

WARNING:
State Budget Cuts can be
Hazardous to Your Health



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The Health Care Safety Net



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Introduction

The images of Colorado — blue skies, snow-capped mountains, broad prairies, clear streams — also include healthy people. A broad system of health care supports that healthy image, helping people who are sick, injured or aging.

Access to health care and public health services is critical to the people of Colorado. But rising costs, the recent recession and the state government's current fiscal crisis combine to threaten this access.

The costs of health insurance are rising fast, and the increase hits small businesses and their employees particularly hard. Colorado employers are ahead of businesses in other states in providing workplace health insurance coverage for workers.



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But when the recession hit, many small businesses shut down or laid off workers, and 75,000 Colorado workers lost their jobs, and their health insurance. By 2004, 450,000 workers, nearly one-fifth of the state's workforce, did not have health insurance.

Even as jobs come back to the state, fewer employers are able to offer health care coverage to their employees.

Colorado's Medicaid program, meant to be a safety net in tough times, is a highly restrictive program that could not absorb the growth in uninsured people. Colorado ranks second to last in the country for its Medicaid coverage of unemployed people and uninsured workers.

But people without insurance still get sick or injured. Without insurance, they often end up using emergency rooms, the most expensive type of care. This drives up costs for health care and health insurance for everyone else.

Doctors, clinics and hospitals absorb some of the costs, as do federal, state and local governments. The rest is passed on to the people who can pay — people with insurance.

As a result, businesses, workers and families pay more for health care.

The health care squeeze is worse in rural areas, where fewer workers are covered by health insurance, accidents are more frequent, and hospitals and clinics are many miles away.

How did this happen? What is at stake? What can be done?

This booklet offers answers to these questions.

The good news is that we have the opportunity to stop the decline, and perhaps eventually reverse the trend. Referenda C and D on the Nov. 1 ballot give Coloradans the option to improve access to health care and revitalize public health services.

One thing is clear. With the budget cuts forced in health care and public health programs, Colorado's fiscal crisis can be hazardous to your health.



Rising health care coverage costs hit business, workers More Colorado workers have no insurance

Small businesses paying more for health insurance

Every Colorado business is struggling to deal with rising health insurance costs but the burden is heaviest for small business.

The Colorado Health Institute reports that from 1996 to 2002, small group insurance premiums jumped an average of 84 percent.

A National Federation of Independent Business (NFIB) survey in 2003 found that 99 percent of 12,000 small-business owners paid more for employee health benefit premiums than the previous year. From 2000 through 2004, health care premiums grew by 20 percent or more per year for at least half of Colorado's small business owners.

The burden of increasing health care cost is greater for small businesses. A Colorado Health Institute study reports that in 2004, Colorado small businesses paid health insurance premiums that were 3 to 6 percent higher, on average, than premiums paid by large businesses.

Table 1: Average health insurance premiums for singles and families, combined total paid by employer and worker, for the U.S. and Colorado, 1996-2002

Year	Family Premium		Single Premium	
	U.S.	Colorado	U.S.	Colorado
1996	\$4,954	\$4,717	\$1,992	\$1,910
1997	\$5,332	\$4,989	\$2,051	\$1,932
1998	\$5,590	\$5,537	\$2,174	\$2,169
1999	\$6,058	\$5,822	\$2,325	\$2,312
2000	\$6,772	\$6,797	\$2,655	\$2,450
2001	\$7,509	\$7,318	\$2,889	\$3,083
2002	\$8,469	\$8,504	\$3,189	\$3,301

Source: Agency for Healthcare Research and Quality, Center for financing, Access and Cost Trends. Medical Expenditure Panel Survey (1996, 1997, 1998, 1999, 2000, 2001, 2002, Table II. C. 1).



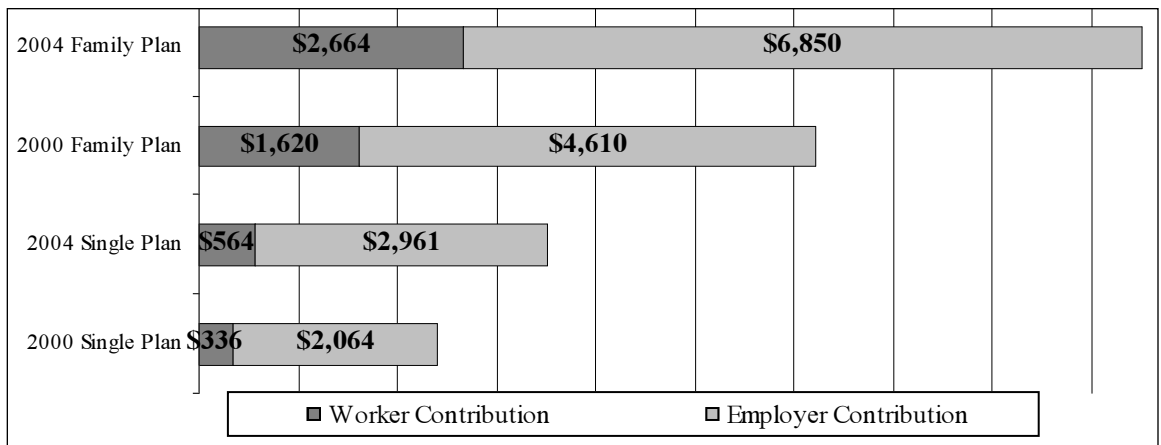
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Workers pay a larger share of employer-provided insurance

In Colorado, employers provide health insurance for workers at a higher rate than in most other states. But as costs go up, workers are being asked to pay a bigger share of their insurance premium, particularly those who opt to insure their families. Workers take on more cost through increased co-pays, higher deductibles and cuts in covered treatments.

A Kaiser/HRET Employer Benefits Survey found that in 2004, a conventional health plan cost firms an average of \$294 per month or \$3,525 per year for single coverage and \$793 per month or \$9,514 per year for family coverage. Workers pay about 16 percent to the total premium cost for single coverage and 28 percent for family coverage, Kaiser reports, as Figure 2 shows. This study also found that the cost of family health insurance nearly equals the gross earnings of a full-time minimum-wage worker.

Figure 1: Worker and employer contributions for single and family health insurance coverage, 2000 and 2004

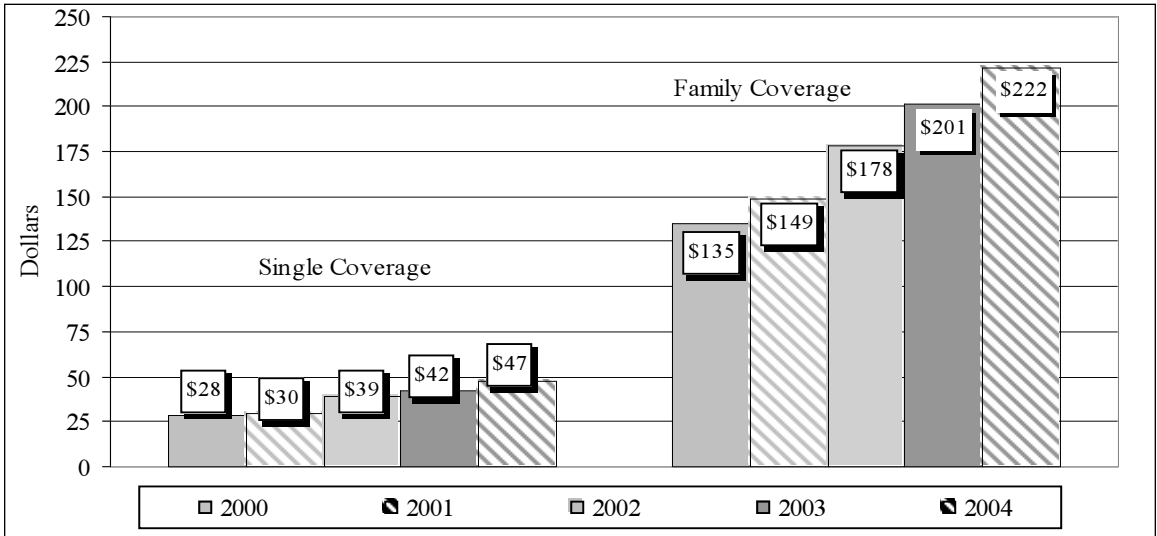


Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2000-2004

Health care costs are rising faster than overall inflation

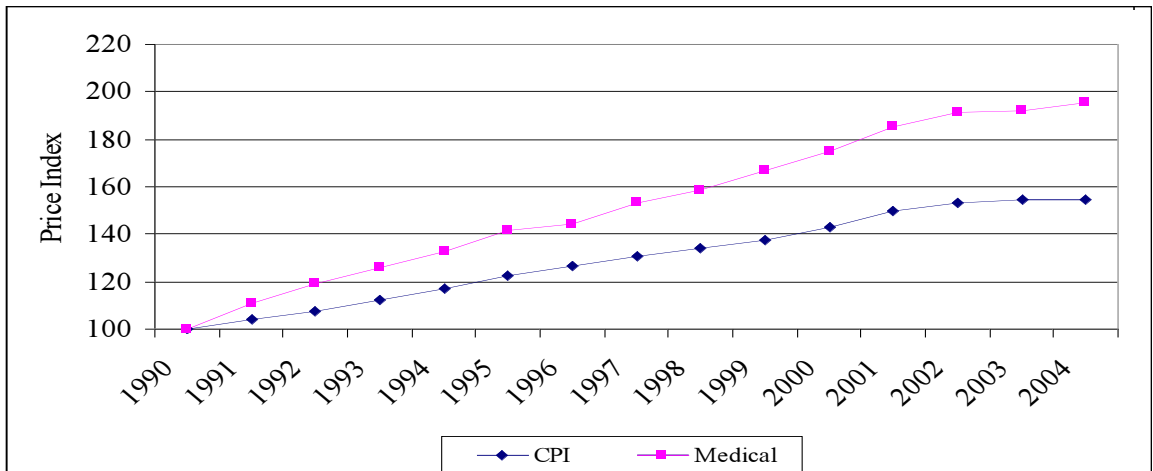
Health care costs have grown faster than consumer-price inflation for more than a decade. In fact, Coloradans spend more on health care than on consumer goods. And the gap between consumer-price inflation and medical-price inflation is widening, as shown in Fig. 3.

Figure 2: Average monthly worker's share for employer-provided health insurance, 2000-04



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2000-2004

Figure 3: Comparison of Denver-Boulder-Greeley consumer-price index and medical-price index, 1990-2004



SOURCE: Bureau of Labor Statistics, Annual Percent Change, Denver-Boulder-Greeley CPI and Medical Care data, 1990 – 2004. Medical care data includes commodities such as non-prescription, prescription drugs and medical supplies and medical care services from doctors, specialists and other professionals.



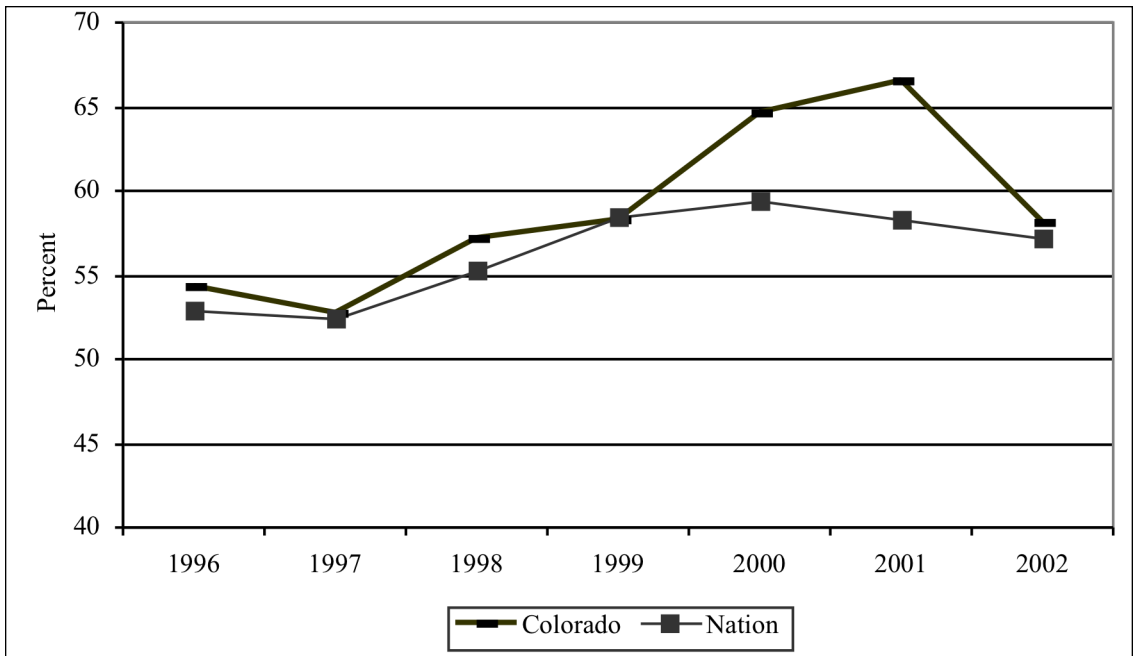
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Coloradans lost health insurance in the post-2001 recession

Small businesses are big employers in Colorado and more than half provide health insurance for their workers, a higher rate than in most other states. That's a positive trend, until the economy goes into a recession. When the economy faltered from 2001-03, many small businesses shut down or laid off workers, and 75,000 Colorado workers lost their jobs.

Other employers were forced to raise workers' share of premium costs or cut health insurance benefits entirely. Once the recession hit, Colorado's above-average rate of workplace health insurance dropped close to the national average.

Figure 4: Comparison of small businesses offering health insurance for workers in Colorado and the U.S., 1996 – 2002



Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 1996, 1997, 1998, 1999, 2000, 2001, 2002 Medical Expenditure Panel Survey (Table II.A.2).

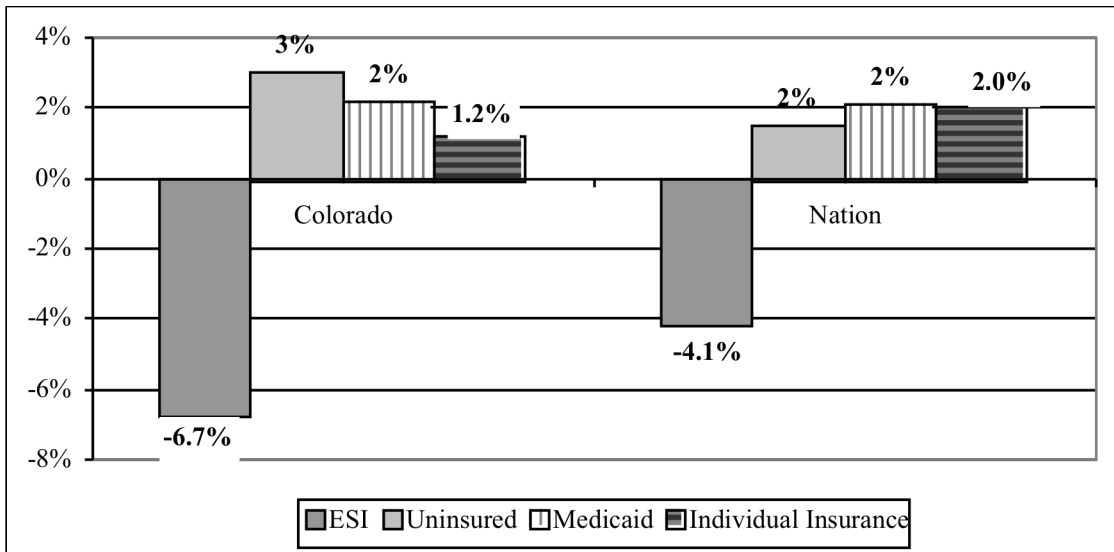
Between 2000 and 2004, the number of Colorado workers employed at small businesses covered by workplace health insurance plans declined by more than 30 percent. In 2000, 538,000 were covered by small group insurance plans. By 2004, that dropped to 373,000.

Not all the people who lost workplace health insurance found coverage elsewhere. Many still made too much money to qualify for the state's highly restricted Medicaid program. But their family budgets had no room for costly private health insurance policies.

Of all Colorado workers ages 18-64, nearly 19 percent, more than 450,000, did not have health insurance in 2004, an increase of 28,000 from 2003.

From 2000 to 2003, the number of people covered by workplace health insurance fell by 6.7 percent. Meanwhile, Colorado Medicaid enrollment grew 2 percent and private insurance grew 1.2 percent. As a result, the number of uninsured Coloradans grew by 3 percent, compared to the 2 percent growth in uninsured nationally.

Figure 5: Comparison of percentage change in source of insurance coverage in the U.S. and Colorado, 2000 and 2003



Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured, estimates based on March 2001 and March 2004 Current Population Surveys.



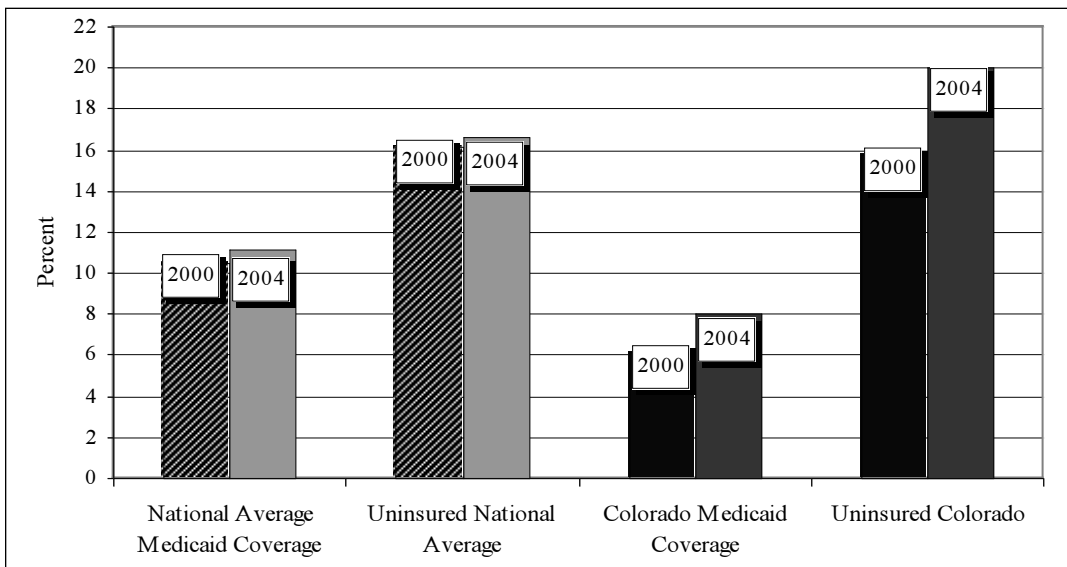
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Colorado's Medicaid program could not fill the void

As health care costs increased, Medicaid consumed a greater percentage of the state budget. In 1990, Colorado spent 13 percent of its budget on health care. By 2005, the share hit 23 percent. Because state government spending limits are based on consumer-price inflation, which is lower than medical-price inflation (See Figure 2, page 7), legislators had to cut other programs to pay for rising Medicaid costs.

Colorado's Medicaid program is lean compared to other states, offering fewer optional services and covering fewer people. From 2001 to 2004, enrollment in Colorado Medicaid program grew by 114,700 people, a 40 percent increase. Even with this growth, Colorado still ranked second to last nationally for its coverage rate. That means a greater share of Colorado residents are uninsured, falling into the gap between Medicaid and private or workplace health insurance.

Figure 6: Comparison of U.S. and Colorado non-elderly residents with Medicaid coverage and uninsured, 2000 and 2004



Source: U.S. Census Bureau Table Health Insurance Coverage Status and Type of Coverage by State--People Under 65: 2000; 2004 US Medicaid and Uninsured estimates from the Center for Disease Control, national Health Interview Survey, Health Insurance Estimates (2005), available at www.cdc.gov; 2004 Colorado Medicaid and Uninsured estimates from the Center for Tobacco Cessation, Colorado State Facts (2005), available at: www.ctcinfo.org



Medicaid is a safety net for people and a boon for the economy

Medicaid is a dollar-for-dollar state and federal partnership that provides health and long-term care coverage. It is the single largest source of federal funding for most state budgets, including Colorado.

Medicaid provides a health care safety net for low-income and unemployed people. When the economy turns downward and unemployment increases, Medicaid helps pick up the slack for those who lack private health insurance.

Medicaid is also good for the economy. In its 2005 *Colorado Medicaid Primer*, the Colorado Health Institute projects the state's share of Medicaid spending to be \$1.3 billion, which will bring another \$1.3 billion of federal money into Colorado for the health care industry.

In Colorado's most recent recession, however, the budget shortfall forced Colorado to trim Medicaid coverage to the bone, retaining only those services that qualify for the federal matching dollars. Cuts included:

- Reducing payments to doctors, clinics and hospitals
- Limiting treatments
- Restricting care for legal immigrants
- Limited enrollment
- Restricted payment for long-term care services

Legislators say further Medicaid cuts will eat away federal matching dollars. Colorado's Medicaid program already pays below-cost rates for health care, passing more of the total cost on to hospitals and clinics. Additional cuts may lead health care providers to limit the care they offer to Medicaid patients, or pass on costs to other patients.

Cuts in Medicaid drive up medical costs for everyone

People without insurance still get sick or injured. They still need health care, and it still costs money. So who pays?

Federal, state and local governments shoulder some of the costs. But employers and workers pay much of the cost in the form of higher insurance premiums.

Just as Colorado has cut thousands of people from standard Medicaid coverage, it has cut programs that pay hospitals to care for people who can't pay for treatment.

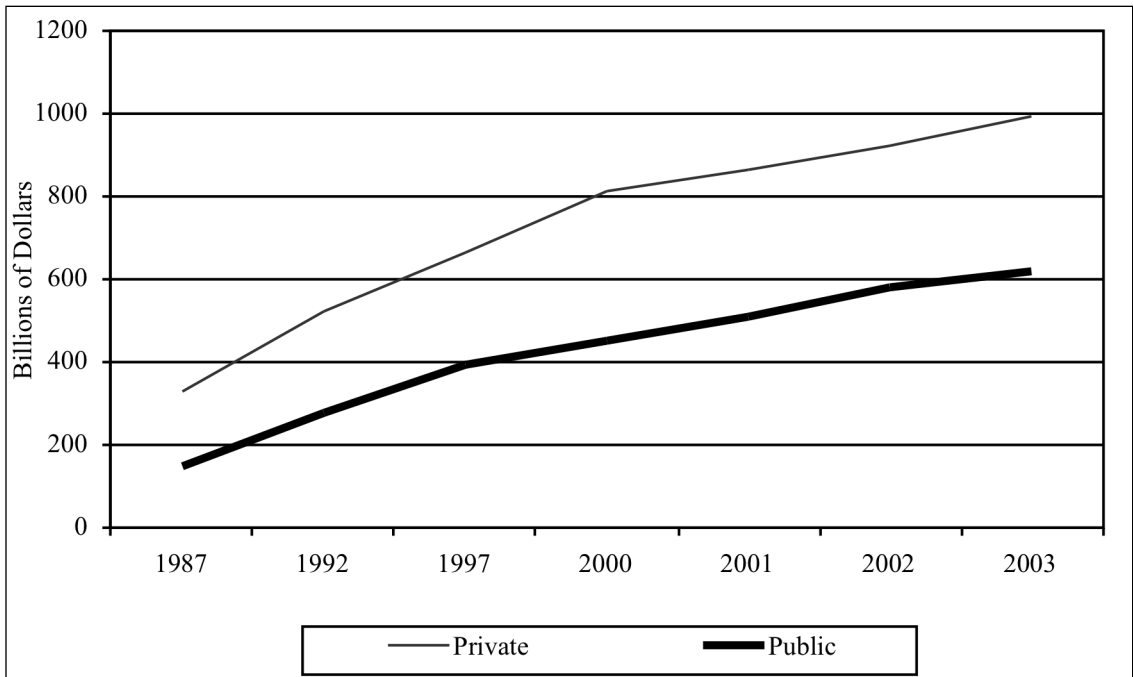


In 2002, Medicaid covered 14 percent of Colorado hospital patients. Hospitals got paid an average of 72 percent of the total cost of treatment, taking a 28 percent loss. Hospitals and doctors absorbed some of that loss.

But as unpaid care increases because more people are uninsured, hospitals and doctors are shifting some of those costs onto people who can afford to pay — people who have health insurance.

Public and private spending for health care have both increased. But the gap between the two is growing wider, indicating that private health care is shouldering more of the cost burden.

Figure 7: Spending for health services and supplies by private and public insurance programs in the U.S., 1987 – 2003



SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, 2005. Cowan, C. A. & Hartman, M. B. (2005). Financing Health Care: Businesses, Households, and Governments, 1987-2003. Health Care Financing Review, 1(2). Graph adopted from Table 1, Expenditures for Health Services and Supplies, p. 4. Note: Private includes businesses, households, and other private; Public includes federal, state and local governments.

Hospitals write off care for uninsured patients

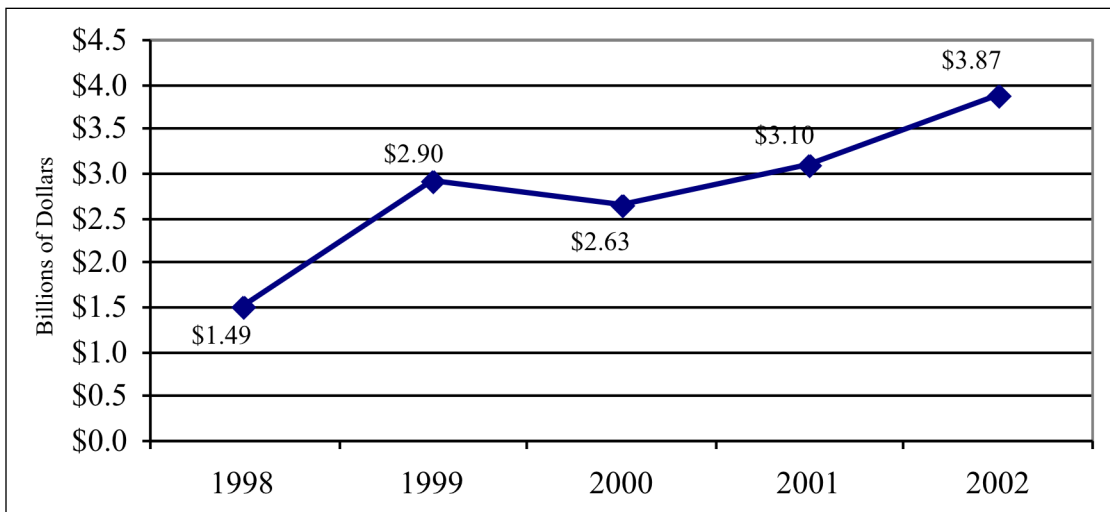
People who don't have health insurance often wait to seek help until their illness becomes severe. Then they go to a hospital emergency room — an option that costs far more than seeing a doctor at a clinic. Often, hospitals have to write off these patient visits as uncompensated care. This includes:

- Care provided for free or reduced rates to patients without insurance
- Unpaid bills for care to patients who don't qualify for assistance
- The difference between a hospital's costs and how much the government reimburses for patients covered by Medicare or Medicaid.

Uncompensated care nearly doubled from 1998 to 2002, according to the Colorado Health & Hospital Association (CHA). During that period, free care to uninsured people increased 93.3 percent, and unpaid bills increased 98.6 percent. CHA reports that between 2001 and 2002, hospital uncompensated care grew 25 percent for a total of \$3.9 billion in 2002.

For example, Denver Health reports absorbing \$100 million in 1991 to treat people without insurance. By 2004, that cost hit \$285 million.

Figure 8: Colorado hospital uncompensated care, 1998 – 2002



Source: Colorado Hospital Association, 2004. Note: uncompensated care refers to charity care, bad debt and under-funded Medicaid and Medicare reimbursements.



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As uncompensated care costs increase, hospitals pass higher prices on to private health care plans. A study conducted in 2004 by Blue Shield of California, that state's third largest health plan, estimated that 15 to 20 percent of health insurance premiums charged to customers were used to offset the cost of care for people without insurance. (Blue Shield of California is a subsidiary of the national Blue Cross Blue Shield company.)

Colorado's Centura Health estimates that if hospitals were fully reimbursed for caring for the uninsured and for Medicare and Medicaid patients, they could lower rates to health plans by about 26 percent.

Health care cuts hurt rural areas more than cities and suburbs

More people living in remote rural areas lack workplace health insurance coverage, according to the Colorado Rural Health Council.

Health care in rural counties is also hard to come by. Of the state's 47 rural counties, 38 have a shortage of health care services. And clinics and hospitals in those rural areas have a hard time recruiting and retaining doctors and nurses.

Rural areas have more uninsured adults, migrant workers, elderly adults, Medicaid recipients and higher levels of poverty. Rural residents suffer more on-the-job injuries, car accident injuries, infant deaths and suicide.

As the state cut Medicaid reimbursements, rural areas were hit especially hard. Unlike urban areas, rural areas do not have a tax base to supplement health care services for residents. Because a higher proportion of rural residents are on Medicaid, health care providers in rural areas are more dependent on adequate Medicaid reimbursements.

Partial list of cuts to Colorado's health care safety net in order to balance the state general fund budget, 2001-04



Hospital and clinics

Reduced:

- Drug reimbursements
- Psychotherapy treatments
- Hospital reimbursement
- Home and community-based services
- Long-term care
- Home health care reimbursement
- Laboratory and x-ray services
- County medical transportation
- Medicaid co-pays for families and children
- Indigent care reimbursement
- Enrollment caps for the Children's Basic Health Plan Trust Fund

Mental health

Reduced:

- Cost of living increases
 - Alcohol and drug abuse programs
- Eliminated:
- Mental health early intervention programs
 - Mental health program for detained youth
 - Residential treatment for youth
 - Early childhood mental health program

Closed:

- Fort Logan Mental Health Institute, two units, 43 beds, aftercare program
- Pueblo Mental Health Institute, three units, 50 beds

Developmental disability

Reduced:

- Community services, training and employment incentives for adults
- Support services for children, adults and families
- Reimbursement to vocational rehabilitation independent living centers
- Aid to needy disabled program

Eliminated:

- Vocational rehabilitation teaching program for the blind
- Early intervention and children's support program



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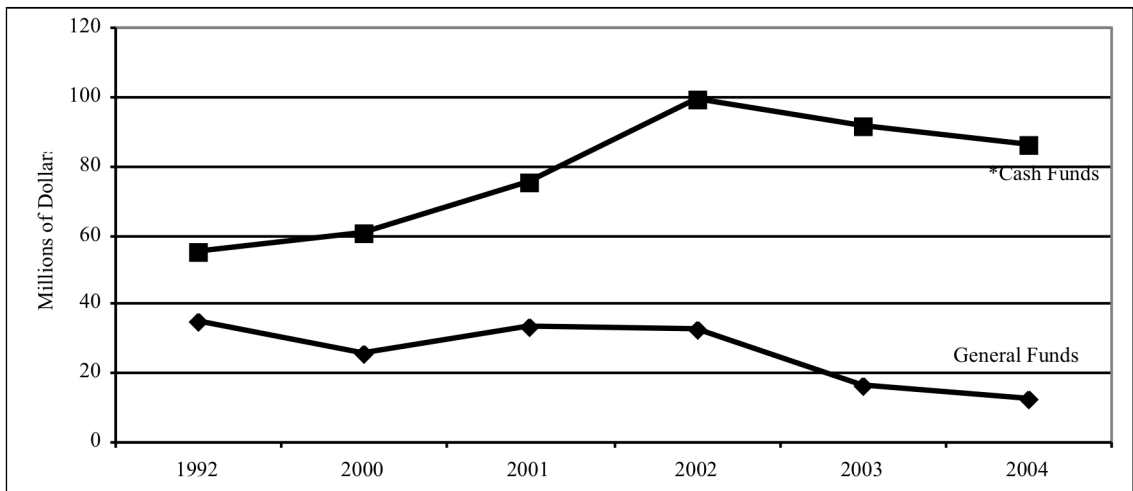
Public health: a quiet epidemic of budget cuts

The Colorado Department of Public Health and Environment is responsible for protecting the health of Colorado residents and visitors. But the job is getting harder as budget cuts slice programs and staff, and as more people move here and more diseases invade.

From 1990 to 2000, Colorado gained 1 million people, growing from 3.3 million to 4.3 million, a 33.3 percent increase. Meanwhile, spending for public health fell slightly each year on a per-person basis.

With the recession of 2001-2004, state tax revenues fell steeply, and lawmakers cut general fund spending to the health department by 60 percent. By 2004, Colorado ranked 37th in the country for per-person spending on public health. In response, the health department raised existing fees and instituted new fees to keep some services afloat. The fee hikes boosted cash fund revenues to make up some of the loss from the general fund.

Figure 9: Colorado Department of Public Health and Environment, general and cash fund (fee) appropriations 1992, 2000-2004 (Dollars adjusted for inflation)



Joint Budget Committee Appropriations Reports for 1992 and 2000-04; adjusted for inflation by Bell Policy Center

Table 2: Colorado Department of Public Health and Environment: General fund, cash fund (fees), federal funds and total appropriations 1992, 2000-2004 (in million of dollars)

	1992	2000	2001	2002	2003	2004
General fund	\$34.5	\$25.6	\$33.4	\$32.6	\$16.3	\$12.5
Cash funds	\$54.8	\$60.5	\$75.4	\$99.1	\$91.2	\$86.0
Federal funds	\$140.5	\$158.8	\$155.0	\$151.7	\$162.3	\$159.7
Total funds	\$229.8	\$245.0	\$263.8	\$283.4	\$269.8	\$258.2

Source: Bell Policy Center inflation-adjusted figures from Joint Budget Committee appropriation reports, 1992, 2000-04. Cash funds line includes cash exempt funds.

Cutting the public health funding pie

The state health department runs on money from the federal government, from fees paid by a variety of services, from a tobacco lawsuit settlement fund, and from the state's general fund, which is largely filled by income and sales tax revenues. Federal funds, state fees and tobacco funds come with strings attached — they can be spent only on designated programs.

Federal funds are limited to:

- Study and analysis of disease epidemics, health risks, and access to health care
- Providing health care and nutrition for needy families
- Preparing for bioterrorism and emergencies
- Cleaning up contaminated sites

State fees and tobacco settlement funds are limited to:

- Water and air quality inspections and permits
- Hazardous materials cleanup
- Social service programs
- Smoking prevention programs

The state's general fund is the health department's only flexible source of money. Some is earmarked for immunizations. The remainder pays for a wide variety of state programs and community health efforts by local health departments and public health nursing offices.



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How the Colorado Department of Public Health and Environment uses federal funds, cash funds (fees) and general funds (including pass-through federal funds)

Federal funds

Women, Infants and Children (WIC)
Maternal and Child Health (MCH)
Health Facilities and Emergency Medical Services
Disease Control and Environmental Epidemiology
EPA Partnership Grant monitors air pollution and other environmental hazards
Contaminated sites cleanup
Emergency preparedness (i.e., smallpox, anthrax, biological and chemical agent laboratory capacity, training, education, public communication)

Cash funds

Health facility licensing
Assisted living facility licensing
Emergency medical licensing and services
Newborn screening, genetic counseling
Water quality protection: drinking water, groundwater, wastewater
Air quality protection
Hazardous waste licensing and cleanup
Business' share for restaurant inspections
Youth services
AIDS and HIV programs
Nurse home visitors
State Tobacco Education and Prevention Program
Dental loans
Business' share for laboratory services

General funds

Dairy inspection
Mosquito control
Health fraud investigation
State's share for restaurant inspections and training for safe food handling
Childhood immunization
State's share lab services
Community nursing
Tuberculosis control
Birth defects monitoring and prevention
Disease control
Cancer registry
Suicide prevention
Women's health, prenatal care, family planning
Local dental programs
Prevention partnerships
Children with special needs
Health education
Funding for local needs

Nursing shortage drives health care costs higher



The chronic shortage of nurses across the country could soon become an acute case in Colorado. The state's hospitals and clinics are dealing with an 11 percent vacancy rate for nursing positions — twice the national average.

Without a big expansion in nurse training programs, projected retirements will push the nursing vacancy rate to 30 percent by 2020, according to *The 2004 Colorado Nursing Faculty Supply and Demand Study*, published in March 2005 by the Colorado Center for Nursing Excellence. CCNE works to develop and support the state's nursing workforce of the future.

The main reason for the nurse shortage is a parallel lack of training opportunities for new nurses. Nursing colleges are running short on faculty and on clinical internships for nursing students.

In 2003, while 26 colleges and universities in Colorado graduated about 1,000 new registered nurses (RN) and licensed practical nurses (LPN), the schools turned away 2,600 aspiring nursing students.

The University of Colorado Health Sciences Center averages 700 applicants a year to its undergraduate nursing program, but can admit only 210, according to Mary Blegen, associate dean of research for the CU School of Nursing.

At Aims Community College in Greeley, 335 aspiring nurses are on the waiting list — 10 times the number of students admitted each year, according to Donna Souther, academic dean for allied health and human services.

Mesa State College in Grand Junction doesn't keep a waiting list. The college receives 120 to 160 applicants per year, and presently admits 60, according to Kathleen Ryan, administrative assistant for the nursing program. In 2006, Mesa will launch a new LPN training program that will accept another 30 students per year.

Young people are eager to start medical careers, but there simply aren't enough professors to teach college nursing programs. At the close of the 2002-03 academic year, CCNE reported, the state's nursing training programs counted 38 faculty vacancies.

Health care is expensive today with a moderate nursing shortage. If the decline in qualified nurses isn't reversed, wage competition will make future health care costs skyrocket.



In essence, college and university nursing programs are competing for talent against the same industry they are supplying with graduates. Colleges are running short on nursing faculty because:

- Teaching salaries can't compete with wages nurses can earn at hospitals and clinics.
- Few nurses make a career move to teaching because graduate school takes so long and costs so much.
- Many nursing instructors are reaching retirement age. The average age in Colorado for top-level faculty is 53.
- Nursing faculty toil under a heavy workload, resulting in early burnout.

Colleges also must limit enrollment because they are using around-the-clock clinical internship slots at community hospitals and clinics. Even at present levels of clinical placement, CCNE reports that some nursing school graduates are not fully prepared to begin work because they haven't gotten enough hands-on experience.

State budget constraints on higher education are forcing cuts in some nurse training programs at the very time they should be expanding.

Some colleges have raised tuition to keep their nursing programs afloat. While it's a necessary move for now, higher tuition raises the barrier for qualified applicants to start training in a much-needed profession.

That's opposite the direction Colorado should be heading.

CCNE and other medical industry leaders say Colorado must double the capacity of its nurse training programs.

Colorado policy makers should be growing opportunities for aspiring nursing students and for nurses taking postgraduate classes who plan to teach. Without more skilled faculty, Colorado will never catch up on its nursing shortage.

Colleges need more funding to aggressively compete for nursing faculty and more innovation to expand clinical placements.

But in a rush to expand, nursing programs must emphasize depth and quality in training so nursing graduates start work with independent technical and thinking skills.

After all, nurses are expected to care for patients, not just carry out tasks.

Referenda C and D: a plan for recovery

The Colorado General Assembly, with the support of Gov. Bill Owens, has referred two measures to the Nov. 1, 2005, ballot to address the state funding crisis, including the crisis in health care funding.

Referendum C would give the state permission to retain all the revenues it collects above the existing TABOR limit for the next five years, and impose a new growth limit based on population plus inflation after 2010. The additional revenues retained under Referendum C would be divided in thirds and used to restore cuts in K-12 education, public colleges and universities, and health care.

Referendum D would give the state permission to issue approximately \$2 billion in bonds, with most of the resulting revenue going to roads and bridges.

State economists predict Referendum C will generate between \$2.9 billion and \$3.6 billion between 2005 and 2010 to restore services, without creating any new taxes or raising any existing tax rates.

In June, 2005, the Legislative Council staff projected a total of \$3.574 billion will be collected between 2005 and 2010 above the TABOR limits. That same month, the Governor's Office of State Planning and Budgeting projected a collections total of \$2.903 billion over the same period above the limits.

Under current law, these revenues must be returned to taxpayers as rebates. Under Referendum C, they could be retained and used to restore budget cuts made during the recession.

Under separate legislation, the General Assembly has committed to spending a third of those revenues on programs to lower the cost of health insurance premiums for individuals and small businesses, and on health care for Colorado's elderly, low-income, and disabled people, including:

- Physician visits
- Hospital visits
- Long-term care services, including nursing home care, home-based care, and community-based services
- Prescription drugs
- Mental health services
- Prenatal care
- Immunizations
- Services for people with developmental disabilities
- Medical services premiums



Based on state projections, Referendum C could yield \$792.6 million to \$1.016 billion in additional support for health care over the next five years. Projections start at between \$94.8 million and \$145.2 million in 2006, and increase to between \$225.4 million and \$252.2 million in 2010.

These increases are modest and sensible given the many health care and public health services Coloradans have lost since 9/11. Some of the cuts and lost services outlined in this report will not receive any of this money, given the careful earmarking done by the Legislature. And those that will be eligible will likely not be restored fully.

For example, it would require \$770 million a year just to offset the increase in uncompensated care Colorado hospitals experienced between 2001 and 2002. Even under the most optimistic projections, the entire \$250 million annual share allocated by Referendum C to health care would cover less than a third of that need.

And these are conservative estimates. They assume no further cuts in health care and public health, even without Referendum C. That is a very optimistic assumption.

Referenda C and D are modest and sensible responses to the funding crisis that has affected the state's health care and public health infrastructure.

They will not solve the problem entirely, and they certainly won't open the floodgates for spending. At best, they will stop the decline in investments in our future and help us recover some of the ground we've lost since 9/11. They will stop, or at least slow the bleeding.

Colorado has gone through a serious budget crisis since 2001, and today our health care safety net is tattered and torn – endangering the health and well-being of every Coloradan.

The decline in the state's commitment to health care and public health must be reversed if Colorado is to ever be a state of opportunity for all. For our communities to be safer, our families to be healthier and more of our small businesses to be able to provide health coverage to workers and their families, we must renew our investment in health care.

Referenda C and D offer Coloradans the opportunity to renew that commitment to quality health care, and voting against them would truly be hazardous to the health and well being of all Coloradans.

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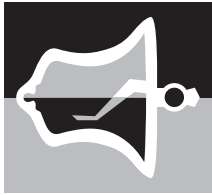
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