We envision a universal, affordable, sustainable win-win health care system benefitting everyone in Colorado for the long-term.

The Colorado Foundation for Universal Health Care will perservere in our mission (bringing the best solutions forward through research and education) until we achieve our vision: Because **every Coloradan should have the health care he or she needs.**

The people of Colorado deserve the opportunity to learn about health care proposals that are in their own best interests, and in the interests of Colorado. While it's true the current health care system is in crisis, mired in inefficiency and more complicated than most people understand, the best solutions can be remarkably elegant and simple.

- Link Coloradans with data
- Empower Coloradans to recognize and understand options for universal, sustainable health care.

Research **Advocate**

Research can illuminate which propasals show promise. At the Colorado Foundation for Universal Health Care, we believe universal health care isn't just the right thing to do: It's practical, too. We are interested specifically in universal health proposals likely to benefit Colorado's businesses, economy and people. That's why we harness expert researchers to evaluate options: To empower Colorado decision makers with the data to choose well.

- Win grants to engage in major research
- Harness in-house expertise to evaluate data

We want Coloradans engaged and empowered to choose a health care future that works for Colorado. We can help distill the issues at stake in health care policy. Our goal is Colorado voters and leaders who are inspired and empowered to recognize promising solutions, and savvy enough to see through lobbying and the advertising to the facts: Will this universal health care plan be good for me? My employees? My family? My business? My constituents? My state?

COLORADO FOUNDATION FOR
UNIVERSAL HEALTH CARE

A healthy Colorado
includes everyone.

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COLORADO FOUNDATION FOR
UNIVERSAL HEALTH CARE

Mission: The Colorado Foundation for Universal Health Care develops ideas for, and educates the public about, health care development proposals that provide quality universal coverage, are fiscally responsible, and are advantageous to consumers, providers, and employers.

Purpose: The Colorado Foundation for Universal Healthcare is a 501(c)(3) nonprofit organization dedicated to informing policy that supports affordable, quality, universal health care for all Coloradans.

Vision: We envision a universal, affordable, sustainable, win-win health care system benefiting residents in Colorado for the long-term. The Colorado Foundation for Universal Health Care will persevere in bringing the best solutions forward through research and education until we achieve our vision, that **all Coloradans have the health care they need.**

Do you share our vision? The Colorado Foundation for Universal Health Care is growing. We need caring board members who work and play well with others and investors willing to help power Colorado's growing universal health care movement.

A Healthy Start

In 1996, the Patient Advocacy Coalition formed with the aim to help individuals overturn denials from health insurance companies. Our mission soon evolved to educate Coloradans about the benefits of universal health care. The federal Affordable Care Act, with its opportunity for states to seek a Waiver for State Innovation, became law in 2010, opening the door for states to lead the way. In 2011, the board voted to change the organization's name to the Colorado Foundation for Universal Health Care.

Publications, accomplishments

- *ColoradoCare 2015 Implementation and Updated Economic Report*
- *Focus groups with Colorado stakeholders, P & L Research, Inc. February, 2015*
- *ColoradoCare: How it Would Work booklet*
- *Boulder Health Care Forum with State Sen. Irene Aguilar, T.R. Reid, Eric Whitney and Julie Carpenter, MD*
- *Three Possibilities for Colorado's Future Health Care Financing and Delivery by Gerald Friedman of the University of Massachusetts, Amherst with a grant from the Caring for Colorado Foundation)*
- *Stakeholder Input Project*
- *The Colorado Health Care Cooperative Video*

2015-2016 Goals

- To inspire successful state-based health reform innovation through research, education, and outreach
- Produce a high-quality video that inspires widespread statewide support of universal health care
- Print and distribute at least 5,000 print copies of the "How it Would Work Booklet" on ColoradoCare
- Commission an independent, in-depth implementation plan and economic analysis for ColoradoCare
- Grow local grassroots understanding shorter videos, social media, spectacles, media outreach and events

COLORADO'S CURRENT HEALTH CARE PAYMENT SYSTEM

WHAT'S THE PROBLEM? IS THERE A PROBLEM?

TOO BAD TO BE TRUE (BUT ACTUALLY TRUE) FACTS ABOUT OUR CURRENT HEALTH CARE PAYMENT SYSTEM

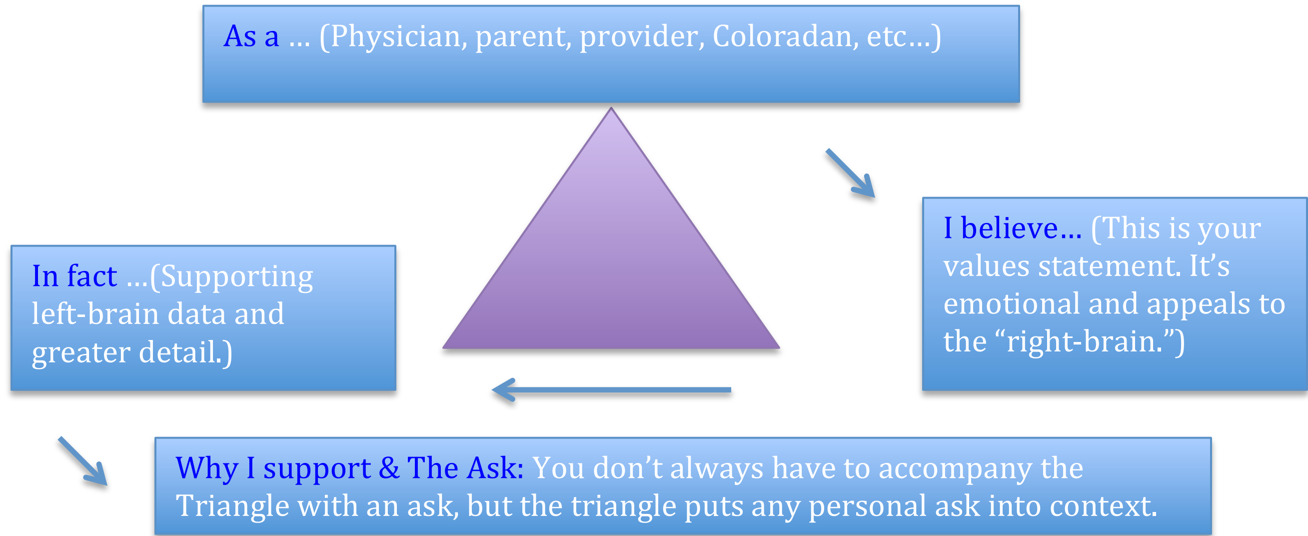
- In 2015, 23.1% of Coloradans were either uninsured or underinsured according to the 2015 Colorado Health Institute's Health Access Survey, which also found that:
    - The percentage of Colorado uninsured is 6.7%, 353,000 people.
    - The percentage of underinsured is 16.4%. (Out-of-pocket medical costs eat up 10% or more of these folks' annual income.)
    - One-third of all Coloradans (29.9%) have health plan with a deductible of $1,300 or more.
- All of us are paying more for health care than is necessary to stay healthy.
- Coloradans will spend $29.7 billion this year on health care using our current system. (According to the Center for Medicare and Medicaid studies, Colorado's portion of national Health Expenditures is $49.5 billion, but that includes the cost of federal programs and administrative waste that Coloradans don't pay for directly. Learn more: www.couniversalhealth.org/wp-content/uploads/2015/08/coloradocareeconomicanalysiswith2016and2019projections.pdf)
- Colorado wastes $4.5 billion every year primarily on unnecessary administrative costs, for-profit costs associated with health care, and unnecessary procedures. Put another way: Coloradans would save $4.5 billion annually in out-of-pocket costs with ColoradoCare.
- Health Care in America is a paradox, according to the 2010 Institute of Medicine report: "The past 50 years have seen an explosion in biomedical knowledge, dramatic innovation in therapies and surgical procedures and management of conditions that previously were fatal yet American health care is falling short on basic dimensions of quality, outcome, cost, and equity."
- If banking worked liked health care ATM transactions would take days. If home building were like health care, carpenters, electricians, and plumbers would work from different blueprints. If shopping were like health care, prices would not be posted and could vary widely within the same store depending on who was paying.

- The Institute of Medicine report showed that waste accounted for 30% of health care spending or some $750 billion each year, more than our nation's entire budget for K-12 education. In comparison, the US military spending in 2014 was $610 billion, $140 billion less than we wasted in health care spending.
- Between 2005 and 2015, the cost of premiums for employer-sponsored health care rose 61%, while the cost of worker contributions rose 83 %, according to the Kaiser Family Foundation's 2015 Employer Health Benefits Survey.
- During the same time, the percentage of covered workers with high deductibles more than tripled from 10% in 2005 to almost half (46%) in 2015.
- UnitedHealth Group Inc. CEO Stephen Hemsley made more than $66.1 million in 2014, according to the Star Tribune.
- Four cancer charities scammed generous people out of $187 million, CNN reported.
- In nearly all indicators of mortality, survival, and life expectancy, the US ranks at or near the bottom among high-income countries.
- Per H&R Block, 61 % of its customers had to repay a portion of the subsidies they received when they bought insurance policies through Affordable Care Act health exchanges. The average payment was $729.
- Drug companies spend more than $4 billion advertising their products directly to consumers each year, according to the Pharmacy & Therapeutics journal, and leads 27% of Americans to schedule an appointment with their doctor about a condition not previously discussed.
- Drug companies spend an estimated $24 billion annually marketing directly to doctors, according to The PEW Charitable Trusts.
- Between 1999 and 2012, inflation grew 38% and workers' incomes grew 47%. During the same period, insurance premium costs grew 172% AND workers' contributions to premiums grew 180%.

Being an Emissary: The Messaging Triangle

We can each help raise awareness for the Foundation's mission through regularly sharing why we are involved. This is a key exercise I learned from JVA, and it's something we should all do on a regular basis and as part of any ask. That's because **people give to people, not to causes.**

The Messaging Triangle works like this:



Here's mine:

As a Coloradan

I believe Colorado can do it better, that health care is a basic human need, and that people need health care to contribute to our state.

In fact, the Colorado Health Care Cooperative would save counties, cities, and school districts an average of 61 percent and large employers more than half on their health care costs while ensuring every Coloradan has access to comprehensive, quality health care without deductibles.

That's why I (serve on the board of) work for the Colorado Foundation for Universal Health Care. We work to educate and research viable, Colorado-grown universal health care proposals.

Can I count on you to give us $5,000 which will help us develop the Crowd Funding and Social Media Campaign we need to fund a plan to implement ColoradoCare in Colorado?

Colorado's proposal overcomes problems that stymied Vermont

Ivan J. Miller, Executive Director
Colorado Foundation for Universal Health Care
April 10, 2015

On December 18, 2014 Vermont Gov. Peter Shumlin made a surprise announcement that he no longer supported the Vermont universal health care proposal because he said it would be too expensive and would unfairly burden businesses and Vermonters at a time when their economy was struggling. This was a major reversal in Vermont politics. Before the announcement, the majority of voters, the majority of the legislators in both Vermont chambers, and the governor had endorsed and campaigned on universal health care. Universal health care systems work and cost less in all other industrialized countries. All previous analysis of universal health care showed it was more affordable, but the Governor's Vermont proposal did not find much savings. Is the Governor correct in saying universal health care is too expensive or did something go wrong?

Vermont approved a single payer health care system without specifying the policies that would make it work. Not surprisingly, policy issues matter. Dr. William Hsiao, who designed and guided the implementation of the successful Taiwan universal health care system in the 1990s, offers relevant commentary on a similar situation in Taiwan. He reports that before he went to Taiwan, problems arose when four technical experts tried and failed to come up with a successful universal health care proposal. He said, "It was like a wagon drawn by four horses, with each going in a different direction and nobody driving.[1]" Vermont's proposal, in which political forces and political concessions shaped a plan that did not have a driver keeping track of realistic economics, is similar to the first, unsuccessful attempt at a plan in Taiwan. Interestingly, Dr. Hsiao, who has experience designing and at times implementing health care systems around the globe, also conducted the preliminary analysis of the Vermont proposal before the political concessions, and he found that it was economically feasible.

The governor's economic proposal is a plan with too many political concessions and too little focus on what would work. Vermont adopted universal health care based primarily on a "health care is a human right" campaign without an emphasis on economics. The proposal's governing body, the Green Mountain Care (GMC) Board, which was not responsible for financing, designed a system without a focus on the economic and policy decisions needed to make it economically feasible. Its design included political concessions to insurers, hospitals, and providers. On top of that, the Governor offered financing concessions to low-income constituents, high-income constituents, and the self-employed, and as a result, the cost for the remaining payers—middle-income workers and employers—became too high.

In addition, Vermont faces a number of situational challenges. Vermont has a high per capita health care cost, limited median family income, a small population, and a workforce and medical services that intermingled with neighboring states. All of these factors decreased Vermont's ability to reduce costs. Colorado, fortunately, does not have these challenges.

How is the Colorado proposal different?

The Colorado proposal for ColoradoCare aka Colorado Health Care Cooperative is a system designed to establish universal, high-quality, and accessible health care; decrease the overall costs of health care through efficiencies; and collect premiums in an efficient and fair manner. It differs from Vermont's approach and plan in multiple ways:

- *Colorado's plan does not make an alliance with the insurance industry*. The GMC Board Chair was closely associated with the insurance industry and had been a strong advocate of the RomneyCare program in Massachusetts[2], which expanded coverage but also greatly increased costs. The Board agreed to subcontract with a large insurance company and promoted this as a public-private partnership. This partnership did not report the administrative savings that are expected to come from removing the multiple, for-profit, middle managers.

- *Colorado would obtain the benefit of savings, not pass the benefits onto hospitals for higher profits.* Vermont made a political decision to eliminate the Hospital Provider Tax, presumably because in a universal health care system such a tax only increases the cost to GMC. However, the economic analysis showed that GMC would not reap any benefit of lower cost, and the hospitals would retain the savings.
- *Colorado would pursue decreases in the cost of pharmaceutical and durable medical equipment*. Multiple analyses, as well as model programs such as the VA Hospital system, have found that a unified system can use its market power to lower the costs of pharmaceuticals and medical equipment. However, Vermont decided not to pursue lowering pharmaceutical costs.
- *The Colorado proposal decreases administrative complexity instead of increasing it*. The GMC Board decided to implement a complex transition to payment reform through Accountable Care Organizations (ACOs)[3,4] in order to pursue a theoretical cost savings later on. While ACOs are supported by health care economists and offer promise, they are still in the process of development and have not yet been shown to maintain quality care and offer savings when applied over a whole state. This expensive transition consumed natural cost savings from administrative simplification. The Colorado proposal minimizes the Cooperative's administrative expense in order to achieve a savings. Colorado's proposal phases in ACOs and other payment reforms only to the extent that they decrease cost and improve value.
- *The Vermont plan did not attempt to retain obvious savings*. It claimed there would not be any savings, which ignores potential savings from obvious factors, such as the reduction in administrative tasks when there is one primary payer, the elimination of the marketing and advertising costs in the multi-payer system, and the elimination of the need for insurer profits, among other things. When administrative costs go down, someone has more money, and it appears that Vermont allowed providers to use the administrative savings to increase income. The Colorado proposal incentivizes the system to benefit from savings. As a provider's administrative costs decrease, the payments would correspondingly decrease. Colorado's obligation would be to maintain overall provider compensation at a level that is competitive enough with other states so that Colorado would have a sufficient health care work force.
- *The Colorado proposal is less disruptive to employers.*
  While in the long run both the employer's and employee's premium payments come from the funds available for the wage/benefit package, in the short run, the Vermont proposal requires that employers who did not previously pay for health care pay a 10.5% payroll premium. Such a large increase is burdensome. The Colorado proposal:
  - Shares the 10% payroll premium between employer and employee so that the employer pays 6.67% and the employee pays 3.33%.
  - Allows employers that have previously paid for most of health care to pay employee's share if the employer agrees to do so by union contract or any other contract.
  - Covers the medical portion of workers' compensation, which decreases workers' compensation costs by 60%. This reduces the administrative and financial burden on employers.
- *The Colorado proposal has premiums that are fairer—one combined employer/employee rate for everyone without the large difference between the effective rates for low-income and high-income residents.* The Colorado proposal is modeled after the successful Social Security and Medicare insurance premium collections. Everyone pays the same percentage rate for combined employee and employer contributions (10% split between employer and employee). In addition, to be fair to working people, the same percentage rate is applied to non-payroll income. Vermont would have collected its premiums using two methods, a payroll premium tax of 11.5% paid by the employer, and a progressive income premium tax that rose to 9.5% of adjusted income. The combined employer/employee premium contribution varied greatly as the Table below shows.

Comparison of Vermont and Colorado proposal premium rates for payroll and other income
(Employer and employee rates are combined because both come from wage and benefit package.)

Income level or source	Vermont Proposal	Colorado Proposal
Low-income (below 138% Federal Poverty Level)	Employer pays **10.5% payroll**	Employer pays **6.67% payroll**, and the 3.33% employee contribution is refunded due to Medicaid waiver.
Working people	Employer pays 10.5% of payroll and employee pays progressive income tax that rises to 9.5% so that working people pay **between 10.5% of payroll and 21% of wage benefit package** on pay increases once the top level of income is reached.	Employer pays 6.67% payroll and employee pays 3.33% payroll resulting in a **10% impact on the wage/benefit package.**
Non-payroll income usually associated with high income.	Pay 9.5% of income after deductions resulting in a rate **below 9.5%.**	Pay **10% of non-payroll income**.
Self-Employed	Pay 9.5% of income after deductions resulting in a rate **below 9.5%.**	**10% of net income** is assessed on the business, which gives self-employed the same tax advantage as employers by reducing Social Security and Medicare taxes and reducing the **impact on the self-employed to between 8.537% and 5.637** of net income depending on tax bracket.
High income	Premiums are **capped at $27,500**	Premiums are capped at 10% of $450,000 for joint filers, which is **$45,000**

Vermont has more challenges than Colorado in creating a universal health care system.

- Vermont's per capita health care costs are 26% higher than Colorado's (2009)
- The median Vermont family income is 6% lower than Colorado's (2012).
- Vermont's economic recovery has been stalled while Colorado has a robust economy. (In the Kiersz. & Holodny (2015) ranking of state economies, Colorado ranked number one for the fastest growth, and Vermont ranked 49th[5].) Premiums based on income are decreased when the economy is down.
- Vermont would have lost some tax revenue by converting to Green Mountain Care because it has a tax on insurance claims. Colorado does not have a comparable tax.
- Medical services for Vermont are often located in neighboring states (1/3 of Vermont residents have received treatment at the Manchester, NH, hospital system). Consequently, the state needed to build a more complicated provider network including negotiating and contracting with out-of-state providers. Colorado can just include all Colorado providers, simplifying the administration of a provider network as well as reducing the administrative burden in providers' offices.
- Vermont's 2014 population is 626,562 compared to Colorado's 5,355,866[6]. The small population size reduces Vermont's market power for decreasing the cost of pharmaceuticals and durable medical equipment.
- Vermont's workforce is mixed with neighboring states making the efficient, payroll-based premium collection system a difficult way to collect premiums from residents. Colorado's workforce overlaps very little with neighboring states. This allows Colorado to rely primarily on the payroll-based system similar to Social Security and Medicare.

Vermont endorsed universal health care without a plan. In the planning process, Vermont granted concessions to the insurance industry, providers, hospitals, the self-employed, and both low-income and high-income residents. These concessions in Vermont made a system that could not work. Colorado, on the other hand, is presenting a plan, ColoradoCare, that works as a coherent whole. It is not subject to the concessions that could cause it to drift

from the mission of universal, high-quality, and accessible health care. Colorado, also, is healthier and wealthier, and has geographical advantages. Although the Vermont proposal needs to be reworked, the Colorado proposal remains strong and on solid ground.

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[1] Underwood, A. (2009) Prescriptions: Making sense of the health care debate. Health Care Abroad: Taiwan. N.Y. Times, NY/NY. http://prescriptions.blogs.nytimes.com/2009/11/03/health-care-abroad-taiwan/?_r=1

[2] Woolhandler, S. & Himmelstein, D.U. (2015). What happened in Vermont: Implications of the pullback from single payer. Physicians for a National Health Program, Chicago. http://www.pnhp.org/news/2015/january/what-happened-in-vermont-implications-of-the-pullback-from-single-payer

[3] Ibid

[4] State of Vermont. (2014) Green Mountain Care: A Comprehensive Model for Building Vermont's Universal Health Care System. State of Vermont, Montpellier. http://www.leg.state.vt.us/jfo/healthcare/Health%20Reform%20Oversight%20Committee/2015_01_06/Reports_GMC%20FINAL%20REPORT%20123014.pdf

[5] Kiersz, A. & Holodny, E. (2015). Here's how all 50 state economies are doing, ranked from slowest to fastest (3/15/15). Business Insider. http://www.businessinsider.com/state-economic-growth-rankings-2014-8#1-colorado-50

[6] http://en.wikipedia.org/wiki/List_of_U.S._states_and_territories_by_population

Additional Resources:

Friedman, G. (2015) Professor Friedman's Analysis of Shumlin's Financing Proposal. Healthcare-NOW, Washington, DC. http://www.healthcare-now.org/professor-friedmans-analysis-of-shumlins-financing-proposal

Goozner, M. (2015) Lessons from Vermont. Modern Health Care. http://www.modernhealthcare.com/article/20150103/MAGAZINE/301039984?utm_source=AltURL&utm_medium=email&utm_campaign=am%3Fmh

In support of universal, publicly financed health care in Vermont

Open letter to the Vermont Governor and Legislature from Economists in the U.S.

February 2015

As economists, we understand that universal, publicly financed health care is not only economically feasible but highly preferable to a fragmented market-based insurance system. Health care is not a service that follows standard market rules; it should be provided as a public good. Evidence from around the world demonstrates that publicly financed health care systems result in improved health outcomes, lower costs and greater equity.

Public financing is not a matter of raising new money, but of distributing existing payments more equitably and efficiently. Especially when combined with provider payment reforms, public financing can lower administrative costs, share health care costs much more equitably, and ensure access to comprehensive care for all.

We support publicly and equitably financed health care at federal and state level, and we encourage the government of the state of Vermont to move forward with implementing a public financing plan for the universal health care system envisioned by state law.

Signed,

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   University of Massachusetts Amherst
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   Benedictine University
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   Center for Economic and Policy Research
5. Radhika Balakrishnan
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41. John F. Henry
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Colorado Foundation for Universal Health Care
501(c)(3) Training for Board Members 101

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What is a 501(c)(3)?

- Section 501 of the Federal Code is about nonprofit organizations, part (c) of that section is definitions, and the third definition (3) is “charitable and educational organizations.” While all nonprofits are exempt from paying Federal corporation taxes, the (c)(3) enjoys a special tax status. Money donated to a (c)(3) is exempt from the donor’s income taxes.
- Because the money given to (c)(3)s enjoys this special tax status, the IRS has rules and regulations about what a (c)(3) organization can do and what happens to the money given to a (c)(3). In other words, the rules and regulations are about the organization and money, which need to serve the charitable and educational mission.
- A 501(c)(3) must stay within its “educational and charitable” mission and not advocate for any specific legislation or ballot initiative, with the exception of the “h selection.
- A 501(c)(3) may advocate for a general good such as the end of poverty, world peace, or universal health care. (As you can see, we have chosen the easiest one.)
- When a 501(c)(3) dies, the funds must be given to another 501(c)(3). The reason is that

What is the “h selection”?

- When a nonprofit files an “h selection,” which the Foundation has, it is allowed to spend up to 20% of expenses on advocacy for legislation or ballot initiative.
- The “h selection” requires that the funds diverted to advocacy for legislation or ballot initiative must have separate entries in the accounting. For example, the hours that employees devote or the resources expended must be tracked separately.
- A 501(c)(3) may not support a political candidate, but a political candidate may support a 501(c)(3).

What is a 501(c)(4)

The fourth 501(c) definition is (4) social welfare organizations. These organizations are nonprofits that advocate for issues that promote social welfare and are therefore allowed to spend all of their money on advocacy for issues such as legislation or a ballot initiative.

What is a (c)(3) and sister (c)(4)

The IRS recognizes that it is common practice to have sister (c)(3)s and (c)(4)s working together with the (c)(3) conducting the education and research and the (c)(4) more directly involved in advocacy, and consequently, issues some guidelines on how they may work cooperatively. In addition, the Alliance for Justice also provides some guidelines.

- Generally speaking, the (c)(3) cannot support the (c)(4) as a primary activity, but can as an incidental activity. For example, the (c)(3) website cannot refer viewers to the (c)(4) as the first item on the home page, but could do so as the last item or one of the side bar items.
- Sister (c)(3)s and (c)(4)s can have overlapping Board members, but each must have separate Board meetings.
- Sister (c)(3)s and (c)(4)s can share office space and have retreats together, but there must be separate accounting of the funds that come from each organization.
- A (c)(3) cannot give funds to the (c)(4) unless it is part of the “h selection,” but a (c)(4) can give funds to a (c)(3).
- Many of the decisions about how to maintain boundaries between a (c)(3) and a (c)(4) require judgment calls. In the Foundation, there are 501(c)(3) Monitors who may make these

judgment calls. It should be understood, these are the kinds of decisions that do not have a black and white answer but have a range of solutions that are within good judgment. It is not expected that the Monitors will completely agree in any situation, but that their judgment will be within the accepted range of good judgments.

Additional information about (c)(3) status:
It his helpful to understanding the rules and regulations to know they are about the organization and money, and are not about restricting people or conflict of interest as the following examples demonstrate.

- A (c)(3) Board member must stay within the (c)(3) IRS rues and regulations when acting on behalf of the (c)(3), but at other times could be a politician, owner of a for-profit company, or serve a (c)(4).
- While there are pros and cons to the number of overlapping Board members on sister (c)(3) and (c)(4) combinations, it is recognized that some overlap is likely.
- A board member of officer of a (c)(3) could volunteer for a (c)(4). However, in such situations, it is important for the board member to make it clear in which capacity they are functioning. For example, the President of a (c)(3) who is volunteering in a role for a (c)(4) should say if appropriate, "I am not representing the (c)(3) and am acting as volunteer for the (c)(4)."
- A paid employee of a (c)(3) (it is different because money is involved), cannot work for a (c)(4) while being paid by the (c)(3). If the employee is off the clock, it is okay.

Additional resources:
The Internal Revenue Service website www.IRS.gov
Basic description of 501(c)(3) responsibilities http://www.irs.gov/pub/irs-pdf/p4220.pdf

The Alliance for Justice at www.afj.org
I have a number of their past publications about how 501(c)(3)s can use the "h" selection to for advocacy, and how they can work with a 501(c)(4) for Board members who are interested in being a person who can monitor IRS compliance. I have attached a "Bolder Advocacy" comparison of (c)(3)s and (c)(4)s.

Colorado Foundation for Universal Health Care
Proposed Policy and Guidelines for Compliance with IRS 501(c)(3) Rules and Regulations

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The Foundation shall use the following resources and guidelines for compliance.

- The IRS publishes multiple guidelines and suggested and/or wording for compliance. When these are available and applicable, they shall be used.
- The Foundation shall have an employment contract with a Certified Public Accountant (CPA) who has expertise with both 501(c)(3)s and combinations of a 501(c)(3) and a sister 501(c)(4). The accountant shall be the primary expert consultant.
- The Alliance for Justice provides a number of publications and guidelines regarding 501(c)(3) compliance with particular attention to involvement in lobbying, co-operation between a 501(c)(3) and a 501(c)(4), and relationships with politicians. The Foundation shall use these resources and the Alliance for Justice website, www.afj.org.

Operational compliance with 501(c)(3) regulations

- All Board members shall be given an educational package about 501(c)(3) rules and regulations.
- The Accountant and Executive Officer shall designate which Board members or employees have sufficient training, education, and experience with 501(c)(3) rules and regulation to make independent or supervisory judgments about compliance in daily operations and publications, and serve as 501(c)(3) Monitors.
- The 501(c)(3) Monitors shall generally observe the publications, activities, and communications of less expert personnel, and when needed, provide education and guidance to keep the Foundation in compliance with 501(c)(3) rules and regulations.
- The Accountant, President, or Executive Officer shall make decisions about when the CPA shall be consulted.

Colorado Foundation for Universal Health Care

Non-Discrimination Policy

The Colorado Foundation for Universal Health Care hereby states and affirms that it complies with all affirmative action, equal employment opportunity, and anti-discrimination laws and regulations and confirms that it does not discriminate in its employment practices or services with regard to race, disability, color, creed, religion, gender, age, sexual orientation, national origin, ancestry, citizenship, veteran status, handicap, or any other protected classification.