Health Care Vision 2007 and Beyond: Colorado's Health Care Marketplace

policy brief

Colorado Health Institute

Denver, Colorado

Health Care Vision 2007 and Beyond: Colorado's Health Care Marketplace

The Colorado Health Foundation™

A NOTE TO THE READER

I am pleased to share this paper about past health care reform efforts in Colorado with the readership of the Colorado Health Institute (CHI). The genesis of the paper was a small working group that met at CHI during 2006 interested in promoting an action-oriented, evidence-based discussion about health reform efforts—past, present and future—in Colorado as the health care coverage crisis was continuing to worsen.

We have watched over time as the small group insurance market in Colorado has continued to erode, despite significant market reforms enacted in 1994 to encourage the uptake of health insurance in this market. Concomitantly, the Medicaid caseload has expanded and contracted, surging during economic downturns when budgetary pressures have been tight. The numbers of uninsured continue to grow in spite of the most recent economic recovery at both the national and state levels.

At the request of a working group member relatively new to Colorado, CHI was asked to provide a baseline policy analysis from which informed stakeholders could look to the future, based on an understanding of what had been tried in the past and the relative level of success of these efforts.

The Colorado Health Foundation provided a grant to CHI to do the research needed to provide this baseline policy analysis. Amy Downs, CHI senior research analyst, took on the monumental task of identifying a broad range of individuals who lived through the past 16 years of health policy activities and were active participants in the many policy debates represented by reform efforts. In many ways, this policy brief represents an oral history of health reform in Colorado since the early 1990s. Downs has supplemented these expert perspectives with data obtained from the national Medical Expenditure Panel Survey, state budget documents and state agency administrative records.

I hope that you will find this policy brief informative and instructive. It is meant to provide a historic review of health reform attempts in Colorado through the eyes of some of the more active participants in these efforts.

Pamela P. Hanes, PhD
President and Chief Executive Officer

HEALTH CARE VISION 2007 AND BEYOND: COLORADO'S HEALTH CARE MARKETPLACE

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INTRODUCTION

Much like the rest of the country, for the past 16 years the state of Colorado has grappled with significant medical cost inflation and double-digit increases in health insurance premiums. The end result has been a commensurate increase in the ranks of the uninsured, attributable by experts to higher costs, but also Colorado's shrinking small group insurance market and limits of public programs. Over the years, a variety of legislative and regulatory initiatives have been implemented to mitigate this decrease in access, although health care policy experts and opinion leaders are divided on whether the initiatives have achieved desired results.

Clearly, efforts and debate over these new policies and programs have illustrated the complexities involved in trying to increase access and lower costs for health care in Colorado. As we move forward in 2007 with a renewed focus on the current issues and how to resolve them, we must first better understand where we are now and how we got here.

Based on research conducted in early 2006 by the Colorado Health Institute (CHI), this paper provides an overview of changes in health care access and costs over a 16-year period, from 1990-2006. CHI staff interviewed 16 key individuals, including health policy experts and opinion leaders engaged in health policy from various vantage points and sectors. In addition, CHI used a wide variety of primary and secondary data sources including public documents covering the entire period as available.

This paper examines four areas:

- Trends in the private health care market
- Small group insurance reforms
- Impact of the tobacco settlement and Amendment 35
- Colorado's publicly-financed health programs

Key findings of the data and analysis include:

- Colorado's consolidation of health insurance plans and hospitals may be affecting costs. Also, the majority of the top 10 health insurance plans doing business in Colorado (Kaiser Permanente being a notable exception) are publicly traded, which likely pushes premiums upward.
- Colorado insurance coverage and costs closely mirror national trends. The cost of insurance has increased significantly with family premiums more than doubling from 1996 through 2003.[1] Higher premiums are a significant reason for the growing ranks of the uninsured.
- To address cost and coverage issues, in the mid-1990s Colorado implemented some of the most far-reaching small group health insurance market reforms in the country. Many of these reforms have been undone by the Colorado General Assembly over the past five years, while others have been federally codified through the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Despite the reforms, the number of individuals covered in the small group market has decreased substantially.

[1] Expenditures are reported in nominal terms and therefore not adjusted for inflation.

- The evolution of publicly-funded health programs in Colorado has been heavily influenced by the state's fiscal conservatism and the electorate's desire for a limited role for state government. Colorado's Medicaid program is viewed as among the leanest in the country.

- Although state policymakers have been reticent to tap the state's General Fund to finance new health care programs, alternative funding mechanisms have been used, including revenues from the tobacco Master Settlement Agreement (MSA) and a new tax on tobacco products to expand access and the availability of health care services.

TRENDS IN COLORADO'S HEALTH CARE MARKET AND THE UNINSURED

In most ways, changes in Colorado's health care marketplace mirror national trends. Among them is the consolidation of health plans over the past 10 years. As in other states, this has altered the dynamics of the health care market, resulting in less choice for consumers and a less competitive insurance market. And since the majority of the top 10 carriers are publicly traded, their business focus is on increased revenues and profits. Enrollment in Colorado's top 10 health plans has gone from 1.8 million at the close of 1995 to 2.9 million in September 2005.[2] Only a portion of this increase is attributable to population growth, as the state's population grew by only 22 percent during the same period.

Consolidation is also widely apparent in the hospital industry. Beginning in the mid-1990s, local hospitals began merging with national hospital chains to access capital for expansion and the modernization of aging facilities. Currently, the majority of hospital beds in Colorado are owned by three prominent hospital systems – Exempla, Centura and HealthONE. This consolidation has allowed hospitals to negotiate higher reimbursement rates from health insurance plans, which in some cases, may be passed on to health insurance plan members.

As a result of these and many other factors, employers and employees in Colorado and nationally have experienced steadily increasing health insurance premiums. Between 1996 and 2003, Colorado saw a higher increase than the nation as a whole, with the average individual premium increasing 91 percent compared with a 75 percent average increase nationally.[3] The increase in the cost of family coverage has been even more dramatic. Between 1996 and 2003, the cost of family coverage in Colorado increased by 102 percent, while the national average increased by 87 percent. (Graph 1)

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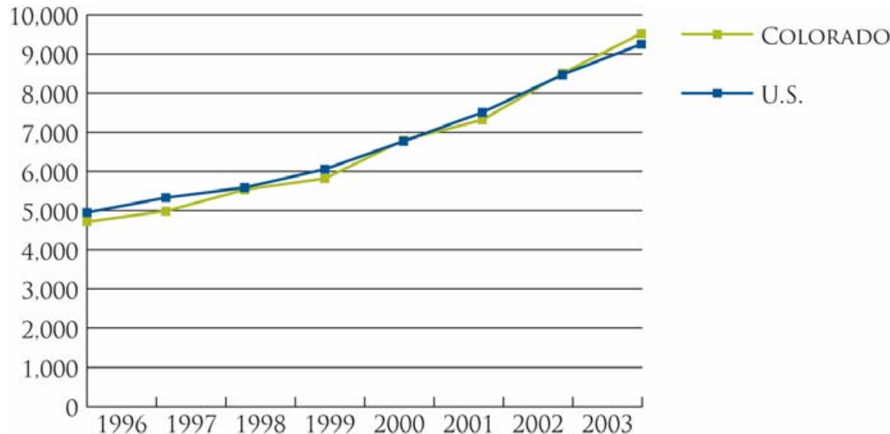
[2] Colorado Managed Care, Volume XII, No. 13, February 21, 2006.
[3] Medical Expenditure Survey, 2003.

Graph 1: Average total family premium per enrolled employee at private-sector firms that offer health insurance, United States and Colorado[4]



Source: Medical Expenditure Survey, 2003.

Of particular note is the gradual erosion of the small group market. An increasing number of small business employers are reducing coverage and more workers are opting out of coverage due to increasing premiums. These trends have resulted in larger numbers of workers and their dependents joining the ranks of the uninsured.

A recently completed analysis of the uninsured in Colorado (using 2003-04 data.[5]) found that:

- Between 1999 and 2004[6], the rate of uninsured adults in Colorado increased from approximately 18 to 20 percent, but the rate of uninsured children remained basically unchanged at 14 percent.
- The number of uninsured Coloradans is estimated to be 770,000, or 17 percent of the population compared to 15 percent nationally.
- Regardless of income, 18-34 year olds were the largest segment of Colorado's uninsured.
- Employees in small- and mid-sized companies were nearly twice as likely to be uninsured as those who worked for large employers.

SMALL GROUP INSURANCE REFORMS

State regulatory requirements specify premium rate factors and other conduct for insurance carriers serving companies of 50 or fewer employees in order to protect those businesses and guarantee access to affordable health care for their employees.

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[4] Expenditures are nominal. They are not adjusted for inflation.

[5] Colorado Health Institute. January 2006. *Profile of the Uninsured in Colorado, 2004*. Available at: www.coloradohealthinstitute.org/documents/bulletin_uninsured05.pdf. Data for the bulletin are from the Current Population Survey conducted by the U.S. Census Bureau on an annual basis.

[6] 1999 represents the average between 1999 and 2001. 2004 represents the average between 2002 and 2004.

Prior to the small group health insurance reforms of 1994, insurance carriers in Colorado could not terminate an employer's coverage based on the experience of one or more individuals in the group. Consequently, as health care costs began to escalate in the late 1980s, small group insurers in Colorado used "rate banding" to charge higher premiums for small companies. In addition, carriers could either decline coverage for individuals in the small group market or limit the coverage provided for pre-existing conditions.

Small group employers felt the situation was reaching crisis proportions in the first half of the 1990s with roller coaster increases in premiums that were difficult to absorb. So in 1994, after much debate, the General Assembly passed legislation that led to comprehensive reform of Colorado's small group health insurance market:

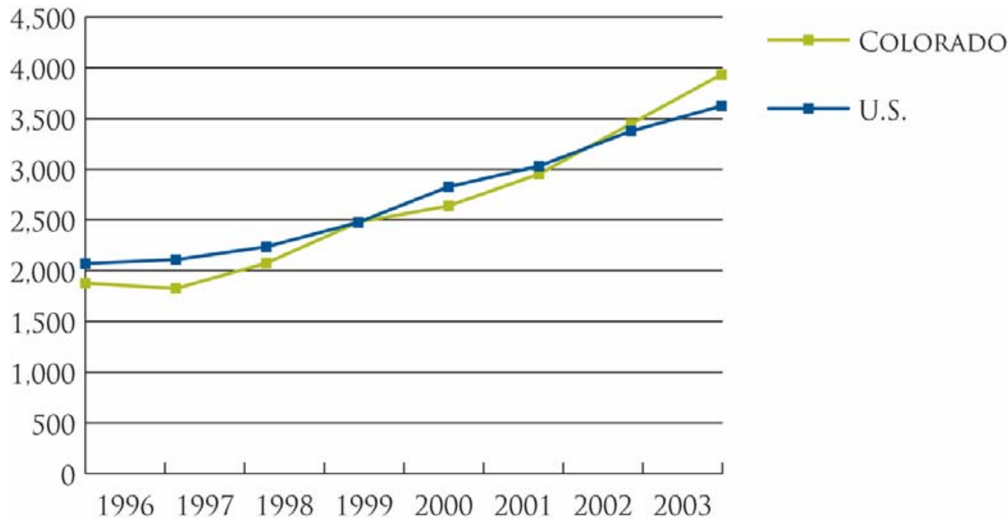
- All carriers marketing to small companies would be required to offer companies between two and 50 employees both a standard and a basic plan regardless of employees' health status. This requirement is known as guaranteed issue.
- The costs of plans would be based on a limited number of rating factors including age, family size and nine geographic regions.
- Rating factors based on health status, gender, claims experience and duration of coverage would no longer be allowed, after a three-year phasing-out period.
- All carriers marketing to small employers would be required to adhere to a strict set of market conduct rules.
- Beginning on January 1, 1996, self-employed individuals could enter the small group market as a "business group of one" (BG1). BG1s would receive the protection of the small group market reforms that did not extend to the individual market.

Over the next several years, certain provisions were modified. The geographic rating factor was modified, providing a mechanism for insurance carriers to create additional rating differences across communities. Rules regarding the definition and requirements for BG1s were tightened, and the community rating provisions were weakened, allowing insurance carriers to use additional factors, such as health and smoking status, claims experience and industrial job classification to set rates for small group employers.

In 1996, the U.S. Congress passed the Health Insurance Portability and Accountability Act (HIPAA). HIPAA mandates many of the provisions contained in Colorado's original 1994 legislation (H.B. 94-1210), including guaranteed issue and renewal for small group plans. Remaining provisions in Colorado's regulations that are not mandated by HIPAA include the BG1 designation, market conduct provisions and additional rate protections.

Despite the many regulatory changes implemented in the small group market since the mid-1990s, health insurance premiums for Colorado's small businesses increased 110 percent between 1996 and 2003, similar to national trends (Graph 2).

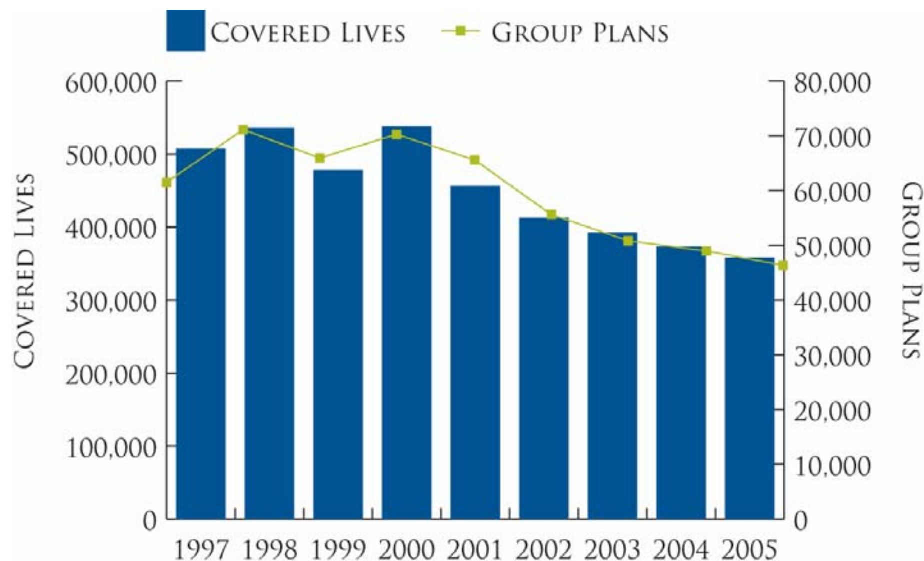
Graph 2: Annual employee-only health insurance premiums for workers in small businesses, Colorado and United States, 1996-2003



Source: Medical Expenditure Survey, 2003.

The number of individuals covered in the small group market decreased from 538,000 in 2000 to 373,000 in 2004 and by another 15,066 individuals in 2005. Graph 3 shows the fluctuations in the number of people covered and the number of group plans participating in the small group market from 1997 through 2004.

Graph 3: Small group market in Colorado, number of covered lives and small employer plans, 1997-2005



Source: Colorado Division of Insurance.

Experts disagree on the cause of this market erosion. Some note that more employers are electing to self-fund their insurance plans and purchase products outside the regulated small group market. Others contend that small group market reform has been overly prescriptive and has contributed to the decline.

IMPACT OF TOBACCO SETTLEMENT AND AMENDMENT 35

The evolution of state-funded health care programs has been influenced by the state's fiscal conservatism, codified in constitutional amendments that limit state spending and revenue growth. Consequently, the receipt of millions of dollars from the Master Settlement Agreement with tobacco companies represented a unique opportunity for the state to build health care programs with funds not subject to Arveschoug-Bird or TABOR limits. After much debate about how to spend the tobacco settlement funds, compromise legislation was passed in 2000 that called for funds to be allocated to a number of areas including health care, smoking cessation and educational programs, the *Read to Achieve* program and the establishment of a trust fund.

Since then, the allocation of funds has been highly political and volatile. For example, the Tobacco Substance Abuse Research Program was eliminated in FY 2003-04, but tobacco settlement funding for the Nurse Home Visitor Program has more than doubled since its inception. To the frustration of the health care lobby, the General Assembly has relied on tobacco settlement funds to help balance the state budget. For example, in FY 2001-02, 2002-03 and 2003-04, revenues totaling $231 million were transferred from cuts in tobacco settlement programs and the trust fund to the General Fund.[7]

The state's revenue shortfall situation led various individuals and groups to support a plan for partial or full securitization of tobacco settlement funds. Interviewees noted that securitization has never happened because of widespread support for the programs funded with tobacco settlement dollars.

Frustrations about budget reductions in tobacco education and cessation programs and difficulties in expanding health care programs for low-income Coloradans prompted the formation of Citizens for a Healthier Colorado, the coalition that campaigned to raise the cigarette excise tax from 20 to 84 cents and the excise tax on other tobacco products from 20 to 40 percent of the manufacturer's list price.

Despite the electorate's fiscal conservatism, Amendment 35 to the Colorado Constitution passed in November 2004. Interviewees noted that the measure was popular with voters because the tax increase was linked to prevention of tobacco use, particularly among young people. At the time of the campaign, Colorado had one of the lowest tobacco taxes in the country and it was made explicit that the revenues raised from the tax were to be spent on targeted health care programs. In addition, Amendment 35 allows the General Assembly to allocate tobacco tax funds for general health care programs during an economic downturn.

PUBLICLY-FINANCED HEALTH PROGRAMS

Over the past 16 years, various constituencies have attempted to increase access to care through state programs. Following is a summary of noteworthy programs:

ColoradoCare

Initially suggested in 1989 by the Colorado Coalition for Health Care Access, a private, nonprofit citizens group, ColoradoCare aimed to achieve universal coverage by reorganizing the state's health care system. In 1992, the Colorado General Assembly directed Governor Romer's administration to study this universal health insurance proposal. The governor established the Health Care Reform Initiative office, which produced a feasibility study of ColoradoCare.

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[7] Legislative Council. 2005. *Summary of Tobacco Settlement Activity in Colorado*.

The ColoradoCare feasibility study included three benefit plans, each of which emphasized preventive care but with varying benefit designs and cost-sharing obligations. The ColoradoCare proposal included several core design features:

- All Coloradans would have uninterrupted health insurance coverage that included comprehensive health care benefits and preventive health care services. Residents would have a choice of private health plans and employers would no longer be responsible for selecting plans for their employees.
- The state would create one or more regional health purchasing pools to negotiate the best health insurance packages available on a geographic basis.
- Administrative costs would be reduced by incentivizing plans to reduce inefficiencies through uniform billing and electronic data exchange requirements.[8]
- Proposed financing packages included various combinations of increasing payroll, state personal income, tobacco and alcohol taxes and employer purchasing.[9]

Governor Romer's staff conducted 32 public hearings in fall 1993 to gain feedback and input from communities around the state. By the time of the public hearings, the national debate regarding President Clinton's plan for universal coverage was heating up and receiving significant media attention. The heated national discourse and opposition from the Colorado business community led Romer to distance himself from the feasibility study and not endorse the program. Based on the national reception to the President's proposal, substantive discussion of ColoradoCare ceased and the plan was never introduced as legislation.

Colorado Uninsurable Health Insurance Program/CoverColorado

In 1990 the General Assembly passed legislation creating the Colorado Uninsurable Health Insurance Program (CUHIP) to provide health insurance coverage to "high-risk" Colorado residents.[10] High-risk individuals were those who, because of a health condition, could not secure health insurance or could obtain it but only at prohibitively high rates.

Program enrollment since CUHIP's inception has been influenced by policy and economic changes as illustrated in Graph 4. With small group insurance reforms of 1994 (H.B. 94-1210), medical underwriting was prohibited in the small group insurance market and subsequently a substantial number of individuals in the high-risk pool could now secure health insurance in the small group market. As a result, CUHIP enrollment began to decline.

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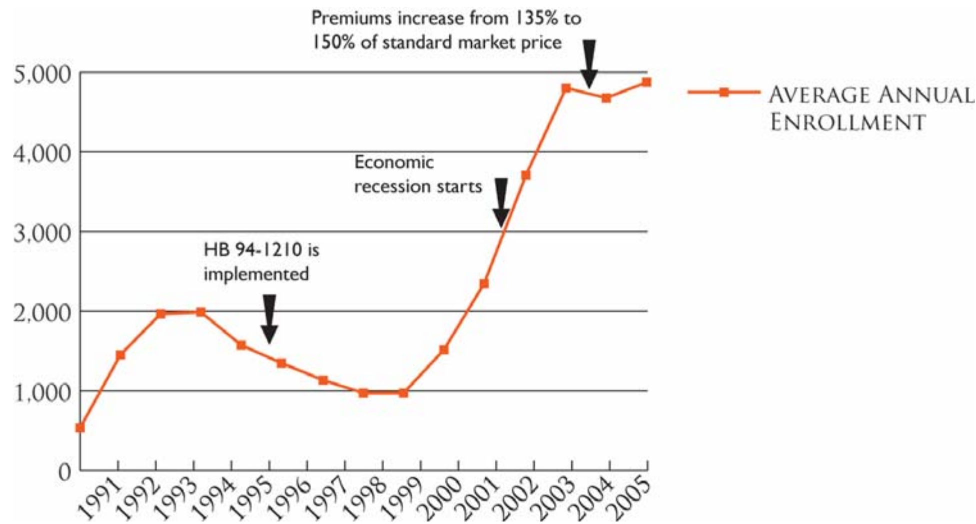
[8] Colorado Health Care Reform Initiative. 1993. *ColoradoCare Preliminary Feasibility Study*, Report to the General Assembly. pp. 4-5.

[9] Colorado Health Care Reform Initiative. pp. v-viii.

[10] The program operates as a nonprofit, unincorporated public entity created pursuant to the Colorado High Risk Insurance Plan Act, C.R.S. §10-8-501 et seq.

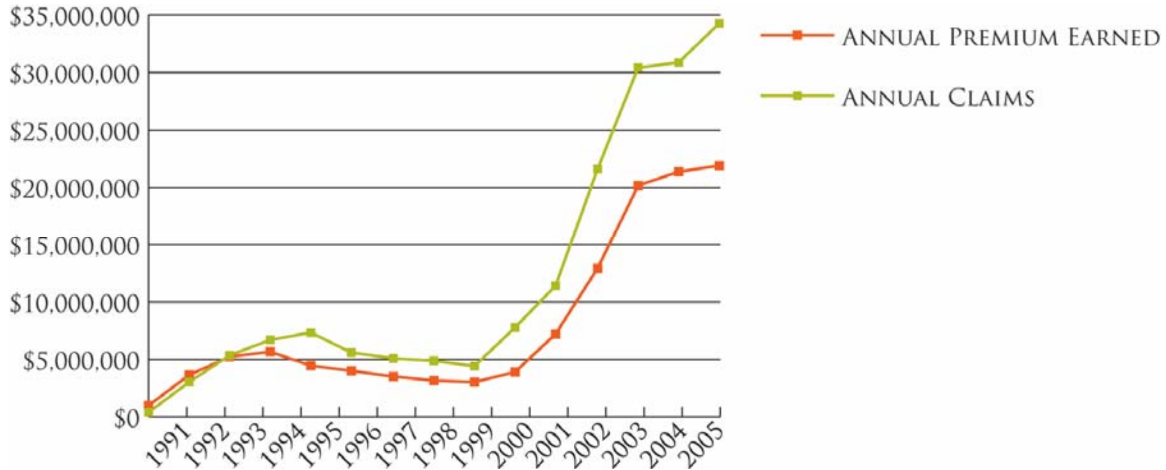
Graph 4: Average annual enrollment in CUHIP/CoverColorado, 1991-2005



Source: Leif and Associates.

Seven years later, Colorado entered an economic recession and enrollment began to increase significantly. As the number of enrollees increased, the gap between claims paid and premiums collected widened significantly, straining the program's financial solvency (Graph 5).

Graph 5: Annual cost of claims and annual premium revenues in CoverColorado, 1991-2005



Source: Leif and Associates.

In 2001, the program became CoverColorado and several other changes were implemented:

- Coverage limits were increased from $500,000 to $1 million
- Coverage for dependents of eligible individuals was allowed
- Premiums were increased from 120 percent to 135 percent of the standard market rate for an individual policy

- The General Assembly authorized the CoverColorado Board to levy a special assessment on insurance carriers operating in the state to improve financial solvency.[11]

To fund the gap between premiums and costs since the middle of 1993, CoverColorado has been subsidized by the Unclaimed Property Trust Fund. But in 2002 the property fund instead was tapped to mitigate the state's General Fund revenue shortfalls.[12] This reduction in available funds, coupled with CoverColorado's enrollment increases, amplified concerns about the program's financial solvency.

Consequently, in August 2003, the CoverColorado Board collected a $9.8 million assessment from insurance carriers operating in Colorado. At this time, carriers successfully lobbied for an increase in CoverColorado premiums from 135 percent to 150 percent of the standard market rate. The board also approved another insurer assessment of $29.8 million collected in May 2004.

As noted in Graph 4, however, program enrollment did not continue to increase as anticipated, likely because of the increase in premiums.

The high cost of CoverColorado premiums has meant that many Coloradans with pre-existing conditions have remained uninsured, or to the extent possible, have obtained insurance as a BG1 under the small group insurance statutes. Consequently, in March 2006, Governor Owens signed a bill authorizing the CoverColorado board to set premiums as low as 100 percent of the average premium. As a result, lower premiums took effect January 2007.

Medicaid

The Colorado Medicaid program is often described as among the leanest in the country. While Colorado's program complies with federal requirements, it authorizes only a few optional services and eligibility categories beyond those mandated by federal law. Despite its relative leanness, Medicaid continues to consume a growing proportion of the state's General Fund. In FY 1980-81, Medicaid and related programs consumed about eight percent of the General Fund compared to 22 percent in FY 2005-06. Colorado's relatively high average per-capita income means the state is among those receiving the lowest federal Medicaid match in the country – the federal government pays for 50 percent of Colorado Medicaid expenditures.

Despite increases in Medicaid expenditures, reimbursement to providers remains low. In 2001, a report by the Denver Metro Chamber of Commerce concluded that Medicaid costs not covered by the state were being shifted to the private sector in the form of higher premiums. At that time, the Denver business community outlined a number of potential Medicaid reform measures, pressing for legislative relief. However, because of the state's revenue crisis, policymakers were not inclined to institute any significant changes in an already costly program.

In FY 2001-02, Colorado's General Fund revenue declined 13 percent and another three percent in FY 2002-03.[13] While the economy was souring, Medicaid caseloads were increasing rapidly. To balance the budget, policymakers made across-the-board reductions, including Medicaid. Cuts affected a variety of service areas, including reimbursement rates for in-patient hospitalization, prescription drugs and outpatient visits. Increases to partially compensate providers for inflation were suspended and legislation

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[11] CoverColorado has the authority to assess all carriers that provide group or individual benefit plans and are subject to state insurance regulations in Colorado.

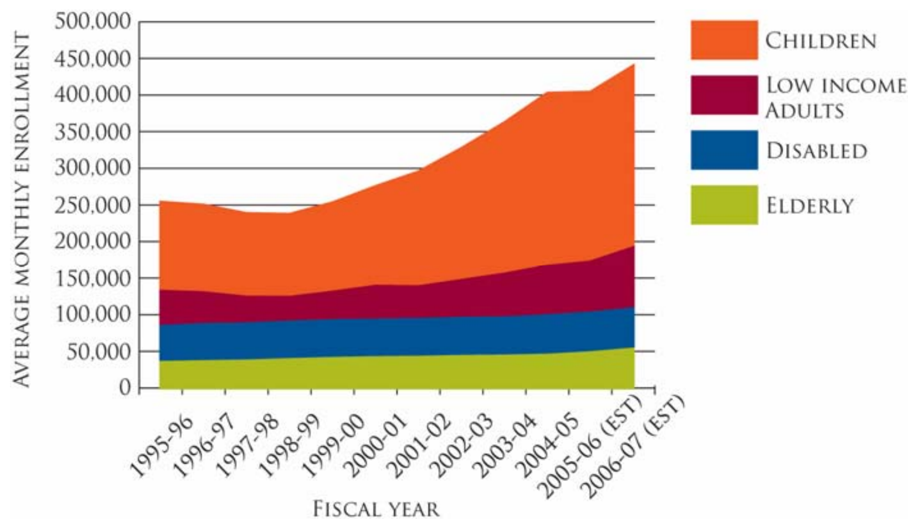
[12] In FY 2001-02, Colorado's General Fund revenue declined 13 percent and an additional 3 percent in FY 2002-03.

[13] Office of State Planning and Budgeting. Sept. 2004. TABOR—The Taxpayer's Bill of Rights, p.8.

was passed to eliminate optional services for legal immigrants.[14] Despite these reductions, between FY 2002-03 and FY 2004-05, the General Fund appropriation for the Department of Health Care Policy and Financing (HCPF), which oversees Medicaid, as well as the Colorado Indigent Care Program and Child Health Plan *Plus,* increased by 23 percent.[15]

Increases in Medicaid expenditures are driven by increases in enrollment, utilization and medical cost inflation. Medicaid caseloads increased almost 60 percent from FY 1995-96 through FY 2004-05. (Graph 6) While the children's caseload experienced the most significant increase, children's medical costs were relatively low compared to other Medicaid eligibility categories. As Graph 7 illustrates, while children represent 57 percent of the caseload, they account for only 18 percent of Medicaid expenditures. Conversely, the elderly and disabled make up 12 and 13 percent of the caseload respectively, but account for 35 and 32 percent of expenditures.

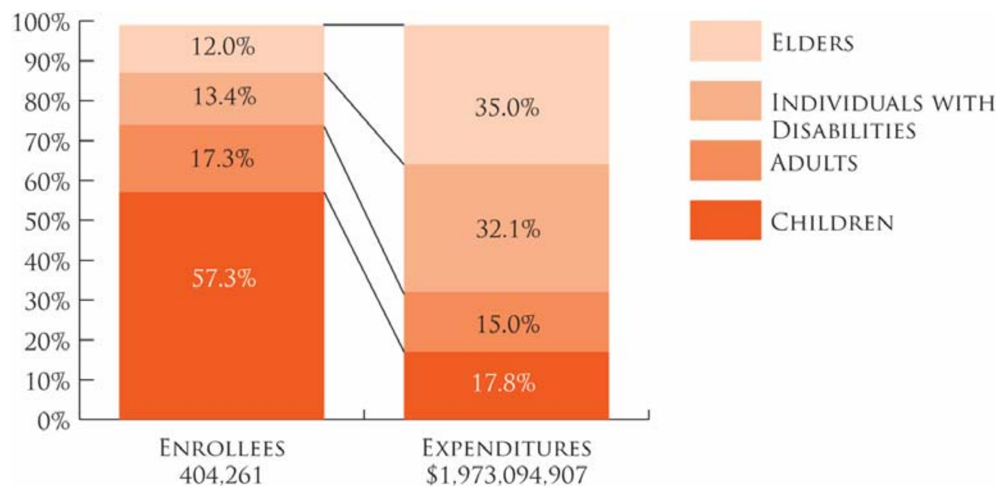
Graph 6: Growth of Medicaid caseload, FY 1995-96 to FY 2006-07



Source: Joint Budget Committee staff budget briefing Dec. 2005, p. 176.

[14] This provision was challenged in court. H.B. 05-1262 restored services.
[15] Joint Budget Committee. July 2005. FY 2005-06 Appropriations Report, p.95.

Graph 7: Medicaid Enrollees and Expenditures, FY 2005-06 (Est.)



Source: Department of Health Care Policy and Financing Medicaid Premiums Supplemental, 2/15/06.

Changes to eligibility and services

Colorado's Medicaid program primarily covers only those individuals as mandated by federal law, with a few exceptions. One exception is the "300 percenters," disabled individuals with limited resources and incomes up to 300 percent of the Supplemental Security Income standard or 219 percent of the Federal Poverty Level (FPL). Secondly, in the 1990s, the General Assembly passed legislation to provide optional services for certain legal immigrants.

While expansions in Medicaid have been limited, changes have occurred in the delivery of some services.

- Community-based service – Since the early 1980s, Colorado has been a leader in providing long-term care services through federally authorized home and community-based service (HCBS) waiver programs. These programs enable individuals to receive long-term care services in their homes and community residences as opposed to more costly institutions. In the early 1990s, Colorado expanded these services to cover disabled children at risk of placement in a nursing facility or long-term hospitalization. Colorado also was one of the first states to create a single entry-point system, which provides information and referral, assessment for long-term care services, care management and a wide variety of community support for Medicaid-eligible individuals.

- Consumer-directed care – In the mid-1990s, after being lobbied by the disability community, HCPF pursued a consumer-directed attendant care program. Now, the Medicaid program supports a number of programs in which clients may select, hire, train, supervise and dismiss their personal care workers.

- School-based services – Beginning in 1997, school districts were allowed to receive federal Medicaid reimbursement for eligible services provided in schools to eligible Medicaid children. The federal funds must be used to expand health services for all children and 30 percent of the

funds can be used to improve health care access for underinsured and uninsured children. For FY 2006-07, it is estimated that 134 school districts will take part in the program.[16]

- Expanded coverage for women with breast and cervical cancer – During a special legislative session on redistricting, full Medicaid benefits were extended to women with breast and cervical cancer whose incomes are below 250 percent of the FPL. Funding was derived from interest earnings on some of the tobacco settlement funds.

During the past few years, the most significant expansions in Medicaid occurred as a result of using funds from Amendment 35 which included the raising Medicaid eligibility for parents to 60 percent of the FPL, expanding the CHP+ eligibility for pregnant women and children from 185 percent to 200 percent of the FPL and the removal of the Medicaid asset test for all children and low-income families on Medicaid. There were several other expansions which included extending coverage to children with autism and providing substance abuse treatment to Native Americans. Legislation providing the latter coverage stipulates that the services will be continued only if they reduce costs to the Medicaid program.

Child Health Plan Plus

Child Health Plan *Plus* (CHP+), created by the Colorado Legislature in 1997 as the Children's Basic Health Plan, is a full-service health and dental plan for Colorado's uninsured children age 18 and under whose families meet income eligibility requirements.

CHP+ is the Colorado equivalent of the federal government's State Children's Health Insurance Program (SCHIP), established to provide health insurance for uninsured children in working families in all states. SCHIP provides a 65 percent match to state expenditures, compared to the 50 percent match for Medicaid. Support for CHP+ has been widespread and includes children's advocacy organizations, the business community and chambers of commerce around the state.

A number of differences between Medicaid and CHP+ make the latter more popular with policymakers and health care providers. Some of the more notable program differences include:

- The federal government provides approximately $1.85 for every state dollar spent on CHP+ compared to the federal match of $1 for every state dollar spent on Medicaid.
- CHP+ is not an entitlement program and can be capped or eliminated. While the federal government allows states to use their federal SCHIP allotments to create Medicaid expansion programs, the Colorado General Assembly created CHP+ as a stand-alone program to give the state more flexibility. According to the enabling legislation, "it is not the intent of the General Assembly to create an entitlement for health insurance coverage."[17]
- CHP+ is intended for low-income children and pregnant women who cannot afford or do not have access to health insurance and thus income eligibility extends up to 200 percent of FPL as opposed to 60 percent[18] of FPL for parents in Medicaid.
- The program is modeled on a standard private health insurance plan for small employers.

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[16] November 15, 2006. Colorado Department of Health Care Policy and Financing. Executive Budget Request, p.M232.

[17] Colorado General Assembly. S.B. 97-1304

[18] Prior to July 2006, Medicaid parents' eligibility threshold was 36 percent of FPL, with new revenues from the tobacco tax, the state increased this to 60 percent.

In 2000, the CHP+ program faced numerous challenges. For one, Colorado's program charged among the highest premiums in the country, as high as $30 per month per child.[19] Advocacy organizations believed enrollment was low because of these high premiums, with an average of 23,000 enrollees out of an estimated eligible population of 69,157 children in FY 1999-00.[20] Of the families that joined, many were not able to pay the monthly premiums. By law, the names of parents who did not pay the premiums were sent to collection agencies. After the program received substantial negative press and families' stories were highlighted in local newspapers, the governor requested implementation of a series of reform measures that were approved by the General Assembly:

- At the end of 2000, a four-month enrollment holiday was granted during which time families could enroll and participate in CHP+ for free
- Beginning January 1, 2001, families were charged an annual fee instead of monthly premiums. Families with incomes between 151 and 185 percent of the FPL were charged $25 for one child and $35 for two children; families below 151 percent of the FPL could participate in the program for free.

The governor requested and the state treasurer agreed to forgive the accrued debts of CHP+ families.

Shortly thereafter, lawmakers expanded the CHP+ program to cover prenatal and postnatal care and labor and delivery services for pregnant women 19 years and older with incomes between 134 and 185 percent of the FPL.[21] After a delivery, the program automatically enrolls the baby in the CHP+ children's program. The program initially was funded with tobacco settlement funds.

CHP+ enrollment continued to climb and reached a peak of more than 52,000 in October 2003. As Colorado continued to grapple with plummeting state revenues, the program ceased its marketing activities in January 2003. New enrollment for pregnant women was suspended between May 2003 and June 2004, while new enrollment for children was suspended between November 2003 and June 2004.[22]

Enrollment for these groups was reinstated in July of 2004, and then in 2005, after passage of Amendment 35, the state increased CHP+ eligibility for children and pregnant women to 200 percent of FPL. In addition, the program received funding to reinstate marketing activities to encourage greater enrollment.

CHP+ was considered such a success that in 2005 HCPF, after two years of planning, presented a proposal to create *Colorado Family Care,* a streamlined and consolidated Medicaid and CHP+ program that would more closely resemble CHP+ while maintaining federally-mandated benefits to Medicaid recipients. While the proposal ultimately was not approved by the joint House and Senate Health and Human Services Committees, some legislators and advocates were interested in pursuing certain provisions legislatively. After several months of negotiations during the 2006 legislative session, the possibility of introducing a bill was ended because of the inability to achieve budget neutrality.

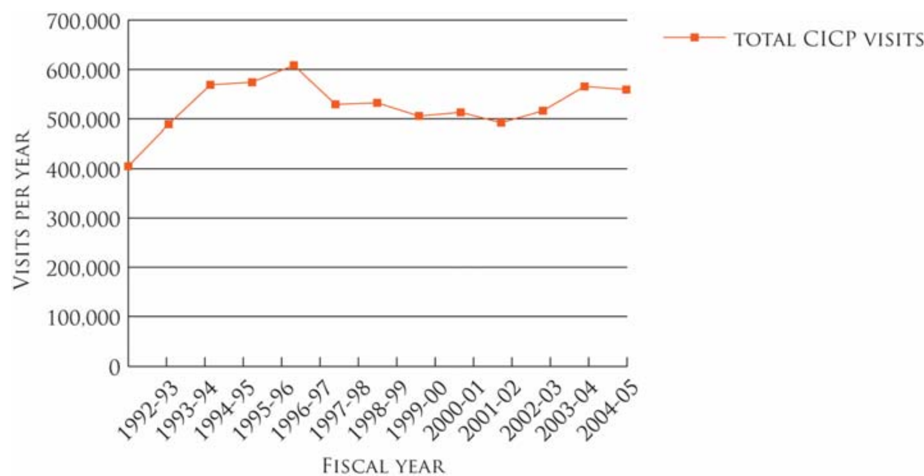
[19] Expert interviews.
[20] CHP+ Annual Report, FY 1999-00.
[21] The program operates under a Health Insurance Flexibility and Accountability (HIFA) waiver.
[22] Colorado Joint Budget Committee, December 19, 2005. FY 2006-07 Staff Budget Briefing, Department of Health Care Policy and Financing. p.130.

Colorado Indigent Care Program
Originally implemented in 1983, the Colorado Indigent Care Program (CICP), also referred to as the Medically Indigent Program or the Colorado Resident Discount Program, is a state program that partially reimburses hospital- and clinic-based providers for uncompensated services rendered to eligible indigent patients. As a reimbursement mechanism, CICP is neither an insurance program nor an entitlement program and is subject to an annual appropriation by the General Assembly. To qualify for services reimbursed by CICP, individuals must be Colorado residents, have incomes at or below 250 percent of the FPL (this was raised from 185 percent of FPL in the 2006 session), limited assets, be uninsured or underinsured and not qualify for Medicaid or CHP+. Covered services include emergency care, inpatient and outpatient care and prescription drugs. Co-pays are based on patients' financial resources, but may not exceed 10 percent of a patient's income over a 12-month period.

Few states have programs similar to CICP, which served almost 180,000 clients in FY 2004-05. One reason CICP is a payment source for such a large number of Coloradans is due to Colorado's Medicaid limits on adult eligibility. Graph 8 summarizes the number of CICP outpatient visits and hospital admissions from FY 1992-93 through FY 2004-05.[23]

While the number of CICP visits and admissions peaked in FY 1996-97 at 608,387, it then began a downward trend through FY 2001-02, largely because many children moved from CICP to CHP+.

Graph 8: Total CICP visits, FY 1992-93 through FY 2004-05

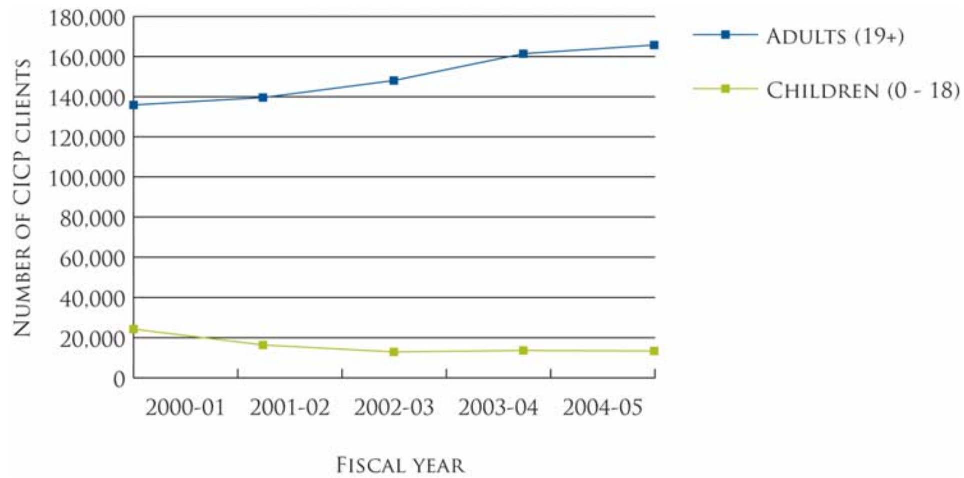


Source: Department of Health Care Policy and Financing and University of Colorado Health Sciences Center, CICP Annual Reports, FY 1992-93 through FY 2004-05.

Graph 9 illustrates the differential trends between children and adult participants in the CICP program. As children were being enrolled in CHP+ and their numbers decreased in CICP, the number of adults receiving services through CICP increased by three percent in FY 2001-02, six percent in FY 2002-03 and nine percent in FY 2003-04.

[23] Colorado Department of Health Care Policy and Financing and University of Colorado Health Sciences Center. Medically Indigent and Colorado Indigent Care Program, Annual Reports FY1992-93 through FY 2004-05.

Graph 9: CICP unduplicated clients, children and adults, FY 2000-01 through FY 2004-05



Source: Department of Health Care Policy and Financing. CICP Annual Reports, FY 2000-01 through FY 2004-05.

Currently, CICP is financed principally with federal Disproportionate Share Hospital (DSH) funds available to help states compensate hospitals that provide a disproportionate share of medical care to uninsured, indigent and Medicaid clients. The state also contributes from the General Fund to the program, and certain expenditures made by local governments are used as part of the state match that draws down federal funds.

Although the number of CICP participants has increased, the percentage of costs reimbursed has decreased. Table 1 summarizes this trend.

Table 1. CICP compensation for hospitals, FY 2000-01 through FY 2004-05

Fiscal Year	Privately owned hospitals	Publicly owned hospitals[24]	All hospitals
2000-01	49%	71%	67%
2001-02	30%	54%	49%
2002-03	23%	46%	41%
2003-04	26%	50%	43%
2004-05	18%	46%	38%

Source: Department of Health Care Policy and Financing, Jan. 5, 2006; FY 2006-07 Joint Budget Committee Hearing, p.8.

[24] "Publicly owned" denotes full or partial ownership by a governmental entity.

Low reimbursement rates have resulted in CICP providers dropping out of the program or threatening to drop out, especially in the Denver-metropolitan area.[25] For the first time since 1999, patient co-pays were increased in 2006. For example, for individuals between 40 and 62 percent of the FPL, co-pays for prescription drugs have increased 100 percent, from $5 to $10.[26]

2007 AND BEYOND

While the past sixteen years have witnessed a variety of attempts to intervene in the private health insurance market to stimulate the expansion of employer-sponsored health insurance coverage, the private market, particularly the small group market, continues to erode. The number of Colorado's uninsured relative to its total population is two percentage points higher than the national average, despite the fact that Colorado ranks ninth in the country for estimated median household income.[27] Some health policy experts contend it's simply the prices that are driving up the numbers of uninsured in Colorado and elsewhere in the United States.[28]

At the same time, state public programs, though modest relative to those in other states, continue to require more funding.

Colorado's programs are intricately linked, with program changes and subsequent enrollment changes affecting enrollment in other programs. And despite the efforts of many over the past 16 years, questions remain: How can we reduce the number of uninsured, and guarantee access to affordable health care for all Coloradans? Are Coloradans best served by a highly regulated environment, or a free-market environment? What consolidations should be considered in Colorado's current programs, and what new programs should be considered?

As Colorado looks for comprehensive reform, we must take account of where we have been, what has been tried and the interrelatedness of public and private systems. There is no "magic bullet" to fix all that is broken, but there is a path that will increase access, quality and affordability.

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[25] January 23, 2006. "CICP Co-Pays Increased," *Colorado Managed Care.* p.1.
[26] January 11, 2006. "Health Costs Will Rise for Poor." *The Denver Post*, p. A1.
[27] Source: http://www.census.gov/hhes/www/saipe/county.html
[28] Anderson, G, U. Reinhart et al. (2006) "It's the prices stupid" Health Affairs

HEALTH CARE VISION 2007 AND BEYOND: COLORADO'S HEALTH CARE MARKETPLACE

APPENDIX 1: GLOSSARY OF TERMS AND ACRONYMS

300 Percenters – disabled individuals with limited resources and incomes up to 300 percent of the Supplemental Security Income standard or 219 percent of the FPL.

Amendment 35 – an amendment to the Colorado Constitution passed by voters in 2004 that increased the tax on tobacco products.

Arveschoug-Bird Limit – a Colorado statute enacted in 1991 that allows for annual increases in General Fund appropriations of no greater than six percent.

Business Group of One (BG1) – self-employed individuals who would be considered a small group when they entered the small group insurance market, in order to receive special protections and greater access to health insurance.

Child Health Plan Plus (CHP+) – passed in the legislature as the Children's Basic Health Plan to provide health insurance coverage throughout the state; intended for low-income children and pregnant women whose families cannot afford or do not have access to health insurance.

Citizens for a Healthier Colorado – a coalition comprised of more than 20 statewide organizations, which in 2003 launched the campaign for Amendment 35.

ColoradoCare – a proposal crafted in 1989 by the Colorado Coalition for Health Care Access to ensure universal access to health care coverage for all Coloradans.

Colorado Division of Insurance – regulates the insurance industry and assists consumers and other stakeholders with insurance issues. The Division also performs both market and financial examinations on insurance companies licensed to conduct business in the state to determine compliance with Colorado insurance laws by identifying violations and ensuring company solvency.

Colorado Family Care – a streamlined and consolidated Medicaid and CHP+ program proposed in 2005 that would more closely resemble CHP+ while maintaining federally mandated benefits to Medicaid recipients.

Colorado High Risk Insurance Plan Act – the 2001 act that changed the name of the Colorado Uninsurable Health Insurance Program to CoverColorado and clarified eligibility requirements.

Colorado Indigent Care Program (CICP) – Originally implemented in 1983, and also referred to as the Medically Indigent Program or the Colorado Resident Discount Program, this is a state program that partially reimburses hospital- and clinic-based providers for uncompensated services rendered to eligible indigent patients.

Colorado Uninsurable Health Insurance Program (CUHIP) – Also named CoverColorado, this plan provides health insurance coverage to "high-risk" Colorado residents. High-risk individuals are those who, because of a health condition, cannot secure health insurance or can obtain it but only at prohibitively high rates. CoverColorado became the Health Insurance Portability and Accountability Act (HIPAA) state alternative for HIPAA-eligible individuals who were entitled to health insurance when they left the group market.

CoverColorado – see Colorado Uninsurable Health Insurance Program

Disproportionate Share Hospital (DSH) Funds – funds available to help states compensate hospitals that provide a disproportionate share of medical care to uninsured, indigent and Medicaid clients.

Fee-for-Service – a type of health insurance plan that allows the holder to make almost all health care decisions independently. The plan holder pays for a service, submits a claim to the insurance company, and, if the service is covered in the policy, receives reimbursement. Fee-for-service plans often have higher deductibles or co-pays than managed care plans.

Federal Poverty Limit (FPL) – The set minimum amount of income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, this level is determined by the Department of Health and Human Services and is typically issued in February in the form of poverty guidelines. Public assistance programs such as Medicaid define eligibility income limits as a percentage of FPL. In 2006, FPL for a family of four was $20,000.

Guaranteed Issue – the requirement that health insurance providers may use only a limited number of factors in determining health insurance rates for small businesses, thereby guaranteeing that a small business will be issued a health insurance policy at a reasonable rate. Guaranteed issue also requires all carriers serving the small group market to offer both a standard and basic plan regardless of employees' health status.

Health Care Policy and Financing (HCPF) – the Colorado state agency responsible for the administration of the Medicaid program, Child Health Plan Plus, and the Colorado Indigent Care program.

Health Insurance Portability and Accountability Act (HIPAA) of 1996 – comprehensive legislation by the U.S. Congress that allows persons to qualify immediately for comparable health insurance coverage when they change their employment or relationships, invokes standard billing practices and gives patients a means to the documents which pertain to their medical care. As part of this legislation, HIPAA mandated guaranteed issue and renewal for small group plans.

Health Insurance Flexibility and Accountability (**HIFA)** waiver – this initiative by the U.S. Department of Health and Human Services is a waiver of Medicaid and S-CHIP that allows states to waive certain requirements of the laws to experiment with new ideas for improving the programs.

Home and Community-Based Service Waiver – enables individuals enrolled in Medicaid to receive long-term care services in their homes and community residences as opposed to more costly institutions. Established in 1981, this rule refers to "waiving" Medicaid's usual requirement of funding care only in institutions. Federal funding for community-based services is available to states under this waiver.

Indigent – One who is needy or poor. Medically indigent patients are those who have little or no health insurance and who are without sufficient resources to pay for essential health care.

Master Settlement Agreement (MSA) – a settlement agreement signed by the state of Colorado in 1998 with the five largest tobacco companies. Colorado gave up the right to sue tobacco companies for their violations (including breach of consumer protection laws, withholding evidence of the health impacts of tobacco consumption and marketing strategies targeted at children and teenagers)in exchange for annual payments to be made in perpetuity. Colorado's annual payments from the MSA are

estimated to range from actual receipts of $78 million in 2000 to estimated receipts of $164 million in 2046.

Managed Care Organizations (MCOs) – a health insurance provider that requires insured patients to gain referrals from a primary care physician for utilization and delivery of medical services.

Medicaid – the nation's health care program for low-income individuals and families, funded jointly by the states and the federal government, that reimburses hospitals and physicians for providing care to qualifying people who cannot finance their own medical expenses. Colorado's Medicaid program primarily covers only those individuals as mandated by federal law.

Rate Banding – also known as tiered or durational rating, this strategy by insurance companies meant that if one individual in a small group incurred higher than anticipated expenses, the employer was charged higher premiums for the whole group the following year.

Small Group Insurance Market – the market for insurance coverage for small businesses of two to 50 employees. Also includes provisions for self-employed individuals, known as business groups of one (BG1).

State Children's Health Insurance Program (SCHIP) – created by the U.S. Congress to provide health insurance for uninsured children in working families in all states. CHP+ became Colorado's SCHIP equivalent.

Taxpayers Bill of Rights (TABOR) – a 1992 Colorado constitutional amendment that limits revenue growth to the sum of inflation and population growth from the prior year's allowable revenue base.

APPENDIX 2: SUMMARY OF SIGNIFICANT HEALTH CARE LEGISLATION IN COLORADO, 1990-2006

Small Group Insurance Reform

1994 H.B. 94-1210

Led to comprehensive reform of Colorado's small group health insurance market. The legislation set in place a number of reform provisions including guarantee of coverage for small businesses of between two and 50 employees, and a limited number of factors allowed for consideration in setting rates. In addition, this legislation introduced eligibility of self-employed individuals as "business groups of one" (BG1).

1997 S.B. 97-54

Permitted insurance companies to offer only basic and standard health insurance policies to a sole proprietor (BG1) if they did not meet the standard underwriting criteria.

2002 HB 02-1003

Changes requirements that a BG1 work 24 hours a week to require a BG1's gross income be 24 hours multiplied by federal minimum wage OR gross income must be sufficient to pay for annual premiums. Extends pre-existing period to 12 months for BG1.

2003 H.B. 03-1164

An adjustment in rates for claims experience, health status, and standard industrial classification may be made but shall not be charged to the individuals under the plan; The carrier may increase the rate by 10 percent or decrease by more than 25 percent based on health status from the carrier's filed rate.

2006 S.B. 06-036

Eliminated the sunset provision in H.B. 94-1210 and required insurance companies to offer a standard and basic plan based on latest medical evidence. Other provisions of original H.B. 94-1210 were protected by the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Tobacco Settlement and Amendment 35

2000 S.B. 00-71

Allocates funds from the Master Settlement Agreement signed by Colorado and the five largest tobacco companies. Funds are designated for a number of priorities including health care, smoking cessation and educational programs, *Read to Achieve* and the establishment of a trust fund.

2004 Constitutional Amendment 35

A ballot initiative passed by voters to increase the tobacco tax and allocate revenues to targeted health care programs. This tax was expected to generate approximately $175 million per year in new state revenue, to be used to fund: public health insurance expansion for Colorado families through the

CHP+ and Medicaid; comprehensive primary care through Community Health Centers and other clinics serving a high portion of uninsured; tobacco education, prevention and cessation programs; and prevention, early detection and treatment of cancer, cardiovascular and pulmonary diseases. In 2005, the General Assembly codified the amendment and specified distribution of funds by passing H.B. 05-1262.

<u>Colorado Public Health Care Programs</u>

ColoradoCare

1992 S.B. 92-04

Instructed the Department of Regulatory Agencies to conduct a feasibility study for ColoradoCare, a proposal crafted by the Colorado Coalition for Health Care Access to ensure universal access to health care coverage for all Coloradans.

Colorado Uninsurable Health Insurance Program

1990 H.B. 90-1305

Created the Colorado Uninsurable Health Insurance Program (CUHIP) to provide health insurance coverage to Colorado residents who are unable to purchase health insurance at affordable rates from commercial insurance companies.

2001 H.B. 01-1319

Changed program's name to CoverColorado; made it the HIPAA state alternative for HIPAA-eligible individuals who were entitled to health insurance when they left the group market and made several other changes that affected program enrollment and financing.

2006 S.B. 06-180

Authorized the CoverColorado board to set the premiums as low as 100 percent of the average premium to facilitate this coverage option for moderate-income individuals.

Medicaid

1997 S.B. 97-05

Directed the Department of Health Care Policy and Financing (HCPF) to enroll 75 percent of Medicaid clients in managed care organizations and require certain rates paid to those organizations.

1997 S.B. 97-101

Allowed school districts to receive federal Medicaid reimbursement for eligible services provided in schools to eligible Medicaid children.

2001 S.B. 01-063

Expanded the full Medicaid benefit package to low-income women with cervical or breast cancer who lack access to adequate health insurance coverage.

2003 S.B. 03-176

Eliminated most Medicaid services for some legal immigrants. While the legislation was challenged and tied up in the courts, Amendment 35 dollars were dedicated to funding Medicaid services for this population. Eventually, H.B. 05-1262 restored services.

2005 H.B. 05-1015

Required HCPF to seek federal approval to provide substance abuse treatment to Native Americans.

2005 H.B. 05-1243

Allowed all Medicaid recipients in a home- and community-based services waiver to participate in consumer-directed attendant care programs.

2006 H.B. 05-1262

Expanded Medicaid to parents from 36 percent to 60 percent of the federal poverty level (FPL) by no later than July 1, 2006; Restored Medicaid coverage to legal immigrants; Removed waiting lists for Home and Community Based Services (HCBS) programs and Children's Extensive Support Waivers (CES); Restored Presumptive Eligibility in Medicaid for pregnant women; and removed the Medicaid asset test for all children and low-income families.

Colorado Child Health Plan & CHP+

1990 S.B. 90-25

Created the Colorado Child Health Plan to provide access to comprehensive health care in rural areas.

1997 H.B. 97-1304

Created the Children's Basic Health Plan, marketed as the Child Health Plan Plus (CHP+), to provide health insurance coverage throughout the state.

2000 S.B. 00-71

Authorized dental benefits for CHP+. Network adequacy and funding considerations prevented the managed care CHP+ dental benefit from being implemented until 2002.

2002 H.B. 02-1155

Expanded the CHP+ program to cover prenatal and postnatal care and labor and delivery services for pregnant women. After a delivery, the program automatically enrolled the baby in the CHP+ children's program.

2006 H.B. 05-1262

Expand the eligibility for CHP+ for pregnant women and children from 185 percent to 200 percent of the FPL. Provided funding for marketing efforts for the CHP+ program.

Colorado Indigent Care Program

Originally implemented in 1983, the current Colorado Indigent Care Program, also referred to as the Medically Indigent Program or the Colorado Resident Discount Program, is a state program that partially reimburses hospital- and clinic-based providers for uncompensated services rendered to eligible indigent patients.

2006 S.B. 06-044

Created the Colorado Health Care Services Fund, allocating $15 million per year for five years to fund Colorado Indigent Care Program primary care services to low income and underinsured adults at or below 250 percent of the FPL.

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