STATE OF COLORADO

PROGRESS REPORT TO THE SECRETARY
HRSA STATE PLANNING GRANT

OCTOBER, 2004

INTRODUCTION

Colorado received its HRSA State Planning Grant (SPG) in March 2001, and filed an Interim Report to the Secretary in April 2002. The State received an extension until December 31, 2003 from HRSA to complete additional data analysis that will enable it to select appropriate coverage strategies, as well as to conduct other activities. This Progress Report serves to highlight the major activities undertaken under the auspices of the grant and an explanation of tasks to be completed during the extension period.

BACKGROUND: CHANGES TO COLORADO'S ECONOMIC AND POLITICAL ENVIRONMENT DURING THE COURSE OF THE GRANT

There is never an easy time to make substantive policy changes, but economic developments in Colorado over the past 18 months have combined to create a particularly challenging environment.

Colorado received its HRSA monies in March 2001, and began active work on its grant that summer. At that time, Colorado's economy was beginning to feel the impact of the nationwide economic slowdown, especially in the tech sector. After the events of September 11, however, Colorado experienced the same exacerbations of the slowdown as the rest of the country. In the past year, unemployment statewide has risen by three-tenths of a point (according to data from the Colorado Division of Labor and Employment), to 5.2 percent. Since March 2001, approximately 60,000 Coloradoans have lost their jobs – a notable development in a state with a population of about 4.3 million (according to US Census 2000 data).

Over this period of time, private sector health insurance premiums have continued to rise, in Colorado as elsewhere in the country. And, budget pressures on public programs have increased as a result of the $850 million budget shortfall faced by the State. In the health sector, the implications of implementing the Health Insurance Portability and Accountability Act (HIPAA) have further strained State resources. Under these circumstances, it seems unlikely that any additional funds will be available to expand public health care coverage programs. In fact, some benefits and services may have to be reduced to generate cost savings.

PROJECT MANAGEMENT STRUCTURE

Colorado's Governor's Office continues to serve as the lead agency for this project. The HRSA State Planning Grant is administered through its Project Management Team. The Project Management Team has worked closely with the Colorado Strategic Planning Group on Health Care Coverage that was convened by Governor Bill 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.

Four workgroups emerged from the Strategic Planning Group: Consumer Education, Employer-Based Coverage, Health Care Marketplace and Uninsured Individuals and Families. Each workgroup reviewed data from Colorado and other states germane to its area of focus, and developed policy recommendations to bring to the Strategic Planning Group for discussion and follow-up.

MAJOR RESEARCH PROJECTS FUNDED BY HRSA GRANT TO DATE

Colorado Household Survey (CHS 2001)
As detailed in Colorado's Interim Report to the Secretary, Colorado conducted the largest telephone survey (10,000 households) in the State's history on health care coverage issues. The survey, completed in late summer 2001, allowed Colorado to measure, for the first time, coverage variations across health care marketplaces and regions.

The CHS 2001 estimated that 11.7 percent of Coloradoans, or approximately 516,000, were uninsured in 2001.[1] The standard error for this point-in-time uninsured estimate is 0.7 percent, giving a 95 percent confidence interval – meaning that the actual rate could fall between 10.3 percent and 13.1 percent.

Further, the survey estimated that 15.9 percent of Coloradoans were uninsured at any time during the previous 12 months (SE: 0.8 percent). An estimated 7.8 percent of people in Colorado were uninsured for all of the previous 12 months (SE: 0.6 percent).

However, other sources provide higher estimates. Most notably, the Current Population Survey (CPS) 2000-2002 estimates Colorado's uninsurance rate at 15.1 percent, consistent with the difference between CPS and other state surveys. Researchers attribute this difference in uninsurance estimates to important methodological differences. In addition, the CPS three-year merge includes data collected after September 11, 2001 and the resulting economic downturn, compared to the CHS 2001 that was fielded prior to those critical developments.

As noted in the April 2002 interim report, in general, the uninsured in Colorado are likely to:

- Have annual income below 300% FPL (67%)
  $\Rightarrow$ Between 15 and 18% fall below 100% FPL
- Be adults (76%)
- Be male (52%)
- Be non-Hispanic white (59%)
- Have been born in the U.S. (80%)
- Be employed or a full-time student (70%)

[1] 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.

- Have a permanent job (85%)
- Be in good to excellent health (83%)
- Live in an urban area

Since that preliminary analysis, additional analysis has been conducted, including:

- Uninsurance rates by age and region. At a statewide level, adult rates of uninsurance are higher than child rates. However, differences emerge on a regional basis. Four regions within the State – Boulder, Denver, Mountain and Northeast – show the reverse trend of children having higher uninsurance rates (note that Boulder and Denver are two of the most populous regions in the State). Each of these four regions has child rates of uninsurance that are also above the statewide child uninsurance rate of 9.7 percent.
- Child uninsurance rates by ethnicity and other correlates. The rate of uninsurance among Hispanic children in Colorado is triple that of non-Hispanic children. The analysis suggests a strong relationship between language spoken in the home with uninsurance. In fact, the group least likely to have heard about the Child Health Plan *Plus* (CHP+, Colorado's SCHIP program) is Spanish-speaking households with children uninsured for a year or more.
- Uninsurance rates by size of employer. People who work for very small employers (1-10 employees) are more than twice as likely as the average Coloradoan to be uninsured, and this difference cannot be explained by a higher prevalence of demographically "at-risk for uninsurance" groups (e.g., poor, Hispanic) that work for small employers. This analysis also examined the relationship between regional rates of uninsurance in Colorado and small business penetration, and found that only three of the six regions with uninsurance rates that are statistically higher than the statewide uninsurance rate also have rates of small business penetration that are statistically higher than the statewide norm. These regions are San Luis Valley, Western Slope – Central and Western Slope – South.

Small Employer Focus Groups

In the summer and fall of 2002, the HRSA Project Team oversaw 14 focus groups with representatives of small businesses statewide. The purpose of this qualitative research effort was to better understand those employers' views of the value and drawbacks of employer-sponsored health coverage and the factors that contribute to their decision to provide (or not provide) coverage, and explore their views on options such as tax credits and purchasing pools to assist with the purchase of health insurance.

Key findings include:

- Focus group participants said they feel a sense of social responsibility to provide health insurance to full-time employees. That sense of responsibility does not appear to extend to employees' families, as most do not offer dependent coverage.
- Participants noted that health insurance remains an important recruitment and retention tool. They look to industry norms to help them determine the level and type of coverage to offer.

- At the same time, participants said they were increasingly shifting the cost of coverage to their employees, as premiums continue to escalate. They expressed frustration that no government agency has yet made significant progress in addressing rising costs.
- Many participants noted that they feel ill equipped to make decisions about insurance coverage – they don't fully understand the options available to them and don't believe that insurance brokers offer objective advice.
- Participants were asked to respond to a variety of proposals for making coverage more affordable:
    - *Tax credits*. Among all the groups, this option was felt to be insufficient to address the underlying issues of rising costs of health care coverage options. They noted that tax credits only work if businesses post a profit – but many small businesses try to drive their profits to zero in order to minimize tax liability. For such companies, only a refundable credit would make sense. Nonprofit participants noted that they would receive no benefit from tax credits at all. Participants also questioned how a tax credit would be funded, and expressed concern about creating an additional paperwork burden. Those who expressed support for the concept cautioned that it would only work at the Federal level, and should be permanent.
    - *Subsidies for employers.* This incentive received a skeptical response from all groups, with reactions being very similar to those voiced about the tax credit. Participants wondered where the money would come from to pay for subsidies, how long they would last, and voiced concerns about the administrative burden of such an approach. Several participants noted that such an approach also "feeds" the insurance companies without tackling the more difficult issue of reducing the costs of insurance and health care.
    - *Employer giving money to employees.* The groups generally agreed that providing money directly to employees to let them purchase their own insurance or to set aside money for medical expenses was not a good approach. The primary concern expressed by the groups is that healthy employees are more likely to use the money for something other than health insurance. Participants recognized that, when that happens, the risk pool worsens, leading to higher premiums for those in the market. They also noted that older employees who are not yet eligible for Medicare would have a difficult time finding affordable coverage in the individual market. Some also expressed concern about the tax implications of such an approach for both the employer and employee.
    - *Purchasing pools or alliances.* Though the groups were cautious, they were more receptive to this strategy than the others described above. Many participants believed that the ability to spread risk over a large group would moderate premium increases; however, others were skeptical. Some expressed concern that their own employees, either because of age or medical history, would be allowed into any purchasing pool.

Workgroups
In July 2002, four workgroups were created from the Strategic Planning Group overseeing Colorado's HRSA State Planning Grant. Those workgroups examined issues relative to Consumer Education, Employer-Based Coverage, Health Care Marketplace and Uninsured Individuals and Families. Each workgroup reviewed data from Colorado and other states germane to its area of focus, and developed policy recommendations to bring to the larger group for discussion and follow-up.

Following is an outline of specific activities undertaken by each workgroup.

Consumer Education Workgroup
This group was formed in response to numerous conversations in the Strategic Planning Group regarding the systemic problems created because of the lack of understanding about the real cost of health care and the options available for care and coverage. The workgroup discussed possible approaches, potential costs and perceived benefits of a variety of educational campaigns:

- A campaign to educate consumers about health care costs, in hopes of spurring prudent health care choices.
- A campaign to educate the uninsured about public programs and safety net providers, in order to discourage unnecessary use of hospital emergency rooms.
- A campaign to help small employers be smart purchasers of health coverage for their employees, in response to feedback from focus groups that employers don't understand the options available to them, don't know the questions to ask and want an objective source of information.

Ultimately, the workgroup decided to focus most of its energies on the third initiative, in collaboration with private sector business groups that have expressed an interest in pursuing similar activities. This project will be pursued during the grant extension period.

Employer-Based Coverage Workgroup

This workgroup provided insight on the issues raised in Section 2 of the final report, "Summary of Findings: Employer-Based Coverage." They also were asked to explore ways of facilitating access to affordable coverage in the small group marketplace. The workgroup developed the idea of a Small Group Enrollment Center, to facilitate access to multiple insurance products for micro-employers (those with ten or fewer employees).

> <u>Small Group Enrollment Center</u>
> The Small Group Enrollment Center would serve as a single entry point to the insurance system for all micro-employers; require all carriers writing business in the small group market to participate; allow all licensed agents to place business through the center for a per-head fee; allow employers to select any two plans available through the Center for offering to their employees. The Center was not envisioned as a purchasing pool, but simply an entry point.

The Center was designed to address issues faced by all those attempting to write or purchase coverage in the "very small group" market:

- Very small employers have difficulty locating an agent to provide small group health coverage.
- Very small employers cannot provide their employees with a choice of carriers due to participation requirements.
- Agents are finding it increasingly difficult to represent multiple companies due to recent covered lives quotas required by carriers.
- Carriers complain that administrative costs (enrollment/billing) for very small groups are disproportionately high.
- Employers "gaming" the system by jumping from one carrier to the next creates administrative burden.

The Center would maintain a Web site with standardized benefit description forms for all carriers. Because it would be responsible for verifying eligibility and enrolling members, and would process payments through automatic bank drafts, it was thought that the Center could minimize both the administrative burden and associated costs for carriers writing business for micro-employers. Additionally, because it would be set up as a "closed" system, gaming problems could be minimized.

The workgroup determined that the idea merited further discussion and should be presented to various stakeholder groups for comment and discussion.

Health Care Marketplace Workgroup
This workgroup offered input on Section 3 of the final report, "Summary of Findings: Health Care Marketplace."

Uninsured Individuals and Families Workgroup
This workgroup first reviewed data from the CHS 2001 to identify populations to target subgroups in which substantive incremental reform with respect to health care coverage might be feasible. Those populations included:

- Employees of micro employers (<10 employees)
- Hispanics and possible subpopulations within that group
- Individuals below 200 percent FPL
- Rural residents
- 18-24 year-olds

The Uninsured Individuals and Families Workgroup asked the Employer-Based Coverage Workgroup to focus on the micro-employer segment. The group focused on identifying other subpopulation groups where additional research might be warranted. The workgroup considered the following options:

Understanding barriers to CHP+ enrollment among Hispanic populations
While the Child Health Plan *Plus* (CHP+, Colorado's SCHIP program) has enjoyed substantial enrollment growth since its inception, Hispanic enrollment has lagged behind that of other ethnic groups. At the recommendation of the Uninsured Individuals and Families Workgroup, Colorado's HRSA Strategic Planning Group has chosen to use some of the HRSA grant funds during the grant extension period to support an assessment of CHP+ outreach strategies among Hispanic populations that might result in the development and implementation of new strategies to reach those populations.

Because CHP+ and Medicaid share an application form and screening process, any effort to increase CHP+ outreach and enrollment inevitably boosts Medicaid enrollment as well.

Revising definition of dependent coverage to include 18-24 year-olds
Based on data from CHS 2001 showing the uninsurance rate for this age group to be disproportionately high relative to other age groups, legislation was introduced in the 2002 session of the Colorado General Assembly expanding the definition of "dependent" in State law to include 18-24 year olds who are not full time students. Presently, only full-time students in this age bracket are considered to be dependents. However, the legislation was defeated because many legislators viewed it as a mandate with unknown fiscal implications.

Other options considered but not pursued
The Uninsured Individuals and Families Workgroup also looked with interest at programs developed in other states (e.g., Delaware's Community Healthcare Access Program and Michigan's Ingham Health Plan) to cover uninsured individuals who are not eligible for public programs. Unfortunately, ongoing funding for such new programs (many of which are funded through one-time Federal grants, tobacco settlement dollars and foundation dollars) appears problematic; Colorado is reluctant to establish programs that may not require State dollars now but could well do so in future, if their initial funding base is not reliable over the long term. Accordingly, the HRSA Project Team did not spend additional time investigating such alternatives.

IMPORTANT ACTIVITIES UNDERTAKEN SINCE PREVIOUS REPORT

Colorado used its grant extension period to conduct additional analyses in order to identify economically and politically feasible options, as well as to implement activities described above. Specifically, the extension period was used for the following purposes:

- Analyze potential approaches for a HIFA waiver.
- Analysis of Federal funds available to Colorado programs and institutions, to identify opportunities to better leverage those funding streams.
- Analysis of barriers to CHP+ enrollment among Hispanics and development of new strategies for reaching those Hispanic subpopulations.

Potential Approaches for a HIFA Waiver

The work on both the streamlining and expansion populations has been complex and iterative. The Governor's Office and the Department of Health Care Policy and Financing have managed the work in phases to be able to assess the results against state policy and financing options and to determining the feasibility of continuing to explore these options. Some phases took more time than originally anticipated, especially the analysis of Medicaid and CHP+ utilization data. The work associated with combining two large, disparate data sets was more complicated than originally planned. There were also delays in completing the analysis during data testing and validation.

The first phase of Colorado's planning process involved a significant amount of public input, which will continue during the operational planning phase. One of the things that the state learned during the conceptual plan development is that Coloradans are interested in expanding and enhancing the existing public health programs if funding is available. The public is attracted to such an approach because, as other states have shown, it's an effective way to cover significant numbers of the uninsured, and federal matching funds are available.

During the first phase of Colorado's development of a plan to reduce the number of uninsured, interviews with health plan representatives, purchasing coalitions and Medicaid staff nationally were conducted to learn their concerns that may prevent them from participating and steps that can be taken to address these concerns. Colorado learned that its program must include:

- Sufficient capitation rates that reflect actual utilization and case mix of the population with particular attention to enrollees with significant medical expenses that may not have a defined special health care need.
- A critical mass of members to allow plans to spread financial risk, diminishing the potentially problematic impact of financial outliers on the plans.
- Relatively stable member enrollment (e.g. a continuous enrollment guarantee).
- Collaborative, business-oriented relationships between the state and plans.
- Efficient and plan-focused administrative processes and procedures.
- Consistency between the streamlined program and commercial lines of business.

Colorado held meetings in 2003 and 2004 in Alamosa, Colorado Springs, Denver, Ft. Collins, Grand Junction and Pueblo to meet with providers, consumers, policy makers and other interested parties to gather input about their priorities for expanding coverage, how to best serve children with special health care needs in a streamlined program, their opinions about streamlining public health programs, and which currently uninsured populations would be prioritized for expanded coverage if there was sufficient funding. The community voiced general support for a streamlined program, depending on final design and structure, and enthusiastic support for expansion.

Colorado gave each of these factors serious consideration in the design of a streamlined

program and will continue to involve health plans, providers, consumers, policy makers and other interested parties in the operational design phase of planning for the streamlined program and expansion population.

The conceptual planning process yielded a program that should work theoretically, but a large amount of work is yet to be done to develop an operational plan that will flesh out the program in great detail and devise solutions to the potential stumbling blocks posed by a program of this scope. Colorado is confident that the public and key stakeholders support the program design that was identified during the first phase. The program enjoys broad-based community support and has committed funds for further development from the Colorado Children's Health Foundation, the Rose Community Foundation and the Robert Wood Johnson Foundation. The previous work garnered a commitment from plans, providers, consumers and employers to work with the state throughout this planning process.

Identify Potential Opportunities to Leverage Existing Funds

Colorado examined whether federal funds would be available to Colorado programs and institutions, to identify opportunities to better leverage those funding streams. Work is ongoing to identify available funding to support potential eligibility expansions. Colorado is particularly interested in focusing expansions for children up to 200% of the federal poverty level and low-income parents of Medicaid children.

Analysis of Barriers to CHP+ Enrollment Among Hispanics

From October 2002 to June 2003, Colorado contracted with Texture Media, a research and marketing communications firm, to better understand families of eligible for CHP+ yet unenrolled children. The study sought to understand hard-to-access segments of the eligible population in order to determine better ways of reaching them. The ultimate goal of this work was to raise the health status of uninsured children. The SPG specifically funded research around the Latino community, a population that has been documented as having a higher proportion of uninsured. Key recommendations include:

- Immediate actions to better support the process
    - Leverage non-traditional channels; connect to personal support networks
    - Develop communications that target each of the following steps in the experiential learning model:
        - Creating a general awareness of CHP+ and where to find further information;
        - Reinforce the belief that health insurance is a priority in protecting both health and finances;
        - Encourage learning about what insurance provides, how it works, and how to apply;
        - Access to the CHP+ enrollment process; and
        - Making use of the coverage for both routine check-ups and unexpected health care needs.

- Build and support referral networks
    - Create marketing tools and resources for current enrollees to act as ambassadors;
    - Develop incentives to motivate participation and support peer referral; and
    - Develop tracking mechanisms to identify best peer resources.
- Long-term development of processes for feedback and participation from enrollees that ultimately become a continuous source of ways to better support the experience and build referral networks.
- Broaden channels for customer feedback loops to include eligible but unenrolled children.
- Develop methods for monitoring and measuring success based on identified behavioral groups.

NEXT STEPS

The State was notified by HRSA that it has received a SPG Continuation Grant. The State intends to use the SPG Continuation Grant to determine if the proposed streamlining model that has been developed would provide a sufficient foundation to enable low-income children and their parents to maintain coverage as they move from publicly-funded health insurance programs to private insurance, and determine if coverage could also be expanded to include additional populations. The State has submitted a revised budget request and implementation plan for the SPG Continuation Grant and will proceed with the activities under that grant as soon as the grant request revision has been approved.

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