



Oct. 28, 2019

Director Kim Bimestefer
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Commissioner Mike Conway
Colorado Department of Regulatory Agencies
Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Dear Director Bimestefer and Commissioner Conway:

On behalf of more than 100 hospitals and health systems across Colorado, Colorado Hospital Association (CHA) appreciates the opportunity to provide feedback on the “Draft Report for Colorado’s State Coverage Option,” (“Polis proposal”) released Oct. 7, 2019.

Colorado hospitals are proud to be a leading voice for ensuring all Coloradans have access to high-quality, affordable health care. We have done this by being steadfast advocates of coverage expansions and health care transparency; providing voluntary price reductions in competitive negotiations; focusing on providing high-quality care delivered at the right place at the right time; addressing public health crises such as the opioid epidemic; and investing in social determinants of health and community benefits that improve the overall health of Coloradans.

These efforts have paid off – Colorado ranks 9th in the country for overall health system performance and consistently ranks among the best states for measures such as physical activity, obesity, smoking, avoidable hospital use and cost, deaths from cancer, diabetes and cardiovascular disease.¹ And progress is accelerating: for the first time, individual market premiums will decrease by 20 percent on average next year, and even without the state’s new reinsurance program, premium increases submitted by insurers were just 0.5 percent year-over-year – lower than both population growth or inflation, and a testament to the fact that Colorado is successfully constraining health care costs.²

House Bill (HB) 19-1004 offered the opportunity to examine whether Colorado could craft a “competitive state option for more affordable health care coverage,” and CHA supported the legislation because it promised to bring patients, hospitals, providers, insurers, pharmaceutical manufacturers and policymakers together to discuss ways to improve the health care system, and these types of conversations are crucial to the success of any and all solutions.

Unfortunately, despite considerable stakeholder input provided during town hall-style forums hosted by the administration over the past several months, the process lacked any substantive and iterative discussions or debate of genuine solutions. As a result, the Polis proposal misses the mark because it prioritizes lower premiums at the expense of patient access and choice.

¹ <https://scorecard.commonwealthfund.org/rankings/>

² <https://www.colorado.gov/pacific/dora/news/polis-administration-projects-182-average-decrease-premiums-individual-health-insurance-plans>



Specifically, the Polis proposal:

- Fails to prioritize coverage and affordability for Colorado’s remaining 375,000 uninsured, leaving this at-risk population even further behind.
- Fails to protect patient choice by undermining competition among insurers and health care providers.
- Fails to defend access to care by cutting hospital payments up to 40 percent.

CHA provides detailed feedback in the content below, but in general, we request that the final proposal submitted to the legislature incorporate the following changes:

- Refocus broad-scale affordability on the state’s total spending on health care to support long-term, sustainable and comprehensive solutions that improve value for Coloradans.
- Consistent with legislative intent, identify ways to incentivize – not mandate – provider participation.
- Ensure all strategies contained in the proposal have actuarially sound cost savings projections and assess impact on patient choice and access to care.

We look forward to continuing to work with the Polis administration and legislators as we continue to fulfill our shared commitment to maintain and improve Coloradans’ access to high-quality, affordable health care.

Sincerely,

A handwritten signature in black ink, appearing to read 'Chris Tholen', is written over a light blue horizontal line.

Chris Tholen
Executive Vice President
Colorado Hospital Association

Hospital Feedback on the Polis Proposal for a Draft State Coverage Option

The proposal fails to close the coverage gap for 375,000 Coloradans who are uninsured today.

Acknowledging less than 2 percent of Colorado's uninsured would gain coverage, the proposal ignores the uninsured and perpetuates existing inequities, leaving vulnerable Coloradans even further behind. While the uninsured rate is 6.5 percent statewide, there is significant variation across communities – from 2.6 to 14.3 percent, a more than five-fold difference that creates different challenges for different communities.³ The state's first priority should be enabling access to affordable coverage for all Coloradans by focusing on enrolling the 60 percent of uninsured individuals already eligible for existing public coverage programs. If Colorado achieved the uninsured rate of the best-performing state (Massachusetts), an additional 213,000 people would gain coverage. Two alternative approaches to improving affordability and increasing coverage adopted in other states include funding additional subsidies and instituting a state-level individual mandate.⁴

The proposal may *increase* health insurance costs for more than half of Coloradans.

With at least \$235 million in cuts to health care providers in the first year – and upwards of \$1.5 billion over five years – costs will be shifted to the 53 percent of Coloradans with employer-sponsored insurance. In addition, the proposal would actually result in *decreased* federal subsidies, increasing premiums for 114,000 Coloradans currently receiving subsidies through Connect for Health Colorado. While this would undoubtedly be an unintentional side effect of well-intentioned efforts to reduce costs, this is exactly what we have seen with the creation of reinsurance under HB 19-1168: while individual market premiums will decrease by 20 percent on average for 2020, actual premiums for subsidy-eligible Coloradans will *increase* 19 percent. HB 19-1004 required the proposal to “evaluate the impact on consumers eligible for financial assistance for plans purchased on the exchange.” However, this analysis has not been conducted, and neither has analysis modeling the effects of this program running concurrently with other significant policy changes currently being implemented, such as reinsurance, new surprise billing regulations that take effect in January 2020 and the Hospital Transformation Program, all of which are facing significant implementation challenges.

Forcing providers to participate ignores the General Assembly's instructions.

The legislature provided clear guidance to the Polis administration in the legislation authorizing the development of this proposal. Specifically, the administration was directed to assess “provider rates necessary to *incentivize* participation and *encourage* network adequacy and high-quality health care delivery.” The legislature expressly directed the administration to focus on voluntary participation, and yet the proposal acknowledges the administration's intent to “implement measures to ensure health systems participate.” This kind of unduly coercive language aims to intimidate providers into participating “voluntarily” and undermines trust in state officials, who should be focused on collaborative, win-win solutions.

³ https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/CHAS2019InfoPackage.zip

⁴ <https://www.kff.org/health-reform/issue-brief/state-actions-to-improve-the-affordability-of-health-insurance-in-the-individual-market/>

The proposal fails to balance cost, access and quality, and the rate setting approach will not result in significant savings.

Polis administration officials have repeatedly cited that their goal is to bring hospital payments in line with the “national average,” citing RAND Corporation data for the premise that 175-225 percent of Medicare payments provides an appropriate payment.⁵ However, the very chart cited by the administration shows most states’ hospital payments are closer to 225-250 percent of Medicare. HCPF’s own data for the same time period as the RAND study acknowledges that Colorado hospitals receive 220-240 percent of Medicare on average across all services, all hospitals.⁶ Further, the RAND data includes only half of states and is not adequate to assess what “national average” would be. CHA commends the administration for setting a clear spending goal in moving to the national average; however, we also assume that the administration does not feel that “average” is an adequate goal for Colorado’s health care quality or health outcomes – cost alone is an insufficient metric. As is consistently recognized through countless national and objective metrics, Colorado’s health care delivery system is much better than “average,” and Colorado hospitals will not be complicit in the destruction of our high-performing system.

Choosing fee-for-service rate setting over value-based care is the wrong direction for Colorado.

Rate setting inherently conflicts with other value-based concepts advanced in the proposal because it relies on the existing fee-for-service payment model. As recently noted by Massachusetts Gov. Charlie Baker, “[i]f you cap rates under the current regime, you’re going to get exactly what you have now, just less.”⁷ HB 19-1004 required the state to “determine whether the state option plan should be a fully at-risk, managed care, fee-for-service, or accountable care collaborative plan, or a combination thereof.” This is not directly addressed in the proposal, but the underpinning infrastructure doubles-down on a fee-for-service payment system inconsistent with the state’s standing commitments to payment reform and value-based care.

The proposal creates perverse economic incentives and will fail to restrain overall costs.

By limiting government rate-setting to some providers and not others, the proposal incentivizes providers without price caps to charge higher rates and drive care away from price-regulated settings that may deliver higher-quality care and achieve better outcomes. Maryland, the only state with functional all-payer rate setting, acknowledged similar flaws in their model after more than 30 years when it shifted to an all-payer, all-provider regulatory model in 2014. Maryland has further acknowledged that their model is dependent on Medicaid and Medicare increasing payments to eliminate cost-shifting. To be clear, CHA does not support government rate setting in any form, but this proposal suffers from significant and irrational design flaws that will jeopardize access and quality for patients and fails to incorporate lessons learned from other states’ successes and failures.

The proposal neglects the reality of shared responsibility for improving health care affordability.

Under the Polis proposal, hospitals – which comprise 40 percent of health spending – will bear 100 percent of the burden, which will be passed on to our employees and our patients. With at least \$235 million in cuts to health care providers in the first year – \$1.5 billion over five years – our patients may face longer wait times and fewer providers to choose from when they need care the most. The proposal

⁵ https://www.rand.org/pubs/research_reports/RR3033.html

⁶ <https://www.colorado.gov/pacific/sites/default/files/2019%20January%20HCPF%20Cost%20Shift%20Analysis%20Report%20Draft.pdf>

⁷ <https://www.masslive.com/news/2019/10/gov-charlie-bakers-new-health-care-plan-envisions-major-spending-increase-on-primary-and-behavioral-health-care.html>

cuts reimbursements to hospitals without holding insurers, pharmaceutical manufacturers and physicians equally accountable for reducing cost. Our employees may face layoffs, hiring freezes, increased pressure to care for more patients with fewer resources and added strain on existing workforce shortages and efforts to recruit and retain talented employees. This is particularly true in rural and underserved areas of Colorado, where hospitals are often the largest employer and where downsizing will cause a cascading effect across other businesses, schools and local programs throughout the community.

The proposal fails to articulate long-term intent, and the analysis lacks sophistication. As a result, the work to-date is insufficient to proceed.

There are a number of areas in the proposal where the administration's policy objectives are shockingly vague, which could be perceived as either a lack of commitment to developing detailed policy prescriptions or an intent to be opaque and breed distrust. Without a clearly articulated intent and objective, evidence-based analysis that assesses both advantages and disadvantages, stakeholders and legislators cannot fairly evaluate the policy prescriptions. Just four key examples include:

- *Does the Polis administration intend to seek legislative authority for its proposal?*
While HB 19-1004 was largely characterized as a "study bill" during the legislative debate, repeated statements by Polis administration officials have suggested the administration received "carte blanche" from the legislature to implement its ideas. As recently as the week of Oct. 21, officials have reportedly offered different answers to the question of whether legislation is necessary and will be sought to enact any or all of their proposal.
- *Does the Polis administration intend to collapse private insurance into the "state option?"*
By setting rates below current market rates and forcing insurers and providers to participate, the proposal clearly intends for the "state option" to undercut its existing competition. The natural result of this is that higher-priced "competitors" will no longer be viable, ultimately eliminating competition and choice in the individual market. This approach is highly likely to threaten the viability of emerging market-based solutions that the Polis administration itself has championed, such as the Peak Health Alliance. If this is not the intent, it is an obvious consequence that should be guarded against.
- *Does the Polis administration intend for the state to intentionally manipulate insurer and provider competition by forcing providers and payers to participate?*
The proposal lacks significant operational detail and related policy and actuarial analysis, especially regarding impacts on insurance markets, provider markets and consumer choice. By forcing some payers and providers to participate, the state will be picking winners and losers and fostering imbalances in the market. Further, the proposal may enable commercial insurers to unfairly reduce rates for vulnerable hospitals that already lack negotiating leverage and receive lower commercial payments. This is a stark, unprecedented and highly interventionist role for state government that will undoubtedly have consequences that should be carefully scrutinized.
- *Does the Polis administration intend to expand mandatory participation and rate setting to physicians and other providers, or just to hospitals?*
The proposal repeatedly uses the term "providers" and on one occasion uses "health systems." However, public comments from administration officials regarding the proposal indicated that only hospitals will be forced to participate and subject to rate setting. The breadth of application of rate setting has wide-ranging consequences, and the proposal should be transparent and not obfuscate the administration's intent.

When compared to more than a dozen health care plans developed by leading Democrats, the Polis proposal is more extreme in several respects.

Since the 2018 elections, Democrats' focus on health care reforms has renewed and is likely to further intensify throughout the presidential election contest in 2020. As a result, there are more than a dozen public plans for large-scale health care reforms published by leading elected Democrats and presidential candidates. While these vary significantly and range from improving on the Affordable Care Act to implementing a national single-payer system, they also share many common traits. In contrast, the Polis proposal is the *only* plan that would:

- Not significantly expand coverage to the uninsured
- Force insurers and hospitals to participate
- Exclusively target hospitals for rate setting
- Fail to provide additional subsidies while supporting profitability of private insurance companies

The proposal fails to articulate how it would protect rural and other vulnerable hospitals.

A full half of Colorado hospitals are unable to cover costs with enough certainty to be considered sustainable in the long-term, and the Polis proposal is likely to disproportionately impact vulnerable hospitals that have a hard time making ends meet. In some cases, hospitals are paid less than the proposal's rate setting range of 175-225 percent of Medicare, yet it is unclear if the administration proposes to raise payments for these hospitals, which would decrease total savings. Costs associated with ensuring viability of rural and other vulnerable hospitals should not be shifted onto other hospitals. Without the pertinent details of how these hospitals are to be protected, this promise of protection falls flat.

The Polis proposal is not the only way to support struggling hospitals. In partnership with the Hickenlooper administration, CHA spearheaded an effort to pursue a global payment model for rural hospitals. That effort has been abandoned by the Polis administration, and we recommend the legislature invest in further analysis of this concept.

The Polis proposal gives joint decision-making capacity and unprecedented power to multiple unelected bureaucrats.

The proposal states that three state agencies will have responsibility for the state option (HCPF, DOI and Connect for Health Colorado). This gives enormous power to multiple unelected bureaucrats without any oversight from the legislative branch or a single board. Nowhere in the proposal is a process outlined for how the leaders of the three agencies will make decisions or who will have ultimate authority. Nowhere in the proposal is any system of checks and balances contemplated. Although the proposal would establish an "advisory board" for consumers, the group will have no real power or oversight capabilities. Instead, the state should learn from other states' models and best practices and establish an independent, nonpartisan governing board with broad representation and with oversight and authority over key decisions.⁸

While the proposal includes some promising high-level ideas, the proposal lacks evidence of their ability to lower cost or improve value.

CHA has been a long-standing supporter of the Triple Aim, which focuses on reducing cost while also improving access, quality and outcomes. There are a number of general ideas in the proposal that could

⁸ <https://www.urban.org/sites/default/files/publication/73841/2000516-Hospital-Rate-Setting-Revisited.pdf>; <https://www.mass.gov/orgs/massachusetts-health-policy-commission>

improve value and which CHA might support, including identifying benefits that qualify for “first dollar” coverage; advancing primary care; increasing value-based insurance design and alternative payment models; and ensuring prescription drug rebates benefit consumers. However, neither the stakeholder process nor the draft proposal provided any actuarial analysis, savings estimates or impact assessments for these ideas, and we encourage the administration to more thoroughly develop and vet these concepts prior to the final report’s release.

Our Bottom Line:

CHA does not support the Polis administration’s proposal in its current form and instead offers viable policy alternatives.

Despite the administration’s expressed desire for radical solutions that consolidate power with the state and eliminate choice, there are actually evidence-based solutions that have can, or already have been implemented in Colorado to address the affordability of health care and health insurance while strengthening the private market system we have today. CHA has met repeatedly during this comment period with administration officials to share our concerns, our perspectives and our solutions. We hope that the final report addresses these concerns and reflects the following alternatives:

- **Total Cost of Care (TCOC):** A squeezed balloon is often used as a metaphor to describe health care; pressure to lower costs in one area results in increased costs in another. Comprehensive solutions that look at health spending broadly are needed to effectively address affordability. Under a TCOC system, patients, hospitals, providers, insurers, pharmaceutical manufacturers and policymakers come together to set a target for total health care expenditures in order to shrink the whole balloon. Responsibility for meeting shared goals in a manner that improves quality and access rests with all stakeholders. At least six other states have turned to TCOC efforts to slow the growth of health care expenditures, led by Massachusetts, which first passed TCOC legislation in 2012 and has achieved \$5.5 billion in savings since 2013.⁹
- **Community and Market-Based Solutions:** Community-led efforts such as Peak Health Alliance, Valley Health Alliance and Mountain Enhanced Network have sky-rocketed in recent years to bring down cost and improve the health of communities across Colorado. These efforts allow for unique solutions reflective of individual communities or regions. These successful efforts should not be put at risk by heavy-handed government intervention that intends to undercut competition.
- **Value-Based Care and Payments:** Health policy experts have long known that in order to lower costs in the system and improve health care outcomes, a shift from the fee-for-service system to one based on value and improved health is necessary. Both Medicare Accountable Care Organizations and Medicaid Regional Accountable Entities in Colorado have been shown to create a cost-savings over time, but there has been limited uptake of value-based arrangements to date, particularly in commercial insurance. National data suggests that only one-third of total health care payments are in “alternative payment models” (APMs) that reward value over volume, and that commercial payers lag even further behind with just 28 percent of payments in APMs.¹⁰ An alternative Colorado should consider is how to measure and incentivize APMs and set clear targets for public and private payers to expand adoption of these value-based payments.

⁹ <https://www.mass.gov/news/growth-in-overall-spending-lowest-since-passage-of-2012-landmark-health-care-bill>

¹⁰ <https://hcp-ian.org/2018-apm-measurement/>