

## **COLORADO HEALTH SERVICES PLAN OVERVIEW**

### **PREAMBLE:**

The Colorado Single Payer Plan creates a universal health care system for the State of Colorado. The financing of this system utilizes a single risk pool that includes all residents of Colorado, is portable and decoupled from employment, pays for all necessary care out of public funds, and is affordable for all. The health plan retains both public and private delivery of services and offers free choice of providers. Health premiums are based upon a percentage of gross income and family size and are placed into a trust fund from which health services for all are paid.

### **OVERVIEW of COLORADO HEALTH SERVICES PLAN:**

*Proposed in June 2012 by Health Care for All Colorado Single Payer Task Force*

In its purest sense, “single payer” is one entity that oversees and provides the financing of health care. There are numerous countries around the world that follow this model, yet they all do it differently and each independently with their own unique solutions. In fact, right here in the United States, we have several different single payer models – all of which have their own virtues and short comings. These programs include: Medicare, Medicaid, the Indian Health Services, the Veterans Administration, and the military. In fact, the VA and military are truly socialized medicine because their facilities are owned by the government and staff are paid by the government.

We have before us the unique opportunity to review what is good and what is bad in single payer systems, to assimilate that information and to forge a truly sound, just, viable, and sustainable health care system. This program can achieve that.

There are four basic components to any health care system: 1) coverage and benefits; 2) financing; 3) delivery of care, quality assurance, and infrastructure; and 4) governance.

The problem with our current health care system is that it is so fragmented and there are so many different players involved with the regulation and the financing that there is absolutely no way to effectively contain cost or reduce the burden of administrative overhead with multiple payers and plans.

This proposal will enable us to unite and integrate all four basic elements of our health care system in such a way that it will provide equal and universal access for all residents of Colorado and protect patient choice of providers, while maintaining autonomy of physicians and hospitals in an atmosphere of cost containment and quality. All of this can be achieved while also being accountable to the people.

Let's examine the four basic areas in depth:

## 1. Coverage and benefits.

Title I provides universal and equal access to the system with comprehensive benefits as outlined in Section 102. Although there is good evidence and support behind the reasoning to eliminate deductibles and co-payments, it is a minor point and certainly open for discussion. With recent debates over immigration, another point is eligibility. How long should one be a resident of the state before being eligible? It is worth noting that we already are paying for the uninsured under the current system.

## 2. Financing.

Title II creates a trust whose funds are separate from the general state budget. This insulates those funds and prevents the legislature from using them for other purposes. They must be used for delivery of health care. The funding of this trust is well outlined in Section 201. The 208 Blue Ribbon Health Reform Commission in 2007 calculated the financial feasibility of this proposal. Five proposals were selected by the 208 Commission for economic analysis by the Lewin Group. This CHSP single payer proposal was the only one that included all residents of Colorado and the only proposal that would cost less than current overall health care spending in Colorado, resulting in an overall savings of \$1.4 billion per year. Economists have calculated that we can easily pay for this comprehensive health program and have a sustainable mechanism for future cost containment if we do the following:

- 1) Administer a state health premium (tax) based upon a percent of modified adjusted gross income and family size to be put into the CHSP trust.
- 2) Administer a state payroll deduction to go into the trust, in which some or all of the health premium could be contributed by the employer.
- 3) Place into the trust all current federal and state money that currently goes to Medicare, Medicaid, Veterans Administration, etc. along with the current money spent on health care for city, county, and state employees.
- 4) Initiate a 0.25-0.5 percent sales tax to be put into the trust. (May not be needed.)
- 5) Increase the taxes on alcohol and tobacco (to offset the increase in health care expenditures due to their detrimental effects on health) and place those in the trust.

With the savings that would be derived by eliminating excessive profit-taking, dramatically reducing administrative bureaucracy, early and timely intervention through easy and affordable access to care, and promoting preventive medicine, we can easily pay for this program and have a very sustainable mechanism for future cost containment – a cost containment mechanism which is now impossible to achieve.

Of course, critics will be quick to point out that this will cause an increase in taxes, however the out of pocket cost per person for health care will be reduced with the elimination of deductibles, co-payments and caps. The Lewin Group projects that health care costs will be reduced for all individuals and families with annual incomes under \$150,000.

We will be creating a system in which a modest increase in taxes will be offset by huge financial savings for Coloradans collectively and individually (for example, a family of four now

pays on average \$16,000 a year in health insurance premiums plus co-payments and deductibles) and will remove the oppressive burden of health care financing from the business sector.

If the Colorado Health Services Plan is established as a state owned public insurance enterprise, it would be exempt from TABOR since it will generate its own funds and manage them. Contributions from state general funds for a state enterprise must be under 10%.

Actually, this program will be a “consumer driven” system in the truest sense and foster innovation, not suppress it, as well as improve efficiency for everyone with a single payer, single risk pool plan.

Along with that, the health care system will once again become a true service industry to all the people. “Of the people, by the people, for the people.”

We have to remember that medicine is a service profession, and that promoting it as a business industry with profit-taking as a driver of the system is a gross perversion of what medicine is all about.

### **3. Delivery of care, quality assurance, and infrastructure.**

One of the great positive aspects of this proposal is that physicians, hospitals, pharmacists, and durable goods vendors will stay in the private sector if they so choose.

Physicians and hospitals will be reimbursed at the same rate for the same procedures no matter who walks through the door – despite geography, population, rural versus urban, or wealth. Physicians and hospitals will have the option of capitation or global budgets if they choose, rather than fee for service. This will actually allow providers to start competing in the areas in which they are supposed to excel -- patient satisfaction, quality measures, and outcomes.

In contrast, under the current mechanisms of reimbursement, we do have competition, but it may be called “competitive avoidance.” It is a perverted twist of the free market system that we as Americans pride ourselves in. Physicians and hospitals are constantly concerned about quality of care issues, but those concerns unfortunately are directed at those who can pay for those services and not necessarily at those who need them. This does not work well when you are fighting diseases and trying to save lives. As a result, providers find themselves maneuvering toward contracts and neighborhoods to increase their exposure to patients who pay well while “competitively avoiding” those who don’t. The policy of emphasizing consumer-directed health care and high deductible plans while trying to expand already poorly reimbursed government programs, such as Medicare and Medicaid, will only work to exacerbate this perversion of our so-called free market.

Both overutilization and underutilization of health care services present an important problem in the delivery of quality care. Addressing these problems through application of Evidence-Based Medicine principles and practice is the best method for the allocation of health care resources. The Colorado Health Services Governing Board will work with the three boards associated with

quality care including 1) The Health Needs and Planning Board, 2) The Health Quality Board, and 3) The Patient Advocacy Board.

This universal plan utilizes one single, unified, secure electronic medical record system with each patient's individual medical record on a smartcard, which includes a memory chip with their medical record, which will be presented each time the individual accesses medical care from an authorized provider. This will result in improved efficiency and patient safety, as well as handle automatic billing and reimbursement to the provider for services provided, and update the individual's medical record.

Another place that requires reform is in the way that physicians practice medicine. By centralizing billing and reporting, clinical data and outcomes can be truly objective and used to determine quality of care and used to determine quality assurance and to change clinical practice in a way that is more cost effective and beneficial to the community. A single governing board that is accountable to the people will also be able to discuss the truly thorny ethical issues within a democratic platform and help provide general guidelines to physicians that will not only benefit individual patients, but society as a whole.

Under our current system, insurance companies use clinical data to protect their profit margins, pharmaceutical companies use it to promote their sales, physicians use it to protect their practices, and the government uses it to save tax dollars. And all of these special interests many times become diametrically opposed to one another. The real loser ends up being the patient or consumer – caught somewhere in the middle. The standards of care need to be the standards of care for everyone. Sound science with consensus needs to drive the system. Profit must not be in the driver seat. The only way to achieve that is by moving to a single payer system.

The bill also provides for a single statewide formulary. The advantages to this are numerous. It will cause pharmaceutical manufacturers to compete against each other and to prove to the community not only clinical but fiscal benefit of new drugs. With the state purchasing medications in bulk for 5 million lives, the savings will be enormous. It also will help physicians in their prescribing patterns by choosing medications based on efficacy as well as cost and removing the pressure to prescribe based upon marketing. It also will eliminate the overhead and administrative burden currently placed on physician practices trying to keep up with a myriad of formularies and all their different regulations, which increases the cost of doing business in medicine and frustrates both the provider and the consumer.

With the system acting as a central clearing house, it will allow huge savings through bulk buying and will allow the distribution of those medications through local pharmacies. This, in turn, will keep the money within the Colorado economy and maintain the continuity of care and personal attention of the pharmacists that are so desperately needed, especially with the elderly.

#### **4. Governance and administration.**

The final area to cover is described in Title III of the enclosed bill proposal. It is here that the crux of this program lies and where this and other reform proposals distinctly separate. In this bill, the governing board of the Colorado Health Services (CHS) is comprised of representatives from across the state who are either directly or, in this proposal, indirectly (through appointment by the elected state senators) accountable to the people. There are several reasons why this board is so important and why its configuration must be so carefully guarded. We've already mentioned its role includes overseeing utilization of the infrastructure, a statewide formulary, and addressing ethical issues.

The CHSP governing Board will have the responsibility of overseeing the members of the following: 1) Administrative Board, 2) Health Needs, Planning, and Improvement Board, 3) Health Quality Board, 4) Patient Advocacy Board, 5) Public Advisory Committee, 6) Office of the Health Inspector General, 7) Health Trust Fund and Payment Board, and 8) Any other boards that are relevant to carrying out the purposes of the health system.

The primary reason is to give consumers a voice and a choice in their health care. In the current system, consumers have limited, if any, impact. High deductible plans and health savings accounts do not guarantee consumer control nor choice or even access. Health savings account consumers may have limited personal control over their own health care spending, depending on their own health status and disposable income. But, ultimately, consumers have no control over health care inflation. The current system is too complicated. There are too many variables and too many players with self-interests. Consumers and the providers who practice equitable medicine do not have a free market.

The only free market that exists in U.S. health care today is the way that the pharmaceutical and the insurance industries do business – and their business is to make a profit, not fix the health care system. Until we remove the profit motive from the financing of health care, we will not be able to fix the system. Applying the rules of Wall Street economics to the financing of health care is like trying to get an ostrich to fly. On the surface, it appears it should work. After all it is a bird, it has feathers, and it has wings. But no matter how hard you try, or how fast you make that ostrich run, it just can't fly.

So what does this have to do with the governing board? Simply this – for the first time, consumers will actually have a say in how much is spent and how it is spent. There will be a mechanism available for all interested parties to have input – including consumers – to discuss benefits, budgets, and ethical issues on a democratic platform. This is truly consumer-driven health care.

But what about personal fiscal responsibility? This is a question of two opposing philosophies. Either way, the consumers' pocketbooks will be directly affected. But, only one philosophy allows the consumer's choice to make a difference.

In the philosophy to tweak the current system, consumers are directly affected by increases in annual insurance premiums and ever-rising personal deductibles and co-payments while also paying taxes to support Medicare and Medicaid. – all in an environment of out-of-control health

care inflation in which the consumers have minimal, if any, impact. In other words, they can't do anything about it.

In the alternate philosophy, which is the basis for the proposed bill, consumers do have a voice and they choose, as a community, through a vote or through the governing board to increase their own taxes or restructure their own benefits, which, in effect, is true consumer-directed health care. Also a choice of providers is guaranteed.

Let's expand on these two very different philosophical approaches to reform:

- 1) Do we continue down the road of tweaking our so-called market-driven system with private insurance companies in the driver seat? If so, society must understand that there will always be a small group of people who will receive everything that health care can provide, a larger segment of the population who will have poor or no access to it, and the rest of middle class America who are somewhere in the middle and will continue to struggle in a system driven by a motivation of profit and cost-shifting. It's worth noting that, as health care inflation continues to spiral upward, more middle class Americans will fall into the segment with poor or no access to the health care system and are at risk for bankruptcy.
- 2) Or, do we muster the courage necessary to embark in a new direction in which we all share in the burden of cost and responsibility and all patients are treated equally and have access to one standard of care for everyone that includes all necessary care? The more one understands health care, the more one understands you can not have it both ways.

Another primary reason why the governing board and its configuration is so important is to protect the interests of the people. By providing for a member from each state senatorial district appointed by that district's senator (or each of seven geographic state regions), the board members are insulated, to a certain degree, from any single interest that could unduly threaten or influence the board. It also gives equal representation across the state. With the board convening on a quarterly basis, it provides the platform of accountability to the people and the transparency so necessary to keep the system sustainable.

There are some who may argue that this makes the board too large and unwieldy. Certainly, the size of the representative regions and the size of the board are open to debate. Whether the regional board members are appointed or elected is also open to debate. But, the concept of having the system accountable to the people must remain intact to ensure its success.

Health Care for All Colorado Single Payer Task Force

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