Physicians for ColoradoCare
www.ColoradoCare.org

ColoradoCare and Providers: Incomes, Specialty Care, Quality, Choice of Provider, and Morale

5.22.16, v4.2

ColoradoCare was designed by providers and patients who believe that there must be a better way than the insurance industry way. It is a grassroots movement to create a health care system that is good for patients, providers, and employers. Amendment 69 is a Colorado Constitutional Amendment that will be on the ballot in November 2016. It would replace the insurance industry system of paying for health care, giving Coloradans a choice over how to pay for their future health care — ColoradoCare or continuing the insurance industry system.

Guardrails and power structures

Providers are the heart and soul of the health care system, and ColoradoCare was designed to address their issues. The 12-page Amendment establishes requirements and power structures that form guardrails that work together to ensure a well-functioning, businesslike organization, good for patients and providers.

Comprehensive benefit floor ensures specialty care

ColoradoCare provides comprehensive benefits, including specialty care, that are able to be responsive to the changes in health care and the needs of Coloradans. It does this in four ways.

1. Amendment 69 lists an extensive number of benefits that must be provided under ColoradoCare.
2. Under the Affordable Care Act (ACA) ColoradoCare must be granted a waiver to operate. The Affordable Care Act (ACA). has comprehensive requirements for benefits that must be offered in all plans, and a waiver must meet or exceed those requirements. While Platinum Plans on the exchange offer benefits that are close to those in ColoradoCare, they have deductibles and ColoradoCare does not. The specific ColoradoCare benefit package would need to meet or exceed the benefit package described in a Platinum Plan.
3. ColoradoCare is required to obtain a Medicaid waiver. This waiver would compel ColoradoCare to offer all of the benefits and services previously channeled through Medicaid and the Colorado state government Health Care Policy and Finance office. Although Medicaid programs suffer from underfunding and provider shortages, the list of benefits is one of the most comprehensive. ColoradoCare would need to meet or exceed the benefit package offered by Medicaid.
4. The three requirements above set the floor for benefits, and the Trustees are required to consider the expansion of benefits as funds become available. (ColoradoCare can provide additional needed benefits.)

Marketplace protections for provider income

There is much confusion between a national single payer system and a single state that establishes universal health care through one system that is a primary payer. A national system has the ability to override market forces and determine provider compensation. While provider incomes are not the driver of health care costs, accounting for only 8% of health care costs[1], there is a possibility that a national system could lower provider income. As a single state, ColoradoCare does not have the

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[1] Jackson Healthcare, (2011). Physician compensation eight percent of healthcare costs. http://www.jacksonhealthcare.com/media-room/news/md-salaries-as-percent-of-costs/

[2] Miller, I.J. (2015). Colorado's proposal overcomes problems that stymied Vermont, Colorado Foundation for

power to dictate compensation. It must provide competitive compensation in order to retain providers in the state. . ColoradoCare was designed with the knowledge that the national marketplace would protect providers' incomes from being artificially lowered in any one state.

This guardrail is inherent in state-based universal health care proposals, and it is one of the reasons that states are the best places to establish universal health care. Both proponents and opponents completely agree — if ColoradoCare under-compensates providers, they will leave Colorado. A continuous inflow of new providers is needed to replace providers who retire or leave. If the Trustees set a fee schedule that made Colorado an undesirable place to work, it would be the equivalent of consciously destroying ColoradoCare's ability to fulfill its mission. Using the guardrail analogy, under-compensating providers would be like the 21 Trustees making a conscious decision to crash through the guardrail of a mountain road and plunge into the canyon below. Making such a decision is not something that reasonable men and women would do.

Transparency and responsibility for the health care system

ColoradoCare would be a predominant payer for Colorado, which gives it a higher level of responsibility for the viability of Colorado's health care system than the insurance industry, Medicare, or Medicaid. Other programs need only satisfy a niche of responsibility and are able to shift their costs onto other parts of the system.

Medicaid is meagerly funded as a program that is mainly for the poor. It operates in the margins of a health care system. Paying less than the total cost of care, there are few providers who can stay in business on Medicaid payments alone. Many providers often accept Medicaid patients out of an obligation to care for those who are not able to pay the full amount. Other providers and hospitals are able to charge higher rates to private insurers, which shifts the cost of providing care for Medicaid patients to those who have health care insurance. It is truly a safety net that catches those who are falling, not a program designed to build a viable, complete, and healthy health care system.

Medicare is funded at higher levels than Medicaid, but it is generally below a provider's total cost of care. As a national program that covers most seniors and people with disabilities, it has a lot of leverage. Like Medicaid, providers are able to cover the total cost of care by having payers who pay more than the cost of care to offset the funding shortage from Medicare. Even then, in some locations and some specialties, providers may close their practice to new Medicare patients because Medicare under-payments can make their practice financially unsustainable. Medicare is a program that is designed to operate in the margins of a health care system that obtains higher reimbursements elsewhere.

The insurance industry is financially self-sufficient, but it does not assume responsibility for a viable health care system. Because insurance companies can cut their own costs by adding administrative barriers, such as preauthorizations and denials, these administrative costs end up being shifted to the entire system, increasing the total cost of care. Difficulties collecting from insurance companies have caused billing departments to become a large contributor to the cost of care, and insurance industry requirements are consuming an increasing amount of provider time and energy. An even more serious shift of responsibility occurs as insurance companies select healthier and non-disabled patients while the patients with serious illness become the burden of public programs.

None of these payers have the ability or responsibility to take care of the whole system. When there is one predominant payer, costs and responsibility cannot be shifted elsewhere. ColoradoCare will be responsible for quality, access, provider income, specialty care, quality, choice of provider, and provider morale. Through transparency, the Ombudsmen offices for patients and for providers, annual public audits, and the scrutiny of the many organizations that monitor health care, ColoradoCare will be accountable for addressing problems in the entire system and will have the ability to address these issues.

ColoradoCare is mandated to provide accessible health care regardless of location
ColoradoCare was designed to overcome all barriers to necessary health care — lack of insurance, under-insurance, administrative complexity, geographical discrepancies, and provider shortages. It is mandated to address and consider using higher levels of compensation to ensure access to providers in under-served areas. With the insurance industry system, treatment services for some conditions such as psychiatric inpatient treatment or residential treatment for substance abuse are woefully lacking. Many rural areas have provider shortages and high insurance rates. ColoradoCare will address these shortages and others that arise., ColoradoCare has the business flexibility to tailor its solutions to each specific situation.

Competition for quality and choice of provider
The insurance industry restricts choice of provider to their network, and sometimes these networks are narrow. Patients often need to change providers when the patient or an employer changes insurance. ColoradoCare greatly increases choice of provider. Patients are guaranteed choice of primary care provider, including primary care providers who work with an HMO. Because ColoradoCare includes practice models such as HMOs that have restricted specialty care, it does not guarantee choice of specialist. It will be the patient's choice whether to enter a system that has a restricted choice of specialists.

ColoradoCare does not change the way that providers practice. It will include for-profit, nonprofit, and independent practices. ColoradoCare will promote all practices types ranging from solo practices to large integrated multi-specialty groups.

The insurance industry competes to find profitable risk pools. Such competition does not improve the quality of health care. Under ColoradoCare, providers would continue to compete to provide higher quality services that attract more patients.

Adequate funding
Funding determines ColoradoCare's ability to fulfill its mission and responsibilities. It is essential to ensure that ColoradoCare has adequate funds.

There are many examples of underfunded programs that fail. Some states have attempted to provide better health care for the uninsured by adding yet another program to the complex jigsaw puzzle of programs.. These programs increase administrative costs by adding yet one more payer and create an additional burden on taxpayers. ColoradoCare, on the other hand, does not increase costs because it replaces the extremely inefficient insurance industry For most Coloradans and employers the premium tax will significantly lower the amount they pay for health care while providing more comprehensive coverage.

Most recently, Vermont, with the support of the Legislature and Governor, boasted that they would establish a single payer universal health care system. Although ColoradoCare shares with Vermont the idealistic goal of universal health care, the Vermont plan is not like ColoradoCare. Although touted as a single payer program in Vermont, it was developed through a political process that had many exceptions regarding who would be covered. Instead of reducing administrative costs, it added complexity and administrative cost to the health care system. By allowing some groups to not pay premium taxes and applying a variable premium tax rate, it left the middle class and small employers responsible for too large of a burden. Moreover, it is a very small state, one-ninth the population of Colorado, with health care costs that are 30% higher per person than Colorado. The Vermont design was not for a universal health care system with a predominant payer like ColoradoCare, and as Vermont's Governor Shumlin announced, it did not work[2]. On the other hand, the ColoradoCare design is completed, and it has been shown to be economically feasible.

[2] Miller, I.J. (2015). Colorado's proposal overcomes problems that stymied Vermont, Colorado Foundation for Universal Health Care, Louisville, CO.

Economist, Dr. Jerry Friedman's 2013 analysis with updated projections for 2016 and 2019 shows that ColoradoCare would have sufficient funds to maintain current provider incomes, cover all of the residents of Colorado, and pay for the increased usage once financial barriers are removed.[3,4] The analysis builds in a substantial cushion with a $1.5 billion surplus and an additional $1.1 billion set aside for possible dental care. The conclusion that great savings come from a universal health care system is supported by eighteen analyses of similar proposed state-based universal health care programs. All have shown substantial savings[5]. As an additional assurance that ColoradoCare will have sufficient funding, the ACA waiver requires another actuarial analysis that shows ColoradoCare is fiscally sound.

ColoradoCare is better able than the insurance industry to contain future expenses. The insurance industry can only lower costs by cutting services, creating administrative barriers to services, or decreasing provider incomes. As a unified system, ColoradoCare will be able to use different ways to contain future costs. It is projected to increase savings by lowering overhead through administrative simplification and by, in the future, an EMR system that allows providers to share information between EMRs within HIPAA protections. Colorado providers spend as much as 15 million hours a year for preauthorizations[6], and simply removing most of this hassle would greatly reduce overhead. Better coordination of treatment will reduce replication of services. Because provider networks will not change, the expenses related to the churn of patients will be reduced. These kinds of savings will grow over time.

In spite of these increased savings, improved technology and treatments are projected to raise the cost of health care. If the rising costs require additional funding, the patients and providers of Colorado are able to vote to approve a premium tax increase. When asked to approve an increased premium tax, Coloradans will have an objective, annual public audit to fully inform them about the operation and needs of ColoradoCare. Even if a premium tax increase is needed, Colorado will still pay much less than states that rely on the insurance industry.

Cooperative business structure and provider morale

In the insurance industry system, the payers do not have an investment in a provider's quality of work life. The insurance company's interest is in stockholder profits. Medicare and Medicaid are controlled by Washington politics, and these programs have shown little interest in providers' morale. The consequence of this fragmented system, disconnected from patients and providers, is an endless series of administrative annoyances, each intended to lower costs for one payer, without any of the payers having responsibility for the satisfaction of the provider workforce.

ColoradoCare is designed to enhance the power of patients and providers, while protecting the system from some of the destructive dynamics of the current insurance industry system. The stakeholders who care most about provider morale are the providers themselves and their patients. ColoradoCare puts these two groups in power positions. To protect ColoradoCare from the

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[3] Friedman, Gerald (2013). Three Possibilities for Colorado's Future Health Care Financing and Delivery. Colorado Foundation for Universal Health Care, Boulder. www.couniversalhealth.org/research/economicanalysis/.

[4] Miller, I.J. (2015a). Economic analysis of the ColoradoCare proposal, Including addendum with 2019 projections. Colorado Foundation for Universal Health Care, Louisville, CO. www.couniversalhealth.org.

[5] Friedman, (2013b), State level studies all find significant savings. Part of presentation to Colorado Foundation for Universal Health Care, 9/11/13, Denver, CO., with two additional studies since.

[6] Bendix, J. (2014) The prior authorization predicament. Medical Economics. http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/alice-g-gosfield/prior-authorization-predicament?page=full (national estimate is adjusted for Colorado's portion of the national population).

multitude of competing issues that our legislature and governor have to contend with, the board of trustees focuses solely on health care. To protect the organization from being political, the elections are nonpartisan. To protect ColoradoCare from the powerful moneyed interests that might undermine or divert health care funds, it is protected as a Constitutional Amendment.

Health care systems have long aspired to the goals of the Triple Aim — enhancing patient experience, improving population health, and reducing costs. More recently provider morale has been added creating the Quadruple Aim[7]. This highlights the importance of fostering a rewarding and sustainable work life for health care providers. Because the owners of ColoradoCare are the patients and providers there is strong incentive to attend to the morale of the work force. The current insurance industry has shown little or no interest in this issue.

Specific improvements in provider morale would come from administrative simplicity, the reduction in preauthorizations, knowledge that all patients could be referred to the appropriate specialty, and greater continuity of care because patients would not be changed from one provider panel to another. Other improvements could come through the Ombudsman for Providers office.

It is in the best interest of ColoradoCare to have a satisfied workforce. It is likely that a Board of Trustees will include several health care providers. Patients generally think very highly of their providers, and they would be strong advocates for addressing provider concerns. It would be more expensive to attract providers to Colorado if it were not considered a good place for health care providers. With the interests of ColoradoCare, patients, and providers aligned to promote a satisfied workforce, it can be expected that there will be a strong and active ColoradoCare-provider partnership guiding Colorado's health care towards achieving the Quadruple Aim.

Which system can support the Quadruple Aim?

Insurance industry system plus government components	**ColoradoCare**
Does the payer have responsibility for provider morale?	
None of the components – not Medicaid, Medicare, nor the insurance industry – have responsibility for provider satisfaction.	As the predominant payer, ColoradoCare is responsible for the health care system. Providers are partial owners and the other owners are patients. Both patients and providers want satisfied providers and do not want burned-out unhappy providers. These are the people who care about the Quadruple Aim.
What is primary interest of those who control the system?	
Medicare and Medicaid are primarily controlled by the currently dysfunctional Washington political system and are only one of many political footballs. The insurance industry's primary interest is in stockholder profits.	ColoradoCare is managed locally by trustees, who have only one issue, health care. Because they are elected and the system has transparency, it is controlled by the residents of Colorado.

[7] From Triple to Quadruple Aim: Care of the Patient requires Care of the Provider
Thomas Bodenheimer, MD1 and Christine Sinsky, MD2,3 Ann Fam Med November and December 2014 vol. 12 no. 6 573-576. The Quadruple Aim adds improving the work life of health care providers, including clinicians and staff. Triple Aim—enhancing patient experience, improving population health, and reducing costs

Which system wants to hear feedback from providers?	
Provider feedback must go through "customer service" filters or a political process.	ColoradoCare has an independent Ombudsman Office for Providers.
What happens at dinnertime?	
Patients and providers are on the menu.	Patients and providers are sitting at the table.

Provider income and reimbursement rates:

Multiple economic analyses show that once the inefficiencies of the insurance industry are removed, there are sufficient funds to maintain provider incomes at current levels, cover everyone, and save money. ColoradoCare is the first to bring a specific program to voters. This requires a more specific explanation of fees and reimbursement.

ColoradoCare is not a government program like Medicare or Medicaid
Some confusion has arisen between how Medicare operates and how ColoradoCare will operate. To help the general public understand that a universal health care program financed with payroll premium taxes can be highly successful, ColoradoCare has been compared to Medicare for All. Of course, it is not actually Medicare, which is a federal program. The two programs have different mandates. Medicare is dedicated to protecting the Medicare Trust Fund so that it will provide health care for seniors and people with disabilities for as long as possible without a premium tax increase. It has no mandate to finance a comprehensive health care system for everyone. Medicare will strive for the lowest reimbursements possible, and pay less than the cost of care, relying on other payers to compensate for the underpayment. ColoradoCare cannot rely on other payers, so it must ensure providers are compensated for the total cost of care.

Medicaid also has no mandate to finance a comprehensive health care system for everyone. It relies on doing as much as it can with scarce public funds to provide a safety net for people with low incomes.

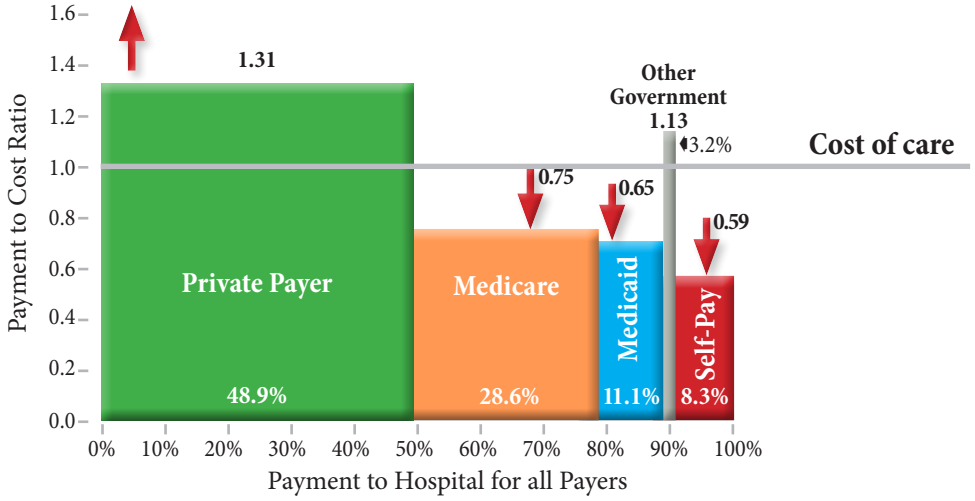
ColoradoCare has the mandate to ensure that there is access to comprehensive, affordable heath care for all Coloradans.

What is the total cost of care?
Total cost of care is the combination of what a provider pays for all overhead and a satisfactory income for the provider. This income must be considered attractive enough so that new providers want to work in Colorado. It can be assumed that in the current insurance system, in aggregate, the total cost of care is covered and that provider incomes have attracted a sufficient workforce to Colorado. Therefore, the economic analysis was based on the current total expenditures in Colorado, which includes current provider incomes.

The Centers for Medicare and Medicaid Services (CMS) publish data about the aggregate total cost of care in their annual National Health Expenditures (NHE) report. This data had been published for decades, and history has shown it to be highly reliable. Based on this data, economists have consistently shown that universal health care can cover everyone and save money. Showing providers how much they would be paid in a universal health care system requires translation.

The 2008 Colorado Blue Ribbon Commission on Health Care Reform (208 Commission) dissects how different payers contribute to the total cost of care in the current health care system. While the total cost of care can be determined from the CMS and its NHE report, the relative payments come from analyzing hospital data.

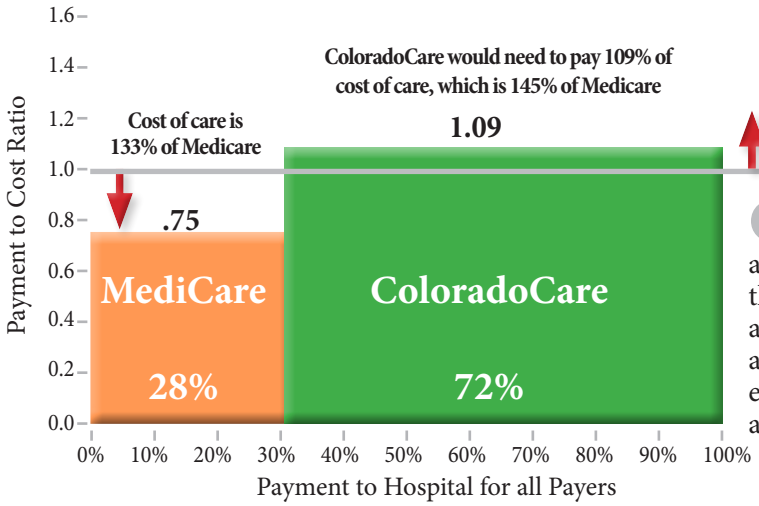
Figure 1
Insurance Industry System of Payments and Total Cost of Care
208 Commission Analysis



How does ColoradoCare cover the total cost of care?

Like the 208 Commission, the economic analyses of ColoradoCare determined the total cost of care from the NHE reports. Figure 2 shows that ColoradoCare combines two sources of underpayment (Medicaid and self-pay) combined with one source of overpayment, private insurance. ColoradoCare must still pay slightly more than the total cost of care to compensate for the payments that are below the total cost of care.

Figure 2
Cost of care compared to ColoradoCare reimbursement example
(without considering savings from administrative simplicity)



Cost of care in this figure assumes that provider income is at the current level, and that overhead and administrative expenses are at the current levels without any expense reduction through administrative simplicity.

How does this economic determination that ColoradoCare will pay more than the total cost of care translate to a fee schedule that providers are familiar with? The 208 Commission analysis in Figure 1 shows how to do an approximate translation. If it were assumed that there was no reduction in the total cost of care, and Medicare continues to pay 75% of the total cost of care, Figure 2 shows that

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[8] Colorado Blue Ribbon Commission on Health Care Reform, (January 31, 2008). Figure: Summary comparison of hospital payment levels in Colorado, Final report to the Colorado General Assembly. Colorado State Government, Denver, CO.

the total cost of care would be 133% of Medicare and ColoradoCare would need to pay 109% of the total cost of care or 145% of Medicare to ensure that providers are adequately compensated.

These comparisons to Medicare fees do not imply that the ColoradoCare economic analysis is based on a specific fee schedule that is a multiple of Medicare. It is not, and it should not be. If ColoradoCare were tied to a program like Medicare, it would not have the option of overcoming problems in Medicare, increasing payments for psychiatric hospital beds, improving access in rural areas, or responding to future needs in a more flexible way than Medicare. Tying ColoradoCare to any existing fee schedule would tie ColoradoCare to the current payment system, which does not solve many of the problems created by the insurance industry system.

The 208 Commission translation of total cost of care to 133% of Medicare and projecting that ColoradoCare would need to pay 145% of Medicare is an approximation based on 2007 hospital costs. Specific reimbursements would be subject to a number of variables. While Medicare pays 75% of the total cost of care for hospitals, the percentage for many specialties may be different than the 2007 hospital figures. Payments in rural or underserved areas may need to exceed the 145% of Medicare to attract providers. Hospitals and practices that provide training for health care professionals may need a higher rate. Payments for psychiatric hospital beds may need to be greater. The total cost of care may be lower when many of the billing staff positions can be converted to patient care positions and preauthorizations are greatly reduced.

ColoradoCare will need to set the specific fees in partnership with Colorado providers. For some specialties, the fee schedule could be in the 133% to 145% of Medicare range, but that would depend on how much Medicare payments are below the total cost of care. It is clear that to cover the total cost of care, ColoradoCare will need to pay substantially above Medicare, and the goal of the fee schedule will be to ensure that ColoradoCare pays as sufficient amount over Medicare to cover provider's total cost of care covered including maintaining provider income at current levels.

Providers will have substantial power in the negotiations. If providers are not satisfied, it will end up increasing ColoradoCare costs. One of the guardrails is that Colorado must attract new providers continuously, and a bad reputation would mean that ColoradoCare would need to pay even more. ColoradoCare will have a strong investment in a satisfying partnership with providers.

Currently the position of respect that providers have earned has been usurped by insurance company administrators who retrospectively determine what is appropriate medical care and base their compensation accordingly. Meanwhile, providers are given take it or leave it contracts and can be dropped or demoted without warning or cause. Adding insult to injury insurance companies have an unwritten "deny or delay" policy that is designed to cause frustration and anguish. The only option for many providers is to be out of network, but each year the insurance companies work to pass legislation to limit this option.

ColoradoCare is determine to change the dynamic between the payer and provider through transparency and by giving providers voice. Providers will be in position to influence the inevitable transformation of the delivery of care from volume based to value based while insuring that compensation remains attractive.

Which choice is more trustworthy with the health care budget?
ColoradoCare is big, and it would have a $38 billion annual operating budget. Anything this big raises concern about what is the design, whose hands are in the pot, and who controls it. It is these factors that will in the long run determine compensation and physician morale.

ColoradoCare is transparent, has an independent Provider Ombudsman Office, and public audits. It is controlled by Trustees who are elected by the patients and providers of Colorado. These owners primary interest is comprehensive, quality, and accessible health care.

After the mergers, the insurance industry will be represented by three dominant insurers: United with $157 billion current annual revenues, Anthem/Cigna with $117 billion annual revenues, and Aetna/Humana with $117 billion annual revenues. These insurers behave much more alike than differently. They are each 3-4 times as big as ColoradoCare.

Instead of being governed by Trustees, they are governed by stockholders. Instead of transparency, most of their operations are proprietary. The primary interest of these owners is maximizing short-term profits and stock value.

Summary

Amendment 69 gives Coloradans a choice over their future health care payment system. ColoradoCare is designed with guardrails and power structures. The current insurance industry system also has guardrails and power structures. There is a great difference between a guardrail that requires making all efforts to increase stockholder profits than one that requires serving the health care needs of Colorado's patients and providers.

How much better than the current insurance system will ColoradoCare be? The exact amount of improvement is uncertain. There is much more certainty about the future with the health insurance industry because the trends are clear. Insurance companies are merging and getting more powerful. Administrative expenses and hassles such as preauthorization are ever increasing. Power is being consolidated in profit-making big hospital chains and insurance companies. As employees of the powerful, provider salaries are squeezed and productivity requirements are raised. The size of deductibles grows every year, leaving patients under-insured and needing to forego necessary care. Coloradans will choose which system to trust with their future, a Colorado owned cooperative health care payment system or the current insurance industry system.