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Cost and Coverage Impacts of Five Proposals to Reform the Colorado Health Care System

Appendix C: The "Better Health Care for Colorado" Proposal

Prepared for:

The Colorado Blue Ribbon Commission for Health Care Reform

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THE "BETTER HEALTH CARE FOR COLORADO" PROPOSAL

Better Health Care for Colorado provides a path to universal health coverage. It includes a public program expansion and a Medicaid-funded low-income premium subsidy program for private coverage. The private coverage would be provided through a newly created health insurance Exchange which would offer a selection of health plans. Non-insuring small businesses would be able to buy coverage through the Exchange by paying a full-cost premium.

All uninsured individuals would have access to a limited core set of benefits with standard premiums and co-payment requirements. The program would be financed with federal Disproportionate Share Hospital (DSH) dollars, savings in uncompensated care, increases in tobacco and alcohol taxes and other administrative savings. We present Better Health Care for Colorado in the following sections:

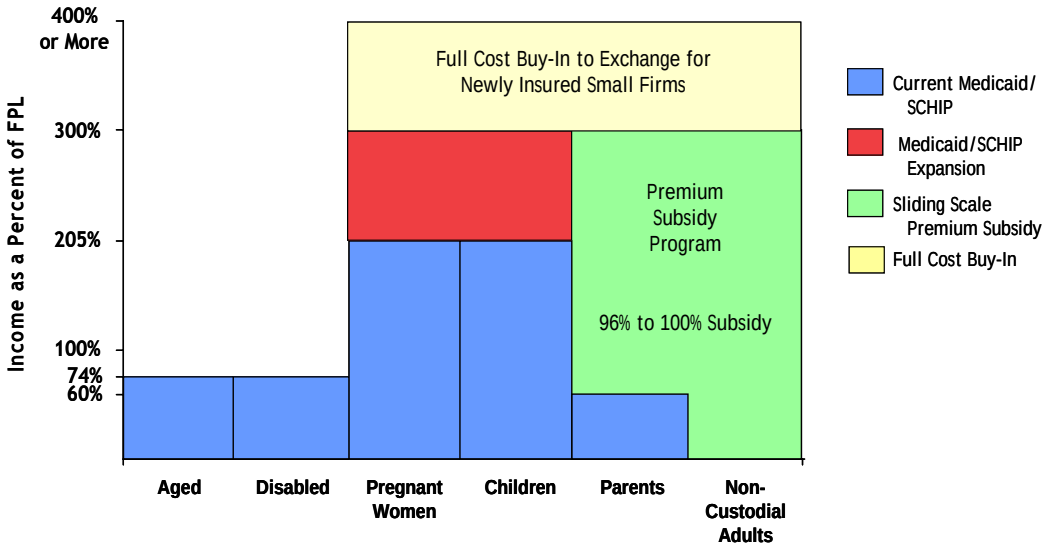
- Key Provisions of Better Health Care for Colorado;
- Assumptions;
- Cost and Coverage Impacts;
- Ten-Year Cost Projections; and
- Cost and Coverage Impacts of Long Term Care Reform.

A. Key Provisions of Better Health Care for Colorado

1. Coverage

This program increases eligibility under Medicaid and CHP+ for pregnant women and children from its current level of 205 percent of the FPL to 300 percent of the FPL (***Figure 1)***. The program would also provide subsidies for the purchase of private health insurance through a newly created "Health Insurance Exchange" for all adults living below 300 percent of the federal poverty level (FPL), except for those eligible for Medicaid. Small firms that have not been offering insurance may buy into the Exchange by paying a full-cost premium. Program coverage and other proposal features are described below.

Figure 1
Eligibility for Subsidized Coverage under Better Health Care for Colorado



Source: The Lewin Group.

a. Public Program Expansion

The proposal ultimately extends health coverage to uninsured, low-income populations up to 300 percent of the federal poverty level (FPL) through the Medicaid and CHP+ programs. These require Medicaid and SCHIP State Plan Amendments and an 1115 Demonstration Waiver. The eligibility expansions would begin in the first year as follows:

- Children up to 300 percent of the FPL;
- Parents up to 250 percent of the FPL; and
- Non-custodial adults (i.e., adults without children) up to 225 percent of the FPL.

Depending on available funds, eligibility levels for all adults would be increased to 300 percent of the FPL.

All newly eligible adults would be provided with subsidies to obtain private coverage offered through the exchange, which is a nontraditional Medicaid benefit package or entitlement. The state would seek an 1115 Demonstration waiver to authorize Medicaid-funding for premium subsidies for the purchase of private insurance through an Exchange. We present our cost estimates below with and without the federal waiver.

The following populations are excluded:

- People with employer sponsored insurance (ESI), including uninsured individuals for whom the employer pays at least 20 percent of costs for individual or 30 percent for families;
- People with private group and 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
- Military dependents and retirees under TRICARE.

b. Private Coverage Expansion

Under the proposal, uninsured Colorado residents who work in qualified small businesses (including part-time workers) would be able to purchase private insurance coverage through the Exchange. To qualify, the worker would have to have been employed in a firm with 50 or fewer workers that has not offered health insurance for at least one year. For small businesses, only workers with income below specified FPL limits would qualify for a premium subsidy, although all employers in the small business would be eligible to purchase health insurance through the Exchange.

c. Residency Requirement

The residency requirement in these expansions would be the same as in the Colorado Medicaid and CHP+ programs. Undocumented immigrants who are low-income or who work for non-insuring small businesses would be eligible to buy insurance from the exchange. However, no subsidies would be provided to this group for the purchase of 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 allowed to offer products to be certified for sale in the Exchange. Products must meet minimum benefit plan coverage and cost sharing requirements ***(Figure 2)***. Co-payments for families would be enforceable but would be capped in proportion to income as follows:

- Families under 100 percent of the FPL, no co-payments required;
- Families between 100 percent through 200 percent of the FPL, maximum co-payment of 2 percent of income; and
- Families between 200 percent and 300 percent of the FPL, maximum co-payment of 4 percent of income.

However, co-payments could be waived as an incentive for wellness and healthy behavior. The proposal would establish a medical home and emphasize access to affordable coverage for primary care services. Patient use of the medical home provider is optional. The minimum benefits package would also create a preferred drug list and a specialty pharmacy program.

Figure 2
Potential Colorado Benefit Design for Core, Basic Benefit, Cost Sharing and Limits [a/]

Covered Benefits/Services	Co-payments	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)
  • Specialist Care
	
	$10
	
	$20	

• Urgent Care	$25	

• Outpatient Hospital
  • Surgical Services
  • Other Outpatient Services
	
	$50
	$25	

• Ambulance (emergency)	$50	
• Laboratory & X-Ray	$0	
• Family Planning Services	$0	
• Mental Health Services	Sliding scale	
• Therapies (consistent w/HMO benefit)	$10	
• 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 impose a $25,000 maximum annual limit for all services and enhanced benefits.
Source: Better Health Care for Colorado Health Reform Proposal

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 in 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). Alternatively, participants with a chronic medical condition would qualify for the state's high risk pool "CoverColorado" and would receive additional premium subsidies.

The state could continue to use a portion of DSH funding to reimburse for the remaining uncompensated care through the Exchange. Medicaid would continue to cover Medicare dual-eligible people and long term care services.

3. Premiums and Subsidies

While premiums would be set based on the basic core benefits package described above, the program's targeted premium is between $150 and $200 per-person per-month (PMPM). However, as described below, premiums for the basic core benefits package would be permitted to vary by age and gender (i.e., modified community rating). Individuals who do not pay their monthly premium would be disenrolled. For specific insurance products already offered, such as CoverColorado, existing policies and procedures would apply.

Figure 3 shows our actuarial estimates of premiums for the basic core benefits package for single and family coverage by the age and gender of the policyholder. These include the cost of benefits and administration of insurance. We estimate an average premium of $184 PMPM, given the mix of newly eligible people who enroll by age and gender. (As discussed below, we estimate the age and gender composition of the population for the eligible population using Colorado population data.)

Figure 3
Better Health Care for Colorado Monthly Premiums PMPM by Age, Gender and Tier: Contracts Effective 2007/2008

	Monthly Premium per Enrollee	
Age/Gender	**Single**	**Family**
Under age 25 Male	$94.40	$341.04
25 - 34 Male	$115.39	$497.16
35 - 44 Male	$152.60	$593.57
45 - 54 Male	$256.19	$667.52
55 - 64 Male	$435.33	$797.39
Under age 25 Female	$168.69	$363.30
25 - 34 Female	$212.31	$512.89
35 - 44 Female	$247.02	$568.51
45 - 54 Female	$325.63	$671.99
55 - 64 Female	$468.52	$824.63

Source: Lewin Group estimates using cost and utilization data supplied by NovaRest Consulting.

This estimate reflects that the uninsured are on average younger than the general population and are therefore less costly to cover. As discussed below, provider payment levels under the program are assumed to be at Medicare levels, which are about 35 percent lower than private reimbursement levels for comparable services. We also assume that administrative costs would be equal to 19 percent of benefits for individual coverage, which is based upon administrative costs for large carriers in the individual market. (Currently administration for individual coverage in Colorado is equal to about 35 percent of the premium.) Detailed assumptions concerning the underlying levels of utilization and costs are presented in ***Appendix J.***

Under the proposal, insurers would be permitted to offer discounts through a wellness and healthy behavior initiative, along with value-based purchasing discounts to encourage use of cost-effective protocols for specific diseases (i.e. diabetes).

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

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

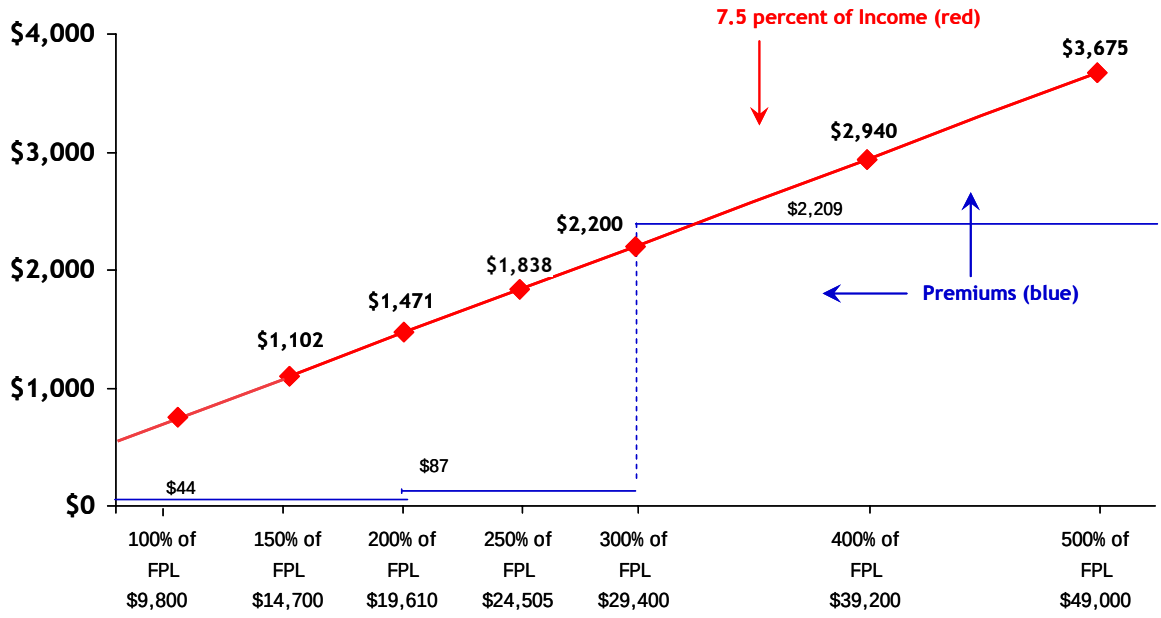
Premium subsidies cannot be used to pay the employee share of the cost of ESI except in one instance. As discussed above, small employers who have not been offering insurance are permitted to take coverage in the Exchange by paying a full-cost premium. Income eligible workers in these firms can receive a subsidy to assist in paying the employee share of the premium.

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 would 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) system. Alternatively, the state could collect premiums for the expansion population through existing Medicaid health insurance purchase arrangements and any other premium collection system now operated by the state.

Figure 4 summarizes the average premiums people would pay net of subsidies at various income levels.

Figure 4
Annual Premiums less Subsidies for a Single Individual under Better Health Care for Colorado



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

4. Consumer Choice

Those currently eligible for Medicaid and CHP+ would continue to be enrolled in these programs as would those eligible under the eligibility expansions. Parents, non-custodial adults and uninsured workers and families would be able to buy private market products offered through the Health Insurance Exchange with the premium subsidies described above.

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

Individuals with higher healthcare costs or chronic conditions would have the option to select a product with broader coverage. This could include a plan with more comprehensive coverage or the state's high-risk pool CoverColorado. 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 has a health condition and qualifies for the program.

5. Enrollment and Coverage Continuation

The plan would specify an initial period of 60 days to enroll once eligible, with an annual open enrollment period and a lock-in period of one year. Exceptions for good cause would be permitted for people experiencing 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.[1]

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 as Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Mental Health clinics, CoverColorado, and school-based health services would be maintained.

7. Employer Provisions

Any employer contribution for the subsidized population would be voluntary. Multiple employers could contribute to coverage in 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. The state would exorcise options under ERISA for states to establish standardized rules concerning Section 125 premium only plans which minimize the cost of establishing these plans for employers. 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 (i.e., minimum coverage, guarantee issue for products on the Exchange). They also would be responsible for administering wellness and healthy behavior programs, disease management, and pay-for-performance requirements. Insurer's roles in marketing, outreach, information sharing and other enrollment functions may be reduced as these functions would be facilitated by the Exchange.

A modified community rating (age and gender) requirement 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.

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

9. Provider Payment Levels

Medicaid and CHP+ services providers would be paid at the current Medicaid and CHP+ payment levels. For the expansion population purchasing insurance on the Exchange, providers would be paid at Medicare rates, although lower rates may exist in competitive markets. The proposal includes the following additional pay-for-performance incentives:

- For hospitals, future increases would be distributed on a provider-specific basis depending on their "score". For example, if the budget provides an overall 3 percent increase in hospital rates, individual hospital rate increases could range from zero to 4.5 percent depending on their score. Insurers in the Exchange and other insurers would be encouraged to emulate the hospital pay-for-performance program in their payment designs;
- For Medicaid Managed Care Organizations (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 performance outcomes;
- Physician pay-for-performance would be required for MCOs or Primary Care Case Management (PCCM) vendors in Medicaid managed care and for all plans offered through the Exchange; and
- 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.

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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 taxes 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); and
    - Beer: from $.05 to $.15 per 6-pack (or $.08 to $.26 per gallon).

The citizens of Colorado would need to demonstrate approval of tax-revenue generating mechanisms as Colorado's Taxpayers Bill of Rights (TABOR) and the Arveschoug-Bird law

which impose limits on state spending without voter approval. This could have implications for the proposed financing mechanisms, unless they can be shown to fall within an exception under these laws.

11. Administration

Enrollment for newly eligible people under the Medicaid CHP+ expansion would be administered by a quasi-public entity, called a "Health Insurance 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 systems 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 disease 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 Exchange would not administer any long term care services.

12. Other Cost Containment

The proposal included several proposals designed to reduce spending under the Medicaid and CHP+ program. These include:

- Implement a cost-effective, quality managed care program;
- Establish pay-for-performance component;
- Adopt Disease management;
- Comprehensive prenatal and care management;
- Hospital pay-for-performance;
- Adding a preferred drug list, participate in multi-state purchasing pool; and
- Incentives to promote wellness and healthy behaviors.

Savings from these initiatives could be used to help meet the budget neutrality requirement under the proposal.

13. Long Term Care Component

Figure 5 summarizes proposed long-term care reforms included in the program, and identifies those that we were able to model in this project. Our estimates of the cost and coverage impacts of these long term care reforms are presented below in Section D.

Figure 5
Long Term Care Reforms

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. • 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. Author originally proposed an increase in the institutional level clinical eligibility criteria for Elderly Blind and Disabled (EBD) waiver to 3.0 ADL limitations. To cover displaced consumers, author proposed an application of the 2.0 ADL limitation clinical eligibility criteria to cover personal care services as a new state plan service. • Author has not had the opportunity to review acuity-level data related to this change, and is not prepared to back the recommendation in the absence of the data. Unless it was determined that a very small population of HCBS consumers under the EBD waiver was affected by the originally proposed shift, author plans to withdraw the recommendation.	√
4. State-funded change • Develop a more robust state-funded, non-institutional option for individuals with limitations in 2 or more ADLs with income between 150 percent of the poverty level and 300 percent of Supplemental Security Income (SSI).	√

Reform Description	Lewin Cost Impact Estimate
5. Income eligibility change • Add DRA personal care services to 150 percent FPL as a state plan service.	∫
6. HCBS Spend Down Program • Develop a HCBS 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 Minimum Data Set (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 Home and Community-Based Waiver (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 Long term Care (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. • Develop supported housing and create partnerships between HCBW providers, Special Needs Plans (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 developers 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.	

Reform Description	Lewin Cost Impact Estimate
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 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 the Program of All Inclusive Care for the Elderly (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(QM)** • Establish a LTC QM Committee • Establish measurable benchmarks and performance standards • Implement a Quality Improvement 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.	
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.	

Reform Description	Lewin Cost Impact Estimate
VII. FINANCING	
State should consider the following as options 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	

Source: Framework for Long term Care Reform & Balancing: A Proposal from SEIU and CAPE.

B. Key Assumptions

As discussed above, this proposal would expand coverage under Medicaid and CHP+ programs to cover all people living below 300 percent of the FPL. Newly eligible children would be covered under CHP+. Newly eligible adults would receive premium subsidies to be used to purchase private insurance coverage through a newly created Exchange. 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 H***.

1. Low-Income Coverage Expansion

We estimated the number of newly eligible children who would enroll in CHP+ based on the Colorado sub-sample of the March Current Populations Survey (CPS) data for 2004 through 2006 using the Health Benefits Simulation Model (HBSM) 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 people and 39 percent for people who currently have private insurance. The proposal includes a 12-month waiting period for uninsured small employers and a 6-month waiting period for low-income uninsured individuals; thus, the participation rate for those currently with Employer-Sponsored Coverage (ESI) is only applied to individuals who would come in as a result of a waiver of the anti-crowd out provisions (e.g., change in jobs or change in family status, such as a divorce);

- We assumed that children currently eligible for Medicaid or CHP+ 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 people who are eligible for, but not enrolled in the existing Medicaid and CHP+ programs; and
- Administrative costs per newly eligible person were assumed to equal average administrative costs for eligibility functions per enrollee under the current program (about 5.7 percent of benefits costs).

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 people. For example, the price elasticity varies from about –0.31 among people 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 people than for high-income people.

We used these price elasticity assumptions to simulate the change in coverage for uninsured people in the HBSM household data. The model was used to estimate the premium faced by each uninsured individual and family in the individual market, and the amount of the premium subsidy that eligible people 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 subsidy (i.e., premium less the premium subsidy received) and the price elasticity assumptions discussed above. This step involved the following assumptions:

- We used actuarial estimates of the premium that individuals face in the non-group market for the specified benefits package by age and sex ***(Figure 2)***.
- All HBSM simulations were performed on a month-by-month basis to account for people who are eligible only part of the year. (The various premium subsidies proposals typically pro-rate the annual subsidy over months of eligibility).

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, CHP+, or subsidized non-group coverage). For example, employers of low-wage workers may

find that the cost to their workers 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 is called "crowd-out."

The program modeled here includes a twelve-month waiting period for uninsured small employers and a six-month waiting period for low-income, uninsured individuals eligible for subsidies. This 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 six 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 six months, before enrolling in the subsidized coverage program.

In this analysis, we assume that the waiting period requirement would be effective in preventing employers and workers from discontinuing their ESI to enroll in Medicaid or the CHP+ premium subsidy program. However, we assume that the waiting period rule is waived for people losing employer coverage due to job change or a change in family status, such as a divorce. For this limited number of people, we assume about 39 percent would enroll. This estimate is based upon analyses of data for prior Medicaid expansions.[2]

4. Program Administration

We assumed that the cost of administering eligibility for the Medicaid and CHP+ expansion would be about $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

Our modeling assumes that changes in employer costs for health benefits are passed-on to workers in the form of changes in wages. Thus, increases in employer costs are assumed to be passed-on to workers in the form of reduced wages while, decreases in health benefits expenses are passed-back to employees in the form of increased wages. We assume that this wage adjustment would occur among government employers as well, assuming that government compensation packages are adjusted to remain competitive in the labor markets. We assume that this pass-through occurs among both insuring and non-insuring firms whose labor costs are affected by the proposal.

Our pass-through assumption is based upon the economic principle that the total value of employee compensation, which includes wages, employer payroll taxes health benefits and other benefits, is determined in the labor markets. Although there is considerable agreement among economists that this pass-through would occur in response to changes in employer benefits costs, there is disagreement over the period of time over-which these adjustments

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

would occur. [3] It is likely that these adjustments would take the form of reduced wage growth over-time. However, the full amount of the pass-through could take several years to materialize.[4]

6. Medicaid Budget Neutral Requirement

The Better Care for Colorado proposal includes several provisions designed to reduce spending under the Medicaid and CHP+ program. Savings from these measures, if effective, could be used to meet the federal requirement that 1115 Demonstration waivers be budget neutral from the perspective of the federal government. This means that the federal cost of any waiver expansion must be at least offset by reductions in federal costs elsewhere in the program. These proposed cost saving measures include:

- Implement a cost-effective, quality managed care program;
- Establish pay-for-performance component;
- Adopt Disease management;
- Comprehensive prenatal and care management;
- Hospital pay-for-performance;
- Adding a preferred drug list, participate in multi-state purchasing pool; and
- Incentives to promote wellness and health behaviors.

Our analysis concluded that returning the program to managed care would actually increase program costs by up to 10 percent. Colorado formerly did have a substantial Medicaid managed care program. However, the managed care organizations (MCOs) eventually terminated their participation in the program because of low payment levels. State Medicaid officials believe that MCO payment levels would need to be about 10 percent higher than current per capita costs under the existing fee-for-service program. Consequently, we did not include this proposal in our estimates.

We were unable to estimate the amount of savings that might come from the other initiatives. Some of these ideas are new to Medicaid and may take some time to implement. Also evidence on the cost effect these measures is either mixed or non-existent. For purposes of these analyses, we did not estimate the cost impacts of these provisions.

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

In this section, we present our estimates of the cost and coverage impacts of the Better Health Care for Colorado proposal in two ways. First, we estimate the impact of the proposal as if it

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[3] See, for example, James Heckman, "What Has Been Learned About Labor Supply in the Past Twenty years?" American Economic Review, (May 1993).

[4] See, for example, Jonathan Gruber and Alan B. Kreuger, "The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers Compensation Insurance," in Tax Policy and the Economy (1991); Jonathan Gruber, "The Incidence of Mandated Maternity Benefits, " American Economic Review, (forthcoming); and Lawrence H. Summers, "Some Simple Economics of Mandated Benefits, " American Economic Review (May 1989).

were mature and fully implemented in 2007/2008. This enables us to compare changes in costs and coverage in current year dollars for each major stakeholder groups.

In a following section, we present a second set of estimates is designed for budgetary purposes. Because these programs could not possibly be implemented in 2007/2008, we developed ten-year cost estimates assuming initial implementation in 2008/2009. These ten-year estimates reflect the proposed phase-in of the expansion for adults and any lags in enrollment as people gradually become familiar with the program and enroll.

1. Transitions in Coverage

The proposal provides coverage through a public program expansion and premium subsidies for the purchase of private health insurance. Uninsured individuals in the private market would be able to purchase coverage through a newly created private insurance pool called an Exchange, which would provide access to a selection of private coverage options for eligible people. Some of these individuals would purchase only the limited benefit package while others would opt for more comprehensive benefits.

We estimate than by 2007/2008 the number of uninsured in Colorado will increase to about 792,000 people under current law. The proposal covers an estimated 324,600 of these uninsured people. This is about 40.1 percent of Colorado's uninsured population. Of these, 42,800 would become covered under Medicaid or CHP+ and 281,900 would take coverage under the Exchange.

Figure 6 illustrates changes in sources of coverage for those who currently have coverage. We estimate that of the 2.7 million people currently receiving ESI, 14,900 would move into the Medicaid and CHP+ programs as a result of the expansion in eligibility. In addition, 29,000 people would become covered through the Exchange. These include workers who are eligible for a subsidy based on income level. Of the 29,000 people enrolling through the Exchange, 9,000 would take the more comprehensive benefits package.

Out of an estimated 158,900 people now obtaining coverage in the non-group market, we estimate that 13,000 would become covered under the limited benefits package and 2,500 would take the more comprehensive benefits package in the Exchange. These include people who would be able to qualify for subsidies and who can obtain less costly coverage through the Exchange. In addition 8,300 people would move from the non-group market to the Medicaid and CHP+ programs as a result of the expansion in eligibility. We estimate that 135,100 people would remain in the non-group market. Better Health Care for Colorado would have no impact on coverage of military dependents and retirees under TRICARE.

Figure 6
Transitions in Coverage under Better Health Care for Colorado in 2007/2008 (thousands)

Current Law Primary Source of Coverage	Total	Coverage under Better Health Care for Colorado proposal							
		Exchange		Private Coverage		Public Coverage			Uninsured
		Limited Benefit	Comprehensive Benefit	Employer	Non-Group	TRICARE	Medicare (excl. dual eligible)	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
TRICARE	112.4	0.0	0.0	0.0	0.0	112.4	0.0	0.0	0.0
Medicare (excl. dual eligible)	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**	**518.1**	**467.2**

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

Figure 7 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 and CHP+ programs. The proposal covers a greater proportion of lower income people because of the subsidies provided to low-income individuals, as well as the expansion in Medicaid and CHP+ eligibility. The proposal would cover about 47.8 percent of uninsured people with incomes below $50,000 compared to 27.7 percent of the uninsured with incomes of $50,000 or more. With the premium subsidies provided through the Exchange and the public expansions to non-custodial adults, the program covers 43 percent of people between the ages of 19 and 34.

Figure 7
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)

2. 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 payments for services, and the cost of administering both public and private health insurance coverage.

Health spending in Colorado would increase by about $595 million in 2007/2008 under the proposal (***Figure 8***). This is an increase in statewide health spending of about 2 percent. This includes several impacts that the program would have on spending including increased utilization for the newly insured, changes in provider reimbursement and the administrative cost of administering subsidies and expanded coverage.

Figure 8
Changes in Statewide Health Spending under Better Health Care for Colorado 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 Statewide 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. Health Services Utilization

As discussed above, we assume that utilization of health services would increase for newly insured people to the levels reported by insured people with similar demographic and health status characteristics. Utilization would also increase slightly for those individuals previously covered in less comprehensive health plans. This approach shows a net increase in utilization, indicating that the savings due to increased primary care are more than offset by increases in utilization for other services that are more elective in nature.

Using these assumptions, we estimate an increase in health services utilization of $374 million, of which $366 million is attributed to increased utilization for newly insured people and $8 million for people who obtain improved coverage.

b. Reimbursement Effects

Under the proposal, total 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 underinsured is shifted to private payers in the form of higher changes in a process known as cost-shifting. Based upon the literature on cost shifting, we assume that 40 percent of the change in provider payment rates would be passed on to private payers in the form of lower negotiated payment rates, thereby reducing cost shifting by about $44 million.

c. Administration

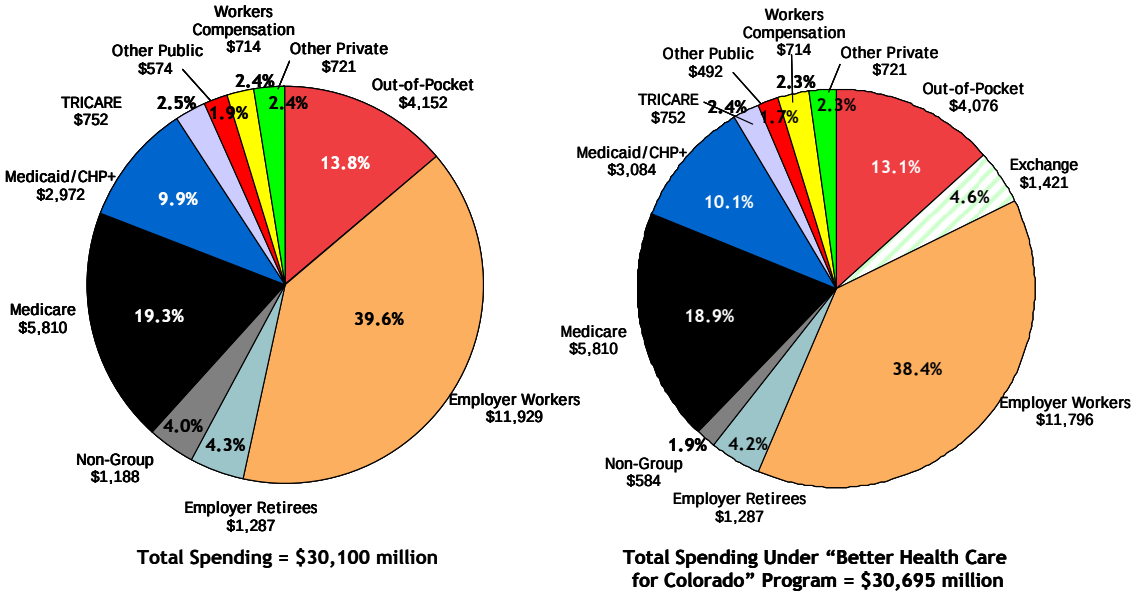
The cost of administration in the health care sector would increase by about $164 million. This includes increased insurer administration for newly insured people of $125 million. The cost of administering subsidies under the proposal would be $39 million.

3. Changes in Health Spending by Payer Source

Figure 9 presents the distribution of health sending by source of payment under current law and under the Commission's proposal assuming it is fully implemented in 2007/2008. Spending under the Medicaid and CHP+ program would increase from 3.0 billion under current law to about $3.1 billion under the program as the CHP+ program is expanded to 300 percent of the FPL. Spending for coverage under the exchange would be about $1.4 billion, of which about 864 million would be financed with premium subsidies (the Author proposes to obtain federal matching funds for these premium subsidies).

There would be a small reduction in spending under private non-group insurance reflecting the shift of some individuals from private coverage to the expanded CHP+ program and the premium subsidies which are available only through the exchange. However, employer health insurance would continue to be the primary source of health insurance coverage in the state.

Figure 9
Estimated Spending by Source of Payment in Colorado under Current Law and Better Health Care for Colorado in 2007/2008



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

4. Program Spending

Figure 10 shows premium subsidy costs under the proposal assuming it is fully implemented in 2007/2008. Newly eligible children are covered under the existing CHP+ program. For newly eligible adults, full premium subsidies are provided for people living below 100 percent of the FPL. The amount of subsidy varies on a sliding scale with income for people between 100 percent and 300 percent of poverty. People living above 300 percent of the FPL receive no subsidy. We estimated the costs of the subsidy including administration to be $473.6 million for

the state and $505.9 million for the federal government, assuming a waiver is provided to receive federal matching funds under the program. We assume a Medicaid 1115 waiver is obtained for the following:

- Retain and redirect existing federal disproportionate share hospital (DSH) revenues to fund coverage expansions;
- Obtain federal matching funds to cover categorically eligible groups with premium subsidies for private coverage; and
- Obtain federal matching funds for non-custodial adults.

Figure 10
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					
Parents Under 250% FPL	137.2	123.7	$322.3	$161.2	$161.2
Parents 250%-300% FPL	16.5	13.9	$48.2	$24.1	$24.1
Childless Adults [d/]					
Childless adults Under 225% FPL	141.5	116.6	$347.5	$173.7	$173.7
Childless Adults 225%-300% FPL	24.6	21.1	$72.0	$36.0	$36.0
Other Spending					
Cost Sharing Subsidies and	n/a	n/a	$35.0	$17.5	$17.5
Administration of Subsidies	n/a	n/a	$39.0	$19.5	$19.5
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 to recapture federal DSH funding, to cover parents under a premium subsidy program and to obtain a federal match for covering non-custodial adults under a premium subsidy program.
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 (HBSM).

5. Impact on State and Local Government Budgets

We mate that new program costs to the state under the Better Health Care for Colorado proposal would be $474 million assuming the proposed 1115 waiver is approved by the federal government. For illustrative purposes, we assumed the proposal is fully phased-in with expansions to 300 percent of poverty in 2007/2008 (***Figure 11***). This includes the cost to the state and local government of $42 million for the expansion of Medicaid and CHP+, and $432 million in premium subsidies for people below 300 percent of FPL, assuming the federal waiver is approved.

These new costs would be offset by savings in other programs and new tax revenues. Program costs for safety-net providers such as clinics and other state and local programs would be reduced as the number of uninsured declines under the proposal. This is because providers would now be reimbursed for health services that were formerly provided free to uninsured people who become covered under the proposal. State and local governments would save about $82 million in safety-net program spending in this way (***Figure 11***)

Figure 11
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**		**$906**
Medicaid Expansion for Children	$42		$42	
Premium Subsidies	$432		$864	
Offsets to New Spending				
Savings to Current Safety-net Programs [b/]		**$82**		**$28**
State & Local Government Employee Health Benefits	--	--	--	--
Workers and Dependents	$51		$51	
Wage Effects [c/]	($51)		($51)	
Program Financing		**$336**		**$336**
Tobacco Tax Increase	$210		$210	
Alcohol Tax Increase	$126		$126	
Tax Revenue Gain Due to Wage Effects [d/]		**$3**		**$3**
Net Cost/(Savings) to State and Local Government		**$53**		**$539**

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 (HBSM).

New tax revenues from the tobacco and alcohol tax increased proposed under the program would be $336 million. There also would be an increase in state income tax revenues of about $3 million due to reduced costs to employers resulting from the reduction in private provider payment levels under the proposal (i.e., 130 percent of Medicare rates). We assume that these savings would be passed on to workers in the form of higher wages resulting in an increase in state tax revenues. An additional $53 million in revenues would be required to fully fund the program assuming the waiver is approved. Without the waiver, the state would need to raise a total of $539 million.

6. Change in Federal Government Health Spending

The net change in federal government spending, less offsets, would be $472 million, assuming an 1115 waiver is approved. Of these new program costs, $74 million are attributed to new Medicaid and CHP+ enrollment. The federal portion of the premium subsidies for adults living below 300 percent of the FPL would be $432 million (***Figure 12***), assuming the waiver is approved. This scenario also assumes that a federal waiver is obtained to continue federal DSH funding of $54 million. This assumes the proposal is fully phased-in with expansions for adults to 300 percent of the FPL in 2007/2008.

Savings to employers throughout the state would also be passed back to workers as an increase in wages resulting in new tax revenues of $34 million. There would be a small savings in federal worker health benefits that we assume would be passed back to workers as higher wages. The net change in federal government spending less offsets, would be an increase of $526 million. If the federal government does not grant the proposed waiver, federal spending in Colorado would actually fall by about $14 million.

Figure 12
Change in Federal 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
Federal Program Costs		
Medicaid/CHP+ Programs	**$74**	**$74**
Federal Matching Funds for Premium Subsidies	**$432**	**--**
Continuation of Federal DSH Payments	**$54**	**(54)**
Total Federal Program Costs	**$506**	**$20**
Federal Programs Revenues and Offsets		
Federal Employee Health Benefits	**$0**	**$0**
Workers and Dependent $6		
Wage Effects [b/] ($6)		
Tax Revenue Gain Due to Wage Effects [c/]	**$34**	**$34**
Net Cost/(Savings) to Federal Government	**$526**	**($14)**

a/ Assumes Medicaid 1115 demonstration waiver is approved and program savings is sufficient to cover expansion for childless adults
b/ Assumes reduced employer costs are passed on to workers in the form of higher wage increases.
c/ Increase in tax revenue is counted as a reduction in Federal Government health spending.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM)

7. Impact on Private Employers

Figure 13 presents our estimates of the impact of the proposal on private employers if fully implemented in 2007/2008. There are no employer requirements under the program, so there is no change in spending for non-insuring firms. Private employers who currently offer coverage would save a total of $107 million in health benefits. This includes $86 million in savings for workers who discontinue ESI and become covered under the expanded Medicaid and CHP+ programs and $21 million in savings due to reduced cost-shifting. Thus, private employers in Colorado overall would save about $107 million under the proposal in 2007/2008.

These savings do not reflect increases in wages as employers pass on savings from lower health care costs to their workers in the form of increased wages. These estimates include employer spending for all covered workers, dependents and retirees living in Colorado, even if the employer is based outside the state. This excludes federal workers and state and local government employees, which were discussed above. This estimate also includes only the employer share of the costs of coverage. Changes in the worker's share of premiums for ESI are presented in the next section.

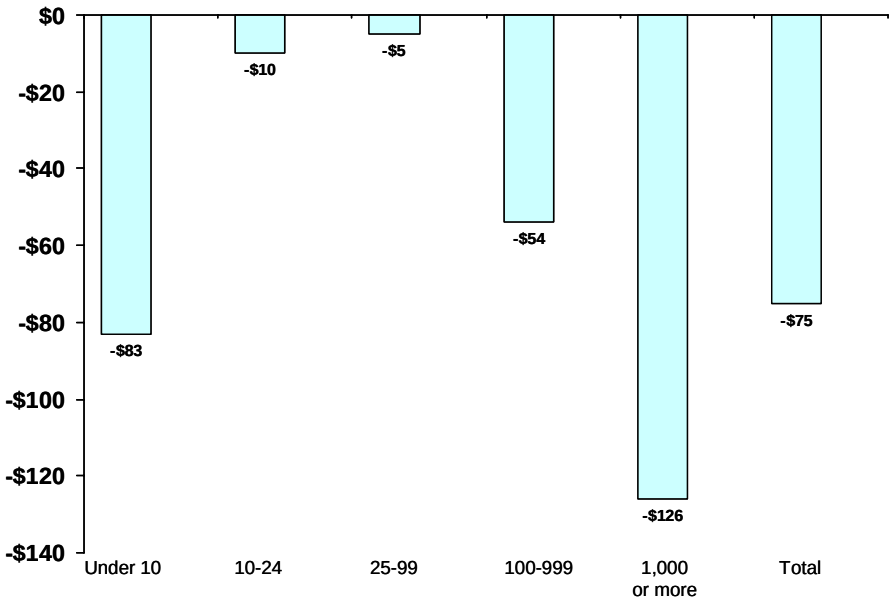
Figure 13
Changes in Private Employer Health Benefits Cost under Better Health Care for Colorado in 2007/2008 (millions)

	Currently Insuring Employers	Currently Non-Insuring Employers	All Employers
Private Employer Spending Under Current Law			
Current			
Workers & Dependents	$7,720	--	$7,720
Retirees	$350	--	$350
Total	**$8,070**	--	**$8,070**
Change in Private Employer Spending Under the Policy			
Employees and Dependents choosing Medicaid or Exchange	($86)	--	($86)
Cost Shift Savings	($21)	--	($21)
Net Change (before wage effects)	**($107)**	--	**($107)**

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

Private employer spending for firms that now provide coverage would decrease by and average of about $75 per worker (***Figure 14***). Currently insuring firms with 10 or fewer workers would save an average of about $83 per worker. Firms with one thousand or more workers would save about $126 on average per worker.

Figure 14
Change in Private Employer Health Spending Per Worker by Current Insuring Status under Better Health Care for Colorado in 2007/2008



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

8. Impact on Family Health Spending

Under this proposal, family premium payments would increase by about $786 million, reflecting the increase in the number of people taking health insurance. This increase in premium payments would be more than offset by $799 million in premium subsidies provided under the proposal. Out-of-pocket spending (including co-pays and deductibles) for families would decrease by $126 million due to expanded coverage (***Figure 15***).

As discussed above, we assume that as employers spend less on health care benefits, they would pass these savings on to workers in the form of increased wages. The increases in after tax wages are counted here as savings in family health spending of $127 million. The program would be partly funded by tobacco and alcohol tax increases of $336 million. Overall, families would spend about $70 million more on health care under Better Health Care for Colorado.

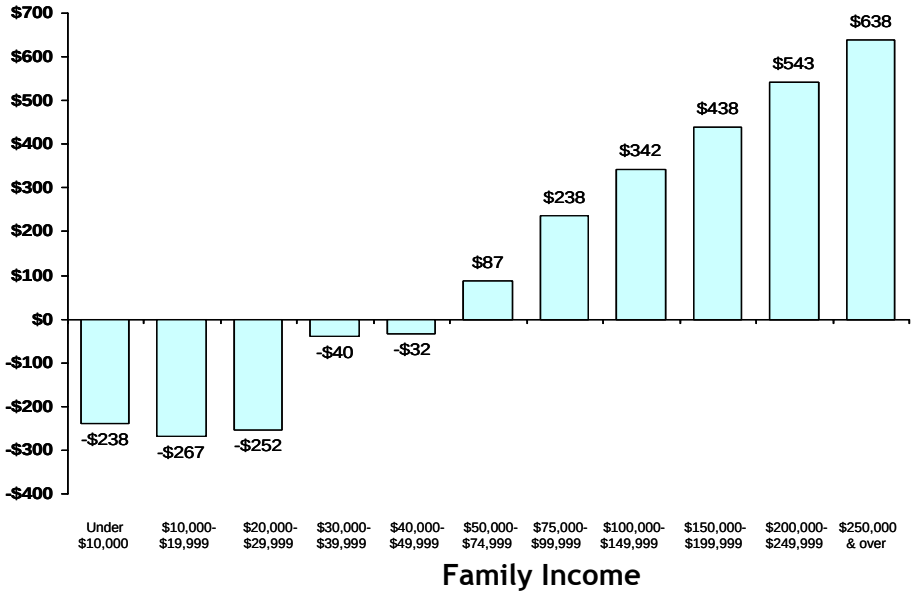
Figure 15
Impact of Better Health Care for Colorado on Family Health Spending in 2007/2008 (millions)

		Change in Spending
Change in Premiums		**($13)**
Change in Family Premiums	786	
Premium Subsidies	($799)	
Change in Out-of-pocket Payments		**($126)**
Program Financing		**$336**
Tobacco Tax Increase	210	
Alcohol Tax Increase	126	
After Tax Wage Increase Counted as Offset to Family Spending [a/]		**($127)**
Net Change in family Health Spending		
Net Change		**$70**

a/ The Increase in after-tax wage income resulting from reduced costs to employers is $127 million. In this analysis, we count the increase in wages as a reduction in family health spending.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

The decrease in health spending is more dramatic for lower-income families because of the premium subsidies (***Figure 16***). Families with incomes of less than $10,000 would save an average of about $238 in 2007/2008. Spending would increase by about $638 for families with incomes of $250,000 or more.

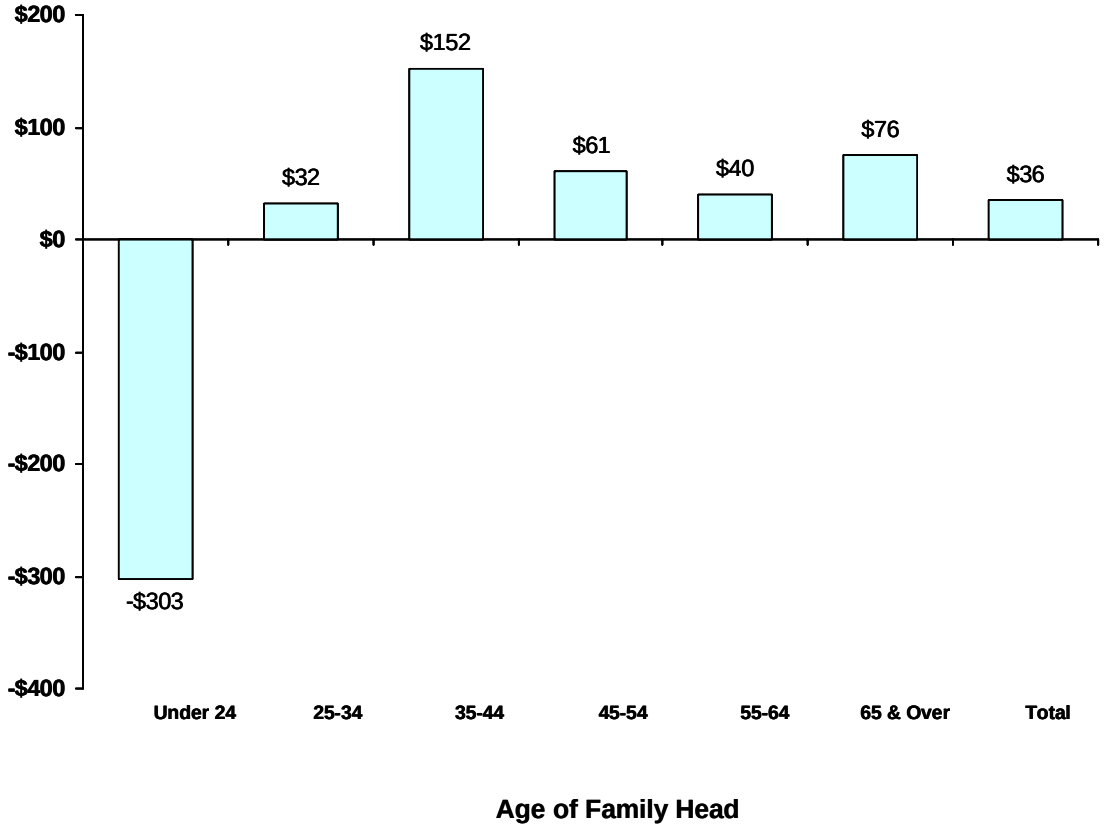
Figure 16
Change in Average Family Health Spending by Income Group under Better Health Care for Colorado in 2007/2008



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

On average, all families would see an increase in spending of about $36 in 2007/2008 under Better Health Care for Colorado program (***Figure 17***). However, people in a family headed by someone age 24 or younger would spend about $303 less per family. This reflects the availability of subsidies for low-income uninsured adults, many of whom are in younger age groups.

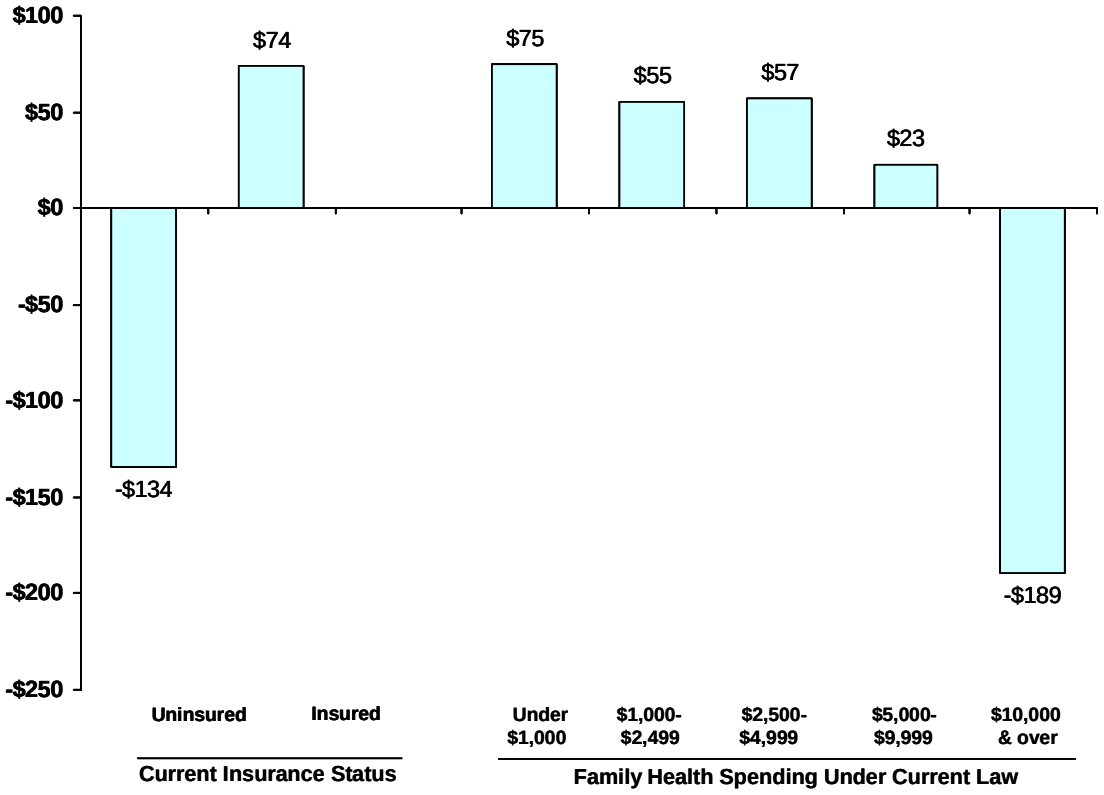
Figure 17
Change in Average Family Health Spending by Age under Better Health Care for Colorado in 2007/2008



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

As illustrated in ***Figure 18***, currently uninsured families would on average save about $134, largely due to the subsidies provided under the program. Those who are currently insured would spend $74 more on average, reflecting the increase in the number of people who have insurance. Those families currently spending $10,000 or more on health care would see average savings of about $189 per family.

Figure 18
Change in Average Family Health Spending by Current Law Insurance Status and Family Health Spending under Better Health Care for Colorado in 2007/2008



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

Figure 19 shows the distribution of families in Colorado by the amount by which the program would change health spending for individual families. This reflects changes in premiums, out-of-pocket spending, subsidies, taxes used to fund the program and after tax wage changes under the proposal. About 87.6 percent of Colorado families would see an increase in health spending of $20 or more. This reflects that the tobacco and alcohol taxes would tend to affect many consumers, although by relatively small amounts per family. About 7.2 percent of families would see a net reduction in spending of $20 or more. Only about 5.2 percent of the population would be unaffected (i.e., changes of less than $20).

D. Ten-year Estimate of Public Program Costs

The estimates presented up to this point assume that the program is fully phased-in and implemented in 2007/2008. We did this to illustrate the potential impact of the fully operational program on the health care system and key stakeholder groups in current year dollars. Of course, the program could not be implemented that quickly, since we are already in the 2007/2008 year. Also, the Better Health Care for Colorado proposal would phase-in the proposed coverage expansions over an unspecified number of years, such that much of the proposal's impact would not materialize for some number of years.

Figure 19
Distribution of Families by the Amount of the Change in Total Family Health Spending Under the Better Health Care for Colorado Program

		PERCENT DISTRIBUTION OF FAMILIES										
	ALL	INCREASE IN FAMILY HEALTH COSTS					NO	REDUCTION IN FAMILY HEALTH COSTS				
	FAMILIES						CHANGE					
	TOTAL	$1,000 +	$500-$999	$250-$499	$100-$249	$20-$99	+/- $20	$20-$99	$100-$249	$250-$499	$500-$499	$1,000 +
Family Income												
< $10,000	176607.9	0.0	0.0	1.1	9.8	36.3	41.1	1.0	1.9	0.8	2.8	5.2
$10K-$19,999	225278.6	0.3	0.0	1.8	12.1	57.0	11.7	2.1	1.6	2.0	4.3	7.2
$20K-$29,999	229048.7	0.4	0.9	3.5	22.3	57.5	0.4	1.3	1.3	2.5	2.8	7.1
$30K-$39,999	237519.9	0.5	0.3	8.6	36.5	47.0	0.7	0.4	0.5	0.9	0.7	3.8
$40K-$49,999	200288.9	0.0	0.7	9.2	44.2	38.8	0.7	0.2	0.4	1.2	0.6	4.1
$50K-$74,999	316232.1	0.9	1.5	21.8	67.5	3.8	0.1	0.6	0.3	0.2	0.5	2.7
$75K-$99,999	238563.4	1.1	3.1	30.2	63.3	0.0	0.0	0.2	0.1	0.1	0.3	1.6
$100K-$149,9	190449.2	1.0	9.4	56.3	32.6	0.0	0.0	0.0	0.1	0.0	0.1	0.5
$150,000 +	177815.6	5.2	28.7	65.1	0.6	0.0	0.0	0.0	0.0	0.0	0.1	0.3
Income as a Percent of the FPL												
Below Poverty	225931.2	0.1	0.0	1.8	11.0	39.1	33.6	1.4	2.0	1.1	4.6	5.4
100%-199%	333666.2	0.4	0.6	5.1	23.2	46.2	7.4	1.7	1.6	2.1	3.0	8.7
200%-299%	319529.9	0.8	0.5	9.4	34.5	40.9	0.9	1.0	0.9	2.4	1.5	7.3
300%-399%	284848.4	1.0	0.9	14.7	50.8	30.6	0.0	0.3	0.1	0.0	0.2	1.4
400%-499%	221889.0	0.5	0.9	23.5	48.0	26.0	0.0	0.0	0.1	0.1	0.0	1.0
500% +	605939.7	1.9	12.7	44.8	38.7	1.3	0.0	0.0	0.0	0.0	0.2	0.3
Age of Family Head												
< 18	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
18 - 24	211676.5	0.1	1.3	9.6	23.0	42.2	9.7	1.0	1.0	1.4	2.9	7.6
25 - 34	417966.1	1.6	3.4	21.1	36.7	25.5	3.3	0.9	0.6	1.1	1.0	4.8
35 - 44	425342.2	1.7	6.7	28.4	38.8	16.5	1.2	0.6	0.9	0.8	1.6	2.8
45 - 54	413248.7	1.1	6.7	29.3	35.4	17.2	3.6	0.8	1.0	0.8	0.9	3.2
55 - 64	257395.7	0.4	3.9	20.1	41.0	21.2	5.7	0.3	0.5	1.1	2.1	3.6
65 +	266175.3	0.0	0.9	5.5	29.7	50.1	12.8	0.2	0.0	0.1	0.1	0.6
Out-of-Pocket Spending under Current Law												
Below $,1000	455032.7	0.5	1.2	8.4	28.1	39.9	13.5	2.0	1.8	2.0	1.5	1.0
$1,000-$2,499	431879.1	1.1	3.2	16.1	35.0	31.6	4.8	0.6	0.5	0.9	2.4	3.8
$2,500-$4,999	528957.7	1.1	5.0	28.4	38.1	20.3	2.1	0.2	0.1	0.3	0.3	3.9
$5,500-$9,999	423133.7	1.1	6.5	27.9	38.5	17.2	1.7	0.1	0.2	0.5	1.1	5.3
Above $10,000	152801.2	1.3	7.5	26.7	36.1	18.0	1.7	0.0	1.1	0.4	1.9	5.3
Families Members with Health Insurance												
1+ Uninsured	385868.6	1.2	2.1	13.6	29.7	27.8	6.7	2.6	2.6	2.7	4.2	6.8
No Uninsured	1605935.9	0.9	4.8	22.7	36.4	26.1	4.8	0.2	0.2	0.4	0.6	2.9
All Families												
Total	1991804.4	1.0	4.3	20.9	35.1	26.4	5.2	0.7	0.7	0.9	1.3	3.6

Source: Lewin Group Estimates Using the Health Benefits Simulation Model (HBSM)

In addition, experience with prior program expansions indicates that there are likely to be substantial enrollment lags in the early years of the program. It will take time for people to become aware of their potential eligibility and then find the time to enroll. Thus, not all of the 324,600 uninsured people we expect to become covered under this proposal would enroll immediately. Based upon analyses of enrollment in prior program expansions, we assume that the program reaches only 40 percent of the ultimate enrollment level in the first year. Enrollment would reach 80 percent of the ultimate enrollment level in the second year and 100 percent of the expected level of enrollment in the third year and beyond.

In ***Figure 20,*** we present estimates of the total cost to the state for the Medicaid expansions and the premium subsidies for the ten-year period from 2008/2009 through 2017/2018. As discussed above, the expansion in coverage to 300 percent of the FPL for children would occur immediately in 2008/2009. The expansion for adults in the first year would be to 250 percent of the FPL for parents and 225 percent of the FPL for non-custodial adults. We assume that the expansion for adults is increased to 300 percent of the FPL for both parents and non-custodial adults beginning in the third year of the program.

Total net new state spending under the program would be $13.3 billion over the 2008/2009 to 2017/2018 period. The state share would be $6.4 billion with the federal government paying $6.9 billion. These are the estimates to use for budgeting purposes because they reflect the expected roll-out of the expansion and likely enrollment behavior in the early years of the program.

Figure 20
New Program Costs for Better Health Care for Colorado in 2008/2009 Through 2017/2018 [a/]
(millions)

	Total Spending (millions)	State Spending	Federal Spending
2008/2009	$364.4	$176.4	$188.1
2009/2010	$782.1	$378.5	$403.6
2010/2011	$1,107.0	$535.8	$571.2
2011/2012	$1,248.4	$604.2	$644.2
2012/2013	$1,371.1	$663.6	$707.5
2013/2014	$1,467.1	$710.1	$757.0
2014/2015	$1,568.3	$759.1	$809.3
2015/2016	$1,675.0	$810.7	$864.3
2016/2017	$1,788.9	$865.8	$923.1
2017/2018	$1,910.5	$924.7	$985.8
Total 2008/2017	$13,282.8	$6,428.9	$6,853.9

a/ Estimates assume lags in enrollment for newly eligible people in the first two years of the program.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

E. COST AND COVERAGE IMPACTS OF LONG TERM CARE REFORMS

We provide our cost and coverage impacts of long term care reforms in the following sections:

- Post eligibility verification of financial information;
- Clinical eligibility changes;
- Income eligibility change; and
- Home and community-based spend down program.

1. Post Eligibility Verification of Financial Information

Better Health Care for Colorado proposes that applicants for Medicaid eligibility under the Aged, Blind or Disabled categories who declare assets below $2,000 should be deemed presumptively eligible for 60 days during which final eligibility determination must be made. If the individual is deemed not to be eligible after the 60-day period, they would be financially responsible for the services provided during this period.

Figure 21 illustrates program eligibility characteristics in eight states including Colorado. Six of these states (KS, MI, NE, OH, PA and WA) have presumptive eligibility. Five of the states (MI, NE, OH, PA and WA) have presumptive eligibility for home and community-based services programs. Error rates for clients determined presumptively eligible range from one percent for three of the six states (NE, OH and WA) to eight percent in Kansas. Pennsylvania's error rate is less than two percent.

Figure 21
Summary of Expedited Eligibility Program Characteristics

	CO[1]	GA	KS[1]	MI[2]	NE	OH	PA	WA
Issue								
Allow self-declaration of income	N	Y	Y	N	N	N	Y	Y
Allow self-declaration of assets	N	Partial	Y	N	N	N	Y	Y
Application may be completed by:								
Mail					Y		Y	Y[3]
Home visit by case manager/eligibility worker	Y[4]	Y	Y	N	Y	Y[5]	Y	Y
Visit to eligibility office					Y			Y
Average time to make decision before initiative	Up to 45 days	Up to 45 days	11 days[6]	Up to 45 days	Up to 45 days	NR	30-60 days	37 days
Average time to make decision after initiative	3 days	25 days	4 days	10-14 days	2 days	1-2 days	2-3 days	25 days

	CO[1]	GA	KS[1]	MI[2]	NE	OH	PA	WA
Presumptive (P) or fast track (F)	F	F	P	P	P	P	P	P
Presumptive Eligibility								
Estimated error rate for presumptive clients	NA	NA	8%	0%	1%	1%	< 2%	1%
Application must be completed within:	NA	NA	10 days	NA	NS	NS	NA	10 days
Groups eligible for presumptive process								
All long term care applicants	NA	NA	Y					
Hospital discharges	NA	NA					Y	Y
Applicants for nursing home admission	NA	NA						
Applicants for HCBS programs	NA	NA		Y	Y	Y	Y	Y
Percentage of applications using the process	NA	NA	36%	0%	5%	50%	100%	5%

1. Pilot programs in Colorado and Kansas are no longer operating.
2. Information for Michigan applies to Area Agencies on Aging.
3. Washington allows applications to be submitted by fax or email.
4. The visits occurred in the hospital.
5. The consumer is informed that a Medicaid application should be made. The case manager/aide may review the application with the consumer. A determination is made based on information collected for the HCBS assessment.
6. During the pilot, the average time to process an application through the traditional process was reduced. NR = not reported. NS = not specified. NA = not applicable.

Source: Robert Mollica, July 2004, www.adrc-tae.org/tiki-page.php?pageName=TAE+Issue+Brief-+Expediting+Eligibility

Based on the information above, for the purpose of estimating potential costs and savings associated with instituting presumptive eligibility for Medicaid HCBS waivers, we assumed that one percent of the nearly 10,000 applications annually would gain HCBS waiver services in error. The 100 erroneous applicants would receive two months of services prior to the completion of the verification of income and assets totaling nearly $200,000 (all state costs). In order to offset these costs, only 30 of the presumptive applicants (0.3 percent of the total) would need to have otherwise have gone into a nursing facility to offset the costs associated with the 100 erroneous applications. We note that these estimates assume all applicants would use the presumptive eligibility process. It is likely that not all individuals will require the initiation of services on this expedited basis to avoid going into a nursing facility and thus even a smaller number would be in error.

1. Clinical eligibility changes

Better Health Care for Colorado proposes to restrict clinical eligibility for nursing facility applicants and nursing facility level HCBS waiver applicants under a State Plan Amendment as permitted under the Deficient Reduction Act. ***Figure 22*** presents those HCB waivers that require nursing facility level of care. These are the waivers that we assume would be impacted by the proposal.

Figure 22
Nursing Facility Level HCBS Waivers Affected by Proposal [a/]

Waiver	Children's HCBS Waiver	HCBS Waiver for Elderly, Blind or Disabled	Consumer Directed Care for the Elderly
What is the primary purpose of this waiver?	To provide Medicaid benefits in the home or community for **disabled** children who would otherwise be ineligible for Medicaid due to excess parental income and/or resources. Children must be at risk of nursing facility or hospital placement.	To provide a home or community based alternative to nursing facility care for **elderly, blind, and disabled persons**.	To provide a home or community based alternative to nursing facility care for **elderly, blind, and disabled persons capable of self-directing care**.
What ages are served?	Birth through age 17	Age 18 and older	Age 55 and older
Who is served?	Disabled children in the home at risk of nursing facility or hospital placement.	Elderly persons with a functional impairment (aged 65+) or blind or physically disabled persons (aged 18-64).	Elderly persons who qualify for the HCBS-EBD Waiver and who are capable of self directing care.
What is the active enrollment cap on the program?	1,106 children in 2006	19,981 persons in 2006	1,328 persons in 2006
What are the medical criteria?	Nursing facility or hospital level of care [b/]	Nursing facility level of care.	Nursing facility level of care

a/ HCBS Waivers for children persons with Brain Injury, Mental Illness (HCBW-MI), and for persons living with AIDS (HCBS-PLWA) have been omitted because of the specialized services needed as a result of their diagnoses.
b/ According to Colorado Children's waiver staff, about 87 percent of children qualify under NF level of care.
Source: Except from the Colorado State Summary of HCBS Waivers, www.chcpf.state.co.us/HCPF/LTC/Waiver%20Chart%20_Feb%2017%202006_.pdf.

Figure 23 outlines criteria for nursing facility clinical eligibility under current Colorado regulations. To qualify clinically for long term care services, applicants must meet the following requirements:

- Have deficits in at least two of six Activities of Daily Living (ADL); or
- Require at least moderate supervision in Behaviors or Memory/Cognition.

Figure 23
Scoring Criteria for Nursing Facility and NF-Level HCBS Clinical Eligibility

	Scoring Criteria
Activities of Daily Living	The individual must have deficits in 2 of 6 Activities of Daily Living, ADLs, (2+ score)
Mobility	0=The client is independent in completing the activity safely. 1=The client is mobile in their own home but may need some assistance outside the home. 2=The client is not safe to ambulate or move between locations alone; needs regular cueing, stand-by assistance, or hands on assistance for safety both in the home and outside the home. 3=The client is dependent on others for all mobility.
Bathing	0=The client is independent in completing the activity safely. 1=The client requires oversight help or reminding; can bathe safely without assistance or supervision, but may not be able to get into and out of the tub alone. 2= The client requires hands on help or line of sight standby assistance throughout bathing activities in order to maintain safety, adequate hygiene and skin integrity. 3=The client is dependent on others to provide complete bath.
Dressing	0=The client is independent in completing the activity safely. 1=The client can dress and undress, with or without assistive devices, but may need to be reminded or supervised to do so on some days. 2=The client needs significant verbal or physical assistance to complete dressing or undressing, with a reasonable amount of time. 3=The client is totally dependent on others for dressing or undressing.
Eating	0=The client is independent in completing the activity safely. 1=The client can feed self, chew and swallow foods but may need reminding to maintain adequate intake; may need food cut up; can feed self if food brought to them, with or without adaptive feeding equipment. 2=The client can feed self but needs line of sight standby assistance for frequent gagging, choking, swallowing difficulty, or aspiration resulting in the need for medical intervention. The client needs reminder/assistance with adaptive feeding equipment; or must be fed some or all food by month by another person. 3=The client must be totally fed by another person; must be fed by another person by stomach tube or venous access.

	Scoring Criteria
Toileting	0=The client is independent in completing the activity safely. 1=The client may need minimal assistance, assistive device, or cueing with parts of the task for safety, such as clothing adjustment, changing protective garment, washing hands, wiping and cleansing. 2=The client needs physical assistance or standby with toileting, including bowel/bladder program, catheter, ostomy care for safety or is unable to keep self and environments clean. 3=The client is unable to use the toilet. The client is dependent on continual observation, total cleansing, and changing of garments and linens. This may include total catheter or ostomy. The client may or may not be aware of own needs.
Transferring	0=The client is independent in completing the activity safely. 1=The client transfers safely without assistance most of the time, but may need standby assistance for cueing or balance; occasional hands on assistance needed. 2=The client requires standby or hands on assistance for safety; client may bear some weight. 3=The client requires total assistance for transfers and/or positioning with or without equipment.
Supervision	The individual must require at least moderate (2+ score) in Behaviors or Memory/Cognition under Supervision
Behaviors	0=The client demonstrates appropriate behavior no concern. 1=The client exhibits some inappropriate behaviors but not resulting in injury to self, others and/or property. The client may require redirection. Minimal intervention is needed. 2=The client exhibits inappropriate behaviors that put self, others or property at risk. The client frequently requires more than verbal redirection to interrupt inappropriate behaviors. 3=The client exhibits behaviors resulting in physical harm to self or others. The client requires extensive supervision to prevent physical harm to self or others.
Memory Cognition	0=Independent no concern. 1=The client can make safe decisions in familiar/routine situations, but needs help with decision making support when faced with new tasks, consistent with individual's values and goals. 2=The client requires consistent and ongoing reminding and assistance with planning, or requires regular assistance with adjusting to both new and familiar routines, including regular monitoring and/or supervision, or is unable to make safe decisions, or cannot make his/her basic needs known. 3=The client needs help most or all the time.

Source: Colorado Guidelines for LTC Services, www.sos.state.co.us

Applicants for home and community-based services must also meet these clinical eligibility requirements as federal regulations require that individuals receive services under a waiver in lieu of institutional care. Better Health Care for Colorado proposes the following:

- Restrict admission to a nursing facility to individuals who have deficits in at least three of the six ADLs; and

- Maintain current clinical eligibility standards for supervision. Based on conversation between the author and former Colorado Medicaid officials, they believe that few of the waiver participants qualify under this category. If more people are eligible under the supervision requirement, the author proposes to reconsider this component of the clinical eligibility proposal.

The combined impact of the clinical and income eligibility changes is presented below ***(Figure 24)***. Colorado's clinical threshold for NF eligibility and also community services is 2.0 ADL limitations. The author originally proposed an increase in the institutional level clinical eligibility criteria for Elderly Blind and Disabled (EBD) waiver to 3.0 ADL limitations. To cover displaced consumers, the author proposed an application of the 2.0 ADL limitation clinical eligibility criteria to cover personal care services as a new state plan service.

Figure 24
Combined Impact of Financial and Clinical Eligibility Changes

Nursing Facility	
• Meet income criteria (up to 300 percent SSI) or income spend-down; and • Have 2 ADL limitations	• Meet income criteria; and • Have less than two ADL limitations or require less than moderate supervision
171 people (1.6 percent of Medicaid residents) displaced. Assuming income less than 150 percent FPL, they could receive PCS under State Plan. PCS cost $1.9 million NF savings ($8.3 million) Net change ($6.4 million) ($3.2 million) state	533 NF residents (5.1 percent) grandfathered in. If discharged, saves $25.7 million ($12.9 million state) in NF spending.
Home and Community-Based Services	
• 2 ADL limitations and no longer eligible for HCBS waiver based on clinical eligibility 349 people (1.6 percent) displaced	
211 have income less than 150 percent FPL and can receive PCS under new State Plan option	PCS Cost $2.3 million HCBS savings ($2.3 million) Net change $0
138 have income between 150 percent FPL to 300 percent SSI and are grandfathered into state general revenue program at full cost	Cost to state $1.0 million (No FFP because above income standard for PCS under the State Plan)

Source: Lewin Group analysis using the Long Term Care Population Tool.

The Author has not had the opportunity to review acuity-level data related to this change, and is not prepared to back the recommendation in the absence of the data. Unless it was determined that a very small population of HCBS consumers under the EBD waiver was affected by the originally proposed shift, Author plans to withdraw the recommendation.

In addition, the following are some of the limitations to the analysis:

- Currently, there is no community level data available on ADL limits or supervision requirements.
- Lewin used nursing facility Minimum Data Set (MDS) and assumed individuals in community would have same distribution of ADL limits and supervision requirements.
- Author originally proposed to increase institutional level ADL for EBD waiver from 2 to 3 ADL limits. To cover displaced clients author proposed to cover personal assistance as a new state plan service.
- Unavailability of acuity data for estimating the community resident impact means the Author may not be prepared to back the recommendation and could withdraw this aspect of proposal.

2. *Income Eligibility Change*

Financial eligibility standards for people applying for HCB waivers in Colorado are as follows:

- The individual's income must be less than $1,863 (i.e., three times the monthly standard maintenance allowance) per month; and
- Countable resources less than $2,000.

In addition to the clinical eligibility changes above, Better Health Care for Colorado proposes to take advantage of the increased flexibility under the Deficient Reduction Act (DRA) by providing HCB waiver services and Personal Assistance Services under a State Plan Amendment for people up to 150 percent of the poverty level.

As mentioned above currently, HCB waivers provide services to certain individuals up to 300 percent of SSI. By tightening the clinical eligibility standards, those individuals who are currently clinically eligible would no longer be eligible for Medicaid for two primary reasons:

- First tightening eligibility would result in those who have only two ADL limits no longer eligible; and
- Second they would lose Medicaid because they are no longer able to take advantage of the higher income level under the HCB waiver and would no longer be eligible.

The Colorado HCPF estimates that about 57 percent of those enrolled in HCB waivers are income eligible at 300 percent of the SSI amount. Some of these individuals would still be eligible at 150 percent of the FPL but most would not. People who are eligible under HCB waivers are also eligible for medical assistance services and they would lose these benefits. We can assume that most of the 57 percent of HCB waiver recipients would lose eligibility.

To address some of the effects of people losing eligibility, Better Health Care for Colorado proposes to require income eligibility for HCB waivers and Personal Assistance of 150 percent of the FPL under the State Plan as permitted by the DRA. Better Health Care for Colorado also proposes to develop a more robust state funded program that is similar to, but more comprehensive than the current Home Care Allowance program.

Individuals with income and resources between 150 percent and 300 percent of the SSI amount with countable resources less than $2,000 would receive the same services as current EBD waiver clients but using state only funds, and benefit costs would be capped at $600 per member per month. These services include:

- Adult day services;
- Alternative care facilities;
- Community transition services;
- Personal Emergency Response System and home modifications;
- Homemaker services;
- In-home support services (IHSS);
- Non-medical transportation;
- Personal care; and
- Respite care.

If clinical eligibility changes described above are not implemented, SEIU proposes to reconsider this component.

Eligibility determination under the HCBS Children's waiver is a little different. Colorado disregards parental income for children whose parental income exceeds the SSI standard. In addition, if the child has income above the SSI standard, have the excess income placed in a medical trust fund. That trust fund is used to defray the cost of services paid for by the state should the child pass away. Thus, most children (even those in higher income families) are able to meet the SSI income standard above. Better Health Care for Colorado proposes to "grandfather" in existing children. Going forward, we estimate that 10 or fewer children who would have qualified under the waiver, but only have two ADLs and income above 150 percent of the FPL would no longer be able to gain access to personal care services. Furthermore, according to state staff, there is an estimated 225 people on waiting list for the children's waiver.

An analysis of the Nursing Facility Minimum Dataset (MDS) assessments indicates that 533 current Medicaid residents (5.1 percent of all Medicaid residents) do not appear to meet either of the two or more ADL and the supervision criteria. While the current nursing facility residents in this situation would be grandfathered in and would continue to receive Medicaid coverage in the nursing facility, with the change in NF eligibility, once these individuals are discharged, the state could expect $25.7 million less in Medicaid NF spending.

Another 171, or 1.6 percent of Medicaid residents, meet the current eligibility criteria, but have two ADLs and thus, under this proposal would need to leave the nursing home. Assuming all of these individuals have income less than 150 percent of the FPL, serving these 171 individuals in the community under the planned DRA state plan personal care services provision outlined below rather than a nursing facility would result in a net Medicaid savings of $6.4 million ($1.9 million in spending for PCS and $8.3 million less for NF). This assumes payment reforms that do not permit nursing facilities to recover all of their costs.

While we were able to rely on data from the NF-MDS for information about the functional status of those on Medicaid in the nursing facility, the state did not have similar information available for those on the waivers with nursing facility eligibility criteria. As a result, in order to estimate the number of individuals currently receiving services under the waiver that would no longer meet the clinical eligibility criteria, we assumed the distribution of individuals resembles those in the nursing facility. This assumption likely understates the number of individuals affected on the waiver because we expect that the distribution of individuals on the waiver by ADL status would more heavily represent those with lesser disability than in the nursing facility.

Using the 1.6 percent from the nursing facility analysis, 349 adults on the waiver would no longer be eligible. Among these, 211 would have income less than 150 percent of the FPL and would be able to obtained personal care services under the new DRA provision for about the same cost as their waiver services ($2.3 million; $1.2 million state funds). The remaining 138 individuals with only 2 ADLs and income between 150 percent of the FPL and 300 percent of the SSI threshold would be served under the new state funded program at a cost of $1.0 million. These costs would be fully borne by the state now rather than with the 50 percent federal financial participation (FFP) under Medicaid. This estimate does not include the reduction in Medicaid acute care costs that would no longer be covered for the individuals now receiving state funded HCBS. However, these individuals would be covered under the acute care benefit provisions of the proposal and most are likely dual eligible where Medicaid is only liable for co-payments for acute care services.

3. Home and Community-Based Spend Down Program

Better Health Care for Colorado proposes to create a separate HCBS waiver program for individuals with two or more ADLs and whose income and resources exceed the program eligibility standards of countable resources of more than $2,000. This would allow individuals who have excessive resources to buy into the program. These individuals would be required to pay a co-pay of 50 percent for services. In addition, Better Health Care proposes to create a private pay non-institutional option for people who are determined financially eligible for the program. Below we discuss the impacts of these two options:

a. HCBS Waiver Spend-down Buy-In

Individuals with two or more ADLs and whose income and resources exceed the Medicaid resource amount of $2,000, but whose income is below 300 percent of the SSI amount would be able to buy into the program with a 50 percent co-pay. They would receive access to the same services under the existing waiver in which they are participating.

Based on analyses of the Survey of Income and Program Participation (SIPP), approximately 17 percent of adults under age 65 (900 individuals in Colorado) and 37 percent of adults age 65 and over (2,800 individuals in Colorado) with income below 300 percent of the SSI amount have financial assets above Medicaid eligibility thresholds. With income levels less than $22,500 for a single individual and the average cost of the waiver benefits more than $7,000, even with moderate financial assets, an average co-pay of $3,500 would deter many individuals from seeking services and they would continue to rely upon family and friends. Assuming a 25 percent participation rate, the cost to the state would be $7.2 million

b. HCBS Non-Institutional Private Program

Individuals with income above 300 percent of the SSI threshold would receive the same services as current EBD waiver clients. These services include:

- Adult day services
- Alternative care facilities
- Community transition services
- Personal Emergency Response System
- Home modifications
- Homemaker services
- In home support services (IHSS)
- Non-medical transportation
- Personal care
- Respite care

Consumers above 300 percent of the SSI threshold would pay the entire cost of services. Based on analyses of the Survey of Income and Program Participation (SIPP), approximately 30 percent of individuals with two or more ADLs have income above 300 percent of the SSI threshold.

This program would be expected to be available to nearly 11,000 individuals. Assuming a 25 percent participation rate, because individuals would be responsible for the full cost of their services, the administrative cost to the state for providing service coordination would be approximately $1.0 million.

4. Overall Impact of Proposal

Figure 25 provides a summary of the programs in which individuals would receive HCB services as a result of the eligibility and income changes, by limitation in ADLs, income and assets (resources) analyzed in this report. As previously mentioned above, some people would lose HCB waiver eligibility as a result of tightening the clinical eligibility requirement. The creation of Personal Care State Plan Services, development of more robust state funded programs, as well as a full cost private pay program is intended to provide other avenues for serving people who may lose eligibility. These programmatic changes may also be withdrawn depending on the author's decision about whether to withdraw the clinical eligibility proposal after the author has had an opportunity to review acuity level data related to the clinical eligibility proposal and its impact on consumers of HCB services under the applicable nursing-facility level waivers.

Figure 25
HCBS Coverage under Better Health Care for Colorado

Current Programs

	<2 ADLs	<=$2,000/$3,000 assets		>$2,000/$3,000 assets	
		2 ADLs	3+ ADLs	2 ADLs	3+ ADLs
>300% SSI					
151% FPL to 300% SSI					
<150% FPL					

Better Health Care for Colorado LTC Proposal

	<2 ADLs	<=$2,000/$3,000 assets		>$2,000/$3,000 assets	
		2 ADLs	3+ ADLs	2 ADLs	3+ ADLs
>300% SSI					
151% FPL to 300% SSI					
<150% FPL					

Medicaid Nursing Facility and Elderly, Blind, Disabled Home and Community-based Waiver (EBD-HCBW)
Personal Care Services through Medicaid State Plan
State-funded program offering EBD-HCBW services with per member per month cap of $600 and no co-pay
State-funded program offering EBD-HCBW services with per member per month cap of $600 with 50% co-pay
State-administered Private Program offering EBD-HCBW services with 100% co-pay

Source: The Lewin Group analysis using the Long Term Care Population Tool.

Lewin did not integrate the LTC analysis results with the acute care results as our analysis of long term care did not include all the reforms proposed. In fact, integrating the long term care results into acute care results would not be a true depiction of the entire Better Healthcare for Colorado proposal. Thus, while the acute care analysis shows a shortfall of about $53 million assuming an 1115 waiver is approved ***(Figure 11)***, the Long- term care provisions could result in savings that may result in the program being fully funded.