

A Healthy Adult Life

Those who enjoy sound physical and mental health or are able to get adequate treatment when they need it are likely to be more productive, advance faster in their careers, earn higher incomes and enjoy a better quality of life throughout their adult years.

Those who face physical or mental health challenges and do not have access to adequate or effective treatment are likely to miss more days of work, be less successful in their careers, face higher health care expenses and have a diminished quality of life.

Ultimately, some will face debilitating conditions that may threaten their family's economic security, shorten their careers or even cause premature death.

Indicator 1: The prevalence of adult smokers

Tobacco-related illnesses are Colorado's leading cause of preventable death.

Indicator 2: Obesity among Colorado adults

If current trends continue, the Centers for Disease Control projects that obesity will overtake smoking as the leading cause of preventable death in the United States.

Indicator 3: Suicide among Colorado adults

Colorado is consistently among the top 10 states for suicide deaths.

Indicator 4: Alcohol abuse among adults

Alcohol abuse is a serious health issue that harms lives and family relationships.

Indicator 5: Health insurance coverage for non-elderly adults

Access to health care is closely related to health insurance coverage.

Indicator 6: Non-elderly adults on Medicaid

One way of compensating for the loss of employer-sponsored health benefits for low-wage workers is to enroll them in the state's Medicaid program.





Indicator 1: The prevalence of adult smokers

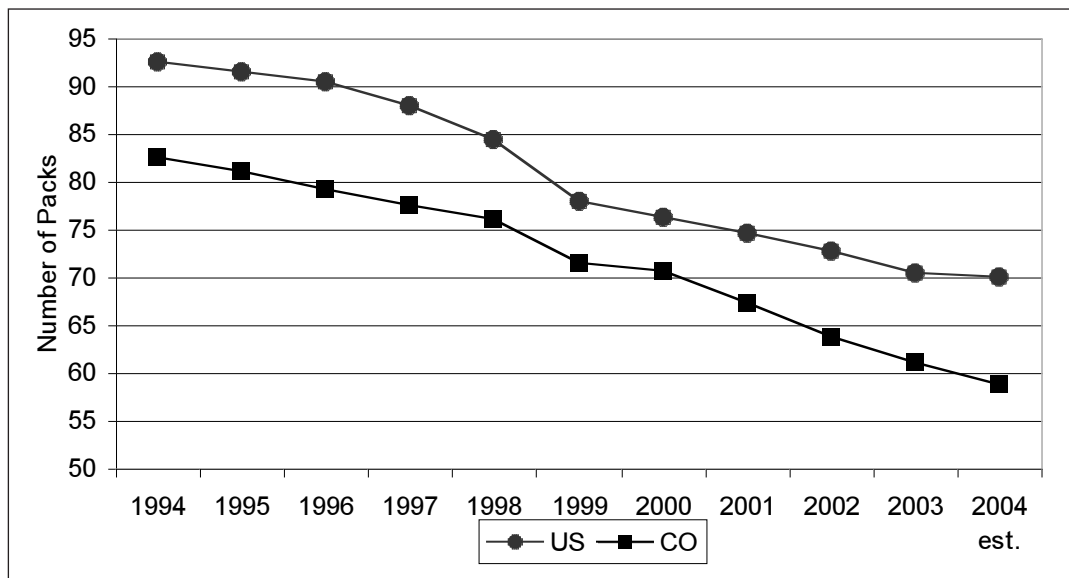
Tobacco-related coronary heart disease, stroke, asthma and other respiratory illnesses kill more people than AIDS, drugs and alcohol abuse, homicide, suicide, car accidents and fires combined, according to the State Tobacco Education and Prevention Partnership.³ Smoking also burdens the nation's economy, causing illnesses costing more than \$1 billion per year.⁴

Per capita cigarette consumption in Colorado continued on a steady decline over the past decade, even as national rates of consumption leveled off since 2000.⁵

However, cigarette smoking is higher among people with less education, lower incomes and among Hispanics.⁶

- About 31 percent of Colorado adults without a high school diploma smoke, compared to 15 percent with at least some college education.⁷
- In 2003, 27 percent of Colorado adults earning less than \$25,000 reported that they smoked cigarettes compared to 14 percent of adults making \$50,000 or more per year.⁸
- In Colorado, 18 percent of whites smoke compared to 21 percent nationally and 15 percent of African-Americans smoke in Colorado compared to 20 percent nationally.⁹
- In contrast, 25 percent of Hispanics in Colorado smoke, compared to 15 percent nationally.¹⁰

Figure 1. Annual per capita cigarette pack consumption: United States and Colorado, 1994-2004

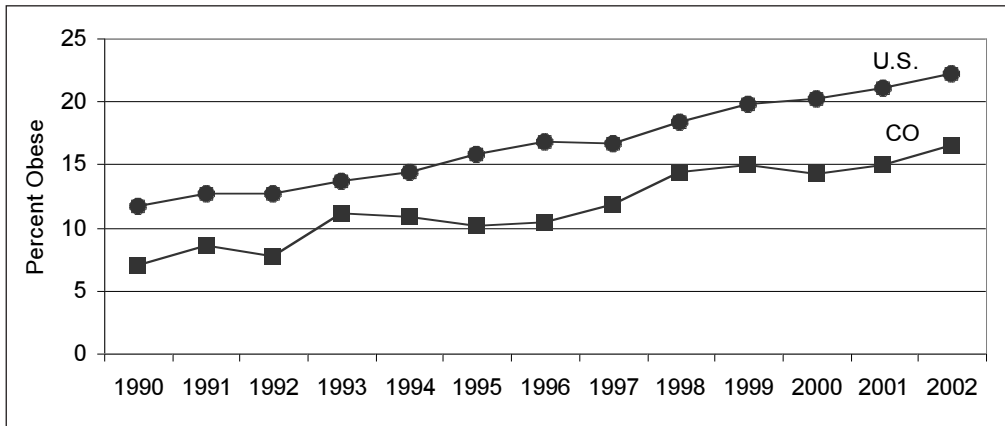


Source: Colorado Tobacco Education and Prevention Partnership 2003-04 Annual Report (2004).

Indicator 2: The prevalence of obesity and diabetes among adults

Obesity is increasingly becoming a risk to adult health. If current trends continue, the Centers for Disease Control projects obesity will surpass smoking as the leading cause of preventable death in the United States.¹¹

Figure 2. Median percentage of obesity for all adults 18 and older with a body mass index of 30 or more, nationwide and Colorado, 1990 – 2002



Source: Centers for Disease Control, National Center for Chronic Disease Prevention & Health Promotion, Behavioral Risk Factor Surveillance System, accessed Sept. 8, 2005.

Compared to the nation, Colorado adults tend to be relatively lean and physically active. Colorado’s overall 15 percent obesity rate is one of the lowest in the nation.¹²

However, as Figure 2 shows, the portion of Colorado adults judged to be obese more than doubled, from 7 percent in 1990 to 17 percent 2002.

Nationally and in Colorado, obesity rates tend to be higher for Hispanics and African-Americans compared to whites.¹³

Between 1990 and 2003, the portion of obese African-Americans increased from 8 percent to 25 percent, whites from 7 percent to 15 percent, and Hispanics from 13 percent to 23 percent. Obesity among African-Americans and whites increased faster than the national average.

Research shows that African-Americans, Hispanics, Asian Americans and American Indians are genetically more susceptible to developing type 2 diabetes.¹⁴

Research also shows that while race and income affect adult obesity and diabetes, income appears to have the stronger effect, as shown in Table 1.

Table 1. Percent of all Colorado adults aged 18 and older who are obese and percent who have diabetes, by income, education and ethnicity, 2002-03

	Obese	Diabetes
Income level		
Less than \$25,000	19.2%	6.6%
\$25,000-\$49,999	18.3%	4.8%
\$50,000 and above	14.6%	3.5%
Educational level		
Less than high school	21.2%	7.7%
High school degree	19.9%	5.5%
Some college or more	14.5%	3.9%
Race/Ethnicity		
Black	25.0%	5.8%
Hispanic	23.0%	5.6%
White	14.8%	4.3%

Source: Colorado Department of Public Health and Environment, Behavioral Risk Factor Surveillance System, accessed August 2005.





Indicator 3: Suicide among Colorado adults

If left untreated, depression-related illness can be fatal. Ninety percent of suicides are associated with depression or substance abuse.^{16, 17}

For reasons that are not clear, suicide rates are higher in the West. Colorado is consistently among the top 10 states for suicide deaths. In fact, Colorado's suicide rate has consistently been 40 percent higher than the national average since data was first collected in 1910.¹⁸

Nationally and in Colorado, women are more likely to consider suicide than are men, but suicide completion rates are four times higher for men.¹⁹

The largest number of suicide deaths occurs among men 35 to 44, with the risk for suicide increasing for those with a mental illness or who abuse alcohol.²⁰

Being unemployed or having a lower income also increases the risk of suicide. In Colorado, adults with household incomes of

Mental health disorders lead to and are the result of lost opportunity

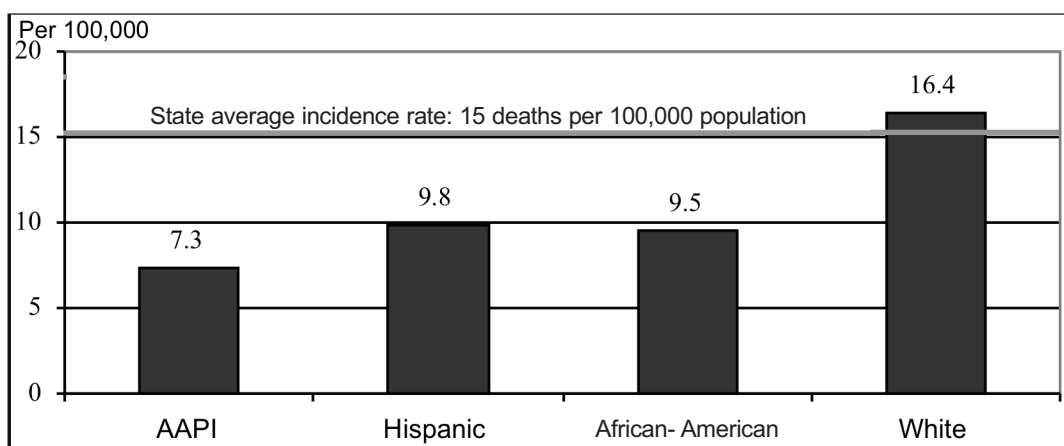
When undetected and untreated, "...mental disorders interrupt careers, leading many into lives of disability, poverty, and long-term dependence.

"Our review finds a shocking 90 percent unemployment rate among adults with serious mental illness – the worst level of employment of any group of people with disabilities."¹⁵

– The President's New Freedom Commission on Mental Health
2003

less than \$15,000 are three times more likely to have suicidal thoughts than those with annual incomes of \$25,000 or higher.²¹

Figure 3. Colorado age-adjusted suicide death rates by race/ethnicity, five-year annual average, 1998-2002



Source: Adapted from the Colorado Department of Public Health and Environment, Racial and Ethnic Disparities in Colorado 2005 report, Figure 49, p. 23.

Note: The number of suicides among American Indians is small and cannot be calculated. AAPI represents Asian Americans and Pacific Islanders.

Note: Age adjustment is a statistical method used to eliminate differences in age distributions among different populations.

Indicator 4: Prevalence of alcohol abuse among adults

Alcoholism has long been misunderstood as a moral problem. However, evidence from biology and population studies show that alcohol abuse has a genetic basis.²² Studies also show that alcohol abuse and mental health problems such as depression often occur together.²³

Alcoholism damages lives and family relationships.

The Colorado Alcohol and Drug Abuse Division estimates that 253,400 teen and adult Coloradans abuse alcohol or drugs.²⁴ According to a 2001 study, Colorado ranked fifth in severity nationally on the Alcohol Problem Index.

Of the women in alcohol treatment programs in 2005, 7 percent were pregnant, compared with 1 percent nationally.²⁵

In 2004-05, 36,281 Colorado children had a parent in an alcohol detox program or in alcohol treatment resulting from a driving under the influence charge.²⁶

According to the Centers for Disease Control, there are about 100,000 alcohol related deaths nationwide each year.²⁷ In Colorado there were 1,082 alcohol related deaths in 2002 and 1,141 in 2003.²⁸

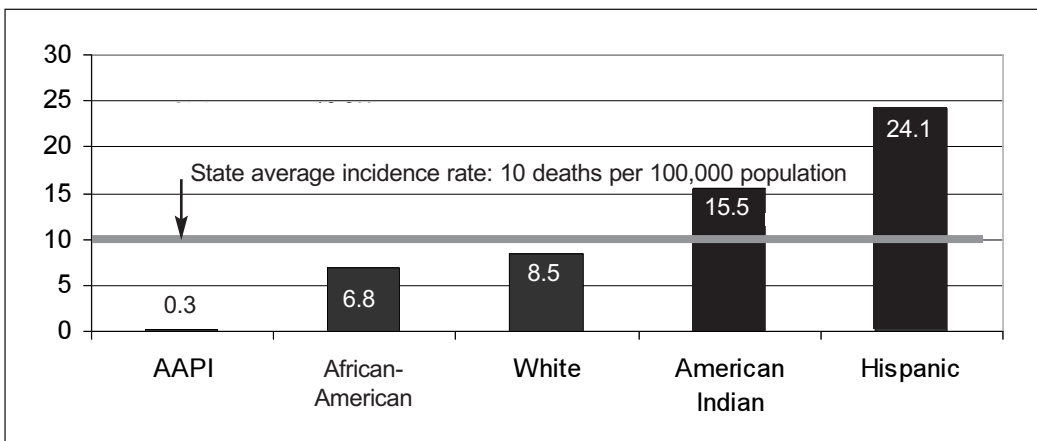
As part of the federal Healthy People 2010 initiative, the National Institutes of Health and the Substance Abuse and Mental Health Services Administration targeted cirrhosis deaths as an indicator of alcohol abuse.

Heavy alcohol consumption is the leading cause of cirrhosis, better known as chronic liver disease, which is the 12th leading cause of death nationally.

Because of the close relationship between chronic liver disease deaths and alcohol and substance abuse, these death rates are an indicator of alcohol abuse. This measure helps identify alcohol abuse and uncover health disparities within segments of the population.

The average death rate in Colorado from chronic liver disease is 10 per 100,000 residents. American Indians and Hispanics have higher rates of death from chronic liver disease than other ethnic groups, and their rates exceed the statewide average. These populations are at greater risk of alcohol and substance abuse.

Figure 4. Colorado chronic liver disease death rates per 100,000 by race/ethnicity, 1998-2002 (age-adjusted)



Source: Adapted from the Colorado Department of Public Health and Environment, Racial and Ethnic Disparities in Colorado 2005 report, Figure 13, p. 10. Note: AAPI represents Asian Americans and Pacific Islanders. See Fig. 3 for explanation of age adjustment.





Indicator 5: Health insurance coverage for non-elderly adults

Access to health care often depends on whether a person has health insurance coverage. Health insurance can be provided by employers, through public programs such as Medicaid or purchased by individuals.

The portion of non-elderly adults in Colorado without health insurance increased from nearly 16 percent in 2000 to 18.5 percent in 2004. Now, nearly one-fifth of Colorado's working-age adults do not have health insurance coverage.²⁹

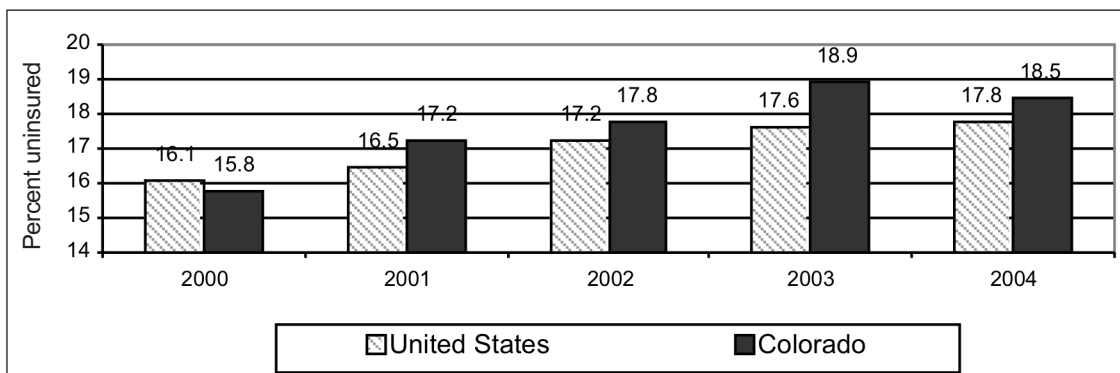
Of those non-elderly adult Coloradans without health insurance, 51 percent are white and 41 percent are Hispanic.³⁰

No data were available to compare the portion of African-American Coloradans without health insurance to those nationally. Members of other races and ethnicities account for 5 percent of Colorado's uninsured non-elderly adults, compared to 7 percent nationally.

Many workers get health insurance through plans sponsored by their employers. As the cost of health insurance increases, more employers are cutting back coverage.

- From 1995 through 2001, a larger portion of private sector employees in Colorado received employer sponsored health insurance coverage than did workers nationally.³¹
- Beginning with the onset of the recession in 2001, the portion of Colorado workers with workplace health insurance coverage declined from 59 percent to equal the national average of 56 percent in 2004.
- Many workers who lost coverage worked in small businesses. In that sector, Colorado employers offering health insurance declined from 67 percent in 2001 to 58 percent in 2002.³²
- The number of people covered by small employer groups in Colorado dropped by 165,000, or 30 percent, between 2000 and 2004.³³ Throughout the 1990s, Colorado was at or above the national average for the percent of small firms (three to 99 workers) that offered health insurance to workers.³⁴

Figure 5. Percent of all people younger than 65 without health insurance, U.S. and Colorado, 2000 to 2004



Source: U.S. Census Bureau, Current Population Survey, 1988 to 2005 Annual Social and Economic Supplements, Table HI-6. Available at: <http://www.census.gov/hhes/www/hlthins/historic/hihistt6.html>

Indicator 6: Non-elderly adults covered by Medicaid

One way of compensating for the loss of employer sponsored health benefits is to enroll low-wage workers in the state’s Medicaid program.

Colorado’s Medicaid program has stringent income limits and covers very few optional services. As a result, the state’s decline in workplace health benefits was not offset by increases in Medicaid coverage.

Although the percentage of Colorado residents enrolling in Medicaid grew faster than the national average between 2000 and 2004 (24 percent compared to 6 percent), the percent of Colorado adults without insurance grew more rapidly.

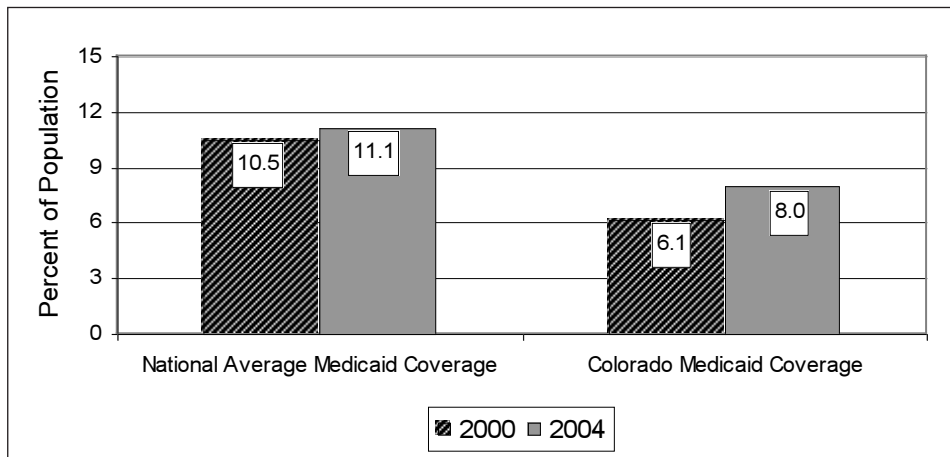
In fact, Colorado Medicaid covers fewer people than nearly any other state; we rank 49 out of 50 states in terms of the percentage of low-income adults covered by Medicaid.³⁵ Overall, we enroll fewer non-elderly adults in Medicaid and have more uninsured residents compared to the nation.

High rates of uninsured and low Medicaid coverage rates lead to greater use of more costly health care such as emergency rooms or hospitalization.³⁶ Because patients are less likely to pay the full costs of treatment, costs go up for health providers. Providers, in turn, shift these costs to other payers, primarily those with private health insurance.

In 2002, Colorado hospitals provided nearly \$3.9 billion in uncompensated care (i.e., bad debt, charity care and the gap between actual cost and government reimbursement), an increase of 136 percent since 1998.³⁷

These costs are often transferred to paying customers in terms of higher health insurance premiums, co-pays and prescription drug costs.

Figure 6. Comparison of non-elderly Medicaid enrollees, nationwide and Colorado, 2000 and 2004



Source: U.S. Census Bureau Table HI-6. Health Insurance Coverage, Status and Type of Coverage by State, People Under 65: 1987 to 2004





What is Colorado doing?

Smoking, obesity and exercise

In 2004, Colorado voters approved Amendment 35, increasing state tobacco taxes by 64 cents per pack of cigarettes.

These new tobacco taxes help fund the Supplemental Old Age Pension, Health and Medical Care Fund, local government health programs, health care expansion, medical benefits for legal immigrants, tobacco education programs, prevention and early detection of cancer, breast and cervical cancer treatment and chronic disease management.

The Colorado State Tobacco Education and Prevention Partnership is developing a comprehensive tobacco control program. The long-term goals are to prevent teens from starting to smoke or chew, encourage teens and adults to quit using tobacco, and reduce everyone's exposure to secondhand smoke.

In 2001, Colorado implemented the Colorado Physical Activity and Nutrition Program for schools, communities and worksites. In 2004, the program launched a campaign to encourage adults to get more exercise and eat better.

Meanwhile, the federal Office of Disease Prevention and Health Promotion put into action its Healthy People 2010 goals and objectives.

The state Department of Public Health and Environment sponsors the program in Colorado. Using money from Colorado's new tobacco tax, the agency is working with community health departments and clinics to improve cardio-vascular health, curb obesity and help smokers quit.

Substance abuse and mental health

In 2005, the Colorado Legislature passed HB05-1015, making substance abuse outpatient treatment a covered service under Medicaid. This will help provide substance abuse treatment to low-income people.

The Legislature also passed SB05-59 to boost local funding for mental health care and substance abuse treatment. Under this bill, local governments may ask voters to approve special districts and related taxes to fund mental health services and programs for residents living within the district.

Following the deaths of two college students in 2004 from binge drinking, Colorado's universities are stepping up alcohol education efforts.

The University of Colorado requires all new freshman to log on to the AlcoholEdu Web site, view a three-hour presentation and pass a test. CU expels students on their second alcohol violation.

Colorado State University formed an alcohol task force, led by Lt. Gov. Jane Norton, to recommend ways to reduce alcohol abuse on campus. In response CSU is better educating students about the dangers of alcohol abuse, increasing communications to parents about alcohol related issues, creating a student-led organization focusing on preventing alcohol poisoning and working to improve oversight of fraternities.

Health insurance

The most significant policy change has been voters' approval of Referendum C. The law directs one third of the revenues retained over the TABOR limit, projected at \$1 billion over the next five years, toward health insurance for citizens and restoring cuts to health services and programs.

The Colorado Legislature assigned three interim committees in 2005 to study health insurance issues and find ways to expand coverage to more Colorado residents.

The committees held hearings and considered policy options to encourage more employers, particularly small businesses, to provide health insurance plans for their employees.

What more should Colorado do?

Alcohol and substance abuse

Prevention and treatment are effective in reducing alcohol and substance abuse in Colorado. However, insurance coverage for alcohol and substance abuse is limited.

People with untreated alcoholism seek emergency room treatment 60 percent more often and are nearly twice as likely to be hospitalized overnight.

In 2003, 82 percent of the 19,569 committed adult population needed substance abuse treatment. Incarcerating one adult drug offender in Colorado cost \$27,825 per year in 2003; average time served is 25 months.

Recommendation: Colorado should create a parity law, giving alcohol and substance abuse treatment the same benefit levels and limits as other chronic relapsing disorders. A study by the National Institute of Mental Health found other states with mental health parity had lower costs than expected.

Recommendation: Colorado should increase the state alcohol excise tax. Colorado has one of the lowest alcohol excise tax rates in the nation, \$2.28 per gallon compared to the national median of \$3.75 per gallon.

Health insurance

An increasing number of workers no longer have employer sponsored health insurance. Colorado's highly restrictive Medicaid program is not an option for many low-income workers.

Medicaid is a dollar-for-dollar state and federal partnership. 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.

Colorado Medicaid was further eroded during the recession, especially physician, clinic, and hospital reimbursements. To contain costs, Colorado further reduced reimbursements, resulting in fewer doctors accepting new Medicaid clients and hospitals absorbing more costs.

Both public and private spending for health care increased yet private health care is shouldering more of the cost burden. To cover uncompensated costs, hospitals are shifting costs onto the private insurance market and insurance premiums continue to climb.

With the passage of Referendum C the state will have additional revenue to invest in the Medicaid program.

Recommendations: Colorado should increase income eligibility requirements for Medicaid from 133 to 185 percent of poverty, as described in Gateways 1 and 2.

The interim committees of the General Assembly studying health care issues have identified several options to expand employer sponsored health insurance plans. The voters' approval of Referendum C means that there will be funding available to help implement these recommendations.

Recommendation: The Legislature should carefully consider the options presented by the interim committees studying health care and adopt legislation to expand the number of workers covered by employer sponsored health insurance plans.

