HRSA STATE PLANNING GRANTS

INTERIM FINAL REPORT TO THE SECRETARY

SUBMITTED BY

THE STATE OF COLORADO,
OFFICE OF THE GOVERNOR

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EXECUTIVE SUMMARY

Funding from the Health Resources Services Administration (HRSA) is permitting Colorado to build upon earlier efforts and position the State to identify the feasible option(s) which will best expand access to affordable health insurance coverage to all citizens of Colorado. Prior to the HRSA grant award, Colorado had already taken major steps towards its goal of offering affordable insurance to its populace. For example, surveys and town meetings had identified consumer needs and issues in an effort to continue the public education process. Important coalitions have been formed between the public and private sectors to better evaluate and analyze the situation. Potential coverage options have been identified and in-depth analysis of each of these options has begun.

Prior to the HRSA grant, Colorado policymakers relied upon data collected through Federal or privately funded efforts to measure the number and characteristics of the uninsured. These survey instruments included use of the Current Population Survey (CPS), the Behavioral Risk Surveillance Survey (BRFSS), and the Medical Expenditure Panel Survey (MEPS). State-specific and sub-state data are critically important in Colorado as illustrated by the following example. The Child Health Plan Plus staff had to estimate what the uninsurance rate in specific counties was by arriving at some mathematical function of unemployment rates because two national surveys do not survey every county or children. For example, using this method of calculation yielded the result that 117 percent of the eligible population in southeast Colorado was enrolled in the Child Health Plan Plus, an obvious and blatant portrayal of the situation. Errors and inaccuracies of this nature can potentially cost the State thousands of dollars in miscalculations with undesirable political and social consequences. Accurate and reliable data results in a higher level of confidence in the policy solutions chosen for a particular problem.

Through its household survey, Colorado, for the first time, measured coverage variations across the State as a result of the funding from the HRSA grant. The largest telephone household survey (10,000 households) ever conducted on health care coverage issues focused on obtaining key information about the uninsured in the State such as who they are, why they are uninsured, and any prior health care coverage they may have had at a prior point in time. Colorado adapted its survey instrument from Minnesota's six-year old instrument and has relied extensively on the technical expertise available through the State Health Access Data Assistance Center (SHADAC). Staff from SHADAC provided assistance in creating the weights, constructing the data tables, and developing guidelines for data imputations and data cleaning. The fieldwork was completed September 6, 2001 and data analysis is nearly completed. The initial preliminary findings are presented in this report.

Other major quantitative and qualitative data collection activities planned in conjunction with the HRSA grant include the following:

- Conducting small business employer focus groups in 13 regions throughout Colorado
- Conducting provider interviews
- Examining the opportunities for Federal waivers and ways to leverage Federal dollars

- Analyzing the impact of TABOR (Taxpayer's Bill of Rights) and current economic conditions on possible coverage options
- Developing a prioritized benefits package model for the private market
- Assessing the current public health insurance programs
- Synthesizing existing literature on the uninsured's ability to pay/willingness to pay
- Exploring ways to build infrastructure to sustain efforts and activities beyond the grant period

Colorado was included in the second round of grantees to be funded and awards for the second round of grantees were announced effective March 1, 2001. The time delay between the submission of the original grant proposal and the actual grant award, together with the current economic downturn and the lingering effects of the September 11 tragedy necessitated a reassessment of the data collection activities contemplated under the original grant. This report reflects a process in Colorado that, in many instances, is still in the relative infancy stages of data collection efforts, let alone policy development, in response to these changed circumstances. Colorado requested, and was granted, an extension until December 31, 2002 to complete its activities under the grant. Additionally, the current budget crisis has remained the center of focus and attention during the current legislative session, and any progress to identify feasible policy options to reduce the rate of uninsurance may have to await better economic conditions.

Additionally, community organizations, as well as governmental agencies, continued their efforts to address health care coverage issues by collecting and analyzing information during the interim period. As a result, Colorado modified some of the projects that were to be funded by the HRSA grant to avoid any duplication and to serve to fill the gaps to optimize research and data collection efforts. Through the HRSA grant, Colorado is also exploring the possibility of joint ventures or partnerships with other community organizations focused on health care coverage and access issues, if those partnerships are appropriate and within the scope of the original grant.

Colorado's Governor's Office serves as the lead agency for this project. The HRSA grant is administered through its Project Management Team, a unique public/private partnership. Representing the private sector is the Colorado Coalition for the Medically Underserved. The Coalition is composed of over 150 individuals and organizations representing health care providers, consumers, business, government agencies, philanthropic organizations and others. The Coalition launched its own independent initiative to uncover the best options to provide access to affordable, quality health care and preventive programs for all Coloradoans by 2007. Representatives from the Office of the Governor, Department of Public Health and Environment, Department of Health Care Policy and Financing as well as the Department of Regulatory Affairs reflect the public sector perspective. Two independent consultants with data analysis expertise and national health care policy expertise complete the Team. By spearheading this effort, the Governor Bill Owens and his Office conveyed a strong message to all state agencies about the importance of coverage for the uninsured. Additionally, the structure of this public/private partnership enhances the probability of advancing feasible coverage options.

The Project Management Team also works closely with the Colorado Strategic Planning Group on Health Care Coverage that was convened by Governor Owens. The Strategic Planning Group is comprised of key leaders from government, including State legislators and executive

branch cabinet members. In addition, leading stakeholders from the business and health care sectors serve as members of this Strategic Planning Group. The Strategic Planning Group meetings serve as a forum by which the Project Management Team can report the progress and research findings of the grant activities. The additional questions, comments and advice offered by the Strategic Planning Group help focus and direct the subsequent efforts of the Project Management Team.

From the outset, the threshold question the Strategic Planning Group has been asked to consider is, "What information do we need to know to develop a plan to address health care coverage and access in Colorado, and why?" Some prevalent themes centered on leveraging Federal dollars, personal responsibility, financing mechanisms, consumer choice, the structure of benefits packages, affordability, cost containment, mandates, and portability. The participants also expressed the importance of creating an equitable and balanced policy solution that includes the appropriate role of the individual, the private sector and the government. Under each section heading, questions developed by the Strategic Planning Group are listed, followed by the accompanying grant activities that will provide answers to those questions in formulating health care policy options.

Following the lead by states funded in the first wave, the Strategic Planning Group was asked to identify guiding principles in developing health care policy strategies. In the ideal world, there was consensus that it desirable for all people to have some type of health care coverage. However, this principle was tempered by the stark reality of an almost $1 billion State budget deficit, spending restrictions, and the lack of political will to raise taxes. Consequently, a major overhaul of the health care system in Colorado seems unlikely. However, the opportunity remains to use the data and information through the HRSA grant to generate policy options that result in "substantive incremental reform" to the health care system that will serve to reduce uninsurance rates.

Colorado has benefited from the experiences of the first round of HRSA-funded states as to what survey instruments yield the best survey results, alternatives for building political consensus, as well as innovative approaches in addressing a very complex problem. Efficiencies have been created in the process because Colorado has the advantage of reviewing the policy options other states considered, proposed or abandoned and the rationale for those decisions. Colorado is in a position to take advantage of the "best practices" of the other HRSA states as well as the "lessons learned" through the process. Colorado continues to hear the message that reverberates at the statewide HRSA meetings, as well as other health care policy meetings, that the changed circumstances in the economy and the world requires policy options that now have an emphasis on "maintenance" rather than "expansion." Colorado is using the HRSA grant experience to "get ready" for any future opportunities that may present themselves that permit consideration of feasible expansion options when the State experiences an economic recovery. State economists and policymakers characterize Colorado as a "lag state" in that it the economic turndown impacted Colorado later than other states and the economic recovery may similarly "lag" behind other states.

The HRSA grant represents a tremendous opportunity for Colorado to craft policy options that address the issue of the uninsured. For the first time, Colorado will have its own sub-state data

and sub-population data on which to base informed health policy decisions. It is highly unlikely that State general fund dollars would have been available to fund these data collection activities, although there is recognition of the critical importance of state-level data in the policy debate. The HRSA grant also is an opportunity for Colorado to exert itself as a leader in the health care policy arena. Because of the HRSA grant, a solid foundation of data and information on health care issues will be established and feasible strategies to reduce uninsurance rates will be fully explored and developed.

Health care policy problems often present themselves as moving targets in a constantly changing environment. The problems are complex, impact society in a variety of unintended ways, and do not easily lend themselves to simple, "quick fix" solutions. Colorado is taking full advantage of the opportunity presented by the HRSA grant funding to "peel away the health care onion" and create strategies and solutions founded on solid Colorado-specific data and information.

SECTION 1. SUMMARY OF FINDINGS: UNINSURED INDIVIDUALS AND FAMILIES

HOUSEHOLD SURVEY OVERVIEW

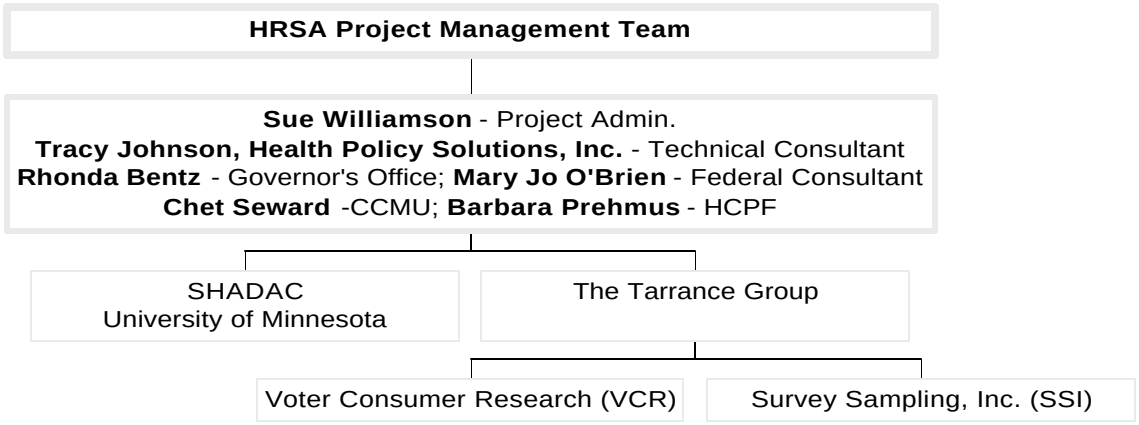
The Colorado Household Survey (2001), hereafter CHS 2001, represents the largest and most comprehensive survey to assess health insurance and health care access ever conducted in Colorado. It surveyed approximately 10,000 households by telephone from August 5 to September 6, 2001. The CHS 2001 aims to obtain state and sub-state estimates of the uninsured in Colorado and to describe the uninsured in terms of demographics, health status, and health care utilization patterns. The survey data will inform policy options to maintain coverage for the insured and expand coverage for the uninsured.

In contrast to national surveys on health insurance status, the CHS 2001 permits the study of sub-state data and trends among insured and uninsured Coloradoans. For instance, the large sample size enables more precise and reliable uninsured estimates by region, age, race and ethnicity than ever before. The survey also includes questions specifically intended to help model coverage proposals for the uninsured, such as income, household size, and "willingness to pay" [for coverage].

Vendors

The HRSA Management Team retained the Tarrance Group to design and implement the CHS 2001. The Tarrance Group is a national research and polling firm based in Alexandria, Virginia. It collaborated closely with Voter/Consumer Research to field the survey. Survey Sampling Inc. (SSI) generated the survey sample according to the Management Team's specifications (e.g., oversampling low-income populations, Blacks, and rural areas).

State Health Access Data Assistance Center (SHADAC) and Health Policy Solutions, Inc. provided technical assistance and quality control during the survey design, fielding, and analysis stages. SHADAC is a privately funded center at the University of Minnesota dedicated to assisting states, at no charge, with survey and other data collection efforts. SHADAC consulted with Colorado extensively on sampling design and implementation. Health Policy Solutions, Inc. is a private consulting firm based in Evergreen, Colorado. It served as technical consultant for the project, in charge of operations and communications between the management team, the survey vendors, and other project consultants. (See CHS 2001 Organizational Chart.)

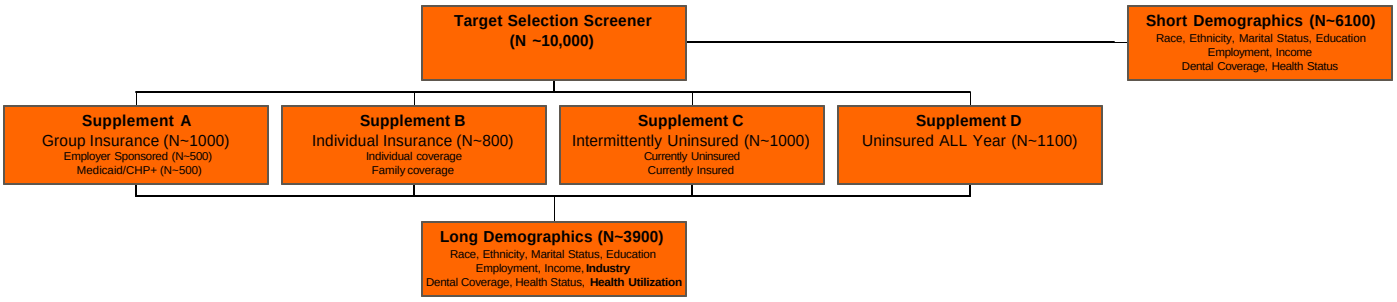


Methodology

The CHS 2001 consisted of a random digit dial (RDD) telephone survey of 10,217 households statewide. It employed a computer-assisted telephone interview (CATI) methodology. The CHS 2001 questionnaire is adapted from a validated survey instrument that was originally developed by the University of Minnesota, School of Public Health, Division of Health Service Research and Policy. SHADAC provided extensive consultation on the adaptation and implementation of the instrument for Colorado's purposes. Most of the modifications were minor, such as changing public program names to correspond to Colorado nomenclature. Colorado also added questions on past public program use, medical debt, and utilization patterns. The survey instrument can be found in the Appendices.

The instrument collected, from an informed adult in the household, detailed individual-level data about one randomly selected person within the household (e.g., health insurance status) and some more general household-level data (e.g., household size and income). The CHS 2001 questionnaire consists of five different versions, depending on one's insurance status. (See diagram of the Colorado Household Survey 2001 Subparts.)

Colorado Household Survey (2001) Subparts



Survey completion time varied according to the specific supplements administered, but the average interview length was just under 12 minutes (11 minutes, 43 seconds).

Survey Sampling and Weights

The CHS 2001 implemented a disproportionate stratified sample design that oversampled low-income areas, predominantly Black neighborhoods, and 13 sub-regions ("health marketplaces") within Colorado. In addition, people over the age of 65 were "undersampled" by imposing a limit of 300 completed interviews.

Combined, the thirteen "marketplaces", "65 and over", "black neighborhoods", and "low-income neighborhoods" result in 16 sampling strata. Population weights were created to account for the differing probability of selection and response rates in each of the 16 strata in the sampling design. Post-stratification weighting calibrated weights to the 2000 Census such that the survey data produce accurate state-level population estimates according to age, gender, and each of the 13 marketplaces. To assess the weights, Table I compares Colorado subpopulation estimates from the U.S. Census 2000 to those derived from the CHS 2001. Based on these results, Colorado decided no further post-stratification weighting was necessary.

However, a second set of weights was developed for exclusive use with certain questions on the long version of the demographics section. The CATI (automated survey) program differentially sorted individuals to these "long form" questions according to several different age and insurance status criteria. The long form weights account for the differing probabilities of selection among individuals receiving these questions.

Table One: Colorado Population Estimates:
U.S. Census Population (2000) as compared to Colorado Household Survey (2001)

Colorado Population Group	U.S. Census (2000) Colorado Estimate	Colorado Household Survey Estimate (2001)	Comments
Persons < 5 years	6.9%	6.5%	
Persons <18 years	25.6%	27.1%	
Persons 65+ years	9.7%	9.7%	
Hispanic Persons	17.1%	18.0%	1.5% with missing data
White Persons	82.8%	81.1%* 83.0%**	
Black or African American Persons	3.8%	3.3%* 3.3%**	
American Indian and Alaskan Native Persons	1.0%	0.9%* 1.0%**	
Asian Persons	2.2%	1.6%* 1.6%**	
Native Hawaiian and Other Pacific Islander Persons	0.1%	0.2%* 0.2%**	
Other Race Persons	7.2%	11.0%* 8.9%**	
2+ Races Person	2.8%	1.9%* 1.9%**	
Males	50.4%	50.3%	
Females	49.6%	49.7%	
Colorado Population Group	**U.S. Census (2000) Colorado Estimate**	**Colorado Household Survey Estimate (2001)**	

High School Graduates (25+ years)	(1990 only)	92.1% (0.9% with missing data deleted)	
College Graduates (25+ years)	(1990 only)	39.0% (0.9% with missing data deleted)	
Persons per Household	2.53	3.28	
Median Household Money Income	$48,506		
Persons below Poverty	10.2% (1997 model-based estimate)		
Children below Poverty	14.6% (1997 model-based estimate)		

*1.9% Non-Hispanics who are missing race data are deleted from this analysis; Hispanics who are missing race data are counted as "other" race
** 4.2 % of ALL those missing race data (Hispanics and Non-Hispanics) are deleted from this analysis

Statistical Testing

The statistical package STATA calculated the rates of uninsurance and standard error estimates. STATA "svy" procedures account for complex sampling designs including stratified samples. They use "linearization" based variance estimators for calculating standard errors. Failing to account for complex sampling design would result in accurate estimates of the uninsured but, in this case, underestimating the standard error.

STATA calculates a Pearson statistic and a corresponding p-value for each cross-tabulation (uninsurance by age, uninsurance by gender, etc.). In addition, the analysis compared sub-population rates of uninsurance to the statewide rate to assess whether such differences are statistically significant. Here, standard error estimates for the sub-population and total population were pooled and the normal approximation to the binomial logic was used to calculate the confidence interval. STATA deletes from the analysis any records that are missing data. Sensitivity testing was completed with certain comparisons in which more than 2% of the data was missing.

1. Who are the uninsursured in your state?

1.1 What is the overall level of uninsurance in your State?

Unless otherwise noted, the Colorado Household Survey (2001) is the data source for the uninsured estimates that appear in this section. As described, the CHS 2001 represents the largest household survey to date that assesses health insurance status in Colorado. The subsequent tables describe the uninsured in terms of: age, gender, region, race, and ethnicity, country of origin, marital status, education, and employment status. Duration of uninsurance is also explored. In Colorado, as elsewhere, uninsurance is related to income and poverty status. However, that relationship (uninsurance and income/poverty status) is addressed more fully in Section 1.4: Affordability and Willingness to Pay. Uninsurance and health care utilization are probed in Section 1.11.

Uninsurance Definitions

The CHS 2001 used a verification methodology to determine uninsurance status similar to that employed by the 2000 Current Population Survey (CPS) and the National Survey of American Families (NSAF).[i,ii iii] Respondents are asked whether they have several specific types of health insurance: employer-sponsored, individual coverage, public programs (Medicare, Medicaid, Child Health Insurance Plan (CHIP), etc. If they report having none of these types of health insurance coverage, they are asked to confirm whether they are uninsured. An individual is "counted" as uninsured if they respond negatively to all of the specific coverage questions AND they confirm their uninsured status in the verification question.

As the name implies, a point-in-time estimate of uninsurance includes only those who report being uninsured at the time of the survey. Unless otherwise indicated, point-in-time uninsurance rates are presented in the narrative and tables. However, the CHS 2001 also included questions to measure the duration of uninsurance. As compared to other states, Colorado's uninsured population includes a relatively high proportion (over two-thirds) of people who have been uninsured for 12 months or more. The CHS 2001 data on the duration of uninsurance is summarized here and discussed again in Section 1.4: Affordability and Willingness to Pay.

Point-in-Time Uninsurance Rate

The CHS 2001 estimates that 11.7% of Coloradoans were uninsured in 2001. The standard error for this point-in-time uninsured estimate is 0.7%, giving a 95% confidence interval of (10.3%, 13.1%). Using Census 2000 population estimates, this means that 502,770 were uninsured in 2000.[iv] Applying this 11.7% to 2001 numbers yields almost 516,000 uninsured in Colorado.[v]

As a point of comparison, the Current Population Survey (CPS) 2000 estimated Colorado's rate of uninsurance at 13.3% with a 95% confidence interval of (11.7%, 14.9%).[vi] (The year 2000 is the first year in which the U.S. Census Bureau used a verification of uninsurance status question

in the CPS.)[vii] The overlapping confidence intervals of the CPS 2000 and the CHS 2001 suggest that the two surveys have yielded statistically equivalent results.

Uninsurance Rates by Duration

The CHS 2001 estimates that 15.9% of Coloradoans have been uninsured at ANY TIME during the past 12 months (SE:0. 8%). This alternate estimate of uninsurance takes those people who are uninsured at the time of the survey and "adds" those who are insured now, but have been uninsured during the last year.

An estimated 7.8% of people in Colorado have been uninsured for all of the past 12 months (SE: 0.6%). As expected, the rate of people persistently uninsured (uninsured for all of the past 12 months) is lower than the point-in-time uninsurance rate (11.7%). However, over two-thirds (67%) of the point-in-time uninsured have been without coverage for the past 12 months. In contrast, other states have found that a large majority of their uninsured are without insurance for less than 6 months.[viii,ix] Colorado's higher rate of persistent uninsurance may reflect its relatively low-income ceilings for public program eligibility, e.g., Medicaid and CHP+.

Child, Adult, Senior Uninsurance Rates

Consistent with national surveys, the CHS 2001 reveals that children have a lower rate of uninsurance than adults: 9.7% versus 12.5%. This is not a statistically significant difference. (Pearson P=. 0593).

However, as the subsequent analyses (Tables 1-3) will detail, rates of uninsurance among adults vary significantly by age group. If adults over the age of 65 (who are largely covered by Medicare) are disaggregated from the rest of the adult category, differences in adult (14.0%) and child (9.7%) rates of uninsurance do become statistically significant, as illustrated by Table 1.

Table 1: Uninsurance Rates by Children, Adults, Seniors

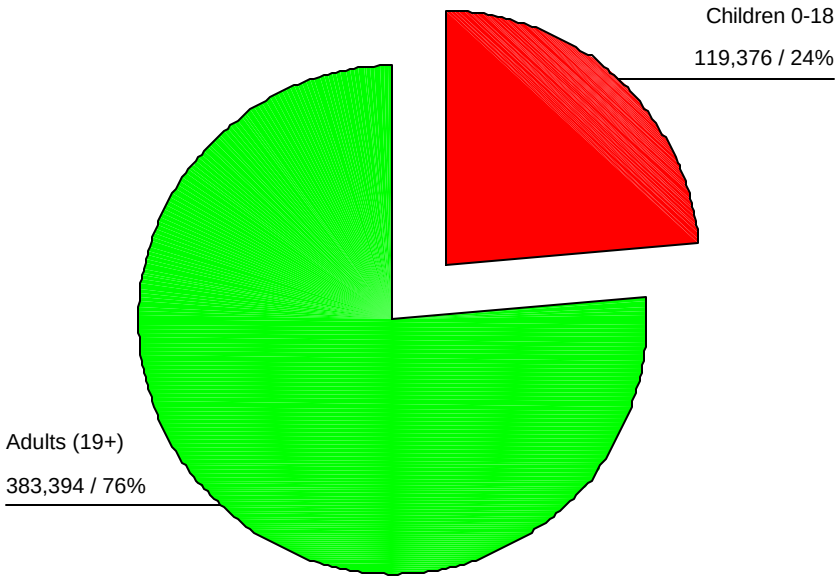
AGE GROUPS	**% Uninsured** (Standard Error)	**2000 Population Estimate**	**Sample (n)**
Children (0-17)	**9.7%** (SE: 1.2%)	**113,710**	(1972)
Adults (18-64)	**14.0% *** (SE: 0.9%)	**380,830**	(7939)
Seniors (65+)	**2.0% *** (SE: 1.0%)	**8,230**	(306)
TOTAL (All ages)	**11.7%** (SE:0. 7%)	**502,770**	(10,217)

* Statistically significant @ p<. 05, as compared to child and statewide rates.

Sources: Colorado Household Survey (2001), U.S. Census Bureau (2000)

Only a few percentage points separate Child and adult rates of uninsurance. However, because the adult population is much larger than the child population, over 75% of the uninsured in Colorado are adults. See Chart 1.

Chart 1: Distribution of the Uninsured: Adults vs. Children



Sources: Colorado Household Survey (2001), U.S. Census Bureau (2000)

Uninsurance by Age Groups

Uninsurance rates also differ by age group, *within* adult and child categories. Table 2 lists uninsurance rates by age group. The rows shaded in red have a higher rate of uninsurance than the statewide estimate. Those shaded in blue are lower than the statewide rates. Young adults have high rates of uninsurance – differences that are statistically significant, as noted.

Table 2: Uninsurance Rates and Population Estimates, By Age Group

AGE GROUPS	UNINSURANCE RATE (Standard Error)	POPULATION ESTIMATE (2000)	Sample (n)
0-6 Years	10.9% (SE: 2.3%)	47,780	794
7-17 Years	9.0% (SE: 1.3%)	65,930	1178
18-24 Years	20.7% * (SE: 2.3%)	73,417	988
25-54 Years	13.8% (SE: 1.1%)	277,242	5473
55-64 Years	8.3% (SE: 1.8%)	30,171	1478
65+ Years	2.0% * (SE: 1.0%)	8,230	306
TOTAL	**11.7%** (SE: 0.7%)	502,770	10,217

* Statistically significant @ p<. 05, as compared to the statewide rate

Sources: Colorado Household Survey (2001), U.S. Census Bureau (2000)

Uninsurance Rates By Age and Gender

This next analysis explores whether the age trends differed by gender. Overall, men have a slightly higher rate of uninsurance (12.2%) than women (11.2%). This pattern of higher uninsurance rates among men is consistent across all age groups below the age of 55. Women 55 years and older, however, have a slightly higher rate of uninsurance as compared to men. The red and blue shading of rows highlight this pattern. However, these differences are NOT statistically significant. (Pearson, P=. 4725) For both genders, young and middle-aged adults (18-54 years) are at the highest risk of being uninsured.

Table 3: Uninsurance Rates and Population Estimates, By Age Group

AGE GROUPS	UNINSURED RATE (Male) (95% Confidence Interval)	UNINSURED RATE (Female) (95% Confidence Interval)	Sample (n)
0-6 Years	11.4% (SE: 3.0%)	10.2% (SE: 3.5%)	794
7-17 Years	11.4% (SE: 2.2%)	6.6% (SE: 1.4%)	1178
18-24 Years	20.7% (SE: 3.2%)	20.6% (SE: 3.4%)	988
25-54 Years	14.0% (SE: 1.6%)	13.6% (SE: 1.6)	5473
55-64 Years	7.9% (SE: 3.1%)	8.8% (SE: 1.8%)	1478
65+ Years	0% (SE: 0%)	3.4% (SE: 1.7%)	306
TOTAL	12.2% (SE: 1.0%)	11.2% (SE: 0.9%)	10,217

* Statistically significant @ p<. 05, male as compared to female by age group

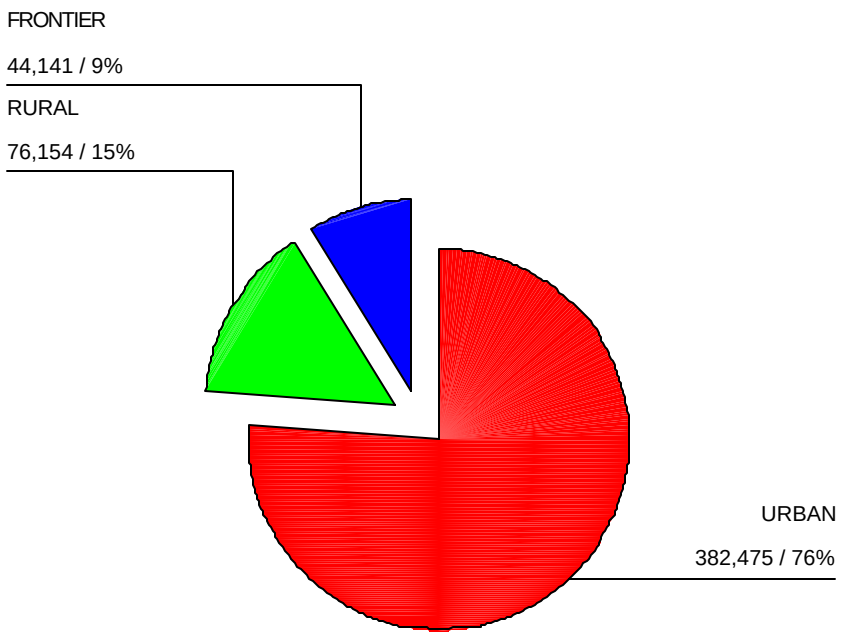
Sources: Colorado Household Survey (2001), U.S. Census Bureau (2000)

Uninsurance Rates by Region

Since a majority of Colorado's population is found in the urban areas, it is not surprising that the uninsured concentrate in urban areas as illustrated in Chart 2.

Uninsurance Rates by Urban, Rural, Frontier

Chart 2: Distribution of Uninsured By Urban, Rural and Frontier



Sources: Colorado Household Survey (2001), U.S. Census Bureau (2000)

The *rates* of uninsurance are higher in non-urban areas. Table 4 reveals that the average rates for rural and frontier (shaded in red) are statistically equivalent, although both rates differ significantly from urban areas and the statewide rate. Typically, this is the lowest level of sub-state analysis -- 2 or 3 large regions -- that is possible with national data (e.g., the CPS) due to small and non-statewide samples. However, this level of aggregation does not permit the study of heterogeneity within non-urban areas.

Table 4: Uninsurance by Urban, Rural, and Frontier

REGION	UNINSURANCE RATE (Standard Error)	POPULATION ESTIMATE (2000)	Sample (n)
URBAN	10.7% (SE: 0.8%)	382,475	6,323
RURAL	16.3%* (SE: 1.5%)	76,154	2,066
FRONTIER	17.3%* (SE: 1.9%)	44,141	1,828
TOTAL	**11.7%** (SE: 0.7%)	502,770	10,217

* Statistically significant @ p<. 05, as compared to urban and statewide rates

Sources: Colorado Household Survey (2001), U.S. Census Bureau (2000)

Uninsurance Rates by Marketplaces

To permit testing of the hypothesis that large categories (urban, rural, frontier) mask some regional differences in uninsurance rates, the CHS 2001 over sampled rural areas. Specifically, the survey sampled 13 sub-state regions based on health care marketplaces as developed by the Colorado Community Health Network, an umbrella agency for Federally Qualified Health Centers (FQHC's).[1] Marketplaces are comprised of one or more whole counties that are relatively self-contained geographic units with respect to the provision of primary care services. Their boundaries also consider hospital access. The survey achieved its sampling objective of obtaining at least 400 completed surveys in each region. The Mountain region had the fewest completed surveys at 410. Metro Denver had the greatest number with 3152 completed surveys.

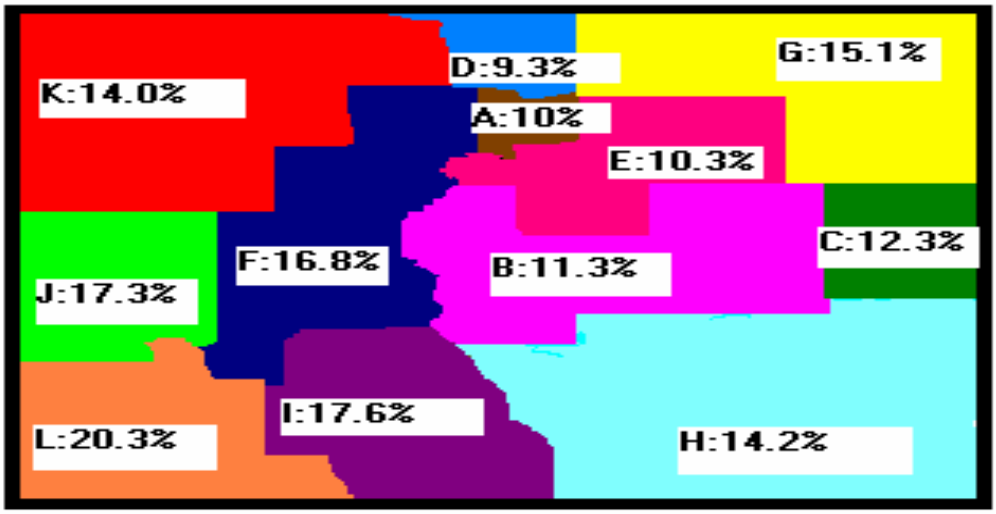
Chart 3 identifies the 12 marketplaces and their respective rates of uninsurance. The letter identifies each region. The numbers in parenthesis after each identifying letter are the uninsurance rates and standard errors. As suspected, there is considerable diversity in uninsurance rates across marketplaces, especially in "rural" and "frontier" areas. The Western Slope is divided into northern, southern and central regions. Uninsurance estimates in these Western Slope marketplaces range from 14.0% to 20.3%. Three southwestern regions -- San Luis Valley (17.6%), Western Slope: Central (17.3%) and Western Slope: South (20.3%) – have rates that are significantly higher than the statewide rate of uninsurance.

Uninsurance Rates, Denver vs. Denver Metro

Chart 3 shows that the overall rate of uninsurance in the Metro Denver is 10.3%. However, as already demonstrated in rural/frontier areas, considerable heterogeneity exists within the metro area. The CHS 2001 sampling strategy permits comparison of Denver County to the Metro Area counties (Adams, Arapahoe, Clear Creek, Denver, Douglas, Jefferson). The uninsurance rate of Denver is 17.3% (SE: 2.2%) as compared to the Metro Area counties' rate of 7.8% (SE: 1.3%). This difference is statistically significant.

[1] CCHN identifies 12 marketplaces. The CHS 2001 sampling strategy used 13 marketplaces, disaggregating Denver from the Metro area to create the thirteenth region.

Chart 3: Uninsurance Rates by Marketplace



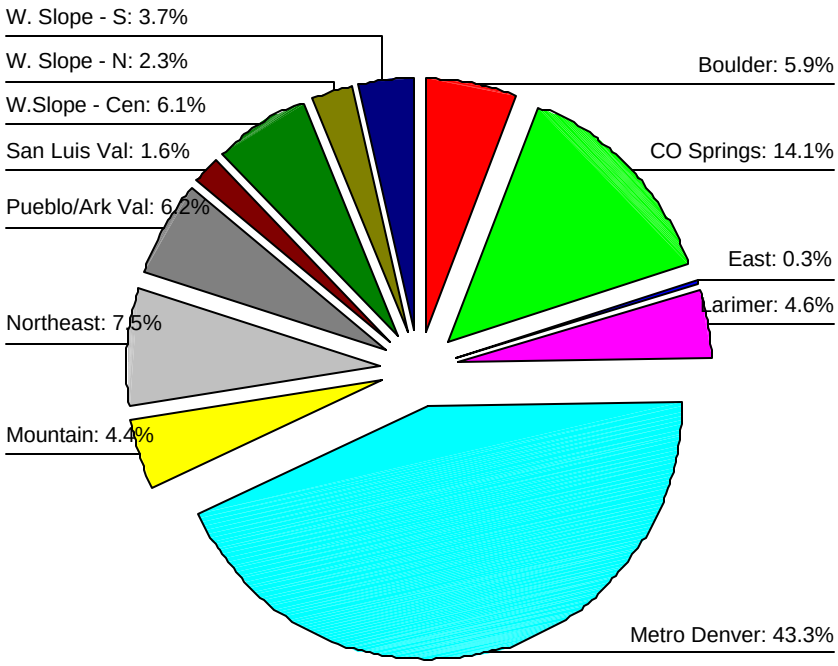
KEY:

REGION	COUNTIES
A: Boulder: 10.0% (SE: 1.9%)	Boulder, Gilpi
B: Co. Springs/Pikes Peak: 11.3% (SE: 1.7%)	El Paso, Elbert, Fremont, Lincoln, Park, Teller
C: East: 12.3% (SE: 2.3%)	Cheyenne, Kit Carson
D: Larimer: 9.3% (SE: 1.4%)	Larimer
E: Metro Denver: 10.3% (SE: 1.1%)	Adams, Arapahoe, Clear Creek, Denver, Douglas, Jefferson
F: Mountain: 16.8% (SE: 2.6%)	Chaffee, Eagle, Grand, Gunnison, Lake, Pitkin, Summit)
G: Northeast: 15.1% (SE: 1.9%)	Logan, Morgan, Phillips, Sedgwick, Washington, Weld, Yuma
H: Pueblo/Ark. Valley: 14.2% (SE: 1.6%)	Baca, Bent, Crowley, Custer, Huerfano, Kiowa, Las Animas, Otero, Prowers, Pueblo
I: San Luis Valley: 17.6%* (SE: 1.7%)	Alamosa, Conejos, Costilla, Mineral, Rio Grande, Saguache
J: Western Slope/Central:17.3%* (SE: 2.0%)	Delta, Mesa, Montrose
K: Western Slope/North:14.0% (SE: 1.8%)	Garfield, Jackson, Moffat, Rio Blanco, Routt
L: Western Slope/South: 20.3%* (SE: 2.2%)	Archuleta, Dolores, Hinsdale, LaPlata, Montezuma, Ouray, San Juan, San Miguel

*** Statistically significant @ p<. 05, as compared to the statewide rate**

Translating uninsurance *rates* into uninsured *population estimates* (people) allows us to answer the question: where do the uninsured live in Colorado? Chart 4 illustrates the distribution of the uninsured by marketplace. The pie slices (and the corresponding percentages) represent the proportion of uninsured that live in each of the 12 marketplaces. As expected, the uninsured concentrate in the more populous urban areas.

Chart 4: Distribution of the Uninsured by Marketplaces



NOTE: Percentages represent the proportion of the uninsured that live in each marketplace. They are NOT uninsurance rates. (See Chart 3 for rates.)

Sources: Colorado Household Survey (2001), U.S. Census Bureau (2000)

Uninsurance Rates by Age and Region

At a statewide level, adult rates of uninsurance are higher than child rates. This analysis explores whether that same trend holds at a regional level. For each region, the column shaded in red highlights the population (adult or child) that has a higher rate of uninsurance within that region. Most regions mirror the statewide trend with adults having higher rates of uninsurance. Interestingly, two of the most populous marketplaces -- Boulder and Denver – as well as the Mountain and Northeast marketplaces show the reverse trend of children having higher uninsurance rates.

Table 5: Colorado Uninsurance Rates by Age and Region

Geographic Region	Adult Uninsurance Rate	Child Uninsurance Rate	Regional Uninsurance Rate
Boulder	9.5%	11.7%	10.0%
Colorado Springs/Pikes Peak	13.2%	6.9%	11.3%
East	12.7%	11.4%	12.3%
Larimer	9.7%	7.4%	9.3%
Denver	15.7%	23.7%	17.3%
Denver Suburbs	9.5%	4.5%	7.8%
Mountain	16.7%	17.1%	16.8%
Northeast	14.4%	17.0%	15.1%
Pueblo/Arkansas Valley	14.4%	13.7%	14.2%
San Luis Valley	19.0%	14.4%	17.6%
Western Slope/Central	18.0%	15.4%	17.3%
Western Slope/North	13.4%	15.9%	14.0%
Western Slope/South	20.9%	18.8%	20.3%
TOTAL	**12.5% (Statewide adult rate)**	**9.7% (Statewide child rate)**	**11.7% (Statewide rate)**

Source: Colorado Household Survey (2001)

Uninsurance Rates by Race/Ethnicity/Country of Origin

The CHS 2001 estimates significant differences in uninsurance rates by race, ethnicity and country of origin. Consistent with U.S. Census Bureau language, the CHS 2001 conceptualizes race and ethnicity as separate categories. Many respondents, however, did not distinguish the terms. In particular, many Hispanics selected the "other, specify" option in the "race" question and further explained that their "race" was Hispanic, Mexican-American, etc.

In Colorado, Hispanics have a significantly higher rate of uninsurance at 22.4% (SE: 2.2%) than non-Hispanics 9.2% (SE: 0.7%). Thus, an uninsurance analysis by race is highly sensitive to what racial assumptions are made about the large proportion (18%) of Hispanics in the Colorado sample. Table 6, therefore, combines race and ethnicity data into a single variable. The last row in Table 6 includes the approximately 2% of respondents who "don't know" their race or refused to answer the question. Estimated uninsurance rates for subgroups with less than 300 surveys must be interpreted with caution, due to the large standard errors that reveal their relative imprecision.

Table 6: Uninsurance Rates and Population Estimates, By Race/Ethnicity

RACIAL/ETHNIC GROUPS	UNINSURED RATE (Standard Error)	POPULATION ESTIMATE (2000)	Sample (n)
Hispanic	**22.4% *** (SE: 2.2%)	170,918	2090
Non-Hispanic White	**9.1%*** (SE:0. 7%)	289,701	7207
Non-Hispanic Black	**8.4%** (SE: 2.1%)	10,292	354
Non-Hispanic American Indian	**20.5%** (SE: 8.0%)	5,939	85
Non-Hispanic Asian/Pacific Islander	**3.0%*** (SE: 1.3%)	2,145	116
Non-Hispanic Multi-racial	**22.3%** (SE: 6.5%)	9,968	135
Non-Hispanic Other	**7.8%** (SE: 7.2%)	986	28
Non-Hispanic Unsure	**15.4%** (SE: 4.8%)	12,821	202
TOTAL	**11.7%** (SE: 0.7%)	502,770	10,217

* Statistically significant @ p<. 05, as compared to statewide rate

Sources: Colorado Household Survey (2001), U.S. Census Bureau (2000)

Uninsurance Rates by Black Subgroups

As described, the CHS 2001 over-sampled majority Black neighborhoods with the aim of obtaining enough Black respondents to estimate their rate of uninsurance separately. However, consistent with Census, CHS 2001 respondents may specify up to three races, and this complicates the analysis.

Table 6 notes that there were 354 non-Hispanic Blacks who responded to the survey. Their uninsured rate is lower (8.4%) than the statewide rate (11.7%) and the non-Hispanic White rate (9.1%), although these differences are not statistically significant. However, in addition to these 354 individuals, another 69 people indicated that they were multiracial including Black (32) or Black Hispanics (37). These 69 individuals are not included in the Non-Hispanic Black rate reported in Table 6. They are counted in the "non-Hispanic Multiracial" and "Hispanic" rows of Table 6, respectively.

In contrast, Table 7 examines the uninsurance rates of *all* individuals that report that they are Black or "part-Black". Table 7 divides these 421 individuals into three groups -- Non-Hispanic Black, Non-Hispanic Multiracial (including Black), and Hispanic Black-- to illustrate how these individuals are sorted into the race/ethnicity categories of Table 6. Note that the point-in-time uninsurance rate for "Blacks" is different in Table 6 (8.4%) than in Table 6 (12.9%). This difference is entirely due to a difference in defining "Black". Although these differences are not statistically significant, it does argue for exercising care with the CHS 2001 race/ethnicity data to ensure "apples to apples" comparisons.

Small sample sizes and large variances preclude a comparison of the Black subgroups to one another. (Note the large standard errors, especially for Hispanic Blacks, in Table 6.) Again, the subgroups in Table 7 are presented to facilitate comparisons to Table 6.

Table 7: Uninsurance Rates and Population Estimates, By Black Sub-Groups

BLACK SUBGROUP	UNINSURED RATE (95% Confidence Interval)	POPULATION ESTIMATE (2000)	Sample (n)
Non-Hispanic Black	**8.5%** (SE: 2.1%)	10,292	352
Non-Hispanic Multiracial (including Black)	**11.7%** (SE: 8.3%)	1,042	32
Hispanic Black	**45.1%** (SE: 24.4%)	7,672	37
TOTAL **ALL BLACK SUBGROUPS**	**12.9%** (SE: 4.4%)	19,006	421

NOTE: Sample is too small to permit statistical testing among Black sub-groups. The total Black rate of uninsurance (12.9%) is not statistically different from the statewide uninsurance rate (11.7%).

Sources: Colorado Household Survey (2001), U.S. Census Bureau (2000)

Uninsurance Rates by Country of Origin

U.S.-born respondents had a slightly lower rate of uninsurance (10.2%) as compared to the statewide estimate. Among those with a different country of origin, uninsurance rates varied widely depending on the country. For example, the uninsurance rate of former German nationals (1.0%) is statistically lower than the statewide rate, while the uninsurance rate of those born in Mexico (46%) is statistically higher than the statewide rate. This latter finding is consistent with the earlier analysis revealing a higher rate of uninsurance among Hispanic Coloradoans. (According to CHS 2001 data, the majority of Hispanics in Colorado are Mexican-American.)

Sufficient data existed to analyze only those born in the U.S., Germany and Mexico as separate groups. Canada was also analyzed separately, but the estimate produced a large standard error. All other countries of origin were lumped into an "other country" category for analytical purposes. This "other country" category includes first and third world countries, so caution is advised in interpreting its uninsurance estimate. Table 8 summarizes point-in-time uninsurance rates by country of origin.

Table 8: Uninsurance Rates and Population Estimates, By Country of Origin

COUNTRY OF ORIGIN	UNINSURED RATE (95% Confidence Interval)	POPULATION ESTIMATE (2000)	Sample (n)
United States	**10.2%** (SE: 0.6%)	404,223	9,376
Canada	**18.5%** (SE: 10.4%)	2,828	30
Germany	**1.0%*** (SE: 0.8%)	265	63
Mexico	**46.0%*** (SE: 5.8%)	86,823	438
Other	**7.1%** (SE: 1.6%)	8,518	295
TOTAL	**11.7%** (SE: 0.7%)	502,657	10,202

* Statistically significant @ p<. 05, as compared to the statewide rate

NOTE: 15 records with missing country of origin data were excluded from analysis

Sources: Colorado Household Survey (2001), U.S. Census Bureau (2000)

Uninsurance Rates by Marital Status

The CHS 2001 reveals that rates of uninsurance differ by marital status in Colorado, with 14.8% of single/divorced/widowed individuals lacking coverage as compared to 11.2% of those who are married/living with a partner/separated. This is a statistically significant difference. See Chart 5. Interestingly, the marital status of child parents/guardians does not appear to be related to child health insurance status. See Chart 6.

Chart 5: Adult Insurance Rates by Marital Status

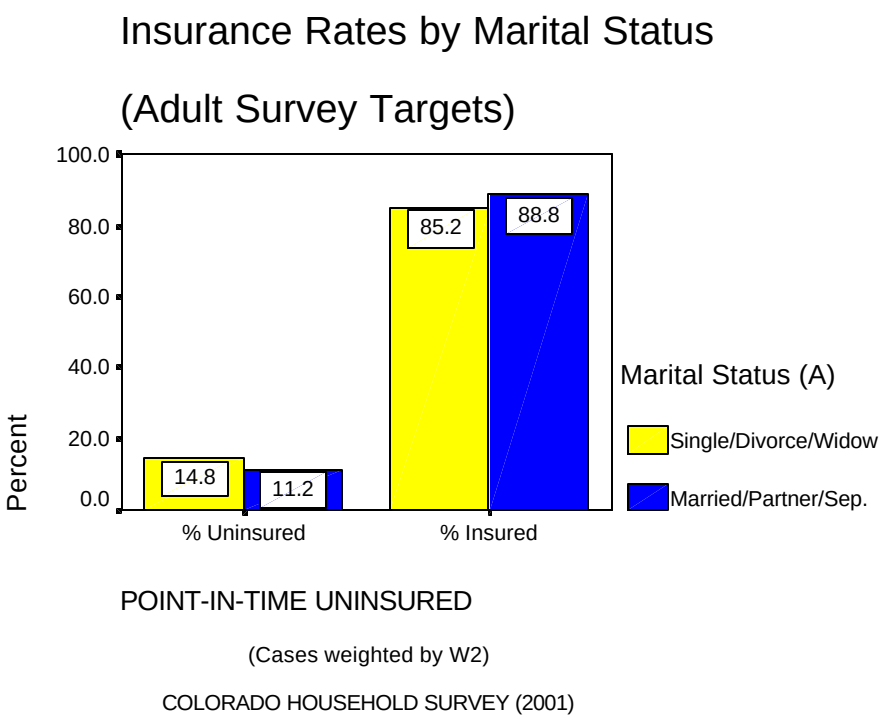
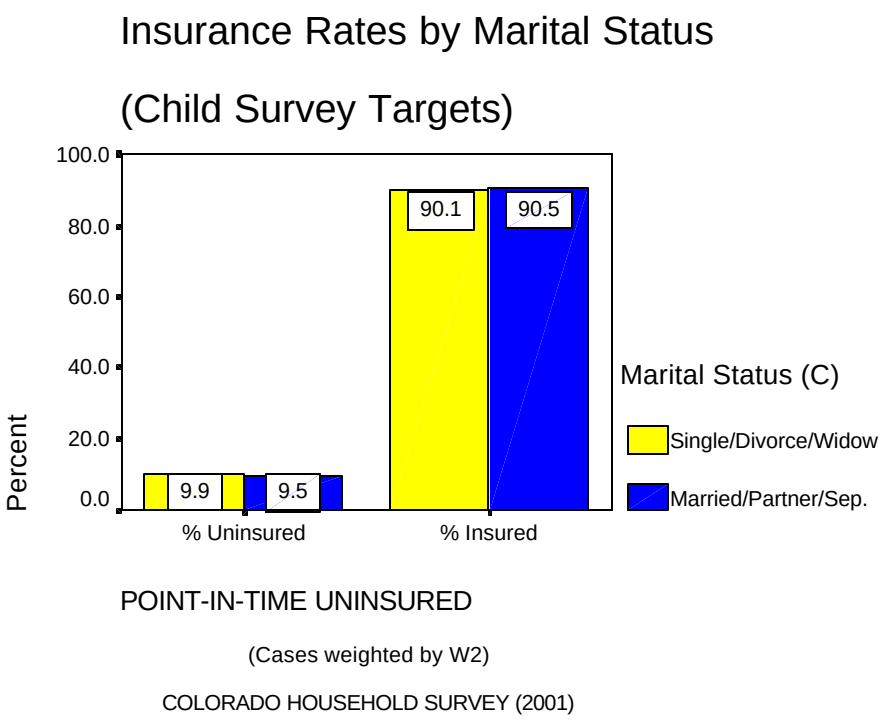


Chart 6: Child Insurance Rates by Parent/Guardian Marital Status



Uninsurance Rates by Education

Uninsurance rates are related to education in a gradient relationship. Each level of educational attainment is associated with a gain in insurance coverage. This is true of both adults and children. The latter comparison assesses the educational attainment of parents/guardians of children. See Charts 7 and 8.

Chart 7: Adult Insurance Rates by Education

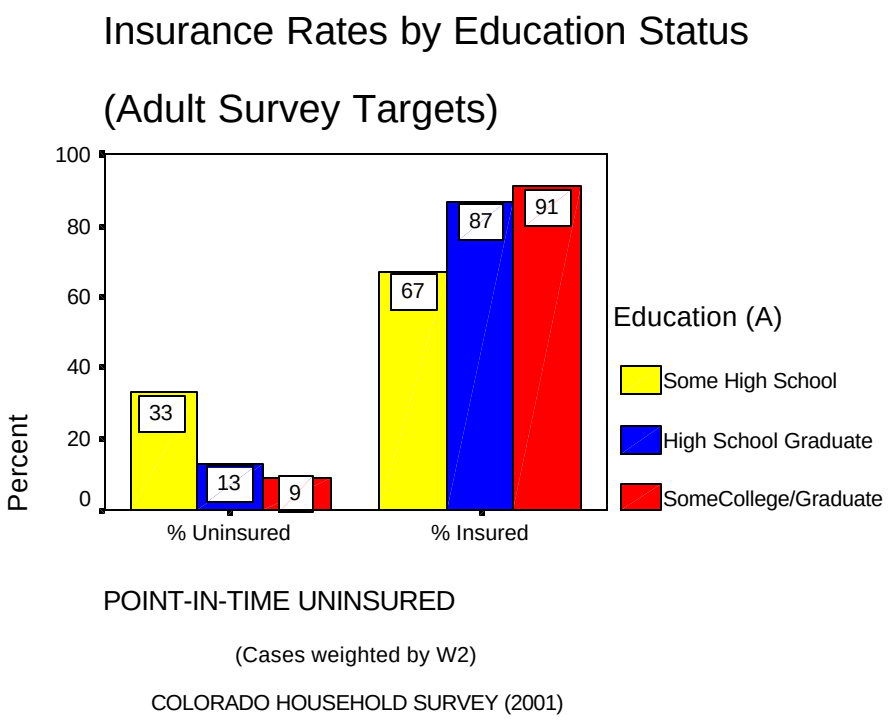
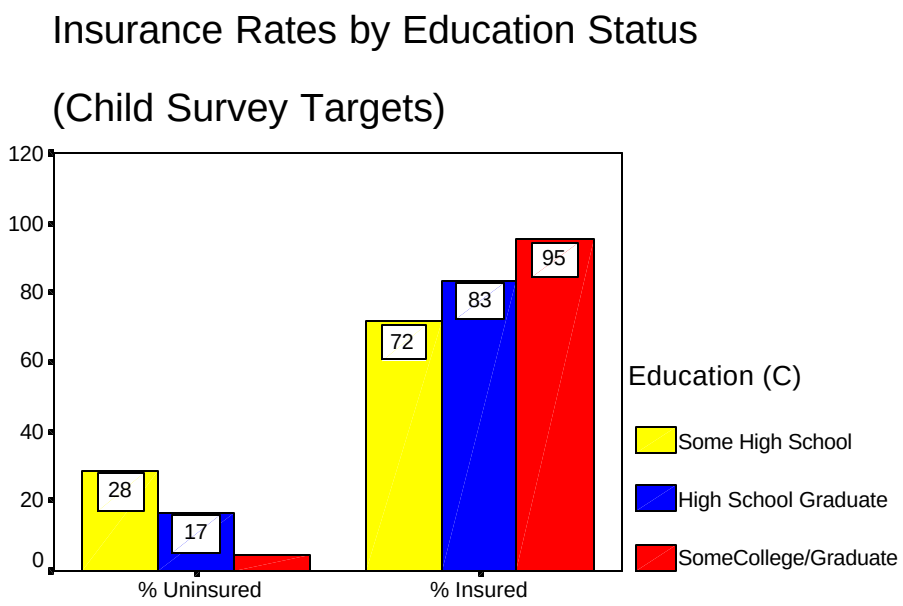


Chart 8: Child Insurance Rates by Parent/Guardian Education



(Cases weighted by W2)

COLORADO HOUSEHOLD SURVEY (2001)

Uninsurance Rates by Employment Status

Uninsurance rates vary according to employment status. Among adults, retired/unpaid workers have the lowest rates (2%), whereas the self-employed (23%) and the unemployed (31%) have the highest rates. Full-time students have an average rate of uninsurance of 13%. See Chart 9. However, rates of uninsurance among students vary significantly by age. Full-time students between the ages of 18-24 have only a 5.5% rate of uninsurance, likely due to the fact that they continue to be eligible for dependent coverage. Child insurance rates also vary according to the employment status of their parents or guardians. See Chart 10.

Chart 9: Adult Insurance Rates by Employment Status

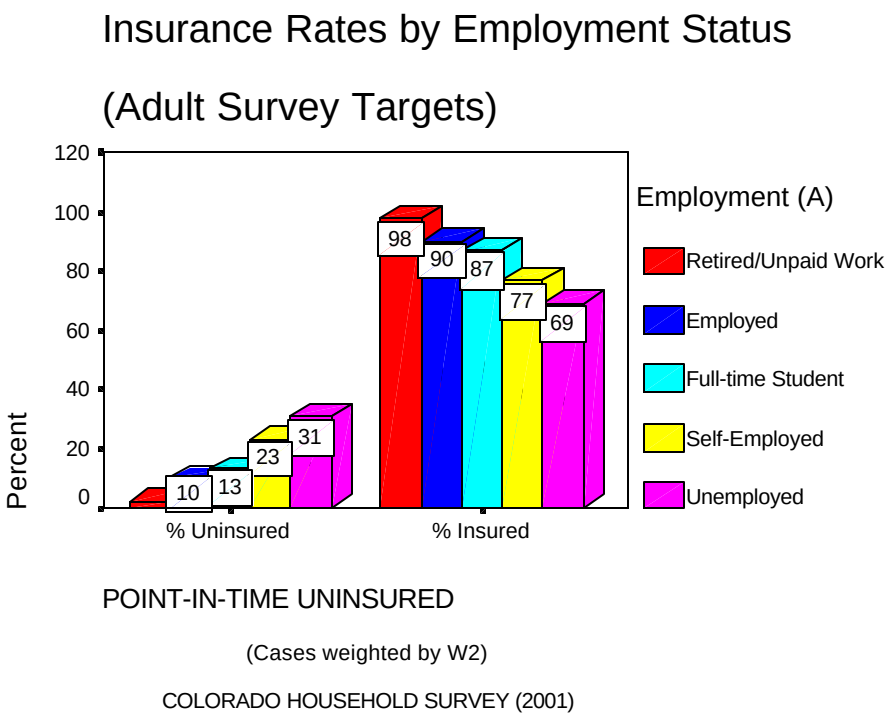
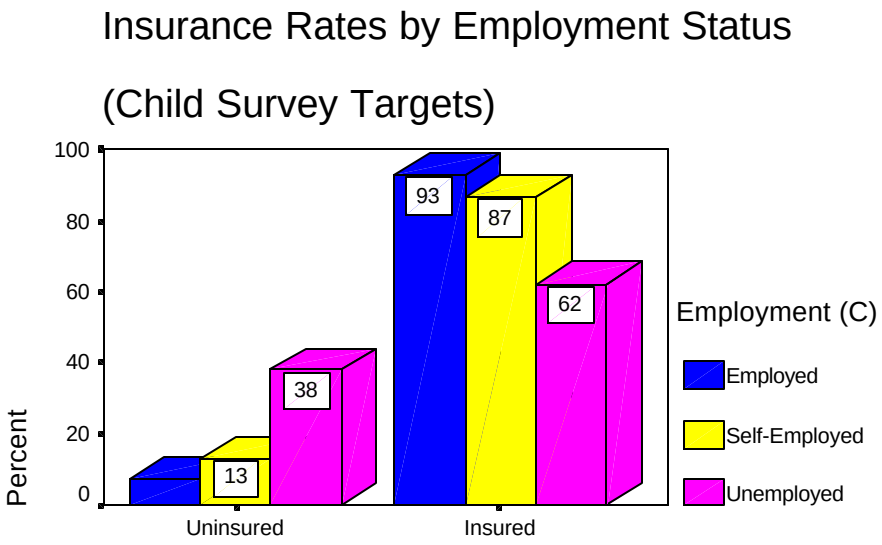


Chart 10: Child Insurance Rates by Parent/Guardian Employment Status



POINT-IN-TIME UNINSURED

(Cases weighted by W2)

COLORADO HOUSEHOLD SURVEY (2001)

1.2. What are the characteristics of the uninsured?

The statistical associations between uninsurance rates and various demographic and personal characteristics are exhaustively explored in Sections 1.1, 1.4, and 1.11. As described therein, *rates* of uninsurance can and do differ significantly across subpopulations. This section summarizes the characteristics of the uninsured population considered as a whole, merging together all of its constituent subgroups. In general, the uninsured in Colorado are more likely to :

? Be adults (76%)

? Be male (52.4%)

? Be non-Hispanic white (59.1%)

? Have been born in the U.S. (80.4%)

? Be employed or a full-time student (69.7% of uninsured adults are employed or full-time students)

? Have a permanent job (84.9% of uninsured adults have a permanent job)

? Be in good to excellent health (83.4%)

? Live in an urban area (76.1%)

1.3.Summarizing the information provided above, what population groupings were particularly important for your State in developing targeted coverage expansion groups?

Colorado continues to study the data for the purpose of identifying and prioritizing those population groups particularly important to our state.

1.4.What is affordable coverage? How much are the uninsured willing to pay?

The CHS 2001 included questions that asked the uninsured if and how much they would be willing to pay for coverage. While that data has not yet been analyzed, inferences can be made about affordability from the relatively low average incomes of the uninsured.

According to the U.S. Census 2000 the median income for Coloradoans is $46,511. The median income for CHS 2001 respondents was $50,000. The slightly higher median income for the CHS 2001 is likely due to the telephone methodology that biases it toward households that can afford telephone service.

The CHS 2001 found that the median income for the uninsured ($27,000) is substantially below – almost half – of the statewide median. In contrast to other states that have found that their uninsured populations are concentrated largely above the federal poverty line, Colorado has a significant number of uninsured adults below it. As Chart I illustrates, between 15-18% of uninsured adults are below 100% of the federal poverty level (FPL). Nearly all (90%) of these poor uninsured adults are between 42% and 100% FPL. Forty-two percent (42%) FPL is commonly used to estimate income eligibility for Medicaid for adults in Colorado.

The relatively low-income ceiling for adult Medicaid coverage in Colorado may explain why so many of the uninsured fall below 100% of FPL. It may also explain the CHS 2001 finding that two-thirds of the uninsured have been uninsured for 12 months or more. Nationally, the trends are reversed. Two-thirds of the uninsured are uninsured for relatively brief periods (6 months or less).[x] Some have hypothesized that these gaps in coverage are partially explained by the lag time in eligibility determination for public programs. In Colorado, most uninsured adults do not appear to qualify for public programs. Approximately half of uninsured adults are under 200% of poverty, and two-thirds of the uninsured are under 300% of poverty. (See Charts II and III.)

Chart I: Uninsured Adults Below the Federal Poverty Level

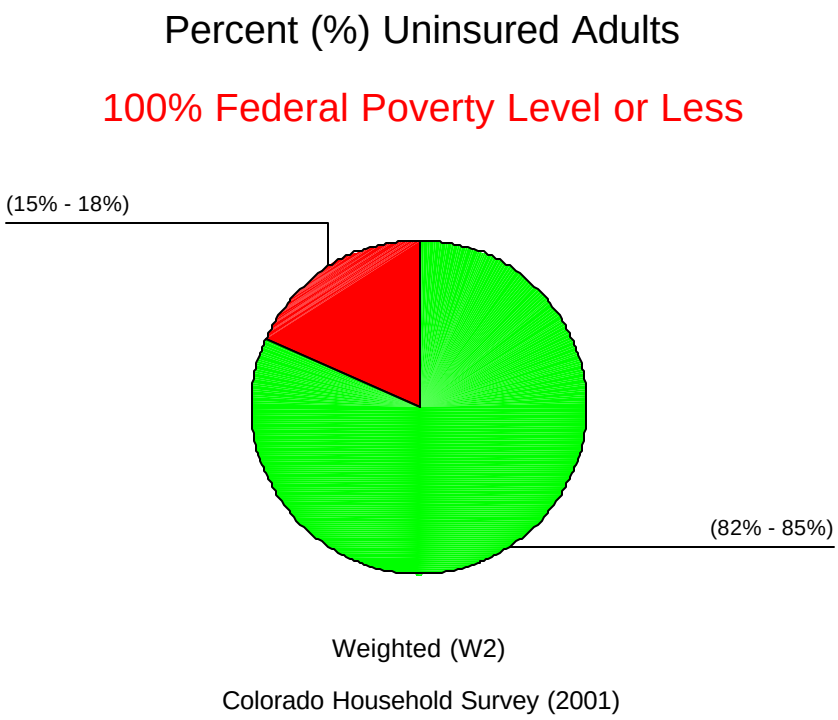


Chart II: Uninsured Adults Below 200% of the Federal Poverty Level

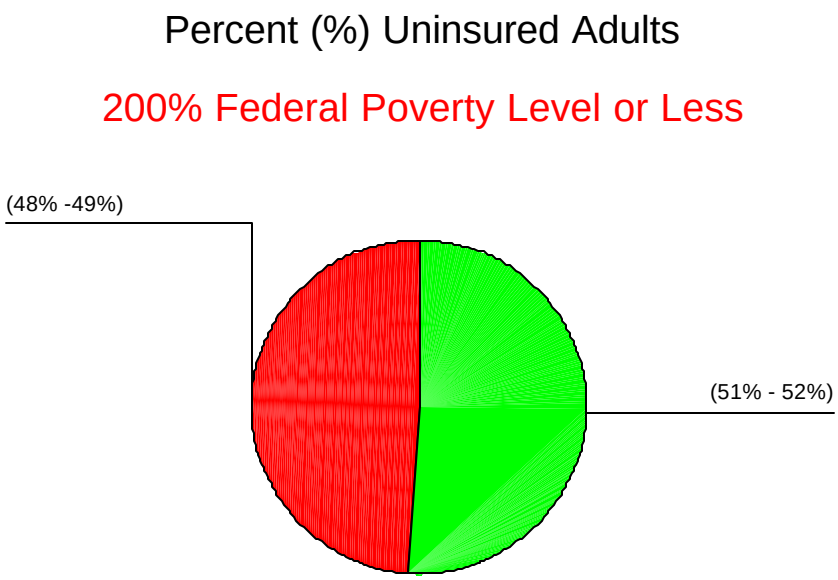
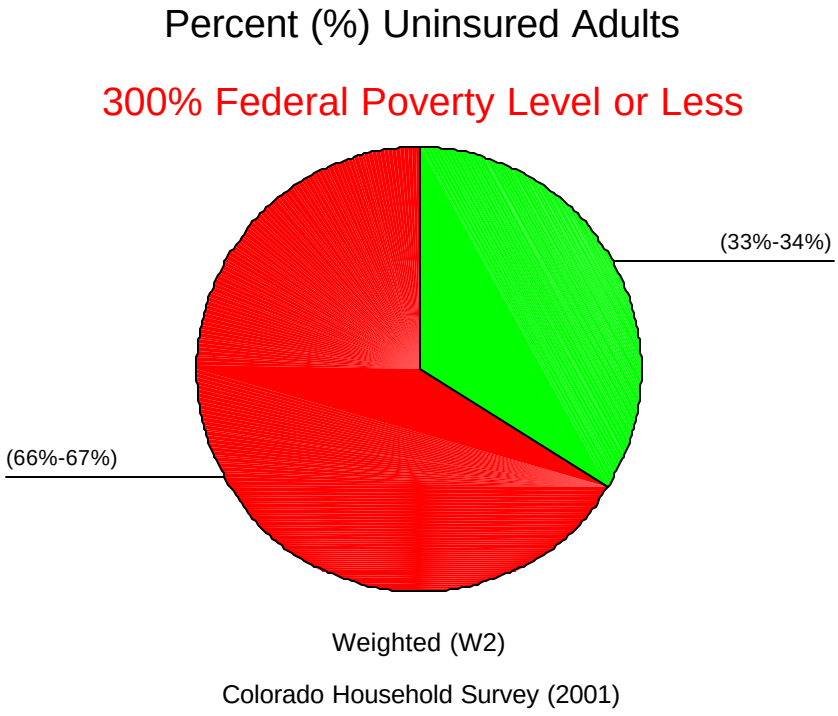


Chart III: Uninsured Adults Below 300% of **the Federal Poverty Level**



Technical Note: The percentage ranges on each "pie slice" of Charts 1-III are NOT confidence intervals. The CHS 2001 used two questions to assess household income. One question asked for an exact figure. If the respondent refused, they were then asked to specify an answer within a range of incomes. Over 12% of individuals refused both income questions.

The data analysis used to generate Charts I-III was done twice, with two different assumptions about the missing data. In the first data run, the missing data was dropped from the analysis. In the second analysis, the missing data was modeled according to a regression methodology modeled on that developed by the University of Minnesota. Estimates from both methodologies (dropped missing data and modeled missing data) are included on the charts. They were typically within a couple percentage points of each other.

Questions 1.5 through 1.10: Data has not yet been collected on these issues or discussed in specific detail with our Strategic Planning Group.

1.11 How are the uninsured getting their medical needs met?

The CHS 2001 included a number of questions in the demographic section that explored the relationship between health insurance status and health status. It also examines the relationship between health insurance status and health care utilization. Health status and utilization patterns are important to quantify because they can help Colorado understand how (and to what extent) insurance coverage relates to health care access help identify appropriate and inappropriate service utilization, and suggest cost and financing models for covering the uninsured.

All respondents answered questions about dental coverage and self-assessed health status. The remainder of the health status and utilization questions was asked only of respondents that received one of the survey supplements. As discussed in the section on sampling and weighting, a special set of weights were developed to group respondents in insured and uninsured categories for comparison purposes.

Briefly, the insured and uninsured groups differed significantly in their health status and use of services. Relatively small minorities of both groups – insured and uninsured – reported poor health status. However, the uninsured were still more likely than the insured to report fair to poor health or an activity-limiting disability. The uninsured were also more likely to admit to having postponed need care and to have unpaid medical bills than those with coverage. Insured people were more likely to have dental coverage, a regular source of care, and consistency in health care professionals than the uninsured. Pharmacy utilization was also higher for the insured group. However, the proportions of insured and uninsured using hospital and emergency room services were about the same for both groups.

Dental Coverage by Health Insurance Status

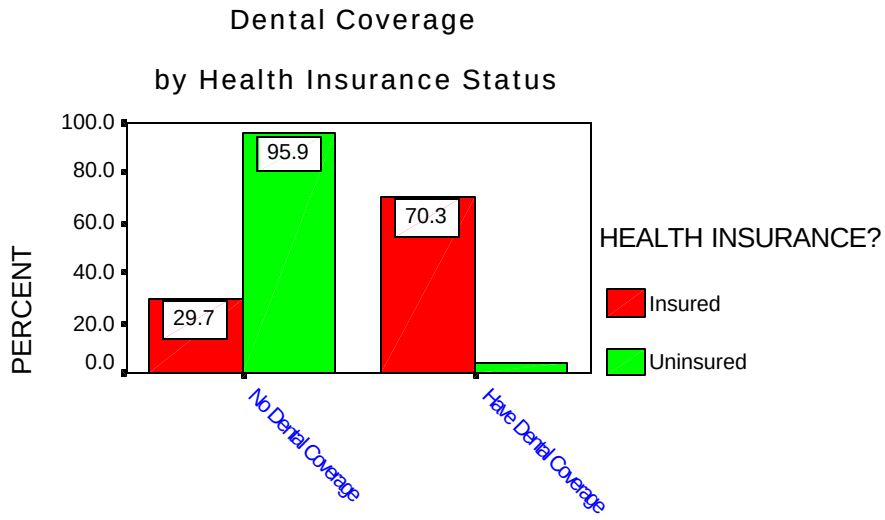
All survey respondents received a question about dental coverage.

Survey Question:

> Do you (Does TARGET) currently have insurance that pays for dental care?

Almost 96 percent (95.9% SE: 1.0) of people with health insurance coverage also have dental coverage, as compared to fewer than 30 percent (29.7% SE: 1.3) of those without health insurance. This is a statistically significant difference in dental coverage. (See Chart 1.)

Chart 1: Dental Coverage by Health Insurance Status



Colorado Household Survey (2001)

Health Status by Health Insurance Status

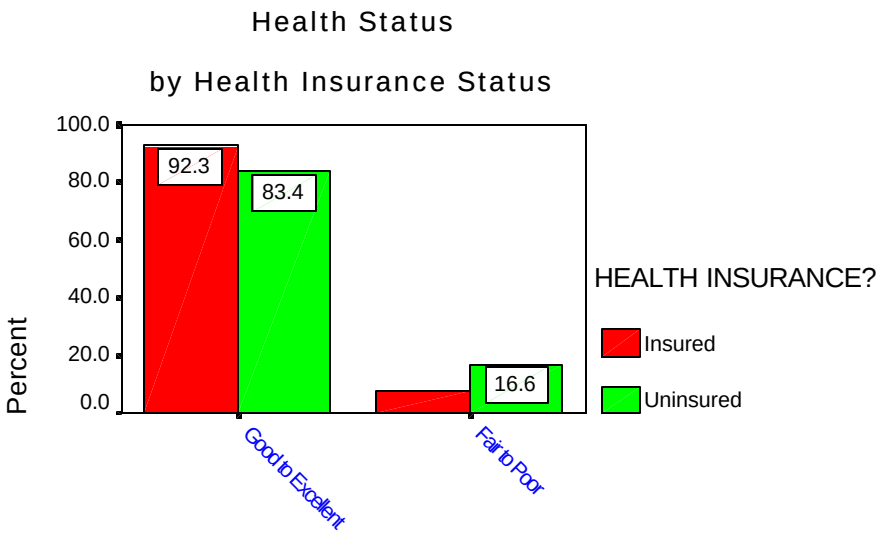
All survey respondents received a question about their self-assessed health status.

Survey Question:

Would you say that your (TARGET's) health – in general – is excellent, very good, good, fair or poor?

Over 92 percent (92.3% SE: 0.9) of people with health insurance coverage report being in good to excellent health, as compared to just under 84 percent (83.4% SE: 2.4) of those without health insurance. This is a statistically significant difference in self-reported health status. (See Chart 2.)

Chart 2: Health Status by Health Insurance



HEALTH STATUS: Excellent, Very Good, Good, Fair, Poor

Colorado Household Survey (2001)

Disability Status by Health Insurance Status

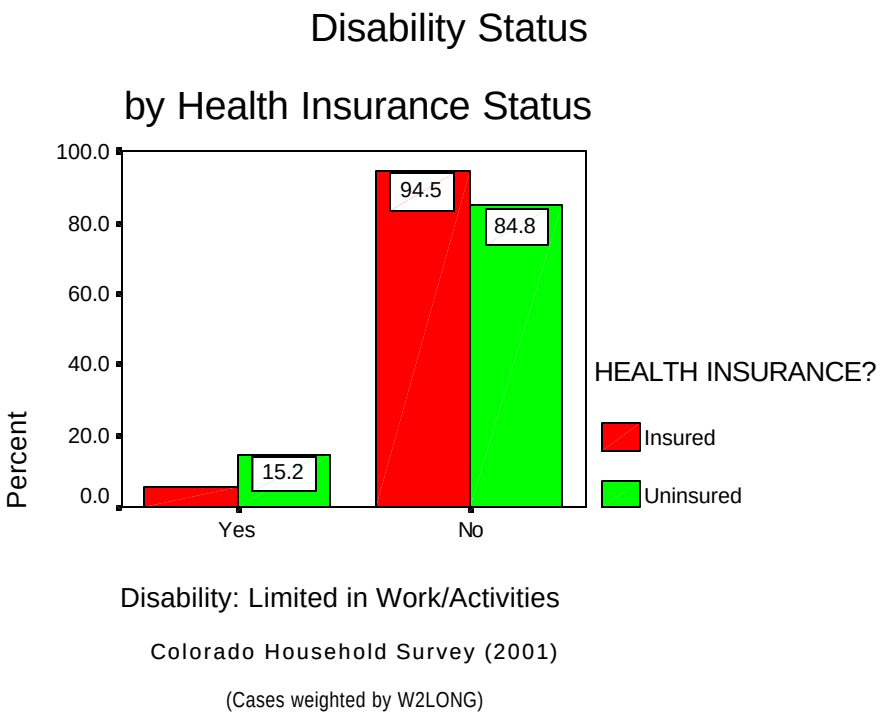
Survey respondents who received one of the four supplements received a question about whether they have a disability that limits activities or work.

Survey Question:

> Has a doctor or other medical provider ever diagnosed you (TARGET) with any medical condition or disability that currently limits you (TARGET) in everyday activities or in the kind of work you (TARGET) can do?

Under 6 percent (5.5% SE:0. 9) of people with health insurance coverage report having a disability, as compared to just over 15 percent (15.2% SE: 2.5) of those without health insurance. This is a statistically significant difference. (See Chart 3.)

Chart 3: Disability Status by Health Insurance Status



Regular Source of Care by Health Insurance Status

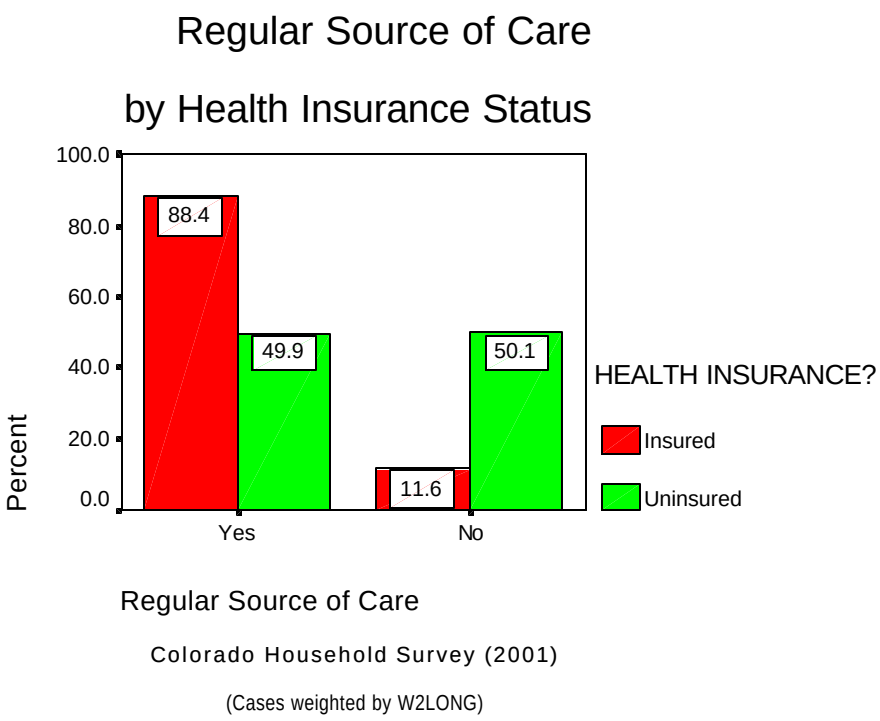
Survey respondents who received one of the four supplements received a question about whether they have a regular source of care.

Survey Question:

> Is there a regular place that you (TARGET) go for medical care?

Almost 89 percent (88.4% SE: 2.8) of people with health insurance coverage report having a regular source of care, as compared to just under 50 percent (49.9% SE: 3.1) of those without health insurance. This is a statistically significant difference. (See Chart 4).

Chart 4: Regular Source of Care by Health Insurance Status



Same Health Professional by Health Insurance Status

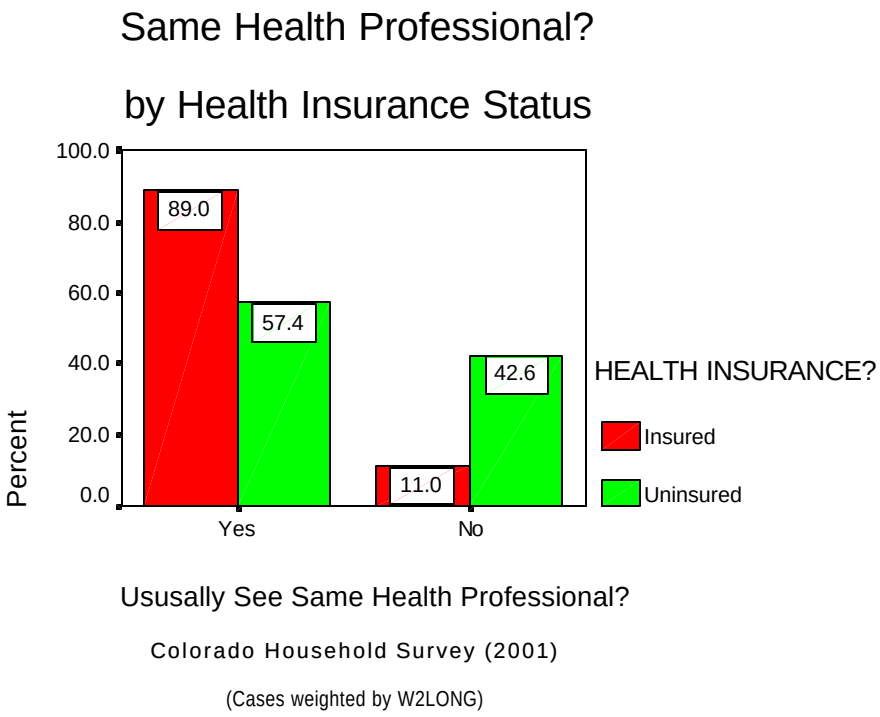
Survey respondents who indicate that they have a regular source of care received a follow-up question about consistency of provider.

Survey Question:

> Is there a particular health care professional or traditional healer you (TARGET) usually see(s) when you (TARGET) go(es) there?

Eighty-nine percent (89.0% SE: 2.0) of people with health insurance coverage report having a person that they usually see when they go to their regular source of care, as compared to just under 58 percent (57.4 SE: 4.6) of those without health insurance. This is a statistically significant difference. (See Chart 5).

Chart 5: Same Health Professional by Health Insurance Status



Postponed Care by Health Insurance Status

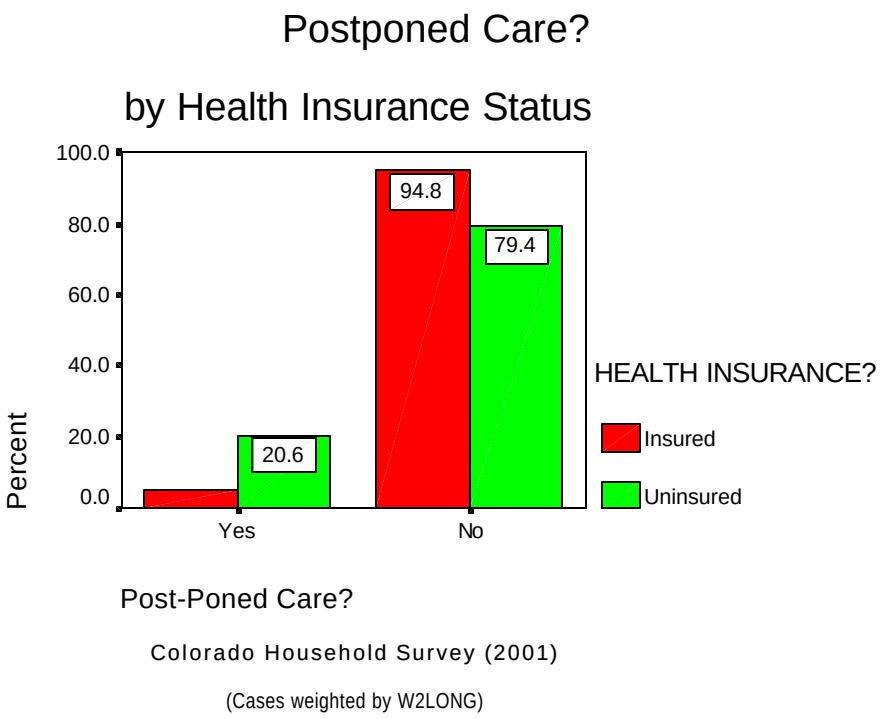
Survey respondents who received one of the four supplements received a question about whether they have postponed needed care.

Survey Question:

> During the past twelve months, did you (TARGET) not get, or postpone getting, medical or surgery when you needed it? INFORM: This does not include dental care.

Over one fifth (20.6% SE: 2.5) of people without health insurance coverage report having postponed needed health care, as compared to just 5 percent (5.2% SE: 1.4) of those who have health insurance. This is a statistically significant difference. (See Chart 6).

Chart 6: Postponed Care by Health Insurance Status



Unpaid Medical Bills by Health Insurance Status

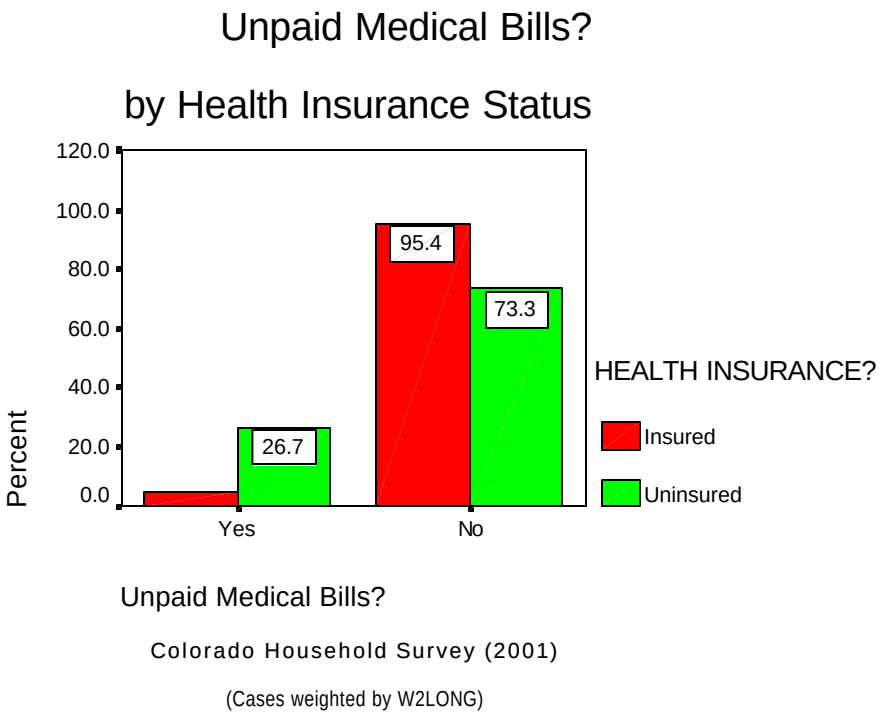
Survey respondents who received one of the four supplements received a question about whether they have unpaid medical bills.

Survey Question:

> During the past 12 months, did you (did TARGET) have a medical bill that you (TARGET) couldn't pay?

Over one quarter (26.7% SE: 2.9) of people without health insurance coverage report having unpaid medical bills, as compared to just under 5 percent (4.6% SE:0. 8) of those who have health insurance. This is a statistically significant difference. (See Chart 7).

Chart 7: Unpaid Medical Bills by Health Insurance Status



Hospital Utilization by Health Insurance Status

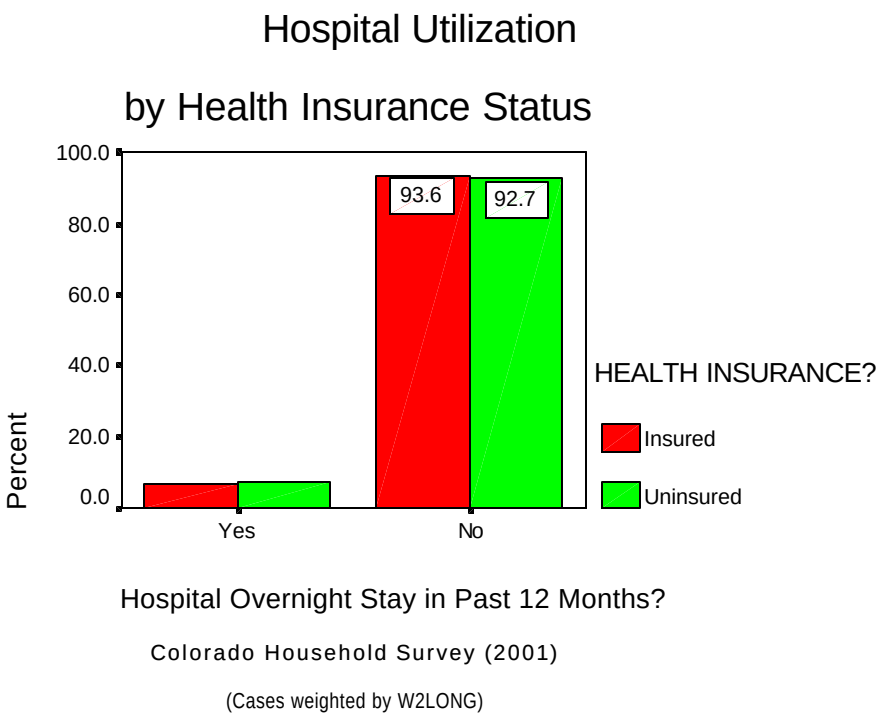
Survey respondents who received one of the four supplements received a question about whether they had a hospital admission in the past year.

Survey Question:

During the past 12 months, have you (TARGET) been a patient overnight in a hospital?

The proportion of people reporting one or more hospital admissions in the last year is similar among insured and uninsured groups. Survey data estimates that 6.4% (SE: 1.9) of people with health insurance coverage had had an overnight hospital stay as compared to 7.3% (SE: 1.5) of uninsured people. This is a NOT statistically significant difference. (See Chart 8).

Chart 8: Hospital Utilization by Health Insurance Status



Emergency Room Utilization by Health Insurance Status

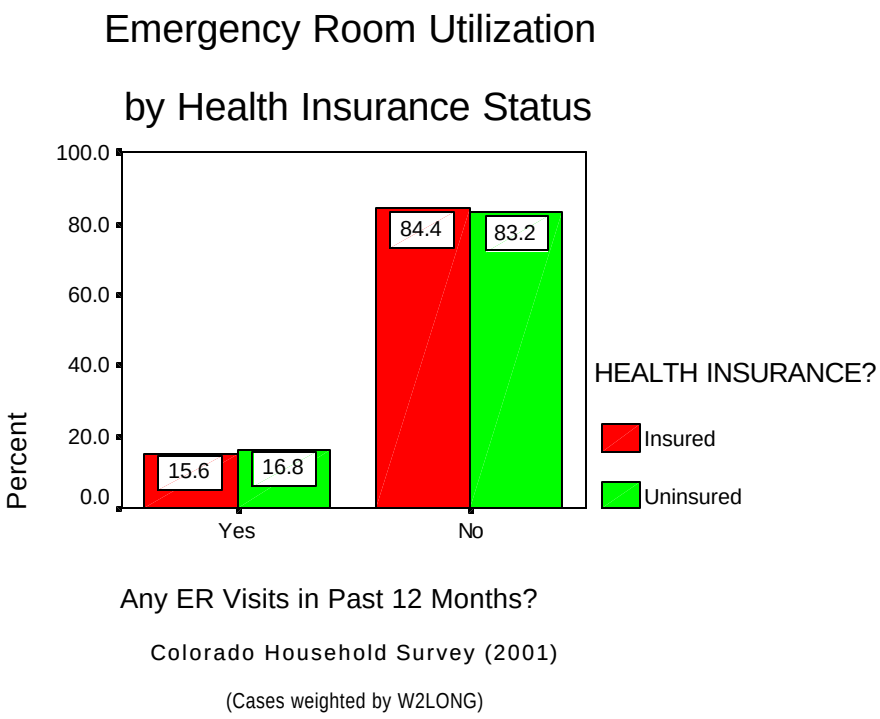
Survey respondents who received one of the four supplements received a question about whether they had an emergency room visit in the past year.

Survey Question:

During the past twelve months, have you (TARGET) been to a hospital emergency room?

The proportion of people reporting one or more emergency room visits in the last year is similar among insured and uninsured groups. Survey data estimates that 15.6 % (SE: 3.2) of people with health insurance coverage had had an overnight hospital stay as compared to 16.8% (SE: 2.2) of uninsured people. This is a NOT statistically significant difference. (See Chart 9).

Chart 9: Emergency Room Utilization by Health Insurance Status



Pharmacy Utilization by Health Insurance Status

Survey respondents who received one of the four supplements also received a question about whether they had a prescription in the past year.

Survey Question:
In the past 12 months were you (TARGET) prescribed medication by a doctor?

Those who reported receiving pharmacy prescriptions were asked a follow-up question about what proportion of prescriptions they actually filled.

Survey Question:
Did you (TARGET) fill all, most, some or none of these prescriptions?

People who have health insurance are more likely to report receiving one or more prescriptions in the last year, and they are more likely to fill all those prescriptions, as compared to those without health insurance. Over half (54.9%, SE: 4.5) of people with health insurance coverage had had a prescription, as compared to approximately one third (35.7, SE: 2.7) of the uninsured group. (See Chart 10). Among those insured and uninsured individuals who received prescriptions, only about three quarters of the uninsured group (75.6, SE: 3.5) filled ALL of them, as compared to 86.7% (SE: 3.8) of the insured group. (See Chart 11.) These are statistically significant differences.

Chart 10: Pharmacy Utilization by Health Insurance Status

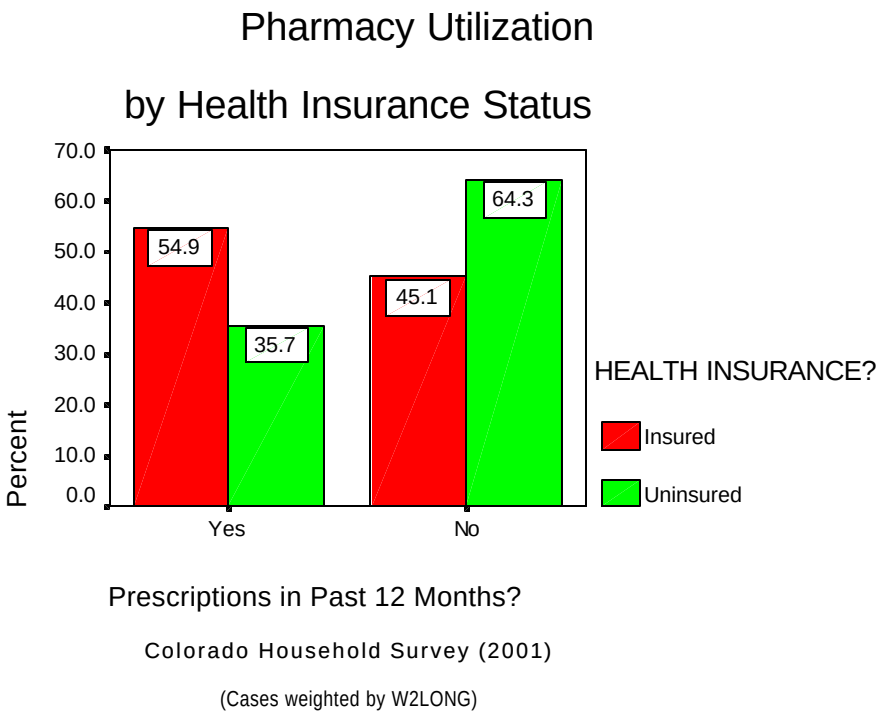
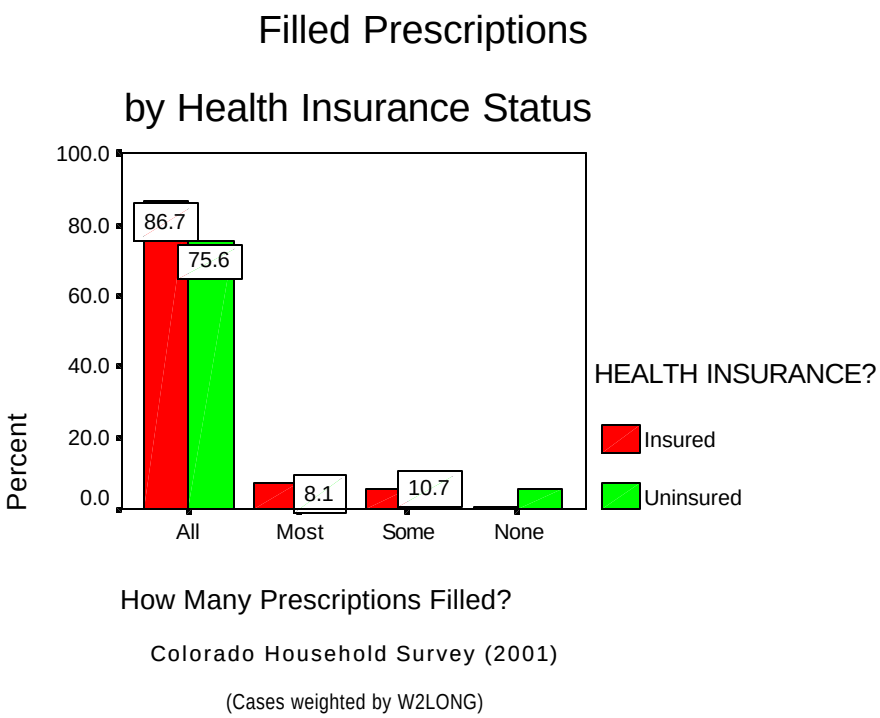


Chart 11: Filled Prescriptions by Health Insurance Status



SECTION 2. SUMMARY OF FINDINGS: EMPLOYER-BASED COVERAGE

2.1. What are the characteristics of firms that do not offer coverage, as compared to firms that do?

The Colorado Coalition for the Medically Underserved, a partner on the HRSA Project Management Team, published their fourth edition of the *Colorado Health Book*. The *Data Book* served as a definitive reference on the current picture of the health care delivery and financing system in Colorado. The data with respect to the employer-based coverage contained in the *Data Book* come from the Medical Expenditure Panel Survey Insurance Component (MEPS-IC). Based on this information, only 71.9% of full-time working Coloradoans have access to insurance through their own employer. This is a lower percentage than is true nationally. It is interesting to note that compared to the U.S. as a whole, Colorado employees in smaller firms (under 100 employees) have more access, to coverage than is true nationally, and employees in larger firms have less access. Just 23.4% of part-time Colorado employees have access to coverage through their own employer.

In Colorado, the data extracted from the MEPS-IC also shows that the larger the firm, the more likely it is to offer coverage. Just 41.7% of firms with fewer than 10 employees offer coverage, compared to effectively 100% of large firms with 1,000 or more employees. In all cases, Colorado firms are more likely to offer coverage than is true nationally.

The Governor's Office is addressing the problem that small business owners confront when the prospect of providing health care insurance to their employees is too cost prohibitive. The Governor is supporting legislation in this area that would create new basic health plan options that insurance carriers could offer to small businesses. Under current Colorado law, insurance carriers are prohibited from offering low-cost and preventative plans based on restructuring the benefits offered.

To address the qualitative research work that must be completed in order to craft informed policy options, Colorado intends to conduct small employer focus groups throughout the State to identify the factors that influence employers' decisions to offer or not to offer insurance to employees. Thirteen (13) regional small employer focus groups will be held to mirror the 13 defined regions used in the Colorado Household Survey.

The focus groups will be conducted through the months of April and May of 2002. The HRSA Project Management team in collaboration with the Colorado Strategic Planning Group on Health Care Coverage will select 8-10 small employers representing diverse small business owners representing various industries, types of employees and health care insurance status. The HRSA Project Management Team will coordinate all logistical arrangements such as meeting places, times, and hiring court reporters to record the event. The contractor is the Department of Family Medicine Research and Evaluation through the University of Colorado Health Sciences Center, Attention: Dr. Debbie Main.

Table 1: Small Business Perspectives on Insuring Employees Geographical Breakdown

Date	Time	City	Location	Counties
April 18, 2002	4 p.m.	Boulder	Chamber of Commerce	Boulder, Gilpin
April 22, 2002	8 a.m.	Burlington	TBD	Cheyenne, Kit Carson
April 22, 2002	4 p.m.	Fort Morgan	TBD	Logan, Morgan, Phillips, Sedgwick, Washington, Weld, Yuma
April 23, 2002	8 a.m.	Colorado Springs	TBD	El Paso, Elbert, Fremont, Lincoln, Park, Teller
April 23, 2002	1 p.m.	Aurora	TBD	Adams, Arapahoe, Clear Creek, Douglas, Jefferson
May 7, 2002	10 a.m.	Ft. Collins	TBD	Larimer
May 7, 2002	4 p.m.	Denver	TBD	Denver
May 20, 2002	10 a.m.	Pueblo	TBD	Baca, Bent, Crowley, Custer, Huerfano, Kiowa, Las Animas, Otero, Prowers, Pueblo
May 20, 2002	4 p.m.	Alamosa	TBD	Alamosa, Conejos, Costilla, Mineral, Rio Grande, Saguache
May 21, 2002	8 a.m.	Durango	TBD	Archuleta, Dolores, Hinsdale, La Plata, Montezuma, Ouray, San Juan, San Miguel
May 21, 2002	4 p.m.	Montrose	TBD	Delta, Mesa, Montrose
May 22, 2002	8 a.m.	Gunnison	TBD	Chaffee, Eagle, Grand, Gunnison, Lake, Pitkin, Summit
May 22, 2002	4 p.m.	Glenwood Springs	TBA	Garfield, Jackson, Moffat, Rio Blanco, Routt

Table 2: Small Business Survey on Health Care Coverage - Pre-Focus Group Questionnaire

We would like to better understand the issues facing small business owners and providing health care coverage for their employees. Please answer the following questions about your business.

1. Name and address of your business: _____

_____

2. Is your business a ? a private, for-profit company/professional practice, OR a ? private, non-profit organization?

3. Does the company ? operate out of one location OR ? does it have branch offices or other locations in the United States in addition to the headquarters or main offices?

4. What is the total number of employees at ALL locations and branch offices that are now on the company's payroll? ? 1 (sole proprietor) ? Total 2 employees ? Total 3 – 9 employees ? Total 10 –24 employees ? 25 – 50 employees

5. Including yourself, how many permanent full-time employees does your business employ? (Full-time is defined as working an average of 30 hours per week or more.) _____

6. Including yourself (if applicable), how many permanent part-time employees does your business employ? (Part-time time is defined as working an average of less than 30 hours per week.) _____

7. How many seasonal employees does your business employ? _____

8. What is the main focus of your business?

? aviation/transportation	? government	? retail
? communications	? health care	? services
? construction	? law	? technology
? education	? manufacturing	? agricultural
? entertainment/resort	? mining	? wholesale
? financial/banking	? research/development	? other _____

9. What is the average annual salary of your employees?

	% Employees		% Employees
? Below $10,000	_____	? $25,000-29,999	_____
? $10,000-14,999	_____	? $30,000-34,999	_____
? $15,000-19,999	_____	? $35,000-39,999	_____
? $20,000-24,999	_____	? $40,000 or more	_____

10. What is the number of years this company has been in business? _____

11. How would you rate the general health status of your employees?
? Excellent ? Good ? Average ? Fair ? Poor ? Don't Know

12. Does your company offer or contribute to a health insurance program for your employees?
? Yes ? No

If No, what is the primary reason for not offering a health insurance program? _____
_____

If Yes, please complete questions 14 – 18.

14. What type of health insurance is offered to your employees?
? Contract with a health insurer
Deductibles and co-pays _____
? Self funded and administered by a third party
Deductibles and co-pays _____
? Self funded and administered by your company
Deductibles and co-pays _____
? Union provided plan (provide name of union)
Deductibles and co-pays _____

15.

What type of health insurance benefits do you offer to your employees and their dependents? (Check all that apply)		Benefit not offered	Full time	Part time	Seasonal
Comprehensive Health Insurance *(Medical services, hospital, etc.)*	Employee	?	?	?	?
	Dependent	?	?	?	?
Dental Insurance	Employee	?	?	?	?
	Dependent	?	?	?	?

Vision Insurance	Employee	?	?	?	?
	Dependent	?	?	?	?
Other	Employee	N/A	?	?	?
	Dependent	N/A	?	?	?

16. How long must an employee work at your company before he/she is eligible for health benefits? _____

16. What percentage of your eligible employees participates in the health insurance plan? _____

17. What is the total cost of the company policy per month? _____

18.

	Employment Type		
What is the monthly premium cost of the standard health benefit plan that is paid by the company?	**Full Time**	**Part Time**	**Seasonal**
For employee only plan			
For employee with dependents (family plan)			
What is the monthly premium cost of the standard health benefit plan that is paid by the employee?	**Full Time**	**Part Time**	**Seasonal**
For employee only plan			
For employee with dependents (family plan)			

19. Based on your own experiences and knowledge, please estimate the average cost of the following health services:

Five mile ambulance ride to hospital _____
Routine chest x-ray _____
Double by-pass coronary surgery _____
Normal labor and delivery _____
Prescription for Penicillin _____

Table 3: Small Business Survey on Health Care Coverage - Focus Group Questionnaire

1. We'd like your views on this country's health care system such as the quality of health care available for you and your employees, the cost of health care and health insurance, the administrative ease in purchasing employee health insurance and submitting claims for reimbursement.

2. In your opinion, would most people be better off if they got their health insurance policy through the place where they work OR if they purchased health insurance on their own? Related to this question, do you feel it is the employer's responsibility to offer health insurance to his or her employees?

3. What factors influence the employer's decision about whether or not to offer coverage? (For example, need for owner's coverage, need to be socially responsible, need to compete for qualified workers.)

4. What are the primary reasons employers give for electing not to provide coverage? (For example, health insurance premiums are too high, employee turnover is too great, etc.)

5. What factors go into an employer's decision regarding premium contributions, benefits packages, and other features of the coverage?

6. What would be the likely response of employers to an economic downturn or continued increase in costs? (For example, would you drop coverage altogether, increase the amount employees have to pay for insurance, have the company absorb the costs, reduce the scope of benefits you offer.)

7. Related to the above question, how much do you think your company could afford to contribute PER MONTH toward one of your employee's health insurance coverage? What's the most you think your typical employee could afford to pay PER MONTH toward their own health insurance?

8. Suppose the government provided financial assistance, like a tax credit, to help companies like yours pay health insurance premiums. In general, how would having government financial assistance influence your decision to offer health insurance to your employees?

9. What is your opinion of the limited tax deductibility of health care insurance premiums for owners of Sub-S corporation, Limited Liability Companies, or sole proprietorships?

10. How much would the government need to contribute in the form of cash assistance or subsidy on insurance premiums to influence your decision to offer health insurance to your employees? 25% of the monthly premiums? 50% of the monthly premiums? 75% of the monthly premiums? Is this government's responsibility?

11. How likely is it that sometime in the next five years your company will stop negotiating directly with health insurance companies and instead give employees cash to buy health insurance on their own? This is sometimes called a "defined contribution." Would you or your employees prefer this option or not and why? What might be the advantages and disadvantages of such an approach?

12. How likely would you be influenced by the availability or expansion of purchasing pools or alliances in offering health care insurance to your employees?

13. Publicly funded health care programs like Medicaid provide a safety net for the uninsured, but they also "crowd out" private insurance. What employer and employee groups are most susceptible to "crowd out" in your opinion?

14. What other alternatives might be available to motivate employers not now providing or contributing to coverage?

15. Is the system becoming better or worse for employers, and why?

16. What are the specific challenges that you feel your community faces, related to health care?

17. What would you most like to see changed?

SECTION 3. SUMMARY OF FINDINGS; HEALTH CARE MARKETPLACE

The Colorado Strategic Planning Group on Health Care Coverage identified the following questions that require additional data and information for the purposes of developing a plan to address health care coverage issues:

Where does the direct payment of providers fit in the equation versus a strict insurance approach?
What is the willingness of providers to participate in programs such as Medicaid and CHP+ and what incentives could be offered to providers to accept current levels of reimbursement?
How can we address the rising costs of providing health care?
Are there cost savings that can be created in the health care delivery system?
Are there circumstances when health care coverage does not translate into health care access?
What benefits are we willing or able to cover?
What will be the impact of any federal legislative mandates, such as a pharmacy benefit for Medicare recipients?
Are there cost savings when money is spent on preventive health care at the front end as opposed to spending it on the back end?

HRSA Activities Presently Proposed to Address Questions:

- **Provider Interviews**
- **Health Care Cost Analysis**
- **Prioritized Benefits Analysis**
- **Analysis of Colorado Market Including Consumer Choice and Role of Competition**

SECTION 4. OPTIONS FOR EXPANDING COVERAGE

The Colorado Strategic Planning Group on Health Care Coverage identified the following questions that require additional data and information for the purposes of developing a plan to address health care coverage issues:

What available funding sources exist to expand coverage?
What efficiencies exist in using current financial resources such as leveraging Federal dollars or creating pools of money?
Is it feasible to expand coverage for public sector programs by proposed waivers to the Federal government regarding the current benefits covered under Medicaid and CHP+?
How does TABOR impact the feasibility of crafting plans that involve the expansion of existing programs?
How could administrative cost savings associated with credentialing, eligibility and the payment of claims contribute to expanding coverage to the uninsured?

HRSA Activities Presently Proposed to Address Questions:

- **Feasibility of Federal waivers**
- **Health Care Cost Analysis**
- **Prioritized Benefits Analysis**
- **Impact of TABOR**

SECTION 5. CONSENSUS BUILDING STRATEGY

Colorado's Governor's Office serves as the lead agency for this project. The HRSA grant is administered through its Project Management Team, a unique public/private partnership. Representing the private sector is the Colorado Coalition for the Medically Underserved. The Coalition is composed of over 150 individuals and organizations representing health care providers, consumers, business, government agencies, philanthropic organizations and others. The Coalition launched its own independent initiative to uncover the best options to provide access to affordable, quality health care and preventive programs for all Coloradoans by 2007. Representatives from the Office of the Governor, Department of Public Health and Environment, Department of Health Care Policy and Financing as well as the Department of Regulatory Affairs reflect the public sector perspective. Two independent consultants with data analysis expertise and national health care policy expertise complete the Team. By spearheading this effort, the Governor Bill Owens and his Office conveyed a strong message to all state agencies about the importance of coverage for the uninsured. Additionally, the structure of this public/private partnership enhances the probability of advancing feasible coverage options.

The Project Management Team also works closely with the Colorado Strategic Planning Group on Health Care Coverage that was convened by Governor Owens. The Strategic Planning Group is comprised of key leaders from government, including State legislators and executive branch cabinet members. In addition, leading stakeholders from the business and health care sectors serve as members of this Strategic Planning Group. The Strategic Planning Group is co-chaired by two cabinet level executive directors (the Department of Health Care Policy and Financing and the Department of Regulatory Agencies). The two Strategic Planning Group meetings held in October and November served as a forum by which the Project Management Team could report the progress and research findings of the grant activities. The additional questions, comments and advice offered by the Strategic Planning Group have helped focus and direct the subsequent efforts of the Project Management Team. A legislative sub-committee on health care met over the summer and possible legislation for the next session in January will also be presented to the Strategic Planning Group for their input and feedback.

The Strategic Planning Group has approximately 40 members. The size of the group, as well the relatively limited meeting time (two hours every month) poses a set of challenges to the process and group dynamics. In spite of the relatively large group and limited meeting time, group participation and an interactive exchange of ideas is encouraged. For the first six months, the Strategic Planning Group was presented with information from various health care leaders in the industry and community in the form of expert panels. Additionally, data collected and analyzed

under the Colorado Household Survey was presented to the Strategic Planning Group on an ongoing basis. During the recent months, the approach of the HRSA Project Management Team has been to focus on specific subpopulation groups (for example, geographical, demographic and occupational subgroups) with higher than average uninsurance rates and invite discussion about possible strategies to address these subpopulation groups.

For example, the data presented to the Strategic Planning Group indicated that young adults between the ages of 18 to 24 have the highest rate of uninsurance (more than 20%) of any age group. This group was also found to be more likely to have an emergency room visit and unpaid medical costs. Colorado law does not permit parents to cover their children as dependents under their health insurance plan if they are not full-time students. As a result of the awareness of this problem, House Bill 1255 was introduced this legislative session. House Bill 1255 would have changed the definition of dependent for the purposes of health insurance to include non full-time students under the age of 24, as long as they were financially dependent on a parent and did not have access to health insurance through their own employer. Additionally, it would have permitted insurance carriers to charge higher premiums for dependent children who were not full-time students. The bill died in appropriations, but reflected the "substantive incremental reforms" that can be directed for specific sub-populations. This approach to addressing the policy issues associated with the problem of the uninsured would had not been possible without the Colorado specific data obtained through the Colorado Household survey.

The Strategic Planning Group is very interested in the strategies and options utilized by other HRSA states. The plan is now to develop a menu list of possible options that may merit further study and discussion advanced by other HRSA states. From this menu, the Strategic Planning Group will determine priorities and any remaining data collection efforts through the HRSA State Planning Grant will be organized. There is interest by members of the Strategic Planning Group to form working groups to facilitate the process for the duration of the HRSA grant period.

Another consensus building strategy was the choice to conduct small business employer focus groups as opposed to a telephone employer survey. It is important to be in the communities that may be impacted by any proposed health care policy options adopted. Colorado has a very high percentage of small business employers and sole proprietors throughout the State. Colorado also has a large number of seasonal workers employed by the tourism, agricultural, and service industries. In Colorado, it was estimated that the economic downturn resulted in 100,000 fewer jobs at its worst point. Because of the uncertain economy, many people were fearful that they are "one pink slip away" from not having health care coverage for themselves and dependents. The small business employer focus groups will permit Colorado to gather qualitative information about the nature, extent, and possible solutions to the health care coverage challenges that confront small business owners.

The Project Management Team is also conducting outreach activities in the community to promote the activities of the HRSA grant. Team members are meeting with the Chamber of Commerce Health Care Committee members to discuss possible linkages and ways to collaborate. Team members have made presentations to the Colorado Coalition for the Medically Underserved as well as to other public and private agencies interested in health care

issues. The Rose Community Foundation and possibly the Colorado Coalition for the Medically Underserved have discussed sponsoring an expert panel to discuss the idea of tax credits to reduce the number of uninsured.

The governance structure of the Project Management Team as well as the Strategic Planning Group represents a bipartisan approach to addressing the issue of the uninsured. The Project Management Team recognizes the inherent political nature of the process once proposed health care policy options are proposed. However, the underlying themes embraced by the Project Management Team have focused on integrity, communication and respect. The Team discusses proposed activities, contractors and outcomes in an open environment. Patience, flexibility, and perseverance are the hallmarks by which consensus has been reached. The Project Management Team experienced personnel changes in the early stages of this project that presented challenges around the issues of leadership, ownership and mission. However, the Team has worked exceedingly hard to overcome the initial adversity and has made substantial progress in accelerating the timeframe for activities to be conducted under the grant.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

It doesn't take a rocket scientist to appreciate the fact the problems that exist in health care are extremely complex and the challenge to craft feasible policy options seems daunting. In fact, the suggestion has been made that states are in need of a "Health Houdini" able to perform incredible feats of magic to unravel the tangled and interconnected strands that contribute to rising health care costs and make access to health care coverage out of the reach of so many. However, experts advise that when a problem seems overwhelming, one approach may be to divide it into smaller, more manageable parts. Colorado is adopting this approach.

Colorado recognizes the importance of developing both short-term policy solutions as well as solutions that must be implemented over a longer period of time. As stated previously, the focus of this project is to identify and implement "substantive incremental reform" that will reduce uninsurance rates and increase the stability of the health care marketplace. At this juncture, Colorado is not in a position to identify what "substantive incremental reform" might include in the way of policy options.

Colorado has benefited from the experiences of the first round of HRSA-funded states as to what survey instruments yield the best survey results, alternatives for building political consensus, as well as innovative approaches in addressing a very complicated problem. Efficiencies have been created in the process because Colorado has the advantage of reviewing the policy options other states considered, proposed or abandoned and the rationale for those decisions. Colorado is in a position to take advantage of the "best practices" of the other HRSA states as well as the "lessons learned" through the process. Colorado heard the messages presented at the recent statewide HRSA meetings that the changed circumstances in the economy and the world required policy options that now have an emphasis on "maintenance" rather than "expansion" and had the luxury of adapting the proposed activities under the HRSA grant accordingly.

Colorado would reiterate and echo the sentiments expressed by other states that the technical assistance and funding that allowed states to meet regularly and to share and collaborate with each other have been extremely valuable networking and learning opportunities.

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

At this time, Colorado is not in a position to make recommendations to the Federal Government with respect to legislative or administrative policies. However, Colorado would highly recommend that the Federal government initiate, develop and sustain a mechanism whereby states could continue to meet, exchange information and network on health care related activities that evolved through the HRSA grant process.

[i] Nelson C and Mills R. The March CPS Health Insurance Verification and Its Effect on Estimates of the Uninsured. 2001;Census Bureau: Washington, DC. http://www.census.gov/hhes/hlthins/verif.htm.

[ii] Rajan, S et al. Confirming Insurance Coverage in a Telephone Survey: Evidence from the National Survey of America's Families. Inquiry. Fall 2000:37(3): 317-327.

[iii] What is Behind the 8 Percent Drop in Uninsurance: Changes in the CPS Health Insurance Measurement and Effect on State Policy. State Health Access Data Assistance Center Issue Brief. February 2002/Issue 4. http://www.shadac.org

[iv] US Census Bureau. Colorado Quick Facts from the U.S. Census Bureau. 2000. http://quickfacts.census.gov/qfd/states/08000.html

[v] Assumes Colorado's total population in 2001 is 4,406,266 as estimated by the Demography Section, Colorado Division of Local Government as cited in Yondorf B. 2001 Colorado Health Data Book: Insurance, Access & Expenditures. Colorado Coalition for the Medically Underserved. Denver, CO: October 2001

[vi] U.S. Census Bureau. Health Insurance Coverage: 2000. Issued September 2001 P-60-215. Table D.

[vii] Nelson C and Mills R. The March CPS Health Insurance Verification and Its Effect on Estimates of the Uninsured. 2001;Census Bureau: Washington, DC. http://www.census.gov/hhes/hlthins/verif.htm.

[viii] Duchon L et al. Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk. Findings from The Commonwealth Fund 2001 Health Insurance Survey. The Commonwealth Fund, December 2001.

[ix] Czajk Jl. Analysis of Children's Health Insurance Patterns: Findings from the SIPP. Mathematica Policy Research for the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, May 12, 1999.

[x] Duchon L et al. Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk. Findings from The Commonwealth Fund 2001 Health Insurance Survey. The Commonwealth Fund, December 2001.