

COMMUNITY BASED HEALTH PLANS

An initial assessment of options for the Roaring Fork Valley

DRAFT

Healthy Mountain Communities
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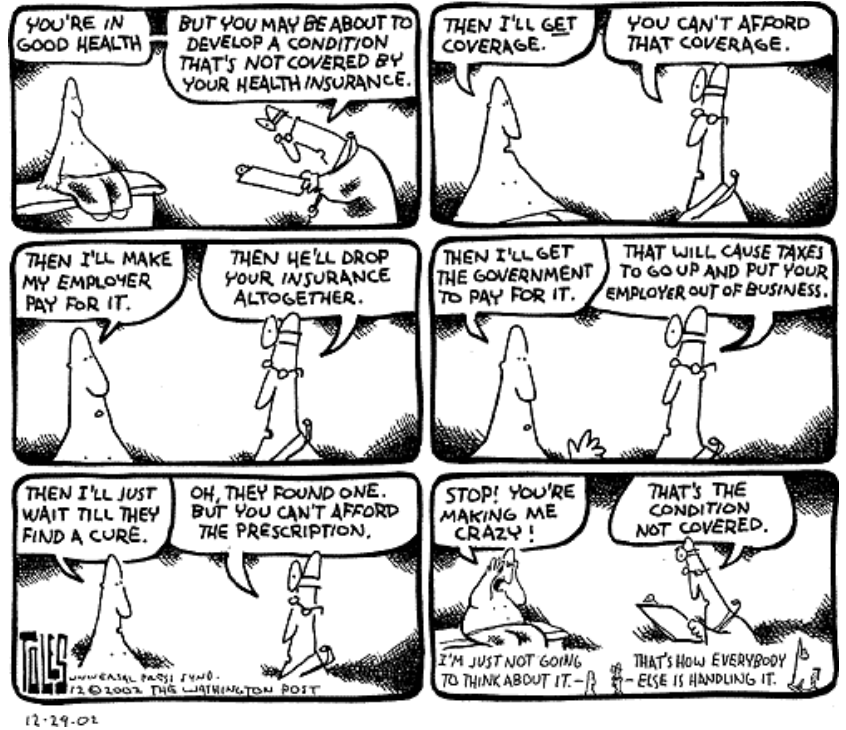
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INTRODUCTION

While the health insurance debate is stalled at the national level, and the cost of insurance and the number of uninsured increases, more and more communities across the U.S. are developing innovative programs to provide health insurance and quality health care to their residents.

This paper takes an exploratory look at many of these efforts with an eye to how they might be applicable in the Roaring Fork and Colorado River Valleys. Based on this initial research, it includes a list of recommendations and “next steps for consideration” by local governments and community leaders to address the increasing costs and availability of health insurance in our region.



This effort to assess potential improvements to health care and insurance issues in our region, grew out of discussions between Garfield and Pitkin County Commissioners and their concerns about the rising costs of health insurance for county employees as well as general the lack of coverage for many families that live and work in the region.

This assessment was researched and written by Healthy Mountain Communities, a nonprofit organization creating regional strategies, collaborative solutions, and decision-making support tools to strengthen the Roaring Fork and Colorado River Valleys for the future. More information on HMC is available at www.hmccolorado.org.

RESEARCH FOCUS

The focus of the research conducted for this assessment was guided by the following questions:

- Why are people and communities concerned about healthcare and health insurance?
- What can a community do to reduce/manage insurance costs, increase health insurance availability and enrollment, and provide health insurance to all residents who need it?

As will become evident in this assessment, there are a number of reasons people are concerned about health care and health insurance. To address these concerns, a number of communities across the U.S. have developed, supported, and managed programs to increase the availability of health insurance and health care to residents. Many of these efforts target specific groups such as children, low-income residents, and small businesses. This paper highlights several models that could be applicable and adaptable to the needs of the residents of the Roaring Fork and Colorado River Valleys.

This assessment is an *initial* look at the potential for a more comprehensive approach to health insurance and health care in our region and steps our region could take to make such potential a reality. It is not an exhaustive examination of the issue.

FINDINGS

A PERFECT STORM

Joel Miller sees a perfect storm rising over health care. As an analyst with the National Coalition on Health Care, he has tracked as three elements that have grown to make health care an issue of tragic proportions. Each element contributes to the growth of the other in a vicious cycle that make each harder to address. The elements of the health care “perfect storm” include mounting costs, rising unemployment growing numbers of uninsured, and the sustained economic downturn.¹

Mounting Costs

Health spending in the U.S. accounts for roughly 15% of the gross national product (GNP)– a total of \$1.55 trillion or \$5,440 for every person in the U.S.² This amount is an increase from the 13.3% of the U.S. economy in 2000. Health spending in other developed nations range from 9 to 11 percent of the GNP.

This increase in health spending is reflected in the *2003 Annual Employer Health Benefits Survey* released by the Kaiser Family Foundation and Health Research and Educational Trust (HRET). The survey presents a startling and troubling picture of the costs of health insurance in the U.S. According to the survey, insurance premiums increased by 13.9% in 2003, the third consecutive year of double digit increases.³ The National Coalition on Health Care estimates that the average annual insurance premiums for employer-sponsored family health coverage will increase from \$9,160 in 2003 to over \$14,000 in 2006.⁴

In Colorado, health insurance prices increased an average of 18% in 2003, significantly higher than the national average.⁵

Rising Unemployment

People who lose jobs usually lose their health insurance. Laid off workers can purchase their insurance (commonly referred to as COBRA for the 1985 legislation), but they must pay the full cost plus a 2 percent

¹ “A Perfect Storm: The Confluence of Forces Affecting Health Care Coverage,” Joel E. Miller. National Coalition on Health Care, 2001.

² “Health-care spending sets record,” Robert Pear. New York Times in Denver Post, January 9, 2004.

³ *2003 Employer Health Benefits Survey*. Kaiser Family Foundation - www.kff.org/content/2003/20030909a

⁴ “Charting the Course of Inaction,” Henry E. Simmons and Mark A. Goldberg, National Coalition on Health Care, 2003.

⁵ “Health Insurance rates rise 18% in Colo,” Marsha Austin, Denver Post, Nov. 20, 2003.

administrative fee. Consequently, many unemployed workers cannot afford this option.

To make matters worse, states across the country are experiencing budget deficits due to dramatic decreases in revenues over the last few years. To reduce those deficits and balance their budgets (often required by their constitution), many states are enacting across-the-board spending cuts. Consequently, states are cutting Medicaid funding, seeking waivers to increase cost sharing with Medicaid beneficiaries, and /or creating stricter eligibility requirements at a time when more and more people are becoming eligible and will need insurance.

Sustained economic downturn

Increasing insurance premiums and the recession that has gripped the nation over the last few years, has made it harder for employers to offer health insurance coverage to employees. While most employers are increasing the employee share of health insurance cost, some are dropping coverage altogether. Some employers have moved to part-time or contract workers to avoid health insurance costs. Recent surveys and studies estimate that the number of uninsured in the U.S. will rise from the 41 million in 2001 to over 50 million in 2006.⁶

These elements of the storm impact hospital and clinic operations, worker productivity, and ultimately help increase health care and insurance costs.

LOCAL EXPERIENCE

The local experience with insurance costs mirrors national trends. For example:

RE-2 School District

In 2001-02, Re-2 saw a 26 percent increase, amounting to an additional \$247,000, paid out in health care costs. The district, which includes public schools in New Castle, Silt and Rifle, employs 455 full-time teachers, administrators and staff eligible for benefits. And in 2002-03, the district faces another 26 percent increase. The district's 2003 projected budget is at \$20.5 million. Out of that, \$1.79 million will be spent on health insurance for employees.⁷

⁶ Joel E. Miller, *ibid.*

⁷ "Employers ill over health care costs, Carrie Click, December 16, 2002, Glenwood Post Independent, www.postindependent.com

Glenwood Springs

Sales tax revenues in 2002 fell by 2.4 percent, or \$261,000, compared to 2001, but city spending last year still left healthy balances in most accounts. The one trouble spot in the budget was the city’s self-insurance fund, which handles health insurance for city employees. Finance Director Mike Harman reported that the fund spent \$177,000 over income, and went further in debt to \$260,000.⁸ The City is currently exploring a number of options to contain rising costs.

Town of Carbondale

Carbondale uses the Colorado Employee Benefit Fund, a trust fund used by government agencies, to provide health insurance for employees. Costs have increased significantly over the last few years but Carbondale has not found a better insurance program to switch to. The Colorado Employee Benefit Fund has administrative overhead of about 8-9%, which seems to very competitive in the industry. Carbondale would be initially interested in regional discussions to create a local health insurance system.⁹

COMMUNITY BASED RESPONSES

A number of communities and community groups are not waiting for solutions at the state or federal level. Instead, they are taking matter into their own hands. The amount of community and organizational effort across the U.S. to provide health insurance and access to care reflects in the growing concern over health care issues. There are over 600 communities working to increase access to health care services, reduce health care and insurance costs, increase insurance coverage, create more coordinated services, and find innovative ways to finance their efforts.¹⁰

Given the range of issues and resources available at the local level, there are a number of ways in which communities have attempted to address their health care and health insurance needs. Some efforts worth noting include:

“Most would agree that there is no real system of health care in the United States – no working mechanism for the provision and payment of health care services across the board. [. . .] health care in the U.S. remains a patchwork of services and payment streams that can vary by municipality, region, and state.”

More than a Market:
Making Sense of Health
Care Systems. W. K.
Kellogg Foundation

⁸ “Glenwood budget in black despite sales tax revenue dip,” Heather McGregor, June 9, 2003 Post Independent www.postindependent.com

⁹ Source: John Hier, Town Manager.

¹⁰ “Grassroots Health Care Coverage: Local Communities are trying novel approaches to providing care for the indigent and the working uninsured,” Dianna Gordon. State Legislatures, October/November 2003.

Community-Based Health Plans

Community-based health plans attempt to integrate health insurance and health care at the local level. Many of these plans have been working since the 1940s and are directed by local members.

Group Health Cooperative of South Central Wisconsin

Group Health Cooperative of South Central Wisconsin serves 50,000 members in Dane County and South Central Wisconsin (including several local governments). GHC received federal qualification in 1977. Group Health Cooperative is governed by a board of directors, elected by the members at the annual membership meeting.

As of June 30, 1999 Group Health Cooperative had a net worth of \$23.6 million. Consistent with its status as a 501(c)(3) nonprofit organization, Group Health Cooperative returns all net income to the members in the form of benefits and services.

Coordinated health networks

Coordinated health networks work to streamline and coordinate health services already provided in a community. They can also coordinate and administer claims among self-insurers in a region to reduce costs and enable services not usually available.

Pittsburgh Coordinated Care Network

Formed by 12 safety net agencies in 1996, Pittsburgh's Coordinated Care Network sells preventative case management, disease prevention/management and pharmacy services to HMOs, then reinvests profits to provide "whole-person healthcare" to at-risk and uninsured residents of Allegheny County. The 501(c)3 non-profit corporation began operating in 1998 with \$4 million in grants from two national and 10 local foundations, and provides services to more than 57,000 people per year (of whom 20 percent are uninsured).¹¹

Community Health Plan of the Siskiyou (CHPS), Siskiyou County California

CHPS currently provides self-insured employers with claims processing and medical management services, as well as a

"One of the biggest myths is that there's not enough money to address healthcare needs or that government regulation precludes innovation. What's really going on is a lack of core competency on how to structure and coordinate these types of programs."

Jeffrey S. Palmer
Pittsburg Coordinated
Network

¹¹ *Communities in Action: Best Practices on Expanding Access to Health Care*. National Association of Counties www.naco.org.

network of over 500 contracted facilities and professionals throughout the region. CHPS serves over 3,000 enrollees, and plans a joint venture with a licensed carrier to offer fully-insured coverage to small employers and individuals. CHPS also allocates a portion of its income to subsidize wellness care for the high risk uninsured.

These services help CHPS accomplish its mission in several ways. First, they redirect back into the local economy dollars that would otherwise leave to pay for management expenses and dividends of for-profit companies, and to pay for medical and administrative services that could be provided locally. Second, by effectively managing care, CHPS not only improves people's health, but also reduces costs. In turn, lower costs expand access by making services and coverage more affordable, and by freeing up resources to subsidize wellness care for the uninsured. Third, as higher incomes correlate with healthier lifestyles, a strong health care system and a healthy population help attract businesses to Siskiyou County, further fueling this positive cycle.¹²

Cooperative Purchasing Alliances

These efforts coordinate pools of consumers of health insurance (individuals, small business, etc) and negotiate favorable rates with insurance providers to keep costs lower than they otherwise would be for the individual or small business seeking coverage on their own.

Roaring Fork Community Health Plan, Aspen to Glenwood Springs, Colorado (RFCHP)

Roaring Fork Valley Community Health Plan acts as an insurance cooperative that is open to individuals or businesses in the Roaring Fork Valley. Health care providers such as the hospitals in Aspen and Glenwood Springs and physician groups have agreed to participate in the program. The Plan signed a contract with regional insurer PacifiCare to provide "competitive" coverage for employees of valley businesses. The contract is good for three years and can be extended.¹³

Approximately 7,000 residents are enrolled in the plan -- from large employers (the Aspen Skiing Company) to individuals. The

¹² Community Health Plan of the Siskiyous - www.healthysiskiyou.com

¹³ "Valleywide health plan unveiled," Scott Condon. Aspen Times www.aspentimes.com, 6.20.2003

Roaring Fork Transportation Authority is considering enrolling in the program in 2004. The RFCHP is managed by a local board of directors with several working committees which help to reduce premiums through PacifiCare.

RFCHP has negotiated specific revenue/cost/profit parameters with PacifiCare, including medical management information so the RFCHP can analyze local medical trending and identify medical protocols to negotiate lower insurance premiums in the future. Additional efforts include partnering with the larger community to encourage healthy lifestyles and a more efficient use of the regional medical system.¹⁴

Working Today

Created in 1995, Working Today is a New York City based, national nonprofit organization ensuring that independent workers (currently 30% of the nation's workforce) have access to health insurance and other benefits. Working Today pools large numbers of independent workers from professional associations, membership- and community-based organizations, unions and companies and helps them to gain access to insurance and benefits usually reserved for the traditional full-time workforce. Working Today offers health insurance from multiple providers including HIP Health Plan of New York and Guardian Life, investment planning services from Salomon Smith Barney, and financial services from Citibank.¹⁵

HealthPass Purchasing Alliance - New York Metro Region

HealthPass is a small business purchasing alliance created in 1999 through a public-private partnership between the New York Business Group on Health and the City of New York.

HealthPass participants (small businesses with 2 to 50 employees) can access health and dental plans from multiple providers. Employees can select from 25 different options, but the employer gets one itemized bill each month and makes one payment to HealthPass. Employees get the freedom and flexibility to select the insurance plan, benefit options and provider network they want rather than accepting one-size-fits-all plan offered by the employer. Furthermore, employers don't have to worry about

"The major thing that the portable benefits network does is show a new delivery system. Instead of going to your employer for benefits, you can go to your union or a nonprofit [group] or some other source."

Sarah Horowitz
Working Today founder

¹⁴ Communication with Bill Hanisch, Executive Director, Roaring Fork Community Health Plan.

¹⁵ Working Today – www.workingtoday.org

finding the plan that meets employee needs – HealthPass does the hard work and lets employees decide.

At the end of 2002, HealthPass was serving more than 1,000 companies (several hundred of which are offering insurance for the first time) and covering more than 9,100 individuals.¹⁶

Community-sponsored health insurance programs

Community sponsored health insurance programs target low-income uninsured residents. Communities have found that it is less expensive to provide insurance and care to residents without insurance than through hospital emergency rooms.

Hillsborough County (Tampa), Florida

In 1991, Hillsborough County created and now manages and funds an HMO that provides healthcare for 30,000 to 40,000 county residents who don't have health insurance. The HMO is funded by a ½ cent county sales tax, which raises about \$100 million and annually underwrites care for the uninsured. The impetus for this effort came from the annual \$6 million increase in costs to the County Hospital for serving the uninsured.¹⁷

“By developing innovative and effective homegrown remedies to healthcare, [communities] are proving that the situation is not hopeless. In fact, all the ingredients for lasting and effective healthcare reform are present in the cities, towns and counties across America. And the primary ingredient is political will.”

Phyllis Busansky,
Former Hillsborough
County Commissioner

¹⁶ HealthPass – www.healthpass.com

¹⁷ *Communities in Action: Best Practices on Expanding Access to Health Care*. National Association of Counties www.naco.org.

RECOMMENDATIONS & NEXT STEPS

This paper has offered an initial assessment of innovative community efforts to provide health insurance and quality health care to their residents. Recommendations and next steps in this section attempt to address challenges and gauge opportunities to how residents of the Roaring Fork and Colorado River Valleys can benefit from improvements to our current health care and health insurance system, what those improvements could be and how they can be best implemented.

CHALLENGES

Complexity

Health care in the US is one of the most complicated systems in the world. This complexity combined with the vested interests and layers of regulation of the current system make the idea of a community based insurance effort seem insignificant and difficult to implement. Many powerful constituencies have a lot investment in the current system and will resist changes however rational, cost-effective and beneficial to the user.

Scale

The number of residents eligible or interested in a community-based insurance program might not be large enough for a community plan to be offered at a reasonable cost.

Competing Efforts at State and Federal Level

Although a federal level solution could address many health care and insurance questions for everyone through comprehensive program, a more likely scenario is for Congress to continually tinker within the confines of the current system.

State level efforts hold promise for improvement to the health insurance system since the effort can be citizen driven and put to a public vote via referendum, but the scale and complexity of the change, interest group opposition, and the concern of unintended consequences have made it difficult for state efforts to move forward. Although there are a few states pursuing innovative health care / insurance initiatives (Maine, Oregon, Maryland); such an approach is difficult in Colorado without constitutional amendments and resolution to some of the state's financial challenges.

Time and Cost

It difficult to unravel the possibilities for improving a community's health insurance and care options. It is equally (if not more) difficult to gauge the costs and time involved in implementing the improvements (the Roaring Fork Community Health Plan took 10 years to implement).

Different perspectives on the problem and the solution

There a number of differing perspectives on U.S. health care. These perspectives will shape responses to how a community attempts to address health care issues. Furthermore, the insured, the uninsured, employers, elected officials, doctors, insurers, brokers, hospitals, clinics, and public health officials don't often work together. The demands of their jobs and lives often keep them apart. Any community efforts to change the status quo of the current system will require cooperation between these groups as well as broad agreement on the problem, otherwise prospect for a and proposed solution being implemented is severely limited.

OPPORTUNITIES***A Tangible Problem***

Rising health insurance costs, and flat or declining household and local government revenues have made a health care and health insurance a issue for almost everyone. The fact that so many people, businesses, health care providers, and local governments are affected by the increased cost of health insurance makes the issue ripe for community action.

Social Capital¹⁸ and Community/Political Leadership¹⁹

Fortunately, the Roaring Fork community has already tackled some health care and insurance 'gaps' in the past, which gives it a solid foundation of addressing health care and insurance issues today. Efforts such as the Family Visitor Program, Healthy Beginnings, and Roaring Fork Family Resource Centers and most recently, the Mountain Valley Family Health Center and the Roaring Fork Community Health Plan point to significant social capital and community leadership necessary to innovate in the healthcare arena. The challenges to reform in health care are significant, but committed leadership that values collaboration and appreciates the

¹⁸ Social capital is often defined as people and their ability to collaborate and cooperate to solve problems and achieve mutual benefits. Also includes skills, education, and health status.

¹⁹ Phyllis Brusansky, former Hillsborough County Commissioner is the Chair of the National Association of Counties' Community Health Leadership Network.

time involved in innovative efforts can help overcome many of these challenges.

Scale

The size of the Roaring Fork and Colorado River Valleys is both a challenge and opportunity. Although there may not be enough people living in the region to make certain health care and insurance options viable, the success of the Roaring Fork Community Health Plan confirms that the scale of our region can be just right for innovation that would be more challenging at a state or federal level.

NEXT STEPS

Given these challenges and opportunities, HMC recommends the following next steps for community leaders to consider.

I. Assess the political landscape and interest in alternatives

To date, only Pitkin County and (to a lesser degree) Garfield County Commissioners have discussed the impact of rising health insurance costs and the potential for local government and/or community action to mitigate such costs. A more thorough assessment of the local and regional political landscape would help elected officials and community leaders better determine what actions make the most sense.

Specific Tasks

This suggested step could be accomplished as preparation for grant proposal to a number of Colorado foundations with an interested in health care and health insurance. One goal would be to engage a critical number of local governments, health care providers and insurers to commit to a process of exploring health insurance innovations and options.

- A. Hold a joint work-session with Bill Hanisch, Executive Director of the Roaring Fork Community Health Plan. A key question for local governments to explore is how joining the Roaring Fork Community Health Plan could reduce their costs and create a foundation for further innovation in providing access to health services and health insurance to all residents who need it. *(The potential savings to local governments makes this work session valuable regardless of any interest in the following steps.)*

“We are organized to address challenges and deliver services at the federal, state, and local levels, but the tough challenges are not respecting jurisdictional boundaries. They are primarily emerging at the neighborhood, regional, and global levels.”

William Dodge

- B. Interview elected officials and managers/senior staff from each local government, major health care providers, insurers, brokers, the uninsured, and community leaders about health insurance issues.
- C. Document experiences, concerns, hopes, and gauge interest in collaboratively exploring alternatives from tasks A & B. Use results as the foundation of a grant proposal to health-focused foundations in Colorado (Caring for Colorado Foundation, Colorado Trust, etc.) and potentially at the national level as well. Grant could seek funding for recommendations 2-4.

II. Survey resident health insurance needs.

The Four Rivers Health Insurance Initiative surveyed residents 5 years ago. The previous survey information helped in the formation of the Mountain Valley Health Center and the Roaring Fork Community Health Plan. A revised survey would confirm resident needs, interest in alternatives and focus the evaluation of options and implementation in recommendations #3 and #4.

Specific Tasks

- A. Assemble survey advisory team (i.e., local staff and health professionals).
- B. Develop and distribute request for proposals.
- C. Select survey firm.
- D. Revised survey instrument and methodology.
- E. Implement survey.
- F. Evaluate and report survey results.

III. Expand the matrix of options

This initial assessment reveals a number of community based efforts offer better access to care, insurance, etc. but it is only a cursory look at the options and the role that local governments, local hospitals, and community leaders can play (on their own or in collaboration). Tapping expertise in the arena of health care innovation and reform to expand the range of options available to communities (for example, from tax supported initiatives to cooperative efforts such as the Roaring Fork Community Health Plan) is an critical part of understanding what options and innovations would work best in our region. There are a number of consultants that could help in this regard at the local, state, and national level.

Specific Tasks

- A. Expanding the matrix of options could be a one/two day workshop with a panel of experts or a series of shorter workshops with individual experts. Including, but not limited to:
 - a. A presentation from the working group evaluating the potential of a commercially available health plan based on the prioritized list (similar to Oregon’s public efforts).
 - b. A discussion with health care and insurance advocate (and former Hillsborough County Commissioner) Phyllis Brusansky and/or independent health care policy consultant Barbara Yondorf (who had worked extensively with the Colorado Coalition for the Medically Underserved) to help fully assess the local and regional pieces and the capacity necessary to create a more community-based health insurance program.
 - c. Facilitated discussions and problem solving focusing on the gap between existing resources and full coverage for the uninsured, the hidden costs we pay anyway, and the various ways to finance the gap.

IV. Evaluate and rank the options to focus and direct effort

There are so many parts of the healthcare system that can be improved that a community effort can be paralyzed by the scale, complexity and costs of change. Improvements will also take time, so it is important that community efforts prioritize what are the most urgent health needs and how they contribute to an overall plan of improvement.

Specific Tasks

- A. Create a Health Care Roundtable to evaluate and rank options worth pursuing in our area.

The numerous and varied interests involved in healthcare make a broad coalition of supporters (that extends beyond the obvious choices) a necessary condition for community-based reform to occur. Such a coalition is crucial to help identify a problem, craft a solution and convince people the community has the resources to solve it.

1. Plan the purpose, membership, timeframe, facilitation, and staffing of the roundtable.
 2. Use the results from the interviews in recommendation #1 to help identify and select roundtable members.
- B. Evaluate options based on need, cost/benefit, funding source, and timeframe.
- C. Create an implementation strategy for prioritized options.

BUDGET & FUNDING OPTIONS

Each of the recommended next steps has a range of associated costs. The following budgets for each recommendation are included for discussion purposes.

I. Assessment

This step will require initial funding from local governments. The information gathered through this step shapes the nature of the subsequent steps and directs the goals and objectives of a potential grant proposal to support steps 2, 3, and 4.

II. Survey

This component and subsequent steps (III & IV) could be funded through a grant or grants with match from local sources (local governments, hospitals, insurers, etc.)

III. Matrix of options

There are a number of firms that could fully expand the matrix of health insurance options for a region such as ours. A request for proposals process would be the best way to determine the most appropriate team to complete this task.

IV. Evaluation and implementation strategy

Since process is such a big part of this next step, it could take longer to complete and require more resources than this conceptual budget indicates. This step could also be funded through grants and local matching funds.

Draft Budget

	Rate	Duration	Total
ASSESSMENT			
Joint work session planning	\$50/hr	10 hours	\$500
Worksession Facilitation	\$100/hr	2hour prep +2 hour meeting	\$400
Interviews & Reporting	\$80/hr	Roughly 20 one-hour interviews + 20 hours on report	\$3,200
Proposal Development	\$80/hr	20 hours	\$1,600
Subtotal			\$5,700
SURVEY			
Advisory team development	\$50/hr	2 hours	\$100
RFP Development & Review	\$80/hr	10 hours	\$800
Interview set up and selection	\$50/hr	5 hours	\$250
Advisory Team review of survey	\$50/hr	2 hours	\$100
Resident Survey			\$30,000
Project Management	\$80/hr	20 hours	\$2,000
Subtotal			\$33,250
MATRIX OF OPTIONS			
RFP development & proposal review	\$80/hr	10 hours	\$800
Consultant team			\$30,000
Project management	\$80/hr	20 hours	\$2,000
Subtotal			\$32,800
EVALUATION & IMPLEMENTATION			
Consultant support	\$1,000/ day plus expenses	6 Days	\$6,000
Roundtable staffing	\$80/hr	10 - 2hr mtgs + prep (2hrs.)	\$3,200
Roundtable Facilitation	\$100/hr	10 - 2hr mtgs	\$2,000
Subtotal			\$11,200
Total			\$82,950

Total project cost = \$82,950 (approx.)

The costs included in this budget exercise are for purposes of discussion only.

HEALTHY MOUNTAIN COMMUNITIES POTENTIAL ROLE

As a regional nonprofit corporation helping communities collaborate, innovate, and prosper. Healthy Mountain Communities can offer a range of services to assist local governments in implementing the recommendations in this assessment. This assistance could involve any or all of the following: project management, fund development/ grant writing, research, facilitation, policy development, and report writing.

Healthy Mountain Communities is a 501(c)3 not-for-profit, public corporation working on quality of life issues in the Roaring Fork and Colorado River Valleys since 1994. HMC provides non-partisan coordination, facilitation, and analytical services to citizens, nonprofit organizations, local governments, and businesses seeking to better understand and address specific problems such as the lack of affordable housing, traffic congestion, growth and economic development. HMC organizes ongoing forums for regional dialogue, collaboration and networking and provides a package of data, research and decision support tools to help community leaders better understand issues and implement solutions at the local and regional level.

Healthy Mountain Communities operates under a few basic principles:

Regional Focus

Many problems cross political boundaries, which makes them difficult for individual communities to solve alone. Taking a regional perspective can help pool resources to address common problems.

Collaboration

More people can win and win more often when we work with each other. Collaboration often means working with unlikely partners and across community sectors to achieve common goals. Such an approach to problem solving takes advantage of the many talents and resources in our region to the fullest extent possible.

Systemic thinking

The health of a community relates to the jobs people have, the neighborhoods they live in, and the state of their environment, as well as numerous other factors. Systemic thinking assumes that many of our current problems are connected and cannot be addressed in isolation and that good solutions solve multiple problems.

Citizen Democracy

Creating healthy communities requires more citizen participation than a trip to the voting booth every four years. Fortunately, citizens are a wealth of information, skills, and perspectives waiting to be tapped. Broader citizen

participation in problems that affect our everyday lives can make addressing problems easier and solutions more enduring.

SERVICES OFFERED

PROJECT MANAGEMENT, COORDINATION & FACILITATION

HMC works with local governments to develop, fund raise, and manage projects on issues of regional importance such as affordable housing, transportation, economic development, youth development, and human services.

Examples include:

- Local and Regional Travel Patterns Study 1997-98
- Regional Affordable Housing Initiative 1998-99
- Four Rivers Youth Developmental Assets Initiative 2000
- Regional Housing Trust Initiative 2002-2003

REGIONAL DIALOGUE & COLLABORATIVE PROBLEM SOLVING

HMC convenes ongoing forums for regional dialogue and to encourage collaborative problem solving in the Roaring Fork and Colorado River Valleys.

Specific components include:

- Planners and Managers Roundtable
- Watershed Collaborative
- The Colorado Communities Report
- Workshops and Trainings
- Annual “State of the Valley” Symposium

Previous efforts include:

- Coordinating a regional transportation roundtable to discuss transportation issues 1996-98
- Coordinating a regional affordable housing roundtable 1998-99
- Establishing a regional volunteer network for senior programs 1997

DECISION-SUPPORT TOOLS

HMC provides local governments with a package of quality of life indicators along with analytical and process tools to help elected officials and citizens better understand and take action on issues such as the transportation, affordable housing, economic development, land use impacts, etc. at the local and regional level.

- Colorado Smart Growth Scorecard, 2003
- Community Socio-Economic Profiles, 2003
- Index report on Colorado’s quality of life, 2001
- Regional Quality of Life Indicators, 1996

The rate for these services ranges from \$50-\$80/hour depending on the scope of the project and the specific services needed.

ATTACHMENTS

- A. Prioritized List Health Plan**
- B. Direct pay**
- C. Mandatory health insurance**
- D. What is Single Payer?**
- E. Selected Resources**

ATTACHMENT A – PRIORITIZED LIST HEALTH PLAN

DR. A. J. KAUVAR FOUNDATION

INNOVATIVE EVIDENCE-BASED HEALTH INSURANCE INITIATIVE

Problem

National studies indicate that health care costs grew faster in 2002 than any time since 1990, and that they will continue to increase substantially in 2003. For example, in Colorado, the National Federation of Independent Business found that a majority of Colorado small business owners and their employees have experienced increases in their health care insurance premiums of 20 percent or more in each of the last four years.

Initiative

The Kauvar Foundation has funded initial work on a private sector health care insurance alternative designed to enhance:

- health care accessibility,
- cost containment, and
- quality of care.

The core element of the plan would be a list of health services developed in Colorado that is prioritized based on treatments that are most medically beneficial to patients. Treatments in the higher, more medically effective and cost effective tiers would have low patient co-pays relative to services in the tiers with less beneficial treatments, encouraging physicians and consumers to focus on evidence-based medical care. This would allow the plan to be offered at lower than average cost. Education of practitioners and consumers on effective treatments and costs would be another key component of the plan, so both would have the information needed to make good health care decisions.

Under the auspices of the Kauvar Foundation, a committee of independent medical and financial experts will develop the Colorado list in 2003. The committee will seek significant input from the medical community statewide in developing the list. Although this proposal uses a list of health services similar to the Oregon Health Plan, it is fundamentally different because its goal is to provide a more affordable and medically effective choice in the private sector, not as a basis for limiting Medicaid services.

Other state and national foundations are interested in the initiative, as are representatives of the Colorado and Denver medical societies. After Kauvar Foundation representatives discussed the idea with Colorado-based insurance carriers, Rocky Mountain Health Plans has become a project partner and plans to introduce a demonstration plan in 2004. Possible 2004 legislative changes needed to allow introduction of the plan would be identified during 2003. Governor Owens' administration and legislative leaders will be given periodic updates on progress being made throughout 2003. For more information, please contact [The Adams Group](#) at 303-282-9250

ATTACHMENT B – DIRECT PAY

The Rising Cost of Healthcare

www.simplecare.com

Billing, administrative costs and low reimbursement rates put healthcare providers at financial risk and drive up costs for patients.

HMO's and insurance companies often reimburse physicians at such a low rate that it does not adequately cover costs incurred, and many services are never compensated for at all.

Insurance companies do not reimburse doctors for the full amount of the bill, and yet they require an increasing level of administration and documentation for submitting claims. Rejected claims must be billed to the patient, adding to the collection costs.

Ethically, cash-pay patients should not be forced to pay for the cost of those who have insurance. SimpleCare attempts to solve this problem, making healthcare more affordable for everybody. SimpleCare creates a system that is sensible and more economical for patients, employers and healthcare providers.

SimpleCare patients are a doctor's simplest, least-expensive patients. They pay at the time of service, eliminating billing costs. CPT codes and referrals are unnecessary for these patients. Physicians get paid immediately, with no hassle.

By eliminating costs associated with billing, insurance claim forms, coding diagnoses and procedures, referrals, authorizations, payment delays, EOB reviews, claim denials, re-submissions, collection risks, and other managed care costs, physicians can provide patients a fair price for services without the administrative hassles and bureaucracy.

So many costs are eliminated using SimpleCare that providers can usually charge 30-50% less for SimpleCare patients while actually increasing their profit.

By using SimpleCare, healthcare providers have the freedom to establish a price that is fair for the services provided.

SimpleCare eliminates the administrative burden and the cost associated with it.

SimpleCare eliminates much of the paperwork, administration and billing that have been inflating the cost of healthcare. This allows healthcare providers to cut these charges out of their fees and offer a fair price to their patients. SimpleCare visits cost providers less money, allowing them to pass along some of the savings to their patients. Providers can usually reduce their rates by 30-50% while increasing their profitability. There are no third parties to bill, and therefore no hoops for doctors to jump through to get paid. SimpleCare patients pay in full at the time of the visit. This saves both time and money -- time providers can now spend with

patients instead of doing paperwork, and money otherwise wasted on billing, coding and administrative costs.

Any patient or person may become a member of SimpleCare.

Whether you are insured, underinsured, uninsured, or on Medicare, Welfare or other government programs, SimpleCare may reduce your out-of-pocket medical expenses. Use SimpleCare when insurance does not pay for the health services, providers, or alternative care you choose. Remember however, that SimpleCare IS NOT an insurance company nor does it provide any insurance services.

Any licensed health care provider may participate.

Selecting the right doctor is an important health care decision, so SimpleCare encourages all licensed health care providers to join and asks that patients tell all their personal doctors about SimpleCare. SimpleCare provides the structure and the momentum for health care providers frustrated with the current system to break free from the burden associated with third party billing and contracting. You can start providing SimpleCare and build up the cash paying part of your practice; continue billing insurance companies and withdraw from third party contracts when the time is right for you to do so. SimpleCare makes sense - and makes dollars too! A true Win-Win for patients and doctors!

SimpleCare is a win for businesses too!

Many businesses are interested in the SimpleCare approach for their employees. They are considering employer defined contributions, for example, setting their own level of how much they can afford to contribute toward their employees health care. SimpleCare allows the individual business to maintain control over their health care costs while providing an employee directed model for health care services.

SimpleCare makes sense... Common sense!

SimpleCare is a common-sense health care program designed by members of the **American Association of Patients and Providers** (AAPP). The non-profit AAPP was formed by practicing board-certified physicians in an effort to bring together the voices and strengths of patients, physicians and all health care providers as the "agents of change" across the nation.²⁰

²⁰ SimpleCare – www.simplecare.com

ATTACHMENT C – MANDATORY HEALTH INSURANCE

Health Insurance Required

By Ted Halstead

President and CEO, New America Foundation

and Laurie Rubiner

Director, Universal Health Insurance Program

The Washington Post
August 5, 2003

Last week Sen. John Edwards became the first presidential candidate in U.S. history to propose solving the problem of the uninsured by making health insurance mandatory. Although his proposed health care mandate is limited to children and young people -- all those under the age of 21 -- it offers the most promising way forward for eventually covering all 41 million uninsured Americans, and it marks a major turning point in our nation's health care debate.

The United States spends more on health care per capita than any other nation, yet one in seven of our citizens, and 12 million children, still lack basic health insurance. There are essentially only two ways to overcome this and achieve universal health insurance. One is to adopt a single-payer, government-run system, which is the norm in Canada and most of Europe. Such a system would have the government acting as the purchaser, administrator and health care decision-maker for all Americans. But a government-run approach has been flatly rejected by the American people time and again, despite the best efforts of five presidents, from Truman to Clinton.

The other -- and far more promising -- path to universal coverage is to approach health insurance as we approach car insurance: Make it mandatory. In essence, all Americans should be required to purchase their own health insurance from among competing private providers, with the government providing subsidies to those who need them.

The first and most obvious benefit of an individual mandate is that it would achieve universal coverage. By contrast, neither President Bush's proposal for refundable health care tax credits nor the various plans put forth by other Democratic candidates could meet this test, because all approach the problem in a piecemeal fashion.

The promise of "universal coverage for universal responsibility" goes beyond solving the problem of 41 million uninsured Americans. Structured correctly, such a policy would also bring down health care costs for most Americans (by virtue of forcing a large number of relatively young and healthy Americans into health care pools), and offer citizens more health care choices. It would also provide all Americans who now have insurance something they don't

now have but badly want: the ability to take their health plan and doctors with them from job to job.

One of the overwhelming benefits of mandatory coverage is that health insurance would gradually become citizen-based instead of employer-based, enabling all citizens to select and keep the health insurance provider of their choice and to take advantage of group rates, regardless of their employment status. This would help American workers at all levels: from the highly compensated executive changing jobs to the single mother working two part-time jobs to the independent contractor who can't afford the prohibitive costs of getting insured in today's individual market.

For political reasons, it is understandable why Edwards would start by requiring health insurance for all children. After all, parents are spending the month of August making sure their children have the immunizations and physicals required to enter school in September. But if we force parents to meet these basic medical requirements, shouldn't we also make it easier for them to secure the health insurance necessary to comply with the law? And in a country that prizes the virtue of personal responsibility, is it really too much to expect parents to insure their children, especially if the government provides a helping hand for those who need it?

The logic of personal responsibility and of requiring all parents to cover their children raises the obvious question: Why not apply the individual mandate to all Americans? The Edwards campaign estimates that its plan would cover 21 million Americans who lack health insurance at a cost of approximately \$53 billion a year. By comparison, both the Blue Shield of California Foundation and the Commonwealth Fund recently released independent analyses showing that by applying an individual mandate to all Americans, we could reach universal coverage for \$70 to \$75 billion a year. Is the value of covering the remaining 20 million Americans not worth the incremental cost of about \$20 billion?

Although John Edwards is the first to propose mandatory insurance as part of his presidential platform, he is not the first presidential candidate to have endorsed the concept. Bob Dole, the 1996 Republican nominee for president, once co-sponsored legislation with the late Sen. John Chafee to require all Americans to secure health insurance by the year 2005. At the time, Dole and Chafee were joined by 18 of their Republican colleagues, half of whom remain in the Senate today. This suggests that John Edwards has not only put his finger on the most promising way to solve the problem of the uninsured but also on the approach most likely to garner bipartisan support.²¹

²¹ New America Foundation – www.newamericafoundation.org

ATTACHMENT D – WHAT IS SINGLE PAYER?

Physicians for a National Health Program

www.pnhp.org

Single-payer is a term used to describe a type of financing system. It refers to one entity acting as administrator, or “payer.” In the case of health care, a single-payer system would be setup such that one entity—a government run organization—would collect all health care fees, and pay out all health care costs. In the current US system, there are literally tens of thousands of different health care organizations—HMOs, billing agencies, etc. By having so many different payers of health care fees, there is an enormous amount of administrative waste generated in the system. (Just imagine how complex billing must be in a doctor’s office, when each insurance company requires a different form to be completed, has a different billing system, different billing contacts and phone numbers—it’s very confusing.) In a single-payer system, all hospitals, doctors, and other health care providers would bill one entity for their services. This alone reduces administrative waste greatly, and saves money, which can be used to provide care and insurance to those who currently don’t have it.

Access and Benefits

All Americans would receive comprehensive medical benefits under single payer. Coverage would include all medically necessary services, including rehabilitative, long-term, and home care; mental health care, prescription drugs, and medical supplies; and preventive and public health measures. Care would be based on need, not on ability to pay.

Payment

Hospital billing would be virtually eliminated. Instead, hospitals would receive an annual lump-sum payment from the government to cover operating expenses—a “global budget.” A separate budget would cover such expenses as hospital expansion, the purchase of technology, marketing, etc.

Doctors would have three options for payment: fee-for-service, salaried positions in hospitals, and salaried positions within group practices or HMOs. Fees would be negotiated between a representative of the fee-for-service practitioners (such as the state medical society) and a state payment board. In most cases, government would serve as administrator, not employer.

Financing

The program would be federally financed and administered by a single public insurer at the state or regional level. Premiums, copayments, and deductibles would be eliminated. Employers would pay a 7.0 percent payroll tax and employees would pay 2.0 percent, essentially converting premium payments to a health care payroll tax. 90 to 95 percent of people would pay less overall for health care. Financing includes a \$2 per pack cigarette tax.

Administrative Savings

The General Accounting Office projects an administrative savings of 10 percent through the elimination of private insurance bills and administrative waste, or \$150 billion in 2002. This savings would pay for providing medical care to those currently underserved.

Cost Containment The Congressional Budget Office projects that single payer would reduce overall health costs by \$225 billion by 2004 despite the expansion of comprehensive care to all Americans. No other plan projects this kind of savings.

Different Perspectives on the Benefits of Single-Payer

Patients

Each person, regardless of ability to pay would receive high-quality, comprehensive medical care, and the free choice of doctors and hospitals. Individuals would receive no bills, and copayment and deductibles would be eliminated. Most people would pay less overall for health care than they pay now.

Doctors

Doctors' incomes would change little, though the disparity in income between specialties would shrink. The need for a "wallet biopsy" before treatment would be eliminated; time currently wasted on administrative duties could be channeled into providing care; and clinical decisions would no longer be dictated by insurance company policy.

Medical endorsements include PNHP (9,000), the American Public Health Association (30,000), American Association of Community Psychiatrists, Massachusetts Academy of Family Practice, American Medical Women's Association (13,500), Alameda-Contra Costa Medical Society, American Medical Student's Association, D.C. Medical Society, National Medical Association (6,500), American College of Physicians (Illinois Chapter), Long Island Dermatological Society, Islamic Medical Association, American Nurses Association, the Nurses' Network for a National Health Program, and the D.C. chapter of the American Medical Association.

Hospitals

The massive numbers of administrative personnel needed to handle itemized billing to 1,500 private insurance companies would no longer be needed. A negotiated "global budget" would cover operating expenses. Budgets for capital would be allocated separately based on health care priorities. Hospitals would no longer close because of unpaid bills.

Insurance Industry

The need for private insurance would be eliminated. One single payer bill currently in the House (H.R. 1200) would provide one percent of funding for retraining displaced insurance workers during its first few years of implementation.

Business. In general, businesses would see Single Payer limit their health costs and remove the burden of administering health insurance for their employees.

Congress

Single payer would be the simplest and most efficient health care plan that Congress could implement.

ATTACHMENT E – SELECTED RESOURCES

Publications

Community Initiatives for the Uninsured: How Far Can Innovative Partnerships Take Us? The New York Academy of Medicine. Division of Health and Science Policy Office of Urban Populations. Dennis Andrulis Michael Gusmano August 2000.

Communities in Action: Best Practices on Expanding Access to Health Care. National Association of Counties www.naco.org.

Communities sustain public health improvements through organized partnership structures. April 2003 The Lewin Group. W. K. Kellogg Foundation. www.wkkf.org

Community Based Health Plans for the Uninsured: Expanding Access, Enhancing Dignity. November 2001. Community Voices. www.communityvoices.org

Healthy Colorado: First Thoughts on a Plan to Ensure Coverage for All Coloradans. August ,2001. Barbara Yondorf, Yondorf & Associates. Colorado Coalition for the Medically Underserved. www.ccmu.org.

A National Health Program for the United States: A Physicians' Proposal. Physicians for a National Health Program. www.pnhp.org.

The Health of Nations: Instead of forcing seniors into HMOs, how about forcing them to exercise? Phillip Longman, April 2003. The Washington Monthly.

Health Care Meltdown: Confronting the Myths and Fixing Our Failing System. Bob LeBow. Alan C Hood & Co. July 2003.

2001 Colorado Health Data Book: Insurance, Access & Expenditures. Colorado Coalition for the Medically Underserved. www.ccmu.org.

Finding the Balance Points: The Changing State of Health Care in King County. January 2000. King County Health Action Plan: Collaborative Partnerships Improving Community Health. www.metrokc.gov/health.

More than a Market: Making Sense of Health Care Systems. September 2002. Community Voices. W. K. Kellogg Foundation. www.communityvoices.org.

Journals

American Journal of Public Health - www.ajph.org

Health Affairs – www.healthaffairs.org

Organizations

American Association of Patients and Providers – www.aapp.net

Colorado Coalition for the Medically Underserved - www.ccmu.org

Health Care for All Oregon - www.healthcareforalloregon.org

Universal Health Care Action Network - www.uhcan.org

The New Rules Project - www.newrules.org/equity/statesinglepayer.html

The New America Foundation – www.newamericafoundation.org/

National Association of Counties - www.naco.org.

National Coalition on Health Care - www.nchc.org

Roaring Fork Community Health Plan – www.rfchp.com

Physicians for National Health Program – www.pnhp.org

Colorado Health Institute - www.coloradohealthinstitute.org

Colorado Rural Health Center – www.coruralhealth.org

The Colorado Trust - www.coloradotruster.org

The Rose Community Foundation - www.rcfdenver.org

Caring for Colorado Foundation - www.caringforcolorado.org

Colorado Department of Health Care Policy and Financing - www.chcpf.state.co.us