

Healthy Colorado:
First Thoughts on a Plan to
Ensure Coverage for All Coloradans

Colorado Coalition for the Medically Underserved

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I. Introduction

The Colorado Coalition for the Medically Underserved (CCMU) is a coalition of more than 150 Colorado individuals and organizations, representing consumers, providers, business, government agencies, local health foundations, insurers and others. It is committed to the following goals:

Table 1 Goals of the Colorado Coalition for the Medically Underserved	
1.	To achieve health insurance coverage for all Coloradans through a variety of public and private mechanisms by 2007.
2.	To take interim steps to optimally meet the needs of Colorado's medically underserved and to phase in affordable coverage solutions for those most in need.

In order to reach these goals, the Coalition has developed Healthy Colorado. This is a plan designed to ensure that all Coloradans have access to affordable, comprehensive, quality health insurance coverage. It is a plan that was developed by and for Coloradans. It reflects the preferences and advice CCMU heard from more than 1,000 Coloradans who attended town hall meetings around the state and gave their input on how best to provide coverage for all. The plan also takes into account research on what we know about the uninsured and what works and doesn't work in getting people covered.

The paper briefly reviews the extent and nature of the problem of the uninsured and underinsured in Colorado. It sets out the organizing principles CCMU used in developing the Healthy Colorado framework and presents the basic components of the plan. It looks at basic benefit packages that might be offered through Healthy Colorado, the general administrative structure for the program, and cost considerations and possible funding sources. Finally, the paper discusses the next steps CCMU intends to take in order to realize its goal of health insurance coverage for all Coloradans.

This paper is intended to stimulate public discussion about the best way for Colorado to ensure that everyone in the state has access to affordable, comprehensive, quality coverage. The Coalition welcomes comments on the following questions:

- What do you think about the CCMU organizing principles for a plan for Colorado that are set out in this paper?
- What is your reaction to the proposed Healthy Colorado policy framework and plan components presented in this paper?
- As CCMU proceeds to work on the details of the plan, what specific questions should it address first?
- What other comments or concerns do you have?

Please send your comments to Anita Wesley at CCMU, 7351 Lowry Blvd, Denver 80203 or e-mail them to anita_wesley@cms.org.

II. Background

1. The Problem

It is estimated that there are between 600,000 and 700,000 Coloradans who, at any given time during the year, are uninsured. The main reason most people are uninsured is that they cannot afford coverage. They earn too little to afford to buy coverage on their own and too much to qualify for government-sponsored insurance programs such as Medicaid or the Child Health Plan Plus (CHP+).

Unless a low- or moderate-income family receives a government subsidy or employer contribution, most cannot afford the \$6,000-\$7,000 a year it costs a family to buy the typical comprehensive health plan sold in the market. (See Table 2 for a description of the typical expenses for two average low-income Colorado families of four.)

Table 2 Average Annual Expenditures for a 4-Person Colorado Household With Mean Annual Incomes of Just Under 100% and 185% of the Federal Poverty Level, 1997		
Annual Income After Taxes	\$12,904	\$14,230
Essential Expenditures (except health care):		
Food	\$4,607	\$4,899
Housing (including child care)	\$7,766	\$9,547
Apparel & services	\$1,228	\$1,568
Transportation	\$3,755	\$6,569
Education (including school supplies)	\$165	\$328
Cash contributions (including alimony and child support)	\$58	\$535
Insurance, pensions	\$666	\$2185
Total Annual Expenditures on Essentials (excluding health care and other miscellaneous expenditures, such as entertainment)	\$18,245	\$25,631
Mean Annual Income Left after Expenditures on Essentials	-\$5,341	-\$1,401

Source: Glazner, 2000.

At the same time, most low-income non-elderly adults in Colorado do not qualify for Medicaid (the state's main public insurance program for low-income persons) either because their incomes exceed Medicaid guidelines or because they do not have dependent children or are not blind, disabled, or pregnant. (See chart at the end of this report, "Nonelderly Coloradans with Incomes Below 250% of the Federal Poverty Level (Affordability Level), by Eligibility for Public Insurance.") Compared to other states, Colorado has among the most stringent categorical, income, and asset test requirements for Medicaid eligibility in the country. As a result, just 4.9% of non-elderly Coloradans are on Medicaid, compared to a national average of 10.6% (Hoffman, 2000). Table 3 lists some of the key characteristics of uninsured Coloradans.

Table 3
What Kinds of People Make Up Colorado's Uninsured?

- 80.9% of uninsured adults are employed. Of those who are employed and uninsured, more than half are employed full-time, full-year but in most cases are not offered coverage at the work place.
- Persons working for very small Colorado firms (less than 25 employees) are the most likely to be uninsured and account for 45.6% of all uninsured working adults in Colorado. Persons working for a firm with fewer than 25 employees have a better than one-in-four chance of being uninsured.
- 30.7% have incomes under the federal poverty level, which is equivalent to an annual income of \$8,950 for a single person and \$17,650 for a family of four.
- More than half of Colorado's uninsured have incomes under 200% of the federal poverty level.
- Nearly a fifth are young adults ages 18 to 24. Very few (0.8%) are age 65 or older, because most seniors are covered by the federal Medicare program.
- Two-thirds of Colorado's uninsured are white.

Sources: U.S. Census Bureau and 1998 Medical Expenditures Panel Survey.

2. CCMU's Healthy Colorado Now Initiative

In 2000, CCMU set in motion the Healthy Colorado Now Initiative. The purpose of the Initiative is to uncover the best options and build the will to provide access to affordable, quality health care and preventive programs for all Coloradans by 2007.

The Coalition kicked off the Initiative by sponsoring 20 town hall meetings throughout the state during the fall of 2000. More than 1,000 people attended the meetings. The purpose of these meetings was to provide information about the problem of the uninsured in Colorado, to ask for local input on how best to provide coverage for all, and to find out what characteristics of a reformed system Coloradans desired most (e.g., choice, access, affordability, etc.).

Table 4
Most Important Features of a Plan to Cover All Coloradans,
CCMU Town Hall Meeting Findings, Fall 2000

Cover everyone	39%	Features that facilitate access to health services*	11%
Choice of plans and providers	33%	Features that are other administrative or Coverage aspects of an insurance plan	10%
Low administration	23%	Cost containment	9%
Accessibility	19%	Use of existing systems and programs	8%
Basic set of benefits	16%	Equity	6%
Portability	16%	Quality	5%
Prevention	15%	Fair and timely reimbursement	5%
Affordability	14%	Cover children	5%
Personal responsibility	13%		

* For example, off hours, no stigma, provider acceptance, accessible providers, incentives for appropriate utilization, etc.)

The results of the town hall forums were published in a report that CCMU issued in January 2001, called "Healthy Colorado Now: Coloradans Preferences and Advice Around Health Insurance Coverage for All." Table 4 shows the features that participants said were the most important to include in a plan to ensure access to affordable coverage for all Coloradans.

When asked to rank different options for achieving access to affordable coverage for all, Coloradans attending the town hall meetings ranked them as follows:¹

Table 5 Coloradans' Ranking of Options to Achieve Coverage for All, CCMU Town Hall Meeting Findings, Fall 2000	
<u>Option</u>	<u>Percent Ranking as 1st or 2nd choice</u>
• Single payer but not necessarily single delivery system	66.6%
• Expand existing programs	59.9%
• Provide refundable tax credits for the purchase of health insurance	32.1%
• Require individual proof of coverage and create a comprehensive safety net plan	22.7%
• Establish an employer pay or play system	21.9%

Further analysis of the feedback CCMU received from a survey of town hall meeting participants indicated:

- The ranking of options did not differ significantly by the occupation, age, gender, or health status of those filling out the survey.
- Both single payer and tax credit advocates often selected expand existing programs as their second or third choice.
- While about one-third of town hall meeting participants picked single payer as their first choice, another 10-20% voiced strong opposition to this option.
- Many who ranked tax credits low did so because they thought tax credits were not an effective way to ensure coverage for low-income uninsured families.
- While there was strong support for a basic benefits package, people had different ideas of what this meant to them.
- A number of people said no one option was perfect and recommended that CCMU put together a hybrid taking the best pieces from the various options to create a Colorado-specific plan.

¹ For more information on the options, see Yondorf, 2000.

III. Organizing Principles for a Plan to Ensure Coverage for All

Based on the public input it heard at the town hall meetings, the next step CCMU took as part of the Healthy Colorado Now Initiative was to develop a list of organizing principles to be used in shaping a plan for coverage for all. The organizing principles are listed below:

Table 6 CCMU Organizing Principles for a Colorado Plan for Coverage for All	
•	Develop a Colorado-specific solution that responds to the needs and concerns of different stakeholders, and that takes into account feedback from the town hall meetings concerning Coloradans' core values and preferences.
•	Develop a plan that crosses partisan and ideological boundaries.
•	Develop a plan for <u>all</u> Coloradans that ensures everyone has access to quality, affordable coverage.
•	Build on and improve existing, successful private insurance and public coverage programs, but don't disrupt arrangements that are working well.
•	Maximize the cost-effective use of limited dollars. Leverage new and existing funds to the extent possible. Simplify and streamline. Emphasize best practices.
•	Put a priority on getting coverage for low-income, uninsured persons who don't currently have access to affordable coverage.
•	Push for substantial incremental reforms that further the vision of health care for all, rather than trying to reform the whole system all at once or making marginal reforms only.
•	Recognize that with a hybrid-type plan that has several different components, the plan will be successful only if <u>all</u> of the components of the plan are implemented.

Using these principles, the Colorado Coalition for the Medically Underserved drafted the basic outlines of a policy framework to ensure coverage for all Coloradans. It is based on the values and preferences that Coloradans voiced at the town hall meetings and the organizing principles listed above.

Before going on to describe the policy framework and plan components, a few caveats should be noted:

- What is being presented is a basic policy framework only. Once a general consensus has been reached in support of the framework, the details of the plan will need to be worked out. This will require close collaboration with all stakeholders, including consumers, business, providers, insurers, government officials, and others.
- The proposal does not, at this time, constitute an official, final policy position on the part of CCMU as to exactly how the state should ensure that all Coloradans have access to affordable coverage. Rather, CCMU is putting forth this proposal in the belief that it best addresses the diverse concerns and values of Coloradans in dealing with the problem,

and in order to get public feedback so that the proposal can be refined. The Coalition is interested in hearing suggestions as to how the proposal could be improved.

- The policy framework that is being put forth will put affordable coverage within reach of all Coloradans only if all the component programs are implemented. The proposal stands or falls as an integrated plan and no one piece can be removed without jeopardizing the goal of coverage for all.

IV. Policy Framework and Plan Components of Healthy Colorado

There are three basic components to the Healthy Colorado proposal that CCMU is putting forward for public discussion and feedback:

Table 7 Healthy Colorado Policy Framework: Basic Components	
	1. Expand existing private health insurance and public coverage programs by:
a.	Providing refundable tax credits to uninsured persons for the purchase of coverage;
b.	Expanding eligibility for the Medicaid and CHP+ programs and giving low-income uninsured persons the choice of enrolling in these programs or using a refundable tax credit or risk-adjusted coupon to purchase private coverage;
c.	Making tax credits available to uninsured small employers to encourage them to offer their employees coverage; and
d.	Shoring up the safety net for those unlikely to be reached by the programs listed above.
	2. Establish a prescription assistance program for those who do not have and cannot afford prescription drug coverage, called ColoradoRx.
	3. Establish a <i>voluntary</i>, universal health insurance program called the Personal Responsibility Option for Colorado (PRO-Colorado).

The following sections briefly describe each of the components of the policy framework. As was noted earlier, this is only a general policy framework. The details of how each of the components would be implemented have yet to be worked out. CCMU is interested in securing widespread public support for the basic policy framework first, and then working with stakeholders on the details of the plan. Key questions that would need to be addressed before implementing the plan are listed at the end of each of the plan component descriptions.

1. Expand existing private insurance and public coverage plans

Although the current private-public health insurance system is far from perfect, it does appear to work for most people. While it is true that one in seven Coloradans is uninsured, it is also true that the remaining six out of seven (84.2% of the population) get their coverage either through the private health insurance system (68.2%) or through public insurance programs such as Medicaid, Medicare, or CHP+ (16.0%). (U.S. Census Bureau, 1997-1999)

Most of those who are uninsured are uninsured because they have low or moderate incomes, cannot afford the entire cost of private insurance on their own, are not offered insurance at the work place, and are not eligible for publicly-subsidized insurance. Healthy Colorado proposes to

deal with this problem by reducing the effective price people in this “gap group” face, thus making it possible for them to afford coverage in either the private or public health insurance systems. The plan does so through the provision of refundable tax credits and coupons for the purchase of private coverage, and through the expansion of eligibility for public programs for the very low-income uninsured. It also shores up the safety net for those who may continue to fall between the cracks.

A key component of the first major element of Healthy Colorado is choice. As is discussed in more detail in the following sections, low-income persons needing a subsidy in order to afford coverage could opt to either use a tax credit, get a coupon to purchase private coverage, or join a public program such as Medicaid or the child health plan. Under all options, they would receive the same subsidy and thus could select the mechanism for coverage best suited to their circumstances.

a. Provide refundable tax credits to the uninsured for the purchase of private coverage

Under this provision of the plan, uninsured Coloradans below a certain income level would be entitled to a refundable tax credit to cover part of their cost of purchasing coverage. A refundable tax credit is a type of tax credit whereby if the value of the credit exceeds a person's tax liability he can apply for a refund from the government for the difference. Those uninsured persons with higher incomes for whom the cost of coverage exceeded a certain percentage of their income (e.g., 7%) would also be eligible for a credit for that portion of their cost exceeding this percentage. Persons between 55 and 64 years of age who do not have access to group insurance are most likely to fit into this category. This is because individual health plans are age-rated and tend to be particularly expensive for older persons (e.g., \$5,760 per year for a 60-year-old under a comprehensive PPO plan with a \$500 annual deductible).

The size of the credit would vary based on income or could be a flat amount.

A health insurance refundable tax credit would be most likely to help working uninsured families where there was at least one full-time worker who could adjust the amount deducted from his paycheck to account for the refundable tax credit he is due. Provisions may have to be made to allow people to take their tax credit at the time they purchase insurance rather than waiting until they file their annual income tax return. It would also be important to make sure that the credit could be used only for the purchase of health insurance coverage—a concern expressed by several town hall meeting participants.

Tax credits are included in Healthy Colorado for several reasons. One is that nearly a third of those who participated in the town hall meetings said this was either their first or second choice for how best to achieve coverage for all. Another is that tax credits are very easy to administer. Colorado already has in place a tax collection and refund system that would be used to administer the program. Also, this approach allows the individual receiving the credit to pick the plan that best fits his needs.

The primary drawback of relying on refundable tax credits to ensure coverage for all is that studies show that tax credits do not work well for very low-income uninsured individuals, for those who don't owe taxes or normally file returns, or for those who change jobs frequently or work part-time (Feder, 1999). To address these concerns, this proposal gives low-income uninsured families the choice of a refundable tax credit, a risk-adjusted coupon that can be used to purchase coverage, or enrollment in an expanded Medicaid or CHP+ program. This is discussed in more detail in the next section. The plan also allows the tax credits and coupons to be applied toward coverage provided

through PRO-Colorado, a voluntary universal health program that is described later in this paper.

Key questions:

- Up to what income level should people be eligible for a refundable credit?
- How much should the tax credit be? Should the value of the credit be based on income, declining as income increases, should it be a flat amount, or should it depend in part on the cost of coverage?
- Should only the uninsured be eligible for the credits or should all people with the same incomes be eligible?
- What types of insurance plans should be eligible for a credit—all plans, only plans that provide at least a floor of benefits, or only plans where there is risk pooling?
- How can we make sure people are able to take advantage of the credit when they need it (i.e., when their premium payments are due)?
- How can we make sure that currently insured persons don't drop their coverage in order to qualify for the credit?
- How would people make their selection between taking a tax credit, getting a coupon, or enrolling in Medicaid or CHP+? Could a person switch from one option to another? If so, under what circumstances and how often?

a. *Expand eligibility for existing public insurance programs and allow low-income uninsured persons a choice of enrolling in one of these programs or getting a tax credit or coupon to purchase coverage on their own.*

This provision of the plan is designed to meet the needs of the very low-income uninsured. These are people who, given their other basic needs expenses for such things as housing, food, clothing, heat, electricity and transportation simply cannot afford the full cost of coverage on their own. To make coverage affordable, they need substantial subsidies. Because tax credits are unlikely to be an effective means of helping many of the people in this category (see discussion above), Healthy Colorado would offer them a choice of other ways to get a subsidy. In addition to the tax credit option, they could also get coverage through an expanded Medicaid or CHP+ program. They would also have the option of getting a risk-adjusted coupon that they could use to buy private coverage.

Eligibility for Medicaid would be increased to include anyone with an income below a certain amount (e.g., 100% or more of the federal poverty level). Currently the only uninsured non-elderly persons who are eligible for Medicaid are pregnant women with incomes under 133% FPL, the parents of Medicaid-eligible children with incomes under 36% of the FPL, and certain disabled persons. In part because of Colorado's strict eligibility requirements for Medicaid, two out of five non-elderly Coloradans with incomes under the federal poverty level are uninsured ("Snapshots," 2000).

Eligibility for Child Health Plan Plus (CHP+) would be expanded from the current 185% FPL to 200% or 250% of the federal poverty level. The state would also take advantage of the federal option to include parents in the program. As noted earlier in this paper, a number of town hall meeting participants said that coverage of all children should be a priority. Among uninsured children in Colorado, 67.5% live in families whose annual income is under 200% FPL (equivalent to \$35,300 per year for a family of four) (U.S. Census Bureau, 1997-1999).

Asset tests for public coverage programs would be loosened or eliminated to promote administrative streamlining, reduce bureaucracy, and ease access to coverage.

Another part of the move to expand eligibility for and ease the enrollment process in public insurance programs would be that the state would seriously look at moving from its current fixed, traditional benefits packages for Medicaid and CHP+ to an Oregon-style prioritized benefits list. (For a description of an Oregon-style prioritized benefits plan, see Part V, Covered Benefits.) This would have several advantages. First, it would ensure that proven cost-effective treatments were covered by the plan. Second, it would put in place a systematic, rational process for determining what is and isn't covered. Third, it would allow for the same benefits package to be offered or subsidized in the private sector, with higher copays imposed as one goes down the prioritized list. (See discussion under PRO-Colorado.) Fourth, it would provide a mechanism for controlling costs that ensured that everyone always had coverage for the most important and most effective services.

A major advantage to the state of expanding eligibility for existing public programs is that these programs qualify for anywhere between a dollar-for-dollar to a two-for-one federal-state match. Thus, the federal government would pick up a substantial share of the cost of the expansion, and millions of additional dollars would flow into the state to invest in the health care of all Coloradans.

In order not to "force" people who need a subsidy into a public program to get a subsidy, very low-income persons could instead choose to get a refundable tax credit or risk-adjusted coupon that they could apply toward the purchase of private coverage. The coupon would need to be risk-adjusted rather than being a fixed amount so that the state would not end up over-paying or under-paying for private coverage, since private coverage is less expensive for healthier and younger individuals and more expensive for older and sicker ones. Under no circumstances would the value of the tax credit or coupon exceed the cost to the state of providing coverage under Medicaid or CHP+.

Key questions:

- To what income levels should eligibility for Medicaid and CHP+ be raised?
- What new eligibility categories should be added (e.g., allowing the parents of CHP+ children to join the program)?
- Should the state move to an Oregon-style prioritized benefits plan for its Medicaid and CHP+ programs?
- What administrative streamlining features should be included in Medicaid and CHP+?
- How would providers be assured of timely and adequate reimbursement under the expanded public programs?
- What steps would need to be taken to make sure there were an adequate number of providers around the state participating in CHP+ and Medicaid?
- How would people make their selection between enrolling in Medicaid or CHP+, taking a tax credit, or getting a coupon? Could a person switch from one option to another? If so, under what circumstances and how often?
- What kinds of plans would qualify for a tax credit or coupon?

b. Provide tax credits to currently uninsured small employers with disproportionately large numbers of low-income employees

Under this provision, very small employers who do not currently offer health insurance and who have a disproportionately large number of low-income employees would be eligible for a tax credit if they made coverage available. A very small employer might be defined as one that has 25 or fewer employees or might also include larger firms. The credit would be based on the number or proportion of low-wage employees or currently uninsured employees who sign up for coverage. The purpose of the small employer tax

credit would be to increase the availability of employer-sponsored insurance, since this is one of the most effective and efficient means of expanding coverage. Studies show that more than 80% of employees sign up for health insurance when it is offered at the work place (Cooper and Schone, 1997).

The reason for targeting the tax credit to very small employers is that their workers account for a disproportionate share of the uninsured in Colorado. More than a quarter of uninsured working adults employed by Colorado firms with 25 or fewer employees are uninsured. In large firms with more than 1000 employees, the figure is 10.8% (U.S. Census Bureau, 1997-1999). Also, while 85-100% of private establishments with more than 25 employees currently offer coverage, just 48% of Colorado firms with 25 or fewer employees do so (1998 Medical Expenditure Panel Survey). Targeting very small employers, particularly those with large numbers of low-wage employees, should stimulate more private sector coverage.

Key questions:

- What should the size of the credit be?
- What firms should be eligible for the credit—very small firms only, those with a disproportionate share of uninsured low-income employees, other?
- For how long after a small employer starts offering coverage should the firm be entitled to claim the credit?
- Does the credit need to be refundable in order to help firms that don't pay taxes?
- What requirements, if any, should there be on the type of coverage an employer could offer and still be eligible for a credit? For example, would a catastrophic coverage-only policy qualify?
- To qualify for a credit, would the employer have to make some minimum contribution to coverage (e.g., 75% of employee and 50% of dependent coverage)?
- How do we keep very small firms who are already offering coverage from dropping coverage in order to then reoffer it and claim the credit as a formerly uninsured employer?
- Is there a way for small employers to get the dollar value of the credit at the time their premium payments are actually due rather than having to wait until they file their taxes?
- To pay for the tax credits, could we get the federal government to share the expense of the tax credit or use moneys that would otherwise go toward subsidizing public insurance for uninsured workers?

c. *Shore up the safety net*

Although implementation of all the component programs of Healthy Colorado should result in all Coloradans having access to affordable coverage, this does not mean that everyone will in fact be covered at all times. Inevitably some people will fall between the cracks. For example, some people with serious mental health problems or severe drug or alcohol problems might fail to fill out the forms necessary to obtain coverage. Also, persons who are homeless or transient who do not have a permanent address might not sign up for coverage or might have difficulty doing so. It is also possible that a person who is temporarily uninsured might experience a catastrophic medical event during a period of temporary uninsurance. And there likely will always be some people who are simply unaware that they can get affordable coverage and thus don't sign up for it.

For people who fall between the cracks, it is important that even if they don't have coverage, they can still get medically necessary, affordable care. Therefore, Healthy Colorado would ensure that there is a comprehensive, adequately funded network of safety net providers across the state. To encourage people to sign up for insurance

coverage rather than relying on the safety net, required out-of-pocket costs for care through the safety net would be higher than if the same person enrolled in an affordable coverage plan.

Implementation of Healthy Colorado will also not mean that the whole problem of an adequate delivery system in all parts of the state will be solved. People could have insurance coverage and still have trouble accessing care if providers are not available where they live. This may be a particular problem in rural and economically depressed areas of the state. To deal with this, Healthy Colorado would continue to ensure that direct subsidies are provided to community clinics and other providers in traditionally underserved areas of the state to ensure availability of care.

Key questions:

- What incentives to encourage people to enroll in an affordable insurance plan can be built into Healthy Colorado in order to try to minimize the number of people who might still need safety net services?
- What are the current holes in the safety net that need to be filled (e.g., specialty care)?
- What kinds of reductions in bad debt, charity and indigent care can providers expect to see from the other provisions to reduce the numbers of uninsured that are included in Healthy Colorado? How much of these savings could be applied toward plugging holes in the existing delivery system and how much could be used to help offset the costs of the plan's subsidized health insurance programs?

2. Establish a prescription drug assistance program—ColoradoRx

Under this provision, Colorado would set up a prescription drug assistance program for persons who do not have and cannot afford prescription drug coverage. The purpose of ColoradoRx would be to make sure that all Coloradans have access to affordable prescription drug coverage.

The problem of affordable prescription drug coverage is particularly acute for many of Colorado's seniors and disabled persons. Although virtually all seniors and many disabled Coloradans have health care coverage through the federal Medicare program, the traditional Medicare program does not cover prescription drugs. Only if a Medicare beneficiary's income is so low that he qualifies for Medicaid is he entitled to prescription drug coverage. Otherwise, his options are to: sign up for a Medicare managed care plan that provides a drug benefit, if such a plan is available locally; buy an expensive Medicare supplemental policy that includes prescription drug coverage; or pay for all drug costs out-of-pocket. For some seniors and disabled persons on limited incomes, prescription drug costs can run hundreds of dollars or more each month, eating up a third or more of their incomes.

The Healthy Colorado prescription assistance program would cover all proven, cost-effective, medically necessary prescription drugs. Enrollees would pay a flat annual enrollment fee (e.g., \$25 per person per year) and would be expected to pay at least a nominal copayment for each of their prescriptions. Incentives would be built into the system for covered individuals to buy and for their doctors to prescribe the least-cost, medically appropriate drugs. The state would work with the pharmaceutical industry and pharmacists to negotiate discounted payments. The total value of the pharmaceutical benefit might have to be capped, as it is in most other states, to control program costs.

Key questions:

- Up to what income level should persons be eligible for the program?

- What kinds of enrollment fees, copays and deductibles should eligible persons be required to pay?
- What could the program do to control prescription drug costs?
- Should the program have an assets test?
- Should persons who are eligible for but fail to enroll in an available Medicare managed care plan that covers prescription drugs be prohibited from enrolling in ColoradoRx?

3. Establish a *voluntary* universal health plan—the Personal Responsibility Option for Colorado (PRO-Colorado)

This component of Healthy Colorado attempts to be at least partially responsive to the interest in a single payer plan CCMU heard expressed among significant numbers of town hall meeting participants.

Healthy Colorado provides for a voluntary rather than a mandatory universal health insurance-type program.

The program is not being proposed as a mandatory system for several reasons. First, while significant numbers of people at the town hall meetings voiced their preference for a single payer system, 15-20% of Coloradans stated their unequivocal opposition to such an approach. Second, in order for Colorado to establish a mandatory single payer system, it would either have to raise taxes by as much as 300% or mandate that business and individuals contribute to coverage for all. While it is possible that these new costs might be substantially if not entirely offset by savings from current expenditures for health care, neither a massive tax increase nor an employer or individual mandate appears to be politically viable at this time. Relatively few town hall meeting participants supported either an individual or an employer mandate. Third, if Colorado were to set up a true, universal coverage program, it might be difficult to keep sick people from moving to Colorado to get coverage. Some firms might also avoid locating in Colorado in order to avoid having to contribute to a universal plan, although others might value the administrative simplicity of the program and appreciate not having to deal with health benefits issues.

Healthy Colorado addresses both the substantial interest in and the concerns about a universal health plan such as single payer system by creating a voluntary universal insurance-type plan, called the Personal Responsibility Option for Colorado (PRO-Colorado).

PRO-Colorado would look similar to the Federal Employees Health Benefit Plan. Participants in the plan would have a choice of private health insurance plans (such as Kaiser, Anthem Blue Cross/Blue Shield, Aetna, Colorado Access, etc.). At least one of the plans would cover most or all of the current safety net providers so that people who were used to seeing those providers could enroll in PRO-Colorado and continue to see the same providers. Plan choice would be an important component of PRO-Colorado. Not only would this stimulate competition but it would also give tens of thousands of Coloradans with employer-sponsored insurance who do not have it now a choice of plans. Currently, only about 18.5% of Colorado employers who provide health insurance coverage offer two or more plans (Branscome 2000).

PRO-Colorado would be privately administered. Like the employer health insurance purchasing cooperative sponsored by The Alliance here in Colorado or the Pacific Business Group on Health in California, government would not administer the program but would authorize a private entity to do so.

Employers could decide whether or not they wanted to enroll their employees into PRO-Colorado. In order to join the program, they would have to agree to continue to make the same contribution to employee coverage under the program that they did before joining PRO-Colorado. For those employers who join the program but who did not previously offer coverage, a minimum contribution level would be set. Employers could make their contribution either as a percentage

of the total premium for their employees' coverage or as a defined contribution. To keep employers from dropping in and out of the program, those who left the program might be prohibited from re-enrolling for some given period of time (e.g., three to five years) if their group had substantial health problems.

Under the program, a formula would be developed for limiting the amount by which an employer's contribution could increase each year. A major focus of PRO-Colorado would be on cost containment—a key concern of Coloradans generally and employers in particular. Administrative streamlining, a carefully constructed benefits package, linking subsidies to the least cost plans, incentives for personal responsibility and health maintenance/promotion, value-based purchasing, and other cost containment elements would all be prominent features of the plan.

The employee share of premiums would be paid through payroll deductions. However, low-wage employees would be eligible to have some or all of their share of the premium subsidized, if the cost of coverage would otherwise be prohibitive. Individuals and small businesses eligible for the tax credits, coupons, and public program subsidies discussed earlier in this paper would be able to apply them towards the purchase of coverage through PRO-Colorado.

Persons enrolled in PRO-Colorado would have the ability to stay in the program and on their plan of choice indefinitely. For example, if a person was laid off from his job, he and his family could continue to stay in the program so long as they continued to pay premiums. If the family's income dropped to the point where they qualified for a tax credit, the credit could be applied toward their premium payments in PRO-Colorado. If their income dropped so low that they became eligible for Medicaid or CHP+, they would have the option of staying in PRO-Colorado and having Medicaid or CHP+ make the same contribution to their coverage as if they enrolled directly in either of those programs.² If a person who had been enrolled in PRO-Colorado changed jobs, he could continue in PRO-Colorado even if his new employer did not provide coverage through PRO-Colorado. In this situation, the new employer would not be required to join PRO-Colorado but would be required to contribute exactly as much to the employee's coverage under PRO-Colorado as he contributed to his regular plan. The result of these provisions would be that individuals would have true insurance portability—they could continue on the same plan regardless of job or income changes, divorce or remarriage, or other events in their lives.

PRO-Colorado would pay competitive commissions to agents who enrolled employer groups in the program.

PRO-Colorado might offer an Oregon-style plan of prioritized benefits. (See Part V for a description of the Oregon prioritized health benefit list.) Copayments and coinsurance could be structured so that as one went down the prioritized list of diagnosis-treatment pairs from the most to the least beneficial in terms of improving or maintaining an individual's health, the copayment the covered person would have to pay would increase. This would ensure good coverage for the most effective interventions. It would also allow for cost controls to be administered on the basis of community values and data on the clinical effectiveness of various medical interventions.

Finally, one of the most important features of PRO-Colorado is that it would promote personal responsibility. Among other things, PRO-Colorado would require everyone to contribute something toward the cost of their own care and pay at least a nominal copayment towards the services they receive. The program would charge discounted premiums to people who actively took steps to improve or maintain their health. Examples might include such things as exercising regularly, keeping children up-to-date on their immunizations, following the recommended course

² Ultimately the goal would be to bring the Medicaid and CHP+ programs into PRO-Colorado, in order to get greater economies of scale and foster ease of transition of individuals between and among programs. It might, however, be necessary to keep the risk pools for the Medicaid and CHP+ programs separate from the regular PRO-Colorado risk pool of employers and employees.

of prenatal care, always requiring all automobile passengers to wear seat belts, not smoking or taking steps to quit smoking, etc.

Key questions:

- Should PRO-Colorado have just one basic benefits package that would be offered by different insurers? If so, should individuals and/or employers be able to buy additional benefits to enrich the basic benefits package?
- What kind of board or authority should oversee the administration of PRO-Colorado? Who should be on it and how should they be selected?
- Should any carrier that wants to participate in PRO-Colorado under the conditions of participation (e.g., non-discrimination, adequate provider networks, etc.) be allowed to do so, or should participation be limited?
- How should rates for the program be set?
- What additional features could be added to the program to make it more attractive to employers?
- What federal waivers might be required to implement the program?
- How exactly would the subsidy levels be determined?
- What kinds of savings might be realized from reducing the “churning” in the current system because individuals would be able to stay on the same plan over time? Would insurers invest more heavily in prevention and early intervention knowing that individuals may stay enrolled in their plan for many, many years despite changes in personal, employment or financial circumstances?

V. Covered Benefits³

The question of what benefits would be covered under Healthy Colorado has yet to be decided. More work needs to be done soliciting public opinion on the elements of a desirable and affordable package, and the costs of alternative benefit designs. This Part V looks at the types of benefit package options Colorado might consider and the key questions it would need to answer in resolving the benefit design issue.

Although there are an endless number of ways in which a benefit package might be designed, the options generally fall into three main categories: catastrophic coverage plans, traditional comprehensive major medical or managed care plans, and Oregon-style prioritized benefits plans.

Option 1: Catastrophic basic benefits plan

Catastrophic health plans are usually characterized by sizable front-end deductibles (e.g., \$5,000 or \$10,000 per year). The insured is required to pay the deductible out-of-pocket before the plan pays any benefits. The purpose of a catastrophic policy is to provide protection against the cost of treating severe or lengthy illness or disability. It is not intended to cover routine care.

Several people at the town hall meetings said that the minimum benefits package to which all Coloradans should have guaranteed affordable access should be a catastrophic policy.

A catastrophic basic benefits plan has several appealing elements. It would be relatively inexpensive to ensure that everyone has access to an affordable catastrophic plan. Catastrophic coverage for all would guarantee that everyone had coverage in the event of a severe or lengthy illness. Such coverage would also help Colorado hospitals to defray some of the high unreimbursed hospital emergency room expenses that they currently incur on behalf of the uninsured.

At the same time, providing only catastrophic coverage in a basic benefits package has several major drawbacks. A catastrophic plan does not cover preventive or primary care—two of the most cost-effective forms of medical intervention. With catastrophic-only coverage, many currently uninsured Coloradans would still face crippling financial expenses in meeting the high front-end deductible. Also, catastrophic-only coverage may encourage people to wait until they are seriously ill before seeking care.

Option 2: Traditional comprehensive major medical and/or managed care benefit plans

A traditional comprehensive major medical or managed care plan usually requires the enrollee to pay a relatively low or no deductible, covers most of the cost of covered care after the deductible, has broad benefits, and covers routine as well as specialty and catastrophic care. Such plans can take many forms. They include indemnity policies, which pay on a fee-for-service basis and allow the insured to go to any provider for care; preferred provider organization (PPO) plans, which pick up more of the cost of care if the enrollee uses in- rather than out-of-network providers; and health maintenance organization (HMO) plans, which for the most part cover in-network care only. Such plans may also include a medical savings account feature whereby an

³ Part V does not discuss the benefits that might be offered under ColoradoRx, the prescription drug assistance program. For a brief description of the issues that need to be addressed in designing the prescription drug plan, see the discussion in Part IV.2.

employer or employee may put tax-exempt deposits into a medical savings account and use the money in the account to pay the deductible, coinsurance amounts, or other non-covered medical expenses (e.g., contact lenses). Most Colorado employers offer an HMO and/or a PPO plan.

The major advantage of using a traditional comprehensive major medical or managed care plan as the basic benefits plan for Healthy Colorado is that this is the type of coverage that most insured Coloradans have now. Thus, it would cause the least disruption to the system. Also, unlike catastrophic policies, comprehensive major medical and managed care plans typically cover preventive as well as acute care, and non-hospital as well as in-hospital prescription drugs.

There are some drawbacks to this approach. Compared to coverage under a catastrophic policy, it would be more expensive to cover all Coloradans under a comprehensive major medical or managed care plan. In addition, there is increasing concern about rising premiums for comprehensive major medical and managed care plans. Finally, such plans may not meet the full range of needs for certain groups with chronic illnesses or special needs.

Option 3: Oregon-style prioritized benefits plan

In the late 1980s, Oregon embarked on a series of initiatives designed to implement a blueprint for universal access to basic and affordable health coverage, in part through the design of a prioritized basic benefits package (“Oregon Health Plan,” 1998). An Oregon-style prioritized benefits plan is similar to a traditional comprehensive major medical or managed care plan in that it is intended to cover a substantial portion of the cost of the health care services most frequently sought or needed by enrollees. However, what is covered or excluded from the policy is not based on the type of provider-based care needed (e.g., hospital care, outpatient care, prescription drugs), nor is it based on category of illness (e.g., mental illness, heart problems, etc.). Rather, it is based on two sets of factors. The first is community values regarding the importance of various types of services. (See Table 8 for the results of the community values assessment process conducted in Oregon.) The second is an objective, scientifically-based assessment of the clinical effectiveness of various medical interventions.

Table 8	
Community Values Assessment on the Importance of Treating Various Conditions and Providing Various Health Services: Results of the Oregon Public Input and Public Health Assessment Process	
Essential Services:	
<ol style="list-style-type: none"> 1. Acute fatal condition—full recovery with treatment 2. Maternity care 3. Acute fatal condition—treatment prevents death without full recovery 4. Preventive care for children 5. Chronic fatal condition—treatment improves life span and quality 6. Reproductive health (except infertility treatment) 7. Comfort care 8. Preventative dental care 9. Proven effective preventive care for adults 	
(Table 8 continued on next page.)	

Table 8 (continued)

Results of the Oregon Community Values Assessment Process

Very Important Services:

10. Acute nonfatal condition—treatment returns patient to previous health status
11. Chronic nonfatal condition—one-time treatment improves quality of life
12. Acute nonfatal treatment—treatment improves quality of life without return to previous health
13. Chronic nonfatal condition—repeated treatment improves quality of life

Valuable to the Individual:

14. Acute nonfatal condition, self-limiting without treatment
15. Infertility services
16. Less effective preventive care for adults
17. Fatal or nonfatal condition—minimal or no change with treatment

The result is that an Oregon-style plan covers diagnosis-treatment pairs that are ranked by their priority both in terms of community values and clinical effectiveness. Examples from Oregon's current prioritized benefits list, which is used in their Medicaid program, are shown in Table 9. Oregon uses the list to determine what services it will or won't cover under the Oregon Health Plan. Currently, the program covers all diagnosis-treatment pairs through number 574.

An Oregon-style prioritized benefits list can serve several purposes. The ranking of benefits covered under an Oregon-style plan can be used as the basis for determining what should be added to or excluded from coverage when additional funds are available or services need to be cut. The Oregon Legislature decided it would include all diagnosis-treatment pairs through number 574 on the prioritized list in the Oregon Health Plan. Also, copayments can be varied, with the lowest copayment required for the most cost-effective and valued services at the top of the list and the highest required for those near the bottom.

An Oregon-style prioritized benefits package has several advantages to recommend it. First, it provides an explicit rationale for ranking different medical interventions, with a high value placed on proven clinically effective interventions and on community values about different categories of interventions. Second, it provides a rational way for determining what should be dropped from a benefits plan if not everything can be provided for everybody. Third, it obviates the need for discussions about mandated benefits. A given intervention either does or doesn't rank high on the priority list. If it does it is covered and if not it may not be.

The biggest drawback of using an Oregon-style basic benefits package for Healthy Colorado is that it would require a significant front-end investment to develop the prioritized list. Unless Coloradans believed that their values regarding the importance of treating various conditions were identical to those of Oregonians, Colorado would not simply want to adopt Oregon's list wholesale. Using an Oregon-style benefits package would also require an educational campaign to inform enrollees and providers about the new approach to benefits. In addition, if employers continued to buy and insurers continued to sell more traditional health policies, there could be some gaming of the system, with people switching in and out of an Oregon-style plan depending on what care they needed or wanted.

Table 9

Selected Examples from the Oregon Plan Prioritized List of Diagnosis-Treatment Pairs

As of October 1, 1999, with Interim modifications Effective April 1, 2001

Priority Ranking	Diagnosis--Treatment Pairing
1	Severe/moderate head injury—medical surgical treatment
2	Insulin dependent diabetes mellitus—medical therapy
10	Injury to internal organs--medical surgical treatment
12	Appendicitis--medical surgical treatment
17	Pneumonia--medical therapy
55	Pregnancy—maternity care
71	Low birth weight—medical therapy
108	Cystic fibrosis—medical therapy
119	Acute lymphocytic leukemia (child)—medical therapy (including radiation and chemotherapy)
120	Hodgkin's disease—bone marrow transplant
146	Preventive services, children—medical therapy
158	Congestive heart failure, cardiomyopathy—cardiac transplant
160	Asthma—medical therapy
163	Schizophrenic disorders—medical/psychotherapy
164	Recurrent major depression—medical/psychotherapy
172	Malignant melanoma, skin—medical surgical treatment
177	Heart failure—medical therapy
178	Fracture of hip, closed—medical surgical treatment
185	Preventive service for adults with proven effectiveness—medical therapy
186	Tobacco dependence—medical therapy, brief counseling
188	Abuse or dependence of psychoactive substance—medical/psychotherapy
192	Hypertension and hypertensive disease—medical therapy
268	Terminal illness regardless of diagnosis—comfort care
273	Cancer of the prostate gland, treatable--medical therapy (including radiation, chemotherapy)
286	Stroke—medical therapy
296	Epilepsy and febrile convulsions—medical therapy
303	Preventive dental services—cleaning and fluoride
306	Post traumatic stress disorder—medical/psychotherapy
333	Chronic hepatitis—medical therapy
337	Neurological dysfunction in posture and movement caused by chronic condition—medical surgical treatment (e.g., durable medical equipment and orthopedic procedure)
372	Rheumatoid arthritis & osteoarthritis—medical therapy, injections, arthroplasty, reconstruction
435	Treatable dementia— medical therapy
461	Migraine and tension headaches—medical therapy
505	Thrombosed and complicated hemorrhoids—hemorrhoidectomy, incision
542	Osteoporosis— medical therapy
570	Contact dermatitis—medical therapy
Oregon draws the line at 574. Nothing below 574 is covered under the Oregon Medicaid program.	
578	Sexual dysfunction—medical surgical treatment, psychotherapy
593	TMJ disorder—TMJ splints
611	Infertility—artificial insemination, medical therapy
617	Hypotension—medical therapy
685	Acute upper respiratory and common cold— medical therapy
739	Dental services (e.g., orthodontics)—cosmetic
743	[End of the list]

Additional Considerations

Regardless of what basic benefits package is used in Healthy Colorado, cost containment would be an important element. Among other things, the basic benefits plan would need to include features that promote personal responsibility, reward healthy behaviors, encourage prevention and early intervention, encourage care in the least cost appropriate setting, use disease management techniques, and foster prudent purchasing.

Whatever approach to benefits design one selects, the more generous the benefits package, the more expensive the plan will be. As noted earlier, more public input and cost analyses are needed before determining what the minimum coverage should be under Healthy Colorado. It will also be necessary to decide whether the rules for what constitutes a basic benefits package should vary based on which component of Healthy Colorado one is talking about. For example, the minimum requirements for a plan that is eligible for a tax credit may be different than those for the plan offered through PRO-Colorado.

Many additional questions about a basic benefits package will have to be answered, some of which are listed below.

Key Questions

- What should the basic benefits package cover/exclude? Should the package vary based on ability-to-pay?
- In order for a plan to be eligible for a tax credit, would it have to meet the same requirements as the basic benefits package for the PRO-Colorado plan?
- Should copays and deductibles vary based on income?
- Should people be allowed or encouraged to use medical savings accounts as part of the basic benefits package?
- Should the benefits package include different or additional benefits for special populations?
- What cost controls should the basic benefits plan include—personal responsibility features, coverage of certain drugs only, emphasis on prevention, limits on provider networks, prior authorizations for care, etc.?
- Is it viable to set up an Oregon-style plan with greater copayments as one goes down the prioritized list? Is this administratively feasible? What savings could be realized from this approach?

VI. General Administrative Structure

Healthy Colorado would not require a large new bureaucracy to administer it. The plan intentionally builds on existing private insurance and public coverage programs in order to take advantage of administrative structures that are already in place. This makes it possible to benefit from economies of scale. Likewise, the tax credit program relies on the current tax collection and refund system.

There are five areas where there may be some new administrative costs, primarily in the start-up phase. The five areas involve:

- (1) Design of and annually reviewing the basic benefits package. Colorado already has processes in place for determining the benefits provided under the Colorado Basic and Standard Small Employer Health Benefit Plans, and the CoverColorado plan for uninsurable persons.
- (2) Administration of the coupon program for those who select a coupon for the purchase of insurance in lieu of signing up for Medicaid or CHP+. Health care experts at the American Enterprise Institute have suggested that the government could mail out the coupons to eligible persons based on W-4 forms ("Tax Credits," 2001).
- (3) Setting up and operating PRO-Colorado. In setting up and operating this program, Colorado could build on the experience of purchasing cooperatives not only here in Colorado (e.g., The Alliance), but also in other states (e.g., the Pacific Business Group on Health).
- (4) Setting up and operating the prescription drug assistance program. Experience with pharmaceutical assistance programs in other states suggests they can be operated with very small staffs. For example, in 1999, Connecticut's program, which has been in operation since 1986, had a staff of just four people.
- (5) Conducting outreach activities to alert Coloradans to the components of Healthy Colorado and their eligibility for coverage. Marketing staff would work with health insurance agents, insurers, health providers, consumers, groups, business, and others to advertise the availability of the programs under Healthy Colorado and conduct other outreach and enrollment activities.

Each of these functions could be contracted out to the private sector or could be operated through independent authorities. Preliminary conversations with staff of several of Colorado's major health foundations indicate they may be willing to cover a substantial portion of the administrative start-up costs for Healthy Colorado.

VII. Costs and Possible Funding Sources

It is too early to say how much Healthy Colorado would cost. Many of the factors that will determine the final cost have yet to be resolved. Once the policy framework for Healthy Colorado has been refined through a public input process, CCMU will work with stakeholders (e.g., consumers, business, providers, insurers, etc.) to flesh out the plan's details. Only then can the plan be costed out. The key questions raised in Part IV of this paper are examples of some of the issues that would need to be resolved before a price tag could be put on Healthy Colorado.

Critical variables that will have a major impact on cost estimates include:

- What benefits are covered, how much eligibility is expanded under current government-sponsored health insurance programs, and how large the tax credit would be;
- The number and types of cost containment and personal responsibility features in the final plan;
- The extent to which the state can leverage new and existing health dollars to raise matching federal or other funds for the plan;
- The extent to which administrative costs can be minimized and bureaucracy streamlined;
- The amount that is currently spent on care for the uninsured that could be saved and redirected to Healthy Colorado;
- Assumptions about the number and types of people who are currently uninsured, and which of them would actually sign up for coverage once affordable insurance was made available to them;
- Whether Congress goes ahead and enacts a federal health insurance tax credit; and
- Whether Congress makes funds available to pay for state-sponsored prescription drug assistance programs or adds a prescription drug benefit to Medicare.

There are many possible ways to fund Healthy Colorado. Since the plan continues to rely in part on an employer-based system, it is assumed that voluntary contributions by employers would be a major source of funding for expanded coverage. For example, low-income workers who have not been able to take advantage of coverage offered at the work place because they could not afford the employee-share of cost would be able to do so under the plan because they would be eligible for subsidies to cover their share. Thus expanded coverage for this group would be paid for with a combination of dollars coming from employers who already offer their employees coverage, an affordable employee contribution, and a public subsidy to cover the balance.

It is expected that Colorado would be able to raise at least half the moneys necessary to fund the plan with federal matching dollars. For example, Colorado currently has among the strictest eligibility requirements for Medicaid and the child health insurance plan in the country (Hoffman, 2000). It could easily expand these programs to cover persons that most other states already cover and get one-for-one federal-state matching dollars under Medicaid and two-for-one federal-state matching dollars under CHP+.

To the extent that federal, state or local moneys are currently being used for the care of uninsured persons and substantial numbers of these uninsured persons get coverage through Healthy Colorado, the state should be able to redirect some of the dollars from indigent care programs to the plan. However, some funds will still have to be retained in the publicly supported community health system and may even have to be augmented in the short run. This is because some Coloradans may still fall between the cracks and continue to need indigent care. Also, parts of the state may still be underserved in terms of provider availability. (See safety net discussion in Part IV.1.d.)

In addition to the financing sources that have already been mentioned-- federal funds, individual premium contributions, foundation money to finance start-up costs, voluntary employer

contributions to employee coverage, savings from current indigent care budgets, and tax credits—there are several other sources that the state might need to tap. Possibilities include the income or sales tax, tobacco settlement fund moneys, the tobacco tax, or the insurance premium tax. Some states use a provider tax to help defray the costs associated with care for low-income persons. Certainly voter approval would be required in order to devote a portion of existing excess revenues to the plan, to authorize new taxes or fees, or to authorize increases in existing taxes or fees to pay for some of the plan's costs.

Whatever the sources of new funding for the program, the costs would need to be distributed fairly. Also, the financing formula would need to have broad public support and in no way adversely affect Colorado's business climate.

VIII. Next Steps

The policy framework presented in this paper is intended to provide a starting place for the development of a plan to ensure that all Coloradans have access to affordable coverage. In developing the framework, CCMU has attempted to respond to the diversity of thought and opinion it heard at town meetings throughout the state. Now CCMU needs to get additional feedback and input. Over the next 12 months, in order to further its vision, CCMU will engage in the following activities:

- Disseminate the town hall meeting findings. Persons interested in reading the full report on the results of the town hall meetings may do so by accessing CCMU's web site at www.ccmu.org or by calling Emily Larson at 720-858-6333 and requesting a copy of the town hall meetings report.
- Solicit community feedback on the organizing principles and proposed policy framework presented in this paper. Persons interested in participating in this process may do so in one of two ways. First, they may send their written comments to: Colorado Coalition for the Medically Underserved, P.O. Box 17550, Denver, CO 80217-0550, or e-mail comments to chet_seward@cms.org. Second, they may attend one of the upcoming regional meetings that CCMU will be holding during the fall of 2001. For more information see the CCMU web site, www.ccmu.org.
- Get public input on the design of a basic benefits package, cost out alternative benefits packages, estimate the impact on total program cost, and share this information with the public.
- Solicit the input and participation of interested organizations and individuals in helping to refine Healthy Colorado once there is general agreement on the policy framework.
- Determine the cost of and financing sources for the plan.
- Pursue foundation and federal support for planning and start-up costs.
- Take the steps necessary to implement the plan, such as enacting any legislation that may be necessary to authorize the plan, securing federal waivers, and getting voter approval.

IX. Conclusion

Healthy Colorado is a plan to ensure that all Coloradans have access to affordable, quality care. It is a plan that was developed by and for Coloradans. It emphasizes choice and builds on what works best in the current system.

The main components of Healthy Colorado include expansion of existing private insurance and public coverage programs; creation of a prescription drug assistance program called ColoradoRx; and establishment of a voluntary universal health insurance program called PRO-Colorado. A work in progress, Healthy Colorado will be refined over the coming months based on extensive feedback from groups and individuals across the state.

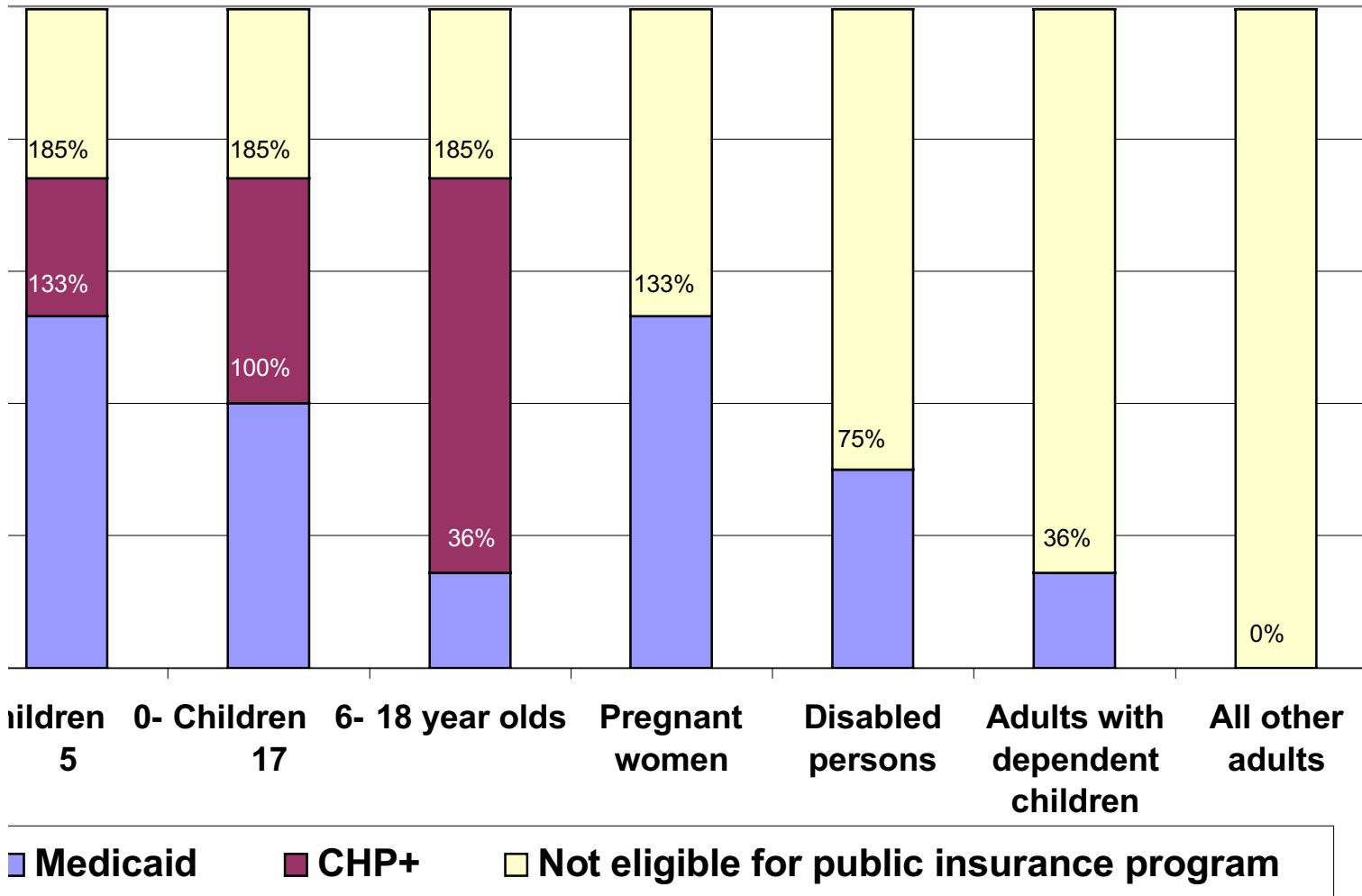
It is expected that implementation of Healthy Colorado will:

- Ensure that all Coloradans have access to affordable coverage;
- Improve the overall health of Coloradans by making sure that everyone has coverage for medically necessary care;
- Promote prevention and early intervention;
- Reduce the rate of personal bankruptcies that result from high personal medical expenses incurred by people with health insurance coverage;
- Reduce the costs of care borne disproportionately by business that are associated with paying for unreimbursed care for the uninsured;
- Reduce expensive emergency room use; and
- Infuse large amounts of new capital into the local economy.

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Nonelderly Coloradans, Incomes < 250% FPL (Affordability Level), by Eligibility for Public Insurance



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