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Colorado Hospital Association

STANDARDIZED HEALTH BENEFIT PLAN COLORADO OPTION

REPS. ROBERTS AND JODEH, SEN. DONOVAN

Oppose House Bill 21-1232

Overview

The bill includes two "phases." Phase 1 directs the Commissioner of Insurance to develop a standardized health insurance plan that may be offered by health insurance by carriers beginning in 2023, with premium reduction goals based on 2021 premium levels. If the health care industry does not meet premium reduction goals by 2025, Phase 2 would be implemented. The Colorado Option Authority would be created as a nonprofit public entity to offer health insurance.

CHA opposes HB 21-1232 for the following reasons:

Accountability needs to be fair.

The current approach of many targets – even at the county level – significantly increases the chances of "partial failure" that will penalize good-faith actors who meet the targets. Fair accountability requires an objective assessment of whether targets were met or not, and the opportunity for due process if a consequence is to be imposed.

Questions:

- *Why are there no protections in this bill for good-faith actors who have already and may continue to be good-faith actors in addressing affordability concerns?*
- *Public policy is a blunt force object. What options have or should be considered to ensure that penalties imposed by state government are fair and proportional to the respective segments of the health care system?*
- *Pharmaceutical costs are one of the fastest growing segments of our health care system. Can you point me to the provisions of this bill that directly impact pharmaceutical costs to patients, providers, and hospitals?*

Adequate governance is lacking for multiple components of the proposal.

Throughout both Phase 1 and Phase 2, the Insurance Commissioner, an unelected official, is provided broad and unfettered authority, including the ability to establish and modify the standardized plan, develop and submit an undefined 1332 waiver, administer any 1332 funds, establish payment rates, and choose which market actors can access the Colorado Option rates.

Questions:

- *What kind of checks and balances currently exist for the Insurance Commissioner, and given the extraordinary added authority for the position included in this bill, what protections are added by this bill?*
- *Per the bill, the Colorado Option is a health plan. However, the bill only contemplates an Executive Director and the Insurance Commissioner "running" the plan. Private carriers, even Medicaid employ hundreds and thousands of employees to carry out the work of administering private and public health plans. How is this anywhere close to realistic?*

For questions or more information, contact Joshua Ewing, CHA VP of Legislative Affairs, at 720.635.3493.

The proposal should be limited to the individual market.

The individual market has been the focal point of state and federal affordability efforts since 2010. It has a markedly different regulatory framework than employer-sponsored insurance (ESI) in the small or large group. This makes public reporting and affordability benchmarking possible in the individual market in ways that are currently infeasible in the small group market.

Questions:

- *Can you provide the actuarial analysis that shows the potential impacts for consumers, provider, and hospitals in the small group market?*
- *There really isn't much of a large group market in rural Colorado. What impact is rate setting in both the individual and small group markets going to have on our rural health care system given the vast underpayment by Medicare and Medicaid?*

Phase 1 Concerns

There should be a sunset review provision for Phase 1.

The goal of this legislation should be for Phase 1 to succeed and Phase 2 to serve as a last resort. Instead, the voluntary period merely serves as an interim step, set up for failure, while the infrastructure for Phase 2 is stood up. Including a sunset provision demonstrates a commitment to Phase 1 by allowing all parties to examine what works, what doesn't, and if needed, the opportunity for course corrections that will serve to strengthen the approach should it be working by most measures.

Questions:

- *We put sunsets on everything in Colorado. It's just good policy to check in to see how things are going, what's working, and what can be improved. Why doesn't this bill include a sunset provision, especially given the magnitude of the policy?*

The premium reduction target needs to be reasonable and evidence-based.

There is no evidentiary support for a 20 percent absolute reduction in premiums to be achievable or sustainable, either through market actions or government-imposed price controls. Any premium reduction threshold must be grounded in evidence-based policy and economics.

Questions:

- *Can you provide the actuarial analysis that shows the justification for a 20 percent reduction and the potential impacts for consumers, providers, and hospitals in the individual and small group markets?*

The baseline selected for Phase 1 should provide credit for existing cost reduction work.

The selection of 2021 as the "baseline" year will have the effect of penalizing significant work done in recent years to reduce the cost of care – through development of purchasing collaboratives, narrow network products, accountable care organizations, etc. It is recommended that 2019 be considered as the baseline year, as it is "COVID-free" and aligns with the timeline around which a significant number of market-driven affordability efforts began to take effect.

Questions:

- *Colorado has seen significant progress in both premium reductions and hospital costs based on the latest data, why not provide credit for those providers, hospitals, and carriers who have done exactly what's been asked of them by setting 2019 as the baseline year?*
- *Regardless of the baseline year, there is year over year growth in health care (and everything), why is that not reflected until 2025 in the bill? Isn't this just forcing even greater cuts to our health care system?*

For questions or more information, contact Joshua Ewing, CHA VP of Legislative Affairs, at 720.635.3493.

The primary metric determining Phase 1 success or failure should be further simplified.

The current proposal would require affordability targets to be hit across hundreds of metrics – multiple carriers, multiple metal tiers, multiple geographic areas. A single – or limited – number should be agreed upon as the "sentinel" metric for success or failure (e.g., statewide average premium, at least one product available at lower cost, etc.).

Questions:

- *If we're serious about giving the market a real chance at success, shouldn't we simplify and target the metrics so we're not punishing the entire system if one county misses the mark by 1 percent?*

Phase 1 targets should account for other federal/state policies impacting health care costs.

Some policy measures drive consumer costs up (e.g., insurance benefit mandates), while others drive costs down (e.g., additional federal APTC subsidies). These intersecting policies should be equitably accounted for in the target, either through inclusion or exclusion.

Questions:

- *Every year for the past number of years, the General Assembly has passed numerous policies that add costs to the system. Not making a value judgment on the specific policies, but how will we account for decisions made by this body if we're holding industry accountable for meeting cost reduction targets?*

An additional year should be built into Phase 1, potentially through a performance improvement model that would give the market a final opportunity to achieve the goals.

While the delay to 2023 is appreciated in order for the health care ecosystem to get beyond the pandemic, it is still a fairly short time frame to implement the kind of drastic cost reductions requested. The addition of a third year would allow for better preparation and the development of trend data, such that an objective and evidence-based assessment could be conducted prior to the imposition of consequences.

Questions:

- *COVID case counts and hospitalizations are rising again. It will be years before we know the full effects of the pandemic on our health care system. How is 2023 a reasonable target for such a significant policy shift?*

There is no apples-to-apples comparison for current market plans and the standardized plan.

While premium pricing is based on 2021, the plan that will be required in 2023 is unknown and will be different from 2021 plans. The premium reduction requirements don't take these changes into consideration.

Questions:

- *How will actuarial value differences of the standardized benefit plan that has not been created yet be accounted for?*

For questions or more information, contact Joshua Ewing, CHA VP of Legislative Affairs, at 720.635.3493.

There are MANY unknowns about how funding under the proposed 1332 waiver will work.

How much funding does DOI anticipate receiving with this 1332 waiver? How much will the Authority cost to administer? What if the revenue estimates are wrong? (Minnesota anticipated 1332 waiver revenue from the feds at $130 million annually; their payments in their first three years have been closer to $70 million annually.) What is the timeline for the 1332 waiver, and when will 1332 funding be available to the Authority, which will have deliverables starting as early as 2023?

Questions:

The bill states that the CO Authority is contingent upon a 1332 waiver (page 10, line 10) and that the DOI may use any federal money received through a 1332 (page 18, lines 3-13).

- *How much funding does DOI anticipate receiving with this 1332 waiver?*
- *How much will the Authority cost to administer?*
- *What if the revenue estimates are wrong? (Minnesota anticipated 1332 waiver revenue from the feds at $130 million annually; their payments in their first three years have been closer to $70 million annually.)*
- *What is the timeline for the 1332 waiver, and when will 1332 funding be available to the Authority, which will have deliverables starting as early as 2023?*

Phase 2 Concerns

The proposed structure of the Phase 2 Colorado Option premium increases will create a vice grip on health care provider payments.

The current draft requires Colorado Option premium increases to grow no faster than CPI-U+1. At the same time, the established base premium for the Colorado Option is set untenably low (2021 prices minus 20% for plan year 2025 – no accounting for inflation, actuarial value of standardized plan, EHB changes, or other factors), and provider rates will be tied to that cost goal. As costs rise for providers to deliver care, the insufficiency of the rates will increase, and because the Authority cannot increase premiums, adjust benefits, or develop high-value networks, they have no tools other than decreasing provider rates to retain solvency.

Questions:

- *Can you provide the actuarial analysis for this year's bill that justifies the fee schedule that will be used by the Commissioner of Insurance to set rates for providers and hospitals?*
- *How is that fee schedule built? We never received the math behind the formula last year—just a one-page fact sheet.*

For questions or more information, contact Joshua Ewing, CHA VP of Legislative Affairs, at 720.635.3493.

The Phase 2 fee schedule infrastructure is woefully lacking in detail, threatening providers and access to care across the state.

Safeguards are needed and significant expertise is essential to ensure providers can be sustainably compensated under any Phase 2 infrastructure. As a comparison, Maryland – the only other state with government rate setting – spends over $30 million per year just to ensure hospital rates alone are adequate. This funds adequate market and pricing analysis, review and appeals processes, a governance infrastructure, and more and has been expertise developed over nearly 40 years.

Questions:

- *The bill gives DOI the authority to promulgate rules to establish a "reasonable reimbursement fee schedule" (page 14, lines 23-26). What justification does DOI have for having the appropriate expertise to do this?*
- *Maryland – the only other state with government rate setting – spends over $30 million per year just to ensure hospital rates alone are adequate. This funds adequate market and pricing analysis, review and appeals processes, a governance infrastructure, and more and has been expertise developed over nearly 40 years. The fiscal note doesn't show costs for this portion of the bill. How much is DOI estimating for this annual process?*

The Colorado Option is likely to push insurers out of the individual and small group markets.

Access to unsustainably low rates and the "mandatory open network" approach creates significant advantages as compared with private market "competitors." It's unclear whether the Colorado Option will secure other market advantages – for example, different standards for financial reserves, potentially limited liability, exclusion from tax burden, etc., as these are not addressed in the bill. If the policy approach forces insurers out of the market, what prevents them from leaving? Even Phase 1 places new – and potentially untenable – requirements on carriers, and Phase 2 introduces a new "competitor" with a distinct market advantage of lower underlying cost. If they can't compete with Colorado Option rates or feel market participation requirements are too onerous, their exit would lead to the perverse result of ***less*** choice, when a central promise of the bill to increase consumer choice.

Questions:

- *What protections do we have that private payers won't simply leave the individual and small group markets because they can't compete with a plan that doesn't have to play on an even playing field?*

What happens if the Colorado Option premiums are insufficient to cover claims cost and/or it becomes insolvent?

Will the state or the Guaranty Fund be required to cover incurred claims cost? How will that impact enrollees, especially if market competition decreases over time? When the Colorado HealthOP failed in 2015, other carriers (and thus their enrollees) had to cover the cost – over $70 million.

Questions:

- *The bill is clear that the State of Colorado will not be the financial backstop for this plan. If that's the case, who will?*

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The mandate for providers to participate is unprecedented and may harm access to care for or "crowd out" other Coloradans.

Even Medicare and Medicaid do not have mandatory participation requirements for providers. In these programs, rates that do not cover cost of care can lead to limited patient panels to prevent unsustainable operating margins. If providers aren't able to manage their Colorado Option patient panels to manage income and expenses, they are more likely to limit panels of patients with other payers, especially those that pay under cost (i.e., Medicare and Medicaid).

Questions:

- *Providers must balance public payers that generally underpay for services with private payers who cover the difference. With mandatory participation in a plan that will underpay, what analysis has been done around access for Medicare and Medicaid patients who represent about half of Coloradans?*

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2021 Timeline

- **Jan. 6** – CHA, CAHP and CMS sent a letter to Governor Polis and copied legislative leaders, asking to be engaged after it was clear the Administration had been holding meetings and was pushing forward with a Public Option proposal despite still being in the midst of the third wave of COVID-19 at the time.
- **Jan. 25** – A high-level document with bullet points was distributed to stakeholders.
- **Feb. 11 – CHA provided an initial response to the limited details included in the 1/25 document and began substantive conversations with Rep. Roberts.**
- **March 1 –** Initial bill draft released to stakeholders.
- **March 5 – CHA provides principle-driven feedback about what hospitals needed to see in the introduced version (based on draft language).**
- **March 12 – In response to a request from Rep. Roberts for information that would move CHA to neutral, the Association provided detailed feedback on Phase 1 and further questions/considerations on the approach for Phase 2.**
- **March 18** – HB 21-1232 introduced.
- **March 24 – Following additional conversations with Rep. Roberts and a request for additional information around CHA neutrality, the Association provided a clear set of changes (with language) on what would get it to neutral (based on the introduced version).**
- **March 30 –** Colorado Option Alternative strike below proposal shared with stakeholders.
- **April 1 – In preparation for a lengthy in-person negotiation that occurred 4/2, CHA and CAHP collaborated on feedback that would have moved <u>both</u> organizations to neutral on the Colorado Option Alternative.**
- **April 2 –** PO strike below outline shared after the conclusion of 8+ hour meeting of proponents and opponents, including language not discussed during the meeting.
- **April 2 – CHA provided additional feedback to Rep. Roberts and Commissioner Conway.**
- **April 5 –** Draft strike below legislative language (L.028) shared with stakeholders, including language not discussed during the stakeholder process.
- **April 6 – CHA provides a detailed feedback on L.028 less than 24 hours later; CHA Board of Trustees votes to oppose (despite being convened with the intention of approving the compromise in advance of Committee).**

For questions or more information, contact Joshua Ewing, CHA VP of Legislative Affairs, at 720.635.3493

April 1 Neutrality Proposal from CHA and CAHP

- Following the receipt of the Colorado Option Alternative on March 30, CHA, CAHP and CMS met with Speaker Garnett the next morning and reiterated the goal of reaching an agreement prior to committee.
- CHA and CAHP staff then locked themselves in a conference room the afternoon of April 1 and **developed a full proposal that would move both organizations to neutral**. That proposal was vetted with the memberships of both organizations the following morning (April 2), still less than 48 hours since receiving the strike below proposal from Rep. Roberts.
- The CHA/CAHP neutrality proposal:
    - **Met the savings goals** established by the sponsors and proponents while giving credit to the hospitals, providers, and health plans who have already achieved significant savings over the past three years (you don't want to punish the good actors with new policy).
    - **Added evidence-based approaches** to determining goals and success/failure in meeting the objectives rather than subjective determinations by the Commissioner of Insurance.
    - **Added fair accountability mechanisms** that appropriately targeted providers/hospitals/carriers failing to meet premium reduction targets without punishing participants for costs outside of their control (e.g., rate setting on hospitals for increased pharma prices).
- Despite being assured consistently throughout the stakeholder process that many of the provisions included in the CHA/CAHP proposal were "on the table" in order to get a deal, **this proposal was almost entirely rejected** on April 2.

Roberts Strike Below Proposal – April 5 (and follow-up communication on April 6)

- Despite the limited negotiations on April 2, CHA continued to provide constructive feedback in an effort to reach a deal. Late in the evening on April 2, **CHA sent additional feedback that, if accepted, staff would take back to the CHA Board of Trustees with a favorable recommendation**.
- **The Association worked day and night through the Easter holiday** with member hospitals and health systems, Rep. Roberts, and Commissioner Conway on those additional details in order to reach a deal before committee.
- **The two main topics of conversation** (floor for rate setting and inflationary factor beginning in 2021) **were not included in the April 5 strike below.**
- The strike below also included lots of previously undiscussed language, **including fining authority of $10,000 to $40,000 per day to be levied against hospitals.**

Next Steps

- For months, **CHA has demonstrated time and time again a willingness and a desire to find an amicable and reasonable solution.**
- **The Association remains willing to work with the General Assembly on a compromise.**
- Due to lack of progress, **CHA Board took an "oppose" position Tuesday.**
- **If the sponsors, proponents, and others want to continue working on a consumer-focused, evidenced-based policy solution, we stand ready and willing to put in the work** – but as currently contemplated, this proposal will reduce access to care and disproportionately affect the most vulnerable among us.

For questions or more information, contact Joshua Ewing, CHA VP of Legislative Affairs, at 720.635.3493

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Recent Trends in Affordability

It was reported in 2018 that Colorado hospitals and health systems had the highest total hospital margin percentage in the US. Those percentages reflected both operating margins and non-operating items (e.g., investment income, other non-patient activities). In 2018, total hospital margins were $2.8B or 15.6% of revenue, but hospital operating margins were $1.5B or 8.9% of revenue.

However, it is also important to note: Looking at just one year of financial results is not a trend, but just one data point. 2018 was an outlier year for CO hospital margins.

- **Just one year of data is not a trend** (i.e., just 2018 data). For the 5 years of 2014-2018, Colorado hospital operating margins were 5.5% of revenue, in line with industry wide sustainable margins of 3-5%.

- **Colorado hospitals have been able to manage expense trends.** For the same 5 years, Colorado hospitals had expense growth trends of 5.6%, compared with the US median of 5.1%. When adjusted for the higher inflation in CO, Colorado hospitals have lower expense trends of 4.1% compared to the US median of 5.1%. *Source: HCRIS hospital cost reports analyzed by Colorado Hospital Association and inflation data from US Bureau of Labor Statistics*

- More recent data shows that **in 2019, Colorado hospital expenses per adjusted discharges increased just 0.1%**, placing Colorado 9th best in the US, with a US median growth of 2.6%, for this reflection of expense trends. *Source: Kaiser Family Foundation State Health Facts, January 2021.*

- **Colorado continues to outperform other states in health insurance costs**. In 2019, Colorado had lower health insurance costs than the US for employer sponsored coverage for both single and family coverage, overcoming consistently higher inflation in Colorado. *Source: Commonwealth Fund brief, Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, State Trends in Employer Premiums and Deductibles, 2010–2019.*

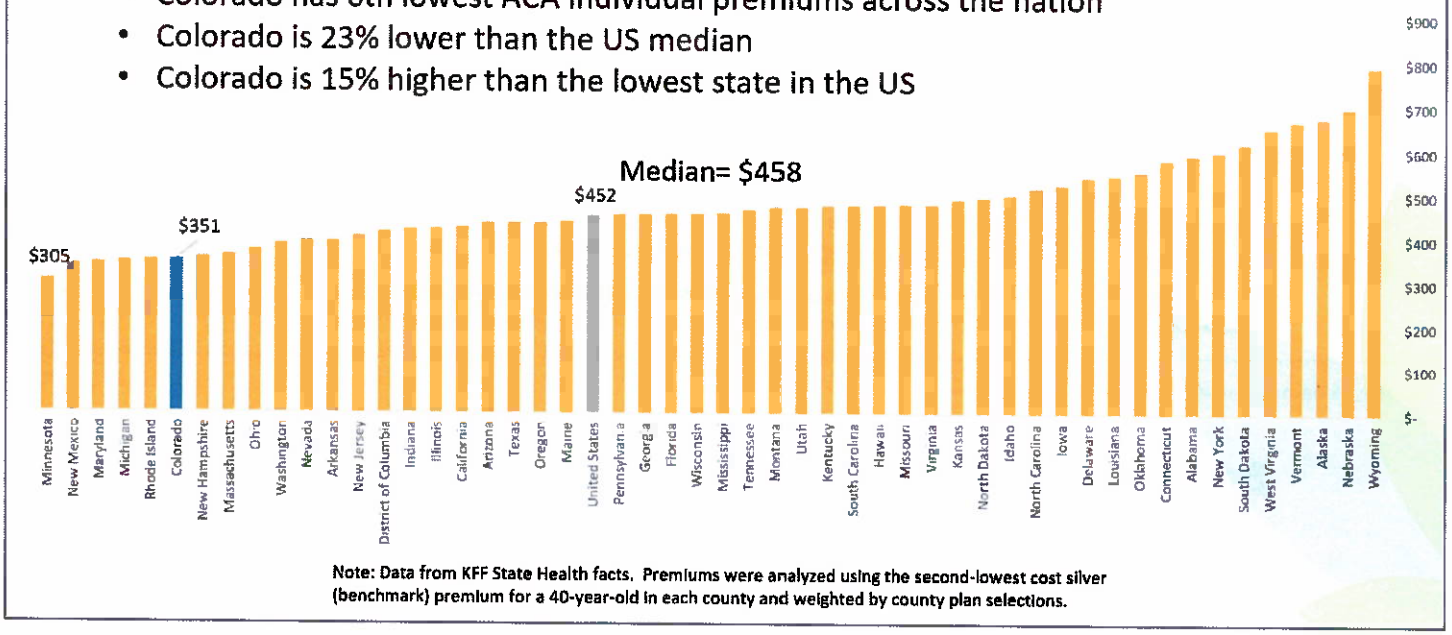
- **In 2021, Colorado has the 6th lowest ACA individual market premiums in the US**, premiums which are 23% lower than the US median premium price. *Source: Kaiser Family Foundation State Health facts.*

For questions or more information, contact Joshua Ewing, CHA VP of Legislative Affairs, at 720.635.3493

At-A-Glance: 5 Charts Explaining Affordability in Colorado's Individual Market

Colorado has some of the lowest premiums in the nation:

- Colorado has 6th lowest ACA individual premiums across the nation
- Colorado is 23% lower than the US median
- Colorado is 15% higher than the lowest state in the US

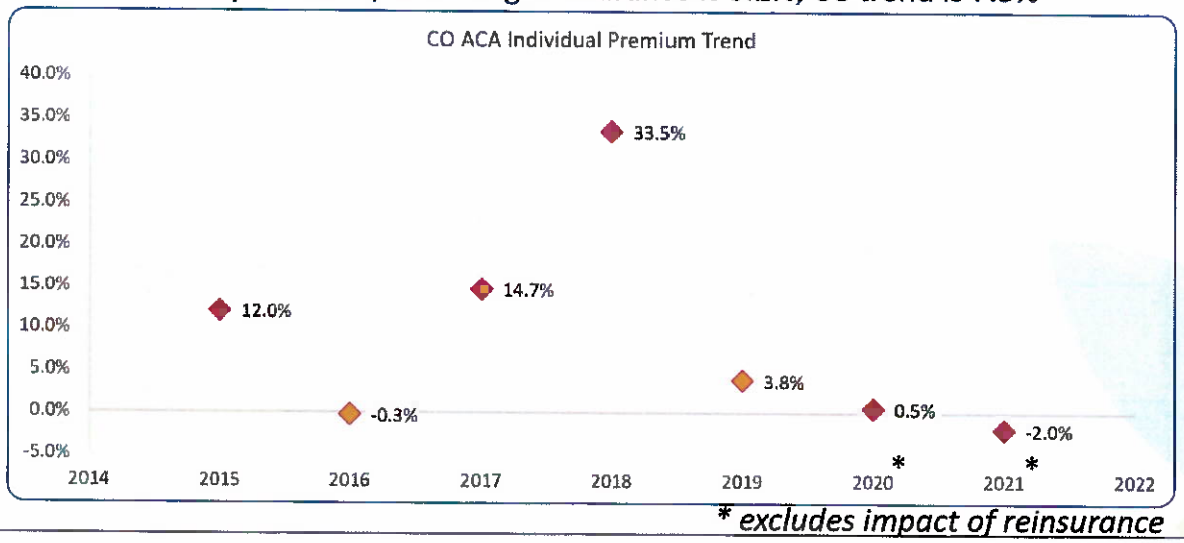


Note: Data from KFF State Health facts. Premiums were analyzed using the second-lowest cost silver (benchmark) premium for a 40-year-old in each county and weighted by county plan selections.

Source: Kaiser Family Foundation

Even without reinsurance, premiums have declined in last 2 years:

- At 2.7%, Colorado 5-year trend is best in the nation
- ACA rates have a high degree of year-over-year volatility
- CO 7-year trend, excluding reinsurance is 8.2%; US trend is 7.5%



Source: Kaiser Family Foundation

For questions or more information, contact
Joshua Ewing, CHA VP of Legislative Affairs, at 720.635.3493.

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2021 federal stimulus achieves affordability:

>400% Creates new subsidies for Americans over 400% FPL

8.5% Expands subsidies so premiums won't exceed 8.5% of income for anyone

6% Premiums won't exceed 6% of income for those under 300% FPL

FOR IMMEDIATE RELEASE
April 1, 2021

HHS Secretary Becerra Announces Reduced Costs and Expanded Access Available for Marketplace Health Coverage Under the American Rescue Plan

An average of three out of five eligible uninsured Americans can access $0 plans after advance payments of tax credits and an average of four out of five current HealthCare.gov consumers will be able to find a plan for $10 or less per month after advance payments of tax credits

FOR IMMEDIATE RELEASE
April 7, 2021

HHS Secretary Becerra Announces More Than 500,000 Americans Have Enrolled in Marketplace Coverage During Special Enrollment Period

Largest increase in enrollment among Black consumers and among Americans near the poverty level in two years

3 out of 5 uninsured can access $0 premium plans — **$0**

4 out of 5 marketplace customers can access plans for $10 per month — **$10**

500,000 Americans have enrolled in coverage — **500k**

Source: US Department of Health and Human Services

Both state and federal programs have helped reduce costs:

Federal Subsidy Programs	State Subsidy Programs
ACA Advance Premium Tax Credits (APTC): Based on Income (MAGI)	**Reinsurance Program: Based on Geography**
ARP APTC: Based on Income	**Cost Sharing Reductions: Based on Income**
Cost Sharing Reductions: Based on Income	

Source: Colorado Hospital Association

Coloradans' premiums dropping up to 66% with ARP:

Potential net premium differences of Connect for Health Colorado enrollees under new affordability percentages

FPL GROUP	AVG NET PREMIUM OLD	AVG NET PREMIUM NEW	$ Difference	% Difference
400%+	$ 460.91	$ 304.43	$ (156.48)	-34%
301% to 400%	$ 195.26	$ 131.76	$ (63.50)	-33%
251% to 300%	$ 147.47	$ 68.88	$ (78.59)	-53%
201% to 250%	$ 124.00	$ 50.42	$ (73.58)	-59%
151% to 200%	$ 86.03	$ 29.17	$ (56.86)	-66%
133% to 150%	$ 59.48	$ 19.98	$ (39.50)	-66%
<133%	$ 18.02	$ 14.98	$ (3.04)	-17%

Source: Connect for Health Colorado, presented to the Health Insurance Affordability Board

For questions or more information, contact Joshua Ewing, CHA VP of Legislative Affairs, at 720.635.3493.

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GOOD BUSINESS COLORADO Association

Celebrating 15 Years SMALL BUSINESS MAJORITY

April 8, 2021

Colorado General Assembly
200 E Colfax Avenue
Denver, CO 80203

RE: HB 211232-Colorado Option

Dear Colorado General Assembly,

Small businesses make up 75% of our state's employers and of these, more than two-thirds are unable to provide health insurance to their employees, according to a February 2020 report by the Colorado Health Institute. Small business owners across Colorado care about their employees and have a strong desire to provide benefits that enable them and their families to thrive. Among the biggest concerns of business owners is the ability to provide affordable, comprehensive healthcare to their employees. But access to affordable, comprehensive coverage is out of reach for many small businesses, which also makes it difficult for them to attract and retain talented employees. This has become even more of a challenge during the pandemic as small businesses faced unexpected and unprecedented financial setbacks. Our healthcare market is broken - with unaffordable premiums that continue to rise and a lack of competition in many communities across our state, and this is putting our small businesses in a bind.

> *"Our health plan rates for our employees increased by 17% last time we renewed, and this was only because we moved to a worse (lower coverage, higher deductible) plan. Small businesses that do provide insurance will soon not be able to do so."*
>
> *Carol Cochran, Owner of Horse & Dragon Brewing - Fort Collins*

The Colorado Option for Health Insurance could be the solution small business owners in Colorado have been waiting for.

Collectively, Good Business Colorado and Small Business Majority represent nearly 5,500 businesses in the state. We're writing to you today to ensure the needs of Colorado small businesses are addressed in the Colorado Option for Health Insurance. We have identified four main concerns that will help close the gap and enable small businesses to provide this vital benefit to their employees. We ask that you:

1. Guarantee at least a 20% reduction in premium costs
2. Include small group insurance options in the program from the get-go
3. Ensure that people across the state can get the care they need in the communities where they live
4. Establish a state Authority to provide The Colorado Health Insurance Option if insurance carriers cannot meet the goals of the state-defined health insurance plans

> *"These premium rates make it impossible for me to be competitive in my industry with larger agencies that get a break on their group premiums, and therefore I am unable to acquire the candidates I want."*
>
> *Shawn Satterfield, Owner of Mozaro - Evergreen*

Colorado hospitals are among the most profitable in the country. As representatives of small businesses across Colorado, we understand that businesses need to be profitable - but that profit cannot be made at the expense of the small businesses that are the foundation of our economy.

Sincerely,

Debra Brown, Good Business Colorado Executive Director - she/her

Angelique Espinoza, Good Business Colorado, Policy Director - she/her/ella

Jordan Pryczynski, Good Business Colorado, Membership Director - he/his

Lindsey Vigoda, Small Business Majority, Colorado Director - she/her

Anna Stevens, Small Business Majority, Colorado Outreach Manager- she/her

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Adair Andre, Kitchen Door Landscaping, Denver 80206

Adam Alleman, The Denver Game Lounge LLC, Denver 80220

Andrew Beckler, Grass Sticks, Steamboat Springs 80487

April Archer, SaraBella Fishing, Erie 80516

Carol Cochran, Horse & Dragon Brewing Company, Fort Collins 80524

Connie Neuber, Designs in Motion, Longmont 80504

Cynthia Ord, YellowDog, Denver 80205

Dana Nelson, Dairy Arts Center, Boulder 80302

Elliot Strathmann, Spuntino, Denver 80214

Guy Dennis, Dennis Consulting Services LLC, Northglenn 80233

Jacquie Jaeger Chacon, Revel & Roots Events, Denver 80203

Jenn Mendelson, Leap Interior Design, Boulder 80302

Jenny Davies, Progressive Promotions, Denver 2011

John R. (Grizz) Deal, IX Power Clean Water, Inc., Golder 80401

Katharine Knarreborg, Merlin Instrument Company, Centennial 80122

Laureen Direnna, Mediral, Denver 80202

Laura Reed, Laurel Active Learning LLC, Evergreen 80439

Lauren Gundy, Animal Party INC, Denver 80212

Lawrence Martin, Yamaguchi Martin Architects, 80118

Leslie Glustrom, Clean Energy Action, Boulder 80303

Luba Fridnerova, LF Architect, Denver 80219

Margaret McRoberts, Stella Sustainability, Denver 80207

Maria Cooper, Sopris Investment Group LTD, Lakewood 81623

Markus Bohunovsky, 5 Star Salt Caves, Denver 80209

Mary Rogers, The New Kitchen, Boulder 80304

Meg Mothershed, Mothershed Design Company, Brighton 80601

Melissa Fathman, Dairy Arts Center, 80302

Mez Charney, MC Evolution, Denver 80205

Natalia Antezana, Denver 80231

Robert Bogatin, Ecliptic Imagery, Longmont 80503

Sarita Parikh, glow + gather, Castle Rock 80104

Shannon Bean Scalise, Book See Financial Group, Arvada 80004

Shawn Satterfield, Mozaro, Evergreen 80439

Shay Wescott, Dairy Arts Center, Boulder 80302

Stephanie Farrell, Left Hand Management, Brighton 80601

Steven Waters, Run For The Roses, Denver 80202

Stuart Eynon, Meier Skis, Denver 80210

Tim Wheeler, Durango 81301

Vicki Carey-Davis, Twigs + Co., Boulder, 80302

Whitney & Obe Ariss, The Preservery, Denver 80205

Good Business Colorado
Good Business Colorado is a coalition of over 360 statewide small businesses, working to help make Colorado a more sustainable, equitable, and prosperous state. Learn more at goodbusinesscolorado.org.

Small Business Majority
Small Business Majority is a national small business organization that empowers America's diverse entrepreneurs to build a thriving and equitable economy. Learn more at smallbusinessmajority.org.

Quotes from small business owners:

"Our health plan rates for our employees increased by 17% last time we renewed, and this was only because we moved to a worse (lower coverage, higher deductible) plan. Small businesses that do provide insurance will soon not be able to do so."

Carol Cochran, Owner of Horse & Dragon Brewing - Fort Collins

"As a small business owner, a healthcare professional, and someone with a pre-existing condition, I am deeply concerned about the rising costs of quality healthcare, and I know I am not alone in this. Having high premiums and deductibles means that I am paying for everything out-of-pocket, and I simply cannot afford to continue to do so. This is why we need the Colorado Health Option."

Sarita Parikh, Co-Owner of glow + gather - Castle Rock

"These premium rates make it impossible for me to be competitive in my industry with larger agencies that get a break on their group premiums, and therefore I am unable to acquire the candidates I want."

Shawn Satterfield, Owner of Mozaro - Evergreen

"As Medicaid consultants, we are experts on healthcare, and yet we cannot afford to fund an insurance plan for our own employees. Instead, we offer a paid subscription to a concierge doctor that addresses all of our primary care needs. We see the pitfalls in working with the commercial insurance companies since we work with them every day, and we are not interested in supporting their posting of record profits while denying care to those who need it and have paid for it. Please implement a better solution. It is time to stop talking about it and start doing something."

Stephanie Farrell, CEO of Left Hand Management - Brighton

Coloradans Need the Colorado Option

Colorado Consumer Health Initiative

Healthcare That People Can Afford And Use

Many Coloradans are going without health insurance because they cannot afford it.

"Right now I don't have health insurance because it costs $600/month, which is too expensive for me."
- Amy, Arapahoe County

"Two of my best friends work and do not have health insurance during a pandemic! I am worried about them."
- Liza, Jefferson County

Health insurance costs exhaust Coloradans' financial resources, rendering them unable to pay necessary living expenses.

"I pay $300-400 a month for health insurance. I make too much for Medicaid and am stuck paying so much for premiums and deductibles. I have to choose between my health insurance or bills and it's so ridiculous."
- Corinthiah, Adams County

Coloradans want more affordable options for health insurance coverage.

"Healthcare should be affordable for everyone. If you're sick you shouldn't have to go into debt to get treatment. There should be more options for people who can't afford healthcare on their own."
- April, Pueblo County

Even when covered by an employer, Coloradans still struggle with the cost of premiums and deductibles.

"The price of insurance is too high, even with both me and my husband working. Our employers don't cover premiums and we have a high deductible, so it's difficult for us to afford insurance for our family."
- Roberta, Pueblo County

Many Coloradans feel that healthcare is unaffordable, the current system is not working for everyone, and action needs to be taken to decrease costs.

"It is not okay that people who have health insurance cannot afford health care either. They need to do better. People need help now!"
- Lisa, Denver County

"I have health insurance through my employer but I am still concerned about high insurance pricing. There should be affordable health insurance."
- Alisa, Adams County

BIPOC, people with disabilities, and low-income households are disproportionately affected by high healthcare costs.

"I have struggled to afford healthcare because the bills are too high. It's especially hard for people with disabilities."
- John, 48, Adams County

"I feel like minorities are being targeted."
- Shavonne, Adams County

Colorado Consumer Health Initiative

Health insurance is particularly expensive in Colorado.

"The cost of living in Colorado is super high, and the cost of health insurance isn't affordable when you're paying to live here. I live paycheck to paycheck, and don't qualify for Medicare because my income is too high. I feel like I'm stuck between a rock and a hard place."
- Crystal, Arapahoe County

The cost of healthcare in Colorado is sometimes comparable to the cost of housing here.

"There was a time when my healthcare for me and my kid was $120 less than my mortgage."
- Kimberly, Arapahoe County

"I had to move back to South Carolina because I was getting charged about the same as a mortgage for healthcare"
- Joseph, Arapahoe County