AN FTI CONSULTING REPORT – UPDATED MAY 2021

Colorado Government Option:
Impact on Racial and Ethnic Minority Groups

EXPERTS WITH IMPACT™

As Colorado lawmakers prepare for the close of the 2021 legislative session, the state's public option proposal, referred to here as the "state government option," remains under consideration. Previously, FTI detailed how the policy could prove detrimental to health care providers while resulting in marginal coverage gains in the state. In this brief, FTI revisited our analysis of the state government option to update our impact findings with the most recently proposed state government option hospital payment rates and to understand how the proposal could affect vulnerable populations, particularly those in communities that rely on hospitals that would be at high financial risk—meaning they would face losses of $1 million or more—under the new system.

Given the COVID-19 pandemic, and its disproportionate impact on racial and ethnic minorities, FTI updated this brief in May 2021 to reflect the greater challenges that these populations face under a strained health care system. We explored how systemic inequities in Colorado impacted racial and ethnic minority communities during the COVID-19 pandemic. The pandemic further revealed existing barriers to care for racial and ethnic minorities – namely transportation constraints and limited internet access. Should the state government option threaten the viability of health care providers that serve racial and ethnic minority communities, these barriers could amplify their existing health care access challenges.

FTI analyzed the demographics of those communities and patients served by providers expected to suffer significant losses under the proposal. The analysis allowed us to detail the potential impact a reduction of services—either through service line cuts or full facility closures—could have on the economically disadvantaged and racial and ethnic minority groups in Colorado. While Colorado ranks above the U.S. median for general health status, significant variations exist across the state.[1] Ultimately, we conclude that ensuring adequate resources for providers that serve higher percentages of minority populations is essential to protecting access to care and tackling health disparities.

Background: The State Government Option and Previous Findings

In March 2020, lawmakers in the Colorado General Assembly introduced a bill that would establish a state government option for health care coverage. Due to the COVID-19 pandemic and the resulting shutdown of the 2020 legislative session, consideration of the legislation was postponed until 2021.

Previously, FTI examined this proposal to determine its impact on health care access, insurance coverage, premiums, and the continued availability of private insurance plans. In our previous analysis, we modeled a government option and assessed its impact on existing ACA plans and the insurance market. We found that coverage gains under the program would be limited, resulting in a reduction in the uninsured rate of just 0.3 percentage points. In addition, introducing a government option would result in a discrepancy in premiums that would cause half of the current ACA enrollees in Colorado to move to the government plan by 2030.

Despite the program's limited impact on coverage, our previous analysis found that rate setting under the state government option, which we assumed would be set at 185 percent of Medicare, would lead to significant losses in hospital reimbursements over time. The reduction in revenue and the cuts would disproportionately impact certain regions and hospitals in the state, putting up to 23 rural hospitals at increased risk of closure. Meanwhile, 25 urban hospitals would see reimbursement cuts ranging from 28 to 57 percent for services provided to patients covered under the state government option. The revenue cuts could result in a reduction of services and limit access to care in impacted communities. This analysis updates and builds upon those findings to determine the impact of proposed reforms on specific underserved populations, including low-income Coloradans and racial and ethnic minority populations.

Colorado State Government Option

In March 2020, the Colorado state legislature introduced a bill to establish a state government option for health care coverage. The legislation is based on policy recommendations that were submitted in 2019 by the Department of Health Care Policy and Financing (HCPF) and the Division of Insurance (DOI). Key provisions of the plan include:

- Administration of the state government option by private commercial insurers operating in the individual market. Insurers would be required to offer the Colorado option alongside their private plans and to take on the associated risk.
- Offering the state government option as a Qualified Health Plan (QHP) through Connect for Health Colorado. Consumers eligible for federal premium tax credits or subsidies could use them to purchase the state government option.
- A minimum medical loss ratio (MLR) requirement set at 85 percent, reflecting the percent of premium dollars that must go towards patient care.
- Hospital-specific variable payment rates set by the Insurance Commissioner (DOI and HCPF have recommended between 155 and 218 percent of Medicare).
- Mandatory participation by hospitals (non-compliance could jeopardize a hospital's license).
- An effective date of January 1, 2022, if passed by the state legislature.

Sources: Final Report for Colorado's Public Option (November 15, 2019) and HB20-1349 Colorado Affordable Health Care Option (March 5, 2020)

Key Findings

- Introducing a state government option would result in a discrepancy in premiums that would cause half of the current ACA enrollees in Colorado to move to the government plan by 2030. Still, coverage gains under the proposed state government option would be limited, resulting in a reduction in the uninsured rate of just 0.3 percentage points.
- Once fully implemented, 78 percent of Colorado hospitals would face cuts to reimbursements due to government rate setting under a public option, totaling up to $112 million in losses annually.
- Despite overall measures of health that place Colorado well above the national average, health disparities persist—even within its largest cities—rendering certain populations in the state disproportionately vulnerable to even modest reductions in health care access.
- Hospitals in the state fill a critical gap in care for Black and Hispanic/LatinX Coloradans, who are more likely to face access challenges compared to their white counterparts and rely more heavily on hospital services to meet basic health care needs.
- Access to care is not solely a function of insurance coverage. Should the state government option result in hospital closures or the elimination of service lines, the state government option could exacerbate health care access challenges that plague racial and ethnic minority communities.
- The introduction of a state government option may negatively impact payer mix for Colorado providers, particularly among those who predominantly treat racial and ethnic minority patient populations. To remain financially viable, these providers may be forced to increase volume and reduce time spent with individual patients.
- Over 40 percent of hospitals at higher risk for closure as a result of reimbursement cuts under the state government option serve racial and ethnic minority communities, many of which already contend with significant disparities in health status, access, and outcomes.
- Black residents of Colorado experience the largest health disparities, including the highest rates of heart disease, high blood pressure, obesity, asthma, and diabetes. Nearly one-third of at-risk hospitals serve communities with Black populations above the state mean.
- Hispanic/LatinX residents of Colorado represent the largest minority population in the state and experience higher rates of chronic disease than non-Hispanic whites. From Denver to Colorado Springs to Garfield County, hospitals serving Hispanic/LatinX communities would be especially hard hit.
- Ethnic and racial minority populations in rural areas of the state are especially vulnerable. Although the Indian Health Service (IHS) maintains three outpatient facilities in Colorado, tribal health systems such as that of the Southern Ute Indian Tribe rely upon regional hospitals, such as Mercy Regional Medical Center, which stands to lose $2.5 million as a result of declining revenues under a state government option, potentially increasing access challenges for Native Americans in the region.
- Several hospitals at high financial risk are in counties adjacent to rural areas that experience higher rates of poverty and have few, if any, acute care hospitals. Critical Access Hospitals in those rural communities rely upon referral agreements with larger regional hospitals to ensure access to care, arrangements that could be disrupted by hospital closures associated with the introduction of a state government option.

Colorado Demographics and Disparities

Overview

A snapshot of Colorado often shows that the state's 5.8 million residents experience lower poverty rates compared to the rest of the nation. Colorado also consistently ranks among the healthiest states in the country, with the vast majority of residents (85.2 percent) reporting good or excellent health.[2]

However, a closer look into underserved groups, including racial and ethnic minorities and low-income populations, reveals disparities in health care outcomes and access throughout the state, with some underserved groups experiencing rates of poverty and disease that are much higher than the nation's average. As policymakers evaluate the impacts of the state government option on state residents, they should consider where and how Colorado's most vulnerable populations seek care. The benefits of

a state government option must be weighed against the potential disruption to critical lines of care for communities with the highest rates of disease and largest barriers to care in the state.

Colorado's communities of color have faced similar challenges and barriers accessing healthcare coverage during the COVID-19 pandemic. The state's COVID-19 vaccination pace clearly showcases this. By late April of 2021 the discrepancies in access to vaccines between Hispanics/ LatinX, 22 percent of the state's residents, and white residents, 68 percent of the state's residents, were telling enough.[3] White residents had received 80 percent of the state's vaccinations, while Hispanics/ LatinX had received 10 percent.[4] In turn, white residents in Colorado were two times as likely to receive a COVID-19 inoculation than a Hispanic/ LatinX resident.[5]

The Racial and Ethnic Makeup of Colorado

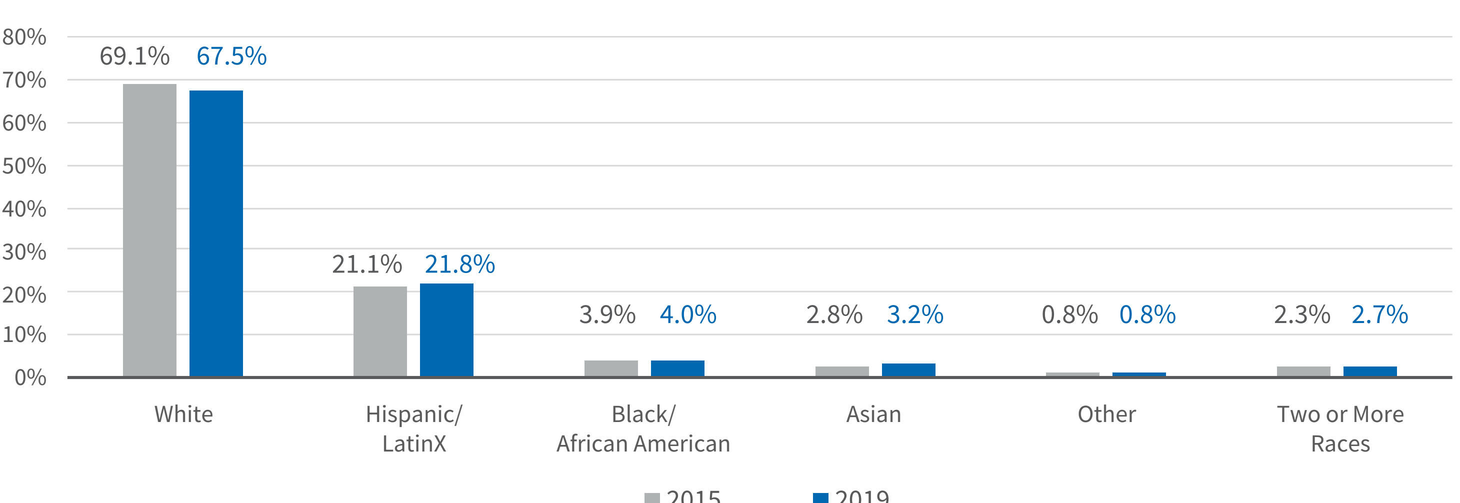
Colorado's racial and ethnic minority population has increased over the last decade, currently comprising about one third of the state's total population (**Figure 1**).

Hispanic/LatinX residents make up the largest ethnic minority population in the state. In fact, Colorado's Hispanic/ LatinX population is among the largest in the country, and with a median age of 27 compared to a median age of 42 among non-Hispanic whites, the population is likely to grow in the coming years.[6,7] The state's prominent Hispanic/ LatinX population traces back to Spanish settlement of the state in the 1800s, which is why the majority of Hispanic/ LatinX people in Colorado were born to families that have resided in the state for generations. In contrast, foreign-born Hispanic/LatinX residents make up only four percent of Colorado's total population.[8] Of those who have immigrated to Colorado, Hispanic/LatinX people still make up the largest portion, with about 40 percent of immigrants in the state hailing from Mexico.[9]

While the Black population in Colorado has long remained below the U.S. average, it has increased by about three percent in recent years, with the city of Aurora—which spans Arapahoe, Adams, and Douglas Counties—seeing the largest increase in Black residents within the last decade. Black Aurora residents make up more than 15 percent of the population in the city and have one of the highest labor force participations of all races and ethnicities in the county.[10]

Over 50,000 people in Colorado identify as Native American, the vast majority of whom reside in the urban Denver and Colorado Springs areas.[11] Since World War II, Denver has served as a central hub for many Native American populations, as the city was one of the first areas to conduct the majority of the Bureau of Indian Affairs' support programs, including relocation and employment assistance. There are at least 200 tribal nations in Denver today and two reservations in Southern Colorado, which are mostly comprised of the Southern Ute Indian Tribe and Ute Mountain Ute Tribe.[12] Colorado is home to three Indian

FIGURE 1: Demographics of Colorado in 2015 and 2019



Source: Census ACS. Note: 'Other' includes some other race alone, or two or more races.

Health Service (IHS) facilities, though none of these are full service hospitals. This means the state's public and private hospitals are essential sources of care for Native Americans.

More than one in three Black residents said they did not go to the doctor in the previous year.

Income and Health Disparities

ACCESS TO CARE

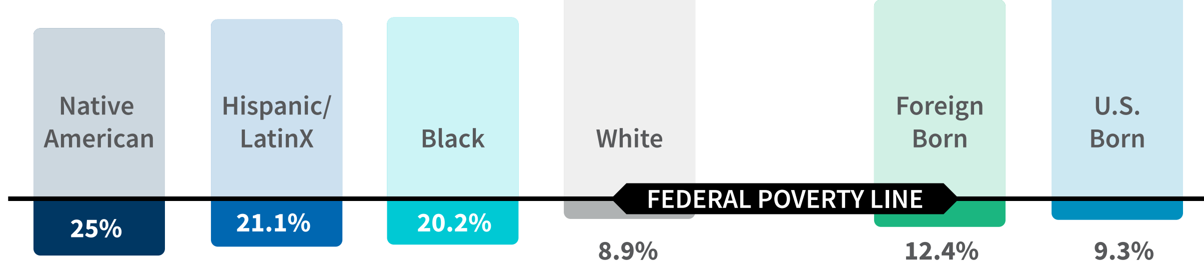
There is an established link between income and health status, meaning low-income Coloradans may be disproportionately impacted by policies that reduce access to health care services, an unintended consequence of the state government option documented in FTI's previous analysis.

Although the poverty rate in Colorado (9.3 percent) is lower than the U.S. average (10.5 percent), racial and ethnic minorities in the state tend to experience poverty at a rate that is even higher than the national average.[13, 14] Coloradans with incomes below the Federal Poverty Line (FPL) are more than twice as likely to report fair or poor health compared to those with higher incomes.[15] Low-income groups also reported challenges accessing care. Nearly one-quarter of low-income Coloradans surveyed in 2016 had not used any preventive care services in the prior year and, strikingly, nine percent did not know where to obtain those services.[16]

Different populations across the state experience these challenges at different intensities. More than a quarter of Hispanic/LatinX Coloradans said they were unable to get an appointment when it was needed compared to about 20 percent of non-Hispanic whites, and more than 23 percent reported they had not visited a general doctor in the past month compared to 17 percent of whites.[17] Similarly, Black Coloradans were among the least likely to report seeing doctors and specialists in the past year compared to other Coloradans. More than one in three Black residents said they did not go to the doctor in the previous year.[18]

Native Americans in Colorado have access to three Indian Health Service (IHS) health centers, two of which are located on or near the Southern Ute reservation and the Ute Mountain Ute reservation, and one that is located in Denver.[19] However, these health centers are not full-service hospitals—meaning they often do not provide certain services, including emergency care or imaging— making Native American Coloradans living in Denver and the reservations dependent on nearby hospitals for purchased or referred care (PRC), even if they are eligible for IHS.[20] In addition, although many Native Americans are eligible for IHS care, some who do not live on or near a reservation or are not part of a federally recognized tribe are dependent on other sources of care, including nearby hospitals and emergency rooms, for specialized and emergency services.[21] About 40 percent of Native Americans in the United states with public insurance and half of those with private insurance report using non-IHS sources of care.[22]

FIGURE 2: Percent of Coloradans Below FPL by Race/Ethnicity



Source: The Bell Policy Center

HEALTH OUTCOMES

In Colorado and across the country, such wide variations in income and access to care contribute to racial and ethnic disparities in health outcomes. About 19.4 percent of Hispanic/Latinx and 18.3 percent of Black Coloradans report fair or poor health compared to only 13 percent of white Coloradans.[23] Overall, Black Coloradans experience some of the worst health outcomes in the state. The incidence of high blood pressure among Black Coloradans is 33.9 percent compared to 26.6 percent among non-Hispanic white populations.[24] Black Coloradans also experience the highest rates of heart disease, obesity, asthma, and diabetes compared to all other racial and ethnic groups.[25] Health measures for the Hispanic/LatinX population follow a similar trajectory. Hispanic/LatinX residents have the second-highest rate of obesity at 29.8 percent, compared to 21.3 percent among white Coloradans.[26] They also experience higher rates of diabetes and asthma compared to their white counterparts, as well as elevated rates of tuberculosis and HIV compared to the state average.[27] Native Americans in Colorado die of vascular disease and diabetes at a higher rate than non-Hispanic whites.[28] Women of Native American heritage are also almost five times more likely to die in childbirth compared to non-Native people.[29]

Through its Health Equity Commission and other initiatives, Colorado is taking important steps to reduce these health disparities, which will require addressing the social determinants of health and ensuring equitable access to care across diverse communities. To this end, each public policy decision must be evaluated not just on its overall impact, but on its specific effects on vulnerable populations and communities in the state. FTI's analysis finds that a state government option could make it even more difficult for vulnerable groups to access essential health care services by threatening the financial stability of health care providers in underserved areas.

State Government Option and Access Challenges

The state government option is promoted as a lower-cost insurance option that will expand coverage to more Coloradans and, as a result, improve their access to care. While insurance coverage does offer greater financial security, access to care is not just a function of insurance coverage, but also of the affordability of care (even with insurance), the proximity or ease of transport to a provider, and the ability to identify an in-network provider. While the state government option might extend insurance coverage to a small number of newly insured Coloradans by offering coverage at a lower premium, it could also unintentionally exacerbate the existing health care access challenges that racial and ethnic minorities and low-income groups in the state currently face.

Access Dictated by Insurance Type

One way that the state government option will be structured to achieve lower costs for consumers is by cutting reimbursements to providers through rate setting. In the health care system today, private plans nearly always pay at higher rates than public plans such as Medicare and Medicaid. In fact, studies have shown that reimbursement rates under private plans are typically double Medicare reimbursements. A 2020 review by the Kaiser Family Foundation found that private insurance paid, on average, 199 percent of Medicare rates. In certain categories, the differential was even higher, with private plans reimbursement for outpatient hospital services specifically averaging 264 percent of Medicare.[30]

Providers are often able to manage the differences in payments between public and private plans by maintaining a balanced payer mix across insurance types. This is usually feasible for providers given that a majority of Americans, including Coloradans, have private, employer-sponsored insurance (ESI). However, some conditions can make it difficult for providers to maintain a healthy payer mix, including in communities where a disproportionate share of patients are covered by public insurance plans with reimbursement rates that fail to cover the cost of providing care.

This can lead to financial distress for providers as well as access challenges for patients, particularly those covered by public plans. In 2017, 10.8 percent of Coloradans could not get a doctor's appointment because the office did not accept their type of insurance.[31] Patients with Medicaid were among those who had the hardest time scheduling appointments, with approximately one in five reporting this challenge.[32] Seniors on Medicare also confront access issues. In 2019, 7.1 percent of Colorado Medicare beneficiaries had trouble finding a provider that would take their insurance, and 7.8 percent reported that a doctor's office told them that they

were not accepting new patients.[33, 34] Furthermore, seniors are increasingly experiencing difficulties getting timely appointments. Over one in six seniors (17.6 percent) above the age of 65 reported going without needed medical care in 2019 because they could not get an appointment quickly enough. This represents more than a six-percentage point increase over the previous year.[35]

Coloradans with certain types of insurance are sometimes able to access care more easily than others. In 2019, Coloradans with ESI were more likely to receive care compared to Coloradans with individual insurance from the market (where the state government option would be offered) or on Medicaid.[36] Coloradans with ESI were also more likely to see a specialist and to have a preventive health care visit.[37]

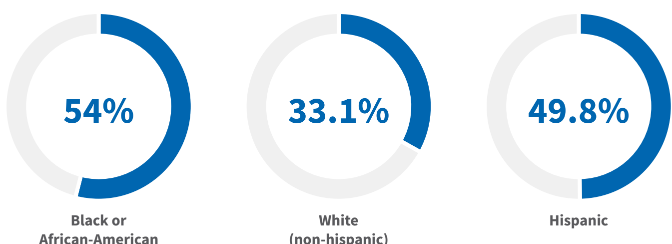
These access barriers may be indicative of the outlook for access if the state government option were implemented. The creation of a new public plan—and the resulting influx of more publicly insured patients—could disrupt providers' payer mixes, leaving more Coloradans restricted by their insurance type than before.[38] In our previous analysis of the state government option, we also speculated that lower reimbursements by the state government option may limit insurers' ability to offer plans with strong provider networks, further exacerbating provider access challenges.[39]

Hospitals Fill Gaps in Care for Vulnerable Coloradans

Hospitals serve as a critical component of the state's health care infrastructure, providing access to both emergent and non-emergent care across Colorado. In 2019, approximately one in five Coloradans went to the emergency room (ER) at least once and, among that group, over one-third (38 percent) reported going to the ER for something that could likely have been treated by a "regular doctor."[40]

In 2018, Black Colorado residents were more likely to visit the ER for a non-emergent condition compared to their white counterparts (**Figure 3**). Furthermore, they were also less likely to see a doctor at all compared to other Coloradans.[41] Hispanic/LatinX Coloradans also went to the ER for non-emergency visits at higher rates than their white counterparts.[42]

FIGURE 3: Percentage of ER Visits That Were Non-emergency by Race, 2015-2017



Source: Colorado Health Institute

So why are Black and Hispanic/LatinX Coloradans more likely to visit the ER for conditions that could be treated by an outpatient physician? Research shows social determinants of health, or the conditions and environments in which people live and work, play a role. For instance, Black Coloradans highly cited transportation as a barrier to care.[43] Other determinants, including income level and work status, can dictate people's ability to afford care or take time off to attend an appointment. Access challenges, such as difficulty getting an appointment or inability to get care after hours, are also factors.[44]

As a result, hospital emergency rooms, which often remain open after primary care centers are closed and are usually easy to access via public transport in urban areas, have emerged as a primary source of care for low-income and racial and ethnic minority groups in the state. A reduction in services or closure of one of these hospitals could take away a crucial source of care for these populations.

State Government Option and Provider Challenges

Changes in Payer Mix Will Strain Providers Caring for Vulnerable Populations

If the state government option is implemented, it will be vital to ensure that providers remain financially viable in order to continue serving the patients who need them most. Under the state government option, achieving the balanced payer mix necessary to remain financially viable may be even more challenging. Patients with private insurance will switch over to the state government option over time,

increasing the share of patients covered by public plans with lower reimbursements. In our previous analysis of the state government option, FTI found that by 2030, 32 percent of Coloradans who currently have private commercial insurance will migrate to government plans.[45]

Such changes in payer mix as a result of the public plan may disproportionately affect providers who already serve a high percentage of racial and ethnic minority patients. In Colorado, the Hispanic/LatinX and Black populations are more likely to have public insurance such as Medicare or Medicaid. For example, in 2017, 43.7 percent of Blacks had public insurance coverage compared to approximately 25 percent in the whole population.[46] Research shows that U.S. physicians in high-minority practices that have higher dependency on government programs like Medicaid face barriers to delivering the full continuum of quality care necessary. To remain viable with limited resources, these providers are often forced to compensate through higher patient volume or shorter visit times.[47] Nearly one in four physicians with a high-minority practice reported having insufficient time with patients during office visits, and providers in these practices reported spending almost 30 percent less time with patients than providers in low-minority practices.[48] Such time constraints on patient visits may exacerbate challenges associated with addressing specific cultural or socioeconomically-related needs due to language barriers, lower incomes, or a lack of transportation access.

Providers face similar challenges serving low-income beneficiaries. Interviews with primary care researchers by The Commonwealth Fund found that low reimbursement under public programs impact providers' ability to provide high-quality care to low-income beneficiaries.[49] Just as with high-minority practices, providers serving low-income populations reported experiencing limitations on the amount of time they could spend with patients.[50] In interviews with primary care providers serving low-income populations, many physicians expressed frustration with limitations on their time, noting that they can only address a couple of problems per patient. Yet, many of their low-income patients have needs associated with social determinants of health (such as issues with housing), which are beyond what can be addressed in a short visit.[51]

Providers across geographies have expressed difficulty remaining viable when confronted with an influx of patients on government plans, a trend likely to follow implementation of the state government option. In communities where much of the population is already covered by public plans, the financial implications of even modest shifts in payer mix may be financially devastating for those operating under tight margins.

Cuts to Hospitals Serving Large Racial and Ethnic Minority Populations Could Worsen Access Challenges and Existing Health Disparities

Limited Effects on Coverage, but Major Impacts to Hospital Finances

Given the health care access and outcome challenges faced by racial and ethnic minorities in Colorado, we sought to further explore how the state government option would specifically impact these populations and the providers that serve them. In our previous analysis, FTI determined that the state government option itself would have a limited impact on health insurance coverage in the state, insuring just over 18,000 people and driving the uninsured rate down by only 0.3 percent.[52] The state government option would, however, have major implications for hospital finances in the state, including many hospitals that serve populations comprising higher-than-average rates of racial and ethnic minorities. Changes in service delivery in these areas could be harmful to these populations.

Based on Medicare cost reports for 77 hospitals across Colorado, our original analysis found that 83 percent of these hospitals would see a reduction in payments under the state government option.[53, 54] To better account for varying reimbursement patterns across hospitals and regions, FTI updated our analysis and findings in this report to include hospital-specific carveout rates released in March 2020 by the Colorado Division of Insurance. These are the specific payments as a percentage of Medicare that each hospital will be reimbursed at under the state government option.[55] Our updated results are consistent with the original findings and show that, when using the 2020 hospital-specific rates, 78 percent of hospitals (60) would face pay cuts under the state government option, totaling up to $112 million in losses annually once the policy is in full effect.

Hits to hospital finances can create ripple effects across the health care delivery system. If hospitals cannot absorb

these impacts, they may be forced to limit service offerings or shut down altogether. For example, some hospitals facing financial difficulties over the last several years have taken dramatic steps such as eliminating obstetric services or closing down their emergency rooms.[56, 57, 58] The COVID-19 pandemic has served as a real-time example of the implications of reduced hospital revenue. Many hospitals nationally have closed under the financial strain and are considering reducing services.[59] Research shows that altering travel time to a hospital, even by as little as five minutes, can increase the risk of death due to an emergency issue, such as a heart attack, demonstrating how reductions in access to care have the potential to dramatically impact health outcomes in a community.[60]

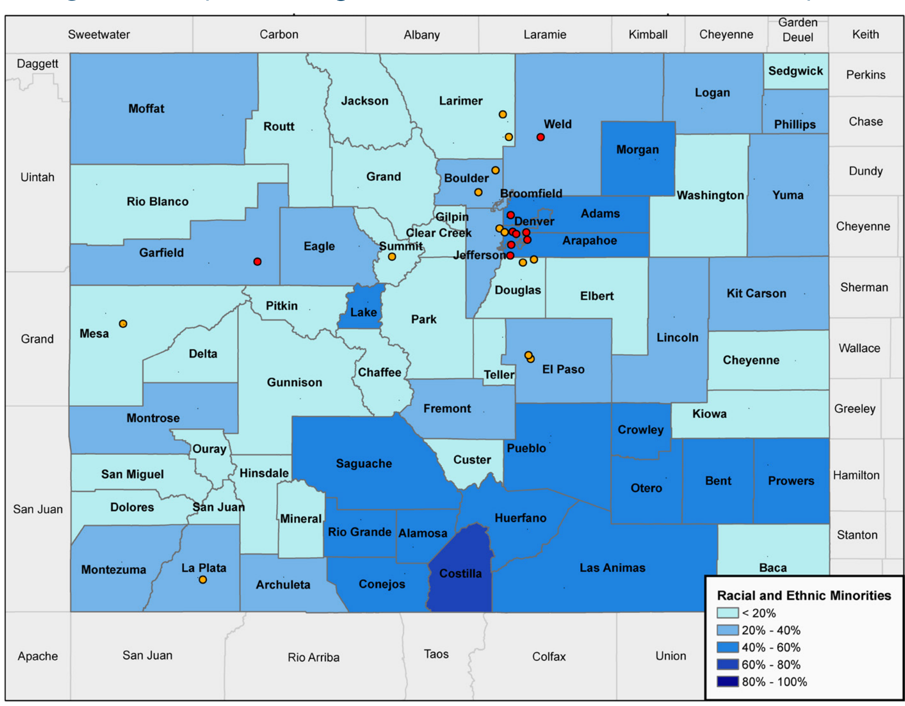
Hospitals and Areas at Highest Risk of Severe Cuts

While nearly all Colorado hospitals will experience rate cuts under the state government option, some hospitals will face larger cuts than others. We consider a hospital "high-risk" if it would face greater than $1 million in losses under the public program. A total of 22 Colorado hospitals are considered high-risk, with losses ranging from $1 million up to $16 million (see Appendix Table 1). These hospitals, shown as both red and orange dots on the map (**Figure 4**), are concentrated in Colorado's major population centers and urban areas, such as the larger Denver area and along the Front Range Urban Corridor. Several high-risk hospitals are also located in rural parts of the state, such as La Plata County (Durango) and Garfield County (Glenwood Springs). These hospitals serve diverse populations across racial and ethnic groups and socioeconomic statuses.

Hospitals Serving Racial and Ethnic Minority Populations Face Significant Financial Risk

To understand how these hospital financial challenges could specifically impact Colorado's racial and ethnic minority populations, we examined how many of the high-risk hospitals are located in areas with an overall racial and ethnic minority population above the state average of 33 percent. Of the 22 high-risk hospitals, nine (marked in red on Figure 4 and in Appendix 1) are in counties with racial and ethnic minority populations that are larger than the state average, with most in the Denver region, including the cities of Aurora, Denver, Englewood, Littleton, and Thornton. Many of these cities are also in the bounds of Arapahoe County, which is designated a primary care health professional

Figure 4: Hospitals at High-Risk Under the State Government Option



Points represent high-risk hospitals. Red denotes that hospital is located in county with ≥ 33 percent (average) racial and ethnic minority population. Orange denotes hospital is located in county < 33 percent (average) racial and ethnic minority population.

Source: Authors calculations using Medicare cost reports, hospital reimbursement rates, and American Community Survey (ACS).

shortage area (HPSA), a federal designation indicating health care access challenges.[61] Two hospitals are located an hour or more from Denver, including one 50 miles outside of Denver in Weld County, and another in rural Glenwood Springs on the state's Western slope.

Given that Hispanic/LatinX populations are the largest racial and ethnic minority group in the state, it is unsurprising that this group is disproportionately represented in the high-racial and ethnic minority counties where these nine high-risk hospitals are located. However, the larger Denver area is extremely diverse and is also home to a higher-than-average percentage of Blacks, Asians, and other minority populations such as Native Americans.

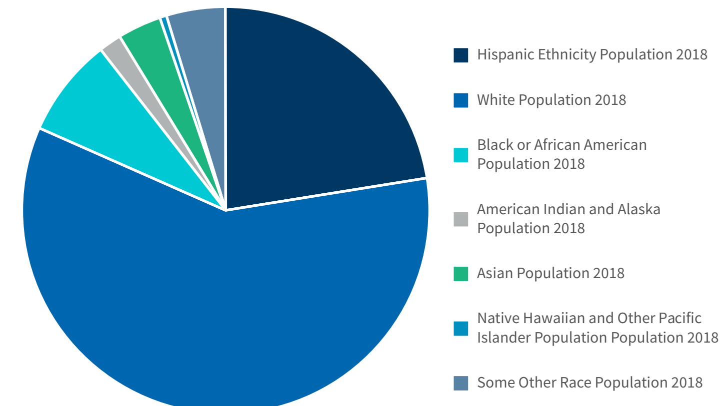
It is worth noting that the socio-economic barriers that limit access for communities of color tend to worsen within rural communities. For instance, Hispanics/LatinX tend to have limited access to internet, a resource needed to book critical health care services such as COVID-19 inoculations. In a similar vein, communities of color have been reportedly more likely to face transportation challenges when procuring COVID-19 vaccine inoculations.[62] It's well known that challenges such as access to internet and transportation means aggravate within rural areas, further challenging the access needs within the rural, mostly Hispanic/ LatinX, counties of Southern Colorado.

GREATER DENVER

Denver and its neighboring cities have many health care facilities, including hospitals that serve racially and socioeconomically diverse patient populations. But health disparities and barriers to health care access exist in Denver just as they do across the nation.

Community needs assessments have identified that Denver residents face several barriers when it comes to accessing health care, and this is particularly true of Hispanic/LatinX and Black residents. These assessments found common themes such as difficulty accessing health care services by public transportation, difficulty accessing specialty care, and limited hours of operation by providers.[63] Many of these issues particularly affect Hispanic/LatinX and Black populations, who make up Denver's largest minority populations (**Figure 5**) and who have been pushed into neighborhoods farther outside of the city and away from community resources due to increased gentrification.[64]

Figure 5: Denver Population by Racial/Ethnic Group



Source: Denver Health and Hospital Authority

Where people live in Denver plays a role in their health status and life expectancy. Certain neighborhoods in Denver with large Black and Hispanic/LatinX populations, such as Mar Lee and Northeast Park Hill, have life expectancies up to ten years lower than more white, affluent areas of the city, such as Washington Park and Hampton.[65] There is also overlap between life expectancy and rates of chronic disease among the Denver neighborhoods. According to the 2020 Denver Health and Hospital Authority Community Health Needs Assessment, neighborhoods with lower life expectancy also tend to be neighborhoods with higher hospitalizations from chronic diseases such as asthma, diabetes, and heart disease.[66]

Similarly, access to health care—particularly hospital services—varies across the Denver area. If a hospital is put at financial risk, this could create barriers to care or worsen access challenges that residents of that community already face. For example, our analysis finds that two Denver hospitals, Presbyterian St. Luke's Medical Center and Rose Medical Center, as well as the nearby University of Colorado Hospital, The Medical Center of Aurora in the city of Aurora, and Swedish Medical Center in Englewood, are considered high-risk financially due to the state government option. In total, we estimate the reduction in revenues to Denver hospitals at higher risk of closure is approximately $5.3 million.

When examining the communities that these hospitals serve, it is apparent that service cuts or closures of these hospitals could disproportionately impact racial and ethnic minority populations. For example, Presbyterian St. Luke's Medical Center is one of the closest hospitals to the Elyria Swansea neighborhood, a majority Hispanic/

LatinX community (82 percent), and to the Northeast Park Hill Neighborhood, which has a large Black population (42 percent).[67, 68] Similarly, Swedish Medical Center is one of the closest hospitals to the largely Hispanic/LatinX neighborhoods of College View, South Platt, and Ruby Hill.[69] Furthermore, University of Colorado Hospital in Aurora is the closest hospital to Montbello, a majority Hispanic/LatinX community (62 percent) in Denver that has become increasingly diverse in recent years due to the rapid gentrification of central Denver.[70] Beyond Denver, the city of Aurora itself has become increasingly diverse following an influx of Black residents over the last decade.[71] Any reduction in services or facility closures in these communities threatens to exacerbate existing health disparities in the Denver region.

GREELEY/WELD COUNTY

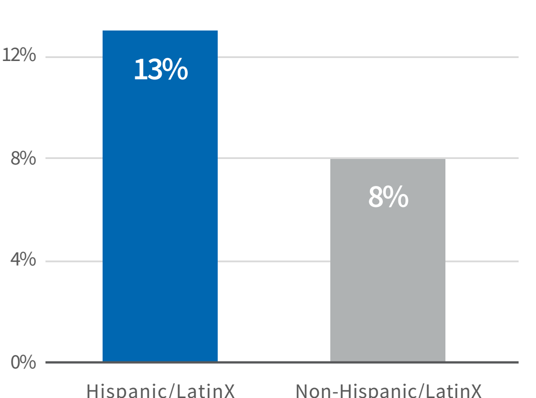
The state government option may also disproportionately impact vulnerable populations in Weld County, which extends from the Denver suburbs to the Wyoming and Nebraska borders. Today, residents of Greeley, the county seat known for its meatpacking and sugar beet industries, experience a higher prevalence of chronic conditions like high blood pressure, obesity, and asthma than other parts of the county.[72, 73, 74] These residents are also more likely to rely upon the ER for non-emergency conditions, rendering the small city's hospitals a critical source of care (**Figure 6**).[75] Hispanic/LatinX residents, who make up 39 percent of the population in Greeley, experience chronic health issues at higher rates than their non-Hispanic peers.[76] Should the state government option be implemented in Colorado, one of the city's two hospitals would be put at significant financial risk. Cuts to North Colorado Medical Center from the state government option estimated at $6.3 million represent a significant threat to jobs and access to care for the city's diverse population.

GLENWOOD SPRINGS/GARFIELD COUNTY

On Colorado's Western Slope, residents of Garfield County are served by just one full-service acute care hospital, Valley View Hospital in Glenwood Springs, and a Critical Access Hospital (CAH) nearly 30 miles west. While CAHs are essential to rural communities, these providers depend upon referral agreements with larger regional hospitals to meet the full spectrum of patient care needs. We estimate that rate setting under the state government option would result in a reduction in revenues of $2.4 million for Valley View Hospital, threatening the hospital's viability and access to care for residents of Greeley, 28 percent of whom are Hispanic/LatinX, as well as those in the surrounding area. With higher rates of obesity, hospitalizations due to asthma, and prevalence of alcohol and drug abuse compared to the rest of the state, any reduction in access to care could result in an increase in health disparities among vulnerable groups.[77]

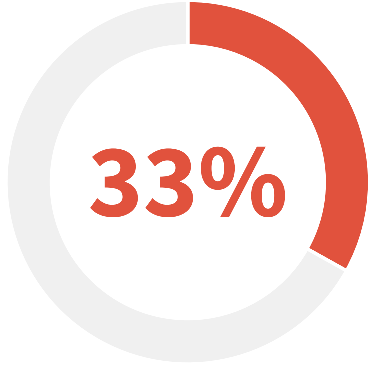
Figure 6: Weld County Health Care Statistics

Diabetes among Hispanic/Latinx residents compared to non-Hispanic/Latinx in Greeley



Source: 2016 Weld County Community Health Survey Part I

Weld county ER use for non-emergent conditions among residents who went to ER in last 12 months



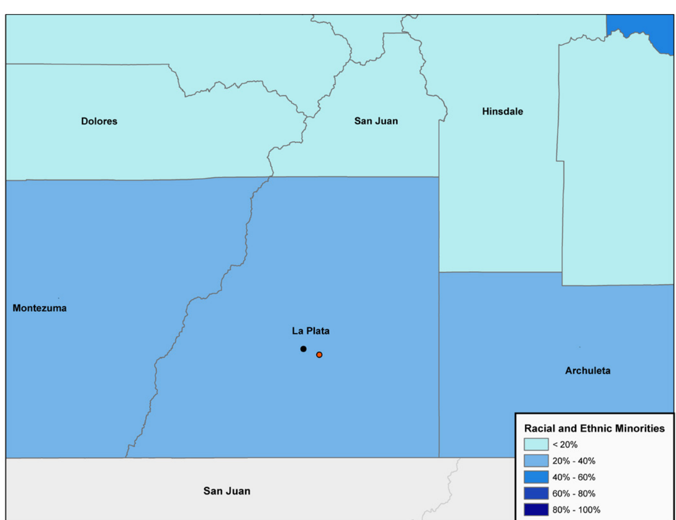
Source: 2016 Weld County CommunityHealth Survey Part II

Hospitals Serving Other Vulnerable Communities at High-Risk Due to the State Government Option

In some cases, Colorado hospitals at high financial risk under the state government option serve significant populations of a single racial or ethnic minority group. For example, of the 22 high-risk hospitals in the state, nearly one-third serve communities like El Paso County, where the Black population is well above the state average at six percent. Black residents in El Paso experience the highest rate of obesity (35.9 percent) compared to white residents (21.8 percent) and the highest rates of smoking (27 percent) compared to other racial and ethnic groups in the county.[78, 79] A strong health care delivery infrastructure is critical to tackling these public health challenges and managing chronic diseases. Rate setting under the state government option, however, would put Penrose-St. Francis Hospital at higher risk of closure, potentially leaving just two full-service acute care hospitals to serve a population of nearly half a million.

Rural southwestern Colorado, home to the Southern Ute Indian Reservation, is also vulnerable to policy changes that would impact the region's health care delivery system. Native Americans living on the Southern Ute reservation do not have access to a full-service hospital on site, but rather a health center with more limited services. For more intensive care, these residents must seek care at one of the county's two hospitals in the City of Durango. These hospitals serve as essential sources of care, both for the county's Native American population, which is four and half times the state average, as well as residents living in neighboring Montezuma, Hinsdale, Archuleta, and Dolores Counties.[80] Under the proposed state government option, Mercy Regional Medical Center, the facility closest to Southern Ute Indian Reservation, stands to lose $2.5 million as a result of declining revenues, potentially increasing access challenges for Native Americans in the region.

Figure 7: Full-Service Hospitals in La Plata and Neighboring Counties



Source: Authors calculations using Medicare cost reports, hospital reimbursement rates, and American Community Survey (ACS).

Conclusion

While the vast majority of Colorado hospitals would experience a reduction in revenues due to rate setting under the state government option, our analysis finds significant variation in the impact of the policy across regions and health care facilities. Of the hospitals at higher risk of closure under the state government option proposal, over 40 percent serve communities with significant racial and ethnic minority populations, threatening to exacerbate health disparities within communities and across the state. Policymakers should carefully consider the costs and benefits of coverage-focused policies like the state government option in the context of the current reality of Colorado residents, many of whom have insurance but still struggle to access providers when needed.

Acknowledgments: This work was supported by the Partnership for America's Health Care Future Action.

Appendix

TABLE 1

Full List of Hospitals at High-Financial-Risk Due to State Government Option

*Red denotes that hospital is located in county with ≥ 33 percent (average) racial and ethnic minority population.

HOSPITAL NAME	COUNTY	CITY	LOCATION TYPE	SERVICE TYPE
Memorial Health System	El Paso	Craig	Rural	Critical Access Hospital
Valley View Hospital	Garfield	Glenwood Springs	Rural	Acute Hospital
Mercy Regional Medical Center	La Plata	Durango	Rural	Acute Hospital
St. Anthony Summit Medical Center	Summit	Frisco	Rural	Acute Hospital
University of CO Hospital	Adams	Aurora	Urban	Acute Hospital
North Suburban Medical Center	Adams	Thornton	Urban	Acute Hospital
The Medical Center of Aurora	Arapahoe	Aurora	Urban	Acute Hospital
Swedish Medical Center	Arapahoe	Englewood	Urban	Acute Hospital
Littleton Adventist Hospital	Arapahoe	Littleton	Urban	Acute Hospital
Boulder Community Hospital	Boulder	Boulder	Urban	Acute Hospital
Longmont United Hospital	Boulder	Longmont	Urban	Acute Hospital
Presbyterian-St. Luke's Medical Center	Denver	Denver	Urban	Acute Hospital
Rose Medical Center	Denver	Denver	Urban	Acute Hospital
Sky Ridge Medical Center	Douglas	Lone Tree	Urban	Acute Hospital
Parker Adventist Hospital	Douglas	Parker	Urban	Acute Hospital
Penrose/St. Francis Healthcare	El Paso	Colorado Springs	Urban	Acute Hospital
St. Anthony Hospital	Jefferson	Lakewood	Urban	Acute Hospital
Lutheran Medical Center	Jefferson	Wheat Ridge	Urban	Acute Hospital
Poudre Valley Hospital	Larimer	Fort Collins	Urban	Acute Hospital
Medical Center of The Rockies	Larimer	Loveland	Urban	Acute Hospital
St. Mary's Hospital & Medical Center	Mesa	Grand Junction	Urban	Acute Hospital
North Colorado Medical Center	Weld	Greeley	Urban	Acute Hospital

Endnotes

1 Bains J. 2020 County Health Rankings. Colorado Health Institute. https://www.coloradohealthinstitute.org/blog/2020-county-health-rankings. Published April 9, 2020.

2 2019 Colorado Health Access Survey: Health of Coloradans. Colorado Health Institute. https://www.coloradohealthinstitute.org/research/2019-colorado-health-access-survey-health-coloradans. Published February 25, 2020.

3 Pham O, Ndugga N, Hill L, Artiga S, Alam R, Parker N. Latest Data on COVID-19 Vaccinations Race/Ethnicity. KFF. https://www.kff.org/coronavirus-covid-19/issue-brief/latest-data-on-covid-19-vaccinations-race-ethnicity/. Published April 28, 2021. Accessed April 30, 2021.

4 Ibid

5 Ibid

6 This includes both white and non-white Hispanic and Latino residents.

7 Latino Research: Colorado's Demographic Destiny. Latino Leadership Institute. https://latinoslead.org/latino-research/#:~:text=The%20median%20age%20of%20Latinos,42%20for%20non%2DHispanic%20whites.

8 Krogstad JM, Lopez MH. For three states, share of Hispanic population returns to the past. Pew Research Center. https://www.pewresearch.org/fact-tank/2014/06/10/for-three-states-share-of-hispanic-population-returns-to-the-past/. Published June 10, 2014.

9 Immigrants in Colorado. American Immigration Council. https://www.americanimmigrationcouncil.org/research/immigrants-colorado. Published August 6, 2020.

10 Aurora, Colorado Population 2020. World Population Review. https://worldpopulationreview.com/us-cities/aurora-co-population. Published 2020.

11 Urban Indian Population. Colorado Commission of Indian Affairs. https://ccia.colorado.gov/tribes/urban-indian-population.

12 Indigenous Tribes of Colorado. American Library Association. http://www.ala.org/aboutala/offices/denver-colorado-tribes. Published November 21, 2017.

13 U.S. Census Bureau QuickFacts: Colorado. U.S. Census Bureau. https://www.census.gov/quickfacts/CO.

14 Friedrich M. Income, Poverty and Health Insurance Coverage in the United States: 2019. The United States Census Bureau. https://www.census.gov/newsroom/press-releases/2020/income-poverty.html. Published September 15, 2020.

15 2019 Colorado Health Access Survey: Health of Coloradans. Colorado Health Institute. https://www.coloradohealthinstitute.org/research/2019-colorado-health-access-survey-health-coloradans. Published February 25, 2020.

16 The Health Care Services Low-Income Coloradans Value, Know About and Use: Results From a 2016 Survey. Colorado Health. https://coloradohealth.org/sites/default/files/documents/2018-01/ServicesBrief_v7%20(00000002).pdf. Published 2017.

17 2019 Colorado Health Access Survey: Progress in Peril. Colorado Health Institute. https://www.coloradohealthinstitute.org/research/CHAS. Published December 6, 2019.

18 MacKenzie P, Zubrzycki J, Ahmad K, et al. Colorado Health Access Survey: Increasing Coverage, Lingering Barriers; Access to Care for Black and African Americans In Colorado. Colorado Health Institute. https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/CHAS%20Brief%20Black%20and%20African%20American%20Health_1.pdf. Published September 2018.

19 Indian Health Service (IHS): Find Health Care. Indian Health Service. https://www.ihs.gov/findhealthcare/.

20 Denver Indian Health and Family Services: Medical and Clinic Services. Denver Indian Health and Family Services. https://www.dihfs.org/medical.html.

21 Frequently Asked Questions. Indian Health Service. https://www.ihs.gov/forpatients/faq/.

22 Rhoades ER. American Indians and the private health care sector: The growing use of private care by Indians has implications for patients, providers, and policymakers. The Western Journal of Medicine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1071637/. Published January 2002.

23 2019 Colorado Health Access Survey: Access to Care. Colorado Health Institute. https://www.coloradohealthinstitute.org/research/2019-colorado-health-access-survey-access-care. Published February 19, 2020.

24 VISION: Visual Information System for Identifying Opportunities and Needs. Colorado Department of Public Health & Environment. https://cdphe.colorado.gov/vision-visual-information-system-for-identifying-opportunities-and-needs.

25 Ibid.

26 VISION: Visual Information System for Identifying Opportunities and Needs. Colorado Department of Public Health & Environment. https://cdphe.colorado.gov/vision-visual-information-system-for-identifying-opportunities-and-needs.

27 2015 Health Disparity Fact Sheet Hispanics/Latinos in Colorado. colorado.gov. https://www.colorado.gov/pacific/sites/default/files/OHE-CO-Hispanic-Health-Disparities-Fact-Sheet-2015.pdf. Published 2015.

28 2017 Community Health Profile: Denver UIHP Service Area. Urban Indian Health Institute. http://www.uihi.org/uihp-profiles/denver/. Published August 30, 2017.

29 Maternal Mortality Prevention. Colorado Department of Public Health & Environment. https://www.colorado.gov/pacific/cdphe/maternal-mortality.

30 Neuman T, Lopez E, Jacobson G, Levitt L. How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature. Kaiser Family Foundation. https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/. Published April 15, 2020.

31 Bontrager J, Boone E, Silvernale R, et al. Progress in Peril: 2019 Colorado Health Access Survey Storybook. Colorado Health Institute. https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/CHAS%20Storybook%202019%20for%20Web.pdf. Published January 2020.

32 Ibid.

33 2019 Colorado Health Access Survey: Health of Coloradans. Colorado Health Institute. https://www.coloradohealthinstitute.org/research/2019-colorado-health-access-survey-health-coloradans. Published February 25, 2020.

34 Ibid.

35 Ibid.

36 Bontrager J, Boone E, Silvernale R, et al. Progress in Peril: 2019 Colorado Health Access Survey Storybook. Colorado Health Institute. https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/CHAS%20Storybook%202019%20for%20Web.pdf. Published January 2020.

37 Ibid.

38 2019 Colorado Health Access Survey: Health of Coloradans. Colorado Health Institute. https://www.coloradohealthinstitute.org/research/2019-colorado-health-access-survey-health-coloradans. Published February 25, 2020.

39 Manning SH, Nighohossian J. Evaluating the Risk to Colorado's Health System Posed by a State Government Option. FTI Consulting. https://www.fticonsulting.com/insights/reports/evaluating-risk-colorados-health-system-state-government-option. Published March 20, 2020.

40 2019 Colorado Health Access Survey: Health of Coloradans. Colorado Health Institute. https://www.coloradohealthinstitute.org/research/2019-colorado-health-access-survey-health-coloradans. Published February 25, 2020.

41 MacKenzie P, Zubrzycki J, Ahmad K, et al. Colorado Health Access Survey: Increasing Coverage, Lingering Barriers; Access to Care for Black and African Americans In Colorado. Colorado Health Institute. https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/CHAS%20Brief%20Black%20and%20African%20American%20Health_1.pdf. Published September 2018.

42 Ibid.

43 Ibid.

44 2019 Colorado Health Access Survey: Health of Coloradans. Colorado Health Institute. https://www.coloradohealthinstitute.org/research/2019-colorado-health-access-survey-health-coloradans. Published February 25, 2020.

45 Manning SH, Nighohossian J. Evaluating the Risk to Colorado's Health System Posed by a State Government Option. FTI Consulting. https://www.fticonsulting.com/insights/reports/evaluating-risk-colorados-health-system-state-government-option. Published March 20, 2020.

46 MacKenzie P, Zubrzycki J, Ahmad K, et al. Colorado Health Access Survey: Increasing Coverage, Lingering Barriers; Access to Care for Black and African Americans In Colorado. Colorado Health Institute. https://www.coloradohealthinstitute.org/sites/default/files/file_attachments/CHAS%20Brief%20Black%20and%20African%20American%20Health_1.pdf. Published September 2018.

47 Reschovsky JD, O'Malley AS. Do Primary Care Physicians Treating Minority Patients Report Problems Delivering High-Quality Care? Health Affairs. https://www.healthaffairs.org/doi/10.1377/hlthaff.27.3.w222. Published 2008.

48 Ibid.

49 Lewis C, Abrams MK. Listening to Primary Care Physicians for Low-Income Patients: What Gets in the Way of Good Care? The Commonwealth Fund. https://www.commonwealthfund.org/blog/2018/listening-primary-care-physicians-low-income-patients-what-gets-way-good-care. Published November 27, 2018.

50 Ibid.

51 Ibid.

52 Manning SH, Nighohossian J. Evaluating the Risk to Colorado's Health System Posed by a State Government Option. FTI Consulting. https://www.fticonsulting.com/insights/reports/evaluating-risk-colorados-health-system-state-government-option. Published March 20, 2020.

53 There are about 100 hospitals in total in the state of Colorado; our analysis includes 77 hospitals (these 77 hospitals are included in our sample because they had reimbursement rates reported by CHA).

54 This analysis assumes payment rates will be set at 185% of Medicare, the midpoint of the range cited by the Colorado DOI and HCPF.

55 Expected Hospital Reimbursement Rates - Colorado Affordable Health Care Option. colorado.gov. https://drive.google.com/file/d/1reV18qe6KQo0WrJ--nZ2cgaqqIVE2JDP/view. Published March 6, 2020.

56 Wilson K. Obstetrics unit at Santa Paula Hospital to close with business plummeting. VC Star. https://www.vcstar.com/story/news/2019/05/31/santa-paula-hospital-closing-obstetrics-unit-june/3768765002/. Published May 31, 2019.

57 Baranowski SK. Seeking a cure: Hospital sees future in hard decisions for customers. The Gazette. https://www.thegazette.com/subject/news/health/rural-health-care-hansen-family-hospital-iowa-falls-birth-unit-closed-20191007. Published October 7, 2019.

58 Hsia RY, Kellermann AL, Shen Y-C. Why Are Many U.S. Emergency Departments Closing? RAND Corporation. https://www.rand.org/pubs/research_briefs/RB9607.html. Published 2011.

59 Kliff S. Hospitals Knew How to Make Money. Then Coronavirus Happened. The New York Times. https://www.nytimes.com/2020/05/15/us/hospitals-revenue-coronavirus.html. Published May 15, 2020.

60 O'Neill L. Estimating Out-of-Hospital Mortality Due to Myocardial Infarction. SpringerLink. https://link.springer.com/article/10.1023/A:1024463418429. Published January 2003.

61 HPSA Find. Health Resources & Services Administration. https://data.hrsa.gov/tools/shortage-area/hpsa-find.

62 Seaman, J., 2021. Racial disparities remain in Colorado's COVID-19 vaccination campaign. The Denver Post, [online] Available at: https://www.denverpost.com/2021/04/26/colorado-covid-vaccinations-racial-disparities [Accessed 29 April 2021].

63 Denver Health and Hospital Authority Community Health Needs Assessment. Denver Health. https://www.denverhealth.org/-/media/files/about/dhha-community-health-needs-assessment-2020.pdf?la=en&hash=B3718AEC98962ECD0C23D2AF35D3C4028E1E295F. Published September 1, 2020.

64 Ibid.

65 Ibid.

66 Ibid.

67 2013-2017 American Community Survey 5-Year Estimates: Elyria Swansea Neighborhood Profile Fact Sheet. Denver Human Rights & Community Partnerships. https://www.denvergov.org/content/dam/denvergov/Portals/643/documents/Neighborhood%20Profiles/Elyria_Swansea_17.pdf.

68 2013-2017 American Community Survey 5-Year Estimates: Northeast Park Hill Neighborhood Profile Fact Sheet. Denver Human Rights & Community Partnerships. https://www.denvergov.org/content/dam/denvergov/Portals/643/documents/Neighborhood%20Profiles/Northeast_Park_Hill_17.pdf.

69 American Community Survey 2013-2017 Five Year Estimates: Neighborhood Profiles. City and County of Denver Official Site. https://www.denvergov.org/content/denvergov/en/human-rights-and-community-partnerships/programs---initiatives/neighborhood-profiles.html.

70 2013-2017 American Community Survey 5-Year Estimates: Montbello Neighborhood Profile Fact Sheet. Denver Human Rights & Community Partnerships. https://www.denvergov.org/content/dam/denvergov/Portals/643/documents/Neighborhood%20Profiles/Montbello_17.pdf.

71 Lee K, Meyer JP. Aurora's growth reflects that African-Americans are finding base in Denver 'burbs. The Denver Post. https://www.denverpost.com/2012/03/24/auroras-growth-reflects-that-african-americans-are-finding-base-in-denver-burbs/. Published March 24, 2012.

72 Amestoy L. Greeley among the nation's fastest growing metropolitan areas. Greeley Tribune. https://www.greeleytribune.com/2019/04/18/greeley-among-the-nations-fastest-growing-metropolitan-areas/. Published April 18, 2019.

73 Heffel N. Cow Town Opts For Funk Over Funky Smell. NPR. https://www.npr.org/2013/08/03/207645081/colorado-city-tries-to-cleanse-its-reputation-for-cow-odor. Published August 3, 2013.

74 Kronauge C, von Klinggraeff L. 2016 Weld County Community Health Survey: Key Findings - Part 1 Health Status and Conditions. Weld County Government. https://www.weldgov.com/departments/health_and_environment/data_and_statistics/2016_community_health_survey_results. Published October 1, 2017.

75 Kronauge C, von Klinggraeff L. 2016 Weld County Community Health Survey: Key Findings - Part ll Health Insurance and Use. Weld County Government. https://www.weldgov.com/departments/health_and_environment/data_and_statistics/2016_community_health_survey_results. Published October 1, 2017.

76 U.S. Census Bureau QuickFacts: Greeley city, Colorado. U.S. Census Bureau. https://www.census.gov/quickfacts/greeleycitycolorado.

77 Brainard S, Smart RJ. Public Health Improvement Plan Garfield County, Colorado 2013-2017. Garfield County Public Health. http://garfield-county.granicus.com/MetaViewer.php?view_id=3&clip_id=314&meta_id=29114. Published 2018.

78 Bennett V, Harris H, Oller D, Hewitt M, Vivian K, Liebert M. El Paso County Community Health Improvement Plan 2018-2022. El Paso County Public Health. https://www.elpasocountyhealth.org/sites/default/files/CHIP_For%20print.pdf.

79 El Paso County: Health Indicators 2017 Report. El Paso County Public Health. https://www.elpasocountyhealth.org/sites/default/files/CHA%20Report%202017_0.pdf. Published December 2017.

80 U.S. Census Bureau QuickFacts: La Plata County, Colorado. U.S. Census Bureau. https://www.census.gov/quickfacts/laplatacountycolorado.

FTI Consulting is an independent global business advisory firm dedicated to helping organizations manage change, mitigate risk and resolve disputes: financial, legal, operational, political & regulatory, reputational and transactional. FTI Consulting professionals, located in all major business centers throughout the world, work closely with clients to anticipate, illuminate and overcome complex business challenges and opportunities.©2021 FTI Consulting, Inc. All rights reserved. **www.fticonsulting.com**