

The Honorable Max Baucus  
Senate Finance Committee  
219 Dirksen Senate Office Building  
Washington, DC 20510

The Honorable Charles Grassley  
Senate Finance Committee  
135 Hart Senate Office Building  
Washington, DC 20510

May 21, 2009

Dear Senators Baucus and Grassley,

*The organizations whose signatures appear below represent Colorado health care consumers and providers dedicated to the goal of comprehensive health care reform. We are very grateful that Congress has taken up this important issue and look forward to real solutions to the problems that far too many Coloradans face every day. To that end, we offer the following comments on the U.S. Senate Finance Committee's May 14, 2009 Policy Options Paper: Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans. We thank you for your attention to our comments and hope that you continue to make progress on this issue. Reform is long overdue.*

**OVERALL STRUCTURE:**

**Public Private Combination**

We agree that building on and improving the current public/private system is the most likely way to realize substantial health care reform at this time. Colorado's Blue Ribbon Commission on Health Care Reform reached the same conclusion regarding the need to build on current systems with respect to options for State reform. We also agree that we must have mandatory participation on an equitable basis in a reformed system. The premise of health insurance is risk pooling, and the only way to ensure that we maximize the overwhelming social and economic benefits of risk pooling including avoiding cost shifting resulting from uncompensated care and ensuring access to health care at every stage of life is through mandatory participation. The following principles ought to guide your efforts on coverage expansion:

- a. Health care must be available to and affordable for all, particularly in a system that requires participation.
- b. No one should be required to purchase policies that do not offer good value.
- c. Benefits and services must be comprehensive.
- d. Reform must include simplification and not repetition of the eligibility and benefits mazes that exist in our current public health insurance programs.
- e. Coverage must be accessible, seamlessly administered, continuous and portable.
- f. Everyone should have the option of participating in a public health insurance program.

**Public Health Insurance Option**

A public program option is a critical component of health care reform. It is the only way to achieve true portability and presents significant opportunities for improved continuity

of care, as under such a system people would not have to change providers with every move, job change, or life event. The Public Insurance Option would also offer seamless and efficient administration, features that are extremely important to large numbers of people. We are very pleased that this option is included in the Report.

One problem we see with the options presented is that they are built on a private insurance model. They do not reflect any new thinking about what a public program could offer to participants. As an example, the options presented all use the same rating rules as the new proposed non-group and small group rating rules. We believe and strongly urge Congress to consider the advantages of spreading risk on an equal basis across a large group of people, rather than continuing to single individuals out for differential premiums. While we understand the concerns about a level playing field, those concerns ought not to drive us to recreate exactly all of the features of the private market place. We strongly encourage you to be creative about the possibilities and maximize the benefits available through the creation of a public program option

It would be helpful to clarify the benefits that would be offered under would be under the public option model; it is not clear that they would be broadly comprehensive. No reform will be adequate in our view unless benefits are comprehensive and we fail to see any advantage in failing to offer at least equal benefits in the new public program as are offered in the Exchange. In fact, we assume that the Public Program would be one option offered through the Exchange to individuals and business.

We also strongly encourage you in designing this public option to align benefits so that people in and moving in and out of Medicaid and CHIP could opt to participate in the public option program. Again, the public program is the only option on the table for portable, continuous coverage, and participants in both public and private insurance programs ought to have equal access. There may be a need to create wrap around benefits for people on public programs, but that ought not be any more difficult to administer through the public program than, for example, for people who opt to participate in ESI through Medicaid.

**Features of any public program:**

- a. This should not be still another plan with a mixture of public and private features and still another set of rating rules and reimbursement rates for providers. Individuals should be able to enroll in this plan and stay with it permanently, regardless of job, location or other changes in their lives.
- b. We are concerned that a third party administrator model (Option 2) adds a layer of unnecessary complexity and administrative costs, including the costs associated with proper oversight. In the event this option is selected, it ought to be administered by a not-for-profit.
- c. We understand concerns about unfair competition and agree that the playing field ought to be level in regard to uniform regulations and benefit minimums. We agree that it would be unfair for the same entity that makes the rules to administrator the public plan. However, leveling the field too much obviates the very purpose of a public plan. Government can play a beneficial role in

meeting critical social goals by providing a yardstick to industry and to the public. The federal government's unique role as protector of the national interest, and its sheer size, makes it uniquely suited to act effectively and creatively, setting a standard with which others may compete. We believe this is a healthy and productive competition that will enable us to reach genuine health care reform.

- d. We do not believe that we ought to set up individual state run systems which could result in 50 dramatically different public plans. The point of this public option ought to be equity and lifetime portability, people move from state to state and state fiscal circumstances and budget priorities change.
- e. We recommend the public program be modeled on an option such as that recommended for further evaluation by The Colorado Blue Ribbon Commission on Health Care Reform. The Commission examined a state public program option: the Optional Continuous Coverage Portable Plan (OCCPP).
  - o OCCPP would: use the tax system to collect funds to finance the program from enrolled employees and their employers; gather any funds that would otherwise go to people eligible for Medicaid, CHP+ or other current government health programs (except Medicare) and any subsidy dollars for which people would otherwise be eligible to also help finance the program; and would cover people continuously.
  - o Benefits would be comprehensive and, once enrolled, people would have to stay in the program for a minimum of period of time (in Colorado 10 years). The requirement to stay in the program would be designed to minimize gaming and adverse selection and to realize the administrative and health benefits of having people in one plan over a long period. An analysis by the Lewin Group showed this option could be viable in a system where everyone was mandated to have coverage, people received subsidies for premiums on a sliding scale, and coverage was guaranteed issue.

#### **ACCESS AND COVERAGE:**

##### **Public Program Coverage and Integrity**

We strongly support the continuation of Medicaid and the inclusion of adequate protections so that the program remains intact. Medicaid provides necessary protections against cost sharing and has enhanced benefits precisely because it serves low income and other vulnerable populations without access to supplemental resources. We agree that we should raise eligibility standards under the program and make eligibility criteria uniform across all low income populations. Enrolling people in Medicaid through the Exchange would help to ensure that transitions in coverage are as seamless to the individual as possible.

We strongly oppose the option that would require Medicaid eligible children, pregnant women, parents and childless adults to secure private coverage through the Exchange. While we agree that crowd out provisions are important, there are significant implications

for cost sharing and benefits adequacy that we do not believe can be satisfactorily addressed through a system that offers coverage through the private market place. In addition, Medicaid operates at a very low administrative cost. Adoption of a private delivery structure would undercut these administrative savings and unravel the Medicaid program for low income participants. We hope this is not your intention.

**We strongly support the creation of a single set of federal rating rules.**

For too long, the insurance industry has held the public interest hostage by threatening to leave states that restricted their ability to set rates. A single federal standard will provide equity throughout the nation, guaranteeing that everyone who seeks insurance coverage will be able to get and keep coverage regardless of health status. This is an enormous step toward basic fairness in the health care system. We also applaud the use of a risk adjustment mechanism to manage adverse selection and potentially excessive costs to those with pre-existing conditions. Risk adjustment will allow carriers to compete on quality and price, not customer selection.

**Advantages of A Health Insurance Exchange**

A Health Insurance Exchange is a major step forward in increasing transparency for consumers, developing efficiencies through increased standardization, and increasing access to coverage through increased enrollment sites. We believe that the option of multiple, competing exchanges has the potential to undermine the goals of streamlining and simplicity and think this holds little if any benefit to consumers. We think the advantages of an Exchange are so numerous, that we would wish everyone to have its benefits. We are concerned about workers whose plans are grandfathered. Employers who choose not to change coverage may be providing their workers, and their new hires, with coverage inferior to the new federal minimums. We would suggest either establishing a clear timeline for a change-over to new federally regulated plans, or allowing currently covered workers to choose to use their employer subsidy to purchase through the Exchange.

**Due Process and Accountability Must Be Guaranteed**

All health insurance offered through the Exchange must meet state coverage and appeals requirements. All federal laws applicable to federally funded programs must be explicitly applied to any new public plans or coverage options. Regardless of coverage, individuals must have effective methods of redress for denial, reduction, termination, or delay of services and the ability to enforce their rights to high quality, appropriate and timely care administratively and in court to receive high quality and timely care.

**Failure to include ERISA regulated plans**

The options regarding market reforms are resoundingly silent on the issue of the large group market. While this market generally provides superior benefits and affordability, it is still problematic from a portability and system-cost standpoint. Self-funded employers pay high percentages of increasingly large premiums each year, compromising their profitability and global competitiveness. Workers may wish for greater portability than

such plans allow. Consumers and employers both deserve choice in the system. Including large employers provides the benefits of greater pooling and encompassing everyone in the Exchange's goal of providing uniform standards and consumer protections for all. State reform on these issues has been stymied by ERISA; in the name of reducing system fragmentation and increasing equity, we believe the federal government is missing an important opportunity by ignoring the self funded group market. We believe, therefore, that self funded employer groups also should have the choice to access the Exchange

## *AFFORDABILITY*

### **Affordability: Cost Sharing**

A federal minimum standard for benefits that prohibits lifetime or annual limits on covered benefits is an enormous step toward the goal of affordable coverage. However, capping premium costs alone will not ensure that health care is affordable. Caps must include all out-of-pocket costs including premiums, co-pays, deductibles, and uncovered expenses. This is especially important since the coverage options require consumers, depending upon income, to be responsible for between 7% and 24% of "health care expenses," which we assume means expenses above and beyond the cost of premiums. Under this scenario, families face potential economic catastrophe in the event of a major illness. A recent Colorado report, based on findings from household budget workshops, shows that families and individuals earning less than 200%FPL have nothing available to spend on health care. Those families, therefore, should receive full subsidies without cost sharing obligations, or be covered under Medicaid/CHIP. Not until income surpasses 400%FPL are the majority of families able to make substantial contributions to health care costs, including insurance premiums. Even at 400%FPL, however, at least a quarter of budget workshop participants would require assistance to pay for health insurance.<sup>1</sup> Given this data, we suggest the reform package include a full subsidy for those below 200%FPL and a sliding scale subsidy between 200% and 500% FPL. Furthermore, a recent California study found that families paying more than 2.5% of total household income on out-of-pocket expenses faced a significant increase in their chances of medical debt and serious financial pressures.<sup>2</sup> It is absolutely essential that health care reform establish caps on *total* health spending. Health care should be affordable for all, regardless of coverage mechanism, and not only for those receiving subsidies. If the option to allow those nearing retirement to buy-in to Medicare is implemented, costs should also be capped at a percentage of income for this population as well.

- Based upon data, we recommend no premiums or cost sharing for those under 200%FPL, a sliding scale between 200%FPL and 500%FPL, and reasonable caps on total out of pocket spending above 200%FPL.

### **Affordability: Concerns Raised by the Rating Rules Proposal**

We are concerned that age rating will still be allowed, and are especially concerned about the high ratio permitted for this characteristic. Age rating is contrary to the principles of

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<sup>1</sup> Elizabeth Feder, "The Cost of Care: Can Coloradans Afford Health Care," Colorado Center for Law & Policy," April 2009.

<sup>2</sup> Peter Cunningham, Carolyn Miller and Alwyn Cassil, "Living on the Edge: Health Care Expenses Strain Family Budgets," Center for Studying Health System Change, December 2008.

pooling and social insurance. Like health status, age too can easily be risk adjusted so that some carriers don't accept excessive risk if their covered population happens to be older than average. Moving toward guaranteed issue and risk adjustment is a laudable move toward pooling risk, but continued age rating continues the contrary concept of individual risk adjustment. Practically, an overall premium variation of 7.5% could create significant affordability problems for middle-age and pre-Medicaid senior Americans at the very point they need to save in earnest for retirement and potentially finance children's college educations.

- We recommend eliminating age rating in all insurance products.

#### **Affordability: Bankruptcy Protection**

No family or individual in the United States should face bankruptcy as a result of catastrophic medical expenses. In no other industrialized country do people face the prospect of personal bankruptcy as a result of medical debt. Reform should include absolute protections against bankruptcy as a result of medical debt.

#### **Affordability: Calculating Income and The Reality of Family Budgets**

Health care competes with many other essential family needs, so if health care is not to crowd out housing, transportation, child care, educational expenses, and savings from household budgets, it must be genuinely affordable. The impulse to eliminate competing definitions of income for different programs is an excellent one, but the Colorado data suggest that MAGI may not be the best measure of income. Colorado data show that families paying over 5% of total household income make substantially lower contributions to savings and spend less on education. Families are trading off one asset for another, at the expense of their future economic security. It makes no sense from a policy standpoint to ask families to purchase health care only to discover that they are unable to finance a child's education or their own retirement. We recommend therefore that income from which all asset building activities – retirement savings, education savings, student loan payments, business start-up expenses – has been deducted is the appropriate income level to use. Adjusted Gross Income meets this definition more closely than Modified Adjusted Gross Income. Purchasing health insurance must not penalize low-income families for saving or jeopardize their long-term security.<sup>3</sup>

- AGI rather than MAGI should be the standard used to calculate income.

#### **ADEQUACY**

##### **Adequacy: Covered benefits must be sufficient to ensure that individuals and families get the care they need.**

Benefits adequacy is integral to affordability. As we understand the proposed reform structure, the difference between tiers or program levels will be in cost sharing structures, not benefits levels or annual out of pocket maximums. We support such a structure, so long as there is a reasonable and income appropriate annual cap on total out of pocket expenses, including insurance premiums. Inadequate benefits packages, or underinsurance, results in cost shifting, leaves families and individuals, even though

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<sup>3</sup> Elizabeth Feder, "The Cost of Care: Can Coloradans Afford Health Care," Colorado Center for Law & Policy," April 2009.

insured, unable to seek appropriate medical treatment or follow prescribed treatment plans, and results in household debt, sometimes leading to bankruptcy.

**Adequacy: Dental and Vision Should Be Part of the Package**

We support the list of covered services outlined in the Committee’s Report, but note that dental and vision services are absent from the minimum benefit package. Dental services are essential to overall health and can no longer be considered separate from total health given its correlation to other systemic conditions. Vision services are essential to performing to potential at school and at work. The omission of both these services is unacceptable. The addition of a mandatory dental benefit to the SCHIP program came after a highly publicized case made the nation aware that children without access to dental care are at risk of serious physical illness, and even death. Dental health is integral to physical health in both children and adults; children who cannot see cannot learn and adults who cannot see cannot work safely.

- Dental and vision benefits must be included in the benefits package and family spending cap calculation.

**Adequacy: EPSDT should be extended to all children**

We strongly support the addition of EPSDT benefits to SCHIP. Once that is accomplished, however, we then face the problem of benefit inequity between middle and lower income families. Our public programs include increased benefit levels because we recognize that we realize critically important public policy goals by ensuring that lower income children have access to all medically necessary care and services. As we move to comprehensive reform, however, we ought not to create gaps in coverage or a “cliff effect” for families moving up the income ladder. Families that qualify for subsidies but are still at the lower end of the income scale, will have little “left over” after paying their share of a premium to purchase additional necessary health services. For policy and political reasons we believe that all children ought to have the same benefits level- and that level should be the higher, EPSDT standard.

**MINIMIZING GAPS IN COVERAGE AND ACCESS**

**Seamless Transitions:**

We strongly support efforts to address gaps in coverage; as examples the proposed opportunity for people close to retirement age to enroll in Medicare, and the elimination of the two year waiting period for people with disabilities in Medicare. We also strongly support the uniform application of rules and eligibility criteria across all public programs. We must also ensure that the transition between public programs and the private market place is as seamless as possible. This is a significant concern in Colorado, where many people are dropped from or not enrolled in public programs because of problems and delays in enrollment and reenrollment systems.

**Part Time and Seasonal Workers**

Under the proposed option, an eligible worker is one who works at least 30 hours per week. We support a structure that ensures that employers contribute based on the total number of FTE and provides adequate mechanisms for enrollment of part time workers and seasonal workers.

**Immigrants: Mandatory Participation without Mandatory Eligibility**

We are very pleased at the inclusion of a state option to expand the CHIPRA provision to lift the five year bar for eligibility for public programs to all lawfully present low-income immigrants. We assume this same option applies to immigrants who will be income eligible for premium subsidies.

There is a significant issue raised, however, in making this an optional program when participation in a health insurance program will be mandatory with penalties. The only route to coverage available to a low income family will be through public programs. It is inequitable to penalize a family for failure to participate when such participation is barred by the state in which they reside. All lawfully present immigrants ought to have access to public programs and subsidies.

**Language and Disability Access**

We strongly support strengthening language access to programs and services. This is a critical piece of reform; far too many people are denied essential services because of language barriers and the current education and dissemination of information about this issue, as well as the financing structure, and enforcement provisions must be improved in order for reach the goal of ensuring access to care. We believe you ought to reinforce through this document that ADA compliance is imperative, and people with disabilities must have access to programs and services and receive appropriate assistance in doing so.

**Health Disparities**

Health disparities among racial/ethnic minorities and women are well documented in the United States. Equity in access, treatment, and research, and resources for people and communities of color and women are absolutely critical to achieving the American promise of equality as well as achieving significantly better health outcomes for these populations. As Congress moves forward in designing health care reforms, we hope to see a genuine commitment to eliminating these disparities. We call for the design of effective disparity reduction programs that significantly improve the overall health of these populations and that includes substantially increasing minority representation within the health care workforce, in any health reform package.

**Safety Net Must Be Preserved and Strengthened**

**Federally Qualified Health Centers, Public Health Services**

FQHC's and other health clinics provide critical primary care services throughout the state of Colorado. They are an integral part of our safety net, as is our public health system. We hope that reform includes attention to and increased support for the role these clinics and public health departments play, as well as increased flexibility so they may better coordinate services and funding streams in order to support varying needs across geographic regions.

**FINANCING**

**The FMAP Formula Could Be More Responsive to States Changing Circumstances**

We support the addition of factors into the FMAP formula that will permit additional sensitivity to state fiscal circumstances. We submit, however, that the formula may still lack responsiveness because it may not adequately account for changes to a state's poverty level when a state's poverty level remains lower than the national average. Despite being better off relative to the national average, a state that is experiencing increases in poverty may have limited capacity to respond to a corresponding increase in Medicaid caseload without a change to its FMAP formula. For example, Colorado witnessed a 73% increase in child poverty between 2000 and 2006. While Colorado's overall poverty rate remains below the national average, the alarming increase in child poverty is a nuance that would not likely be captured with the proposed formula change. In order for states like Colorado to adequately respond to additional need associated with increasing poverty rates without making cuts to eligibility or benefits, increased sensitivity in the FMAP formula that allows for additional responsiveness is highly desirable.

Additionally, the Proposed Option does not indicate that the statutory minimum would be maintained. We strongly encourage the maintenance of that minimum at the risk of compromising the fiscal health of our state.

***We support an Automatic Countercyclical Stabilizer***

We support the inclusion of an FMAP trigger for periods of economic downturns because it allows for a quicker response to economic downturn than is possible through passage of independent legislation. However, we have a concern that the 23-state threshold may be too high and may compromise the intended responsiveness of the automatic stabilizer. Waiting for 23 states to show ten percent increases in unemployment may delay needlessly FMAP increases to states in critical need.

Thank you for considering our comments. We sincerely thank you for all your hard work on this important issue of bringing quality health care to all.

The Health Advocates Alliance:

Bell Policy Center

Colorado Center for Law & Policy

Colorado Progressive Coalition

Barry Keene, President. KEENE Research & Development

Colorado Coalition for the Medically Underserved (CCMU)

Oral Health Awareness Colorado (OHAC!)

Barbara Yondorf, President. Yondorf & Associates

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