HRSA STATE PLANNING GRANTS

INTERIM REPORT TO THE SECRETARY

SUBMITTED BY

THE STATE OF COLORADO,
OFFICE OF THE GOVERNOR

Sue Williamson
Project Administrator
303/692-2324

November 21, 2001

EXECUTIVE SUMMARY

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

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

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

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

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

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

Colorado was included in the second round of grantees to be funded and awards for the second round of grantees were announced effective March 1, 2001. The time delay between the submission of the original grant proposal and the actual grant award, together with the current economic climate and the recent, tragic events necessitated a reassessment of the data collection activities contemplated under the original grant.

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

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

The Project Management Team also works closely with the Colorado Strategic Planning Group on Health Care Coverage that was convened by Governor Owens. The Strategic Planning Group is comprised of key leaders from government, including State legislators and executive branch cabinet members. In addition, leading stakeholders from the business and health care sectors serve as members of this Strategic Planning Group. The Strategic Planning Group meetings serve as a forum by which the Project Management Team can report the progress and research findings of the grant activities. The additional questions, comments and advice offered by the Strategic Planning Group help focus and direct the subsequent efforts of the Project Management Team.

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

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

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

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

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

SECTION 1. SUMMARY OF FINDINGS: UNINSURED INDIVIDUALS AND FAMILIES

The Colorado Household Survey (2001) completed data collection on September 6, 2001. Data cleaning and editing, recoding and data imputation efforts are still underway. The following represents *preliminary data* summarizing some demographics of the uninsured. Specifically, this section analyzes the uninsured in Colorado by age, gender, race, ethnicity, geographical regions, and duration of uninsurance.

Survey Sampling and Weights

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

Combined, the thirteen "marketplaces", "65 and over", "black neighborhoods", and "low-income neighborhoods" result in 16 sampling strata. Population weights were created to account for the differing probability of selection and response rates in each of the 16 strata in the sampling design. Post-stratification weighting calibrated weights to the 2000 Census such that the survey data produce accurate state-level population estimates according to age, gender, and each of the 13 marketplaces. Additional post-stratification adjustments to weights (e.g., to calibrate weights to Census race/ethnicity distributions) are still under consideration.

Statistical Testing

The uninsurance and standard error estimates were calculated using the statistical package STATA. STATA "svy" procedures account for complex sampling designs including stratified samples. They use "linearization" based variance estimators for calculating standard errors. Failing to account for complex sampling design would result in accurate estimates of the uninsured but, in this case, underestimating the standard error. STATA calculates a Pearson statistic and a corresponding p-value for each cross-tabulation (uninsurance by age, uninsurance by gender, etc.). In addition, the analysis compared sub-population rates of uninsurance to the statewide rate to assess whether such differences are statistically significant. Here, standard error estimates for the sub-population and total population were pooled and the normal approximation to the binomial logic was used to calculate the confidence interval.

Data Analysis Results:

Point-in-Time Uninsurance Rate

The CHS 2001 used a methodology to determine insurance status based on that employed by the (revised) Current Population Survey (CPS) and the National Survey of American Families (NSAF). Respondents are asked about whether they have several specific types of health insurance: employer-sponsored, individual coverage, public programs (Medicare, Medicaid,

Child Health Insurance Plan (CHIP), etc. If they report having none of these types of coverage, they are asked to confirm whether they are uninsured. An individual is "counted" as uninsured if they respond negatively to all of the specific coverage questions AND they confirm their uninsured status in the confirmation question. This leads to a point-in-time estimate of uninsurance because it is based on those reporting to be uninsured at the time of the survey.

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

Uninsurance Rates by Duration

An estimated 7.8% of people have been uninsured for all of the past 12 months (SE: 0.6%). As expected, the rate of people persistently uninsured (uninsured for all of the past 12 months) is lower than the point-in-time uninsurance rate (11.7%). However, over two-thirds (67%) of the point-in-time uninsured have been without coverage for the past 12 months.

The CHS (2001) further estimates that 15.9% of Coloradoans have been uninsured at ANY TIME during the past 12 months (SE:0.8 %). (This latter estimate takes those people who are uninsured at the time of the survey and "adds" those who are insured now, but have been uninsured in the last year.)

Child, Adult, Senior Uninsurance Rates

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

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

Table 1: PRELIMINARY DATA
Uninsurance Rates by Children, Adults, Seniors

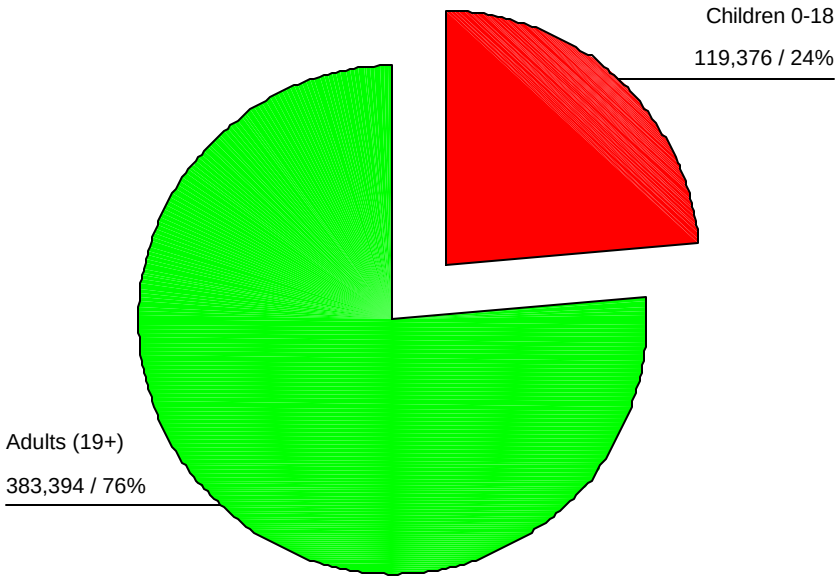
AGE GROUPS	**% Uninsured** (Standard Error)	**2000 Population Estimate**	**Sample (n)**
Children (0-17)	**9.7%** (SE: 1.2%)	**113,710**	(1972)
Adults (18-64)	**14.0% *** (SE: 0.9%)	**380,830**	(7939)
Seniors (65+)	**2.0% *** (SE:1.0%)	**8,230**	(306)
TOTAL (All ages)	**11.7%** (SE:0.7%)	**502,770**	(10,217)

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

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

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

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



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

Uninsurance by Age Groups

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

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

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

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

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

Uninsurance Rates By Age and Gender

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

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

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

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

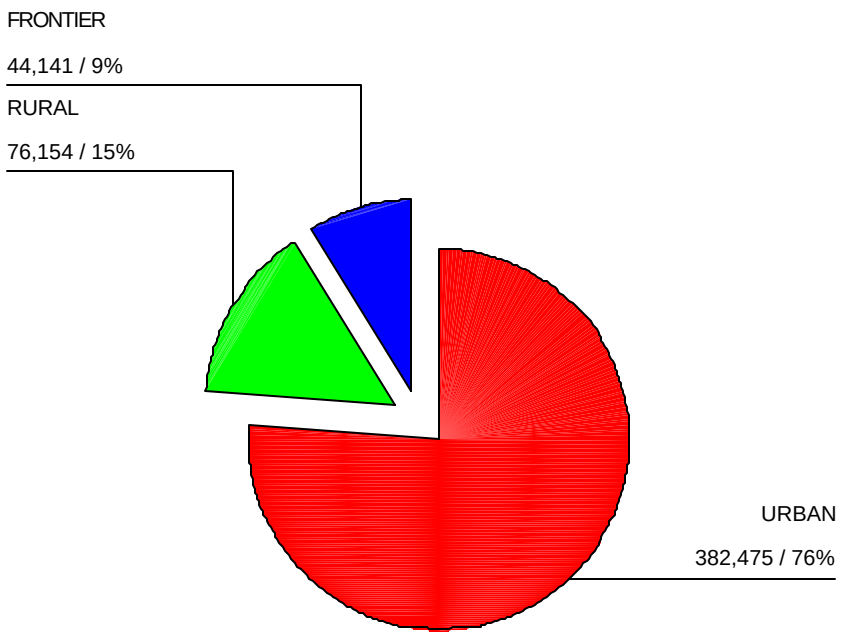
Sources: Colorado Household Survey (2001), U.S. Census Bureau (2000)

Uninsurance Rates by Region

Small and non-statewide samples limit the ability to use national survey data for regional analyses. Typically, national data can be disaggregated only into 2 or 3 large regions, such as urban, rural, and frontier, as shown in Chart 2. Since a majority of Colorado's population is found in the urban areas, it is not surprising that the uninsured concentrate in urban areas as well.

Uninsurance Rates by Urban, Rural, Frontier

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



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

The *rates* of uninsurance are higher in non-urban areas. Table 4 reveals that the average rates for rural and frontier (shaded in red) are statistically equivalent, although both rates differ significantly from urban areas and the statewide rate. This level of aggregation does not permit the study of heterogeneity within non-urban areas.

Table 4: PRELIMINARY DATA
Uninsurance by Urban, Rural, Frontier

REGION	UNINSURANCE RATE (Standard Error)	POPULATION ESTIMATE (2000)	Sample (n)
URBAN	10.7% (SE: 0.8%)	382,475	6,323
RURAL	16.3%* (SE: 1.5%)	76,154	2,066

FRONTIER	17.3%* (SE: 1.9%)	44,141	1,828
TOTAL	**11.7%** (SE: 0.7%)	502,770	10,217

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

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

Uninsurance Rates by Marketplaces

To permit testing of the hypothesis that large categories (urban, rural, frontier) mask some regional differences in uninsurance rates, the CHS 2001 oversampled rural areas. Specifically, the survey sampled 13 sub-state regions based on health care marketplaces as developed by CCHN.[1]) Marketplaces are relatively self-contained geographic units with respect to the provision of primary care services . They also consider hospital access. The survey achieved its sampling objective of obtaining at least 400 completed surveys in each region. The Mountain region had the fewest completed surveys at 410. Metro Denver had the greatest number with 3152 completed surveys.

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

Uninsurance Rates, Denver vs. Denver Metro

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

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

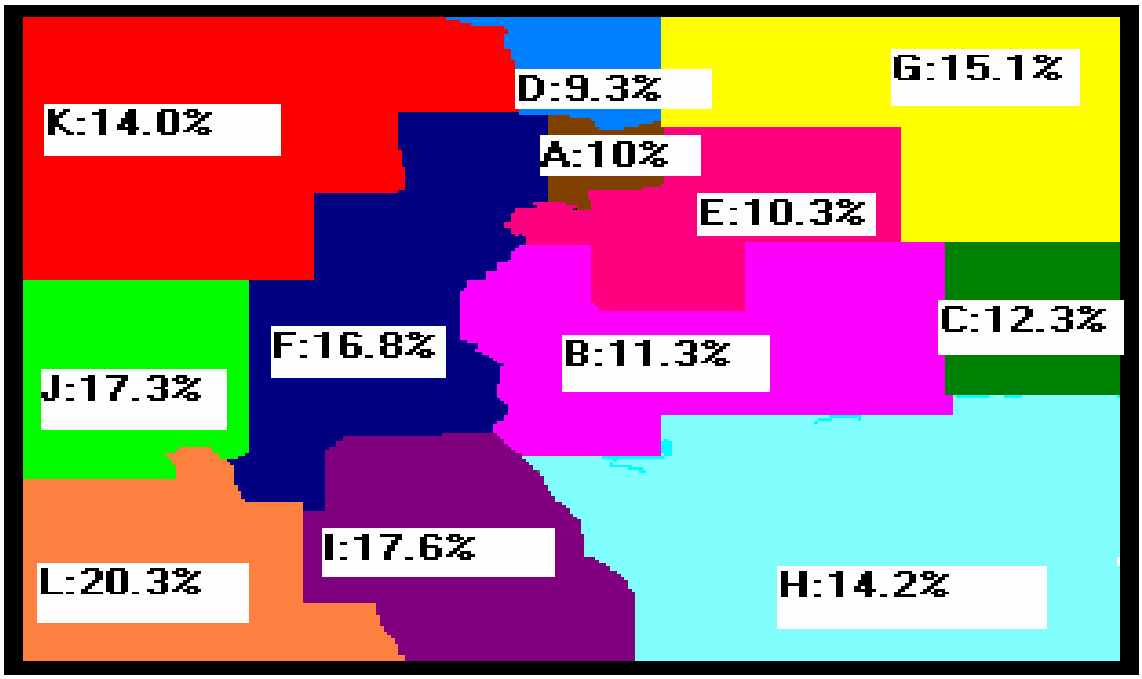


Chart 3: Uninsurance Rates by Marketplace

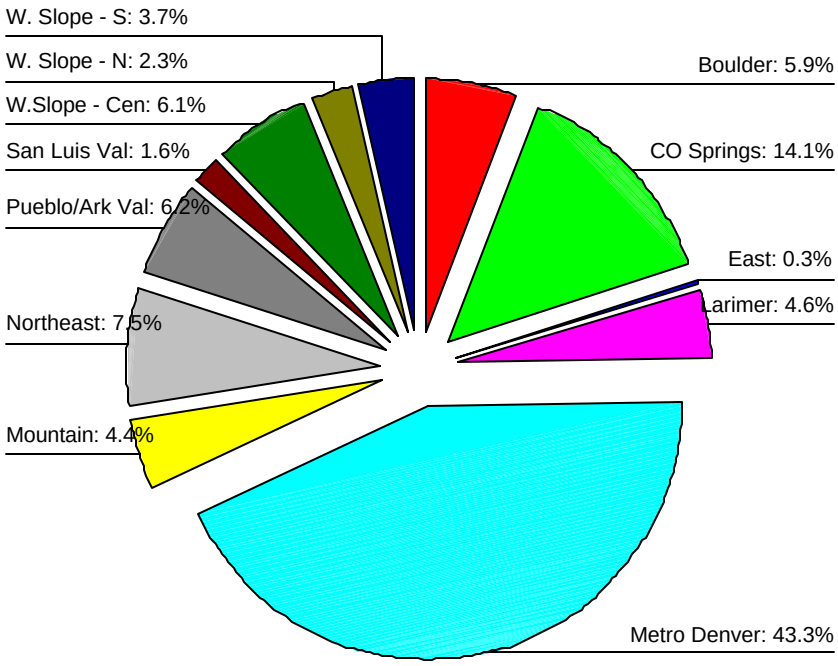
KEY:

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

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

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

Chart 4: PRELIMINARY DATA
Distribution of the Uninsured by Marketplaces



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

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

Uninsurance by Race/Ethnicity/Country of Origin

The Colorado household survey estimates significant differences in uninsurance rates by race, ethnicity and country of origin. Consistent with Census, the Colorado Household survey conceptualizes race and ethnicity as separate categories. Many respondents, however, did not distinguish the terms. In particular, many Hispanics selected the "other, specify" option in the "race" question and further explained that their "race" was Hispanic, Mexican-American, etc. Hispanics have a significantly higher rate of uninsurance 22.4% (SE: 2.2%) than non-Hispanics 9.2% (SE: 0.7%). Thus, an uninsurance analysis by race is highly sensitive to what racial assumptions are made about the large number of Hispanics (2090) in the Colorado sample. Table 5, therefore, combines race and ethnicity data into a single variable. Table 5 includes approximately 2% of respondents who "don't know" their race or refused to answer the question. An analysis of these missing values is on-going at this writing.

Table 5: PRELIMINARY DATA
Uninsurance Rates and Population Estimates, By Race/Ethnicity

RACIAL/ETHNIC GROUPS	UNINSURED RATE (Standard Error)	POPULATION ESTIMATE (2000)	Sample (n)
Hispanic	**22.4% *** (SE: 2.2%)	170,918	2090
Non-Hispanic White	**9.1%*** (SE:0.7%)	289,701	7207
Non-Hispanic Black	**8.4%** (SE: 2.1%)	10,292	354
Non-Hispanic American Indian	**20.5%** (SE: 8.0%)	5,939	85
Non-Hispanic Asian/Pacific Islander	**3.0%*** (SE: 1.3%)	2,145	116
Non-Hispanic Multi-racial	**22.3%** (SE: 6.5%)	9,968	135

Non-Hispanic Other	**7.8%** (SE: 7.2%)	986	28
Non-Hispanic Unsure	**15.4%** (SE: 4.8%)	12,821	202
TOTAL	**11.7%** (SE: 0.7%)	502,770	10,217

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

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

Uninsurance Rates by Black Subgroups

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

Table 5 notes that there were 354 non-Hispanic Blacks who responded to the survey. Their uninsured rate is lower (8.4%) than the statewide rate (11.7%) and the non-Hispanic White rate (9.1%), although these differences are not statistically significant. However, in addition to these 354 individuals, another 69 people indicated that they were multiracial including Black (32) or Black Hispanics (37). These 69 individuals are not included in the Non-Hispanic Black rate reported in Table 5. They are counted in the "non-Hispanic Multiracial" and "Hispanic" rows of Table 5, respectively.

In contrast, Table 6 examines the uninsurance rates of *all* individuals that report that they are Black or "part-Black". Table 6 divides these 421 individuals into three groups -- Non-Hispanic Black, Non-Hispanic Multiracial (including Black), and Hispanic Black-- to illustrate how these individuals are sorted into the race/ethnicity categories of Table 5. Note that the point-in-time uninsurance rate for "Blacks" is different in Table 5 (8.4%) than in Table 6 (12.9%). This difference is entirely due to a difference in defining "Black". Although these differences are not statistically significant, it does argue for exercising care with the CHS 2001 race/ethnicity data to ensure "apples to apples" comparisons.

Small sample sizes and large variances preclude a comparison of the Black subgroups to one another. (Note the large standard errors, especially for Hispanic Blacks, in Table 6.) Again, the subgroups in Table 6 are presented to facilitate comparisons to Table 5.

Table 6: PRELIMINARY DATA
Uninsurance Rates and Population Estimates, By Black Sub-Groups

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

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

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

Uninsurance Rates by Country of Origin

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

Sufficient data existed to analyze only those born in the U.S., Germany and Mexico as separate groups. Canada was also analyzed separately, but the estimate produced a large standard error. All other countries of origin were lumped into an "other country" category for analytical purposes. This "other country" category includes first and third world countries, so caution is advised in interpreting its uninsurance estimate. Subsequent analyses may further disaggregate the "other country" category. Table 7 summarizes point-in-time uninsurance rates by country of origin.

Table 7: PRELIMINARY DATA
Uninsurance Rates and Population Estimates, By Country of Origin

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

* Statistically significant @ $p<.05$, as compared to the statewide rate
NOTE: 15 records with missing country of origin data were excluded from analysis
Sources: Colorado Household Survey (2001), U.S. Census Bureau (2000)

Next Steps
As described, data cleaning and editing, recoding and data imputation efforts are currently underway. As the analysis progresses, additional data will be appended to this report. If future analyses effect assumptions made in the data published here, all tables will be updated to reflect the updated analysis.

SECTION 2. SUMMARY OF FINDINGS: EMPLOYER-BASED COVERAGE

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

How can we address the rising costs of insurance premiums for small businesses?
How can small businesses be encouraged to provide health care coverage for their employees?
Is offering just catastrophic coverage an option for employers or their employees?
What is causing small employer groups to drop their health insurance coverage?
What kind of incentives could be provided to small businesses, like tax credits, to keep them in the market?
Should employers be mandated to provide health care coverage to their employees?
What are the ERISA implications?

How do mandates contribute to the cost of businesses offering health care coverage to their employees?

HRSA Activities Presently Proposed to Address Questions:

- ✍ **13 small business employer focus groups throughout the State**

SECTION 3. SUMMARY OF FINDINGS; HEALTH CARE MARKETPLACE

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

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

HRSA Activities Presently Proposed to Address Questions:

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

SECTION 4. OPTIONS FOR EXPANDING COVERAGE

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

What available funding sources exist to expand coverage?
What efficiencies exist in using current financial resources such as leveraging Federal dollars or creating pools of money?
Is it feasible to expand coverage for public sector programs by proposed waivers to the Federal government regarding the current benefits covered under Medicaid and CHP+?

How does TABOR impact the feasibility of crafting plans that involve the expansion of existing programs?
How could administrative cost savings associated with credentialing, eligibility and the payment of claims contribute to expanding coverage to the uninsured?

HRSA Activities Presently Proposed to Address Questions:

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

SECTION 5. CONSENSUS BUILDING STRATEGY

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

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

The Strategic Planning Group has approximately 40 members. The size of the group, as well the relatively limited meeting time (two hours every month) poses a set of challenges to the process

and group dynamics. For example, how can full group participation be maximized and an interactive exchange of ideas be accomplished with that many participants and limited time? What can be done to keep the participants actively engaged in the process and create a meaningful experience that doesn't feel like "just another meeting?" How can the Project Management Team capitalize on the talents, skills and resources of the membership to formulate feasible policy options? Is there interest by the participants to subdivide into smaller working groups? Is the group committed to working beyond the end of the HRSA grant period? The Strategic Planning Group is in its infancy stages and the answers to these questions will evolve over time. However, obtaining consensus from the Strategic Planning Group is critical to advancing any policy options on health care coverage issues.

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

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

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

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

To this point, the most obvious lesson learned by Colorado is that the problems that exist in health care are extremely complex and the challenge to craft feasible policy options seems daunting. However, experts advise that when a problem seems overwhelming, one approach may be to divide it into smaller, more manageable parts. Colorado is adopting this approach. From the data collected in the household survey, sub-groups have been identified that have higher rates of uninsurance. For example, Colorado has a high percentage of uninsured people in the 18 to 25 age ranges. Presently, parents can only cover dependents over the age of 18 on their plan if the dependents are full-time college students. Colorado is studying this specific issue and sub-population group with the goal of developing strategies that will reduce the uninsurance rate for this sub-group.

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

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

SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

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