

COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING; FY 08-09 BUDGET REQUEST

Schedule 13  
Change Request for FY 08-09 Budget Request Cycle

Decision Item FY 08-09:  Base Reduction Item FY 08-09:  Supplemental FY 07-08:  Budget Request Amendment FY 08-09:   
 Request Title: Children's Basic Health Plan Medical Premium and Dental Benefit Costs  
 Department: Health Care Policy and Financing  
 Priority Number: DL-3  
 Dept. Approval by: John Bartholomew  
 OSPB Approval: *John W. Bartholomew*  
 Date: November 1, 2007  
 Date: 10/29/07

	1	2	3	4	5	6	7	8	9	10
	Prior-Year Actual FY 06-07	Appropriation FY 07-08	Supplemental Request FY 07-08	Total Revised Request FY 07-08	Base Request FY 08-09	Decision: Base Reduction FY 08-09	November 1 Request FY 08-09	Budget Amendment FY 08-09	Total Revised Request FY 08-09	Change from Base (Column 5) FY 09-10
<b>Total of All Line Items</b>	<b>Total</b>									
	FTE	107,967,627	93,569,872	93,569,872	98,507,771	33,995,928	132,503,699	0	132,503,699	31,613,505
	GF	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	11,243,215	11,011	11,011	22,762	2,362,423	2,405,185	0	2,405,185	0
	GFE	0	0	0	0	0	0	0	0	0
	CF	232,136	246,943	246,943	248,694	59,962	308,656	0	308,656	59,962
	CFF	33,923,166	32,818,722	32,818,722	34,543,222	11,083,854	45,627,076	0	45,627,076	11,083,854
	FF	62,569,091	60,493,196	60,493,196	63,693,093	20,469,689	84,162,782	0	84,162,782	20,469,689
<b>(4) Indigent Care Program HB 97-1304 Children's Basic Health Plan Trust</b>	<b>Total</b>	<b>11,475,361</b>	<b>256,475</b>	<b>256,475</b>	<b>271,456</b>	<b>2,442,365</b>	<b>2,713,841</b>	<b>0</b>	<b>2,713,841</b>	<b>59,962</b>
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	11,243,215	11,011	11,011	22,762	2,362,423	2,405,185	0	2,405,185	0
	GFE	0	0	0	0	0	0	0	0	0
	CF	232,136	245,464	245,464	248,694	59,962	308,656	0	308,656	59,962
	CFF	0	0	0	0	0	0	0	0	0
	FF	0	0	0	0	0	0	0	0	0
<b>(4) Indigent Care Program Children's Basic Health Plan Premium Costs</b>	<b>Total</b>	<b>89,657,433</b>	<b>86,426,598</b>	<b>86,426,598</b>	<b>91,098,718</b>	<b>28,607,957</b>	<b>119,706,675</b>	<b>0</b>	<b>119,706,675</b>	<b>28,607,957</b>
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0
	CF	0	1,479	1,479	0	0	0	0	0	0
	CFF	31,530,990	30,408,342	30,408,342	32,045,063	10,052,899	42,097,962	0	42,097,962	10,052,899
	FF	58,126,443	56,016,777	56,016,777	59,053,655	18,555,058	77,608,713	0	77,608,713	18,555,058
<b>(4) Indigent Care Program Children's Basic Health Plan Dental Benefit Costs</b>	<b>Total</b>	<b>6,834,843</b>	<b>6,886,799</b>	<b>6,886,799</b>	<b>7,137,597</b>	<b>2,945,586</b>	<b>10,083,183</b>	<b>0</b>	<b>10,083,183</b>	<b>2,945,586</b>
	FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	GF	0	0	0	0	0	0	0	0	0
	GFE	0	0	0	0	0	0	0	0	0
	CF	0	0	0	0	0	0	0	0	0
	CFF	2,392,196	2,410,380	2,410,380	2,468,159	1,030,965	3,529,114	0	3,529,114	1,030,965
	FF	4,442,647	4,476,419	4,476,419	4,669,438	1,914,621	6,554,069	0	6,554,069	1,914,621

Letternote revised text:

Cash Fund name/number, Federal Fund Grant name:  
 IT Request:  Yes  No  
 Request Affects Other Departments:  Yes  No  
 If Yes, List Other Departments Here:

CF: Annual enrollment fees of CBHP enrollees. CFE: Tobacco Master Settlement Funds, Fund 11G (CBHP Trust Fund), Fund 18K (Health Care Expansion Fund), Supplemental Tobacco Litigation Settlement Account in the CBHP Trust Fund, and Colorado Immunization Fund, FF: Title XXI

**CHANGE REQUEST for FY 08-09 BUDGET REQUEST CYCLE**

Department:	Health Care Policy and Financing
Priority Number:	DI-3
Change Request Title:	Children's Basic Health Plan Medical Premium and Dental Benefit Costs

**SELECT ONE (click on box):**

- Decision Item FY 08-09
- Base Reduction Item FY 08-09
- Supplemental Request FY 07-08
- Budget Request Amendment FY 08-09

**SELECT ONE (click on box):**

- Supplemental or Budget Request Amendment Criterion:
- Not a Supplemental or Budget Request Amendment
  - An emergency
  - A technical error which has a substantial effect on the operation of the program
  - New data resulting in substantial changes in funding needs
  - Unforeseen contingency such as a significant workload change

Short Summary of Request:

This request is to increase the total funds appropriation for the Children's Basic Health Plan Premium Costs by \$28,607,957 from the FY 08-09 Base Request of \$91,098,718. This request also seeks to increase the Children's Basic Health Plan Dental Benefit Costs appropriation by \$2,945,586 from the FY 08-09 Base Request of \$7,137,597. The adjustments requested for FY 08-09 are the net result of increased caseload estimates and higher medical and dental costs. This request also seeks to increase the appropriation of Cash Funds for annual enrollment fees into the Children's Basic Health Plan Trust Fund by \$59,962, as well as a General Fund appropriation to the Children's Basic Health Plan Trust Fund in the amount of \$2,382,423 for FY 08-09 in order to balance the Trust Fund due to increased expenditures for traditional clients.

Background and Appropriation History:

The Children's Basic Health Plan, marketed as the Child Health Plan Plus, is a program that provides affordable health insurance to children under the age of 19 in low-income families (up to 200% of the federal poverty level) who do not qualify for Medicaid and do not have private insurance. The Children's Basic Health Plan is a non-entitlement program with a defined benefit package that uses privatized administration. The federal

government implemented this program in 1997, giving states an enhanced match on State expenditures for the program. Colorado began serving children in April of 1998. Where available, children enroll in a health maintenance organization. The Plan also has an extensive self-insured managed care network that provides services to children until they enroll in a selected health maintenance organization, and to those children who do not have geographic access to a health maintenance organization.

In October 2002, under an expansion authorized by HB 02-1155 and a federal demonstration waiver, the program began offering health benefits to pregnant women earning up to 185% of the federal poverty level who are not eligible for Medicaid. Due to budget balancing, enrollment into the Prenatal and Delivery Program was suspended from May 2003 through June 2004, with SB 03-291. The Prenatal and Delivery Program stopped funding care in November 2003, when the remaining prenatal care, deliveries, and postpartum care became a responsibility of the State-Only Prenatal Program, until all enrolled women had delivered and received two months postpartum care. Also, the children's program was capped in November 2003. In July 2004, both programs began accepting new applicants again.

HB 05-1262 (Tobacco Tax bill) contained several provisions that affected enrollment in the Children's Basic Health Plan. The following have fiscal and caseload impacts to the Children's Basic Health Plan:

- Increase eligibility to 200% of the federal poverty level, which was implemented on July 1, 2005;
- Provide funding for enrollment above the FY 03-04 enrollment level;
- Provide funding for cost-effective marketing, which began on April 1, 2006, and;
- Remove the Medicaid asset test effective July 1, 2006, which has moved clients from the Children's Basic Health Plan to Medicaid.

The FY 07-08 Long Bill (SB 07-239) appropriated \$89,825,813 in total funds to the Children's Basic Health Plan Premium Costs. This appropriation was reduced by \$3,399,215 to \$86,426,598, with changes for the following five bills:

- SB 07-004, which requires the Children's Basic Health Plan to provide Early Intervention Services in line with those provided under Medicaid;
- SB 07-036, which mandates coverage of certain mental health disorders;
- SB 07-133, which moves the Children's Basic Health Plan Premium Costs line item to cash-based accounting, resulting in one-time savings;
- SB 07-097, which increases eligibility in the Children's Basic Health Plan to 205% of the federal poverty level, and;
- HB 07-1301, which requires that the cervical cancer immunization be provided in the Children's Basic Health Plan.

The dental benefit for children was added to the Children's Basic Health Plan on February 1, 2002. This benefit has been managed through a capitated contract with Delta Dental, a dental plan administrator. As such, the contracted administrator bears the risk associated with the dental benefit. The dental contract was re-bid for FY 07-08, and a new contract was executed with Delta Dental. The plan administrator has an extensive statewide network with over seven hundred providers. The Children's Basic Health Plan dental benefit is comprehensive, and now limits each child to \$600 worth of services per year.

The FY 07-08 Long Bill (SB 07-239) appropriated \$7,104,840 in total funds to the Children's Basic Health Plan Dental Benefit Costs. This appropriation was reduced by \$218,041 to \$6,886,799, with changes for the following two bills:

- SB 07-133, which moves the Children's Basic Health Plan Dental Benefit Costs line item to cash-based accounting, resulting in one-time savings, and;
- SB 07-097, which increases eligibility in the Children's Basic Health Plan to 205% of the federal poverty level.

General Description of Request:

- This request seeks:
- The funding necessary to allow natural enrollment growth for children and pregnant women;
  - To adjust the per capita costs for medical and dental services in accordance with actuarial projections, and;

- To adjust the Cash Funds appropriation to the Children's Basic Health Plan Trust Fund for a revised estimate of enrollment fees, as well as the General Fund appropriation to balance the Trust Fund in FY 08-09.

**I. Description of Request Related to Children's Premiums**

*Caseload Restatement (Exhibit C.12)*

Through FY 06-07, the Children's Basic Health Plan Premiums Costs and Dental Benefit Costs line items were using accrual-based accounting. As a result, caseload was adjusted for up to five months to include retroactive enrollments, as counted by capitation payments. SB 07-133 moved these line items to cash-based accounting beginning in FY 07-08. As a result, caseload will no longer be adjusted for retroactivity. Reported caseload will now be a snapshot of enrollment as of the end of the month, similar to the reporting of Medicaid caseload.

Due to this change, caseload is being restated back to FY 01-02. Because caseload will no longer take into account clients who become retroactively eligible in subsequent months, caseload will now be lower than previously reported estimates. Using reports generated from the Colorado Benefits Management System between January and June 2007, the Department estimates the non-retroactive caseload to be approximately 10.5% lower than the caseload previously reported. This estimate is used to restate the caseload, which included retroactivity, to one without retroactivity. Monthly caseload through FY 03-04 is reduced by 10.5%, and the new time-series is smoothed into the old caseload series over the course of FY 01-02 and FY 02-03. Please note that the caseload restatement affects the FY 03-04 enrollment level, above which all traditional children are funded through the Health Care Expansion Fund. This new restated level is 41,786, whereas the level was 46,694 under accrual-based accounting. The expansion children's caseload is restated back to the population's inception in July 2005 using the same estimate. Although the caseload is lower under cash-accounting, this does not mean that fewer children have been or will be served in the program. See Exhibit C.12 for a historical comparison of the capitation-based and restated caseloads, as well as a monthly

comparison for FY 06-07. Comparisons of these caseloads are also presented in graphical form in Exhibit C.11.

*Caseload Projections (Exhibit C.6)*

In FY 06-07, many factors caused unexpected volatility in the traditional children's caseload (up to 185% of the federal poverty level). The Medicaid asset test was removed on July 1, 2006, and was implemented gradually over the course of FY 06-07 as clients came up for their annual redetermination. The Department anticipated that the asset test would increase the number of low-income children moving from the Children's Basic Health Plan to Medicaid. The number of children exiting the Children's Basic Health Plan did in fact increase in the first three months of FY 06-07, but decreased in subsequent months. Because asset information is no longer collected at the client level, the Department cannot identify clients moving from the Children's Basic Health Plan to Medicaid specifically because of the removal of the asset test. However, as discussed in the Department's June 20, 2007 FY 06-07 Emergency Supplemental #1, "Adjustments to the FY 06-07 Children's Basic Health Plan Caseload and Costs", the number of low-income children leaving the Children's Basic Health Plan was lower than anticipated.

In addition to the removal of the asset test, which was expected to decrease caseload, two factors were expected to have a positive effect on the traditional children's caseload. First, the citizenship requirements of the Deficit Reduction Act of 2005 may have had a positive impact on the Children's Basic Health Plan caseload. Children who do not provide proper proof of citizenship may not gain Medicaid eligibility, but would still be eligible for the Children's Basic Health Plan, which is not subject to the Deficit Reduction Act. The Department clarified this policy in late October 2006 and established more specific procedures to accomplish this. The Department currently has no way to quantify this impact because the documentation process is manual and is not yet incorporated into the Colorado Benefits Management System.

Second, marketing of the Children's Basic Health Plan began in April 1, 2006. The marketing campaign has been successful, and the Department believes that it has had a

positive effect on caseload in both the children and prenatal programs. A new marketing campaign began on January 29, 2007. This television and radio campaign was launched statewide, and targeted low-income and Hispanic populations. The Department believes that the strong caseload growth during the second half of the fiscal year is indicative that recent marketing is having a positive and stronger than previously experienced effect on caseload.

Caseload for expansion children (between 186% and 200% of the federal poverty level) has not been affected by either the removal of the Medicaid asset test or the citizenship requirements of the Deficit Reduction Act. Regardless of whether the child's family has assets, the family's income would be too high for the child to be eligible for Medicaid, which goes up to 100% or 133% of the federal poverty level, depending on age. In addition, if a child otherwise eligible for Medicaid cannot produce proper documentation, the child would be eligible for the traditional children's population in the Children's Basic Health Plan, as their income would be too low to enter the expansion population.

Between October 2006 and June 2007, the traditional children's caseload increased by an average of 1.9% per month. This is the net effect of the removal of the asset test, the documentation requirements of the Deficit Reduction Act, natural population growth, and marketing. During the same period, the expansion population increased by an average of 2.4% per month. As discussed above, the expansion population is not affected by either the asset test removal or the Deficit Reduction Act, so this growth is due to marketing and natural population increases. The average monthly growth in the traditional and expansion populations are relatively close, which seems to imply that the effects of the asset test removal and the Deficit Reduction Act are nearly offsetting. The slightly stronger monthly growth in the expansion population is largely due to high growth in October 2006, and the monthly growth rate moderated markedly over the course of FY 06-07.

Net of the effects of policy changes, it is reasonable to expect the caseloads in Medicaid Eligible Children and the Children's Basic Health Plan to partially move in opposite directions. In times of economic growth or stability, Medicaid caseload is expected to drop with employment or income increases. Some children whose family income is now

too high for Medicaid eligibility may be within the Children's Basic Health Plan income guidelines. So as Medicaid caseload declines, the Children's Basic Health Plan caseload may increase. The Children's Basic Health Plan caseload would not be expected to increase by the same magnitude as the Medicaid children's caseload is dropping, as some children in the higher income levels of the Children's Basic Health Plan may also lose eligibility due to the economic conditions. As seen in the Department's November 1, 2007 Budget Request, Exhibit B, page EB-1, the Medicaid Eligible Children caseload is projected to decline by 13,336 children in FY 07-08, a 6.47% decrease over FY 06-07. This caseload is projected to remain nearly unchanged in FY 08-09, with a 0.06% decline from FY 07-08.

In FY 07-08, the number of children leaving the traditional children's population in the Children's Basic Health Plan due to the removal of the asset test should decline, as all children will have undergone an annual eligibility redetermination by the end of FY 06-07. In addition, all Medicaid children will have undergone an annual redetermination under the Deficit Reduction Act rules by October 2007, so the number of children moving from Medicaid to the traditional children's population in the Children's Basic Health Plan should decrease in FY 07-08. As discussed, the Department believes that the 1.9% monthly growth experienced between October 2006 and June 2007 was due to marketing and natural growth, owing to factors such as the improved economy and general population growth, and the forecasted declines in the Medicaid Eligible Children's caseload supports a relatively healthy caseload projection in Children's Basic Health Plan children. Due to recent volatility in the traditional children's caseload, the Department opted to model the forecasted FY 07-08 caseload growth on data from FY 01-02. Current economic conditions are similar to those from this period of time, and there was marketing of the Children's Basic Health Plan. During FY 01-02, monthly growth averaged 1.6%, and caseload was half the current size. Because caseload is significantly higher and potentially approaching a saturation point, it is reasonable to expect that the monthly growth would be lower than that experienced in FY 01-02, despite similar economic conditions and marketing. Based on this, the Department projects that the traditional children's caseload will increase by an average of 1.1% per month in FY 07-08. The monthly variations in growth rates are retained from FY 01-02, and are due to things such as the distribution of

annual redeterminations and seasonality in caseload caused by strong marketing around the beginning of the traditional school year.

In FY 08-09, the Department anticipates the average monthly growth to decrease from that in FY 07-08. The moderation in the declines in the Medicaid Eligible Children caseload, from a decrease of 6.47% in FY 07-08 to a decrease of 0.06% in FY 08-09, should slow growth in the Children's Basic Health Plan children's populations. Extending the FY 07-08 forecast, the Department's FY 08-09 forecast is modeled after the caseload growth experienced during FY 02-03. During FY 02-03, monthly growth averaged 1.2% per month. As with the FY 07-08 forecast, it is reasonable to expect that caseload growth would be lower than this given the higher caseload level. Based on this, the Department projects that the traditional children's caseload will increase by an average of 0.7% per month. The pattern of monthly variations in growth rates is retained from the FY 07-08 forecast, for the reasons outlined above.

As previously discussed, FY 06-07 monthly growth in the expansion children's caseload was approximately the same as that for the traditional children once effects of the asset test removal and the Deficit Reduction Act began to offset. The expansion population has now been in place for two years, and the Department believes that the converging of growth rates is reflective of a maturing population that is approaching a stable long-term growth rate. As such, the Department projects that the expansion population will grow at the same rate as the traditional children throughout the forecast period, or an average of 1.1% per month in FY 07-08 and 0.7% per month in FY 08-09. For the reasons outlined above, the monthly variations in the growth rates are retained in the forecast for expansion children.

#### *Caseload Adjustments*

In addition to the base caseload outlined above, there are two bottom line adjustments to the children's caseload for the forecast period. HB 06-1270 (*Public School Eligibility Determinations*) directs the Department to establish medical assistance sites in public schools to allow qualified personnel to make Medicaid eligibility determinations. Based

on the fiscal note for HB 06-1270, which assumes the participation of three school districts, the total children's caseload forecast is increased by 102 clients in FY 07-08 and 121 in FY 08-09. The adjustment is split between traditional and expansion populations based on the relative size of each group.

The Department is implementing income disregards to allow for eligibility up to an equivalent of 205% of the federal poverty level. SB 07-097 provides Supplemental Tobacco Litigation Settlement funding for the medical and dental costs for these new clients. The fiscal note for this bill included an inflation factor to adjust for retroactivity in CHP+ caseload. However, with the move to cash-based accounting in the Children's Basic Health Plan, caseload no longer includes retroactivity. After removing this factor, the children's caseload forecast is increased by 108 clients in FY 07-08 and 235 in FY 08-09. These clients are included in the expansion population projections.

*Total Children's Caseload Projection*

The total FY 07-08 children's caseload forecast is 56,323, a 19.7% increase over the FY 06-07 restated caseload of 47,047. While this growth rate is high, had caseload increased by 2.1% per month for all of FY 06-07 (as experienced between November 2006 and June 2007), the growth rate in total children would have been approximately 32.0%. The total FY 08-09 children's forecast is 62,481, a 10.9% increase over FY 07-08. Please see Exhibit C.6 for children's caseload history and detailed projections.

<b>Children's Caseload Summary</b>	<b>FY 07-08 Appropriated Caseload</b>	<b>FY 07-08 Revised Caseload</b>	<b>FY 08-09 Request Caseload</b>
Traditional Children (up to 185% FPL)	49,364	52,724	58,382
Expansion Children	4,352	3,599	4,099
<b>Final Caseload Forecast</b>	<b>53,716</b>	<b>56,323</b>	<b>62,481</b>

*Children's Rates (Exhibit C.5)*

Children's Basic Health Plan children are served by either a health maintenance organization (HMO) at a fixed monthly cost, or by Anthem, which is a no-risk provider that maintains the State's managed care network and bills the State directly for all costs incurred (self-funded). In FY 05-06 and FY 06-07, approximately 58.0% of Children's Basic Health Plan children were served by an HMO, while the remaining 42.0% were in the self-funded network. Actual and estimated caseload ratios between HMOs and the self-funded network are used to develop blended capitation rates.

The Children's Basic Health Plan is responsible for all costs incurred by members in the State's self-funded network, including any extraordinary health care services. While the per member per month medical cost includes some variability in costs per client, a single child with catastrophic health care claims (such as a life-threatening illness or severe auto accident) could cost the program potentially hundreds of thousands of dollars. Unlike Medicaid, the Children's Basic Health Plan is not an entitlement program and the Department does not have overexpenditure authority for this program; the Children's Basic Health Plan must pay all claims incurred through its annual appropriation. Presently, the Department mitigates this risk by purchasing reinsurance. Reinsurance protects insurers from catastrophic claims by paying for claims over a predetermined dollar amount. Reinsurance premiums are paid by a per member per month charge. Like the State, health maintenance organizations are responsible for covering claims for catastrophic cases enrolled in their plans, and often use reinsurance coverage to mitigate their financial risk in this area as well.

For the development of the FY 07-08 rate for children in the self-funded network, the Plan's contracted actuary assumed that health care costs would grow by an estimated 7.2% based on history, published surveys, and reports. In addition, the total administrative costs are projected to increase by 4.6% to \$31.43. This amount includes an estimated \$29.00 in claims and network administration costs and \$2.43 in reinsurance costs per client per month in the self-funded program. The resulting FY 07-08 base per month cost for each child in the self-funded network is a total of \$129,64, a 7.0% increase over the FY 06-07 rate. This is higher than that previously reported in the Department's November 1, 2006 FY 07-08 Budget Request DI-3, as an income rating category was

omitted from the original actuarial rates in anticipation that the removal of the Medicaid asset test would eliminate all clients under 100% of the federal poverty level.

In the development of the FY 07-08 rate for each HMO client, the contracted actuary also assumed growth in health care costs of 7.2%. Administrative costs are projected to increase by 5.6% to \$14.42 per member per month. The resulting FY 07-08 base per month cost for each child in an HMO is \$107.87, a 12.9% increase over the FY 06-07 rate. This increase is due largely to higher claims costs during the base period used to calculate the FY 07-08 rates relative to that for the FY 06-07 rates. In addition, the HMO rate decreased in FY 06-07, and has increased by an average of 4.1% per year between FY 03-04 and FY 06-07, compared to average growth of 8.9% per year in the self-funded rate. As with the self-funded rate, the FY 07-08 rate is higher than previously reported for the reasons already outlined. While similar assumptions are used to derive both the self-funded and HMO rates, it should be noted that the HMOs define their own benefit structures and, as such, can offer more benefits than the Department requires. In calculating the HMO rates, the contracted actuary disregards the additional benefits and costs of services provided above and beyond those required by the Department.

The Department estimates that approximately 42.0% of children will be served in the self-funded network in FY 07-08 and the remaining 58.0% will be enrolled in an HMO. This is based on historical experience as well as the expectation that the growth in children new to the Children's Basic Health Plan will support a higher percentage of children in the self-funded network, as new children are often in the self-funded network for a number of months prior to enrolling in an HMO. Applying these weights to the actuarial rates yields a blended rate of \$117.01 for all children in FY 07-08. This is an increase of 10.5% over the FY 06-07 blended rate of \$105.85, as calculated using the actual caseload mix between self-funded and HMO.

The following four bills were passed in the 2007 legislative session and have impacts on the FY 07-08 benefit package and capitation rates in Children's Basic Health Plan:

- SB 07-004: Mandates that the Children's Basic Health Plan provide Early Intervention Services in line with those provided in Medicaid. The Children's Basic Health Plan will begin providing physical, occupational, and speech therapies for children under the age of 3 who have developmental delays. This change to the benefit package is effective November 1, 2007.
- SB 07-036: Mandates coverage of certain mental health disorders, including but not limited to general anxiety disorder, post traumatic stress disorder, and drug and alcohol disorders. Coverage of the certain mental health disorders is required to be no less extensive than that provided for physical illness. This change to the benefit package is effective January 1, 2008.
- HB 07-1301: Mandates coverage for the full cost of the cervical cancer vaccination for all females for whom a vaccination is recommended, generally at age 11 to 12, as well as older women who have not previously been vaccinated. This change to the benefit package is effective January 1, 2008.
- SB 07-097: Provides Supplemental Tobacco Litigation Settlement funding to expand eligibility in the Children's Basic Health Plan from 200% to 205% of the federal poverty level. This change in eligibility is effective March 1, 2008.

The following table shows a comparison of the estimated change in the capitation rate that was used to appropriate funds for the implementation of each bill to the actual change in the blended rate:

	Estimated (Appropriated) Impact on Rate from Fiscal Note	Actual Rate Impact	Difference
SB 07-004 Early Intervention Services	\$0.10	\$2.50	(\$2.40)
SB 07-036 Mandatory Coverage of Mental Health Disorders	\$0.08	\$0.16	(\$0.08)
HB 07-1301 Cervical Cancer Immunizations	\$1.99	\$3.98	(\$1.99)
SB 07-097 Allocation of Tobacco Litigation Settlement Monies	\$0.00	\$0.00	\$0.00

The final impact on the children's capitation rate for SB 07-004 (Early Intervention Services) is significantly higher than that included in the fiscal note estimate. The current benefit package provides physical, occupational, and speech therapies only in cases where

such therapy is medically needed due to illness or injury, and the benefits are limited to 30 visits. However, per the current benefit package, specifically excluded are “therapies for learning disorders, developmental delays, stuttering, voice disorders, or rhythm disorders”. In estimating the fiscal note, only the cost of removing the cap on visits was included. The higher than estimated cost for adding these benefits is because the exclusion of developmentally delayed clients is being removed, and unlimited therapies for these clients will be provided beginning November 1, 2007. The assumed utilization and cost per therapeutic visit assumed by the contracted actuary are in line with those experienced in the comparable population in Medicaid.

The final impact on the children’s rate for the cervical cancer immunization is also notably different than the fiscal note estimate. In the calculation of the per member per month increase due to the benefit, the contracted actuary’s assumed cost for the immunization series, including that of administering the vaccine, exceeds that used in the fiscal note estimate by 11.6%. In addition, the utilization rate assumed by the contracted actuary is 50% of females aged 11 through 18, whereas the fiscal note assumed 40.9% utilization.

The final FY 07-08 blended rate, including the legislative impacts outlined above, adjusted for effective dates, is \$120.75 per member per month. This is a 14.1% increase over the FY 06-07 blended rate of \$105.85, as calculated using the actual caseload mix between self-funded and HMO. See Exhibit C.5, page C.5-2 for calculations.

For the rates effective in FY 08-09, the Department contracted with the same actuary to develop the self-funded (Anthem) and HMO rates. As with the FY 07-08 rates, the contracted actuaries based rates on history and industry trend sources, and assumed that health care costs would grow by 6.7% in the self-funded network, down from a 7.2% trend in FY 07-08. In addition, total administrative costs are projected to increase by 4.2% to \$32.75. This amount includes an estimated \$30.45 in administrative costs and \$2.30 in reinsurance costs per client per month in the self-funded program. The resulting projected FY 08-09 self-funded rate is \$141.54 per member per month, a 5.9% increase over the FY 07-08 Anthem rate of \$133.71 (blended to include all legislative impacts).

The contracted actuary utilized historical Children's Basic Health Plan data in the FY 08-09 HMO rate development. Based on claims costs incurred in 2005 and 2006, the contracted actuary assumed a cost trend of 6.9% for the HMOs, which is in line with other industry studies. The rates were also adjusted for the impacts of the 2007 legislation outlined above, as these costs were not already included in the claims costs from which the FY 08-09 costs are projected. However, the FY 08-09 rate does not incorporate the impact of SB 07-004 (Early Intervention), as the contracted actuary will be monitoring the utilization and cost for the new benefits. Based on recent growth, administrative costs are projected to increase by 14.1% to \$16.46 per member per month. The resulting FY 08-09 HMO rate is \$109.65, a 1.5% decrease from the FY 07-08 HMO rate of \$111.37 (blended to include all legislative impacts). This overall decrease is largely due to a projected reduction in costs for children under age 6, which comprise approximately 20% of children enrolled in the HMOs.

As previously discussed, the Department estimates that 42.0% of children will be served in the self-funded network in FY 07-08 and the remaining 58.0% will be enrolled in an HMO. The Department assumes that this enrollment mix will remain constant in FY 08-09, for the reasons outlined above. Applying these weights to the actuarial rates yields a blended rate of \$123.04 for all children in FY 08-09. This is an increase of 1.9% over the FY 07-08 blended rate of \$120.75, which includes all legislative impacts adjusted for effective dates.

*Children's Per Capita (Exhibit C.5)*

In prior years, the Children's Basic Health Plan Premium Costs projections for children were calculated by first forecasting caseload, which included retroactivity, and multiplying by twelve to estimate the number of member months for which capitation payments would be made in the year. This estimate of total member months was then multiplied by per member per month capitation rates to project the total expenditures. This methodology using forecasted member months, however, includes the impact of retroactive payments, which is inconsistent with the move to cash-based accounting. Beginning in FY 07-08, the Children's Basic Health Plan Premium Costs projections will no longer be directly

calculated based on per member per month capitation rates, but rather using per capita costs.

The Department has analyzed cash-based expenditures, as reported from the Colorado Financial Reporting System, and the restated non-retroactive caseload to estimate historical children's per capitas. While the expenditure projections will no longer be directly calculated with capitation rates, growth in historical per capita has tracked with growth in the blended capitation rate over recent years. Given this and the short per capita history, the Department's FY 07-08 and FY 08-09 forecasted per capita growth rates mirror those of the actuarially developed rates. This forecast assumes that the capitation rate for the self-funded network is indeed in line with the costs incurred for these children, and that other factors that may affect per capita costs remain constant from FY 06-07. Examples of other factors that may affect per capita costs include the length of stay in the program, enrollment mix between the more expensive self-funded network and HMOs, and the average length of time taken for a child to enroll in an HMO.

As discussed in the Department's June 20, 2007 FY 06-07 Emergency Supplemental #1, "Adjustments to the FY 06-07 Children's Basic Health Plan Caseload and Costs", the Department booked an accounts receivable for overpayments to Anthem in FY 05-06. It was discovered during the FY 05-06 cost settlement with Anthem that the Department had over-estimated this amount, and the accounts receivable had to be reversed and the expenditures accounted for in FY 06-07. This, in effect, artificially pushed FY 05-06 expenditures into FY 06-07, thus inflating the FY 06-07 cash-based expenditures from the Colorado Financial Reporting System, and therefore the calculated per capita. The reversed accounts receivable affected only the children's expenditures, and accounted for approximately 5.2% of the accrual-based expenditures for children in FY 06-07. The FY 06-07 cash-based children's medical expenditures from the Colorado Financial Reporting System are decreased by a like amount in order to approximate the FY 06-07 expenditures without the artificial inflation. These adjusted expenditures are used to calculate the FY 06-07 per capita of \$1,385.96, from which the FY 07-08 and FY 08-09 per capitas are projected.

The growth in the FY 07-08 blended capitation rate is used to project the FY 07-08 per capita. The base growth of 10.5% is applied to the calculated FY 06-07 per capita to estimate a base per capita. For the impacts of the legislative changes discussed above, the percent change in the per member per month rate relative to the base FY 07-08 rate is calculated for each change in benefits. These percentages are then applied to the base per capita, and adjusted for partial years according to effective dates, to estimate the final per capita. The FY 07-08 estimated children's per capita, adjusted for all legislation and the corresponding effective dates, is \$1,581.01.

Similar to FY 07-08, the growth in the FY 08-09 blended capitation rate is used to project the FY 08-09 per capita. The blended rate increase is estimated to be 1.9% in FY 08-09. Applying this growth to the final blended FY 07-08 per capita yields an estimated FY 08-09 per capita of \$1,611.05. There are no adjustments for changes in either eligibility or benefit packages in FY 08-09. See Exhibit C.5 for per capita history and detailed projections.

## **II. Description of Request Related to the Prenatal Program**

### *Caseload Restatement (Exhibit C.12)*

As with the children's population, the prenatal caseload is being restated back to the program's inception due to the change to cash-based accounting. Because caseload will no longer take into account clients who become retroactively eligible in subsequent months, caseload will now be lower than previously reported estimates. In addition, prenatal caseload was previously reported in total member months, due to the fact that pregnant women do not receive eligibility in the program for a full year. Prenatal caseload will now be reported and forecasted at the client level, yielding a caseload similar to that for children.

Using reports generated from the Colorado Benefits Management System between January and June 2007, the Department estimates the non-retroactive caseload to be approximately 15.2% lower than the caseload previously reported. This estimate is used

to restate the prior caseload, which included retroactivity, to one without retroactivity. Monthly caseload through the program's inception in October 2002 is reduced by 15.2%. Please note that the caseload restatement affects the FY 03-04 enrollment level, above which all traditional prenatal clients are funded through the Health Care Expansion Fund. This new restated level is 101, whereas the level was 119 under accrual-based accounting. The expansion prenatal caseload is restated back to the population's inception in July 2005 using the same estimate. Although the caseload is lower under cash-accounting, this does not mean that fewer prenatal women have been or will be served in the program. See Exhibit C.12 for a historical comparison of the capitation-based and restated caseloads, as well as a monthly comparison for FY 06-07. Comparisons of these caseloads are also presented in graphical form in Exhibit C.11.

*Caseload Projections (Exhibit C.7)*

In FY 06-07, the Children's Basic Health Plan prenatal population did not experience the volatility in caseload that was seen in the children's population. The removal of the Medicaid asset test did not affect this population, as pregnant women were never subject to asset limitations to qualify for the Baby and Kid Care Program in Medicaid. In addition, the prenatal population was subject to the identification requirements of HB 06S-1023. With the passage of SB 07-211, the CHP+ prenatal population will be exempted from the HB 06S-1023 identification requirements beginning July 1, 2008, which may increase the monthly growth rate above that experienced in FY 06-07. However, as evidenced by the children's population, the effects of such a policy change are difficult to predict or quantify. The Department believes that pregnant adults are more likely than children to have proper identification documentation, so the effects may be mitigated from those experienced in the children's population.

Therefore, until caseload data is available with the effects of the change in policy, the Department sees no compelling reason to deviate from forecasts based on the most recent caseload growth. The Department believes that the recent declines in monthly growth are reflective of a maturing population that is approaching a stable long-term growth rate. Based on monthly growth rates experienced in FY 06-07, the Department projects that the

traditional prenatal caseload will increase by an average of 1.0% per month in FY 07-08. The monthly variations in growth rates are retained from this period, and are due to factors such as the distribution of annual redeterminations and seasonality in caseload caused by strong marketing around the beginning of the traditional school year. The Department projects this growth to continue in FY 08-09, as this forecast yields moderate growth in line with a mature population.

While the expansion prenatal population has been in place for the same amount of time as the expansion children, its growth rate is not converging with the traditional prenatal population, as is occurring with the child populations. In FY 06-07, average monthly growth in the expansion prenatal was 1.9%, nearly twice that seen in the traditional population. Similar to the traditional population, the Department sees no compelling reason to deviate from forecasts based on recent growth trends until caseload data is available that incorporates the effects of the SB 07-211 policy change regarding identification requirements. Growth in the expansion prenatal population is forecasted to continue from FY 06-07, and caseload is projected to increase by an average of 1.9% per month in FY 07-08. Forecasted monthly variations in growth rates mirror those in the traditional prenatal population. As with traditional prenatal, the Department projects the FY 07-08 growth to continue into FY 08-09, as the forecast yields moderate growth.

#### *Caseload Adjustments*

In addition to the base caseload outlined above, there is a bottom line adjustment to the prenatal caseload for the forecast period for SB 07-097, which expands eligibility in the Children's Basic Health Plan to 205% of the federal poverty level. The fiscal note for this bill included an inflation factor to adjust for retroactivity in CHP+ caseload. However, with the move to cash-based accounting in Children's Basic Health Plan, caseload no longer includes retroactivity. After removing this factor, the prenatal caseload forecast is increased by 7 clients in FY 07-08 and 19 in FY 08-09. These clients are included in the expansion population projections.

#### *Total Prenatal Caseload Projection*

The total FY 07-08 prenatal caseload forecast is 1,297 clients, a 10.9% increase over the FY 06-07 restated caseload of 1,170. The FY 08-09 total prenatal forecast is 1,497 clients, a 15.4% increase over FY 07-08. Please see Exhibit C.7 for children's caseload history and detailed projections.

<b>Prenatal Caseload Summary</b>	<b>FY 07-08 Appropriated Caseload</b>	<b>FY 07-08 Revised Caseload</b>	<b>FY 08-09 Request Caseload</b>
Traditional Prenatal (up to 185% FPL)	1,175	1,078	1,214
Expansion Prenatal	482	219	283
<b>Final Caseload Forecast</b>	<b>1,657</b>	<b>1,297</b>	<b>1,497</b>

*Prenatal Rates (Exhibit C.5)*

All clients in the prenatal program are served by the self-funded program (Anthem) and the costs of their services are billed in full directly to the State. For the development of the FY 07-08 rates, the contracted actuary did not have multiple years of claims experience to develop cost trends, so the same trends by category of service from the self-funded network's children population were used for the prenatal program. Applying these trends by service category yielded an estimated average growth rate in health care costs of 4.7%. The actuarial analysis also assumes that 95% of all pregnant women in the prenatal program will have deliveries in the Children's Basic Health Plan, and that the average length of stay will be 7.8 months. As with the children's rates, the total administrative costs are projected to increase by 4.6% to \$31.43, which includes an estimated \$29.00 in claims and network administration costs and \$2.43 in reinsurance costs per client per month (see Children's Rates, Section I). The FY 07-08 base prenatal rate developed by the contracted actuary is \$864.09, a 17.4% decrease from the FY 06-07 rate. This decrease is due to a decline in the claims costs during the base periods from which the rates are trended. The FY 07-08 rate is lower than that previously reported in the Department's November 1, 2006 FY 07-08 Budget Request DI-3 for the reasons outlined in Children's Rates, Section I.

The Department is implementing income disregards to allow for eligibility up to an equivalent of 205% of the federal poverty level. SB 07-097 provides Supplemental Tobacco Litigation Settlement funding for these new clients. This change in eligibility is effective March 1, 2008. While the fiscal note for this bill assumed that the addition of this population would not change the capitation rate, the contracted actuary adjusted the FY 07-08 rates down slightly. The final FY 07-08 blended rate, after adjusting for the effective date of SB 07-097, is \$864.08 per member per month.

Similar to the development of FY 08-09 rates for the children's population, the contracted actuaries based prenatal rates on history and industry trend sources. The assumed growth in health care costs in FY 08-09 is 6.7% for prenatal women in the self-funded network, up from a 4.7% trend in FY 07-08. Utilization assumptions were retained from FY 07-08, and the actuarial analysis assumes that 95% of all pregnant women in the prenatal program will have deliveries in the Children's Basic Health Plan, and that the average length of stay will be 7.8 months. As in the children's self-funded rates, total administrative costs are projected to increase by 4.2% to \$32.75, which includes an estimated \$30.45 in administrative costs and \$2.30 in reinsurance costs per client per month. The resulting projected FY 08-09 prenatal rate is \$921.30 per member per month, a 6.6% increase over the final FY 07-08 prenatal rate of \$864.07 (including the impact of SB 07-097).

*Prenatal Per Capita (Exhibit C.5)*

Similar to the children's projections, the Children's Basic Health Plan Premium Costs estimate for the prenatal program in prior years was calculated by first projecting caseload in total member months, which included retroactivity. This estimate of total member months was then multiplied by per member per month capitation rates to estimate the total expenditures. This methodology using projected member months, however, includes the impact of retroactive payments, which is inconsistent with the move to cash-based accounting. Beginning in FY 07-08, the Children's Basic Health Plan Premiums Costs projections will no longer be directly calculated based on per member per month capitation rates, but rather using per capita costs.

The Department has analyzed cash-based expenditures, as reported from the Colorado Financial Reporting System, and the restated non-retroactive caseload to estimate historical prenatal per capitas. While the expenditure projections will no longer be directly calculated with capitation rates, growth in historical per capita has tracked with growth in the prenatal capitation rate over recent years. Given this and the short per capita history, the Department's FY 07-08 and FY 08-09 forecasted per capita growth rates mirror those of the actuarially developed rates, similar to the methodology used in the children's population. This forecast assumes that the capitation rate is indeed in line with the costs incurred for prenatal clients in the self-funded program, and that other factors that may affect per capita costs, such as the length of stay in the program, remain constant from FY 06-07.

The FY 06-07 calculated prenatal per capita is \$14,438.28. The calculated FY 06-07 per capita is decreased by the base decline of 17.4% in capitation rates to estimate a base per capita for FY 07-08. The change to the capitation rate for SB 07-097 was so slight that it did not change the per capita. The FY 07-08 estimated prenatal per capita is \$11,933.24.

Similar to FY 07-08, the growth in the FY 08-09 prenatal capitation rate is used to project the FY 08-09 per capita. The capitation rate increase is estimated to be 6.6% in FY 08-09. Applying this growth to the FY 07-08 per capita yields an estimated FY 08-09 per capita of \$12,723.22. There are no adjustments for changes in either eligibility or benefits packages in FY 08-09.

### **III. Description of Request Related to the Children's Dental Benefit Costs**

#### *Dental Caseload (Exhibit C.6)*

Children who qualify for the Children's Basic Health Plan are eligible to receive dental benefits in addition to medical benefits. There are consistently fewer members enrolled in the dental program than in the medical plan, because new members do not receive dental coverage during their pre-HMO enrollment period. Previously, the Department calculated a ratio of dental enrollment to medical enrollment to project dental caseload and costs.

Through FY 06-07, the Children's Basic Health Plan Premiums Costs and Dental Benefit Costs line items were using accrual-based accounting. SB 07-133 moved these line items to cash-based accounting beginning in FY 07-08. As a result, the Department will no longer estimate a separate children's dental caseload. Rather, the dental caseload will be the same as the medical caseload, and the per capita will incorporate a lower cost per client due to a shorter length of stay in the dental program.

*Dental Rates (Exhibit C.5)*

The actuarially developed dental capitation rate presented in the Department's November 1, 2006 FY 07-08 Budget Request DI-3 was \$13.97 per member per month for FY 07-08. The dental vendor contract was re-bid for FY 07-08, and a new contract was executed with Delta Dental at a negotiated rate of \$13.84 for FY 07-08. This is an increase of 4.1% over the FY 05-06 capitation rate. As part of the re-bid process, Delta Dental was also able to offer an increased benefits package. These changes include increasing the cap on dental benefits from \$500 to \$600 per year, removing the age limit on sealants and fluoride varnishes, and increasing the cap on fluoride varnishes from one to two per year.

For the development of the FY 08-09 dental capitation rate, the contracted actuary assumed a cost trend of 3.0%, based on historical dental claims data as well as industry publications. The FY 08-09 actuarially developed dental rate is \$14.66 per member per month, an increase of 5.9% over the FY 07-08 rate. This rate assumes the continuation of the enhanced benefits package described above, as well as an estimated \$1.09 in administrative costs per member per month.

*Dental Per Capita (Exhibit C.5)*

In prior years, the dental caseload was estimated to be a fixed percent of the medical caseload for expenditure projections, typically around 80%. As with the medical projections, this estimated caseload, which included retroactivity, was then multiplied by twelve to estimate the number of member months for which capitation payments would be

made in the year. This estimate of total member months was then multiplied by per member per month capitation rates to project the total expenditures. This methodology using projected member months, however, includes the impact of retroactive payments, which is inconsistent with the move to cash-based accounting. Beginning in FY 07-08, the Children's Basic Health Plan Dental Benefit Costs projections will no longer be directly calculated based on per member per month capitation rates, but rather using per capita costs.

The Department has analyzed cash-based expenditures, as reported from the Colorado Financial Reporting System, and the restated non-retroactive caseload to estimate historical dental per capitas. Rather than estimating dental caseload as a percent of medical caseload, the historic and projected per capitas are based on the medical caseload. While the expenditure projections will no longer be directly calculated with capitation rates, growth in historical per capita has tracked with growth in the capitation rate over the recent years. Given this and the short per capita history, the Department's FY 07-08 and FY 08-09 forecasted per capita growth rates mirror those of the actuarially developed rates. This forecast assumes that other factors that may affect per capita costs, such as the length of stay in the Children's Basic Health Plan and the average length of time taken for a child to receive dental benefits, remain constant from FY 06-07.

The FY 06-07 calculated dental per capita is \$146.42. Base growth of 4.1% from the capitation rate is applied to the calculated FY 06-07 per capita to estimate the FY 07-08 per capita of \$152.36.

Similar to FY 07-08, the growth in the FY 08-09 dental capitation rate is used to project the FY 08-09 per capita. The capitation rate increase is estimated to be 5.9% in FY 08-09. Applying this growth to the FY 07-08 per capita yields an estimated FY 08-09 per capita of \$161.38.

**IV. Description of Request Related to the Trust Fund (Exhibit C.1)**

Expenditures from the Trust Fund include program expenses from the Children's Basic Health Plan premiums, dental, and administration line items, as well as a portion of the Department's internal administration expenses allocated to the Children's Basic Health Plan. The program expenses and projection of the Trust Fund balance are presented in Exhibit C.1.

The Children's Basic Health Plan Trust Fund is funded primarily through Tobacco Master Settlement appropriations and General Fund (when necessary); however, enrollment fees from clients of the program and interest earnings on the Fund's balance also serve to subsidize the Trust. In FY 05-06, \$900,000 was refunded to the Trust in January of 2006, as repayment for a 2002 transfer to the Department of Treasury used to reduce the State's General Fund deficit. In the FY 07-08 Long Bill Add-ons, the Trust was appropriated \$11,243,215 General Fund with the intent of providing funding for traditional clients that are paid for from the Trust Fund through FY 07-08.

The original estimate of the FY 07-08 Tobacco Master Settlement allocation to the Trust Fund was the statutory minimum of \$17,500,000. However, due to the higher than expected payment received in late FY 06-07, the base allocation to the Trust was increased to \$20,147,800. In addition, HB 07-1359 accelerated payments from the Strategic Contribution Fund in the Master Settlement Agreement, which increased the Trust's allocation further by \$1,500,000. Accounting for the Trust's portion of the State Auditor's Office payment, the revised FY 07-08 Tobacco Master Settlement allocation to the Trust is \$21,612,590. The current estimate for the FY 08-09 allocation to the Trust is \$23,972,821.

While the Trust Fund balance is expected to be sufficient for the FY 07-08 program costs, the Trust Fund is forecasted to have a shortfall in FY 08-09. Based on total projected program expenses of \$138,488,664 for FY 08-09 and total revenues (including the beginning balance, Health Care Expansion Fund monies, Supplemental Tobacco Litigation Settlement account funds, and federal matching funds) of \$136,063,834, there would be a Trust Fund balance shortfall of \$2,424,830 for FY 08-09. Due to the fact that the funds

would collect interest while in the Trust, the Department estimates a need of \$2,382,423 in General Fund for FY 08-09 to balance the Trust (see Exhibit C.1, line V).

Because the Department is projecting the traditional caseload for both children and prenatal to exceed the FY 03-04 enrollment levels of 41,786 and 101, respectively, the caseload funded from the Trust Fund will be maximized. However, increases in the per capita will continue to drive increasing expenditures from the Trust Fund. The forecasted increases in the children's, prenatal, and dental per capita are increasing costs beyond the Tobacco Master Settlement funding, resulting in the forecasted shortfall in the Trust Fund.

Consequences if Not Funded:

If this request is not funded, the Children's Basic Health Plan would have insufficient funding to support the projected caseload growth and per capita increases. As such, enrollment in the Children's Basic Health Plan would have to be capped. If revenues are insufficient to pay for the costs for traditional children, the prenatal program would be suspended because it is an optional program. However, because funding for all prenatal enrollment above the FY 03-04 level of 101 clients is provided through the Health Care Expansion Fund, capping the prenatal program would do little to help prevent an overexpenditure from the Trust.

Children's enrollment may be capped in two ways. First, the program may be closed to new applicants, and redeterminations would be allowed to continue. The attrition rate of this method would be slower than a strict cap on the program, as those who are still eligible at their redetermination would be allowed to stay on the program. However, the date to apply the cap would have to be sooner. Second, the program may be closed to new clients as well as redeterminations. Clients would be disenrolled in the program when they came up for redetermination. The attrition rate of this method is faster than the previous method and may allow the Department to implement the cap later in the year.

If the prenatal program were suspended for FY 08-09, there would still be a \$1,975,064 shortfall in the Trust, and an additional cap on the children's program would be required in FY 08-09. Such a shortfall would require enrollment of traditional children to be capped at approximately 38,875. Because expansion clients cannot be funded to the exclusion of

any traditional clients, the Department would also need to cap enrollment of expansion children. As enrollment of traditional clients would be capped at approximately 66.6% of the projected caseload, enrollment of the expansion clients would be capped at approximately 2,730. Thus, the shortfall would require the denial of benefits to approximately 20,876 children in FY 08-09, most of which would have been funded through the Health Care Expansion Fund. The Department would not be able to utilize any Health Care Expansion Fund monies for enrollment above the FY 03-04 level, and the funding for expansion clients would not be maximized.

Calculations for Request:

<b>Summary of Request FY 08-09</b>				
<b>(4) Indigent Care Program- HB 97-1304 Children's Basic Health Plan Trust</b>				
	<b>Total Funds</b>	<b>General Fund</b>	<b>Cash Funds</b>	
FY 07-08 Final Appropriation (Column 2)	\$256,475	\$11,011	\$245,464	
Annualization of SB 07-036 (Mandatory Coverage of Mental Disorders)	\$11,751	\$11,751	\$0	
Annualization of SB 07-097 (Tobacco Master Settlement Agreement Reallocation)	\$3,230	\$0	\$3,230	
FY 08-09 Base Request (Column 5)	\$271,456	\$22,762	\$248,694	
FY 08-09 Incremental Need (Column 6)	\$2,442,385	\$2,382,423	\$59,962	
<b>Total FY 08-09 Request (Column 7)</b>	<b>\$2,713,841</b>	<b>\$2,405,185</b>	<b>\$308,656</b>	

<b>Summary of Request FY 08-09</b>				
<b>(4) Indigent Care Program- Children's Basic Health Plan Premium Costs</b>				
	<b>Total Funds</b>	<b>Cash Funds</b>	<b>Cash Funds Exempt</b>	<b>Federal Funds</b>
FY 07-08 Final Appropriation (Column 2)	\$86,426,598	\$1,479	\$30,408,342	\$56,016,777
Annualization of SB 07-004 (Early Intervention for Children)	\$24,596	\$0	\$8,609	\$15,987
Annualization of SB 07-036 (Mandatory Coverage of Mental Disorders)	\$33,576	\$0	\$11,751	\$21,825
Annualization of SB 07-097 (Tobacco Master Settlement Agreement Reallocation)	\$484,328	(\$1,479)	\$170,994	\$314,813

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Annualization of SB 07-113 (HCPF Cash Accounting)	\$3,865,396	\$0	\$1,352,889	\$2,512,507
Annualization of HB 07-1301 (Cervical Cancer Immunization)	\$264,224	\$0	\$92,478	\$171,746
FY 08-09 Base Request (Column 5)	\$91,098,718	\$0	\$32,045,063	\$59,053,655
FY 08-09 Incremental Need (Column 6)	\$28,607,957	\$0	\$10,052,899	\$18,555,058
<b>Total FY 08-09 Request (Column 7)</b>	<b>\$119,706,675</b>	<b>\$0</b>	<b>\$42,097,962</b>	<b>\$77,608,713</b>

<b>Summary of Request FY 08-09</b>				
<b>(4) Indigent Care Program- Children's Basic Health Plan Dental Benefit Costs</b>				
FY 07-08 Final Appropriation (Column 2)	\$6,886,799	\$2,410,380	\$4,476,419	
Annualization of SB 07-097 (Tobacco Master Settlement Agreement Reallocation)	\$27,951	\$9,783	\$18,168	
Annualization of SB 07-113 (HCPF Cash Accounting)	\$222,847	\$77,996	\$144,851	
FY 08-09 Base Request (Column 5)	\$7,137,597	\$2,498,159	\$4,639,438	
FY 08-09 Incremental Need (Column 6)	\$2,945,586	\$1,030,955	\$1,914,631	
<b>Total FY 08-09 Request (Column 7)</b>	<b>\$10,083,183</b>	<b>\$3,529,114</b>	<b>\$6,554,069</b>	

Assumptions for Calculations:

All calculations and assumptions are presented in Exhibits C.1 through C.12 included with this request. Detailed caseload and per capita assumptions are outlined below.

*Assumptions for Caseload Restatement: Exhibit C.12*

- The Department assumes that historical enrollment without retroactivity would follow a similar pattern to that observed in the second half of FY 06-07. Thus, it is assumed that the non-retroactive children's caseload is a constant 10.5% lower per month than the reported caseload which included retroactivity. Similarly, the non-retroactive prenatal caseload is assumed to be a constant 15.3% lower per month than the reported caseload which included retroactivity. Due to the enrollment cap at the beginning of FY 03-04, the annual caseload is restated downward by 15.1%.

- HB 05-1262 provided funding from the Health Care Expansion Fund for enrollment of traditional clients (up to 185% of the federal poverty level) above the FY 03-04 level. This enrollment level is being restated downward for children by 10.5% from 46,694 to 41,786. The prenatal enrollment level is being restated downward by 15.1% from 119 to 101.

*Assumptions for Children's Caseload Projections*

*FY 07-08 and FY 08-09 Enrollment Projection: Exhibit C.6*

- The Department assumes that any positive effect on the FY 06-07 traditional children's caseload from the identification requirements of the Deficit Reduction Act was approximately offset by the negative effect of the removal of the Medicaid asset test. The remaining caseload growth is assumed to be due to economic factors, including a declining Medicaid Eligible Children's caseload, population growth, and increased marketing of the Children's Basic Health Plan.
- The Department's FY 07-08 caseload forecast is based on FY 01-02, during which economic conditions approximated those currently seen and the Children's Basic Health Plan had marketing. During FY 01-02, monthly growth averaged 1.6%, and caseload was half the current size. Because caseload is significantly higher and potentially approaching a saturation point, it is reasonable to expect that the monthly growth would be lower than that experienced in FY 01-02, despite similar economic conditions and marketing. Based on this, the Department projects that the traditional children's caseload will increase by an average of 1.1% per month in FY 07-08. Further, the Department assumes that the monthly growth rates will vary and follow the same distribution as experienced in FY 01-02.
- The Department assumes that the monthly growth rate in traditional children will moderate in FY 08-09, as the declines in the Medicaid Eligible Children's caseload are forecasted to moderate. Continuing the FY 07-08 forecast, the Department's FY 08-09 caseload forecast is modeled after FY 02-03, during which monthly growth averaged 1.2% per month. As with the FY 07-08 forecast, it is reasonable to expect that caseload growth would be lower than this given the higher caseload level. Based

on this, the Department projects that the traditional children's caseload will increase by an average of 0.7% per month. The monthly variations in the growth rates are retained from the FY 07-08 forecast.

- Given the decreasing monthly growth rates for the expansion children in FY 06-07 and the convergence of the growth rates between the two children's populations, the Department assumes that the expansion population has reached a level of maturity where large monthly increases are not expected simply due to the newness of the program. The Department assumes that the expansion population's growth will mirror that seen in the traditional children, and that caseload will increase by an average of 1.1% per month in FY 07-08 and 0.7% in FY 08-09. Additionally, the monthly variations in the growth rates are retained in the expansion children's forecasts.

*Assumptions for Prenatal Caseload Projections (Exhibit C.7)*

- The Department assumes that the growth pattern experienced in the traditional prenatal population in FY 06-07 will continue into FY 07-08 and FY 08-09. This forecast yields average monthly growth of 1.0% per month, with the monthly variations being retained.
- The growth in the expansion prenatal population does not appear to be converging with that in the traditional population, as was seen in the children's program in FY 06-07. Therefore, the Department assumes that the expansion prenatal caseload will increase by an average of 1.9% per month, as was seen in FY 06-07. Due to volatility in the monthly caseload, the variations in the expansion prenatal caseload are modeled after those in the traditional population.

*Assumptions for Per Capita Projections (Exhibit C.5)*

- The forecasted children's and prenatal per capitas assume that the actuarially developed self-funded program capitation rates are indeed in line with the costs incurred by clients served in the network.
- All forecasted per capitas assume that growth will mirror that in the actuarially developed capitation rates. Thus, the Department assumes that factors other than the

capitation rate that may effect the per capita remain constant from FY 06-07. Such factors may include the children's caseload mix between the self-funded network and HMOs, average length of time to enroll in an HMO or to receive dental benefits, and the average length of stay in the Children's Basic Health Plan.

Impact on Other Government Agencies: Not applicable.

Cost Benefit Analysis:

<b>Cost</b>	<b>Benefit</b>
\$2,382,423 General Fund \$11,083,854 Cash Funds Exempt, including \$9,279,435 from the Health Care Expansion Fund	The Department would be able to provide health care and dental services to a total of 62,481 children, and medical services to 1,497 pregnant women in the Children's Basic Health Plan. The Department would not have to suspend the prenatal program and place an enrollment cap on the children's program in FY 08-09 in order to prevent overexpenditures. This would allow an estimated 1,497 prenatal women and 20,876 children to receive medical services in FY 08-09 above what base funding would allow.

Implementation Schedule: Not applicable. This request is only to update caseload and per capita costs, and does not have any programmatic changes to implement.

Statutory and Federal Authority: Children's Health Insurance Program is established in federal law in the Social Security Act, Title XXI (42 U.S.C. 1397aa through 1397jj). SEC. 2101. [42 U.S.C. 1397aa] (a) *PURPOSE-The purpose of this title is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children. Such assistance shall be provided primarily for obtaining health benefits coverage...*

25.5-8-105 C.R.S. (2007) (1) *A fund to be known as the Children's Basic Health Plan Trust is hereby created... all monies deposited in the trust and all interest earned on the moneys in the Trust shall remain in the Trust for the purposes set forth...*

25.5-8-109 C.R.S. (2007) (3) *The Department may establish procedures such that children with family incomes that exceed one hundred eighty-five percent of the federal poverty guidelines may enroll in the plan, but are not eligible for subsidies from the Department; ... (5) (a) (I), . . . Once determined eligible for the plan, a pregnant woman shall be considered to be continuously eligible throughout the pregnancy and for the sixty days following the pregnancy, even if the woman's eligibility would otherwise terminate during such period due to an increase in income. Upon birth, a child born to a woman eligible for the plan shall be eligible for the plan and shall be automatically enrolled in the plan . . .*

25.5-8-107 (1) (a) (II), C.R.S. (2007) (1) *In addition to any other duties pursuant to this article, the department shall have the following duties: (a) (II) In addition to the items specified in subparagraph (I) of this paragraph (a) and any additional items approved by the medical services board, on and after January 1, 2001, the medical services board shall include dental services in the schedule of health care services upon a finding by the board that: (A) An adequate number of dentists are willing to provide services to eligible children; and (B) The financial resources available to the program are sufficient to fund such services.*

24-22-117 (2) (a) (II), C.R.S. (2007) *...moneys in the Health Care Expansion Fund shall be annually appropriated by the general assembly to the Department of Health Care Policy and Financing for the following purposes: (A) To increase eligibility in the Children's Basic Health Plan, Article 19 of Title 25.5, C.R.S., for Children and Pregnant women from one hundred eighty-five percent to two hundred percent of the federal poverty level; (B) To remove the asset test under the Medical Assistance program, Article 4 of Title 25.5, C.R.S., for children and families; ... (F) To pay for enrollment increases above the average enrollment for state fiscal year 2003-04 in the Children's Basic Health Plan, Article 19 of Title 25.5, C.R.S.*

Performance Measures:

The Department believes that avoidance of an enrollment cap can be achieved by providing funding to support natural caseload growth in children and prenatal women in the Children's Basic Health Plan. This would ensure continuity of care, and clients in the

program would have better health outcomes and show a high level of satisfaction with their care. As such, the Department believes that this request supports the following Performance Measures:

- Increase the number of clients served through targeted, integrated care management programs.
- Increase the number of children served through a dedicated medical home service delivery model.