The tyranny of dead ideas requires a paradigm shift to reveal solutions.

ANSWER THE HARD QUESTIONS FIRST

Massachusetts became the first state to attempt universal coverage through an individual mandate requiring all residents to purchase private insurance. While they have achieved the lowest rate of uninsured they have created a fiscal train wreck. This has happened because they got it backwards. Massachusetts is now studying cost control through uniform billing procedures, medical outcome incentives in reimbursement models and toughening control of hospital construction through their "Payment Reform Commission". Due to their extreme dissatisfaction with the starting point of the Massachusetts plan last November voters passed a landslide ballot measure to force a single payer discussion in state legislature.

HB_1273 is designed to go right at the hard questions up front. Controlling healthcare cost is its principle means to achieve affordable universal coverage. In section 25.5-9-106, Required Elements of the System: The Authority formed by HB_1273 must successfully address basic issues such as:

Responsibility for employment transformations during transition;
Uniform sustainable reimbursement baselines;
Funding redesign;
Best Practices for efficacy;
Improved Rural access;
Procurement;
Long Term care;
IT Standards for Claims & EMR;
And ending cost shift among other items

We must break through the paradigm that creating a unified affordable system is too disruptive. That there will be employment transformation is a given, but fear leads us to see this as a bad thing rather than a tremendous opportunity. The recently released "Institute for Health & Socio-Economic Policy" report demonstrates a growth of 2.6 million jobs created nationally by a unified healthcare system model.

Employment transformation opportunities in the insurance industry include but are not limited to:

1) Personnel knowledgeable in medical terminology can convert hardcopy records for a new Electronic Medical Record system. This is a principle stumbling block for small providers to enter the age of EMR and can be mitigated by using displaced insurance personnel.

2) Front line personnel can be cost effectively employed in a telemedicine triage network to serve rural areas 24/7. These point of entry personnel can expedite getting a

caller to the right provider at a much lower cost. This can further extend the reach of rural providers.

3) As a state we have the opportunity to become a highly attractive setting for new business by offering controlled healthcare costs. In the growing renewable energy economy combining Colorado's already knowledgeable workforce and resource setting with a rational cost effective healthcare model will be a blockbuster for economic growth.

But we must have an integrated unified public-private approach to systemic reform of healthcare financing and delivery. Unilateral schemes continue to foster greater fragmentation. It is fragmentation on many fronts that is the principle enemy of cost control. Plugging a leak in Medicaid one place only pushes the balloon out somewhere else. Creating so called low cost insurance policies just puts more people at risk of bankruptcy.

The American Hospital Association "Health for Life" presentation (pg 30 bottom left column) *"Develop a single source for coverage determination and claims processing across insurers"(1)* clearly delineates an administrative mechanism like planned under HB_1273.

HB_1273 is both a blockbuster piece of economic reform and benign at the same time. The Authority is either self sustaining or defeating, if the interest isn't really there we won't raise the money for the first phase. If we aren't making progress the money will dry up.

ATTACK THE COST DRIVERS ON EVERY FRONT

I have attached a photo of $14,688 machined parts used to repair my wife's badly broken leg in late 2005. I am very thankful for the process and the care given her. However, taken in a corrected context these are just machined parts and their actually cost should be on the order or 20% made to NASA specs. As the common man draws closer to modern medicine laymen are asking simple questions and getting unsatisfying answers.

The New America Institute model shows Colorado's insurance costs almost doubling again by 2016, just as they have since 2000 **(2)**. Doing nothing is simply not an option. HB_1273 presents the Colorado Legislature with a unique opportunity to move forward courageously but at virtually no cost to the State.

California passed SB_840 twice in less than 3 years. While this bill was vetoed each time by their Governor the growing acceptance of the unified public-private finance and delivery model cannot be ignored. Among the near 300 endorsers of CA-SB_840 are dozens of cities, counties and other local government entities. Like Colorado they are limited in their ability to raise taxes and as such find the growth in healthcare expense driving other services out of their budgets. California's bill uses the same, solve the hard problems up front strategy that HB_1273 embraces.

The Colorado State Legislature owes local governments a realistic solution. Ballooning healthcare insurance costs are causing service cutbacks and layoffs at the municipal level.

The Lafayette's ambulance service is in the red due to low reimbursements and the city laid-off employees for the 1st time in its history this year. Personnel costs are 60% of Lafayette's budget and healthcare insurance is an ever growing portion of that. Last year during testimony on HB_1389 we heard about school districts no longer able to provide healthcare insurance for their teachers.

The findings of the Lewin Group, presented in the SB_208 Commission report show in stark relief 4 models that sustain in some form the basics of the current system and one model that stands apart, the "Colorado Health Services Plan". HB_1273 would create a system that performs similarly. The Colorado Legislature simply can no longer afford not to investigate such huge costs savings and inclusive coverage of the population.

Systemic healthcare cost has two basic components:

First is the current and escalating cost of administration and delivery of procedures and therapies of every kind, coupled to evolutions in technology that brings the Hippocratic oath into conflict with the public's ability to pay.

Second, is the demand for services created by needs of patients. The escalation of demand brought about by the legacy if poor health now being built into the population will put our economy over the edge well before individual procedure costs.

The Surgeon General of Arkansas (3) recently demonstrated the dramatic cost effect of having one of 3 common risk factors; smoking, obesity, sedentary life style. His findings indicate that just one risk factor raises actual annual medical expenditures 44%. As aging of those who already have medical consequences from these risk factors is played into his model to costs quickly grow exponentially.

We must get on top of wellness, yet the fragmented multi-payer system presents obstacles and inequities to engaging the whole population in primary and preventative care and education. Policy holders moving in and out of private insurers every few years provide zero incentive for carriers to nurture wellness. Why would a private company invest in the wellness of a policy holder to only pass their investment on to a competitor? Consequently, the for-profit multi-payer format we have today is undermining population wellness and continuing to build-in a legacy of poor health and the associated down stream costs to society.

In a unified system where the payer has its policy holders for life the wellness model is intrinsic. Focus on prevention and treatment at the earliest least costly point of intervention is the norm.

TRANSPARENCY IS GOLDEN

It makes no sense to try to lower costs without really understanding what they are. Today's multi-payer fragmentation and proprietary provider negotiations have left a completely indefinable terrain.

In 2006 my wife and I received 50% discount on a $42,000 hospital bill during a 5 minute conversation with the first point of entry in the accounts payable telephone tree. Later I learned that this was their "timely payment discount". In most businesses the timely payment discount is 1 or 2% at most. So who is paying list price and more to the point what was the actual cost?

Consequently, HB_1273 will engage providers in a reality process to develop an understanding of the cost components of care delivery. This process will lead to the development of a reimbursement structure that will transparently take into account the low reimbursements from federal programs in such a way that all providers will be motivated to service all patients.

A uniform definition of benefits supports a greatly simplified invoicing procedure and significant reduction in administrative overhead currently necessary to insure maximum reimbursement from each source in the heavily negotiated multi-payer system.

The private for-profit insurance industry is on a self imposed death spiral that is steadily raising costs while continually leaving more people out of ever shrinking risk pools. There is no country on the planet with universal coverage that is using a multi-payer system where for-profit insurers are operating. It is time to move past the paradigm that we can or must make something work that no one else has. Unified public funding of privately delivered healthcare to provide universal coverage that is affordable and sustainable is doable if we can lay down our fears in favor of our hopes amplified by our innovativeness.

Respectfully,

Barry Keene, President
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1309 Alexandria St
Lafayette, CO 80026
303-665-0180

References:

(1) American Hospital Association "Health for Life", pg 30
(2) New America Foundation, "Cost of Doing Nothing", pgs 20, 21, Sarah Axeen, Elizabeth Carpenter
(3) "Opportunities & Challenges: Mapping the Future", Joseph F. Thompson MD Surgeon General Arkansas

Opportunities for Leadership: Insurers

Examples of ways to reach the goal:

Safe

Timely

- Ensure provider networks include 24-7 access to urgent care in a setting other than the emergency department.

Effective

- Include coverage for prevention and wellness in all policies.
- Collect and share outcomes data across insurers.
- Base coverage decisions on comparative effectiveness research.
- Share practice variation data with physicians and hospitals.

Efficient

- Make information about insurance products, offerings and prices transparent and easily available to the public.
- Develop a single source for coverage determination and claims processing across insurers.

Efficient (cont.)

- Adopt a single uniform bill across insurers.

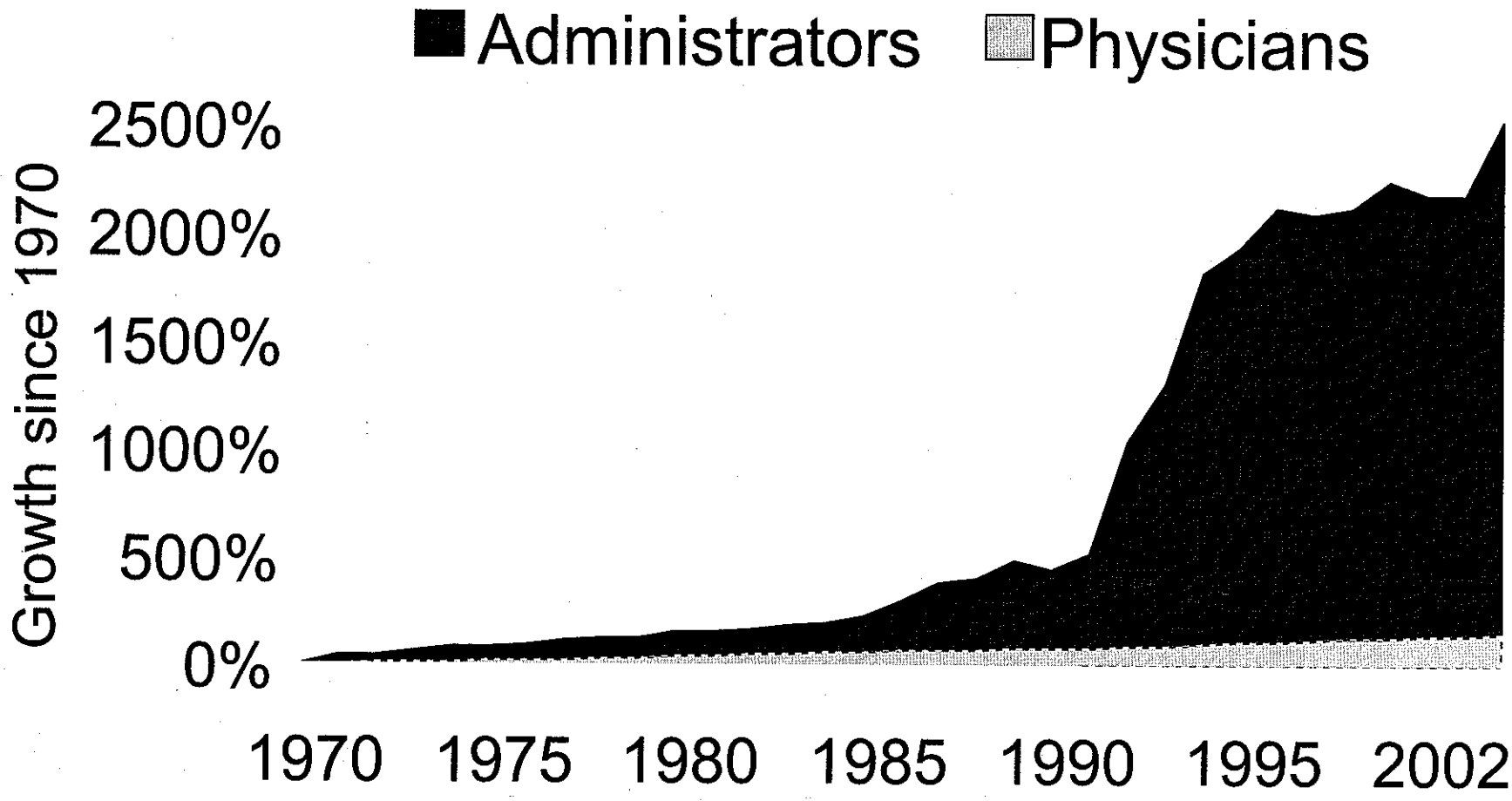
Equitable

- Guarantee coverage policies will be issued equally to everyone.
- Pool risk across all policy holders.
- Work with other insurers to create coverage portability across plans and employers.
- Eliminate benefit "carve outs."
- Eliminate lifetime caps on coverage.
- Create parity in coverage for physical and mental health needs.

Patient-centered

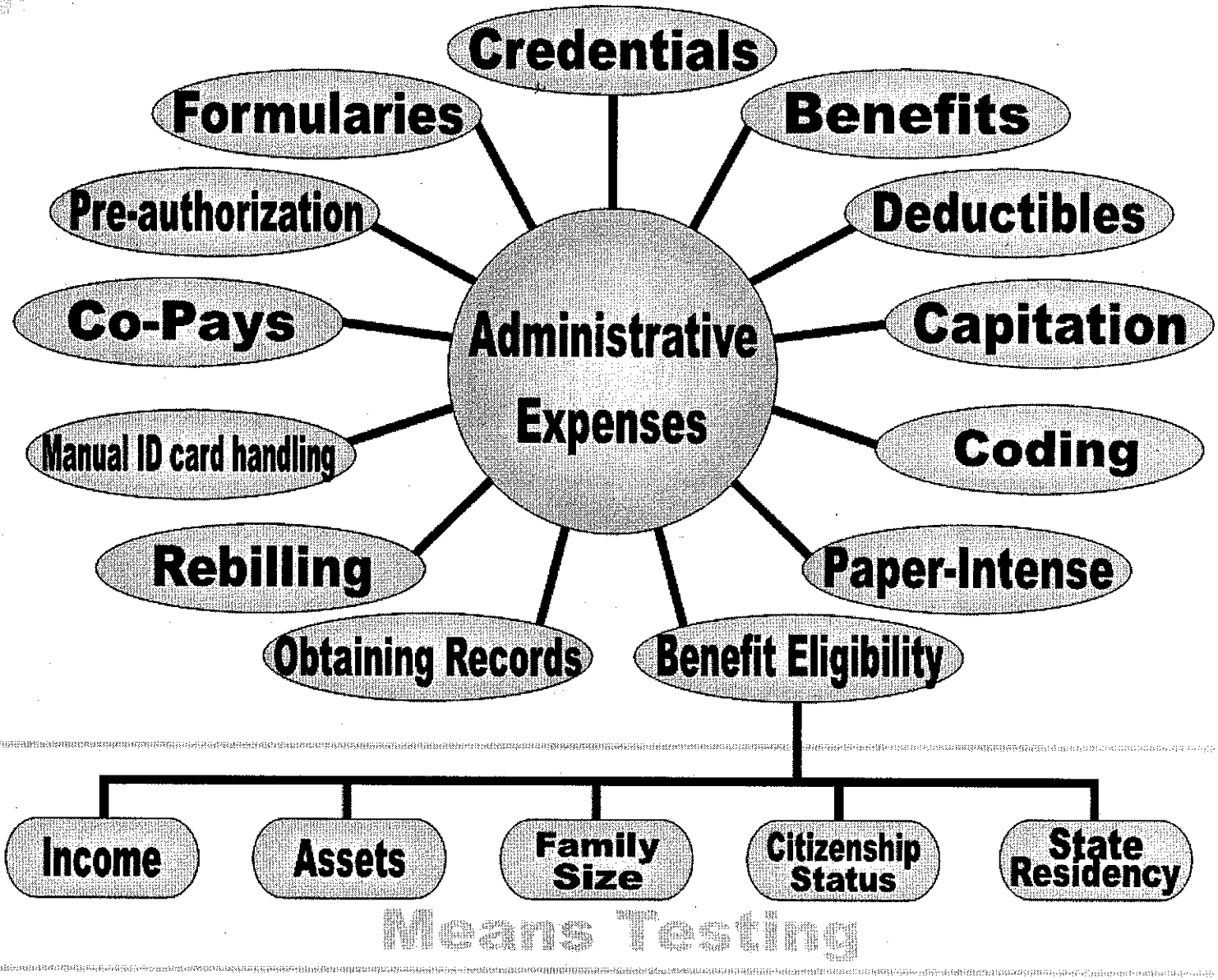
- Give enrollees smart cards that electronically access co-payment and deductible requirements.
- Give enrollees electronic access to claims information so they can share it with other providers.
- Adopt automated prescription delivery for maintenance medications.

Growth of Physicians and Administrators, 1970-2002



Bureau of Labor Statistics & Himmelstein/Woolhandler/Lewontin Analysis of CPS data

Administrative Overhead



Colorado

Colorado's economy lost as much as $3.9 billion because of the poor health and shorter lifespan of the uninsured in 2007. This equates to almost $4,900 per uninsured Colorado resident.

Table 1. Economic Cost of Failure, 2007
(Ranked by High Bound and Per Uninsured)

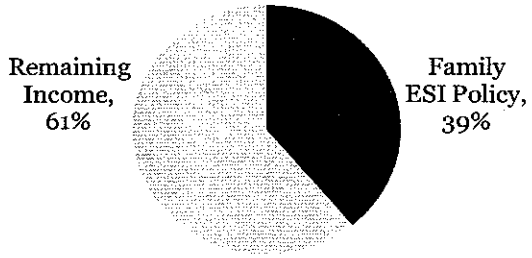
Low Bound	High Bound	Rank (High Bound)	Per Uninsured Cost	Rank (Per Uninsured)
$1.82 Billion	$3.87 Billion	37	$4,825	37

By 2016, Colorado residents will have to spend more than $25,000 or almost 40 percent of median household income to buy health insurance for themselves and their families. This represents a 91 percent increase over 2008 premium levels.

Table 2. Affordability of Premiums,
(Ranked by Level in 2016 and Percent Change)

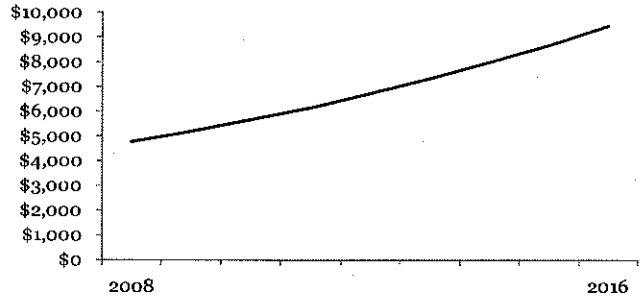
	2008	2016	Rank (2016)	Percent Change	Rank (%)
Full Cost of Family ESI	$13,159	$25,119	32	90.9%	37
Full Cost of Family ESI as a Share of Median Household Income	22.0%	38.9%	11	n/a	n/a

Figure 1. Full Cost of Family ESI as a Share of Median Household Income, 2016



The cost of health insurance for single individuals in Colorado will grow faster than any where else in the country–almost 9 percent a year between 2008 and 2016. Premiums will reach nearly $9,500–almost double 2008 levels.

Figure 2. Full Cost of Individual ESI, 2008-2016



During that same period, individual contributions to employer-sponsored health insurance will grow from $840 to more than $1,500 by 2016.

Table 3. Affordability of Premiums: Employee Contributions, (Ranked by Percent Change)

	2008	2016	Percent Change	Rank
Individual ESI	$840	$1,597	88.1%	20

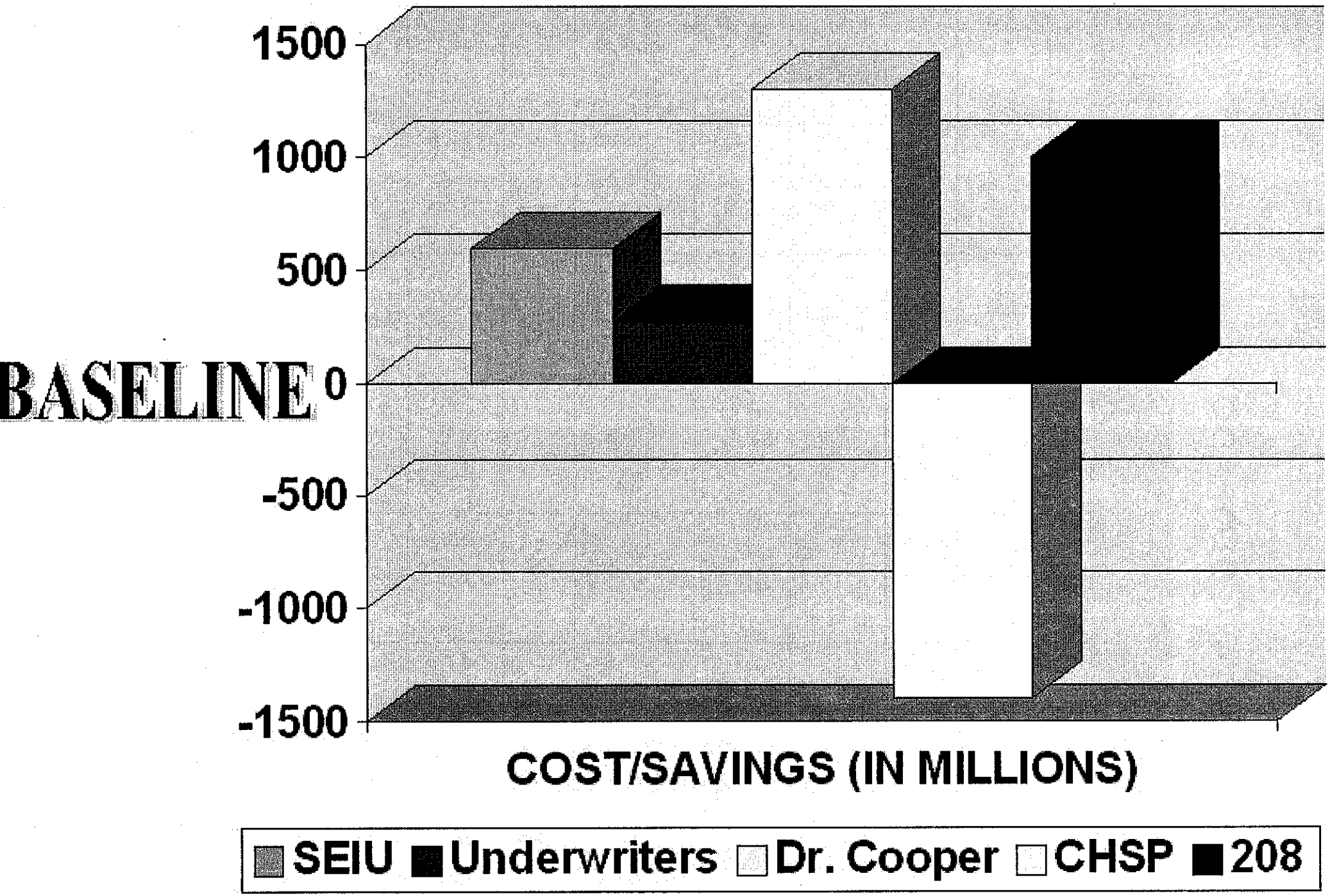
The amount Colorado residents will have to pay to see a doctor will rise sharply by 2016 when the average copayment reaches $37. This is one of the highest copayment levels in the country.

Table 4. Benefits: Copayments and Deductibles,
(Ranked by Level in 2016 and Percent Change)

	2008	2016	Rank (2016)	Percent Change	Rank (%)
Average Copayment	$24	$37	44	51.1%	36
Average Deductible	$1,831	$3,069	33	67.6%	25

State Data: Colorado

Metric	2006 (Reported Data)	2008 (Projection)	2012 (Projection)	2016 (Projection)	Annual Rate of Growth
Full Cost of Family ESI	$11,195	$13,159	$18,181	$25,119	8.4%
Full Cost of Family ESI as a Share of Median Household Income	20.8%	22.0%	29.3%	38.9%	n/a
Employee Contribution to Family ESI Premium	$2,851	$3,212	$4,075	$5,171	6.1%
Employee Contribution to Family ESI as a Share of Median Income	5.3%	5.4%	6.6%	8.0%	n/a
Employee Contribution to Family ESI as a Share of Full Cost of Family-ESI	25.5%	24.4%	22.4%	20.6%	n/a
Full Cost of Individual ESI	$4,024	$4,774	$6,718	$9,455	8.9%
Full Cost of Individual ESI as a Share of Median Annual Wage	12.2%	13.8%	17.9%	23.1%	n/a
Employee Contribution to Individual ESI	$717	$840	$1,151	$1,579	8.2%
Employee Contribution to Individual ESI as a Share of Median Annual Wage	2.18%	2.43%	3.06%	3.86%	n/a
Average Copayment	$22	$24	$30	$37	5.3%
Average Deductible	$1,609	$1,831	$2,370	$3,069	6.7%
Percent of Employees Offered ESI	85.2%	85.3%	85.6%	85.9%	0.1%
Percent of Employees Eligible for ESI	61.4%	60.3%	58.2%	56.2%	-0.9%
Percent of Employees who Enroll in ESI	48.9%	47.4%	44.5%	41.8%	-1.5%


1500
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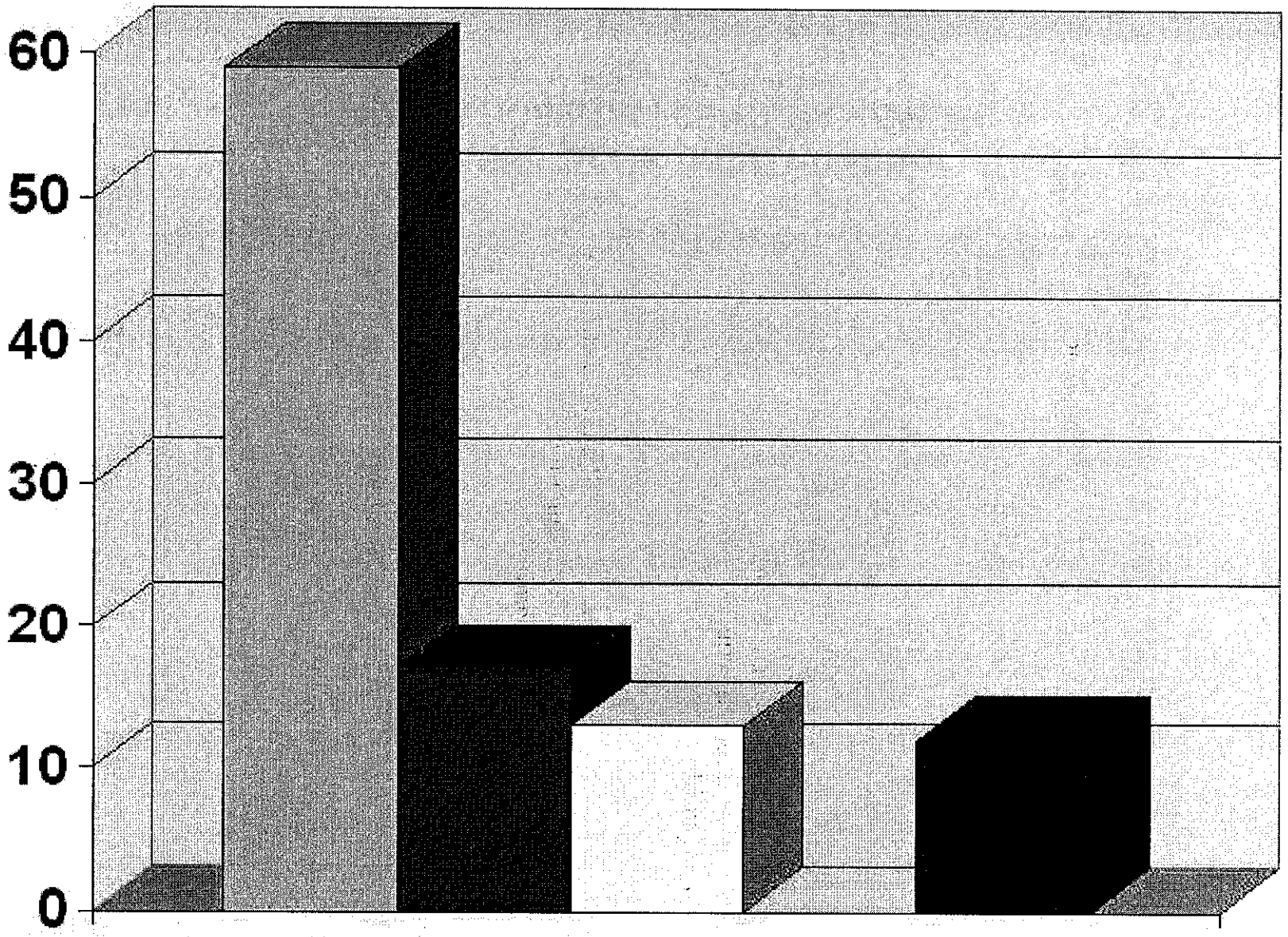
COST/SAVINGS (IN MILLIONS)
SEIU
Underwriters
Dr. Cooper
CHSP
208


60
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% of Current Uninsured Who Would Remain Uninsured
SEIU
Underwriters
Dr. Cooper
CHSP
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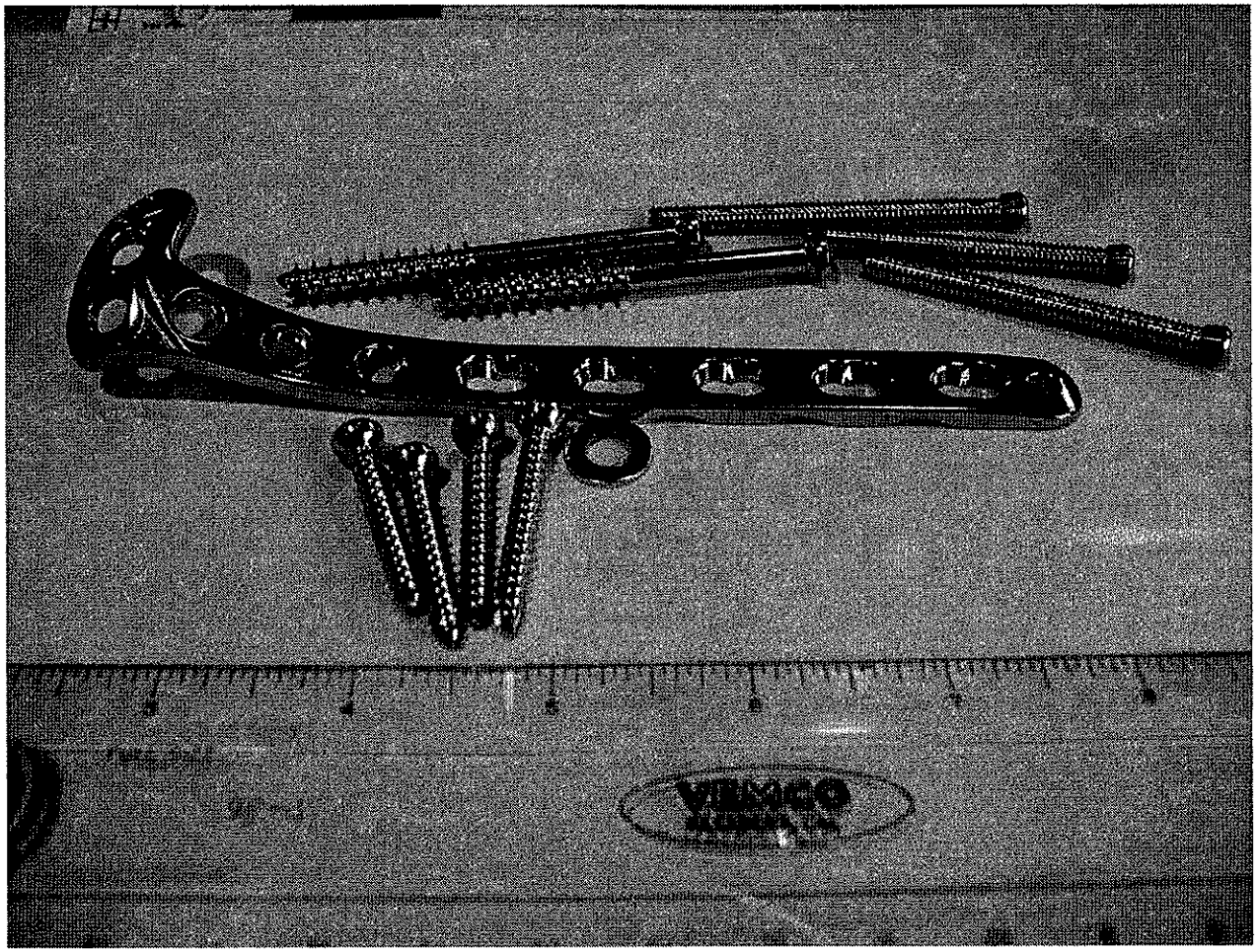

$14,688 parts only, no labor

AVISTA HOSPITAL, CENTURA HEALTH

Brenda VonStar, 10/15/05

Opportunities and Challenges: Mapping the Future

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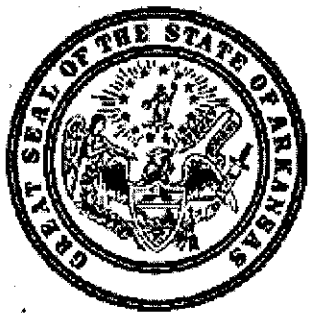

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ARKANSAS CENTER FOR HEALTH IMPROVEMENT

Dorsey Hughes Symposium

July 2008

Average Annual Total Costs (Med + Rx)

Average cost for all HRA respondents eligible to incur claims
$3,097