House Bill 09-1273 Pro/Con Analysis

For the Health District of Northern Larimer County Board of Directors

Bill Title:	Concerning the Creation of a Health Care Authority to Develop a Health Care System that shall be the Administrator for Health Care Services in Colorado.
Issue summary:	Creates the Colorado Health Care Authority as a political subdivision of the state with the mission to create a public system to recommend to the General Assembly that is the benefits definer, administrator and payer for health care services in Colorado. Establishes a board to create the system. Specifies comprehensive medical benefits to be covered and requires that all necessary waivers, exemptions, and agreements from the federal government be secured to ensure current levels of federal funding for health care in the state under the new system. Prohibits the implementation of the creation and development of the system if the Board does not raise sufficient grants and donations by July 1, 2011, to fully fund its activities. Prohibits the implementation of the system until all necessary federal agreements are in place; the Board certifies that it has received sufficient funding; and the General Assembly acts by bill to implement the system.
Bill History:	Introduced in the House on February 4, 2009; Assigned to Appropriations and Business Affairs and Labor (BAL) Committees; passed out of BAL Committee in a 5 to 4 vote along party lines and passed Appropriations on 4/3/2009. The bill passed 2nd reading in the House on 4/6/09. There are currently 16 House sponsors and 3 Senate sponsors, all Democrats.
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BILL SUMMARY

The bill creates the Colorado Healthcare Authority. The Board of Directors of the Authority is charged with creating a health care system in Colorado that will be the benefits administrator and payer for health care services. The Authority is further charged with creating a system to recommend to the General Assembly that provides comprehensive medical benefits to all eligible participants in Colorado. Eligible participants are not defined in the bill. The activities of the Authority during this planning stage will be paid for by private grants and donations; no general fund monies will be used. If sufficient funds are not raised by July 1, 2011, the planning will be suspended. Actual implementation of the Authorities recommendations for the health care system requires the General Assembly to pass a subsequent bill.

The Authority Board is explicitly charged with making recommendations on the following elements:

- membership of a board of directors to govern the Authority after implementation
- establishing regional systems to administer and pay for comprehensive medical benefits coverage
- the impact of incorporating the medical portions of state liability insurance, worker's compensation insurance, and auto insurance into the health system
- cost-effective benefit design, eligibility requirements, standards and qualifications for health care providers, provider rates
- how to streamline funding sources and use of public money spent on health care in Colorado
- creation of a medical home for all participants
- a plan for the short-and-long- term health care needs of the participants
- the development of information technology specifications for:
    - standards for electronic health records
    - automated claims processing, billing and payment
    - statewide and regional collection and analysis of clinical data include utilization, quality measures, outcomes and errors
- establishing mechanisms for the use of clinical data to establish standards of best practices through the application of evidence-based medicine;
- improving the health of Coloradans with community health initiatives, coordinated care, wellness and end-of-life education
- establishing a central purchasing authority for pharmaceuticals and medical supplies;
- designing a transition plan that accommodates retraining of workers displaced by implementation of the new system and addresses anticipated workforce shortages of primary care physicians and nurses;

- establishing a system for filing and arbitrating all grievances regarding delay, denial or modification of health care services
- creating a Colorado health care quality and dispute resolution system to measure quality, investigate reports of poor quality and develop an efficient and fair dispute resolution system
- collaborating with local organizations (including health districts) to address the needs of special populations;
- recommending a financing system capturing all current public funding streams, with consideration given to collection of means-based fees or premiums from both income earners and employers;
- analysis of how to finance and address health care for those ineligible to participate including visitors, nonresident students, refugees and other ineligible persons.

The bill outlines a comprehensive package of benefits that includes primary and preventive care, outpatient, emergency and inpatient care, mental health and substance abuse treatment, dental services, prescription drugs, medical equipment, vision care, hearing aids, long-term care, and chiropractic services.

The twenty-three member board is to be composed of consumers, representatives of various provider groups, representatives of business, and several experts, appointed by the majority and minority leaders of the Senate and House and the Governor, and supported by a team of administrators and consultants. Membership of the 23-member Board is composed of the following:

1) licensed primary care doctor
2) licensed dentist
3) health care consumer
4) representative of organized labor
5) representative of a federally qualified health center
6) licensed physician with experience in public health or epidemiology
7) licensed pharmacist
8) member of the disabled community or a care giver
9) representative of small business
10) representative of hospitals
11) licensed mental health care provider
12) licensed professional nurse
13) health care consumer who is at least 65 and has served as an advocate for senior citizens
14) representative of large business
15) representative of the insurance industry
16) an actuary with experience in the insurance industry
17) representative of ambulatory surgical centers
18) representative of an integrated health care delivery system
19) representative of rural communities
20) advanced practice nurse
21) representative with expertise in hospital and physician costs, billing and fees
22) one consumer
23) representative of the long-term care industry

The charge of the Authority does not explicitly include (or exclude):

- addressing the role, if any, of private insurance;
- restructuring the health care delivery system.

BACKGROUND

Definitions

Single-payer system - An approach to health care financing with only one source of money for paying health care providers. The payer may be a governmental unit or other entity such as an insurance company. Single-payer health care pays health professionals that are either in the private or public sector. It is also used to pay both privately and publicly owned health care facilities. Single-payer health care is distinct and different from socialized medicine in which doctors and hospitals work for and draw salaries from the government.

Definitions, Continued

Universal Coverage –Health care coverage that is extended to all eligible residents.

Guaranteed Issue – A requirement that insurance companies issue policies to anyone who applies regardless of health status. Guaranteed issue does not require insurance companies to charge the same premiums to everyone who applies which is known as community rating.

General Background
The 208 Commission was created in 2007 to study health care reform models and recommend a comprehensive set of reforms for expanding coverage and decreasing health care costs for Colorado residents. Of the five proposals selected by the Commission for detailed modeling analysis, one was a single-payer model with attributes that resemble those prescribed in this bill. A report from the Lewin Group, a consulting firm based in Church Falls, Va., showed that this was the only proposal among the five estimated to both increase coverage (including coverage for long-term care) and reduce combined public/private healthcare spending in the state.

The bill makes clear that the Authority may only commence the planning stage of the health system design once sufficient gifts, grants and donations are received. If sufficient funding is received and the system design moves ahead, the recommendations cannot be implemented until all necessary waivers, exemptions and agreements are in place to effectively implement the system and the General Assembly approves the implementation of the system by passing another bill.

Federal Health Reform Efforts
For the first time since the Clinton administration, there are major efforts at significant health reform underway at the federal level. The Obama Administration is committed to health care reform as are several influential members of Congress, including Senator Edward Kennedy and Senator Max Baucus. In addition, the business community and public are greatly concerned by the escalating cost of health care and have made reform a priority.

A recent article in the *New York Times* indicated that the major Democratic members of Congress who are working on legislation have agreed to some basic principles: all Americans should be required to have health insurance; employers should be required to help pay for it; and the government should offer a public health insurance plan as an alternative to private coverage.[1] One of the central issues in the federal debate on health reform is whether or not to give people an option to purchase either a government run public health insurance plan in addition to those run by private insurers. The health insurance industry is opposed to the creation of a public plan as are some members of Congress. Most Congressional leaders are not discussing the elimination of the private insurance industry nor proposing a single-payer plan.

A new development is the health insurance industry's announcement that it would agree to accept a requirement to guarantee issue of insurance policies if it is accompanied by a mandate requiring that all people to have health insurance. According to the same New York Times article, the industry also offered to end the practice of charging higher premiums to sick people in the individual market. While the timeline of federal reform efforts is unclear, Congressional leadership is indicating that the House and Senate could be debating different versions of a bill by July of this year. The Obama administration has indicated that movement on health care should come sooner rather than later and certainly this year.

WHY IS THIS ISSUE IMPORTANT?

Health care is unavailable or unaffordable to 800,000 Coloradans, and many more are underinsured. For business, the increasing cost of providing employee health care is not economically sustainable. All Coloradans currently pay for the care accessed by the uninsured through higher health insurance premiums as the cost of caring for the uninsured is offset by higher charges to the privately insured. The Center for American Progress recently updated a study done by Families USA that estimates this cost-shift increases a family's health care premium by $1100 per year. The current situation in the US of mixed private and public financing and payment for health care services engenders high administrative costs and inefficiencies compared to schemes in other industrialized countries. This bill proposes to overhaul the entire system of financing and paying for healthcare in Colorado. The only other bill currently being considered in the legislature to expand coverage is HB 1293, the hospital provider fee. If passed, that bill will expand coverage by an estimated 100,000 if it generates sufficient funding.

CHALLENGING ISSUES

[1] "Democrats Agree on a Health Plan; Now Comes the Hard Part", Robert Pear, published March 31, 2009 *New York Times*

Waivers Needed
Implicit in the planning the bill directs the Board to do is solving several big riddles related to financing: how to sustain federal funding for health care by reallocating federal Medicare, Medicaid, and other program monies to the single payer fund, and how to get around the federal Employee Retirement Income Security Act (ERISA, 1974) in order to capture all employer and employee premium contributions. What is clear from the bill is that implementation of the system designed by the Authority would require a number of federal waivers. The state would need federal approval to use Medicare and Medicaid funding in this new way and a waiver of the ERISA statute that prohibits states from regulating self-insured health plans. The bill recognizes the need for federal approval and requires that all necessary waivers, exemptions, and agreements be in place before any plan could be implemented. It is not clear what the chances might be of obtaining the necessary federal waivers and statutory changes that would allow implementation of the system envisioned in HB 1273. Staff research at the start of the session found several congressional bills that would allow for single payer system demonstrations, even granting federal waivers for ERISA, but it is unclear if they will go anywhere with a national reform effort being discussed.

Role of Private Insurance Uncertain
The goal of HB 1273 is a single payer health care system although the bill is silent on the role of the private health insurance industry. The bill does not explicitly prohibit private insurance. Thinking generally, the goal of a single payer system is to ensure that everyone has access to health insurance and to spread the risk across the largest pool of people and to eliminate the high administrative cost of medically underwriting insurance policies. Allowing private insurance to compete with the public system would reduce risk pooling, shrink economies of scale (drugs and durable medical equipment), and likely increase total administrative costs, so may not be pursued.

Relationship to Federal Health Care Reform Efforts
Another critical question is how the effort described in HB 1273 might coordinate with federal health care reform. On the one hand, there may be the possibility of advancing a valuable federal/state partnership, but others might argue that it would be best to wait and see what legislation is passed at the federal level. Those who delayed working on state reforms during the Clinton era, when major federal health care reform was also anticipated, might argue that the state should keep making progress on its own options in case federal reform fails to materialize.

Authority Board
The size and structure of the board may not be the best configuration to achieve the goals of the Authority. A group as large as 23 could prove too unwieldy to drive consensus. The Board is composed almost exclusively of representatives of stakeholder special interests. The only member without a constituency is a person who is an expert in health care costs and payment. Prescribed representation of special interests will make decisions (even with respect to decisions about recusing votes) very difficult. Stakeholder representation could be better situated in advisory committees. Were this board to manage the system once implemented, it would be apt to be politicized due to short terms (4 years) and obligatory partisan appointment privileges.

As amended, this board is established for the planning phase and could potentially be restructured in the implementation phase. The committee convened by the Health District to create a 208 Commission proposal (which was one of the five chosen for modeling) considered the creation of a governing body to recommend and implement changes to the health system. After serious deliberation, the type of authority board proposed was modeled after the Federal Reserve Board. The committee recommended an Authority to the 208 Commission, but recommended that it be a much smaller board comprised of expert members, who would be appointed to lengthy terms and insulated from political and special interest interference. While required to have substantial expertise in their subject area, their mission on the Board would be to represent the interests of the people of the state of Colorado, not to lobby for particular special interest groups. They would have an adequate staff and budget to gather objective information and perform complex analyses.

Cost Control
A critical issue at the heart of any discussion about the potential of the bill to achieve substantive change of the health care system is the bill's ability to control costs. The bill contains a few measures that aim to reduce costs, including a direction that the Authority's Board examine cost-effective benefit design and the establishment of a central purchasing authority to negotiate prices for prescription drugs and durable medical equipment. The bill also directs the Board to investigate a health technology component that could generate data to drive the establishment of best-practices. The bill does not mention a realignment of physician and other provider incentives to discourage overuse and misuse of resources although the Authority Board could issue recommendations to change the healthcare delivery system in a way that

achieves those goals. It's possible that the new efforts in comparative effectiveness research included in the federal stimulus bill could also help drive some changes in medical practice that might curb costs.

While the cost reduction possibility of the above mentioned items are not perfectly clear (some argue that full implementation of health information technology would not be money saving for a significant period of time) we do have the analysis of a statewide single-payer system modeled by the Lewin Group for the 208 Commission. Lewin concluded that a single payer system achieves significant cost savings in statewide health spending, mainly through large reductions in administrative spending and efficiencies achieved through bulk purchasing of prescription drugs and durable medical equipment.

Supporters and Opponents

The bill is strongly supported by Health Care for All Colorado. At the House Business Affairs and Labor hearing, the Colorado Academy of Family Physicians testified in support of the bill as did Health Care for All Colorado and a number of private citizens. Health Care Policy and Financing Director Joan Henneberry testified in opposition to the bill, indicating the Governor's preference for moving forward by expanding eligibility and enrollment in the public health insurance programs. Other opponents of the bill included the National Federation of Independent Business, the South Metro Denver Chamber of Commerce, the Colorado State Association of Health Underwriters, and the Colorado Hospital Association.

The Herndon Alliance has done national polling on health care reform and, in poll results dated March 2, 2009 on their website, found strong support for reform.[2] According to a Herndon survey of 800 likely voters nationwide, "Voters express a strong desire for change in our healthcare system, with over two-thirds saying we need a complete overhaul or major reform." However, staff has not seen any polling or research on how the public in Colorado feels about a state-based single payer system.

REASONS TO SUPPORT BILL

- HB 1273 advances the effort to secure comprehensive healthcare reform and coverage for all in Colorado. The planning process strikes a balance between the political commitment required to establish the Authority and private, or at least non-state government, commitment to fund the effort through grants and donations.
- HB 1273 proposes the only system studied by the 208 Commission that has the potential to cover everyone without increasing total healthcare expenditures.
- Proponents of the bill might argue that we should not wait for federal efforts to reform the health care system and there is always the possibility that there will not be successful federal legislation. Waiting to see if a viable federal plan for expanding coverage happens could put our state further behind in solving the problem of adequate, affordable health care coverage for everyone. Passage of this bill and the approach favored by the bill could create some important progress on state options to address affordability and coverage in the absence of federal change. In the event of federal legislation, the process created by the bill to address creation of a single payer system might be able to shift gears to address any shortfalls in a federal plan. For example, if in fact federal health care reform legislation passes this year without a public insurance plan to compete with private insurance plans, this bill may provide a vehicle for crafting an alternative
- The state does not spend any money on the planning process as no general fund dollars are committed. Although there might be a concern that the system being shaped could be influenced by where the funding comes from, it is possible to keep the identity of the funders from the Authority Board members.
- The financing plan of the proposed system directs the Board to consider "collecting fees or premiums" from individuals and firms that go directly into a health care fund that is separate from the state's General Fund. Citizens will likely have more positive attitudes towards a "premium" than a tax. If they know the fund the assessments go to is segregated, that the funds go directly to pay for services they are eligible to get in return, it is likely to increase voluntary compliance. It is the insurance system that Taiwan has recently established as opposed to the Canadian system which relies on general revenues. It can be assessed almost as equitably as income tax funding and it pools the risk just as widely.
- The bill establishes a planning "authority" as opposed to a department of state government, a special district or a chartered non-profit public benefit corporation. A benefit of an authority is that it may cross physical political boundaries. Many public authorities in the U.S. are created in order to meet a public goal that crosses state or municipal/county boundaries, so this could expand beyond the state over time or could be regionalized. Another

[2] http://www.herndonalliance.org Lake Research Partners Summary of System Change Research, accessed April 7, 2009

benefit of an authority, if structured differently than the current proposal, is insulation from political or special interest interference.

REASONS TO OPPOSE OR AMEND BILL

- Eventual movement to a single-payer system as described in the bill would cause significant disruption and employment shifts. Although the bill instructs the Board to consider employees who would be displaced by a move to a single-payer system, it is a significant change and there would certainly be people negatively affected by the disappearance of the private insurance industry. Staff is not aware of an analysis that has quantified what the negative employment effects of such a shift would be.
- The size and structure of the board are a concern. First, a group as large as 23 is too large for the best decision-making. The Board is composed almost exclusively of representatives of stakeholder special interests which makes it likely that the members will protect their constituency's special interest rather than neutrally consider what's best for the people of Colorado as a whole. Prescribed representation of special interests will make decisions (even with respect to decisions about recusing votes) very difficult. Stakeholder representation could be better situated in advisory committees, with the policy decisions left to a more neutral, smaller expert board that does not receive pay from any special interest group. Were the currently configured board to manage the system once implemented, it would be apt to be politicized due to short terms (4 years) and obligatory partisan appointment privileges. As amended, this board is established for the planning phase and could potentially be restructured in the implementation phase. However, it is unlikely that a more neutral board would be recommended by the appointees outlined in the bill.
- Effective Authorities need to be carefully developed with attention given to issues of public transparency, accountability and the reach and limits of powers, which are not specifically spelled out. The bill specifies an annual report to the governor and the Joint Health and Human Services committees of the legislature once per year.
- With a board composed of all the stakeholder groups and very little consumer representation, a set structure for consumer input is an important component of the planning process that is missing in the bill.
- The current bill does not assure that the Authority Board have an adequate staff and budget to do complex analyses and to facilitate difficult decisions. Another concern is that although Board members would be paid for meeting attendance, the task required of them is difficult and enormously time-consuming and it would be important for the Board to be adequately compensated.
- The bill intends to create a rich package of comprehensive benefits. This can create challenges in moving forward on a state by state basis – if some states provide greater coverage, would there be incentive for people who need that coverage to move into the state? For example, comprehensive long term care is unavailable in most other states. Also, the package of benefits listed may not be entirely evidence-based, which could unnecessarily drive up costs.