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

Appendix D: The "Solutions for a Healthy Colorado" Proposal

Prepared for:

The Colorado Blue Ribbon Commission for Health Care Reform

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THE "SOLUTIONS FOR A HEALTHY COLORADO" PROPOSAL

The Solutions for a Healthy Colorado proposal requires all Colorado residents to have health insurance or face penalties. The program provides coverage to all Colorado residents by implementing a Core Limited Benefit Plan in the private sector, and expanding coverage under Medicaid and Child Health Plus (CHP+). Premium subsidies also would also be provided to lower-income adults. The program would be financed through a combination of program savings, a newly created nutrition tax and increased tobacco and alcohol taxes. We present our analysis of the Solutions for a Healthy Colorado proposal in the following sections:

- Key Provisions of Solutions for a Healthy Colorado;
- Assumptions;
- Cost and Coverage Impacts; and
- Ten-year Cost Projections.

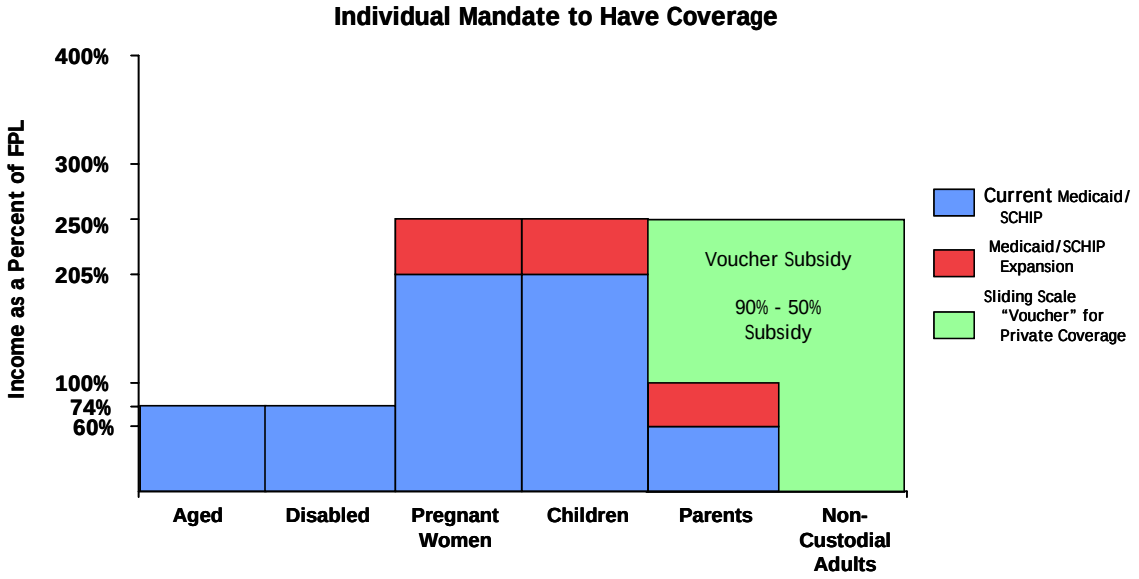
A. Key Provisions of Solutions for a Healthy Colorado

1. Coverage

All Colorado residents would be required to obtain coverage. Access to a guaranteed issue Limited Core Benefit Plan would be available to low-income uninsured individuals and families. Self-employed individuals also would be required to have coverage.

The program increases eligibility under Medicaid and CHP+ for pregnant women and children from its current level of 205 percent of the FPL to 250 percent of the FPL (***Figure 1***). Eligibility for parents is also increased to 100 percent of the FPL. All of these Medicaid and CHP+ eligibility expansions are eligible for federal matching funds. In addition, the program would provide vouchers for the purchase of private insurance for adults living below 250 percent of the FPL.

Figure 1
Eligibility for Subsidized Coverage under "Solutions for a Healthy Colorado"



Source: The Lewin Group.

Residency requirements for the Medicaid/CHP+ expansion populations would be the same as under the existing program. For the voucher subsidy program, an individual would be considered a resident if they are a resident for purposes of filing Colorado state income taxes, or if they have been in Colorado for at least six months.

2. Covered Services and Cost-Sharing

The benefits package provided to the people enrolled in the Medicaid and CHP+ expansion groups is the same as under the current program. For others, the program includes a limited core benefits package. Covered services and co-payments under the core limited benefits package are presented in ***Figure 2***. However, the program includes a maximum covered amount of $50,000 per person.

Figure 2
Core Limited Benefits Plan Summary

	In Network	Out of Network	Limitations
Routine Office Visit	$15 Co-pay	$15 Co-pay	Limited to 10 visits per year $200 max per visit
Preventive Care	$15 Co-pay	$15 Co-pay	Limited to 1 visit per year plus all child and adult preventative
Individual Deductible	$100	$200	
Mental Health and Substance Abuse	80%	60%	$1,000 annual maximum
Emergency Benefit	$100 co-pay	$100 Co-pay	$3,000 annual maximum
Hospitalization Cost	80%	60%	$3,000 per day limit
Outpatient/Ambulatory Surgery	80%	60%	$2,000 annual maximum
Lab & X-Ray	80% Coinsurance	60% Coinsurance	$2,000 annual maximum
CT, MRI, Pet, Nuclear	80% Coinsurance	60% Coinsurance	$2,000 annual maximum
Prescription	$10 Generic $20 Preferred Brand 100%	50% Coinsurance	$300 per month maximum
Durable Medical Equipment	80% coinsurance	60% coinsurance	$1,000 annual maximum
Out of Packet Maximum	$3,000 annual maximum per individual up to annual maximum benefit (i.e., $50,000)		
Annual Maximum	$50,000 In and Out of Network		

Source: Solutions for a Healthy Colorado

Eye exams and hearing tests would be covered under routine office visits. Dental services and eyeglasses would be excluded from the Core Limited Benefit package.

Individuals would be able to purchase more comprehensive coverage in the private market (i.e., in the individual market or through their employer group plan) or under CoverColorado, if eligible (i.e., the high-risk pool).

3. Premiums and Subsidies

The proposal establishes the following premium categories:

- Employee only, employee + spouse;
- Employee + one child;
- Employee + two children;
- Employee + three or more children;
- Employee + spouse + one child;

- Employee + spouse + two children;
- Employee + spouse + three or more children; and
- Child only.

In our analysis, we assume that all children eligible for Medicaid or CHP+ would enroll there. Therefore none of the premium categories for families including children were actually used in the simulation.

Figure 3 shows our actuarial estimates of premiums for the core limited 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 $199.24 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
"Solutions for a Health Colorado" Premiums for the Limited Core Benefits Package PMPM by Age, Gender and Tier: Contracts Effective 2007/2008

	Monthly Premium per Enrollee	
Age/Gender	**Single**	**Family**
Under age 25 Male	$99.7	$360.18
25 - 34 Male	$121.92	$525.05
35 - 44 Male	$161.22	$626.86
45 - 54 Male	$270.66	$704.97
55 - 64 Male	$459.75	$842.13
Under age 25 Female	$178.16	$383.68
25 - 34 Female	$224.21	$541.67
35 - 44 Female	$260.86	$600.41
45 - 54 Female	$343.90	$709.69
55 - 64 Female	$494.81	$871.38

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 average at about 130 percent of Medicare payment levels, which are about 15 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.***

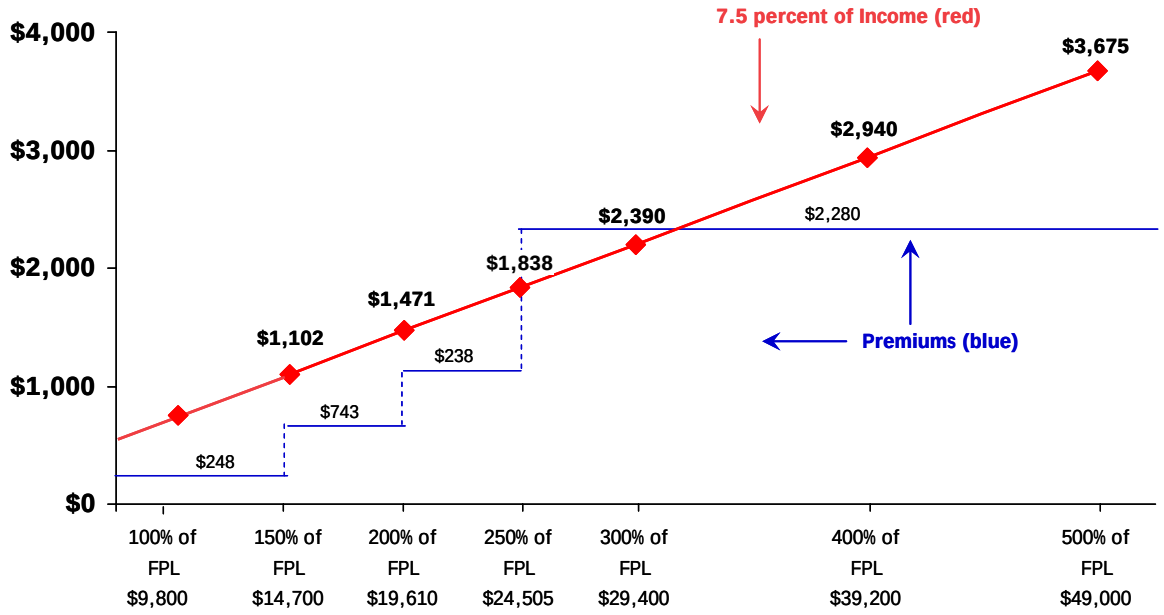
The voucher premium subsidies voucher would be available to individuals up to 250 percent of the FPL. The subsidy amounts would be as follows:

- 90 percent of the premium for a core limited benefit plan to individuals between Medicaid income eligibility levels and 150 percent of the FPL;
- 70 percent subsidy to those between 150 percent and 200 percent of the FPL;
- 50 percent subsidy for those between 200 percent and 250 percent of the FPL; and
- No subsidy for those above 250 percent of the FPL.

Individuals could use their voucher to pay the worker share of the premium for employer health plans. It also could be used to obtain a major medical plan that is more comprehensive than the core limited benefits package. Also, people who purchase coverage that is more comprehensive than the Core Limited Benefit plan would be responsible for the full premium difference between the Core Limited Benefit plan and the enhanced plan they select. Premiums would be collected in the current fashion through payment directly to the entity or carrier providing the health plan.

Figure 4 summarizes the premiums people would pay at various income levels after accounting for subsidies available under the program.

Figure 4
Annual Premiums less Subsidies for a Single Individual under Solutions for a Healthy Colorado



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

4. Insurance Market Reforms

Insurers would be required to offer the core limited benefits package that is eligible for the voucher subsidies on a guaranteed issue basis using modified community rating. Guaranteed issue means that an insurer is not permitted to decline to cover someone for the core limited benefits package due to health status. (Guaranteed issue is not required for other coverage options in the individual market and guaranteed issue already exists in the group market). Modified community rating means that premiums may vary with age, gender, geography and family type (e.g., single, family etc.), but may not be varied with health status. For other benefits plans, rating rules would be unchanged from current law, and the Cover Colorado high-risk pool would be retained for those who cannot obtain more comprehensive coverage due to health status.

The author proposes to eliminate the following group coverage barriers:

- Requiring the purchase of life insurance when purchasing health insurance;
- Imposing a 35 percent penalty on individuals and businesses for coming back into the fully insured market;
- Requiring high employee participation in group coverage; and
- Excluding dedicated 1099 employees from group-sponsored health care coverage.

Insurers would continue to perform their current roles in the areas of plan administration, claims processing, network development, marketing, implementation of disease management, transparency and customer service tools.

5. Consumer Choice

The state would organize a selection of health plans for people to select from through a new organization called a "Connector." Consumers would have a choice of plans through the Connector. All licensed carriers would be required to offer the Core Limited Benefit Plan to participate in the Connector and would pay a registration fee. The plan would provide an initial open enrollment window of either six or twelve months. There would be a premium surcharge and pre-existing condition limitations for enrollment beyond the open-enrollment period.

The Connector model, in the short term, would provide information and access to health insurance application and assistance. In the longer term, once this program is stabilized, there is the opportunity for the Connector to operate as a mechanism for true portability. Individual core COBRA and continuation of coverage would still be available and Core Limited Benefits would be recognized as creditable coverage. Individual policies would be as they are now, not subject to these factors. Benefit plans would be guaranteed renewable and portable as long as premiums are paid.

Individuals would receive a 30-day grace period for non-payment of premiums after which coverage could be discontinued. People who change employers would continue to be able to purchase continuation coverage under COBRA for groups with 20 or more workers and as provided under current state law for groups with fewer than 20 workers.

6. Disposition of State/Local Programs

The program increases CHP+ eligibility for children to 250 percent of the FPL and increases Medicaid eligibility to 100 percent of the FPL for parents. As discussed below, Medicaid provider reimbursement rates would be increased to Medicare payment levels for all hospital and physician care provided to Medicaid enrollees. There are no further changes proposed to Medicaid, CoverColorado or other government programs.

7. Reinsurance

The Solutions for a Healthy Colorado proposal includes a reinsurance program designed to share the risk of high-cost cases across all carriers. Because the proposal requires guaranteed issue for the core limited benefits package, plans are more likely to acquire high-cost chronically ill cases with catastrophic losses. To protect against this, all insurers, except self-funded plans, would be required to pay a reinsurance premium into a reinsurance pool. The reinsurance program would cover high-cost cases as follows:

- The primary insurer would retain responsibility for 100 percent of each claim up to a cap amount (e.g., $50,000);
- Reinsurance would cover 80 percent of costs between $50,000 and $100,000;
- It would cover 90 percent of costs between $100,000 and $200,000; and
- The reinsurance would cover 100 percent of claims above $200,000 but no more than or $1 million (amount to be determined).

We did not model the effects of the reinsurance program.

8. Employer Provisions

Employer contributions would not be mandated, though they would be encouraged. Employers who currently have group medical plans would be required to accept premium subsidy vouchers in payment for part or all of a low-wage worker's share of employer sponsored medical coverage. There would be no requirement for employers to offer a selection of medical plans.

Employers would be encouraged, but not required to establish section 125 programs that permit workers to pay their premiums in pre-tax dollars. Also, even if the employer does not provide insurance, they could establish a section 125 plan and withholding for premiums that enable people to pay premiums for individual coverage in pre-tax dollars.

9. Financing

The plan would be financed as follows:

- Redirection of Colorado Indigent Care Program funding to pay for premium subsidies; and

- A Nutrition Sales Tax on all consumable food items that have little or no nutritional value to finance the costs that are not covered by participant premiums, including 65 percent sales tax on all fountain sodas and walk-up coffee locations.

In addition, to fully fund the proposal, Lewin assumed the following increases in alcohol and tobacco taxes:

- An increase in tobacco—from $.84 up to $2.00 per pack; and
- An increase in alcohol taxes as follows:
  - Spirits: from $.60 to $5.63 for a liter (or from $2.28 to $21.30 per gallon);
  - Wine: from $.07 to $.66 per liter (or from $.32 to $2.50 per gallon); and
  - Beer: from $.05 to $.15 per 6-pack (or $.08 to $.26 per gallon).

For illustrative purposes we assume that these tax increases would be permitted under current law. The Colorado's Taxpayers Bill of Rights (TABOR) and the Arveschoug-Bird law impose limits on state spending without voter approval. We assume that either the voters approve these tax increases or that these tax increases fall within an exception under these laws.

10. Mandate Enforcement Provisions

The plan proposes a penalty for those who do not have coverage. Colorado residents would be required to file proof of coverage with their individual tax return as well as with their vehicle registration and application for a driver's license or state identification card. Individuals who do not have evidence of coverage at the time of the application would be referred to the Connector to obtain coverage and would have 30 days to obtain coverage.

Individuals would be denied vehicle registrations, licenses and identification cards if they do not have proof of coverage. In addition tax filers with no proof of coverage would pay a state income tax penalty of $500 per person up to $1,500 per household.

11. Provider Payment Levels

Medicaid reimbursement levels would be increased to the Medicare payment levels. Payment rates for the private sector would be between 120 percent and 150 percent of Medicare reimbursement levels, depending upon the quality of care provided. Future increases in payments in the private sector (not modeled in this analysis) would take into account quality ratings ranging from "Average" to "Superior Quality" as follows:

- Level one - 125 percent of Medicare (entry level);
- Level two – 130 percent of Medicare (average quality measures);
- Level three – 140 percent of Medicare (above average quality measures); and
- Level four – 150 percent of Medicare (superior quality measures).

In our analysis, we assume that these adjustments are applied such that payment rates across all four levels would average 130 percent of Medicare rates.

For out-of-network services, plans must pay providers at 120 percent of the Medicare rate. In addition, no provider can charge the patient above the difference between the provider's reasonable and customary charge and the provider's Medicare payment level. Under this proposal the maximum reimbursement a provider would receive would be at 150 percent of the Medicare payment level.

12. Administration

The proposal establishes an internet-based, public/private Colorado Health Insurance Connector to provide information to consumers about government programs and private insurance plans. A limited agency website would be created called the "Health Care Coverage Matrix" with links to public entity programs such as Medicaid and CHP+. Premium subsidies would be administered through the tax system under the Department of Revenue.

The Connector model would be structured to reduce administrative costs and barriers to coverage. To reduce administrative costs, the plan creates a consistent pricing model, standardized applications and claims payment; and consistent medical underwriting where that exists. (These factors were considered in developing the administrative cost assumptions below.)

The program would take several steps to maximize enrollment. The proposal would provide increased outreach to individuals who are eligible but not enrolled in government-sponsored programs. In addition, through the Connector, insurance brokers would be available to provide personalized expert advice on insurance choices, including government sponsored programs. Members of the Colorado State Association of Health Underwriters who choose to participate in the program would receive training on government programs.

13. Medical Malpractice Reform

The proposal recommends comprehensive medical malpractice reform including:

- Limiting non-economic damage awards;
- Allocating damages in proportion to degree of fault;
- Placing reasonable limits on punitive damages and attorney fees with a statute of limitations on claims; and
- Implementing stricter disciplinary rules on physicians as a means to reduce costs associated with medical errors.

The assumptions used to estimate the impact of these reforms is based upon prior Lewin Group studies of medical malpractice reforms.

B. Assumptions

As discussed above, this proposal would expand eligibility for children under CHP+ to 250 percent of the FPL and increase Medicaid eligibility for parents to 100 percent of the FPL. The program also provides a premium subsidy to people living below 250 percent of the FPL that

can be used to purchase either non-group coverage or to pay the worker share of the premium for ESI. Our key assumptions in simulating the impact of these proposals are presented below.

1. Low-Income Coverage Expansion

We estimated the number of newly eligible children who would enroll in the program based upon the Colorado sub-sample of the 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 people 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 people based upon a Lewin Group analysis of program participation rates under the current Medicaid and CHP+ programs. This approach results in participation rates of about 70 percent for uninsured people and 39 percent for people who currently have insurance from some other source;
- We assumed that children who are 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 that people who are currently eligible for, but not enrolled in the existing Medicaid and CHP+ program would enroll due to the mandate only if they file taxes in the year. Others are assumed to be beyond the reach of enforcement;
- Our participation model simulates "crowd-out" (i.e., the substitution of public for private coverage) based upon enrollment of children eligible for the pre-CHP+ poverty level expansions under Medicaid.[1] The model indicates that without anti-crowd-out provisions, up to 39 percent of newly eligible persons with employer coverage would eventually shift to the public program;[2] 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).

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

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

2. Premium Subsidies

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

We simulated the impact of this reduction in price using a multivariate model of how the likelihood of purchasing coverage changes as the price of coverage (i.e., the premium) is reduced. This model shows an average price elasticity for coverage of –0.34 (i.e., a 1.0 percent decrease in premiums is associated with an increase in coverage of about 0.34 percent). However, the impact of changes in premiums on coverage varies with the income and demographic characteristics of affected persons. For example, the price elasticity varies from about –0.31 among persons with family incomes of $50,000 to –0.55 among those with incomes of $10,000. Thus, the price response tends to be higher for low-income persons than high-income persons.[3]

We used these price elasticity assumptions to simulate the change in coverage for uninsured people in the MEPS-based HBSM data. The model was used to estimate the premium faced by each uninsured individual or family in the individual market, and the amount of the subsidy that eligible person would receive. Affected individuals were then randomly selected to become covered based upon 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 HBSM to estimate the premium that individuals face in the non-group market for a given benefits package by age, sex and self-reported health status;
- All HBSM simulations were performed on a month-by-month basis to account for people who are eligible for only part of the year (The various subsidy proposals typically pro-rate the annual subsidy over months of eligibility.); and
- All income-eligible people who are currently purchasing non-group coverage are assumed to take the premium subsidy.

3. Mandate Compliance

The proposal includes a mandate for all Colorado residents to have health insurance. We first simulate voluntary enrollment for people newly eligible for subsidized coverage as described above. All of those simulated to take coverage due to the subsidies, as estimated above, are assumed to take that coverage. Among those who remain, we assume full compliance among people where the cost of insurance is less than 9.0 percent of family income.[4] Others would

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[3] As discussed below, we assume that anyone facing a premium in excess of nine percent of family income would not comply with the mandate, unless they are voluntarily simulated to enroll.

[4] Our estimate of affordability is based on a review of a recent article by Mark V. Pauly and Bradley Herring, "Risk Pooling and Regulation: Policy and Reality in Today's Individual Health Insurance Market," in Health Affairs [Health Affairs 26, no. 3 (2007): 770-779].

remain uninsured. (Note, we do not override the simulation to voluntarily take coverage in response to the subsidy based upon the cost of insurance as a percentage of income.

4. Employer Response to Mandate and Premium Subsidies

This program potentially has major ramifications for employer-sponsored insurance (ESI). The program provides premium subsidies that can be used by workers to purchase non-group insurance as an alternative to the employer plan. The availability of subsidies for non-group coverage reduces the relative advantages of taking coverage through tax preferred ESI, which could cause some employers to discontinue their coverage. Also, the expansion in eligibility for Medicaid and CHP+ would encourage would lure some of the lower-wage workers away from ESI and into public programs. However, the requirement that all people have insurance would increase worker demand for group coverage, which could result in an increase in the number of employers offering insurance. The fact that the premium subsidy may be used for the worker share of the premium further strengthens incentives to have group coverage.

We simulate employer coverage decisions based upon whichever approach allows the employer's worker force to purchase coverage at the lowest cost. We did this by first calculating the cost of covering their workers and dependents under ESI, less any premium subsidies their workers are eligible to receive and the taxes saved due to the tax exclusion for employer provided health benefits. We then calculate the cost to the group of enrolling their workers in Medicaid, CHP+ or the premium assistance program where eligible. We also include the unsubsidized cost of individual coverage for people with incomes above 250 percent of the FPL.

We assume that employers will do whichever minimizes the cost of coverage to the group. Thus, those that find that the cost of providing ESI is greater than the cost of acquiring non-ESI coverage do not offer coverage. Those who find it is less costly for the group to obtain coverage through ESI are assumed to purchase ESI. The methods used to simulate the employer's decision are presented in ***Appendix H.***

5. Provider Payment Levels

The proposal would also adjust provider payment levels. As discussed above, payment levels for public providers are typically lower than for privately insured people. The payment level differentials are shown in ***Figure 5.*** Under the proposal, Medicaid payment levels would be increased to match Medicare payment levels. Private sector payment levels would be adjusted to 130 percent of Medicare payment levels, which generally represents a reduction in reimbursement for hospital care, but a small increase in reimbursement for physician care.

Figure 5
Private Provider Payment Adjustments

	Medicaid to Medicare	Private to 130 percent of Medicare
Hospital	+15 percent	-26 percent
Physician	+35 percent	+5 percent

Source: Lewin Group analysis

6. Program Administration

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

7. Wage Effects

HBSM 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 would be 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 due to changes in health benefits costs. We also assume these wage changes would occur in response to both mandates affecting employers and voluntary changes in employer coverage induced by health reform.

There is considerable agreement among economists that this pass-through would occur in response to changes in employer benefits costs.[5] However, there is disagreement over the period of time over which these adjustments would occur. It is likely that these adjustments would usually take the form of reduced wage growth over-time. However, the full amount of the pass-through could take several years to materialize.[6]

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

6 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).

8. Medical Malpractice Reform

We estimated savings from the various medical malpractice reform proposals based upon a study of similar malpractice reforms conducted by the Lewin Group. The study indicate that savings these reforms would reduce spending for public and private insurance programs by about 3 tenths of one percent.[7]

C. Cost and Coverage Impacts

In this section, we present our estimates of the cost and coverage impacts of Solutions for a Health Colorado proposal in two ways. For illustrative purposes, we present estimates of the proposal's impact as if it were mature and fully implemented in 2007/2008. We also assume that the wage pass-through effects occur immediately in that year. This enables us to compare changes in costs and coverage in current year dollars for each major stakeholder groups.

We present a second set of estimates in the next section that are designed to present estimates suitable 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 expected lags in enrollment in the early years of the program as people gradually become familiar with the program and enroll.

1. Transitions in Coverage

The proposal provides coverage through a public program expansion and through the private market. Uninsured individuals would be required to obtain private coverage. A guaranteed issue, Core Limited Benefit Plan would be available to low income and previously uninsured individuals as one avenue of compliance with the mandate.

Figure 6 illustrates where people would become covered under the proposal. Of about 2.7 million people now with ESI, 5,300 become covered under Medicaid or CHP+ expansions. About 65,300 people would move into the non-group market as some employers drop their health plans.

However, about 100,800 currently uninsured people would become covered as some employers start to offer coverage in response to increased worker demand for health coverage as a result of the mandate. This also includes people who have declined coverage available at work who would now take that coverage to meet the coverage mandate. This results in a net increase in the number of people with employer coverage of about 84,500 people.

Out of an estimated 158,900 people now getting coverage in the non-group market, we estimate that 102,000 would continue with this coverage. About 51,300 people with non-group coverage would become covered under employer health plans in cases where the employer decides to offer coverage for their workers in response to the individual mandate (i.e., worker demand for group coverage would increase under an individual mandate). About 5,600 would move to

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[7] John F. Sheils and Randal Haught, "Bush and Kerry Health Care Proposals: Cost and Coverage Compared: Appendix C," The Lewin Group, September 2004.

Medicaid or CHP+ as eligibility is expanded. Solutions for a Healthy Colorado would have no impact on coverage for military dependents and retirees covered through TRICARE. Likewise, there is little change in coverage under the Medicare program.

We estimate that under current law, the number of uninsured in the state will increase to about 791,800 people by 2007/2008. Under the proposal, all but about 138,400 would take coverage. About 108,800 of uninsured people would be covered under ESI and almost 446,300 would get coverage in the private non-group market as a result of the mandate and premium subsidies. Another 103,400 of the uninsured would become covered through Medicaid or CHP+.

Figure 6
Transitions in Coverage under Solutions for a Healthy Colorado in 2007/2008 (thousands)

		Coverage under Solutions for a Healthy Colorado proposal					
Current Law Primary Source of Coverage	**Total**	**Private/ Employer**	**Private/ Non-Group**	**TRICARE**	**Medicare (excl. dual eligible)**	**Medicaid/ CHP+**	**Uninsured**
Employer	2,691.7	2,616.1	65.3	0.0	0.0	5.3	5.0
Non-Group	158.9	51.3	102.0	0.0	0.0	5.6	0.0
TRICARE	112.4	0.0	0.0	112.4	0.0	0.0	0.0
Medicare (excl. dual eligible)	413.0	0.0	0.0	0.0	413.0	0.0	0.0
Medicaid / CHP+	452.1	0.0	0.0	0.0	0.0	452.1	0.0
Uninsured	791.8	108.8	446.3	0.0	0.0	103.4	133.4
Total	**4,619.9**	**2,776.2**	**613.6**	**112.4**	**413.0**	**566.4**	**138.4**

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

Figure 7 shows the change in the number of uninsured people under the proposal by age and income. The proposal reduces the number of uninsured by 664,000 people, or 84 percent of the uninsured population. The proposal would cover about 61 percent of the uninsured earning less than $10,000. However, it would cover 93 percent of uninsured earning $150,000 or more annually, due to the penalty for being without health coverage. It would provide coverage to almost 90 percent of uninsured people 18 years old and younger.

Figure 7
Change in Uninsured under Solutions for a Healthy Colorado in 2007/2008 (thousands)

	Uninsured Under Current Law	Newly Covered Under Program	People who Become Uninsured	Net Reduction in Uninsured
	Family Income			
Under $10,000	90	55	0	55
$10,000-$19,999	109	89	0	89
$20,000-$29,999	127	109	1	110
$30,000-$39,999	118	98	0	98
$40,000-$49,999	79	64	1	65
$50,000-$74,999	123	112	2	113
$75,000-$99,999	66	60	1	61
$100,000-$149,999	48	45	1	46
$150,000 & over	30	28	0	28
Age				
Under 6	59	54	0	54
6-18	99	88	0	88
19-24	123	93	0	93
25-34	192	166	1	167
35-44	147	125	1	126
45-54	112	90	2	92
55-64	58	42	1	43
65 and over	1	1	0	1
Total	**792**	**658**	**5**	**664**

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 both payments for services and the cost of administering private insurance and public programs.

Health spending in Colorado would increase by about $271 million in 2007/2008 under the Solutions for a Health Colorado proposal (***Figure 8***). This is an increase in statewide health spending of about one percent. This includes increases in utilization for newly insured people that would be partially offset by reduced cost shifting.

a. Health Services Utilization

Provider payments would increase by about $781 million due to increased utilization of services under the proposal. This includes an increase in health services for newly insured people. It also reflects increases in utilization for those individuals previously covered in a plan that is less comprehensive than the core limited benefits package. As discussed above, we developed this

by assuming that uninsured people who become covered under the proposal would use health care services at the same rate as is reported by currently insured people with similar age, sex and health-status characteristics.

Figure 8
Changes in Statewide Health Spending under Solutions for a Healthy Colorado in 2007/2008 (millions)

Current Statewide Health Spending		**$30,100**
Change in Health Services Expenditures		**$781**
Change in utilization for newly insured	$722	
Change in utilization for currently insured	$59	
Reimbursement Effects		**($558)**
Payments for previously uncompensated care	$203	
Increase Medicaid Payment Rates to Medicare Levels	$247	
Reduce Private Payment Rates to 120%-150% Medicare	($1,008)	
Medical Malpractice Reform		**($33)**
Change in Administrative Cost of Programs and Insurance		**$81**
Change in Insurer Administration	$55	
Administration of Subsidies [b/]	$26	
Total Change in Statewide Health Spending		**$271**

a/ Assumes $171 per family for determining income eligibility for subsidies.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

This assumption encompasses two important effects. First, the increase in access to primary care for this population would result in savings due to a reduction in avoidable emergency room visits and hospitalizations. Second, there would be a general increase in the use of services such as preventive care, advanced diagnostic tests, and other care that the uninsured often forego or delay. Using this methodology, we estimate that the expansions in coverage result in a net increase in health services utilization (i.e., $781 million).

b. Provider Reimbursement

The increase in revenues due to new utilization would be largely offset by a reduction in provider payment rates of about $558 million. As the number of uninsured is reduced, provider reimbursement would increase by about $203 million as providers are reimbursed for services that would have been provided free as uncompensated care. Also, increasing provider payment rates for the Medicaid and CHP+ programs to Medicare payment levels would increase provider reimbursement by an additional $247 million. These increases in reimbursement would be more than offset by a reduction reimbursement of about $1.0 billion as a consequence of lowering private sector payment levels to 130 percent of Medicare payment rates.

We also estimate savings from Medical malpractice reform of $33 million state-wide.

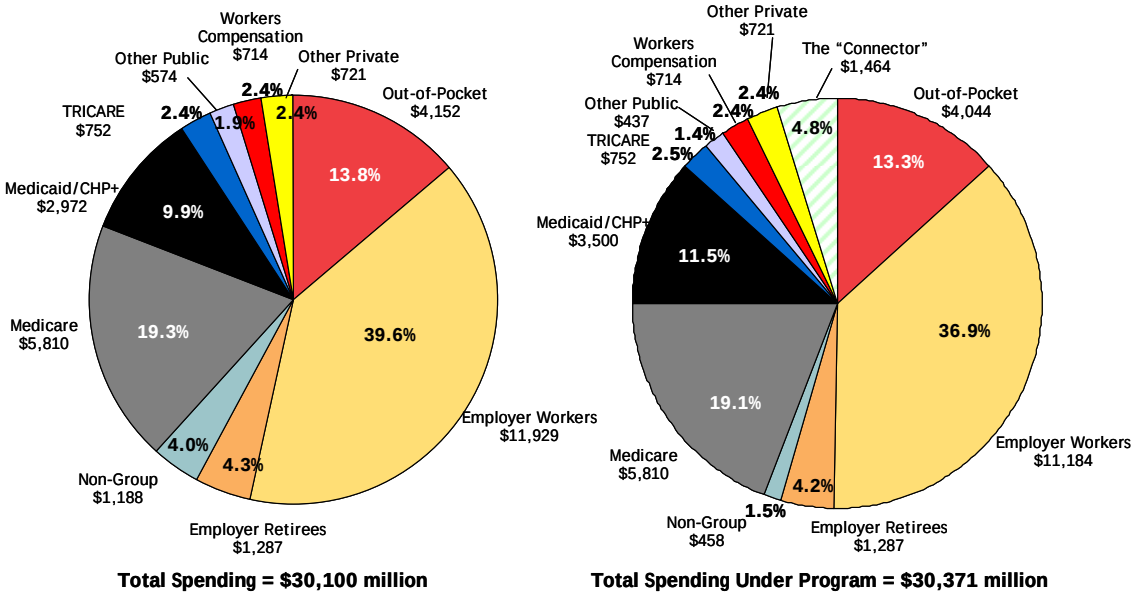
c. Administration

The cost of insurer and program administration of health insurance would increase by $55 million as the number of insured people increases. In addition, the cost of determining eligibility for low-income subsidies would be about $26 million.

3. Changes in Spending by Payer Group

Medicaid and CHP+ spending for 2007/2008 would increase from about $3.0 billion under current law to about $3.5 billion under the "Solutions for a Healthy Colorado" program (***Figure 9***). Total spending for private insurance in the newly formed Connector would be about $1.5 billion in 2007/2008. However, total spending in the non-group market would fall from about $1.2 billion under current law to about $458 million under the proposal as income-eligible people shift to subsidized coverage in the Connector. There also would be a small reduction in spending under ESI due to shifts in the number and characteristics of people with such coverage under the proposal.[8]

Figure 9
Estimated Spending by Source of Payment in Colorado under Current Law and under Solutions for a Healthy Colorado



Source: The Lewin Group estimates.

[8] Firms with higher cost people are more likely to drop coverage to take the community rated (i.e., modified by age) subsidized coverage.

4. Cost of Public Program Operations

Total program costs including the Medicaid expansions would about $1.4 billion ***Figure 10***. The expansions in Medicaid and CHP+ eligibility would cover about 114,300 Coloradans at a cost of $527.8 million. Federal matching funds would be available for this coverage. The state would pay $248.0 million and the federal government would pay $279.8 million.

We estimate that the total costs of the premium subsidy program, including administration of the subsidy would be $838 million. The state would pay the full cost of the premium subsidy program. As discussed above, the Solutions for a Health Colorado program provides premium subsidies for lower-income people to purchase private coverage with the Core Limited Benefit package for people up to 250 percent of poverty on a sliding scale with income.

Figure 10
Enrollment and Costs under Solutions for a Healthy Colorado in 2007/2008

	Number Enrolled (thousands)	Total Costs (millions)	State Costs (millions)	Federal Costs (millions)
Medicaid Program				
Increased Medicaid Payment Rates	n/a	$247.0	$123.5	$123.5
Children Expansion to 250% FPL	30.0	$58.9	$20.6	$38.3
Parents Expansion to 100% FPL	24.4	$88.4	$44.2	$44.2
Enrollment due to mandate				
Medicaid Children	23.9	$47.0	$16.5	$30.6
CHP+ Children	26.4	$51.9	$26.0	$26.0
Medicaid Adults	9.5	$34.6	$17.3	$17.3
Total Medicaid	**114.3**	**$527.8**	**$248.0**	**$279.8**
Premium Subsidy Program				
Non-Group Premium Subsidies	348.1	$479.9	$479.9	$0.0
Employee Premium Subsidies	566.0	$331.6	$331.6	$0.0
Premium Subsidy Administration	n/a	$26.0	$26.0	$0.0
Total Premium Subsidies	914.1	$837.5	$837.5	$0.0
Total Program				
Total	**1,028.4**	**$1,365.3**	**$1,085.5**	**$279.8**

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

5. Impact on State and Local Governments

We estimate that new program costs under Solutions for a Healthy Colorado would be $1.1 billion assuming the proposal is fully phased in 2007/2008 (***Figure 11***). These include $248 million for the state's share of the cost of the Medicaid/CHP+ expansion, and $838 million for the Core Limited Benefit subsidy for people living below 250 percent of the FPL.

Program costs would be partly offset by savings in current safety-net programs and new tax revenues. There would be savings of $137 million for safety-net programs that now provide free care to the uninsured. The state would also receive about $55 million in tax penalty revenues for

those who do not obtain coverage as required under the mandate ($500 per person with a maximum of $1,500 per household). In addition, the state and local governments save about $127 million in employee health benefits costs due to reductions in provider payment rates for the privately insured, which we assume are passed on to workers over-time as increased wages.

As discussed below there would be savings to employers with private health insurance due to the reduction in provider payment levels for private payers 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 a $41 million increase in state tax revenues. Tax revenues from the nutrition, tobacco and alcohol taxes under the program would be $853 million. Thus, new state costs under this proposal are fully funded with various tax revenues and savings to existing state safety-net programs. However, the state would need to raise additional revenues of about $54 million if the 1115 Waiver to retain federal DSH funds is not approved.

Figure 11
Change in State and Local Government Spending under Solutions for a Healthy Colorado in 2007/2008 (millions)

	Change in Spending Assuming 1115 Waiver is Approved		Change in Spending Assuming 1115 Waiver is not Approved	
New Program Costs		**$1,086**		**$1,086**
Medicaid Expansion and Individual Mandate	$248		$248	
Premium Subsidies	$838		$838	
Total Program Offsets		**$1,086**		**$1,032**
Savings to Current Safety-net Programs [a/]		**$137**		**$83**
Tax Penalty for remaining uninsured		**$55**		**$55**
State & Local Government Employee Health Benefits		**--**		**--**
Workers and Dependents	$127		$127	
Wage Effects [b/]	($127)		($127)	
New Dedicated financing		**$853**		**$853**
Nutrition Sales Tax	$522		$522	
Tax Collection Administration (1 percent)	($5)		($5)	
Tobacco Tax Increase	$210		$210	
Alcohol Tax Increase	$126		$126	
Tax Revenue Due to Wage Effects [c/]		**$41**		**$41**
Net Cost/(Savings) to State and Local Government		**$0**		**$54**

a/ Includes care currently paid for by other safety-net programs. These estimates include some federal funding for Medicaid DSH and community health centers. These include funds provided by the federal Public Health Services Grants to fund underserved areas in Colorado. Assumes waiver is approved to allow state to continue to receive Federal DSH funding to be used for the program.
b/ Assumes reduced employer costs are passed on to workers in the form of higher wage increases.
c/ Reduction in tax revenue is counted as an increase in State and Local Government health spending.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

6. Change in Federal Government Health Spending

New costs to the federal government under the proposal would be $334 million (***Figure 12***). This includes the federal share of the cost of the expansions in Medicaid and CHP+, and increases in provider reimbursement under the proposal. This assumes the proposal is fully phased-in with expansions in coverage for parents to 100 percent of the FPL under Medicaid and children to 250 percent of the FPL in 2007/2008. We also assume a waiver is approved for the state to retain existing federal disproportionate share hospital (DSH) revenues to help fund the coverage expansions.

These program costs to the federal government are partly offset by savings in federal employee health benefits as some employees become eligible for the expanded public programs. We assume these savings are passed on to the workers over time as increased wages. Saving to other employer health plans due to the reductions in private payer reimbursement levels under the proposal also would be passed on to workers as increased wages resulting in an increase in federal income and payroll tax revenues of $306 million. The net effect would be a net savings to the federal government of $26 million. Federal savings would increase to $80 million if the federal government does not grant the 1115 waiver to continue DSH funding for the state.

Figure 12
Change in Federal Government Spending under Solutions for a Healthy Colorado in 2007/2008 (millions)

	Change in Spending Assuming 115 Waiver is Approved		Change in Spending Assuming 115 Waiver is not Approved	
Federal Program Costs		**$334**		**$226**
Medicaid Expansion for Parents	$61		$61	
CHP+ Expansions for Children	$95		$95	
Payment rate increase	$185		$185	
Elimination of DSH Payments	$54		(54)	
Federal Employee Health Benefits		**$0**		**$0**
Workers and Dependents	$52			
Wage Effects [a/]	($52)			
Tax Revenue Due to Wage Effects [b/]		**($306)**		**($306)**
Total Federal Program Revenues and Offsets		**$306**		**$306**
Net Cost/(Savings) to Federal Government		**($26)**		**($80)**

a/ Assumes savings are passed on to workers in the form of higher wage increases.
b/ Reduction in tax revenue is counted as an increase in Federal Government health spending.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

7. Impact on Private Employers

Private employers who currently offer coverage would save about $701 million in health benefits under the proposal. As discussed above, some employers would respond to the increases in Medicaid/CHP+ eligibility and premium subsidies by discontinuing their

coverage, resulting in savings of about $67 million to private employers. The reduction in private payer reimbursement levels under the proposal would save employers an additional $710 million (***Figure 13***). These savings would be partly offset by new spending of about $76 million as workers who currently decline the coverage offered by the employer take that coverage in response to the mandate.

These estimates include private employer spending for all covered workers, dependents and retirees living in Colorado, even if the employer is based outside the state. It excludes federal workers and state and local government employees, which reflected in the cost impacts estimates for these governments presented above. These estimates also include only the employer share of costs of coverage. The impact on worker health spending is presented in the following section.

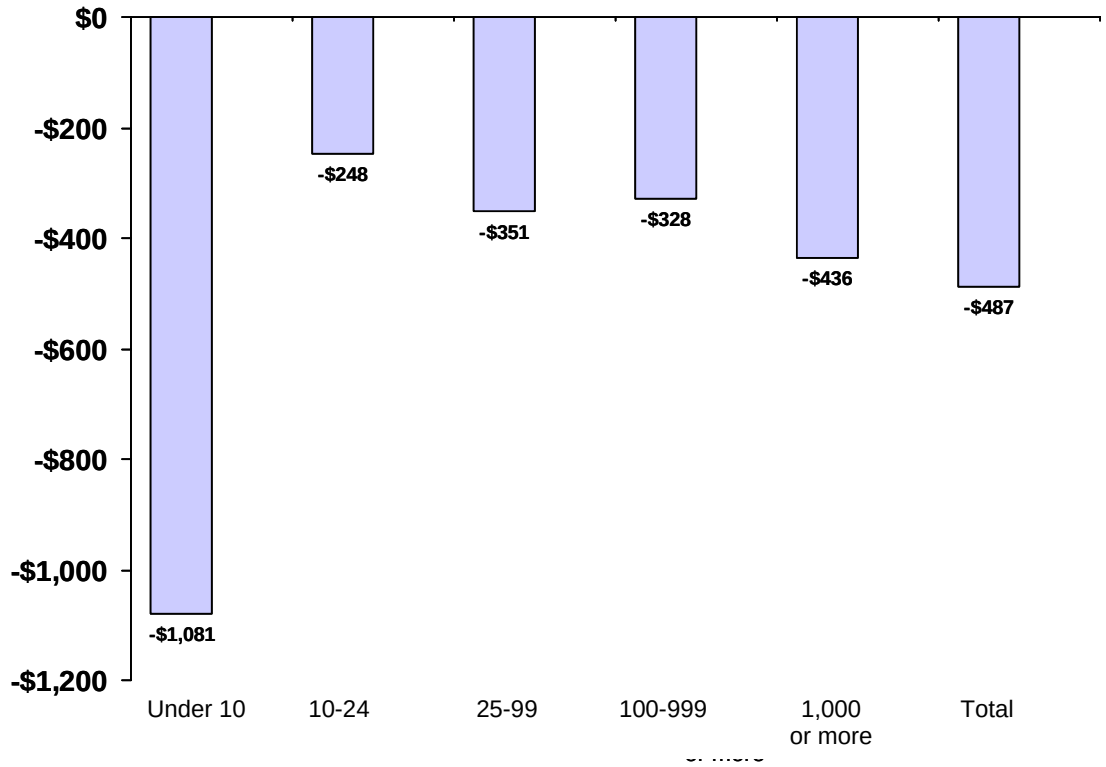
Figure 13
Change in Private Employer Health Benefits Costs under Solutions for a Healthy Colorado in 2007/2008 (millions)

	Currently Insuring Employers	Currently Non-Insuring Employers [a/]	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 Previously Decline Coverage	$76	--	$76
Employers Dropping Coverage	($67)	--	($67)
Change in Payment Rates	($710)	--	($710)
Net Change (before wage effects)	**($701)**	**--**	**($701)**

a/ We estimate that 89,000 workers and dependents will be covered by firms not currently offering coverage that will decide offer coverage due to the individual mandate. However, we assume these employers will not contribute to the cost of the premium.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Private employer spending for firms that now provide coverage would decrease by an average of about $487 per worker (***Figure 14***). Currently insuring firms with 10 or fewer workers would save about $1,081 per worker on average. Those firms with one thousand or more workers would save about $436 on average per worker.

Figure 14
Change in Private Employer Health Spending Per Worker for Currently Insuring Firms under Solutions for a Healthy Colorado in 2007/2008



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

8. Household Impacts

Under the proposal, family premium payments would increase by about $638 million due to the mandate to have coverage. However, families would receive premium subsidies of $823 million under the proposal. Thus, there would be a net reduction in family health spending on premiums of $185 million (***Figure 15***).

Out-of-pocket spending, including co-payments and deductibles for families would increase by $108 million. This reflects shifts in coverage from existing employer plans to the core limited benefits package, which included caps on annual benefits costs. Also, we assume that savings to employers in health spending are passed back to workers as increased wage growth, which we estimate to be about $481 million. We count this increase in wages as a reduction in family health spending.

The program would be partly funded by a nutrition sales tax, a tobacco tax and a tax on alcohol. This would increase family health spending by $858 million. The penalty for families who do not comply with the individual mandate would cost families $55. Overall, families would spend about $355 more on health care under Solutions for a Healthy Colorado, reflecting that all individuals are required to obtain coverage under this proposal. We estimate that families

would see an increase in spending averaging about $177 per family in 2007/2008 under Solutions for a Healthy Colorado.

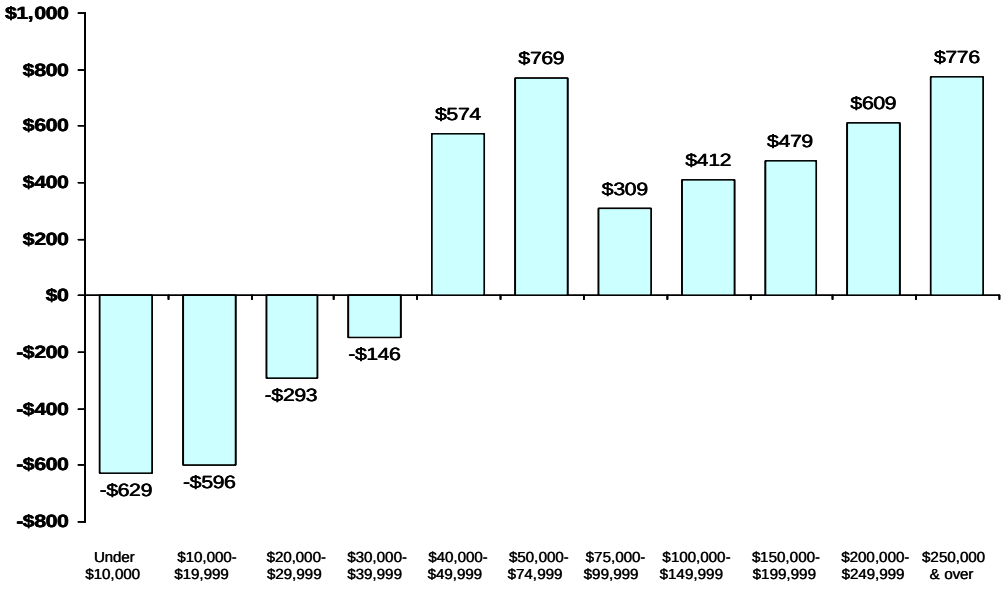
Figure 15
Impact of Solutions for a Healthy Colorado on Family Health Spending in 2007/2008 (millions)

		Change in Spending
Change in Premiums		($185)
Change in Family Premiums	$638	
Premium Subsidies	($823)	
Change in Out-of-Pocket Payments		$108
Tax Penalty for Remaining Uninsured		$55
New Taxes		$858
Nutrition Sales Tax	$522	
Tobacco Tax Increase	$210	
Alcohol Tax Increase	$126	
After Tax Wage Increase Counted as Offset to Family Spending [a/]		($481)
Net Change in Spending Less Wage Increases		**$355**

a/ The Increase in after-tax wage income resulting from reduced costs to employers is $481 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).

Figure 16 shows changes in family health spending by income group. Because premium subsidies are provided on a sliding scale with income, families with incomes below $10,000 would save an average of about $629 per family. Families with incomes between $30,000 and $39,999 would receive lower subsidies and thus, would save a smaller amount averaging $146 per family. People with incomes of $40,000 or more would on average see increases in family health spending reflecting the new taxes under the program and the requirement that people obtain health insurance, even if they do not qualify for subsidies (i.e., incomes above 250 percent of the FPL.

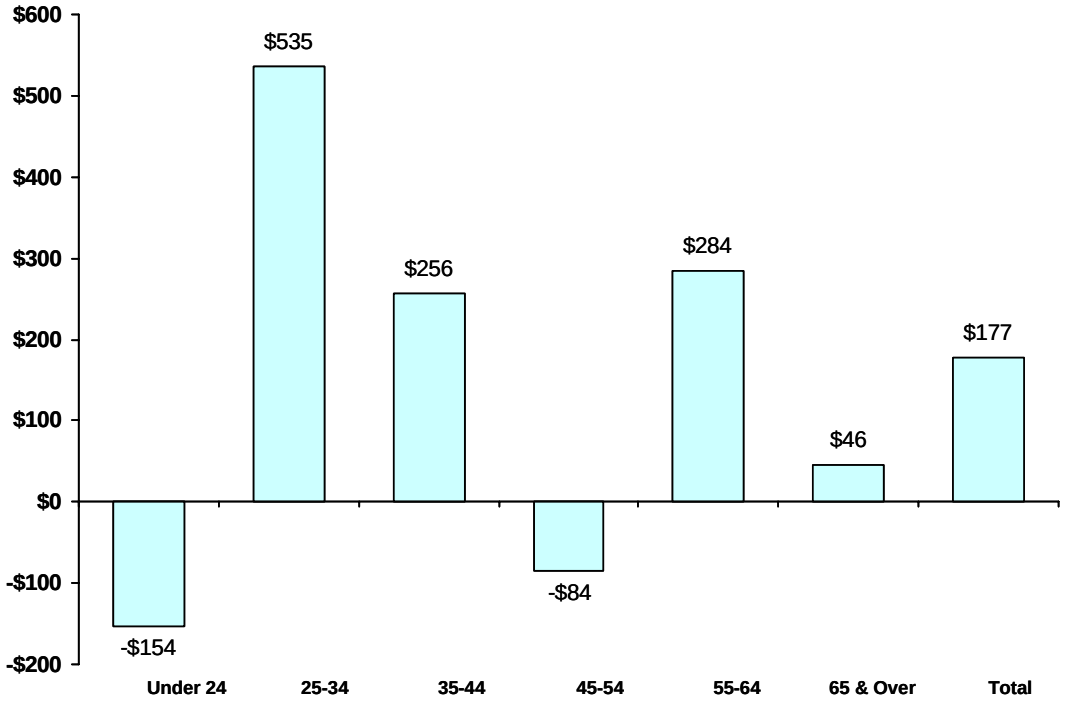
Figure 16
Change in Average Family Health Spending by Income Group under Solutions for a Healthy Colorado in 2007/2008



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

We estimate that families headed by someone under the age of 25 would save about $154 per family, while families headed by people age 45 to 54 would save an average of about $84 per family (***Figure 17***). However, people in all other age ranges would spend more on average in health care. Families between the ages of 55 to 64 would spend about $284 more per family because these families often pay relatively higher premiums due to their age, and often have higher out-of-pocket expenses. Families between the ages of 25 and 34 would see and increase in health spending of about $535 per family.

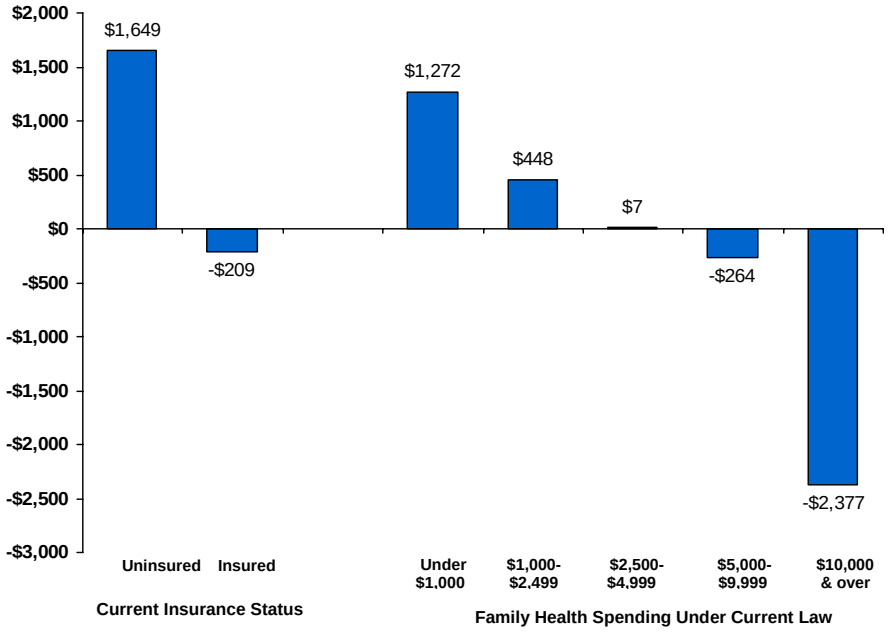
Figure 17
Change in Average Family Health Spending by Family Head under Solutions for a Healthy Colorado in 2007/2008



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

As illustrated in ***Figure 18,*** currently uninsured families would spend $1,649 more on average as all residents are now required to have coverage. This reflects that not all of the uninsured would receive a subsidy and many of the uninsured are younger and use little health care under current law. Some people who currently have coverage would now benefit from a subsidy making coverage less costly to them. Those who currently have coverage would save an average of about $209, due to the subsidies. Families who are currently spending more on health care would save the most. Those spending $10,000 or more would save $2,377 on average, compared to those spending between $5,000 and $10,000 who would save $264 on average.

Figure 18
Change in Average Family Health Spending by Current Law Insurance Status and Family Health Spending Under Solutions for a Healthy Colorado in 2007/2008



Source: The Lewin Group estimates using the Health Benefits Simulation 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 resulting under the proposal. About one-half of all Colorado families would see a net increase in health spending of $20 or more. About 47 percent of families would see a net reduction in spending of $20 or more. Only about 3.0 percent of the population would be unaffected (i.e., changes of less than $20).

Figure 19
Distribution of Families by the Amount of the Change in Total Family Health Spending Under Solutions for a Healthy Colorado

		PERCENT DISTRIBUTION OF FAMILIES										
	ALL FAMILIES	INCREASE IN FAMILY HEALTH COSTS					NO CHANGE	REDUCTION IN FAMILY HEALTH COSTS				
	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	3.0	8.7	6.8	13.2	20.5	14.7	0.4	1.6	2.9	4.3	24.0
$10K-$19,999	225278.6	6.4	15.4	8.3	7.9	27.1	0.1	1.0	4.2	5.6	4.3	19.7
$20K-$29,999	229048.7	15.9	8.3	8.0	14.7	8.8	0.1	3.5	5.8	5.8	8.0	21.0
$30K-$39,999	237519.9	19.0	7.3	8.0	11.0	2.5	1.0	3.1	9.4	8.9	9.8	20.0
$40K-$49,999	200288.9	16.2	4.8	5.4	10.0	2.4	1.4	4.8	12.7	11.6	11.9	18.7
$50K-$74,999	316232.1	18.1	6.8	6.0	5.1	4.0	2.4	6.3	10.2	16.1	11.5	13.5
$75K-$99,999	238563.4	14.8	4.3	8.5	8.1	6.3	4.4	4.4	10.9	14.6	13.9	9.8
$100K-$149,9	190449.2	14.7	10.3	6.7	8.2	6.1	4.3	7.2	13.0	13.9	9.6	6.1
$150,000 +	177815.6	20.8	17.4	14.8	12.3	4.7	1.1	4.0	5.5	6.7	5.6	7.1
Income as a Percent of the FPL												
Below Poverty	225931.2	4.8	9.9	8.0	12.8	19.4	11.5	0.4	1.4	3.6	4.4	23.7
100%-199%	333666.2	11.6	11.8	8.0	7.9	16.9	0.1	1.0	3.7	4.8	6.0	28.2
200%-299%	319529.9	17.7	6.7	6.0	12.3	6.7	0.6	2.5	6.0	8.9	12.6	19.9
300%-399%	284848.4	20.7	6.2	6.1	8.6	2.4	1.9	5.3	10.6	15.0	12.0	11.1
400%-499%	221889.0	15.9	5.6	7.2	7.8	2.2	1.6	7.7	17.5	14.2	9.4	10.9
500% +	605939.7	15.0	10.7	9.9	9.5	6.9	3.7	5.7	10.2	12.0	9.1	7.1
Age of Family Head												
Under Age 25	211676.5	12.2	6.8	8.2	7.9	7.5	5.6	2.3	8.1	8.2	8.2	25.1
25 - 34	417966.1	17.5	11.5	7.7	8.4	7.2	2.8	3.7	8.4	8.2	8.5	16.2
35 - 44	425342.2	20.5	9.5	6.8	6.9	5.8	2.0	4.6	8.3	9.8	9.5	16.2
45 - 54	413248.7	16.2	10.0	6.7	6.5	5.1	3.0	4.1	9.5	10.2	10.4	18.1
55 - 64	257395.7	10.4	6.2	6.2	9.1	6.9	3.8	6.1	6.5	16.1	13.6	15.0
65 and Older	266175.3	4.1	7.0	13.3	23.4	24.9	2.0	2.3	8.4	8.5	3.5	2.6
Out-of-Pocket Spending under Current Law												
Over $1,000	455032.7	25.3	17.1	10.0	11.8	11.7	6.1	3.4	6.5	3.8	3.0	1.2
$1,000-$2,499	431783.1	16.0	7.5	9.0	7.8	13.3	3.0	5.1	8.8	11.5	7.4	10.5
$2,500-$4,999	529014.4	11.8	6.1	6.8	10.3	7.4	2.1	4.6	10.8	12.8	10.1	17.2
$5,000-$9,999	422722.5	8.6	5.9	6.2	9.4	4.2	1.3	3.4	8.2	13.3	15.4	24.1
> $10,000	153251.8	5.5	7.0	7.1	8.2	5.0	1.2	1.7	4.3	5.6	10.7	43.5
Family Members without Health Insurance												
1+ Uninsured	385868.6	44.3	17.7	7.9	5.3	2.9	1.6	0.9	1.8	3.0	2.9	11.6
No Uninsured	1605935.9	7.5	6.8	7.9	10.8	10.2	3.3	4.7	9.9	11.7	10.6	16.5
All Families												
Total	1991804.4	14.6	9.0	7.9	9.7	8.8	3.0	4.0	8.3	10.0	9.1	15.6

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

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.

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, even with the mandate to have coverage. Thus, not all of the 664,000 uninsured people we expect to become covered under this proposal would enroll immediately.

Based upon analyses of enrollment under prior program expansions, we typically assume that the program reaches only 40 percent of the ultimate enrollment level in the first year, 80 percent in the second year and 100 percent every year thereafter. However, we assume that enrollment would occur more rapidly under the program due to the mandate to have insurance. We assume that enrollment would reach 75 percent of its ultimate enrollment level in the first year of the program, 90 percent in the second year and 100 percent there-after.

Total net new spending under the program would be $19.6 billion over the 2008/2009 to 2017/2018 period (***Figure 20***). About $4.0 billion of this would be covered with federal matching funds, with the state paying $15.6 billion. These are the estimates that should be used for budgeting purposes because they reflect likely enrollment behavior in the early years of the program.

Figure 20
New State Program Costs for Solutions for a Healthy Colorado in 2008/2009 through 2017/2018 a/ (million)

	Total Spending (millions)	State Spending	Federal Spending
2008/2009	$1,095.7	$871.0	$224.6
2009/2010	$1,410.8	$1,121.6	$289.2
2010/2011	$1,675.7	$1,332.2	$343.5
2011/2012	$1,789.6	$1,422.7	$366.9
2012/2013	$1,914.9	$1,522.3	$392.6
2013/2014	$2,048.9	$1,628.9	$420.0
2014/2015	$2,190.3	$1,741.3	$449.0
2015/2016	$2,339.3	$1,859.7	$479.5
2016/2017	$2,498.3	$1,986.2	$512.2
2017/2018	$2,668.2	$2,121.2	$547.0
Total 2008/2017	**$19,631.6**	**$15,607.1**	**$4,024.5**

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)