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Senator Tom Daschle  
Washington, D.C.

December 5, 2008

Dear Senator Daschle,

Congratulations on your nomination as Secretary of Health and Human Services, a position for which you are so well-qualified.

I want to share with you something about Colorado's experience of soliciting and evaluating health care reform proposals from 2006, when state Senate Bill 208 created a Blue Ribbon Commission for Health Care Reform, until 2008, when the Commission's final report was delivered to the Colorado legislature.

Enclosed is a brief overview of the Lewin Group evaluation of 5 Colorado health care reform proposals. Also enclosed is a 2-page evaluation of the Commission's final report that I wrote as a member of Health Care for All Colorado (authors of the Single Payer proposal evaluated by the Lewin Group in 2007).

In brief, the Colorado Health Services Single Payer Plan was the only reform proposal that demonstrated savings for the state, and the only one demonstrating the capacity to provide comprehensive health coverage for all. Nevertheless, the proposal was limited to a four-sentences dismissal in the Commission's final report. The report failed to recommend any follow-up study of the many possibilities for the proposal to overcome current problems of financing and delivery of health care.

I understand the wishful thinking that we in the U.S. can somehow create a public-private system of insurance that will function for the benefit of all. However, there is much information that points to the difficulty of applying oversight of profit-centered private insurances that would be necessary to provide coverage for all, and to control costs.

An aside: I corresponded with a couple of activists in Minnesota, who related how the insurance industry bypassed that state's legislation to create a system of not-for-profit insurances. By their accounts, the insurers utilized "creative bookkeeping" to conceal their profits, and quickly gained a controlling influence over that state's legislature and Insurance Commissioner, negating the intent of creating not-for-profit private insurances.



We cannot afford the continued practice of insurance and pharmaceutical lobbies writing health care policy, epitomized by Medicare prescription drug reform of 2003 that privatized Medicare and increased its costs above costs of traditional Medicare. The big lobbies wrote Medicare reform with billions of dollars of taxpayer subsidies and inflated profits to benefit their bottom lines, and prohibited negotiation of bulk drug prices. Such legislation defeats the intent of quality health care for all, and feeds a "profit-first" instead of "quality first" health care model.

Over 20 federal and state studies since 1991 have demonstrated the ability of the Single Payer model of health care to save costs, while providing comprehensive coverage for all. The single remedy of systemic health care reform could lift all boats and benefit not only families and individuals, but also small and large businesses. Meaningful health care reform could greatly ameliorate the U.S. economic crisis. General Motors is not the only business compromised by multi-billion dollar annual costs of employee and retiree health coverage. State and city governments also bear such health costs that cut significantly into their strained budgets.

I urge you and other policy-makers to think beyond incrementalism that only results in continued shifted costs and burdens.

A summary of 20 federal and state studies can be viewed at: <http://healthcareforallcolorado.org/index.php?p=10&ID=332&d=1> Other studies and summaries of the reports referred to here can also be seen at [www.HealthCareforAllColorado.org](http://www.HealthCareforAllColorado.org). We would gladly share any information regarding our efforts at health care reform.

Best Regards,

Michele Swenson

Enclosures:

- 1) Overview of the 2008 final report of the Colorado Blue Ribbon Commission for Health Care Reform to the Colorado General Assembly
- 2) Summary of 5 Colorado Health Care Reform Proposals, including comprehensive savings with the Colorado Health Services Single Payer Proposal



## **2-page Overview: Colorado Blue Ribbon Commission for Health Care Reform (Draft) Final Report / Recommendations to the Colorado General Assembly (1-08)**

*Prepared by Michele Swenson, Health Care for All Colorado*

During its nearly 16-month length of service, the Colorado Blue Ribbon Commission for Health Care Reform -- comprised of 27 members statewide appointed by two governors and 4 legislators -- will have received 31 proposals (23 comprehensive, 7 Single Payer). The Commission selected four of these proposals for evaluation by the Lewin Group, in addition to a 5th Proposal written by a subcommittee of the Commission. The *Colorado Health Services Single Payer Proposal* is the only reform proposal that demonstrated any savings for the state -- \$1.4 billion -- and also the only one demonstrated capable of providing comprehensive health care for all. The Colorado Commission chose to base most of its recommendations on its own (5th) Proposal, modeled on Massachusetts reform of 2006.

The 208 Commission Recommendations fail to address:

- Rising cost of health insurance premiums (82% increase in 6 years in Colorado), copays, deductibles and prescriptions
- U.S. fragmented health insurance system that siphons more than 20 percent of health care dollars to profits, exorbitant CEO salaries, etc. and layers of administrative waste.
- A greater than doubling of median family income spent on health insurance: 7.7% in 1987 to 19% in 2005
- As premium costs continue to increase, coverage has decreased: "Insurance does not equal health care."

The 208 Commission's proposed solution:

- A cornerstone of the Commission Recommendation is the Massachusetts-style "Individual Mandate" to purchase private insurance, with a substantial tax penalty for failure to comply.
- The Commission counts heavily on taxpayer subsidies to private insurances.
- The Commission asserts that all cost-shifts are due to the uninsured - yet Lewin's Graph on Cost Shift shows that the uninsured and underinsured combined (labeled 'self-pay') contribute less than 20% to the total cost-shift burden. John Sheils of the Lewin Group informed the Commission that half of all uninsured payer their own health care bills.
- Commission Recommendation states: "A minimum benefit plan - a leaner health insurance package with high deductibles, annual caps or limited benefits (average monthly premium \$200/individual) is considered essential for assuring availability of an affordable product."

Shortcomings of 208 Commission Recommendations:

- The Massachusetts-style 'Individual Mandate' creates a captive market for commercial insurance without quality or cost controls on insurance charges. In Massachusetts, 2008 marks the 8<sup>th</sup> year of average double-digit premium increases, resulting in more who cannot afford insurance and are moved onto public insurance rolls at taxpayer expense. (*Boston Globe*, 9/13/07, 12/5/07)
- The 208 Commission seeks to solve one problem by exacerbating another — by moving more of the uninsured into underinsurance, or Minimum Benefit Plans. Attributing all unpaid medical bills to the uninsured and to under-reimbursed public programs, the Commission disregards the rising trend of unpaid medical bills by the underinsured. The annual *TrendWatch Reports* of the American Hospital Association reveal that out-of-pocket costs have risen from \$146.3 billion in 1995 to \$249.4 billion in 2005 - a 59% increase that parallels the 60% increase in unpaid medical bills over the same period.
- The Families USA Report *Too Great a Burden: Colorado's Families At Risk* (12-13-07) reveals that 1,054,000 people under the age of 65 in Colorado are in families that will spend more than 10% of their family income on health care costs in 2008 before accounting for taxes. Out of these people, the vast



majority, 82.6%, *have insurance*. Out of these Coloradans, 299,000 live in families that will spend more than 25% of their pre-tax income on health care costs in 2008. The numbers of underinsured people have increased since previous studies in 2000, and as a result, put thousands of families at risk due to a growing health care burden.

- As premium rates continue to rise faster than the rate of inflation or wage increases, more employers will either drop health coverage or move employees into Catastrophic ‘Minimum Benefit Plans’ with high out-of-pocket costs that leave families vulnerable to increasing health and financial risk, and contribute to over 50% of personal bankruptcies precipitated by high medical bills.
- The Commission Recommendations add many new categories of coverage, eligibility testing, and new departments of administration, as well as additional taxpayer subsidization, multiplying administrative and public costs of health care.

Some goals defined by the Commission — to provide consumers with "a choice of insurances" and to "ensure the ongoing viability of Colorado’s insurance markets" — falsely equate insurance with health care access. People want a true choice of health care, not choice of “minimum benefit” insurances. The Commission Report begs the question: Is reform intended to insure the bottom line of the health insurance industry, or health care access for all?

It is telling what the Commission left out of the final report — Statements from the Vulnerable Populations Task Force Report to the Blue Ribbon Commission, September 28, 2007:

- "Mandating the purchase of a minimum benefits package forces residents to pay for *underinsurance* and is in direct conflict with the guiding principles of the Commission. We must not exchange our uninsured for masses of underinsured."
- "The Lewin analysis established that current expenditures in health care would finance comprehensive health insurance for all Colorado residents under the Colorado Health Services proposal with **\$1.4 billion in savings to the state of Colorado**. We should not consider healthcare to be a commodity, as we do not choose to get sick. The Vulnerable Populations Task Force asks the legislature to have the vision to do what is best for all the residents of Colorado. If this is not possible, we offer our recommendations on elements of health reform that could benefit Vulnerable Populations."

Single Payer merited just 4 sentences in the Commission’s final report. Single Payer: "...viewed by the Commission as being too disruptive of current coverage and also unworkable in a single state."

Nevertheless, the Single Payer model is uniquely capable of overcoming many problems that the current system and other proposals cannot. No other proposal would create a single Health Trust Fund combining administration of all health care monies, insulated from the politics of the State General Budget (and such budget constraints as TABOR and Averschoug-Bird, etc.).

Single Payer transparency and accountability of data overcomes the problem of secret proprietary data of numerous private insurance companies, and permits evaluation of best practices and outcomes in a statewide Health Information Technology system. While all other proposals call for substantial increases of state Medicaid spending (funds constrained by General Budget rules that simultaneously limit spending in other areas), Single Payer alone can create a true cost-effective single-risk pool insurance by consolidating multiple categories of medical care that now fall under Auto, Workers’ Comp and Medicaid/Medicare to eliminate administrative waste. Single payer can overcome the federal limits on provider reimbursements that hamper Medicaid/Medicare. Only Single Payer provides true choice of providers and hospitals. Currently, employees’ choice of providers is limited within an employer’s health plan; change of plans requires change of providers, disrupting health care. See: [Improved Coverage & Cost Savings of Colorado Health Services Single Payer Proposal](#)

The Commission’s Reform Proposal sets the stage for a continued downward spiral: As premiums increase and benefits decrease, more people can no longer afford insurance and more are moved into public programs at taxpayer expense. (Overview with live links at [www.healthcareforallcolorado.org](http://www.healthcareforallcolorado.org))



**Summary: Lewin Group Technical Assessment of Four Colorado Health Care Reform Proposals (Proof Report, August 20, 2007)**  
Prepared for The Colorado Blue Ribbon Commission for Health Care Reform\*

**BETTER HEALTH CARE FOR COLORADO** - Provides care through a public program expansion and access to private insurance coverage with low-income subsidies through a Health Insurance Exchange. Individuals who purchase private coverage would have access to a limited core set of benefits, with premiums copays.

467,200 - number remaining uninsured      \$595 million - increase in health spending

**SOLUTIONS FOR A HEALTHY COLORADO** - Provides coverage to Colorado residents under a Core Limited Benefit Plan in the private sector and expands coverage under Medicaid and Child Health Plus (CHP+). Low-income people who are not be eligible for the government programs would receive a premium subsidy.

133,400 - number remaining uninsured      \$271 million - increase in health spending

**A PLAN FOR COVERING COLORADO** - Provides coverage to Coloradans through a public program expansion and a mandatory private pool for all residents not eligible for the public program. It provides a minimum benefits package in a private pool and premium assistance based on income for those who cannot afford insurance. All plans would provide a comprehensive minimum benefits package, and differ mainly on cost-sharing amounts.

106,500 - number remaining uninsured      \$1.3 billion - increase in health spending

**COLORADO HEALTH SERVICES SINGLE PAYER PROGRAM** - A single payer plan that would provide coverage to all residents of the state, including state and local workers, and residents currently covered under Medicare, Tricare, Veteran's Health, Indian Health Services and Federal Health Benefits programs. Provides comprehensive health care benefits for all - benefits of the Colorado Medicaid benefits package plus preventive dental. Consumers would have their choice of providers and hospitals within the state.

0 - number remaining uninsured      \$1.4 billion - decrease in health spending

**PROPOSAL 5\*** - An Individual Mandate requires Coloradans to purchase private insurance or pay a penalty. Tax subsidies for purchase of basic benefit plans to 400% FPL. Combines & expands Medicaid/CHP+. Adds 'Medically Needy' & 'Medically Correctable' programs; expands Cover Colorado to cover more with chronic conditions.

27,500 - number remaining uninsured      \$1.1 billion - increase in health spending

\*Proposal 5 evaluation presented by Lewin Group November 15, 2007

Lewin's Technical Assessment of Health Care Reform Proposals (230 page report):

<http://www.colorado.gov/cs/Satellite?c=Page&childpagename=BlueRibbon%2FRIBBLayout&cid=1178305890619&p=1178305890619&pagename=RIBBWrapper>



### Colorado Health Services Single Payer Proposal – Cost Savings

Overview of Lewin Group Evaluation Prepared for Colorado Blue Ribbon Commission for Health Reform (August 2007)

The **Colorado Health Services Single Payer Plan** represents a comprehensive health care program for all residents of the state, administered by a publicly owned not-for-profit governing board. It is the only proposal that would cut costs *and* insure everyone.

**Financing:** Federal, State and Local government health dollars are transferred to the Colorado Health Trust, insulated from the general state budget. Overhead costs of the CHS are limited to no more than 5%.

- Federal programs - i.e., Medicare, Medicaid, Tricare/CHAMPUS, Veterans' Affairs, Indian Health Services and the Federal Employees Benefits Plan.
- State and Local health programs - i.e., Medicaid, employee health benefits, Workers' Compensation and other safety net funding.
- "Sin taxes" on alcohol and tobacco

#### Individual / Employer Costs -- No health premiums or deductibles; nominal copays

- All employers, including self-employed: 6% employer payroll tax
- Individuals and families - additional tax: 7.5% income tax

#### Health Cost Savings under CHS Single Payer Plan (2007/2008)

Overall health cost savings for Colorado employers:

Overall health cost savings for Colorado families:

\$2.34 billion  
\$187 million

CHS is funded in part by administrative savings realized across many segments of health care. A large savings results from eliminating high administrative costs of private insurers - 14% average - compared to 1.8% administrative costs for Medicare. Cost of coverage of uninsured and improved coverage of under-insured would be somewhat offset by reduced chronic health conditions, emergency room visits and hospitalizations; and reduced cost-shifting for uncompensated care.

#### Administrative Savings:

- Providers savings = 26%
- Hospitals savings = 9.8%

\$669 million  
\$332.2 million

#### Additional Savings: Negotiated bulk rate prices - Prescription Drugs + Durable Medical Goods

\$682 million.

Statewide health spending 2007/2008: Current - \$30.1 billion CHS - \$28.7 billion **Total Net Savings: \$1.4 billion**



## ***FREQUENTLY ASKED QUESTIONS ABOUT SINGLE PAYER***

### **1) What is Single Payer Health Care?**

Single Payer Health Care is a not-for-profit health care finance model that provides comprehensive health care coverage for everyone in the most cost-effective manner by broadly spreading risk across the largest insurance risk pool.

The Health Care for All Colorado (HCAC) Single-Payer proposal is a “public-payer, private-provider” model, permitting each individual free choice of private providers and hospitals.

The Veteran’s Administration uses a different health care model – “public-payer, public-provider” – where “public providers” (doctors, nurses, etc) work for the government, and its health care facilities (hospitals, etc.) are owned by the government.

### **2) How is Single Payer health care funded?**

Single Payer insurance is funded by a progressive tax, collected with existing income tax forms. The money is put into a Health Care Trust (isolated from the General Budget and the legislature), managed by a public, not-for-profit agency.

A Single-Payer insurance model limits government’s role to the act of collecting health insurance premiums through the income tax mechanism. Government then turns the funds over to a publicly- owned/managed agency to reimburse health care providers. The quasi-government agency operates much like a public utility, and is regulated by a governing board, independent of the legislature.

### **3) Does Single Payer provide true choice of providers and hospitals?**

Yes. The Single-Payer model guarantees free choice of providers and hospitals.

By contrast, the “market-based” network of over 1200 private insurances limits choices to “in-plan” providers and hospitals. When plans are changed, providers and hospitals must also often be changed.

### **4) Does Single-Payer health care protect individual health care choices?**

Yes. Single-Payer permits patients with their providers to determine their health care. By contrast, private insurers can override decisions by patients and their providers.

### **5) Is Single-Payer health care more cost-effective?**

Yes. Single-payer plans are financed with a *progressive tax* that costs less for the large majority of families and individuals than current premiums, copays, deductibles and other out-of-pocket costs required by private insurances. Single payer *eliminates the financial risk of medical bankruptcy* that is now so common -- currently 50% of personal bankruptcies are attributed to health care costs.

*Over 20 federal and state studies since 1990 demonstrate that Single-Payer saves money and also has the ability to provide comprehensive health care for all. Cost-effective single payer plans, like traditional Medicare, limit overhead costs to 3-5%.*

By contrast, overhead costs of multiple (over 1200) for-profit insurances exceed 30% of all health care dollars – 20% of health care dollars go to profits, CEO salaries, marketing, lobbying and administrative costs. Another 12% of health care dollars go to providers’ added administrative costs, e.g., for hiring extra staff to manage different paperwork of multiple insurances.



Single Payer saves by permitting planning to reduce unnecessary, wasteful duplication of facilities and services. It also permits negotiation of annual budgets with health care facilities, fair prices with provider associations, and bulk rates for pharmaceutical and medical devices.

**6) Does Single Payer provide cost-savings to large and small businesses?**

Yes. Single-Payer would reduce businesses' health care contributions to a simple tax. Relieved of costs of managing employee health care plans, business would be freed to compete on equal footing in the world marketplace. Single Payer would increase effective employee take-home pay, and reduce added costs to consumers of goods and services (e.g., \$1,600 added to the cost of each U.S.-made car).

Under the current private insurance model, many businesses, states, cities, etc., finance the rising health costs for employees and retirees. Employees also experience reduced effective take-home pay, as employers pass rising health costs to them. Businesses also pass on their rising health costs to consumers, who pay extra for goods and services, e.g., \$1,600 added to the cost of each U.S.-made car in 2005.

**7) Would Single Payer health care provide comprehensive health care for all?**

Yes. Only the Single Payer model demonstrates the ability to provide comprehensive health care for all.

Currently, health care is rationed by ability to pay. The Institute of Medicine (2003) revealed that 18,000 uninsured Americans die preventable deaths annually. "Free-market" Health Savings Accounts (HSAs) and catastrophic coverage benefit only the healthy and the wealthy who can afford to save. Under multiple private insurance risk pools, as the healthy leave a risk pool, the sick remain, triggering cost rise and prompting employers to drop coverage, leaving still more uninsured.

**8) Does Single Payer provide quality health care?**

Single Payer permits oversight by a governing board, with consumer input, to create a quality-centered, instead of profit-centered, health care system.

**9) Why consider Single Payer Health Care at the state level?**

States including Colorado, California, Pennsylvania and Michigan have health care reform proposals based on a single-payer model. There is proposed federal "enabling" legislation (HR 506 & S 1169) that would provide federal funding for state pilot programs for health care reform. Federal cooperation would also neutralize issues around federal requirements like Medicaid and Medicare waivers, etc.

While it is preferable to enact national health care reform, like HR 676, it may require time to implement an improved Medicare-for-All program. In the interim, states can implement reform more quickly that could serve as a pilot for the federal program, to demonstrate how Single Payer could function at the state level.