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

Appendix E: "A Plan for Covering Coloradans" Proposal

Prepared for:

The Colorado Blue Ribbon Commission for Health Care Reform

By:
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"A PLAN FOR COVERING COLORADANS" PROPOSAL

Under A Plan for Covering Coloradans, all Colorado residents would be required to have health insurance. The program assists lower-income families in obtaining coverage through a public program expansion and subsidies for private insurance. It also creates a new private insurance pool for all residents except those covered under public assistance or self-insured employer-sponsored insurance (ESI) health plan. The program provides a minimum benefits package in the private pool and premium assistance based on income.

All plans would provide a comprehensive minimum benefits package, and differ mainly on cost-sharing amounts. Benefits packages would be easily comparable so that consumers can make informed choices. The private pool would be administered by a quasi-governmental entity, but subsidies would be administered through the tax system. The program would be financed through an employer assessment and a variety of taxes. We present A Plan for Covering Coloradans in the following sections:

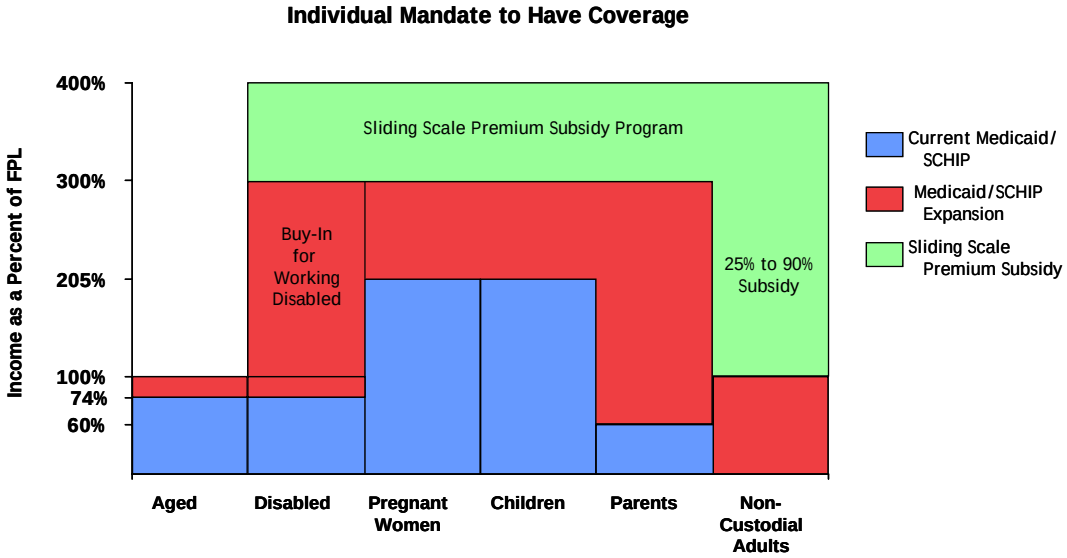
- Key Provisions of A Plan for Covering Coloradans;
- Assumptions;
- Cost and Coverage Impacts; and
- Ten-Year Program Cost Projections.

A. Key Provisions of A Plan for Covering Coloradans

1. Coverage

This program increases eligibility under Medicaid and CHP+ for pregnant women, children and parents with custodial responsibilities for children to 300 percent of the FPL (***Figure 1***). In addition, eligibility for the aged and disabled is increased to 100 percent of the FPL. These Medicaid and CHP+ eligibility expansions are eligible for federal matching funds. The state would apply to the CMS for a waiver to receive federal matching funds to cover non-custodial adults living below 100 percent of the FPL under Medicaid.

Figure 1
Eligibility for Subsidized Coverage under A Plan for Covering Coloradans



Source: The Lewin Group.

In addition, the program would provide vouchers for the purchase of private insurance for adults living below 400 percent of the FPL. All Colorado residents are required to have health insurance.

2. Public Program Expansion

The combined Medicaid and CHP+ coverage expansions would be as follows:

Figure 2
Proposed Expansions for Public Programs

#	Age or Population Group	Current Eligibility (FPL)	Expansion Proposed (FPL)
1	Children ages 0-5 years	133% (Medicaid) 200% (CHP Plus)	300%
2	Children ages 6-19 years	100% (Medicaid) 200% (CHP Plus)	300%
3	Pregnant Women and New Mothers	133% (Medicaid) 200% (CHP Plus)	300%
4	Parents of eligible children	60%	300%
5	Non-disabled adults without children	--	100%
6	Disabled working adults	--	300% (buy-in)
7	65+	74%	100%
8	Medically needy	--	50%
9	COBRA Premium Assistance	--	100%
10	Severely disabled Children	--	HCBS waiver eligibility

Source: A Plan for Covering Coloradans

The proposal would:

- Remove the income eligibility "steps" for families (groups 1-4) by increasing eligibility for children and their parents to 300 percent of the FPL, phased in over two years;
- Offer Medicaid coverage to cover non-custodial adults (i.e., non-aged non-disabled without custodial responsibilities for children; group 5) up to 100 percent of the FPL using state-only dollars (unless a waiver is approved by CMS to cover these individuals under the federal program);
- Expand eligibility for the elderly and disabled by
  - — Raising the eligibility limit for Coloradans who receive Supplemental Security Income (group 7) to 100 percent of the FPL; and
  - — Establishing a Medicaid sliding fee "buy-in" for working people with disabilities (group 6) up to 300 percent of the FPL through the federal Ticket to Work and Work Incentives Improvement Act of 1999;
- Add a medically needy program under Medicaid for children, parents, disabled and elderly people. Under this program, people whose incomes are above the Medicaid and CHP+ eligibility standards for these groups could obtain Medicaid coverage if high medical expenses drop their remaining income to less than 50 percent of the FPL;
- Seek federal matching funds to pay COBRA premiums for people between jobs with minimal assets (group 9) whose income is below 100 percent of the FPL (referred hereafter as the "COBRA premium assistance group"). Due to data limitations, we did not model this provision; and
- Expand coverage to all severely disabled children who qualify under Colorado's Children's Home and Community Based Services waivers, as well as the Children with Extensive Support waiver (group 10). Due to data limitations, we did not model this provision.

Individuals and families who appear to be eligible in government programs would be enrolled presumptively, subject to subsequent verification. For the Medicaid and the CHP+ programs, residency is defined according to federal standards.

3. Benefits for the Combined Medicaid and CHP+ Program

All people in the combined Medicaid CHP+ expansion would be covered by the standard Medicaid benefits with one exception. Children and parents in families with incomes between 200 percent and 300 percent of the FPL would receive the CHP+ like benefit package. However, these families would also pay a premium and co-payments, similar to the premium assistance program in the private pool. Providers would be paid at Medicare payment levels for both currently eligible people and people who become eligible under the expansion. We summarize the Medicaid and CHP+ like benefits packages in ***Figure 3***.

Figure 3
Comparison of Colorado Public and Private Health Insurance Options-Coverage, Limits and Out-of Pocket Costs

	Medicaid[a/]	Child Health Plus (CHP+)-Like Plan[b/] (Families with incomes between 200% and 300% of FPL)
Premium/Deductible	None	Premiums- Based on sliding scale same as Premium Assistance Program (*Figure 5*) No deductible
Max Annual Out-of-Pocket	None	5% of yearly income
Coinsurance/Co-pays	Limited co-pay for some services if enrolled in Primary Care Physician Program (PCPP) or fee-for-service. No co-pays if enrolled in HMO, enrolled in the Community Mental Health Services Program, 18 years or younger, pregnant or in a nursing home, for family planning clients of child-bearing age or for emergency services.	Co-pays: Based on sliding scale same as Premium Assistance Program (*Figure 5*)
Lifetime Benefits Max Paid by Plan	No limit	No limit
Services		
Emergency Services	Covered in full-no co-pay	$15 co-pay
Emergency Transport-Ambulance Services	Covered in full-no co-pay	Covered in full
Inpatient Hospital Stay	$10 per day up to 50% of the Medicaid rate for the first day of care in the hospital.	Covered in full
Outpatient Ambulatory Surgery	$3/visit	Covered in full
Lab, x-ray and Diagnostic Services	$1 per day of service	Covered in full
Medical Office Visit	$2/visit	0-250%: $5 co-pays 251-300% FPL: $10 co-pay
Preventive Services	$2/visit, not distinguished from office visit.	Covered in full
Maternity Care	Covered in full-no co-pay	Covered in full
Neurobiologically Based Mental Illness	No copay under the CMH Services Program. $0.50 per unit of service for psychiatric services. Brief, individual, group and partial care $2/visit.	0-250%: $5 co-pays 251-300% FPL: $10 co-pay

	Medicaid[a/]	Child Health Plus (CHP+)-Like Plan[b/] (Families with incomes between 200% and 300% of FPL)
Other Mental Health Services	No copay under the CMH Services Program. $0.50 per unit of service for psychiatric services. Brief, individual, group and partial care $2/visit.	0-250%: $5 co-pays 251-300% FPL: $10 co-pay Limits: 45 inpatient days or 90 outpatient treatment days per benefit period. 20 outpatient visits.
Alcohol and Substance Abuse Treatment	Covered in full-no co-pay	0-250%: $5 co-pays. 251-300% FPL: $10 co-pay. 20 outpatient visits per diagnosis. No inpatient coverage.
Physical, Occupational and Speech Therapy	Covered in full-no co-pay	30 outpatient visits per diagnosis.
Durable Medical Equipment	$1 per day of service.	Max $2,000, excluding glasses contacts or hearing aids.
Prescription Drugs	$1 generic, $3 brand-name	Generic: No co-pay Name brand: $5 co-pay
Vision Services	$2/visit	Coverage of age appropriate preventive and specialty care. $50 benefit for lenses, frames or contacts. Per visit co-pay: 0-250%: $5 co-pay 251-300% FPL: $10 co-pay
Audiological Services	Covered in full-no co-pay	Coverage for age appropriate preventive care, hearing aids max $800
Transplant Services	Covered in full-no co-pay	Coverage for limited transplants with prior authorization
Dental Care	Excluded unless surgical	$5 co-pays per procedure for fillings and extractions Covers periodic cleanings, exams, x-rays, filings, root canals. Annual max $500.
Podiatry Services	$2/visit	Excluded
Skilled Nursing Facility	Long term care-may have to pay portion of income	Covered in full
Hospice Care	Long term care-may have to pay portion of income	Excluded
Home Health Care	Long term care-may have to pay portion of income	Covered in full
Spinal Manipulation	Excluded	Excluded

a/ Information from Colorado HCPF Staff.
b/ Colorado HCPF staff. Co-pays have been modified based on sliding scale.
Source: Lewin analysis of A Plan for Covering Coloradans, Committee for Colorado Health Care Solutions, Appendix H and Medicaid and CHP+ benefit package

4. Individual Mandate/Personal Responsibility and Enforcement

Individuals and families not enrolled in public insurance would be expected to purchase private health insurance. Individuals, families and employers (including the self-employed) would be able to buy coverage through a private sector purchasing pool which combines the current individual, small group and large group markets. This includes the following population who would not be eligible for the expanded Medicaid CHP+ program:

- Children and parents above 300 percent of the FPL;
- Pregnant women above 300 percent of the FPL;
- Disabled working adults above 300 percent of the FPL;
- Non-disabled childless adults above 100 percent of the FPL;
- COBRA premium assistance group above 100 percent of the FPL;
- Medically needy group above 50 percent of the FPL;
- Any individual with Employer Sponsored Insurance.

However, premium assistance would be available to people with incomes up to 400 percent of the FPL on a sliding scale as discussed below.

Proof of insurance would be required at the time of tax filing. If there is no proof of coverage, the following assessment would apply:

- For individuals who would participate in the private insurance pool, the assessment would be equivalent to the annual premium in the least expensive plan, or if they appeared to be eligible for premium assistance, the individual or household's portion of the annual premium in the least expensive plan eligible for premium assistance; and
- For those who would be eligible for the public programs, they would be determined presumptively eligible based on participation in other public programs (e.g., food stamps, school-lunch programs) and automatically enrolled in Medicaid or CHP+ as applicable.

5. Private insurance pool

Individuals not eligible for the expanded Medicaid/CHP+ program would be able to purchase from a variety of standard plans in the purchasing pool. There would be two plans available under a premium assistance program and at least two plans not available for premium assistance.[1]

For modeling purposes, plan benefits for people who would not be receiving premium assistance would be based on the services provided to federal workers in Colorado under the Federal Employee Health Benefits Program (FEHBP) but would vary based on cost-sharing

[1] Lewin would determine how to allocate people among plans based on the Health Benefits Simulations Model (HBSM) data and assumptions.

arrangements and deductibles. For illustrative purposes, we assume the following Plan choices (***Figure 4***):

- **Plan A:** One plan based on the FEHBP Blue Cross/Blue Shield standard benefit option with standard PPO cost-sharing arrangements; and
- **Plan B:** A less expensive Plan B high deductible, higher-cost-sharing health plan. For illustrative modeling purposes, we assume that this least expensive plan would be the plan into which people who are not eligible for premium assistance would be auto-enrolled at the time of tax filing.

People not seeking premium assistance could also choose either of the plans offered in the premium assistance program, but would have to pay the full cost, less their employer contribution.

Figure 4
Non-Premium Assistance Benefits, Cost Sharing and Limitations

Benefits	Member Out-of-Pocket by Plan	
	Plan A **FEHBP BCBS Standard Option** [a/]	**Plan B** **Aetna HealthFund HDHP** [b/]
In-network medical and dental preventive care	Varies	Nothing at a network provider
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: 10%* of our allowance; $15 per office visit Non-PPO: 25%* of our allowance	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Services provided by a hospital:		
• Inpatient	PPO: $100 per admission Non-PPO: $300 per admission	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
• Outpatient	PPO: 10%* of our allowance (no deductible for surgery) Non-PPO: 25%* of our allowance (no deductible for surgery)	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Skilled Nursing Facility	Patient pays nothing	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.

Benefits	Member Out-of-Pocket by Plan	
	Plan A FEHBP BCBS Standard Option [a/]	Plan B Aetna HealthFund HDHP [b/]
Hospice		In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
• Home hospice	Patient pays nothing	
• Inpatient hospice for members receiving home hospice care benefits	Preferred: $100 per admission co-payment.	
Emergency benefits:		In-network or out-of-network: 10% of our Plan allowance
• Accidental injury	PPO: Patient pays nothing for outpatient hospital and physician services within 72 hours; regular benefits thereafter Non-PPO: Any difference between our payment and the billed amount within 72 hours; regular benefits thereafter	
• Medical emergency	Regular benefits for physician and hospital care*; $50 per trip for ambulance transport services (no deductible)	
Mental health and substance abuse treatment		
	In-Network (PPO): Regular cost sharing, such as $15 office visit co-pay; $100 per inpatient admission	In-network: 10% of our Plan allowance
	Out-of-Network (Non-PPO): Benefits are limited	Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Prescription drugs		After your deductible has been satisfied, your co-payment will apply.
• Retail Pharmacy Program:	PPO: 25% of our allowance; up to a 90-day supply	In-network: For up to a 30-day supply: $10 per generic formulary; $25 per brand name formulary; and $40 per non-formulary (generic or brand name)
	Non-PPO: 45% of our allowance (AWP); up to a 90-day supply	Out-of-network (retail pharmacy only): 30% plus the difference between our Plan allowance and the billed amount.

Benefits	Member Out-of-Pocket by Plan	
	Plan A FEHBP BCBS Standard Option [a/]	Plan B Aetna HealthFund HDHP [b/]
• Mail Service Prescription Drug Program:	$10 generic/$35 brand-name per prescription; up to a 90-day supply	(Available in-network only) For a 31-day up to a 90-day supply: Two co-pays
Dental care	Scheduled allowances for diagnostic and preventive services, fillings, and extractions; regular benefits for dental services required due to accidental injury and covered oral and maxillofacial surgery	No benefit other than in-network dental preventive care
Vision care	Covered as medical service.	In-network (only) preventive care benefits-no co-pay; $100 reimbursement for eyeglasses or contact lenses every 24 months
Hearing	Covered only as medical/surgical service	Covered if medical/surgical services. Also 1 hearing exam per 24 months
Special features	Flexible benefits option; online customer and claims service; 24-hour nurse line; services for deaf and hearing impaired; Web accessibility for the visually impaired; travel benefit/services overseas; health support programs; and Healthy Families Program	Aetna InteliHealth, Aetna Navigator, Contact Plan. Informed Health Line, and services for the deaf and hearing-impaired.
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Patient pays nothing after $4,000 (PPO) or $6,000 (Non-PPO) per contract per year; some costs do not count toward this protection against catastrophic costs (your 19-20 catastrophic protection out-of-pocket maximum)	In-network: Patient pays nothing after $4,000/Self Only or $8,000/Self and Family enrollment per year. Out-of-network: Nothing after $5,000/Self Only or $10,000/Self and Family enrollment per year. Some costs do not count toward this protection. Your deductible counts toward your out-of-pocket maximum.
Calendar Year Deductible	$250	$2,500 individual/$5000 family

a/ www.opm.gov.insure/07/brochures/pdf/71-005.pdf
b/ www.opm.gov.insure/07/brochures/pdf/73-828.pdf.
Source: The Lewin Group analysis of Federal Health Employee Benefits schedule in Colorado.

For the premium assistance program there would be two plans available with comprehensive benefits, one an HMO and the other a PPO.[2] The premium assistance plans would offer low deductibles, first dollar coverage for preventive services, minimal to no co-payment for chronic disease medications, and lower cost-sharing for the use of safety-net providers and other "high-value" providers (***Figure 5***). Co-payments would as specified in ***Figure 5***. There would be no co-payments for people with income below 100 percent of poverty and no co-payment for preventive care or chronic disease management.

Figure 5
Premium Assistance Plan Benefits, Limits and Out-of-Pocket Payments

Covered Benefits	Benefit Limits and Out-of-Pocket Payments
Physician/Routine Office Visit	0-250%: $5 co-pay 251-399%: $10 co-pay
Prevention	0-250%: Covered in full 251-399%: Covered in full
Maternity Care	0-250%: Covered in full 251-399%: 90% coinsurance
Urgent Care	0-250%: $5 co-pay 251-399%: $10 co-pay
Outpatient Hospital **Surgical** **All Other Outpatient**	All outpatient hospital 0-250%: Covered in full 251-399%: 90% coinsurance
Ambulance-Emergency	0-250%: covered in full 251-399%: $25-50 co-pay
Hospital-Emergency	0-250%: $15 co-pay 251-399%: $25-50 co-pay
Inpatient Hospital	0-250%: covered in full 251-399%: 90% coinsurance
Lab and X-Ray	0-250%: Covered in full 251-399%: 90% coinsurance
Other Diagnostic (e.g. CT,MRI, PET, nuclear)	0-250%: Covered in full 251-399%: 90% coinsurance
Transplants	0-250%: Coverage limited w/prior authorization 251-399%: 90% coinsurance for covered transplants
Family Planning	0-250%: Covered in full 251-399%: Covered in full No coverage for infertility treatment

[2] See Appendix G "Health Care Reform Proposal", submitted by The Committee for Colorado Health Care Solutions; April 6, 2007.

Covered Benefits	Benefit Limits and Out-of-Pocket Payments
Mental Health	Neurobiologically based MI Parity: inpatient same as hospitalization; outpatient same as medical office visit Other Mental Services Parity: inpatient same as hospitalization; outpatient same as medical office visit
Substance Abuse	Residential: Same as inpatient hospital Outpatient: $5 co-pay
Therapies (Speech, PT, OT)	0-250%: $5 co-pay 251-399%: 90% coinsurance Limited to 30 visits per year for diagnostic services
Durable Medical Equipment	0-250% Covered in full Annual maximum $2,000 251-399% 90% coinsurance Annual maximum $2,000
Prescription Drugs	0-250% $2 Generic $5 brand 251-399% $10 co-pay preferred generic $15 co-pay preferred brand $25 co-pay non-preferred All income levels No co-pays for chronic disease management drugs
Vision	0-250% Exam, specialty care covered Co-pay $5; $100 towards lenses, frames, or contacts 251-399% 90% coinsurance for exam, specialty care; $50 towards lenses, frames, or contacts
Dental	0-250% Periodic cleaning, exams, x-rays, fillings, extractions, root canals Annual maximum $750 251-399% 90% coinsurance Annual maximum $750 Dental services resulting from an accident 0-250%: Covered in full 251-399%: 90% coinsurance No annual maximum

Covered Benefits	Benefit Limits and Out-of-Pocket Payments
Audiology	0-250% Hearing aids, co-pay $25 Annual maximum $1000 251-399% Hearing aids, 90% coinsurance Annual max $1000
Skilled Nursing Facility	0-250%: Covered in full 251-399%: 90% coinsurance 100 days per year maximum
Hospice	0-250%: Covered in full 251-399%: 90% coinsurance
Home Health	0-250%: Covered in full 251-399%: 90% coinsurance
Deductibles	None for < 250% FPL $150 per person per year for all others Not applicable to preventive care (e.g., routine physicals, immunizations, PAP tests, mammograms, and other screening and testing provided as part of the preventive care visit) or office visits (primary care, consultations, mental health and chemical dependency outpatient visits, office-based surgeries, and follow-up visits)
Maximum	5% of yearly income annual maximum

Source: A Plan for Covering Coloradans, Committee for Colorado Health Care Solutions

Case management would be available for high cost cases in the private market. In addition all people in the private market would be required to have a medical home.

6. Premiums

Premiums would be charged to for coverage under the private insurance pool. The program would require community rating of premiums. This means that for the insurer must charge a single premium for each health insurance product that is the same regardless of age, health status and other risk factors. Premiums could vary only by geography, and family type (individuals, individuals with spouses, individuals with children and families).

For the private insurance pool, the premium assistance group would be required to have lived in Colorado for at least 6 continuous months, in addition to any other requirements under current law (e.g., citizenship requirements). For all other individuals in the private insurance pool, there is no durational requirement and residency would be as under current law.

We estimate that the community rated premiums for the non-premium assistance program would be $341.18 per-person-per-month (PMPM) for plan A and $335.20 PMPM for plan B (***Figure 6***). These costs were estimated based on the benefits packages described above, using commercial fees for the western region. We assumed that the population would be comparable to the commercial population under age 65 years.

Figure 6
Community Rated Premiums PMPM by Age/Gender/Tier: Contracts Effective [a/]

Plan Type: Community Rated Premiums	Single	Family	Per-Member Per-Month
FEHBP BCBS Standard Option (Plan A)	$438.06	$1,116.59	$341.18
Aetna Health Fund (Plan B)	$430.45	$1,097.20	$335.20
Premium Assistance Plan [b/]	$423.91	$894.74	$330.11

a/ These estimates include benefits and administrative costs. The variation in Medical costs under these policies is presented in *Appendix J*.
b/ Assumes cost sharing that applies to those over 250 percent of the FPL.
Source: Lewin Group estimates using cost factors developed by NovaRest Consulting.

The premium for the premium assistance benefits package described above would be $330.11 PMPM. This reflects the fact that those qualifying for these premium assistance program are on average younger and less costly than the currently insured commercial population.

Under the proposal, the program would use private payer provider reimbursement levels for all three benefits packages. We assume that administrative costs in the non-group market would be equal to 19 percent of benefits for all three benefits packages. This assumption is based upon administrative cost data 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.***

7. Premium Subsidies

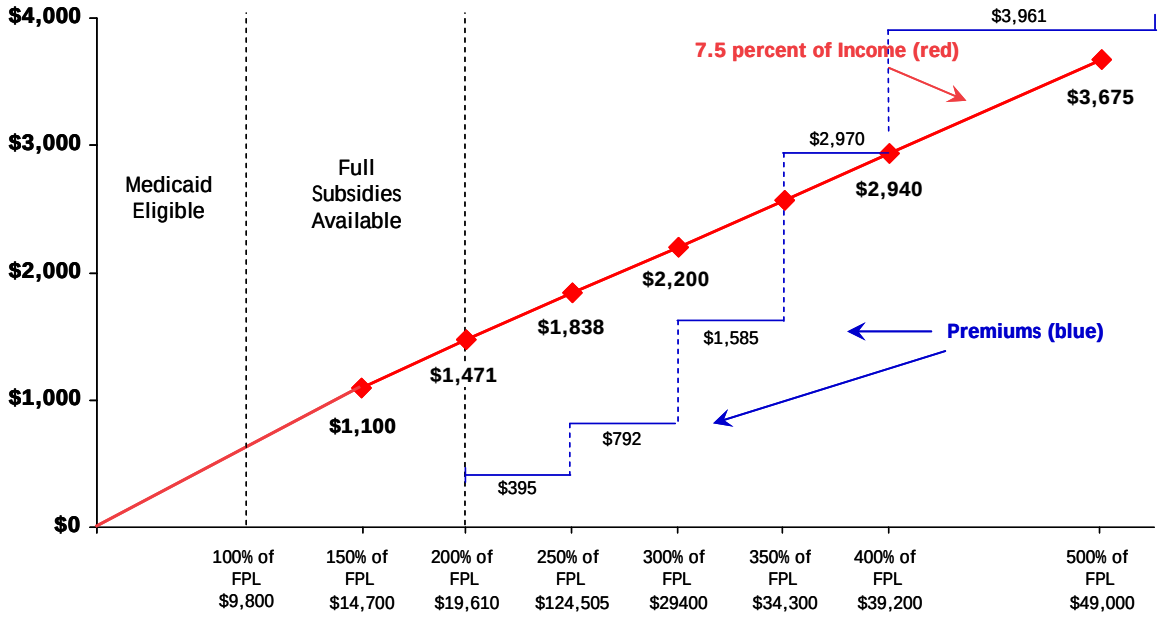
The proposal would provide premium assistance to people with incomes up to 400 percent of FPL from a shorter list of plans that participate in the premium assistance program. Subsidies would be available for people purchasing coverage on their own and the worker share of premium contributions in employer health plans. The premium assistance would be as follows:

- Full subsidies for individuals and families at or below 200 percent of the FPL;
- Sliding scale subsidy between 200 percent and 400 percent of the FPL as follows:
  - 201-250 percent of FPL - 90 percent subsidy;
  - 251-300 percent of the FPL - 80 percent subsidy;
  - 301-350 percent of the FPL - 60 percent subsidy;
  - 351-400 percent of the FPL - 25 percent subsidy; and
- No subsidy for any individuals or families above 400 percent of the FPL.

The subsidy levels for 250 percent through 400 percent of the FPL were specified by Lewin at the request of the author of the proposal. The author requested that Lewin assume a sliding fee scale which is non-linear, with substantial premium subsidies on the lower end of the scale that decline as income as a percent of the FPL rises. The adjustment is designed to account for the

fact that people between 200 percent and 250 percent of the FPL have only limited capacity to share in premiums. ***Figure 7*** presents annual premiums less subsidies under the proposal by income as a percent of the FPL.

Figure 7
Annual Premiums Less subsidies for Single Individuals under A Plan for Covering Coloradans



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

A benchmark premium would be negotiated by the Authority for the subsidized plans. For modeling purposes, the median premium of plans participating in the premium assistance pool would be the benchmark premium. Workers with coverage under self-insured employers who offer at least minimum benefits package would be eligible for subsidies as well.

Employers would define their level of contribution. If the employer contribution does not cover the full cost of the premium for individual or family coverage, employee dollars would be applied through a payroll deduction up to a maximum out-of-pocket premium defined by income, the subsidy schedule and the benchmark premium. For example: for people between 200 percent and 250 percent of the FPL, once the employer makes their contribution, if it does not cover the full cost, the individual or family would be expected to pay up to 10 percent of the benchmark premium plus any amount in excess of the benchmark the plan they select. The government would pay the remainder.

Example: government subsidy amount for people between 201-250 percent of poverty

Government Subsidy = (90% x benchmark premium) – employer contribution.

8. Consumer Choice

Consumers in the private pool would be able to choose among a number of plans based upon a limited set of standardized, comprehensive benefits packages. Coverage options would include various types of health plans such as HMOs and PPOs. These health plans would compete on the basis of price and customer service ratings. Consumers enrolled in the premium assistance programs would be able to select among just two of these plans, one an HMO, the other a PPO, both with low cost-sharing.

People who are eligible for government sponsored programs (combined Medicaid and CHP+) would be enrolled in a managed care plan—automatic or passive enrollment would apply if they do not select a plan. Individuals who are not eligible for the Medicaid and CHP+ programs who do not purchase a plan would be assessed a fee by the Department of Revenue equal to the cost of the annual premium in the lowest cost plan and provided enrollment information. Individuals would not be disenrolled for non-payment of premiums but would face penalties.

9. Administration

The Department of Health Care Policy and Finance would continue to administer the newly combined Medicaid and CHP+ programs. Administration of premium subsidies and penalties would be through the tax system under the Colorado Department of Revenue.

The proposal creates an independent, quasi-governmental Authority with a governance Board responsible for setting policy and standards, and an administrative structure to manage the private pool.

The Authority Board would perform the following:

- Define the minimum benefit package;
- Define and periodically update the set of standard benefit packages based on evidence of effectiveness and cost-effectiveness;
- Define and certify "high-value" providers;
- Define the requirements for participation of plans in a premium subsidy program;
- Define and periodically update an affordability standard below which individuals will be eligible for premium assistance;
- Establish a benchmark premium for the premium assistance program;
- Bring stakeholders together to develop a standardized uniform billing and payment system; and
- Convene stakeholders to select robust outcome measures and determine how accountability and incentives for delivery of high quality care are allocated.

Administrative functions of the Authority would include but not be limited to, certifying plans, assuring regional coverage and network adequacy, enrolling individuals and groups in plans of

their choosing, collecting premiums, collecting claims data from insurers, managing the risk adjustment process, disbursing payments to insurers, and assuring public outreach and education.

Health plans would continue to be responsible for claims processing and provider network development. However, there would be a decrease in broker and agent functions as the Authority conducts enrollment, premium collection and other administrative functions. In addition, the guaranteed issue and community rating requirements eliminate medical underwriting costs (i.e., the process of basing acceptance and premiums on the basis of health status).

10. Employer Responsibility

Employers would be required to offer coverage or pay an assessment which can be waived for employers who provide adequate coverage for their employees. Adequate coverage would be defined as offering health benefits that meet or exceed the minimum benefit package defined by the Authority, and contributing at least 85 percent of the median cost of a standard individual plan.

For illustrative purposes, we assumed that the assessment would be $347 per full-time equivalent worker that is not offered a plan meeting the benchmark benefit standard. Self-employed individuals who do not have employees (i.e., business groups of 1) are exempt from the assessment. Because the state can not impose a tax on the federal government, there would be no assessment for federal workers in Colorado that are not covered by health insurance.

Employers would be required to allow workers to pay their share of premiums through a payroll deduction and would be required to establish a Section 125 plan so that workers can make these payments in pre-tax dollars. The pool would provide employers with standardized information and forms for employers to set up Section 125 premium-only-plans for workers. The state would also implement procedures defined in ERISA that simplify the process of establishing such plans within a state.

11. Program Financing

The program would be funded with savings to existing programs, a premium tax, and other dedicated taxes. These funding sources include:

- **Employer Assessment:** As discussed above, the plan imposes an assessment of $347 per full time equivalent worker that they do not cover.
- **Premium Tax:** The proposal imposes a premium tax on insurers, to recover a portion of the insurer's administrative costs savings under the proposal:
    - Estimated private insurer administrative savings of $240 million;
    - Premiums in fully-insured market of $4.1 billion; and
    - Tax rate of 5.8 percent.
- **Savings to Existing Programs:** The proposal would use savings that can be gained from the following to finance the program:

- Administrative savings from simplification, elimination of underwriting, and pooling risk in the purchasing pool;
- Any savings from Medicaid enrollees being required to use 340B drugs3;
- Any savings from adopting a formulary similar to Oregon's Medicaid formulary for the Medicaid/CHP+ newly expanded program;
- Savings from requiring the Medicaid/CHP+ population to enroll in a mandatory, capitated, statewide managed care program;4
- Implementing mandatory case management for high users/high cost individuals; and
- Implementing a statewide nurse advice line.

- **Provider Tax:** The program establishes a tax on hospital, physician ant other professional net-revenues that is designed to collect an amount equal to the reduction in provider uncompensated care plus the reduction in provider payment shortfalls under Medicaid:
  - Reduced uncompensated care of $226 million;
  - Medicaid Reimbursement increase of $462 million;
  - Net Patient Revenue subject to tax is $22.0 billion; and
  - The required tax rate is 3.1 percent.
- **State Tobacco Tax Increase**: An increase in tobacco taxes from the current $.84 per pack to $2.00 per pack;
- **State Alcohol Tax Increase:** the current taxes on Alcohol would be increased as follows:
  - Spirits: from $.60 to $5.63 for a liter (or from $2.28 to $21.30 per gallon)
  - Wine: from $.07 to $.66 per liter (or from $.32 to $2.50 per gallon)
  - Beer: from $.05 to $.15 per 6-pack (or $.08 to $.26 per gallon)

The proposal does not specify what other funding sources would be used to pay for the program if the amounts raised through the sources listed above are not sufficient to fully fund the program. For illustrative purposes, we assumed that the state personal income tax rate would be increased by the amount needed to fully fund the program. We estimate a required increase in the state income tax rate (currently 4.6 percent) of 0.6 percentage points.

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[3] The 340B Drug Pricing Program was established in response to the passage of Section 340B of U.S Public Law 102-585, the Veterans Health Care Act of 1992. Section 340B of this law limits the cost of drugs to federal purchasers and to certain grantees of federal agencies.

[4] Conversations with Colorado's Health Care Policy and Finance (HCPF) staff informed Lewin that given previous managed care experience in the state that, the state would have to pay at least fee-for-service equivalent rates to managed care organizations to gain their participation in a mandatory managed care program. However, the author of the proposal believes that increasing provider payment rates to Medicare levels should create a strong incentive for provider participation in managed care resulting in programmatic savings. Lewin did not model the effects of managed care proposed in A Plan for Covering Colorado.

For illustrative purposes, we assume that state laws that restrict the state's ability to increase taxes would be waived to permit collection of these revenues if necessary. These include the Colorado Taxpayers Bill of Rights (TABOR) and the Arveschoug-Bird law, which impose limits on state spending without voter approval.

12. Health Information Technology

The proposal recommends funding rapid development of Health Information Technology (HIT), facilitated by the Colorado Department of Health and Environment, which would create an Office of Health Information Technology (OHIT) responsible for the following:

- Creating standards of interoperability;
- Soliciting bids for and certifying a limited number of electronic health record product licenses that include essential elements such as stability, technical support services, registry functionality, tracking and reminder systems, evidence-based decision support and interoperability; and
- Providing technical assistance to providers who are selecting systems.

Due to data limitations we did not model this provision.

13. Insurance Market Reforms

As discussed above, the proposal retains the private insurance market, but creates a risk pooling mechanism by combining individual, large group and small group fully insured markets. The proposal requires guaranteed issue and community rating of insurance products, which prevents insurers from varying premiums by health status and other risk factors such as age. While Plans would not be allowed to develop risk-adjusted rates, they would receive risk adjusted payments from the Authority, based upon the characteristics of those who enroll in each plan.

The law would require that all plans cover dependent adults through the age of 26. None of these provisions would apply to self-funded employer plans, which are exempt from state regulation under the Employee Retirement Income Security Act (ERISA).

Because plans would be required to guarantee issuance of coverage at community rates, the state's high-risk pool CoverColorado would be closed.

B. Key Assumptions

The author's program expands coverage under the Medicaid and CHP+ programs to cover all parents and children living below 300 percent of FPL, and childless adults living below 100 percent of the FPL. It also establishes a purchasing pool where individuals can purchase coverage with a premium that is subsidized on a sliding-scale with income for people living below 400 percent of the FPL. People are required to have insurance coverage and employers are required to pay a fee for each worker they do not cover.

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 used the Health Benefits Simulation Model (HBSM) described above to estimate the number of newly eligible people who would enroll in the program based on the Colorado sub-sample of the Current Populations Survey (CPS) data for 2004 through 2006. These data provide information on income and insurance coverage for a representative sample of the state's 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 73 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-SCHIP poverty level expansions under Medicaid.[5] The model indicates that without anti-crowd-out provisions, up to 39 percent of newly eligible people with employer coverage would eventually shift to the public program; and[6]
- 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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[5] 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.

[6] 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 reduce the cost of insurance to eligible people, resulting in an increase in the number of people taking 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 voluntarily purchase coverage.

We simulated the impact of this reduction in price by 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 MEPS-based HBSM data. The model was used to estimate the premium faced by each uninsured individual and family in the individual market compared to the premium in the private pool, and the amount of the subsidy that eligible people would receive. Affected individuals were then randomly selected to become covered based upon the change in the net cost of insurance to the individual (i.e., premium less the premium assistance received) and the price elasticity assumptions discussed above. This step involved the following assumptions:

- We used the premiums that we estimated for the premium assistance program (i.e., 288.06 PMPM);
- All HBSM simulations were performed on a month-by-month basis to account for people who are eligible for only part of the year; and
- All income-eligible people who are currently purchasing non-group coverage are assumed to take the premium subsidy if eligible.

3. Employer Response to Employer Assessment 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 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. Also, the employer assessment effectively increases the cost of not providing insurance, thus lowering the relative cost of providing 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+ where eligible, the public assistance plan where eligible and unsubsidized individual coverage for people with incomes above 400 percent of the FPL. We also include the cost of paying the employer fee for workers they do not cover.

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.***

4. Program Administration

We assumed that the cost of administering eligibility for the Medicaid CHP+ expansion would be about $170 per family per year. This is based on 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 benefit packages was equal to 19 percent of covered claims. This assumption is based on experience in large health plans operating in the non-group market. This estimate is lower than the rate in the existing market of about 35 percent and assumes economies of scale under the proposal that would reduce administrative costs.

5. Wage Effects

We assume that 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. This 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.

There is considerable agreement among economists that this wage pass-through would occur in response to changes in employer benefits costs.[7] However, there is disagreement over the period of time over which these adjustments would occur. It is likely that these adjustments would often take the form of reduced wage growth over time. However, the full amount of the pass-through could take several years to materialize. For illustrative purposes, we present our estimates assuming the pass-through is complete in the first year.[8]

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

8 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).

6. 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. We then assume full compliance among people where the cost of insurance would not exceed 9.0 percent of their income.[9] Others would remain uninsured.

7. Case Management and Medical Home

Under this proposal, case management would be available for high cost cases in the private market. In addition all people in the private market would be required to have a medical home. However, the proposal does not specify a requirement for people to use the case management services. It also does not create financial incentives for people to use their medical home for coordination of care. Based upon discussions with actuaries about the effectiveness of such features, we assume savings equal to one-half of one percent for affected groups.

C. Cost and Coverage Impacts

In this section, we present our estimates of the cost and coverage impacts of A Plan for Covering Coloradans 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 group.

We present a second set of estimates in the next section that reflect the lead time required to implement such a program. 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. These estimates are intended to be suitable for budgetary purposes.

1. Transitions in Coverage

The proposal provides coverage through a public program expansion and through a private pool with low-income premium subsidies. ***Figure 8*** illustrates where people would become covered under the proposal.

Of the 2.7 million people now getting coverage through their employer, 2.5 million would remain with that coverage (some in the pool and some in their self-funded employer plan). About 72,800 people would lose employer coverage and take non-group insurance, and 88,000 would move into Medicaid/CHP+ as a result of the program expansions. About 2,100 workers and dependents would become uninsured in cases where the employer drops coverage.

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[9] 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].

However, about 50,300 people currently with non-group coverage and about 84,300 currently uninsured people would become covered under employer insurance in firms that decide to start offering coverage. Taking these coverage transitions into account, we estimate that the number of people with ESI would continue to be about 2.7 million workers and dependents.

Out of an estimated 158,900 people now getting coverage in the non-group market, we estimate that 92,200 would continue with that coverage. Another 16,400 people would be covered through Medicaid and CHP+ as a result of the expansions. A Plan for Covering Coloradans has no impact on coverage for military dependents and retirees covered through TRICARE. Similarly, there would be no change in coverage in the Medicare program.

Figure 8
Transitions in Coverage under A Plan for Covering Coloradans in 2007/2008 (thousands)

		Transitions in Coverage under A Plan for Covering Coloradans 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	2,528.8	72.8	0.0	0.0	88.0	2.1
Non-Group	158.9	50.3	92.2	0.0	0.0	16.4	0.0
TRICARE	112.4	0.0	0.0	112.4	0.0	0.0	0.0
Medicare (excl. dual eligibles)	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	84.3	230.3	0.0	0.0	370.7	106.5
Total	**4,619.9**	**2,663.4**	**395.3**	**112.4**	**413.0**	**927.2**	**108.6**

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

Of the estimated 791,800 uninsured in 2007/2008, all but 106,500 would become insured. About 84,300 uninsured would take employer coverage. This includes both those in firms that decide to offer coverage and those who have declined the employer coverage available to them who would now take that coverage to comply with the mandate to have insurance. About 230,300 uninsured people would get coverage in the private pool with premium subsidies. Another 370,700 of the uninsured would become covered through Medicaid or CHP+ leaving 106,500 people remaining uninsured in the state (About 13.5 percent of the currently uninsured population).

Figure 9 shows the change in number of uninsured under the proposal by age and income. The proposal covers an estimated 687,000 uninsured or 86.8 percent of the uninsured population. The proposal would cover about 86.6 percent of the uninsured with incomes below $10,000 annually and 93.3 percent of uninsured people with an income of $150,000 or more annually. It would provide coverage to 91.1 percent of uninsured people age 18 years old and younger, and 84.8 percent of all uninsured age 55 years and older.

Figure 9
Change in Uninsured under A Plan for Covering Coloradans 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	77	0	77
$10,000-$19,999	109	91	0	91
$20,000-$29,999	127	113	0	113
$30,000-$39,999	118	104	0	104
$40,000-$49,999	79	66	1	67
$50,000-$74,999	123	102	0	102
$75,000-$99,999	66	57	1	58
$100,000-$149,999	48	46	1	47
$150,000 & over	30	28	0	28
Age				
Under 6	59	53	0	53
6-18	99	91	0	91
19-24	123	101	0	101
25-34	192	167	0	167
35-44	147	124	1	125
45-54	112	99	1	100
55-64	58	49	0	49
65 and over	1	1	0	1
Total	**792**	**685**	**2**	**687**

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

2. Impact on Statewide Health Spending

Under current law, we estimate that total health spending in Colorado will reach $30.1 billion by 2007/2008. This includes spending for all health services by all payers including Medicare, Medicaid, ESI, non-group insurance, workers compensation and various safety-net programs. Spending includes both payments for services, insurance, and program administration.

Under A Plan for Covering Coloradans, health spending in Colorado would increase by about $1.3 billion if fully implemented in 2007/2008 (***Figure 10***). This is an increase in statewide health spending of about 4.3 percent. Provider payments would increase by about $805 million due to increased utilization of services by newly insured people and by $63 million for currently insured people who would have improved benefits under the proposal. There would be an increase in provider reimbursement of $412 million resulting from reduced uncompensated care and the increase in Medicaid provider payment levels to Medicare levels under the proposal. Insurer administration would increase by $39 million and administration of subsidies would add $26 million to program costs.

Figure 10
Changes in Statewide Health Spending under A Plan for Covering Coloradans in 2007/2008 (millions)

Current Statewide Health Spending for All Payers		**$30,100**
Change in Health Services Expenditures		**$868**
Change in utilization for newly insured	$805	
Change in utilization for currently insured	$63	
Reimbursement Effects		**$412**
Payments for previously uncompensated care	$226	
Medicaid Payment Rate Increases (current program)	$247	
Medicaid Payment Rate Increases (expansion / mandate)	$215	
Reduced Cost Shifting [a/]	($276)	
Provider Taxes		**$0**
Provider Tax	($688)	
Tax Payments Passed on to Consumers as Higher Charges	$688	
Case Management / Medical Home Model in Fully Insured Market		**($56)**
Change in Administrative Cost of Programs and Insurance		**$65**
Change in Insurer Administration	$39	
Administration of Subsidies [b/]	$26	
Total Change in State Health Spending		**$1,289**

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

3. Changes in Provider Revenues

The proposal would affect revenues for health service providers in several ways. As discussed above, there would be increased utilization of health services for those who become insured or who switch to more comprehensive coverage. Providers would be paid for services they now provide free to the uninsured. Provider payment levels for the Medicaid and CHP+ populations would be increased under this proposal as well.

a. Utilization for the Uninsured

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

Using this methodology, we estimate that health spending among the currently uninsured population will increase. We estimate an increase in spending due to the increase in utilization to be $805 million in 2007/2008.

b. Utilization for the Underinsured

Some insured have a benefit package that does not cover certain services including prescription drugs, dental care, orthodontia and medical equipment. Often, these individuals access such services through government-funded clinics and health centers or forego services. Under A Plan for Covering Coloradans, most of these individuals would have access to a more comprehensive benefits package in the private insurance pool.

In this analysis, we assume that utilization of these services by people who are not currently covered for these services would increase to the levels observed among those with similar demographic and health status characteristics who have coverage for these services. Spending under the Plan would increase by $63 million for under-insured people in 2007/2008.

c. Case management and Medical Home

As discussed above, the proposal requires private plans to make case management available for high cost cases and requires people to have a medical home. We estimate that the case management component would result in savings of about $56 million.

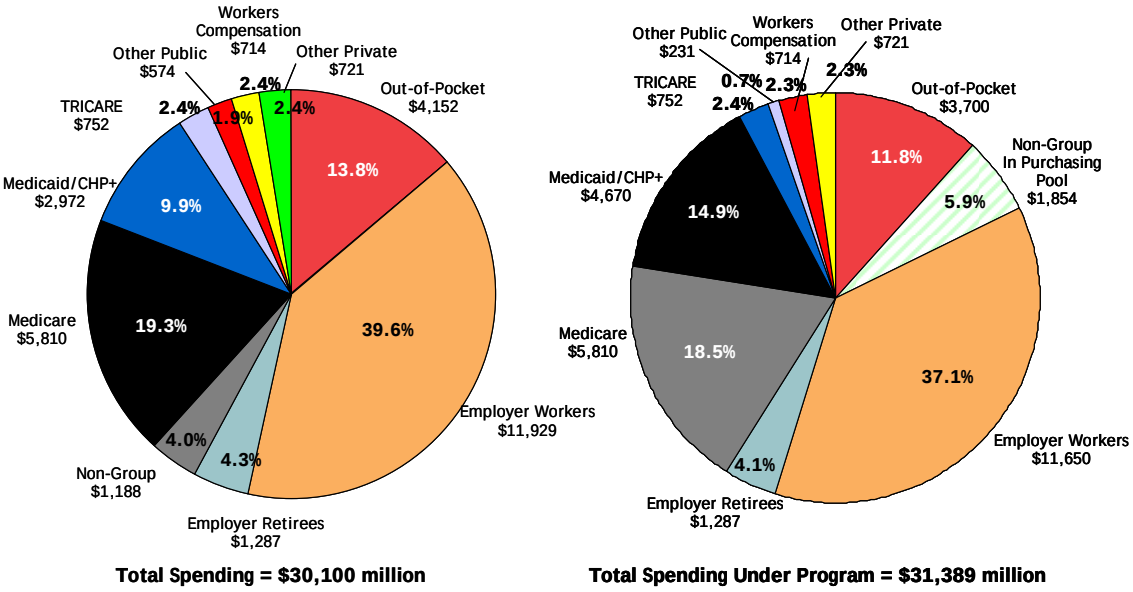
d. Reimbursement Effects

Under the current system, uncompensated care from services to the uninsured and under-insured is shifted to other payer sources (primarily private payers) as are shortfalls in reimbursement under public programs. Under the proposal, total benefit payments to providers for previously uncompensated care would be $226 million in 2007/2008. In addition, Medicaid payment increases would add $462 million to provider income. Based upon prior research, we assume that 40 percent of these increases in provider payments would be passed back to private payers in the form of lower charges (i.e., reduced cost shifting). We assume that the provider taxes of $688 million would be fully passed on to consumers in the form of higher charges with a corresponding increase in premiums (shown below).

4. Changes in Spending by Payer Group

Medicaid and CHP+ spending would increase from about $3.0 billion to about $4.7 billion under the Plan for Covering Colorado proposal (***Figure 11***). Total spending for people purchasing coverage as individuals (i.e., non-group) would increase from $1.2 billion under current law to about $1.9 billion. The figure also shows the portion of health spending that would be through the purchasing pool for people purchasing coverage as individuals.

Figure 11
Estimated Spending by Source of Payment in Colorado under Current Law and A Plan for Covering Coloradans



Source: The Lewin Group estimates.

5. *Spending under Newly Created Programs*

The program expands eligibility for Medicaid and CHP+ and provides premium subsidies to people with income up to 400 percent of the FPL.

The program includes a proposed Medicaid 1115 waiver to obtain federal matching funds. The waiver is required for the following:

- Retain and redirect existing federal disproportionate share hospital (DSH) revenues to fund coverage expansions;
- Obtain federal matching funds to cover children and parents with incomes between 200 percent and 300 percent of the FPL under the CHP benefits package; and
- Obtain federal matching funds for non-custodial adults (Better Health care for Colorado proposal and A Plan for covering Coloradans).

Assuming the waiver is approved, the state share of new Medicaid spending under the expansions would be $811 million. Premium subsidy costs to the state would be an additional $1.4 billion, including the cost of administration. Total costs to the state government of the public programs including subsidy costs would be $2.3 billion (***Figure 12***). Federal matching funds under the waiver would be $887 million in that year.

Figure 12
Enrollment and Costs under A Plan for Covering Coloradans in 2007/2008

	Enrollment (thousands)	Total Costs (millions)	State Costs (millions)	Federal Costs (millions)
Medicaid Expansion & Individual Mandate [a/]				
Increased Medicaid Payment Rates to Medicare Levels	n/a	$247	$124	$124
Children to 300% FPL	135.4	$253	$89	$164
Parents to 300% FPL	185.1	$638	$319	$319
Childless Adults to 100% FPL [b/]	154.8	$561	$280	$280
Total New Medicaid Enrollment & Spending	**475.3**	**$1,698**	**$811**	**$887**
Premium Subsidies				
Employer Plans	1,134.5	$653	$653	$0
Non-Group Plans	292.2	$769	$769	$0
Administration of Subsidies	n/a	$26	$26	$0
Total Premium Subsidies and Administration	**1,426.7**	**$1,448**	**$1,448**	**$0**
Total Program				
Total Public Program Costs	**1,902.0**	**$3,146**	**$2,259**	**$887**

a/ Net costs includes benefits and administrative costs less premium collections. We estimate about $46 million in premium contributions for families between 200% and 300% of FPL.
b/ Assumes Medicaid 1115 waiver is approved to receive Federal matching funds for the expansion for childless adults.
Source: The Lewin Group estimates using the Health Benefits Simulation Model.

6. Changes in State and Local Government Health Spending

The cost to the state of the Medicaid and CHP+ expansions and the premium subsidy program would be $2,259, assuming the Medicaid 1115 waiver is approved (***Figure 13***). Program costs would be partly offset by savings of $206 million in current safety-net programs, as care currently provided free to uninsured people becomes covered as the number of uninsured is reduced. In addition, the state and local governments save about $21 million in employee health benefits which we assume is passed on to workers as increased wages over time.

Figure 13
Change in State and Local Government Spending A Plan for Covering Coloradans in 2007/2008 (millions)

	Change in Spending Assuming Medicaid 1115 Waiver is Approved [a/]		Change in Spending Assuming Medicaid 1115 Waiver is not Approved	
New Program Costs		**$2,259**		**$2,540**
Medicaid and CHP+ Programs	$811		$1,092	
Premium Subsidies	$1,448		$1,448	
Offsets and Revenues				
New Revenues and Offsets to Existing Programs		**$2,259**		**$2,205**
Savings to Current Safety-net Programs [b/]		**$206**		**$152**
State & Local Government Employee Health Benefits		--		--
Workers and Dependents	($21)		($21)	
Wage Effects [c/]	$21		$21	
Tax Penalty for Remaining Uninsured [d/]		**$43**		**$43**
Program Financing		**$2,014**		**$2,014**
Employer Assessment	$179		$179	
Premium Tax	$240		$240	
Tobacco Tax Increase	$210		$210	
Provider Tax	$688		$688	
Alcohol Tax Increase	$126		$126	
Income Tax (0.6%)	$571		$571	
Tax Revenue (Loss)/Gain Due to Wage Effects [e/]		**($4)**		**($4)**
Net Cost				
Net Cost/(Savings) to State and Local Government		**$0**		**$335**

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/ Assumes the ability to collect penalty of $500 per uninsured tax filer.
e/ Increases in tax revenue is counted as an offset to State and Local Government health spending.
Source: The Lewin Group estimates using the Health Benefits Simulation Model.

Revenues from dedicated taxes created under the proposal would be $2.0 billion. This includes the provider tax, the employer assessment, the premium tax, the alcohol and tobacco taxes and the increase in the income tax (i.e., 0.6 percentage point increase in income tax rate). The cost of the proposal would be fully covered by the combination of savings to existing programs and

new tax revenues, assuming the proposed federal waiver is approved. If the waiver is not approved, the state would need to raise an additional $335 million in funding.

7. Change in Federal Government Health Spending

The federal share of the cost of the Medicaid and CHP+ eligibility expansions would be $887 million, assuming the expansion is fully phased-in in 2007/2008 (***Figure 14***). In addition, federal government spending for federal employee health benefits would increase by $27 million due to the employer assessment for uninsured workers and the premium and provider taxes created under the program. This increase in cost would be passed on to workers as lower wages.

Also, increases in employer costs from the assessment and other effects of the proposal would result in wage losses for affected workers resulting in a corresponding reduction in federal income and payroll tax revenues of $37 million. Overall, the federal government would spend $978 million more under the proposal assuming the 1115 waiver is approved. However, if the waiver is not approved, the increase in federal spending under the proposal would decline to about $590 million.

Figure 14
Change in Federal Government Spending under A Plan for Covering Coloradans in 2007/2008 (millions)

	Change in Spending Assuming Medicaid 1115 Waiver is Approved	Change in Spending Assuming Medicaid 1115 Waiver is not Approved
Medicaid and CHP+ Programs	**$887**	**$607**
Discontinuation of DSH funding	**$54**	**($54)**
Federal Employee Health Benefits	--	--
Workers and Dependent	$27	$27
Wage Effects a/	($27)	($27)
Tax Revenue Loss/(Gain) Due to Wage Effects b/	**$37**	**$37**
Net Cost/(Savings) to Federal Government	**$978**	**$590**

a/ Assumes reduced employer costs 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).

8. Impact on Private Employers

Private employers in Colorado will spend about $7.7 billion on health insurance benefits for their workers (***Figure 15***) and $350 million on retiree health benefits for a total of $8.1 billion in health spending. This includes only the portion of benefits costs paid by the employer and excluded government worker benefits, which are discussed above.

Private employers who currently provide insurance would see savings of about $150 million under the proposal. Employers who discontinue their health plans in response to the program would save about $381 million in benefits. Spending would be reduced by about $190 million

due to reduced cost-shifting and employers would save about $163 million due to administrative savings in the private pool and the effects of community rating.

These savings would be largely offset by other effects under the program. Employer costs would increase by about $471 million as the cost of the provider and premium taxes under the proposal is passed on to consumers as higher prices. Spending would increase by an additional $31 million for workers who currently decline employer insurance who would now take up coverage due to the mandate.

Figure 15
Change in Private Employer Health Benefits Costs under A Plan for Covering Coloradans 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			
Employers Dropping Coverage	($381)	--	($381)
New Employer Coverage	$31	$122	$153
Impact of Purchasing Pool [a/]	($163)	--	($163)
Employer Assessment [b/]	$82	$84	$166
Provider Tax Pass Through Effect [c/]	$471	$13	$484
Reduced Cost Shifting	($190)	($4)	($194)
Net Change (before wage effects)	**($150)**	**$215**	**$65**

a/ Includes the impact of reduced administrative costs under a mandatory purchasing pool and the impact of pure community rating in the purchasing pool.
b/ Includes a $347 annual assessment for each worker without employer coverage, prorated for part-time workers.
c/ Assumes premium and provider taxes are passed through to consumers as higher prices.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

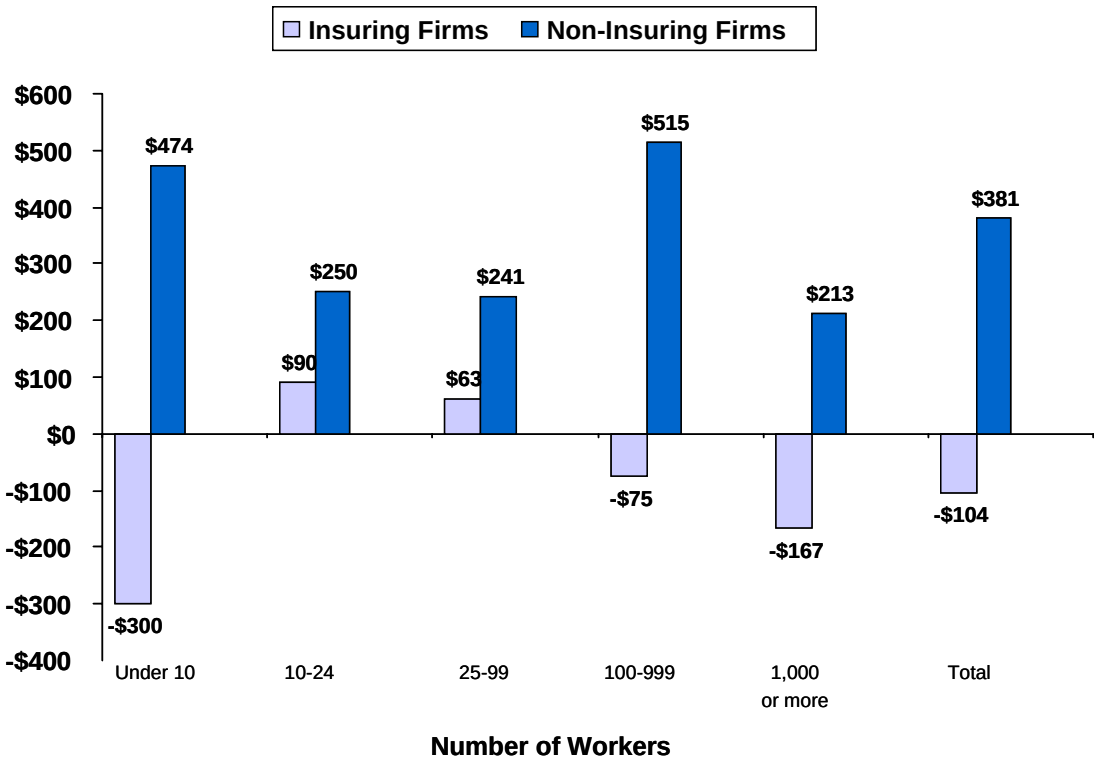
Assessment payments for part-time and temporary workers who are not eligible for coverage under the employer's plan would be $82 million. Not all of those working for firms that offer coverage are eligible to participate in the employer plan. These employers would have to pay an annual assessment of $347 for each part-time or temporary worker that is not eligible for employer coverage, for a total of $82 million in additional spending.

Currently non-insuring firms would now spend $215 million on health care due to the proposal. This includes $122 million in health care benefits in firms that respond to the coverage mandate by offering insurance. Employer assessment revenues in firms that do not establish a health plan would be $84 million.

Total health spending for private employers including those who do or do not offer coverage would increase by about $65 million under the proposal. These estimates include out-of-state employers with workers in Colorado. This estimate also includes only the employer share of costs of coverage. The impact on the worker health care costs is discussed below.

Private employers that now provide coverage would save an average of about $104 per worker in 2007/2008 (***Figure 16***). Currently non-insuring firms would see spending increase by an average of about $381 per worker. ***Figure 18*** shows how these costs impacts vary by firm size.

Figure 16
Change in Private Employer Health Spending Per Worker for Currently Insuring Firms under A Plan for Covering Coloradans in 2007/2008



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

9. *Impact on Family Health Spending*

Under the proposal, family premium payments would decrease by about $205 million despite the mandate for people to have insurance due to the premium subsidies (***Figure 17***). Family premium payments would increase by about $1.1 billion as uninsured people are required to obtain insurance. Also, premiums would increase by $144 million as the cost of the insurer and provider taxes are passed back to consumers in the form of higher prices. These costs are more than offset by $1.5 billion in premium subsidies.

Out-of-pocket spending for families, including co-pays and deductibles would decrease by $452 million under the proposal. The program would be partly funded by the alcohol and tobacco sales tax increase as well as an income tax increase (0.6 percentage points) resulting in about $907 million in new tax payments for families. Those who remain uninsured would also pay about $43 million in penalties. These increases in employer health spending are assumed to be passed on to workers in the form of lower wages, which we estimate to be $72 million. We count this wage loss as an increase in family health spending.

Overall, families would spend about $365 million more on health care under A Plan for Covering Coloradans. This is equal to about $184 per family in 2007/2008.

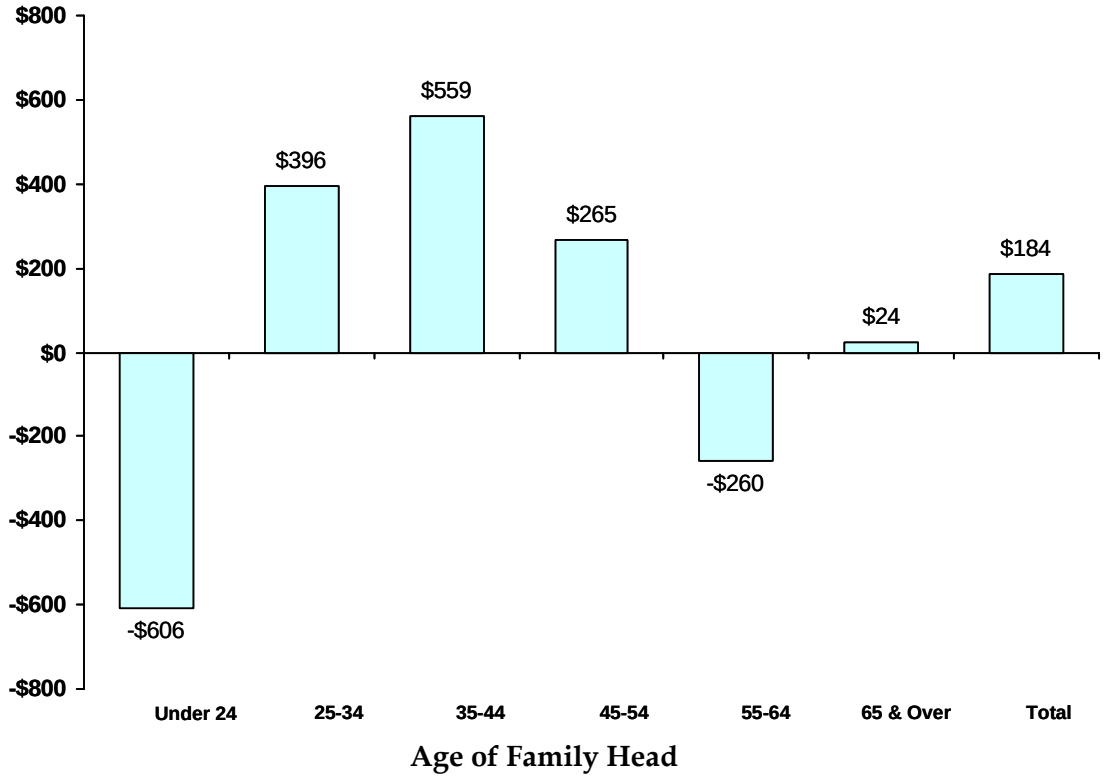
Figure 17
Impact of A Plan for Covering Coloradans on Family Health Spending in 2007/2008 (millions)

		Change in Spending
Change in Premiums		**($205)**
Change in Family Premiums	$1,073	
Premium Tax Pass Through	$144	
Premium Subsidies	($1,422)	
Change in Out-of-Pocket Payments		**($452)**
Tax Penalty for Remaining Uninsured		**$43**
Program Financing		**$907**
Tobacco Tax Increase	$210	
Alcohol Tax Increase	$126	
Income Tax (0.6%)	$571	
After Tax Wage Reduction Counted here as an increase in Family Spending a/		**$72**
Net Change		**$365**

a/ The reduction in after-tax wage income resulting from reduced costs to employers is $72 million. In this analysis, we count the reduction in wages as an increase in family health spending.
Source: The Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Figure 18 presents estimates of the impact of the program on families by age of family head. Savings for those headed by someone age 24 or younger would average $606 per family. Also, families headed by someone age 55 to 64 would be reduced by an average of $260. Families headed by someone age 35 to 44 would on average pay $559 more as a result of the proposal.

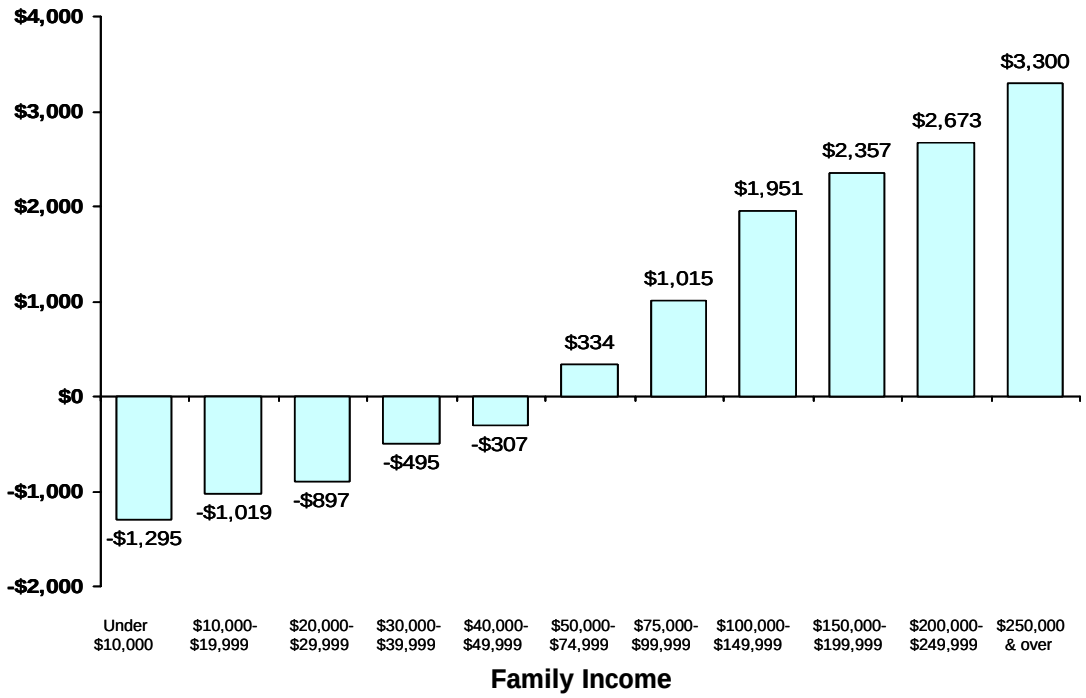
Figure 18
Change in Average Family Health Spending by Family Head under A Plan for Covering Coloradans in 2007/2008



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

Figure 19 shows the change in average family health spending by income group. As shown above, families would on average see an increase in spending of about $184 per family in under A Plan for Covering Coloradans. Families earning $50,000 or more would on an average see an increase in health spending. Lower-income families would on average save more due to the expansion in Medicaid and CHP+, and the premium subsidy program. Families with incomes below $10,000 would save $1,295 on average. This compares with average savings of $307 per family for those earning $40,000-$49,999.

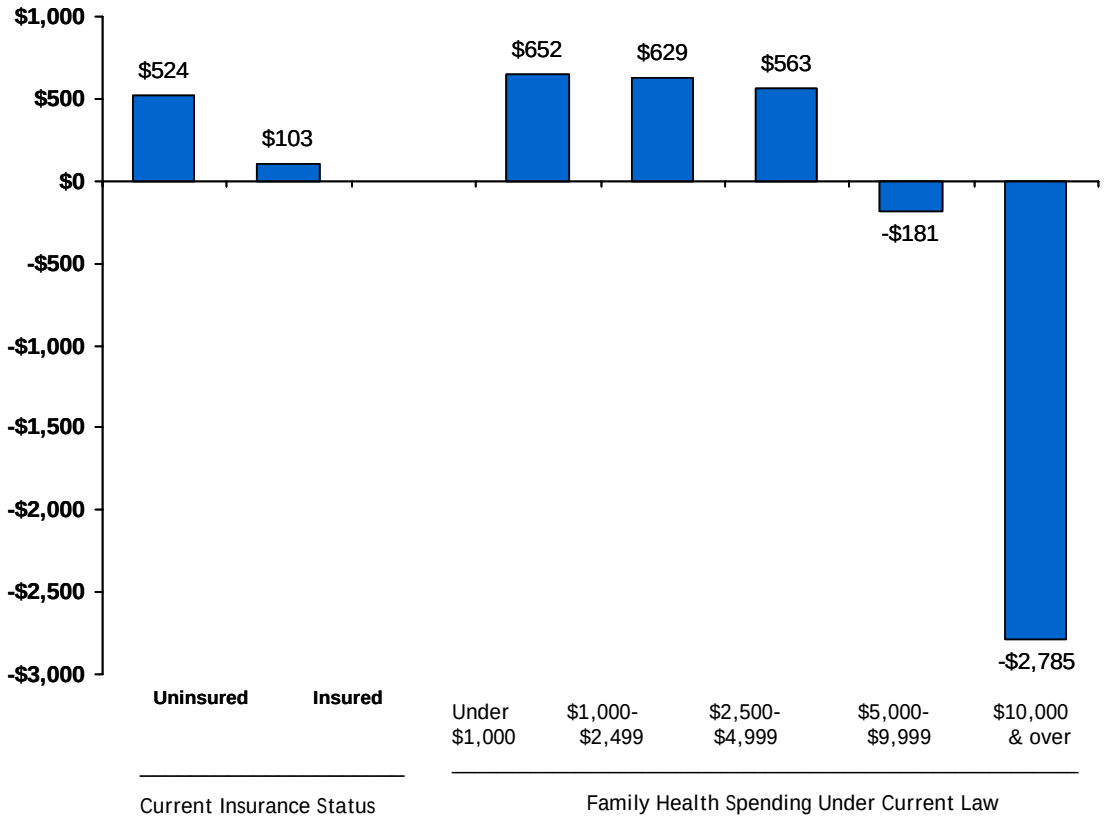
Figure 19
Change in Average Family Health Spending by Income Group under A Plan for Covering Coloradans in 2007/2008



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

As illustrated in ***Figure 20*** currently uninsured families would spend an average of about $524 more as all families are required to obtain insurance. Families who would have spent more than $5,000 on health care under current law would on average see savings under the proposal. For example, families who would spend over $10,000 on health care in the year under current law would save an average of $2,785 per family.

Figure 20
Change in Average Family Health Spending by Current Law Insurance Status and Family Health Spending Under A Plan to Cover Coloradans in 2007/2008



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

Figure 21 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 70.4 percent of all Colorado families would see a net increase in health spending of $20 or more. About 26.1 percent of families would see a net decrease in spending of $20 or more. Only about 3.4 percent of the population would be unaffected (i.e., changes of less than $20) in terms of the amount spent on health.

Figure 21
Distribution of Families by the Amount of the Change in Total Family Health Spending Under the Plan for Covering Colorado

		PERCENT DISTRIBUTION OF FAMILIES										
	ALL FAMILIES	INCREASE IN FAMILY HEALTH COSTS					NO CHANGE	REDUCTION IN FAMILY HEALTH COSTS				
	TOTAL	$1000 +	$500-$999	$250-$499	$100-$249	$20-$99	+/- $20	$20-$99	$100-$249	$250-$499	$500-$499	$1000 +
Family Income												
< $10,000	176607.9	0.5	2.4	9.1	11.4	10.0	25.2	1.9	4.7	3.7	4.9	26.2
$10K-$19,999	225278.6	3.9	4.3	14.6	13.2	22.6	8.2	0.6	2.5	1.7	4.7	23.8
$20K-$29,999	229048.7	9.7	7.6	10.1	15.0	15.9	1.1	2.2	3.5	4.7	4.8	25.4
$30K-$39,999	237519.9	17.6	8.8	15.6	14.5	6.0	0.5	0.9	1.4	3.0	4.7	27.1
$40K-$49,999	200288.9	16.6	8.9	28.7	12.9	1.1	0.2	0.1	1.5	3.2	6.6	20.3
$50K-$74,999	316232.1	22.7	22.4	28.3	3.4	0.6	0.1	0.9	1.2	2.1	4.6	13.7
$75K-$99,999	238563.4	25.6	48.2	9.7	1.3	1.5	0.0	0.5	2.1	1.4	2.5	7.3
$100K-$149,9	190449.2	49.6	39.3	2.2	1.0	0.2	0.0	0.0	0.2	0.8	2.7	3.9
$150,000 +	177815.6	87.6	4.3	1.2	0.3	0.0	0.2	0.3	0.5	0.4	1.0	4.1
Income as a Percent of the FPL												
Below Poverty	225931.2	0.8	2.8	11.4	12.2	10.9	20.4	2.1	4.4	3.0	4.7	27.3
100%-199%	333666.2	4.1	5.7	12.5	9.4	17.0	5.5	0.7	2.2	3.5	5.5	33.9
200%-299%	319529.9	16.5	8.3	11.0	13.3	11.6	0.6	1.6	3.6	4.9	5.2	23.4
300%-399%	284848.4	27.1	16.0	22.8	12.9	1.6	0.3	0.7	0.5	1.6	3.3	13.1
400%-499%	221889.0	20.4	24.0	30.6	7.4	0.2	0.1	0.4	0.6	1.1	4.5	10.8
500% +	605939.7	49.3	31.0	8.3	1.0	0.7	0.1	0.3	1.1	0.9	2.8	4.6
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	13.1	8.8	15.2	9.7	4.1	5.3	1.4	2.2	6.0	6.5	27.8
25 - 34	417966.1	25.0	18.6	17.6	5.7	2.5	1.6	1.4	3.0	2.9	4.0	17.9
35 - 44	425342.2	33.5	19.9	13.6	3.8	1.9	0.8	0.8	1.5	2.2	4.1	17.9
45 - 54	413248.7	32.3	19.0	11.8	5.1	2.7	1.6	0.6	2.0	1.6	6.3	17.0
55 - 64	257395.7	24.1	21.3	15.1	7.2	4.1	3.5	0.5	1.8	2.1	2.6	17.6
65 +	266175.3	7.2	9.1	12.9	22.8	29.6	11.6	0.2	0.7	0.3	0.5	5.1
Family Out-of-Pocket Expenses												
Below $1,000	455047.8	22.4	12.3	20.8	11.0	7.3	9.1	1.7	3.2	3.2	5.0	3.9
$1,000-$2,499	431768.0	25.3	15.8	14.0	9.1	6.5	3.3	0.8	2.2	2.7	5.5	14.9
$2,500-$5,000	529014.4	27.8	20.0	14.0	6.9	5.4	1.1	0.5	1.7	2.6	2.6	17.2
$5K - $9,999	423343.7	23.3	21.1	11.2	5.6	6.2	1.0	0.5	0.9	1.4	3.8	25.1
Over $10,000	152630.5	21.8	12.1	5.9	7.3	7.4	1.3	0.4	0.7	0.7	3.5	39.0
Family Members with Health Insurance												
1+ Uninsured	385868.6	33.6	13.1	15.1	5.9	3.0	2.2	1.6	2.9	2.4	4.2	15.8
No Uninsured	1605935.9	22.4	17.9	14.2	8.6	7.2	3.7	0.6	1.7	2.3	4.1	17.3
All Families												
Total	1991804.4	24.6	17.0	14.3	8.1	6.4	3.4	0.8	1.9	2.3	4.1	17.0

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

D. Ten-Year Cost Projections

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 687,000 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 $45.2 billion over the 2008/2009 to 2017/2018 period (***Figure* 22**). About $12.8 billion of this would be covered through federal matching funds. 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 22
New State Program Costs for A Plan to Cover Coloradans in 2008/2009 through 2017/2018 [a/] (million)

	Total Spending (millions)	State Spending	Federal Spending
2008/2009	$2,524.7	$1,812.7	$712.0
2009/2010	$3,250.8	$2,334.0	$916.7
2010/2011	$3,861.2	$2,772.3	$1,088.9
2011/2012	$4,123.7	$2,960.8	$1,162.9
2012/2013	$4,412.4	$3,168.1	$1,244.3
2013/2014	$4,721.3	$3,389.9	$1,331.4
2014/2015	$5,047.0	$3,623.8	$1,423.3
2015/2016	$5,390.2	$3,870.2	$1,520.0
2016/2017	$5,756.8	$4,133.4	$1,623.4
2017/2018	$6,148.2	$4,414.4	$1,733.8
Total 2008/2017	**$45,236.3**	**$32,479.7**	**$12,756.6**

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).