

STATE OF COLORADO FY 2010-11 BUDGET REQUEST CYCLE: DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

| Schedule 13 Change Request for FY 2010-11 Budget Request Cycle | | | | | | | | | | | |
|--|--------|---|--------------------------|---------------------------------|---|-------------------------|-------------------------------------|--|-----------------------------|---|--|
| Decision Item FY 2010-11 | | Base Reduction Item FY 2010-11 | | | Supplemental FY 2009-10 | | | Budget Amendment FY 2010-11 | | | |
| Request Title: | | Children's Basic Health Plan Medical Premium and Dental Benefit Costs | | | | | | | | | |
| Department: | | Health Care Policy and Financing | | | Dept. Approval by: John Bartholomew | | | Date: February 16, 2010 ^{2/23/10} | | | |
| Priority Number: | | S-3, BA-3 | | | OSPb Approval: <i>[Signature]</i> | | | Date: <i>2-23-10</i> | | | |
| | Fund | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| | | Prior-Year Actual FY 2008-09 | Appropriation FY 2009-10 | Supplemental Request FY 2009-10 | Total Revised Request FY 2009-10 ^{A,B} | Base Request FY 2010-11 | Decision' Base Reduction FY 2010-11 | November 1 Request FY 2010-11 | Budget Amendment FY 2010-11 | Total Revised Request FY 2010-11 ^{C,D} | Change from Base (Column 5) FY 2011-12 |
| Total of All Line Items | Total | 131,199,962 | 146,001,217 | 7,229,733 | 153,230,950 | 208,469,896 | 27,066,326 | 236,536,222 | (12,117,714) | 223,418,508 | 0 |
| | FTE | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | GF | 4,525,182 | 2,500,000 | 0 | 2,500,000 | 0 | 9,435,683 | 9,435,683 | 0 | 9,435,683 | 0.0 |
| | GFE | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | CF | 42,104,333 | 47,939,304 | 2,562,131 | 50,501,435 | 73,343,931 | (3,287,636) | 70,056,296 | (4,275,461) | 66,780,836 | 0 |
| | CFE/RF | 0 | 2,500,000 | 0 | 2,500,000 | 0 | 9,435,683 | 9,435,683 | 0 | 9,435,683 | 0 |
| | FF | 84,570,447 | 93,061,913 | 4,667,602 | 97,729,515 | 135,125,955 | 11,482,595 | 146,608,560 | (7,842,253) | 138,766,307 | 0 |
| (4) Indigent Care Program; H.B. 97-1304 Children's Basic Health Plan Trust | Total | 513,604 | 2,500,000 | 0 | 2,500,000 | 0 | 9,435,683 | 9,435,683 | 0 | 9,435,683 | 0 |
| | FTE | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0 |
| | GF | 4,525,182 | 2,500,000 | 0 | 2,500,000 | 0 | 9,435,683 | 9,435,683 | 0.0 | 9,435,683 | 0.0 |
| | GFE | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | CF | (4,011,576) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | CFE/RF | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | FF | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| (4) Indigent Care Program; Children's Basic Health Plan Premium Costs | Total | 120,809,604 | 133,438,868 | 6,972,366 | 140,411,234 | 195,047,718 | 17,256,761 | 212,306,479 | (12,018,904) | 200,287,575 | 0 |
| | FTE | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | GF | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 |
| | GFE | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | CF | 42,659,047 | 44,417,482 | 2,472,052 | 46,889,534 | 68,646,168 | (3,417,793) | 65,228,375 | (4,240,878) | 60,987,497 | 0 |
| | CFE/RF | 0 | 2,500,000 | 0 | 2,500,000 | 0 | 9,435,683 | 9,435,683 | 0 | 9,435,683 | 0 |
| | FF | 78,150,557 | 86,521,366 | 4,500,314 | 91,021,700 | 126,401,650 | 11,240,871 | 137,642,421 | (7,778,026) | 129,864,395 | 0 |

STATE OF COLORADO FY 2010-11 BUDGET REQUEST CYCLE: DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

| Schedule 13 | | | | | | | | | | | | |
|--|------|--|----------------------|--|---|--------------|--------------------------|---|--------------------------------|---------------------------|-----------------------------|-----|
| Change Request for FY 2010-11 Budget Request Cycle | | | | | | | | | | | | |
| Decision Item FY 2010-11 <input type="checkbox"/> | | Base Reduction Item FY 2010-11 <input type="checkbox"/> | | | Supplemental FY 2009-10 <input checked="" type="checkbox"/> | | | Budget Amendment FY 2010-11 <input checked="" type="checkbox"/> | | | | |
| Request Title: | | Children's Basic Health Plan Medical Premium and Dental Benefit Costs | | | | | | | | | | |
| Department: | | Health Care Policy and Financing | | | Dept. Approval by: | | John Bartholomew | | Date: February 16, 2010 | | | |
| Priority Number: | | S-3, BA-3 | | | OSPB Approval: | | | | Date: | | | |
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| | | Prior-Year Actual | Supplemental Request | Supplemental Request | Total Revised Request | Base Request | Decision/ Base Reduction | November 1 Request | Budget Amendment | Total Revised Request | Change from Base (Column 5) | |
| | Fund | FY 2008-09 | FY 2009-10 | FY 2009-10 | FY 2009-10 ^{a,b} | FY 2010-11 | FY 2010-11 | FY 2010-11 | FY 2010-11 | FY 2010-11 ^{c,d} | FY 2011-12 | |
| (4) Indigent Care Program; Children's Basic Health Plan Dental Benefits Costs | | Total | 9,876,754 | 10,062,349 | 257,367 | 10,319,716 | 13,422,178 | 371,882 | 13,794,060 | (98,810) | 13,695,250 | 0 |
| | | FTE | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| | | GF | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | GFE | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | CF | 3,456,864 | 3,521,822 | 90,079 | 3,611,901 | 4,697,763 | 130,158 | 4,827,921 | (34,583) | 4,793,338 | 0 |
| | | CFE/RF | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | FF | 6,419,890 | 6,540,527 | 167,288 | 6,707,815 | 8,724,415 | 241,724 | 8,966,139 | (64,227) | 8,901,912 | 0 |
| Non-Line Item Request: | | None. | | | | | | | | | | |
| Letternote Revised Text: | | <p>FY 2009-10: ^a Of this amount, \$27,881,882 shall be from the Children's Basic Health Plan Trust created in 25.5-8-105, C.R.S.; \$20,705,924 shall be from the Health Care Expansion Fund created in 24-22-117 (2) (a) (I), C.R.S.; \$443,456 shall be from the Hospital Provider Fee Cash Fund created in 25.5-4-402.3 (4), C.R.S.; and \$428,272 shall be from the Colorado Immunization Fund created in 25-4-2301, C.R.S. Reappropriated Funds shall be from the Children's Basic Health Plan Trust created in 25.5-8-105, C.R.S.</p> <p>FY 2009-10: ^b Of this amount, \$2,240,448 shall be from the Children's Basic Health Plan Trust created in 25.5-8-105, C.R.S.; \$1,349,813 shall be from the Health Care Expansion Fund created in 24-22-117 (2) (a) (I), C.R.S.; and \$21,640 shall be from the Hospital Provider Fee Cash Fund created in 25.5-4-402.3 (4), C.R.S.</p> <p>FY 2010-11: ^c Of this amount, \$32,716,825 shall be from the Children's Basic Health Plan Trust created in 25.5-8-105, C.R.S.; \$28,906,674 shall be from the Health Care Expansion Fund created in 24-22-117 (2) (a) (I), C.R.S.; \$8,301,401 shall be from the Hospital Provider Fee Cash Fund created in 25.5-4-402.3 (4), C.R.S.; and \$498,280 shall be from the Colorado Immunization Fund created in 25-4-2301, C.R.S. Reappropriated Funds shall be from the Children's Basic Health Plan Trust created in 25.5-8-105, C.R.S.</p> <p>FY 2010-11: ^d Of this amount, \$2,502,072 shall be from the Children's Basic Health Plan Trust created in 25.5-8-105, C.R.S.; \$1,898,294 shall be from the Health Care Expansion Fund created in 24-22-117 (2) (a) (I), C.R.S.; and \$392,972 shall be from the Hospital Provider Fee Cash Fund created in 25.5-4-402.3 (4), C.R.S.</p> | | | | | | | | | | |
| Cash or Federal Fund Name and COFRS Fund Number: | | CF: Children's Basic Health Plan Trust Fund 11G, Health Care Expansion Fund 18K, Hospital Provider Fee Cash Fund 24A, and Colorado Immunization Fund; FF: Title XXI | | | | | | | | | | |
| Reappropriated Funds Source, by Department and Line Item Name: | | None. | | | | | | | | | | |
| Approval by OIT? | | Yes: <input type="checkbox"/> No: <input type="checkbox"/> | | N/A: <input checked="" type="checkbox"/> | | | | | | | | |
| Schedule 13s from Affected Departments: | | None. | | | | | | | | | | |

CHANGE REQUEST for FY 2010-11 BUDGET REQUEST CYCLE

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

SELECT ONE (click on box):

- Decision Item FY 2010-11
- Base Reduction Item FY 2010-11
- Supplemental Request FY 2009-10
- Budget Request Amendment FY 2010-11

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 FY 2009-10 total funds appropriation for the Children's Basic Health Plan Premium Costs by \$6,972,366 and decrease the FY 2010-11 appropriation by \$12,018,904 total funds from the Department's November 6, 2009 request included in DI-3. This request also seeks to increase the FY 2009-10 total funds appropriation for the Children's Basic Health Plan Dental Benefit Costs appropriation by \$257,367 and decrease the FY 2010-11 appropriation by \$98,810 total funds from the Department's November 6, 2009 request included in DI-3. The adjustments requested for FY 2009-10 and FY 2010-11 are the result of increased caseload estimates. FY 2009-10 was last requested in February 2009 and FY 2010-11 was last requested in November 2009.

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 205% 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.

Many programmatic changes occurred in the 2007 and 2008 Legislative Sessions. In 2007, services provided to Children's Basic Health Plan children were expanded to include Early Intervention Services in line with those provided under Medicaid, mandated coverage of certain mental health disorders, and cervical cancer

immunizations. In addition, SB 07-097 expanded eligibility for both children and prenatal women from 200% of the federal poverty level to 205%, which was effective March 1, 2008.

The Department requested funding to implement multiple changes to the Children's Basic Health Plan in FY 2008-09. Pursuant to the Department's FY 2008-09 BA-A1A ("Building Blocks"), the Department was appropriated funding to implement a Medical Home initiative in the Children's Basic Health Plan. Along with funding for the increased per capita costs, the Department was also appropriated funding for a projected caseload increase from this initiative, as it is anticipated to improve retention in the program. The Department was also appropriated \$1,400,000 in its Children's Basic Health Plan Administration line item for expanded outreach in the Children's Basic Health Plan (the Department's FY 2008-09 DI-3A, "Additional Children's Basic Health Plan Outreach"). The Department was appropriated funding for anticipated caseload growth due to this expanded outreach.

During the 2008 Legislative Session, the following three bills impacted the Children's Basic Health Plan:

- SB 08-057, which requires the Children's Basic Health Plan to provide coverage for medically appropriate hearing aids for children with medically verified hearing loss, and;
- SB 08-160, which includes the following provisions:
 - Expands eligibility for children in the Children's Basic Health Plan to 225% of the federal poverty level effective March 1, 2009;
 - Expands eligibility for pregnant women in the Children's Basic Health Plan to 225% of the federal poverty level effective October 1, 2009, and;
 - Expands mental health benefits provided to children in the Children's Basic Health Plan by requiring parity with the mental health benefit provided in Medicaid.
- SB 08-022, which granted the Department overexpenditure authority for the Children's Basic Health Plan with a General Fund limit of \$250,000.

In response to State budgetary concerns, the Department submitted a number of supplemental requests in FY 2008-09 to reduce costs in the Plan. In its January 15, 2009 S-13 "Suspend Outreach Efforts", the Department requested the suspension of the funding appropriated in FY 2008-09 for expanded outreach in the Children's Basic Health Plan (the Department's FY 2008-09 DI-3A, "Additional Children's Basic Health Plan Outreach"). This reduction to the Administration line item is \$600,000 in FY 2008-09 and \$1,400,000 in FY 2009-10. Accompanying the Department's FY 2008-09 Supplemental #23, SB 09-211 was passed during the 2009 Legislative Session to eliminate the eligibility expansion to 225% of the federal poverty level. The Premiums Costs appropriation was also decreased by \$2,900,000 pursuant to the Department's FY 2009-10 Budget Amendment #33, "Provider Volume and Rate Reductions", as a result of reinsurance recoupments and participation in the Vaccines for Children program.

The FY 2009-10 Long Bill (SB 09-259) appropriated \$145,664,212 in total funds to the Children's Basic Health Plan Premium Costs. The passage of SB 09-265 "Timing of Medicaid Payments" resulted in a one-time decrease to this appropriation of \$12,225,334 as managed care capitations are moved from a prospective to a concurrent payment schedule. In addition HB 09-1293 "Health Care Affordability Act" (also known as the Hospital Provider Fee) was passed, which increases eligibility in the Children's Basic Health Plan from 205% to 250% of the federal poverty level effective April 1, 2010. The appropriation for this expansion is conditional upon federal approval of the hospital provider fee, which the Department anticipates to receive by April 1, 2010.

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 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 appropriation to the Dental Benefits line item was decreased in FY 2008-09 due to the passage of SB 09-211, which eliminated the eligibility expansion to 225% of the federal poverty level. The FY 2009-10 Long Bill (SB 09-259) appropriated \$10,948,462

in total funds to the Children's Basic Health Plan Dental Benefit Costs. In addition HB 09-1293 "Health Care Affordability Act" (also known as the Hospital Provider Fee) was passed, which increases eligibility in the Children's Basic Health Plan from 205% to 250% of the federal poverty level effective April 1, 2010. The appropriation for this expansion is conditional upon federal approval of the hospital provider fee, which the Department anticipates to receive by April 1, 2010.

General Description of Request:

This request seeks to adjust the projected enrollment for children and pregnant women in the Plan. The per capita costs for FY 2009-10 and FY 2010-11 have not changed significantly from those requested in the Department's February 16, 2009 and November 6, 2009 budget submissions, respectively.

I. Description of Request Related to Children's Premiums

Caseload Projections (Exhibit C.6)

Many factors have caused volatility in the traditional children's caseload (up to 185% of the federal poverty level) since FY 2006-07. The Medicaid asset test was removed on July 1, 2006, and was implemented gradually over the course of FY 2006-07 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 2006-07, but decreased in subsequent months.

In addition, 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 (DRA) 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 issued its final Deficit Reduction Act rules effective January 1, 2008, which include citizenship and identification requirements for children in the Children's Basic Health Plan. The

Department currently has no way to quantify the impacts of these policy changes because the documentation process is manual and is not yet incorporated into the Colorado Benefits Management System. With the passage of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), the DRA citizenship documentation requirements for Medicaid are now required for children in the Children's Basic Health Plan, and the Department anticipates full implementation in the Colorado Benefits Management System by February 1, 2010. Second, marketing of the Children's Basic Health Plan began in April 1, 2006. The marketing campaign was successful, and the Department believes that it had a positive effect on caseload in both the children and prenatal programs in FY 2006-07 and FY 2007-08. Outreach efforts were expanded in FY 2008-09 through many initiatives, including trainings, enrollment fairs, issuance of community grants, and Spanish translation of brochures.

Due to required budget cuts, the Department began reducing its outreach activities in January 2009, and eliminated entirely the funding appropriated for the expanded outreach efforts beginning in FY 2009-10 (see the Department's FY 2009-10 BA-21, "Reductions to Outreach Efforts"). The Department reduced FY 2009-10 outreach funding by a further \$250,000 in its FY 2009-10 ES-3 "Department Administrative Savings", and has requested a further reduction of \$550,000 beginning in FY 2010-11 in BA-19 "CHP+ Administrative Savings". Total outreach funding has been reduced from \$2,700,000 in FY 2007-08 to \$500,000 in FY 2010-11, with this funding earmarked for the Healthy Communities Partnership program for initiatives including care coordination, medical home, early and periodic screening and diagnostic testing, and assistance for navigating the CHP+ and Medicaid programs. Due to the recent extensive budget cuts, the Department does not believe that the remaining outreach funding is sufficient to drive large increases in caseload. Rather, the funding is being directed toward retention of existing eligible clients.

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. Similarly, in times of economic decline, Medicaid caseload is expected to increase, with some children entering Medicaid rather than the Children's Basic Health Plan. So as Medicaid caseload increases, the Children's Basic Health Plan caseload may increase at a slower rate. As seen in the Department's February 16, 2010 Budget Request, Exhibit B, page EB-1, Medicaid Eligible Children caseload increased by 31,107 in FY 2008-09, a 15.25% increase from FY 2007-08. Children's caseload in the Children's Basic Health Plan increased by only 3,787 in FY 2008-09, or 6.55%. The base Medicaid Eligible Children caseload is projected to grow by a further 42,699 children, or 18.16%, in FY 2009-10 and 10.60% in FY 2010-11.

The Department's November 6, 2009 forecast for traditional children was for annual average caseload of 60,453 and average monthly growth of 168. Growth in the first half of FY 2009-10 has been much higher than this forecast, with average monthly growth of 737. The Department believes that growth in FY 2009-10 is due to natural population growth and economic condition.

The Department believes that there is now sufficient data to project caseload for traditional children using econometric models, similar to those used to forecast Medicaid caseload. The selected trend for FY 2009-10 for traditional children is higher than the Department's November 2009 forecast, and would result in average growth of 0.82%, or 536 children, per month between January and June 2010. This is an increase from the November 2009 forecast, in which monthly growth was projected to average 0.28%. This high forecast is reflective of the increasing monthly growth seen since the second half of FY 2007-08. Because the economy is believed to be largely responsible this change, the Department believes that projected economic conditions give no indication that the trend will not continue to be positive throughout FY 2009-10, though the unemployment rate has decreased over the last four months.

Similar to the pattern seen in low-income Medicaid categories, the out-year trend is expected to temper with moderating monthly growth, reflective of projected moderating economic conditions beginning in 2010. Monthly growth is projected to average 0.69% in FY 2010-11. This is an increase from the November 2009 forecast, in which monthly

growth was projected to average 0.51%. See Exhibit C.10 for details on the models used to project trends for the traditional children.

After accounting for policy changes that affected traditional and expansion populations over the last two years, monthly growth in the expansion children's caseload was approximately the same as that for the traditional children since FY 2006-07. The expansion population has now been in place for three 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 anticipates that growth in expansion children will mirror that in traditional children in both FY 2009-10 and FY 2010-11. This forecast results in average monthly growth of 0.82% per month between January and June 2010 and 0.69% per month in FY 2010-11. These monthly growth rates are higher than those included in the Department's November 2009 forecast, which were 0.28% in FY 2009-10 and 0.51% in FY 2010-11.

Eligibility in the Children's Basic Health Plan was expanded from 200% to 205% of the federal poverty level through SB 07-097 (known as Supplemental Expansion Children), and was implemented beginning March 1, 2008. Growth in this population in FY 2007-08 was significantly higher than the forecast included in the fiscal note for SB 07-097. The Department was appropriated resources for 36 children in FY 2007-08. The Department believes that this higher than anticipated growth is due largely to the number of children that moved within CHP+ from lower income groupings. Between January and June 2009, caseload in this group decreased by an average of 3.76% per month. The Department believes that this may be partially due to economic conditions, as declining employment or wage and salary income tends to increase the lower income groups at the expense of higher income categories.

Growth in supplemental expansion children in FY 2009-10 has been much higher than the Department's November 2009 forecast, in which annual caseload was projected to be 1,376 and monthly growth was projected to be 6. The selected trend for FY 2009-10 for supplemental expansion children is higher than the Department's November 2009 forecast of 0.44% per month, and would result in average growth of 21 per month between January and June 2010. This is based on the average monthly growth of 1.18%

that was experienced between August 2008 and October 2009 (excluding July 2009, which the Department does not believe is representative of expectations of future growth). Out-year trends remain positive, as current forecasts indicate that economic conditions should begin to improve in 2010 and growth is forecasted to average 0.71% per month in FY 2010-11, a decrease from the November 2009 forecast of 0.87% growth per month.

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, both from the passage of the Health Care Affordability Act, HB 09-1293. Effective April 2010, eligibility in the Plan will be increased from 205% to 250% of the federal poverty level. The legislation also extends 12-month guaranteed eligibility to children in Medicaid beginning in January 2012, which is anticipated to decrease the length of stay in the Children's Basic Health Plan as fewer children move between programs and result in a caseload decrease beginning in FY 2011-12. The bottom-line adjustment for the expansion to 250% of the federal poverty level has changed from the November 2009 forecast for the following two reasons:

- The Department has received updated uninsured estimates that indicate that the population between 205% and 250% of the federal poverty level that would potentially be newly eligible due to this expansion is smaller than prior estimates.
- The implementation of this expansion in the Colorado Benefits Management System that will be active in April 2010 will not redetermine eligibility for current clients. This will result in no movement from existing clients into this new population, which normally accounts for a large portion of the growth in caseload at the beginning of an expansion. This results not only in a smaller caseload adjustment for the new expansion group, but correspondingly higher growth in lower income populations.

Total Children's Caseload Projection

The total FY 2009-10 children's caseload forecast is 70,102, a 13.84% increase over the FY 2008-09 caseload of 61,582. The total FY 2010-11 children's forecast 83,676, a 19.36% increase over the FY 2009-10 projection. The expansion to 250% of the federal

poverty level is responsible for most of the high trend in both years. Please see Exhibit C.6 for children’s caseload history and detailed projections.

| Children's Caseload Summary | FY 2009-10 | | | | FY 2010-11 | | |
|--|-----------------------|---------------|---------------|--------------|---------------|---------------|---------------|
| | Appropriated Caseload | November 2009 | February 2010 | % Change | November 2009 | February 2010 | % Change |
| Traditional Children (up to 185% FPL) | 60,090 | 60,453 | 63,776 | 5.50% | 63,508 | 70,258 | 10.63% |
| Expansion Children (186-200% FPL) | 4,596 | 4,030 | 4,208 | 4.42% | 4,232 | 4,666 | 10.26% |
| Supplemental Expansion Children (201-205% FPL) | 2,466 | 1,376 | 1,698 | 23.40% | 1,491 | 1,892 | 26.89% |
| Expansion Children (206-250% FPL) | 6,300 | 6,300 | 420 | -93.33% | 14,700 | 6,860 | -53.33% |
| Final Caseload Forecast | 73,452 | 72,159 | 70,102 | 5.50% | 83,931 | 83,676 | -0.30% |

Children’s Per Capita (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 the State’s managed care network, which is administered by a no-risk provider. Actual and estimated caseload ratios between HMOs and the self-funded network are used to develop blended capitation rates and per capita costs. The Children's Basic Health Plan Administrative Services Organization contract was re-bid for FY 2008-09, and Colorado Access was selected as the new vendor. Effective January 2009, the schedule of claims reconciliations has changed from annually to monthly. This will reduce the large year-end payments that have occurred in past years, and should help the Department identify changes in utilization trends sooner.

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; the Children's Basic Health Plan must pay all claims incurred through its annual appropriation and has only limited overexpenditure authority. 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.

Beginning with FY 2009-10, the Department and its contracted actuary have changed the schedule for developing capitation rates. Previously, rates were calculated one year in advance, which required the actuary to rely on utilization data from at least two years prior to the year in question. For example, the original FY 2008-09 HMO rates were developed in July 2007 and were based on claims costs incurred in 2005 and 2006. The rate development now begins 6 months later, which allows the actuaries to use the entire prior fiscal year of utilization data in its calculation. This change should decrease the variation in rates between years, as well as making the rates more accurate.

The FY 2009-10 base rates have not changed since the Department's February 16, 2009 S-3, though there have been two subsequent post-base adjustments. First, the expansion to 250% of the federal poverty level effective April 2010 impacts the blended rates for both the self-funded network and the HMOs. While the contracted actuary anticipates that the claims costs and age distribution of the expansion population will be equivalent to the 150%-205% of the federal poverty level income bracket, the Department will be imposing higher copays on the higher income grouping. This results in small increases in every age group in both the self-funded network and the HMOs. However, due to the anticipated increase in the number of high cost children under age 2 in the self-funded network in the higher income bracket, the expansion results in an increase to the self-funded rate.

The second adjustment to the FY 2009-10 budgeted rate is a change to the assumed distribution of enrollees between the self-funded network and HMOs. In the Department's February 16, 2009 request, the Department assumed that 40% of children would be served in the self-funded network and the remaining 60% will be enrolled in an HMO. However, there have been consistent increases in HMO enrollment and one of the Plan's HMOs is expanding into counties where only the self-funded network was previously available. Due to these factors, the Department now assumes that 39% of children would be served in the self-funded network and the remaining 60% will be enrolled in an HMO. This results in a decrease to the blended rate used to estimate the per capita trend.

Applying these weights to the actuarial rates yields a blended base rate of \$141.80 for all children in FY 2009-10. This is an increase of 16.13% over the final FY 2008-09 base rate of \$122.11 (calculated based on actual caseload shares between HMOs and the self-funded network) and a decrease of 0.32% from the FY 2009-10 blended base rate of \$149.16 presented in the Department's February 16, 2009 S-3. See Exhibit C.5, page C.5-2 for calculations.

The Department's FY 2009-10 forecasted per capita growth rate mirrors that of the actuarially developed rate. 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 2008-09. 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.

The growth in the FY 2009-10 blended capitation rate is used to project the FY 2009-10 per capita. The base growth of 16.13% is applied to the calculated FY 2008-09 per capita to estimate a base per capita of \$1,839.42. In addition to the base, there are four required adjustments to the per capita costs for programmatic changes, three of which were included in the Department's February 16, 2009 request. Subsequently, SB 09-265 was passed and changes all managed care payments in the Children's Basic Health Plan from a concurrent payment schedule to a retrospective schedule effective June 2009. Thus, the

June 2009 capitation payments will be paid in the first week of July 2009 rather than in June. The per capita cost is decreased by the blended monthly rate to adjust for the shift in pay date.

The final projected FY 2009-10 per capita is \$1,780.14. This is a 9.17% increase over the FY 2008-09 calculated per capita of \$1,630.54 and a 7.73% decrease from the FY 2009-10 per capita of \$1,929.26 requested in the Department's February 16, 2009 S-3.

The Department is currently working with the contracted actuary on the final FY 2010-11 rates. As such, the Department's estimated FY 2010-11 per capita trend is based on historical growth in the self-funded network and HMO rates, and has not changed from the Department's November 6, 2009 DI-3.

The Department has used a five-year average growth rate to project the FY 2010-11 HMO and self-funded rates separately. The Department is currently working with the contracted actuary on the final FY 2010-11 rates. Early analysis shows that the self-funded network trend may continue to be strong, as the high costs seen in FY 2007-08 appear to have continued into FY 2008-09. The blended rate is then calculated assuming that 39.0% of children will be served in the self-funded network in FY 2008-09 and the remaining 61.0% will be enrolled in an HMO. This results in an increase of 12.57% for FY 2010-11 from the FY 2009-10 base blended rate, and an increase of 7.36% in the final rate. This relatively high trend incorporates all prior year legislative impacts and the correction of trends that have historically been too low.

Similar to the FY 2009-10 per capita, the projected growth in the FY 2010-11 blended capitation rate is used to project the FY 2010-11 per capita. The Department applies the projected 7.36% growth to the total FY 2009-10 per capita of \$1,928.83 to estimate a FY 2010-11 per capita of \$2,070.79. This estimated FY 2010-11 per capita is 0.16% lower than that included in the Department's November 6, 2009 budget submission. There are currently no adjustments to the FY 2010-11 per capita for programmatic changes.

II. Description of Request Related to the Prenatal Program

Caseload Projections (Exhibit C.7)

In FY 2006-07 and FY 2007-08, 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 Medicaid Baby and Kid Care Program. In addition, the prenatal population was subject to the identification requirements of HB 06S-1023. With the passage of SB 07-211, the prenatal population is exempted from the HB 06S-1023 identification requirements beginning July 1, 2007, which may be partially responsible for some of the strong growth in FY 2007-08.

Similarly to the Medicaid Baby and Kid Care Program Adults, the traditional prenatal population experienced unusually strong growth in FY 2007-08 and a negative trend in the first half of FY 2008-09. Traditional prenatal caseload in the Children's Basic Health Plan continued to exhibit declines in the last half of FY 2008-09. Pregnant women in Medicaid are required to provide proof of citizenship and identification under the Deficit Reduction Act. Strong growth in the Medicaid population and the negative trend in FY 2008-09 indicate that the exemption of the prenatal population in the Children's Basic Health Plan from similar requirements under HB 06S-1023 was not the sole driver behind the large increases in FY 2007-08. Prior to January 2008, all functions for presumptive eligibility for pregnant women in the Children's Basic Health Plan were performed by an external contractor. Presumptive eligibility is now processed in the Colorado Benefits Management System, which may impact the growth trends by moving clients from presumptive eligibility into the Plan immediately upon full eligibility determination.

Caseload trends for pregnant women in Medicaid and the Children's Basic Health Plan have mirrored each other closely since FY 2005-06 (after the enrollment cap in Children's Basic Health Plan was lifted). Though the cause of the recent declines is unknown at this time, the Department does not anticipate that the decreases in these populations will continue. The Department has modeled the FY 2009-10 projection for the traditional prenatal population on the projected average monthly growth of 0.03% from Medicaid

Baby Care Adults. This forecast is lower than that from the Department's November 2009 forecast of 0.34% per month, reflecting the lower than anticipated growth since FY 2008-09. Similarly, the Department is modeling the out-year trends after the forecast for Medicaid Baby Care Adults. Moderate growth of 0.03% per month is projected for FY 2010-, down from the November 2009 forecast of 0.18% per month.

The Colorado Department of Public Health and Environment Family Planning Initiative was awarded a grant for approximately \$3.5 million to address the issue of unintended pregnancy in Colorado. This funding will provide local Title X Family Planning clinics with money to purchase long acting methods of contraception, funding for sterilizations and funding to expand clinic capacity to see more Title X clients. The vast majority of Title X clients are under 200% of the federal poverty level. This Family Planning initiative as well as the Family Planning waiver that was submitted by the Department in accordance with SB 08-003, and assuming a stable economy, support moderate trends in the traditional prenatal 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. As with the children's populations, it appears that the expansion to 205% of the federal poverty level (known as Supplemental Expansion Prenatal) is partially responsible for the caseload decline in March 2008. This effect is expected to be mitigated in the prenatal population, as there is no period of guaranteed eligibility that would allow for movement within the program.

Unlike the traditional prenatal population, this income group has seen growth in the first half of FY 2009-10. The Department's forecast for the remainder of FY 2009-10 for expansion prenatal is based on growth experienced between July 2008 and December 2009, during which the monthly increases averaged 0.65%. The Department projects that this moderate growth will continue in FY 2010-11. The Department's November 2009 forecast included projected monthly increases of 0.32% per month in both FY 2009-10 and FY 2010-11.

Eligibility in the Children's Basic Health Plan was expanded from 200% to 205% of the federal poverty level through SB 07-097 (known as Supplemental Expansion Prenatal),

and was implemented beginning March 1, 2008. Growth in this population in FY 2007-08 was significantly higher than the forecast included in the fiscal note for SB 07-097. The Department was appropriated resources for 2 prenatal women in FY 2007-08. The Department believes that this higher than anticipated growth is partially due to the women moving within the Children's Basic Health Plan from lower income groupings.

The Department's forecast for this population for the remainder of FY 2009-10 is based on growth experienced between January and December 2009, during which caseload increased by an average of 2.30% per month. This revised forecast for FY 2009-10 is higher than the Department's November 2009 forecast of 1.86% per month, and is reflective of the recent trends. The Department assumes that growth will moderate to an average of 2.01% per month in FY 2010-11 as current forecasts indicate that economic conditions should begin to improve in 2010. This FY 2010-11 forecast is higher than the Department's November 2009 projection, which included monthly increases of 1.86%.

Caseload Adjustments

In addition to the base caseload outlined above, there is a bottom line adjustment to the prenatal caseload for the forecast period from the passage of the Health Care Affordability Act, HB 09-1293. Effective April 2010, eligibility in the Plan will be increased from 205% to 250% of the federal poverty level. As discussed in the total children's section, this bottom-line adjustment has changed from the November 2009 forecast for the following two reasons:

- The Department has received updated uninsured estimates that indicate that the population between 205% and 250% of the federal poverty level that would potentially be newly eligible due to this expansion is smaller than prior estimates.
- The implementation of this expansion in the Colorado Benefits Management System that will be active in April 2010 will not redetermine eligibility for current clients. This will result in no movement from existing clients into this new population, which normally accounts for a large portion of the growth in caseload at the beginning of an expansion. This results not only in a smaller caseload adjustment for the new expansion group, but correspondingly higher growth in lower income populations.

Total Prenatal Caseload Projection

The total FY 2009-10 prenatal caseload forecast is 1,607 clients, a 3.48% decrease over the FY 2008-09 caseload of 1,665. The FY 2010-11 total prenatal forecast is 2,426 clients, a 50.96% increase over FY 2009-10. The expansion to 250% of the federal poverty level effective in April 2010 is responsible for most of the high trend in both years. Please see Exhibit C.7 for the prenatal caseload history and detailed projections.

| Prenatal Caseload Summary | FY 2009-10 | | | | FY 2010-11 | | |
|--|-----------------------|---------------|---------------|----------------|---------------|---------------|----------------|
| | Appropriated Caseload | November 2009 | February 2010 | % Change | November 2009 | February 2010 | % Change |
| Traditional Prenatal (up to 185% FPL) | 1,507 | 1,405 | 1,291 | -8.11% | 1,440 | 1,266 | -12.08% |
| Expansion Prenatal (186-200% FPL) | 203 | 173 | 179 | 3.47% | 185 | 192 | 3.78% |
| Supplemental Expansion Prenatal (201-205% FPL) | 111 | 78 | 84 | 7.69% | 98 | 110 | 12.24% |
| Expansion Children (206-250% FPL) | 750 | 750 | 53 | -92.93% | 1750 | 858 | -50.97% |
| Final Caseload Forecast | 2,571 | 2,406 | 1,607 | -33.21% | 3,473 | 2,426 | -30.15% |

Prenatal Per Capita (Exhibit C.5)

All clients in the prenatal program are served by the self-funded program (now administered by Colorado Access) and the costs of their services are billed in full directly to the State. As discussed in Children's Rates in Section I, the FY 2009-10 base rates have not changed since the Department's February 16, 2009 S-3, though there has been a subsequent adjustment. The higher copays to for the higher income groups with the expansion to 250% of the federal poverty level in April 2010 results in a small decrease to the budgeted rate. This reduces the FY 2009-10 budgeted rate to \$821.35, a 10.31% decrease from the FY 2008-09 budgeted rate (excluding the impacts of 2008 legislation)

and a decrease of 0.02% from the FY 2009-10 budgeted rate of \$831.23 presented in the Department's February 16, 2009 S-3.

The growth in the FY 2009-10 capitation rate is used to project the FY 2009-10 per capita. The Department applies the projected 10.31% decrease to the calculated base FY 2008-09 per capita of \$11,674.22 to estimate a base FY 2009-10 per capita of \$10,470.21. There is an adjustment for SB 08-160, which was included in the Department's February 16, 2009 request. Subsequently, SB 09-265 was passed and changes all managed care payments in the Children's Basic Health Plan from a concurrent payment schedule to a retrospective schedule effective June 2009. Thus, the June 2009 capitation payments will be paid in the first week of July 2009 rather than in June. The per capita cost is decreased by the blended monthly rate to adjust for the shift in pay date.

The final projected FY 2009-10 per capita is \$9,719.87 This is a decrease of 16.74% from the FY 2008-09 per capita of \$11,674.22 and a 10.49% decrease from the FY 2009-10 per capita of \$10,859.07 requested in the Department's February 16, 2009 S-3.

The Department is currently working with the contracted actuary on the final FY 2010-11 rates. As such, the Department's estimated FY 2010-11 per capita trend is based on historical growth and has not changed from the Department's November 6, 2009 DI-3. The Department has used a three-year average growth rate to project the FY 2010-11 rate, which results in forecasted base growth of 5.53% for FY 2010-11. The projected FY 2010-11 per capita is \$11,134.44. This estimated FY 2010-11 per capita is 1.16% higher than that included in the Department's November 6, 2009 budget submission. There are no per capita adjustments for the prenatal program for FY 2010-11.

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. Beginning in FY 2007-08, the Department no longer estimates a separate 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 Per Capita (Exhibit C.5)

The dental vendor contract was re-bid for FY 2007-08, and a new contract was executed with Delta Dental. As part of the re-bid process, Delta Dental was 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.

As discussed in Children's Rates in Section I, the FY 2009-10 base rates have not changed since the Department's February 16, 2009 S-3, though there has been a subsequent adjustment. The higher copays to for the higher income groups with the expansion to 250% of the federal poverty level in April 2010 results in a small decrease to the budgeted rate. Combined with the projected change in the age and income distribution in the Plan, the projected capitation rate of \$14.81 is a 1.02% increase over the FY 2008-09 capitation rate and an increase of 0.20% from the FY 2009-10 base rate of \$14.78 presented in the Department's February 16, 2009 S-3.

The Department's FY 2009-10 forecasted per capita growth rates mirrors that of the actuarially developed rate. 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 2008-09. Base growth of 1.02% from the capitation rate is applied to the calculated FY 2008-09 per capita of \$160.38, resulting in a projected FY 2009-10 per capita of \$162.02. There is an adjustment due to SB 09-265, which changes all managed care payments in the Children's Basic Health Plan from a concurrent payment schedule to a retrospective schedule effective June 2009. Thus, the June 2009 capitation payments will be paid in the first week of July 2009 rather than in June. The per capita cost is decreased by the

blended monthly rate to adjust for the shift in pay date. The resulting FY 2009-10 per capita cost is \$147.21, an 8.21% decrease over the FY 2008-09 per capita of \$160.38.

The Department is currently working with the contracted actuary on the final FY 2010-11 rates. As such, the Department's estimated FY 2010-11 per capita trend is based on historical growth and has not changed from the Department's November 6, 2009 DI-3. The Department has assumed that the growth rate for FY 2009-10 will remain constant in FY 2010-11, as historical trends are greatly influenced by changes in utilization, which appears to have become less volatile in the last two years. The projected FY 2010-11 per capita is \$163.67. This estimated FY 2010-11 per capita is 0.41% lower than that included in the Department's November 6, 2009 budget submission. There are no per capita adjustments for the dental program for FY 2010-11.

IV. Reprourement of Eligibility and Enrollment Vendor

The Department currently contracts with Affiliated Computer Services to process applications for the Children's Basic Health Plan, complete the enrollment process, provide customer service, and other various administrative services for the Plan. This contract was scheduled for re-bid after FY 2007-08, but the Request For Proposals (RFP) was cancelled by the State Controller's Office after the award was appealed and protested. These administrative functions will now be included as part of a larger RFP for the Eligibility and Enrollment Services for Medical Assistance Programs that is anticipated to be released in early FY 2009-10. As stipulated in the RFP, the cost for the Children's Basic Health Plan administrative functions is not to exceed \$3,816,240, which is the current contract amount. Thus, there is no anticipated need for additional funds due to the re-bid of this contract.

V. Update on Budget Reduction Initiatives

The Children's Basic Health Plan Premiums Costs appropriation was decreased by \$2,900,000 pursuant to the Department's FY 2009-10 Budget Amendment #33, "Provider Volume and Rate Reductions". Of this, \$900,000 was due to participation in the

Vaccines for Children (VFC) program and \$2,000,000 was as a result of additional reinsurance recoupments.

As discussed in the Department's November 12, 2009 response to Legislative Request For Information #24 regarding the implementation of the Vaccines for Children program for clients served by the Children's Basic Health Plan, the Department has been unable to implement this initiative. Due to the heavy volume of work and resources that the Colorado Department of Public Health and Environment (CDPHE) must dedicate to the H1N1 virus, the staff working in the Immunization Program that operates VFC will be unable to facilitate the introduction of Children's Basic Health Plan providers into the VFC program. However, the Department has resumed working with CDPHE on a plan for a pilot program in January 2010. Due to limited resources and stringent requirements imposed by the Centers for Disease Control (CDC), which administers VFC on the federal level, CDPHE can only commit to a small pilot program for Children's Basic Health Plan participation in VFC. This pilot program will not yield any notable savings, but will pave the path for broader Children's Basic Health Plan participation in VFC in the future. The Department is currently working on developing other initiatives to propose to OSPB that will achieve the savings that were projected to result from participating in VFC.

To date, the Department has achieved savings of \$975,000 of the estimated \$2,000,000 in reinsurance recoupments from prior years. The Department continues to work with the contracted actuary to identify claims that exceed \$100,000 that may be eligible for recovery.

VI. 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 2005-06, \$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 FY 2006-07 and FY 2007-08, the Trust was appropriated \$11,243,215 and \$5,564,404 General Fund, respectively, with the intent of providing funding for traditional clients that are paid for from the Trust Fund. While the Trust Fund did not receive a General Fund appropriation in FY 2008-09, the State Treasurer transferred \$1,000,000 from the General Fund to the Trust Fund pursuant to SB 09-269. This amount is an offset to the anticipated decrease in revenues to the Trust Fund due to a cap on Master Settlement allocations included in the bill.

The estimated Tobacco Master Settlement base allocations (Tier 1) to the Trust Fund are \$24,000,000 in FY 2009-10 and \$23,095,581 in FY 2010-11, which include the annual allocation of \$3,696,000 in accelerated payments from the Strategic Contribution Fund in the Master Settlement Agreement per HB 07-1359 per year. The estimated Tier 2 distributions to the Trust Fund are \$1,750,000 in FY 2009-10 and \$1,663,111 in FY 2010-11. Accounting for the Trust's portion of the State Auditor's Office payment, the current total forecasted Tobacco Master Settlement allocations to the Trust are \$25,707,311 in FY 2009-10 and \$24,687,611 in FY 2010-11. SB 09-269 caps the amount of Tobacco Settlement revenue allocated to Tobacco Settlement programs at \$100.0 million for FY 2009-10, which decreased the Fund's allocation by \$775,395 in FY 2009-10. For FY 2010-11, the forecasted Master Settlement allocations to the Trust decreased by \$1,564,843 from that included in the Department's November 6, 2009 DI-3. This is due to Legislative Council's projected collection of total Master Settlement monies decreasing by 6.2% between the January 2009 and January 2010 forecasts. Large declines in Master Settlement revenue are projected to continue in FY 2011-12 and FY 2012-13.

Including the General Fund request included in the Department's November 6, 2009 DI-3, the Trust Fund balance is expected to be sufficient for program costs in both FY 2009-

10 and FY 2010-11. Based on total projected program expenses of \$220,769,257 for FY 2010-11 and total revenues (including the beginning balance, Tobacco Litigation Settlement funds, Health Care Expansion Fund monies, Hospital Provider Fee monies, and federal matching funds) of \$220,829,369, there would be a Trust Fund balance of \$60,112 at the end of FY 2010-11 (see Exhibit C.1, line Y). The Department is not requesting a reduction to its November 6, 2009 General Fund request in this February request, as it is anticipated that program costs will increase in FY 2011-12 to fully use this balance.

Caseload funded from the Trust Fund for traditional children is maximized because the Department is projecting the traditional caseload for both children and prenatal to exceed the FY 2003-04 enrollment levels of 41,786 and 101, respectively. However, increases in the per capita will continue to drive increasing expenditures for these clients from the Trust Fund. The forecasted increases in the children's, prenatal, and dental per capitas are increasing costs beyond the Tobacco Master Settlement funding, resulting in the forecasted shortfall in the Trust Fund. While the amount of Master Settlement funding varies based on payments received in the prior year, growth in the Tier 1 allocation averaged only 0.53% per year from FY 2005-06 to FY 2008-09, and is currently forecasted to show contractions of an average 4.48% per year in FY 2009-10 to FY 2011-12 (excluding the impacts of HB 07-1359 and SB 09-269) instead of the November 2009 forecasted contraction of an average of 0.23% per year. Per capita growth has been significantly higher than this 4.48%, with average annual from growth from FY 2005-06 through FY 2008-09 of 6.56% for children's medical, 5.65% for dental, and 0.41% for prenatal medical. From FY 2009-10 to FY 2011-12, per capita costs are forecasted in this February request to increase by an average of 9.93% for children's medical (instead of 10.17% requested in November 2009), 2.42% for dental (instead of 2.38%), and prenatal medical is projected to show a large decrease in FY 2009-10 followed by growth above 4.00% in subsequent years.

Consequences if Not Funded:

If this request is not funded, the Children's Basic Health Plan would have insufficient appropriations 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 the funding is insufficient to support the costs for traditional children, the prenatal program would be

suspended because it is an optional program. However, due to the size of the prenatal program relative to the children's program and the timing of a potential enrollment cap, suspending the prenatal program would do little to help prevent an overexpenditure. In addition, children above 185% of the federal poverty level that are supported through the Health Care Expansion Fund would have to be capped, as children at higher income levels cannot retain eligibility if a cap is in place for lower income clients.

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. The Department can not disenroll existing children in the program that are not due for an annual redetermination, as children are guaranteed 12-months continuous enrollment per 25.5-8-109 (4), C.R.S. (2009).

Calculations for Request:

Please note that the Department is not requesting cash funds to be incorporated into their FY 2011-12 base budget at this time. Requests for funding in FY 2011-12 will be addressed in future budget requests, and all FY 2011-12 tables shown below are for informational purposes only. The FY 2011-12 base will be consistent with the FY 2010-11 base request, as shown in Column 5 of the accompanying Schedule 13.

| Summary of Request FY 2009-10 (4) Indigent Care Program, HB 97-1304 Children's Basic Health Plan Trust | Total Funds | General Fund | Cash Funds |
|---|--------------------|---------------------|-------------------|
| FY 2009-10 Long Bill Appropriation | \$2,500,000 | \$2,500,000 | \$0 |
| FY 2009-10 Final Appropriation (Column 2) | \$2,500,000 | \$2,500,000 | \$0 |
| FY 2009-10 Supplemental Request (Column 3) | \$0 | \$0 | \$0 |
| FY 2009-10 Total Revised Request (Column 4) | \$2,500,000 | \$2,500,000 | \$0 |

STATE OF COLORADO FY 2010-11 BUDGET REQUEST CYCLE: DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

| Summary of Request FY 2010-11 (4) Indigent Care Program, HB 97-1304 Children's Basic Health Plan Trust | Total Funds | General Fund | Cash Funds |
|---|--------------------|---------------------|-------------------|
| FY 2009-10 Final Appropriation (Column 2) | \$2,500,000 | \$2,500,000 | \$0 |
| Remove One-time Appropriation from Trust | (\$2,500,000) | (\$2,500,000) | \$0 |
| FY 2010-11 Base Request (Column 5) | \$0 | \$0 | \$0 |
| FY 2010-11 November 6, 2009 DI-3 (Column 6) | \$9,435,683 | \$9,435,683 | \$0 |
| FY 2010-11 Requested Budget Amendment (Column 8) | \$0 | \$0 | \$0 |
| Total FY 2010-11 Revised Request (Column 9) | \$9,435,683 | \$9,435,683 | \$0 |

| Summary of Request FY 2011-12 (4) Indigent Care Program, HB 97-1304 Children's Basic Health Plan Trust | Total Funds | General Fund | Cash Funds |
|---|--------------------|---------------------|-------------------|
| Total FY 2011-12 Revised Request (Column 10) | \$0 | \$0 | \$0 |

| Summary of Request FY 2009-10 (4) Indigent Care Program, Children's Basic Health Plan Premium Costs | Total Funds | Cash Funds | Reappropriated Funds | Federal Funds |
|--|----------------------|---------------------|-----------------------------|----------------------|
| FY 2009-10 Long Bill Appropriation | \$145,664,212 | \$48,696,353 | \$2,500,000 | \$94,467,859 |
| SB 09-265 Timing of Medicaid Payments | (\$12,225,344) | (\$4,278,871) | \$0 | (\$7,946,473) |
| FY 2009-10 Final Appropriation (Column 2) | \$133,438,868 | \$44,417,482 | \$2,500,000 | \$86,521,386 |
| FY 2009-10 Supplemental Request (Column 3) | \$6,972,366 | \$2,472,052 | \$0 | \$4,500,314 |
| FY 2009-10 Total Revised Request (Column 4) | \$140,411,234 | \$46,889,534 | \$2,500,000 | \$91,021,700 |

| Summary of Request FY 2010-11 (4) Indigent Care Program, Children's Basic Health Plan Premium Costs | Total Funds | Cash Funds | Reappropriated Funds | Federal Funds |
|--|----------------------|---------------------|-----------------------------|----------------------|
| FY 2009-10 Final Appropriation (Column 2) | \$133,438,868 | \$44,417,482 | \$2,500,000 | \$86,521,386 |
| HB 09-1293 Annualization (Hospital Provider Fee) | \$49,383,506 | \$17,449,815 | \$0 | \$31,933,691 |
| SB 09-265 Annualization (Delay Managed Care Payments) | \$12,225,344 | \$4,278,871 | \$0 | \$7,946,473 |
| Remove One-time Appropriation from Trust | \$0 | \$2,500,000 | (\$2,500,000) | \$0 |
| FY 2010-11 Base Request (Column 5) | \$195,047,718 | \$68,646,168 | \$0 | \$126,401,550 |
| FY 2010-11 November 6, 2009 DI-3 (Column 6) | \$17,258,761 | (\$3,417,793) | \$9,435,683 | \$11,240,871 |
| FY 2010-11 Requested Budget Amendment (Column 8) | (\$12,018,904) | (\$4,240,878) | \$0 | (\$7,778,026) |
| Total FY 2010-11 Revised Request (Column 9) | \$200,287,575 | \$60,987,497 | \$9,435,683 | \$129,864,395 |

| Summary of Request FY 2011-12 (4) Indigent Care Program, Children's Basic Health Plan Premium Costs | Total Funds | Cash Funds | Reappropriated Funds | Federal Funds |
|--|--------------------|-------------------|---------------------------------|--------------------------|
| Total FY 2011-12 Revised Request (Column 10) | \$0 | \$0 | \$0 | \$0 |

| Summary of Request FY 2009-10 (4) Indigent Care Program, Children's Basic Health Plan Dental Benefit Costs | Total Funds | Cash Funds | Reappropriated Funds | Federal Funds |
|---|---------------------|--------------------|---------------------------------|--------------------------|
| FY 2009-10 Long Bill Appropriation | \$10,948,462 | \$3,831,962 | \$0 | \$7,116,500 |
| SB 09-265 Timing of Medicaid Payments | (\$886,113) | (\$310,140) | \$0 | (\$575,973) |
| FY 2009-10 Final Appropriation (Column 2) | \$10,062,349 | \$3,521,822 | \$0 | \$6,540,527 |
| FY 2009-10 Supplemental Request (Column 3) | \$257,367 | \$90,079 | \$0 | \$167,288 |
| FY 2009-10 Total Revised Request (Column 4) | \$10,319,716 | \$3,611,901 | \$0 | \$6,707,815 |

| Summary of Request FY 2010-11 (4) Indigent Care Program, Children's Basic Health Plan Dental Benefit Costs | Total Funds | Cash Funds | Reappropriated Funds | Federal Funds |
|---|---------------------|--------------------|---------------------------------|--------------------------|
| FY 2009-10 Final Appropriation (Column 2) | \$10,062,349 | \$3,521,822 | \$0 | \$6,540,527 |
| HB 09-1293 Annualization (Hospital Provider Fee) | \$2,473,716 | \$865,801 | \$0 | \$1,607,915 |
| SB 09-265 Annualization (Delay Managed Care Payments) | \$886,113 | \$310,140 | \$0 | \$575,973 |
| FY 2010-11 Base Request (Column 5) | \$13,422,178 | \$4,697,763 | \$0 | \$8,724,415 |
| FY 2010-11 November 6, 2009 DI-3 (Column 6) | \$371,882 | \$130,158 | \$0 | \$241,724 |
| FY 2010-11 Requested Budget Amendment (Column 8) | (\$98,810) | (\$34,583) | \$0 | (\$64,227) |
| Total FY 2010-11 Revised Request (Column 9) | \$13,695,250 | \$4,793,338 | \$0 | \$8,901,912 |

| Summary of Request FY 2011-12 (4) Indigent Care Program, Children's Basic Health Plan Dental Benefit Costs | Total Funds | Cash Funds | Reappropriated Funds | Federal Funds |
|---|--------------------|-------------------|---------------------------------|--------------------------|
| Total FY 2011-12 Revised Request (Column 10) | \$0 | \$0 | \$0 | \$0 |

The tables below illustrate the projected impact to FY 2011-12.

| Projected Impact FY 2011-12 (4) Indigent Care Program, HB 97-1304 Children's Basic Health Plan Trust | Total Funds | General Fund | Cash Funds |
|---|--------------------|---------------------|-------------------|
| FY 2009-10 Final Appropriation (Column 2) | \$2,500,000 | \$2,500,000 | \$0 |
| FY 2010-11 Base Request (Column 5) | \$0 | \$0 | \$0 |
| FY 2010-11 November 3, 2008 DI-3 (Column 6) | \$9,435,683 | \$9,435,683 | \$0 |
| FY 2010-11 Requested Budget Amendment (Column 8) | \$0 | \$0 | \$0 |
| Remove One-time Appropriation from Trust | (\$9,435,683) | (\$9,435,683) | \$0 |
| FY 2011-12 Change from Base (Column 10) | \$0 | \$0 | \$0 |

| Projected Impact FY 2011-12 (4) Indigent Care Program, Children's Basic Health Plan Premium Costs | Total Funds | Cash Funds | Reappropriated Funds | Federal Funds |
|--|--------------------|--------------------|-----------------------------|----------------------|
| FY 2009-10 Final Appropriation (Column 2) | \$133,438,868 | \$44,417,482 | \$2,500,000 | \$86,521,386 |
| FY 2010-11 Base Request (Column 5) | \$195,047,718 | \$68,646,168 | \$0 | \$126,401,550 |
| FY 2010-11 November 6, 2009 DI-3 (Column 6) | \$17,258,761 | (\$3,417,793) | \$9,435,683 | \$11,240,871 |
| FY 2010-11 Requested Budget Amendment (Column 8) | (\$12,018,904) | (\$4,240,878) | \$0 | (\$7,778,026) |
| Remove One-time Appropriation from Trust | \$0 | \$9,435,683 | (\$9,435,683) | \$0 |
| FY 2011-12 Change from Base (Column 10) | \$5,239,857 | \$1,777,012 | \$0 | \$3,462,845 |

| Projected Impact FY 2011-12 (4) Indigent Care Program, Children's Basic Health Plan Dental Benefit Costs | Total Funds | Cash Funds | Reappropriated Funds | Federal Funds |
|---|--------------------|-------------------|-----------------------------|----------------------|
| FY 2009-10 Final Appropriation (Column 2) | \$10,062,349 | \$3,521,822 | \$0 | \$6,540,527 |
| FY 2010-11 Base Request (Column 5) | \$13,422,178 | \$4,697,763 | \$0 | \$8,724,415 |
| FY 2010-11 November 6, 2009 DI-3 (Column 6) | \$371,882 | \$130,158 | \$0 | \$241,724 |
| FY 2010-11 Requested Budget Amendment (Column 8) | (\$98,810) | (\$34,583) | \$0 | (\$64,227) |
| FY 2011-12 Change from Base (Column 10) | \$273,072 | \$95,575 | \$0 | \$177,497 |

Cash Funds Projections:

| Cash Fund Name | Cash Fund Number | FY 2008-09 Expenditures | FY 2008-09 End of Year Cash Balance | FY 2009-10 End of Year Cash Balance Estimate | FY 2010-11 End of Year Cash Balance Estimate | FY 2011-12 End of Year Cash Balance Estimate |
|------------------------------------|------------------|-------------------------|-------------------------------------|--|--|--|
| Children's Basic Health Plan Trust | 11G | \$32,626,199 | \$6,608,063 | \$817,042 | \$2,586,082 | (\$7,626,685) |
| Health Care Expansion Fund | 18K | \$94,003,143 | \$119,601,623 | \$81,320,908 | \$34,980,659 | (\$22,867,838) |
| Hospital Provider Fee Cash Fund | 24A | - | - | - | - | - |
| Colorado Immunization Fund (CDPHE) | - | - | - | - | - | - |

At the close of FY 2011-12 the Children’s Basic Health Plan Trust and Health Care Expansion Fund are projected to be insolvent, as show in the table above. As a result the Department is not requesting cash funds to be incorporated into their FY 2011-12 base budget at this time. Requests for funding in FY 2011-12 will be addressed in future budget requests.

Assumptions for Calculations:

All calculations and assumptions are presented in Exhibits C.1 through C.10 included with this request. Detailed caseload and per capita assumptions are outlined below.

Assumptions for Children’s Caseload Projections

FY 2009-10 and FY 2010-11 Enrollment Projection: Exhibit C.6

- The Department’s forecast for the remainder of FY 2009-10 assumes that the monthly growth rate will average 0.82% per month, based on econometric models outlined in Exhibit C.10. This is an increase from the November 2009 forecast, in which monthly growth was projected to average 0.28%. Growth in FY 2009-10 should be due to natural population growth and economic conditions.
- Current forecasts indicate that economic conditions will begin to improve beginning in 2010, and growth in Medicaid Eligible Children caseload is projected to moderate from 18.27% in FY 2009-10 to 9.99% in FY 2010-11. The Department forecasts that

the traditional children caseload will increase by 0.69% per month in FY 2010-11, reflecting moderating economic conditions. This is an increase from the November 2009 forecast, in which monthly growth was projected to average 0.51%.

- After accounting for policy changes that affected traditional and expansion populations over the last two years, monthly growth in the expansion children's caseload was approximately the same as that for the traditional children since FY 2006-07. The expansion population has now been in place for three 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 anticipates that growth in expansion children will mirror that in traditional children in both FY 2009-10 and FY 2010-11. This forecast results in average monthly growth of 0.82% per month for the remainder of FY 2009-10 and 0.69% per month in FY 2010-11.
- Eligibility in the Children's Basic Health Plan was expanded from 200% to 205% of the federal poverty level through SB 07-097 (known as Supplemental Expansion Children), and was implemented beginning March 1, 2008. The Department's forecast for this population for the remainder of FY 2009-10 is based on growth experienced August 2008 and October 2009 (excluding July 2009, which the Department does not believe is representative of expectations of future growth), during which caseload increased by an average of 1.18% per month. This revised forecast for FY 2009-10 is reflective of the recent trends and is higher than the Department's November 2009 forecast of 0.44% per month. Out-year trends remain positive, as current forecasts indicate that economic conditions should begin to improve in 2010. Growth is forecasted to average 0.71% per month in FY 2010-11, a decrease from the November 2009 forecast of 0.87% growth per month.

Assumptions for Prenatal Caseload Projections (Exhibit C.7)

- The Department has modeled the FY 2009-10 projection for the traditional prenatal population on the projected average monthly growth of 0.03% from Medicaid Baby Care Adults. This forecast is lower than that from the Department's November 2009 forecast of 0.34% per month, reflecting the lower than anticipated growth since FY 2008-09. Similarly, the Department is modeling the out-year trends after the forecast

for Medicaid Baby Care Adults. Moderate growth of 0.03% per month is projected for FY 2010-11, down from the November 2009 forecast of 0.18% per month.

- 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. The Department's forecast for FY 2009-10 for expansion prenatal is based on growth experienced between July 2008 and December 2009, during which the monthly increases averaged 0.65%. The Department projects that this moderate growth will continue in FY 2010-11. The Department's November 2009 forecast included projected monthly increases of 0.32% per month in both FY 2009-10 and FY 2010-11.
- Eligibility in the Children's Basic Health Plan was expanded from 200% to 205% of the federal poverty level through SB 07-097 (known as Supplemental Expansion Prenatal), and was implemented beginning March 1, 2008. The Department's forecast for the remainder of FY 2009-10 for this population is based on growth experienced between January and December 2009, during which caseload increased by an average of 2.30% per month. This revised forecast for FY 2009-10 is much higher than the Department's November 2009 forecast of 1.86% per month, and is reflective of the recent trends being much higher than originally projected. The Department assumes that growth will moderate to an average of 2.01% per month in FY 2010-11 as current forecasts indicate that economic conditions should begin to improve in 2010. This FY 2010-11 forecast is higher than the Department's November 2009 projection, which included monthly increases of 1.86%.

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 2008-09. 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: Not applicable. This request is only to update caseload and per capita costs, and does not require a cost benefit analysis.

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. (2009) (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...*

25.5-8-103 (4) C.R.S., (2009) "Eligible person" means: (a) *A person who is less than nineteen years of age, whose family income does not exceed two hundred fifty percent of the federal poverty level, adjusted for family size...; or (b) A pregnant woman whose family income does not exceed two hundred fifty percent of the federal poverty level, adjusted for family size.*

25.5-8-107 (1) (a) (II), C.R.S. (2009) (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. (2009) *...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:

- Expand coverage in the Children's Basic Health Plan.
- 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.