a level similar to that of commercial plans and between 26 and 84 percentage points higher than the unassigned group across all six measures of access. HEDIS 2005 Health Plan Employer Data & Information Set. Evaluation of Quality of Care Delivered to Colorado Medicaid Clients in 2004. 2005; Denver, CO: State of Colorado Department of Health Care Policy and Financing.

CHP+ programs.[51] In addition to the long-term care needs of these populations, disabled and elderly enrollees in Colorado Medicaid account for a large share of physician and hospital spending, or 36 percent of these costs for Colorado Medicaid.[52] Therefore, finding effective ways to ensure access to high-quality care for this population may have the greatest potential for improving their health status and reducing costs to the program.

Just as with the previous recommendation regarding combining Medicaid and CHP+, improvements in reimbursement for elderly and disabled Medicaid recipients should be implemented before expanding the Medicaid program.

Recommendations

In developing strategies to serve the needs of disabled and elderly Medicaid recipients, the Commission looked to the recommendations of its Vulnerable Populations Advisory Task Force (the Task Force's complete recommendations may be found in Appendix 6). Where possible, the Commission recommends the following:

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

b) **Promote care delivery in a consumer-directed, culturally competent manner to promote cost-efficiency and consumer satisfaction**.

c) **Increase the number of people served by the home- and community-based programs equal to the number of people on the current waiting list for these services, increase the Child Autism Waiver program to 760 slots, and increase funding per child in the Child Autism waiver program to $36,000 per child.**.[53] (see Recommendation 24c).

d) **Cover adult dental, care coordination, and targeted case management services benefits in Medicaid, including for the disabled and elderly (see Recommendations 22e, 8b and 8c).**

e) **Explore potential for further reforms to Medicaid, particularly for those who are disabled** (see Appendix 7).

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[51] The Lewin Group. "Appendix B: Health Spending in Colorado" in "Cost and Coverage Impacts of Five Proposals to Reform the Health Care System in Colorado." Prepared for the Colorado Blue Ribbon Commission for Health Care Reform. January 2008. See Appendix 4 of this report.

[52] ibid

[53] Including the Children's HCBS waiver program, the Child Autism waiver program, the Adult Comprehensive waiver program, the Adult SLS waiver program, the Early Intervention waiver program, the CES waiver program and the Family support waiver program.

Summary of Commission's Recommended Reforms to the Colorado Medicaid and CHP+ Programs

Combine Medicaid and CHP+ into a single program to serve eligible childless adults, parents and children:

- Provide CHP+ benefit package with Medicaid supplemental benefits
- Require enrollment in managed care, where available
- Improve provider and health plan reimbursement, using current CHP+ payment methodologies
- Provide one-year eligibility to enrollees

Improve delivery system for disabled and elderly Medicaid enrollees:

- Increase physician reimbursement to 75% of Medicare
- Review other provider reimbursement rates

Improve benefits for all populations:

- Provide a dental benefit to adults with an annual cap of $1,000
- Provide care coordination and targeted case management as a covered benefit

24) Improve delivery of services to vulnerable populations.

Rationale

In addition to improved Medicaid benefits, the Commission believes that additional efforts are needed to meet the needs of people with disabilities and other high-need populations. The recommendations that follow reflect strategies that are intended to ensure that vulnerable populations receive the medical care and services they need to remain healthy, to participate in the workforce and to reside in non-institutional settings.

Recommendations

a) **Create a Medicaid buy-in program for working disabled individuals**. The Commission agrees with the Vulnerable Task Force recommendation to create a Medicaid buy-in program for working disabled individuals. The program would provide subsidized Medicaid buy-in for disabled individuals up to 450 percent FPL and a full-cost buy-in for those over that level.

b) **Create a $5 million Medically-Correctable fund for those who can return to work or avoid institutionalization through a one-time expense**. Analysis by the Colorado Department of Health Care Policy and Financing showed that a medically-correctable fund administered by the Department 1993 to 2003 recouped some of its cost in savings to Medicaid, due to some

temporarily-disabled individuals recovering from their disabilities and moving off of Medicaid.

c) **Increase the number of people served by the home- and community-based programs equal to the number of people on the current waiting list for these services, increase the Child Autism Waiver program to 760 slots, and increase funding per child in the Child Autism waiver program to $36,000 per child..**[54]

d) **Provide mental health parity in the Minimum Benefit Plan** (Recommendation 20).

e) **Establish a Medically-Needy or other catastrophic care program for those between 300-500 percent FPL** ($30,000-$50,000 annual income for an individual) **to address the issue of people who have health insurance but do not have coverage for catastrophic events** (fund at $18 million in state funds).

- **Table 5: Summary of Commission's recommended new programs for individuals with high needs**

Population Served	Program	Program Description
Disabled working individuals earning more than 75 percent FPL	Medicaid Buy-In	Allows working disabled individuals to buy in to the Medicaid program on a sliding scale basis
High-cost individuals over 300 percent FPL purchasing coverage in the individual market (those under 300 percent FPL are eligible for fully-subsidized coverage in Medicaid/CHP+ or the premium subsidy program)	Restructured CoverColorado	Provides subsidized premiums to high-cost individuals purchasing insurance in the individual market; subsidizes so that premiums in CoverColorado are equal to those in the individual market
Those with developmental disabilities, children with disabilities and children with autism	Home- and Community-Based Waiver Expansions	Increases enrollment in Medicaid waiver programs that provide home- and community-based services to those with long-term care needs

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

Rationale

The Commission believes that individuals and families who earn more than 205 percent FPL (or approximately $42,000 annual household income for a family of four) should enroll in private and employer health coverage, and, that those over 250 percent FPL (or approximately $50,000 annual household income for a family of four), can afford to contribute something toward the cost of their health insurance, as described in the preceding recommendations.

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[54] Including the Children's HCBS waiver program, the Child Autism waiver program, the Adult Comprehensive waiver program, the Adult SLS waiver program, the Early Intervention waiver program, the CES waiver program and the Family support waiver program (developmental disability waivers).

The Commission believes, however, that families and individuals that earn less than these income levels do not earn an adequate amount to contribute toward the cost of premiums, out-of-pocket costs, or uncovered benefits. Research on affordability has shown that families below 250 percent FPL (or approximately $51,000 annual household income for a family of four) have "little or no funds available to devote to health insurance coverage."[55]

A significant benefit to expanding public programs is that the federal government pays for at least one-half of all program expenses for eligible populations, making expansion of health coverage for this segment of Colorado's population significantly less expensive to the state. (Note, though, that federal financing is not always simple or guaranteed. See "A Note on Financing" at the conclusion of the Recommendations.)

Both Colorado health care stakeholders and the evaluation results suggest that expansion of public programs is an important component to guaranteeing health care coverage for all Coloradans. More than one-third of all health care reform proposals submitted to the Commission suggested expanding the Colorado Medicaid and CHP+ programs to serve more low-income individuals and families. Secondly, The Lewin Group estimates that expanding Medicaid and CHP+ to 205 percent FPL for all Coloradans would cover approximately 335,600 uninsured people, or 42 percent of the state's uninsured.[56]

Finally, the Commission has crafted its recommendations regarding public program expansion to allow families to enroll in a single program to receive medical care. Under current Colorado program rules, a family at 133 percent FPL (about $27,000 annual household income for a family of four) with a 7-year-old child and a 3-year-old child would be required to enroll in three separate programs for medical care: the parents in the Colorado Indigent Care Program, the 7-year-old in CHP+ and the 3-year-old in Medicaid. Not only does this require the family to apply for three programs – a difficult task for any of us – it also may require the family to enroll in three separate health plans and potentially to seek care from three separate physicians. To encourage this family to receive needed coverage and medical care, income and asset eligibility for public programs should be reformed so that families can always enroll in a single program for medical care coverage.

Recommendations

a) **Expand Medicaid/CHP+ to cover all uninsured legal residents of Colorado under 205 percent FPL (about $42,000 annual income for a family of four).** The State of Colorado currently provides Medicaid or CHP+ coverage for children up to this level of income; covering low-income adults through these programs would build on existing systems. The expansion would include any income-eligible adults such as parents, childless adults and disabled adults. These public programs serve low-income populations well by providing a comprehensive benefit package and requiring small co-payments. The Commission recommends, however, that nursing home coverage not be included in the benefit package for these newly-covered groups.

[55] Glazner J. Prices and Affordability of Health Insurance for Colorado's Uninsured Population. (1998).
[56] The Lewin Group. "Appendix G: The Commission Proposal for Health Reform" in "Cost and Coverage Impacts of Five Proposals to Reform the Colorado Health Care System." January 2008. See Appendix 4 of this report.

b) **Expand the Child Health Plan Plus to cover children in families earning up to 250 percent FPL (approximately $51,000 annual income for a family of four).**

c) **Provide assistance with premiums and copayments to elderly Medicare enrollees up to 205 percent FPL. This program will expand the number of low-income, elderly Medicare enrollees who are eligible for Medicaid assistance that covers their Medicare premiums and copayments on their behalf.**

d) **Restrict the expansion to adults with less than $100,000 in assets** excluding car, home, qualified retirement and educational accounts, and disability-related assets. The Commission also considered revising the current asset test ($2,000) for the disabled and elderly eligible for nursing home care but was concerned about the potential for significantly increased enrollment and cost that might result. This issue could be reconsidered in the future when further analysis of the impact of raising that asset test is available.

e) **Work with the federal government to ensure federal funding for low-income childless adults;** do not fund expansion through reduction of services to current Medicaid and CHP+ eligibles. The Commission believes that the federal government should allow states more flexibility in how they structure their Medicaid and CHP+ programs, including federal financing for childless adults and waiting periods for higher-income enrollees. These are important policy tools for assuring coverage of the lowest-income Coloradans and also maintaining existing private insurance coverage.

26) Ease barriers to enrollment in public programs.

Rationale

Current systems for obtaining coverage can be confusing and time-consuming, particularly for families who are eligible for public assistance. While the "Connector" presented in Recommendation 3 is designed to make enrollment in private coverage easier, other mechanisms are necessary to facilitate access to public coverage and the subsidy program.

Recommendations

a) **Use automatic enrollment strategies to increase enrollment, reduce fraud and lower administrative costs; pursue presumptive eligibility where possible.** Automatic enrollment means using existing state data (e.g. tax, wage, and nutrition program data) to identify and enroll families in coverage. These strategies reduce the administrative burden on families and state agencies and reduce opportunities for fraud. These strategies are particularly effective at covering children who are eligible for Medicaid and CHP+, but not enrolled. The Lewin Group estimates that automatic enrollment strategies in Colorado would cover nearly 50,000 uninsured children, assuming other recommendations of the Commission are implemented.[57]

b) **Provide one-year continuous eligibility to childless adults, parents and children in the newly merged Medicaid/CHP+ program. Currently, the average length of enrollment** for a child in Colorado Medicaid is six months. This relatively short period of enrollment creates

[57] The Lewin Group. "Appendix G: The Commission Proposal for Health Reform" in "Cost and Coverage Impacts of Five Proposals to Reform the Colorado Health Care System." January 2008. See Appendix 4 of this report.

administrative costs to the state and provider and interruptions in care for the family. Providing one year of eligibility promotes continuous care and reduces administrative costs for providers and the state.

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

Rationale

> Access to coverage doesn't equal access to care, especially in rural Colorado. Expanding insurance coverage in rural areas is moot unless there are sufficient providers, of all types, to serve them.
>
> --Rural Advisory Task Force of the Blue Ribbon Commission for Health Care Reform

The federal government has designated 34 percent of Colorado counties as Health Professional Shortage Areas, meaning that residents do not have ready access to an adequate number of providers.[58] As indicated in the excerpt above, insurance coverage alone is not sufficient in these areas to assure access to care.

In addition, in many rural communities, "safety net" providers such as federally qualified health centers and rural health centers are the only source of care. It is critical that any reforms implemented by the state enhance, not detract from, these providers' ability to serve their communities.

The Commission drew largely on the recommendations of its Rural Advisory Task Force in crafting recommendations to increase access to care in underserved areas of the state. (The entirety of the Rural Advisory Task Force's recommendations may be found in its final report, Appendix 6). The Rural Advisory Task Force comprised 15 members from rural areas of Colorado, representing health care providers, businesses and consumers.

Recommendations

The Commission recommends five major strategies for improving access to care in underserved areas of the state:

a) **Continue to pay all qualified safety net providers enhanced reimbursement for serving Medicaid patients.** The Commission recommends that safety net providers, such as community health centers, continue to receive their existing Medicaid payment levels to ensure that they can continue as the sole source of care in some underserved communities and for populations across the state, including both urban and rural areas.

b) **Explore ways to minimize barriers that keep such mid-level providers as advanced practice nurses, dental hygienists and others from practicing to the fullest extent of their licensure and training.** Midlevel providers can substantively improve health care access and are an

[58]Colorado Department of Public Health and Environment. Primary Care Health Professional Shortage Areas. July 2007. http://www.cdphe.state.co.us/pp/primarycare/shortage/pchpsa.pdf.

important part of the heath care resource mix in rural areas. See Recommendation 7 for additional discussion of this strategy.

c) **Promote and build upon the existing statewide nurse advice line.** Such a mechanism can benefit rural populations and is likely to reduce the use of emergency departments for non-emergency healthcare services, reducing costs to small rural providers.

d) **Expand telemedicine benefits for Medicaid and CHP+ enrollees, especially in rural areas.** The Commission recognizes that technology infrastructure in rural areas is sometimes not sufficient to support telemedicine. Yet, in areas that can support this type of care, the Commission believes that use of telemedicine should be reimbursed, because this technology is a critical means of expanding access to care.

e) **Develop and expand mechanisms to recruit and retain health care workers who will provide services in underserved areas of Colorado**, such as state-based loan repayment, loan forgiveness programs, tax credits and other approaches.

28) Create a Consumer Advocacy Program including an Ombudsman Program.

Rationale

As previously uninsured Coloradans become eligible for public coverage and subsidized private coverage, some may need assistance in understanding how to access health care insurance programs and needed health care services. Consumers also may need assistance with accessing needed services and appealing a benefit denial.

Recommendation

a) **Create a Consumer Advocacy and Ombudsman Program that is independent and consumer-directed.** Functions would include providing system navigators to guide people through the system, resolving problems, providing assistance with eligibility and benefit denials, helping people qualify for Medicaid and Social Security Income, and providing ombudsman services.

29) Continue to explore the feasibility of giving Coloradans the option to enroll in coverage that will stay with them regardless of life changes, such as the Optional Continuous Coverage Portable Plan that the Commission modeled.

Rationale

More than one-quarter of the proposals submitted to the Commission proposed that Colorado create a single, public payer of all health care, similar to the system used in Canada. While the Commission evaluated one of these proposals (Proposal 4), the Commission decided against recommending this type of reform in Colorado. The Commission was interested, however, in adopting one aspect of a single-payer plan: completely portable coverage that allows people to keep their health insurance coverage even through such life changes as switching jobs. Under the voluntary program modeled by the Commission, residents of the state could enroll in a state-run health program that would cover them regardless of their employment, income or

health status. Thus, coverage continues regardless of life changes. This type of program also raised questions, however, such as how to encourage both high-cost and low-cost residents to enroll and how to structure premiums.

Recommendation

a) **Continue to explore the feasibility of giving Coloradans the option to enroll in coverage that will stay with them, regardless of life changes, such as the Optional Continuous Coverage Portable Plan that the Commission modeled.** Features of the plan that the Commission modeled included low co-payments and a commitment to enroll for a minimum number of years, possibly 10. (This minimum enrollment period would prevent people from enrolling only when they were sick.) Enrollees would pay for their enrollment through an additional state annual income tax of 8.1 percent. The state would have to pursue a major federal waiver to capture existing employer and Medicaid/CHP+ contributions for enrollees in the program. Although a voluntary program does not have the same attributes as a mandatory system (e.g. the elimination of most heath insurance companies and their related administrative costs), the program would give Colorado residents the option of enrolling in a health plan that will cover them as long as they remain residents of Colorado.

30) Continue to explore the feasibility of allowing employers to offer 24-hour coverage

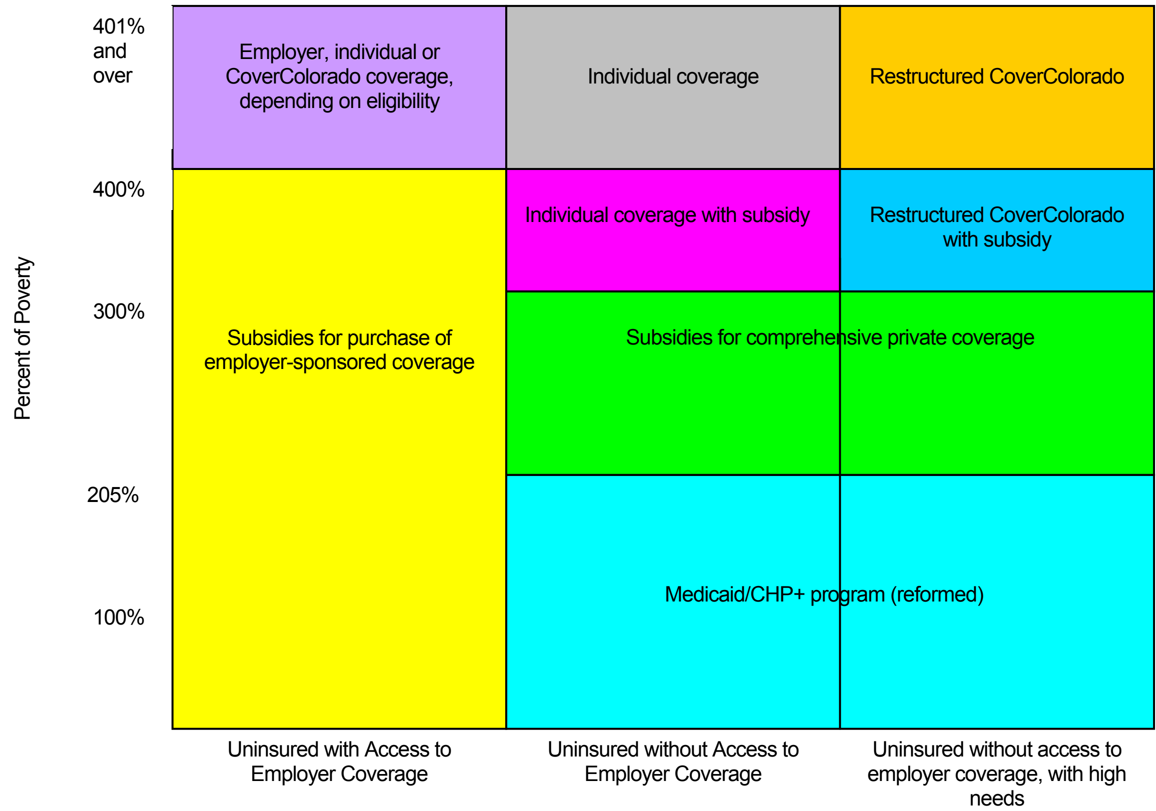
Rationale

In 24-hour coverage, all of an employee's health needs—whether work-related or not—are covered by a single health insurer. Employers participating in 24-hour coverage could experience savings in two areas: administrative costs and reduced litigation. Administrative costs may be reduced because employers contract with only one insurer for coverage of their workers instead of two insurers. Another possible area of savings is reduced litigation that stems from carriers disputing whether a given claim is work-related or not. Despite these possible savings, the Commission identified possible downsides to voluntary 24-hour coverage, such as only higher-risk employers opting for 24-hour coverage and what the resulting impact on disability claims, health claims and premiums would be for all employers.

Recommendation

a) **Continue to explore the feasibility of allowing employers to offer 24-hour coverage**. Given the potential benefits and risks of a voluntary 24-hour coverage policy, the Commission recommends that Colorado continue to analyze the pros and cons of 24-hour coverage, possibly further refining the concept to ensure that it would reduce premiums for participating employers and employees, without raising premiums for others.

• **Figure 12: Summary of Coverage Options for the Uninsured under the Commission's Recommendations**



PART 3: Adopt Recommendations as a Comprehensive Plan; Implement in Stages

31) Implement these recommendations of the Blue Ribbon Commission on Health Care Reform as a comprehensive, integrated package.

Rationale

This is a package of interconnected recommendations; together they are the Commission's vision for comprehensive health care reform in Colorado. The recommendations work together to increase affordability, increase access to health care and ensure ongoing viability of Colorado's insurance markets. For example if Colorado were to implement an individual mandate (Recommendation 17), without providing subsidies for the purchase of private health insurance (Recommendations 18 and 20), many uninsured Coloradans would not comply with the mandate, because health insurance premiums would remain unaffordable for them. Another example is the Commission's recommendation to expand the Colorado Medicaid and CHP+ programs to all uninsured Coloradans under 205 percent FPL (Recommendation 26). If this recommendation were to be implemented without reforming Medicaid provider reimbursement, as in Recommendation 23, thousands of uninsured Coloradans would become eligible for Medicaid, but likely would not be able to find a health care provider willing to treat them.

The following is a sampling of the interconnectedness of the Commission's recommendations:

Individual Mandate (Recommendation 16) depends on:

- Creation of a premium subsidy program (Recommendations 17 and 19)
- Creation of a Colorado Connector (Recommendation 18)
- Reforms in the individual insurance market (Recommendation 21)
- Expansion of Medicaid and CHP+ (Recommendation 25)

Reforms in the individual market (Recommendation 21) depend on:

- Creation of an individual mandate (Recommendation 16)
- Restructuring of CoverColorado (Recommendation 21c)

Expansion of Medicaid and CHP+ (Recommendation 25) depends on:

- Improvements to health plan and provider reimbursement (Recommendation 22)

In addition, the Commission recommends that, where flexibility exists, certain health care reform strategies be implemented before others. The Commission recommends that strategies that 1) serve vulnerable and poorest populations and 2) fix elements of the

health care system that are ineffective, be pursued before other health care reform strategies.

Further, the Commission urges that cost containment efforts be instituted at the outset. The Commission provides recommendations to reduce administrative costs, and also believes that minimizing the cost shift from uncompensated care will help to stabilize costs. Yet many other factors, including the proliferation of medical technology, medical errors, medical waste due to inefficiency and others, contribute to rising costs. Addressing these issues requires ongoing, coordinated effort among a variety of stakeholders. The Commission believes that the Improving Value in Health Care Authority included in these recommendations can serve this role, and urges that its creation be one of the first steps in the implementation of these reforms.

Recommendations

a) **Adopt these recommendations of the Blue Ribbon Commission on Health Care Reform as a comprehensive, integrated package but do so in stages, increasing efficiency and assuring access before expanding coverage**. The implementation schedule that follows these recommendations does not propose specific timelines or propose phases of a certain length, but recommends the sequencing of health care reform implementation. Further, the implementation schedule does not include financing, but assumes that funding for each strategy is available. Finally, the implementation schedule is presented both by recommendation and by stage.

Recommendations: Suggested Implementation Schedule By Health Care Reform Strategy

Stage 1A	Stage 1B	Stage 2	Stage 3	Stage 4
Reduce Cost of Health Care and Improve Quality of Care				
Create the Colorado Health Care Value Authority (Rec.5)	Authority creates rules regarding administrative simplification (Rec.3), health care transparency (Rec.12) and the Consumer Advocacy Program (Rec.28),(Rec.15b)	Authority issues reports on prevention (Rec.4) medical homes (Rec.), and end-of-life care (Rec.6). (Rec.15c)	Authority issues reports on evidence-based medicine (Recommendation 10) and provider reimbursement (Rec.1). (Rec.5c)	Authority issues evaluation of health care reform (Rec.5c)
Reduce Costs of Employer and Individual Private Coverage				
Create Colorado Connector				
	Create Colorado Connector (Rec.18)		Offer enrollment in the Colorado Connector to small businesses and individuals (Rec.8)	
Require employers to offer 125 premium-only plans (Colorado Department of Labor)				
	Issue rules regarding state 125 plans (Rec.17a)	Require Colorado employers to set up Section 125 premium-only plans (Rec.17a)		
Reduce health insurance premiums for low-income uninsured workers and their families (Colorado Connector)				
		Issue rules regarding the premium subsidy program (Rec.19)	Implement premium subsidy program for low-income uninsured workers (Rec.17b and 19)	

Stage 1A	Stage 1B	Stage 2	Stage 3	Stage 4
Expand and Reform Colorado Medicaid and Child Health Plan				
Reform Colorado Medicaid for adults and children (Department of Health Care Policy and Financing)				
Partner with federal government to secure approval and funding for Colorado Medicaid reform and expansion (Rec.22)	Secure approval from federal government for Colorado Medicaid reform and expansion (Rec.22)	Combine and restructure the Colorado Medicaid and Child Health Plan programs for adults and children (Rec.22)		
Increase physician and health plan participation in Medicaid (Department of Health Care Policy and Financing)				
Implement one-year continuous eligibility for Colorado Medicaid (Rec.6) Create Medicaid Provider Reimbursement Committee to review and make recommendations regarding Medicaid provider rates	Increase Medicaid physician reimbursement to at least 75% of Medicare (Rec.2c)	Pay physicians and health plans in combined Medicaid/CHP+ program using CHP+ methodology (Rec.22b) Require enrollment in managed care for the combined Medicaid/CHP+ program (Rec.22e)		
Improve Medicaid benefits (Department of Health Care Policy and Financing)				
		Cover care coordination, targeted case management, and dental care (Rec.23)		
Expand Colorado Medicaid and Child Health Plan for parents, children, and childless adults (Department of Health Care Policy and Financing)				
Implement auto enrollment and one-year continuous eligibility for Colorado Medicaid (Rec.26)	Expand child eligibility to 250% of poverty and parent eligibility to 205% of poverty(Rec.5)	Create Medicaid coverage for childless adults up to 205% of poverty (Rec.5)		
Expand Colorado Medicaid and Child Health Plan for disabled and other vulnerable populations (Department of Health Care Policy and Financing)				
Create Medicaid Buy-In program for working disabled individuals (Rec.24)	Create Medically-Correctable Program (Rec.4)	Increase number of people served by home-and-community-based waivers (Rec.24)		Create Medically Needy or Catastrophic Care Fund (Rec.24)

Stage 1A	Stage 1B	Stage 2	Stage 3	Stage 4
Improve Access to Individual Private Coverage				
Require health insurance companies to offer the Minimum Benefit Plan in the individual market (Colorado Health Care Value Authority)				
			Authority issues rules on the Minimum Benefit Plan (Rec.6)	
Restructure CoverColorado (CoverColorado)				
		Issue rules regarding restructured CoverColorado program (Rec.21)	Implement rules regarding restructured CoverColorado program (Rec.21)	
Reform the Colorado individual insurance market (Colorado Division of Insurance)				
		Issue rules regarding guarantee issue and modified community rating the individual market (Recommendation 21a and 21b). Implement with the individual mandate (Rec.16)	Implement guarantee issue and modified community rating in the individual insurance market for those who are not eligible for the restructured CoverColorado program (Rec.1a and 21b)	
Require Every Legal Resident of Colorado to Have Health Insurance at Least Equal to the Minimum Benefit Package				
		Issue rules regarding the individual mandate, including the affordability exception and tax penalty (Rec.16). Implement with guarantee issue and modified community rating in the individual market (Rec.21 and 22).	Implement individual mandate, with affordability exception and tax penalty (Rec.16)	

Stage 1A	Stage 1B	Stage 2	Stage 3	Stage 4
Assure Access to Care, Especially in Rural Areas				
Create safety net provider transition plan to assure adequate funding during health care reform for these providers.	Explore ways to minimize barriers to physician and dentist extenders from practicing to the fullest extent of their licensure and training (Rec.7)	Develop and expand mechanism to recruit and retain health care workers who will provide services in underserved areas of Colorado (Rec.27)		
Continue to Explore Options for Improving Access to Health Insurance for Coloradans				
Continue to explore the feasibility of giving Coloradans the option to enroll in coverage that will stay with them, regardless of life changes, such as the Optional Continuous Coverage Portable Plan that the Commission modeled (Rec.9)	Continue to explore the feasibility of allowing employers to offer 24-hour coverage (Rec.30)			

Recommendations: Suggested Implementation Schedule By Stage

	Authority	Medicaid/CHP+ Reform	Provider Reimbursement	Medicaid/CHP+ Expansion	Safety Net	Connector, Insurance Reform	Other Options
Stage 1A	Create the Colorado Health Care Value Authority (Rec 15)	Partner with federal government to secure approval and funding for Colorado Medicaid reform and expansion (Rec 22)	Create Medicaid Provider Reimbursement Committee	Implement auto-enrollment and one-year continuous eligibility for Medicaid (Rec 26)	Create safety net provider transition plan		Explore feasibility of voluntary continuous coverage portable plan (Rec 29)
				Create Medicaid buy-in program (Rec 24)			
Stage 1B	Authority creates rules re: administrative simplification (Rec 3) and transparency (Rec 12), creates Consumer Advocacy Program (Rec 28)	Secure federal approval for Colorado Medicaid reform and expansion (Rec 22)	Increase Medicaid physician reimbursement to at least 75% of Medicare (Rec 22c)	Create medically-correctable program (Rec 24)	Explore ways to minimize barriers to midlevel practitioners practicing to full extent of licensure and training (Rec 7)	Create Connector (Rec 18)	Explore feasibility of 24-hour coverage (Rec 30)
				Expand child eligibility to 250% FPL, parent eligibility to 205% FPL (Rec 25)		Issue rules re: S125 plans (Rec 17a)	

	Authority	Medicaid/CHP+ Reform	Provider Reimbursement	Medicaid/CHP+ Expansion	Safety Net	Connector, Insurance Reform	Other Options
Stage 2	Authority issues reports on prevention (Rec 4), medical homes (Rec 8) and end-of-life care (Rec 6)	Combine and restructure Medicaid and CHP+ (Rec 22)	Pay physicians and health plans in combined Medicaid/CHP+ prorgram using CHP+ reimbursement methodology (Rec 22b)	Require enrollment in managed care for participants in combined Medicaid/CHP+ program (Rec 22e)	Develop and expand mechanisms to recruit and retain health care workers for underserved areas (Rec 27)	Require employers to set up S125 plans (Rec 17a)	
				Cover care coordination, targeted case management and dental care (Rec 23)		Issue rules re: premium subsidy program (Rec 19)	
				Create Medicaid coverage for childless adults up to 205% FPL (Rec 25)		Issue rules re: restructured CoverColorado program (Rec 21)	
				Increase number of people served by HCBS waivers (Rec 24)		Issue rules re: guaranteed issue and modified community rating in individual market (Recs 21a, b)	
						Issue rules re: individual mandate (Rec 16)	

	Authority	Medicaid/CHP+ Reform	Provider Reimbursement	Medicaid/CHP+ Expansion	Safety Net	Connector, Insurance Reform	Other Options
Stage 3	Authority issues reports on evidence-based medicine (Rec 10) and provider reimbursement (Rec 15c)					Offer enrollment through the Connector to individuals and small businesses (Rec 18)	
	Authority issues rules on Minimum Benefit Plan (Rec 16)					Implement premium subsidy program (Recs 17b, 19)	
						Implement rules re: restructured CoverColorado program (Rec 21)	
						Implement individual mandate (Rec 16) with guaranteed issue and modified community rating in the individual market (Recs 21 a, b)	
Stage 4	Authority issues evaluation of health care reform efforts (Rec 15c)			Create Medically Needy or Catastrophic Care Fund (Rec 24)			

PART 4: Dissolve the Commission on January 31, 2008

32) Dissolve the Commission once its final report is made to the General Assembly on January 31, 2008

A Note About Financing

The Commission recognizes that its charge did not include identifying funding sources for its reforms, and that such decisions are the purview of the General Assembly. We note, however, a few important considerations for legislators:

By building upon the existing system of employer-sponsored insurance, these reforms retain a crucial funding mechanism: employer contributions.

The public program expansions suggested here will allow Colorado to maximize federal dollars coming into the state but will, in some instances, require waivers from the federal government. The Lewin Group has identified approximately $1 billion in annual federal funding that would be depending on Colorado's ability to secure a federal waiver to fund Medicaid and CHP+ expansions and premium subsidies.[59]

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[59] The Lewin Group. "Appendix G: The Commission Proposal for Health Reform" in "Cost and Coverage Impacts of Five Proposals to Reform the Colorado Health Care System." January 2008. See Appendix 4 of this report.

Chapter 8: How Task Force Recommendations were Incorporated into Commission Recommendations

Task Force Recommendation	How the Commission Incorporated the Recommendation
Business Advisory Task Force Recommendations	
Do not require employers to offer insurance or pay an assessment.	Commission does not recommend an employer mandate or assessment.
Exempt businesses under 10 employees from providing Section 125 plans.	Commission modified recommendation to require all Colorado employers to offer Section 125 *premium-only* plans, which are less burdensome to establish (Recommendation 17a).
Require Coloradans to have health insurance.	Commission recommends that all Coloradans be required to have health insurance (Recommendation 16a).
Expand public programs to reduce cost-shifting, with considerations for the effect on state taxes and provider reimbursement.	Commission recommends expansion of public programs to reduce the number of uninsured and reduce cost-shifting. The Commission further recommends increases to Medicaid physician reimbursement. The Commission does not identify a financing mechanism for expansion of public programs. (Recommendations 22 and 25).
Structure premium subsidies to reduce administrative burden on employers.	Commission recommends that premium subsidy checks be sent directly to employees, not employers, so that administrative burden on employers will be reduced. (Discussed in Recommendation 17).
Provider Advisory Task Force Recommendations	
Enable the provision, coordination and integration of patient-centered care, including "healthy hand-offs."	The Commission adopted this recommendation in its recommendation regarding medical homes. (Recommendation 8).
Encourage the development of a statewide system aggregating data from all payer plans, public and private.	The Commission adopted this recommendation as part of its recommendations regarding the promotion of evidence-based medicine (Recommendation 10b).
Standardize benefit packages, claim forms, payment processes, etc across health plans to improve transparency and minimize administrative costs.	The Commission recommends the standardization of claims attachment requirements, eligibility and coverage verification systems, standard electronic ID cards, standard prior authorization procedures and uniform insurance application forms. (Recommendation 3a).

Task Force Recommendation	How the Commission Incorporated the Recommendation
Integrate public and private physical health systems to incent consumer adherence and enable care to be provided by the most appropriate health care provider.	The Commission does not directly address the issue of public and private physical health system integration.
Get serious about changing reimbursements and incentives across all payers—public and private.	The Commission recommends that providers be paid based on the quality of care they provide and that price and quality information be made readily available to consumers (Recommendations 11 and 12).
Develop and expand state-based loan repayment/forgiveness systems/tax credits and other mechanisms to recruit and retain health care workers who will serve the underserved and provide a primary care based health care home for all.	The Commission adopted this recommendation in its recommendations addressing access to care (Recommendation 27e).
Rural Advisory Task Force Recommendations	
Use the Rural Urban Commuter Area definition of "rural."	The Commission does not recommend a definition for rural, but suggest strategies aimed to improve access to care in areas of the state where there have traditionally been a shortage of health care providers (Recommendation 27e).
Test reform proposals to assure that safety net providers are not negatively affected.	The Commission recommends that current cost-based Medicaid payments to safety net providers continue (Recommendation 27a) and that a Safety Net Transition Plan be developed in the early stages of health care reform in Colorado to ensure adequate funding to these providers (Recommendation 31 and Implementation Schedule).
Expand the scope of practice for non-physician health care professionals.	The Commission recommends that Colorado explore ways to minimize barriers to physician and dentist extenders such as advanced practice nurses and dental hygienists and others from practicing to the fullest extent of their licensure and training (Recommendation 7).
Increase funding to health care provider loan repayment providers who serve in Health Professional Shortage Areas.	The Commission recommends that Colorado develop and expand mechanisms to recruit and retain health care workers who will provide services in underserved areas of Colorado, such as state-based loan repayment, loan forgiveness programs, tax credits, and other approaches. (Recommendation 27e).

Task Force Recommendation	How the Commission Incorporated the Recommendation
Increase funding and marketing for medical education of providers who are on a rural track program in a primary care specialty.	The Commission did not directly recommend this strategy, but this recommendation could be studied as part of the Commission's recommendation to further study a variety of strategies to increase the number of health care workers who will provide services in underserved areas of Colorado (see previous recommendation).
Assure basic plan coverage to include oral health, behavioral health and vision care services.	The Commission recommends that the Minimum Benefit Plan provide mental health parity coverage (Recommendation 24d). The Commission did not further specify the benefits to be included in the plan, but rather recommends that a multi-stakeholder group design and periodically review the Minimum Benefit Plan to balance coverage and affordability (Recommendation 16b).
Modify state regulations that prevent or set unacceptably high standards for the co-location and mixed use of some healthcare facilities.	The Commission did not directly address this issue in its recommendations.
Increase Medicaid reimbursement to parity with Medicare reimbursement in designated Health Professional Shortage Areas.	The Commission is recommending that Medicaid physicians be reimbursed at least 75 percent of Medicare rates, with a recommendation that it eventually be raised to 100 percent. In addition, the Commission is recommending that all Medicaid providers serving children and parents be reimbursed at CHP+ rates (e.g. for physicians, approximately 80 percent of Medicare[60]) (Recommendation 22)
Assure adequate technical infrastructure and staff for telemedicine programs in rural areas to deliver chronic disease management and specialty consultation.	While the Commission does not make recommendations regarding technical infrastructure and staff, the Commission recommends that Colorado Medicaid and CHP+ expand their telemedicine benefits (Recommendation 27d).
The use of a 24-hour telephone triage nurse line for patients will benefit rural populations.	The Commission recommends that Colorado promote and build upon the existing statewide nurse advice line (Recommendation 27c).

[60] This rate is used in the CHP+ managed fee-for-service network.

Task Force Recommendation	How the Commission Incorporated the Recommendation
Increase support for community-based organizations and local governments to assist families through eligibility and enrollment processes.	While the Commission does not directly make recommendations regarding local support for eligibility processes, the Commission recommends that eligibility and enrollment be simplified through the use of auto enrollment in public programs (use of existing tax, wage, and nutrition data) to reduce application burden on families (Recommendation 26).
Enrollment in any state mandated health plan must occur automatically at the point of service, if the patient has not previously enrolled in an insurance plan.	The Commission does not directly address the issue of where application and enrollment would happen in Colorado communities, but believes that auto enrollment and one-year continuous eligibility should make application and enrollment into public programs faster, more accurate, and less burdensome for families and providers (Recommendation 26).
The use of an insurance connector is likely to benefit rural populations; however, access to a connector should not be limited to the Web.	The Commission recommends that the Colorado Connector be accessible to individuals and families in Colorado statewide (Recommendation 18).
Any governing body, which emerges from reform efforts, must include at least proportional representation from rural areas of Colorado.	The Commission does not address the issues of governance in its recommendations.
Test any geographic community rating proposals, which isolate rural populations from urban populations, to assure that they do not disadvantage rural populations.	The Commission recommends that the individual market in Colorado adopt modified community rating, which eliminates health status rating, but allows age and geographic rating. (Recommendation 21b) The Commission believes that geographic rating will benefit most rural areas, as urban areas tend to have higher health care costs than rural areas.
Test all proposed financing mechanisms to determine if they will disparately affect rural populations.	The Commission does not address financing in its recommendations.
Test economic incentives to providers and insurance plans to assure that modeling considers the limited health care provider capacity in most rural areas of Colorado.	The Commission recommendations attempt to increase access to providers in rural areas through a variety of mechanisms (Recommendation 27). The Commission also hopes that a reformed individual market, restructured CoverColorado, and new Colorado Connector will expand access to health insurance in rural areas (Recommendations 18 and 21).
Establish rules to protect rural providers from unreasonable financial risk.	The Commission recommendations do not dictate the use of managed care in rural areas.

Task Force Recommendation	How the Commission Incorporated the Recommendation
Healthcare reform must place a greater emphasis on wellness and prevention by increasing funding for the public health system.	The Commission recommends increasing funding for local public health agencies in Colorado to perform functions such as preventing disease and injury, assessing community health, and promoting healthy behavior (Recommendation 4e).
Vulnerable Populations Advisory Task Force Recommendations	
The safety net must be preserved and strengthened.	The Commission recommends that current cost-based Medicaid payments to safety net providers continue (Recommendation 27a) and that a Safety Net Transition Plan be developed in the early stages of health care reform in Colorado to ensure adequate funding to these providers (Recommendation 31 and Implementation Schedule).
Long term care needs to be evaluated and planned for in detail, both current and projected future needs.	The Commission believes that it did not have enough time to adequately address long-term care in Colorado. Instead, the Commission recommends that Colorado conduct a comprehensive review of current Colorado long-term care information as a supplement to the Commission's recommendations (Recommendation 5).
Any new proposal should include existing mandates provided by state law.	The Commission does not recommend elimination of any mandate provided by state law.
Build on successful local initiatives that are working for vulnerable populations.	The Commission recommends that Colorado examine and expand the efforts of Colorado communities which have been proven over the years to enhance quality and lower cost (Recommendation 14).
Ensure that insurance plans provide comprehensive, high quality health care.	The Commission recommends that every Coloradan under 205% of poverty be eligible for a Medicaid-equivalent benefit package (Recommendation 25). The Commission further recommends that uninsured workers between 205% and 300% of poverty be given a subsidy for a CHP+ benefit package (Recommendation 19a). Finally, the Commission did not recommend the benefits that would be included in the Minimum Benefit package, but suggests that a multi-stakeholder group design and periodically review this benefit package (Recommendation 16b).

Task Force Recommendation	How the Commission Incorporated the Recommendation
Focus on wellness and prevention. Incentivize consumers to engage in healthy behaviors and use appropriate preventive care. Eliminate co-payments for evidence based preventive care such as mammography screening.	These recommendations are similar to the Commission's recommendations regarding prevention (Recommendation 4).
Decrease complexity of health care plans and provide consumer education in acceptable mediums. Provide tools that enable consumers to make informed choices. Health care plans should be easy to navigate.	The Commission recommends that the state create a Colorado Connector to make health insurance easier to buy (Recommendation 18), that the state make information on insurer and provider price and quality more available (Recommendation 12), and that the state create a Consumer Advocacy Program to assist people with accessing the insurance and medical care they need (Recommendation 28).
Provide consumer/family friendly appeals processes with advance notice and ombudsmen.	The Commission did not directly address the issue of appeals processes. (*although the Commission does recommend the creation of a Consumer Advocacy Program that would include Ombudsman services. See Recommendation 28).*
Consumer satisfaction data should be collected and reported by an entity without conflict of interest.	The Commission recommends that Colorado ensure that information on insurer and provider price and quality is available to all Coloradans, with consumer satisfaction data being an important component of quality information (Recommendation 12).
Provide transparency and accountability.	The Commission recommends that Colorado increase transparency by providing more information to consumers on the cost and quality of health insurance and health care in Colorado (Recommendation 12). The Commission did not directly address the issue of governance of programs in its recommendations.
Contain administrative costs while providing high quality comprehensive care, i.e. National Association of Community Health Centers.	The Commission's recommendations do not require consumers or the State of Colorado to use a particular kind of health care provider. The Commission does recommend that Colorado ensure the viability of safety net providers (Recommendation 27).
Expand Health Information Technology to allow quality seamless care, reduce medical error and forgo the need to duplicate care.	The Commission recommends the creation and expansion of the use of health information technology to increase quality and reduce health care costs in Colorado (Recommendation 9).

Task Force Recommendation	How the Commission Incorporated the Recommendation
Recognize the value of culturally appropriate and holistic medicine including non-allopathic medicine and traditional healers/non-traditional western providers.	The Commission did not directly address holistic and alternative medicine in its recommendations.
Provide continuous coverage with portability that allows interstate travel and reciprocity with other states.	The Commission recommendations attempt to increase portability of health insurance coverage for Coloradans through two mechanisms: the Colorado Connector (Recommendation 18) and further study of a program like the Optional Continuous Coverage Program modeled by the Commission (Recommendation 29).
Promote research into best medical practices for vulnerable populations.	The Commission's recommendations do not directly address medical research. The Commission does recommend, however, that the new Value Authority develop of a statewide system aggregating data from all payers, public and private, which it believes is the measuring the efficacy and efficiency of care for different populations.
Expand Medicaid to Federal Levels. Endorse Medicaid Buy-In and Ticket to Work.	The Commission recommends that Medicaid and CHP+ be expanded to cover every individual and family in Colorado under 205 percent FPL (Recommendation 25). The Commission also recommends that the state create a buy-in program that includes Ticket to Work eligibility, for working disabled individuals (24a).

Task Force Recommendation	How the Commission Incorporated the Recommendation
Decrease the complexity of Medicaid via: a simplified application process, 12 months continuous eligibility, presumptive eligibility, passive reenrollment, and elimination of unnecessary verifications; expansion of the state definition of developmental disability to match the federal definition and consolidate the 14 Medicaid Waiver programs accordingly.	The Commission recommends 12 month continuous eligibility for Medicaid (Recommendation 26b) and presumptive eligibility where possible (Recommendation 26a). Expansion of Medicaid to childless adults up to 205 percent FPL will also allow disabled adults under 205 percent FPL to become income-eligible for Medicaid, without a wait for SSI eligibility determination. The Commission also recommends further study of the combining of waiver programs (Appendix 7).
Increase reimbursement for Medicaid providers, with incentives for those who provide quality care to high needs populations.	The Commission recommends that Medicaid physicians be reimbursed at least 75 percent of Medicare rates, with a recommendation that it eventually be raised to 100 percent. In addition, the Commission is recommending that all Medicaid providers serving children and parents be reimbursed at CHP+ rates (e.g. for physicians, approximately 80 percent of Medicare[61] - Recommendation 22). The Commission also recommends that all providers in Colorado be paid based on the quality of their outcomes (Recommendation 11).
Build on the success of the Consumer Directed Attendant Support Program by expediting implementation of HB 05-1243.	The Commission recommends increasing consumer direction in health care (Recommendation 13); however, the Commission believes that it did not have enough time to adequately address long-term care in Colorado. Instead, the Commission recommends that Colorado conduct a comprehensive review of current Colorado long-term care information as a supplement to the Commission's recommendations (Recommendation 5).
Enable consumer directed care for Medicaid DME purchase to maximize cost savings.	The Commission recommends increasing consumer direction in health care (Recommendation 5), but did not directly address the issue of DME purchase in Medicaid.
Allow Medicaid services to be provided in the family home.	The Commission recommends expansion of the Medicaid Home-and-Community-Based Waiver programs (Recommendation 24c). The Commission also recommends further study of home-based care (Appendix 7)

[61] This rate is used by the CHP+ managed fee-for-service network.

Task Force Recommendation	How the Commission Incorporated the Recommendation
Encourage Medicaid fraud detection via consumer education and incentives.	The Commission recommends further study of consumer training programs to allow consumers to identify savings in their own care (Appendix 7).
Expand Medicaid benefits to include oral/dental, glasses, hearing aids, transportation and respite care.	The Commission recommends that adult dental care be added to the Medicaid benefit package (Recommendation 22d). The Commission also recommends further study of Medicaid transportation benefits (Appendix 7). The Commission also recommends further study of respite care (Appendix 7).
Allow Medicaid reciprocity with neighboring states.	The Commission did not address this issue in its recommendations.
Realize cost savings by facilitating the transition of nursing home residents desiring community placement out of institutions.	The Commission believes that it did not have enough time to adequately address long-term care in Colorado. Instead, the Commission recommends that Colorado conduct a comprehensive review of current Colorado long-term care information as a supplement to the Commission's recommendations (Recommendation 5).
Develop a process to evaluate in 2 years whether changes have had an impact on the health of Colorado's vulnerable populations and the number of uninsured.	The Commission recommends that Colorado direct the Value Authority to evaluate and report on the effectiveness of reforms, especially their impact on vulnerable populations and safety net health care providers (Recommendation 15e).

Chapter 9: Issues for Further Study

The Commission has identified the following issues that the General Assembly may need to study further as part of its consideration and implementation of the Commission's recommendations.

Individual Mandate

1. Should employers and providers be required to report to the state those employees and patients who are uninsured?

CoverColorado

2. If an individual enrolls in CoverColorado, does his/her entire family enroll?
3. What benefit packages will be offered in CoverColorado?

Basic benefit plans

4. Should plans be required to produce summaries of how their benefit packages compare with a reference benefit package?
5. What happens to employees and individuals who have expenses over Minimum Benefit Plan cap?

Restructure Medicaid and CHP+

6. What will be the trigger for accessing Medicaid wrap services under the new CHP+ benefit package?

Improve Medicaid/CHP+ outreach

7. How will local Medicaid match (from counties and local providers) for eligibility determination be maintained if eligibility is centralized?

Increase private coverage for Medicaid/CHP+

8. How can the Medicaid Health Insurance Buy-In program be improved?

Preventive care and wellness

9. How will first dollar coverage for prevention be assured in the different benefit packages?

Other issues

10. Should insurers, not providers, be required to collect co-pays and deductibles from patients?

Chapter 10: Minority Reports

Minority Report

Linda Gorman
R. Allan Jensen

January 2, 2008

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SECTION 1: Introduction

This document offers an alternative to the recommendations approved by the Colorado Blue Ribbon Commission for Health Care Reform (the 208 Commission or Commission) at its meeting on November 19, 2007. Its authors are among the Commissioners who voted against that set of recommendations. On November 7, 2007, the Commission passed a rule requiring any commissioner who wished to submit a minority report to vote against the entire package of recommendations. Although the authors voted against the entire package, they do agree with some of the recommendations contained in the set.

In general, the authors believe that the Commission recommendations view the private sector as the source of U.S. health care woes and an expansion of government control as the solution. The authors of this report have an opposite view. They believe that ill designed government interference has done positive harm to the development of the U.S. health care system over the last 80 years. As government programs have grown, they have begun to stress U.S. health care to the breaking point.

In short, government is the problem, not the solution. Significant health care reform requires a transformation of government policy, with the goal of lowering costs through deregulation and of aligning incentives by ensuring, to the largest extent possible, that individuals buying health care are not spending someone else's money.

One of the biggest problems in health care reform is that parties with different viewpoints do not agree on basic facts. Simple logic dictates that it is nearly impossible to agree upon a reform plan without agreement on what needs to be reformed, and a basic weakness in the overall 208 Commission process was the failure to establish an agreed upon body of basic facts. Without this factual basis, the Commission members often could not even agree upon the problems that needed to be addressed let alone on sensible solutions to them.

There are three main areas in which the Commission recommendations fall short. The first is that a vibrant free market for private health care and health insurance, one that offers responsible people a wide choice of health plans, physicians, and treatments, with a variety of ways to pay for each, should be the central part of any serious health care reform plan. Though some Commission recommendations mention consumer choice and market reform, other recommendations make such reforms impossible, too many of its recommendations would destroy or severely damage private health plans, private health insurance, and private medical care.

An unacceptable number of Commission recommendations simply mimic the salient control points in the 2006 Massachusetts health care reform legislation, along with the disastrous Massachusetts decision to imposing guaranteed issue and community rating on the individual insurance market in the early 1990s. Those regulations destroyed the Massachusetts individual insurance market and ultimately led to the adoption of the 2006 statute. Similar regulations had similar effects in other states, effectively destroying the individual insurance markets in New Jersey, Maine, Tennessee, Kentucky, New York, and Vermont. Their imposition in Colorado will cripple its individual market, increase health insurance costs for large numbers

of people, expand dependence on government programs, and retard innovation in health care delivery and coverage.

The second major area of disagreement is the Commission's neglect of promising developments in account-based consumer-directed health care initiatives and the decision to instead favor various mandated insurance programs directed or controlled by government. While there is considerable evidence that account-based consumer-directed programs reduce costs, there is no evidence that the Commission recommendations for government expansion programs decrease costs. There is, in fact, some evidence that such programs actually increase them.

The third area of disagreement is that the Commission recommendations substantially extend government control of medical practice without addressing compelling evidence that this has the potential to degrade care and increase costs. Though the Commission frequently asserts that its recommendations will lower costs, improve care, extend medical care to more people, or foster useful innovation, it does not provide adequate evidence to support its case. Cost estimates for the reform plans are likely understated because the model used to estimate costs was subject to a number of known problems. They are discussed further in Section 4.

It is the authors' view that any successful health care reform policy needs to address: 1) substantive reform of government programs, 2) incentives to reduce waste, and 3) the reduction of costly and unneeded administrative and regulatory burdens. These are the foci of the largest cost problems in the current health care delivery system. When the cost of health care drops, health insurance premiums drop and paying cash for care becomes possible. Paying cash further reduces costs by reducing third party payer overhead, with the result that more people can receive better health care for the same money.

The authors also believe that the organizational processes adopted by the Commission likely caused its decision making to suffer from moderate to severe anchoring, framing, and availability biases. The lack of structured fact finding, discussed in detail in Section 5.4, was an important contributor to these problems.

Report Format

The second section of this document summarizes the areas of agreement and dissent. The third section provides detailed explanations of the authors' reasons for dissenting. The fourth section discusses the organizational imperatives that impelled the Commission to produce recommendations with such a narrow view of health care reform and includes alternative recommendations for the operational structure of future Commissions. The fifth section provides recommendations for health care reform not endorsed by the Commission.

The authors would like to thank their colleagues on the Commission for the time they spent on Commission activities, their principled participation, and the education that they provided. The Commission consisted of twenty seven citizens with different backgrounds, experiences, and areas of expertise that provided a valuable resource.

The Commission staff was notable for its efficiency, knowledge, and good work in keeping Commission deliberations on track.

This report does not discuss all of the recommendations made by the Commission. It addresses the draft Commission recommendations adopted in the November 19, 2007 meeting. The final draft of all Commission recommendations was not available until 24 hours before the deadline for the submission of this minority report. Silence about a recommendation does not signify the authors' agreement with it. In the following discussion, comments about various numeric quantities do not refer to the estimates provided by the Lewin Group unless the fact that a given quantity is a Lewin estimate is specifically noted.

SECTION 2: Overview

2.1 Evaluative principles

The Commission itself promulgated a set of principles for guiding its discussions. They are discussed in Section 5. The authors used the following set of principles in assessing the package of Commission recommendations:

- Provide the most medical care to the largest number of people at the lowest possible cost.
- People should pay for their own medical care.
- If people cannot pay for their own medical care, taxpayers subsidize certain kinds of care.
- Market competition in the provision and financing of health care lowers costs.
- Lower costs are essential to ensuring that more people can pay for their own medical care.
- Choice is an American cultural imperative. An efficient health care system will respect this and ensure that people can choose their own health care and means of financing.
- Regulation increases costs and retards innovation. New regulations should be adopted only if they have been conclusively demonstrated to improve efficiency and further meaningful consumer choice. In general, a necessary but not sufficient requirement for meaningful consumer choice is that individuals control the funds used to pay for their health care.
- The failure of the government, at all levels, to properly fund Medicare and Medicare is unethical, and should be remedied before those programs are expanded or any additional government programs are adopted.

2.2. Areas of Agreement with Commission Recommendations

Areas of agreement with Commission recommendations are listed below. In general, these areas of agreement overlap individual Commission recommendations. They do not reflect the specific language adopted by the Commission and may be broader, or more narrow, than the specific recommendation adopted by the Commission. Where applicable, references to specific Commission recommendations are in parentheses. They refer to the document entitled "Summary of Approved Recommendations" dated November 19, 2007 that was downloaded from the Commission website on December 2, 2007. In some cases these recommendations were subsets of larger recommendations. Inclusion of a subset of a larger recommendation does not signify agreement with the rest of the recommendations in a particular category. The same is true of recommendations that refer to a major category heading. Agreement with a

major category heading does not imply agreement with the way that subsequent related recommendations interpret the major category.

2.2.1 Reform Medicaid

- Build on the success of the Consumer Directed Attendant support program in the Colorado Medicaid program.
- Study the Commission recommendations for specific Medicaid reforms contained in Appendix 7 of the Commission recommendations.
- Seriously study extensive Medicaid reform, including the possibility that Medicaid regulatory burdens are such that the state of Colorado could save enough by opting out of Medicaid to provide better health care for those dependent on it.[62]

2.2.2 Reduce overall health system administrative and regulatory burdens and costs (2.D.3)

2.2.3 Devolve the health care delivery system to consumer control. (2.E)

2.2.4 Eliminate uncompensated care by reforming existing government programs (2B, 2D2, 3W))

2.2.5 Eliminate laws preventing health insurance premiums from being adjusted to reward healthy behaviors

2.2.6 Minimize licensing barriers for medical practitioners

2.2.7 Support the appropriate use of information technology in health care (2.J)

2.2.8 Look for opportunities to duplicate successful local efforts that improve health care and lower cost. (2.O.)

2.3: Areas of Disagreement with Commission Recommendations

This section summarizes areas of disagreement with Commission recommendations. As noted above, these areas of disagreement overlap individual Commission recommendations. They do not reflect the specific language adopted by the Commission and may be broader, or narrower, than the specific recommendation adopted by the Commission. Extended discussions of the reasons for dissent are located in Section 3.

2.3.1 The Commission recommendations mandate that people to buy health insurance before anything else. This is an unethical policy recommendation.

[62] Readers should note that while the Commission discussed reforming Medicaid, it never discussed studying whether Colorado could improve care for current Medicaid recipients by dropping out of the program. The savings from not having to abide by Medicaid rules were roughly estimated for one Western state a decade or so ago. The estimate suggested that this option might be worthy of more careful study.

2.3.2 The Commission recommendations promote an increase in the bureaucratic control of health care. This will increase the cost of health care, denigrate individual health, and is contrary to the Commission's charge.

2.3.3 The Commission recommendations put care of the vulnerable at risk by altering the state's focus from caring for the vulnerable to requiring insurance for all, implementing wellness programs of dubious value, and controlling medical practice.

2.3.4 The Commission recommendations do not implement effective consumer directed account-based reforms. Innovative private and public programs have shown that consumer-directed account-based reforms significantly reduce cost, improve health, and motivate consumer education.

2.3.5 The Commission recommendations claim cost savings for programs that have not performed well when tested in the real world, or for which convincing evidence of performance is lacking.

2.3.6 The Commission recommendations would destroy the market for individual insurance in Colorado, eliminating low cost coverage that encourages thousands of satisfied families to take control of their own health care. It will also raise the costs for these Coloradans and severely restrict consumer choice.

2.3.7 The Commission recommendations treat different residents of Colorado differently. For example, not all residents would be subject to the individual insurance mandate.

2.3.8 The cost estimates for Commission recommendations are unreliable due to the assumptions behind the model used to estimate them and to the fact that the Commission did not take public choice theory into account when in developing recommendations aimed at minimizing cost.

2.3.9 The Commission recommendations would have government needlessly duplicate a number of functions already available in the private sector, thus increasing health care costs.

2.3.10 Because preferred health care arrangements will vary from person to person, and over time as innovation occurs, government should be neutral with respect to the choice between alternative methods of health care delivery and financing. The Commission recommendations support particular health care delivery systems and discriminate against cash payment.

2.3.11 The recommendations include payments by taxpayers to particular groups without adequate supporting evidence that such payments are the most valuable use of taxpayer funds.[63]

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[63] For example, the Commission recommends increasing payments to safety net providers, increasing payments to providers in health service shortage areas, and increasing funding for the public health system. Although health service shortage area sounds like an important designation, the HRSA website suggests that in addition to the rural parts of the state where one would think that health professionals might be in short supply, the criteria used to designate a HRSA are so broad that Colorado shortage areas include parts of Commerce City, Littleton, the Fort Lyon Correctional Facility, Denver, Colorado Springs, Arvada, and Englewood. http://hpsafind.hrsa.gov/HPSASearch.aspx as of December 11, 2007.

SECTION 3: A Detailed Critique of Certain Commission Recommendations

3.1 The Commission recommendations force people to buy health insurance before they buy anything else. This is unethical.

A lot of things can be more important than having health insurance, including buying food, paying for housing, having a job, and having reliable transportation to get to that job. The individual insurance mandate recommended by the Commission ignores this. It specifies that all legal Colorado residents will be required to purchase health insurance regardless of cost, and before meeting any of their other needs. Illegal residents of Colorado will be exempt from this requirement.

The recommendations contemplate requiring proof of coverage when registering for school, and getting or renewing a driver's license or car registration. People who cannot show proof of coverage will be fined a year's worth of premiums when they file their income taxes. By recommending that the power of the Colorado Department of Revenue and the Department of Motor Vehicles be used to enforce the requirement that people have health insurance, the Commission implicitly supports a significant increase in government control over individual decisions in normal household matters.

The philosophical issue of what constitutes minimal health insurance is likely to be a much larger problem than is commonly recognized. In Commission discussions, and in the reform plans presented to the Commission, there was a distinct split between those who favored the imposition of policies with low deductibles and low plan limits, policies like those that had $100 deductibles with a plan maximum of $50,000, and those who felt that individual mandates should be limited to policies designed to cover catastrophic events, generally those with deductibles of thousands of dollars and plan limits in the millions of dollars. Individual insurance needs vary with things like age, location, health status, wealth, income, medical care preferences, and propensity to travel. Commission recommendations do not take these individual differences into account.

Under Commission recommendations, an unelected, unaccountable, panel periodically reviews what the government will accept as a minimum health insurance policy. Benefits will be adjusted as needed. Legal Colorado residents will be required to pay for those minimum benefits whether or not they are a good value relative to other household needs. For example, the unelected panel might arbitrarily decide that the minimum benefit package should include dental care. At present, many people use cash to pay for their dental care. Paying for dental care via insurance is more expensive than paying cash— in addition to the dentist's charges, people who buy dental insurance must also pay for insurance company profit and overhead. Should the unaccountable panel decide that the minimum policy includes dental care, following the Commission recommendations would have increased the overall expenditure on dental care.

The Commission recommends that the minimum mandated health insurance policy have an average monthly premium of approximately $200. As a current scan of the available health insurance policies on ehealthinsurance.com for the Denver shows, policies offered in Colorado that meet that standard with a low deductible are temporary health coverage plans with

varying plan maximums and deductibles. Long-term major medical coverage at those prices has deductibles that rise with age, hovering at about $2,000 for a 47 year old man.

In view of the content of Commission discussions and of the progress of the debate over minimum coverage in the failing Massachusetts health reform plan, the imposition of an individual mandate will likely mean that thousands of Coloradans who currently have health insurance will find that their policies do not meet the minimum coverage requirement because their deductibles are deemed to be "too high." This decision will be made by a panel that has no idea of the incomes, assets, health status, or values of the policyholders.

From an individual's point of view, the Commission is also recommending a new tax. By forcing people to buy a product that they may not want at a price that they cannot control, the individual mandate functions as an unlimited tax for health insurance. It should at least be subject to a statewide vote for approval. The individual mandate may also violate the Commission's charge. It will likely increase the cost of health care for Colorado residents. People who currently get health care but have no insurance will be required to purchase insurance, thus increasing their costs. People who cannot purchase insurance because they are said to be unable to afford it will have to be subsidized to a larger extent than they are at present. Funding those subsidies will require tax increases that will raise costs for all Coloradans whether they be taxes on insurance premiums, provider taxes, sales taxes, taxes on food, or increases in the income tax.[64]

Because individual mandates are always coupled with subsidies to people judged to have too low an income to comply, enforcement of this provision, and the administration of the subsidies that make it possible, will require the collection of substantially more income data than is presently the case. Although the Massachusetts plan has been in operation only since April 1, 2006, it has already generated a 13 page Certificate of Exemption application that allows people to ask for permission to not purchase health insurance if they can demonstrate sufficient hardship. Among other things, hardship is defined as a notice of eviction, notice of utility shutoff, natural disaster or human caused event that causes large damage to you, your home, or your possessions, or you can establish that purchasing health insurance would have "caused you to experience serious deprivation of food, shelter, clothing or other necessities." In effect, the individual mandate in Massachusetts requires Massachusetts citizens to petition the government for relief whenever they suffer a serious financial reversal.

[64] The Lewin Group has presented a number of charts showing average family health spending by income group under various reform proposals. Usually the groups shown are incomplete and the numbers shown do not provide a picture of overall spending as they do not show how many families are in each group. They also do not include the economy-wide effects of various tax increases on jobs, business formation, and incomes. In slide 18 of a November 15th presentation, the effect on people with incomes below $50,000 was given for each $10,000 in income. For amounts above $50,000 the increments increased to $24,999 and then to $49,999. In 2004-2006, the Census Bureau put median household income in Colorado at $54,039. As the chart is restricted to averages between income groups, it is impossible to know what will happen to overall average spending. In the November 1 interim report by the Lewin Group reported that "About 70.4 percent of all Colorado families would see a net increase in health spending of $20 or more."

3.2 The Commission recommendations substitute bureaucratically ponderous government health programs for individual choice in health care arrangements. This will likely endanger health by limiting access and choice.

The Commission recommends that an unaccountable group study the "best scientific evidence to foster clinically, ethically, and culturally appropriate end-of-life care." It also recommends the establishment of the Orwellian-sounding "Improving Value in Health Care Authority" to "fundamentally realign incentives" in the Colorado health care system by regulating provider payment and determining acceptable treatment. These recommendations endanger Colorado citizens. Although the Commission recommendations state that the Authority should simply study end-of-life care and best practices, based on what has happened in other cases when these recommendations have been put into practice, the Authority will end up transferring control over medical care and practice from individual citizens and their doctors to unaccountable, unelected, regulatory authorities.

The potential for harm is made clear by the Commission recommendation to 'Pay providers based on quality, such as use of care guidelines, performance on quality measures, coordination of patient care, and use of health information technology.' While the Commission never defines quality, it is confident that the Authority will know it when it sees it. Physicians who do not do what the Authority demands will face financial harm. If what the Authority wants differs from what patients want, the Commission recommendations will give physicians an incentive not to act in the best interests of their patients The Commission has not discussed the possibility for harm in these regulations. Neither has it explained why it believes that an Authority will do a better job of aligning incentives than a program of deregulation that puts smart shoppers using their own money in charge of health care decisions, a system that has amply proven its ability to successfully align the incentives that producers face.

The pay for quality recommendation means that the Improving Value in Health Care Authority would end up using evidence-based measures to regulate physician behavior and, ultimately, medical practice. At present, physicians are free to disregard evidence-based recommendations that conflict with their experience in clinical practice or with their patients' wishes. Physician freedom of action is crucial to good medical care because it protects physicians and patients from researchers and regulators with an agenda, and from those whose values conflict with those of patients and doctors.

The U.S. National Heart Lung and Blood Institute's JNC 7 clinical guidelines for treating hypertension provide a recent example of how agenda driven research that can create seriously flawed evidence-based national guidelines with the potential to increase patient morbidity and mortality. The JNC 7 guidelines recommend starting all patients with high blood pressure on thiazide-type diuretics. In support of this, the express JNC 7 guideline for primary care physicians flatly states that "Thiazide-type diuretics have been the basis of antihypertensive therapy in most outcome trials. In these trials, including the recently published Antihypertensive and Lipid Lowering Treatment to Prevent Heart Attack Trial

(ALLHAT), diuretics have been virtually unsurpassed in preventing the cardiovascular complications of hypertension."[65]

This statement is grossly misleading. In fact, the ALLHAT study has been subjected to withering criticism and the JNC 7 guidelines are not widely agreed upon. In Britain, the National Institute for Health and Clinical Excellence recommends ACE inhibitors as the first choice for initial therapy in patients younger than 55. The JNC 7 guidelines also ignore evidence suggesting that treatment with diuretics may increase the risk of developing new-onset type 2 diabetes. Newer antihypertensive drugs appear to have a beneficial or neutral effect on the glucose and lipid metabolism.[66]

By combining evidence-based standards with the pay-for-performance rules as advocated by the Commission, the Improving Value in Health Care Authority might use the results from poorly designed clinical trials to pressure physicians to use less expensive, older, and less effective therapies regardless of their relatively poor side effect profiles or of their effect on individual patients. The Commission recommendations also set the stage for various methods of provider profiling, including hospital and physician report cards, two currently fashionable quality initiatives which have been shown to have serious technical problems. They also give physicians an incentive to deny care to people who are very ill. Seriously ill people pose higher risk for a poor outcome. The physician may decide that he is better off not risking the poor report card grade produced by treating riskier patients.[67]

When such power is concentrated in the hands of an unaccountable group that has no personal contact with those affected by its decisions, patients become mere costs. The usual results of such policies are severely restricted access to advanced therapies for those who have complex medical needs, or are disabled, chronically ill, or in need of advanced medical care. In the Netherlands, physician caused deaths are increasingly commonplace. The utilitarian ethic adopted by the Royal Dutch Medical Society has virtually eliminated any prosecution for physicians who kill the elderly, the mentally ill, or the disabled.[68]

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[65] *JNC 7 Express*, The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. National Heart, Lung and Blood Institute, National Institutes of Health, U.S. Department of Health and Human Services, p. 7. Online version accessed November 28, 2007. http://www.nhlbi.nih.gov/guidelines/hypertension/express.pdf

[66] There is a growing literature exploring possible relationships between treatment for high blood pressure and the onset of type 2 diabetes. For an example, see Kuti *et al.* April 23, 2007, "The development of new-onset type 2 diabetes association with choosing a calcium channel blocker compared to a diuretic or beta-blocker," *Curr Med Res Opin*; Stas *et al.* October 2006. "Metabolic safety of antihypertensive drugs: myth versus reality," *Curr Hypertens Rep.*

[67] For sample literature on the topic of problems with quality measurement and report cards see Hofer TP *et al.* June 9, 1999. "The unreliability of individual physician 'report cards' for assessing the costs and quality of care of a chronic disease," *JAMA*, 281(22): 2098-05; Sorokin R. 2000. "Alternative explanations for poor report card performance," *Eff Clin Pract. 3(3)*: 156; Shahian DM *et al.* March 27, 2007. "Comparison of clinical and administrative data sources for hospital coronary artery bypass graft surgery report cards," *Circulation*, 115(12):1508-10; Normand SL *et al.* Jan-Feb 2007. "Assessing the accuracy of hospital clinical performance measures," *Med Decis Making,* 27(1): 9-20; Epstein, AJ. August 2006. "Do cardiac surgery report cards reduce mortality? Assessing the evidence," *Med Care Res Rev.* 63(4); Krumhlolz, HM. March 13, 2002. "Evaluation of a consumer-oriented internet health care report card: the risk of quality ratings based on mortality data," *JAMA*, 287(10), 1277-87.

[68] For a general discussion of the Dutch experience see Ezekiel Emanuel. March 1997. "Whose Right to Die," *Atlantic Monthly.*

The importance of private sector benchmarking for government health programs was also ignored in Commission discussions.

3.3 The Commission recommendations will likely increase the cost to taxpayers of providing health care for people who cannot pay for their own health care.

3.3.1 The governing assumption of U.S. health care policy is that people who can afford health care should subsidize essential health care for those who cannot. In fairness, those who must pay for people who cannot pay for themselves deserve to have an efficient system for providing subsidized care, one that minimizes their costs. It should be noted that by international standards, virtually all competent people in the United States, regardless of their ability to pay, do get health care.

Because the Commission recommendations include individual health insurance mandates and those mandates require providing large subsidies to people judged unable to afford health insurance, it likely that they will end up increasing the cost of already existing government programs designed to ensure that those who cannot pay get essential health. It will do this, in part, by encouraging people who presently pay for their own health care to stop doing so.

Commission recommendations include subsidies for people with incomes up to 400% of the federal poverty level, $40,810 for a single person and $82,600 for a family of 4. This is higher than Colorado median incomes, which in 2006 were roughly $30,000 for households with no earners, $41,700 for households with 1 earner, and $77,000 for households with two earners. These policies have the potential to increase taxes on families who have employer health insurance but make $40,000 a year in order to subsidize families who make almost twice as much.

3.3.2 Even if users of Veterans Administration hospitals are counted as uninsured, studies suggest that the uninsured also pay for at least half of their own health care.[69] Expanding public programs to cover people who are already paying for their care will eliminate those payments. As health insurance is an expensive way to buy health care, it is possible that it may actually be less expensive to provide care under the existing mixture of public subsidies to providers and private charity than to provide care under the system that would be created by the Commission's recommendations. The Commission did not study alternatives to insurance coverage. It has not provided a compelling case that mandated health insurance buttressed by a large new bureaucracy dedicated to the control of insurance markets, medical practice, and extensive income redistribution is the lowest cost method of providing health care to those who need it but cannot pay.

[69]For an example of a case in which care provided by the Veterans Administration is counted as care for the uninsured, see Jack Hadley and John Holahan. February 12, 2003. "How Much Medical Care Do the Uninsured Use, And Who Pays For It?" *Health Affairs*, Web exclusive. The problem, of course, is that the Veterans Administration is not supposed to serve those who are not Veterans. The second problem is that people meeting the criteria for lifetime health care from the Veterans Administration might rationally consider themselves insured and would not purchase private policies or enroll in other public ones.

3.3.3 Contrary to popular belief, the uninsured use emergency rooms at about the same rate as the insured.[70] Generous estimates of the uncompensated care that the uninsured generate suggest that it is about 3 to 5 percent of private insurance premiums, which may be less than the revenue collection that has been proposed to finance the Commission recommendations. The 30 percent increase in private premiums that is widely bruited about as the additional premium cost for those who are insured includes the overcharges caused by Medicare and Medicaid. The Commission says that

In addition to reducing the number of uninsured Coloradans, an individual mandate would also reduce the premiums paid by those who are currently insured. This is due to the "cost shift" created when hospitals and other providers increase their rates to private insurance companies in order to cover the cost of care provided free or at reduced rates to the uninsured. Colorado health care providers gave $777 million in uncompensated care in 2007.[71]

The Lewin Group estimated that total Colorado health spending was about $30 billion. This means that the estimated cost of uncompensated hospital care for the uninsured is less than 3 percent of overall spending. In another context, the Lewin Group estimated that about 40 percent of the Colorado hospital shortfall is passed along to private payers. If correct, this would suggest that hospital care for the uninsured is about 1 percent of total spending. The reform proposal created by the Commission would increase health spending in Colorado by $2.7 billion, $854 million of which would come from an increase in personal income taxes.

It is not clear to what extent these estimates of the premium increase caused by a "cost shift" include the amounts of uncompensated care generated by care for those nominally insured under government programs like Medicare and Medicaid.[72] In Washington state, Milliman, Inc. estimated that the cost shift from Medicare and Medicaid to private payers was 14.3 percent of commercial hospital cost or about 4.8 percent of commercial premiums. With typical commercial health insurance premiums of $850 a month per family contract in 2004, the government program cost shift was about $490 a year. Physician underpayment by

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[70] For examples see Pines, JM and Buford, K. April 2006. "Predictors of frequent emergency department utilization in Southeastern Pennsylvania. *J Asthma*, 43, 3, pp 219-23; Sun, BC, Burstin, HR, and Brennan, TA. April 2003. "Predictors and outcomes of frequent emergency department users." *Acad Emerg Med.* 10, 4, 320-8; Hunt, KA *et al.* July 2006. "Characteristics of frequent users of emergency departments," *Ann Emerg Med.* 48, 1, 1-8; Fulda, KK and Immekus, R. July 2006. "Frequent users of Massachusetts emergency departments: a statewide analysis." *Ann Emerg Med.* 48,1,6-16; Cunningham PJ. 2006. "What accounts for differences in the use of hospital emergency departments across U.S. communities?", *Health Aff,* Sep-Oct; Zuckerman and Shen. 2004. "Characteristics of Occasional and Frequent Emergency Department Users: Do Insurance Coverage and Access to Care Matter?" *Med Care, Feb 42(2).* Urban Institute researchers Zuckerman and Shen concluded that "The uninsured do not use more [ER] visits than the insured population as is sometimes argued," they write. In fact "the publicly insured are overrepresented among [ER] users."

[71] The Lewin Group. Technical Assessment of Health Care Reform Proposals. Appendix B: Health Spending in Colorado. p B-30.

[72] In a personal communication with Commission staff, the Lewin Group cited a paper on physician pricing by Thomas Rice *et al.* as a source for its assumption that shortfalls in reimbursement were passed along to private payers in the form of higher hospital charges. As that paper discussed the effect of changes in Medicaid compensation changes on the volume of services provided this reference was apparently provided in error. The remainder of the communication simply said that "Our [Lewin's] own analysis of hospital data indicates that about 40 percent of the increase in hospital payment shortfalls (i.e., revenues minus costs) in public programs were passed on to private payers in the form of the cost-shift during the years studied. Based upon this research, we estimate that 40 percent of increases in reimbursement would be passed back to payers in the form of reduced charges."

government programs was higher.[73] By expanding Medicaid and Medicaid-like programs, the Commission recommendations run the risk of expanding uncompensated care, even with the higher Medicaid reimbursement rates recommended by the Commission. The Medicaid expansion will likely increase utilization and encourages people to substitute government payments for health care for their own payments for health care. TennCare, the Tennessee Medicaid expansion designed to insure everyone, also promised to reduce uncompensated care. Some years later, uncompensated care costs had increased. Tennessee abandoned the program after its costs threatened to bankrupt the state.

3.3.4 The Commission also failed to address losses that might arise from the disincentive to work created by the high marginal tax rate that people who receive subsidies will face as their incomes rise. People are free to make the choice between leisure and labor, between part-time work and full time work, between high paying jobs and jobs that pay less but are more congenial. By recommending such rich subsidies for health insurance the Commission may promote policies that increase the number of people who choose lower incomes in order to qualify for taxpayer supported programs. This appears to have been a particular problem with SCHIP/CHP+ where an estimated 6 out of 10 new enrollees drop private insurance to participate in the subsidized public program. The rate is higher as more of the family is made eligible for insurance coverage. And, contrary to Commission assertions that waiting periods can control crowd-out, Gruber finds that "the anti-crowd out efforts that have accompanied the SCHIP program have probably raised crowd-out more than lowering it."[74]

3.3.5 Finally, the Commission recommends that subsidies be provided to any household between 300 and 400 percent of the federal poverty level that cannot buy employer group insurance and spends more than 9% of its income on health insurance.[75] This means that any family of 4 with an income of $61,950 that spends more than $5,576 on health insurance, and any family of 4 with an income of $82,600 that pays more than $7,434 on health insurance, is eligible for subsidies. According to the 2006 Consumer Expenditure Survey, families in this income bracket spent 5.3 percent of their household incomes on entertainment, 4.3 percent of their incomes on cash contributions, 3.8 percent of their incomes on household furnishings and equipment, and 5.5 percent of their incomes on food away from home. In view of this spending pattern, meeting a 9 percent premium burden would not seem to be beyond the range of possibility for these households, and subsidizing them would seem to place an unfair burden on other taxpayers.

Focusing on the payments for health insurance discriminates against people who substitute cash savings for insurance, and only purchase health insurance that covers very large expenses. People who purchase a health insurance policy with a $10,000 deductible may never pay more than 9 percent of their incomes for health insurance but may very well have total health expenses that exceed 9 percent of income in one or two years every so often. Policies

[73] Will Fox and John Pickering. May 2006. *Payment Level Comparison Between Public Programs and Commercial Health Plans for Washington State Hospitals and Physicians.* Milliman, Inc.
https://www.premera.com/stellent/groups/public/documents/pdfs/dynwat%3B5724_15009501_3580.pdf

[74] Jonathan Gruber and Kosali Simon. January 2007. *Crowd-Out Ten Years Later:Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?* Working Paper No. 12858, National Bureau of Economic Research, Cambridge, Massachusetts. p. 28.

[75] 9 % was chosen because research suggests that 75% of people with incomes in the subsidy range considered spend 9 percent or less on health care.

that encourage the purchase of health care using third party payment and discriminate against cash payments increase the cost of health care by increasing administrative overhead.

Subsidies are likely to be more expensive than currently envisioned. One reason for the individual mandate is to limit the need for subsidies by requiring that everyone spend money on government defined health insurance. The fact that people who have low medical expenditures are exceptionally resistant to purchasing standard insurance policies should be an indicator that simply expanding the insurance model is a mistake unless regulators act to also lower economic costs. A substantial fraction of the uninsured simply feels that health insurance is a bad deal at current prices. Shifting that bad deal to taxpayers does little to change the cost/benefit situation.

Estimates of the price elasticity of demand for individual insurance, the percentage change in policies bought divided by the percentage change in price, range from -1.0 to -0.3, suggesting that a 10% increase in insurance premiums results in a 3 to 10 percent decline in the number of policies purchased. Those in poor families without access to group coverage and not eligible for public plans are least likely to purchase individual insurance regardless of subsidy. Married couples tend to be less affected by price increases, single people are more sensitive. Marquis et al. find that even substantial subsidies for individual insurance would "have modest effects on the number of uninsured."[76]

The Lewin Group uses an average price elasticity of -0.34 percent to estimate the price elasticity of the demand for health insurance to develop its estimates of coverage. Its estimate is derived from data from the Current Population Survey for 1987 to 1997. However, it goes on to say that it varies the elasticities that it uses by income. For those with incomes of $10,000 the income elasticity is assumed to be -0.55. For those with incomes of $100,000 the price elasticity is assumed to be -0.09.[77] While the Lewin assumptions may be among the most reasonable available, how accurately this application of elasticities mirrors actions in the real world is unknown.

In Wisconsin, a 2004 evaluation of the BadgerCare program speculated that "the mere perception of the premium [one equal to 3 percent of income for those with incomes over 150 percent of the federal poverty level] could be holding back applicants who would not be required to pay it."[78] Bundorf et al. find that the likelihood of purchasing health insurance increases with expected health expenditures, and that this effect is more likely to be observed in the large group market than in the individual market.[79] Bundorf reported that in 2002 the average employee payment for single coverage was $450—about the average expected health expenditure for a man 25-29 years old. "If the wage difference between jobs without [sic] and without health insurance reflects the average premium for coverage ($3,060 for single coverage in 2002), the reduction in wages associated with coverage may generate income effects for low

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[76] M. Susan Marquis, *et al*. October 2004. "Subsidies and the Demand for Individual Health Insurance in California," *Health Services Research*, 39(5), p. 1564.
[77] The Lewin Group. August 20, 2007. Technical Assessment of Health Care Reform Proposals, Proof Report. Prepared for the Colorado Blue Ribbon Commission for Health Care Reform, p. D 12.
[78]Chris Swart, Nina Troia, and Dorothy Ellegaard. July 2004. *BadgerCare Evaluation.* Evaluation Section, Office of Strategic Finance, Wisconsin Department of Health and Family Services, p. 54
[79] M. Kate Bundorf, Bradley Herring, Mark Pauly. September 2005. *Health Risk, Income, and the Purchase of Private Health Insurance,* National Bureau of Economics Working Paper No. 11677, Cambridge, Massachusetts.

income workers that make jobs with coverage unattractive relative to those without coverage." If people with the largest expected health costs are already insured, estimates of the savings from insuring the uninsured may be overstated.

For employer provided insurance, Gruber and Washington use results from the transition of U.S. federal employees to pre-tax health insurance premiums from 1991 to 2002 to estimate the effect of after tax price on insurance takeup and plan choice. They find that lower premium shares led people to choose more expensive plans but had little effect on overall plan choice. The authors point out that targeting people who are already offered employer subsidized insurance but refuse it is very costly because the fact that these people have already turned down a highly subsidized produce means that they are exceptionally price sensitive or already have insurance from another source. They estimated that the federal government spent between $31,000 and $83,000 per person who was newly insured.[80] This conclusion is roughly in line with the results in Maine, where the DirigoChoice program spends almost $16,000 in taxpayer funds to insure one additional uninsured person.[81]

Economic theory predicts that people with smaller medical expenditures would be more sensitive to the price of health insurance than those with larger, and less discretionary, medical expenditures. Empirical research produces some support for this supposition, suggesting that individuals self-select into insured or uninsured status depending on their knowledge of their individual health. The result is that the uninsured are not an isolated population subgroup, and to make sure that the majority of people have health insurance it is necessary to change behavior at relatively high levels of the income distribution.

There is little evidence that insurers act to "cherry pick" and sort across plans, suggesting that worries about adverse selection in insurance markets are likely exaggerated. This means that the regulatory schemes proposed to correct the problem, mainly guaranteed issue and community rating, are unnecessary and likely do more harm than good.[82]

The other problem with subsidies is that means tested subsidies have the potential to be extremely unfair and create a disincentive to act responsibly. For example, if the Commission recommendations are followed, the State of Colorado could end up taxing a young married couple with employer provided health insurance, a baby, and an income of $25,000 to provide health insurance subsidies to an older married couple with substantial home equity and retirement savings, with three children, an annual income of $68,000, and a business that does not provide health insurance.

In order to provide more health care for all at a lower cost, other options than the comprehensive insurance model—subsidized clinics, designated hospitals to which those who

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[80] Jonathan Gruber and Ebonya Washington. March 2003. *Subsidies to Employee Health Insurance Premiums and the Health Insurance Market,* Working paper No. 9567, National Bureau of Economic Research, Cambridge, Massachusetts.
[81] Tarren Bragdon. January 30, 2006. "Eight Challenges for Dirigo Health in 2006." *DirigoWatch*, 3(1), Maine Heritage Policy Center, Portland, Maine.
[82] Patrick Bajari, Han Hone, and Ahmed Khwaja. August 2006. *Moral Hazard, Adverse Selection and health expenditures: A Semiparametric Analysis.* Working Paper No. 12445, National Bureau of Economic Research, Cambridge, Massachusetts; M. Susan Marquis and Melinda Beeuwkes Buntin. October 2006. "How Much Risk Pooling Is There in the Individual Insurance Market?," *Health Services Research*, 41(5), 1782-1800.

cannot pay can be transferred, removing the regulations that discourage physicians from participating in charitable activities and charitable organizations from operating them, insurance plans that provide small benefits for low cost and insurance plans that offer catastrophic benefits—need to be explored and evaluated.

3.4 The Commission recommendations divert focus from the efficient use of Medicaid dollars in caring for the vulnerable.

Because tax supported health programs essentially consist of telling law abiding citizens that they should "either hand over the money for someone else's health care or face punishment," government has a responsibility to ensure that tax dollars flow to those who are most in need of other people's support.

Historically, tax supported health care programs have focused on two areas: public health programs to limit environmental health hazards, the spread of infection, and communicable diseases, and public programs providing individual care for people who were unable to provide it for themselves, primarily children, the frail and impoverished elderly, people with grievous injuries or diseases, and people with severe birth defects or developmental disabilities.

There is a finite amount of tax money available for subsidizing health care. In our view, the Commission recommendations would divert substantial resources to areas in which state government has little prior experience and, in some cases, a poor record of success. These include extensive record keeping on large numbers of complex transactions for every individual in the state, developing and deploying effective information technology architectures that are new and untested, developing new regulations for every area of medical practice, developing and promoting wellness initiatives of dubious merit, vastly expanding means testing for subsidies, enforcing the health insurance mandate, and doing extensive systems design research.

Tax money spent on these initiatives is tax money not available for projects to ameliorate the conditions of those with serious disease or disability. This is of particular concern in view of the fact that many of the people who testified before the Commission were concerned about the inadequate care being given by existing public subsidy systems.

3.5 The Commission recommendations virtually ignore consumer-directed account-based reforms. These have been shown to significantly reduce costs, improve wellness, and motivate education.

For the purposes of this discussion, consumer-directed accounts should be understood to be sums of money that people control, benefit from, and can spend at will on certain broadly designated categories. In health care, they are usually combined with health insurance policies that have lower premiums and deductibles of at least $1,100. If people save money on health care, savings accumulate in their health savings account. Health Savings Account (HSA) balances belong absolutely to the person who owns them, accrue interest tax free, and can be spent on any medical expense recognized by the Internal Revenue Service. HSA balances can be willed to beneficiaries. After age sixty-five, funds can be used for other purposes. Health Reimbursement Accounts are not owned by individuals and amounts in them may be lost

when an individual changes employers. Health care reforms that arbitrarily limit financing choices to a few, governmentally approved, options are not consumer-directed.

With the exception of the Medicaid reform recommendation that would create consumer-directed account-based program for purchasing supplies like adult diapers, the Commission recommendations do not promote any of the consumer-directed private or public sector initiatives that have been reducing costs and improving health in both the public and private sectors since the late 1990s.

The use of consumer-directed health savings accounts (HSAs) coupled with high deductible health insurance policies (HSA/HDHP) has grown rapidly since their inception in December 2003. There were 1 million HSA/HDHP accounts open by March 2005. The number had risen to 4.5 million by January 2007. Projections recently released by AHIP forecast that the use of HSAs will double in the coming year, and that the use of all consumer-directed products will more than triple. In employer sponsored plans, the Mercer National Survey of Employer-Sponsored Health Plans suggests that enrollment in consumer-direct health plans has risen to 5% of all employees. The 2007 average cost per employee for HSA plans is $5,679, roughly $700 less than the average $6,644 cost for PPOs with deductibles of at least $1,000. Mercer comments that this "lends support to the theory that the account feature encourages more careful health spending."[83]

Private insurers have already begun to increase coverage and lower costs using consumer-directed account-based products. The lower premiums associated with the HSA/HDHP policies have helped to reduce the number of insured: an estimated twenty-seven percent of the 1 million people covered by individual HSA/HDHP policies in force by January 2007 previously had no health insurance. They are particularly appealing to the young: 39 percent of the people covered by HSA/HDHP policies are under age 29. Disease management is offered with over 80 percent of the policies, covering conditions such as diabetes, coronary artery disease, congestive heart failure, asthma, and chronic obstructive pulmonary disease. Over 85 percent of the companies writing HSA policies offered health education information, information on physicians, hospital-specific quality data, and health care cost information. Seventy-two percent offered online personal health records. Policies that are owned by individuals are portable from job to job and, if purchased from a national company, are often portable when someone moves within the United States.

Consumer-directed account-based reforms also have reduced costs and improved health for disabled Medicaid participants. The Colorado Consumer Directed Attendant Support Program has improved health while saving 20 percent or more on attendants for the disabled simply by freeing those in the program from Medicaid regulation. The flexibility that the Robert Wood Johnson Foundation's Cash & Counseling accounts have brought to Medicaid spending have also unambiguously increased access to needed services and reduced unmet needs.

Results from private sector employers like Wendy's, John Deere, and Whole Foods suggest that in addition to reducing costs, account-based consumer-directed health insurance increases

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[83] Mercer Group. November 19, 2007. *U.S. employers' health benefit cost continues to rise at twice inflation rate, Mercer survey finds.* http://www.mercer.com/referencecontent.jhtml?idContent=1287790

the use of preventive care. Reports from other employers indicate that people covered by consumer-directed accounts are more compliant in their use of recommended medications and more active in disease management programs.

A recent paper by Greg Scandlen reviews the evidence on consumer-directed account-based health care reform and considers whether consumer-directed insurance has lived up to initial predictions. It concludes that initial indications suggest that account-based insurance is changing patient behavior by reducing the demand for unnecessary services, encouraging higher compliance with treatment recommendations, and increasing the use of preventive care. The rate of increase in costs for users of the account-based plans has decreased substantially. There are early indicators that account users are fueling a transformation of service delivery.[84]

It should be noted that discussions at Commission meetings suggested that a number of Commissioners are hostile to the continued use of HSA/HDHP policies. Enacting a number of the Commission recommendations, including those on guaranteed issue, community rating, a ban on medically underwritten policies, and the specification of a minimum benefit policy for all Coloradans, would likely eliminate or severely restrict the availability, and benefits from, HSA/HDHP policies currently in force in Colorado.

The Commission's animus towards consumer-directed solutions is reflected by the fact that the Commission voted to recommend that the legislature study the possibility of imposing complete government control over all Colorado health care via the imposition of a single payer system. On the same day, it defeated a motion to recommend that the legislature also study the possibility of using account-based consumer-directed health care reforms in health care reform.

If the experience in New York, Maine, New Jersey, Tennessee, and Massachusetts are any guide, the enactment of Commission recommendations to impose guaranteed issue and community rating will severely damage the individual insurance market, stop the consumer-directed insurance market in its tracks, stifle important health care innovations, and lessen competition among insurers. This could expand the number of people who are either uninsured or dependent on government for health coverage.

Expanding the number of people on government programs could be costly if they are removed from innovative private programs designed to manage chronic health conditions. In Colorado, Aetna's migraine headache management program reduced MRI use, increased the use of appropriate medications, and improved the quality of life for migraine suffers. Great-West's oncology management program reduced the rate of hospital readmissions by 17 percent by hiring nurse managers to help patients cope with treatment. Rocky Mountain Health Plans developed a diabetes management program that combined pay-for-performance measures with case management fees. It improved the percentage of diabetic members with good blood pressure control, and increased the number of members with acceptable LDL-cholesterol levels. The Kaiser Permanente ALL program has pharmacists call all members with diabetes or coronary artery disease to ensure that they are taking all of the medication that

[84] Greg Scandlen. November 2007. *Working as Intended: What We Have Learned About Consumer Driven Health Care.* Consumers for health care Choices, Hagerstown, MD.

they should. Humana analyzes monthly data on claims to ascertain whether people might benefit from its personal nurse coaching service.[85]

Judging from the extent to which Commission recommendations would require government to develop programs already in development in the private sector, it is not clear that the Commission was aware of the innovations occurring in private insurance. It is also not clear that the Commission fully appreciated the extent to which the internet, coupled with the consumer-directed health insurance revolution, has simplified comparing, pricing, and purchasing a health insurance policy.

3.6 The Commission recommendations assume cost savings for programs that have not been tested, and that have been tested but have not performed well in the real world.

Although the Commission asserts that centralized electronic medical records will cut costs, evidence supporting this assertion is lacking. In general, it did not systematically study the costs and benefits of its information technology mandates or assess the existing evidence on whether a statewide reporting system would be a sensible use of health care dollars. Had it done so, it would likely have been compelled to note that such data systems have yet to prove themselves in practice.[86]

The evidence to date suggests that electronic medical records will increase the risk of misuse of individual health information. Identity theft is already common. New criminal uses of individual health information include using someone else's name to get expensive health care services and attempting to extort money from employers by threatening to publish patient records, a breach that could lead to serious penalties for being in violation of HIPAA.

Electronic records also increase the risk to state taxpayers, who could be liable for damages caused by stolen or misused records. The Veterans Administration, long praised for its electronic records, has repeatedly lost sensitive data on millions of patients and has spent tens of millions of dollars repairing the damage caused by such thefts.[87,88]

Although popular mythology assumes that electronic records will reduce cost, the evidence from hospital based systems is mixed. Hospital based computerized order entry systems for prescription drugs do appear to reduce medication prescribing errors at the possible cost of increased workloads and decreases in human vigilance against error. Experts fear that this combination may harm patients in situations when rapid treatment is essential. There are scant data on whether electronic prescribing records improve health outcomes, and a small but growing literature on the new kinds of errors that they facilitate. [89]

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[85] America's Health Insurance Plans. March 2007. *Innovations in Chronic Care: A New Generation of Initiatives to Improve America's Health.*

[86] Evidence on the effectiveness of electronic health records in improving care differs. Crosson *et al.* 2007. "Electronic medical records and diabetes quality of care: results from a sample of family medicine practices," *Annals of Family Medicine,* found that practices not using electronic medical records were more likely to meet their standards for high quality care.

[87] FierceHealthIT. June 17, 2007, "VA could spend $20M on data breach response," http://www.fiercehealthit.com/story/va-could-spend-20m-on-data-breach-response/2007-06-18

[88] http://www.aao.org/publications/eyenet/200402/news.cfm

[89] For an example, see Koppel *et al.* 2005. "Role of computerized physician order entry systems in facilitating medication errors," *JAMA*, 293(10).

Other problems with electronic records that the Commission did not address before issuing its recommendations include how to control error propagation, and the lack of correspondence between clinical and administrative records. Medical records contain errors, and those errors are neither reduced nor corrected by computerizing them. A November 21, 2007 article from the AP described the errors that physicians found in their own medical records.[90] Under HIPAA, there is no requirement that those who maintain health records be required to correct them. There are important questions about who should have the authority to alter electronic patient records. Data system robustness is a concern. There are also studies that have found that the records themselves change behavior. In the Veteran's Administration system, a significant number of patient records have case notes that are electronically copied from one record to another in order to save time.

A final problem is that the drive to use patient records for billing and monitoring may degrade their usefulness in patient care. Patient records were originally developed to help clinicians provide care. If administrators insist on standardizing them in order to use them for process control and provider evaluation it is likely that clinicians will respond by not keeping notes that can be used against them. In Britain, hospital trusts have "adjusted" patient records in order to suggest that patients had been treated on time. [91] In the U.S., physicians already keep multiple sets of records. One is in the format demanded by payers like Medicare. The other may be private notes that suit a physician's personal style and helps him facilitate patient care.

3.7 The Commission recommends extending guaranteed issue and community rating to the individual insurance market. These recommendations have increased costs and reduced coverage in the other states in which they have been applied.

3.7.1 As the Commission deliberated, all manner of claims were made about the cost of individual health insurance in Colorado. Many of them are incorrect. As there are a number of websites that give basic information on this, there is little reason for not knowing basic facts. One of those facts is that the Massachusetts Connector Authority is now quoting individual insurance prices that are higher than those currently prevailing in Colorado. This is illustrated by the representative premiums given in the table below. Massachusetts is the real world outcome of the Commission recommendations for an individual mandate and guaranteed issue and community rating in all insurance markets.

The Commission recommends guaranteed issue for all health insurers operating in Colorado. It apparently believes that by requiring applicants with specified pre-existing conditions to enroll in Cover Colorado, the state's guaranteed issue plan for individuals, a "cushion" will be created that will offset the increased cost of making everyone who already has insurance pay the bills for any person who knows he will have high medical expenses and wishes to buy an insurance policy to pay his bills.

In fact, individual insurance underwriters currently have three options: accept an individual application as applied for, decline the application, or accept it with conditions, such as waivers and ratings. They already charge higher prices for higher risks. People with specified pre-

[90] http://ap.google.com/article/ALeqM5jophmSjTNwlCyvhfctYIJbcrht0AD8T288Q07
[91] BBC, December 19, 2001. "Crackdown on waiting-list 'fiddles,'"
http://opinionjournal.com/editorial/feature.html?id=95000390

existing conditions are already covered by Cover Colorado. This means that there is no particular reason to believe that the Commission plan will create premium stability. And every reason, based on experience in other states, to believe that premiums will rise significantly.

A Comparison of Massachusetts and Colorado Monthly Health Insurance Premiums (as quoted to insurance brokers the week of December 3, 2007)				
	Colorado individual market (zip: 80222)	Cover Colorado guaranteed issue	Massachusetts (zip: 02101) Guaranteed issue	
10 year old child	$102.00	$125.30	$193.81	$2,000 deductible
40 year old man	$172.00	$250.18	$246.10	$2,000 deductible

3.7.2 The Massachusetts plan penalizes the parents of the healthy children, and people who purchase health insurance before they get sick. This is inefficient and unfair. It raises the rates paid by the vast majority of people. In doing so, it discourages the purchase of private insurance coverage, especially in lower income brackets where people are especially sensitive to premium price increases.

Colorado achieves guaranteed issue for all, but does it by directly subsidizing insurance for the uninsurable and letting those who act responsibly save by purchasing medically underwritten insurance in a market with far more flexible pricing. Rather than supporting a bureaucracy to control all health insurers, Colorado efficiently uses taxes to support a far more limited bureaucracy that focuses on providing coverage to thousands of Colorado residents who cannot purchase health insurance due to pre-existing conditions. In short, it achieves the Massachusetts result of making insurance available for everyone, and does so at a lower cost.

3.7.3 Recommending the extension of community rating and guaranteed issue to Colorado's individual insurance market is also irresponsible in view of the agreement that it will increase cost and reduce access to insurance. The academic literature on this is clear: guaranteed issue and community rating increase costs and decrease coverage. Examples of statements from the literature include: "States limiting risk rating in individual insurance display lower premiums for high risks than other states, but such rate regulation leads to an increase in the total number of uninsured people;"[92] "only small changes in risk pooling because the extent of pooling in the absence of regulation is substantial;"[93] such regulations "have succeeded only in making individual health insurance coverage more expensive and less available than it otherwise would have been;"[94] "individual health insurance markets deteriorated after the introduction of GI and CR reforms…premium rates tended to increase, sometimes dramatically. We did not observe any significant decreases in the level of uninsured persons."[95]

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[92] Mark V. Pauly and Bradley Herring. May/June 2007. "Risk Pooling and Regulation: Policy and Reality in Today's Individual Health Insurance Market," *Health Affairs*, 26(3), 770-779.
[93] Bradley Herring and Mark V. Pauly. August 2006. *The Effect of State Community Rating Regulations on Premiums and Coverage in the Individual Health Insurance Market,* Working Paper No. 12504, National Bureau of Economic Research.
[94] Conrad F. Meier. 2005. *Destroying Insurance Markets.* The Heartland Institute, Chicago, Illinois.
[95] Leigh Wachenheim and Hans Leida. August 2007. *The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets.* Milliman, Inc. Brookline, Wisconsin.

Recommendations known to increase costs and reduce coverage are not in accord with the Commission's legislative charge.

3.8 The Commission recommends replicating a Massachusetts Style Connector in Colorado. This is unnecessary as it duplicates existing private systems and is very costly.

A good deal has been written about Connectors ever since Massachusetts incorporated the concept into its reform measures. A recent academic analysis by Schneider, et al., of the Health Economics Consulting Group (Aug 2007) allows that the "connector" concept, as a proposed mechanism of moving commercial health insurance market away from an employer-sponsored to an individually based environment holds certain "intuitive appeal." However, they note that there are numerous trade offs and consequences, which prevent such programs from accomplishing their goals.

The information centralization function envisioned by these programs is an unnecessary and costly addition to the administrative costs of the health care coverage system. In fact, well developed mechanisms already exist to offer consumers the opportunity to search for and compare various health coverages. Various internet and insurance carrier websites provide complete coverage descriptions and allow coverage comparisons. Government publications in various forms explain health insurance. As is the case in other markets selling complex financial products, agents provide significant amounts of consumer education, act as ombudsmen to intervene with insurers on behalf of clients, and provide a check on insurer quality by refusing to market plans that treat customers poorly.

Other problems with connectors include:

- Displacement of existing coverage which may stress remaining risk pools
- Legal issues including ERISA, the implications of using the Section 125 provisions of the IRS code, HIPAA and COBRA 1985, list billing and guaranteed issue
- Loss of product innovation and choice
- Disproportionate risk and premium cost increases due to adverse selection whether risk pools are voluntary or mandatory
- Fairness in the allocation of risk and financial burden

Connectors are not inexpensive. In 2006, the Massachusetts Connector Authority estimated that its expenses of $24 million in 2007 would be rising to $36 million in 2009.[96]

It is not clear that the Commission was aware of these costs, and of the other issues cited, when it made its recommendation to create a Connector agency.

[96] Commonwealth Health Insurance Connector Authority. December 14, 2006. *Plan of Operations: Three Year Financial Plan/Budget.*

SECTION 4: Assessing Commission Cost Projections

4.1 Modeling Overview

The Commission hired the Lewin Group to model its health reform proposals. The Lewin Group has developed a specialty model that looks at health spending with a 1990s perspective and can be adapted to various front end conditions with the creation of a synthetic population. In its June meeting, the Commission listened to a presentation of the baseline estimates developed using the Lewin model. Commissioners immediately began to view Lewin as an expert source of policy information. This effect was so pronounced that it can be fairly reported that the choices of which proposals to send forward for modeling were based on the briefing received from Lewin.

The numbers developed by Lewin are those against which health care reform proposal modeling forecasts will be compared. At the outset, the Lewin group warned the Commission that it could not model the broader, long-term, economic impacts of various health reforms on such things as earnings or job losses. It also warned that it could not forecast the health care shortages or waiting lists that might be created by various reforms.

Since relatively little is actually known about health insurance and health spending in the Colorado population, the Lewin model creates a synthetic population based on some known facts about the Colorado population and puts that population through its paces based on its general assumptions on how various population segments will change their behavior in response to different policy requirements.

If the synthetic population is accurate, and assumptions about costs and individual behavior in response to change are accurate, then modeling results may be accurate predictions of future results. It should be noted that the baseline estimates made for Colorado appear to make a number of choices that may overstate the population of the uninsured. (See 4.2.2)

For a sense of the errors that can be introduced in modeling, and why models must always be thoroughly checked against common sense and the real world, the following discussion outlines some of the issues raised by Lewin documents describing the development of the Commission's baseline estimates, the modeling estimates against which estimated outcomes for the selected reform plans will be compared.
Like any other model, the one used by the Lewin Group has strengths and weaknesses and the cost and benefit estimates produced by it must be placed in proper perspective.

For policy purposes, the Lewin estimates share three important limitations with almost all other models. Although they provide valuable information about how policy changes might interact, their applicability to the real world is limited for the following reasons:

1) Model estimates reflect conditions at a specific time and generally assume instant adjustment to new conditions. The long-term effects of some proposed actions cannot be considered, nor can cost estimates account for changes that might occur over time. These might include significant price changes that increase or decrease the costs of specific policies. This makes the models much less reliable for cost predictions in the mid or long-term, than the short term.

2) The cost projections assume that every aspect of a proposal is put into place at the same time. The cost estimates do not apply to policies that are implemented a piece at a time.
3) Lewin informed the Commission at the outset that it could not model shortages created by inappropriate pricing. It also does not model broader economic effects such as the effect of tax increases on employment and earnings.

4.2 Specific Shortcomings

4.2.1 The administrative costs assumed for private insurers are too high.

In one case, a Lewin presenter said that the administrative costs for individual insurance products were as high as 44 percent. The administrative costs more commonly cited in Lewin written materials were in the range of 34 to 35 percent based on data from the Department of Insurance. Administrative data typically view administrative costs as the difference between revenues received and benefits paid. In this formulation everything that is not a benefit payment is an administrative cost. This includes profits, programs that generate savings on health care (and therefore reduce benefit payments), and fraud control that reduces benefits payments. For individual policies, all administrative functions are included in the premiums. For employer group policies, the difference between premiums and benefits payments would not include all of the additional human resources costs that companies incur to run their insurance plans. The authors of this report contacted 12 insurance carriers during the preparation of this minority report. They said their administrative costs for individual policies ranged from 15 to 23 percent.[97]

4.2.2 Data limitations make the model rely on small samples that may or may not represent Colorado

The detailed estimates of Colorado health spending and insurance coverage depend on 2004 Medical Expenditure Panel Survey (MEPS) data. When the MEPS sample was redesigned in 2004, MEPS expected roughly 560 responses from Coloradans in the private sector. No one knows how those 560 people would self-select for participation. Perhaps they are more likely to have time on their hands because they are in poor health and miss more days of work or work less, perhaps not.

As the small number of Colorado MEPS survey participants provides severely limited information about conditions in Colorado, the Commission model creates a baseline Colorado population using MEPS estimates for the western United States. These MEPS estimates are used to estimate household spending, spending by military personnel and veterans, out-of-pocket spending, the cost of employer sponsored insurance, retiree premiums for employer provided insurance, and spending on state and local government employees. The Western United States includes California.

Although Lewin used generally accepted methods to account for Colorado characteristics by weighting the Western United States results, the weights chosen may not accurately reflect differences in the use of health care. For example, Lewin weighted the MEPS results to account for the fact that the California population is 25% Hispanic while the Colorado is only 18%

[97] Allan Jensen, personal communication.

Hispanic. But simply being Hispanic is a crude measure of health care utilization. For example, for those over 35 years old, the diabetes related mortality rate varies from 251 per 100,000 Mexican Americans, to 204 per 100,000 for Puerto Ricans, and 101 per 100,000 for Cuban Americans,[98] asthma prevalence varies from 13.2 percent for Mexican Americans to 23.0 percent for Cuban Americans,[99] birth rates range from 105.1 births per 1,000 women of Mexican origin to 49.3 per 1,000 for Cuban women,[100] and Hispanic immunization rates vary by area or origin.[101] Absent other controls, it would also not account for the large difference in public program participation between those who have recently moved to the United States and those who have been in the U.S. for several generations.[102]

4.2.3 The method chosen to estimate the number of uninsured likely produces overestimates.

Lewin bases its estimates for the number of uninsured in Colorado on the March Current Population Survey (CPS), pooled from 2004 to 2006 to provide a bigger sample size. For a variety of technical reasons, it is generally agreed that the CPS overestimates the number of uninsured, in part because respondents appear to report their insurance status at the moment they are questioned rather than for the whole year. [103] The differences between CPS estimates and those of other surveys can be large.

A 2004 comparison of CPS estimates with those from the Survey of Income and Program Participation (SIPP) found that the CPS estimate of the uninsured was 8 percent higher than the SIPP estimate. [104] In 1998, the Wisconsin Family Health Survey estimated that 4 percent of Wisconsin residents were uninsured for an entire year. The CPS estimate for that year was 11.8 percent. [105] Wisconsin believes that the Family Health Survey is more accurate. To estimate the baseline estimate of Colorado uninsured, the Lewin model took the CPS estimates and combined them with Colorado Medicaid enrollment data to estimate the "real" number of uninsured.

It then reduced the number of Colorado uninsured from 758,800 to 562,800 people to account for the Medicaid undercount associated with the CPS. Saying that it "estimates that there were

[98] Smith CA, Barnett E. Dec 2005. "Diabetes-related mortality among Mexican Americans, Puerto Ricans, and Cuban Americans in the United States," *Rev Panam Salud Publica*, 18(6);

[99] Davis AM *et al.* August 2006. "Asthma prevalence in Hispanic and Asian American ethnic subgroups: Results from the California Healthy Kids Survey," *Pediatrics*, 118(2).

[100] Sutton PD and Mathews TJ. May 2006. "Birth and fertility rates for states by Hispanic origin subgroups: United States, 1990 and 2000." *Vital Health Stat 21.*

[101] Herrera GA, *et al.* May 2001. "Variation in vaccination coverage among children of Hispanic ancestry." *Am J. Prev Med.*

[102] For example, see Borjas GJ and Hilton L. May 1996. "Immigration and the Welfare State: Immigrant Participation in Means-Tested Entitlement Programs," *Q J Economics*, 111(2).

[103] For an example of the literature on this topic see Cathi M. Callahan and James W. Mays. March 31, 2005. *Estimating the Number of Individuals in the United States Without Health Insurance.* Working paper for the Department of Health and Human Services, online version accessed December 10, 2006, http://aspe.hhs.gov/health/Reports/05/est-uninsured/report.pdf.

[104] Shailesh Bhandari. June 8, 2004. *People with Health Insurance: A Comparison of Estimates from Two Surveys,* Report No. 243, The Survey of Income and Program Participation, U.S. Census Bureau. Online version, assessed July 10, 2007. http://www.sipp.census.gov/sipp/workpapr/wp243.pdf

[105] Catherine A. Frey. March 2000. "Wisconsin's Uninsured Population:How Low—4% or 11.8%?" Population Health Institute, University of Wisconsin, 1,1. Online edition, assessed July 11, 2007. http://www.pophealth.wisc.edu/UWPHI/publications/briefs/march00brief.htm

another 506,800 people who were uninsured for part of year [sic]," Lewin added this to its estimate of 562,800 to arrive at a figure of 1,069,000 people uninsured at any point in the year. Further calculations provide an estimate of 785,200 people uninsured in any given month, 17.2 percent of the Colorado population.

The effort to number the uninsured on a monthly basis is a result of the fact that Medicaid enrollment is reported a month at a time. But someone who is uninsured for a month or two in a year does not face the same difficulties as someone who is uninsured due to chronic illness. Judging policy by the elimination of everyone who was ever uninsured may distort policy, leading people to favor expensive measures to take care of large groups when in fact a much smaller group is in real need of assistance. Obviously more people will be uninsured in any given month than over an entire year. It also makes comparisons subject to error introduced by various adjustments—other data used in the baseline estimates, like that from MEPS and the employer surveys, are on an annual footing. As a check, note that the 2005 CPS estimate for the uninsured in Colorado for 2003-2005 was 16.6 percent ± 1 percent.[106]

4.2.3 Odd assumptions about administrative costs almost certainly overstate the administrative cost savings from centralizing control.

The Lewin model makes various assumptions about cost allocations. These depend heavily on assumptions about administrative costs. For example, 13 percent of total hospital costs are attributed to administration, a number arrived at based on conversations with the hospital industry. To allocate facilities costs to administrative and non-administrative functions, the baseline numbers allocate 13 percent of all expenses for plant maintenance, housekeeping, depreciation, and leasing and rental expense to administrative costs.

The physician administrative costs used in the Lewin model are based on a survey of 335 physician practices conducted by the Medical Group Management Association. The survey is voluntary. Most of those who fill it out are members of the MGMA. Typical MGMA members are specialty groups of 3 or more physicians. The MGMA provided one of the speakers invited to address the Commission. It sells software and a variety of other services.

4.2.3.1 Lewin documents suggest that it used a subset of the 335 responses in developing baseline numbers for the Commission. Its June 15 report to the Commission says "We used the distribution of operating costs for non-hospital or IDS (Integrated Direct Service) multi-specialty practices" in the Western region. Based on whatever those cost numbers were, Lewin assumed that 10 percent of nurses' time was administrative. Physician administrative expense was arrived at by "allocating costs to expense categories not directly attributable to providing patient care." The document also says that "Building and furniture expenditures were attributed to administrative functions in proportion to the allocation of other physician costs to administrative functions (approximately 35 percent)." So, if a physician rents an office to see patients, 35 percent of his rent is allocated to administrative costs. Other examples of physician costs attributed to administration in developing the Commission baseline data include medical record costs, employee staff benefits, general administration, information technology expenses, expenses for furniture, housekeeping, and insurance premiums.

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[106]U.S. Census Bureau, http://pubdb3.census.gov/macro/032006/health/h06_000.htm

4.2.3.2 Other difficulties include getting an idea of hospital cost ratios. The Commission model gets its hospital information from a databank maintained by the Colorado Hospital Association. The data set includes "general, financial and utilization information at the facility level for 62 Colorado hospitals in fiscal year 2004." The problem is that hospital payment to cost levels are calculated using hospital charges. Hospital charges often bear little relation to the price actually paid, one of the major problems in health care that has been exacerbated by government programs and other forms of third party payment. As the Colorado Hospital Association points out in its reference guide,

Charity care, bad debt, Medicare and Medicaid underfunding are defined below in terms of charges. Charges reflect expenses for providing care, plus an amount for underfunded and unpaid care and a margin for capital replacement, principal payments on long term debt, and other financial needs. Charges within a hospital must, by federal law, be the same for all patients for the same service. What a hospital actually collects can be quite different. [107]

Interpreting reported hospital charges is also difficult given that hospitals actively manage their financial reports. For example, there is evidence that non-profit hospitals adjust discretionary spending and accounting accruals to manage their earnings to a range just above zero. This makes many hospital financial reports difficult to interpret.[108]

4.2.4 Employer behavior and workforce data are limited and date as far back as 1991.

The Lewin model uses the survey of employers conducted by the Kaiser Family Foundation and the Health Research and Education Trust (HRET) to model employer behavior. In 2005, the survey telephoned 2,013 firms nationwide. The response rate was roughly 50 percent. Its estimates say that 60 percent of the firms surveyed employ 3 to 9 workers. Firms with fewer employees are not represented because the survey sample was drawn from a Dun & Bradstreet list of employers with three or more workers. [109]

In 2004, the Statistics of U.S. Business from the Census Bureau reported that 79 percent of Colorado firms had 9 or fewer workers, including 20,183, or 16 percent, which had no employees at all. [110] These numbers suggest that the data used in the Lewin model may not accurately reflect the Colorado business climate.

To create workforce statistics which are ultimately used to predict the amount that employers will save on health spending in the various reform proposals, the Lewin model statistically matches each MEPS household worker to the HRET firms. But some detailed information that affects health insurance coverage, things like age, sex, coverage status, policy type, and wage level, is not covered in the HRET survey. To create it, the Lewin model uses data from the 1991

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[107]Colorado Hospital Association. March 2005. *Reference Guide to Colorado Hospital Financial & Utilization Data 2002 & 2003.* Colorado Health & Hospital Association, Greenwood Village, Colorado. p. 12. Online version accessed July 10, 2007, http://www.chha.com/download/referenceguidenp.pdf

[108] See for example Andrew J Leone and R. Lawrence Van Horm. 2005. "How do nonprofit hospitals manage earnings? *Journal of Health Economics*, 24, p. 815-837.

[109]The Kaiser Family Foundation and Health Research and Educational Trust. Undated. *Survey Design and Methods*, Employer Health Benefits 2005 Annual Survey, online edition accessed July 11, 2007. http://www.kff.org/insurance/7315/sections/upload/7315DesignandMethods.pdf

[110] U.S. Census Bureau. Statistics of U.S. Businesses: 2004. Online version, accessed July 11, 2007. http://www.census.gov/epcd/susb/2004/co/CO--.HTM

Health Insurance Association of America employer survey data for "detailed" information on employer workforce. [111] This adjustment is a reach. Using these data are equivalent to assuming that the Colorado population and economy have remained fairly static in the 16 years since 1991.

4.2.5 Data specifying individual insurance choice predate the introduction of HSA/HDHP policies, relying on 1987 to 1997 CPS data.

In evaluating reform plans, the Lewin model estimates things like the number of people who drop private coverage to take up state coverage, the number of people eligible for Medicaid who actually enroll, how employers and employees respond to changes in the cost of insurance, and how employers decide to provide coverage using an unspecified "multivariate analyses." Some of the parameters controlling this analysis are based on the 1997 Robert Wood Johnson Survey of Employer Characteristics and 1996 MEPS data on people offered coverage through an employer. Individual decisions to purchase individual coverage are modeled using an unspecified multivariate analysis of the likelihood that an individual will purchase coverage from the 1987-1997 CPS data. Premiums are imputed based on employer survey data. Needless to say, there is no room in these estimates for the effect of individual high deductible plans on either spending behavior or coverage take up. The new HSA qualified plans were not available in 1997.

4.2.6 Health spending projections have been projected from 2004 estimates and adjusted using 1998 Medicare data.

Health spending projections by payer and type of service comes from 2004 estimates from the State Health Expenditure Accounts developed by CMS. These estimate spending on provider using Census surveys of service establishments and state tax data. The amounts were projected to FY 2007-2008 based on estimates from FY 2004, adjusted to eliminate double counting, adjusted to exclude "non-health items that are included in national health spending estimates," and partly based on hospital financial reports. The projections were based on past ratios of the growth of Colorado health spending and U.S. health spending. Since state health expenditure accounts include spending by people from other states and exclude spending by Colorado residents outside of Colorado, the data were adjusted. The adjustment used is based on 1998 Medicare data. The bulk of the Medicare population is over 65.

Another example of an adjustment that is difficult to follow in the Lewin model is the apparent use of CPS survey data on average and marginal tax rates for the households used from the MEPS survey. Why this is done is unclear as MEPS contains significant income data in its own right. Those income data match well with the CPS results. About 22 percent of MEPS income supplement data is missing wages, which are imputed from the employment section. [112]

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[111] The Lewin Group. January 29, 2007. *Summary Description of the Health Benefits Simulation Model (HBSM), Attachment B,* p. 5.

[112] This is discussed in *Attachment B, Summary Description of the Health Benefits Simulation Model (HBSM)* dated January 29, 2007 and distributed to the Colorado Health Care Reform Commission. The comparison of CPS and MEPS results is outlined in Jessica S. Banthin and Thomas M. Selden. July 2006. *Income Measurement in the Medical Expenditure Panel Survey*, Working Paper No. 06005, Agency for Healthcare Research and Quality. Online version, accessed July 11, 2007, http://207.188.212.220/mepsweb/data_files/publications/workingpapers/wp_06005.pdf.

4.2.7 The estimates of the illegal population in Colorado are significantly less than those used by other sources.

The original Lewin baseline estimates found that 167,000 of an estimated 785,200 Colorado uninsured are non-citizens. Using the 2000 Census data and CPS data from 2002, the Urban Institute estimated that there were 175,000 to 200,000 illegal aliens in Colorado. [113] The Center for Immigration studies used the 2005 CPS to estimate that the illegal population in Colorado is 220,000, of whom an estimated 152,000 were uninsured. Including illegal aliens and their foreign and U.S. born children under age 18, an estimated 183,000 are uninsured. [114] In all, the Center estimates that a fifth of the uninsured in Colorado are illegal aliens. One fifth of the Lewin estimate of 785,200 is 157,040 people, 94 percent of the estimate of Lewin's estimate of the non-citizen uninsured.

Omitting estimates of illegal aliens in the uninsured has implications for spending if a reform plan contemplates using federal Medicaid matching funds to defray Colorado health expenses. The reason is that Colorado cannot legally claim matching federal funds for non-emergency Medicaid health services provided to illegal aliens. Reform plans that use federal disproportionate share funds to pay for coverage extensions may also create significant problems for hospitals. The hospitals will still be required to provide services to illegal aliens under EMTALA, but the disproportionate share funds intended to compensate them for this will have been diverted to other uses.

SECTION 5: An Overview of the Commission's Operations

In evaluating the Commission's work, it is important to understand the depth of disagreement that persisted throughout the Commission's term. Opinions on health care reform range from a belief that government programs like Medicaid and Medicare are a major cause of the problems in U.S. health care to those who believe that government control of health care is the cure for all that ails health care delivery. Virtually the entire spectrum of health care reform beliefs was represented on the panel.

5.1 The 208 Commission and Its Charge

It is the opinion of the authors that limitations and vagaries kept the Commission from being as useful as it might have been. In fact multiple opportunities were missed that would have presented a more substantive range of solutions for legislators to consider. The following section provides background on how this happened.

SB 208 required that the Commission:

1) Examine health care coverage and reform models "designed to ensure access to affordable coverage for all Colorado residents" with technical assistance and guidance from the project administrator

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[113] Jeffrey S. Passel *et al.* January 12, 2004. *Undocumented Immigrants: Facts and Figures*, Immigration Studies Program, Urban Institute. http://www.urban.org/UploadedPDF/1000587_undoc_immigrants_facts.pdf,

[114] Steven A. Camarota. December 2005. *Immigrants at Mid-Decade: A Snapshot of America's Foreign-born population in 2005.* Center for Immigration Studies. Washington, DC. http://www.cis.org/articles/2005/back1405.pdf

2) Select three to five specific health care reform proposals to meet the needs of the residents of Colorado.
3) Solicit reform concept papers and detailed proposals from interested parties.
4) Select the top proposals for detailed "technical analysis" by an independent consultant.
5) Hold at least one meeting in each Congressional district for the purpose of receiving public comment
6) Present a final report to the General Assembly.

The Act also stipulated that the Commission was to be administered by a project administrator. That administrator was not appointed by the Commission; in fact the commission staff was hired before the commission first met.

The administrator was to "submit acceptable proposals as determined by the administrator to the Commission for discussion and the ultimate selection of three to five favorable proposals." The process to identify "insurance reform proposals" was to "include, but not be limited to" an invitation for interested parties to submit proposals that followed the content proposals developed by the administrator, and any proposals that the administrator found acceptable."

What in fact occurred was that the Commission assumed the powers given to the project administrator. This made it less effective. The Commission focused on the characteristics of external reform plans submitted by groups that had an interest in, and the ability to outline, full blown reform plans. After that, during the summer of 2007, it focused on building its own reform plan. With a single exception the plans submitted uniformly proposed decreasing individual choice in health care and health insurance and increasing government control over individual health decisions. The proposal developed by the Commission followed the same pattern.

5.2 The Ambiguities in the Commission Charge

In addition to the results created by limiting reform discussions to the plans submitted, other ambiguities in the statute created problems for the Commission. In Section 2, the SB208 charges the Commission with:

1) "studying and establishing health care reform models to expand health care coverage and to decrease health care costs for Colorado residents."
2) examining "options for expanding affordable health coverage for all Colorado residents in both the public and private sector markets"
3) paying "special attention" to the "uninsured, underinsured, and those at risk of financial hardship due to medical expenses."

This section refers to "health coverage." Some Commission members made an assumption that health coverage referred to health insurance. Others pointed out that health insurance is not the same as health coverage because having health insurance is no guarantee that someone can get medical care.

Matters were further confused by the references to health care reform, health care spending, and health care in Section 1 and the reference to identifying "insurance reform proposals" in

section 2, paragraph (4)(a). A Commission member who had attended the original committee hearings on the bill reported that legislators were not clear on the coverage versus insurance problem at the hearings, either.

In practice the Commission operated as if its charter was to extend health insurance to all and that it was appropriate to assume that the mere extension of third party payment to all guaranteed appropriate medical care. As a result, the Commission operated as if its charge was to create a totally new mechanism for delivering health care and health insurance to everyone without regard for any upset caused by increasing government control of Colorado's health care system.

Commissioners who believed that this assumption was incorrect were unsuccessful in altering this operating mindset although they frequently pointed out that many people eligible for Colorado Medicaid, and on government plans in other countries, were unable to access appropriate medical care.

5.3 Operating Methods

The first few months of the Commission's efforts were given over to what was described as "operational and procedural" discussions. The time spent on this frustrated some Commissioners because there was little to show for the time spent. Bylaws created by the Commission's Operating Committee were brought forward and voted on. They required consensus decisions without explicitly defining what that meant. In retrospect, this blurred how decisions were reached. A phrase often heard at commission meetings was "When was that decided?"

Decisions made by the Operations Committee affected agendas, timeframes, and invited speakers. As a supermajority was needed to change agendas put forth by the Operations Committee, it effectively controlled the items presented for Commission consideration. Speakers invited to address the Commission were, with one or two exceptions, from organizations devoted to increasing government control of health care, people affiliated with organizations that collected the data used in the Lewin model, or people presenting the results of polls exploring people's attitudes towards health care reform.

On one memorable day, a speaker representing the Colorado Progressives was invited to talk for almost ½ hour on the results of a poll that surveyed people who attended Colorado Progressives meetings on the kind of health care reform they preferred. The sample consisted of 200 self-selected people who, to no one's surprise, wanted a single payer health care system. The presentation was so patently political that more than one Commissioner noted that this kind of presentation was completely inappropriate.

The compressed time frame under which the Commission operated severely limited thoughtful discussions. There were significant delays between commission meetings and the publication of that meeting's minutes. This made it difficult to ascertain whether the minutes were full and accurate transcriptions of all matters. Sub-committee meetings did not, in most cases, produce minutes.

5.4 Lack of Agreement Concerning Basic Health Care Facts

The most serious flaw in Commission procedures were produced by its failure to adopt any of the standard academic or legal methodologies for establishing agreement about basic facts. As a result, its activities were ill-suited to building the consensus that its bylaws envisioned. Quite often, statements and assertions were made during Commission deliberations that reflected nothing more than anecdotes or "popular wisdom," a problem which likely resulted in availability bias in Commission recommendations.

For example, a fundamental assumption in the 208 legislation is that the uninsured pose a problem for the health care delivery system, and that this problem will be mitigated if all of those people have a third party payer for their health care bills. As discussed above, it is not clear that a third party payer will reduce expenditures because coverage increases utilization and reduces self-payment. Furthermore, there is considerable evidence suggesting that the uninsured are less of a burden to the health care system than government programs, the main source of uncompensated care. The Commission did not consider questions like this. Nor did it consider who needs care and is not getting it, how many of those people there are, and whether they are the same as the uninsured. If Commission recommendations are poorly targeted at helping the needy, it is because the Commission did not see this as its charge.

The authors of this report believe that Commission discussions would have benefited from a well organized fact finding period. Its deliberations were frequently marred by popular claims that have little or no support when subjected to close examination, or in available academic studies. A few examples of these claims are given in Table 5.4.1.

Table 5.4.1: Popular claims and alternative evidence

Claim	Other viewpoints
People without health insurance have no access to care	Among those with comparable incomes, the uninsured get about the same amount of health care as those with insurance.
Insuring people will eliminate uncompensated care	The largest amounts of uncompensated care are generated by Medicare and Medicaid patients. This occurs because Medicaid and Medicare pay providers less than cost. Eliminating the uninsured by putting them on Medicaid may actually increase the amount of uncompensated care by eliminating the payments that the uninsured make for their own care, increasing utilization, and increasing administrative overhead. In the 1990s, Tennessee insured everyone in the state under the TennCare program. The program was supposed to eliminate uncompensated care. By the late 1990s, uncompensated care had increased. [115]

[115] Data from the RAND Health Insurance Experiment suggest that "we estimate that with no insurance at all, people would have spent about half the cost of free care." Emmett B. Keeler. Summer 1992. "Effects of Cost Sharing on Use of Medical Services and Health, *Medical Practice Management*, P.318. Online version accessed December 10, 2007. http://www.rand.org/pubs/reprints/2005/RP1114.pdf

Table 5.4.1: Popular claims and alternative evidence	
Claim	Other viewpoints
Health insurance is unaffordable for individuals.	In Colorado, a 40 year old woman can choose from a number of comprehensive health insurance policies that cost less than $100 a month. Adding two children adds about $50 to $100 a month. The most that woman would have to pay for health care, regardless of health status, would be $425 a month under Cover Colorado, the state's insurance plan for the uninsurable.
Medicare has lower administrative costs than private insurance plans; private insurers have administrative costs of 30 percent.	Recent papers[116] suggest that Medicare administrative costs are similar to those in the private sector even without including the administrative costs of Medicare supplemental policies or the fact that Medicare is not solvent. Overhead is not necessarily bad. It includes case management for patients with chronic conditions, health education expenses, fraud detection, and customer service, areas in which Medicare is notoriously weak.[117] In 2002, the Washington State Office of the Insurance Commissioner determined that administrative expenses for companies filing annual statements with the state averaged 12.6 percent of overall revenues.
People who are uninsured for even one month should be counted as uninsured.	This was the definition of the estimate of the uninsured provided by the Lewin Group, the modeler hired by the Commission. Obviously there are a number of different estimates of the uninsured including those who are uninsured for a year or more, those who are covered by Medicaid but have simply not enrolled, and those who are uninsured by choice because they believe that they do not need health insurance.
Mandating electronic health records will lower costs and improve quality	Evidence from existing system suggests that results are mixed and that there are significant concerns with record availability, accuracy, and security.
Mandating evidence-based medicine will lower costs and improve quality	Where evidence-based medicine decision processes have been implemented, there is evidence that they are used to control costs by denying access to effective therapies.
Care coordination and case management will lower costs	The State of Colorado has experimented with disease management. It lowers costs in some cases but not in others. Case management for expensive events like trauma is already routine for private insurers. Ongoing experiments concentrate on managing some chronic conditions known to generate avoidable costs.

[116] See Merrill Matthews. January 10, 2006. , *Council for Affordable Health Insurance*, Alexandria, Virginia. http://www.cahi.org/cahi_contents/resources/pdf/CAHI_Medicare_Admin_Final_Publication.pdf; Banjamin Zycher. October 2007. *Comparing Public and Private Health Insurance: Would A Single-Payer System Save Enough to Cover the Uninsured?*, Medical Progress Report No. 5, Center for Medical Progress, Manhattan Institute, New York, New York. http://www.cahi.org/cahi_contents/resources/pdf/CAHI_Medicare_Admin_Final_Publication.pdf
[117] JP Wieske.May 2007. *High Loss Ratios Undermine Affordable Health Insurance.* Council for Affordable Health Insurance, Alexandria, Virginia. http://www.cahi.org/cahi_contents/resources/pdf/n141lossratio.pdf

Table 5.4.1: Popular claims and alternative evidence	
Claim	Other viewpoints
Because the U.S. has the highest per capita health care spending, it "spends too much on health care."	Not all higher spending is waste. Wealthier people spend more on health to improve functioning just as they spend more on housing, transportation, and entertainment. Countries with lower levels of health care spending have worse health outcomes than the U.S. along a variety of measures. Within the U.S., vacationers admitted to the emergency room in high spending areas have lower mortality rates than similar visitors in lower-spending areas.
The U.S. health system spends more money and has poorer outcomes than health systems in other countries.	The medical literature shows the opposite. Disparities between health care access for the rich and poor are lower in the U.S. than in other countries. A few examples of comparative outcomes include: lower infant mortality rates in the U.S., higher cancer survival rates, better population blood pressure control, lower mortality and morbidity from cardiac disease, better diabetic treatment, more preventive care, and better health and quality of life for spinal cord injury patients. Compared to the NHS, US medical care provides more services for roughly the same expenditures.
More spending on the indigent will improve health outcomes	Spending on the indigent has risen significantly and there is little evidence of positive effects. It may be time to study how money is spent rather than simply spending more.
Integrated health care systems will lower costs.	Integrated health care systems have raised costs in states such as Wisconsin, where hospital networks use primary care practices as feeders to their higher margin hospital services and as barriers to competition. The State of Colorado has determined that Medicaid managed care costs more than its current fee for service system,[118] possibly due to higher overhead costs.
People are better off if their health insurance policies have lower deductibles and pay for routine care.	Buying insurance for expected expenses is the most expensive way to purchase them. Lower deductibles come with higher premiums. Someone spending $10,000 on health insurance with a $500 deductible might be able to buy a policy with a $5,000 deductible for $5,000 a year and save the remaining $5,000 in a tax free health savings account. How does the higher deductible make him worse off?

[118] In its December 2006 Joint Budget Committee hearings, the Colorado Department of Health Care Policy and Financing wrote that "Although managed care organizations should experience savings over fee-for-service due to their improved ability to reduce unnecessary hospitalizations, emergency room visits, and other overutilization, there are also extensive administrative costs for care management, utilization management, providing networking to ensure access, and other processes such as bill paying and risk management." Colorado Department of Health Care Policy and Financing. FY 07-08 Joint Budget Committee Hearing. page 55. Online version, accessed October 16, 2007. http://www.chcpf.state.co.us/HCPF/Budget/jbc%2007-08%20hearing/FY%2007-08%20HCPF%20Hearing%20Agenda%20and%20Response_new.pdf

Table 5.4.1: Popular claims and alternative evidence	
Claim	Other viewpoints
The uninsured get their care at the emergency room driving up costs for everyone.	A recent look at a census of all frequent users of Massachusetts emergency rooms suggests that ER use by the uninsured is roughly the same as for the privately insured. The Urban Institute has concluded that the uninsured do not use emergency rooms at a higher rate than the insured.[119]
Centralizing administration will lower costs.	If this were true, the Soviet Union would have had the lowest costs in the world. In fact, smaller systems tend to have lower administrative costs. Counter evidence for the superiority of competitive systems includes a comparison of the Northern California Kaiser Health Plan with the British National Health Service. The researchers found that costs were comparable but that Kaiser provided more for the money.
Insurance company profits increase the cost of care	There is a great deal of evidence showing that for-profit entities minimize cost better than non-profit entities. Competitive markets generally make price increases difficult. When that happens, only cutting costs will generate certain profits. In some cases, the efficiencies created by the drive to minimize costs allow for-profit firms to provide services that are better and less expensive than their non profit competitors even though the for profit entities must pay higher taxes and shareholder dividends. There is no evidence that health insurers are making abnormal profits.
More preventive care will save money.	With the exception of some childhood immunizations, preventive care increases expenditures. This is because most preventive care consists of screening for early detection of diseases that are less expensive to treat if caught early. While screening lowers individual risk, it increases overall expenditures because the savings from the relatively small number of early cases detected are smaller than the total costs of screening the population. This is why there is more preventive care screening in the U.S. than in government run health care systems. Individuals are more likely to pay more to lower their own risks, government accountants are more likely to be concerned with total expenditures.

Consensus was elusive on such basic facts such as how one should measure the uninsured, whether state taxpayers should pay for insurance policies for illegal aliens, how private insurance markets operate, and the current cost of health insurance in Colorado. In the end, virtually all disagreements ended up being settled by a vote or by a ruling by the Chairman.

[119] Stephen Zuckerman, Yu-Chu Shen. February 1, 2004. Do Insurance Coverage and Access to Care Matter? *Medical Care.* 42(2), 176-82.

5.5 The Commission's Guiding Principles

Early on, the Commission voted to adopt a number of principles for health care reform. The principles were notable for the fact that they contain undefined terms that are central to any discussion of health care reform. The Commission did not grapple with the fact that the value placed on many of its reform principles will vary with individual preferences. It is therefore likely that any reform satisfying them would be required to increase system flexibility so as to maximize innovation and individual choice. If this were the case, adherence to the principles adopted by the Commission would preclude most of the reform proposals recommended by it.

Colorado Health Care Reform Commission Principles for Health Care Reform	Undefined concepts in Principles for Health Care Reform
1. Protect and improve the health status of all Coloradans. 2. Expand coverage of essential health care services for all Coloradans, with an emphasis on the uninsured and underinsured. 3. Align incentives to provide high-quality, cost-effective and coordinated care. 4. Support a system that is financially viable, sustainable and fair. 5. Provide opportunities for meaningful choice and encourage personal responsibility. 6. Emphasize wellness, prevention, health education and consumer empowerment.	Health status Coverage Essential health care services Underinsured Uninsured[120] High-quality Cost-effective Coordinated care Financial viability Sustainable Fair Meaningful choice Personal responsibility Wellness Consumer empowerment

Without knowledge of what individuals value, is difficult to determine how one measures health status, what defines essential health care services, how one defines the underinsured, how one measures high quality care, how one defines cost-effective, how one determines what is fair, how one measures financial viability, what constitutes meaningful choice, what is encompassed in personal responsibility, and what constitutes consumer empowerment.

The Commission did not define coordinated care, consider what initiatives constitute wellness, or outline what was meant by a "sustainable" system. It also failed to ask whether there is evidence to support the effectiveness on additional spending on health education in view of the fact that people with chronic conditions do get health education and the results suggesting that many health education programs have at best a weak effect on the outcomes at which they are targeted.[121]

[120]Although uninsured would seem to be a fairly clear term, some people define uninsured as someone without health insurance for even a day in a given year. The term is often used to include people who are in fact eligible for government health care programs should they need them, but who have not signed up. They do have someone else to pay for their health care, but are technically uninsured. Uninsured also refers to people who have significant assets that they can use for care and so have no need to purchase insurance from a third party.

[121] The evaluation of the outcomes of health education programs finds that many of the studies on which the enthusiasm for health education are based are relatively weak. A 2002 Cochrane Database Systematic Review of school-based smoking prevention programs by Thomas and Perara, for example, found that roughly half of good quality studies show that smoking education reduces smoking.

That Commission deliberations would have benefited from more substantive discussions of these issues is evident. For example, those in favor of extending community rating and guaranteed issue to Colorado's individual insurance market also favored a mandate requiring that everyone purchase insurance. The reason given for this was that since community rating would raise the cost of insurance for young people, they would drop policies and increase the number of uninsured unless they were forced to purchase the higher cost policies. Those who are older typically have higher incomes and greater assets. Whether it is fair to overcharge the young in order to benefit those who are older and wealthier was never systematically examined.

The question of individual mandates and minimum acceptable coverage are examples of other generally accepted reform principles that violated Commission principles. Many Commissioners supported an individual mandate to require people to purchase health insurance. At various times, Commissioners gave various reasons for their enthusiasm for this idea. The Commission never discussed whether this was fair or whether it diminished individual choice and consumer empowerment, two principles that were said to be important. The Commission also appears to have violated its principles by ignoring most financing questions about the health care reforms that it did examine.

The lack of agreement on the core principles was to bedevil discussions throughout the Commission's tenure. It was a particular problem because a number of Commissioners were simply unwilling to seriously consider any reforms intended to increase the diversity of available insurance plans, place more emphasis on cash payment, deregulate the medical sector, or systemically reform Medicaid. Only two changes in Medicaid were seriously considered: its expansion and the possibility that some provider reimbursements would have to be raised.

This unwillingness was particularly unfortunate in view of recent evidence documenting early successes of higher deductible, lower premium plans in increasing insurance coverage, reducing cost, and improving health. It prevented the Commission from exploring the notable success that cash practices are having in reducing costs in other states. It prevented the Commission from exploring the success that some specialty hospitals are having in lowering costs and improving outcomes by focusing on a particular type of medical procedure. This will likely be a particular problem in Colorado. Its legislature recently followed the poor example of Medicare in outlawing specialty hospitals in which physicians have a financial interest.

What was not recognized in these principles, and what is central to any sensible discussion of health care reform, is that the definition of such things as fairness, quality, essential services, and meaningful choice varies from individual to individual and depends on whether or not the individual in question has to pay for the service. As the RAND health insurance experiment clearly showed, the average person significantly alters behavior when he must use his own money to pay for health care, and these alterations have no discernable effect on health.

Having passed principles that were not well defined, the Commission then proceeded to a set of discussions on what were said to be "Key Questions" for health reform. These questions,

and the answers to them, supposed to provide a basis for choosing among various health care reform options. On Friday, June 15, 2007 an email was sent to Commissioners and other parties asking that ideas for key questions be mailed in by Monday, June 18th for consideration at the meeting on Tuesday June 19. Staff summarized "key threads" in the questions mailed back. The key questions were chosen from those threads using an exceptionally fuzzy process at the unusually confusing June 19,th 2007 meeting. The key questions which were developed by Commission staff are presented in the following table.

Note that none of the Key Questions deal with substantive system reform, cost minimization, or the reform of government programs. Although the answer to question 1 includes the comment individuals can use "resources" to pay for health care, by the answer to question 2, those resources are discounted and individuals must have insurance because they have "responsibilities to the larger community." No philosophical justification for this statement is given.

Given that the FY 05-06 Colorado budget included almost $2 billion in spending on health care subsidies for roughly 400,000 people in Medicaid and SCHIP programs, question 7, "Will there be subsidies to assure affordable coverage," indicates the lack of a factual basis. To further illustrate the limited nature of the Commission's "Key Questions," an alternative list of key questions is provided in Appendix A. This list, which has been distributed nationally, was submitted to the Commission by one of the authors of this report when the Commission asked Commissioners to submit suggestions for key reform questions.

Tentative Answers to Key Questions
July 18th, 2007 Commission Meeting

1. What will be the role of the individual?

Individuals have responsibility for being able to pay for care, through resources or insurance. Individuals have the responsibility for taking care of themselves (e.g., through healthy lifestyles), and for using the health care system appropriately. Individuals have responsibilities toward the larger community.

2. Will there be an individual mandate?

Yes, although other decisions will affect this decision, such as the minimum benefit package and subsidies for low-income individuals.

3. What will be the role of employers?

Employers will not be required to provide coverage to employees, but they may be required to contribute toward a health care reform plan. Possible roles include arranging 125 plans and payroll deductions for their employees, or contributing revenue for subsidies or uncompensated care.

4. What will be the role of government?

Government will provide subsidies for purchase of private coverage or to reform/ expand Medicaid and CHP+. Government will continue to provide services such as public health services and support for safety net providers.

5. Will there be an expansion and/or reform of the Medicaid and CHP+ programs?

There may be an expansion and reform of the Medicaid and CHP+ programs.

6. Will portability or continuity of coverage be assured?

The Commission did not have the time to fully consider this question. (Portability will be considered at the August 13th Proposal Committee meeting.)

7. Will there be subsidies to assure affordable coverage?

Government will provide subsidies to assure affordable coverage

8. What will the minimum benefits be?

There will be a minimum benefit package for all of those who are subject to the mandate. The minimum benefit package may be an actuarial value for a package, allowing for flexibility in plan design. A separate minimum benefit standard may be created for those who qualify for a subsidy, to assure that these individuals have affordable out-of-pocket costs.

5.6 Missed Opportunities

The work of the Commission was limited by its self-imposed charge. If a proposal for a particular method for health care reform was not submitted, the Commission did not consider it. It was unwilling, in the development of its 5th proposal, to consider regulatory and

Medicaid reform initiatives being experimented with in other states, ideas for funding and reimbursement reform, and current efforts to eliminate waste.

In May 2007 when the Commission first selected 4 proposals to model, it was driven by the desire the present a range of options. The options that were selected proposed the following plans:

1) Expanding Medicaid/CHP+; no other market alterations except offering a limited benefit medical plan like those already available, with subsidies to cover the working poor
2) Impose an individual mandate, expand Medicaid/CHP+, subsidize a limited benefit medical plan for the working poor, use Medicare reimbursement rates for provider reimbursement.
3) Individual mandate, employer mandate, state managed guaranteed issue insurance products, Medicaid/CHP+ expansion.
4) Have state government take over and pay for all Colorado health care.

The authors believe that the most appropriate use of the 5th proposal position would have been to expand this range of proposals to investigate the possible effects of deregulation and government program reform. A market oriented reform proposal was included in the original submissions. It was not selected for a variety of reasons, some related to the proposal itself. At the time, some commissioners hoped that the 5th proposal option would be used to explore market based reforms. Once the 5th proposal committee began to meet, market oriented reforms were never seriously considered. In November 2007, the Commission even voted against recommending that the legislature study market oriented reforms while voting for legislative study of a single payer plan.

SECTION 6: Further Recommendations

Changes in the delivery system for health care must, of simple necessity, be considered comprehensively and the implementation of changes phased into place. These are some of the recommendations that we believe should have been considered.

6.1 As government assistance forms the basis for most fee schedules, including private insurance, submit Medicaid and CHP+ to true reform. Use the Section 1115 and HIFA waiver system to institute greater flexibility and innovation within the delivery system of these programs so that existing dollars can be optimized. Use these dollars to purchase private health care coverage, except in the cases of the most sick and vulnerable for which dedicated funds (medically needy) be established. Revise the benefit schedule to more realistic coverage levels. Permit and expand CDAS types of programs which incent people to use their health care dollars wisely;

6.2 Attack waste, especially that caused by government regulation. The area of duplicative services offers an excellent opportunity for collaboration as one point of departure.

6.3 As the above processes are underway, the reform of the current regulatory and administrative system that oversees the private health insurance be completed to achieve lowest possible costs of compliance, and to ensure that available premium dollars are

optimized for health care delivery. A list, without discussion or any particular order, is provided below. It primarily concentrates on regulatory reforms that the state can affect that will lower premium costs by reducing administrative overhead. There are a few suggestions that will also increase the competitiveness of the health care market.

1) Reconsider regulations that require that insurers must charge the same premium for policies covering 1 or 12 children. Right now policies are priced at 2.8 to 3.2 children per family. People with fewer children, particularly single mothers with one or two children, pay more per child than others.
2) Maternity coverage should not be mandated for people who do not need it
3) Colorado should make sure that waiting periods in its laws harmonize with Federal law. Harmonization will decrease administrative overhead.
4) Non-network physicians, (generally these are specialists like radiologists and anesthesiologists) get paid whatever they charge under the network adequacy laws in order to protect the individual policy holder. As a consequence, overall rates for non-network care are passed along in the overall rate structures (millions of dollars per year) and premiums go up. Colorado law should be changed to allow negotiated networks in network facilities — that is, any provider giving service in that facility should only be paid reasonable and customary charges, which would allow lower insurance policy premiums, thus favoring policyholders.
5) Hospitals are protected from the "general contractor" rule by allowing physicians "privileges" to practice in their facilities (related to #4). Changing this rule should be studied.
6) Recent statute requires that private policies pay for court ordered mental health treatment. Courts are not accountable for the costs that they impose on others. The legislature should revisit this.
7) Recent statute requires that private policies pay for self-inflicted injuries due to the influence of alcohol and controlled substances. This drives up costs for responsible policy holders, and should be revisited by the legislators.
8) Insurance mandates should be revisited. In 2007 Colorado had 46 mandates. Arizona had 29, Indiana had 34, Kansas had 37.
9) Reconsider the mandate requiring that private policies pay for early childhood disability evaluation.
10) Statute provides that small groups under 15 may self-insure for maternity, however Colorado's Department of Insurance interprets a 1980s era lawsuit (Budde) in a way that effectively prohibits small groups from doing so. A close reading of the decision makes this regulatory stance questionable, but the current effect is higher premium pricing for all small groups
11) Consider eliminating the statute that prohibits list billing;
12) Reconsider the statute rescinded rating flexibility for small groups. This increases the effect of the community rating straitjacket and will increase premiums;
13) Examine Department of Insurance regulations that deviate from the National Association of Insurance Commissioner standards, which are intended to decrease administrative costs by increasing uniformity across states;
14) Reconsider regulatory restrictions on solving the retro term problem;
15) Reconsider state continuation regulations. They are not the same as COBRA, which causes significant administrative problems;

16) Reconsider regulations requiring that men and women be charged the same amounts regardless of their use of health care. Men cost less from roughly age 18 to age 50. After age 50 they cost more. Premiums should reflect this to effectively communicate differences in health care usage to policy holders.
17) State law prohibits short term medical plans in excess of 6 months, with a limit of 2 per 12 month period. Reconsider those limits.
18) Common ownership restrictions create excess administrative costs, and loss of opportunities to create larger risk pools.
19) Consider reforms of regulations that create fragmented risk pools
20) Reconsider state statutes making it illegal for physicians to have financial stakes in specialty hospitals. As physicians are highly qualified to invent a better delivery model, prohibiting them from doing so limits competition and innovation. Concerns about conflict of interest can be handled with disclosure requirements.
21) Consider allowing insurers in the individual market to offer mandate-free or mandate-light insurance policies, perhaps on an experimental basis of a few hundred or few thousand policies per year, or, alternatively, to those policyholders with HDHL/HSA policies.
22) Consider allowing Colorado residents to purchase health insurance from any insurer authorized to do business in any state, not just those licensed in Colorado.

Once government assistance programs and payments are brought into line, once waste within the system is properly addressed, we will find that the private coverage system will adapt to the new, more efficient realities of the overall health care delivery system and we will find stabilized and relatively lower costs. In addition, the private coverage system will further adapt and innovate, bringing products to consumers that are more sensitive and useful, as well as being more cost effective.

Appendix A: Key Health Care Reform Questions That Should Be Asked

1. **Does the proposal organize the health care system so as to provide maximum value to those who use its services, with value defined from their point of view?**

1.1. Pricing

1.1.1. Does the proposal further market pricing for medical services? Does it rely on price controls of any kind, including administrative price setting?

1.1.2. Does the proposal ensure that any physician or health provider, and any facility, is free to treat any patient in exchange for direct payment of a mutually agreeable fee?

1.2. Outcomes

1.2.1. Does the proposal ensure that patients can determine the treatments they will receive and physicians the treatments they will provide subject to their own consciences?

1.2.2. Does the proposal include organizational provisions that ensure that firms, industries, professions, and subsidy recipients will not be able to use the reform plan to their financial advantage?

1.3. Consumer protection

1.3.1. Does the proposal ensure that participation in government programs is voluntary?

1.3.2. Does the proposal encourage people to accumulate assets that may be used for future health care expenses in lieu of third party insurance?

1.3.3. Does the proposal allow people to modify the amount of financial risk they are willing to bear by choosing among different third party insurance policies as their circumstances change?

1.3.4. Does the proposal remain neutral with respect to the form that third party insurance should take as long as insurers can meet their contractual obligations?

1.3.5. Does the proposal remain neutral with respect to paying for health care with cash or with third party insurance?

1.3.6. Does the proposal subject businesses operating in health care to the same rules as businesses operating in other sectors of the economy with respect to anti-trust, ownership, pricing, contracting, and reporting requirements?

1.3.7. Does the proposal protect people from involuntary participation in any non-governmental insurance program?

1.3.8. Does the proposal allow the purchase of health insurance that is not associated with an employer?

1.3.9. Does the proposal ensure that people can buy health insurance from any insurance company approved by a state government?

1.3.10. Does the proposal allow for the fact that people purchase health care from a variety of sources, some of which are both outside of Colorado and outside of the United States?

1.3.11. Does the proposal protect consumers from arbitrary restrictions on their ability to access medical therapies?

1.4. Government obligations

1.4.1. Does the proposal include mechanisms to ensure that government programs do not use government power to compel unpaid services from providers?

1.4.2. Does the proposal have mechanisms to ensure that government treats all providers fairly and does not discriminate between providers via different payments for the same service or regulatory structures that favor some providers over others?

2. Does the proposal contain adequate structures for reducing costs?

2.1. Does the proposal ensure that all providers and third party payers in the health care systems are subject to credible competitive threats?

2.2. Does the proposal expose existing providers, including government and quasi-government entities, to competitive pressures?

2.3. Does the proposal ensure that all entities using or providing health care are free to contract with others as they see fit?

2.4. Does the proposal ensure that participation in any health care program under the control of Colorado state government, or any entity created by statute, is voluntary?

2.5. Does the proposal ensure that any physician or health provider, and any facility, is free to treat any patient in exchange for direct payment of a mutually agreeable fee?

2.6. Does the proposal ensure that for profit and non-profit providers are treated equally?

3. **Regulatory reform**

3.1. How does the proposal plan to determine which health care regulations produce a net benefit and which produce a net cost?

3.2. Does the proposal embrace legal reforms that protect participants in the Colorado health care system from unreasonable torts and contradictory regulations?

3.3. Does the proposal require that businesses operating in health care are subject to the same rules as businesses operating in other sectors of the economy with respect to things like anti-trust, ownership structure, pricing, contracting, payment, purchasing, taxation, and reporting requirements?

3.4. Does the proposal protect consumers from unreasonable charges?

3.5. Does the proposal contemplate legal reforms that would encourage all participants to exercise good judgment?

3.6. How does the proposal plan to determine whether current licensing, inspection, and reporting requirements produce net benefits?

3.7. Does the proposal contemplate legal structures that will protect providers from arbitrary and capricious peer reviews?

3.8. Does the proposal reduce legal barriers to entry affecting hospitals, specialty hospitals, long-term care providers, in-store medical practices, insurers of all kinds, providers of professional services, drug and device manufacturers, and suppliers of drugs and medical equipment?

3.9. Does the proposal contemplate the legal reforms that would be necessary to encourage people who wish to create charity care clinics can do so without risking their personal assets?

4. Does the proposal promote the use of economically efficient subsidies designed to maximize the general welfare?

4.1. Does the proposal reform Medicaid?

4.1.1. Do Medicaid subsidies accrue to individual patients rather than to providers?

4.1.2. Can individual Medicaid patients spend the money that they receive at the provider of their choice? Can they purchase necessary supplies and services from the supplier of their choice?

- 4.1.3. Does the proposal contemplate regulatory reform that allows the program to develop regulations and programs that treat different Medicaid populations according to their needs?
- 4.1.4. Does the proposal contemplate Medicaid reforms that encourage Medicaid clients to use their Medicaid benefits wisely?
- 4.1.5. Does the proposal include public access to Medicaid financial data so that amounts paid to providers, vendors, consultants, administrators, contractors, overseers, investigators, tax collectors, auditors and so on, as well as the purpose of the expenditures, can be clearly discerned?
- 4.1.6. Does the proposal provide ways to discriminate between—and effectively manage—financial arrangements for people in legitimate need and those who take unfair advantage of subsidized and safety net programs?
- 4.1.7. Does the proposal ensure that taxpayer-funded services will be provided only to eligible persons for eligible services?
  - 4.1.7.1. How will the proposal ensure that taxpayer-funded services are not provided to deceased persons, persons with fraudulent identification, nonresidents, persons not meeting financial requirements, illegal aliens, and so on?
  - 4.1.7.2. What penalties will be assessed for those who try to defraud the system by faking evidence of eligibility?
  - 4.1.7.3. What mechanisms in the proposal are designed to ensure that payment for taxpayer-funded services is actually rendered?

- 4.2. How does the proposal contemplate providing medical care for people who, by reason of incapacity or simple cussedness, do not comply with administrative requirements?
- 4.3. Will the subsidies contemplated by the proposal encourage or crowd-out private mechanisms for financing medical services?
- 4.4. Does the way subsidies are distributed in the proposal deepen Colorado's "low-wage trap" by imposing effective marginal tax rates on low-income people trying to work their way out of dependency?
- 4.5. How does the proposal plan to distinguish between essential and non-essential health care services?
- 4.6. How does the proposal contemplate ensuring that taxpayer-funded programs provide good value for the money spent?
- 4.7. Given that funds for taxpayer-funded programs are limited, how will the proposal manage the tradeoffs that are necessary in a resource constrained subsidy program?
- 4.8. How does the proposal propose to measure the effectiveness of taxpayer-funded subsidy programs?
- 4.9. How does the proposal plan to determine the type and level of subsidies?

5. **Programmatic considerations**
   - 5.1. Does the proposal have a sunset provision?
   - 5.2. How does the proposal plan to measure whether it is a success?
   - 5.3. What trigger mechanisms automatically sunset the proposal in the event of budget excesses or poor performance?

Minority Report Submitted by Commissioner Simon

Blue Ribbon Commission on Health Care Reform
- Dissenting Opinion -
Mark Simon
January 8, 2007

Executive Summary

While I consider many of the Commission's recommendations to be sound, there are significant omissions and general philosophical issues that have inspired and necessitated this dissent. The Commission's recommendations reflect certain philosophical predispositions. Chief among them is the notion that because most Coloradans have insurance, the state should build exclusively upon the strengths of the current system. We should, therefore, keep and expand those things that work in order to minimize dislocation for those with good coverage, while making changes to better meet the needs of those who currently lack affordable health coverage.

What has resulted from this approach is a complex system that requires significant public funding for the private, for profit, insurance industry and providers. This system does not spread the expense and risk beyond the taxpayer and consumer, and does not mandate greater efficiency from the private sector. As a result of these initial predispositions, the Commission may not have addressed all issues with the appropriate degree of depth, excluded some ideas that deserved more extensive consideration, and certainly have not taken full advantage of the opportunity to craft the health care debate.

Fiscal Issues and Concerns

- The Commission's final recommendations reduce costs to employers, increase compensation to providers, and give the insurance industry 221,600 new/subsidy clients. Unfortunately, in this newest effort at cost shifting, the consumer and taxpayer are required to pay for it all.
- $553.7 million in new tax dollars for "premium subsidies" will go to insurance companies, and $77 million in new insurance company administrative costs. The commission's recommendations and proposal will also remove a significant portion of the high risks/high costs from the commercial risk pool and would transfer them to segregated high risk pools, reducing insurance companies' exposure to high costs, and allows them to continue to operate as they currently do.
- $240 million in additional payments to providers without requiring them to decrease per-patient charges, see anyone without the ability to pay, and without any requirement to increase quality standards.
- Employer costs will be reduced by $334 million in the unverifiable hope that this will translate into an equivalent increase in employee wages.
- Family (consumer) out of pocket spending will increase by $75 million.
- Medicaid expenditures will increase to $2.688 billion, doubling the current budget.

- Health care spending in Colorado will increase by $987 million. Yet, as modeled, the single-payer proposal clearly indicates that there is sufficient money in the system to provide all Colorado residents with access for all medically necessary and home care.
- A critical omission in data modeling the fifth proposal and the final commission recommendations concerns start up and implementation costs. Initial costs associated with any of the five proposals essentially remains unknown

Insurance Reform

- The Recommendations have no financing mandates for any of the other players in the health care system other than consumers and taxpayers.
- The Recommendations contain no true insurance reform. While it proposes some changes, in practical terms, the industry can make or waste just as much as they currently do. In addition, merging the individual market, the small group and large group markets were not discussed. Nor did the Commission substantively address the issues of insurance rate review, medical loss ratios, excess profit taxes, or any provision requiring insurers to reduce administrative costs. Nor did the Commission recommend that the Insurance Commissioner's office collect their own "unbiased data" for use in the rate-making process, etc.
- Under the Commission's recommendations the number of uninsured and underinsured Coloradans may increase as a result of moving them from the small group to individual insurance market. This could lead to an erosion of the minimum benefits that insurers are currently required to offer under the small group plans.
- There was little discussion regarding any workers compensation reform, other than the 24 hour coverage concept.

Long Term Care

- The commission did not adequately discuss or address the issue of long term care in spite of the growing demand and significant cost to the state of Colorado. Long term care is critical for many Coloradans with disabilities, as well as, the elderly and people with chronic conditions.

Health Care Consumers

- ***Coverage does not equal access.***
- The recommended "Minimum Benefit Plan" benefit package will result in a large number of underinsured, and will not ensure that people actually have access to necessary medical care, nor that they can afford all the put of pocket costs. Making an inadequate product affordable does not correct the problem!!!
- The imposition of an individual mandate may encourage employers to stop offering insurance coverage to their employees. In other cases, it may lead to reduced employee coverage based upon the minimum basic benefits plans required by the state.

- The only mandate required of employers is to establish a payroll deduction plan to pay for insurance.
- The recommendations do not address prescription drug reforms, the better coordination and sharing of high cost medical technology, medical malpractice reform, Non traditional medical treatments used by many Coloradans.
- Resources currently serving vulnerable populations must not be shifted to expanding eligibility for less needy/vulnerable populations, and future funding cuts should impact vulnerable populations last.
- The Medicaid "asset test" is kept at a woefully inadequate $2,000 for people with disabilities and elderly, and was not adequately and fairly addressed, while the Commission proposed it be set at $100,000 for CHIP+ kids, parents and for childless adults. This omission perpetuates FORCED POVERTY for many Coloradans and is discriminatory.
- The modeler was unable to model many of the issues affecting persons with disabilities, ranging from Long Term Care to the impact of having Consumer Directed Attendant Services as a statewide program. As a result, in some areas the modeling excludes two groups (disabled and elderly) that consume the vast majority of medical care.
- The Commission does not address the issue of illegal residents (about 95,000 people).
- According to modeling data of the proposal, Cover Colorado would operate at a $95 million deficit unless current funding for the program was increased. There was only a brief discussion as to whether the current mechanism to fund shortfalls in the Cover Colorado, through an assessment on insurers, should be continued.
- The Medicaid buy-in recommendation, while it will help people with disabilities to return to work, will become ineffective once they exceed 450% of FPL. Under this scheme they will pay an insurance premium approximately five times more than a non-disabled individual. This is especially true if they need attendant care, as this is the only program to provide it.
- The Commission does not address non-discrimination in health care access, accessibility to individually appropriate health care, particularly for people with disabilities and elderly.
- Much of the proposed Medicaid expansion relies upon additional federal funds, in spite of the fact that the current federal administration is reducing funds available to the states ($28 Billion over the next 5 years).

Positive Aspects of the Commission's Recommendations

Many of the commission's recommendations are especially laudable in their promotion of consumer directed health care and the manner in which they improve conditions for vulnerable populations. Details of the positive recommendations are listed in the full dissenting opinion. They include, but are not limited to; Medicaid Buy-in, Medically-Needy and Medically Correctable programs, which target our most vulnerable populations, care delivery in a consumer-directed and culturally competent manner, the creation of a Consumer Advocacy Program, increasing available providers, adding dental coverage, promoting care

coordination and integration of patient-centered care, improve quality, and further examination of allowing employers to offer 24-hour coverage, etc. among others. Additional details can also be found in the Commission's report.

Introduction

The Blue Ribbon Commission for Health Care Reform has undertaken an extremely difficult set of tasks concerning an incredibly complex subject while under extreme time constraints. Due to this, the commission has been unable to treat every issue with the degree of attention that it might have under other circumstances. As a result, the commission may not have addressed all issues with the appropriate degree of depth, may have excluded some ideas that deserved further consideration, and has almost certainly missed some opportunities to craft the health care debate.

The recommendations as developed by the Commission reflect certain philosophical imperatives, including "Because most Coloradans have insurance, we should build on the strengths of the current system, keeping and broadening what works to minimize dislocation for those who already have good coverage, while making important changes to better meet the needs of those who currently lack affordable health coverage." This is putting band aids on an elephant that is hemorrhaging in buckets!

The specific, dissenting commentary herein, and my dissenting position generally, are based on both the Commission's final recommendations and the 5th proposal developed by the Commission. While the Commission does not recommend the 5th proposal as a "preferred" option, its final recommendations are based largely on the document. The 5th proposal contains far more detail and therefore provides a much clearer picture of what was intended by the recommendations and the underlying cost.

This dissenting opinion is based upon some key areas of disagreement with the Commission's final recommendations, as well as, the Fifth Proposal. This disagreement is by no means total. But there are areas of concern, especially in the areas of insurance reform, consumer interests, and the health care available for vulnerable populations, and those issues form the core of this dissent.

While I consider many of the Commission's recommendations to be sound, there are significant omissions and general philosophical issues which have inspired and necessitated this dissent. I also wish to be clear, in the problems I identify, there are solutions that were not pursued or adopted by the Commission, that in my opinion would be more effective, or at minimum do less harm, particularly for consumers and the taxpayers.

A general observation is that the fifth proposal and the recommendation that derive from it represent a significantly complex system. These provisions are likely to lead to a health care system that will be complicated and expensive to implement and may be even more difficult for Colorado citizens to navigate through and use. This will be especially true for the uninsured population that has little previous experience with even the current Health insurance system. The amount of education, support, and maintenance that will be required will be significant.

Specific points of concern are listed below:

Fiscal Issues and Concerns

- The Commission's final recommendations reduce costs to employers, compensates providers for everyone they see (except for those left out of this reform [e.g. undocumented residents], underinsured or those who's care is paid for with federal dollars), and gives the insurance industry 221,600 new/subsidy clients, of which 117,400 are currently uninsured. Unfortunately, in this newest effort at cost shifting, the consumer and taxpayer are required to pay for it all. For many consumers it will appear as though special interests have figured out a way to open the taxpayer coffers for self enrichment and corporate (welfare) risk management. ***Coverage does NOT equal access!***
- $553.7 MILLION tax dollars in new money in "premiums subsidies," a portion of which would potentially be Medicaid dollars, will go to insurance companies, of which $283.5 Million is for individuals that are currently uninsured. The recommendations/proposal will also remove a significant proportion of the high risks/high costs from the commercial risk pool and would transfer them to high risk pools. In return, there is no requirement, oversight, or incentive for the insurance industry to operate at a level of greater efficiency or produce higher quality outcomes for the consumer!
- $77 MILLION in new administrative costs for insurance companies. According to the McKinsey Global Institute's January 2007 report on National Health Care Costs, 64% of all private payor administrative costs are spent on health risk underwriting, sales, and marketing.
- *The redirection of $630.777 million dollars of public funds to the insurance industry will simply not improve health care quality*. During the public hearings it was raised several times that the recently retired CEO of United Health Care, a major insurer, received a retirement package of $1.3 BILLION dollars!
- $2.688 BILLION in increased Medicaid expenditures, which doubles the current budget, will be incurred by adding 347,500 parents and childless adults alone (out of 472,700 eligible), as well as, some additional populations (at additional expense). This doubles the Medicaid budget that was already growing, and fiscally puts more vulnerable populations at risk during times of decline in public revenues/spending. The Commission's recommendations further require a three-month waiting period for these expansion populations. This waiting period effectively denies care to vulnerable people for that entire period. This provision, alone, will impact more than 10,000 people. Generally the federal government does not allow wait periods.
- $240 MILLION in payments to providers for previously uncompensated care, plus $166 MILLION in administrative savings, without requiring them to decrease per-patient charges, see those without ability to pay, any increase in quality standards, or anything else for that matter; that it goes to patient care and not the bottom line. The Proposal does not fully compensate providers, at least in Medicaid. The Commission has included an increase for doctors and proposes a review of other provider rates.
- $987 MILLION in increased health care spending in Colorado, yet the single-payer proposal modeled clearly indicates that there is currently sufficient money in the system

to provide all Colorado residents with access for all medically necessary care as well as increasing the home care budget to meet the rising demand.

- $334 MILLION in reduced costs to employers, which it is claimed will then result in increased wages in an equal amount, but there is no way to verify that it actually occurs.
- $75 million in <u>increased</u> family out of pocket spending, when one "backs out" of the modeling (which shows $14.9 MILLION in deceased family spending), the $89.9 million in decreased family spending shifted to Medicaid, by eliminating the waiver waiting lists in Medicaid. (*NOTE: The figure for family out of pocket spending is low due to the caps in the recommended "Minimum Benefit Plan", and the current design for medically needy or catastrophic care. Under the current recommendation some citizens in Colorado will still risk facing bankruptcy.*) The figures in the modeling are also somewhat deceptive as they include new taxes/tax increases to lower the family spending, but at least a portion of the new/increased taxes will be paid by those same families.
- The Commission recommendations support the adoption of a Health Information Technology network in Colorado (which is a good recommendation). However, the Commission does not recommend a viable method of funding and incentivizing this effort. No method of funding is defined in the final recommendations, and the fifth proposal only advocates an effort to "support and incentivize (the) use of health information technology through tax credits, uniform standards, and data sharing". Funding HIT through tax credits alone will be a fundamentally insufficient incentive for this type of extensive program development.
- In the 5th Proposal the Commission recommends several new taxes as funding streams for the proposed reform. While we were informed by legislative leadership that funding was not our concern, in the modeling process a funding mechanism was required. It is instructive to note that while there were a number of ideas put forward that were modelable, many of which the data would likely be useful to the legislature, all proposed that impacted special interests were set aside. It also proposed shifting funds from safety net providers and hospitals that serve a disproportionate number of individuals who lack the ability to pay, to more for-profit/profitable providers, who will also see other savings in the recommended reforms.

Negative Aspects of the Commission's Recommendations or Processes

Insurance Reform

- The Recommendations have no financing mandates for any of the other players in the health care system EXCEPT CONSUMERS AND TAXPAYERS who must also finance the new system

  The mandate to purchase insurance has severe penalties but no "carrot" to provide incentives for people to go ahead and do the right thing. It will cost one a years worth of premium for those who file without proof of coverage and will be contacted for assistance in enrolling in coverage. Those who are eligible for fully-subsidized public coverage programs will be automatically enrolled. So if you are poor you have NO choice about which plan you will be enrolled in, but if wealthy we are going to give you "assistance to

pick a plan. The Commission recommendations mandate that people to buy health insurance before anything else. This is an unethical policy recommendation. (*I would comment I do not object to mandates, but only if they apply to all stakeholders and are applied in a fair and equitable manner*)

- The Recommendations contain NO true insurance reform. While it proposes requiring all insurers to offer a Minimum Benefit Plan, guaranteed issue, community rated with adjusters for geography and age, it still establishes that insurers be "actuarially sound" in the individual market.
- In practical terms, this means that the industry can make or waste just as much as they currently do.
  - The insurers underwriting costs will drop significantly as a result of no longer having to do health status rating.
  - They will be able to charge elderly significantly more than younger enrollees.
  - And while using standard claims attachment requirements, eligibility and coverage verification systems, standard electronic ID cards, etc. will save providers they will still have to invest much time and staff resources to deal with multiple insurers, all with different (negotiated) rates, treatment protocols (which also impacts continuity of care for patients), billing and prior authorization procedures, etc. all of which drive provider costs.
- Negative aspects of the "Connector" to facilitate connecting consumers and insurers and to administer an insurance subsidy program (Also see Positive Aspects of the Commission's Recommendations).
  - There will be no subsidy for any insured employee's share of employer sponsored insurance (only uninsured employees to 300% of FPL). It will be mandatory for an insured employee to continue to purchase coverage, without a subsidy, regardless of potential financial hardship
  - If you are in the subsidy program and under 300% of FPL you cannot have a Health Savings Account, even if you come in with one, and even though it may reduce the premium (and therefore the subsidy).
- For childless adults, parents and children, below 205% of FPL, they would get a benefit package through Medicaid (with the recommended merger of CHP+ and Medicaid) that was a CHP+ "look alike" benefit plan, with a Medicaid "wrap around" if their needs increased. There is no mechanism in the Recommendations to access the "wrap around" benefits. Alternatively they could take their Medicaid dollars and give them to the insurance companies to purchase the "underinsurance" Individual Minimum Plan. This was done as "some people will not be in a public benefit program due to the stigma", yet the recommendations contain no mention of trying to break down those stigmas. Those individuals would also, in all probability be (unknowingly) giving up many of the protections and due process rights available to them in the Medicaid program.

- The subsidy for those 205% - 300%, we would provide a subsidy (more money to insurers) of 80% - 100% of the cost of the premium, for a CHP+ "look alike" benefit plan (205-300 Subsidy Plan)

- The subsidy structure for those 300% - 400% FPL would be a premium subsidy (more money to insurers) for any portion of the premium over 9% of income (the 9% Income Subsidy Program) for the Minimum Benefit Plan only. While you can "buy-up" to a more comprehensive plan, the subsidy would still only be for the Minimum Benefit Plan. The Recommendations are silent on whether the premiums for the "buy-up" would be limited or not.

- Those over 400% of FPL for whom the premium is more than 9% of income (most likely elderly who do not receive Medicare, since they can be charged more for premiums) are exempt from the mandate. This provision perpetuates the uninsured status of this group, and may add to it, at a point in time where they are likely to need it most.

- Also see the section on Cover Colorado below.

- In terms of private market insurance reform, the Commission did not substantively address the issue of insurance rate review. In practice, with one recent exception, institutionalized rate review has not been effective. That exception occurred in late October 2007 when the current Insurance Commissioner ordered rating modification that created a $72.5 million consumer savings in workmen's compensation. All of this in spite of industry objections. Excluding this exception, rates have continued to rise even in the face of past legislation designed to limit those increases. It is not clear from the Commission's recommendations that the "Connector" concept or the "Improving Value in Health Care Authority" does anything substantive with respect to insurance rate review.

  Several suggestions that could significantly reform the current insurance market were either ignored or insufficiently explored. Some of these suggestions are included below:

  - **Medical loss ratios**, where insurers are required to spend a minimum amount of premiums collected on medical care.

  - **Excess profit taxes**, with potential incentives for insurers to reduce administrative costs. In Medicaid/Medicare, administrative costs are 3%-3.5% of each dollar, in the commercial market administrative costs represent 25% of each dollar, (*International Journal of Health Services 2005:35(1):64-90*) yet their overall performance is comparable.

  - There was only brief discussion of **merging the individual market and the small group market**. There was no discussion concerning merging the large group market into either of the others. With the implementation of the Recommendations, one must also ask what happens to the current mandates in the small group market? Are they carried over to individual market or with a migration to individual coverage are they going to be lost? With a recommended premium of $199…

  - It may also be the case that the number of uninsured and underinsured Coloradans may increase due as a result of moving them from the small group to individual insurance market.

- There was little discussion regarding any **workers compensation reform**, other than the 24 hour coverage concept, which did encounter significant resistance. They would not even consider recommending going after employers who do not buy workers comp and shift the costs of their work related injuries and illnesses.

- The proposal could result in a reduction of the minimum benefits insurers are currently required to offer under the small group plans.

- An idea was proposed to **sell Pinnacol Assurance**, a state owned workers compensation provider. The sale of Pinnacol could potentially result in hundreds of millions of dollars in revenue for the state of Colorado was given little attention.

- Does not **require the Insurance Commissioner to collect their own "unbiased data"** for use in the rate-making process.

Employer Considerations

- There is a 6 month waiting period to change from employer sponsored coverage in order to receive a subsidy. This is a draconian and unfair provision which will drive up the number of uninsured, underinsured, and at risk of financial hardship as a result of medical costs. It was intended to act as a disincentive to keep individuals from migrating away from employer coverage to less costly publicly subsidized programs, and employers from dropping coverage, (who may not experience any hardship, nor does the proposal contain any penalty to discourage employers from dropping coverage), but has a great potential to harm employees, who's only recourse may be to quit. If such an employee either has a pre-existing condition or becomes ill during that six month period, they contribute to the current problem of more uninsured people forced to use emergency rooms. If there really would be a large migration, I also think that we will see a large number of people dropping coverage just prior to this taking effect. And what do we do about new hires? That is not addressed.

- If a resident's employer unilaterally drops coverage, depending on the criteria "for involuntary loss of coverage", that individual may have no recourse. In the Commission's effort to avoid any employer mandates, it refused to even consider a financial penalty for employers who drop coverage. Such penalty was an option which the modelers recommended as an effective strategy to get employers to keep coverage (but that was an employer mandate). Unless an individual drops coverage for at least 6 months, they receive no assistance, even though it may create significant financial distress.

- The ONLY mandate we require of employers in the entire proposal/recommendations is that they establish Section 125 plans (which is a very nominal cost to employers) so their employees can pay premiums with pre-tax dollars. The Commission was so opposed to ANY employer mandate that they even refused to propose a nickel per hour assessment for employers who do not offer employee coverage. It was suggested that for small employers a mandate to provide coverage would harm them, and the solution offered was to provide small employers, based on the company's earnings would have subsidies available. This would have a greater benefit that giving the individual employees a subsidy and increased income (maybe, if the employer actually passes their health care

savings to the employees instead of adding it to the bottom line) as for the employer the premiums are tax deductible, for individuals they are not.

- The recommendations will encourage employers to stop offering coverage because everyone is mandated to have it (there are claims that this mandate will result in employers increasing wages). Premiums are tax deductible for employers but not employees, creating a double whammy for workers. The tax benefits of a Section 125 plan, which withholds and pays premiums for employees with pre-tax income are simply not comparable or commensurate with the tax benefit employers accrue in paying health insurance premiums. As a result, if the employer does not buy their employees health insurance and decide to pay out the savings in increased wages, the after tax-effects will result in a decrease net to the employee.

Medical and Provider Considerations

- The recommendations do not even mention prescription drug reforms, and any attempt at raising the issue was promptly dismissed. This includes pricing, availability, preferred drug lists, polypharmicopia (multiple medications) reviews, etc.. There recently has been a preferred drug list implemented in Medicaid, and there is evidence that preferred drug lists can harm higher needs vulnerable populations, but do fine for those with low needs, yet the Commission declined to discuss a preferred drug list for those not in Medicaid.
- The recommendations do not require any real reform or contribution from providers. In addition, an excess profit tax was also suggested, but while this provision was discussed, it was not modeled. The proposal also did not adequately address quality measures, or dealing with issues such as medical mistakes and the cost of those.
- Reimbursement for physicians up to 75% of Medicare rates (also see positive aspects of the Commission's recommendations), when existing reimbursement is lower, with eventual goal of 100% of Medicare; possibly vary rates by specialty. We need to know the appropriate percentage of Medicare we need to pay in order to attract an adequate number of providers to serve all the new Medicaid/CHP+ clients, rather than simply pick a number from the air. There does not seem to be any data or studies on that point. We do not have a sufficient number of providers to serve the current client base. It does no good to expand Medicaid/CHP+ if there are no providers, it would be a meaningless benefit.
- They assure that providers will be paid for nearly everyone who comes through the door, significantly reducing uncompensated/undercompensated (e.g. Colorado Indigent Care Program) care, but the recommendations do nothing to improve patient safety, service delivery, etc. It also potentially increases rates in Medicaid (which I agree we need to do to get adequate provider participation, but it still increases provider revenues even more at taxpayer's expense). It will reduce cost shifting by $92 million and the modeler assumes that (only) <u>40% of reduced cost-shifting is passed back</u> to health plans and consumers. We are also reducing administrative costs to providers estimated to be $166 million per year, but there is no provision made to ensure that any of it goes to patient care and not the bottom line.

- Moves hundreds of millions of dollars from the safety net providers to other providers, including for-profit entities.
- The recommendations create no requirements for provider education (doctors are one of only a few licensed professionals that do not have a continuing education requirement).
- There is no requirement to try to better coordinate and share use of high cost medical technology. $1 million dollar machines should be used 24/7, not 8 to 5 at every hospital.
- There was no discussion about any form of medical malpractice reform.
- All discussion about non-traditional western medicine care, including chiropractic, acupuncture, holistic healing, etc. was promptly cut off.

Long Term Care Considerations

- The recommendations do not include any long term care for many people with disabilities and elderly (other than a single reference to looking at previous work on the subject), Nursing Facility Transitions, etc. Nor is there any mention of encouraging the purchase of Long Term Insurance, or reform of that market to make it more affordable and available, which will reduce the burden to the taxpayer in the future.
- LTC accounts for 70% of Medicaid's budget and its omission hides significant costs in the modeling results. This represents a critical omission in terms of care quality and reducing state and consumer costs. LTC is the major emerging health care issue in this country and in Colorado with the impending aging of the baby boomers, nor the need to grow a stable workforce to meet that demand. It is unfortunate that the commission did not go further than recommending a comprehensive study of long term care. Colorado is facing a population demographic shift that is far more significant than most states. The impact that the baby boom generation will have on the long term care infrastructure in Colorado demands immediate consideration and planning, if we are to avoid or ameliorate the fiscal consequences.

Consumer Considerations

- Much has been made of the often used statistic that 70% of Coloradans are happy with their current insurance coverage. It may well be that a substantial number of these people are content with the current situation because they are not heavy users. It may be the case, that satisfaction with the current health coverage system is much less for vulnerable populations, or individuals with chronic or catastrophic conditions who are fundamentally dependent upon it.
- A general observation is that there appears to be a number of areas where the transition of care is not likely to be seamless. There are a number of hand-over points where that transition could become more difficult from the point of view of the user. Specifically, transitions to and from Medicaid, employer based coverage, Cover Colorado, and basic plan coverage to Medically Needy/Catastrophic care. These transitions may require a more complex application process and will require some education in the use of the "Connector".
- The Commission refused to even entertain making a strong recommendation that no resources currently serving vulnerable populations be shifted to expanding eligibility for less needy/vulnerable populations, and that any future cuts in funding affect vulnerable

populations last. The only recommendation made on this matter is *"do not fund expansion through reduction of services to current Medicaid and CHP+ eligibles"*. The lack of such recommendation sends a message to the disabled and low income elderly that there is indeed an intention to cut their life sustaining services in order to serve others who are healthier and wealthier.

- One primary focus of the Commission in the development of the 5th Proposal was to keep the premium below $199/mo for the premium for the Minimum Benefit Plan for "healthy" and primarily low needs individuals. The recommended "Minimum Benefit Plan" benefit package will result in a large number of underinsured, and will not ensure that people actually have access to necessary medical care. Making an inadequate product affordable is not helping the problem!
- The Commission does not cap "out of pocket" costs, only out of pocket costs for premiums. This does not include co-pays, deductibles, non-covered benefits. The standard used for premium out of pocket costs is at the high end that a number of studies recommend for total out of pocket costs. The Minimum Benefit Plan recommended will mean significant out of pocket costs for anyone with any sort of health problem.
- The Commission elected to use Federal Poverty Level as its standard for affordability even though there was evidence provided to the Commission that FPL is not an adequate affordability standard, particularly for health care.
- While the recommendation is to provide a taxpayer subsidy for those between 300% and 400% of FPL, the subsidy is only for the Minimum Benefit Plan, the amount of the subsidy is based ONLY on the Minimum Benefit Plan, but the individual can buy-up at their own expense. Any additional coverage is wholly at the expense of the consumer and insurers may charge whatever they want for it. This will likely perpetuate to our multi-tier health care system of the have's and have-not's. And at 300% of FPL there is a "cliff effect", where the subsidy goes from 80% of premium to a maximum income expenditure for premiums of 9% of income, to those with income over 400% of FPL receiving NO SUBSIDY, and they are exempt from the mandate to buy insurance, at a time when they may need it most. This could be addressed by using a sliding scale to determine subsidy level.
- If employer coverage is available that is equivalent to a CHP+ benefit package for the subsidy program between 205% - 300% of FPL, the individual must buy employer coverage. The employee would get a subsidy for their share of premium, based on income.
- If under 200% you go to Medicaid or the employer's plan, assuming it meets or exceeds the CHP+ benefit equivalency requirement for those in the subsidy program with a 100% subsidy (paid for with Medicaid dollars to for-profit insurance companies, endangering the stability of the program) for the employees share (see above paragraph)
- There are other features that will contribute to or leave existing populations uninsured or at risk of financial hardship as a result of medical care costs, e.g. proposed Minimum Benefit Plan in the Fifth proposal. As the impacts could not be modeled, it skews the results.
- The Commission does not adequately and fairly address the "asset test" that currently applies only to people with disabilities. Such a recommendation opens up the state to a

lawsuit under the Americans with Disabilities Act. It is proposed to be set at $100,000 for CHIP+ kids, parents and for childless adults in Medicaid, but is kept at $2,000 for people with disabilities and elderly. This is FORCED POVERTY. As an example:

- A primary wage earner for a family, sustains a catastrophic injury, obtains a settlement for $300k (the cap in CO under tort reform), invested in Government bonds would result in a rate of return of about $15k/yr, or 75% of FPL for a family of 4. But if the individual needs medical or attendant care which is only provided to disabled Medicaid recipients, they will have to spend the $300,000 in order to get "coverage" from the Medicaid program for people with disabilities (and the benefits needed are likely not provided through the 200-300 Subsidy Plan, Minimum Benefit Plan package or the reformed Medicaid/CHP+ program for childless adults, parents, children). This forces them into government subsidy programs for housing subsidies, food stamps, utility assistance, cash assistance, etc., likely for life, significantly increasing the costs to the taxpayer.

- The modeler appears to be unable to model much of the issues affecting Persons with disabilities (among others), ranging from Long Term Care to the impact of having Consumer Directed Attendant Services as a statewide program (the pilot program, with 150 clients saved the state $600,000 in direct costs and $6 MILLION in indirect costs last year alone). As a result, since this population includes the 2 groups (disabled and elderly) that consume the VAST MAJORITY of medical care (70% of Medicaid, who is the single largest purchaser of health care, is spent on Long Term Care), it brings their entire evaluation into question. The modeler was also unable to model the cost savings in the criminal justice system (likely in the hundreds of millions of dollars) if adequate community based mental health services were provided. They indicate their inability to model this is due to lack of data and time.

- A critical omission in data modeling the fifth proposal and the final commission recommendations concerns start up and implementation costs. For example, there is no discussion about the design, development, and implementation costs associated with the creation of the "Connector". In addition, initial costs associated with any of the five proposals essentially remains unknown. It will be critical for the Legislature to understand what these start up and implementation costs might be, as well as, an estimate for the ramp-up time involved. This would be a critical consideration for a state that is statutorily and constitutionally limited in the amount of revenue it can receive

- Additionally in the modeling process, the Commission pursued recommendations that would reduce costs in the modeling process. In part by shifting individuals to underinsured and "those at risk of financial hardship as a result of medical care costs" (from Senate Bill 06-208) which cannot be modeled_ e.g. the basic plan modeled in the 5th proposal and the inadequate benefits/caps, individual suffering due to lack of appropriate and adequate necessary care, etc. **The cost is the cost, is the cost. You can hide it anyway you want, but it is still a cost, hidden or not!**

- The optional continuous coverage plan may address some portability issues but it is only being considered for further study as opposed to an approved recommendation. In addition, any individual that buys into the Continuous Portable Coverage Plan must remain in that program for many years. Other than this option, portability is relatively

unaddressed. In addition, the proposal does not address how portability is assured during periods of unemployment, particularly if it is not a subsidy eligible plan, etc. What does an individual do if they are on employer sponsored coverage and need continuity of care, etc.?

- The Commission does not address the issue of illegal residents (about 95,000 people), This was done to address a perceived concern that if this provision was included, a small but vocal group might distract attention form the rest of the proposal. We need to keep this population from becoming a public health risk, ending up in the ER (which is where they go now, at the highest cost delivery method), and giving birth to $4 million premature babies. The Commission decided to leave it as is, they get ER, delivery and 2 months of post partum care, and anything the health clinics can afford to provide. In addition, a further barrier is created regarding required documentation. While the Commission recommendations include all legal residents, some legal residents, such as homeless persons and people living off the "grid", etc, will have trouble producing documentation proving that they are legal residents. This may deny health care access to individuals who would otherwise be eligible, but cannot access it due to documentation restrictions. This will also continue to perpetuate cost shifting in the system as providers are unlikely to be paid for serving these populations.
- The recommendations contain no exceptions for religious exemptions, in spite of that issue being raised by the public.
- The insurance Minimum Benefit Plan package modeled in the Fifth proposal has a $50,000 annual limit, with interim caps of $25,000 inpatient, $1000 Emergency Room. This means if an individual ends up in the ER, and runs up a bill of $48,000 without being admitted as an inpatient, they would be liable for $47,000. Worse yet, in the case of a catastrophic injury or illness they will likely be forced into bankruptcy. The Commission's position was that they should have bought a better policy.
- The recommendations eliminate patient co-payments for preventive care and reduce patient co-payments for chronic care management services. If an individual continues to have low needs they have no co-pays, but if their level of need increases their co-pays go up.
- In its Final Recommendations the Commission recommended that the standard for minimum benefits for the "Minimum Benefit Plan", be passed to some future group, the "Improving Value in Health Care Authority". That group could also potentially change the benefits standard for the "Minimum Benefit Plan" at any time during a "periodic review". Citizens need to know what their benefits will be in order to make informed decisions about whether or not they support this reform.
- The revamped "Cover Colorado" risk pool where most high needs individuals over 300% of poverty and not eligible for at least an 80% subsidy will have to go. This was done specifically to "lower the costs for the healthy populations." The determination will be based on a yet to be defined list of conditions, and if you have one you cannot buy coverage in the individual health insurance market. No choice, no option to buy in the individual market if one chooses to.
- If one is 205% - 300% of FPL you would buy your coverage through the "205-300 Subsidy Program", but the 205-300 Subsidy Plan, based on CHP+, would be inadequate for many

high needs individuals due to limits on mental health, durable medical equipment (wheelchairs, ventilators, feeding pumps, etc.) therapies, dental care, etc. You can "buy-up" to a more comprehensive plan, but the Recommendations are silent on whether the premiums for the "buy-up" would be limited or not.

- If you have a high cost rare or other condition that is not on the Cover Colorado list and you are above 300% FPL, you can buy coverage in the individual market, including a Minimum Benefit Plan that may not meet your needs, but the Recommendations are silent on whether the premiums for the "buy-up" would be limited or not, with the exception that it be the same as outside Cover Colorado. For those between 300% and 400% who receive a subsidy, there is no subsidy for the "buy-up" to a more comprehensive plan, again the Recommendations are silent on whether the premiums for the "buy-up" would be limited or not, except that it be the same as outside Cover Colorado. This increases the likelihood that it will be unaffordable for those with high needs who end up in the individual market because they are not eligible for Cover Colorado. The amount of the subsidy is based upon the Minimum Benefit Plan, but the individual can "buy-up" to a more comprehensive plan, but the Recommendations are silent on whether the premiums for the "buy-up" would be limited or not.

- Cover Colorado will be available only to people in the individual insurance market and not in the Medicaid, CHP+ or 205-300 Subsidy Program. Rates for people purchasing through Cover Colorado will be the same as if they were not in Cover Colorado pool (i.e. no 50% rate up). People in Cover Colorado could buy a Minimum Benefit Plan. A more comprehensive benefits package through Cover Colorado, which could cost far more or less than in the individual market, (which we must assume it may be given the population), and the state will subsidize the premium for the "buy-up" to make it equal to 100% of the individual market (and the cost of that subsidy <u>does not appear</u> to have been included in the modeling numbers). If the person does not purchase comprehensive coverage as they currently do not need one but subsequently do, or cannot afford to buy comprehensive coverage, too bad, even though this is where we will dump all the high needs individuals who do not qualify for Medicaid or the premium subsidy program as they are over 300% FPL, and even though they may have little spendable income after paying all disability related ancillary costs.

- In the 5th proposal as modeled, Cover Colorado would operate at a $95 million deficit unless current funding for the program was increased. Cover Colorado could also be subject to cuts if the State falls on hard times making things worse for those who need it.

- There was only a very brief discussion as to whether the current mechanism to fund shortfalls in the Cover Colorado, an assessment on insurers, should be continued. As a result it was omitted from the Recommendations.

- There was a brief discussion regarding end of life care issue, it was decided it would discussed in an ad-hoc committee that was never scheduled, and was just inserted at the end of the process.

- The Medicaid buy-in recommendation (also see positive aspects of the Commission's recommendations), while it will help people with disabilities to return to work and become contributory, once they exceed 450% of FPL (please remember that this population will likely have many ancillary disability related costs not covered/provided by another source) they will have to pay a premium approximately five times what a non-

disabled individual would pay for insurance. This is especially true if they need attendant care.

- The Commission promotes enrollment in managed care systems for all kids, parents and childless adults in Medicaid. This recommendation is a matter of some concern since Colorado's experiment at Medicaid managed care has historically proved to be less than successful and has been demonstrated to be more costly than traditional fee for service.
- The recommendations omit pursuing savings to Medicaid by requiring a private insurer to pay first where the individual has commercial insurance in addition to Medicaid, and then appeal if they think Medicaid should pay ("pay and chase").
- Much of the proposed Medicaid expansions rely on additional federal funds, in spite of the fact that the current administration is reducing funds available to the states ($28 Billion over the next 5 years)
- The Commission does not address non-discrimination in health care, accessibility to individually appropriate health care for people with disabilities.
- The Commission does not require the "Ombudsman/Advocacy" program (see positive aspects of the Commissions Recommendations) to be insulated from the vagaries of the political process. In specific, the political influence of the Executive branch, legislative leadership, etc. This provision would be most effective if it was a non-governmental consumer-controlled entity.
- Consumer education recommendations are inadequate. At minimum we should mandate consumer education classes as a condition of high school graduation. Changing attitudes about consumerism in health care will be intergenerational (one statistic we were provided was that 98% of Americans find shopping for health care "crass").
- The Commission does not address the needs of any Coloradoan who may get health benefits through any ERISA or another federal program. While it is true we have little to no control over programs preempted by federal law, it does not address that group, even in terms of their utilization of health care systems in Colorado.
- Prevention and wellness measures will be critical to reducing health care costs by reducing demand. The ultimate success of this program will <u>only be as good as the availability of access</u>. In the fifth proposal, almost 97,500 undocumented residents, and opt-out populations will be unable to take advantage these types of programs and will continue to cost the state because of preventable health problems. It is important to remember in this provision that individuals with disabilities or chronic conditions must be accommodated for. My concern is that without specific consideration these populations that cannot achieve the prevention and wellness results available to the general population may be unintentionally discriminated against.

Positive Aspects of the Commission's Recommendations or Processes

The following is a list of Commission recommendations that represent positive steps forward in addressing State-wide health care concern, coverage, or access. My comments are in italics.

- The addition of Buy-in, Medically-Needy and Medically Correctable programs in Medicaid will allow us to assist some of the most vulnerable people in our state, and

assure access to medical care for those who genuine are in need or those who lose everything as a result of medical care needs.

- The increase to 205% of FPL for adults and 250% for children with respect to Medicaid eligibility will allow some PWD's (Persons With Disability) who have been above the current (approx) 74% of FPL standard used now, to have access to necessary medical care. In the long term this will reduce costs by reducing reliance on acute care utilization, e.g. emergency room care.
- The increase in funding to eliminate waiting lists for children with various disabilities, (*but does not address future growth, nor is there a buy in using the new deficit reduction act option to have families with money pay into the system*).
- Increasing reimbursement for physicians to 75% of Medicare rates, depending on the Medicaid population served, (also see negative aspects), when existing reimbursement is lower, with eventual goal of 100% of Medicare; possibly vary rates by specialty. We need to pay an adequate rate in order to attract a sufficient number of providers (of all types) to actually serve all the Medicaid/CHP+ clients. We don't have enough to serve the current ones. There is little benefit in expanding Medicaid/CHP+ if there are no providers. It would provide no discernable benefit.
- Reducing the administrative burden on providers. However, the recommendations are inadequate and were developed by an outside insurance/provider group, absent consumer input. (also see negative aspects)
- Promote consumer choice and direction in the health care system.
- Increase price and quality transparency, including making the various provider licensing authority records open to the public and included in quality comparator information provided to consumers .
- Provide consumers with evidence-based medical information at the point of service to aid in decision-making through patient-centered care. Adopt population-specific care guidelines and performance measures, where they exist, based on existing national and evidence-based guidelines and measures. It is critical to recognize the importance of patient safety and best care for each patient. It is important to remember that evidence based medicine cannot be applied to distinct populations or those with complex needs, as there is little or no information on those populations.
- Increase use of prevention and chronic care management
- Eliminate patient co-payments for preventive care
- Encourage individual responsibility for health, wellness and preventive behavior.
- Increase funding for local public health agencies in Colorado to perform functions such as preventing disease and injury, assessing community health, and promoting healthy behavior.
- Provide a medical home for all Coloradans (*but we do need adequate providers*).
- Enhance the provision, coordination and integration of patient-centered care, including "healthy handoffs."

- Reimburse providers for care coordination and case management, particularly in the Medicaid/CHP+ and Cover Colorado programs.

- Pay providers based on quality. (*Quality measures must be designed so as not to provide discouragement for providers to take patients that may have negative impact on providers "quality incentives", such as frail elderly, disabled*)
- Support the adoption of health information technology, including the creation of a statewide health information network, focusing on interoperability and the creation of an electronic health record for every Coloradoan, with protections for patient privacy.
- ***Ensure that information on insurer and provider price and quality is available to all Coloradans and that it is easily accessible through a single entry point (e.g. Web site).***
- ***Create a multi-stakeholder "Improving Value in Health Care Authority" in order to fundamentally realign incentives to in the Colorado health care system: The purpose of this Authority is to reduce costs and improve outcomes. To do so, this provision must have:***
    - Rule-making authority to implement recommendations regarding administrative simplification and health care transparency
    - An Consumer Advocacy Program
    - Authority to study and make recommendations to the Governor, state legislature, and rule-making agencies,
    - Authority to assess and report on the effectiveness of reforms, including their impact on vulnerable populations and safety net health care providers.
- Conduct a comprehensive review of current Colorado long-term care information as a supplement to any review of the Commission reports, such as the SB 173 report , the report of the Developmental Disability Interim Committee, the Medicaid Redesign Project (SB 06-128), and the National Clearinghouse for Long-Term Care Information. (*This is woefully inadequate though, for a program that consumes 70% of the Medicaid budget.*)

- Restructure and combine public programs (Medicaid and the Child Health Plan Plus) for parents, childless adults and children (excluding the aged, disabled and foster care eligibles). (*If adequately funded*).
    - For all non-CHP+ Medicaid enrollees, ensure that physicians are reimbursed at least 75% of Medicare.
- Improve benefits and case management for the disabled and elderly in Medicaid by encouraging enrollment of the aged and disabled into integrated delivery systems that have incentives to manage and coordinate care. Promote care delivery in a consumer-directed, culturally competent manner to promoting cost-efficiency and consumer satisfaction. Providing care coordination and targeted case management services. Providing dental coverage up to $1,000 per year. Exploring potential for further reforms to

Medicaid, particularly for those who are disabled (*see the Appendix 7 of the 208 Commission Report*).

- Improve delivery of services to vulnerable populations.
  - Create a Medicaid buy-in program for working disabled individuals.
  - Create a medically-correctable fund for those who can return to work or avoid institutionalization through a one-time expense.
  - Increase number of people served by the home- and community-based programs equal to the number of people on the current waiting list for these services. [122]
  - Provide mental health parity in the Minimum Benefit Plan (Recommendation 21).
  - Establish a Medically-Needy or other catastrophic care program for those between 300% and 400% FPL to address the issue of people who have health insurance but do not have coverage for catastrophic events (fund at $18 million in state funds). (*The eligibility thresholds and criteria are not delineated. In the second iteration of the fifth proposal a [more comprehensive] catastrophic fund was modeled at an estimated $325.6 million. This estimate may be insufficient when compared to costs for far less vulnerable populations. During public comment, the commission heard testimony from several individuals with high incomes and "gold plated" health insurance coverage that still became bankrupt as the result of a catastrophic event. This also the only item in the Recommendations that proposes a cap.*)
- Expand eligibility in the combined Medicaid/CHP+ program to cover more uninsured low-income Coloradans. (*But only if adequately funded and not at the expense of more vulnerable populations*)
- Ease barriers to enrollment in public programs
- Enhance access to needed medical care, especially in rural Colorado where provider shortages are common
  - Continue to pay all qualified safety net providers enhanced reimbursement for serving Medicaid patients
  - Expand telemedicine benefits for Medicaid and CHP+ enrollees, especially in rural areas. (*This recommendation should also include anyone who has difficulty in accessing the doctor's office or that has a condition that does not require a face to face visit with the doctor. This also omits the concepts of using automated telephone based patient status monitoring systems*)
  - Develop and expand mechanisms to recruit and retain health care workers who will provide services in underserved areas of Colorado, such as state-based loan repayment, loan forgiveness programs, tax credits, and other approaches.
- Create a Consumer Advocacy Program

[122] Including the Children's HCBS waiver program, the Child Autism waiver program, the Adult Comprehensive waiver program, the Adult SLS waiver program, the Early Intervention waiver program, the CES waiver program and the Family support waiver program.

- ◦ Create a program that is independent and consumer-directed
- ◦ Provide system navigators to guide people through the system
- ◦ Resolve problems
- ◦ Provide assistance with eligibility and benefit denials (and they should also provide representation in appeals)
- ◦ Help qualify people on Medicaid for Medicare
- ◦ Help people qualify for SSI

- ■ Continue to explore the feasibility of allowing employers to offer 24-hour Coverage

General Comments on Criticisms and Process

I want to be clear that my criticisms below are not intended in anyway to reflect on the Commission staff. I believe they did their best efforts to accomplish a huge task and are to be commended, but they were impaired by others. E.g. inspection of the time stamps imbedded in electronic documents show the vast majority were sent out shortly after being received by staff, but may were provided to them hours before meetings.

I came into this process believing there was something between total free market system and single payer. Having been in Medicaid for a number of years, I have strong objections to government running health care. I have come to the conclusion that if there is the desire to truly and significantly change the current health care system (as opposed to a band-aid approach), Single-payer is the only option that may politically feasible, if there is enough ground swell of public support and strong advocates for it in public policy makers. I am concerned that special interests who currently profit from the current system will do everything they can to obstruct real reform. If we are gong to add approximately 500,000 people to Medicaid, Colorado may as well move to single payer plan, as we will be well on the way.

Unfortunately, I feel that we have missed a unique opportunity to do something that will truly benefit the people of Colorado. This could have been alleviated to some degree had the commission been more representative of Colorado's actual population. Only three commissioners were consumer representatives or advocates. None of the commissioners were uninsured or underinsured and only one a Medicare or Medicaid recipient. This composition may have skewed the final result.

There were also procedural difficulties. The process the commission followed changed relatively frequently with respect to materials, meeting format, and presentational order, etc. This made it very difficult to adequately prepare and follow the process. On several occasions we were asked to participate in a "straw poll" to get a sense of where we were on an issue or series of issues. In some instances that "straw poll" became a binding vote. This occurred in the final selection of the 4 proposals selected for modeling, the selection of "key questions" that guided the development of the 5th proposal, as well as, at other key points in the process. It is worth noting, that of the 4 proposals submitted to the Commission selected for modeling, 3

were developed by organizations with some relationship to Commissioners, and as has been stated in public forums, lending the appearance of favoritism.

Simply because I participated in the process, and tried to make the best of it, I have been told that it was presumed that I was in consensus with the Commission; that I agreed with much of the recommendations. That is not the case. I made a commitment to my appointing authority to follow through in the process and seek the best result possible, which I did. That does not mean I agree with the final recommendations, as is evidenced by this dissenting opinion.

Many issues that deserved more exploration and many ideas that had real merit were consigned to a repository that the Commission identified as "the parking lot". The implication was that these issues would be reviewed at a later point in the proceedings. In a great many cases that re-review did not occur. Unfortunately, many of these parking lot ideas and issues deserved far great examination than they received. I am of the opinion that part of the Commission's charge was to gather data on various ideas regarding health care reform. As a result, I believe the 5th proposal should have been as encompassing of all ideas not addressed in the other 4 proposals modeled, as possible

In spite of the Commission's decision to wholly comply with the spirit and intent, the violations of the Sunshine Act became to numerous to keep track of and there were numerous public complaints about it as well. Meeting announcements were not timely posted; there was no list of interested persons kept and notice provided, etc. While it did improve slightly near the end of the process, we were frequently provided with materials (frequently voluminous) just prior to, or at meetings, which we were then expected to make decisions based upon.

I made numerous requests for accommodations as a result of my disability and other persons with disabilities from the public, in order to maximize public participation, a significant proportion of which were not provided.

Public input, while solicited, could have received greater attention and inclusion. There has never been any consolidation or summary of public comments and testimony. Some public testimony was discounted or labeled as "not indicative of the general population of Colorado, that most of the people who attended have an agenda". The most egregious example is when the Commission held "listening sessions" regarding the proposal solicitation criteria it had developed; the issue that "transparency and accountability" had been omitted from the criteria was noted by several people. Those suggestions were not added. It is my estimate, having attended numerous hearings across the state, is that on average, about 30% of those who testified were part of an organized effort, and the rest were spontaneous. The clear majority supported a single-payer system.

On several occasions the Commission received presentations that seemed to have a bias to special interests, on a few occasions the Commission heard from a representative from the insurance industry for technical advice, but such opportunity was never provided for any other interest groups. On several occasions over a period of several months I requested a presentation on the issues of long term care, as it is 70% of the Medicaid budget which never occurred. The result, the only recommendations at all on long term care is just a single short paragraph suggesting a review of the past work on the issue, nor is there a mention of it in the Commissions recommendations to our federal representatives. Other Commissioners made

requests for presentations also, on issues they felt they or other Commissioners needed more education on. E.g. one of the primary reasons for the lack of recommendations for substantial worker's compensation reform was due to the lack of knowledge about the workers compensation system by every single Commissioner, but two, including myself.

Many issues were put off for "later", with representations it was due to the short time frame given by the legislature. This became an almost blanket reason for everything not discussed.

While some of the Task Force reports/recommendations were included in the recommendations, the Vulnerable Populations Task Force report, in specific, received insufficient attention and review, and neither of the Task Force chairs was even in the room at the time. Consumers were woefully under represented on the other Advisory Task Forces.

The author cannot make any guarantee of accuracy, particularly given the Commission has not finalized it's report at the time of this writing, (and has since made significant changes to the final report since the due date of this dissent, in part as a result of this dissent), although this dissenting opinion was required to be submitted prior to that finalization. The draft of Final Recommendations available at the time of this writing states "We will elaborate upon the rationale behind of specifics of these recommendations for the Commission's final report to the Colorado General Assembly, due Jan. 31, 2008.", so all of the details are not available for those writing a dissenting opinion, which is due the same day the 2nd draft of the final report will be distributed. There have been repeated attempts to limit the content of the dissenting opinion(s), and it was decided that the drafts of dissenting opinions would have to be based on the Commission's recommendations (without the benefit of much of the details yet to be provided), not the final report, "due to time constraints". As a result, there may be issues that I have misunderstood as a result of the lack of clarity.

I also wish to thank and commend staff for their time and invaluable efforts to assure to the greatest extent possible, the accuracy of the opinion.

The information and opinions contained herein are solely the opinions of the author.

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Chapter 11: Cost and Coverage Impacts of Five Proposals to Reform the Colorado Health Care System: Prepared by The Lewin Group