Cutting the Cost of Care:
CHARTING A SUSTAINABLE FUTURE FOR COLORADO
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# LIST OF ACRONYMS

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<th>Acronym</th>
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<tbody>
<tr>
<td>ACA</td>
<td>Patient Protection and Affordable Care Act</td>
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<td>ACC</td>
<td>Accountable Care Collaborative</td>
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<td>CMMI</td>
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<td>Centers for Medicare &amp; Medicaid Services</td>
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<td>Fee-For-Service</td>
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<td>Colorado Department of Health Care Policy and Financing</td>
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<td>HHS</td>
<td>Department of Health and Human Services</td>
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<td>HSCRC</td>
<td>Heath Services Cost Review Commission</td>
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<td>JAMA</td>
<td>Journal of the American Medical Association</td>
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<td>L&amp;E</td>
<td>Lewis &amp; Ellis, Inc.</td>
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<td>MSA</td>
<td>Metropolitan Statistical Area</td>
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<td>OMB</td>
<td>Office of Management and Budget</td>
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<td>ORP</td>
<td>Oregon Reinsurance Program</td>
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<td>RAE</td>
<td>Regional Accountable Entity</td>
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<td>SIM</td>
<td>State Innovation Model</td>
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<td>TABOR</td>
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<td>TRP</td>
<td>Transitional Reinsurance Program</td>
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Executive Summary

As part of our graduate policy workshop at the Woodrow Wilson School of Public and International Affairs at Princeton University, our team reviewed the Colorado health care system to recommend policy options to control costs in the state for the Colorado Governor’s Office, Division of Insurance, and Connect for Health Colorado. This report identifies two pressing challenges facing the Colorado health care system: high premiums in rural and mountain communities and the steady growth of overall systems costs.

After several months of research and a week of site visits around the state of Colorado, we strongly encourage state policymakers to look at these problems as related but distinct issues, each demanding dedicated policy solutions. Using Colorado’s recent Cost Commission as a starting point, our report explains our approach, our methodology, and our process for arriving at our four key policy proposals, two each in each of the two problem areas.

To address high insurance premiums, we encourage Colorado to pursue:

1. a robust reinsurance program using a 1332 waiver
2. geographic factor rating bands

We believe a retrospective claims-based invisible reinsurance program is a possible path forward in Colorado. Geographic factor rating bands would further compress the gaps between premiums paid in urban and non-urban regions in the state. Taken together, these steps could bring material relief to Coloradans paying high premiums.

To address overall system cost growth, we believe Colorado should move forward with:

1. “global budgeting” payment reform
2. a heightened focus on greater transparency in health care prices

Global budgeting is an emerging payment system reform model that holds great promise for reducing long term health care costs while maximizing local autonomy so spending matches local needs and priorities. Global budgeting also has the additional benefit of providing financial stability to rural and urban hospitals alike. A renewed focus on transparency was the single most common recommendation we heard from stakeholders, reflecting wide agreement that greater transparency will lead to greater efficiency. We agree that more transparency will help the state move forward — especially alongside a global budgeting payment reform model — but we caution against seeing it as a panacea. Greater transparency is an important piece, but not the end-all-be-all of health care reform in Colorado.

Our report carefully documents the problems facing Colorado, the various policy options we considered, our evaluation methodology, and how we came to our final recommendations. We provide in-depth explanations of reinsurance, geographic factor rating bands, global budgeting, and greater transparency and explain why we believe they are the best path forward.
Cutting the Cost of Care

FULL REPORT
Introduction

This report was prepared by 12 graduate students at Princeton University’s Woodrow Wilson School of Public and International Affairs as their capstone project for the Master in Public Affairs program. Our state clients in Colorado — the Governor’s Office, Connect for Health Colorado, and the Colorado Division of Insurance — requested our assistance to prioritize the recommendations from the Colorado Commission on Affordable Health Care (also known as the Cost Commission) and to use those proposals to craft a broader state-level plan to reduce health care spending. We combed through the Cost Commission’s recommendations, carefully studied the national health care context, and met with stakeholders across sectors and with diverse perspectives to better understand Colorado’s unique situation.

Based on our work, we believe the Centennial State faces two key health care spending challenges. The first problem is the “house on fire” emergency of high and rising premiums in the rural and mountainous parts of the state. The second problem is the “boiling water” challenge of steadily rising health care system spending throughout Colorado. While the Cost Commission identified both levels of problems, many of the stakeholders we spoke to felt that its recommendations focused on systemic costs were not receiving adequate attention. We hope that by prioritizing and expanding the purview of those recommendations, we can help Colorado’s health policy conversation move forward.

Consequently, this report focuses on state-level solutions to Colorado’s challenges. We are acutely aware of the dynamic policy environment at the federal level and the need for further national health care reform. Those challenges however, are beyond the scope of this report. Rather, our proposals focus on policy changes Colorado can make with limited reliance on Washington.

One of our top priorities was to examine how the policy recommendations would affect Colorado as a whole, rather than performing a more segmented analysis. We hope this report will advance the health care policy dialogue in Colorado, and we believe our approach is underpinned by several unique strengths. First and foremost, because our research was fully funded by Princeton University’s Woodrow Wilson School, we were able to approach our research question as neutral, independent outsiders. Further, our group represents a range of political backgrounds and our members have worked with respected health care providers, policymakers, and technical assistance groups around the country. Finally, our research approach benefited from the guidance of two national health care policy experts, Heather Howard and Daniel Meuse. They helped connect us to the state’s most important health care stakeholders and drew on their decades of experience to provide invaluable subject matter expertise. We are confident in our research, our process, and our policy recommendations.

We hope this report may be used as a starting point for the state’s political leaders and policymakers to begin a new conversation about swiftly addressing the twin health care challenges facing Colorado: an ongoing crisis of runaway localized premiums and the long-term threat of uncontrolled spending growth.
Problem Statement

The cost of health care in Colorado is high. Health insurance premiums are unaffordable for large numbers of Coloradans who purchase their plans on the individual or small group markets. Results from the 2017 Colorado Health Access Survey (CHAS) show that 78.4 percent of the uninsured in Colorado report the high cost of health insurance as the reason for not having coverage. In fact, 10.1 percent of Coloradans did not receive needed care from a doctor because it was too expensive. High underlying costs of health care services, in addition to structural and geographic challenges specific to the state, drive the high premiums.

BACKGROUND

At first glance, Colorado’s health insurance premiums seem affordable when compared to the rest of the country. On the individual market in 2013, Colorado fell below the national average for premiums. However, this comparison masks the broad differences in premium costs across the state. In 2015, four counties in the mountainous Western Slope region of the state had the highest premiums in the country, sparking outrage from locals. Variation in premium costs across Colorado further angers those in high-cost areas of the state. Premiums in the metro corridor increased less than 20 percent between 2016 and 2017, half that of the increases in the southern and eastern plains. Figures 1 and 2 further illustrate this geographic variation. Figure 1 shows the average monthly premium for plans offered on Connect for Health Colorado (C4) in 2018. Rating areas 9 and 5 along the Western Slopes have the highest average premiums across the state at more than $700.00 per month before subsidies.

FIG. 1: 2018 Average Individual Premium Costs (by rating area)

Data from Colorado DOI

2 Kaiser Family Foundation. Average monthly premiums per person in the individual market, 2013. Retrieved from https://www.kff.org/other/state-indicator/individual-premiums/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Average%20Monthly%22,%22sort%22:%22desc%22%7D
Figure 2 shows these same 2018 premiums as a share of each county’s median household income. In seven rural counties (Dolores, San Juan, Alamosa, Costilla, Huerfano, Crowley, and Otero), premiums can account for more than 25 percent of annual household income. These figures together underscore the unaffordability of health insurance premiums in the more rural and mountainous areas of the state.

Colorado has seen success in achieving and sustaining high levels of health insurance coverage. As is noted in the 2017 CHAS, the state’s insurance rate of 93.5 percent, maintains the gains first seen in 2015 that came from the state’s embrace of the Affordable Care Act (ACA). However, the high cost of obtaining health insurance coverage is the main reason many Coloradans still do not have insurance. Among those who do have coverage, almost 20 percent report that they go without care because the cost of health care services is too high. Further, those purchasing coverage through the marketplace are twice as likely to go without care as those with employer-based coverage. The uninsured rate has dropped by half since 2014, but the specter of high and increasing premiums and health care services costs, and the recent individual mandate repeal, threaten further progress.

Alongside Colorado’s rising health care costs, results from the 2017 CHAS indicate that Coloradans see a need for improvements in the health care system. Figure 3 shows the percentage of respondents who are unsatisfied with the current health care system’s ability to meet the needs of their family by health statistic region. Communities in the northwest (e.g. Summit, Moffat, etc.) and the San Luis Valley (e.g. Rio Grande, Saguache, etc.) report the most negative assessment of how Colorado’s health system helps their families. When the question is expanded to consider the needs of most Coloradans, more respondents report being dissatisfied (Figure 4).

**FIG 2: 2018 Annual Premiums as Share of Median Household Income (by county)**

In several northwest communities, 2 out of every 5 respondents strongly disagree that the health system meets the needs of most Coloradans.

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5 Colorado Health Institute. (September 2017).
6 Ibid.
7 Ibid.
8 See 2017 CHAS Regional Data. Retrieved from https://www.coloradohealthinstitute.org/data. Possible categories include: Strongly agree, somewhat agree, somewhat disagree, strongly disagree (with all categories summing up to 100 percent for each health statistics region). Colorado has 21 health statistics regions, which are aggregations of counties classified by the Colorado Department of Public Health and Environment. Retrieved from http://www.chd.dphe.state.co.us/HealthDisparitiesProfiles/dispHealthProfiles.aspx.
9 For this assessment, we look at the percentage ranges, noting that the latter figure (23.26-41.73%) have a higher percentage of respondents reporting "strongly disagree" than the earlier figure (11-26.16%).

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FIG. 3: Percent who Strongly Disagree that the Current Health System is Meeting the Needs of Their Family

Source: CHAS 2017

FIG. 4: Percent who Strongly Disagree that the Current Health System is Meeting the Needs of Most Coloradans

Source: CHAS 2017
In several northwest communities, two out of every five respondents strongly disagree that the health system meets the needs of most Coloradans. This analysis suggests Coloradans are deeply and personally affected by the geographic variations in health care costs and substantiates calls to improve the state's health care system.

To date the Colorado Legislature has convened two commissions to investigate growing health care costs and identify policy recommendations to curb growth. The first was the Colorado Blue Ribbon Commission for Health Care Reform (also known as the “208” Commission after the authorizing legislation) in 2006. The 208 Commission consisted of 27 commissioners appointed in a bipartisan manner, representing a diverse array of health care stakeholders and political ideologies. The 208 Commission proposed 32 recommendations, many of which were then implemented either through state legislation or federal action under the ACA. Following continued problems with health costs, in 2014 the state created the Colorado Commission on Affordable Health Care (Cost Commission). The Cost Commission was similarly structured to the 208 Commission, with 12 voting members representing a broad spectrum of health care interests and perspectives. The Cost Commission identified key drivers of health care costs in Colorado, which formed the basis of the Cost Commission’s final 43 recommendations.

FEATURES OF COLORADO’S HEALTH CARE SYSTEM

To motivate the recommendations in the remainder of this report, this section discusses relevant features of Colorado’s health care system. Building on the foundational work on drivers of health care costs in the 208 Commission and Cost Commission reports, this section will focus on specific features of the state’s health care landscape most salient to the conversation on costs. These include brief discussions on geographic cost variations, Colorado’s current payment delivery systems, geographic rating areas, and Colorado’s all-payer claims database.

RURAL VS. URBAN HEALTH CARE COSTS

The reasons for large geographic cost variation in Colorado are multifaceted and complex, and addressing these issues requires a variety of approaches. Specifically, the Cost Commission focused on the more rural, mountainous West region (DOI’s Rating Area 9) and found the following trends:

- **Large variation** in both unit price (e.g. dollars charged for a procedure) and utilization rates (e.g. how often a procedure is performed) within the West region, suggesting heterogeneity in cost drivers across mountain communities.
- **High utilization** of imaging, advanced imaging, and lab/pathology for most medical diagnoses, beyond those associated with physical injuries (which may be expected due to the popularity of skiing, mountain biking, and other strenuous physical activities in the West region).
- **Lack of carrier competition**, which, if addressed alone, may still not significantly decrease insurance premiums across the region. For instance, there was no consistent relationship between the number of carriers in a region and unit prices for a variety of outpatient services examined.

Generally, the Cost Commission identified the demographic and health status mix of residents, different patterns of practice among providers, and complex market interactions as the main contributors to higher health care costs in the region. The Cost Commission also stressed the need for more data (e.g. clinical data, more reliable...
data on individual providers and provider referrals) and research into the drivers of geographic cost variation to inform an effective response.

**PAYMENT DELIVERY SYSTEMS**

Another cost-driver is the way providers are paid for the services they supply. Providers paid under a fee-for-service model (FFS) are incentivized to oversupply health services, thus driving up both the total cost of care and, in turn, health insurance premiums. Payment delivery system reform controls the overall cost of care by reducing wasteful volume and incentivizing preventative services. Early efforts to control costs through payment delivery system reform have been focused on Medicaid beneficiaries, but more recent state-wide programs cover both publicly and privately insured Coloradans. Two of Colorado’s experiments with payment delivery system reform are the Regional Accountable Entities (RAEs) and the State Innovation Model (SIM).

**Regional Accountable Entities (RAEs)**

Colorado developed the Accountable Care Collaborative (ACC) to incentivize providers to reduce the cost of care for Medicaid beneficiaries through coordination and communication. RAEs, which are part of Phase Two of the ACC and will be rolled out in 2018, build on the infrastructure of the ACC and address acute, primary, and specialty care; pharmacy; and behavioral health services. RAEs improve care coordination by integrating services on a regional basis. Participating providers are rewarded financially for reducing total health spending while maintaining quality care, but are at risk of losing money if they do not provide care efficiently. One state evaluation found that the ACC effectively reduced cost of care for beneficiaries without sacrificing quality.

**State Innovation Model (SIM)**

In 2016, Colorado launched SIM, a program to improve access to behavioral health care services, integrate physical and behavioral health care services, and reform payment delivery to reduce the cost of care by controlling chronic conditions. SIM built on the Comprehensive Primary Care Initiative, a Centers for Medicare & Medicaid Services (CMS)-funded program that strengthened primary care practices to better coordinate care for patients. The program has not yet been evaluated, but SIM is working toward shifting from fee-for-service to prospective payment models, an effort that will limit service overuse and potentially bring down costs.

**INDIVIDUAL HEALTH INSURANCE MARKET IN COLORADO**

At the time of the writing of this report, the 2017-2018 Open Enrollment Period in Colorado is on-going. Over the 2016-2017 Open Enrollment Period in Colorado, more than 178,000 Coloradans chose health insurance coverage through the C4 marketplace, the highest number seen to that point. One hundred thirty-two medical plans were offered to individuals and families from the seven health insurance companies offering coverage on the exchange. Only one insurance carrier offered plans in all counties through the exchange. Eleven carriers offered 145

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In 2017, only 8.1 percent of Coloradans received coverage through the individual market, compared to 49.4 percent who received employer-sponsored insurance, 14.4 percent who received Medicare coverage, 19.9 percent who received Medicaid coverage, and 6.5 percent who were uninsured. It is worth noting the outsized attention the individual market receives in discussions of coverage and costs when it is a relatively small segment of the broader health insurance market.

For those who are not eligible for a health insurance subsidy through the exchange and who switch to the plan with the lowest premium cost, the average premium cost per member per month is $460 in 2018. For an individual who is eligible for a subsidy through the exchange and switches to the plan with the lowest premium cost, the average premium cost per member per month is $76 in 2018.

**GEOGRAPHIC RATING AREAS**

Colorado currently has nine geographic insurance rating areas, a breakdown that is in line with other states of comparable size. The rating areas largely account for geographic differences in unit cost and utilization patterns, and they facilitate competitive health insurance premiums. In 2016, DOI commissioned a study to analyze a policy proposal to establish a single geographic rating area aimed at making health insurance premiums more affordable, especially in mountain and rural communities. The study concluded that a single rating area could be detrimental to the state’s health care market, as carriers would leave the state, premiums would increase for low-cost regions, and there would be less generous plan benefits. DOI instead emphasized reining in underlying health care costs as a more effective means of lowering premium rates.

**ALL-PAYER CLAIMS DATABASE**

In 2010, a recommendation from the 208 Commission launched Colorado’s all-payer claims database (APCD), which is run by the non-profit Center for Improving Value in Health Care (CIVHC). The APCD plays an instrumental role in devising effective cost containment and quality improvement efforts through health data collection and analytics. As of March 2016, CIVHC collected health insurance claims from Medicare, Medicare Advantage, Medicaid, and 33 of the state’s largest insurance carriers. The Colorado APCD contains more than 65 percent of the state’s insured population, representing more than 3.5 million covered lives.

**POLITICAL CONSIDERATIONS**

In addition to the unique attributes of its health care system, several features of Colorado’s political landscape will impact the state’s ability to bring down health care costs both in the short and long term. Below is a discussion of some of these features.

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18 Colorado Division of Insurance. Medical plan counts for plan year 2017. Retrieved from https://drive.google.com/open?id=0BwguXutc4vbpRHkhsmMDtHx5ZEE.
19 Colorado Health Institute. (September 2017).
22 Ibid. p. 15
23 Salazar, M. (August 1, 2016). Correspondence from Marguerite Salazar to the Colorado State Legislature. Retrieved from https://drive.google.com/open?id=0BwguXutc4vbpQy02dGF2cnBmVjg.
**TAXPAYER BILL OF RIGHTS**

Colorado is the only state with a Taxpayer Bill of Rights (TABOR) constitutional amendment, which restricts increases in taxes and spending at the state and local level. Any new tax or tax increase must be approved by voters through a ballot referendum. Additionally, government spending may not grow beyond the rate of inflation plus state population growth. Voters rarely approve taxes or spending that exceed the limits imposed under TABOR, which severely restricts Colorado’s options for increasing funding or creating new programs. However, government activities performed by government-owned “enterprises” are exempt from TABOR limits, subject to constitutional and legal restrictions on these entities.

**REGULATORY CULTURE**

Any recommendations to change Colorado’s health care system should also consider the state’s unique regulatory culture. In a 2016 case study on Colorado’s health care system, the Urban Institute concluded that “[t]here is a strong bias in Colorado against regulation and public spending. To overcome this bias, stakeholders must clear the path for public action.” In other words, future health care policy changes will likely be catalyzed through collective action, consensus building, and legislative vehicles rather than regulatory authority.

**POLITICAL ENVIRONMENT**

Colorado’s state politics pose a challenge to previously proposed legislation to reform the health system, bring down the systemic cost of care, and address high premiums. The state legislature is split between Republican control in the Senate and Democratic control in the House. Although the state has voted for a Democrat in the last three presidential elections, Coloradans on both sides of the political spectrum have become more entrenched in their views. According to one measure, Colorado’s state legislature is the most polarized in the country. These political trends follow demographic shifts in the state over the past 10 years. Colorado has seen a population boom in the metro Denver area, increasing the overall number of registered Democrats in the state. At the same time, the rest of the state has stayed Republican. According to one study, the polarization in the state legislature has been driven by the increased conservatism of Republicans in the state senate.

Politics surrounding the 2018 gubernatorial election will complicate any major legislative efforts this year. High-profile issues like health care will attract more intense scrutiny, making any near-term legislative fixes unlikely. High health care premiums and service costs may not be unique to Colorado, but the political and geographic challenges, as well as the tools to combat rising costs, are specific to the state. Any effective strategy to lower costs and improve Colorado’s health care system must be sensitive to the circumstances in the rural and mountainous areas of the state, as well as the statewide political context.

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costs and improve Colorado’s health care system must be sensitive to the circumstances in the rural and mountainous areas of the state, as well as the statewide political context. At the same time, Colorado is well positioned to leverage existing components of the health care system to promote measures to curb costs. These measures include: exploring modifications to the geographical rating areas, taking advantage of federal opportunities for state innovation, using data from the APCD to better inform decision-making, and pushing forward payment system reforms. The remainder of this report discusses the methodology used to answer our research question, lays out our four health policy recommendations, and concludes with final thoughts for moving forward.
Methodology

Our goal is to recommend policy options that the state of Colorado — specifically the Governor’s Office, Division of Insurance (DOI) and Connect for Health Colorado (C4) — can use to address the rising costs of health care. The framework we used to identify the most effective and feasible cost-reducing recommendations incorporates both short-term and long-term strategies. Short-term recommendations address the urgent problem of high insurance premiums in Colorado, which are acutely felt by mountain and rural communities. Long-term policy options focus on lowering the underlying cost drivers of Colorado's health care system.

This section details how we evaluated and prioritized policy recommendations for reducing health care costs. We discuss the process we undertook for learning about Colorado’s health care landscape. We define the six criteria we used for assessing the impact and feasibility of each policy recommendation. Finally, we briefly discuss how we prioritized recommendations using these six criteria.

PROCESS

To research the question of health care affordability in Colorado, we followed a five-step process to gather, analyze, process, and synthesize information.

First, we conducted qualitative field interviews with stakeholders in Colorado over a one-week period. We met with this report’s direct clients as well as consumer advocates, health care provider groups, data analysts, representatives of the Cost Commission, Medicaid administrators, brokers, health care navigators, and local officials. In this fieldwork, we interacted with individuals residing and/or working in the Denver metropolitan area, Summit County, and Larimer County.

Second, we developed an extensive list of potential policy solutions for the state of Colorado by reviewing the recommendations of Colorado’s Cost Commission report and by developing additional potential policy recommendations on the basis of stakeholder interviews and of current proposals under discussion or implementation in other jurisdictions.

Third, we divided this set of policy options into two distinct categories of policies: (1) short-term policies that address the problem of high insurance premiums and (2) long-term policies that address the problem of rising health care system costs. Lowering Colorado’s health care system costs will have a significant impact on the premium costs for consumers in the long-term, while a complementary set of policies is necessary to slow or reduce the growth of premium costs in the short to mid-term.

Fourth, we assessed the impact and feasibility of these policy options based on six qualitative criteria. We evaluated the likely degree of impact each policy option would have on (1) system costs, (2) coverage/access, and (3) quality. We then evaluated the feasibility of each option given potential (4) political, (5) financial, and (6) administrative constraints. These criteria were informed by a literature review to gather relevant background on the state’s current challenges as well as information on the costs, challenges, and impact of relevant innovative policies from other states and localities.

Fifth, we completed a thorough analysis of implementation considerations for the policies we prioritized in our criteria framework. To inform this analysis, we conducted interviews with government officials from other states that have implemented our priority policies.
ASSESSMENT CRITERIA

We used six criteria to assess the merits of each cost-saving policy proposal. Given the breadth and complexity of policy proposals in the health care field, this matrix provides a consistent framework with which to examine and compare different policy proposals. We used a qualitative assessment strategy to rate each policy option along each criterion and to compare ratings between policies. Rather than provide a single score for comparing policies, these criteria provide a framework for us to make an informed and consistent assessment of the strengths and weaknesses of the policy proposals.

Impact Criteria
To assess impact, we evaluated the likely effectiveness of a given policy at lowering health care costs without negatively impacting coverage, access, or quality.

Potential Impact on Cost
This criterion measures the expected magnitude of each policy’s effect on health insurance premiums and/or underlying health care costs.

The key questions we asked for this criterion were:

▶ How much will the policy lower costs?
▶ What kinds of costs will it lower?
▶ Who will benefit from these changes?
▶ What evidence do we have to make this judgment?
▶ What kind of certainty do we have in making this assessment?

In our assessments, we applied this metric to the policy as it pertains to the relevant context. For example, as we assessed a reinsurance program, we were assessing that program’s effect on premiums, not on overall system costs. Depending upon the policy under consideration, the contexts we used considered the health care industry overall, specific sectors within health care, or a particular geographic area.

Potential Impact on Coverage and/or Access
Because we also aim to maintain coverage rates and quality levels, we rated each policy option on its potential to impact coverage or access to health care. For policies aimed at reducing premiums, this criterion measures the expected change in the number of people with health insurance as a result of the policy. For policies geared towards lowering long-term health care costs, this criterion measures the expected change in patient access to health services.

To evaluate effects on coverage/access, we asked:

▶ How much will the policy change coverage/access?
▶ Who will benefit and will anyone be worse off?
▶ What evidence do we have to make this judgment?
▶ What kind of certainty do we have in making this assessment?

Potential Impact on Quality
We also rated each policy option on its potential impact on quality of care. According to the Institute of Medicine and the Department of Health and Human Services, quality of care can be defined as “the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are

To assess changes to quality, we asked:

- Would the recommendation have an effect on quality of care, and if so, for whom?
- Who will benefit, and will anyone be worse off?
- What evidence do we have to make this judgment?
- What kind of certainty do we have in making this assessment?

\textbf{Feasibility Criteria}

Significant barriers exist to successfully executing even the most effective policies and achieving the desired goals. We separate these feasibility challenges into three distinct criteria: political feasibility, financial feasibility, and implementation feasibility.

\textit{Political Feasibility}

Using stakeholder analysis, we examined the relative difficulties of garnering sufficient support from decision-makers in Colorado. This analysis goes beyond merely looking at the officeholders but also at interest groups, health care consumers, providers, and the public at large.

For this criterion we asked:

- Who would support or oppose the policy?
- What is the basis for their position on the policy?
- What leverage do they have in the policy-making process?

\textit{Financial Feasibility}

This criterion assesses whether funding issues could prevent successful policy implementation. We focus especially on whether the program would be subject to TABOR and any additional restrictions that may come with any federal funding.

For this evaluation we asked:

- How much funding would be needed and where would it come from?
- Would the policy be subject to TABOR limitations and/or federal approval?

\textit{Post-Passage Implementation Feasibility}

This criterion assesses the likelihood of executing the policy successfully. For this criterion, we asked:

- Is the policy straightforward or complex to implement?
- Does the state of Colorado have the administrative capacity to enact the policy?
- Are there significant legal and constitutional barriers to execution?
- Do we expect coordinating among key stakeholders to pose challenges to implementation?
**Prioritizing Criteria**

To find the most promising policies from among our list of options, we considered the pros and cons to each option and prioritized these factors as follows: we placed the most weight on a policy's ability to impact cost. We then further narrowed down the policy options by considering the political, financial, and implementation feasibility of each policy, in that order. We only used the ratings for coverage and quality in our prioritization if the policy would positively impact coverage and quality of care, and we disqualified policies that would clearly reduce coverage or quality.
Recommendations

Using the methodology described in the past section, we rated a subset of the most salient recommendations from the Cost Commission Report and our conversations with stakeholders. Table 1 illustrates, at a high level, how these 13 policy options rated on the six criteria chosen.

Four policy options showed the most promise to reduce health care costs without imposing too much political, financial, or implementation burden on policymakers. A reinsurance program and geographic factor rating bands address the immediate issue of high premiums, while payment reform through global budgeting and greater health system transparency target long-term systemic costs. In the following sections, we first describe the elements of each policy recommendation and why it is particularly relevant for Colorado. Where possible, we then share relevant experiences from other states. Next, we discuss the political and implementation challenges that Colorado could face by pursuing each option. Finally, we include immediate next steps for policymakers.

POLICIES TO ADDRESS HIGH PREMIUMS

REINSURANCE

Reinsurance helps stabilize the individual market by shielding carriers from financial risk. While commercial reinsurance has long been available to protect companies against catastrophic expenses, the ACA’s transitional reinsurance program (TRP) that began in 2014 guaranteed reimbursements to carriers for the actual expenses they spent on patients above a certain amount, or “attachment point.”\(^3^4\) Once a patient’s cost of care crossed this threshold, the reinsurance plan would pay the carrier back at an agreed upon coinsurance rate. This reimbursement continued until the person’s health care costs reached the reinsurance cap, at which point the insurer once again bore responsibility for the full amount of medical expenses. For example, in 2015 the TRP reimbursed carriers at a proposed rate of 50 percent for per capita expenses within a reinsurance corridor of $45,000 and $250,000.\(^3^5\) Though funded by an annual fee on nearly all individual, small group, and large group plans, the TRP only provided support for individual plans offered on the exchange.

By protecting insurers from the risk of high medical costs, the program incentivized companies to participate in more markets, increasing competition and driving down premiums. The TRP also helped lower premiums because carriers no longer needed to pass along higher costs of care to consumers. While the program sunsetted in 2016, it now serves as a model for the state-based reinsurance programs created through 1332 waivers. New state-run reinsurance programs have the potential to curb the large growth of premiums in the individual market and keep health insurance affordable and accessible to all.

Pros & Cons

Reinsurance is an appealing model for many reasons, especially for a state like Colorado, where both premiums and cost of care are increasing across regions. First, a reinsurance program would directly affect the price of premiums in both the short and medium-term as described above. The American Academy of Actuaries estimated that the first year of TRP reduced premiums by 10 percent of what they would have been without


the program. Lower premiums in turn entice some healthier people into the market who may have previously deemed health insurance too expensive. This influx of healthier patients into the risk pool will then lead to even lower premiums. Table 2 shows how a reinsurance program could serve as a targeted fix for exchange customers in high-premium areas who are ineligible for Advance Premium Tax Credits (APTC).

In addition to the positive effects reinsurance could have for non-subsidized households, it may also have a positive impact in some of Colorado’s single-carrier counties. Providers and insurers alike have attributed the state’s regional disparities in premium costs on different utilization patterns and high-cost procedures. However, by lowering the financial risk to carriers for higher-cost procedures and higher utilization patterns, more insurers may be incentivized to enter current one-carrier counties. Furthermore, because attracting new carriers to areas previously dominated by one insurer would increase competition in these regions, premiums may be reduced further as carriers work to attract and retain customers.

Reinsurance subsidizes insurers on the individual market based on actual costs, rather than on expected costs like in a high-risk pool. This makes it an especially appealing approach for insurers, which ultimately makes the policy more politically feasible. Compared to high-risk pools, the retrospective payment model appears fairer to

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**TABLE 1: Recommendations Matrix**  

<table>
<thead>
<tr>
<th>POLICY OPTIONS</th>
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<th>FEASIBILITY</th>
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<tbody>
<tr>
<td>PROBLEM 1: HIGH PREMIUMS</td>
<td></td>
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<tr>
<td>Reinsurance/1332 Waiver</td>
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</tr>
<tr>
<td>Geographic Factor Rating Band</td>
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<td>Website Enrollment Process Changes</td>
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<tr>
<td>Standardized Plan Benefit Designs</td>
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<tr>
<td>Single Rating Area</td>
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</tr>
<tr>
<td>Medicaid Buy-In</td>
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<td>POSITIVE</td>
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<tr>
<td>PROBLEM 2: HIGH UNDERLYING COSTS OF CARE</td>
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<tr>
<td>Global Budgeting (Payment Reform)</td>
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<tr>
<td>Transparency</td>
<td>MEDIUM</td>
<td>NEUTRAL</td>
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<tr>
<td>Medical-Loss-Ratio for Hospitals</td>
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<td>NEUTRAL</td>
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<tr>
<td>Free-Standing Emergency Departments</td>
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</tr>
<tr>
<td>Braided/Blended Funding</td>
<td>LOW</td>
<td>NEUTRAL</td>
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</tbody>
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36 See Appendix A and Appendix B for the definitions behind each classification and a more detailed explanation of our findings, respectively.

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**TABLE 1: Recommendations Matrix**
insurers, since it means they get compensated when "low-risk" patients experience unexpectedly high health care costs. There is also evidence that reinsurance programs may be more efficient than invisible risk pools. Though these systems would have a similar effect on premium prices, they come with higher annual costs and a greater administrative burden.39

For these reasons, state-run reinsurance programs are gaining attention and momentum as a potential response to recent premium hikes, which averaged 25 percent across the country in 2017.40 However, there are still limitations to what this method can accomplish. Most importantly, while reinsurance would change who bears the risk for expensive patients, reinsurance alone is not designed to address the underlying costs of Colorado’s health care system.41 Therefore, reinsurance ought to be thought of as a temporary fix to address high premium costs that can free up resources for serious discussion of more long-term solutions or perhaps even be designed to incorporate cost control measures.

Secondly, while state-run reinsurance programs should easily satisfy the ACA’s four 1332 waiver guardrails,42 uncertainty at the federal level may make pursuing a waiver more difficult. As seen in CMS’s response to several states’ 1332 requests, most notably Minnesota’s,43 the federal government’s unpredictable timeline and interpretation of the law can introduce additional difficulty into the process. This may make passing, proposing, and implementing a reinsurance program in Colorado more difficult.

Finally, though reinsurance mitigates carrier risk within a defined corridor, it will not affect costs beyond the reinsurance cap. If there are regions with a large number of patients requiring medical services beyond the set annual cap, reinsurance likely wouldn’t reduce premiums or increase coverage. Though Colorado’s comparatively healthy population44 mitigates some of this risk, policymakers should pay special attention when setting reinsurance caps and rates to maximize the plan’s effectiveness.

### Case Study

Facing significant premium increases, carriers leaving the state or reducing their coverage areas, and plans with increasingly narrower networks, Oregon passed authorizing legislation to develop the Oregon Reinsurance Program (ORP) on July 5, 2017 with bipartisan support. The program was

<table>
<thead>
<tr>
<th>CURRENT HOUSEHOLD APTC</th>
<th>PRE-REINSURANCE</th>
<th>POST-REINSURANCE</th>
<th>CONSUMER SAVINGS</th>
<th>FEDERAL PASS-THROUGH</th>
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<td>Premium Subsidy</td>
<td>Net Premium</td>
<td>Premium Subsidy</td>
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<td>$450</td>
</tr>
<tr>
<td>None</td>
<td>$500</td>
<td>$0</td>
<td>$500</td>
<td>$450</td>
</tr>
</tbody>
</table>

Source: Milliman

Table 2: Impact of Reinsurance on Consumers

Reinsurance ought to be thought of as a temporary fix to address high premium costs that can free up resources for serious discussion of more long-term solutions.

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42 Ibid.


“intended to further stabilize the individual market, reduce rates, and to encourage insurance companies to offer plans in more parts of the state.”

Administered by the Oregon Department of Consumer and Business Services (DCBS), the ORP is funded through both a 1.5 percent premium assessment on fully insured commercial medical premiums (including self-insured public plans), and existing excess funds from two state programs. For 2018, Oregon estimates that state funding sources will provide an estimated $90 million, along with approximately $30 million in federal pass-through funds.

The ORP is a traditional reinsurance program and will reimburse 50 percent of claims between a yet-to-be-determined attachment point and a $1 million reinsurance cap. After an expeditious review period of just 40 days, Oregon’s waiver received CMS approval in October 2017, and the program went into effect on January 1, 2018. It is responsible for reducing individual market premium rates by 6 percent, while adding a 1.5 percent increase to small group premiums for the 2018 plan year.

What Colorado’s Reinsurance Program Would Look Like

Under SB17-300, DOI was tasked with studying interventions that provide coverage for high-risk individuals and lower health insurance premiums. One intervention they explored was a state-based reinsurance program. Through a series of stakeholder meetings with carriers, providers, and advocacy groups, DOI found general consensus on the following:

- **Program Goals:** Any program should be designed to significantly reduce premiums, given available funds. Although Colorado needs to respond to rising premiums, any reinsurance program should also consider strategies to contain the rising health care costs underlying high premium rates.

- **Program Structure:** A retrospective claims-based invisible reinsurance program, similar to Minnesota’s, garnered the most stakeholder support. The reinsurance program would need to 1) allow enrollees to stay in the individual market, 2) leverage the existing infrastructure from the federal TRP, and 3) not rely on condition-based reinsurance.

- **Use of Federal Funds:** Any reinsurance program should leverage federal funds, including federal risk adjustment dollars.

- **Guiding Principles for State Funding:** Stakeholders generally agreed that the ultimate funding mechanism for reinsurance should be insulated from future budgetary fluctuations and consider TABOR implications. They also agreed on broad-based health care market assessments and on utilizing funds outside of the health care system.

Stakeholders also agreed that actuarial analysis would be instrumental in designing the reinsurance program, especially in setting reinsurance parameters based on the available funding, impact on premiums, and program costs. An actuarial analysis from Milliman asserted that a state-based reinsurance program would both lower premiums for enrollees not receiving federal financial assistance and strengthen the individual market risk pool by attracting new enrollees who were previously uninsured. The Milliman study also claimed that a robust

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reinsurance program would achieve these benefits without harming households that already receive subsidies.\textsuperscript{49}

Under one scenario, Milliman projected that a $346 million reinsurance fund, consisting of $168 million in federal pass-through funding and $178 million in state funding, would reduce average premiums by 21 percent. These changes were also associated with a projected increased enrollment of 17,000 people. However, Milliman also noted that because Colorado has fewer (APTC) dollars relative to other states of comparable ACA market size, Colorado may also receive less in federal pass-through funds.\textsuperscript{50}

**Feasibility**

As noted in Table 1, we assessed a reinsurance policy as having high political feasibility but medium financial and implementation feasibility. Evidenced by Milliman’s research and results from other state-based reinsurance programs, reinsurance could effectively lower health insurance premiums in Colorado. However, Colorado faces several challenges in determining the state funding mechanism, identifying an overseeing entity, building interagency support, and navigating a dynamic state and federal policy landscape.

Although stakeholders reached consensus on many aspects of a Colorado reinsurance program, the state-funding mechanism and the supervising entity for the program have yet to be finalized. In the final SB17-300 study, DOI analyzed several potential funding sources for the Legislature’s consideration, ranging from a health insurance assessment to a premium tax to a state individual mandate penalty.\textsuperscript{51} Another item for discussion is whether a new quasi-governmental entity or an existing entity should administer and supervise the reinsurance program. Several stakeholders we spoke to identified the lack of consensus on a state-funding mechanism as the largest impediment to Colorado’s reinsurance program, especially in light of TABOR, with the supervising entity as a lesser concern.

Stakeholders we interviewed were also concerned about coordination and buy-in across the various state health care-related entities (i.e. DOI, C4, and HCPF), as well as potential legislative and federal hurdles. Acquiring federal approval for the 1332 waiver may be particularly challenging. Colorado has to meet the standard waiver requirements (e.g. meeting the CMS and Office of Budget and Management (OMB) standards for budget neutrality) while navigating the complex and unpredictable dynamics within CMS. Notably, both Iowa and Oklahoma withdrew their 1332 waiver requests, citing frustration with CMS’s overly restrictive requirements and protracted review period, respectively.\textsuperscript{52} However, potentially in response to criticism that CMS was slow to approve Oklahoma’s reinsurance waiver, CMS expeditiously approved Oregon’s waiver shortly after Oklahoma withdrew their application.\textsuperscript{53}

Factors that bolster the feasibility of this recommendation include momentum both within Colorado and nationwide for state-based reinsurance programs. In Colorado, SB17-300, which directed DOI to study reinsurance options, passed with bipartisan support, indicating an aligned interest in reinsurance across political parties. However, we acknowledge that such support may be difficult to maintain once the details of Colorado’s 1332 waiver are released. Thus, policymakers must create and maintain a broad consensus on the purpose and details of a reinsurance program, especially around the state funding mechanism. Colorado can also strengthen its program by learning from other state reinsurance models, especially those in Minnesota and Oregon. In


\textsuperscript{50} Ibid. p. 15

\textsuperscript{51} DOI. (October 2, 2017). p. 20


addition, the state should monitor the progress of legislation from Senators Susan Collins (R-ME) and Bill Nelson (D-FL) to provide federal reinsurance funding, given the bill’s potential to overcome state funding barriers.\textsuperscript{54}

\textbf{Next Steps}

Following the Milliman actuarial study, if legislators pursue state-based reinsurance, the Legislature would first have to pass legislation authorizing the Commissioner of Insurance to apply for a federal 1332 waiver. The authorizing legislation would also have to establish the program and provide operational and funding details. Colorado would then need to demonstrate that the 1332 waiver meets each of CMS’s basic requirements (e.g. covers at least the same number of individuals as under the ACA) and that the state has met the process requirements (e.g. allowed for public comment and conducted an actuarial analysis).

\textbf{GEOGRAPHIC FACTOR RATING BAND}

A geographic factor rating band is a limitation set on the amount by which the geographic factor can vary between rating areas in a state. Under Section 2701 of the ACA, health insurance companies are allowed to vary the premium rates they charge for a plan based on only four factors: age, tobacco use, family size, and geography.\textsuperscript{55} Subsequent rulemaking clarified that CMS assesses rating areas established by states based on whether they (1) are actuarially justified; (2) are not unfairly discriminatory; (3) reflect significant differences in health care unit costs by rating area; (4) lead to stability in rates over time; (5) apply uniformly to all issuers in a market; and (6) are based on the geographic divisions of counties, three-digit zip codes, or metropolitan statistical areas (MSAs) and non-MSAs.\textsuperscript{56}

\textbf{Pros and Cons}

In 2015, Colorado established nine rating areas, seven of which are MSAs (Boulder, Colorado Springs, Denver, Fort Collins, Grand Junction, Greeley, and Pueblo) and two of which are non-MSAs (West and East).\textsuperscript{57} There is considerable variation in the total cost of care between these rating areas. In 2015, the total cost of care was roughly 40 percent higher in the West region than in Boulder.\textsuperscript{58} There is similarly wide variation across rating areas in the geographic rating factor calculated by insurance companies to set premium rates, with a difference of as much as 62 percent between the lowest geographic factor in Boulder and the highest in the West region (Figure 5).\textsuperscript{59}

This difference in geographic factors across rating areas contributes to the wide disparities in premium costs across the state. For example, APTC-ineligible individuals purchasing the lowest cost 2018 plan on the C4 marketplace will pay $727 per member per month in the West region, but only $425 per member per month in Denver. This is a differential of 71 percent.\textsuperscript{60}

The Colorado State Legislature passed House Bill 16-1336 in 2016, which required the Colorado Division of Insurance (DOI) to conduct a study to determine the impacts and viability of establishing a single insurance

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\textsuperscript{57} Colorado Division of Insurance. Geographic rating areas – individual & small group health insurance. Retrieved from https://drive.google.com/file/d/0BwguXutc4vbpUC1wbkpjbkJ4QW/view.

\textsuperscript{58} Total cost of care is the sum of payments made to health care providers by insurance companies plus the cost sharing paid by members in the form of deductibles, copayments and coinsurance. Total cost does not include insurance premiums. This review is limited to those on fully insured commercial plans, not including Medicare and Medicaid.

\textsuperscript{59} Brown, Huckaba, & Louden. (July 28, 2016).

\textsuperscript{60} Colorado Division of Insurance. (October 19, 2017).
To complete this study, the DOI contracted the actuarial firm Lewis & Ellis, Inc. (L&E). In its July 2016 report, L&E recommended against establishing a single rating area, since such a change would reduce premiums for people in high-cost areas but raise premiums for those in low-cost areas. Furthermore, L&E predicted unintended consequences from moving to a single rating area that would negatively impact the same individuals the change is meant to help. For example, statewide carriers forced to raise prices in low-cost areas may no longer be able to compete and drop out of the market altogether. Alternatively, carriers may drop out of the market in only the high-cost areas in order to offer lower prices in low-cost areas.

Either course would reduce competition, which would exacerbate the shallow offerings that currently exist in the state: in 2018, there will be three or fewer carrier options in 56 of 64 counties in the state, and 14 counties will only have one option. A further reduction in competition would likely raise premiums, limit the range of plan options in high-cost areas, and put statewide carriers at a disadvantage. Carriers might also try to get around the single rating area’s requirement that carriers charge a similar premium in all regions by creating separate plans with higher premiums offered only in high-cost areas. Similarly, a carrier could adjust the provider network factor of the market’s risk pool index rate in order to charge higher premiums in higher cost areas.

While the L&E study recommended maintaining the number of rating areas, it also suggested limiting the amount of variation in the geographic factor between rating areas through a rating band. Instead of having as much as 62 percent variation between areas, the state could require, through statute and/or regulation, that carriers not have a differential in geographic factors greater than a set ratio, such as a 1.4:1 band. The amount of differential allowed would be determined through further study and stakeholder engagement by DOI.

A geographic factor rating band is a plausible compromise option that would spread the premium burden across individuals in different regions of the state. Compared to a single rating area, a geographic factor rating band would have a muted yet balanced impact on how much premiums decrease in high-cost areas and increase in low-cost areas. Areas such as the West region would see lower premiums, but carriers would only slightly increase prices in high-cost areas.
increase premiums in low-cost areas like Denver and Boulder. Using a rating band also minimizes the probability that insurers drop out of high-cost areas, create separate products for high-cost areas, or increase select premiums via the provider network rating factor.64

**Case Studies**

Setting a banded ratio for premium-setting factors is not a new concept. The ACA defines an age rating ratio of 3:1 under which an adult aged 64 or older cannot pay more than three times the age rate of a person below age 64. Similarly, the ACA allows insurers to vary premiums based on whether an individual uses tobacco up to a maximum ratio of 1.5:1. However, the ACA does not limit the degree to which premiums may vary across geographic rating areas, instead leaving this authority to the states.65

There are five states that have geographic factor rating bands in place: Kentucky, Maine, Massachusetts, and Washington. Kentucky state law establishes a rating ratio for all characteristics, including geographic area and age.66 Maine state law requires that the highest area factor not be more than 1.5 times the lowest area factor.67 Massachusetts state law allows for area rate adjustments that range from 0.8 to 1.2.68 Under Washington state law, the premium ratio for the highest cost geographic rating area compared to the lowest cost geographic rating area must not exceed 1.15.69 New Mexico has five geographic rating areas70 and, by statute, limits the cost ratio between the geographic rating areas in the state.71 The state’s insurance marketplace additionally restricts the differential between the lowest and highest rated area to no more than 40 percent.72

**Feasibility**

A geographic factor rating band would not reduce premiums in high-cost areas by as much as a single rating area, meaning those most impacted by high premiums may reject this option as an insufficient solution. However, given the concerns about a single rating area, policymakers can frame a geographic factor rating band as a policy option that is both politically feasible and could reduce premiums.73 If those currently burdened by high premiums see this measure as a strong short-term fix, they could in turn become the strongest advocates for banded rates.

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64 Ibid.
66 Kentucky Revised Statues 304.17A-0952 states that premium rates charged during a rating period to an individual with similar case characteristics for the same coverage shall not vary from the index rate by more than thirty-five percent (35%) of the index rate upon any policy issuance or renewal. Retrieved from http://www.lrc.ky.gov/statutes/statute.aspx?id=17388. Maine Revised Statutes Title 24-A, Chapter 33, Section 2736-C. Retrieved from http://legis.maine.gov/statutes/sta/statutes/24-A/title24-Asec2736-C.html.
67 Maine Revised Statutes Title 24-A, Chapter 33, Section 2736-C. Retrieved from http://legis.maine.gov/statutes/sta/statutes/24-A/title24-Asec2736-C.html.
72 New Mexico Office of Superintendent of Insurance, “Frequently Asked Questions (FAQs) for QHP Submissions in New Mexico”. Retrieved from https://www.osi.state.nm.us/HealthcareReform/docs/2016%20QHP%20FAQ.pdf
Insurance companies may oppose this change as well, because it limits their ability to set premium rates based on the underlying health care costs in an area. However, the potential for disruption to insurance markets is considerably less with banded rates than with a single rating area. It maintains insurers' ability to adjust rates based on real geographic differences in the cost of care while providing a one-time, short-term reduction in premiums for high-cost areas.

Next Steps
A geographic factor rating band is relatively easy to implement, though it would require new legislation. Unlike a single rating area, Colorado would not need HHS approval to implement a rating band. The administrative burden would also be comparatively light, given that the move does not change the rating areas, but simply requires that the geographic factor not vary beyond a set limit. The most likely course to move forward would be for the state legislature to set the geographic rating band in statute. After the legislature determined the specific ratio, DOI could issue rulemaking on the rating band for 2019 insurance rate filings.

POLICIES TO ADDRESS HIGH SYSTEMIC COSTS
Payment reform through global budgeting and policies that increase transparency in health care will help Colorado bring down health care system costs, while also reducing high premiums.

GLOBAL BUDGETING
Global budgeting is an emerging payment system reform model that holds great promise for reducing the cost of health care in the United States. Pioneered in Maryland and currently piloting in parts of rural Pennsylvania, the global budgeting model works to realign financial incentives, encourage investment in preventative care and community services, and provide financial stability to rural and low-volume hospitals that struggle to keep their doors open. When implemented well, global budgeting brings together patients, providers, and payers to create health care systems that provide better care at a lower cost.

Under this model, hospitals and payers work together to prospectively set an annual expenditure allowance for all the care a hospital provides to patients covered by a specific payer. In its simplest form, this “global budget” is determined based on historical patterns of expenditures and is adjusted annually based on care utilization by the hospital’s reference population. A hospital’s reference population should be both large and made up of all the different kinds of patients a hospital sees in a given year. Over time, global budgets ideally reflect the number of patients a hospital serves, patients’ preferences based on market shifts, demographic trends, and the cost of care. In both Maryland and Pennsylvania, reference populations are based on the population living in a hospital’s service area.

To ensure continued access to high-quality care, global budgets should be accompanied by performance-based incentives as well as quality and access metrics. Absent such provisions, hospitals may simply reduce the quality of care or deny high-cost patients access to care in order to meet the global budget or find savings. In addition to accountability for quality and accessibility, such metrics can be used to reward providers that show positive results year after year. For example, in addition to reflecting growing (or shrinking) reference populations, adjustments to a hospital’s annual global budget can also reflect improved health outcomes and positive patient experiences in the community a hospital serves.

The global budgeting model is promising for its ability to realign financial incentives; encourage investment in

preventive care and community services that, in turn, improve the quality of care; and provide financial stability to hospitals struggling to keep their doors open.

**Realignment of Financial Incentives**

Global budgets eliminate the perverse incentives under FFS models to drive up volume to make ends meet or turn a profit. In traditional FFS models, “unbundled” payments to hospitals are based on the quantity of services rather than the quality of care. Under this structure, hospitals that provide more care receive more dollars, creating an environment hostile to innovation, care coordination, and other cost-reduction and health-improvement efforts.

With global budgets, hospitals are incentivized to do the opposite. Participating hospitals get a prospectively determined annual amount for all the patients each will see in a year, and they are free to use those funds to provide care however they deem most effective. If, at the end of the year and after all patients have received adequate care, a hospital’s expenditures are below its global budget, it keeps the savings. If a hospital has spent beyond its budget, it is on the hook for the overrun.

By offering savings if they are successful in reducing the cost of care, the global budget model encourages hospitals to both reduce unnecessary health services and create innovative care delivery plans that cost less, all while improving the care of patients. The model gives hospital management and physicians the autonomy and flexibility to provide care in the most efficient, effective way possible. In areas with multiple providers, the annual adjustment of global budgets can reward hospitals that provide better care to their communities.

Consider, for example, a hospital that lowers readmission rates for pneumonia—one of the leading conditions requiring readmission among Medicare beneficiaries—through an innovative new course of treatment that leads to better outcomes for patients. Not only does this hospital keep the associated cost savings from that year’s global budget, it also develops a reputation among patients for providing high-value care. This in turn attracts new patients and leads to a larger global budget in future years. Conversely, if the hospital fails to provide sufficient care to patients and they pursue services elsewhere, the hospital is allotted a lower global budget going forward.

**Investment in Preventive Care and Community Services**

In addition to lowering costs, global budgets hold promise for increasing the value of care patients receive. One of the primary ways hospitals can deliver high quality care for less money is by investing in preventive care that keeps patients healthier and avoids costly treatment in the future. Traditional payment models that reward hospitals for keeping beds full do not incentivize investments in preventative care that would keep patients out of the hospital in the first place. Under global budgets, hospitals are encouraged to invest in preventive care, as hospitals with fewer preventable admissions keep the savings from their global budgets that would have paid for those admitted patients.

Under this payment model, a hospital system treating people at risk of developing diabetes may work with patients to create diet and exercise plans, and use home-based tele-monitoring for blood glucose and blood pressure. By improving the quality of the care it provides, this hospital simultaneously improves the health of its community and saves money through a reduced need for inpatient care.

Additionally, global budgets encourage cooperation among providers. Such cooperation, known as care integration, involves hospitals seeking out care for their patients outside their own walls. This approach recognizes that such care often costs less and may even be better for the patient. In an integrated care model,
there is ongoing communication and collaboration between physicians and nurses who see a patient at the hospital, that patient’s primary care physician, and any other care providers.

Consider the case of a hospital located near a nursing home, where an elderly patient has fallen ill. Under the FFS model, the provider would bring the patient into the hospital for treatment and then receive payment for all the costly inpatient services it provides. With a global budget however, it may make more sense for the hospital to send a doctor or nurse next door to the nursing home facility. These professionals can then provide less-costly outpatient care in the comfort of the patient’s own home, limiting the overall cost of care while improving the value of that care for everyday Coloradans.

Financial Stability for Rural Hospitals

Frontier hospitals, like those in rural Colorado, have struggled to keep their doors open under the FFS models due to declining admissions and shrinking service populations. Global budgets reduce the financial risk and uncertainty facing these hospitals by guaranteeing a payment that covers the annual care of their populations, regardless of inpatient volume in any given moment. While the model does not guarantee these hospitals will stay open in perpetuity, it provides an avenue for financial sustainability that does not rely on the volume of inpatient care.

Consider a frontier hospital whose revenue model is dependent on a spike in inpatient admissions in the winter months when more community members are hospitalized for flu treatment. For this provider, a year when the community remains relatively healthy and experiences fewer cases of the flu is actually bad news financially. This hospital depends on payments for these patients to keep its doors open and provide many other critical health care services. Or take the case of a hospital whose budget is built around a certain number of babies born each year needing intensive care. If one year more babies than normal are born healthy, the hospital is in financial trouble. With a global budget, these hospitals do not experience revenue dips when their patient populations are healthier and have better health outcomes. Instead, their revenue streams remain steady, or even grow, and they are able to designate those savings to other care and administrative needs. Under global budgeting, there is no such thing as a “bad flu season” because too few people got the flu or a budget crisis when there are not enough NICU babies.

Considerations for Successful Implementation

All-Payer Model

Successful implementation of global budgeting requires an all-payer model, through which all payers in a health care system use the same payment model for all hospitals. In Maryland, these rates are determined by an independent rate-setting commission. In Pennsylvania, a hospital’s global budget is broken down by payer, with each insurer paying the provider a percentage of the overall budget that corresponds to the percentage of the hospital’s population it insures. Both Maryland’s state-wide global budgeting efforts and Pennsylvania’s rural hospitals pilot involve an all-payer model, and both states achieved public payer buy-in via federal waivers from CMS.

Participation by Medicare and Medicaid are critical, given the sizable share of a hospital’s population insured by Medicare and the importance of Medicaid reimbursements for hospitals serving low-income populations. It is also critical that commercial payers, especially those with large shares of a patient population, also participate. Without the participation of any insurers with a large share of payer dollars, it becomes even more difficult to

change provider behavior.

**Strong Administration and Governance**

Strong administrative structures and governance are also important to successfully adopt global budgeting. The agency charged with administration and oversight of global budgets must be seen as both neutral and credible and be staffed by experts without strong ties to either payers or providers. This entity must be strategic and savvy, transparent and fair, and nimble and responsive in order to manage the design and implementation of global budgets across hospital systems throughout the state.

Global budgeting in Maryland is managed by the Health Services Cost Review Commission (HSCRC), an independent agency authorized in state statute, whose goals are to "constrain hospital cost growth, ensure that hospitals have the financial ability to provide efficient, high-quality services to all Marylanders, [and] increase the equity or fairness of hospital financing." Commission members are appointed by the governor and represent a mix of payer, provider (physician and hospital administrators), and patient interests. Administrative duties in Pennsylvania are housed in the Health Innovation Office of the state's Department of Health and have benefited from strong support and leadership from Governor Tom Wolf. The state is creating a new a public-private partnership called the Pennsylvania Rural Health Redesign Center, to spearhead the global budget pilot and work with hospitals, payers, and communities to achieve buy-in and sustained participation.

**Statutory Authority**

Both Maryland’s and Pennsylvania’s global budgeting activities are authorized under state statute, and Colorado may need legislation to make its pursuit of global budgeting as effective as possible. In the meantime, there may also be things the Governor’s Office and the Department of Health can do under existing statute to pursue elements of the payment reform model. While Pennsylvania is currently proposing legislation to authorize a public-private partnership model to manage global budgeting, the current work of the Department of Health has been possible without passing any new legislation.

**Financial Considerations**

Shifting to a global budgeting payment model will require human and financial resources. It may be possible to begin working on the model without invoking TABOR however, by shifting resources within the existing budgets and by drawing upon support from CMS. As in Pennsylvania, Colorado could draw upon start-up funds from the federal government to facilitate the early creation and implementation of its global budgeting model. Longer term however, Colorado may need to pursue additional funding sources, possibly from foundations or through partnerships with academic institutions.

**Case Studies**

**Maryland**

Over recent years, Maryland has adopted per-capita global budgets for payments to both rural and non-rural hospitals. Maryland was uniquely well-positioned to adopt global budgets thanks to its all-payer rate-setting body and history of collaboration between payers, the government, and hospital providers. The impetus for a move to global budgeting came from a general recognition that rate-setting under an FFS framework still fails to remove incentives for health care overuse.

From 2008 to 2011, Maryland rolled out a Total Patient Revenue model to ten rural hospitals. This initial step leveraged the state’s experience with Garrett County Memorial Hospital, which has used a global budget for

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20 years.\textsuperscript{78} These sole community provider hospitals have clearly defined patient populations, with non-overlapping coverage areas. This feature made it much easier for the HSCRC to identify progress in both savings and quality outcomes.\textsuperscript{79}

In 2014, using new authority under the ACA, Maryland collaborated with CMMI to expand global budgets to all inpatient and outpatient hospital services. Under the global budget program, Maryland is required to limit “the growth in the per capita hospital revenues for all payers to the long-term growth rate of the State's economy (3.58 percent per year)”\textsuperscript{80}, and save Medicare $330 million in hospital expenditures over five years.\textsuperscript{81}

Results so far have been promising. According to independent analysts, health costs grew only 1.47 and 2.31 percent in 2014 and 2015 respectively\textsuperscript{82}. Though Maryland's $429 million in hospital savings to date greatly exceeds the five-year target, some of these savings were counteracted by an increase in home health, skilled-nursing and care management expenses.\textsuperscript{83} Still, the adjusted savings to date of $319 million is close to the benchmark, and reflects greater investment in valuable preventative care.

Challenges continue around readmission, as Maryland's hospital readmission rate remains higher than the national average. Additionally, there has yet to be any meaningful improvement around continuity of care following hospital discharge, despite providers listing it as a priority.\textsuperscript{84} Harnessing these collaborative models of care could both improve outcomes and lead to more substantial cost savings.

Also noteworthy is a recent study in the \textit{JAMA Internal Medicine} of changes in health care utilization under the Maryland model, which found no consistent evidence of reduced hospital utilization or enhanced primary care, beyond what would have taken place anyway. However, the study's authors note that there were initial challenges in aligning physician and staff behavior in the early months of implementation, so the study does not actually cover a full two years of operation and therefore may not fully capture impact.\textsuperscript{85} What is more, the model may simply need more than two years to show consistent, significant impact on hospital utilization. As it considers a global budgeting model, Colorado should both pay attention to future findings in Maryland and consider adjusting program design and implementation to address some of the shortcomings of the Maryland model.

Though Colorado can learn from Maryland's model, the consistent support for a strong state regulatory body like the HSCRC diverges from the general anti-regulation culture in Colorado. Maryland is a much more politically homogeneous state than Colorado and leans Democratic, despite two of the last three governors (including the incumbent Larry Hogan) being Republicans. However, given the political importance of many of these struggling rural and mountain hospitals to individual state legislators, Colorado could put these hospitals at the forefront of a bipartisan statewide push for global budgets.

\textsuperscript{78} Maryland Health Services Cost Commission. \textit{TPR rate setting methodology}. Retrieved from http://www.hscrc.state.md.us/Pages/init_tpr.aspx.
\textsuperscript{81} Ibid.
\textsuperscript{82} Ibid.
\textsuperscript{83} Ibid.
Pennsylvania

Pennsylvania recently joined Maryland as one of the first states employing a global budget approach to help manage long-term costs and protect its rural hospital communities. The state received an ACA waiver to pilot global budgeting in 30 rural hospitals on January 12, 2017. CMS will provide $25 million in technical assistance and implementation support to the state over the next four years to help it meet its objectives. Through this seed funding, CMS will help the state administer its global budgets, aggregate and analyze data, compile and submit reports, conduct quality assurance, and provide technical assistance to participating hospitals through the care delivery redesign and payment reform processes.  

For Pennsylvania, payment reform is part of a larger rural health initiative focused on transforming health care delivery and improving the health status of rural Pennsylvanians. To this end, Pennsylvania’s waiver lets it tie financial incentives for participating hospitals to the state’s performance in three areas: increased access to primary and specialty care, reduced rural health disparities through improved chronic disease management, and decreased substance abuse deaths. Global budgeting represents an opportunity to focus on the transformation of care delivery to a value-based care model. By shifting control, responsibility, and accountability to the local level, global budgeting will empower hospitals to make the decisions that work best for themselves and the rural communities they serve.  

While it is too early to know the outcomes or impact of global budgeting in Pennsylvania, the state’s experiences to-date could inform Colorado’s future pursuit of payment reform models. Politically, Pennsylvania is similar to Colorado in many ways. Both are “deeply purple” states, in which neither Democrats nor Republicans have clear advantages in state-wide races. Currently, both Colorado and Pennsylvania are governed by Democratic administrations and divided legislatures, and both are represented by one Democrat and one Republican in the U.S. Senate. Further, both have small, highly-populated urban centers that lean liberal surrounded by expansive rural areas populated with conservative voters. Importantly, Pennsylvania’s model is also voluntary, a characteristic that likely makes it more relevant for a state like Colorado.  

While Pennsylvania is still very much in the early stages of its global budgeting program, it is eager to serve as a model for other states if its efforts prove successful. Colorado policymakers should initiate conversations with officials in Pennsylvania involved in global budgeting, as Colorado considers moving forward with global budgeting.

Feasibility

Given the broad impact that global budgeting would have throughout Colorado’s health system, we analyzed its feasibility by considering support and opposition from major stakeholders.

Hospitals

Recognizing that there are distinct effects that global budgeting would have on different hospital types, this section is broken down to address Western Slope, Front Range and Rural/Low-Volume hospitals separately.

- Western Slopes: The stance of Western Slope hospitals on global budgeting is difficult to predict due to their distinct care patterns and patient populations. On one hand, given their higher than normal costs of care, they may stand to lose out financially if their global budget comes in below their annual payments. However, given the evidence of potential overuse discussed in the Background section, these hospitals could see financial windfalls by curbing expensive procedures that they are no longer incentivized to

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88 Center for Medicare & Medicaid Innovation. (October 31, 2017).
perform. Defining a reference population may be more difficult for Western Slope hospitals where there are large seasonal changes in the types of patient and their needs. This would require greater state-provider collaboration to adapt the reference population to these dynamics.

- **Rural/Low-Volume:** Small rural hospitals would benefit from the stable revenue stream under global budgeting, and could more easily predict their reference populations from year to year. Both Maryland and Pennsylvania's global budgeting programs started in rural hospitals, due to their stark needs and clear reference populations. One potential downside risk is a "death spiral" wherein a rural area's shrinking population gradually erodes the responsible hospital's global budget to below a breakeven point.

- **Front Range/ I-25 Corridor:** Global budgeting in the large metro areas along the Front Range presents unique difficulties. Given the greater opportunity for reference population overlap in urban areas, hospitals could more easily shift costs by sending high-need patients to other providers. However, quality and access requirements should mitigate this risk, meaning hospitals will instead compete on quality of care and increased savings.

**Private Insurance Companies**

Under global budgeting, private insurance companies would know the upper-bound of their annual payments to participating hospitals. Unlike the current system where payers must predict total health care utilization and consumption year to year, global budgets give payers reliable and contractually enforceable limits on their total payments to hospitals.

However, this approach requires payers to cede authority over their total savings. Under the current FFS system, payers can nudge individuals or providers away from particularly expensive treatments in order to contain total costs. Payer response to global budgeting will thus vary across insurers based on how confident and/or effective each carrier is at containing costs through these behavioral approaches.

Additionally, switching from a FFS to global budget framework requires payers to invest financial and organizational capital in converting their business model to a new payment system. Officials in PA working on their global budget framework discussed concerns insurers have about the global budget methodology and how to operationalize payments, as these represent changes from their standard practices. Costs to payers would be especially problematic under a gradual roll-out approach, where hospital global budgets and FFS systems would have to exist side-by-side.

**CMS**

A benefit to using global budgets is that there is precedent for CMS granting the required waivers. Though the Colorado plan would be unique to the state's context, building off of past efforts increases the likelihood that CMS would approve the waiver request. Requesting a waiver for global budgeting should be easier politically than requesting a waiver for reinsurance, which the current executive branch has painted as "insurer bailouts." To date there has been no such negative messaging campaign from the Trump administration on global budgeting.

**Next Steps**

Looking ahead, the state should conduct a more detailed landscape analysis to determine how global budgeting fits in to Colorado's current health care and political environments. This analysis should determine how much collaboration or resistance to expect among payers and providers under this new approach, particularly among rural and mountain hospitals. It should also consider political will within government itself and identify agency interactions that could bolster or hamper the process.

The analysis should look into what authority, if any, the state has to design and implement innovative health care financing models like global budgeting. If the state does not have this authority under existing statute, it
should consider pursuing legislation to facilitate the pursuit of global budgeting. The state should also review past efforts in the state legislature to implement similar policies and what political obstacles such policies faced. Further, it should determine the best avenue for achieving an oversight and management body that can guide the design and implementation of global budgeting, ideally an independent body like Maryland’s Health Services Cost Review Commission or Pennsylvania’s Rural Health Redesign Center.

Alongside the landscape analysis, Colorado should consider the scale of a potential global budgeting model, whether statewide or geographically-focused. We recommend Colorado start with an ambitious, statewide approach, as this would do the most to bring down costs. However, piloting a program with rural and/or mountain hospitals like the approach taken by Pennsylvania is another option the state could consider.

The state should also begin conversations with CMMI about the possibility of creating a waiver that would allow Colorado to pursue global budgeting and possibly to draw down federal funds in support of these efforts.

Based on Pennsylvania’s experience, Colorado should expect the process of designing a pilot program to take 1-2 years. Depending on financial and political hurdles, it may then take another 1-2 years to launch the program. During this time, the health care landscape in Colorado and Washington D.C. could change. Policymakers should design the program with these considerations in mind and be prepared to adapt to a dynamic policy environment.

TRANSPARENCY

Price transparency was the most common recommendation we heard from stakeholders in Colorado. There are two main arguments for how transparency can lower costs. First, transparency will allow providers, carriers, and policymakers to see what services are really driving costs. As a result, they will be better able to eliminate waste in the system. Second, transparency will enable consumers to shop around for less expensive services.

We agree transparency is a useful tool for health care professionals and government officials, especially in conjunction with global budgeting. We also believe transparency for consumers could lower costs if combined with quality metrics, though the evidence to date is mixed. Ultimately, however, transparency is not a panacea—it is simply one part of the solution.

Providers, Carriers, and Policymakers

Providers don’t actively aim to be wasteful. However, due to the disconnect between billing systems and clinical systems, many providers do not know the prices of their services and can struggle to control spending. Without clear cost information, there is little they can do to rein in costs.

Transparency would help remedy this situation. If providers knew where they stood relative to their peers in terms of tests, medication, and general cost of services, they would compete to be as cost-effective as possible. Likewise, primary care physicians would refer patients to less expensive specialists. Importantly, this competition would happen regardless of whether consumers compared prices, as providers who delivered cost-effective care would develop better reputations and attract more patients.

A number of academic studies illustrate the cost-saving potential of transparency for providers. Research from Johns Hopkins found that when providers saw the costs of laboratory tests at the time of order, rates...
of test ordering fell 8.5 percent. Other research has found that even when providers do not order significantly fewer tests after seeing prices, they order significantly less expensive tests. These results extend to medication choice as well — when researchers showed anesthesiologists the prices of muscle relaxants, total expenditures fell 12.5 percent. Overall, a majority of studies in the past 30 years has found that displaying prices to providers leads to significant cost reductions without compromising patient safety.

Most studies have focused on prospective transparency — transparency at the time of service. However, transparency can also be retroactive. For example, Tennessee has been able to reduce the volume of high cost services by giving providers a report of all the services they provided in the last quarter and the costs associated with those services. Hospitals can also take the lead themselves, implementing automated systems to create quarterly or annual reports that share cost information and make recommendations.

On the insurance side, transparency would give carriers more bargaining power. Whereas in the current system, providers can plead ignorance, in a fully transparent system, providers would have to justify why they provided more costly services. If providers could not justifiy their expenses, insurers could drop them from the network (absent provider monopoly power). While there is the risk that transparency will lead to low-cost providers demanding higher prices, on balance we believe transparency will lead to lower negotiated prices.

Finally, transparency would inform public policy in important ways. Currently, state legislators seek to control costs without actually knowing the prices and utilization rates of most procedures. As with providers, if lawmakers received a report every quarter with this information, they could better target excessive spending.

Global budgeting provides a framework to tie all these pieces together. With detailed price information, payers could set reimbursement rates that incentivize cost-effective care. The new reimbursement rates would then form the foundation of the global budget. Consequently, providers could not afford to prescribe superfluous, high cost services. The end result would be lower health care spending overall.

**Consumers**

Basic economic theory says that as the price of a product increases, consumers demand less of it. However, consumers often do not know health care prices. Thus, the same exact service can sell for twice as much in one hospital as in another a few miles away. In theory, price transparency could solve this problem; if consumers knew the prices at both hospitals, they would never go to the more expensive one. The recently passed “Transparency in Health Care Prices Act” represents one attempt to solve this problem by making providers post prices for common services.

In practice, there are several reasons why consumers may not select the cheaper hospital. First, according to the Health Care Cost Institute, only 40 percent of health care services are "shoppable." For example, shopping is not an option for someone with a medical emergency who is under duress, and even after an emergency, decision-making under duress is likely to be impaired. Second, it is not possible to shop when the consumer has a condition that only one hospital in the area can treat. Third, consumers do not care about the sticker cost of care—they care about how much they pay out of pocket. In other words, consumers who have already met their

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deductibles will have no incentive to shop for lower prices. Fourth, price information can be overwhelming; most people will simply go with their doctor’s recommendation. Finally, there is the risk that price information could lead people to demand more expensive services if they equate prices with quality.

Empirical findings are mixed on these issues. A 2015 survey by the nonprofit Public Agenda found 71 percent of respondents did not view more expensive care as being higher quality, and 63 percent did not view inexpensive care as being lower quality. But a 2012 study by University of Oregon Professor Judith Hibbard found the opposite: when people just saw price data, a plurality of respondents viewed the highest priced provider as being the highest quality. Fortunately, Hibbard also found that when quality ratings accompanied price data, respondents were significantly less likely to equate higher cost with higher quality. This finding underscores the importance of linking prices to well-established, easily comprehensible quality metrics.

Unfortunately, on the more direct question of whether consumers will shop when they have price information, the answer seems to be “no.” While 56 percent of respondents in the Public Agenda survey said they have tried to find price information before getting care, only 21 percent said they actually compared prices across providers. Further, this lack of shopping is not the result of a lack of information. A 2016 study published in the American Journal of Managed Care found most plans provide price information, but only 2 percent of enrollees look at it. Similarly, a 2016 study published in the *Journal of the American Medical Association (JAMA)* found only 10 percent of employees at two large firms used an easily accessible price transparency tool.

Nevertheless, there is some evidence price transparency can lower costs when people use it. A 2014 study published in JAMA found total claims payments were up to 14 percent lower for patients who searched a pricing website prior to receiving care. Most recently, a study published this year in the American Economic Journal found price searching reduced prices paid by 10-17 percent.

In conclusion, price transparency for consumers, combined with quality metrics, could be an effective tool for reducing costs. The key challenge for policymakers and carriers is getting people to use it. One promising idea which has worked well in California, is reference pricing. Under the consumer-facing version of reference pricing, patients know the set cost for a given procedure that their payer provides in full, and then pay the difference if their chosen provider charges more. Another is direct outreach to patients to help them find less expensive services. Going forward, Colorado should explore these options and others to determine how transparency can have the biggest impact on consumer behavior.

**Next Steps**

Transparency is arguably the most politically popular proposal to rein in health care costs. Consumer advocates see it as a way to prevent patients from getting ripped off, and free-market advocates view it as a way to create

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101 Frakt, A. (December 19, 2016).

102 Ibid.
more competition. Most of the opposition will come from expensive providers who do not want their data to come under public scrutiny. Some business groups may also claim releasing more data is burdensome. At the same time, providers who deliver cost-effective care should cheer the effort, as should business groups who truly believe in competitive markets.

Colorado is also well-positioned to implement transparency since it already has an all-payer claims database run by CIVHC. The main implementation challenge is that no agency has the authority to mandate that providers release their prices. The state legislature could pass a law delegating this authority to someone, but until that happens, the state’s best bet is to work with private carriers to make price data as widely available as possible.

Other implementation challenges include matching quality metrics to price data and presenting this data in a way that is comprehensible to consumers. Aside from the obvious questions associated with these challenges (e.g. how should quality be measured and what format is most comprehensible), there is the question of who takes on these responsibilities. If the state requires additional technological systems or personnel to implement these tasks, it will also need to get the money from somewhere. Given these concerns, the state should prioritize transparency for providers and carriers over transparency for consumers.
Conclusion

Though Colorado has long ranked among the nation’s healthiest states, there is no doubt that the Centennial State’s health system faces significant challenges. During our conversations with Colorado experts and stakeholders, we heard two common refrains: (1) crisis-level premiums in rural and mountain communities and (2) unsustainable statewide health cost growth. We kept our focus on these twin challenges as we evaluated the recommendations from Colorado’s Cost Commission report and assessed other policy options.

We are also aware that the dynamic federal health policy environment creates significant challenges and uncertainty for Colorado policymakers. During our site visits in late 2017, both HCPF and C4 were focused on contingency planning around Congress’s failure to fund the Children’s Health Insurance Program. Though that storm has passed, further federal uncertainty will likely complicate future Colorado policymaking.

Despite these complications, state lawmakers must move forward as best they can to both control premiums and bend the state’s health cost curve. We believe our recommendations can move Colorado in this direction, and we hope this report will advance the state’s policy conversation.
Chloe Brown is from Santa Barbara, California and graduated from Williams College in 2010. Prior to Princeton, she spent six years as a theater artist and administrator in New York City, working for small producing organizations, Off-Broadway theaters, and a large research and advocacy nonprofit. Since then, she has interned with the NYC Mayor's Office of Operations and consulted for the Burke Foundation on programs to increase access to education and social services. At Princeton, she focuses on urban issues and anti-poverty policy.

Sebi Devlin-Foltz grew up in the Maryland suburbs of D.C. before attending Occidental College in Los Angeles. He then moved to D.C. proper to work at the Center on Budget and Policy Priorities, and then at the Federal Reserve Board. At the Fed, his work focused on household wealth, survey administration and trends in economic inequality. At WWS, we studies economic and anti-poverty policy in the U.S. context.

Prior to enrolling in the Woodrow Wilson School, Sasha Frankel worked in international development on issues of health financing and health systems strengthening in Washington, DC. After graduating from George Washington University, she spent a year as a Fulbright English teaching assistant in Bartin, Turkey. At Woodrow Wilson, Sasha is focusing on domestic health and aging policy. After her first year, she interned with the Center for Health Care Strategies in Hamilton, New Jersey, working on improving health plans that serve individuals eligible for Medicaid and Medicare. Sasha is pursuing a dual degree and spent last year at Duke University’s Fuqua School of Business. This past summer, she interned in medical strategy at Cardinal Health, a health services and distribution company in Columbus, Ohio. In her free time, Sasha plays soccer, cooks soup and listens to myriad podcasts.

Elizabeth Garlow has worked across public and private sectors to build collaboration and align resources to support thriving local places and economies. She launched her career working in domestic microfinance with ACCION USA. In 2012, Elizabeth returned to her hometown of Detroit to build an organization called Michigan Corps to support Detroit and Michigan’s economic transformation through social entrepreneurship and impact investing. Elizabeth spent two years serving as a Community Solutions fellow at the White House, working with the Obama Administration to reform the Federal government to work better for cities, towns and tribal communities across the country. She is a graduate of Kalamazoo College and focuses on urban and social policy while pursuing her Master in Public Affairs degree at Princeton University.

Devin Gould is a New York native and graduated from Brown University in 2011. He worked in the Taxpayer Protection Bureau of the the New York State Attorney General’s Office and as a Budget Analyst at the NYC Economic Development Corporation before starting graduate school at Princeton. At Princeton, he focuses on tax and fiscal policy.

Anita Gupta was born in Philadelphia and grew up in a small suburb in nearby Camden County, New Jersey. She currently resides in Princeton and is a well-recognized leader and voice on the prescription and opioid overdose epidemic on both a local and national level. Anita is both a physician anesthesiologist specializing in pain management, and a pharmacist, which allows her to share unique thoughts on this serious public health issue. She has worked for the last ten years in academic clinical medicine both at the University of Pennsylvania and Drexel University in Philadelphia as a professor where she served to train residents and medical students while caring for ill patients with intractable pain. Anita has been a tireless advocate on national media outlets on a broad range of issues related to her specialty, specifically pain and surgery on behalf of the American Society of Anesthesiology and the American Osteopathic Association. She continues to work closely with leaders both on Capitol Hill and the FDA to find solutions to solve the opioid epidemic and pain crisis in the United States.
Anita’s interest in domestic policy allowed her to participate in the recent 2017 election on the issue of the opioid epidemic and to engage with leaders on a bipartisan level to discuss solutions to the healthcare system in general.

Alex Kasdin is from Princeton, NJ and graduated from Princeton University in 2014 with a degree in Ecology and Evolutionary Biology. She took two years away from the Woodrow Wilson School’s Master in Public Affairs program to pursue a two-year fellowship with the federal government, as part of the Scholars in the Nation’s Service Initiative. During this fellowship, she worked for the U.S. Fish and Wildlife Service on endangered species conservation and public lands management. She focuses on domestic environmental policy at the Woodrow Wilson School.

Amy Li is originally from Chicago and graduated from Pomona College in 2013. Following graduation, Amy worked as a fellow in the California State Senate and then as a policy analyst at a health care consulting firm. Her work supported program implementation under the Centers for Medicare & Medicaid Services. At the Woodrow Wilson School, Amy focuses on domestic policy, with an emphasis on urban and social policy.

Aaron Tobert is from Pennington, New Jersey and graduated from Colgate University in 2014. Prior to coming to Princeton, he worked for two years as an economic research assistant at the Federal Deposit Insurance Corporation (FDIC) in Washington, D.C. He has continued to study economic policy at the Woodrow Wilson School, with a focus on anti-poverty policy.

Matthew Richardson is a Wyoming native and attended Utah State University for his undergraduate studies in political science and speech communication. After graduating from Utah State in 2011, Matthew moved to Washington, D.C., where he began working for Senator Orrin Hatch. Matthew worked for five years in the Senate, ultimately serving as Senator Hatch’s legislative assistant on health policy. Matthew’s studies at the Woodrow Wilson School of Public and International Affairs at Princeton University focus on domestic and health policy.

Zach Wahls is a graduate of the University of Iowa, a small business owner, and author of the bestselling book My Two Moms: Lessons of Love, Strength and What Makes a Family. Zach is a proud Eagle Scout, and he co-founded and served as Executive Director of Scouts for Equality, which led the national campaign to end discrimination in the Boy Scouts of America. At the Woodrow Wilson School, he focuses on domestic policy, with an emphasis on health care and social services programs.

Laura Williamson grew up in Hillsborough, North Carolina and majored in International Studies and English at the University of North Carolina at Chapel Hill. At the Woodrow Wilson School, Laura focuses on leveraging public policy tools to expand voting rights in the South. Previously, Laura worked on voting rights advocacy at the Southern Coalition for Social Justice in Durham, North Carolina, organized for racial justice with high school students at Puentes New Orleans, and supported multi-issue youth leadership development at Young People For in Washington, D.C.
Appendix A: Detailed Criteria Definitions

This appendix describes the definitions used for the scoring found in Table 1, which contain a summary of our recommendation findings by criteria.

IMPACT

Potential Impact on Cost
We rated each policy using the following scale:

- **High** indicates that the expected effect of the policy would be to significantly reduce health costs or substantially slow the predicted rate of price growth.

- **Medium** indicates the expected effect of the policy would have a moderate impact on health costs or price growth.

- **Low** indicates that the expected effect of the policy would be mild or that the effect is unlikely to have more than a mild effect on slowing the predicted rate of growth.

Potential Impact on Coverage (premiums)
We rated each policy using the following scale:

- **Positive** indicates that the policy would increase the number of people with health insurance above current levels.

- **Neutral** indicates that the policy would maintain the number of people with health insurance at current levels.

- **Negative** indicates that the policy would decrease the number of people with health insurance below current levels.

Potential Impact on Access (system costs)
We rated each policy using the following scale:

- **Positive** indicates that the policy would increase access to health care services above current levels.

- **Neutral** indicates that the policy would maintain access to health care services at current levels.

- **Negative** indicates that the policy would decrease access to health care services below current levels.

Potential Impact on Quality
We rated each policy using the following scale:

- **Positive** indicates that the policy would increase the quality of health care services above current levels.

- **Neutral** indicates that the policy would maintain current levels of quality of health care services.

- **Negative** indicates that the policy would decrease the quality of health care services below current levels.
FEASIBILITY

Political Feasibility
In evaluating political feasibility of each policy option, we considered the following four factors:

(1) The policy would have broad public support among Colorado voters.
(2) The policy aligns with the unique regulatory and political culture of Colorado.
(3) The policy appeals to relevant interest groups.
(4) The policy appeals to key decisions-makers.

For this criterion we considered the following:

**High** indicates that the policy would be expected to fulfill most or all of the four factors.

**Medium** denotes that policy would be expected to fulfill two of the factors.

**Low** indicates that the policy would be expected to fulfill one or none of the factors.

Financial Feasibility
For this criterion we considered the following:

**High** connotes a policy that is expected to have low cost and would be relatively easy to secure.

**Medium** signifies that the policy is expected to have low cost but it will be difficult to get money or high cost but easy to get money.

**Low** indicates the policy is high cost and the money would be difficult to secure.

Post-Passage Implementation Feasibility
For this criterion we considered the following:

**High** indicates that, considering all four of the above factors, execution or applying the policy will be simple and without significant challenges.

**Medium** signifies that, among the four factors above, at least one will pose a significant challenge to successful policy application and execution.

**Low** connotes that, among the factors above, a majority or all present barriers to successful execution.
Appendix B: Detailed Recommendations Matrix

This appendix offers a detailed evaluation of each recommendation considered during the development of this report.

<table>
<thead>
<tr>
<th>POLICY OPTIONS</th>
<th>BENEFITS</th>
<th>FEASIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROBLEM 1: HIGH PREMIUMS</strong></td>
<td></td>
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<tr>
<td>Reinsurance/1332 Waiver</td>
<td>By recent estimates, this would lower premiums by up to 20%. As example, Alaska’s successful waiver led to a premium increase of 7% instead of the 42% predicted otherwise.</td>
<td>Likely to increase coverage through lowering carrier participation by lowering risk.</td>
</tr>
<tr>
<td>Geographic Factor Rating Band</td>
<td>Should see a decrease in premiums in high-cost areas and a slight increase in premiums in low-cost area.</td>
<td>Likely to increase coverage through lower premium costs.</td>
</tr>
<tr>
<td>Silver Loading</td>
<td>Would lower premiums for marketplace plans and potentially drop costs for off-marketplace silver plans.</td>
<td>Muted, but potential increase in coverage if more people purchase insurance due to lower premium costs.</td>
</tr>
<tr>
<td>400-500% FPL Subsidy</td>
<td>Increased subsidies would lower premiums for middle-income workers, especially in rural areas where premiums are higher.</td>
<td>May increase coverage by lowering premiums and attracting new enrollees.</td>
</tr>
<tr>
<td>Website Enrollment Process Changes</td>
<td>Potential to lower health expenses and premium costs for subsidy-eligible people not currently receiving credits.</td>
<td>Potential to increase coverage among subsidy-eligible people not receiving currently receiving credits.</td>
</tr>
<tr>
<td>Standardized Plan Benefit Designs</td>
<td>Standardizing plan benefit designs may reduce unexpected out-of-pocket costs and incentivize insurers to compete on value (price per benefit), rather than premiums alone.</td>
<td>N/A</td>
</tr>
<tr>
<td>Single Rating Area</td>
<td>Premiums likely to increase due to unintended consequences of insurance market disruption.</td>
<td>Coverage likely to decrease due to unintended consequences of insurance market disruption.</td>
</tr>
<tr>
<td>Medicaid Buy-In</td>
<td>Lower premium option for those who currently face high unsubsidized premiums. May attract others with lower out-of-pocket costs. Unlike to reduce off-marketplace new premiums via competition due to different cost structures. Could raise costs for non-Medicaid patients through provider cross-subsidization.</td>
<td>Likely to increase coverage among those forgoing insurance due to high premiums.</td>
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<tr>
<td>POLICY OPTIONS</td>
<td>BENEFITS</td>
<td>FEASIBILITY</td>
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<tr>
<td>Global Budgeting (Payment Reform)</td>
<td>Potentially significant impact on overall system cost. Maryland</td>
<td>If designed well, global budgeting should maintain or slightly improve</td>
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<td>experienced nearly $116 million in Medicare savings in its first year of operation (2014). Also in 2014, per capita hospital costs for all payers grew at just 1.47%, well below the 3.58% waiver target.</td>
<td>access in the short term, and it should increase coverage in the long term as health care costs drop.</td>
</tr>
<tr>
<td>Transparency</td>
<td>Could have significant impact on provider side if paired with global</td>
<td>N/A</td>
</tr>
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<td>budgeting. Some potential to lower costs on the consumer side if officials actively encourage shopping and tie prices to quality metrics.</td>
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</tr>
<tr>
<td>Systemic costs could be reduced substantially if this policy were paired with payment reform. Without coinciding reforms, hospitals could use fee for service to inflate medical payments which would subsequently inflate the amount they are able to spend on administrative and/or capital investments. No other states have implemented such a policy.</td>
<td>MLRs for hospitals would not directly impact coverage. Indirectly, lower system costs would contribute to controls on premium growth, likely increasing take-up of insurance coverage.</td>
<td>Despite support from consumer advocates and insurance companies, this policy proposal would likely spur fierce opposition from hospital and provider associations, lawmakers and voters who view policy as additional regulation without enough market competition, and mountain communities who require fancy facilities for tourists.</td>
</tr>
<tr>
<td>Medical-Loss-Ratio for Hospitals</td>
<td>Impacts on cost depend on specific policy. Ideally, policies would bring FSEDs prices in line with urgent care centers and reduce unexpected costs to consumers.</td>
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<td>Free-Standing Emergency Departments</td>
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<td>Braided/Blended Funding</td>
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