COLORADO
House of Medicine

October 7, 2021

Commissioner Michael Conway
Colorado Division of Insurance
1560 Broadway, #110
Denver, CO 80202

RE: Colorado Option Standardized Plan Design

Dear Commissioner Conway,

We appreciate the opportunity to provide ongoing feedback throughout the Colorado Option standardized plan design process. Prior comments from the Colorado Medical Society (CMS) have emphasized guiding principles, identified priority areas, and recommended specific strategies and steps. This feedback has been focused on how to promote health and design a Colorado Option plan that enables the provision of high-value health care for the benefit of Coloradans. The following comments are respectfully offered to highlight key issues as the end of the plan design process approaches.

We recognize that the objectives for this process are to develop a defined benefit structure and cost sharing that improve access and affordability, as well as to craft a standardized plan that improves racial health equity and reduces racial health disparities. Leading up to the final stakeholder meeting, it is unclear if the kinds of promised innovative changes that would be necessary to achieve those objectives will actually be implemented. It appears that key components of value-based insurance design (VBID) will not be operationalized within the plan, like mechanisms to facilitate chronic disease management and address social determinants of health. These are foundational elements to providing high-value care and improving racial health disparities–elements that we believe are essential to achieving the cost-saving goals within the plan required by HB21-1232. We are concerned that without utilizing these VBID approaches, the plan will, by default, not meet patient needs and simply drive health insurance carriers to push the required cost cuts onto the backs of physicians and other providers alone.

During the last stakeholder meeting on September 24, 2021, information was presented that raises questions about whether or to what extent a VBID approach will be used. In fact, the Wakely actuary noted that their modeling cannot account for such a design—the modeling cannot, for example, take into account the savings that would come from increasing access to primary care physicians or outpatient specialty care to manage chronic conditions, which has been shown to reduce unnecessary diagnostic testing, referrals for urgent care visits, emergency room visits, and hospitalizations for chronic disease patients. Where they did try to incorporate limited elements of VBID, like providing first-dollar coverage for three primary care and mental health visits, there was an adverse impact on the actuarial values modeled.

If the cost-saving impacts of evidence-based VBID approaches are not recognized—if the plan does not account for the fact that high-value services are up-front investments that prevent future utilization of costly services—then the plan design process appears to disregard a key part of the equation.

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We therefore respectfully highlight the following comments we have previously provided in order to advocate that the design of the standardized plan operationalize a focus on:

- VBID to drive delivery and use of high-value services and discourage low-value services
  - Decreased or no cost-sharing for defined high-value services (evidence-based)
  - Increased cost sharing for low-value services (expensive and overutilized)
    - With an evidence-based, physician-led exception process that recognizes individual patient needs and protects the vulnerable
- Chronic disease management
  - Must enable and empower physicians to care for chronic disease patients wholistically
  - Must include medications to manage chronic diseases
- Strong primary care and mental/behavioral health care (embedded in primary care where possible and appropriate)
- Adopt best practices for addressing key, state-identified disparities
  - Tobacco use and cessation
  - Diabetes and pre-diabetes
  - Cardiovascular disease
  - Asthma
  - Obesity
  - Maternal and infant mortality
  - Appropriate childhood and adult immunizations
- Encourage the delivery of care at appropriate, high-value sites of service

We have repeatedly emphasized that we need to focus on quality and access and not just cutting costs—this plan must drive better value in health care, increase competition, and enable broad provider participation. Physicians and other providers must not be held responsible for the statutorily required cost reductions on a plan design that may be flawed from the start. Without using a plan design that focuses on prevention and chronic disease management and that drives the provision of high-value care, there are few options left to commercial plans besides sweeping, blunt provider payment cuts and onerous utilization management procedures that harm patients and burn out physicians and other providers.

Thank you again for the opportunity to provide feedback. We know that much work remains and hope that these comments are helpful as we all work toward the shared goals of finding cost savings for patients so they will have greater and more equitable access to high-quality care.

Sincerely,

Mark Johnson, MD

Mark Johnson, MD, MPH
President
Colorado Medical Society

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