The LEWIN GROUP
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Technical Assessment of Health Care Reform Proposals

Proof Report

Prepared for:

The Colorado Blue Ribbon Commission for Health Care Reform

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EXECUTIVE SUMMARY

I. INTRODUCTION

The Lewin Group was engaged by the Colorado Blue Ribbon Commission for Health Reform to assist in developing and analyzing alternative proposals to expand health insurance coverage and reform the Colorado health care system. We began by developing a "baseline" projection of what health care coverage and costs will be in Colorado in 2008 under current law for major stakeholder groups, including governments, providers, employers and families. We then estimated the cost and coverage effects of several proposals to expand insurance coverage for major stakeholder groups in Colorado. In this report, we describe the health reform proposals analyzed in this study, present our estimates of program effects, and summarize the data and methods used in conducting the analysis.

A unique aspect of this study is that we worked with the authors of four distinct health reform proposals to specify program features and estimate their effects. Early in the project, we met with the authors of each of these proposals to specify the details of their plans to a level where it was possible to estimate their effects. Once specified, we used Lewin Group models to estimate the cost and coverage impacts of each proposal across various stakeholder groups, based upon the baseline health spending data developed in the project. After reviewing the results with each author, we assisted them in revising their plans to improve each proposal's effectiveness and correct for unintended consequences. We repeated this process about three times for each of the proposals until the authors were satisfied with their specifications.

The four proposals analyzed in this study include:

- **"Healthy Solutions for Colorado":** This proposal, authored by the Colorado Association of Health Underwriters, would expand eligibility for children under Child Health Plus to 250 percent of the FPL. Medicaid eligibility for parents would be increased to 100 percent of the FPL. In addition, the program provides a premium subsidy for private coverage to people living below 250 percent of the FPL that can be used either to purchase non-group coverage or to pay the worker share of the premium for employer provided coverage;
- **"Better Health Care for Colorado":** This proposal, authored by the Service Employees International Union (SEIU) and the Colorado Association of Public Employees (CAPE) would expand coverage under Medicaid/SCHIP programs to cover all children living below 300 percent of the FPL. It also provides subsidies for private coverage for parents through 250 percent of the FPL and childless adults through 225 percent of the FPL. After a period of time, eligibility levels for parents would be increased to 300 percent of the FPL. All residents of Colorado would be required to have health insurance;
- **"A Plan for Covering Coloradans":** This proposal, authored by the Committee for Colorado Health Care Solutions, would require employers to either provide coverage for their workers of pay a fee. The program expands coverage under the Medicaid/SCHIP programs to cover all parents and children living below 300 percent of the FPL, and childless adults living below 100 percent of the FPL. It also establishes a purchasing pool where individuals can purchase coverage with a premium that is subsidized on a sliding-scale, with income for people living below 400 percent of the FPL. All residents of Colorado would be required to have health insurance;

- **"Colorado Health Services Plan (CHSP)":** This proposal, authored by the Health Care for All Coalition and the Colorado Nurses Association, would be a single-payer program covering all Colorado residents. Coverage for the Medicare and Medicaid populations would be folded into the statewide program. Employers would no longer cover their workers for the services covered under the CHSP. The program would be funded with an employer payroll tax and an increase in personal income taxes;

Our analysis is based on a combination of economic and actuarial models. We developed estimates of the cost of the benefits packages specified by the authors for each of the four proposals. We then used the Lewin Group Health Benefits Simulations Model (HBSM) to estimate the number of people affected and program costs, using the actuarial estimates as inputs. HBSM is a "micro-simulation" model of the U.S. health care system designed to simulate the impact of initiatives to expand insurance coverage on various stakeholder groups at the state and federal levels. We updated the model to use Colorado-specific health coverage and spending data available from public and private sources in the state.

For illustrative purposes, we assume that federal and state laws are changed to permit the implementation of these programs as proposed. Because all of these proposals would increase state government spending, we assume that state law is revised to permit implementation of the various revenue raising measures proposed by the authors. We also assume that the federal government will provide the various waivers and exemptions from federal law required to implement these plans. These include:

- **ERISA exemption for Colorado:** We assume that the employer contribution requirement under "A Plan for Covering Coloradan" would not be pre-empted by ERISA if challenged in court. Alternatively, we assume that Congress acts to exempt Colorado from ERISA for purposes of the program in Colorado;
- **Medicaid Waivers:** The "Better Health Care for Colorado" proposal and the "healthy Solutions for Colorado Plan" require a Section 1115 Demonstration waiver to cover expansion populations that are not currently eligible for federal matching funds (such as low-income childless adults); and
- **Medicaid and Medicare block grants:** Under the CHSP single-payer proposal, the federal government is assumed to provide Colorado with a lump-sum payment (i.e., block grant) for what the federal government would have spent for Coloradan's under current law. For illustrative purposes, we assume that Congress acts to provide these block grants for Colorado.

Because these changes in law may not be forthcoming, we also show the effect of these programs assuming that these federal waivers and exemptions are not provided.

We present our analysis on the following sections:

II. HEALTH SPENDING AND COVERAGE IN COLORADO

The first step in this study was to develop a detailed analysis of the Colorado health care system. This includes an analysis of sources of coverage in the state and characteristics of the uninsured. We also estimated the amount of health spending in the state by type of service and source of payment. This is presented in the following sections:

- Sources of Coverage in Colorado, and
- Health Spending in Colorado

A. Sources of Coverage in Colorado

Our primary data source for this study is the March Current Population Survey (CPS) conducted annually by the Census Bureau. These data are the source of the annual Census Bureau estimates of the number of uninsured in the US and by state. We pooled the Colorado sub-samples of the CPS data for 2004 through 2006 to increase the sample size to a level sufficient to provide detailed analyses for the state.

While the CPS provides the most current data on insurance coverage, it under-reports the number of people covered under the Medicaid program by roughly 30 percent, which causes it to over-estimate the number of uninsured in the US. Consequently, we corrected the CPS data for under-reporting of Medicaid coverage to provide a more accurate count of the number of people without coverage. We also adjusted the data to the under-reporting of employer coverage. In this section, we describe the data sources and methodology that we used to estimate the total number of uninsured in the US and by state. We present coverage estimates in Colorado in the following sections:

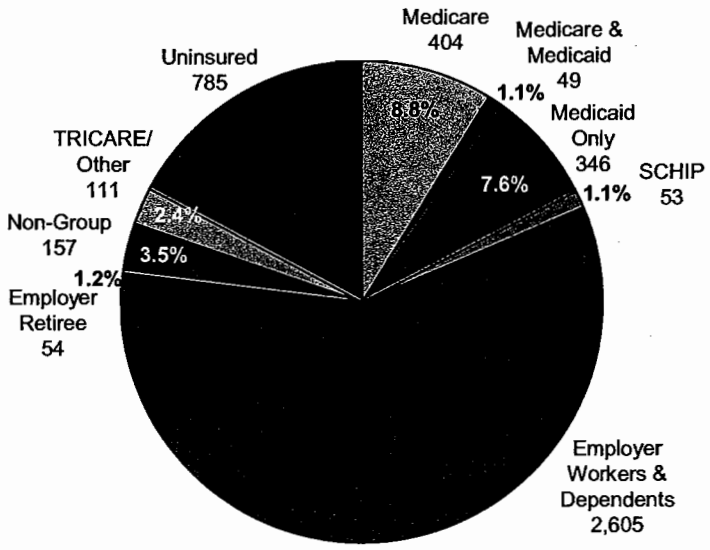
- Primary Source of Health Insurance
- Number of Uninsured by Age
- Uninsured by Family Income

Detailed description of our methodology for estimating coverage in Colorado is in ***Appendix A.***

1. Primary Source of Health Insurance

Figure 1 presents our estimates of the distribution of Colorado residents by primary source of coverage. Because many people have coverage from more than one source, we defined the primary source of coverage based on the prevailing coordination of benefits practices now in use. For example, about 49,000 aged and disabled people are covered under both Medicare and Medicaid. For these individuals, Medicare is the primary source of coverage, with Medicaid as secondary payer covering Medicare co-payments and services not covered by Medicare.

Figure 1
Colorado Residents by Average Monthly Primary Source of Health Insurance [a/]
(thousands)



Total Population = 4,564

a/Primary payer is determined on the basis of prevailing coordination of benefits practices now in use.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

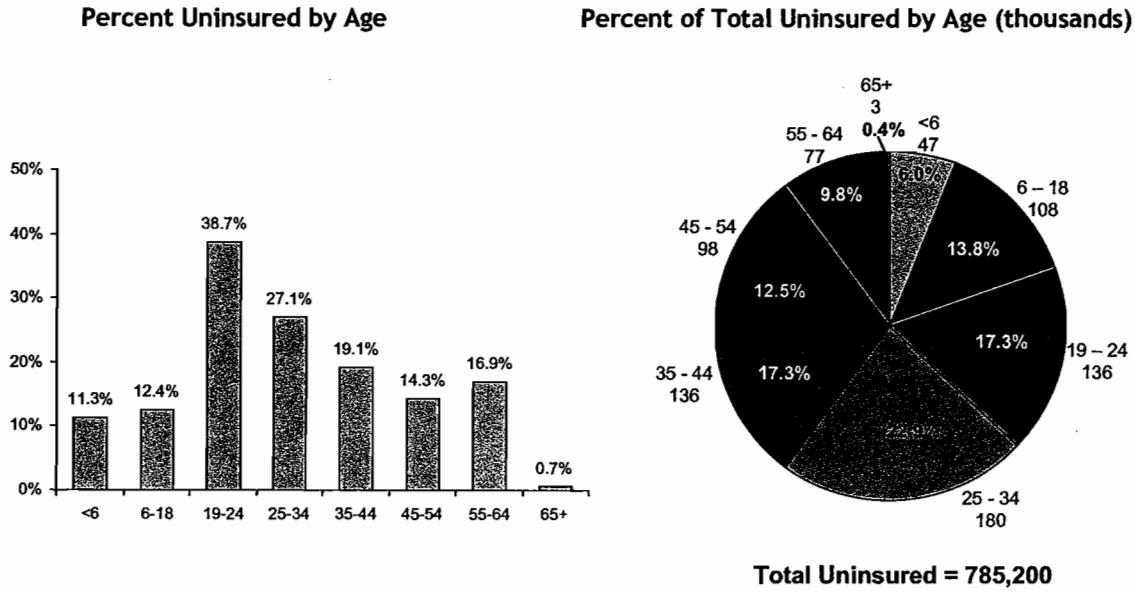
Employer-based coverage is the primary source of health insurance for most people in Colorado. More than one half of the population (57.1 percent) has employer based coverage as a worker or a dependent at any given point in time (***Figure 1***). Another 54,000 people are receiving employer coverage as an early retiree (i.e., excludes retiree supplemental coverage for Medicare eligible retirees). In addition, about 157,000 people have individually purchased non-group coverage as their primary source of coverage.

Medicare is the primary source of coverage for 453,000 aged or disabled people of whom about 49,000 are also covered under Medicaid. Average monthly enrollment in Medicaid is about 447,000, including 49,000 people who are also covered under Medicare. About 399,000 people have Medicaid as their primary source of health insurance coverage. There are about 83,000 people covered as military retirees or dependents under the TRICARE program. This leaves an average of about 785,200 uninsured people on an average-monthly basis.

2. Number of Uninsured by Age

Young adults are more likely to be without health insurance coverage than any other age group (***Figure 2***). About 38.7 percent of people age 19 through 24 are without health insurance, while about 27.1 percent of those age 25 through 34 are uninsured. About 16.7 percent of people age 55 through 64 are uninsured. Roughly 12 percent of children under the age of 19 are uninsured.

Figure 2
Percent of Colorado Residents Who are Uninsured by Age



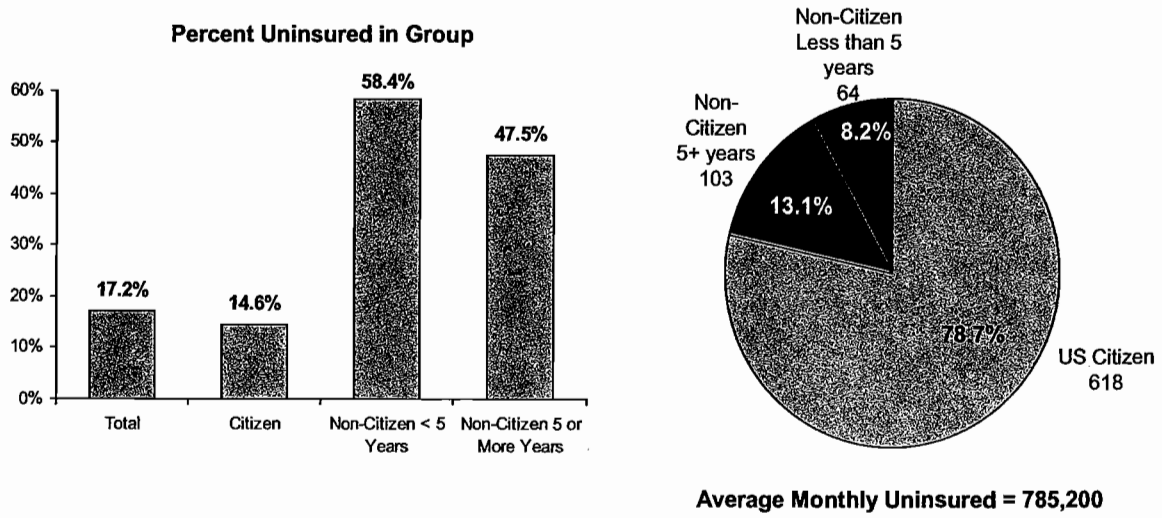
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Of the 785,200 people without health insurance coverage, about 19.7 percent (i.e., 155,000) were children. About 40.2 percent of the uninsured are adults between the ages of 19 and 34.

3. Uninsured by Citizenship

About 167,000 of the uninsured (i.e., 21.3 percent) are not-citizens of the US (*Figure 3*). This is important in a policy context because immigrants must wait 5 years before they can qualify for Medicaid. Undocumented immigrants are ineligible for Medicaid regardless of income, except for emergency services. About 8.2 percent of the uninsured are non-citizens who have been in the US for less than 5 years and would not qualify for assistance under Medicaid or SCHIP except for emergencies. Another 13.1 percent of the uninsured are non-citizens who have been in the US for more than 5 years.

Figure 3
Uninsured in Colorado by Citizenship Status (thousands)



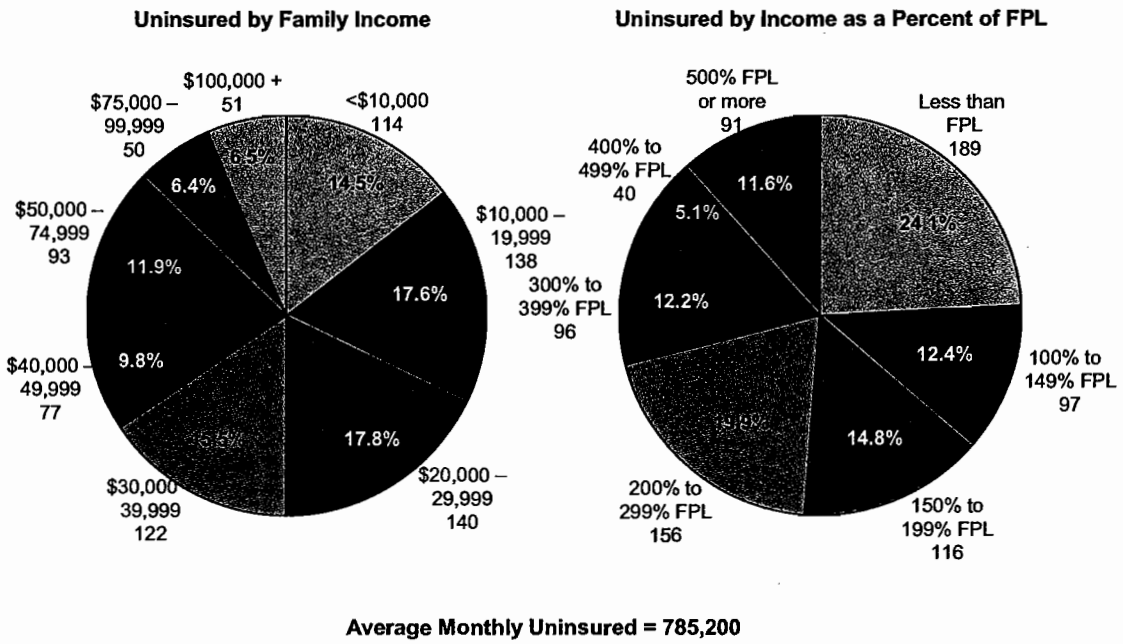
Source: Lewin Group estimates using the Health Benefits Simulations Model (HBSM)

Over half (58.4 percent) of all immigrants who have been in the country less than 5 years are uninsured. Among immigrants who have been in the US for 5 or more years, 47.5 percent are uninsured. About 14.6 percent of US citizens in Colorado are uninsured.

4. Uninsured by Family Income

The uninsured are found in all income groups (***Figure 4***). About 24.1 percent of the uninsured live below the federal poverty level (FPL). About 47.0 percent of the uninsured have incomes between 100 percent and 300 percent of the FPL, and about 28.9 percent of the uninsured have incomes in excess of 300 percent of the FPL. In fact 6.5 percent of the uninsured have family incomes of $100,000 or more.

Figure 4
Average Monthly Uninsured in Colorado by Family Income and Income as a Percent of the Federal Poverty Level (FPL) (thousands)



Average Monthly Uninsured = 785,200

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

B. Health Spending in Colorado

We present our analysis of the current Wisconsin health care system in the following sections:

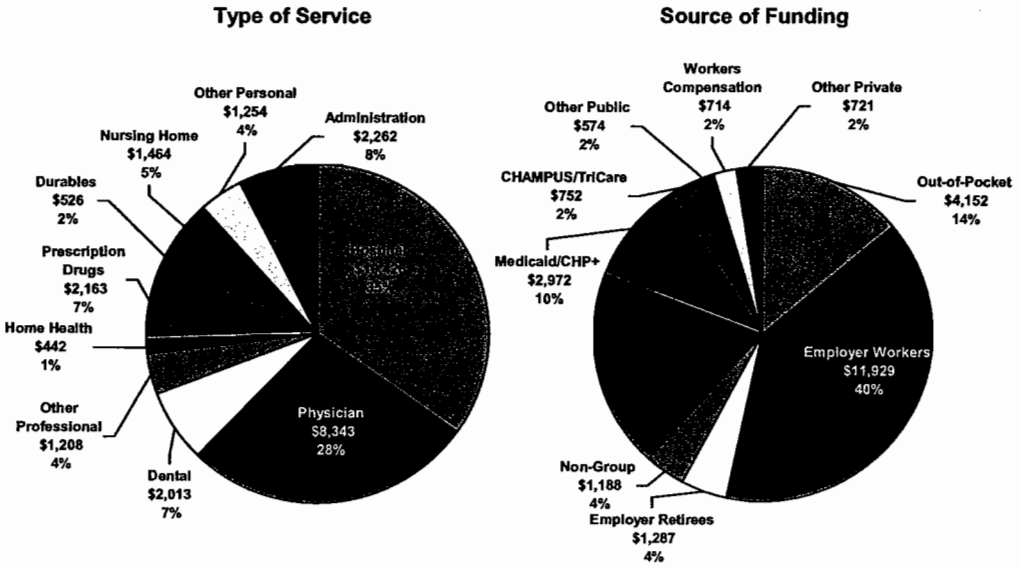
- Spending by Type of Service and Source of Payment
- Historical Spending in Colorado by Type of Service
- Projected Spending in Colorado by Type of Service

Detailed explanation of how we arrived at our estimates is provided in Appendix B.

1. Spending by Type of Service and Source of Payment

Figure 5 presents our estimates of spending by type of service and source of coverage in Colorado. Total health spending in Colorado for FY 2007-2008 is $30.1 billion, which includes administration expenditures.

Figure 5
FY 2007-2008 Estimated Spending in Colorado by Type of Service and Source of Funding [a/] (millions)



Total Spending = $30,100 million

Source: Lewin Group Estimates.

The following sections describe the data and methods used to estimate health spending in Colorado by type of service and source of payment. We estimated health spending for Colorado by type of service for FY 2007-2008 based upon historical data on actual spending in Colorado. For example, the Office of the Actuary (OACT) of the Centers for Medicare & Medicaid Services (CMS) conducts an extensive analysis of health spending by type of service that is designed to provide reliable estimates of spending for each individual state. These data are based upon hospital financial reports for each Hospital in Colorado. Data on income for physicians and other health professionals is based upon the Colorado sub-sample of surveys of businesses conducted by the Bureau of Labor Statistics.

2. Historical Spending in Colorado by Type of Service

We first estimated a control total for FY 2007-2008 health spending in the state of Colorado. We started with estimates of Colorado health spending developed by CMS for Colorado in calendar year (CY) 2004, which is their most recent year available. These estimates are available by type of service and are displayed along with national estimates in ***Figure 6***. Total health spending in Colorado was approximately $21.8 billion in 2004. This includes spending by all payers in the state including individual out-of-pocket payments, and spending for hospitals, physicians,

other health professionals, dentists, prescription drugs and long-term care.[1] It excludes insurer and program administration, research and construction, and public health spending.

Figure 6
Historical Spending in Colorado and the United States by Type of Service: 2000 and 2004 (millions) [a/]

	Colorado			United States		
Type of Service	CY 2000	CY 2004	Avg. Annual Growth 2000-2004	CY 2000	CY 2004	Avg. Annual Growth 2000-2004
Hospital	$5,598	$7,926	9.1%	$417,049	$566,866	8.0%
Physician	$4,719	$6,599	8.7%	$288,609	$393,713	8.1%
Dental	$1,168	$1,577	7.8%	$61,975	$81,476	7.1%
Other Professional [b/]	$738	$967	7.0%	$39,072	$52,636	7.7%
Home Health	$305	$365	4.6%	$30,514	$42,710	8.8%
Prescription Drugs	$1,335	$1,846	8.4%	$120,803	$189,651	11.9%
Medical Durables	$372	$449	4.8%	$19,330	$23,128	4.6%
Nursing Home	$938	$1,192	6.2%	$95,262	$115,015	4.8%
Other Personal Care [c/]	$538	$885	13.3%	$37,076	$53,278	9.5%
Total	**$15,711**	**$21,806**	**8.5%**	**$1,109,690**	**$1,518,473**	**8.2%**

a/ Spending in free-standing ambulatory surgical centers is recorded as physician income. For hospital based ambulatory care centers, the facilities charge is recorded as hospital income with the physician fee for non-hospital staff recorded as physician income.
b/ "Other professional" services are those provided by health practitioners other than physicians or dentists, such as private-duty nurses, chiropractors, podiatrists, and optometrists
c/ "Other Personal" services include industrial inplant services (i.e. health care provided by employers for employees at the employer's establishment), and government expenditures for medical care not delivered in traditional medical provider sites (e.g. community centers, senior citizen centers, schools, and military field stations). Home and Community Waiver programs comprise a large portion of "Other Personal" spending.
Source: Centers for Medicare & Medicaid Services, Office of the Actuary.

In *Figure 7* we display the 2000 and 2004 health spending data in Colorado along with its adjoining States. Colorado had rather moderate growth during this time period in comparison to that of its neighboring states.

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Figure 7
Average Annual Growth Rates of Colorado and Adjacent States: CY 2000 and 2004 (in millions)

	State Spending 2000	State Spending 2004	Average Annual Growth Rate 2000-2004
Kansas	$10,402	$14,061	7.8%
Nebraska	$7,015	$9,715	8.5%
Arizona	$15,891	$23,639	10.4%
New Mexico	$5,457	$7,644	8.8%
Colorado	$15,711	$21,807	8.5%
Utah	$6,458	$9,543	10.3%
Wyoming	$1,615	$2,231	8.4%

Source: Centers for Medicare & Medicaid Services.

3. Projected Spending in Colorado by Type of Service

In order to project Colorado spending to FY 2007-2008 from CY 2004 we first calculate the ratio of the average annual growth rate experienced in Colorado from 2000 through 2004 to the comparable national growth rate for the same time period (see *Figure 8*). Notice that the growth is fairly similar overall (Colorado health spending grew approximately 8.5 percent annually versus 8.2 percent nationally), but there were some significant differences within certain services. For example, Colorado home health spending grew nearly half as much as it did in the US whereas nursing home spending grew nearly 30 percent faster in Colorado.

Figure 8
Projected Spending in Colorado by Type of Service: FY 2007-2008

Type of Service	Ratio State Growth/US Growth 2000-2004	Average Annual Growth - US 2004-2007	State Weighted AAG 2004-2007	State Estimate FY04-05 (in millions)	State Estimate FY07-08 (in millions)
Hospital	1.14	7.2%	8.1%	$8,243	$10,426
Physician	1.08	6.4%	6.9%	$6,824	$8,343
Dental	1.10	6.6%	7.2%	$1,633	$2,013
Other Professional	0.90	7.3%	6.6%	$998	$1,208
Home Health	0.52	10.7%	5.6%	$375	$442
Prescription Drugs	0.71	6.6%	4.6%	$1,888	$2,163
Medical Durables	1.05	4.4%	4.6%	$459	$526
Nursing Home	1.28	4.7%	6.1%	$1,228	$1,464
Other Personal Care	1.40	7.5%	10.5%	$930	$1,254
Total	**1.05**	**6.7%**	**7.1%**	**$22,578**	**$27,838**

Source: Lewin Group estimates using state health spending and cost projections data provided by the Centers for Medicare & Medicaid Services, Office of the Actuary. See National Health Expenditures Projections 2006-2016. http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2006.pdf>

After calculating the ratio of Colorado to US growth in health spending, we apply that ratio to the projected US average annual growth rates for 2004 through 2007 in order to obtain Colorado weighted projected average annual growth rates. The projected US growth rates are also developed by CMS.[2] The Colorado adjusted growth rates are used to extrapolate the 2004 state health spending estimates into the future. After this process, we estimate total health spending in Colorado in FY 2007-2008 to be about $27.8 billion.

4. Provider Payment Levels

The cost of uncompensated care and shortfalls in reimbursement under public programs are passed on to consumers in the form of higher charges through cost-shifting. Similarly, research indicates that reductions in uncompensated and under-compensated care are passed back to private payers in the form of reduced increases in charges. Thus, we assume that a portion of any reductions in uncompensated care or reduced Medicaid payment shortfalls will result in lower charges for private payers, including hospitals and physicians.

There are two separate studies indicating that about half of hospital payment shortfalls are passed-on to private payers in the form of higher charges. However, two other studies showed considerably less evidence of hospital cost-shifting, although they did not rule out a partial cost-shift. One study of physician pricing by Thomas Rice et al., showed that for every one percent reduction in physician payments under public programs, private sector prices increased by 0.4 percent.

Our own analysis of hospital data indicates that about 40 percent of the increase in hospital payment shortfalls (i.e., revenues minus costs) in public programs were passed on to private payers in the form of the cost shift during the years studied. Based upon this research, we estimate that 40 percent of increases in reimbursement would be passed back to payers in the form of reduced charges.

Figure 9 compares hospital payment levels in Colorado that are driven by shortfalls from government payers and the uninsured in Colorado. A detailed explanation is provided in Appendix C. On the public side, Medicaid payments are at 10.8 percent of cost compared to Medicare payment at 27.9 percent and other government payers at 3.1 percent of hospital costs. Private payers pay about 47.8 percent of the cost and self-pay pay about 8.1 percent of cost.

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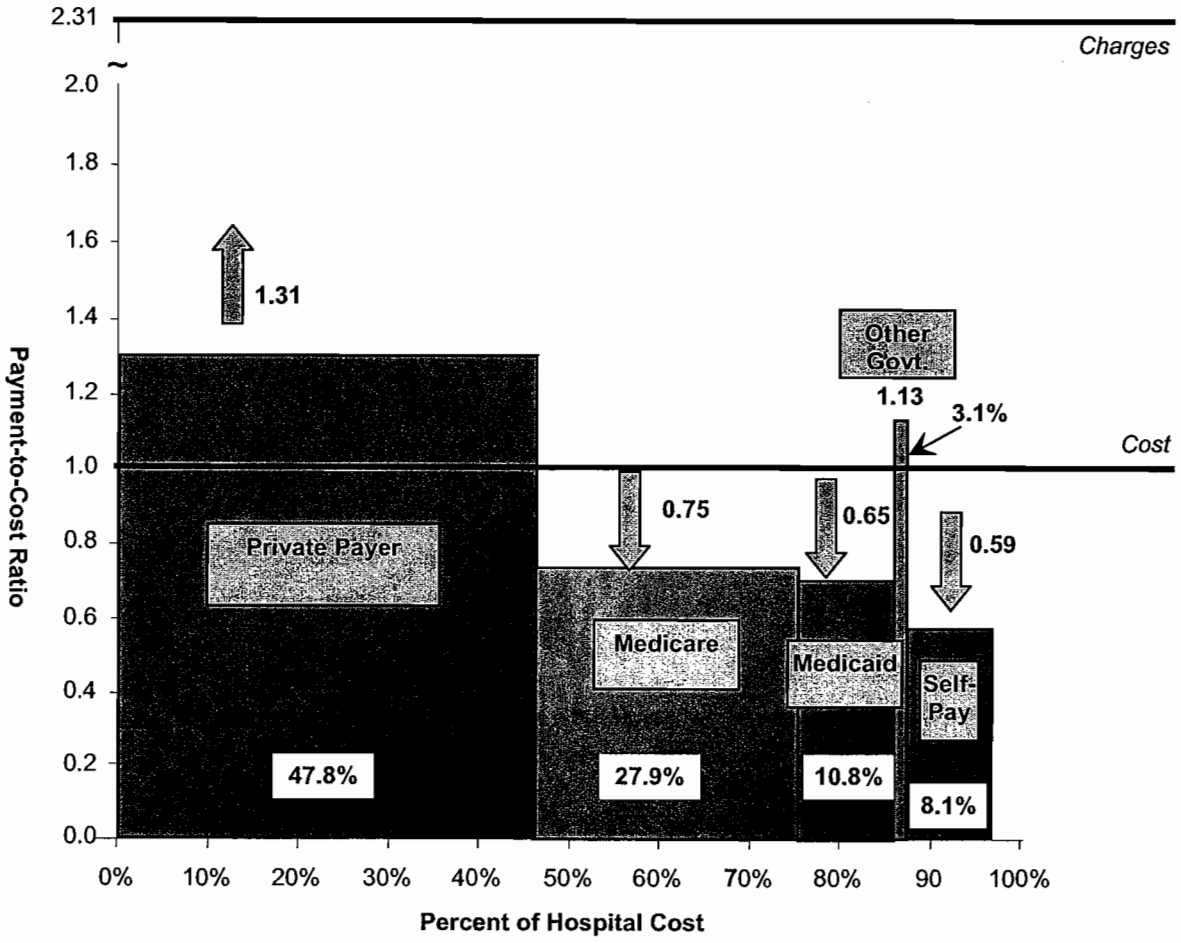
[2] Centers for Medicare & Medicaid Services, Office of the Actuary. National Health Expenditures Projections 2006-2016. <Available as of May 29, 2007 at: http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2006.pdf>

Figure 9
Summary Comparison of Hospital Payment Levels in Colorado



Source: The Lewin Group analysis of Colorado Hospital Association data.

III. BETTER HEALTH CARE FOR COLORADO

Better Health Care for Colorado provides a path to universal health care through a public program expansion and access to private insurance coverage with low-income subsidies through a Health Insurance Exchange. Individuals eligible for public programs would receive benefits under those programs, and individuals who purchase private coverage would have access to a limited core set of benefits, with premiums copays. Financing for the program would be using Disproportionate Share Hospital (DSH) dollars, savings in uncompensated care, and other administrative savings. We present Better Health Care for Colorado in the following sections:

- Key Provisions of Better Health Care for Colorado
- Assumptions
- Cost and Coverage Impacts

A. Key Provisions of Better Health Care for Colorado

Key provisions of Better Health Care for Colorado are summarized below:

1. Coverage

Coverage in the program and residency requirements are described below.

a. Public Program Expansion

The proposal extends health coverage to uninsured, low-income populations up to 300 percent of the federal poverty level (FPL) through the Medicaid and Child Health Plus (CHP+) programs under Medicaid/SCHIP State Plan Amendments and an 1115 Demonstration Waiver, as follows:

- Children up to 300 percent FPL – Medicaid/SCHIP SPA; and
- Parents up to 250 percent of FPL and childless adults up to 225 percent FPL – 1115 Demonstration waiver to authorize Medicaid-funded premium subsidies to purchase private insurance through an Exchange (not a traditional Medicaid benefit package or entitlement).

The following populations are excluded:

- People with employer sponsored insurance (ESI), for which the employer pays at least 20 percent of costs for individual or 30 percent for families;
- People with private non-group insurance;
- People with Medicare or Medicaid coverage;
- People covered under the Federal Employee Health Benefits Program (FEHBP);
- People with state or local employee health benefits; and
- People covered under CHAMPUS/Tricare.

b. Private Coverage Expansion

Under the proposal, uninsured Colorado residents who work in qualified small business (including part-time workers) would purchase private insurance coverage through an Exchange. The worker would have to have been employed in a firm with 50 or fewer workers that has not offered employer sponsored insurance coverage (ESI) for at least one year.

c. Residency Requirement

The residency requirement would be the same as in the Colorado Medicaid program, for children eligible for Medicaid or CHP+ and for parents and childless adults eligible for Medicaid-funded premium subsidies. Undocumented aliens who are low-income or who work for uninsured small businesses would be eligible to buy insurance from the Exchange, however no subsidies would be provided to purchase insurance.

2. Covered Services, Cost Sharing and Benefit Limits

Individuals who are currently eligible for Medicaid and CHP+ would receive the benefits under those programs, including pharmacy benefits and long term care. Applicable cost-sharing requirements under the Medicaid program would apply.

Parents and childless adults in the expansion population and other uninsured workers would enroll in private plans and receive a minimum benefit package described below. Private plans would be required to offer a minimum benefit plan subject to benefit limits, with cost sharing *(Figure 10)*. Copayments would be enforceable and would not exceed the following:

- Under 100 percent FPL, no copayments required;
- 100-200 percent FPL, maximum copayment of 2 percent of income; and
- 200-300 percent FPL, maximum copayment of 4 percent of income.

However, copayments could be waived as an incentive for wellness/healthy behavior. The proposal would establish a medical home and emphasize access to affordable coverage for primary care services. The minimum benefits package would also create a preferred drug list by a specialty pharmacy program.

Figure 10
Potential Colorado Benefit Design for Core, Basic Benefit, Cost Sharing and Limits [a/]

Covered Benefits/Services	Copayments	Limits
All Benefits		• $35,000 Annual Maximum
All Outpatient Services		• $5,000 Annual Maximum
• Physician Services		
◦ Primary Care (including adult preventive services & specialist monitoring a chronic condition)	$10	
◦ Specialist Care	$20	
• Urgent Care	$25	
• Outpatient Hospital		
◦ Surgical Services	$50	
◦ Other Outpatient Services	$25	
• Ambulance (emergency)	$50	
• Laboratory & X-Ray	$0	
• Family Planning Services	$0	
• Mental Health Services	Sliding scale	
• Therapies (consistent w/HMO benefit)	$10	
Other Services		
• Inpatient Hospital Services	$100	• $25,000 Annual Maximum
• Emergency Services	$50*	• $1,000 Annual Maximum
• Durable Medical Supplies/Equipment	$50	• $1,500 Annual Maximum
• Prescription Drugs (Medicaid FFS carve-out, if broad-based PDL is implemented)	Generic-$5 Brand-50% of cost, $25 minimum	• $2,500 Annual Maximum

a/ Plans would be allowed to offer a $25,000 maximum annual limit for all services and enhanced benefits.
Source: Better Health Care for Colorado Health Reform Proposal

The minimum benefit would establish a "floor" for benefits, a guaranteed subsidy for participants and a payment schedule for providers that varies by gender, age and potentially geographic area. Insurers could offer enhanced benefits and employers and unions could negotiate for more comprehensive coverage from selected plans; these plans would be required to extend that benefit package to all participants who choose the product on the Exchange.

In addition, the Exchange could offer different options for insurance coverage such as a more comprehensive "benchmark" benefit plan with higher participant cost sharing (like a state

employee plan) or, for participants who are at high risk and would qualify for the state's high risk pool, a higher premium subsidy to enroll in CoverColorado.

In place of supplemental or wrap-around coverage, the State could continue to use a portion of DSH to reimburse uncompensated care in excess of insurance coverage or, through the low-income pool, could use reinsurance or establish outlier payments for costs that exceed the annual limits. Long term care services would continue to be provided under the Medicaid program and would not be incorporated in the new premium subsidy program.

3. Premiums and Subsidies

Premiums would be set based on the benchmark minimum benefits above. However, monthly per member per month costs for the core benefit would be targeted at $150-$200. Individuals who do not pay their monthly premium would be disenrolled. For specific insurance products already offered, such as CoverColorado, existing policies & procedures would apply.

Figure 11 shows estimated Single and Family premiums by Age and Gender for the benefits package:

Figure 11
Better Health Care for Colorado Premium Estimates

Medical Expense PMPM by Age/Gender/Tier Contracts Effective 2007/2008		
Age/Gender	**Single**	**Family**
<25 M	$122.05	$440.91
25 - 34 M	$149.19	$642.74
35 - 44 M	$197.29	$767.38
45 - 54 M	$331.21	$862.99
55 - 64 M	$562.81	$1,030.89
<25 F	$218.09	$469.69
25 - 34 F	$274.48	$663.08
35 - 44 F	$319.34	$734.99
45 - 54 F	$420.98	$868.77
55 - 64 F	$605.72	$1,066.71

Source: NovaRest Consulting

Premium subsidies would be offered for low income people for private coverage (except undocumented aliens) on a sliding fee scale as follows:

- Under 100 percent FPL, no premiums required;
- 100-200 percent FPL, 98 percent premium subsidy;
- 200-300 percent FPL, 96 percent premiums subsidy; and
- Above 300 percent of FPL, no premium subsidies.

In addition, premium discounts could be offered through a wellness/healthy behavior initiative, along with value-based purchasing discounts to encourage use of cost-effective protocols for specific diseases (i.e. diabetes).

Low income individuals who receive a subsidy and enroll in a higher cost plan would be responsible for any additional premiums in excess of the subsidy provided for the core, basic benefit plan, with the exception of those eligible for the state's high risk pool.

The Exchange will establish a system to administer premium subsidies and collect premiums through payroll deductions and, if not employed, through coupon payments or an Electronic Funds Transfer (EFT). Alternatively, any functions now operated by the state for a Medicaid health insurance purchase arrangement, or any other premium collection system could be expanded to collect premiums for the expansion population.

4. Consumer Choice

Currently Medicaid and CHP+ eligible people would enroll in these programs and cannot enroll in a private plan. Under the expansion population, children would enroll in the Medicaid or CHP+ programs. Parents, childless adults and uninsured workers and families would be able to buy private market products offered by a Health Insurance Exchange. Low-income workers who are eligible for a premium subsidy would have the choice to opt out of the plan to enroll in ESI using the premium assistance to pay for their employee contribution.

Plans would compete through an exchange by offering lower cost-sharing or enhanced benefits packages, for example, lower-cost benefit plan that offers primary and preventive coverage with an annual benefit limit of $25,000 or $35,000. The Exchange would certify plans with preference for HMOs and PPO products that incorporate care management and managed care principles.

Individuals with higher healthcare costs or chronic conditions would have the option to select a product with broader coverage (e.g., a benchmark plan with more comprehensive coverage and higher cost sharing like the State Employees Health Plan with broader coverage or, if eligible under the criteria required for enrollment in the state's high risk pool, CoverColorado). In these instances the annual limit would not apply, but rather the alternative plan provisions selected by the participant would provide a choice of coverage with more comprehensive benefits and higher cost sharing. As noted, a higher subsidy could be provided for those eligible for CoverColorado to eliminate any financial disincentive to enroll in that program if an individual is high risk and qualifies for the program.

5. Enrollment and Coverage Continuation

The plan would specify an initial period of 60 days to enroll once eligible, an annual open enrollment period, and a lock-in period of one year, with exceptions for good cause, such as changes in employment, income or marital status. For specific insurance products already offered, such as CoverColorado, existing policies and procedures would apply. Individuals

could be disenrolled for failure to pay premiums, or denied service for failure to pay required cost sharing after a 30 day grace period.[3]

6. Disposition of State/Local Programs

The plan expands Medicaid and CHP+ as specified above. In addition the plan proposes to establish a high-quality, capitated Medicaid managed care program statewide. All other public programs such us Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Mental Health clinics, CoverColorado school based health services, etc, would be maintained.

7. Employer Provisions

Any employer contribution for the subsidized population would be voluntary. Multiple employers could contribute to coverage on the exchange, and payroll deductions could be drawn from more than one employer for employees with multiple jobs.

Employers would be required to cooperate with the Exchange to coordinate work site enrollment, payroll withholding and the establishment of a Section 125 plan to assure pre-tax treatment of employee contributions for health care. Employers could also make voluntary contributions for plan coverage.

8. Insurer's Role and Insurance Market Reforms

Insurers would offer products to be certified for the Exchange, and would be responsible for meeting benefit requirements (minimum coverage, guarantee issue for products on the Exchange), complying with wellness/healthy behavior, disease management, and for pay for performance requirements. Insurer's roles in marketing, outreach, information sharing and other enrollment functions would be reduced as these functions would be facilitated by the Exchange.

A modified community rating (age and gender) would apply for the basic, core insurance product on the Exchange. The Exchange could also allow rates to be established by geographic area. The rating rules that apply for CoverColorado would continue for that program.

9. Provider Payment Levels

Medicaid and CHP+ services providers would be paid at the Medicaid and CHP+ payment levels. For the expansion population purchasing insurance on the Exchange, providers would be paid at Medicare or comparable market rates. The following additional pay-for-performance incentives would be provided:

- For hospitals, future increases will be distributed on a provider specific basis depending on their "score". For example, if the budget provides an overall 3% increase in hospital rates, individual hospital rates could range from 4.5% to zero depending on their score.

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[3] The proposed grace period is to be comparable to that used in the individual and small group market and ESI coverage.

Insurers in the Exchange and other insurers would be encouraged to emulate the hospital P4P program in their payment designs.

- For Medicaid MCOs - the construct is to set rates at the bottom of the rate range and create incentives for outstanding plan performance that would get a MCO to the mid-point of the rate range. For products offered through the Exchange, a portion of the subsidy will be tied to outcome performance.
- Physician P4P would be required for MCOs or PCCM vendors in Medicaid managed care and for all plans offered through the exchange.
- Rate updates for Medicaid and CHP+ would continue as a function of the state budget process. For the private plans, the Exchange would review and approve rates to be offered, subject to approval of funding in the state budget process.

Rate updates for Medicaid and CHP+ would continue as a function of the state budget process. For the private plans, the Exchange would review and approve rates to be offered, subject to approval of funding in the state budget process.

10. Financing

The program would be financed as follows:

- Redirection of Colorado Indigent Care Program funding from providers to fund premium subsidies;
- Savings from proposed Medicaid 1115 Demonstration waiver provisions;
- Medicaid program savings from implementing disease management programs;
- An increase in tobacco—from $.84 up to $2.00 per pack; and
- An increase in alcohol taxes as follows
    - Spirits: from $.60 to $5.63 for a liter (or from $2.28 to $21.30 per gallon)
    - Wine: from $.07 to $.66 per liter (or from $.32 to $2.50 per gallon)
    - Beer: from $.05 to $.15 per 6-pack (or $.08 to $.26 per gallon)

11. Administration

For the public program expansion (parents and childless adults) and for private plans (unsubsidized small business employees), plan selection and enrollment would be facilitated by a quasi-public entity, "the Exchange". Medicaid and CHP+ administration would continue upon the plan effective date; however, the state could phase in to the Exchange model and could explore the extent to which other existing programs/structures could perform some of the Exchange functions. Functions of the Exchange would be as follows:

- Offer products to subsidized uninsured and non-subsidized small businesses;

- Facilitate enrollment, certify plans, administer premium subsidies, collect premiums through payroll deductions, coupon payments and EFT, ensure portability, and leverage pre-tax contributions to reduce cost.;
- Create an environment where providers would compete on price, quality, and provider networks;
- Certify plans with a preference for managed care and PPO products that incorporate care management and managed care principles, to provide a choice of insurance options, including:
    - Limited benefit health plan with first dollar coverage and annual benefit limit of $25,000 to $35,000;
    - A pre-paid and/or point-of-service plan;
    - A benchmark plan with more comprehensive coverage and higher participant cost sharing, such as the State Employee Health Insurance Plan;
    - State care initiatives (i.e., Colorado Indigent Care Program); and
    - If eligible, the Colorado high risk pool.

In addition to providing access to affordable insurance for the subsidized population, the Exchange would be a platform to offer more accessible, affordable products to uninsured small businesses with streamlined administration and portability for workers. Regulation of insurers in the marketplace would continue to be the responsibility of the Division of Insurance.

To the extent possible, the Exchange would coordinate with and build on Medicaid eligibility systems for outreach, eligibility determinations and coordination of health plan enrollment for multiple family members. The Exchange would also establish new lines of coordination and communication with employers for work site sign-up, payroll withholding and Section 125 plans.

The administration of long-term care services would remain with the Medicaid program; the Exchange would not administer any long term care services. Individuals requiring long term care services would access information/service via the current, but enhanced single entry points.

12. Long-Term Care Component

The proposal included several long term care reforms. Below are the proposed reforms, indicating the reforms for which Lewin would provide a completed analysis:

Reform Description	Lewin Cost Impact Estimate
I. ELIGIBILITY	
1. Post eligibility verification of financial information (Presumptive Eligibility) • Implement a post eligibility verification of financial eligibility for all with assets below $2,000.	✓

Reform Description	Lewin Cost Impact Estimate
• Post-eligibility verification would occur within 60 days of initial service start-date.	
• Individual is financially responsible for services if determined not eligible.	
2. Automated functional assessment system	
• Complete implementation of Benefits Utilization System for CO.	
3. Clinical eligibility changes	↓
• Colorado's clinical threshold for NF eligibility and also community services is 2.0 ADL limitations. Increase the institutional level clinical eligibility criteria for Elderly Blind and Disabled (EBD) waiver to 3.0 ADL limitations. Because the author has not had the opportunity to review acuity-level data related to this change, the recommendation may be modified or eliminated once data is available if there is a severe negative impact in either of these areas.	
• Apply the 2.0 ADL limitation clinical eligibility criteria to cover personal care services as a state plan service.	
4. State-funded change	
• Develop a more robust state-funded non-institutional option for individuals with limitations in 2.0 ADLs with income between 150 percent and 300 percent of poverty.	
5. Income eligibility change: Increase income eligibility of HCBW services to 150 percent FPL as a state plan service.	↓
6. HCBS Spend Down Program	↓
• Develop a HCBW spend down program for people with excess resources to buy into the program.	
• For people who exceed the Medicaid income levels, develop a private pay non-institutional option.	
II. REIMBURSEMENT	
1. Acuity Adjusted and Cost Effective Rate Setting	
• **Nursing facilities:** Use new version of MDS to revise nursing facility case mix rates to better account for behavioral health issues.	
• **Non-institutional Providers:** Develop a methodology that increases payment to non-institutional providers in recognition of greater resource requirements similar to the nursing facility case mix system. Collection and analyses of acuity information should be built into the Benefits Utilization System (BUS) system, Colorado's automated functional eligibility system.	
2. Cost-effective Rate-setting	
• The state should review its nursing facility and HCBW rate setting methodology to ensure that the rates provided encourage cost-effective care.	
• Address payment disparities between nursing facilities and HCBW services.	
3. Pay-for-Performance (P4P)	
• Establish P4P standards for all long term care providers.	
III. HOUSING	
1. Increase access to housing for LTC consumers	
• Establish housing set asides and priority placement for LTC consumers - establish a cabinet level commitment to make LTC consumers a priority to public housing entities.	

Reform Description	Lewin Cost Impact Estimate
• Develop supported housing and create partnerships between HCBW providers, SNPs, and public housing. Encourage SNPs to staff senior centers at public housing locations with on site medical care.	
2. Increase affordable and accessible housing stock	
• Create a housing fund that non-profit develops can access to develop accessible and affordable housing for at risk population. (e.g., Boulder Housing Authority)	
3. Provide local assistance to consumers to find affordable and accessible housing	
4. Provide assistance to NF, private developers and other interested parties in accessing state and federal programs to help finance affordable and accessible housing.	
5. Maximize housing-related funding	
• State review how funds related to housing including HCBW are used to ensure federal funding is being maximized.	
IV. RIGHT SIZING STRATEGY	
1. Establish right-sizing incentives	
• Provide incentives for facility conversions, bed buy-back programs, etc.	
• Consider additional disincentive in rate methodology for nursing facilities with high proportion of low-acuity residents.	
• Provide tiered reimbursement for facilities that provide a comprehensive health healthcare insurance benefit and provide a lower maximum allowable reimbursement for facilities that do not provide a comprehensive healthcare benefit.	
• Consider moving to a more cost-center-based system that promotes quality and improves accountability; e.g., money that is allocated to direct care labor costs cannot be spent on other areas such as capital and overhead and vice-versa.	
2. Promote PACE/SNP Development	
• State actively recruit NFs to partner with carriers do develop SNPs and PACE programs.	
3. Promote HCBW services	
4. Assist with transitioning the workforce	
• Provider training on Consumer Directed Care	
• Benefits-ensure that workers have insurance coverage.	
5. Quality Management	
• Establish a LTC QM Committee	
• Establish measurable benchmarks and performance standards	
• Implement a QI strategy	
• Establish a formal back-up and emergency system	
• Establish a training program	
• Establish a public authority	
V. CARE DELIVERY	
1. Consumer-Directed Care: Increase use of consumer directed options in all LTC programs in Colorado. Develop educational materials and provide training to ensure that all consumers understand this option.	

Reform Description	Lewin Cost Impact Estimate
2. Develop integrated models: • Develop integrated models including SNPs, Coordinated Care programs (to include Medicare and behavioral health services), PACE and PACE-like models. • Develop more integrated state-funded programs. **3. Develop HCBW for Veterans.** **4. Develop non-institutional model for Coloradans not eligible for Medicaid**	
VI. STRUCTURE • **Leadership and State-only funded programs:** State review current organizational structure to facilitate increasing demand for LTC services. • Establish a leadership team from various agencies involved in delivering LTC services (DHCP, Human Services, Housing, etc.) to establish and implement the Administration's vision, allocate resources, and monitor progress.	
VII. FINANCING State should consider the following as options to for developing and maintaining sustainable LTC programs: • Nursing home tax • Review state only spending on LTC to identify opportunities to obtain Medicaid federal match. • Obtain Medicaid match on Veteran's expenditures	

Lewin will present the results of LTC analysis and narrative to be provided in an Addendum to the Report.

B. Key Assumptions

The Author's proposal would expand coverage under Medicaid/SCHIP programs to cover all children living below 300 percent of the FPL. It also provides subsidies for private coverage for parents through 250 percent of the FPL and childless adults through 225 percent of the FPL. After a period of time, eligibility levels for parents would be increased to 300 percent of the FPL.

In this section, we describe the methods and assumptions used to simulate the impact of this proposal. A detailed discussion of the model is presented in ***Appendix D***.

1. Low-Income Coverage Expansion

We estimated the number of newly eligible children who would enroll in the program based on the Colorado sub-sample of the Current Populations Survey (CPS) data for 2004 through 2006 using the Health Benefits Simulation Model described above. These data provide information on income and insurance coverage for a representative sample of the population that is suitable for use in estimating the number of people who are eligible for public coverage expansions.

Key assumptions include:

- We estimated the number of children who would be eligible to enroll under these eligibility expansions using the income and demographic data reported in the CPS and the income eligibility levels used in the state. Estimates were developed using a simulation of month-by-month eligibility, which permits us to account for part-year eligibility.
- We simulated enrollment for eligible children based upon a Lewin Group analysis of program participation rates under the current Medicaid program. This approach results in participation rates of about 70 percent for uninsured persons and 39 percent for people who currently have insurance from some other source.
- We assumed that children currently eligible for Medicaid or SCHIP who are not enrolled would become covered under the program if one of their parents becomes covered under the private insurance subsidy program created for adults. We assume no change in coverage status for all other persons who are eligible for but not enrolled in the existing Medicaid/SCHIP program.
- Administrative costs per newly eligible person were assumed to equal average administrative costs for eligibility functions per enrollee under the current program (about 7.5 percent of benefits costs).
- Our participation model simulates "crowd-out" (i.e., the substitution of public for private coverage) based upon enrollment of children eligible for the pre-SCHIP poverty level expansions under Medicaid.[4] The model indicates that without anti-crowd-out provisions, up to 39 percent of newly eligible persons with employer coverage would eventually shift to the public program.[5]

2. *Premium Subsidies*

The premium subsidies would reduce the cost of insurance to eligible people, resulting in an increase in the number of people taking such coverage. We estimated the impact of the premium subsidy on the number of people purchasing non-group coverage by treating the subsidy as a change in the price of insurance to the individual. This reduction in price would result in an increase in the likelihood that such a family would purchase coverage.

We simulated the impact of this reduction in price using a multivariate model of how the likelihood of purchasing coverage changes as the price of coverage (i.e., the premium) is reduced. This model shows an average price elasticity for coverage of -0.34 (i.e., a 1.0 percent decrease in premiums is associated with an increase in coverage of about 0.34 percent). However, the impact of changes in premiums on coverage varies with the income and demographic characteristics of affected persons. For example, the price elasticity varies from about -0.31 among persons with family incomes of $50,000 to -0.55 among those with incomes of $10,000. Thus, the price response tends to be higher for low-income persons than high-income persons.

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4 Estimates are based upon CPS data showing Medicaid enrolled children with parents who have employer health insurance. The poverty-level expansions did not include anti-crowd-out provisions.

5 Crowd-out could be substantially reduced by requiring states to adopt anti-crowd-out provisions such as a six-month waiting period.

We used these price elasticity assumptions to simulate the change in coverage for uninsured people in the MEPS-based HBSM data. The model was used to estimate the premium faced by each uninsured individual/family in the individual market, and the amount of the credit that eligible persons would receive. Affected individuals were then randomly selected to become covered based on the change in the net cost of insurance to the individual as a result of the credit (i.e., premium less the tax credit received) and the price elasticity assumptions discussed above. This step involved the following assumptions:

- We used HBSM to estimate the premium that individuals face in the non-group market for a given benefits package by age, sex and self-reported health status. As discussed below, this benefits package is assumed to be similar to that offered through the Federal Employees Health Benefits Program (FEHBP), adjusted to reflect recent research indicating that the actuarial value of non-group policies is typically about 16 percent less than that of employer health plans.[6]
- All HBSM simulations were performed on a month-by-month basis to account for persons who are eligible for only part of the year. (The various tax credit proposals typically pro-rate the annual credit over months of eligibility.)
- All income-eligible persons who are currently purchasing non-group coverage are assumed to take the credit.
- All income-eligible persons who have employer coverage are assumed to receive the tax credit less the value of the tax exclusion on their employer-provided coverage.

3. *"Crowd-out" Analysis*

Programs that expand eligibility for Medicaid and various proposals to provide premium subsidies for non-group coverage can lead to reductions in the number of people who have employer-sponsored insurance (ESI). This is because, for those who qualify, these programs either reduce or eliminate the cost of obtaining coverage through other sources (i.e., Medicaid, SCHIP, or subsidized non-group coverage). For example, employers of low-wage workers may find that the cost of obtaining coverage through government subsidized coverage would actually be less than the cost of obtaining coverage as an employer group, even after accounting for the tax advantages of obtaining coverage through ESI. The process of people moving from private to public coverage in called "crowd-out."

The program modeled here includes a 12 month waiting period, which is designed to discourage people from discontinuing their employer coverage to enroll in publicly subsidized coverage. The waiting period rule requires that people must be uninsured for 12 consecutive months before enrolling in the program. Thus, to shift to the publicly subsidized coverage, the individual must terminate their employer coverage and "go bare" of insurance for a year before enrolling in the subsidized coverage program.

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6 Gabel, Jon, et. al., "Individual Insurance: How Much Financial Coverage Does It Provide," *Health Affairs*, April 2002.

In this analysis, we assume that the waiting period requirement would be effective in preventing people from discontinuing their ESI to enroll in Medicaid/SCHIP or the premium subsidy program. However, we assume that the waiting period rule is waived to people losing employer coverage due to job change or a change in family status, such as a divorce.

4. Program Administration

We assumed that the cost of administering eligibility for the Medicaid/SCHIP expansion would equal $170 per family per year. This is based upon detailed data on the cost of administering eligibility under the Medicaid program. We assume that insurer's cost of administering coverage under each of these benefits packages to be equal to 19 percent of covered claims. This assumption is based upon experience in large health plans operating in the non-group market.

5. Wage Effects

We assume that changes in employer health spending under the proposal would be passed on to employees as changes in wages. We also assume that this would occur among government employers as well, assuming that states would need to remain competitive with private employers for labor. This adjustment wage increase would be partly offset by changes in income and payroll tax payments.

C. Cost and Coverage Impacts of Better Health Care for Colorado

We present our findings of the impact of the Better Health Care for Colorado proposal in 2007/2008 in the following sections:

1. Transitions in Coverage

The proposal provides coverage through a public program expansion and through the private market. Uninsured individuals in the private market would be able to purchase coverage through an Exchange. Some of these individuals would purchase only the limited benefit package while others would opt for more comprehensive benefits.

The proposal covers an estimated 324,600 uninsured or 40.99 percent of the uninsured population. ***Figure 12*** illustrates where people would become covered under the proposal. We estimate that, of the 2.69 million people currently receiving employer sponsored insurance (ESI), 14,900 would move into the Medicaid/CHP+ expansion as a result of the program expansion. In addition, 29,000 would seek coverage through the exchange as the proposal allows workers in qualified small firms to purchase coverage through the Exchange with a subsidy based on income level. Of the 29,000 enrolling through the Exchange, 9,000 would seek comprehensive benefits.

Out of an estimated 158,900 people getting coverage in the non-group market, we estimate that 13,000 would seek limited benefit coverage through the Exchange and 2,500 would seek more comprehensive benefits through the Exchange. These would include people who would be able to qualify for subsidies and who can get cheaper coverage through the Exchange. In addition 8,300 people would move from the non-group market to the Medicaid/CHP+ program because of the expansion. We estimate that 135,100 people would remain in the non-group market

without going through the Exchange. Better Health Care for Colorado has no impact on coverage of military personnel under CHAMPUS. Also the estimated number of people to be covered under Medicaid/CHP+ under current law would remain the same.

Figure 12
Transitions in Coverage under Better Health Care for Colorado in 2007/2008 (thousands)

Base Case Coverage	Total	Exchange		Private Coverage		Public Coverage			Uninsured
		Limited Benefit	Comprehensive Benefit	Employer	Non-Group	CHAMPUS	Medicare (incl. dual eligibles)	Medicaid/ CHP+	
Employer	2,691.7	20.0	9.0	2,647.8	0.0	0.0	0.0	14.9	0.0
Non-Group	158.9	13.0	2.5	0.0	135.1	0.0	0.0	8.3	0.0
CHAMPUS	112.4	0.0	0.0	0.0	0.0	112.4	0.0	0.0	0.0
Medicare (incl. dual eligibles)	413.0	0.0	0.0	0.0	0.0	0.0	413.0	0.0	0.0
Medicaid / CHP+	452.1	0.0	0.0	0.0	0.0	0.0	0.0	452.1	0.0
Uninsured	791.8	245.6	36.3	0.0	0.0	0.0	0.0	42.8	467.2
Total	**4,619.9**	**278.6**	**47.8**	**2,647.8**	**135.1**	**112.4**	**413.0**	**494.9**	**467.2**

Source: The Lewin Group estimates using the Health Benefits Simulation Model.

Figure 13 shows the change in the number of uninsured under the proposal by age and income, assuming the program is fully phased in with expansions for parents, adults and children under the Medicaid/CHP+ programs. The proposal covers a greater proportion of lower income people because of the subsidies provided for these individuals as well as the expansion in Medicaid/CHP+. The proposal would cover about 47.80 percent of uninsured people earning less than $50,000 per year compared to 27.72 percent of the uninsured those earning $50,000 or more. Individuals between the ages of 19-34 years are more likely to be healthier and therefore more likely to remain uninsured, particularly if they are lower income unless they fall under categorical groups for public programs. With the premiums subsidies provided through the Exchange and the public expansions to childless adults, the program covers 43 percent of people between ages 19-34 years. Primarily through the public program expansion for children, 27.22 percent of the uninsured under 19 years old would be covered.

Figure 13
Change in Uninsured under Better Health Care for Colorado in 2007/2008 (thousands)

	Uninsured Under Current Law	Reduction in Uninsured	Number Remaining Uninsured under the Policy
Family Income			
Under $10,000	90	36	54
$10,000-$19,999	109	60	49
$20,000-$29,999	127	68	59
$30,000-$39,999	118	49	69
$40,000-$49,999	79	37	43
$50,000-$74,999	123	42	81
$75,000-$99,999	66	16	50
$100,000-$149,999	48	7	41
$150,000 & over	30	9	21
Age			
Under 6	59	17	42
6-18	99	26	73
19-24	123	44	79
25-34	192	92	100
35-44	147	73	74
45-54	112	47	65
55-64	58	25	33
65 and over	1	0	1
Total	**792**	**325**	**467**

Source: The Lewin Group estimates using the Health Benefits Simulation model (HBSM)

6. Impact on Statewide Health Spending

As discussed above, we estimate that health spending for Colorado residents will be about $30.1 billion in 2007/2008. This includes spending for all health services by all payers including Medicare Medicaid, ESI, non-group insurance, workers compensation and various safety-net programs. Spending includes both payments for services, insurance, and program administration.

Better Health Care for Colorado would have several impacts on statewide health spending. There would be an increase in health services utilization as persons who are uninsured or underinsured under the current system become covered. Utilization will also increase slightly for those individuals previously covered in a less generous plan. However, some of these increases in costs would be offset by reductions in administrative costs for insurers and providers as people access coverage through the Exchange.

Health spending in Colorado would increase by about $595 million in 2007/2008 under the proposal (***Figure 14***). This is an increase in state-wide health spending of about 2 percent. Provider payments would increase by about $374 million due to increased utilization of services by newly insured people and a net increase in provider reimbursement resulting from the use

of provider payment levels equal to Medicare or comparable market rates. Medicaid and CHP+ provider payment rates will remain the same under the expanded programs.

Insurer administration would be increased by $164 million and administration of subsidies would add $39 million to the program costs. The impact of the program on health spending is presented below.

Figure 14
Changes in Statewide Health Spending under Better Health Care in 2007/2008 (millions)

Current State Health Spending		**$30,100**
Change in Health Services Expenditures		**$374**
Change in utilization for newly insured	$366	
Change in utilization for currently insured	$8	
Reimbursement Effects		**$65**
Payments for previously uncompensated care	$109	
Reduced Cost Shifting [a/]	($44)	
Medicaid Utilization Measures		**($8)**
Pharmacy Rebate for Adult Expansion Program [b/]	($8)	
Change in Administrative Cost of Programs and Insurance		**$164**
Change in Insurer Administration	$125	
Administration of Subsidies [c/]	$39	
Total Change in State Health Spending		**$595**

a/ Assumes 40 percent of change in provider payment rates are passed on to private health plans in the form of lower negotiated rates.
b/ Pharmacy program for adults in the Exchange will be administered through Medicaid in order to utilize the pharmacy rebates under Medicaid (about 20%).
c/ Assumes $171 per family for determining income eligibility for subsidies.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

a. Impact on Utilization of Health Services

The expansions in coverage and benefits under Better Health Care would result in increased utilization of health services. Utilization of services for uninsured and underinsured people would generally increase due to expanded access to services under the program. In addition, under mandated benefits, utilization for certain services would increase due to the expansion in coverage for those services.

However, these increases in utilization would be partly offset by reduced spending for avoidable complications in health conditions and reduced spending in avoidable health conditions resulting from increased primary care utilization. Below we discuss the utilization impacts of implementing Better Health Care for Colorado.

b. Utilization for the Uninsured

Uninsured people who become covered under the program would use health care services at the same rate as reported by currently insured people with similar age, sex and health status characteristics. This assumption encompasses two important effects. First, the increase in access to primary care for this population would result in savings due to a reduction in avoidable emergency room visits and hospitalizations. Second, there would be a general increase in the use of such services like preventive care, advanced diagnostic tests, and other care that the uninsured often forego or delay.

Using this methodology, we estimate that health spending among the currently uninsured population would increase. We estimate an increase in spending due to utilization increase to a total of $366 million in 2007/2008.

c. Utilization for the Underinsured

Some insured have a benefit package that does not cover certain services including prescription drugs, dental care, orthodontia and medical equipment. Often times, these individuals access such services through government-funded clinics and health centers or forego services. In addition, a smaller underinsured population is covered through government programs that only offer a limited benefit package. Under Better Health Care for Colorado, these individuals will have access to a comprehensive benefits package that all health plans in the private sector must provide in the Exchange. In addition, people can opt for a more comprehensive package in the Exchange.

In this analysis, we assume that utilization of these services by people who are not currently covered for these services would increase to the levels observed among those with similar demographic and health status characteristics who do have coverage for these services. Spending under the Better Health Care for Colorado would increase by $8 million for under-insured people in 2007/2008.

d. Reimbursement Effects

Under the proposal, total benefit payments to providers for previously uncompensated care would be $109 million in 2007/2008. Under the current system, uncompensated care from services to the uninsured and under-insured is shifted to other payer sources (primarily private payers). Providers will be reimbursed directly for services provided to newly insured and underinsured people under the proposal. Based upon the literature on cost shifting discussed above, we assume that 40 percent of the change in provider payment rates are passed on to private payers in the form of lower negotiated rates, thereby reducing cost shifting which we estimate to be $44 million. This savings is included in our estimate of adjustments to provider payments.

7. Change in Government Health Spending

The program would have significant implications for both the state and federal governments. We present estimates of program operations costs and revenues for both the state and federal governments.

a. Premium Subsidy Costs

Figure 15 shows premium subsidy costs to the state and federal government, including costs for the expansion group. The program provides full subsidies for people under 100 percent of poverty. The level of subsidy for people between 100 percent and 300 percent of poverty is based on a sliding scale. People above 300 percent of poverty receive no subsidy. We estimated the costs of the subsidy, including administration of the subsidy to be $473.6 million for the state and $505.9 million for the federal government.

Figure 15
Enrollment and Costs under Better Health Care for Colorado in 2007/2008

	Number Enrolled (thousands)	Reduction in Uninsured (thousands)	Subsidy Costs (millions)[a/]	State Costs (millions)	Federal Costs (millions)
Children					
Medicaid Eligible Children [b/]	4.5	3.2	$7.8	$3.9	$3.9
Medicaid Limit - 300% FPL [c/]	61.5	39.6	$107.8	$37.7	$70.0
Parents					
Under 250% FPL	137.2	123.7	$322.3	$161.2	$161.2
250%-300% FPL	16.5	13.9	$48.2	$24.1	$24.1
Childless Adults [d/]					
Under 225% FPL	141.5	116.6	$347.5	$173.7	$173.7
225%-300% FPL	24.6	21.1	$72.0	$36.0	$36.0
Cost Sharing Subsidies and Administration of Subsidies	n/a	n/a	$74.0	$37.0	$37.0
Workers in small firms [e/]	6.6	6.6	$0.0	$0.0	$0.0
	Total Program				
Total Initial Expansion [f/]	351.2	289.7	$859.4	$413.5	$445.8
Total All Under 300% FPL	392.3	324.6	$979.5	$473.6	$505.9

a/ Includes premium subsidies for adults in the exchange and CHP+ expansion group costs.
b/ Assumes children eligible for Medicaid will be enrolled as parents become eligible and enroll.
c/ Assumes enhanced FMAP and additional SCHIP allotment funds become available.
d/ Assumes Medicaid 1115 demonstration waiver is approved and program savings is sufficient to cover expansion for childless adults.
e/ Workers above 300% FPL who are employed by small firms (under 50 employee) that have not offered coverage in the past year are eligible for the program, but are not eligible for a subsidy.
f/ Initial expansion group includes children to 300% FPL, parents to 250% FPL, childless adults to 225% FPL and workers in small non-insuring firms. Expansion for adults to 300% FPL will be added in the future.
Source: The Lewin Group estimates using the Health Benefits Simulation Model.

b. Impact on State and Local Budgets

We estimate new program costs under the Better Health Care for Colorado proposal to be $474 million assuming an 1115 waiver is approved by the federal government, and assuming the

proposal is fully phased in with expansions to 300 percent of poverty in 2007/2008 (*Figure 16*). The costs include the cost to the state and local government of $42 million for the expansion of Medicaid/CHP+, and the cost of premiums subsidies for everyone below 300 percent FPL would of $432 million.

Program costs would be offset by savings in current safety net programs resulting from payments for previously uncompensated care that are borne partly by safety net programs. In addition there would be increased tax revenue as reductions in employer costs are passed on to workers as increased wages. State and local governments save about $82 million in safety net programs. State and local government would save about $51 million in employee health benefits which would be passed on to workers as increase wages. The increased wages result in tax revenue increases of about $3 million. The net costs of the proposal, after offsets is $53 million.

Figure 16
Change in State and Local Government Spending under Better Health Care for Colorado in 2007/2008 (millions)

		Change in Spending Assuming 1115 Waiver is Approved [a/]		Change in Spending Assuming 1115 Waiver is Not Approved	
New Program Costs			$474		$704
Medicaid Expansion for Children		$42		$42	
Premium Subsidies		$432		$662	
Offsets to Existing Programs			$421		$421
Savings to Current Safety Net Programs [b/]		$82		$82	
State & Local Government Employee Health Benefits		--		--	
Workers and Dependents	$51				
Wage Effects [c/]	($51)				
Program Financing		$336		$336	
Tobacco Tax Increase	$210				
Alcohol Tax Increase	$126				
Tax Revenue Gain Due to Wage Effects [d/]		$3		$3	
Net Cost/(Savings) to State and Local Government			$53		$283

a/ Assumes Medicaid 1115 demonstration waiver is approved and program savings is sufficient to cover expansion for childless adults.
b/ Includes care currently paid for by other safety net programs. Assumes waiver is approved to allow state to continue to receive Federal DSH funding to be used for the program.
c/ Assumes reduced employer costs are passed on to workers in the form of higher wage increases.
d/ Increase in tax revenue is counted as a reduction in State and Local Government health spending.
Source: The Lewin Group estimates using the Health Benefits Simulation Model.