Solutions for a Healthy Colorado
Colorado State Association of Health Underwriters

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The guiding principles of the Colorado State Association of Health Underwriters (CSAHU) are to protect and improve the health status of all Coloradans. We believe the best possible solutions are driven by market competition that continues to offer choice and flexibility to health care consumers. We recognize the necessity to expand essential health care coverage to all Coloradans and realize that any reform must include an emphasis on the uninsured. We believe that the only way to achieve significant reform is for all participants to accept their responsibility as providers and consumers of health care services and to embrace change that establishes measures to ensure a high quality, cost effective system that is financially viable, sustainable and fair. It must also address the responsibility of the health care insurer and provider to provide a system that allows for choice, and emphasizes wellness, prevention, education and consumer empowerment.

As an organization of health insurance professionals, the majority of our membership spends every day of their business lives explaining the cost and benefits of health care coverage to employers and individuals. We understand as well as any organization what the issues really are. Few individuals in any segment of the health care industry if given the chance would design the system that we have in place today. But to design a new system is not our challenge. Our challenge is to reform what is in place today to better meet the needs of all Coloradans and all Americans.

If the challenge or *goal* is coverage for all Coloradans, then asking all Coloradans to be responsible for obtaining coverage should also be part of the solution. CSAHU agrees in principle with the idea of imposing an individual mandate that reduces the number of uninsured Coloradans through the utilization of the private market. However, the idea of an individual mandate also raises many questions and concerns that will need to be addressed. For example, will imposing an individual mandate do anything to reduce the rising costs of health care and thereby the costs of providing healthcare coverge?

This document provides both a benchmark with which the 208 Commission can measure all proposals, and also offers our own reform ideas, which CSAHU believes are solutions for the health care challenges facing Colorado.

Requirements of Reform

►We believe any reform package must guarantee that all Coloradans have access to health care coverage.

►We believe reform must address and reduce skyrocketing medical care costs.

►We believe reform must not bankrupt families or Colorado.

►We believe reform must provide the state's diverse population with equally diverse health care coverage choices.

►We believe reform must promote ongoing and long-term innovation and experimentation that enable the state's health care system to adapt over time to the evolving needs of its citizens.

►We believe reform must provide consumers access to meaningful information that will enable wise treatment choices and expert advice and counseling from licensed and trained professionals.

►We believe reform must not displace the 83 percent of Coloradans that have health care coverage under the current system.

►We believe reform should not create preference toward any particular market or approach.

We believe the Five Indicators the 208 Commission should use are:

1. Cost Containment
    - Does it constrain rapidly rising medical costs?
2. Affordability
    - Can Colorado afford the plan?
    - Can Coloradans afford the plan?
3. Universal Participation
    - Does it guarantee that every Coloradan has access to health care coverage?
4. Consumer Choice
    - Does it empower Coloradans to find and choose the health care coverage which best fits their unique needs?
5. Evolving Needs
    - Does it enable health care coverage to evolve with changes to the state's population, their needs and expectations?

Like the problem of the uninsured, there is neither one cause nor one solution to containing the rising cost of health care coverage. In order to develop effective private and public policy solutions to contain the cost of health care, we need to thoroughly examine the factors causing dramatic increases in health care spending.

Constraining Medical Costs

The key to the success of any health care reform plan will be its ability to address the true underlying problem with our existing system—the cost of medical care. The fact is that true accessibility to health care and private health insurance coverage is dependent upon whether or not it is affordable. Constraining skyrocketing medical costs is the most

critical – and vexing – aspect of health care reform. It is the key driver in rising health insurance premiums and, consequently, it is driving the cost of health care coverage beyond the reach of many Americans.

Statistical evidence supports what the National Association of Health Underwriters (NAHU) has observed relative to the economic impact of health care spending. In 2006, health care spending in the United States will exceed $2 trillion and account for 15.9 percent of the gross domestic product (GDP). This is an increase from $1.3 trillion and 13.3 percent of GDP in 2000, and spending is only continuing to rise. Costs are projected to exceed $2.7 trillion and 17 percent of GDP in 2010[1]. Furthermore, the annual increases in national health care spending consistently outpace both the rate of general price inflation and the average U.S. household income. According to a 2005 study by Hewitt Associates, LLC, health care cost increases have averaged 12 percent per year since 2000. During the same time, increases in the Consumer Price Index have averaged 2.7 percent and the U.S. household income 3.7 percent.

There are many reasons health care costs are skyrocketing, among them, uncontrollable issues like an aging population. New medical technologies and pharmaceuticals also contribute to rising health costs, but are among the greatest assets of our health care system. Addressing this massive societal problem will require a multitude of comprehensive actions by both individual citizens and elected officials. Many of the topics that will need to be addressed to truly lower health care costs in the country, like physical education for children or nutritional choices, are not ones where CSAHU members as a whole have any particular expertise. However, as health insurance producers and employee benefit specialists, we do have extensive knowledge of health insurance markets and factors that are directly driving up health insurance claims costs and as a result health insurance premium rates. CSAHU believes that health insurance and related market reforms need to build on the best aspects of the American health care system and unleash the creative power of a competitively driven marketplace. We feel that the following recommendations would make important improvements to the U.S. health care system to lower costs, improve quality, and create greater efficiency.

A. Behavioral and Lifestyle

Two key factors in the increased cost of health care are unhealthy behavioral and lifestyle choices. Research shows that behavior is the most significant determinant of health status[2], with as much as 50 percent of health care costs attributable to individual behaviors such as smoking, alcohol abuse and obesity. According to the National Center for Health Statistics, 30 percent of adults (more than 60 million Americans) are obese and the problem is worsening. Obesity has risen by 10 percent in the past decade and the trend can now be observed among American children[3]. Other sources show that smoking is responsible for approximately 7

[1] U.S. Centers for Medicare and Medicaid Services
[2] Mercer Management Journal 18; Centers for Disease Control and Prevention.
[3] Employee Benefit News, "Employers tackle obesity." Centers for Disease Control and Prevention; January 2006, http://www.cdc.gov/nccdphp/dnpa/obesity/trend/maps/

percent of total U.S. health care costs[4]. These behaviors lead to many serious chronic health conditions such as cancer, diabetes, heart and cardiovascular disease, and consumers are seeking medical solutions for these lifestyle issues rather than correcting unhealthy behavior.

Recommendations:

We need to explore public-policy initiatives regarding wellness promotion. Health insurance premium costs are rising because Americans are utilizing more and more health care services. Promoting and achieving a healthier America is one way that we can reduce health insurance claims and overall health care costs, and employers are in a unique position to have a positive influence and benefit directly from a healthier workforce. We believe lawmakers should do everything possible to enable employers to provide benefit incentives and premium flexibility through legal protections and tax breaks to enable them to implement smoking, drug, alcohol and wellness programs to encourage healthy lifestyles for employees and their families.

We also believe that our state's largest employers and providers of health insurance coverage - the state governments - should incorporate wellness and disease management programs into both their plans for state government employees, and also all government- subsidized health coverage programs such as Medicaid and CHP+, among others. Such programs could be modeled after the highly successful Healthy Arkansas Initiative, which targets the state's 50,000 state employees, Medicaid recipients and other state residents by encouraging them to stop smoking, lose weight, and exercise more. Arkansas state employees now receive nutrition counseling, "walking breaks" instead of smoking breaks, paid leave as a reward for healthy behaviors, and discounted health insurance premiums if they agree to undergo a voluntary personal health-risk assessment. The state's nearly 600,000 Medicaid recipients have similar incentives and the state Medicaid program now pays for nicotine patches and similar smoking-cessation tools. According to a recent national study, 26% of all adult Medicaid recipients in Arkansas used tobacco products in 2002, costing the state an estimated $540 million. Nationally, approximately one of every seven dollars spent on Medicaid is related to tobacco use. The state Medicaid program is also implementing a highly successful disease management program to help curb costs and improve treatment of diabetes.

We need to create a safe-harbor for those well-meaning employers that take action to promote wellness and healthy activities among their employees from non-intentional discrimination by adopting regulatory changes which adopt bona fide wellness plans under recent federal Department of Labor regulations. We should encourage this behavior by employers the same way we require safety features such as fire sprinklers through commercial and residential real estate insurance policies. State and federal policymakers should adopt rating changes which would permit those employers who are implementing and

[4] Centers for Disease Control and Prevention. *Morbidity and Mortality Weekly Report.* July 8, 1994 .

operating these wellness plans to receive premium savings for their wellness plan adoption.

B. System Inefficiencies

Duplication of procedures and overuse of high-end procedures, in situations where they add little value, have driven up medical spending unnecessarily. Both patients and the provider community should focus on looking for less expensive but equally efficacious alternatives. Preventable mistakes caused by providers of medical care also help account for rising costs. The November 1999 report of the national Institute of Medicine (IOM) indicated that as many as 44,000 to 98,000 people die in hospitals each year as the result of medical errors.[5] Those numbers don't even take into account medical errors that occur in other clinical settings. These medical errors are not only tragic; they also carry a strong financial consequence. IOM estimates that medical errors cost Americans approximately $37.6 billion each year, and about $17 billion of those costs are attributable to preventable medical errors. About $8.5 billion annually is for direct health care payments for preventable errors.[6] Unnecessary medical treatments and prescriptions are also costing the U.S. health care system billions of dollars each year. For example, 25 percent of physician visits (costing $11.4 billion annually) and 55 percent of emergency room visits (costing $14.7 billion annually) are unnecessary according to American Institute for Preventive Medicine. Plus the inconsistent focus on quality outcomes, when providing treatment, is another inefficiency impacting medical costs. According to a report by the National Committee for Quality Assurance (NCQA), "The U.S. health care system is still saddled with an anachronistic payment system that rewards quantity, not quality, of care. This contributes to widespread variations in the way health care is delivered – from failure to deliver needed care, to huge numbers of unnecessary procedures that drive up costs and endanger patients."[7]

Recommendations:

We must provide incentives for doctors and medical facilities with pay for performance, best practice guidelines and evidence based medicine to improve system inefficiencies and eliminate errors.

The government needs to create standards for interoperable electronic medical record technology to help unify the health care system, reduce errors and improve patient satisfaction. Advances in health IT will enable true collaboration between doctors and patients as consumers make more informed choices and doctors become more involved in their care. In the long run, improved technology will also provide better information to track public health problems and advance clinical research.

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[5] Institute of Medicine. *To Err Is Human: Building a Safer Health System.* 2000.
[6] Ibid.
[7] National Committee for Quality Assurance. "The State of Health Care Quality 2005."

C. Medical Malpractice

The amount health care providers must pay for medical liability insurance coverage is on the rise, which has directly impacted health care costs in this country. But an even more costly side effect of rising medical malpractice insurance rates is the cost of defensive medicine (when doctors order more tests, prescribe more medication and make more referrals than they believe are necessary to protect themselves from being accused of negligence). Since 1975, when medical malpractice insurance data was first separated from other types of liability insurance, medical malpractice cost increases have outpaced other tort areas, rising at an average of 11.7 percent a year. In 2004 medical malpractice costs totaled over $28.7 billion, up from about $26.5 billion the previous year.[8] Medical liability costs and defensive medicine combined, currently account for 10 percent of medical care costs.[9]

Recommendation:

We must enact comprehensive medical malpractice reform. Medical liability reforms that limit non-economic damage awards, allocate damages in proportion to degree of fault; place reasonable limits on punitive damages and attorney fees with a statute of limitations on claims would all have a positive impact on medical liability insurance premium rates. If medical liability insurance costs were lower it would likely reduce the health care costs associated with the practice of defensive medicine. In addition, state authorities must do a better job disciplining incompetent doctors, thereby reducing costs associated with their liability rates and medical errors.

D. Cost-Shifting

Cost-shifting occurs when providers of medical care adjust the prices they charge to private insurance companies in order to offset losses from partial or non-payers. These losses are primarily attributable to uncompensated care costs and declining reimbursements from Medicare and Medicaid, and have a significant impact on health insurance costs. The New Hampshire Center for Public Policy Studies estimated that cost shifting added 17 percent to the charges that New Hampshire employers and individuals with private health insurance paid for hospital care in 2001. [10] In 2001, the uninsured received about $35 billion in uncompensated health care treatment, with federal, state and local governments covering as much as 85 percent of the costs. Hospitals deliver two-thirds of uncompensated care and private practice physicians account for more than half of the private subsidies that underwrite the cost of uncompensated care.[11]

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[8] Towers Perrin. *U.S. Tort Costs: 2005 Update.* March 2006.

[9] PricewaterhouseCoopers for America's Health Insurance Plans. *The Factors Fueling Rising Healthcare Costs 2006.* February 2006.

[10] Peter Brodie, MBA student; Thomas Crawford, MBA; Scott Fabry, MBA student; Cindy Hayes, MBA student; Heather Hodgeman, MBA student; Martin Green, PhD. *Franklin Pierce White Papers.* "Cost Shifting: The Cyclical Inflation and Subsequent Erosion of the Health Care System."

[11] 2003 Health Affairs. Report for the Kaiser Commission on Medicaid and the Uninsured.

Recommendations:
In order to eliminate cost-shifting from major federal health care programs like Medicaid, CHP+ and Medicare to private health insurance plans, the State of Colorado should begin reimbursing providers that participate in all health care coverage programs, including Medicaid, Medicare and CHP+ at the same level it compensates providers that give state employees medical care through the Colorado State Employees Health Benefit Plan. In addition to reducing costs for the thousands of Coloradans with coverage in the private insurance market, state programs paying their fair share will have the added benefit of drawing more providers into these programs. More participating providers will not only increase access to care for all public program participants, the increased competition will also have a positive impact on overall reimbursement rates.

E. Increased Utilization

Americans are also consistently using health care services more and more, which has a tremendous impact on private health insurance premiums. In a report prepared by PricewaterhouseCoopers on behalf of America's Health Insurance Plans entitled *The Factors Fueling Rising Healthcare Costs 2006*, "higher utilization of services accounted for 43 percent of the increase, fueled by factors such as increased consumer demand, new and more intensive medical treatments and defensive medicine, as well as aging and unhealthy lifestyles." Americans need to become more engaged as consumers. Informed shoppers are more efficient consumers and efficient consumers spend less money.

Recommendations:
Expansion of access to consumer directed health insurance products, like Health Savings Accounts, Health Reimbursement Arrangements and Flexible Spending Accounts will allow the strength of the free market to help curb the problems and costs associated with over utilization of health care services. Recent changes to HSAs made as part of the Tax Relief and Health Care Act of 2006 will help make this consumer directed health care option much easier for employers and insurers to administer, thereby making HSAs more accessible to all Coloradans.

Transparency of cost is also a critical component of overall cost reduction. The advent of a more consumer directed approach to health insurance coverage is essential to reducing overall health care costs as it will help curb excessive utilization and claims, as well as drive down costs by increasing competition among providers. However, to be fully successful, Colorado consumers must be fully aware of the cost of the health care that they are purchasing.

The best option would be a private sector solution where the health plans and providers overcome policy concerns (e.g. prohibiting gag provisions in provider contractors) and bring a solution to the public as soon as possible. See section 10. But if progress isn't made quickly, we believe that legislative or regulatory action ought to be taken, but these should be seen as a last resort.

Health care coverage is expensive because of the high cost of health care. If we are to gain any advancement towards the goal of providing health care coverage to all Coloradans, we must address the ***cost*** of health care. As an organization, the number one thing for which we advocate is thoughtful, comprehensive reform that benefits consumers, employers, and the providers of health care and health care coverage. To make any advancement in realizing our goal of coverage for all Coloradans, many things must occur, including:

1) Identifying those who currently have no coverage – the Uninsured

A) According to the Colorado Health Institute (CHI), 22.8% of the uninsured in Colorado are below the Federal Poverty Level (FPL)[12], therefore most of them are eligible for Medicaid, but not enrolled. While mass enrollment may be challenging, attempts to identify and cover this population is extremely important. If coverage for all is the goal, then locating, enrolling and funding for this population must be achieved.

B) Low Wage Workers (LWW) are working individuals between 60% and 250% of FPL. We oppose government expansion to include this population, yet acknowledge the need for some type of government assistance to help this segment of our population obtain health care coverage.

C) The Irresponsible Uninsured represents another significant problem. They have the access and income to purchase health care coverage, but do not. 39% of Colorado's uninsured have income levels above 200% of FPL ($40,000 for a family of four).[13]

D) The CHI update for 2005 on the uninsured reports that young adults ages 18 to 34 represent the largest percentage of the uninsured at 40%. This population is arguably the healthiest segment of our society. Because this segment also spans all socio-economic categories, any meaningful reform must address this population. Expansion of dependent status in the group market over the past few years has been a good start. However the market must continue to create plan designs and incentives that attract these individuals into the market place.

We strongly believe that new social programs should not be created without first demonstrating the ability to be successful with existing programs.

We believe the best solution is to create a subsidy program on a sliding scale that will assist these populations obtain coverage in the existing private market. See section 5 for subsidy program.

[12] Colorado Health Institute. Profile of the Uninsured in Colorado, 2004. January 2006.
[13] Ibid.

In addition, we believe that the private market must design and implement a scaled down product with a limited core benefit that will accommodate the needs of this population. See section 3 for core benefits.

Recognizing the need for age and health status rating flexibility in the Small Group Market are important incentives to encourage this population to obtain coverage. Requiring documentation of coverage at time of enrollment at colleges and universities should also be mandatory.

2) Reforming existing assistance programs to operate efficiently - Medicaid and the CHP+ Program

A) The Colorado Medicaid program is often described as one of the leanest programs in the country with an eligibility threshold at 60% or below FPL. Due in part to our higher than average per-capita income, we also have one of the lowest Federal funding matches (50%). Despite its relative leanness, Medicaid continues to consume a growing proportion of the state's general fund, 22% in fiscal year 2005-2006.[14]

While Medicaid eligibility is a problem, Medicaid reimbursement to providers is the major issue. Providers must be compensated fairly for the services they provide. We recommend reimbursing Medicaid on the same schedule that is used for Medicare. The establishment of a uniform pricing model must be introduced and will be discussed further under section 10. Medicaid managed care programs must be re-established that utilize coordinated care and cost efficiencies.

B) The Child Health Plan + was created in 1997 to provide full service health and dental coverage for Colorado's uninsured children ages 18 and younger. It has been expanded in recent years to include pregnant women and children up to 200 percent of FPL. Approximately 52,000 of the estimated 100,000 children eligible are currently enrolled.

The CHP+ program must continue to be funded and enrollment of all eligible children must be accomplished. We recommend increasing the eligibility for CHP+ to children living in households with incomes up to 250% of FPL.

Existing programs should be reviewed and required to prove their effectiveness. New outreach programs should be considered. Enrolling children and young adults in schools and other community organizations should also be considered.

3) Creating new health care benefit plans and promoting existing plans that work

A) Core Benefit Plans

Responsible health care reform should recognize that consumers have different financial situations, risk tolerance levels and different health care needs.

[14] Colorado Health Institute. Health Care Vision 2007 and Beyond: Colorado's Health Care Marketplace.

We would recommend that the Commission work with existing insurance carriers in the marketplace to design a Core Benefit plan. These plans would provide for:
A maximum benefit of $50,000 per year
Wellness and preventative care
Routine doctor visits
Generic and possibly preferred formulary drugs
Hospital benefits and other medical procedures
They would require limited low out of pocket co-pays and deductibles

Limited mandates must be considered to keep these plans as affordable as possible. These plans should be made available on a guaranteed issue basis in the group and individual market, potentially with community rating. However, the disruption to the existing market must be considered.

Creating an initial six to twelve-month open enrollment window could be one solution to expand enrollment, just as the federal government has done with Medicare Part D. Beyond this initial open enrollment, individuals might potentially face surcharges and or preexisting condition periods.

Pueblo County has recently announced the formation of a community-based program designed to provide a similar type of limited benefit package.

We encourage the formation of public/private relationships in rural communities that have unique challenges and lack the ability to benefit from a competitive market.

B) Existing Medical Plans

Recognize and encourage the enrollment into existing major medical plans. As mentioned earlier, Consumer Directed Health Plans such as HSAs will allow the strength of the free market to help curb over-utilization and reward higher personal risk retention with lower premiums and pre-tax payment of health care expenses. By accepting the pre-tax benefit with a higher deductible, they have also encouraged health care consumers to inquire about the cost of care when appropriate.

4) Addressing the Mandate Issue

While we agree with the concept that everyone should be required to purchase coverage, we have great concern with everyone's accepting the responsibility to do so. Colorado has had a compulsory law requiring the purchase of auto insurance since 1979, yet according to the Insurance Research Council the number of uninsured motorists in Colorado still remains at approximately 15%.[15] What this law has accomplished is establishing the expectation of personal responsibility and has then allowed for the punishment of those who do not comply. We believe that a personal responsibility law

[15] Insurance Research Council. *IRC Estimates More Than 14 Percent of Drivers Are Uninsured.* June 28, 2006.

that establishes these same expectations is reasonable. We also believe the assumption that many may not comply with this requirement is a necessary reality.

There has been a lot of attention on recent reforms that have been implemented by the state of Massachusetts. California's governor has also recently proposed similar legislation that previously had been approved by the state's legislators mandating coverage for all.

In order for individual mandates to work, everyone must have equal access to health care coverage. Massachusetts and Colorado have very different situations. Massachusetts does not face the same geographical challenges that Colorado must recognize. Massachusetts currently has guaranteed issue, so mandating coverage for all is not a problem because all health insurance including individual coverage is issued on a guaranteed basis. No one - group or individual - can be denied coverage based on any preexisting medical condition.

Colorado, like 42 other states, does allow for risk adjustment, or medical underwriting in the individual market. While not having guaranteed issue, Colorado has enjoyed a competitive, thriving individual market. Colorado is one of 33 states that have implemented a high risk pool, CoverColorado, for individuals who may be denied coverage. Although CoverColorado has worked well and kept the private market healthy, a consistent funding program continues to be a challenge. There is much less concern currently voiced about the individual and large group market in Colorado because for the most part they work very well.

Mandating guaranteed issue to an individual market that is working well could have serious negative repercussions. With no mechanism in place to guarantee that all individuals eligible will purchase coverage, guaranteed issue will only undermine the individual market along with the high risk pool currently in place. Those who have or acquire a health condition will take advantage of the guaranteed issue and purchase individual coverage. Those who are young and remain healthy will continue to go without coverage as they do now, and cost will rise significantly in the individual market forcing the existing healthy in that market to drop coverage. For these reasons we do not believe that mandating guaranteed issue in the existing individual major medical market can be accomplished until it can be demonstrated that a high percentage (90 to 95%) of all Coloradans have obtained some type of coverage.

To begin with, we would recommend guaranteed issue only to the Core Benefit plans.

Risk Adjustment

Many would argue that the cost and benefit of health coverage should be the same for all. But not everyone's health care needs are the same. Nor is there ability or willingness to pay for coverage. We believe that the individual and large group markets currently work well because they allow for risk adjustment. We do not believe that it makes sense to disturb these existing markets that are functioning well to reform the issues in the small

group market. The ability to evaluate the potential utilization of care allows these markets to price coverage accordingly and spread the potential risk among the largest pool possible. In the individual market this is assisted by ceding the catastrophic risk in to a reinsurance pool, CoverColorado.

Reforms implemented in the small group market in 2003 have had a positive effect on the small group market. Rating flexibility utilizing the additional rating factors of claims experience, health status, and standard industrial code have been available in the Colorado small group marketplace on a phased-in basis since September 2003. The Colorado Division of Insurance surveyed carriers as to their use of RAFs at the end of the first year that they could be fully utilized (September 2005) and again a year later (September 2006). The following conclusions can be drawn from analysis of these survey results:

1. The small group market has been eroding or declining since 2000 but has shown a slight increase in both the number of groups and covered lives between year-end 2005 and September 2006.

2. Each market segment reviewed in this analysis shows very similar results in the percentages of small groups whose rates were discounted and issued at a premium on 9/30/05 and 9/30/06. A little over 60% of these groups received a discount and about half of that number of groups, or almost 30%, were rated up on 9/30/05 and 9/30/06. Between 2005 and 2006, there was movement of both groups and lives to the minimum and maximum RAF-adjusted premium amounts (0.75 to 1.10 of the index rate).[16]

3. Carriers perceive that the ability to use RAFs and rating flexibility has attracted new small groups to them, improved the overall risk profile of small groups, created stability in the small group market, and increased the carriers' willingness to remain and expand their participation in the small group market. As a result, Assurant Health has re-entered the Colorado Small Group Market and both Humana and Aetna have expanded their presence.

5) Deciding how to help those in need - Creating a Subsidy Program

We recognize that there is a significant percentage of the working population that cannot afford the cost of health care coverage. According to recent statistics published by the Colorado Health Institute, 52.1% of the uninsured live in households with annual incomes below 200% of FPL or $40,000 a year for a family of four.[17]

For this reason we believe that a subsidy program should be created that would provide financial assistance to individuals below 250% of FPL. Providing subsidies based on income to LWWs might be structured as follows:

[16] Report of the Commissioner of Insurance to the Colorado General Assembly on Rating Flexibility. January 15, 2007.
[17] Colorado Health Institute. Profile of the Uninsured in Colorado, An Update for 2005. November 2006.

90% assistance to individuals between Medicaid eligible and 150% of FPL
70% subsidy to those between 150% and 200% of FPL
50% for those between 200% and 250% of PFL

We strongly believe this subsidy should be created in the form of a voucher that could be used to purchase group coverage at their place of employment whenever possible. Many of the children of these LWWs are eligible for the CHP program and we encourage the State of Colorado to work with the federal government to restructure current SCHIP guidelines that make participation in employer-sponsored programs prohibitive. Allowing families to remain covered under the same plan reduces confusion and administrative issues.

6) Determining how to finance the assistance that is provided

The need to generate significant, sustainable revenue is critical to any proposal for health care coverage reform. The potential for any single source to experience volatility is probable. Therefore we believe the establishment of multiple sources of revenue is necessary. We propose three potential sources.

A) We support the establishment of an income tax credit for those who do have coverage - and implementing a tax penalty for those who do not. The implementation of an employer tax credit should also be created to reward existing employers and encourage more small businesses to offer employer-sponsored coverage.

As previously mentioned, two key factors in the increased cost of health care are unhealthy behavioral and lifestyle choices. According to the National Center for Health Statistics, 30 percent of adults (more than 60 million Americans) are obese and the problem is getting worse. According to the National Soft Drink Association, consumption of soft drinks is now over 600 twelve-once servings per person per year. Since 1978, soda consumption in the United States has tripled for boys and doubled for girls. Last year soft drink companies grossed over $57 billion in US sales alone.[18]

B) We believe the majority of income could come through the imposition of a Nutrition Sales Tax. We would suggest taxing all consumable food items that contain little or no nutritional value at the point of sale. If we recognize smoking to be harmful to our health and impose a tobacco tax, we should recognize the impact of non-nutritional 'food' items as well. A 2 to 5% sales tax on all fountain sodas and walk-up coffee locations could generate millions of health subsidy dollars annually. Taxing chips, candy, soda and other 'junk' foods at the time of purchase in convenience stores and grocery stores would generate additional millions.

C) An employer-mandated contribution into the subsidy pool for employers who do not sponsor a group benefit plan is the third potential area of revenue. We have significant concerns of the burden this will place on the business community and believe it should only be implemented as a last resort.

[18] Michael F. Jacobson, Ph.D. "Liquid Candy How Soft Drinks Are Harming Americans' Health."

7) Creating a Public/Private Health Care Connector

To address enrollment and access to health care coverage issues, we support the creation of a ***Public/Private Health Care Connector.*** The connector would be created in a combined effort between established health care professional organizations such as CSAHU and CGIA, and the Colorado Division of Insurance. A limited agency/website would be created with the **Health Care Coverage Matrix** with links to public entities such as Medicaid and CHP.

Individuals and businesses looking to purchase coverage would be referred through a directory of approved health insurance professionals that have demonstrated proficiency in both individual and small group market knowledge and licensing.

The accreditation to participate in this process would be provided by Continuing Education Credits earned through membership and participation of these various established professional organizations. The cost to administer the Connector would be funded in part by fees paid by each producer licensed and registered to participate.

With a mandate to purchase health care coverage in place, Colorado residents can then be expected to show proof of coverage when renewing a driver's license, registering a car or applying for other state programs. When an individual presents for care at a hospital or clinic, proof of coverage can be requested. If no coverage is in place, then the individual's personal information is sent to the Health Care Connector. The Connector could then verify eligibility for various programs and/or provide the information to a licensed professional who would then contact these individuals. If eligible for assistance, then the Connector would provide a waiver or voucher that the individual could use to either enroll in an employer sponsored plan or purchase coverage in an individual or a Core Benefits plan. This would also allow penalties such as the inability to renew a driver's license or register a car, as is required currently for auto insurance.

8) Creating cost distribution measures that will benefit all

The true concept of insurance is to spread the risk among the largest possible population. However, over the past 6 years Colorado's small group market has diminished by 180,000 individuals, nearly a 35% reduction. A recent study shows that 10% of the insured population account for 50% of claims dollars spent, while 70% account for only 10% of expenses.[19] As an insured pool grows smaller, the percentage of unhealthy lives increases and adverse selection causes rates to rise even more disproportionately.

When and if Limited or Core Benefit plans are introduced in to the market place, the healthy will accept a lower maximum amount of coverage and the unhealthy will not. For these reasons we recommend that the State of Colorado research, develop and implement a small group re-insurance pool.

[19] Milliman. *USA Health Cost Guidelines – 2001 Claim Probability Distributions.*

Many states including New Mexico, Connecticut, New Hampshire, Idaho, Arizona, Massachusetts and New York have established re-insurance pools to help distribute large claim costs more efficiently. Several other states including Washington are exploring the implementation of a reinsurance pool. While issues such as mandatory vs. voluntary participation by insurance carriers exist, greater success is possible if government participation is involved. If government participates by enrolling and subsidizing Medicaid eligible and LWW's, then private insurers will have greater incentive to participate as well.

Potentially, a reinsurance pool would retain 100% of a claim to a specific amount such as $50,000. Between $50,000 and $100,000, 20% would be retained by the primary insurer creating incentive to follow through with best practices care management. From $100,000 to $200,000 10% might be retained. Then reinsurance would cover 100% from $100,000 to the specified maximum of $500,000 or a $1,000,000.

Creating limited benefit plans that have a benefit maximum adjacent to the reinsurance "floor" allows for seamless extension of coverage into the reinsurance pool when necessary. Once enough public financing is being generated to support the subsidy pool of limited benefit plans, then funding catastrophic risk ceded into the reinsurance pool would be possible. At some point blending CoverColorado with the newly created small group reinsurance pool would also be possible.

While financing must be secured and in place up front to fund the reinsurance pool, there is relief in later years when the number of insured lives reduces. When fewer uninsured large claims are incurred at health facilities, uncompensated care will reduce resulting in lower government spending on the back end. According to the most recent Joint Budget Committee proposal for 2008, Colorado will spend approximately $325 million in 2007 on uncompensated care.[20]

9) Developing, promoting and rewarding administrative efficiencies

As stated earlier under Constraining Medical Costs, duplication of procedures and overuse of high-end procedures have driven up medical spending unnecessarily. We must establish a reasonable deadline for health care providers to switch to the exclusive use of electronic medical records. This step alone could cut administrative expense and help eliminate medical errors.

Rewarding hospitals and doctors for applying less expensive, cost effective outcomes instead of encouraging more expensive procedures must also be explored. In 2005 Seattle's Virginia Mason Medical Center worked in conjunction with Aetna Inc., Starbuck's, Costco and other major clients to re-evaluate several expensive procedures. When it came to treatment of back pain they realized that no standardized path was being followed. By working together, a standardized path was created and the percentage of

[20] Proposed Department of Health Care Policy and Financing Budget. http://www.state.co.us/gov_dir/leg_dir/jbc/hcpbrf.pdf

MRIs being prescribed was reduced by a third, from 15.4% to 10%. In return Aetna agreed to increase Virginia Mason's physical-therapy reimbursements by 16% to compensate the hospital for lost revenue.[21]

We must work to reduce or eliminate other inefficiencies and or barriers currently in place. Some of these include:

- Requiring the purchase of life insurance when purchasing health care coverage
- Imposing a 35% penalty on individuals and businesses for coming back into the fully insured market
- Requiring high employee participation in group coverage
- Excluding dedicated 1099 employees from group-sponsored health care coverage.

10) Establishing measures that allow the consumer to understand health care pricing - Establish a Uniform Pricing Model

The issue of transparency begins with the ability of the consumer/patient to know before receiving care the possible costs associated with that care. This knowledge of cost should encompass the simplest of office visits and certainly more expensive hospital and outpatient related procedures. Further, the consumer/patient should be able to access this information readily and easily.

One of the largest areas of cost-shifting to the privately insured markets, group or individual, comes from the underpayment of services by Medicare and Medicaid. A recent study published jointly by Blue Shield of California and Milliman found that this cost-shift amounted to $951 (9.5% of premium) in additional annual premiums paid on a typical family policy at the end of 2004. In 2000, the premium attributable to this cost-shifting element was only $213(3.6% of premium). As Medicare and Medicaid reimbursements have continued to increase at less than general inflation for the past two years, this figure could well be over $1,000 annually (10+% of premium).[22]

In an effort to break this cycle, we believe that provider reimbursements should be linked to a percentage of Medicare reimbursement. As the Medicare insured population will dramatically rise over the next several years, we cannot allow the continued cost-shifting to occur at increasing rates to those in the private markets.

Today's cost of care structure is tied to the numerous payment and reimbursement sources. These sources include Medicare, Medicaid, the Workers Compensation fee schedule and a different payment structure for each private carrier network operating in the State of Colorado. In addition to these, any care received outside of a mandated fee structure (Medicare) or negotiated reimbursement schedule (carrier networks) may be billed at almost any rate the provider chooses.

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[21] Vanessa Fuhrmans. *Withdrawal Treatment A Novel Plan Helps Hospital Wean Itself Off Pricey Tests.* January 12, 2007.

[22] Managed Care Magazine, *"Confronting the Medicare Cost Shift."* Blue Shield of California and Milliman. December 2006, http://www.managedcaremag.com/archives/0612/0612.costshift.html

Carriers for proprietary and competitive reasons have not made available their negotiated reimbursement schedules in any large scale fashion. While the Medicare fee schedule may be available, it is not easy to find in the public domain.

Our proposal would tie all reimbursement schedules, negotiated or otherwise, to one common basis. Since Medicare currently covers more that 45 million Americans and the possibility of the federal government changing the fee structure it uses appears remote, we believe using the **Medicare Reimbursement Schedule** (MRS) as the basis for all health care reimbursement structures should be implemented for both private and public pricing models.

Colorado-based health plans insured by a Colorado filed commercial carrier would be required to utilize the MRS as the model for all Colorado providers receiving payment for a Colorado resident/insured. The carriers would reimburse all non-contracted providers at 120% of MRS. For example if they paid 120% of MRS for a specific procedure, then the consumer could find the procedure on an MRS schedule, do the math and understand what the out of network cost would be. This would replace the carriers' Reasonable & Customary schedule. This enables a publishable reimbursement level for all health plans and providers in the state.

A study of California reimbursement fees showed the average doctor reimbursement was 120% of MRS.[23]

Additionally, this would help to address the par/non-par issue. Currently, when a consumer/patient receives care from a non-contracted out-of-network provider the carrier's reimbursement payment is based upon that carriers' Reasonable & Customary schedule. Any amount above the R&C schedule is still owed to the provider by the patient. By moving to a standard mandated non-network payment structure the patient is protected from exorbitant additional out-of-pocket costs. Additionally, providers will have further incentive to join a carrier's provider network where higher reimbursement levels will be available (see following paragraph).

For those providers willing to sign a contract with a carrier's provider network, the baseline reimbursement would be at 125% of Medicare (this would become part of the "Standard Provider Contract"). Providers and Carriers would be able to negotiate quality, transparency and outcome guidelines and measures to increase this reimbursement schedule. Based upon the contractual measures the maximum reimbursement level could increase to 150% of the Medicare Reimbursement Schedule. Carriers would be required to publish the reimbursement levels available for various procedures on their websites.

Further, carriers would be required to post the providers' attained quality status of their contracted providers as part of their online provider directory information. We would propose having four levels of quality measurements for the carriers to utilize. The associated reimbursement levels would be something on the order of:

[23] Managed Care Magazine, *"Confronting the Medicare Cost Shift."* Blue Shield of California and Milliman. December 2006, http://www.managedcaremag.com/archives/0612/0612.costshift.html

- Level One- 125% of Medicare (Entry-Level)
- Level Two- 130% of Medicare (Average quality measure)
- Level Three- 140% of Medicare (Above Average quality measure)
- Level Four- 150% of Medicare (Superior quality measure)

Carriers should also be required to publish the quality measures being utilized in their grading of providers. These measures would be published with the differences noted by the provider's practice specialty. In the case of hospitals, the quality measures should be delineated and published for different practice areas within the hospital i.e., cardiac care, maternity, etc. The basis for the quality measures should encompass the utilization of "best practice" standards and where applicable, evidenced based practices. These guidelines should be implemented over a two-year period to allow for the gathering of the necessary data to grade the different providers.

We have chosen 150% of Medicare as the maximum allowed reimbursement as it is similar to the current differential between privately insured in-network reimbursement and Medicare reimbursement levels.

Linking the providers' reimbursement levels to Medicare and capping the differentials at today's levels would effectively eliminate future cost-shifting to the privately insured markets.

Additionally, linking reimbursement levels will focus future reimbursement concerns at the federal level - the source of this inflationary cost-shifting.

11) Creating a Coordinated Time Table that establishes who, when and how solutions are implemented and develops measures to recognize their effectiveness

While many ideas could be implemented in a reasonably short period of time, exact dates are not possible due to the procurement of necessary revenue and the constraints of the Tabor Amendment. However, we advocate that any reform adhere to the initial Requirements of Reform and meet the Five Indicators outlined earlier in this proposal.
Any reform outline should recognize the following:

- Consensus must be obtained between all interested parties for any reform to be successful
- Existing social programs should be reformed to better serve their specific populations and the providers that serve them
- A stable revenue source must be established to support any subsidy programs and reinsurance pool which are paramount to any reform agenda
- A personal responsibility doctrine must be espoused to encourage all Coloradans to accept the responsibility to obtain health care coverage
- Core Benefit plans must be designed and implemented along with any subsidy programs necessary to guarantee coverage for all
- Cost and transparency must be addressed immediately and continuously
- Establish the measures to gauge achievements.

Conclusion

What is access to health care coverage? The reality is that doctors and medical facilities abound throughout our state. When necessary, Coloradans who present themselves to a hospital or doctor for treatment will receive care. The ability to pay for that care and any additional services needed are the real issues. Recognizing that regardless of whom the payer is - individual, government agency or insurance company - controlling the cost is what must be addressed.

NBC's today Show on Wednesday April 4, 2007 ran a report on the price drop of generic Zocor. They reported that the average cost of generic Zocor is now averaging $38 per prescription. Lipitor which is not currently available as a generic medication averages $241 for the same 90 day supply. Both medications are under the category of statins, which are used to control cholesterol. Should consumers have the choice of these two medications? Do they both claim to do a better job of reducing cholesterol? When the less expensive drug is appropriate, should it be recommended? Yes, both claim to do a better job of lowering cholesterol. We believe that one should have the choice of both, and the less expensive should be recommended when appropriate. This illustrates the impact of both cost and competition as it applies to the health care industry today.

Without competition, recent medical and pharmaceutical advancements would not have occurred. Government should regulate industry to assure honesty and integrity in the marketplace. Government should also recognize that health is a personal responsibility that, to a degree, can be controlled and maintained. And it should neither compete with, nor abrogate, the private sector needlessly.