COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Executive Director

November 1, 2011

The Honorable Mary Hodge, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Senator Hodge:

The Department of Health Care Policy and Financing (the Department) presents this letter to the Joint Budget Committee of the Colorado General Assembly in response to Legislative Requests for Information numbers 6 and 8.

Legislative Request for Information number 6:
The Department is requested to submit a report by November 1, 2011, to the Joint Budget Committee providing information on the costs and savings of increasing the monthly premium charged to clients in the Children's Basic Health Plan program for any children and pregnant women enrolled in the program with incomes over 205 percent of the federal poverty level. In the report, the Department is requested to provide information about the monthly premiums charged by other states in their Children's Health Insurance Programs and what similar premium charges would save in the Colorado program. In the report, the Department is also requested to provide information regarding the barriers to health care that monthly premiums cause at this income level.

Legislative Request for Information number 8:
The Department is requested to submit a report by November 1, 2011, to the Joint Budget Committee providing information on the costs and savings of increasing co-payments in the Children's Basic Health Plan program to the maximum amount allowed under federal law.

If you require further information or have additional questions, please contact the Department's Financial & Administrative Services Office Director, John Bartholomew, at 303-866-2854 or john.bartholomew@state.co.us.

Please note that the Joint Budget Committee requested that the Department submit a total of 11 different requests for information on November 1. These reports are in addition to the Department's FY 2012-13 Budget Request, which is also due on November 1. Due to the volume of information due concurrently, the Department has not been able to submit all reports simultaneously. The Department

hopes to work with the Joint Budget Committee in future years to alleviate some of the issues caused by the concurrent deadlines.

Sincerely,

Susan E. Birch, MBA, BSN, RN
Executive Director

SEB:

Cc: Representative Cheri Gerou, Vice-Chairman, Joint Budget Committee
Senator Pat Steadman, Joint Budget Committee
Senator Kent Lambert, Joint Budget Committee
Representative Jon Becker, Joint Budget Committee
Representative Mark Ferrandino, Joint Budget Committee
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COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

REPORT TO THE JOINT BUDGET COMMITTEE

THE CHILDREN'S BASIC HEALTH PLAN MONTHLY PREMIUMS AND CO-PAYMENTS

NOVEMBER 1, 2011

This report is presented to the Joint Budget Committee of the Colorado General Assembly in response to two Legislative Requests for Information.

Legislative Request for Information number 6:
The Department is requested to submit a report by November 1, 2011, to the Joint Budget Committee providing information on the costs and savings of increasing the monthly premium charged to clients in the Children's Basic Health Plan program for any children and pregnant women enrolled in the program with incomes over 205 percent of the federal poverty level. In the report, the Department is requested to provide information about the monthly premiums charged by other states in their Children's Health Insurance Programs and what similar premium charges would save in the Colorado program. In the report, the Department is also requested to provide information regarding the barriers to health care that monthly premiums cause at this income level.

Legislative Request for Information number 8:
The Department is requested to submit a report by November 1, 2011, to the Joint Budget Committee providing information on the costs and savings of increasing co-payments in the Children's Basic Health Plan program to the maximum amount allowed under federal law.

Background
The Children's Basic Health Plan, marketed in Colorado as the Child Health Plan *Plus* (CHP+), is a public-private partnership that provides affordable health insurance to children and pregnant women with incomes under 250% of the federal poverty level (FPL) who do not have private insurance and do not qualify for Medicaid. The Department currently requires certain clients to pay annual enrollment fees and co-payments. Since these types of cost-sharing measures jointly affect clients' overall cost burden for enrolling in CHP+, the Department has included responses to both Legislative Requests for Information in this report.

Federal regulations at 42 C.F.R. §457.530 authorize the Department to vary premiums, deductibles, coinsurance, co-payments or any other cost sharing in CHP+ based on family income in a manner that does not favor children from families with higher incomes over children from families with lower incomes. Per 25.5-8-107 (IV) (b) C.R.S. (2011), the Department does not assess enrollment fees for pregnant women or children whose family income is at or below 150% of the Federal Poverty Level (FPL). Families with incomes above 150% FPL are required to pay an annual enrollment fee before their eligible children can enroll in CHP+. Under this policy, families with one child pay $25 while families with two or more children pay $35. Co-payments are also charged on a sliding fee scale for children with family incomes above 100% FPL. CHP+ imposes no cost-sharing on pregnant women. Children in families with incomes below 101% FPL only pay a $3 co-payment on emergency and urgent/after-hours care per state rule at 10 CCR 2505-3, Section 320.1.A. Additionally, the Department does not impose any cost-sharing charges on children who are American Indians or Alaska Natives per federal regulations at 42 C.F.R. §457.535.

Federal regulations at 42 C.F.R. §457.560 (a) limit total cost-sharing for CHP+ clients to a maximum of 5% of a family's total income for the length of a child's eligibility period in CHP+.

Any family that reaches this 5% maximum, and demonstrates that it has done so receives a co-payment waiver and does not incur any additional costs for the remainder of the enrollment period. Per Colorado's CHIP State Plan, families are required to record and track their own cost sharing amounts and notify the Department if this maximum is reached.

Enrollment Fees and Premiums

Due to the Maintenance of Effort under the Affordable Care Act (ACA), the Department is only allowed to increase enrollment fees for groups that became eligible after March 23, 2010 (the date of enactment of the ACA). This includes only children with incomes from 206% to 250% FPL. Funding for this population was procured through the passing of HB 09-1293 "Hospital Provider Fee," which created a new fee on hospitals which the Department can use to receive federal matching funding.

Since the inception of CHP+, the cost-sharing schedule has not been altered other than to add income categories as the program has expanded eligibility. As a result, Colorado has one of the lowest cost-sharing structures in the nation for a Children's Health Insurance Program. Sixteen states and the District of Columbia impose zero premiums on their CHIP program clients. Twelve states have lower income eligibility levels than CHP+. Of the remaining states, enrollment fees or premiums range from $25 per year in Colorado to $1,224 per year in Missouri. Please see Table 1 on the following page for the specific premiums or enrollment fees charged by states.

As requested, the Department has chosen a sample representing the range of monthly premiums and annual fees charged by other states to model what their effect would be in Colorado. Utilizing historical caseload and projections from its November 1, 2011 FY 2012-13 Budget Request, R-3 "Children's Basic Health Plan Medical and Dental Costs," the Department can estimate the distribution of families by size to model savings from different monthly premiums. The Department has assumed that as the premium amounts increase, an increasing number of families would have difficulty paying these premiums and would choose to drop the program. Of the clients paying monthly premiums, some whose family income is just over 205% FPL would move down into a lower income category as higher health care contributions (i.e. in the form of monthly premiums) are deducted from their incomes and would no longer be required to pay those increased premiums. Moreover, some of these families may alter their behavior to decrease their incomes in order to fall into an income group with lower premiums or fees.

The Department has estimated these rates using prior analyses of the experiences of other states that have increased cost-sharing in their CHIP programs. Due to the complexity of the calculations, the Department has only included a summary table with the costs and savings from each monthly premium example as compared to the current annual fee structure. For the purposes of this report, the Department assumes that these premiums would have been in effect for all of FY 2011-12 in order to perform a comparison of three full fiscal years.

Table 1 - Average Premium Charges by State (as of January 2011)						
	Frequency of Payment	Income Level at which State Begins Requiring Premiums (FPL)	Annual Premiums at 101% FPL	Annual Premiums at 151% FPL	Annual Premiums at 201% FPL (200% FPL if upper limit)	Annual Premiums at 251% FPL (250% if upper limit)
Colorado	Annually	151%	$0	$25	$25	$25
Alabama	Annually	101%	$50	$100	$100	$100
Iowa	Monthly	151%	$0	$120	$120	$240
Vermont	Monthly	186%	$0	$0	$180	$240
California	Monthly	101%	$48	$156	$252	$252
Massachusetts	Monthly	150%	$0	$144	$240	$336
New York	Monthly	160%	$0	$0	$108	$360
Washington	Monthly	201%	$0	$0	$240	$360
Wisconsin	Monthly	200%	$0	$0	$120	$372
New Hampshire	Monthly	185%	$0	$0	$384	$384
West Virginia	Monthly	201%	$0	$0	$420	$420
Oregon	Monthly	201%	$0	$0	$288	$432
Connecticut	Monthly	235%	$0	$0	$0	$456
Illinois	Monthly	151%	$0	$180	$180	$480
Pennsylvania	Monthly	201%	$0	$0	$180	$480
Louisiana	Monthly	201%	$0	$0	$600	$600
Indiana	Monthly	150%	$0	$264	$396	$636
Maryland	Monthly	200%	$0	$0	$576	$720
New Jersey	Monthly	201%	$0	$0	$480	$948
Rhode Island	Monthly	150%	$0	$732	$1,104	$1,104
Minnesota	Monthly	45%	$48	$336	$684	$1,116
Missouri	Monthly	150%	$0	$156	$504	$1,224
Arizona	Monthly	101%	$120	$480	$600	NA*
Delaware	Monthly	101%	$120	$180	$300	NA*
Florida	Monthly	101%	$180	$240	$240	NA*
Georgia	Monthly	101%	$120	$240	$348	NA*
Idaho	Monthly	133%	$0	$180	NA*	NA*
Kansas	Monthly	151%	$0	$240	$360	NA*
Maine	Monthly	151%	$0	$96	$384	NA*
Michigan	Monthly	151%	$0	$120	$120	NA*
Nevada	Quarterly	36%	$100	$200	$320	NA*
North Carolina	Annually	151%	$0	$50	$50	NA*
Texas	Annually	151%	$0	$35	$50	NA*
Utah	Quarterly	101%	$120	$300	$300	NA*

Alaska, Arkansas, District of Columbia, Hawaii, Kentucky, Mississippi, Montana, Nebraska, New Mexico, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Virginia and Wyoming do not charge premiums.
This table does not include any premiums charged to clients above 250% FPL.
NA: No premiums are required in the program.
NA*: Coverage is not available at this income level.

Rhode Island

The average monthly premium for clients from 206% to 250% FPL in Rhode Island's RIte Care is $92 per family, or $1,104 total per year per family. As illustrated in Table 2.a below, the Department estimates that raising premiums to this level would lead almost one third of affected children to drop CHP+ coverage. Since some of these children would not be able to afford other insurance, this would result in a greater number of uninsured children in Colorado, although the exact number is not known at this time. The Department, however, estimates that this would result in General Fund savings between $1.4 and $1.8 million per year.

Table 2.a - Costs/(Savings) From Rhode Island's Monthly Premiums in Colorado			
	FY 2011-12	FY 2012-13	FY 2013-14
Estimated Initial Caseload	7,891	9,785	10,737
Caseload Decrease due to Attrition (32%)	(2,525)	(3,131)	(3,436)
Caseload Decrease due to Movement (25%)	(1,342)	(1,664)	(1,825)
Total Medical and Dental Costs/(Savings)	($6,209,606)	($8,054,121)	($9,245,279)
Additional Fee Collections	$2,495,235	$3,094,693	$3,397,657
Total Hospital Provider Fee Savings	($1,630,895)	($2,209,531)	($2,630,761)
Total Federal Funds Savings	($5,658,147)	($7,246,730)	($8,217,908)
Total General Fund Savings	**($1,415,799)**	**($1,692,553)**	**($1,794,267)**

Vermont

Vermont's Dr Dynasaur charges monthly premiums of $60 per family for clients from 225% to 300% FPL, so each family contributes $720 per year. As illustrated in Table 2.b below, the Department estimates that this level of premiums would result in a 25% attrition rate. This would result in a greater number of uninsured children in Colorado, although the exact number is not known at this time. The lower premium amount, combined with the lower attrition rate, would result in General Fund savings between $0.9 and $1.2 million per year.

Table 2.b - Costs/(Savings) From Vermont's Monthly Premiums in Colorado			
	FY 2011-12	FY 2012-13	FY 2013-14
Estimated Initial Caseload	7,891	9,785	10,737
Caseload Decrease due to Attrition (25%)	(1,973)	(2,446)	(2,684)
Caseload Decrease due to Movement (20%)	(1,184)	(1,468)	(1,611)
Total Medical and Dental Costs/(Savings)	($4,852,100)	($6,292,041)	($7,221,865)
Additional Fee Collections	$1,881,325	$2,333,816	$2,561,431
Total Hospital Provider Fee Savings	($1,427,722)	($1,922,218)	($2,278,098)
Total Federal Funds Savings	($4,376,727)	($5,606,807)	($6,359,143)
Total General Fund Savings	**($928,976)**	**($1,096,832)**	**($1,146,055)**

Oregon

The monthly premiums charged for clients between 200% and 300% FPL in Oregon's Healthy KidsConnect program vary by family size and health plan. The average premiums are $27 for families with one child, $46 for families with two to four children and $66 for families with five or more children. This averages to approximately $432 per family per year. The Department

estimates that this level of premiums would result in an attrition rate of 20%. A number of these children would become uninsured although the exact amount is not known at this time. As illustrated in Table 2.c, this would result in General Fund savings of between $450,000 and $600,000 per year.

Table 2.c - Costs/(Savings) From Oregon's Monthly Premiums in Colorado			
	FY 2011-12	FY 2012-13	FY 2013-14
Estimated Initial Caseload	7,891	9,785	10,737
Caseload Decrease due to Attrition (20%)	(1,578)	(1,957)	(2,147)
Caseload Decrease due to Movement (15%)	(947)	(1,174)	(1,289)
Total Medical and Dental Costs/(Savings)	($3,880,697)	($5,034,147)	($5,776,954)
Additional Fee Collections	$1,249,129	$1,548,534	$1,699,796
Total Hospital Provider Fee Savings	($1,308,029)	($1,744,654)	($2,049,544)
Total Federal Funds Savings	($3,334,387)	($4,278,743)	($4,859,887)
Total General Fund Savings	**($487,410)**	**($559,284)**	**($567,319)**

Alabama

Alabama charges annual fees for its clients above 150% FPL in its All Kids program based on family size. Families with one child pay $100, families with 2 children pay $200 and families with three or more children pay $300 per year. At this level of annual fees, the Department estimates that 8% of children would drop CHP+ coverage. This would result in a greater number of uninsured children in Colorado, although this number is not known at this time. Overall, Alabama's annual fees are estimated to result in less than $200,000 General Fund savings per year. Please see Table 2.d below for more details.

Table 2.d - Costs/(Savings) From Alabama's Monthly Premiums in Colorado			
	FY 2011-12	FY 2012-13	FY 2013-14
Estimated Initial Caseload	7,891	9,785	10,737
Caseload Decrease due to Attrition (8%)	(631)	(783)	(859)
Caseload Decrease due to Movement (6%)	(436)	(540)	(593)
Total Medical and Dental Costs/(Savings)	($1,551,787)	($2,014,173)	($2,311,320)
Additional Fee Collections	$519,203	$643,847	$706,470
Total Hospital Provider Fee Savings	($556,339)	($741,481)	($870,749)
Total Federal Funds Savings	($1,346,144)	($1,727,713)	($1,961,563)
Total General Fund Savings	**($168,507)**	**($188,826)**	**($185,478)**

Barriers to Health Care due to Monthly Premiums

Historical Experience with Monthly Premiums

The Department's experience with monthly premiums in the past has been unfavorable. When the Department instituted its initial cost-sharing rules for CHP+ on December 1, 1998, following new state legislation at 26-19-107 C.R.S., it included nominal co-payments and monthly premiums. In FY 1999-00, the CHP+ cost-sharing schedule required monthly premiums of up to $30 per family. By April 2000, close to 53% of families required to pay premiums, or 37% of all families enrolled in CHP+, were more than 30 days past due. At the same time, an audit by the

Office of the State Auditor dated July 14, 2000 found several examples of families that had left CHP+ during the previous 4 to 16 months that were still owed refunds or monthly premiums ranging from almost $60 to over $170.[1]

In late August 2000, Governor Bill Owens requested that the legislature declare a "premium holiday," suspending premium payments through the end of the year and cancelling any outstanding payments in response to the difficulties families faced in paying CHP+ monthly premiums, as well as the high costs to the Department of attempting to collect those premiums. The Governor also recommended that the State eliminate monthly premiums for CHP+ and charge only those families with incomes above 150% FPL an annual enrollment fee of $25 for one child and $35 for two or more children. Since January 2001, CHP+ has charged the annual enrollment fees recommended by the Governor in fall 2000, along with the co-payments that were established by the Department and the policy board at the start of the program.[2]

Historical caseload data indicates that the enrollment growth in 2000, up to the time when the monthly premiums were replaced by annual enrollment fees in January 2001, was low. The average monthly caseload increased by only 1.4%. Moreover, from May 2000 to July 2000, the caseload actually decreased by 0.5%. From September 2000 when the premiums holiday was in place, to the end of that fiscal year in June 2001, CHP+ caseload grew by an average of 2.8% per month, nearly twice the average monthly growth rate of the period in which the monthly premiums were in effect. By June 2001, the program had enrolled 33,091 children, compared to 25,186 in August 2000 when the premiums holiday was declared, a 31.4% increase.

Other State Experiences

Existing published research literature on increasing premiums and other cost-sharing in public health care programs supports the idea that these changes can have a significant and immediate impact on the coverage for low-income families' coverage and access to care. These low-income families live on slim margins and find it difficult to afford even nominal increases in their out-of-pocket costs. Despite being at relatively higher income levels, families from 206% to 250% FPL are still financially vulnerable and sensitive to increases in their cost-sharing obligations. According to a study of premiums increases of $5 per month per child for enrollees between 185% and 300% FPL in the New Hampshire CHIP program, children's enrollment was still sensitive to premiums increases until family incomes were greater than 250% FPL.[3]

Several states have experienced decreased enrollment due to increased premiums in their CHIP programs. In January 2004, for example, Vermont's CHIP program increased the sliding-scale premiums for families from 185% to 300% FPL from $20-$50 to $25-$70 every three months. In the following month, 6% of children affected by the increased premiums disenrolled from the

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[1] State of Colorado, "Report of the State Auditor: Children's Basic Health Plan, Department of Health Care Policy and Financing Performance Audit," July 2000.

[2] Bajaj, Ruchika and Fasciano, Nancy, "Congressionally Mandated Evaluation of the State Children's Health Insurance Program, Site Visit Report: The State of Colorado's Child Health Plan Plus (CHP+)," from *Mathematica Policy Research, Inc.*, March 2002.

[3] Genevieve Kenney, R. Andrew Allison, Julia F. Costich, James Marton and Joshua McFeeters, "Effects of Premium Increases on Enrollment in SCHIP: Findings from Three States," from *Inquiry*, December 2006.

program, and 26% of disenrollees stated this cost increase as their reason for disenrollment.[4] In January 2002, Rhode Island's RIte Care began charging monthly premiums ranging between $43 and $58 for families above 150% FPL. In the first three months that the policy was enforced, about 18% of families subject to these premiums were disenrolled due to nonpayment. Half of these families stated that they could not afford the new premiums.[5]

The use of monthly premiums, compared to fees collected less frequently, has unique challenges to access to health care. Monthly premiums present families with 12 decisions each year to decide whether they would like their children to remain in CHP+ or drop out of the program. This may result in children moving on and off of CHP+ as their families' financial situation varies throughout the year, or even monthly. Of those children who disenroll from CHP+, some of them may obtain private insurance, while others may not. Surveys of individuals who have disenrolled from public health care programs in various states have shown that up to two thirds of disenrollees remain uninsured. Although most of these surveys are on individuals below 205% FPL, 51% of individuals who disenrolled due to Rhode Island's premiums increase on higher income groups remained uninsured.[6] Hence, despite the fact that families between 206% and 250% FPL have higher incomes relative to other CHP+ clients, they still face difficulties affording higher monthly premiums beyond a certain point.

The use of monthly premiums presents a very unique challenge in Colorado. Because children in CHP+ receive 12-month guaranteed eligibility, the family has to pay only the first month of premium in order to become eligible for the program. After that, the child is guaranteed eligibility for a full year regardless of whether they continue to pay the monthly premium. This would result in lower revenue collected by the State. Families may have to be sent to collections for any unpaid fees depending on the length of time from the last tax season. In addition, the Department would have to develop policies and procedures to prevent families from re-enrolling in CHP+ if they have outstanding premiums owed from the prior year.

Per Governor John Hickenlooper's directive in his letter vetoing SB 11-213 "*Concerning Enrollee Cost-Sharing for Children Enrolled in the Children's Basic Health Plan,*" the Department has actively engaged stakeholders to determine what level of increases to CHP+ cost sharing would result in the lowest attrition of clients and maintain affordability for families while still increasing clients' responsibility in their personal and family health care while realizing savings to the State. The Department's proposal includes increases in annual enrollment fees for children over 205% FPL and various co-payment increases. Details of the Department's proposal can be found in the Department's November 1, 2011 FY 2012-13 Budget Request, R-7 "Cost-Sharing for Medicaid and CHP+."

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[4] Vermont Department of Prevention Assistance, Transition and Health Access, "Impact of Premiums on the Medicaid Program," April 2004.
[5] Center of Child and Family Health, "Results of RIte Care Premium Follow-up Survey," Rhode Island Department of Human Services, January 2003.
[6] Artiga, Samantha and O'Malley, Molly, "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State experiences," The Kaiser Commission on Medicaid and the Uninsured, May 2005.

Co-payments

Federal regulations at 42 C.F.R. § 457.540 limit co-payments charged in CHP+ for children with family incomes at or below 150% FPL. Co-payments for children whose family incomes are at or below 100% FPL must be less than or equal to the amounts permitted under 42 C.F.R. §447.54, which outlines limits for co-payments for Medicaid. Cost-sharing for children with family incomes between 101% and 150% FPL must be less than or equal to the amounts permitted under 42 C.F.R. §457.555. Please see Tables 3.a and 3.b below for these co-payment limits.

Table 3.a - Maximum Co-payments for Children Below 100% FPL

State Payment for Service	Maximum Co-payment
$10 or less	$0.60
$10.01 to $25	$1.15
$25.01 to $50	$2.30
$50.01 or more	$3.40

Table 3.b - Maximum Co-payments for Children between 101% to 150% FPL

State Payment for Service	Maximum Co-payment
$15 or less	$1.15
$15.01 to $40	$2.30
$40.01 to $80	$3.40
$80.01 or more	$5.70

Co-payments for CHP+ clients are collected by providers at the point of service. Currently, CHP+ charges co-payments for various services on a sliding fee scale. The Department does not collect these co-payments, but rather pays its managed care organizations a capitation rate calculated by its contracted actuary. This actuary estimates co-payment collections using CHP+ service utilization data and assumes that co-payments are collected by providers and become part of their compensation for the services they provide to CHP+ clients. This allows the actuary to incorporate these co-payments into lower capitation rates, which result in savings to the Department. At the point of service, however, providers may waive these co-payments if families are unable to pay them. Since the Department is unable to determine whether or not a client actually pays the co-payment amount, the full impact of the cost sharing proposal on providers and clients is difficult to determine.

Since the federally mandated maximum allowable co-payments are tied to the costs of services to the state, the Department would require data on the costs of individual services in order to calculate the maximum allowable co-payments for clients at or below 150% FPL. The calculation of the maximum allowable co-payments for this group is further complicated by the fact that different providers may charge different prices for the same services. However, since the Department contracts with several managed care organizations and pays these monthly capitations, the Department does not have access to the data necessary to estimate these co-payments.

As described above, the Department has worked with stakeholders to increase co-payments in CHP+ in a manner that is as minimally disruptive to families enrolled in CHP+ while increasing clients' responsibility and realizing savings to the State. Details of the Department's proposed co-payment structure can be found in its November 1, 2011 FY 2012-13 Budget Request, R-7 "Cost-Sharing in Medicaid and CHP+."