CLUB 20 Comprehensive Health Care Plan for Colorado

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Preamble:

Can you envision this?

- A health care system that is equally accessible to everyone, which efficiently provides quality essential health care focused on wellness and preventative disease management.
- A system which individuals access using a uniform health ID card that serves as the cornerstone to an integrated Health Information Technology network providing seamless and instant communication linkage between all participants in the system.
- A system which encourages personal responsibility and free choice, where everyone is covered and everyone contributes.
- A system which appropriately utilizes technologies and evidenced-based services reaching through one's entire life span.

We can envision such a health care system, and we offer the following proposal to that end.

This health care reform proposal was developed through the collaborative efforts of a diverse group of individuals representing doctors, nurses, hospital administrators, health insurers, the business community and individual consumers – each representing a critical component in the delivery of health care. Because each of these constituencies has a vested interest in improving the quality and efficiency of health care, they each contributed a unique perspective that was necessary for the development of this comprehensive reform proposal.

This proposal began with a review of similar efforts by other states to reform health care. Reform efforts in Massachusetts, Hawaii, Oregon, Maine and California were considered, with particular attention paid to the recently-adopted Massachusetts Health Care Reform Act. While each of these other state efforts has merit and provides insight to how Colorado might best address our own health care challenges, we don't believe that any of these other state models adequately addresses the need to stem the rising cost of health care, and only Oregon has made a concerted effort to define necessary limitations on the delivery of health care. Without such limits to a health care plan, states will continue to fail in their efforts at reform. We believe that any reform proposal must address the fiscal realities of present day state financing. Unlike the federal government, most states must balance their budgets on an annual basis.

We believe that a great deal of the solution to Colorado's health care challenge has LESS to do with new ideas, and MORE to do with the need for policy makers (and the broader public) to accept the reality of our current health care situation. Once one understands and ACCEPTS the indisputable reality within which we must operate, it's not that difficult to connect the dots to determine the necessary changes that must be made. This reality is not comfortable to accept and we don't expect anyone to embrace it enthusiastically, but it is what it is and this problem demands that we acknowledge that reality truthfully and boldly.

Our proposal is based on several acknowledged realities:

1) On a macro scale, the cost of health care is simply a function of the <u>overall cost of the health care system</u> (the **numerator**) divided by the <u>number of participants who pay into that system</u> (the **denominator**).

$$\text{Cost of Individual Health Care} = \frac{\text{Cost of Overall Health Care System}}{\text{\# of Participants Paying into System}}$$

2) We ALREADY provide "universal" health care to everyone via mandated access to the Emergency Room. This emergency care, however, is one of the most expensive links in the health care system and is doled out on an irrational crisis-oriented basis.
   The question which our society needs to answer is NOT *"SHOULD we provide health care to everyone?"* because we ALREADY do that. Rather, the appropriate question that we answer in this proposal is *"HOW should we provide health care to everyone in the most efficient and equitable way?"*

3) There is a finite amount of money in the system. We CANNOT afford to provide UNLIMITED care to everyone. To ignore this financial reality is to render any health care delivery system unsustainable and ultimately doomed to fail.

4) To the extent that some people do NOT have health care coverage, they will avoid preventive care measures in favor of crisis-driven health emergencies and continue to seek the most

expensive treatment at the emergency room when needed. The result will continue to be an irrational and inequitable cost-shift to those who ARE paying for coverage.

5) Preventive health care in the context of a "medical home" will always be less expensive than emergency health care treatments that arise later as a result of the lack of preventive care – less expensive to the individual AND less expensive to everyone else who pays for health care and shares the burden of supporting the overall health care system.

6) More health care does not necessarily result in better outcomes. Quality health care is a function of provider/patient relationships, timely care, and good standards of practice …NOT quantity of care.

7) Our current health care "system" is plagued by tremendous inefficiencies at all levels.
   Multiple and competing sets of rules.
   Inconsistent reimbursement schedules.
   Duplicative administrative functions.
   Lack of communication between all segments.
   Lack of access for some.
   Our system is built around fractured and adversarial relationships rather than a coordinated effort to deliver seamless care.

With these acknowledged realities in mind, and with a combination of health coverage mandates, benefit limitations, and a simplified delivery system, we believe our plan for comprehensive reform will sustain a health care system that will efficiently and equitably deliver quality care for all. We believe that we must provide basic health care coverage to everyone in order to stop the incredible amount of inequitable cost shifting which drags our system down.

Our plan, if adopted, will also provide a wonderful template of what the federal government could accomplish if they adopted a similar approach. In addition, if the principles of our plan were extended to the federal level – it would also serve to enhance what could be offered under the state plan.

Ultimately, the merits of any health care reform proposal should be evaluated NOT against what we WANT as a society, but rather what we NEED.

We all WANT unlimited access to health care, no cost-shifting, no mandates, benevolent care for everyone who really needs it, and reduced cost. But these objectives are simply contradictory and unrealistic.

What we NEED is a quality health care system that is equitable and sustainable.

a) Comprehensiveness

(1) What problem does this proposal address?

Our proposal includes recommendations to both DECREASE the cost of the overall health care system (the Numerator) and INCREASE the number of people who pay into that system (the Denominator), thus addressing the following fundamental problems with our current health care "system" and ultimately reducing the cost of health care for everyone:

A. Inequitable cost-shift caused by "uninsured" individuals.
B. Inappropriate dependence on expensive emergency treatments.
C. Irrational and inefficient "sky's the limit" approach to providing health care.
D. Inefficient and burdensome health care system processes and reimbursement mechanisms.
E. Insufficient access to quality care for many Coloradans.
F. Ineffective communication links among all segments of the health care system.

(2) What are the objectives of your proposal?

The goals of this health care reform proposal are to:

A. Provide essential health care to everyone in Colorado.
B. Improve the quality of medical care that is delivered.
C. Increase portability and continuity of health care coverage.
D. Increase the number of people who are purchasing insurance (the denominator).
E. Drastically decrease the problem of uncompensated care and cost shifting.
F. Contain the excessive escalation of medical costs by placing rational limits on covered benefits.
G. Promote preventive health care and early disease intervention.
H. Encourage personal responsibility in utilization of health care system.
I. Reduce the burden of health insurance for small businesses to help them be more competitive in the global marketplace.
J. Reform the provider reimbursement system in order to achieve an adequate supply of competent health care providers.
K. Incorporate current Medicaid beneficiaries into a reformed health care system which provides essential coverage for all Coloradans.

L. Promote efficiencies throughout the health care system and, in so doing, decrease system costs.
M. Create a health care system which is both politically viable and sustainable.

b) General

(1) Please describe your proposal in detail.

IN SUMMARY:

A. Mandate all Colorado residents must secure basic "Tier 1" individual health care coverage.
B. Define the essential (and limited) elements of medical care in this "Tier 1" Benefits Package and appropriate associated reimbursement rates.
C. Create the "Colorado Health Commission" to coordinate and direct the new overarching elements of health care reform which our plan introduces.
D. Create the "Colorado Care Connector" to assume the role of the current Medicaid system and efficiently provide "Tier 1" coverage to those who can't afford it.
E. Standardize health information technology utilized by all participants in the health care system.
F. Improve the efficiency and accessibility of quality health care for patients.

IN MORE DETAIL:

A. Mandate all Colorado residents must secure basic "Tier 1" individual health care coverage.

The fundamental basis of our proposal is to mandate basic health care for everyone. This mandate will require an enforcement mechanism to ensure full participation in Tier 1 coverage. This mechanism could be modeled after the mandates and sanctions within the Massachusetts Health Care Reform Act. This mandatory essential coverage accomplishes five things:

i. Injects new money into the system.

Mandatory coverage increases the denominator of the basic health care equation (the number of paying participants in the health care system) and, in so doing, injects new money into the health care system and decreases the cost for everyone who's currently funding the system. The broad category of "uninsured" includes BOTH those who CAN'T afford health insurance and those who can afford

insurance but WON'T pay for it. Mandatory coverage captures additional premium dollars from this latter category.

ii. Provides equitable cost-shifting.

Mandatory coverage acknowledges that some still won't pay but, in so doing, it purposefully creates a rational form of equitable cost-shifting rather than simply defaulting to the irrational form that we endure at present.

iii. Encourages personal responsibility.

While everyone enjoys the right of basic health care coverage, everyone who can afford to pay for insurance DOES. Further, we propose that everyone – regardless of income level – be required to pay some level of co-payment for treatment.

iv. Ensures portability of insurance.

While we advocate for an INDIVIDUAL mandate to achieve this expanded coverage for all, we believe BUSINESSES should be encouraged to partner with employees and offer premium sharing plans. In fact, we believe businesses may choose to offer even greater coverage ("Tier 2") as a non-salary benefit. Should the legislature deem that a mandate for business is required, this would still fit seamlessly in the implementation of our proposal.

With the universal nature of the mandatory basic health coverage, employees who lose their jobs or change jobs would still have their same medical plan; their premium may change based on their income level change or change in employer contribution, but their basic coverage remains the same – absolutely portable.

v. Encourages preventive care.

Mandatory coverage encourages preventive care for those who previously had no access to health care coverage. Rather than waiting for disease to advance to the level of emergency care, these individuals will now be incentivized to seek basic care in the early stages of disease management, when the costs are less for everyone in the health care system. People are encouraged to develop ongoing relationships with the provider of their choice.

B. Define the essential (and limited) elements of medical care in this "Tier 1" Benefits Package and appropriate associated reimbursement rates.

Equally important as the access for everyone to basic preventive health care are appropriate limitations on that care. Whether one chooses to call it "rationing" or "limiting benefits" can

be debated; however, no one can argue that it is fiscally impossible to provide sustainable health care that includes limitless coverage.

Value-ranking of procedures

We propose to utilize a process modeled after that which the State of Oregon has employed to rationally define the level of basic necessary care which should be made available to everyone. (Additional care should be made available for an additional cost at the consumer's option.) The ranking of health care benefits that is medically necessary would be chosen by a Medical Ethics Board (as designed by an outside organization and described in detail in a supplement to this proposal).

Actuarial valuation of the value-ranking

The CHC will guide the determination of appropriate prices for each procedure, and actuaries will determine the resulting cost of each of these benefits to the system incorporating utilization data. These defined prices will establish the provider reimbursement levels for the procedures within Tier 1.

Premium determined by policy makers based on available funds

The State can decide how "deep" into this list the State can afford to offer in its Tier 1 Benefits Package. Clearly, the more state and federal funds that are offered into the system, the more comprehensive the Tier 1 benefits package can be. Premium levels will need to be modest as this is essential for a workable plan.

C. Create the "Colorado Health Commission" (CHC) to coordinate and direct the new overarching elements of health care reform which our plan introduces.

   The CHC will be an independent, apolitical, non-governmental body comprised of representatives of stakeholders in the health care system (similar to the 208 Commission, itself). The CHC membership will be appointed by and accountable to the Governor. Membership terms will overlap, so as to promote long-term stability of operations and minimize the impact of changes in the external political environment.

D. Create the "Colorado Care Connector" to assume the role of the current Medicaid system and efficiently provide "Tier 1" coverage to those who cannot afford it.

In order to provide subsidized Tier 1 coverage to those who cannot afford it, we propose to create the Colorado Care Connector (CCC). The CCC will receive and disburse the non-direct premium dollars (such as federal and state Medicaid funds, Tobacco Tax revenues, etc) in a efficient, consistent and transparent manner. In order to fully implement this process, it will be necessary to secure a federal waiver from Medicaid.

E. Standardize health information technology utilized by all participants in the health care system.

One of the most effective means for increasing efficiency within the health care system is to utilize available technology in the collection and sharing of data. In order to realize this change, we propose that all payers and providers of Tier 1 coverage be required to participate in an integrated end-to-end system of electronic administration that incorporates enrollment records, patient treatment records, payment records and beyond.

The benefits of this technology advancement are many, including:

- Efficient and timely information exchange
- Uniformity
- Accuracy
- Accessibility
- Portability

F. Improve the efficiency and accessibility of quality health care for patients.

Our fundamental objective in providing basic care for everyone is to encourage proactive utilization of preventive care instead of reliance on emergency treatments later on. We will promote the concept of a "medical home" in which consumers develop a relationship with their primary care physician based on trust and what they NEED rather than economics and what they can AFFORD.

At their option, individuals would be able to add extra "Tier 2" coverage similar to what is currently available to them. While Tier 1 streamlines a limited supply of dollars for an essential benefits package, Tier 2 allows for unlimited health care options.

In order to ensure adequate access to care, we must have a sufficient supply of providers. Appropriate provider reimbursement rates are necessary to achieve this desired supply of

providers. The shortage of resources for rural/frontier and vulnerable populations will need to be addressed.

(2) Who will benefit from this proposal?

A. Patients will have improved access to care and preventive medical care.
B. Employers will have the opportunity to provide affordable health care coverage to employees. With a uniform premium and benefits package, small employers will now be able to compete on a level playing field with larger employers, both locally and globally.
C. Providers would have lower administrative costs in dealing with Tier 1 coverage because of standardized electronic data linkages with payers. Providers would also realize more timely reimbursement for their services. The cost to hospitals and clinics for providing uncompensated "charity" care and over-utilization of the emergency ward will be dramatically reduced.
D. Payers will also realize lower administrative costs because of standardized electronic data linkages with providers. Payers will also have the benefit of an expanded pool of paying participants.
E. Consumers who currently pay into the system will realize lower premiums as overall system costs are reduced and cost-shifting is minimized.

Who will be negatively affected by this proposal?

A. To those who CAN afford health insurance but currently DON'T, they will now have to assume the responsibility of paying a premium for Tier 1 coverage.
B. Some aspects of health care which are currently being provided will be denied under our Tier 1 plan as they may be deemed "medically unnecessary" or simply unaffordable.
C. With comprehensive reform comes change. This reform proposal will require some degree of change and adaptation for all participants in the health care system. (For example, the standardized electronic data transfer linkage which we envision will require everyone to alter their systems to conform.)
D. Some Medicaid patients may have their current benefits package change as they are integrated into our Tier 1 Benefits Package.

(3) How will your proposal impact distinct populations (e.g., low-income, rural, immigrant, ethnic minority, disabled)?

In our plan there are no "distinct populations" -- Everyone is treated the same under Tier 1 coverage. Part of the problem with our current health care system is that we DO provide "distinct populations" with different levels of coverage, and the costs are shifted between these populations. Particular attention will need to be paid to the most frontier and low-income counties which will need to strengthen their weak provider infrastructure.

(4) Please provide any evidence regarding the success or failure of your approach. Please attach.

The relationship between physicians in the Grand Valley, Rocky Mountain Health Plans, and State Medicaid is the best model around – this is evidence of how a private entity can manage State dollars in a very effective manner.

The Dartmouth Atlas analysis documents in great detail how more medical treatment does NOT always result in better medical outcomes (see attached example).

The Marillac Clinic in Grand Junction has demonstrated the feasibility of requiring all patients to contribute a co-payment for services. This encourages personal responsibility and helps to offset costs.

Marillac Clinic has established itself as the "medical home" for a significant number of uninsured and, in so doing, has contributed to a large reduction in in-patient and ER costs in the Grand Valley.

(5) How will the program(s) included in the proposal be governed and administered?

The plan utilizes the existing structure of current private entities to deliver care (providers) and administer benefits (payers) at the patient level. However, to coordinate and direct the new over-arching elements of health care reform which our plan introduces, new administrative entities are required: One is the is the Colorado Health Care Commission (CHC) and the other is the Colorado Care Connector (CCC).

The CHC is an independent, apolitical, non-governmental body comprised of representatives of stakeholders in the health care system. The CHC will perform the fundamental tasks necessary to bring essential medical services to all Colorado residents. The CHC's most significant responsibilities will be:

A. Establish an "Ethics Board" to rank medical benefits in terms of evidence-based quality and effectiveness;
B. Assign actuarially-determined cost values to the list of ranked benefits;
C. Recommend to the Legislature the basic package of essential Tier 1 benefits and premiums derived from the list of ranked benefits;
D. Implement an integrated end-to-end system of electronic administration that incorporates the full range of provider, payer and patient activities - from enrollment records to treatment records to payment records and beyond.

The CCC is the entity responsible for collecting and disbursing the non-direct premium dollars (such as federal and state Medicaid funds, Tobacco Tax revenues, etc) in a efficient, consistent and transparent manner. The CCC will determine eligibility for reduced premium payments and government subsidies, and manage and administer those payments.

(6) To the best of your knowledge, will any federal or state laws or regulations need to be changed to implement this proposal (e.g., Medicaid waiver, worker's compensation, auto insurance, ERISA)? If known, what changes will be necessary/

A. Our proposal will require a Medicaid waiver. As a state, we would no longer have a separate Medicaid system. It would, in essence, become integrated within Tier 1 coverage. Current federal Medicaid matching dollars would be used to help finance our Tier 1 package.

B. There may need to be statutory changes governing the writing of insurance coverage.

C. While not necessary for the successful implementation of this reform proposal, we strongly believe that the federal Emergency Medical Treatment and Active Labor Act (EMTALA) needs to be amended to allow Emergency Rooms the flexibility to coordinate with other providers for the redirecting of non-emergency patients to non-emergency facilities. Until this happens, we will continue to over-utilize this most expensive link in the health care chain.

(7) How will your program be implemented? How will your proposal transition from the current system to the proposal program? Over what time period?

We believe that our proposal could reasonably be adopted within 2-4 years. The following fundamental actions would need to be taken to implement this proposal:

A. Pass legislation mandating Tier 1 coverage to all Colorado residents.

B. Form the governing bodies of the CHC and CCC.

C. Define Tier 1 benefits.

D. Extend coverage to the uninsured immediately and phase-in Medicaid recipients when possible.

E. Reallocate existing funding streams to address accessibility.

In order to facilitate the transition, some of the start up logistics could be performed while we continue in our current system.

c) Access

(1) Does this proposal expand access? Is so, please explain.

Access is a function of two factors: eligibility for coverage AND adequate provider resources. By mandating participation and providing for uniform eligibility rules, this plan automatically provides for universal eligibility. And, by providing for proper reimbursement, we increase the chances of provider adequacy. There are geographic areas which will need network development to assure adequate access to providers.

(2) How will the program affect safety net providers?

Our plan should benefit safety net providers by offering a mechanism for adequate reimbursement of care. However, our intent is that fewer people would need the safety net in the first place as more people could utilize any participating physician for their care.

d) Coverage

(1) Does your proposal "expand health care coverage"?

Our plan expands essential health care coverage to the uninsured and under-insured, both those who CAN'T pay and those who can pay but WON'T. Because we've included Medicaid beneficiaries within our Tier 1 coverage, and we've expanded the pool of providers for this care, we've also expanded coverage to these recipients.

The degree to which this health care coverage is expanded will be determined by the dollars generated by the premium for the essential benefits package coupled with state and federal dollars.

(2) How will outreach and enrollment be conducted?

Under the guidance of CHC, the CCC will administer the enrollment of eligible subsidized recipients. In addition, direct enrollment will continue as currently done through individual health plans and employer groups.

(3) If applicable, how does your proposal define "resident"?

Anyone living in the State of Colorado.

e) Affordability

(1) If applicable, what will enrollee and/or employer premium-sharing requirements be?

We are proposing that individuals be responsible for securing their essential Tier 1 coverage. They may pay for this coverage themselves, or their employer may choose to share in this premium payment, or the employer may choose to offer Tier 1 coverage entirely. In addition, some businesses may wish to offer coverage to their employees beyond Tier 1 as part of a competitive benefits package. Those who can't afford to pay for coverage, and can't secure it through employment, will be eligible for subsidized assistance through the CCC.

(2) How will co-payments and other cost-sharing be structured?

We believe that it is absolutely necessary that personal responsibility be a part of the solution, therefore our proposal requires that ALL consumers provide a co-payment whenever they access care. Without co-payments, over-utilization of the system will occur. For low income individuals, co-payment could be set on a graduated scale based on one's income level.

f) Portability

(1) Please describe any provisions for assuring that individuals maintain access to coverage even as life circumstances (e.g. employment, public program eligibility) and health status change.

The design of our proposed system inherently allows for portability because the insurance is attached to the INDIVIDUAL, not the BUSINESS. Individuals are guaranteed the same benefits regardless of who is their employer or even whether or not they're employed at all.

If someone changes jobs – their plan stays the same. They may lose their employer's premium sharing but their plan will still be intact and they would not need to change providers.

If someone loses their job or changes income status, their premium calculation would change based on their income percent of poverty level calculation – but again – their plan does not change and their provider does not have to change.

If they relocate elsewhere in the state, they will still receive the same essential benefits package as they had at their prior location.

For out-of-state employers which have a national or international scope, the company will receive a waiver as long as they have a national insurance plan that provides AT LEAST the basic Tier 1 coverage mandated by the State. If the company does NOT already provide at least this level of basic coverage, then they will have to provide it or the employees will have to secure such coverage individually.

g) Benefits

(1) Please describe how and why you believe the benefits under your proposal are adequate, have appropriate limitations and address distinct populations.

Defining appropriate coverage limitations is one of the most important and difficult aspects of designing a health care system that is financially sound, however, we believe that it is absolutely necessary that such limitations be a component of any sustainable plan. We believe that the level of coverage should be defined more by what is economically sustainable than what we may deem as "adequate" based on our collective value judgments.

To attempt to define coverage based on what we believe is "adequate" – without consideration of whether or not such coverage is economically sustainable – is to doom any plan to failure. In the final analysis, the "adequacy" of coverage will be defined less by what we think ought to be included and more by whether or not we can sustain that coverage for the long-term.

While it is obviously our intent to provide for a benefits package that meets essential needs and encourages participants to seek preventive care, we do not suggest WHAT that coverage should include. Rather, we propose that this answer be sought through the following deliberate and thoughtful process:

A. The CHC's Ethics Board will rank health care services using an approach similar to the Oregon model or the Kovar Plan, which proposes that medical procedures be prioritized on the basis of medical effectiveness and that insurance coverage apply relative to the effectiveness of each procedure.
B. Utilize an actuary to determine the cost for each of the prioritized services.
C. Task the legislature with the responsibility and flexibility to determine how much coverage is provided based on the available funds including the premiums generated, the state budget, and any federal funds available.

(2) Please identify an existing Colorado benefit package that is similar to the one(s) you are proposing (e.g. Small Group Standard Plan, Medicaid, etc) and describe any differences between the existing benefit package and your benefit package.

Our proposal for health care reform is totally different from what is currently offered – it truly represents comprehensive change. Because of the inherent evidence-based nature of the benefits, there is no parallel benefits package that compares to this. Again, the "adequacy" of the benefits package will ultimately be determined by the funds available which, in turn, will be determined by the taxpayers' willingness to fund the Tier 1 coverage.

h) Quality

(1) How will quality be defined, measured, and improved?

Under the purview of the Colorado Health Commission (CHC), we propose that quality be DEFINED and MEASURED in the following terms:

A. patient safety
B. transparency
C. access
D. accuracy of medical records
E. patient satisfaction
F. established standards of care (evidence-based medicine)
G. preventive care
H. clinical competence and care delivery

Further, we suggest referencing organizations which have established outcome measures and performance barometers such as:

A. Health Plan Employer Data & Information Set (HEDIS)
B. Center for Medicare and Medicaid Services
C. Colorado Medical Society's document – *"Reactor Solutions Addressing Quality Improvement, Cost Effectiveness and Patient Safety"* – to identify appropriate quality control measures. (Please see attachment #B.)
D. Joint Commissions' general outline for quality improvement.
E. Dartmouth Atlas –Shows how more medical care does not always mean better health care. (See attachment #C)

In order to promote quality improvement, we propose that reimbursement schedules be tied to provider participation in quality review and improvement efforts. Providing monetary incentives for meeting essential elements of quality control, or penalties for failing to meet these same elements, will provide an additional level of safety in the system.

In addition, payers can continue to serve in quality control and efficiency functions as outlined by the CHC. For example, Rocky Mountain Health Plans (RMHP) currently works with the Independent Physician Association (IPA) in Mesa County to incentivize quality care in diabetes. Providers that meet certain criteria in diabetes care are awarded more incentive money through a pool of dollars designated for such quality measures.

(2) How, if at all, will quality of care be improved (e.g. using methods such as applying evidence to medicine, using information technology, improving provider training, aligning provider payment with outcomes, and improving cultural competency including ethnicity, sexual orientation, gender identity, education, and rural areas, etc.?)

In addition to the quality mechanisms mentioned above, our plan actively requires the application of integrated Health Information Technology within all segments of the health care system, from eligibility determination through electronic medical records and integrated financial management systems.

We suggest referencing organizations which have established medical records networking, such as:

A. The Quality Health Network (QHN) links pharmacy, insurance, providers, etc. on the Western Slope.
B. Colorado Regional Health Information Organization (CORHIO)

i) Efficiency

(1) Does your proposal decrease or contain health care costs? How?

Our proposal decreases health care system costs through several mechanisms:

A. limiting what is covered (eliminating sky's the limit coverage),
B. decreasing ER utilization by increasing preventive care and clinic based care,
C. providing for appropriate provider reimbursement levels,
D. recognizing the inherent limit of state funding as determined by the legislature, and
E. reducing cost-shifting.

In turn, by limiting the level of coverage, this also helps contain the inflation rates of medical care over the years. These are essential elements in keeping a state plan fiscally afloat over the years – especially in Colorado where the budget is limited by TABOR.

(2) To what extent does your proposal use incentives for providers, consumers, plans or others to reward behavior that minimizes costs and maximizes access and quality in the health care services? Please explain.

In addition to the incentives already mentioned above, we propose the following incentives:

Incentives for PROVIDERS:

A. In order to participate in the delivery of Tier 1 care, providers must adhere to established quality and efficiency measures. At the same time, appropriate reimbursement rates will encourage participation in Tier 1 while providing incentives to cooperate with quality and efficiency measures outlined elsewhere in our plan.
B. For optional Tier 2 health care services, the free market will encourage efficient delivery of quality services in order to compete for consumers' dollars.

Incentives for CONSUMERS:

A. Required co-pay for everyone encourages consumers to have a vested interest when they access the health care system.
B. This system doesn't set up an administrative "nanny" system to reward/punish unhealthy behavior. However, we encourage the legislature to explore the merits of assessing a sin tax on items that have evidence-based data demonstrating adverse health impacts (smoking, alcohol). The State could create a fund where the Sin Tax is deposited to help pay for the cost of coverage to the lower-income recipients.
C. By providing access to essential health care for everyone, we encourage utilization of preventive care in a "Medical Home" environment.

Incentives for PLANS:

A. With mandatory coverage, we have increased the number of paying participants within the system, and increased opportunity for serving that pool.

(3) Does this proposal address transparency of costs and quality? If so, please explain.

Quality: Yes. Please refer to answers within Questions h.1. and h.2.

Transparency: Yes.

A. By addressing the irrational cost-shifting which currently plagues our system, we acknowledge the true origin of costs and appropriate payment for those.
B. Publishing the information concerning the established value-ranking of medical procedures and associated reimbursement schedules reveals the true scope and cost of each procedure and the system as a whole.

(4) How would your proposal impact administrative costs?

There are several aspects to our proposal that will result in reduced administrative costs:

A. Utilization of comprehensive Health Information Technology streamlines both the delivery and management of health care at all levels.
B. Uniform standards for eligibility, benefits, and reimbursement results in reduced complexity and duplication of services and associated administrative costs.

j) Consumer Choice and Empowerment

(1) Does your proposal address consumer choice? If so, how?

We are allowing consumers free choice of both providers and health plans. Because of the standardization of Tier 1 essential benefits and the array of providers and payers which participate in the delivery of this care, consumers will enjoy greater choice for accessing such care.

(2) How, if at all, would your proposal help consumers to be more informed about and better equipped to engage in health care decisions?

By creating a "Medical Home" and encouraging an ongoing relationship between consumers and their providers, we are shifting from a crisis-driven decision process to a thoughtful and deliberate approach to comprehensive health care.

Transparent pricing empowers consumers to make value-based choices and co-pay requirements ensure that consumers have a vested interest in making their own health care decisions.

k) Wellness and Prevention

(1) How does your proposal address wellness and prevention?

Again, the “Medical Home” relationship which consumers will have with their providers will promote educated decisions and encourage health and wellness from the start. And, by creating an affordable tier of essential benefits that has been heretofore inaccessible to many, we open the door for all consumers to obtain appropriate evidence-based preventive care.

l) Sustainability

(1) How is your proposal sustainable over the long-term?

We ensure that this system is sustainable through the following features:

A. Everybody has to be part of the system and therefore everyone contributes at some level.
B. Our plan places appropriate and equitable limits on Tier 1 coverage and thus acknowledges the practical financial reality that we cannot provide unlimited services with limited funds.
C. By tying the benefit level to the available funding (as determined by premiums and tax-generated revenues), we fundamentally ensure that consumers get precisely what they pay for and nothing more.

There are barriers and impediments to a truly sustainable health care system that currently exist beyond the scope of this proposal, and we think it’s worthwhile to acknowledge two of them here:

1) Medical education

   We believe funding for higher education and medical and nursing education in our state is essential for our future health care system. Physician and mid-level provider shortages must be addressed and health care professionals should be encouraged to pursue occupations essential to the delivery of Tier 1 care.

2) Tort Reform

   Benefit limitations such as we propose could open the door to a multitude of legal battles (as witnessed in Oregon). It will be increasingly necessary to pursue appropriate tort reforms to create an environment which supports these types of appropriate limitations. Ideally, such tort reforms should be dealt with before the benefit limitations are put in place.

(2) (Optional) How much do you estimate this proposal will cost? How much do you estimate this proposal will save? Please explain.

The cost of this system is a function of the true value of services (as determined by the CHC value-ranking process) and the amount that residents are willing to pay (via the legislature). We do not propose to define either of these values; rather, we propose processes to enable these values to be determined in a transparent, accurate and equitable manner.

(3) Who will pay for any new costs under your proposal?

The only "new" costs to this reformed system is the administrative cost of the CHC. While we envision that the legislature will have to fund this state function, we also recognize that the CHC's primary function of oversight will ensure enough savings throughout the system to at least offset this cost.

Regarding the cost of insuring those who are currently uninsured, it's essential to acknowledge that we ALREADY pay this for this cost, we just pay for it indirectly through cost-shifting and funding for indigent care. The "uninsured" includes BOTH those who CAN'T afford coverage AND those who CAN afford coverage but WON'T pay. We are mandating that the latter group will now pay for their own coverage. And, for those who simply CAN'T afford coverage, their coverage will be paid with the existing non-direct premium dollars (Medicaid, tobacco tax revenues, etc) and whatever additional tax monies that the legislature may choose to appropriate.

(4) How will distribution of costs for individuals, employees, employers, government, or others be affected by this proposal? Will each experience increased or decreased costs? Please explain.

Our proposal replaces the irrational cost-shifting that currently occurs with a purposeful assignment of appropriate revenues to meet those costs. The cost for individuals will change depending on whether or not they are currently paying into the system, but we have now increased the pool of payers and those costs will therefore be spread across a much wider base.

We propose no mandated cost to employers. At their option, employers may or may not choose to contribute to the cost of Tier 1 coverage for their employees.

Overall, the entire cost of the system should be reduced as a result of the purposeful cost-containment and efficiency strategies that we propose. The amount of this savings is unknown, but should be significant and will pay for the level of essential coverage mandated within Tier 1.

(5) Are there new mandates that put specific requirements on payers in your proposal? Are any existing mandates on payers eliminated under your proposal? Please explain.

There are three mandates that are included within this proposal:

A) We will mandate that everyone receive coverage for Tier 1 benefits. The cost of this coverage will be determined by the state legislature.
B) Providers will be required to adopt and use established Health Information Technologies.
C) Providers will be required to participate in quality improvement efforts and meet quality standards.

Because of the inherent funding limitations which we are acknowledging and being responsive to, it is possible that certain benefits which are currently mandated under law may not be included within the mandated Tier 1 coverage.

(6) (Optional) How will your proposal impact cost-shifting? Please explain.

It is a simple reality that cost-shifting must take place in any medical system that covers everyone. We believe our plan creates a mechanism for equitable cost-shifting determined through a deliberate and rationale thought process, rather than the random and inequitable process that now exists. Further, because of the necessary limits set by the plan, the cost-shifting will also be limited for individuals and businesses alike.

(7) Are new public funds required for your proposal?

Residents will receive the coverage which they are paying for and no more. Whatever funds are currently available will determine the level of coverage mandated within Tier 1. If residents are

not satisfied with this level of coverage, then it will be incumbent on them to approve an increase in the level of public funds which they contribute.

(8) (Optional) If your proposal requires new public funds, what will be the source of these new funds?

(See #7 above.)

A single page describing how your proposal is either comprehensive or would fit into a comprehensive proposal

(Our proposal is comprehensive in nature. Please refer to the proposal description in Question B.1.)

(Optional) A single page describing how your proposal was developed

A Plan That Came Together

In 2003, CLUB 20 created a Health Care Subcommittee to provide a forum for Western Slope health care advocates to engage in collaborative dialogue and search for solutions to the growing problem of inaccessible and unaffordable health care options for many in Western Colorado's rural communities.

In the summer of 2006, the leadership of CLUB 20's Health Care Subcommittee began an effort to consider possible health care reform opportunities for Colorado starting with a briefing on the Massachusetts Health Care Reform Act. The Subcommittee decided to monitor the work of the 208 Commission in order to be in a position to provide a Western Slope perspective on proposals. Later, the group invited additional Western Slope health care advocates (who were not members of CLUB 20) to join in this discussion and decided to submit their own proposal for comprehensive health reform for Colorado. Given that CLUB 20's Health Care Subcommittee Chairman serves on the 208 Commission and the corresponding need for him NOT to be involved in both efforts, this decision to participate in the 208 process necessitated that this reform proposal be developed outside of CLUB 20's formal committee process and without the involvement of the Subcommittee Chair. The group met 1-3 times per week for six weeks; each member also assisted in hours of research in between meetings.

The members of the task group have diverse backgrounds and professions, all with a desire to provide a solution to the health care financial crisis that Colorado is facing:

- a retired executive of a large, for profit, managed health care company
- a director of premium rating for a non-profit insurance provider
- a hospital administrator
- a physician practicing in a non-profit clinic
- a physician practicing in a general practice clinic
- a medical scientist and county health board member
- a home health care provider
- an administrator of a non-profit
- two small business owners
- a physician director of an emergency room with rural hospital experience

With the diverse professional representation of this task group, the discussions were often not easy. While the members of this group put all their personal philosophies on the table, the goal of a good comprehensive health plan and health finance proposal was never lost. From very diversely rooted opinions grew consensus on the proposal we have submitted.

The need to provide basic health care at an affordable price requires all players to be at the table with a collective focus on the good of the statewide community. This group has demonstrated through a significant commitment of time and energy that we can find consensus solutions for a sustainable, quality and affordable health care system.

Health Care Reform Proposal – Definitions:

Provider: Any healthcare professional or facility.

Payer: A private for-profit or not-for-profit entity that receives premiums and pays providers according to a medical reimbursement schedule established by the Colorado Health Commission.

Tier 1 Benefits: An essential package of medical benefits that is provided to all Colorado residents. Benefits are determined by the Colorado Health Commission (CHC) based on a ranking of evidence-based procedures and protocols and an actuary-based assessment of cost and value. The base price of the premium, as determined by the CHC, determines the level of benefits to be provided under Tier 1 coverage.

Colorado Health Commission: A non-political, non-partisan commission appointed by the Governor that acts independently to rank medical procedures and protocols, to determine the level of Tier 1 benefits, standardize protocols and procedures for payers and providers, evaluates quality measures for payers and providers, and sets standards for medical information acquisition and transfer. The commission shall be made up of a representative group of stakeholders, with expertise necessary to conduct the assigned duties of the Commission.

Colorado Care Connector: A new state entity that is create to provide subsidized Tier 1 coverage to those who cannot afford it. The CCC will receive and disburse the non-direct premium dollars (such as federal and state Medicaid funds, Tobacco Tax revenues, etc), and determine eligibility for those dollars.

(Attachment C)

Dartmouth Atlas Comparative Analysis of Medicare Spending

Hospital Name	City, State	# of Deaths	Total physician visits (Part B) per decedent during the last two years of life (2000-2003)	ICU days (Part A) per decedent during the last two years of life (1999-2003)	Inpatient (Part A) reimbursements per decedent during the last two years of life (1999-2003)
National Average	**United States**	4,692,623	66.71	5.49	24491.25
State Average	**CO**	35,701	58.11	3.29	20883.2
State Average	**FL**	303,630	82.37	8.38	22676.48
St. Mary's Hospital and Medical Center	Grand Junction, CO	1,046	48.36	2.32	18831.08
North Broward Medical Center	Pompano Beach, FL	1,859	94.02	6.37	23524.48

Note tremendous cost variations between hospitals and regions. Outcomes were often times better when less utilization occurred compared to areas of greater utilization of medical services.

(Attachment D)

(letter from Dr. Jeff Holen, CLUB 20 Health Care Reform Working Group participant)

March 29, 2007

Commissioners:

I transitioned from primary care to emergency medicine when I was the chief of staff at a rural community hospital in an impoverished town in Southeastern Colorado. In a years time a functioning medical staff of 12 deteriorated to broken system with 3 physicians covering a population of 12,000. The hospital abandoned women and children's services for "boutique" and non medical service lines to remain financially viable.

We are seeing an exodus of primary care from our system in Mesa County. My past experience suggests that once the homeostatic balance of the medical system is tipped, the system will crash quickly. Many of us physicians have left the medical home model because the present system penalizes a physician being a primary care physician. This limits the most efficient and financially healthiest model of medicine, and replaces it with a game to be played. The most expensive care model is Emergent care and highly specialized care. I can return to primary care, however some changes need to take place. The family practice model offers a system that provides a more responsible stewardship of community resources.

Some of the important aspects of AAFP Principles for Reform of the U.S. Health Care are:

1. Health care coverage for all without unreasonable financial barriers.
2. Individuals and families must have catastrophic health coverage.
3. Improvement of health care quality and safety.
4. Financing for appropriate health services must be a shared public/private cooperative effort.
5. Cost management by all stakeholders.
6. Less complicated administrative systems to reduce costs.
7. comprehensive health information technology.
8. Comprehensive medical liability reform.

I have been a contributor to the collaborative efforts of CLUB 20. . I strongly encourage you look closely at the proposal for health care reform that came together from discussions of this diverse body of passionate and concerned individuals.

Sincerely,
Jeff Holen MD