

**STRATEGIC PLANNING PHASE:
RECOMMENDATIONS FOR ASSURING ACCESS TO
INSURANCE COVERAGE**

TURNING POINT INITIATIVE



Colorado's



Public Health



Improvement Plan



Colorado Public Health Improvement Plan Colorado Turning Point Initiative August 2001

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Background

ALMOST 14 YEARS AFTER THE PUBLICATION of the breakthrough report *The Future of Public Health* by the Institute of Medicine (IOM), some would contend that the U.S. public health system today is not much closer to realizing the goals of the IOM study than it was in 1988. While there have been public health achievements since then, new and more complex challenges have presented themselves. Among these new challenges are an increasingly diverse political constituency, the resurgence and spread of drug-resistant strains of disease-causing microbes, global transmission of new and emerging diseases, the threat of bioterrorism, decreased funding for public health programs and infrastructure, reduced health insurance coverage and overall access to health care, and health disparities. All of these issues present overwhelming challenges to safeguarding the future health of the public.

In the summer of 1999, the Colorado Department of Public Health and Environment (CDPHE) received a Turning Point strategic planning grant from the Robert Wood Johnson Foundation. The purpose of the grant was to facilitate a collaborative process to assess the health of Colorado residents, examine public health systems in Colorado, and then create a state public health improvement plan. This document is one product of that work. Colorado is one of 21 states participating in the National Turning Point Initiative and is guided by the overriding mission to transform and strengthen the public health system to make the system more effective, more community-based, and more collaborative.

A steering committee carried out the strategic planning process with input from workgroups. In examining health status and health systems within Colorado, it became clear that while Colorado is a relatively healthy state, there are still barriers that prevent optimal health for the general population, and there are specific population groups that are disproportionately impacted by disease, disability, and death, especially minority communities. In looking toward the future, public health is likely to face challenges never before seen, where a strong public health infrastructure and visionary leaders will be critical to maintaining the health of

Colorado residents. Through its assessment, the Turning Point Steering Committee determined that many groups in Colorado have a difficult time accessing health care. This is due in part to a lack of insurance coverage and the fact that many rural areas in Colorado have been federally designated as Health Professional Shortage Areas. In terms of public health infrastructure, funding constraints currently prevent expanding the workforce, increasing information and data systems capacity, and enhancing organizational capacity, especially in local agencies.

Through its public health systems assessment, the steering committee determined that the key strategies for improving health status in Colorado include:

- * Increasing the capacity of public health and environmental agencies
- * Increasing the capacity to conduct population-based health status assessment
- * Assuring access to quality health care
- * Assuring access to insurance coverage
- * Eliminating health disparities
- * Promoting leadership development within the public health field and community partners

Beyond the steering committee and workgroups, the Turning Point Initiative used key informants, a review of the literature, and national and state data to examine each key strategy area. In this document, a national perspective will be included, as these key strategy areas are not unique to Colorado. This planning process was conducted by a diverse set of partners, many of whom are not from governmental public health agencies. The Colorado Turning Point Initiative believes that maintaining and improving the public's health requires partnerships with many different sectors and communities. This plan is meant to be carried out in collaboration and should be used as a guide. We believe that any person, community, or entity can take a leadership role in mobilizing partners around the recommendations in this plan, and we invite this participation in maintaining the health of our state.

Data Issues

This document attempts to provide the latest data available; however, data availability varies by year depending on the data source. In most cases, 1999 is the most recent year for available data. When 1999 data is not yet available, earlier data will be presented.

In preparing this plan, guidance was sought from the *Healthy People 2010* document, which will be referenced often. *Healthy People 2010* is a set of national health objectives to be achieved over the first decade of the 21st century. The objectives were developed by a consortium of partners, led by the U.S Department of Health and Human Services.

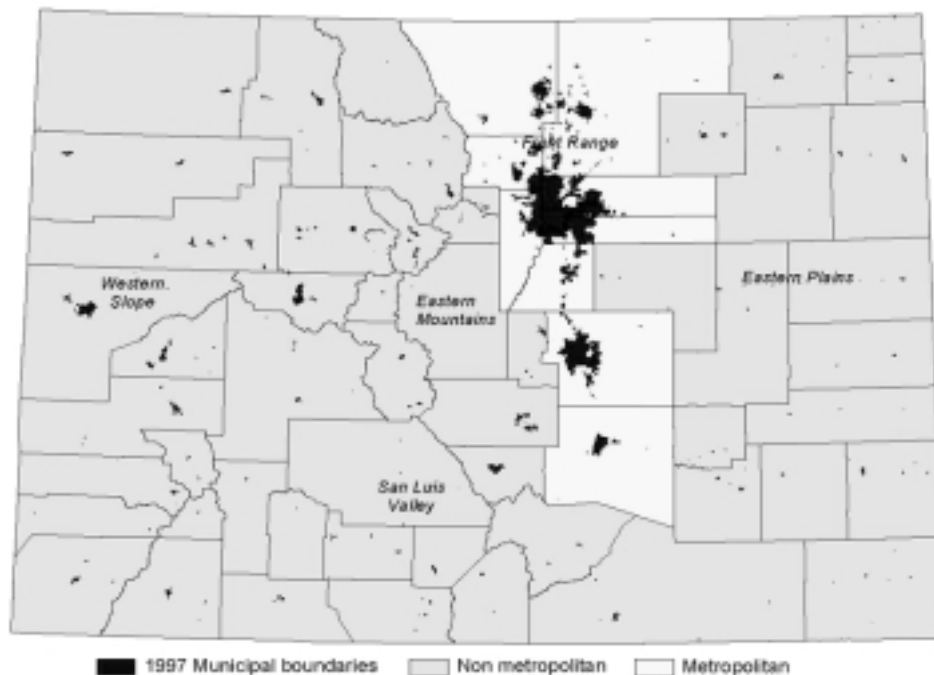
Colorado Turning Point also wishes to recognize the difficult issue of using labels when discussing race and ethnicity. It is hard to gain a consensus on the preference of categories such as “people of color/minority,” “American Indian/Native American,” “African American/black,” “Hispanic/Latino(a),” and “Caucasian/white.” We acknowledge that not everyone identifies himself or herself with these categories, and we very much respect the importance of cultural differences in how communities prefer to be defined.

Finally, in accordance with the Centers for Disease Control and Prevention, Colorado Turning Point also recognizes that race and ethnicity are social constructs representing distinct histories and cultures of groups within the United States and that they are not valid biological or genetic categories.

Profile of Colorado

Colorado’s population is young, healthy, rapidly growing, and increasingly wealthy, relative to national averages. With a population of approximately 4.3 million, Colorado is home to only 1.5 percent of the United State’s population. Colorado’s population density is 39.2 persons per square mile compared to the rest of the nation at 77.1.¹ Colorado is a geographically large state with 80 percent of its residents living in 10 metropolitan counties on the east side of the Rocky Mountains. This region is known as the Front Range. The remaining 20 percent of residents are scattered throughout the mountains, eastern plains, and western plains of the state (Figure 1). Colorado consists of 63 counties, 29 of which are considered rural and 23 are considered frontier (less than 6 people per square mile).^{2,3} In November of 2001, Broomfield will become Colorado’s sixty-fourth county.

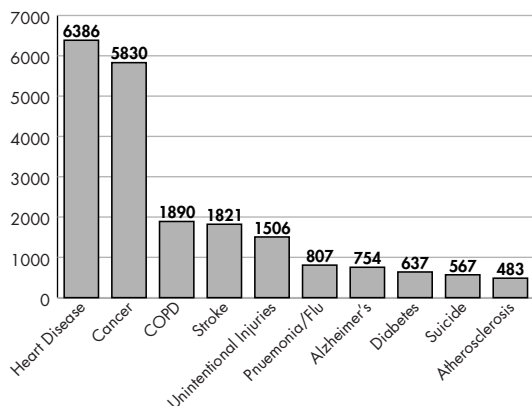
Figure 1: Metropolitan and Rural Regions of Colorado



Health Status

Colorado, by any number of measures, is a healthy state. In 1999, Colorado's age-adjusted death rate for all causes was 801.2 per 100,000 persons, well below the national rate of 881.9.⁴ Colorado's death rate has remained lower than the U.S. rate for the past 16 years.⁵ The fact that this rate has been adjusted for age indicates that the difference between Colorado and U.S. death rates is not due to Colorado's relatively younger population. Many of Colorado's health indicators are better than national health indicators, including leading causes of death. Colorado's death rates are lower than national death rates for chronic disease such as heart disease, cancer, stroke, and diabetes.⁶ Leading causes of death in Colorado are displayed in Figure 2.

Figure 2: Leading Causes of Death, Colorado 1999



Colorado Department of Public Health and Environment, Health Statistics Section, *Colorado Vital Statistics, 1999*. Denver, CO: June 2001.

From a public health perspective, Colorado has much in its favor. In 1998, the state was declared the third healthiest in the nation. When considering *Healthy People 2000* national health objectives, Colorado exceeded or was close to meeting objectives on such preventive indicators as mammograms and pap smears for women over age 50, reducing a number of infectious diseases such as HIV and gonorrhea, reducing births among teens, and reducing infant deaths.^{7,8}

According to 1998 data, the latest data available nationally, Colorado does have a few health indicators that are poorer than the national average, including the death rates from chronic obstructive pulmonary disease, unintentional injuries, suicide,

atherosclerosis, and Alzheimer's disease. Also, Colorado residents failed to meet the *Healthy People 2000* national health objectives for physical inactivity, smoking, and cholesterol screening.⁹

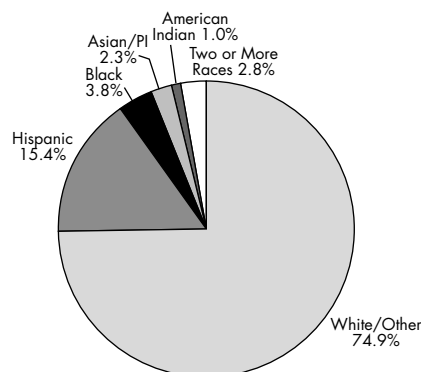
Demographics

In terms of racial and ethnic composition, minority groups account for 25.3 percent of Colorado's general population, and the number is increasing. The percentage of minorities in Colorado has increased over the past decade, mostly due to a nearly 33 percent increase in the number of Hispanics between 1990 and 2000. Population figures are provided in Figure 3. (Percentages do not add to 100 due to rounding.)¹⁰

Colorado's racial and ethnic composition differs from the national composition in that: the number of Hispanics in Colorado is higher, the number of Asian/Pacific Islanders is lower, and the number of blacks is significantly lower than national numbers. The number of American Indians in Colorado is proportionately similar to the rest of the nation.¹¹

In 1999, Colorado's male to female ratio was 49.6 to 50.4. The median age was 35.7. The percentage of the population over age 65 was 10.1 compared to 12.7 percent nationally, and the percentage of the population over age 85 was 1.2 compared to 1.5 percent nationally.¹²

Figure 3: Colorado's Population by Race/Ethnicity, 2000



Source: Colorado Division of Local Government, "Table 3A: Census 2000 Counts of Colorado County Population by Race/Ethnicity and Hispanic Origin," *U.S. Census Bureau: Census 2000 Counts of Colorado Population*, Denver, April 13, 2001.

Poverty

In Colorado, the percentage of people living in poverty has been decreasing since the early 1990s and is below the national rate. In 1999, 8.3 percent of the Colorado population was below the federal poverty level, compared to 11.8 percent nationally. The difference is even more significant for children; 11.2 percent of school-age children in Colorado are below the federal poverty level versus 15.89 percent nationally.¹³

Education

The level of educational attainment for Coloradans is relatively high compared to U.S. average levels. In 1999, 90.4 percent of the population had a high school degree compared to 83.4 percent nationally. Also, 38.7 percent had at least a bachelor's degree, compared to 25.2 percent nationally.¹⁴



Notes

1. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Colorado 2001, State Health Profile* (Atlanta, Ga.).
2. Colorado Rural Health Center, *Colorado Rural Health Plan: Submitted for Colorado's Participation in the Medicare Rural Hospital Flexibility Program* (Denver, January 1999).
3. Colorado Rural Health Center, *Colorado Rural, Frontier, and Urban Counties, 2000 Census* (Denver, 2001).
4. Colorado Department of Public Health and Environment, Health Statistics Section, *Colorado Vital Statistics, 1999* (Denver, June 2001).
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8. U.S. Department of Health and Human Services, Public Health Service, *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* (Washington, D.C.: U.S. Government Printing Office, 1991), No. PHS 91-50212.
9. Colorado Department of Public Health and Environment, Health Statistics Section, *Colorado's Progress Toward Year 2000 Objectives*, Brief No. 26 (November 1998).
10. Colorado Division of Local Government, "Table 3A: Census 2000 Counts of Colorado County Population by Race/Ethnicity and Hispanic Origin," *U.S. Census Bureau: Census 2000 Counts of Colorado Population*, (Denver, April 13, 2001).
11. U.S. Department of Health and Human Services, *Colorado 2000 State Health Profile*.
12. U.S. Department of Health and Human Services, *Colorado 2001 State Health Profile*.
13. *Ibid.*
14. *Ibid.*





KEY STRATEGY:

Assure Access to Health Insurance Coverage

EXECUTIVE SUMMARY

Purpose

The Colorado Turning Point Initiative identified access to health insurance coverage as one strategy for reducing health disparities and improving the health status of Coloradans. Action needs to be taken sooner rather than later to close the gap between the uninsured and the insured citizens of Colorado. This report documents the underinsured and uninsured experience of decreased access to care, poorer health outcomes, and a reduced quality of life. Increasing insurance coverage to those in need is a key component of a multi-dimensional strategy to improve access to quality health services.

Problem

Although 1997 data reports that close to 85 percent of all Coloradans were insured, the number and public health effects of the underinsured and uninsured is devastating. Approximately 20 percent of Americans with insurance coverage fall into an underinsured category; in Colorado it is approximately 12 percent,¹ and more people than ever don't have any insurance at all. The relationship between health insurance and access to quality health care and medical outcomes has been studied often in the past decade. Evidence from these studies shows that health insurance does influence the amount and kind of health care people receive. A lack of health insurance has been scientifically linked to poorer health outcomes, including a higher mortality rate.

Findings

A large majority of the insured has subsidized coverage either through employer-based health insurance or one of several government programs such as Medicaid, Medicare or the Child Health Insurance Plan Plus (CHP+). However a segment of this population does not have adequate health insurance coverage. This population may lack protection against catastrophic illness or injury, dental care, behavioral health services, and pharmacy

benefits or they may experience fluctuation in coverage due to a change in or lack of employment, delay in eligibility periods, or fluctuations in income/assets that determine eligibility in a public health plan. The numbers of uninsured, those without any insurance coverage, varies depending on who is collecting data and if there are any adjustments for underreporting, but according to U.S. data, the proportion of the population younger than age 65 with no usual source of health insurance increased from 25.6 percent in 1977 to 38 percent in 1996. Certain subgroups of this population, such as Hispanic Americans, young adults (age 18–24), people with lower levels of education, those who work part-time, and the foreign born, have had an even more dramatic increase.

Colorado Analysis

Colorado participates in many public health, public/private partnerships and community-based efforts to eliminate the gap between the insured and uninsured populations of the state. However, the challenge continues. A 1998 survey of Colorado households reported almost one in four or 22 percent of households lacked health insurance coverage at some point in the previous year.² According to the 1998 report *Meeting the Needs of the Medically Underserved: A Plan for Colorado*, by the Colorado Coalition for the Medically Underserved (CCMU), characteristics of the uninsured population in Colorado include the working poor with no employer-sponsored health coverage; employed individuals unable to afford employer-sponsored insurance benefits; unemployed poor who are ineligible for Medicaid or CHP+; children without dependent coverage; young adults not covered by their parent's coverage nor an employer-sponsored plan; people who are "uninsurable" due to high risk health problem; immigrants; migrant farm workers; and homeless individuals. Although safety net providers including hospitals, public health departments, and community health centers continue to provide care to the uninsured, low-income population, health care needs of many individuals is still

going unmet due to barriers to obtaining adequate insurance coverage. These barriers include expensive or nonexistent employer-sponsored insurance coverage; complicated enrollment and eligibility processes, especially in government programs; and escalating costs of health care coverage.

Recommendations

The Colorado Turning Point Initiative Steering Committee recommends that the public health field and its partners take a strong leadership role and involve key decision-makers and policy-makers, to make systemic and comprehensive changes in the administration of current insurance systems. Additionally, ways to improve efficiencies and reduce duplication through examination of the public health safety net system should be identified. Expansion of benefit coverage to be comprehensive and include clinical preventive services can impact overall health status. In terms of government insurance programs, the enhancement of effective outreach and enrollment procedures, the elimination of the Medicaid asset test, expanded eligibility, and a streamlined enrollment process for Medicaid and Child Health Plan will also expand coverage.



Access to Health Insurance Coverage

Quality health services are those that are appropriate and responsive to an individual's needs, obtainable for preventive care, and easily accessible. This kind of access is usually available only to consumers who have health care insurance. The lack of health insurance, therefore, partially explains the reduced access to health care, and the resulting reduction in the quality of services contributes to poorer health status.¹ Uninsured Americans are more likely than the privately insured to experience adverse outcomes.²

In a white paper produced for the American College of Physicians—American Society of Internal Medicine, the society's president, Whitney W. Addington, M.D., wrote, "A lack of insurance is not simply an inconvenience. It is a real barrier to access and definitely contributes to poorer health."³ Logic follows that if the uninsured population were to be insured, access to health care would improve.

The Colorado Turning Point Initiative Steering Committee has identified expanding access to health insurance as one strategy for reducing health disparities and improving the health status of Coloradans.

The committee believes that action needs to be taken to close the gap between the uninsured and insured residents of Colorado by increasing insurance coverage. This is a public health issue. The uninsured segment experiences decreased access to care, poorer health outcomes, and a reduced quality of life. Increasing insurance coverage to those in need is a key component of a multidimensional strategy to improve access to quality health services.

Overview of the Insured Population

There are a variety of systems in place that provide health care insurance coverage to the population in Colorado. According to 1997 data, close to 85 percent of all Coloradans are insured. A large majority of the insured has subsidized coverage either through their employer or the government. In Colorado, health care insurance expenditures by payer type show that "government funds account for 39 percent of health care spending, private insurance accounts for 36 percent, and individual out-of-pocket expenditures for 25 percent."⁴

Types of Insurance

Employer-Based Health Insurance: In Colorado, about 65 to 67 percent of the insured population is covered by an employer-sponsored health plan. While the percentage of Coloradans covered by employer-sponsored insurance has stayed the same or has slightly increased, employers are passing on more of the costs of health insurance to employees. Many employees are unable to afford these costs and as a result become uninsured. Fifty-six percent of Colorado employers offer health insurance. Yet these numbers change drastically depending on the size of the employer. Only 42 percent of employers with less than 10 employees offer a benefit, whereas 96 percent of the firms with greater than 1,000 employees offer health benefits. The following two graphs (see Figures 1 & 2) show that the majority of the insured population is covered with an employer-sponsored health plan both at the state and national levels.⁵

Figure 1: Type of Health Insurance Coverage by Age—Colorado

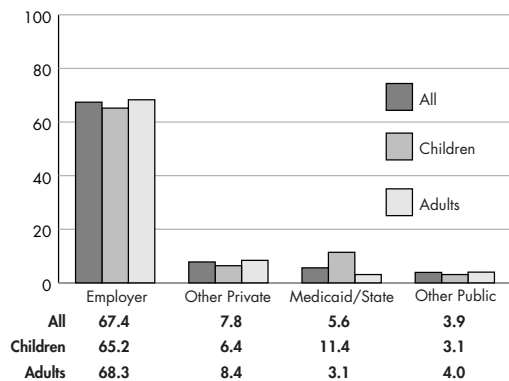
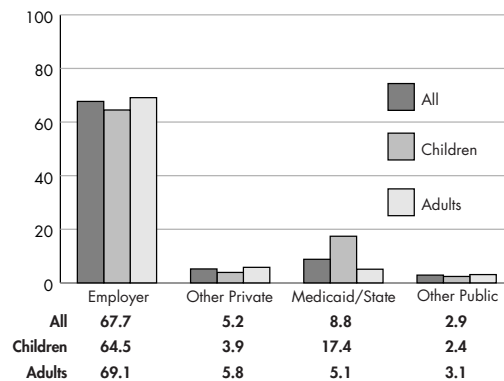


Figure 2: Type of Health Insurance Coverage by Age—United States



Source: The Urban Institute, *Health Insurance, Access, and Use: Colorado Tabulations from the 1997 National Survey of America's Families*, Assessing the New Federalism: An Urban Institute Program to Assess Changing Social Policies, Washington, D.C., July 2000.



Government Programs: In the 1960s, government programs such as Medicaid and Medicare were developed and implemented to assist people without access to employer-based insurance coverage. In the late 1990s, Congress authorized the creation of the State Child Health Insurance Program to provide coverage to children not eligible for Medicaid with family incomes under 200 percent of the federal poverty level (FPL).⁶ These programs are described below.

Medicaid: Medicaid is a joint federal–state program. Medicaid in Colorado covers approximately 270,000 people: families with children, pregnant women, people with disabilities, and under certain circumstances, the elderly. Sixty-seven percent of Medicaid-enrolled children come from two-parent households; 75 percent of families work; and only 5 percent receive welfare benefits. Many Medicaid-enrolled children come from two-parent, working families. Non-U.S. citizens are only covered for emergency care. About two-thirds of Medicaid enrollees are adults and children, and one-third are elderly or people with disabilities. This latter group accounts for more than 70 percent of Medicaid expenditures.⁷

Medicare: Medicare is a federal program that covers people over age 65 or those with a disability. Ninety-eight percent of the elderly are insured in Colorado, primarily through Medicare. The Medicare program will not be addressed in this report.

Child Health Plan Plus (CHP+): CHP+ is a joint federal–state program. Congress enacted the Child Health Insurance Plan in 1997, to broaden the coverage to low-income uninsured children as part of the Balanced Budget Act.⁸ Colorado's CHP+ program began in April 1998. This program offers full coverage and will add routine dental services in the future. The state CHP+ program was developed to cover non-Medicaid-eligible children between birth and 18 years of age with family incomes equal to or less than 185 percent of the FPL. Before the CHP+ program was implemented, there was no other health plan available to low-income families if their income levels were too high to be eligible for Medicaid. CHP+ was designed as a separate stand-alone program and not as a Medicaid expansion program.

According to the CHP+ program, there are approximately 25,000 children enrolled in CHP+ as of July 2000. Many more children are eligible; some estimate that number to be as high as 83,000.⁹

Overview of the Underinsured Population

There is a segment of the insured population that does not have adequate health insurance coverage. This group is referred to as the underinsured. The underinsured may lack protection against catastrophic illness or injury, dental care, behavioral health services, and pharmacy benefits. This lack of coverage may cause an insured family to sustain major medical expenses. The underinsured must sometimes pay an additional 10 percent of their annual income for needed health care services.¹⁰

Another reason families and individuals may be considered underinsured is that they may also experience fluctuation in coverage—part of the time they are covered but not consistently over time. There are a variety of reasons for these gaps in coverage to occur including:

- * Change in or lack of employment;
- * Delay in eligibility periods; and
- * Fluctuations in income/assets that determine eligibility in a public health plan.

This group is vulnerable and can become uninsured very quickly. Approximately 20 percent of Americans with insurance coverage fall into this underinsured category, and in Colorado it is approximately 12 percent.¹¹

Overview of the Uninsured Population

More people than ever are uninsured. The numbers vary depending on who is collecting data and if there are any adjustments for underreporting. According to U.S. data, the proportion of the population younger than age 65 with no usual source of health insurance increased from 25.6 percent in 1977 to 38 percent in 1996.

The U.S. Census Bureau has estimated that 44.3 million people in the United States are uninsured.¹² The numbers are expected to grow to 54 million



over the next 10 years, even in this environment of economic growth. If the economy weakens, the number is estimated to reach 60 million.¹³

Statistics on the uninsured reveal some interesting facts. The following highlights were abstracted from the 1996 Medical Expenditure Panel Survey (MEPS).

- * In the United States, more than 33 percent of Hispanics and 23 percent of blacks were uninsured throughout the first half of 1996. Less than 14 percent of other race/ethnicity groups (including Caucasians) were uninsured.
- * Nearly 25 percent of all uninsured Americans were under 18 years of age. Nearly 11 million children—more than 15 percent of the nation’s noninstitutionalized children—were uninsured throughout the first half of 1996.
- * Among U.S. children most likely to be uninsured throughout the first half of 1996 were Hispanics and children living in families with adults who had less than a high school education.¹⁴

Certain subgroups of this population have had an even more dramatic increase. The proportion of Hispanic Americans lacking health insurance coverage rose from 17.6 percent in 1977 to 34.9 percent in 1996.¹⁵ About 28 percent of Hispanic children under 18 were uninsured in 1996 compared to 18 percent of black children and 12 percent of children of other race/ethnic groups (including Caucasians). Hispanic children represented approximately 15 percent of the nation’s children but 26 percent of the nation’s uninsured children.¹⁶

Other subgroups that experienced a large increase in the percent of uninsured during this same period were young adults (18–24 years of age), people with lower levels of education, those who work part-time, and the foreign born. The percent of uninsured young adults rose from 19.6 percent to 35.7 percent.¹⁷ However by 1998, the Census Bureau esti-

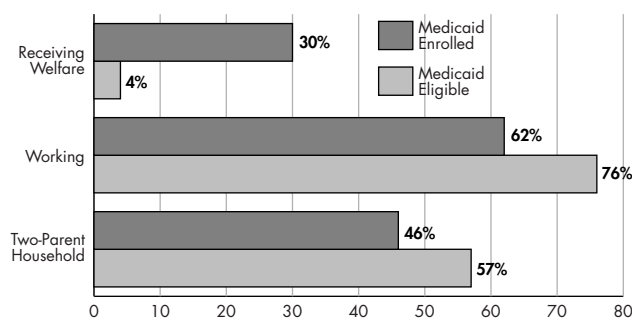
ated that the number of uninsured Americans increased by 1 million in just one year.¹⁸ The trends of the uninsured continued to be similar to those reported in the 1996 MEPS, though some changes were noted:

1. Children 12 to 17 years were more likely to be uninsured than children under 12 years.
2. The working poor were not offered employer-sponsored health insurance or it was too expensive to acquire.
3. A higher proportion of the foreign-born population was without health insurance compared with native born.

The segment of the population that is uninsured is often in the workforce or is a dependent of someone who is working. Nationally, 72 percent of the uninsured are in households where one or more adults is working full-time. The largest group of the uninsured is Caucasian, 56 percent are males, and the age category that is affected most is 18- to 34-year-olds.¹⁹

A report profiling low-income parents looked at family and work status for both Medicaid eligible and Medicaid enrolled.²⁰ The results, presented in Figure 3, show that for both groups a large percentage of children live in two-parent homes, parents are working, and a much smaller than expected percentage receives welfare benefits.

Figure 3: Family and Work Status



Source: M. Perry et al., *Medicaid and Children Overcoming Barriers to Enrollment: Findings from a National Survey*, The Kaiser Commission on Medicaid and the Uninsured, 2000.



The Uninsured Have Poor Medical Outcomes

The uninsured often have difficulty accessing needed health care services. The relationship between health insurance and access to quality health care and medical outcomes has been studied often in the past decade. Evidence from these studies shows that health insurance does influence the amount and kind of health care people receive. A lack of health insurance has been scientifically linked to poorer health outcomes, including a higher mortality rate among the uninsured. The uninsured population is less likely to have a regular source of care, often delaying treatment and seeking care in hospital emergency departments. This care is more expensive and not as efficient as when the care is provided in a more appropriate outpatient setting. Children are at risk, as they do not obtain childhood immunizations and routine well-child care in a timely manner. These delays in service can lead to other problems such as poor performance in school.²¹

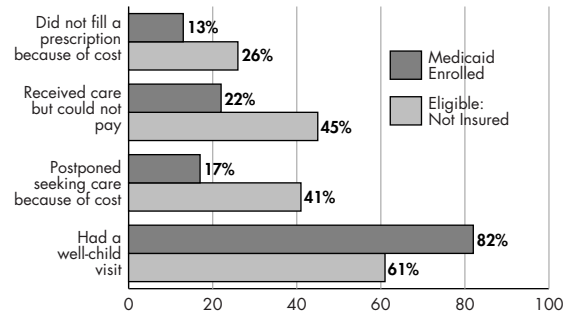
This following chart (see Figure 4) from the Urban Institute shows the types of services in which children experience an unmet need based upon insurance coverage. It also shows that the uninsured are less confident in being able to access care when needed and less satisfied with the care received. Colorado specific data illustrates these trends as well.

Figure 4: Percentage of Children's Access to Health Care

	PRIVATE	PUBLIC	UN-INSURED	ALL CHILDREN
Unmet Need				
Medical/Surgical	1.9	3.4	9.3	3.1
Dental	4.9	6.1	14.4	6.2
Mental	0.8	0.9	0.7	0.8
Prescription drug	0.9	2.6	3.6	1.5
Any	7.3	11.1	21.1	9.7
Not confident in access to care				
	4.0	11.6	28.0	8.3
Not satisfied with quality of care				
	7.3	11.4	17.1	9.2

Source: The Urban Institute, *Health Insurance, Access, and Use: Colorado Tabulations from the 1997 National Survey of America's Families*, Assessing the New Federalism: An Urban Institute Program to Assess Changing Social Policies, Washington, D.C., July 2000.

Figure 5: Access to Care



Source: M. Perry et al. *Medicaid and Children Overcoming Barriers to Enrollment: Findings from a National Survey*, The Kaiser Commission on Medicaid and the Uninsured, (2000).

Perry also documented the problem of the uninsured postponing treatment.²² The results of that survey, presented in Figure 5, show that Medicaid-eligible, but not enrolled, children have less access to services than Medicaid-enrolled children.

The report *The Future U.S. Health Care System: Who Will Care for the Poor and Uninsured?* developed by the Council on the Economic Impact of Health System Change, reviewed two studies that examined the relationship between health insurance and health outcomes. One study surveyed 3,993 adults and found that the uninsured were four times more likely than the insured to report an episode of needing and not getting health care services and three times more likely to report problems with paying for medical bills. The second study found that low-income patients discharged from 15 U.S. urban hospitals experienced higher rates of preventable hospitalizations than patients with higher incomes.²³

Another report revealed that the uninsured experienced a higher mortality rate, specifically a higher in-patient mortality rate. An adjusted risk of deaths was 25 percent higher for uninsured patients than for privately insured patients.²⁴

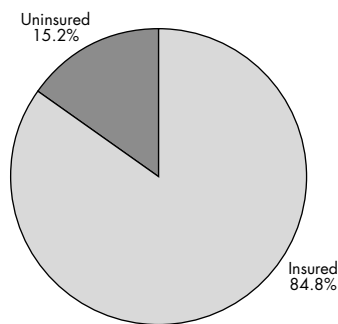
The lack of health insurance not only affects an individual's health and financial status, it also adds significant stress to the U.S. economy. As a result of not receiving care in a timely manner, the uninsured add costs to the health care system and reduce its efficiency. Medical treatments are often more expensive due to delays in care and places of service. These higher costs are absorbed by

providers as free care, passed on to the insured via cost shifting and higher health insurance premiums, or paid by taxpayers through higher taxes to finance public hospitals and public insurance programs.²⁵

Colorado's Uninsured Population

Data from the 1997 *Colorado Health Source Book: Insurance, Access, and Expenditures* shows that almost 580,000 people are uninsured, or 15 percent of the population (see Figure 6).²⁶ (More recent data indicate that the percentage may be closer to 16.8 percent of the citizens, or some 710,000 people.)²⁷ According to a 1998 survey of Colorado households, almost one in four households, or 22 percent, reported lacking health insurance coverage at some point in the previous year.²⁸

Figure 6: Colorado Residents by Insurance Status, 1995–1997 Average



	Number of Coloradans	Percent of Coloradans
Insured	3,243,400	84.8
Uninsured	579,276	15.2
TOTAL	3,822,676	100.0

Source: P. Abel, 1997 *Colorado Health Source Book, Insurance, Access, and Expenditures* (Denver: Colorado Coalition for the Medically Underserved, 1998), p. 8.

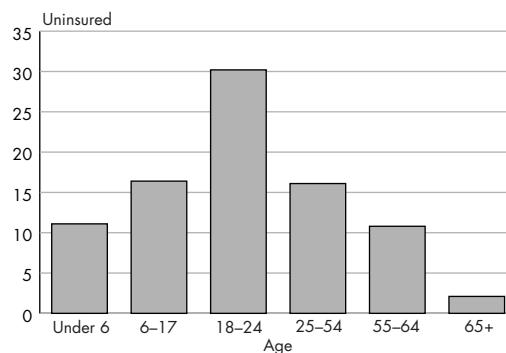
According to the 1998 report *Meeting the Needs of the Medically Underserved: A Plan for Colorado* by the Colorado Coalition for the Medically Underserved (CCMU), some characteristics of the uninsured population in Colorado are:

- * Working poor with no employer-sponsored health coverage
- * Employed individuals unable to afford employer-sponsored insurance benefits
- * Unemployed poor who are ineligible for Medicaid or CHP+

- * Children without dependent coverage
- * Young adults not covered by their parent's coverage nor an employer-sponsored plan
- * People who are "uninsurable" due to high-risk health problems
- * Immigrants
- * Migrant farm workers
- * Homeless individuals²⁸

Colorado's uninsured population exhibits similar trends when compared to the national data (see Figure 7). Young adults are at a higher risk to be uninsured than any other age group. As stated in the 1998 CCMU report, most uninsured adults are employed full-time or part-time.²⁹

Figure 7: Coloradans' Insurance Status by Age, 1995–1997 Average



Age	Number Uninsured	Number Insured	Percent Uninsured
Under 6	39,395	315,233	11.1
6–17	118,994	609,436	16.4
18–24	103,852	240,526	30.2
25–54	278,641	1,457,626	16.1
55–64	30,610	252,982	10.8
65+	7,784	367,597	2.1
	Total Uninsured	Total Insured	Total Percent Uninsured
	579,276	3,243,400	15.2

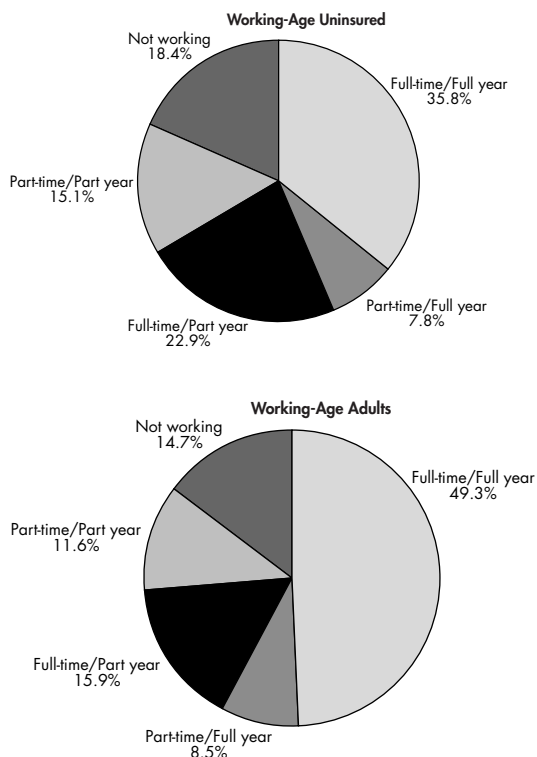
Source: P. Abel, 1997 *Colorado Health Source Book, Insurance, Access, and Expenditure* (Denver: Colorado Coalition for the Medically Underserved, 1998), p. 8.

The majority of uninsured adults in Colorado are working adults. Of these uninsured working adults, 80 percent are employed full-time or part-time. The proportion of employers that pays the full-time employee's health insurance premium declined from 66 percent to 36 percent between 1985 and 1997.²⁹



In 2000, the Colorado Department of Regulatory Affairs, Division of Insurance, released its annual survey of small group carriers, which showed a decrease of 5,178 employer-sponsored groups from December 1998 to December 1999, which affected 58,023 covered lives (see Figure 8).³⁰

Figure 8: Distribution of the Uninsured and Total Population of Colorado Working-Age Adults by Employment Status, 1995–1997 Average



	Percentage of Total Uninsured Working-Age Adults	Percentage of Total Working-Age Adults
Employed	81.6	85.3
Full-time/Full year	35.8	49.3
Part-time/Full year	7.8	8.5
Full-time/Part year	22.9	15.9
Part-time/Part year	15.1	11.6
Not working	18.4	14.7

Source: P. Abel, 1997 *Colorado Health Source Book, Insurance, Access, and Expenditure*, (Denver: Colorado Coalition for the Medically Underserved, 1998), p. 8.

Note: Working-age adults include those between the ages of 18 and 64. Full-time includes those who work 35 hours or more per week. Full year includes those who work 52 weeks per year. Those not working include the unemployed as well as those who do not participate in the labor force.

Safety Net Providers for the Uninsured

Safety net providers including hospitals, public health departments, and community health centers continue to provide care to the uninsured, low-income population. These safety net providers play an important role in the current system and often are the only avenue open to the uninsured. These providers do not restrict access to care based on the financial ability of the customer to pay for care and, sometimes, as is frequently the case with hospitals, are not compensated for their care.

Barriers to Health Insurance Coverage

It is important to understand the reasons why families and children are uninsured so that solutions can be tailored to meet their needs. Barriers do exist in the health care system and will affect how people access health care services or health insurance coverage. The barriers identified in this report are directly related to accessing health care insurance and are considered major obstacles.

Employer-Sponsored Insurance Coverage is Not Available or Too Expensive

Many people obtain their health insurance coverage through an employer-sponsored health plan. Nationally, more than three-quarters of all working adults receive health coverage in this manner. Figure 9 below depicts how working adults obtain their health insurance coverage. These national statistics are similar to the Colorado experience described earlier—the larger the employer, the more likely insurance coverage will be offered.³¹

Figure 9: Percentage of Insured Nonelderly Working Population

	Employer	Other Private	Medicaid/State	Other Public
All working adults	79.1	3.0	1.8	1.0
0–99 employees	71.5	4.2	2.5	1.3
100–999 employees	87.8	1.5	1.2	0.7
1,000 employees or more	93.5	0.8	0.4	0.2

Source: The Urban Institute, *Health Insurance, Access, and Use: Colorado Tabulations from the 1997 National Survey of America's Families*, Assessing the New Federalism: An Urban Institute Program to Assess Changing Social Policies, Washington D.C., July 2000.



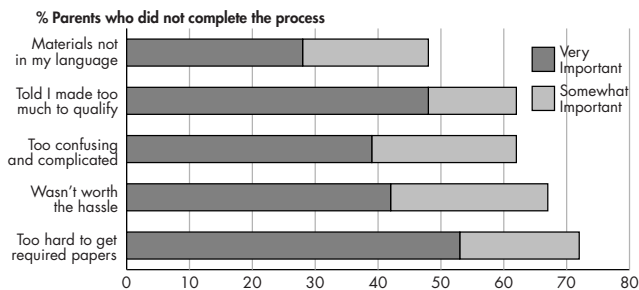
The Kellogg Foundation's Community Voices Initiative also documented a number of contributing factors related to the structure of the voluntary employment-based health insurance system and the changing nature of the labor force:

1. Small firms are unable to offer health insurance benefits primarily due to costs.
2. Nontraditional employment schedules such as part-time, seasonal, temporary, and contract-based have gained popularity.
3. Low-income wage earners cannot afford to pay their employee portion of premiums even when employer-sponsored benefits are offered.
4. Many workers find it difficult to retain coverage when faced with either a job change or loss of a job. This is especially true for those with chronic diseases.
5. Individuals buying health insurance face higher costs, fewer protections, and do not receive the tax benefits that people with work-based coverage receive.³²

Complicated Enrollment and Eligibility Process

When low-income parents were asked about their attitudes regarding the Medicaid enrollment process, the Kaiser Commission on Medicaid and the Uninsured learned that a vast majority thought having health insurance was very important. Parents who enrolled their children in Medicaid valued the program because it provided access to health services. Parents of uninsured children who never tried to enroll their children in Medicaid were surveyed, and they identified several barriers to enrollment (Figure 10):

Figure 10: Important Reasons for Not Completing the Enrollment Process



Source: National Survey on Barriers to Medicaid Enrollment, Kaiser Commission on Medicaid and the Uninsured, 1999. Source: M. Perry et al., *Medicaid and Children Overcoming Barriers to Enrollment: Findings from a National Survey*, The Kaiser Commission on Medicaid and the Uninsured, 2000.

- * A complex and burdensome enrollment process
- * Lack of knowledge of Medicaid eligibility requirements
- * Confusion about the eligibility
- * Medicaid's negative public image from being associated with welfare³³

The reasons for not applying to the CHP+ program are very similar to those given by Medicaid-eligible parents. Contributing factors are related to:

1. Complicated enrollment process
2. Unaware of program, eligibility requirements, and application process
3. Difficulty in gathering required documentation
4. Premiums or other fees³⁴

High Costs of Health Care Coverage

Many low-income people cannot afford to pay for health insurance. According to health economist Judith Glazner, households with incomes below 185 percent of the Federal Poverty Level (FPL) have no money to spend on health insurance after meeting basic needs for food, shelter, clothing, and transportation. Households with income levels between 185 and 250 percent of the FPL have little or no income available to purchase health care coverage. Families find it difficult to allocate money for insurance premiums in these situations. Many strategies are being debated and which could eventually impact public policy.³⁵

Role of the Public Health Field in Assuring Access to Insurance Coverage

The goal of public health is to secure health and promote wellness, for individuals and communities, by addressing the societal, environmental, and individual determinants of health. Core functions of public health include Assessment, Policy Development and Assurance. The core function related to improving access to health care insurance is that of Assurance. Public health is particularly concerned with the number of uninsured in Colorado because uninsured individuals are more likely to experience poor health status and be hospitalized for conditions that could have been treated in an outpatient setting. There are two main components of this

function: (1) Assist families and individuals to obtain access to health care, and (2) provide direct health care services.³⁶

Insurance coverage is a primary strategy in improving access to care. Public health has an important role to play in the development and implementation of programs such as the CHP+ and Medicaid. For example, the public health field can assure that these health insurance programs reflect the multifaceted and complex needs of enrollees.³⁷

As a direct care provider, many public health programs have contracted with managed care organizations to become a participating provider. This has been an important strategy because it allows the public health providers, especially in many rural counties, to continue to provide care to those in need. In addition to providing direct service, public health provides information about the enrollment and eligibility process for Medicaid and CHP+ programs. Colorado's public health role as a safety net provider is changing due to the availability of health insurance for children. This reduces the need for direct clinical services in public health agencies. However, public health does maintain its responsibility to ensure access to care for the citizens of Colorado.³⁸

Other activities in which public health engages to meet its goals and objectives include:

- * Assisting families in applying for Medicaid and CHP+
- * Serving Satellite Eligibility Determination sites by working toward higher enrollments in health insurance programs
- * Participating in quality improvement and evaluation efforts to develop standards of care
- * Providing coordination and "wrap-around" services to children enrolled in health insurance programs
- * Working in collaboration with other community-based agencies to carry out these core functions
- * Serving as the direct service provider of last resort
- * Offering prevention education and services

Other public health functions such as policy development may also play a role in ensuring access to health care services. Public health officials understand the importance of developing partnerships

when trying to change or influence policy decisions. The public health field collaborates with governmental agencies, community-based organizations, managed care organizations, and the business community. The focus of these partnerships has been to extend the traditional work of public health agencies to better serve the communities in which they operate.³⁹

Colorado Efforts to Improve Health Insurance Coverage

Public Health Efforts: Two public health efforts to increase insurance coverage include the statewide Covering Kids Initiative and the Denver-based Community Voices Program. In 1999, the Covering Kids Initiative was awarded a three-year grant of approximately \$1 million by the Robert Wood Johnson Foundation to coordinate and facilitate the development and implementation of model outreach and enrollment activities for CHP+. The Colorado Department of Public Health and Environment is the lead state site for the grant, and Denver, Adams, and Prowers counties received funds to carry out community-based efforts in collaboration with the state. Community Voices is part of a five-year national initiative to improve health care access and quality in the Denver community. It is funded by the W. K. Kellogg Foundation and The Colorado Trust. The goals of Community Voices are to improve the health of Denver's medically underserved through innovation in outreach, enrollment in publicly funded health insurance, enrollment in small employment health plans, intensive community-based case management, and changing public policy at the state and federal level for health program funding.⁴⁰

Public/Private Partnerships and Community-Based Efforts: Many private and community-based organizations are also concerned about the rising numbers of the uninsured and underinsured and are actively pursuing solutions to the problem. The Colorado Coalition for the Medically Underserved (CCMU) is united in the vision that by 2007 all Coloradans will have unimpeded access to affordable, quality health care and preventive programs. This coalition of more than 200 individuals and organizations representing health professionals and provider organizations, consumers, hospitals, clinics, safety net providers, business groups, the state legislature, state agencies, foundations insurers, the faith community, and

others maintains that health insurance coverage should be available to all Coloradans. After researching the magnitude of the problem and analyzing how much the uninsured can realistically be expected to contribute to the cost of coverage, the CCMU developed five basic approaches to achieving health insurance coverage for all Coloradans.⁴⁰

Between August 2000 and January 2001, the coalition presented these ideas to community members during 20 town hall meetings around the state. Coalition representatives also presented information to key civic, provider, business, and consumer organizations; local and statewide media; and other elected officials. Over 1,000 Coloradans from diverse backgrounds were surveyed during these meetings regarding what they liked best and what they liked least about each of the options. Analysis of these data shows that in general, Coloradans want people to have access to affordable and high-quality basic health care. Major features of any plan should include choice of providers and plans, portability, preventive services, and individual responsibility. Final analysis notes that Coloradans want a system that is cost effective, contains administrative costs, and provides for fair and timely reimbursement. In the fall of 2001 the CCMU will embark on a series of 10 regional meetings to gather feedback on a policy framework to ensure coverage for all Coloradans based upon the preferences and priorities expressed during the previous round of town hall meetings.⁴¹

The Health Resources Services Administration of the Department of Health and Human Services recently awarded Colorado a \$1.3 million grant to develop a plan to provide health insurance to all Coloradans. Colorado's Governor's Office is acting as the lead agency for this project. The project offers the opportunity to build upon past and current efforts to conduct a comprehensive analysis of issues related to uninsurance. The grant will also build awareness and publicly investigate the political and economic feasibility of the multiple options for health care coverage for all Coloradans.⁴²

Recommendations

The following recommendations were derived from the Colorado Turning Point Initiative Steering Committee and expert panelists representing the Colorado

Medical Society's Coalition for the Medically Underserved, Colorado Department of Health Care Policy and Financing, Colorado Community Health Network, Denver Public Health, American Academy of Pediatrics, Pacificare, Colorado Department of Public Health and Environment, and Colorado Access.⁴³

General Recommendations

To ensure universal access to insurance coverage, public health and its partners should take a strong leadership role and involve key decision makers and policymakers in making systemic and comprehensive changes in the administration of current public insurance programs.

Additionally, public health and its partners should identify ways to improve efficiencies and reduce duplication through examination of the public health infrastructure. A communication strategy should be developed to increase public awareness of available programs and help the currently uninsured realize the positive health benefits of having insurance.

Provide Access to Insurance for Everyone

All Coloradans, regardless of means, should be assured access to the care they need when they need it. Innovative outreach strategies should be developed and duplicated in order to reach eligible populations and find ways to enroll them in available insurance programs.

The Medicaid asset test should be eliminated. Eligibility standards should be expanded to include a greater low-income population. Requirements should be streamlined for both Medicaid and Child Health Plan.

Expand Benefit Coverage

Health plan benefits should be comprehensive, including clinical preventive services. Efforts should focus on creating a synergy between prevention programs provided by both public and personal health systems. Prevention activities not usually part of an insurance plan should also be included, such as suicide prevention, obesity, and smoking cessation.

Enhance Effective Outreach and Enrollment Procedures

Public health and its partners should actively participate in outreach and enrollment activities

designed to educate all Coloradans, especially the uninsured, on the value of insurance coverage—and the availability of programs. An additional objective should be to foster interagency collaboration and expand the network of enrollment sites. The application process should be simplified and streamlined. These changes should result in a greater number of people seeking enrollment and a larger percentage staying enrolled.

Provide Quality Assurance

Public health and its partners should initiate review processes to ensure quality in all levels of the enrollment and delivery systems.

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