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# Health Policy for Low-Income People in Colorado

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**C**olorado, like other frontier states, places a premium on independence and self-determination. Public policymaking in the area of health care reflects the value the state attaches to

local solutions for local problems and private-sector initiatives. Efforts to reduce the size of state government and to grant more authority to localities are under way. Current fiscal policies tightly constrain public revenues and expenditures, including health care expenditures, even as the state economy surges upward.

Although Colorado is generally viewed as fiscally conservative, it has attempted broad-scale reform of its health care system. In 1992, the state legislature directed Governor Roy Romer's administration to study a proposal for universal health insurance. The proposal called for income- and payroll-tax financing and a single government-run purchasing cooperative. These two features drew a lot of fire, and the full proposal was never introduced as legislation. The state has sought since to expand insurance through private insurance reforms and its newly enacted Child Health Plan Plus (CHP+).

## State Characteristics

Relative to the national average, Colorado's population is young, fast growing, and increasingly wealthy. With a population of 3.7 million, Colorado contains only 1.4 percent of the United States's population. However, Colorado's population growth far exceeds that of the nation (13.7 percent versus 5.6 percent between 1990 and 1995). The state ranks considerably below the national average in terms of percentage of persons age 65 and over—8.5 percent versus 12.1 percent nationally in 1994–95. A larger share of the state's population as compared to the national average is Hispanic, but African-Americans are under-represented in Colorado, making up only 2.9 percent of the total population. Although Colorado is a very rural state, with 31 of its 63 counties classified as "frontier," only about 15 percent of the state's population lives in nonmetropolitan areas (table 1).

Colorado's economy has made a strong recovery from the period when the state's oil industry collapsed in the late 1980s and early 1990s. In 1996, unemployment stood at just 4.2 percent, compared with a national average of 5.4 percent. From 1990 to 1995, per capita personal income rose by nearly one-quarter. A strong economy has translated into a lower poverty rate

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**Table 1**  
**State Characteristics**

|   | <b>Colorado</b> | <b>U.S.</b> |
|---|-----------------|-------------|
| <b>Sociodemographic</b>                                     |                 |             |
| Population (1994–95) (in thousands)                         | 3,689           | 260,202     |
| Percent under 18 (1994–95)                                  | 26.5%           | 26.8%       |
| Percent 65+ (1994–95)                                       | 8.5%            | 12.1%       |
| Percent Hispanic (1994–95)                                  | 11.8%           | 10.7%       |
| Percent Non-Hispanic Black (1994–95)                        | 2.9%            | 12.5%       |
| Percent Non-Hispanic White (1994–95)                        | 82.7%           | 72.6%       |
| Percent Non-Hispanic Other (1994–95)                        | 2.6%            | 4.2%        |
| Percent Noncitizen Immigrant (1996)                         | 5.1%            | 6.4%        |
| Percent Nonmetropolitan (1994–95)                           | 15.1%           | 21.8%       |
| Population Growth (1990–95)                                 | 13.7%           | 5.6%        |
| <b>Economic</b>   |                 |             |
| Per Capita Income (1995)                                    | \$23,961        | \$23,208    |
| Percent Change in Per Capita Personal Income (1990–95)      | 24.6%           | 21.2%       |
| Unemployment Rate (1996)                                    | 4.2%            | 5.4%        |
| Percent below Poverty (1994)                                | 9.3%            | 14.3%       |
| Percent Children below Poverty (1994)                       | 12.4%           | 21.7%       |
| <b>Health</b>   |                 |             |
| Percent Uninsured—Nonelderly (1994–95)                      | 14.0%           | 15.5%       |
| Percent Medicaid—Nonelderly (1994–95)                       | 5.9%            | 12.2%       |
| Percent Employer Sponsored—Nonelderly (1994–95)             | 72.2%           | 66.1%       |
| Percent Other Health Insurance—Nonelderly (1994–95)         | 8.0%            | 6.2%        |
| Smokers among Adult Population (1993)                       | 23.8%           | 22.5%       |
| Low Birth-Weight Births (<2,500 g) (1994)                   | 8.5%            | 7.3%        |
| Infant Mortality Rate (Deaths per 1,000 Live Births) (1995) | 7.1             | 7.6         |
| Premature Death Rate (Years Lost per 1,000) (1993)          | 47.3            | 54.4        |
| Violent Crimes per 100,000 (1995)                           | 440.2           | 684.6       |
| AIDS Cases Reported per 100,000 (1995)                      | 18.0            | 27.8        |

Source: Complete list of sources is available in *Health Policy for Low-Income People in Colorado* (The Urban Institute, 1998).

(9.3 percent in 1994) and a substantially lower rate of children in poverty (12.4 percent) for Colorado compared with the United States overall (table 1).

The proportion of uninsured in Colorado, at 14.0 percent, is not as far below the national average of 15.5 percent as might be expected given the state's booming economy. Employer-sponsored insurance is relatively common in Colorado, but Medicaid coverage is limited. At 5.9 percent, participation by the nonelderly population in Medicaid is less than half the national average of 12.2 percent and the lowest of all the states (table 1).

In Colorado, infant mortality and premature death rates are lower than the rates for the United States as a whole. The incidences of violent crimes and reported AIDS cases are also much lower in Colorado than they are nationwide (table 1).

## Political and Budgetary Landscape

Colorado is a conservative state, with Republicans holding a commanding margin in both houses of the legislature. The governor, Roy Romer, is a third-term Democrat who has been able

to work with the legislature to avoid deadlock and reach compromise. This balance may change substantially in the future because term limits in Colorado will have a major impact on the composition of the state legislature. The outcome of the upcoming gubernatorial election, in which Romer cannot run, may also affect consensus building and policymaking.

As in many states with a concentrated urban population and a large geographic area that has very low population density, Colorado's political divisions often reflect urban-rural tensions. In addition, pockets of very conservative and very liberal citizens can be found throughout the state. For example, the Colorado Springs area has a strong religious community that has pushed for conservative social legislation, while Boulder's strong liberal community is concerned about issues such as the environment and development.

Factors other than urban-rural and conservative-liberal splits are equally important in understanding the political environment in Colorado—namely, the strong fiscal constraints that the state has imposed on both its revenues and expenditures. TABOR (Taxpayers' Bill of Rights), a citizen-initiated referendum passed in November 1992, made an earlier 6 percent annual spending limit part of the state constitution. Any excess revenues in a given year must be refunded to the taxpayers of Colorado; a refund was triggered for the first time in 1997. Because TABOR for the most part is a "zero-sum game," Medicaid, with its high rate of growth in recent years, is viewed as a limit to flexibility in financing other state activities. Consequently, there is great emphasis on finding savings in the Medicaid program and little on expanding it. The state has also resisted expansion of Medicaid because such growth creates entitlements to benefits and carries federal requirements.

## Medicaid Expenditures and Enrollment

In 1995, Colorado's Medicaid program, with a budget of \$1.6 billion, accounted for 18.2 percent of state gen-

eral fund expenditures, up from 10.5 percent in 1990. Medicaid was the fastest-growing major public expenditure, increasing at an annual rate of more than 20 percent over that period. Between 1992 and 1995, spending growth slowed to half the rate of the 1990–92 period. Yet average annual growth during this later period was more than 50 percent higher than that for the country overall—15.3 percent in Colorado, compared with 9.9 percent in the United States. A large jump in disproportionate share hospital (DSH) payments accounts for nearly all of this discrepancy; Colorado’s DSH expenditures grew an average of 43.2 percent per year between 1992 and 1995, compared with 2.7 percent average annual growth nationwide (table 2). This was, however, largely a one-time expansion.

Colorado has closely tracked national trends in Medicaid enrollment and expenditures per enrollee. In both Colorado and the nation, spending increases among elderly and child enrollees over the period 1992–95 were attributable more to growth in expenditures per enrollee than enrollment growth, whereas the reverse was true for

the blind and disabled and nondisabled adults (table 3). In 1995, Colorado spent somewhat less per elderly enrollee and blind and disabled enrollee than the national averages, while it spent more per adult enrollee and child enrollee than the national averages. As was the case nationwide, children were the least costly Medicaid enrollees in Colorado (\$1,247 per enrollee) and the elderly were the most expensive (\$8,493 per enrollee).

Eligibility for Medicaid in Colorado is primarily limited to federally mandated categories, reflecting a state attempt to contain costs. As a result, federally mandated expansions for pregnant women and children beginning in the late 1980s caused Medicaid enrollment in Colorado to soar between 1990 and 1992, at a rate exceeding the national average. The state’s enrollment growth for nondisabled adults and children slowed significantly after 1992, largely due to families leaving welfare rolls. Colorado has attempted to provide a buffer for these families: In its 1997 session, the legislature authorized a buy-in program that will extend Medicaid coverage indefinitely for former welfare

recipients who return to work. The buy-in nature of the program is consistent with Colorado’s philosophy of making health care available without increasing government outlays.

## Medicaid Managed Care

Colorado has been a leader in Medicaid managed care. In 1983, the state became one of the first to obtain a federal waiver to mandate that Medicaid recipients enroll in a primary care case management (PCCM) program. A decade before that, the first health maintenance organization (HMO) in the state to contract with Medicaid began to enroll recipients voluntarily in a full-risk arrangement. Only recently, however, has the number of recipients in HMOs increased substantially. HMO enrollment is proceeding rapidly under a state policy of moving PCCM enrollees into HMOs if their physician case manager belongs to the network of a Medicaid HMO. A relatively new Medicaid-only HMO, Denver-based Colorado Access, has benefited the most from this “rollover” policy and counts as its mem-

**Table 2**  
**Medicaid Expenditures**  
**by Eligibility Group and Type of Service,**  
**Colorado and United States**  
(Expenditures in Millions)

|   | Colorado         |                       |              | United States      |                       |              |
|---|------------------|-----------------------|--------------|--------------------|-----------------------|--------------|
|   | Expenditures     | Average Annual Growth |              | Expenditures       | Average Annual Growth |              |
|   | 1995             | 1990–92               | 1992–95      | 1995               | 1990–92               | 1992–95      |
| <b>Total</b>  | <b>\$1,574.5</b> | <b>33.5%</b>          | <b>15.3%</b> | <b>\$157,872.5</b> | <b>27.1%</b>          | <b>9.9%</b>  |
| <b>Benefits</b>                                       |                  |                       |              |                    |                       |              |
| Benefits by Service                                   | 1,170.5          | 27.5%                 | 10.3%        | 133,434.6          | 18.8%                 | 11.0%        |
| Acute Care  | 679.7            | 39.2%                 | 11.2%        | 79,438.5           | 22.1%                 | 13.0%        |
| Long-Term Care  | 490.8            | 15.9%                 | 9.1%         | 53,996.1           | 14.8%                 | 8.3%         |
| Benefits by Group                                     | 1,170.5          | 27.5%                 | 10.3%        | 133,434.6          | 18.8%                 | 11.0%        |
| Elderly   | 335.2            | 17.9%                 | 11.1%        | 40,087.4           | 16.7%                 | 8.1%         |
| Acute Care  | 69.0             | 19.5%                 | 11.9%        | 9,673.7            | 18.5%                 | 11.9%        |
| Long-Term Care  | 266.2            | 17.5%                 | 10.9%        | 30,413.7           | 16.2%                 | 7.0%         |
| Blind and Disabled                                    | 447.2            | 19.4%                 | 11.3%        | 51,379.4           | 17.7%                 | 12.9%        |
| Acute Care  | 243.6            | 26.6%                 | 16.1%        | 29,760.7           | 22.8%                 | 15.2%        |
| Long-Term Care  | 203.6            | 13.7%                 | 6.6%         | 21,618.7           | 12.3%                 | 10.1%        |
| Adults  | 168.0            | 59.0%                 | 6.7%         | 16,556.9           | 20.4%                 | 9.2%         |
| Children  | 220.0            | 44.8%                 | 10.0%        | 25,410.9           | 24.3%                 | 13.3%        |
| <b>Disproportionate Share Hospital Administration</b> | <b>354.8</b>     | <b>449.6%</b>         | <b>43.2%</b> | <b>18,988.4</b>    | <b>261.5%</b>         | <b>2.7%</b>  |
| <b>Administration</b>                                 | <b>49.2</b>      | <b>-1.1%</b>          | <b>11.3%</b> | <b>5,449.4</b>     | <b>9.8%</b>           | <b>12.8%</b> |

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

**Table 3**  
**Medicaid Enrollment and Expenditure per Enrollee:**  
**Contributions to Total Expenditure Growth**

|   | Colorado |                       |         | United States |                       |         |
|---|----------|-----------------------|---------|---------------|-----------------------|---------|
|   | 1995     | Average Annual Growth |         | 1995          | Average Annual Growth |         |
|   |          | 1990-92               | 1992-95 |               | 1990-92               | 1992-95 |
| <b>Elderly</b>                            |          |                       |         |               |                       |         |
| Total expenditures on benefits (millions) | \$335.2  | 17.9%                 | 11.1%   | \$40,087.4    | 16.7%                 | 8.1%    |
| Enrollment (thousands)                    | 39.5     | 2.3%                  | 4.5%    | 4,116.6       | 5.1%                  | 3.0%    |
| Expenditures per enrollee                 | \$8,493  | 15.2%                 | 6.4%    | \$9,738       | 11.0%                 | 5.0%    |
| <b>Blind and Disabled</b>                 |          |                       |         |               |                       |         |
| Total expenditures on benefits (millions) | \$447.2  | 19.4%                 | 11.3%   | \$51,379.4    | 17.7%                 | 12.9%   |
| Enrollment (thousands)                    | 59.9     | 12.4%                 | 12.8%   | 6,405.2       | 9.8%                  | 9.5%    |
| Expenditures per enrollee                 | \$7,461  | 6.3%                  | -1.3%   | \$8,022       | 7.1%                  | 3.1%    |
| <b>Adults</b>                             |          |                       |         |               |                       |         |
| Total expenditures on benefits (millions) | \$168.0  | 59.0%                 | 6.7%    | \$16,556.9    | 20.4%                 | 9.2%    |
| Enrollment (thousands)                    | 92.6     | 20.9%                 | 3.5%    | 9,584.2       | 11.5%                 | 4.6%    |
| Expenditures per enrollee                 | \$1,814  | 31.5%                 | 3.1%    | \$1,728       | 8.0%                  | 4.4%    |
| <b>Children</b>                           |          |                       |         |               |                       |         |
| Total expenditures on benefits (millions) | \$220.0  | 44.8%                 | 10.0%   | \$25,410.9    | 24.3%                 | 13.3%   |
| Enrollment (thousands)                    | 176.5    | 20.8%                 | 1.2%    | 21,566.0      | 13.1%                 | 4.8%    |
| Expenditures per enrollee                 | \$1,247  | 19.9%                 | 8.7%    | \$1,178       | 9.9%                  | 8.2%    |

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

Note: Expenditures exclude disproportionate share hospital payments and administrative costs.

bership more than half of the state's Medicaid HMO enrollees. Legislation signed into law June 3, 1997, builds on Colorado's current efforts and establishes the goal of 75 percent enrollment of Medicaid clients in managed care by the year 2000.

Currently, any HMO may participate in Medicaid if it meets the requirements of the contract, but by January 1999, the state plans to institute competitive bidding for contracts. Colorado Access, which is thriving financially, is concerned that competitive bidding could force it to reduce payments to safety net providers in its network, which in turn could adversely affect the providers' ability to serve the uninsured.

Colorado's Medicaid program has taken steps to develop a more equitable payment system for HMOs. As of state fiscal year (SFY) 1998, the state is using a diagnosis-based risk adjustment system to set capitation rates. In adopting this payment system, Colorado became one of the first states in the country to adjust Medicaid payments to HMOs for health status of enrollees.

## Other State Insurance Programs

Working outside the eligibility and health benefit requirements of Medicaid, the state has operated several smaller state-only health care programs, including the Colorado Indigent Care Program (CICP) and the Child Health Plan (CHP). CICP provides inpatient and outpatient coverage for uninsured residents of all ages with income below 185 percent of the federal poverty level. The program is essentially a means to reimburse providers for a fraction (less than 30 percent) of the uncompensated care they provide. In SFY 1996 there were 133,772 unduplicated CICP users with 574,096 visits to hospitals and clinics. Funding for hospitals under CICP is largely through the Medicaid DSH program and equaled \$34 million in 1996. Standard DSH payments to hospitals totaled \$36 million in 1996-97. Denver Health Medical Center and the University Hospital are major recipients of both programs, as is the state, which retained \$150 million of the \$361 million in federal matching funds generated through

the DSH program between SFY 1993-94 and SFY 1996-97.

Prior to 1998, CHP covered outpatient services for children in rural areas who were under the age of 13 with family income less than 185 percent of the federal poverty level. Families paid an annual premium of \$25 per child. Under House Bill 97-1304, CHP is merged with a portion of CICP funds and offers both inpatient and outpatient services through capitated managed care plans to rural and urban children up to age 18. The family income standard remains the same as before, and premiums are assessed on a sliding scale based on income. This expansion was incorporated into Colorado's Children's Health Insurance Program (CHIP) proposal. The proposal was approved by the federal government in February 1998, and CHP was renamed Child Health Plan Plus. CHP+ has the flexibility to require cost-sharing that is not allowed under Medicaid, permitting Colorado to emphasize individual responsibility. Moreover, the state's preference for private-sector solutions is visible in a proposal to use some CHIP funds to buy

into employer-sponsored coverage for eligible children whose working parents have the option but cannot afford it.

## The Health Care Market

The health care market in Colorado is undergoing rapid change. Informed estimates are that as much as 80 percent of the privately insured market in Colorado is enrolled in either HMOs or preferred provider organizations (PPOs). This trend has put considerable pressure on providers, especially hospitals, to reduce prices and become more efficient. Colorado's providers have used mergers and joint ventures to reduce redundancies and achieve economies of scale in purchasing, administration, and patient care. Local hospitals that fear for their survival have merged with national hospital systems to take advantage of volume purchasing and reductions in administrative costs. Five major national hospital systems now own numerous hospitals in Colorado. And since four of these systems paired off to form joint ventures for their Colorado hospitals, there are essentially only three independent hospital systems in Colorado.

## Private Insurance Reforms

Private insurance coverage is strong in the state, which helps explain why the overall rate of uninsurance is low. An unusually large number of small employers provide coverage to their workers, probably reflecting, in part, some of the small-group reforms enacted in Colorado to enhance the health insurance market. Colorado implemented substantial reforms of its small-group market on January 1, 1995, pursuant to a 1994 law. The key provisions were guaranteed issue, guaranteed renewal, limits on preexisting condition exclusions, and modified community rating. Some of the specifics of these provisions were superseded by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA also required the state to enact additional individual insurance market reforms.

## The Safety Net

Colorado has a relatively strong safety net of hospitals and clinics, supported in part by the CICIP and DSH programs. The state's public health system also meets some of the important health care needs of the uninsured, although increasingly the state is encouraging county health departments to shift their focus to population-oriented services, such as health promotion and infectious disease control. The Denver area boasts a particularly strong health care safety net, which is a dynamic component of the city's highly

*Employer-sponsored insurance is relatively common in Colorado, but Medicaid coverage is limited.*

competitive health care market. Its biggest safety net providers, Denver Health and Hospital Authority (a publicly funded system that links a hospital and 10 federally qualified health centers) and the University Hospital, are large and financially sound enough to be formidable competitors in the market, especially for Medicaid patients. Nevertheless, the safety net's financial stability may be somewhat tenuous. The number of uninsured and underinsured persons in Colorado is apparently on the rise as a result of the increasing number of jobs that do not include health insurance benefits. In addition, more players are entering the Medicaid market through managed care contracts; the higher level of uncompensated care costs shouldered by safety net providers may render them comparatively less attractive to Medicaid-contracting HMOs.

## Long-Term Care

In its search for ways to maximize state flexibility, Colorado has increasingly relied on Medicaid home and community-based care waivers and the

state-funded Home Care Allowance program to deliver long-term care services. Nonetheless, institutional care, particularly nursing home care, still accounts for the majority of long-term care spending in Colorado, especially among the elderly population. The state has made greater strides in delivering Medicaid home and community-based care to persons with mental and developmental disabilities. The Medicaid Mental Health Capitation pilot project, a mental health "carve-out" that was scheduled to be implemented statewide in 1998, has stimulated growth in noninstitutional mental health care alternatives. In counties where the pilot was operating initially, psychiatric inpatient services comprised less than 20 percent of mental health spending in SFY 1995–96, compared with 50 percent in the previous year. In the area of developmental disabilities, Medicaid home and community-based care waivers are the dominant vehicle for providing services. These waiver programs have generated controversy—and even lawsuits—as a result of lengthy waiting lists.

## Challenges for the Future

A major challenge facing Colorado's health care system in the future is how well it can weather an economic downturn. State programs, including Medicaid, offer only limited protection to Colorado's citizens. The current rate of uninsurance is low due to a healthy economy and large numbers of small firms offering insurance to their employees. These factors could change suddenly, however, and the state's system of support is not well equipped to expand to meet greater needs. The constitutionally required spending limits and the lean nature of the current Medicaid program mean that there is little room to stretch resources further. In addition, Colorado's emphasis on moving its Medicaid recipients into managed care may place some strains on the relatively healthy system of safety net providers that currently serves the uninsured.

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