Health District
OF NORTHERN LARIMER COUNTY

3/22/2019

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POLICY ANALYSIS

HB 19-1176: HEALTH CARE COST SAVINGS ACT OF 2019

Concerning the enactment of the "Health Care Cost Savings Act of 2019" that creates a task force to analyze health care financing systems in order to give the general assembly findings regarding the systems' costs of providing adequate health care to residents of the state

Details

Bill Sponsors:	House – *Sirota* (D) *and Jaquez Lewis* (D), Benavidez (D), Singer (D) Senate – *Foote* (D)
Committee:	House Health & Insurance Committee
Bill History:	2/12/2019 – Introduced
Next Action:	3/27/2019 – Hearing in Health & Insurance Committee
Fiscal Note:	3/20/2019 Version

Bill Summary

This bill responds to increasing health care costs and pricing inequities by creating the Health Care Cost Analysis Task Force. The purpose of this task force is to select a professional analyst to prepare a report for the General Assembly on a variety of health care funding mechanisms. The bill identifies three financing systems that could be potential solutions this policy issue: a public option, multipayer health care, and publicly-funded and privately financed universal health care. The analyst's report shall take into account costs, premiums, coverage rates, and the effect on various types of health care. The report must be delivered on or before January 1, 2021.

Issue Summary

Health Care Costs in Colorado

Health care quality in Colorado has been steadily improving and currently ranks sixth in the nation according to the Commonwealth Fund.[1] However, Colorado still struggles to increase access to health care, particularly in rural areas, Coloradans continue to have strong concerns about the cost of health insurance and care, and people in Colorado can have dire financial circumstances if they develop chronic illness or have emergency or other needs for health care that result in high out-of-pocket costs. Coloradans spend an average of $6,804 per capita (14 percent of their income) on health care, and costs can be far higher for many. Analysis shows that costs will continue to rise and manifest in increased deductibles, with nearly all insurance plans in Colorado relying on deductibles to cover costs.[2] A few of the reasons that the cost of care continues to rise include expensive technologies, consolidation, fee-for-service payments, prescription drugs, low-value care, and the continued aging of the population.[3] Currently, some say that health care costs are rising unsustainably, making the availability of affordable health care a concern for many Coloradans.[4] Moreover,

[1] The Commonwealth Fund. (2017). "Aiming Higher: Results from the Commonwealth Fund Scorecard on State Health System Performance." Retrieved from https://interactives.commonwealthfund.org/2017/mar/state-scorecard/.
[2] Colorado Health Institute (CHI). (Dec. 14, 2018). *Affordability in Colorado: Questions and Answers about Health Care Costs.* Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/CHA%20Q%26A%20no%20crops.pdf.
[3] CHI. (2017). *A Fresh Look at Health Care Cost Drivers: Exploring Free Market and Regulatory Solutions*. Retrieved from https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/X_Cost_Drivers_fact_sheet_SENT.pdf
[4] Colorado Consumer Health Initiative (Feb. 2019). *What Coloradans Are Saying About Health Care.* Retrieved from https://www.cohealthinitiative.org/what-coloradans-are-saying-about-health-care

access to health care is still limited, with rural residents paying disproportionately higher premiums, which may be largely due to the lack of competition in the health care market.[2]

1999 Colorado Health Care Task Force

The 1999 Colorado Health Care Task Force was created in order to review the state of older adult care coverage at the turn of the century. It was dedicated to reviewing long-term health care for older adults but also spent significant time reviewing modern developments in the health care field, including issues regarding pharmacy benefit managers, rural hospitals, health care work force shortages, and telemedicine.[5] The commission was given a five-year time frame for completion.

After its five-year term, the Health Care Task Force sent recommendations to the General Assembly and was extended for the next three years in order to continue to provide recommendations for the General Assembly based on the other parts of their research. Some of the recommendations were introduced in the General Assembly include expanding Medicaid eligibility to 21 years old for those in the foster system, expanding eligibility for CoverColorado[6], requiring school districts to check for health coverage of students, expanding eligibility for the Child Health Plan Plus (CHP+), and the creation of a state maximum allowable cost program in Medicaid for prescription drugs.[7] Of these listed proposals, only one, expanding Medicaid eligibility for foster youth, passed out of the General Assembly and was signed into law by the Governor.

Looking back, the 1999 Colorado Health Care Commission had some success, but access to health care and costs of health care remained significant challenges. While some legislation regarding coverage and financing was recommended, the majority of the legislation was largely focused on other issues. Nonetheless, the 1999 Commission was objectively the most successful in regards to the number of recommendations signed into law. The 1999 Colorado Health Care Task Force was terminated at the end of 2007 after the creation of the Blue Ribbon Commission for Health Care Reform (208 Commission).

2007 Blue Ribbon Commission for Health Care Reform (the 208 Commission)

The Blue Ribbon Commission for Health Care Reform, commonly referred to as the 208 Commission, was created in 2006 to address expanding health care coverage and reducing costs after the expiration of the 1999 Colorado Health Care Task Force. The Commission was tasked with responding to growing uninsured rates and premium increases, which were asserted to be a result of the uninsured rate. The Commission requested proposals for different approaches, chose a few of the proposals for modeling, and selected an analyst from the Lewin Group to perform the modeling and analyze the results.[8] At the time, the Health District worked closely with other experienced leaders (including the head of Denver Health, a renowned health economist, physicians studying alternatives, etc.) to develop one of the proposals, which was one of the few selected for modeling.

The final Commission report consisted of 31 policy suggestions that the Commission believed would address the problems highlighted in their mission. The group believed the solution should be to stabilize rising costs and extend health coverage to more people. The report put their proposals into three parts: “Reduce Health Care Costs, while Enhancing Quality of Care”; “Improve Access to Care, with Mechanisms to Provide

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[5] Health Care Task Force. (2002). “Report to the Colorado General Assembly.” Pursuant to Section 26-15-107. Research Publication No.497. Retrieved from https://www.colorado.gov/pacific/sites/default/files/healthcaretaskforce.pdf.

[6] CoverColorado was a high-risk pool that operated from 1991 to 2013. Each year there were approximately 13,700 individuals in the program with total claims of more than $117 million. The program was funded through monthly premium fees (50%), assessments on state regulated plans including stop loss and reinsurance (25%), and unclaimed property funds (25%).

[7] Burger, Elizabeth. (July 2009). “Activities of the Health Care Task Force from 2005 to 2008.” Memorandum to Members of 2009 Health Care Task Force. Retrieved from http://hermes.cde.state.co.us/drupal/islandora/object/co%3A13829/datastream/OBJ/view.

[8] Blue Ribbon Commission for Health Care Reform (January 2008). “Final Report to the Colorado General Assembly – Executive Summary.” Pages 7-10. Retrieved from https://www.colorado.gov/pacific/sites/default/files/700-832-Commission%20Final%20Report-Executive%20Summary.pdf.

Choices"; and, adopting all 30 proposals under the previous 2 parts as a "comprehensive, integrated package" in various implementation stages.

Of the final 31 recommendations, only 4 were selected for consideration by the General Assembly. The four proposals were an attempt to address both concerns over uninsured rates and health care costs. Under Governor Bill Ritter (D), the Commission's efforts resulted in limited steps towards fixing issues, including the creation of the Center for Improving Value in Health Care (CIVHC), a higher reimbursement rate for doctors treating Medicaid patients, and the expansion of Medicaid in Colorado. Further work was difficult when the national economy crashed and the State's revenues fell dramatically, and the reimbursement and Medicaid policies were shelved at that time. However, later – before the Patient Protection and Affordable Care Act (ACA) - Colorado began to modestly expand Medicaid utilizing limited state revenues. Many of the recommendations were similar to those ultimately included in the ACA, and were more achievable with national regulations and funding.

Public Option

A public option system would create a state-financed health care insurance option that would be available to citizens alongside the private insurance market. This public insurance option could largely mirror a similar existing structure, such as Medicare or Medicaid. A public option was included in early drafts of the ACA but later removed in the final draft of the law.[9] However, as researchers note, there is nothing in current federal law that prevents states from pursuing their own public option.[10] No state has completely enacted a true public option system, though some states (and cities) have begun considering such policies, including New Mexico, Colorado, Washington, Connecticut, and New York City.

In Colorado, HB19-1004 is currently being considered. The bill requires the Colorado Department of Health Care Policy and Financing (HCPF), Division of Insurance (DOI), and Department of Regulatory Agencies (DORA) to develop and submit a proposal to the General Assembly in regards to the design, costs, benefits, and implementation of a state option for health insurance coverage. The proposal must have a detailed analysis of the state option and identify the most effective implementation based on affordability, burden to the state, ease of implementation, and likelihood of meeting outlined objectives.

Universal Health Care

The United States is the only large rich country without universal health care.[11] There are a variety of different types of universal health care systems, including the following.

The Beveridge Model – Health care is provided and paid for by the government using tax dollars.[12] The government represents the "single-payer" for all medical bills. Under this system, care tends to be free at the point of service and the majority of the health workforce are government employees. Examples of this model include the United Kingdom, Spain, New Zealand, and Cuba. Within the U.S. this model is similar to the Veterans Health Administration.[13]

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[9] Halpin, H.A. & Harbage, P. (June 2010). The Origins and Demise of the Public Option. *Health Affairs.* Retrieved from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0363

[10] Halpin, Helen A. and Peter Harbage. (2010). "The Origins and Demise of the Public Option." *Health Affairs* 29 (10): 1117-1124. Retrieved from https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2010.0363.

[11] The Economist (Apr. 26, 2018). *America is a health-care outlier in the developed world.* Retrieved from https://www.economist.com/special-report/2018/04/26/america-is-a-health-care-outlier-in-the-developed-world

[12] Frontline PBS. (April 15, 2008). *Health Care Systems – The Four Basic Models*. Retrieved from https://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/countries/models.html.

[13] Chung, M. (Dec. 2, 2017). Health Care Reform: Learning from Other Major Health Care Systems. *Princeton Public Health Review.* Retrieved from https://pphr.princeton.edu/2017/12/02/unhealthy-health-care-a-cursory-overview-of-major-health-care-systems/

The Bismarck Model – The insurance market remains private as does the ownership of most health care facilities and contracts. However, health insurance covers every person and all insurance plans are jointly-funded by employers and employees. The number of insurers in the market varies by country; France has a single insurer, Germany has multiple, competing insurers, and Japan has multiple, non-competing insurers. No matter the number, government controls prices and insurers do not make a profit.[13] Examples of this system include France, Germany, Japan, Belgium, and Switzerland. Within the U.S. this model is similar to some aspects of Medicaid as well as employer-funded health plans.

The National Health Insurance Model – This model incorporates aspects of the previous two systems. The government acts as the single payer for services and the providers are private. In the most popular version of this system, Canada, this has driven down pharmaceutical costs. The specific aspects of this model vary from country to country. Under Canada's system, private insurance contracting is permitted for those individuals that prefer to do so. This system covers most procedures regardless of the individual's income. Examples of this system include Canada, Taiwan, and South Korea.[13] Within the U.S., this model is similar to Medicare.

Multipayer Health Care

A multipayer system allows multiple private health insurers to operate and receive funding from consumers, employers, government, or some combination of these groups. A recent literature review found that in general, multipayer systems tend to yield additional options to patients but involve a higher administrative cost.[14] Although similar to what is occurring currently, some may point to examples of the Bismarck Model, such as Germany, an example of multipayer health care.

This Legislation

The bill declares the following: health care costs are rising unsustainably; affordable health care is a major concern for most Americans; rural Coloradans pay disproportionately higher premiums; 850,000 Coloradans are uninsured or underinsured; and Colorado needs more facts to determine the most "cost-effective" method of financing health care.

It defines "at-risk insured" as a resident who is not underinsured because they are currently healthy but would become underinsured if they developed a serious medical condition. It defines a "public option system" as a system under which all residents are able to purchase a health care plan managed by the State or Connect for Health Colorado. The bill defines "underinsured" as a person who has health insurance but has health care costs that exceed ten percent of the person's personal income, including high deductibles and out-of-pocket expenses. "Universal health care" is defined as a system under which every resident has access to adequate and affordable health care.

The purpose of the task force is to develop comprehensive fiscal analyses of current and alternative financing systems. The following appointments must be completed by September 1, 2019. The task force shall be composed of eight members from the General Assembly, with two each appointed by the Speaker of the House, the Minority Leader of the House, the President of the Senate, and the Minority Leader of the Senate. The Governor appoints nine members to the task force that are socially, demographically, and geographically diverse as well as demonstrate the ability to represent all Coloradans and can present nonpartisan and evidence-based ideas. Finally, the executive directors, or their designees, of the Department of Human Services (DHS), the Department of Public Health and Environment (CDPHE), and Department of Health Care Policy and Financing (HCPF) will serve on the task force. A chair and vice-chair are chosen from the members. A member of the task force can be removed from their seat with a majority vote from the other members. If there is a vacancy, the original appointing entity fills that seat. Members of the task force

[14] Petrou, P., Samoutis, G., & Lionis C. (Oct. 2018). Single-payer or a multipayer health system: a systematic literature review. *Public Health.* doi: 10.1016/j.puhe.2018.07.006

are not entitled to per diem or compensation for performance, but can be reimbursed for actual and necessary expenses while performing official duties. The members are subject to the Colorado Sunshine Law[15] and state open public records laws[16].

On or before October 1, 2019, the task force shall issue a request for proposals in order to select an analyst to work on the analysis of the health care financing systems. Based on submissions, the task force will select and contract with a professional analyst by majority vote. The analyst should have experience conducting health care costs analyses, is familiar with different methodologies, and is employed by a nonpolitical and unbiased organization. The task force must provide a preliminary report of methodology to the General Assembly by January 1, 2020. Subsequently, by January 1, 2021 the task force is to submit a final report of the findings to the General Assembly. The task force can hire staff and consultants, if necessary, to complete its duties.

The analyst must determine the methodology to be used in the study and consider feedback from stakeholders including:

- Licensed physicians, nurses, dentists, pharmacists, hospitals, and other health providers
- Mental health and substance use disorder providers and advocates
- Health care education organizations
- Individuals with disabilities and advocates for those individuals
- Patient advocates
- Representatives of minority communities
- Representatives of underserved and rural communities
- Faith-based organizations
- Employers and employer organizations
- Employees and employee organizations

The analyst, at a minimum, is to study the following systems:

- Current Colorado health financing system
- A public option system where health plans are sold through, and revenues and premiums are received from, Connect for Health Colorado, with additional funding from the General Fund
- A multipayer universal health system where all residents of the state are covered under a plan with a mandated set of benefits, that is publicly and privately funded and also paid for by employer and employee contributions
- A publicly financed and privately delivered universal health care system that directly compensates providers

In the analysis of each financing system, the analyst must consider the following:

- First, second, fifth, and tenth year costs
- Compensation rates for licensed health care providers at levels that will retain necessary health care workers
- Effect of each system on the numbers of uninsured, underinsured, and at-risk insured individuals
- Health expenditures by payer
- Out-of-pocket costs including coinsurance, deductibles, and copayments
- How each system provides:
    - Services required by the Patient Protection and Affordable Care Act (ACA)
    - Medicare-qualified services
    - Medicaid services and benefits equal or greater to current services and Medicaid services and benefits for individuals with disabilities

[15] C.R.S. Title 24, Article 6, All government actions that discuss public business or take formal action must be open to the public.
[16] C.R.S. Title 24, Article 72 201-206.

  - Coverage for women's health and reproductive care, including abortion services
  - Vision, hearing, and dental services
  - Access to primary specialty services in rural and underserved areas as well as for underserved populations
  - Mental health and substance use disorder services
- Collateral costs to society, including:
  - Cost of emergency room, urgent care, and intensive care treatment for those unable to afford preventive or primary care in lower-cost settings
  - Cost in lost time from work, decreased productivity, or unemployment for those that develop a severe, urgent, or disabling condition due to being unable to afford primary or preventive care
  - Cost of bankruptcies caused by unaffordable medical expenses, including the cost to providers that do not get paid as a result of the bankruptcies
  - Costs and effects on those people that do not file bankruptcies due to medical expenses but are financially depleted by the costs
  - Medical costs due to the diversion of funds from other determinants, such as education, safe food and water
  - Other collateral costs determined by the task force

The analyst's report must consider at least four "sufficient and fair funding systems," that are viable for each of the studied systems outlined above. These systems can raise revenue from the general fund, federal waivers under Medicaid and the ACA, or a combination of income taxes, payroll taxes split between employers and employees, and other taxes (i.e. cigarette, alcohol, marijuana, sugary drink, and premiums based on income).

The General Assembly can appropriate money to HCPF for the purposes of the task force and analysis. HCPF and the task force can seek, accept, and expend gifts, grants, and donations. Appointments to the task force and the analysis are not to occur until there is sufficient funding. This bill is repealed September 1, 2021. The bill is effective upon the Governor's signature.

Fiscal Note

The fiscal note predicts that HCPF would need $95,268 for FY2019-20 for personal services, operating expenses, task force reimbursement, and other costs. Whereas for FY2020-21 this appropriation would need to increase to $378,395, mainly to account for the costs of the contract analyst. Funds needed to implement the bill in FY2021-22 would decrease $111,276 due to fewer hours necessary for the contract analyst, and the end of the task force. For both FY2019-20 and FY2020-21, the Legislative Department would expend $7,668 in order for per diem and reimbursement of legislators on the task force.

Reasons to Support

The bill may provide for a nonpartisan and fact-based analysis of different health care funding mechanisms and their effects in Colorado, specifically. At the least, it will expand knowledge of the pros, cons, and costs of various approaches. At its best, it may lead to viable changes for Colorado that could help contain fast-growing increases in the cost of health care. This bill largely mirrors the requirements of the 208 Commission in 2006, which many proponents argue was a very successful, and a bipartisan approach to health care reform that was interrupted by the economic crisis in 2008. The bill is a low-risk approach to beginning to address health care costs in Colorado. Some believe that the solution needs to be a comprehensive health care financing reform; this analysis could help determine if that is possible. Given recent rejections of one single-payer health care proposal by the voters, many want to explore options for Colorado to change the health care financing system.

Supporters

- The Arc of Colorado
- Colorado Consumer Health Initiative
- Colorado Foundation for Universal Health Care
- Colorado Cross-Disability Coalition
- Colorado Fiscal Institute
- Colorado Medical Society
- Colorado Rural Health Center
- Denver Health
- Healthier Colorado
- National Association of Social Workers, Colorado Chapter

Reasons to Oppose

State task forces are great information-gathering tools but sometimes have a low success record for significant policy accomplishments. Some may argue that neither the 1999 Commission nor the 208 Commission led to major improvements in access to, and cost of, health care. This bill mirrors both of the task forces and the result of this bill could lead to very little substantive policy change. All stated policy solutions involve a top-down, government-based solutions and largely ignore other potential market-based solutions. Some may argue that the bill requires an outlay of state resources when there are more immediate health care needs that must to be addressed.

Opponents

- Any opposition has not been made public at this time.

Other Considerations

The bill does not provide explicit definitions for a "multipayer universal health care system" nor for a "publicly funded and privately financed universal health care system." Additionally, the definition of "public option" states that all residents would be able to purchase coverage managed by the State or Connect for Health Colorado, this definition does not exclude those with employer-sponsored insurance. It is unknown if there is an intent to align a proposed public option with current federal law regarding the individual marketplace. Furthermore, the stakeholders that advise the analyst on methodology could be more robust if it included public and nonprofit health organizations as well as health system analysts and economists. In order to hear differing viewpoints, it would be helpful to require the task force members appointed by the Governor to be bipartisan.

It may be important for the analyst to be mandated to consider how federal law, specifically the Employee Retirement Income Security Act of 1974 (ERISA), would interact with any alteration in health financing system. ERISA regulates most of the private insurance market, specifically health plans that employers directly obtain for their employees, known as "self-insured" plans. ERISA requires that these plans be regulated at the federal level, so state policymakers and regulators cannot enact policies that affect these plans.

Colorado voted on one form of a single-payer health care system with Amendment 69 in 2016. Amendment 69 would have created ColoradoCare, a $36 billion program that would have eliminated private health insurance and established centralized health care through a single, state-run exchange. The measure was hotly debated and received national media attention with then-Presidential Candidate Bernie Sanders endorsing the Amendment.[17] That particular measure was defeated by a 79 percent to 21 percent margin.[18] It would be important to understand which elements were objectionable to Coloradans.

[17] Ingold, John. (November 8, 2016). "ColoradoCare Measure Amendment 69 defeated soundly." *The Denver Post.* Retrieved from https://www.denverpost.com/2016/11/08/coloradocare-amendment-69-election-results/.

[18] Staff. (December 2016). "Colorado Amendment 69. *Ballotpedia.* Retrieved from https://ballotpedia.org/Colorado_Creation_of_ColoradoCare_System,_Amendment_69_(2016).

A public option could offer consumers across the state, particularly those on the individual market who do not get ACA subsidies through the marketplace, a lower-cost plan option than would otherwise be available. Proponents argue that a public health insurance option is a more sustainable and reliable health care option that could drive down costs for private health insurance as well. On the other hand, if too many people move to the public option, some believe it may could negatively impact the private marketplace and possibly increase prices for those who buy health insurance without the use of tax credits.

In regards to a multipayer financing system, competition can drive down costs and encourage innovation. Some maintain that a multipayer system allows providers to meet more flexible needs of patients. Others argue that much like the status quo, a multipayer system does little to solve the high administrative costs and profits within the current system. Another concern is that a multipayer system may harm high-risk patients by allowing certain providers to select based on risk and potential cost.

While there are multiple options for a universal system, many assert that a universal system would create a more stable risk pool and would lower administrative costs, particularly if the system includes some form of single-payer option. They point to the general success of the Medicare program in the US. Opponents largely claim that most forms of universal health care would centralize too much power with the government, which would decrease competition and innovation.

About this Analysis

This analysis was prepared by Health District of Northern Larimer County staff to assist the Health District Board of Directors in determining whether to take an official stand on various health-related issues. The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and governed by a publicly elected five-member board. The Health District provides medical, mental health, dental, preventive and health planning services to the communities it serves. This analysis is accurate to staff knowledge as of date printed. For more information about this summary or the Health District, please contact Alyson Williams, Policy Coordinator, at (970) 224-5209, or e-mail at awilliams@healthdistrict.org.