Governor's Dialogue on Health Care Vision and Values

November-December 2007

ACKNOWLEDGMENTS

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The Governor's Dialogue on Health Care Vision and Values was designed and implemented by The Adams Group, a Colorado-based firm specializing in public policy facilitation and public engagement – www.TheAdamsGroup.org. The project utilizes state-of-the-art technology (including electronic voting devices for participants) to enhance the face-to-face meetings. Chris Adams designed the overall project, Jeffrey A. Roberts was the principal writer of the discussion guide, and Kindle Fahlenkamp-Morell was the graphic designer.

The guide was reviewed for accuracy by staff members of the governor's office, the Colorado Division of Insurance, the Colorado Department of Health Care Policy and Financing, the Colorado Department of Public Health and Environment and the Colorado Health Institute.

The policy concepts outlined in this paper are commonly proposed strategies for health reform. Inclusion or exclusion of any specific idea or concept is not reflective of the Governor's policy priorities.

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Across Colorado people repeatedly tell me about their fears and frustrations with our broken health care system. Businesses, retirees and working families all want to know what's being done to fix a health care system so clearly in need of reform.

Fortunately, the Blue Ribbon Commission for Health Care Reform is studying models for comprehensive reform. The Commission has generated some serious and thoughtful proposals, which will be presented to the Legislature in January.

Its report will undoubtedly lead to a robust discussion of what our health care system should look like. The questions at hand – Who should have access to health care? What can be done to improve quality and contain the growth of costs? – are fundamental to our values and the vision we have for a healthier, stronger Colorado of the future.

The Dialogue on Health Care Vision and Values is a series of meetings being held in nine communities across the state. It is designed to be an opportunity for you and your colleagues - community leaders from all over Colorado – to share your thoughts about improving health care.

The information in this booklet is designed to provide a baseline of information about our health care system and to stimulate your thinking on the topic of health reform. I am looking to you for your vision of a stronger system and the values behind it. Your participation in this discussion will help me further develop my views and inform my decision making on these critically important issues.

As I consider the various policy options for reform, I focus on four guiding principles.

Improved Value. We must demand more from our health care system when it comes to cost, quality and access for everyone from Denver to Durango. Despite spending billions of dollars on health care, we still have a system that is failing to meet the needs of all Coloradans. Simply stated, we are not getting the best value for our investment.

Fiscal Restraint. I understand the value of every taxpayer dollar, and I refuse to throw more money at a problem without addressing the root causes of the crisis. Because we live in a state with many needs and limited budget flexibility, improved value and fiscal restraint are not only guiding principles, but also a necessary reality.

Shared Responsibility. I firmly believe that the only path to success is through shared responsibility and shared commitment. Everyone must be a part of the solution and must have a stake in the successful outcome of reform.

Bold and Realistic Reform. We must be bold in rebuilding our health care system, but we also must be realistic about what we can achieve and the timeframe in which we can do it. Fixing health care will not occur overnight. But we must work towards the goal together with the understanding that this is one of our state's most important and most urgent priorities.

These principles are the foundation of my thinking on health care reform, but I am looking to you to further shape my thoughts and identify priorities for reform.

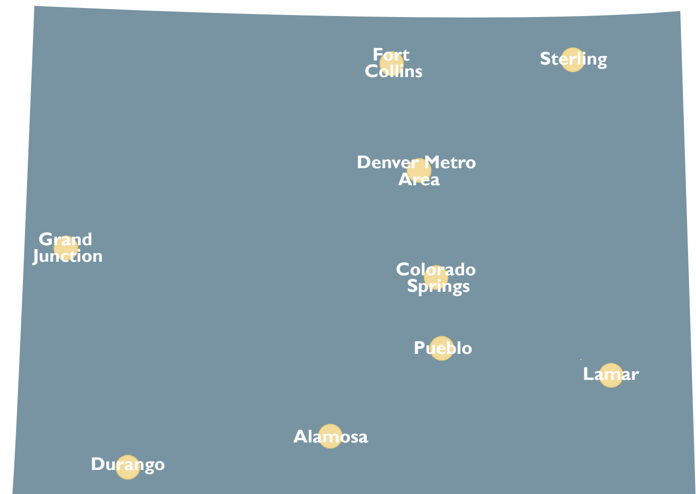
Thank you for your time, attention and thoughtful input.

Sincerely,

Bill Ritter Jr.

Bill Ritter, Jr.
Governor

This Dialogue on Health Care Vision and Values is an opportunity for the Governor's Office to engage you and your colleagues – community leaders from all over Colorado – in a high-level conversation about our priorities as a state for improving health care.



The goal of these sessions is to help inform Governor Ritter, legislators and others about how Coloradans view the state's health care system and how they believe it can be made more efficient, more accessible, more affordable and consistently excellent. Health care reform will be a top priority of the 2008 session of the General Assembly, and your thoughts and insights will help provide a philosophical framework for Governor Ritter's leadership on this critical issue.

You know the problems. Medical costs and health insurance premiums are soaring. Many businesses are struggling to provide health insurance to employees, and some have reluctantly stopped. There are significant gaps in the availability of quality care, especially in rural areas and even for some who have insurance. And those who are uninsured or underinsured put themselves and their families at risk for health and financial disaster.

Fixing the system requires that we ask ourselves some fundamental questions: Who should be covered? What is the role of government? What is the role of employers? What is the role of individuals? Who should pay for those people who can't afford coverage and what form of coverage should they get?

The answers will guide the debate on health care, helping policymakers set priorities and ultimately find pragmatic solutions.

Already, many people in Colorado are hard at work on this issue. A blue-ribbon commission, created by Senate Bill 208 in 2006, is examining several proposals to reform health care and will deliver a report on health reform models to lawmakers in January. The 208 Commission's report will include various options for state health care reform, including cost and coverage estimates.

This outreach by the Governor's Office is designed to complement the 208 Commission's thoughtful and thorough work and provide Governor Ritter with additional context for reviewing and evaluating the options for reform.

As state and federal policymakers focus on health care in 2008, Colorado is poised to be a leader on this issue. But for this effort to be successful, the state will need a clear vision of a health care system that is built upon Colorado values.

Section One: What Does Health Care in Colorado Look Like Now?

History and Current Status

Before World War II, only a few companies in the United States offered health insurance coverage to workers. But that quickly changed as soldiers were sent overseas, creating a labor shortage at home. Wage and price controls prevented employers from offering higher wages to compete for workers, so instead they offered health benefit packages. The U.S. government encouraged the proliferation of employer-based health insurance by making employer contributions to employee health plans exempt from taxable income, and thus the foundation of our current system was laid.

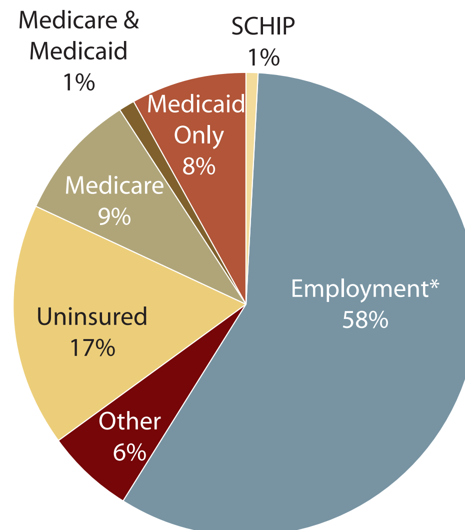
Ways Coloradans can get medical care other than insurance:

- "Safety net" providers offer care for underserved urban and rural communities. The type of services provided varies from place to place. Examples are hospital emergency departments, community health centers, local public health departments and public nursing services, rural health and dental clinics, school-based centers and programs serving migrants or the homeless.
- The Colorado Indigent Care Program (CICP) uses state and federal funds to partially reimburse medical providers for services given at a discount to low-income people who aren't eligible for Medicaid. Services vary from hospital to hospital and clinic to clinic, and not all medical providers participate in the program. Providers were reimbursed for services rendered to approximately 180,000 people in FY 2005-2006.[3]
- Under the federal Emergency Medical Treatment and Active Labor Act (EMTALA), most hospitals (i.e. those accepting Medicare payments) cannot refuse to treat patients in emergency situations or transfer them to other hospitals because the patients are unable to pay or aren't covered by Medicaid or Medicare. Complying with EMTALA results in hospitals providing hundreds of millions of dollars in uncompensated care.

The Medicare and Medicaid programs were created in 1965. Medicare provides health care coverage for Americans 65 and older, and Medicaid helps those with very low income and people with disabilities. The State Children's Health Insurance Program (SCHIP), established in 1997, extended health insurance coverage to children in families that earn too much to qualify for Medicaid, but too little to afford private insurance.

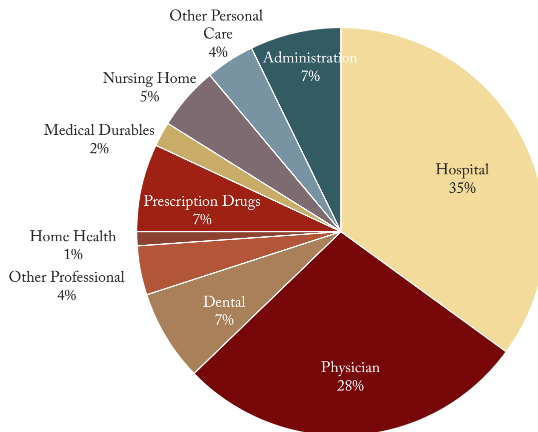
Today, nearly 60 percent of Coloradans are covered by health insurance through a workplace. Medicaid provides health insurance to about 8 percent of Coloradans, and Medicare covers another 9 percent.[1] Colorado's SCHIP program, called Child Health Plan Plus (CHP+), provides affordable health and dental coverage for about 54,000 children.[2] The 6 percent noted as "other" in the chart below includes the U.S. military's health care plan (TRICARE) and individually purchased, non-group insurance products.

COLORADANS BY AVERAGE MONTHLY PRIMARY SOURCE OF HEALTH INSURANCE



Source: The Lewin Group, "Technical Assessment of Health Care Reform Proposals," Aug. 20, 2007, p. 5
**Includes dependents and retirees*

FY07-08 ESTIMATED HEALTH CARE SPENDING IN COLORADO BY TYPE OF SERVICE



Source: The Lewin Group, "Technical Assessment of Health Care Reform Proposals," Aug. 20, 2007, p. 9

Costs

An estimated $30 billion will be spent on health care in Colorado in FY 2007-2008.[4] That would be 77 percent more than what was spent in Colorado in 2000, just seven years ago.[5] The total includes payments by individuals, employer contributions and spending for hospitals, physicians, dentists, prescription drugs and long-term care. Hospitals, physicians and prescription drugs are among the fastest-growing categories of health care spending in Colorado.[6]

Coloradans also are spending much more for insurance coverage. The cost of covering a family in Colorado more than doubled from 1996 to 2003, a bigger increase than the average 87 percent rise seen nationally and much bigger than inflation and wage increases over the same period.[7] It cost an average of $12,106 in premiums to insure a U.S. worker's family in 2007, with an average of $3,281 coming out of the employee's paycheck to cover his or her share.[8]

One reason for higher premiums: When doctors and hospitals care for the uninsured, much of the cost is shifted to private insurance. In Colorado in 2005, premiums for families with insurance through an employer were, on average, $934 higher due to the unreimbursed cost of treating uninsured patients.[9]

Quality of Care

The Institute of Medicine defines health care quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." In a series of reports,[10] the Institute highlighted several indicators that describe a system with serious safety problems:

- Medical errors kill more people each year than breast cancer, AIDS or motor vehicle accidents.
- Medication-related errors for hospitalized patients cost about $2 billion a year.
- More than 40 million uninsured Americans have consistently worse clinical outcomes than the insured and are more at risk of dying prematurely.

Compared with other states, the overall quality of health care in Colorado is considered "average," down from a

> **"The U.S. health care delivery system does not provide consistent, high-quality medical care to all people. Americans should be able to count on receiving care that meets their needs and is based on the best scientific knowledge – yet there is strong evidence that this frequently is not the case. Health care harms patients too frequently and routinely fails to deliver its potential benefits. Indeed, between the health care that we now have and the health care that we could have lies not just a gap, but a chasm."**
>
> **– "Crossing the Quality Chasm: A New Health System for the 21st Century," Institute of Medicine, March 2001**

recent rating of "strong," according to the federal Agency for Healthcare Research and Quality. Among the categories in which the state ranks best: yearly cancer deaths per 100,000 residents for all cancers, percent of people 65 and over receiving influenza vaccinations and survival rate of Medicare dialysis patients. Among the worst-ranking categories for Colorado: percent of pregnant women receiving prenatal care in the first trimester, suicide deaths per 100,000 residents and avoidable hospitalizations for influenza.[11]

A separate study by the Commonwealth Fund ranks Colorado 30th among states for quality. The state is 10th in the percent of adult diabetics receiving recommended preventive care but 50th in the percent of Medicare patients giving a "best" rating for health care received in the previous year.[12]

The Colorado Hospital Association will unveil a web-based report card on hospital performance at the end of November. Mandated by House Bill 1278 in 2006, the report card initially will include information on mortality rates, procedures and safety measures. In the future, additional data will focus on patient satisfaction, clinical quality, best practices and efficiency of care.

Access to Health Care

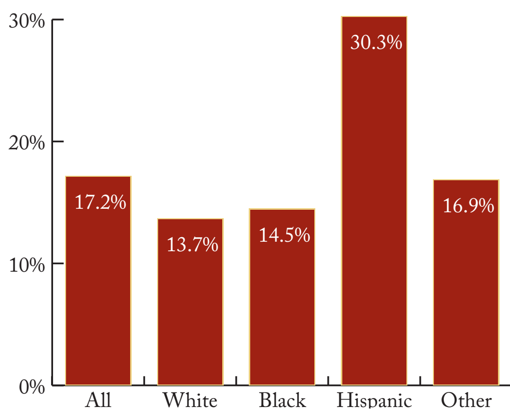
About 785,000 Coloradans, 17 percent of the state's population, are without health insurance in any given month.[13] You are at a higher risk of being uninsured if you are:

- A young adult (ages 18 to 34)
- Living below 200 percent of the federal poverty level (FPL)
- At a workplace with fewer than 100 employees
- Hispanic (nearly a third of Hispanics in Colorado do not have health insurance) [14]
- Less educated
- Not a U.S. citizen

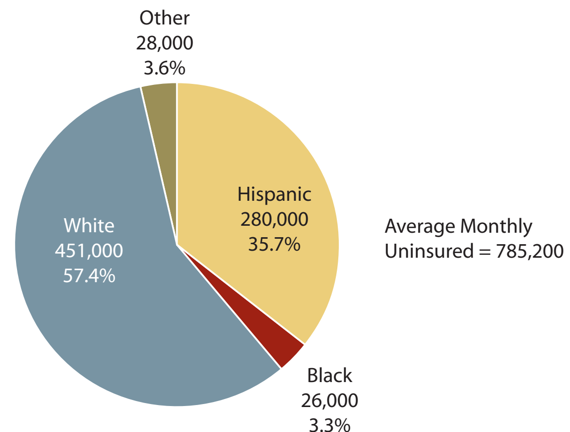
It also matters where you live. In 2000, the seven counties with the highest uninsured rates – as high as 29 percent – were all in southern Colorado. The next highest rates were in counties on the Eastern Plains. The suburban counties around Denver had some of the lowest uninsured rates.[15]

It is estimated that as many as one-fifth of the state's uninsured – approximately 167,000 people – are not U.S.

PERCENT UNINSURED IN TOTAL COLORADO POPULATION BY RACE AND ETHNICITY



DISTRIBUTION OF TOTAL UNINSURED POPULATION IN COLORADO BY RACE AND ETHNICITY



Source: The Lewin Group, "Technical Assessment of Health Care Reform Proposals," Aug. 20, 2007, p.A-8

citizens.[16] Undocumented immigrants are ineligible for Medicaid, except for emergency services. There is no reliable information on how many uninsured people are undocumented immigrants.

About 85,000 uninsured people in Colorado are eligible for Medicaid or SCHIP but not enrolled. Of those, more than 70,000 are children. About 6,000 are ages 19 to 34, and another 9,000 are ages 35 to 64.[17]

Being employed doesn't necessarily mean you are covered. Nearly 300,000 of the uninsured in Colorado are associated with workplaces that do not offer coverage to any employees. More than two-thirds of the uninsured live in families where one or more people are working. For nearly 140,000 uninsured Coloradans, the worker in the family is a part-time or temporary employee and not eligible for coverage. Another 87,000 workers and their dependents have declined coverage made available to them by employers.[18]

Even if you do have insurance or are eligible for a public program such as Medicaid, you still may not have ready access to health care. Many doctors won't treat Medicaid patients because they aren't paid well enough or they consider the paperwork too onerous. In a survey, about one-fifth of U.S. physicians said they accepted no new Medicaid patients in 2004-05, a rate five times higher than for privately insured patients.[19] Rural residents also may have trouble finding health care. In 2004, 15 Colorado counties had two or fewer physicians to care for patients in the entire county. Twenty-five Colorado counties (39 percent) had two or fewer active dentists, and eight had no dentists.[20]

Possible Action at the Federal Level

Much of the focus on health care reform is at the federal level, and some polls show that health care is the top domestic issue in the 2008 presidential election. Reform proposals range from the incremental to those that would cover everyone. Approaches include raising eligibility levels for public programs such as Medicaid and SCHIP, new tax deductions or credits, employer and/or individual mandates, purchasing pools or a single-payer system.

Many policy experts believe that significant action at the federal level is several years away but see significant opportunities for the states to serve as laboratories for reform.

Reform Efforts in Other States

Policymakers are closely watching what happens in Massachusetts, which passed a law in 2006 requiring nearly all residents to have health insurance or face a tax penalty. The law also requires businesses with 11 or more employees to provide health insurance or pay an annual fee. And it subsidizes coverage for low-income people and creates a "connector" agency to help individuals and businesses find affordable insurance.

Vermont in 2006 passed Catamount Health, a program that subsidizes the uninsured on a sliding scale of up to 300 percent of the FPL. It is financed by a combination of premiums paid by those who are covered, an assessment on employers who do not offer coverage, tobacco taxes and federal funds. The goal is to insure 96 percent of all Vermonters with the addition of this program. Vermont also started Blueprint for Health, a public-private partnership focused on preventive care and helping people better manage chronic illnesses.

Any state-level health care reforms must take into account a federal law, the Employee Retirement Income Security Act of 1974 (ERISA), which preempts state regulation of health insurance that is self-funded by an employer. As a result, the state has limited ability to change rules and regulations affecting a large portion of the market.[21]

Section Two: What is Your Vision for Health Care in Colorado?

What Should Health Care Reform Accomplish?

Do you believe that everyone should be covered and, if so, to what degree? Should everyone have access to preventive health care? Primary care? Should the state or federal government play stronger roles than now? Lesser roles? Perhaps health insurance should be portable and not connected to your job. Or do you think employers should play a bigger role than now?

In thinking about your own vision for a reformed health care system, consider the following questions:

- Who should have health insurance?
- What is the role of government?
- What is the role of employers?
- What is the role of individuals?
- What would you do about those who can't afford insurance? Should others pay for their health care and, if so, what kind of services should they get?

As you read below and on the next two pages consider what your vision is for health care in Colorado. How would you answer the questions above?

David Van Sant, Superintendent of Schools in Strasburg, CO

Everyone who lives in Colorado should be covered. I think the role of government is threefold: structure incentives for employers so that all employees can be insured; develop insurance for the uninsured; set up a trust fund for unusual, high-cost catastrophic cases with the goal of reducing rates so that employers could afford to insure additional individuals.

Employers should be expected to provide insurance for their employees and their families. Individuals should expect that a portion of their wages will go to cover health costs. The days of full coverage and no cost are simply not sustainable.

Those who can't afford insurance should be covered by a basic state plan supported by taxpayers. That way they wouldn't have to go to emergency rooms for care, as they are forced to do now.

Kraig Burleson, CEO of Inner City Health Center in Denver

If we are going to make a real difference and have a system that we can all live with, everyone in Colorado must be covered. To accomplish this, government must expand coverage (through existing vehicles like Medicaid, CHP+ and Medicare) to include a greater number of the most disadvantaged.

At the same time, employers must still be relied upon to supply the principal amount of health care coverage through workplace benefits. Significant efforts should also be expended to encourage and enable small businesses to offer health insurance.

However, the greatest challenge is to create an effective mechanism for delivering primary comprehensive care to the mass of currently uninsured. It is equally necessary to address issues pertaining to end-of-life and catastrophic care. Finally, if we are serious about doing something, then we as individuals must be prepared to insist on such action and back it up with tax dollars.

Kevin Hougen, President/CEO of the Aurora Chamber of Commerce

I don't believe that everyone who can afford to pay for health insurance does. Out of the 785,000 people in Colorado without health insurance, how many just decide not to carry it? Health insurance should be run by private organizations, not the government. Individuals and families under the poverty level should be subsidized by the government in which they live.

Walter "Joe" Shaw , Retired University Administrator, Littleton

I believe it is essential and inevitable that Coloradans eventually have some form of universal health care. Our country is now the only developed Western country without a version of single-payer health insurance. In the absence of a national solution to the problem, it seems the obligation must fall on the state.

Nationally, our health care costs are at least 30 percent more than those of most other advanced countries. Our manufactured products, such as automobiles, are more expensive because of the necessary inclusion of health insurance costs in the eventual consumer price. As a result, our products are less competitive at home and in the international market.

Our current practice of individual and corporate responsibility for health insurance embarrassingly leaves about 20 percent of the population without a health care safety net of any kind. Not only is universal health care the moral thing to do, it is the more economical option.

Shelly Fischer, Advanced Practice Nurse, Fort Collins

All people should have health insurance. Every individual has a right to high-quality care, and has a concurrent responsibility to share the cost of that care.

Employers and employees alike should contribute at the current rate to a universal fund rather than contracting with carriers linked to the employer.

The government will need to organize a single-payer program and contract with intermediaries and providers to administer it.

There is enough money in the system now; it just is not spent wisely. An obvious example is the intentional loophole in Medicaid eligibility statutes that allows people to shield their assets in order to access a financial need-based program. We could also provide much more compassionate and lower-cost palliative and end-of-life care in lieu of futile care at an exorbitant cost.

Special interests must be managed effectively in the overall effort if we are to realize the transformation that our system so desperately needs.

Kathy Keyes, Owner, Pagosa Baking Company, Pagosa Springs

My vision for health care in Colorado is quality health care, with an emphasis on health maintenance and prevention, for all individuals. Ideally I would like to see the government or an NGO operate as a gatekeeper and quality assurance provider for citizens in the state. Individuals could pay directly or through their employer into a statewide fund. All citizens would be eligible for medical care.

Steve Federico, MD, Pediatrician, Denver

The responsibility for health care should be shared. It would be really easy just to shift the burden to those who are currently uninsured and thus disenfranchised. We must not blame the victims.

State government has a big role to play due to federal inaction. But government does not have to run health care. It could be a public/private partnership like SCHIP-where government assists with funding and regulation.

Given the current reality, it is unrealistic to think that everyone will have access to every health care service. People should have unlimited access to prevention and acute care, but overall there needs to be a fair and ethical process to establish boundaries around what is covered. At the end of the day we need to be able to look ourselves in the mirror and say we did the best we could with what we had.

Holly Hanson, Insurance Broker and CEO of Health Access Pueblo

Health insurance is available to almost everyone today, but the issue is affordability. Finding a solution for the 17 percent of Coloradans who don't have insurance will ease the problem of affordability by reducing the amount of cost shifting from one payer to another. Each person has a responsibility to be a good health care consumer and make healthy lifestyle choices. Likewise, physicians, hospitals, government and insurance companies have the responsibility to manage their resources wisely.

Asking all Coloradans to be responsible for obtaining coverage should be part of the solution, and individuals should have flexibility in choosing the appropriate coverage. Government can provide a safety net and financial assistance to those who are unable to afford basic coverage. This financial assistance could be applied to coverage purchased through an employer, community or as an individual.

Section Three: What Values Inform Your Health Care Vision?

Why Are Values So Important in Health Care?

You have high blood pressure but can't resist eating those salty french fries. Or you're 30 pounds overweight but won't pull yourself up off the couch. Or you smoke two packs a day, even though you've known since childhood that cigarettes cause heart disease and lung cancer.

Or maybe…

You've been laid off from your job, your COBRA benefits ran out a month ago and you suddenly feel pains in your chest. Or you have a congenital condition and need a potentially life-saving medical procedure, but your insurance company won't cover it. Or you're a child, your family is homeless and you're sick.

How you respond to each of these scenarios says something about the values that underpin your vision for health care. You might be thinking, "Why should the rest of us have to pay higher insurance premiums because some people refuse to make healthy choices and then get a disease?" Or you might say, "Isn't it best for society as a whole if everyone has access to quality health care?"

Or perhaps you find yourself somewhere in the middle, trying to find a balance.

Individual Responsibility and the Common Good

Individual responsibility and the common good are two sides of the same coin. They may seem like conflicting values, but in the context of health care, the goals are largely the same – better health and lower costs.

The concept of individual responsibility in health care is that following a healthy lifestyle – eating right, not smoking and getting regular checkups – will keep you healthy and prevent expensive visits to the hospital for more serious problems. It also means taking responsibility for being an informed and savvy health care consumer – seeking high quality, cost-effective care. And it means taking financial responsibility, too, by contributing to the cost of coverage and care.

The common good concept stresses that a universally accessible and affordable health care system is of vital importance to all members of society, some of whom will develop chronic or life-threatening conditions despite taking good care of themselves. Health status is only partly a function of the choices we make and whether we follow a healthy lifestyle. For example, about 10 percent of people with lung cancer never smoked.[22]

Many people merge the concepts of the common good and individual responsibility into the idea of shared responsibility – the notion that we all have a role to play in the health care debate. Individuals must take responsibility for their health and well being, but it is also in the best interest of employers, health care providers, insurers and the government to empower people to live healthy and make smart decisions.

As you read the quotes on the next page and consider the scenarios mentioned above, frame your own ideas. What values underpin your vision for health care?

"Patients must be central to our efforts to improve health care. For instance, a person with a chronic illness such as diabetes must essentially "own" that illness if he or she is to have any hope of effectively managing it. Providers can help with high-quality treatment and the best recommendations, but patients must act on those recommendations. They must stop smoking, eat right, exercise, take their medication, and monitor their blood sugar, based on their own volition and usually outside of the clinical setting. Public policies must encourage patients to embrace personal responsibility."

– Former U.S. Senator William H. Frist, MD

"By preventing illness, by assuring access to needed community and personal health services, by promoting medical research, and by protecting our people against the loss caused by sickness, we shall strengthen our national health, our national defense, and our economic productivity...We shall bring new security to our people."

-President Harry S Truman

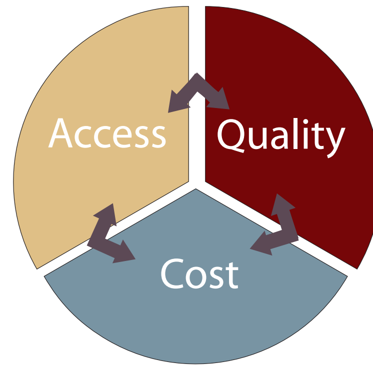
"I am particularly interested in the issue of personal responsibility. I think that has been part of what has been driving the debate with respect to health savings accounts and other such approaches. I have been discussing with my constituents in town hall meetings the idea that if we are to have a system that works for everybody in terms of affordable quality health care, I am prepared to say that an individual should, every time they use a medical service, if they are not destitute, have to make a payment on the spot so as to ensure that there is a clear requirement of personal responsibility. Certainly, that will be controversial, but that is the kind of issue that has to be discussed with respect to health reform."

–U.S. Senator Ron Wyden

"In the ultimate sense, the general good health of our people is the foundation of our national strength, as well as being the truest wealth that individuals can possess. Nothing should impede us from doing whatever is necessary to bring the best possible health care to those who do not now have it--while improving health care quality for everyone–at the earliest possible time."

- President Richard Nixon

Section Four: Approaches to Health Care Reform



Health care policy can be thought of as having three interconnected parts: cost, access and quality. Below are listed a few commonly proposed approaches to address each factor. This list is by no means exhaustive, but is intended to provide you with some food for thought. It is also important to note that many of these strategies have impacts across all three factors.

Cost

- Cutting back on regulations and mandates – Some state-imposed rules and restrictions, such as requiring that certain services be included in an insurance benefits package (e.g. cancer screenings or mental health benefits), may be viewed as onerous and unnecessary. Insurers are prevented, it is argued, from offering fewer benefits, or a different mix of benefits, to reduce costs for consumers.

- Providing incentives for adopting healthy habits and lifestyles – For example, tax breaks and legal protections could be offered to employers who implement wellness programs for workers to quit smoking or maintain a healthy weight.

- Offering basic, "high-value" benefit packages – Costs may be lowered with health benefit packages that are shown to provide the highest quality of care at the lowest price.

- Streamlining administration – Strategies to make the health care system more efficient might include establishing a joint prescription drug purchasing program across health care programs or coordinating after-hours, urgent-care services among different providers. Another possibility might be streamlining and simplifying the Medicaid and CHP+ application process and perhaps making it available online.

- Capping administrative costs – Administrative costs currently account for about 7.5 percent of total health care spending in Colorado.[23] Some have suggested that administrative costs be limited to a fixed amount, such as no more than 6 percent of total spending.

- Requiring cost-benefit analysis of new drugs and technology – Insurance would not cover a new drug or other benefit unless it has been shown to be cost effective. Federally sanctioned Evidence-based Practice Centers already review evidence from scientific research studies to help guide decisions on coverage.

- Managing chronic disease more effectively – Treating people with chronic diseases such as arthritis, diabetes and cancer accounts for more than 75 percent of total health care spending in the United States.[24] Costs may be lowered by helping people manage their conditions more efficiently and effectively, such as disease management programs, computerized tools or courses that teach patients how to cope with symptoms and the importance of adhering to medication regimens.

- Reforming medical liability laws – Colorado already imposes some limits, including a cap on damages for physical impairment or disfigurement. Some argue that more could be done to limit costs associated with malpractice claims.

- Requiring price transparency so consumers know how much their care costs – People often don't know the cost of health care until the bill arrives and many times they never know the cost because much of it is paid by a third party. If consumers had reliable price information for medical services, as they do for other purchases, they would be able to shop for value, as well as quality care.

- Passing on the savings from low utilization of health care to the individual consumer – Consumer-directed approaches such as high-deductible health plans and Health Savings Accounts (HSAs) can help individuals save money if they don't use a lot of health care services.

Access

- Enrolling those who are already eligible for public programs, such as Medicaid and CHP+, but not currently in the programs – About 85,000 of the uninsured in Colorado are eligible for Medicaid but not enrolled.
- Expanding eligibility for public programs – Pregnant women and children up to age 5 are eligible for Medicaid if their family's income is no more than 133 percent of the FPL. Children ages 6 to 18 are eligible for Medicaid if their family's income is no more than 100 percent of the FPL. These eligibility levels are lean compared to some other states. Also, Colorado participates in only a few optional programs under Medicaid and could choose to participate in more to expand access.
- Individual mandate – Some states are considering, or have passed, laws requiring all residents to have health insurance. Such laws could be accompanied by provisions that expand access to public programs and/or provide subsidies to purchase private insurance.
- Employer mandate – Some states require employers to either offer insurance to employees or to pay a fee to help them acquire coverage from other sources.
- Single-payer system –A single entity, such as the government or an independent agency, could be created to administer a health insurance program for everyone in the state.
- Subsidizing the purchase of insurance for low-income people. "Buy-in" programs can help uninsured people afford coverage. State-funded reinsurance may reduce the price of private health insurance by having the state cover a portion of the insurers' high-cost health claims. Tax credits and deductions are other ways to subsidize the purchase of insurance.
- Increasing Medicaid reimbursement rates – Some providers don't accept Medicaid payments because the reimbursements are low. Increasing reimbursement rates could be an incentive for more providers to treat low-income patients.
- Providing publicly funded access to prevention and wellness care – The government could make sure all Coloradans have access to preventive care services and wellness programs, such as nutrition and physical activity classes, aimed at keeping people healthy.
- Providing publicly funded access to comprehensive health care – The government could ensure that everyone has access to comprehensive health care. This could be accomplished by a public, private or hybrid delivery and finance system
- Attracting providers to rural and underserved communities – One strategy to address the provider shortage problem would be to forgive more medical, dental or nursing school debt for those providers who agree to work for a certain amount of time in underserved communities.

Quality

- Enhancing the use of data and making data more transparent – The widespread use of information on important quality-related measures can drive improvements in health care and lead to better health outcomes for patients.
- Creating electronic medical records – Making complete patient histories readily available to providers can help them make better-informed decisions about care and reduce redundancies.
- Supporting the use of treatment guidelines and evidence-based medicine – State and national clinical-care collaborative groups have developed guidelines so that providers can offer treatments that medical evidence shows are most effective.

- Providing incentives to providers for quality and safety improvement – Payers for health care, such as insurance plans or government, could reward providers for meeting quality and performance measures.
- Providing consumers with supports to make quality-based choices – Information resources could help consumers better understand their treatment options and make decisions based on outcomes research.

Glossary

Glossary definitions were developed by the Colorado Health Institute.

Acute care – Medical care provided in response to an immediate illness or a serious injury related to an accident or other form of trauma. Treatment is typically short-term or episodic.

Amendment 35 – The 2004 voter-approved amendment to the Colorado Constitution which increased the sales tax on tobacco products to expand access to health care and fund prevention programs. Forty-six percent of revenues from this new tax provide funding for eligibility expansions in the Medicaid and Child Health Plan Plus (CHP+) programs and 19 percent are distributed through a Primary Care Fund to health care providers who provide a significant level of basic primary care services to uninsured or otherwise medically indigent populations. The remaining funds are designated for tobacco education, cancer, cardiovascular and pulmonary programs.

Benefit package – Medical and other related services that are included in an insurance plan such as hospitalizations, office visits and prescription drug coverage.

Business Group of One (BG1) – A self-employed person or a sole proprietor who qualifies for health insurance as his or her own group under Colorado's small group insurance laws. BG1s are governed by the same rules as small businesses (1-50 employees) and therefore are guaranteed issuance of a policy regardless of pre-existing medical conditions.

Capitation – A contractual arrangement through which a health plan or other entity agrees to provide specified health care services to enrollees for a negotiated prospective payment per member per month (PMPM) as opposed to paying on a fee-for-service basis for individual services used. Under a fully capitated health plan, the plan is at financial risk for the cost of all the services utilized beyond the PMPM paid for each member. In most fully capitated health plans, a risk adjustment tool is used to set rates for members with known extraordinary health care needs.

Centers for Medicare & Medicaid Services (CMS) – The agency within the U.S. Department of Health and Human Services that is responsible for the federal administration of Medicaid, Medicare and the State Children's Health Insurance Program. (The Colorado Medical Society also uses "CMS" as its acronym of choice.)

CHP+ (Child Health Plan Plus) (see State Children's Health Insurance Program)

COBRA (Consolidated Omnibus Budget Reconciliation Act) – The 1986 act containing certain health benefit provisions that amend ERISA, the IRS code and the Public Health Service Act to enable qualified individuals who lose their job to maintain the group coverage in which they were enrolled for an additional 18 months after leaving employment. Qualified individuals can also include retirees, spouses, former spouses and dependent children. COBRA applies to firms with more than 20 employees. Qualified individuals are required to pay the full amount of the standard premium of the plan in which they were enrolled while employed.

Colorado Department of Health Care Policy and Financing (HCPF) – The state agency that administers Medicaid, CHP+ and the Colorado Indigent Care Program.

Colorado Department of Human Services (DHS) – The state agency that administers a broad range of social services in Colorado, including some mental health programs, the system of services for people with developmental disabilities, aging and adult services, and the coordination of early childhood programs and services.

Colorado Department of Public Health and Environment (CDPHE) – The state agency responsible for administering a broad range of public health functions for the state including air and water quality, hazardous waste management, childhood immunization programs and chronic disease management programs, to name a few.

Colorado Department of Regulatory Agencies (DORA) – The state agency that houses the state's health professions licensing boards and the Division of Insurance

that regulates health, auto and property insurance companies in the state.

Colorado Indigent Care Program (CICP) – A state program that provides partial reimbursement to some health care providers who provide a significant amount of health care to the state's low-income uninsured populations up to 250 percent of the federal poverty level. Funds currently are provided to 49 hospitals, 18 clinics and 51 satellite clinics throughout the state.

Community health centers – Federally designated non-profit health clinics that provide comprehensive primary care services regardless of ability to pay, including physical, dental and mental health services. Colorado has 14 centers which operate 118 clinic sites (also known as federally qualified health centers [FQHCs]) in 34 Colorado counties.

Community rating (pure and modified) – A method for actuarially determining health insurance premiums based on the average health care use and costs of a population. Pure community rating is a rate calculated on an entire population regardless of its health status, age, gender or geographic location. Modified community rating permits insurers to consider certain demographic factors in calculating rates such as age, gender, health status, geography or other factors including some combination thereof.

Consumer-driven or consumer-directed health care – A payment system, either through insurance or direct payments to consumers, that allows enrollees to purchase a defined set of health care services to meet their personal needs and allows long-term care consumers to directly purchase and manage the services they need. In its most popular usage, a consumer-directed health plan is usually a combination of a high-deductible health insurance plan with a tax-preferred health savings account which enrollees may use to pay for routine health care expenses.

Cost-sharing – The portion of health care expenses that falls to an insured individual for payment, usually taking the form of a co-payment (the amount a plan member has to pay for a service such as a provider visit or a prescription) and a deductible (the dollar amount that must be paid before insurance coverage begins).

Cost-shifting – Increasing the premium charged to one segment of the insured population, e.g., individuals with employer-sponsored coverage, to make up the difference between the actual costs of providing care and the amount reimbursed by public programs, typically Medicare and Medicaid. This term also applies to the practice used by health care providers such as hospitals to cover the costs of uncompensated care provided to uninsured patients by passing these costs on to insured patients in the form of higher premiums.

CoverColorado (see High-risk pool)

Disease management – Ongoing management of chronic disease through an integrative, multi-disciplinary approach designed to prevent further functional deterioration. Disease management programs are designed to be a cost-effective alternative to managing the costs associated with chronic disease and to improve the quality of life of individuals living with a debilitating chronic illness.

Electronic Medical Record (EMR) – An individual medical record that has been digitized and stored electronically and moves with a patient across providers.

Employer-sponsored insurance (ESI) – Health insurance coverage provided through an employer. ESI can be solely paid for by an employer or provided with cost-sharing between the employer and employee.

ERISA (Employment Retirement Income Security Act) – Federal legislation passed in 1974 that contains a number of health benefit provisions including the setting of minimum standards for voluntarily established private health insurance plans. ERISA prevents states from regulating self-insured health plans offered by employers, thus providing latitude in the benefits self-insured employers can offer to their employees.

Evidence-based medicine – The use of the latest clinical evidence about medical decisionmaking related to individual patient care. The use of practice protocols developed through clinical research is a good example of how evidence-based medicine gets translated and diffused into medical practice.

Federal poverty level (FPL) – Annually updated guidelines established by the U.S. Department of Health and Human Services to determine eligibility for various federal and state programs. In 2007, the FPL for a family of four is $ 20,650.

Federally Qualified Health Centers (FQHCs) – Community clinics that have a federal designation and receive an annual federal grant (330 grants) to support the provision of services to vulnerable populations. FQHCs also receive cost-based reimbursement for Medicare and Medicaid patients as a mechanism to ensure access to primary care services for these vulnerable populations who live in a medically underserved or health professional shortage area.

Guaranteed issue – Health insurance for which there is a guarantee that coverage is available to anyone regardless of health status, occupation, age or gender. Guaranteed issue is required in Colorado's small group market (1-50 employees) but is not required in the individual market.

Health information technology (HIT) – The automation of health information for the purpose of sharing clinical and demographic information at the patient and provider levels with the goal of improving health and health care quality. The intent of HIT is to automate health information at the patient level in order to reduce redundancies in testing and other diagnostic procedures, medical errors and the fragmentation of patient-level information that can lead to suboptimal medical care outcomes.

Health Insurance Flexibility and Accountability (HIFA) Waiver – A federal waiver program that provides states increased flexibility in tailoring their Medicaid and State Child Health Insurance Programs. States may expand eligibility in Medicaid and SCHIP only if they can demonstrate budget neutrality in such expansions. States are also encouraged to use the private health insurance market, to the extent feasible, in designing coverage expansions through a HIFA waiver.

Health Savings Account (HSA) – A tax-sheltered account funded by an employee and/or employer into which pre-tax dollars are deposited for the purpose of paying for qualified medical expenses for an employee and his/her dependents. Under current federal law, employees must be enrolled in a high-deductible health plan to establish an HSA. In 2007 the annual contribution allowed is $2,850 for an individual and $5,650 for a family. Additionally, individuals over 55 years of age may make a catch-up contribution of up to $800 in a calendar year.

High-deductible health plan (HDHP) – A health insurance plan that requires the payment of a specified amount before the insurer begins reimbursing for services provided. The deductible is paid by the enrollee, either out of pocket or through a Health Savings Account, a flexible spending account or a Section 125 cafeteria plan. For 2007, the minimum annual deductible amount established by law is $1,100 for an individual and $2,200 for family coverage. In most products, the deductible amounts are higher and, in some cases, the amount is shared by the employer and employee.

High-risk pool (CoverColorado) – A state-established, subsidized health insurance program designed to provide coverage to individuals who have been excluded from the individual insurance market because of a pre-existing medical condition and who are not eligible for public coverage. In Colorado, the high-risk pool, CoverColorado, provides subsidies to certain low-income individuals, although premiums are generally set at 100-150 percent of prevailing rates in the nine geographic rating regions of the state.

HIPAA (Health Insurance Portability and Accountability Act) – Passed by Congress in 1996, HIPAA includes various health insurance coverage and patient privacy protections. The privacy rules were established to protect patients' privacy through the strict enforcement of confidentiality of medical records and other health information provided to health plans, doctors, hospitals and other health care providers. Rules to implement HIPAA were developed by the U.S. Department of Health and Human Services.

HMO (health maintenance organization) – A health insurance plan that provides a coordinated array of preventive and treatment services for a fixed payment per month, also known as capitation. HMOs provide services through a fixed panel of health care providers. Enrollees

receive medically necessary services regardless of whether the cost of those services exceeds the premium paid on the enrollees' behalf.

Individually purchased insurance – Health insurance products available for purchase by individuals without the involvement of an employer sponsor. Unlike group insurance, insurers in Colorado can deny individual coverage based on an individual's health status.

Long-term care – Health care, personal assistance and other supportive services provided to individuals with significant functional limitations who are unable to care for themselves without the assistance of others. Long-term care services are provided in institutional, home and community-based settings. These services are generally paid for privately or, in the case of eligible low-income elders and people with disabilities, are covered under the Medicaid program.

Managed care – Insurance coverage that integrates service delivery and financing through an identified panel of providers that manages care techniques to coordinate the appropriate health care utilization of plan members. Managed care organizations are reimbursed through a negotiated fixed monthly payment or capitation for services provided.

Medicaid – Title 19 of the Social Security Act, passed in 1965, which established a state-federal partnership to provide health care coverage to low-income children, parents, pregnant women, elders and individuals with disabilities. In Colorado, more than 380,000 people are receiving health care coverage through Medicaid in 2007. Medicaid in Colorado complies with all federal minimum requirements for services and covered eligible groups and additionally authorizes a few optional services and eligibility categories beyond those mandated by federal law.

Medical home – A regular source of medical care that is continuous and comprehensive in its approach to wellness, prevention and health care management. SB 130, which passed in the 2007 legislative session, establishes state policy that all children enrolled in the Medicaid program in Colorado should have access to a medical home to ensure continuous access to preventive, developmental and acute care services.

Medicare – Title 18 of the Social Security Act, passed in 1965, which created an entitlement to health care coverage for individuals age 65 and older and certain eligible individuals with disabilities. Medicare Part A covers inpatient hospital care, some skilled nursing facility care and hospice care. Part B covers physician care, diagnostic X-rays, laboratory tests and durable medical equipment. Part C, originally Medicare + Choice and now Medicare Advantage, allows private insurers to offer a Medicare plan. Part D, the most recent addition to the Medicare program, offers a subsidized prescription drug benefit to Medicare beneficiaries.

Out-of-pocket payments – Direct spending by consumers for health care goods and services, including deductibles and co-payments.

Pay-for-performance – A reimbursement system that rewards health care providers based on measurable improvements in specified health care outcomes of their patients.

Preferred Drug List – A list of prescription drugs covered by a particular health plan or public program that have been selected for their efficacy, safety and cost-effectiveness. Ideally, the list is based on documented scientific evidence.

PPO (Preferred Provider Organization) – A health insurance plan in which health care providers agree to provide services to members at a negotiated price (reduced fee). Covered individuals (members) receive all medically necessary services regardless of whether the cost of the services exceeds the premium paid, although members do have cost-sharing obligations.

Premium – Amount paid to an insurance company for providing health care coverage for specified benefits contained in a contract between an insurer and purchaser (either an employer or individual purchaser).

Primary care – Medical care provided by physicians and other health professionals such as advanced practice nurses, physician assistants and certified nurse midwives

who are licensed to provide preventive, early intervention and continuous care for basic health care services. Primary care is ongoing and can involve the establishment of a medical home for individuals at all stages of the life course from pregnancy and childbirth through old age. Physicians who provide primary care include pediatricians, general medicine, internal medicine, family medicine and obstetricians and gynecologists.

Referendum C – A voter-approved measure that provides Colorado state government a five-year hiatus (FY 2005-06 through FY 2009-10) from the revenue retention limits of the Taxpayer's Bill of Rights (TABOR) Amendment. Additional revenues that are retained due to passage of Referendum C are required to be appropriated for public K-12 education, higher education, health care and transportation.

Safety net – A largely nonprofit and public array of providers including community clinics, school-based health centers, hospitals and others that provide health care for low-income, uninsured and underinsured Coloradans and those enrolled in publicly funded health care programs such as Medicaid and CHP+.

Self-insured or self-funded – Employers that set aside funds to pay for the health care costs of employees and their dependents. A self-insured/self-funded employer assumes complete financial responsibility for the health care costs of its enrolled employees and dependents based on the defined benefit plan offered by the employer. Self-funded health insurance is not regulated by states' insurance commissioners but rather by federal legislation known as ERISA. A self-funded employer may use the services of a third-party administrator, often an insurance company, to administer the benefit plan.

Single-payer system – The term used to describe a health insurance financing system in which one entity -- public (state agency) or private (an insurance company) -- is responsible for collecting health insurance premiums and negotiating rates paid to providers for a defined benefit package available to all covered individuals.

Small group market – The insurance market for products sold to firms with one-50 employees in Colorado. The state's small-group market also includes qualified self-employed individuals or sole proprietors who meet the criteria of the Business Group of One designation specified in state regulations.

State Children's Health Insurance Program (SCHIP) – A federal-state partnership program administered by the states in which the federal government provides a block grant to Colorado based on a 65/35 cost-sharing ratio to assist the state in offering health care coverage to low-income children and other family members who do not qualify for Medicaid based on income. Colorado's program, the Child Health Plan Plus (CHP+) program provides coverage to children and pregnant women with incomes up to 200 percent of the federal poverty level.

TABOR (Taxpayer's Bill of Rights) – Constitutional amendment passed in 1992 by Colorado voters to restrain the growth of all levels of government (state, local, city, county, school and special districts) by limiting annual revenue increases to the prior year's revenue limit plus population growth and inflation. TABOR requires that any state or local tax increase must be approved by voters of the affected level of government.

Transparency – In the context of health care, transparency refers to initiatives that enable purchasers, including employers and individual consumers, to compare the quality, outcomes and price of health care services so they can make informed choices when purchasing or selecting a health care provider or set of services.

Uncompensated care – Services provided by health care providers for which no payment is received from the patient or from a third-party payer. Uncompensated care results in bad debt for providers or may be counted toward the charity care commitment made by individual providers on an annual basis.

Underinsured – Individuals and families with public or private insurance that does not cover all necessary health care services, resulting in out-of-pocket expenses that exceed their ability to pay.

Uninsurable – An individual who does not have health care coverage through private insurance because he or she

falls outside the parameters of standard health insurance underwriting practices. CoverColorado is the state's high-risk insurance program, a quasi-governmental agency that offers health insurance coverage to individuals who have been underwritten out of the individual insurance market because of a pre-existing health condition. (Also see high-risk pool.)

Uninsured – People who lack public or private health insurance coverage.

Wellness benefits – A set of benefits that are covered by a health insurance plan that promote wellness behaviors and may reward a plan enrollee who participates in physical exercise, stress reduction, smoking cessation, nutrition education and weight loss programs that enhance health through reductions in co-payments and deductibles.

End Notes

1 The Lewin Group, "Technical Assessment of Health Care Reform Proposals," (prepared for the Colorado Blue Ribbon Commission for Health Care Reform), Aug. 20, 2007, p. 5

2 Department of Health Care Policy and Financing, "Report to the Joint Budget Committee on the Health Care Policy and Financing Medical Services Premium Expenditures and Medicaid Caseload," Sept. 17, 2007, p.4

3 Department of Health Care Policy and Financing, "Medically Indigent and Colorado Indigent Care Program FY 2005-06 Annual Report," p. 5

4 The $30 billion figure includes approximately $2 billion for administrative costs. Administrative costs for 2000 are not available.

5 The Lewin Group, "Total Health Care Spending for Colorado on a Calendar Year Basis 2000-2007 (in millions)," chart. The 77 percent increase was calculated using a 2000 figure and a 2007 estimate that do not take into account administrative costs.

6 The Lewin Group, "Technical Assessment of Health Care Reform Proposals," (prepared for the Colorado Blue Ribbon Commission for Health Care Reform), Aug. 20, 2007, p. 9-12

7 Colorado Health Institute, "Health Care Vision 2007 and Beyond: Colorado's Health Care Marketplace," p. 2

8 Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits 2007 Annual Survey," p. 11, 66.

9 Families USA, "Paying a Premium: The Added Cost of Care for the Uninsured," June 2005, p. 4

10 Institute of Medicine of the National Academies, "The Chasm in Quality: Select Indicators From Recent Reports," http://www.iom.edu/CMS/8089/14980.aspx

11 Agency For Healthcare Research & Quality, U.S. Department of Health & Human Services, "State Snapshots," http://statesnapshots.ahrq.gov/statesnapshots/strongest_weakest.jsp?menuId=4&state=CO

12 The Commonwealth Fund, "Aiming Higher: Results From a State Scorecard on Health System Performance," http://www.commonwealthfund.org/statescorecard/statescorecard_show.htm?doc_id=495389. Colorado ranks 22nd in the overall performance of its health system.

13 The Lewin Group, "Technical Assessment of Health Care Reform Proposals," (prepared for the Colorado Blue Ribbon Commission for Health Care Reform), Aug. 20, 2007, p. 5

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15 Colorado Health Institute, "Profile of the Uninsured in Colorado, 2004," January 2006, p. 10-12

16 The Lewin Group, "Technical Assessment of Health Care Reform Proposals," (prepared for the Colorado Blue Ribbon Commission for Health Care Reform), Aug. 20, 2007, p. A-8

17 The Lewin Group, "Technical Assessment of Health Care Reform Proposals," (prepared for the Colorado Blue Ribbon Commission for Health Care Reform), Aug. 20, 2007, p. A-9, A-10

18 The Lewin Group, "Technical Assessment of Health Care Reform Proposals," (prepared for the Colorado Blue Ribbon Commission for Health Care Reform), Aug. 20, 2007, p. A-12

19 Centers for Studying Health System Change, Peter J. Cunningham and Jessica H. May, "Medicaid Patients Increasingly Concentrated Among Physicians," August 2006

20 The Colorado Rural Health Center, "Snapshot of Rural Health in Colorado," December 2004, p. 2. This data may change frequently as physicians relocate.

21 The state Department of Insurance estimates that about 30 percent of all Coloradans with private health insurance are exempt from ERISA.

22 American Cancer Society, statement by Carolyn D. Runowicz, MD, national volunteer president, March 7, 2006

23 The Lewin Group, "Technical Assessment of Health Care Reform Proposals," (prepared for the Colorado Blue Ribbon Commission for Health Care Reform), Aug. 20, 2007, p. 9

24 Centers for Disease Control and Prevention, "Chronic Disease Overview," www.cdc.gov/nccdphp/overview.htm

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www.colorado.gov/governor