Report to the Legislature
from: **1176 The Health Care Cost Analysis Task Force**,
Interim Report issued January 1, 2021; Final Report issued September 1, 2021

1. **What is this Task Force?**
   The Task Force was created by HB19-1176, the Health Care Cost Savings Act of 2019. The legislation called on the Task Force to hire a consultant to study three approaches to providing health care for Coloradoans. They are:
   - "*The current Colorado health care financing system in which residents receive health care coverage from private insurers and public programs or are uninsured."* That is, the state's current health care system, with numerous different payment systems, and many of Coloradans uninsured or "underinsured."
   - *"A multi-payer universal health care system in which all residents of Colorado are covered under a plan with a mandated set of benefits that is publicly and privately funded and also paid for by employer and employee contributions."* That is, a system of universal coverage that covers everybody, using both private health insurance paid for by workers and their employers and a public insurance plan for those without private insurance. Those over 65 would be covered by Medicare.
   - *"A publicly financed and privately delivered universal health care system that directly compensates providers."* That is, a system of universal coverage that covers everybody, using a single state-run insurance plan. Those over 65 would be covered by Medicare.

2. **What our experts found:**
   The Colorado School of Public Health (CSPH) was selected to conduct the financial analysis. The full study and an Executive Summary from the CSPH's team of experts is attached to this report.

   Here is the summary paragraph from their report. The "multi-payer" plan cited here refers to a system in which some people get private insurance and all those not so covered are insured by a public insurance plan. The "full publicly financed" plan cited here refers to a single state-run insurance system that covers everybody under 65.

   "Healthcare reform in Colorado introducing universal health coverage that is either a multi-payer or single payer system has the potential to increase access to care, improve health outcomes, and possibly provide sector-specific employment benefits. Our cost estimates suggest that a multi-payer universal health care system will likely lead to small increases in the total cost of Colorado's health care system. Introduction of a full publicly financed and privately delivered health care system could yield significant healthcare savings, particularly if pricing regulations are put in place to control cost growth in the future. The financial health of hospitals and clinics and clinician retention should all be carefully considered with any potential pricing regulations."

   The study offered the following estimates of total annual costs under the three models studied.

1. Current system:	$38.3 billion.
2. Universal coverage, mixed insurance system:	$38.6 billion to $39.34 billion
3. Universal coverage, public insurance system:	$34.62 billion to $37.78

3. **What did Coloradans tell the Task Force?**
We solicited feedback two ways: public sessions held via public video conference platforms and an online questionnaire.

In the public sessions, Coloradans said that they are unhappy with the cost of health care and health insurance and – particularly in rural areas – with their choice of, and access to, doctors and hospitals. They questioned the connection of health insurance to employment. They do not like the "narrow networks" under which insurers restrict their choice of providers. Almost all those who attended said they did not care whether health insurance was provided by a private company or by the government. Many said they could not afford their prescribed medications. Notably, most participants do not think of health care in terms of procedures and specialties; the context for their input was longitudinal and included physical, social, and behavioral health.

There was a strong consensus that all Coloradans should have affordable health insurance. Nearly all challenged the concept of trade-offs: access should not mean increased costs; affordability should not mean less services. Several referenced other developed countries who provide affordable access to care without those consumer trade-offs.

Minority group members expressed distrust of doctors and hospitals and were often mystified by the complexity of the various payment systems. Additionally, they were struck by the trade-offs as described as they were experiencing something more basic: just needing access to care.

Over 25 Coloradans participated in the first of three public sessions, with over 12 cities and towns represented. The subsequent two public sessions had similar numbers involved and similar geographic representation. One was held in Spanish. Demographic details of the second and third public sessions are not available due to a technical challenge with the recordings.

Our online questionnaire was not a random sample of citizens yet gathered feedback from over 550 people from 38 counties; 220 whom provided additional comments in an open-ended text field. The respondents were limited to residing in Colorado. Of the respondents, 30% were male and 65% female while the remaining respondents did not answer. 80% identified as white, 12% as Latinx, and the remainder noted other race/ethnicity in their response. Reported annual income was approximately 50/50 above/below $100,000. The political affiliation distribution was 46% Democrat, 30% Independent, 10% Republican, and 9% other.

A majority of responders to the questionnaire strongly favored the idea of health insurance for everybody. Across several questions the consensus on universal health insurance reflected two key elements: the acceptable minimum of coverage for everyone should include quality care and lower out of pocket costs than traditional catastrophic coverage. There was an especially strong consensus that unexpected medical costs should not create exposure to bankruptcy. Several did not want universal health insurance to come at the expense of their ability to pay more for greater convenience and choice if desired. Among

our three health care system models, 20% preferred the current system, 25% picked universal coverage through a mixed insurance system, and 42% picked a single universal insurance system. Most respondents said that everyone should have access to health care when needed, but a small percentage said people should receive health care only if they can pay for it.

Across both the sessions and questionnaire, except for the Spanish-language session, even when presented with questions about quality and choice, cost of care continued to dominate health care concerns for Coloradans. For the Spanish-speaking participants, fear of racial bias was nearly as important as cost in barriers to accessing care.

4. **How did the Task Force conduct its work?**
   Beginning October 31, 2019, the Task Force met bi-weekly, in public sessions, through August 20, 2021. We met in person at first, and virtually since spring of 2020. All Task Force meetings have been open to the public; patients, doctors, insurers, and hospital representatives have joined, and these public members were invited to comment at each meeting. We created a public website: https://hcpf.colorado.gov/health-care-cost-analysis-task-force

   As directed by the legislation, we hired consultants, under competitive solicitation, to carry out a review of existing literature of health care systems, to design the scope of the financial analysis, and to conduct the financial analysis of the three models dictated in the legislation. A table comparison of the three health care systems we were required to study was also created; is at the end of this report.

   In addition, we held public meetings, in English and Spanish, to let Coloradans tell us their opinions and desires on health care. Because of COVID, we did that through on-line public meetings open to all Coloradans. We also distributed an on-line questionnaire. See Section 3 for details.

5. **How much did this work cost Colorado?**
   The legislature authorized $92,649 for each of two fiscal years and authorized the Task Force to seek additional support from private or public sources as needed.

   In the first year, the Task Force spent $30,000 and returned the unspent $62,649 to the general fund due to fiscal year deadlines and pressures related to COVID. For the second year, the Task Force spent the full appropriated amount for a total cost to Coloradoans of $122,649. All funds went to consultants; Task Force members were not compensated.

   The Task Force searched for private funding, but this proved impossible to get because the foundations that support such work were focused on the COVID crisis. As a result, our work faced limits, but we are confident in the findings of our consultants from CSPH.

6. **Who served on the Task Force?**
   The Task Force had bipartisan membership (see Section 7), appointed by the governor and both parties' leaders in the legislature. Characteristics of members:
   - 9 out of 11 are female (82%); all its officers are women. 1 member is a native Spanish speaker.

- 3 are legislators (2 Democrats, 1 Republican). The vacant Republican seat was not filled when the original legislator left in 2020.
- As directed by the legislation, the Task Force began with:
  - 4 members of the general assembly, 2 from each party.
  - 4 members appointed by the Governor.
  - 4 members serving as delegates for the Department of Human Services; the Department of Public Health and Environment; the Commissioner of Insurance; and the Health Benefit Exchange.

Name	Employer
Jennifer Bacon (as of Feb 2021)	Representative, HD7
Susan Beckman (thru Jan 2020)	Senator, D38
Carrie Cortiglio, Secretary	CO Department of Public Health & Environment
Joann Ginal, Vice Chair	Senator, District 14
Karla Gonzales Garcia	CO Organization for Latina Opportunity & Reproductive Rights
Kate Harris	CO Department of Regulatory Agencies
Dr. Renée Marquardt	CO Department of Human Services
Michelle Miller	CO Department of Health Care Policy & Financing
Mitzi Moran, Chair	Sunrise Community Health
T. R. Reid	Journalist/Author
Emily Sirota (thru Feb 2021)	Representative, HD9
Jim Smallwood	Senator, D4
Monica VanBuskirk, Treasurer	Connect for Health Colorado

7. **What happens next:**
   The Task Force hopes this report, and the full study, will inform legislative decision making toward the goals of a) assuring health insurance for every Coloradan, b) improving the state's overall population health; c) increasing employment and productivity; and d) reducing and controlling Coloradans' health care costs.

   We are excited the modeling created by the CSPH could be used to generate cost estimates of different specific health policy reform proposals.

   Members of the Task Force, minus those employed by State agencies, and the consultants will be available to testify and advise on our findings.

Respectfully submitted,

Mitzi M. Moran, Chair, *for the* 1176 Health Care Cost Analysis Task Force

Summary Table of Health Care Financing Report prepared by the Colorado School of Public Health for the Health Care Cost Analysis Task Force formed by HB19-1176.

Information and analysis by the Colorado School of Public Health.

	A The current CO health care financing system in which residents receive health care coverage from private insurers and public programs or are uninsured	B Multi-payer universal health care system in which all residents of CO are covered under a plan with a mandated set of benefits that is publicly and privately funded	C A publicly financed and privately delivered option that provides universal coverage.
Coverage: **% insured** **# under-insured**	 93.5% 1,000,000 (~18%)	 100% 0	 100% 0
Total healthcare expenditures within the state **1st year** **5th year** **10th year**	$38.2 – 38.3 Billion, depending on uninsured rate $45.55 – 46.77 Billion $56.77 – 56.92 Billion	$38.6 - 39.34 Billion, depending on provider reimbursement rate and private crossover to public product $46.03 – 46.91 Billion $57.36 - 58.46 Billion	$34.62 - 37.78 Billion, depending on provider reimbursement rate $41.28 – 45.05 Billion $51.45 – 56.14 Billion
% of total current spending	99.7 – 100%	100.78% - 102.7%	90.38 – 98.64%
Premiums, deductibles, And co-payments cost of reform option **actual cost to patients would be determined by premium and other subsidies*	N/A	Modeled 34% of total cost as premium, deductible, and co-payments 15% of total cost, comprised of deductible and co-payments (not including premiums)	Modeled 34% of total cost as premium, deductible, and co-payments 15% of total cost, comprised of deductible and co-payments (not including premiums)
Averaged annual utilization cost per individual	Average cost per individual = $6,616 - $6,634, depending on uninsured rate	Average cost per individual = $6,686 – 6,813, depending on reimbursement rate	Average cost per individual = $5,996 - $6,544, depending on reimbursement rate
Compensation for providers	Variable	100 – 250% (multiple scenarios modeled)	100 – 250% (multiple scenarios modeled)
Benefits	Medicare, Medicaid, ACA plans, grandfathered plans, etc.	Private market equivalency	Private market equivalency

Additional Performance Metrics outlined in HB19-1176			
Collateral costs to society from ER, urgent care, intensive care treatment[1]	While the number of Coloradans who report at least one annual preventive care visit increased from 62.4% in 2017 to 74% in 2019, the percentage of Coloradans reporting emergency department utilization has remained around 20%.10 Of those visits, 38% reported that they went for a non-emergent reason.		
Relative performance:	Reference / current system	Same or slightly better than current system	Better than current system
Lost time from work, decreased productivity[2]	Studies have found that decreased productivity and lost time from work due to chronic health conditions constitute most health-related lost productivity costs to employers, employees, and society. Early intervention for acute and chronic health conditions, which occurs with regular utilization of preventive care services, is assumed to improve health, and decrease overall costs to society.		
Relative performance:	Reference / current system	Same or slightly better than current system	Better than current system
Bankruptcies[3]	Medical cost related bankruptcies may range approximately between 2,210 and 5,695 in Colorado in 2019. The Colorado Health Institute's Colorado Health Access Survey (CHAS) estimated that medical bankruptcies have decreased in Colorado over recent years. Among people who had trouble paying medical bills in the past year in Colorado (approximately 18% of Coloradans), only 3.7% reported filing bankruptcy, compared to 11.1% in 2013, the first year the statistic was collected.		
Relative performance:	Reference / current system	Same or slightly better than current system	Better than current system
Medical Financial Hardship[4]	The CHAS found that in 2019, 30% of Coloradans received an unexpected medical bill in the past year and that the percentage of Coloradans who had trouble paying a medical bill in the past year rose for the first time since the ACA was passed. Black Coloradans are nearly twice as likely as white Coloradans to have had problems paying a medical bill. Of the 18% of Coloradans who had trouble paying medical bills, 54% took on credit card debt, and 33% were unable to afford essentials such as food and utility bills.		
Relative performance	Reference / current system	Same or slightly better than current system	Better than current system

[1] Section 1.2.3.1 "Cost of Emergency Care" in Health Care Financing Report prepared by the Colorado School of Public Health.
[2] Section 1.2.3.2 "Lost Time, Productivity, and Unemployment" in the Report.
[3] Section 1.2.3.3 "Medical Bankruptcy" in the Report.
[4] Section 1.2.3.4 "Medical Financial Hardship" in the Report.

Medical costs caused by the diversion of funds from other health determinants, such as education, safe food supply, safe water[5]	The state of Colorado spends about 33% of its total budget on health care, over half of which comes from federal dollars to fund Medicaid, where most of this funding is directed. Nineteen percent of the state budget is used for kindergarten through 12th grade (K-12) education, and a little over 7% goes to human services, which oversees financial and food assistance, child welfare, rehabilitation, mental health and substance use treatment programs, and programs for the aging, among other things.		
Relative performance	Reference / current system	Dependent on governmental spending priorities	Dependent on governmental spending priorities
Economic Impacts for Employers, Employees, and Households[6]	The available evidence suggests that, in states where health care reforms have occurred, rates of employment in the healthcare industry remain approximately the same or eventually decrease if provider reimbursement rates decrease. Furthermore, evidence also suggests that expanded public healthcare options result in a decrease in insurance-related jobs (more so under a publicly financed option), and an increase in overall employment.		
Relative Performance	Reference / current system	Slight sector specific improvements	Decrease in insurance-related jobs, but increase in overall employment that varies by sector
Federal and Legal Constraints to Healthcare Reform in Colorado[7]	A viable model for health care reform at the state level must overcome several legal and federal constraints. The primary legal constraint is The Employee Retirement Income Security Act of 1974 (ERISA). Federal constraints include stipulations of Medicare, Medicaid, and the Affordable Care Act (ACA). Deliberately crafted legislation can avoid the legal constraints associated with ERISA. Federal constraints can be addressed using waivers. States can apply for waivers from the US Department of Health and Human Services requesting exemptions from certain federal requirements in order to develop innovative methods of health care delivery at the state level.		

[5] Section 1.2.3.5 “Health Determinants, Social Spending, and Healthcare Costs” in the Report.
[6] Section 2.3.5.1 “Economic Impacts for Employers, Employees, and Households” in the Report.
[7] Section 1.2.4.2 “Federal and Legal Constraints for Healthcare Reform in Colorado” in the Report.