Actuarial Study

The Feasibility of
A Budget Neutral
Colorado Medicaid Buy-In Program
Under TWWIIA and HB 01-1271

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Executive Summary

Leif Associates was retained by the Colorado Department of Health Care Policy and Financing (HCPF) to determine whether or not a Medicaid Buy-In for those with disabilities would be budget neutral using parameters established under the Ticket to Work and Work Incentives Act (TWWIIA), Colorado House Bill 01-1271, with input from HCPF and the community.

Methodology
Using cost and enrollment data gathered from various sources including HCPF, other states, national experts, national surveys, and other state programs, we estimated the following:

- Potential sources of Buy-In enrollment
- Expected levels of enrollment from each enrollment source
- Expected cost of medical services and administration for each enrollment source
- Expected revenue from State of Colorado based on current funding for some participants
- Expected revenue from Federal matching of Colorado expenditures
- Expected revenue from member fees for three different plan prototypes (A, B, and C)
- Expected revenue from member copays
- Expected revenue from member monthly premiums for three different plan prototypes (A, B, and C)

Findings of the Study
Based on various assumptions for enrollment, medical costs, administration costs, levels of cost sharing and premium, we have concluded that regardless of plan prototype, budget neutrality cannot be achieved under the current laws. This is because of the interplay between the following program requirements and assumptions:

- Federal law generally limits premiums to a maximum of 7.5% of income.
- The average expected income of the participants, based on experience in other states and survey data, is approximately $32,000. Based on the 7.5% of income premium limitation, premiums could not be higher on average than $2,400 per year.
- The estimated average cost of health care and administration for disabled persons expected to participate in the program is approximately $15,000 per year.
- With a maximum premium of $2,400 per year, the premium will cover approximately 16% of the cost of the program. The remaining 84% (or $12,600) would need to come from State and Federal funding.
- The State's contribution and the Federal matching dollars would be based on the contributions currently made for any program participants who are in Medicaid and go back to work. Those contributions are expected to equal approximately $22,000 per year for each program participant who was formerly in Medicaid.
- Federal matching funds are only available for the State's contributions. Matching funds are not available for the portion of costs that are covered by participant cost sharing through premiums and copays.
- Because Colorado's Medicaid Buy-In program has no asset or income limits and because Medicaid program eligibility is based on categorically needy rather than medically needy status, it is expected that over 60% of the program's participants would come from outside of the current Medicaid enrollment.
- If 60% of the participants come from outside of current Medicaid membership, the State and Federal contribution of $22,000 per year would only be available for the other 40% of the

membership. That equates to an average State and Federal contribution of $8,800 per program participant.

- The combination of the $2,400 annual premium and the $8,800 State and Federal contribution totals $11,200 per participant. This falls far short of the $15,000 needed to cover the cost of medical care and program administration.

The inability to achieve budget neutrality is demonstrated in the following table, which shows our estimate of first year cost for three prototype plan designs with varying levels of copays. The calculations are based on our estimate of 353 participants, premiums equal to 7.5% of income, and 40% of the enrollment coming from current Medicaid enrollment.

Revenue	Prototype A	Prototype B	Prototype C
Fees (enrollment and disability determination)	$102,759	$56,725	$10,690
Copays	$203,709	$101,855	$17,696
Premiums	$857,864	$857,864	$857,864
State Contribution	$1,537,423	$1,537,423	$1,537,423
Federal Contribution	$1,537,423	$1,537,423	$1,537,423
Total Revenue	$4,239,178	$4,091,290	$3,961,096

Costs (Medical and Admin)	Prototype A	Prototype B	Prototype C
Total Costs	$5,289,663	$5,289,663	$5,289,663

Margin / (Shortfall)	Prototype A	Prototype B	Prototype C
Revenue Minus Total Costs	($1,050,485)	($1,198,373)	($1,328,567)

Since the shortfall is quite large for such a small membership base, regardless of prototype, we conclude that minor changes to copays or fees will not create the necessary revenue to reach neutrality. Because premiums can not be increased any further due to the federal limitations, the only other sources of revenue is from additional State and Federal funds, which are not available because of the requirement that the program achieve budget neutrality

The following report includes a description of the program, how we performed our calculations, the assumptions we used, and documentation of our detailed calculations.

Background Information

TWWIIA

The Ticket to Work and Work Incentives Improvement Act (TWWIIA) became effective on October 1, 2000. It established two different methods by which a state can allow otherwise ineligible persons to participate in Medicaid through a buy-in program.

- Section 1902 (a)(10)(A)(ii)(XV) of the Social Security Act allows states to offer a Medicaid buy-in program on a sliding fee scale to working age, 16 to 64, individuals who would be eligible for Supplemental Security (SSI) except for increased income. States can set eligibility limits on assets and earned and unearned income. States cannot set a minimum standard for number of hours worked during a period of time or a minimum level of earnings.
- Section 1902 (a)(10)(A)(ii)(XVI) of the Social Security Act permits states to continue coverage for working individuals with disabilities whose medical conditions remain severe but who would otherwise lose eligibility due to medical improvement as determined at a regularly scheduled continuing disability review. Eligibility is limited only to those individuals aged 16 to 64 who were at one time members of the first option, but cease to be eligible for the first buy-in due to medical improvement. A person cannot be eligible for the second option unless they participated in the first, is earning at least the Federally required minimum wage and is working at least 40 hours per month; or is engaged in a work effort that meets an alternate definition of substantial and reasonable threshold criteria for hours of work, wages, or other measures as defined by the State and approved by the Secretary.

For both buy-ins, states may require premiums or cost-sharing set on a sliding scale based on income and charge 100% of the premium to individuals whose income exceeds 250% of the federal poverty level (FPL) but is below 450% FPL provided that these premiums do not exceed 7.5% of income. States must require payment of 100% of the premium for individuals whose adjusted gross income, as defined by the Internal Revenue Service, exceeds $75,000 except that a state may subsidize the premiums with unmatched state funds.

Colorado House Bill 01-1271

Colorado HB 01-1271 was enacted in June 2001. In this legislation, the Colorado General Assembly declared its support for full employment for people with disabilities and established Part 12 of Article 4 of title 26, Colorado Revised Statutes. However, the program must be budget neutral and federal financial participation must be available under the Medicaid program in order for a Medicaid buy-in program to be established.

Within those constraints, individuals with disabilities would be enabled to maintain employment without losing their Medicaid benefits under certain conditions. The conditions include the following:

- The individual meets the requirements for the Basic Coverage Group or the individual was previously in the Basic Coverage Group and now meets the requirements for the Medical Improvement Group (see Appendix One: Definitions).
- The individual maintains premium payments calculated by the State Department unless the individual is exempted from premium payments under rules promulgated by the Medical Services Board.
- The individual meets all other requirements established by the Medical Services Board by rule.

The law specifies that there will be no income or earned asset limitation for the Medicaid buy-in program or for an individual who participates in the Medicaid buy-in program and also receives home and community-based services.

The law sets forth the following requirements regarding the premium for the Medicaid buy-in program:

- An individual who is eligible must pay a premium pursuant to a payment schedule established by the Department of Health Care Policy and Financing.
- The amount of the premium shall be based on a sliding fee schedule adopted by rule of the Medical Services Board.
- The amount of the premium shall be based on a percentage of the individual's income adjusted for family size, and on any impairment-related work expenses. Consistent with federal law, if the amount of the individual's adjusted gross income exceeds $75,000, the individual shall be responsible for paying 100% of the premium.
- The rules must specify the amount of unearned income the Department shall disregard in calculating the individual's earned income.
- The rules setting the premiums and the sliding fee scale must be based on an actuarial study of the disabled population in Colorado.

The law allows the Department to pay premiums for or purchase individual coverage offered by the individual's employer if the Department determines that paying the premiums or purchasing the coverage will not be more costly than providing Medicaid coverage. If federal participation is available, subject to available appropriations, the Department may pay Medicare Part A and Part B premiums for eligible individuals who are also eligible for Medicare.

Actuarial Study

In October 2002, the Colorado Department of Health Care Policy and Financing contracted with Leif Associates, Inc., an actuarial consulting firm, to perform an actuarial study to asses the feasibility of a budget neutral Medicaid buy-in program under the provisions set forth by TWWIIA and HB 01-1271.

The methodology used in the actuarial study involved the following four steps:

- **Data Gathering**. The data used in this study came from two major sources. The first source was the Department of Health Care Policy and Financing's Medicaid eligibility and fiscal year 2001 claim data. This data was used to identify disabled persons currently on Medicaid who might be eligible for the Medicaid buy-in program. The second source of data was the Survey of Income and Program Participation (SIPP) data files. This source was used to estimate the size of the population that would become newly eligible for Medicaid under various changes to income and assets thresholds.
- **Identification of Potential Program Parameters.** A wide range of eligibility and cost sharing scenarios and other creative ideas were identified that might potentially result in budget neutrality.
- **Model Creation.** In order to assess budget neutrality, it was necessary to examine the following characteristics of the potentially eligible population:
  - The average medical claims costs of potential enrollees
  - The number of persons that might enroll

This information was used to create a model for testing the various eligibility and cost sharing scenarios.

- **Assessment of Budget Neutrality.** For each scenario, the budget impact was determined. Subsequent revisions were made to attempt to move toward budget neutrality.

In the course of the actuarial study, we met frequently with representatives from the Colorado Department of Health Care Policy and Financing to gain knowledge on current programs for the disabled, existing systems, eligibility determinations, coordination of benefits, goals and budgetary issues impacting the Department and how these issues relate to this potential program.

We also met several times with representatives from the disabled community. During these community meetings topics discussed including the reasons for the actuarial study, potential financing scenarios, different levels of cost sharing, expected costs of the program, and various concerns of the potential participants.

We also gathered enrollment data from CoverColorado, read numerous papers on other states' experiences with similar programs and spoke with representatives in other states and national experts on Medicaid Buy-In programs.

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Underlying Principles of a Buy-In Program

Sources of Cost Savings and Cost Increases

Cost savings to the State from the buy-in program may occur in five ways:

1. When an already Medicaid-enrolled disabled person who is paying no monthly premium enrolls in the buy-in, in which case the premium contributions and fees reflect savings against the medical costs this person is incurring.

2. When an uninsured person not currently enrolled in Colorado Medicaid but who is eligible or nearly eligible to do so enrolls in the buy-in, accessing health services that change the person's clinical trajectory in a manner that reduces the total claims costs Medicaid would have otherwise experienced.

3. When a working disabled person secures private coverage through employment, and disenrolls from the buy-in when he/she would otherwise have remained Medicaid enrolled.

4. When a working disabled person secures private coverage through employment, and Medicaid, through the buy-in, provides secondary coverage instead of primary coverage had he/she remained Medicaid enrolled.

5. When the premiums collected on behalf of buy-in enrollees exceed their Medicaid claims costs.

Increased costs can also occur.

1. When persons who are not currently enrolled in Colorado Medicaid and who would not become Medicaid enrollees in the near term in the absence of the buy-in participate in the buy-in, all net costs for these individuals (Medicaid claims costs less enrollee premium contributions) are new Medicaid costs.

Achieving Budget Neutrality

In theory, there are a number of ways to maximize the potential for achieving budget neutrality in a buy-in program.

- The program must maximize the number of participants already receiving Medicaid. A person who is receiving Medicaid and begins to participate in the buy-in program will pay a premium for their coverage while their health care expenses will theoretically remain the same. This will result in a new source of revenue for the Medicaid program.

- The program must maximize the number of participants who will earn high salaries. The higher the salary earned, the larger the premium that can be charged.

- The program must maximize the number of participants who will work enough hours to be able to participate in employer-based insurance. The cost to the Medicaid program would then be reduced to the cost of the premium for the insurance, or the premium plus a supplemental amount necessary to fill in the gaps in the insurance program to bring the benefits up to the Medicaid level.

- The program must encourage individuals to earn higher wages. By earning more, the State will generate additional revenue from the increased income in the form of income taxes. The State will also realize more in sales taxes as these individuals will have more money to purchase goods in Colorado.

- The program must result in reduced service utilization. As individuals currently uninsured or underinsured often do not receive the services they need, the overall costs to the State are increased by the time they do participate in a State program. By participating in a program such as the buy-in, some of these high cost services can be reduced through ongoing prevention and earlier access to services.

- The program must result in overall benefits to society. Persons currently in Medicaid are only able to keep their Medicaid coverage by having a very low income and asset base. The buy-in would allow individuals to have higher incomes and accumulate assets. By allowing individuals to have a higher level of assets and income, their ability to participate fully in society are greater. They are better able to care for themselves and their families, purchase goods and services from others, access services in the community, and in general be more self-sufficient and productive.

Our Approach

For this study, we concentrated on the direct impact of the premiums and cost sharing as compared to the costs of the medical services provided in order to determine budget neutrality. Although the other points raised above are important and beneficial components and include positive impacts to the State and the participants, they are not as easily measured and are relatively minor in terms of actual dollars raised in terms of offsetting costs of the program.

Simply, our steps to determine budget neutrality for this program were as follows:

1. Estimate the number of enrollees from various current Medicaid and non-Medicaid programs.
2. Estimate the expected costs for medical services and administration for these enrollees.
3. Estimate the dollars currently contributed by the State and the matching federal funds for those currently in Medicaid.
4. Estimate the value of various other forms of cost sharing (fees and copays).
5. Estimate the level of premiums needed to offset the remaining costs.
6. Determine if it is possible to charge the level of premiums needed.

The Eligible Population

In order to be eligible for the TWWIIA Medicaid Buy-In Program, an individual must be between the ages of 16 and 64 and be otherwise eligible for Medicaid except for increased income. The sources of potential member participation can be grouped into the following categories:

SSI (Supplemental Security Income)

SSI is a means-tested program providing Medicaid and monthly cash income to low-income persons with limited resources on the basis of age and on the basis of blindness and disability. An individual is eligible for Medicaid generally up to an income of $6,624 per year, although higher incomes are allowed based on family size. Those eligible under the state's Medicaid 1619(b) waiver may have income up to $30,728 per year. Assets cannot exceed $2,000 for an individual or $3,000 for a couple. There are two subsets of SSI participants who would be eligible for the TWWIIA Medicaid Buy-In Program if they increased their income and assets by returning to work:

- AND (Aid to the Needy Disabled) participants
- HCBS (Home and Community Based Services) participants

Each of these two groups can be further distinguished by their ability to access other sources of health coverage as follows:

- Those who have no other source of health coverage.
- Those who also have Medicare coverage. These are disabled persons who have a prior work history that gave them eligibility for Medicare, but who are eligible and participate in Medicaid as well. The Medicare benefits are supplemented by Medicaid benefits.
- Those who also have other non-Medicare coverage. The other sources of coverage include private insurance through own employer, spousal employment, parental employment, or other various non-Medicare government programs.
- Those who have both Medicare and other non-Medicare coverage.

SSDI (Social Security Disability Income)

SSDI is a program of federal disability insurance cash benefits for workers who have contributed to the Social Security trust funds and became disabled or blind before retirement age. If an individual has been entitled to SSDI benefits for 24 consecutive months, they are eligible to receive health insurance benefits under the Medicare program. They can receive Medicare for up to 8½ years after initiating employment above the SGA level. They are not eligible for Medicaid unless they receive SSI benefits to supplement SSDI or participate in a HBCS waiver program. In addition to those mentioned above who are Medicaid AND or HCBS participants, there are two additional subsets of SSDI participants who would be eligible for the TWWIIA Medicaid Buy-In Program if they increase their income and assets by returning to work:

- Those who have Medicare coverage only and wish to participate in Medicaid also to provide coverage for benefits that Medicare does not cover, such as prescription drugs.
- Those who have both Medicare coverage and private coverage. The private coverage might be provided by Medicare supplement coverage or employer-provided coverage.

Private Insurance and the Uninsured

Under the TWWIIA Medicaid Buy-In Program, a disabled person who is working need not be currently participating in Medicaid or Medicare in order to take advantage of the opportunity to purchase Medicaid benefits. There are four subsets of persons who might wish to participate in the program:

- Disabled workers who have private insurance purchased through their employer or another source but who find it unaffordable and would drop the coverage if they could purchase Medicaid coverage.
- Disabled workers who have private insurance purchased through their employer or another source but who find the coverage to not be adequate for their needs. These individuals would purchase Medicaid coverage to supplement the coverage provided by their private insurance.
- Disabled workers who are currently participating in CoverColorado. CoverColorado is a high risk health insurance pool with approximately 5,000 participants. Persons are eligible if they have been turned down for individual health insurance because of their health status. The program is funded by premiums and insurance company assessments. Premiums are nearly 150% of typical individual health insurance premiums, and the program has deductibles, coinsurance, and pre-existing conditions waits for those without continuous coverage. Not all of the participants are disabled, but some are. The disabled participants would be interested in the Medicaid Buy-In Program as a way to get lower premiums, less cost sharing, and no pre-existing conditions wait.
- Disabled workers who have no health insurance at all.

The following chart summarizes the sources of expected enrollment in a Colorado TWWIIA Medicaid Buy-In Program. It is expected that enrollment will start off very small but ramp up to the estimated levels, shown in Table 1, during the first couple years of the program. Over time we expect enrollment would change based on participants' experience in the program and the extent of outreach activities. These estimates were based on survey data, the experience of other states, community input, and opinions of national experts. Actual enrollment would be expected to vary based on numerous factors such as the level of outreach to particular eligible groups, depth of training of case workers, and ease of enrollment.

TABLE 1

Current Coverage	Total Number of Colorado Disabled Persons Aged 16-64	Estimated Colorado TWIIA Medicaid Buy-In Enrollment
Medicaid (Non-HCBS) and No Other Coverage	21,695	43
Medicaid (Non-HCBS) and Medicare	10,067	20
Medicaid (Non-HCBS) and Other Non-Medicare Coverage	518	1
Medicaid (Non-HCBS), Medicare and Other Coverage	210	0
HCBS Medicaid and No Other Coverage	3,807	30
HCBS Medicaid and Medicare	4,820	39

Current Coverage	Total Number of Colorado Disabled Persons Aged 16-64	Estimated Colorado TWIIA Medicaid Buy-In Enrollment
HCBS Medicaid and Other Non-Medicare Coverage	457	4
HCBS Medicaid, Medicare and Other Coverage	247	2
Medicare Only	2,000	20
Medicare and Other Coverage	8,000	80
Private Insurance	130,000	70
CoverColorado	158	25
Uninsured	39,000	20
Total	220,979	353

Using these assumptions we estimate a total of 353 persons would elect to participate in a Colorado Medicaid Buy-In. Of these, 140 or 39.7% would come from within current Medicaid eligibility categories.

The estimate of expected enrollment is relatively small based on various factors, including the startup rate experience of other states, the higher levels of expected cost sharing in Colorado due to the budget neutrality requirement, and the fact that Colorado is a "categorically" needy state. If someone currently receives Medicaid, there would be few incentives to enroll in the new program unless their earning increase and they would otherwise be ineligible. For persons who are just above the Medicaid income and asset cut-offs and currently ineligible for Medicaid, the primary considerations that might cause him or her not to enroll in the new program would be if the premium is unaffordable or if they have access to other forms of coverage. Persons may be eligible for this program, but may not enroll even if it results in higher out of pocket expense for care, due to their specific providers not accepting Medicaid patients, the negative stigma related to accepting public assistance or the fear of losing other government assistance such as cash benefits.

Program Requirements

The following rules apply to the Colorado TWWIIA Medicaid buy-in program, either as a result of federal or state law.

Eligibility

- Participants must be disabled individuals aged 16 through 64 who would be eligible for SSI except for increased income.
- A person cannot be eligible for the Medical Improvement Group unless they have participated in the Basic Coverage Group.
- States can set eligibility limits on assets and earned and unearned income. However, Colorado law specifies that there will be no income or earned asset limitations.

Premiums

- If premiums are charged, they must be on a sliding scale based on income.
- If premiums are charged, they must charge 100% of the premium to individuals whose income exceeds 250% of the federal poverty level (FPL) but is below 450% FPL.
- If premiums are charged, they must not exceed 7.5% of income.
- The program must require payment of 100% of the premium for individuals whose adjusted gross income exceeds $75,000, except that a state may subsidize the premiums with unmatched state funds.
- Colorado law specifies that a premium will be charged.

Work Status

- The program cannot set a minimum standard for number of hours worked during a period of time or a minimum level of earnings if they are in the Basic Coverage Group but can set such minimums for the Medical Improvement Group.

Federal Matching Funds

- Federal matching funds are available only for the state's expenditures for the program, not for the premiums or cost sharing paid by the participants in the buy-in program.

Optional Program Parameters

The TWWIIA requirements leave several design elements of the program up to the states, specifically in the areas of premiums and cost-sharing. In order to assess the potential budget impact of program, we worked with Department of Health Care Policy and Financing representatives to establish three prototype plan structures. The intent of the prototypes was to provide a range of possible cost sharing and premium levels to be used in modeling the program. This approach allowed us to assess the sensitivity of budget neutrality to the various program components. The three prototypes were structured in such a way that Prototype A would produce the lowest premium cost, Prototype B slightly higher premium cost, and Prototype C the highest premium cost. The following paragraphs discuss the primary components of the three prototypes used in the actuarial study.

- **Disability determination fee**. Disability reviewers conduct the disability determination process for Medicaid using the same disability determination process that applies to Medicare. Persons entering the TWWIIA Medicaid buy-in program who are currently in Medicaid or Medicare will not need to have a disability determination at the time of entry. Their disability status will be established based on their last disability review. Persons entering the TWWIIA Medicaid buy-in program who are not currently in Medicaid or Medicare will need to have a disability determination. Each Medicaid disability determination costs the state $412. In order to prevent excessive costs to the state for disability determinations, it was agreed that a fee would be charged for the initial determination, resulting in a sharing of the cost between the state and the applicant. Table 2 shows the range of the disability determination fee used in the actuarial modeling.

TABLE 2

Prototype A	Prototype B	Prototype C
$150	$100	$50

- **Enrollment fee**. Similar to the disability determination fee, an enrollment fee would be beneficial to keep persons from moving in and out of the Medicaid buy-in program based on their immediate need for health care services. The enrollment fee would be charged each time that a person enrolled and again annually. Table 3 shows the range of the enrollment fees used in the actuarial modeling.

TABLE 3

Prototype A	Prototype B	Prototype C
$200	$100	$0

- **Premium**. If charging premium, the states are required to use a sliding premium scale based on income, with the premium not exceeding 7.5% of income for persons up to 450% of FPL. For incomes above $75,000, there are no federal matching funds available, and the states can charge premiums as they wish. Some states have chosen to charge premiums ranging from a low of 0% for those with lower incomes to a high of 7.5% for those with higher incomes. Other states have chosen to use a flat rate, such as 5% of income for all participants. The definition of countable income varies from state to state. Income options include individual earned income, unearned income, spousal earned and unearned income, and disregards. Colorado law requires spousal income to be disregarded. Knowing that budget neutrality is of primary concern, we chose to model a similar approach to the sliding

scale for all 3 of the Prototypes. Prototype A, B and C each use 7.5% of income for all income levels, based on the individual's combined earned and unearned income, with no disregards except spousal income. All three prototypes assume that the premium level for each person would be determined every three months based on the previous three months average income level. It was also anticipated that for all three prototypes, termination for failure to pay premium would occur after 60 days.

TABLE 4

	Prototype A	Prototype B	Prototype C
Percent of income	7.5%	7.5%	7.5%
Number of rate tiers	1	1	1

- **Copays**. It was determined that the implementation of a deductible would not be feasible because of the administrative cost of implementation. However, since copays are already used for some aspects of the Medicaid program, it was determined that copays could easily be implemented for the TWWIIA Medicaid buy-in program. Out-of-pocket expenses are currently limited to $150 under the Medicaid program. Table 5 shows the primary components of the copay structure used in the actuarial modeling. The detailed plan designs are shown in Appendix Two.

TABLE 5

	Prototype A	Prototype B	Prototype C
Deductible	None	None	None
Out-of-pocket maximum	None	None	None
Physician office visits	$8	$4	$2
Inpatient hospital stay	$60 per admit	$30 per admit	$15 per admit
Generic drugs	$2	$1	$0.50
Brand name drugs	$8	$4	$2
Emergency room	$20	$10	$0
Durable medical equipment (based on cost of equipment)	<$50 -- $4 $50 to $500 -- $10 > $50 -- $20	<$50 -- $2 $50 to $500 -- $5 > $50 -- $10	$0

- **Work**. Some aspects of the definition of work are left up to the states. For example, they can determine the actual definition of work as long as it does not explicitly state a minimum number of hours. It was determined that the definition of work for all three prototypes would be having earned income every month. States can also determine how long a period of non-working will be allowed before a person is no longer allowed to remain in the program. Table 6 shows the assumptions used in the actuarial modeling.

TABLE 6

	Prototype A	Prototype B	Prototype C
Period of not working due to health reasons or non-voluntary job loss	90 days	120 days	180 days
Period of not working allowed for other reasons	90 days	90 days	90 days

Summary of Results

After estimating the enrollment and setting some program parameters, we estimated the cost of medical services and administration that would be provided to these members. The details of this cost analysis are shown in Appendix Three.

Administrative Costs

Expected administration costs, excluding those services allowed by the infrastructure grant for system changes and developing the new process of premium collection, are 3% of medical cost for HCPF overhead plus $46.58 per member per month for additional administration costs. These additional administrative costs include disability determination fees for the 60% of the membership not enrolling from within other Medicaid programs, community outreach, level of premium determination, premium collection, provider education related to copays, increased coordination of benefits, etc. This amount was based on the actual experiences of both the Child Health Plan Plus program and the CHP+ prenatal program for adults.

Medical Costs

Leif Associates analyzed the actual fiscal year 2001 (June 2000 to July 2001) Medicaid claims experience for the disabled population aged 16 to 64 in the previously described eight categories of potential enrollment from within Medicaid. We then trended the utilization at a rate of 2% per year to calendar year 2004, the first year of implementation for this program.

Table 7 summarizes the expected costs for the Basic Coverage Group, including administration, for each of the expected enrollment types.

TABLE 7

Current Coverage	Annual Medicaid Cost Per Member*	# of Members	Total Cost for Buy-In
Medicaid (Non-HCBS) and No Other Coverage	$6,872	43	$298,165
Medicaid (Non-HCBS) and Medicare	$7,347	20	$147,933
Medicaid (Non-HCBS) and Other Non-Medicare Coverage	$9,787	1	$9,525
Medicaid (Non-HCBS), Medicare and Other Coverage	$14,961	0	$6,296
HCBS Medicaid and No Other Coverage	$36,272	30	$1,104,774
HCBS Medicaid and Medicare	$35,429	39	$1,366,082
HCBS Medicaid and Other Non-Medicare Coverage	$25,978	4	$94,976
HCBS Medicaid, Medicare and Other Coverage	$28,385	2	$56,183
Medicare Only	$7,347	20	$146,946
Medicare and Other Coverage	$14,961	80	$1,196,847
Private Insurance	$8,030	70	$554,032
CoverColorado	$6,872	25	$173,902
Uninsured	$6,872	20	$134,002
Total	$15,008	353	$5,289,663

*Figures exclude the amounts paid by Medicare and/or other non-Medicaid payors.

The average cost per member currently in Medicaid is $22,086 per year, with 50% coming from state funding and 50% from federal funding. The average cost per year for those not currently in Medicaid is assumed to be $10,316 per year, as it is expected that the non-Medicaid participants will utilize fewer HCBS services than those already in Medicaid. The blended average is $15,008 per year for all of the expected Buy-In participants.

Another item of interest is the claim costs of those with and without other coverage. It was expected that Medicaid would see savings if the members had Medicaid as secondary coverage instead of primary. However, as shown in Table 7, the cost to Medicaid is in fact higher if the member has other coverage primary. By performing a detailed service level analysis we were able to identify the specific causes underlying these increased costs. For example, on a per member per month basis, those with Medicare primary coverage had Medicaid pharmacy costs and skilled nursing facility costs that were more than double the cost for persons without Medicare coverage.

We did not estimate the costs or enrollment in the Medically Improved Group due to the requirement that these members first be enrolled in the Basic Coverage Group. Membership in the Medically Improved Group would not be expected to begin for at least a year after implementation of the Basic Coverage Group. We are unaware of any other state that has enrolled members in the Medically Improved Group.

State and Federal Funding

Based on Colorado statutes requiring budget neutrality, we understand the State is willing to contribute to this program what would have otherwise been paid for those in Medicaid, but no more. TWWIIA requires this to take place at a minimum in order to receive federal matching funds. Colorado receives a 100% match in Federal funds for each State dollar spent on Medicaid. In order to determine the available State and Federal dollars available for this program, using the cost analysis above and valuing current copay levels, we estimated the following contributions for the 353 members.

TABLE 8

Current Coverage	Annual State Dollars	Annual Federal Dollars
Medicaid (Non-HCBS) and No Other Coverage	$147,820	$147,820
Medicaid (Non-HCBS) and Medicare	$73,522	$73,522
Medicaid (Non-HCBS) and Other Non-Medicare Coverage	$4,741	$4,741
Medicaid (Non-HCBS), Medicare and Other Coverage	$3,136	$3,136
HCBS Medicaid and No Other Coverage	$550,936	$550,936
HCBS Medicaid and Medicare	$681,876	$681,876
HCBS Medicaid and Other Non-Medicare Coverage	$47,352	$47,352
HCBS Medicaid, Medicare and Other Coverage	$28,040	$28,040
Medicare Only	$0	$0
Medicare and Other Coverage	$0	$0
Private Insurance	$0	$0
CoverColorado	$0	$0
Uninsured	$0	$0
Total	$1,537,423	$1,537,423

Cost Sharing

Besides the State and Federal funds, the participating members must contribute the remaining amount to cover the cost of services and administration. Based on each of our plan prototypes we have estimated the value of the various forms of member cost sharing.

The value of the disability fees and enrollment fees for each of our plan prototypes is as follows:

TABLE 9

	Prototype A	Prototype B	Prototype C
Fees	$102,759	$56,725	$10,690

The value of the copays for each of our plan prototypes is as follows:

TABLE 10

	Prototype A	Prototype B	Prototype C
Copays	$203,709	$101,855	$17,696

Using the following distribution of membership by income level results in the following value of premium assuming our prototype premium level of 7.5% of income:

TABLE 11

Annual Individual Income Level (Earned + Unearned)	# of Members	Premium Per Member Per Month	Total Premium
$5,000	2	$31.25	$663
$7,500	2	$46.88	$994
$10,000	7	$62.50	$5,302
$15,000	14	$93.75	$15,905
$20,000	25	$125.00	$37,111
$25,000	46	$156.25	$86,151
$30,000	85	$187.50	$190,857
$35,000	88	$218.75	$231,945
$40,000	35	$250.00	$106,032
$45,000	28	$281.25	$95,429
$50,000	7	$312.50	$26,508
$55,000	7	$343.75	$29,159
$60,000	7	$375.00	$31,810
	353	$202.27	$857,864

Conclusion

Based on the assumptions we have described for enrollment, medical costs, administration costs, the various levels of cost sharing, and premium to be charged, we conclude that regardless of plan prototype, none are budget neutral as demonstrated in Table 12:

TABLE 12

Revenue	Prototype A	Prototype B	Prototype C
Fees	$102,759	$56,725	$10,690
Copays	$203,709	$101,855	$17,696
Premiums	$857,864	$857,864	$857,864
State Contribution	$1,537,423	$1,537,423	$1,537,423
Federal Contribution	$1,537,423	$1,537,423	$1,537,423
Total Revenue	$4,239,178	$4,091,290	$3,961,096

Costs (Medical and Admin)	Prototype A	Prototype B	Prototype C
Total Costs	$5,289,663	$5,289,663	$5,289,663

Margin / (Shortfall)	Prototype A	Prototype B	Prototype C
Revenue Minus Total Costs	($1,050,485)	($1,198,373)	($1,328,567)

Since the shortfall is quite large for such a small membership base, regardless of prototype, we conclude that minor changes to copays or fees will not create the necessary revenue to reach neutrality. Because premiums can not be increased any further due to the federal limitations, the only other sources of revenue is from additional State and Federal funds, which are not available because of the requirement that the program achieve budget neutrality.

The largest influence on this conclusion is the expected enrollment mix of those currently in Medicaid versus those not in Medicaid. Using the 39.7% within Medicaid assumption produces the results presented in this analysis. In order to achieve budget neutrality for Prototype C, leaving all other assumptions the same, the enrollment mix would need to be closer to 82% from within current Medicaid categories of aid and 18% from non-Medicaid sources. Other states have experienced enrollment from within Medicaid on these levels, but it is not expected in Colorado due to the following four reasons:

1. By having no asset limit, the program is attractive to those with high need but who are not currently in Medicaid due to assets exceeding the current Medicaid limit of $2,000 for an individual or $3,000 for a couple.

2. By having no income limit, the program is attractive to those with high need but who are not currently in Medicaid due to having incomes exceeding the current Medicaid limits which vary based on category of aid.

3. By requiring the premium to be set up on a sliding scale based on the individual's income and not being able to require a minimum number of hours worked, the potential exists for non-working non-Medicaid eligible disabled persons to take advantage of the program by working only minimally in order to get the health coverage. This could result in high costs to the program coupled with only limited premium revenue due to the member working only a minimum number of hours or perhaps still meeting the requirements but not working at all.

This is allowed for medical reasons, when between jobs, or if participating in work related incentive programs such as training.

4. Most of the other states experiencing the higher levels of enrollment from those currently in Medicaid have Medically Needy categories of Medicaid and the enrollment is coming from those Medically Needy categories. Colorado doesn't have Medically Needed categories of aid, thus they are not a source of potential enrollment in Colorado.

Although current State and Federal requirements make it impossible to assure budget neutrality at this time, there are a few possible changes to Colorado law that may allow budget neutrality in the future:

1. Implementing an income limit closer to current Medicaid eligibility limits would maximize the number of current Medicaid participants, State dollars available, and Federal matching dollars.
2. Implementing an asset limit closer to current Medicaid eligibility limits would maximize the number of current Medicaid participants, State dollars available, and Federal matching dollars.
3. Allowing the option to charge premium on a % of family income versus individual income would increase the amount collected in the form of premiums.
4. Eliminating the Medical Improvement Group as an eligibility category would maximize the State dollars available and Federal matching dollars as these members would not be covered in Medicaid otherwise.
5. Federal law does not require a state to include HCBS benefits in a buy-in program, but Colorado's law includes such a requirement. Elimination of HCBS buy-in eligibility would reduce the overall cost per member making neutrality more likely to be obtained with the Federal limitations on premiums.

Appendix One: Definitions

Basic Coverage Group – The category of eligibility under TWWIIA that provides an opportunity to buy into Medicaid consistent with Section 1902 (a)(10)(ii)(XV) of the Federal Social Security Act for workers with disabilities at least sixteen years of age but less than sixty-five years of age who, except for earnings, would be eligible for the Supplemental Security Income program. A person who is eligible under the Basic Coverage Group may also be a home and community-based services waiver recipient.

Disability – The inability to engage in any Substantial Gainful Activity (SGA) by reason of a medically determinable physical or mental impairment that is expected to last for a continuous period of not less than 12 months, or to result in death. This is the definition used by the Social Security Administration for both the SSDI and SSI programs.

Family -- An individual, the individual's spouse, and any dependent child of the individual.

HCBS (Home and Community Based Services) – A waiver program under which individuals receive special services that are outside the scope of the regular Medicaid package of benefits. Services generally include adult day care, alternative care facilities, electronic monitoring, home modifications, non-medical transportation, respite care, personal care and homemaker services. Participants have to limit their income to 300% of the SSI level, or $19,872 annual salary.

Health Insurance – Surgical, medical, hospital, major medical, or other health service coverage, including a self-insured health plan, but not including hospital indemnity policies or ancillary coverages such as income continuation, loss of time, or accident benefits.

Medicaid Buy-In Program – A program that gives disable persons the opportunity to buy into Medicaid if the person meets the specified eligibility criteria.

Medical Improvement Group – The category of eligibility under TWWIIA that provides an opportunity to buy into Medicaid consistent with Section 1902 (a)(10)(ii)(XVI) of the Federal Social Security Act for workers with a medically improved disability who are at least sixteen years of age but less than sixty-five years of age who were previously in the Basic Coverage Group due to medical improvement. A person who is eligible under the Medical Improvement Group may also be a home and community-based services waiver recipient.

SGA (Substantial Gainful Activity) – Countable earnings of $800 per month for the non-blind and $1,330 for the bline, as defined in Federal regulations.

SSDI (Social Security Disability Income) – A program of federal disability insurance cash benefits for workers who have contributed to the Social Security trust funds and became disabled or blind before retirement age. If an individual has been entitled to SSDI benefits for 24 consecutive months, they are eligible to receive health insurance benefits under the Medicare program. They can receive Medicare for up to 8½ years after initiating employment above the SGA level. They are not eligible for Medicaid unless they receive SSI benefits to supplement SSDI or participate in a HCBS waiver program.

SSI (Supplemental Security Income) – A means-tested program providing Medicaid and monthly cash income to low-income persons with limited resources on the basis of age and on the basis of blindness and disability. An individual remains eligible for Medicaid generally up to an income of $6,624 per year.

TWWIIA – The Ticket to Work and Work Incentives Improvement Act of 1999.

Appendix Two: Plan Prototypes

Eligibility	Prototype A	Prototype B	Prototype C
Ages	16-64	16-64	16-64
Disability	As defined by SSI except for earnings	As defined by SSI except for earnings	As defined by SSI except for earnings
Income Upper Limit	None	None	None
Asset Upper Limit	None	None	None
Earned Income Required	Yes	Yes	Yes
Period of not working allowed due to health or non voluntary job loss and looking for a new job	90 days	120 days	180 days
Period of not working allowed for other reasons	90 days	90 days	90 days
Definition of Work	Earned income every month	Earned income every month	Earned income every month
Premium level frequency of determination	Every 3 months based on previous 3 months average income level	Every 3 months based on previous 3 months average income level	Every 3 months based on previous 3 months average income level
Termination for failure to pay premium or copays	60 days	60 days	60 days

Up Front Cost Share	Prototype A	Prototype B	Prototype C
Disability Determination Fee	Applies to anyone who need a disability review	Applies to anyone who need a disability review	Applies to anyone who need a disability review
Amount	$150	$100	$50
Frequency	Once per enrollment	Once per enrollment	Once per enrollment
Enrollment Fee	yes	yes	no
Amount	$200	$100	$0
Frequency	Annually	Annually	Annually

Premium	Prototype A	Prototype B	Prototype C
Definition of "Income"	Earned + unearned	Earned + unearned	Earned + unearned
Disregards	Spouse	Spouse	Spouse
Minimum %	7.50%	7.5%	7.5%
# of Tiers (see examples below)	1	1	1
Targeted Average	Low	Mid	High
Discounts for Other Coverage Primary?	Yes	Yes	Yes

Benefits	Prototype A	Prototype B	Prototype C
Deductibles	No	No	No
Out of Pocket Maximum ($150) - assumes not counting premiums, disability reviews and enrollment fees	None	None	None
Copays	High	Mid	Low

Benefits	Prototype A	Prototype B	Prototype C
Doctor Visits ($2)	$8	$4	$2
Inpatient Hospital Stay ($15) - per admit	$60	$30	$15
Outpatient Hospital Services ($3)	$12	$6	$3
Generic Drugs ($0.50)	$2	$1	$0.50
Brand Drugs ($2)	$8	$4	$2
ER ($0)	$20	$10	$0
Lab/X-Ray ($0)	$4	$2	$0
Ambulance ($0)	$20	$10	$0
Transportation ($0)	$2	$1	$0
Transplants ($0)	$100	$50	$0
Home Health ($0)	$0	$0	$0
Mental Health Inpatient ($0) - per admit	$60	$30	$15
Mental Health Outpatient ($0)	$8	$4	$0
Alc/Sub Abuse Inpatient ($0) - per admit	$60	$30	$15
Alc/Sub Abuse Outpatient ($0)	$8	$4	$0
Physical, Occupational, and Speech Therapy Outpatient ($0)	$8	$4	$0
DME <$50	$4	$2	$0
DME $50 to $500	$10	$5	$0
DME $500+	$20	$10	$0
Disposable Medical Supplies ($0)	$4	$2	$0
Orthotics and Prosthetics ($0)	$20	$10	$0
Oxygen ($0)	$0	$0	$0
SNF ($0) - per day	$10	$5	$0
Dental ($0)	$0	$0	$0
Vision ($0)	$8	$4	$0
Chiropractic ($0)	$8	$4	$0
Second Opinions ($0)	$8	$4	$0
TMJ ($0)	$12	$6	$0
HCBS benefits for those that qualify:	Yes	Yes	Yes
Note: Benefits coverage rules that currently apply to Medicaid members would also apply to Buy-In members.			

Appendix Three: Cost Analysis Detail

Current "cost of care" is annual cost (medical and administration) paid for by the State of Colorado, Federal funds and member cost share.

SSI (AND Category) and no other coverage

Situation: No longer eligible due to increased income or assets

	Current	TWWIIA			
	Cost of Care	Current Plan	Prototype A	Prototype B	Prototype C
Cost per Member:	$6,868	$6,872	$6,872	$6,872	$6,872
Copays:	$54	$58	$345	$172	$43
Paid by Colorado:	$3,407	$3,407	$3,407	$3,407	$3,407
Paid by Feds:	$3,407	$3,407	$3,407	$3,407	$3,407
Premium:	$0	$0	-$287	-$114	$16
Membership:	21,695	43			

SSI (AND Category) with Medicare

Situation: No longer eligible due to increased income or assets

	Current	TWWIIA			
	Cost of Care	Current Plan	Prototype A	Prototype B	Prototype C
Cost per Member:	$7,344	$7,347	$7,347	$7,347	$7,347
Copays:	$41	$44	$527	$264	$44
Paid by Colorado:	$3,652	$3,652	$3,652	$3,652	$3,652
Paid by Feds:	$3,652	$3,652	$3,652	$3,652	$3,652
Premium:	$0	$0	-$483	-$219	$0
Membership:	10,067	20			

SSI (AND Category) with other non-Medicare coverage

Situation: No longer eligible due to increased income or assets

	Current	TWWIIA			
	Cost of Care	Current Plan	Prototype A	Prototype B	Prototype C
Cost per Member:	$9,184	$9,187	$9,187	$9,187	$9,187
Copays:	$39	$42	$473	$237	$39
Paid by Colorado:	$4,572	$4,572	$4,572	$4,572	$4,572
Paid by Feds:	$4,572	$4,572	$4,572	$4,572	$4,572
Premium:	$0	$0	-$431	-$195	$3
Membership:	518	1			

SSI (AND Category) with Medicare & other coverage					
Situation:	No longer eligible due to increased income or assets				
	Current	TWWIIA			
	Cost of Care	Current Plan	Prototype A	Prototype B	Prototype C
Cost per Member:	$14,957	$14,961	$14,961	$14,961	$14,961
Copays:	$51	$55	$1,148	$574	$55
Paid by Colorado:	$7,453	$7,453	$7,453	$7,453	$7,453
Paid by Feds:	$7,453	$7,453	$7,453	$7,453	$7,453
Premium:	$0	$0	-$1,094	-$519	$0
Membership:	210	0			

HCBS and no other coverage					
Situation:	No longer eligible due to increased income or assets				
	Current	Medicaid Buy-In			
	Cost of Care	Current Plan	Prototype A	Prototype B	Prototype C
Cost per Member:	$36,266	$36,272	$36,272	$36,272	$36,272
Copays:	$89	$95	$456	$228	$74
Paid by Colorado:	$18,088	$18,088	$18,088	$18,088	$18,088
Paid by Feds:	$18,088	$18,088	$18,088	$18,088	$18,088
Premium:	$0	$0	-$360	-$133	$22
Membership:	3,807	30			

HCBS with Medicare					
Situation:	No longer eligible due to increased income or assets				
	Current	Medicaid Buy-In			
	Cost of Care	Current Plan	Prototype A	Prototype B	Prototype C
Cost per Member:	$35,425	$35,429	$35,429	$35,429	$35,429
Copays:	$56	$60	$392	$196	$60
Paid by Colorado:	$17,684	$17,684	$17,684	$17,684	$17,684
Paid by Feds:	$17,684	$17,684	$17,684	$17,684	$17,684
Premium:	$0	$0	-$332	-$136	$0
Membership:	4,820	39			

HCBS with other non-Medicare coverage					
Situation:	No longer eligible due to increased income or assets				
	Current	Medicaid Buy-In			
	Cost of Care	Current Plan	Prototype A	Prototype B	Prototype C
Cost per Member:	$25,973	$25,978	$25,978	$25,978	$25,978
Copays:	$70	$75	$373	$187	$72
Paid by Colorado:	$12,952	$12,952	$12,952	$12,952	$12,952
Paid by Feds:	$12,952	$12,952	$12,952	$12,952	$12,952
Premium:	$0	$0	-$299	-$112	$2
Membership:	457	4			

HCBS with Medicare & other coverage					
Situation:	No longer eligible due to increased income or assets				
	Current	Medicaid Buy-In			
	Cost of Care	Current Plan	Prototype A	Prototype B	Prototype C
Cost per Member:	$28,381	$28,385	$28,385	$28,385	$28,385
Copays:	$48	$52	$365	$182	$52
Paid by Colorado:	$14,167	$14,167	$14,167	$14,167	$14,167
Paid by Feds:	$14,167	$14,167	$14,167	$14,167	$14,167
Premium:	$0	$0	-$313	-$131	$0
Membership:	247	2			

Total Cost per Member for Current Medicaid Membership					
	Current	Medicaid Buy-In			
	Cost of Care	Current Plan	Prototype A	Prototype B	Prototype C
Cost per Member:	$22,082	$22,086	$22,086	$22,086	$22,086
Copays:	$61	$65	$413	$206	$55
Paid by Colorado:	$11,010	$11,010	$11,010	$11,010	$11,010
Paid by Feds:	$11,010	$11,010	$11,010	$11,010	$11,010
Premium:	$0	$0	-$348	-$141	$10
Membership:	140	140			

Medicare Only					
Situation:	Wants wrap around coverage for non covered benefits				
	Current	Medicaid Buy-In			
	Cost of Care	Current Plan	Prototype A	Prototype B	Prototype C
Cost per Member:	$0	$7,347	$7,347	$7,347	$7,347
Copays:	$0	$44	$527	$264	$44
Paid by Colorado:	$0	$0	$0	$0	$0
Paid by Feds:	$0	$0	$0	$0	$0
Premium:	$0	$7,303	$6,820	$7,084	$7,303
Membership:	2,000	20			

Medicare and Private Only					
Situation:	Wants wrap around coverage for non covered benefits				
	Current	Medicaid Buy-In			
	Cost of Care	Current Plan	Prototype A	Prototype B	Prototype C
Cost per Member:	$0	$14,961	$14,961	$14,961	$14,961
Copays:	$0	$55	$1,148	$574	$55
Paid by Colorado:	$0	$0	$0	$0	$0
Paid by Feds:	$0	$0	$0	$0	$0
Premium:	$0	$14,906	$13,812	$14,386	$14,906
Membership:	8,000	80			

Private Insurance					
Situation:	Can't afford it wants into Medicaid instead of private insurance				
	Current	Medicaid Buy-In			
	Cost of Care	Current Plan	Prototype A	Prototype B	Prototype C
Cost per Member:	$0	$6,872	$6,872	$6,872	$6,872
Copays:	$0	$58	$345	$172	$43
Paid by Colorado:	$0	$0	$0	$0	$0
Paid by Feds:	$0	$0	$0	$0	$0
Premium:	$0	$6,814	$6,527	$6,700	$6,829
Membership:	65,000	35			

Private Insurance					
Situation:	Wants wrap around coverage for non covered benefits				
	Current	Medicaid Buy-In			
	Cost of Care	Current Plan	Prototype A	Prototype B	Prototype C
Cost per Member:	$0	$9,187	$9,187	$9,187	$9,187
Copays:	$0	$42	$473	$237	$39
Paid by Colorado:	$0	$0	$0	$0	$0
Paid by Feds:	$0	$0	$0	$0	$0
Premium:	$0	$9,145	$8,714	$8,950	$9,148
Membership:	65,000	35			

CoverColorado					
Situation:	Needs lower premiums, lower deductibles, no pre-existing				
	Current	Medicaid Buy-In			
	Cost of Care	Current Plan	Prototype A	Prototype B	Prototype C
Cost per Member:	$0	$6,872	$6,872	$6,872	$6,872
Copays:	$0	$58	$345	$172	$43
Paid by Colorado:	$0	$0	$0	$0	$0
Paid by Feds:	$0	$0	$0	$0	$0
Premium:	$0	$6,814	$6,527	$6,700	$6,829
Membership:	158	25			

Uninsured					
Situation:	Needs all benefits covered at affordable cost				
	Current	Medicaid Buy-In			
	Cost of Care	Current Plan	Prototype A	Prototype B	Prototype C
Cost per Member:	$0	$6,872	$6,872	$6,872	$6,872
Copays:	$0	$58	$345	$172	$43
Paid by Colorado:	$0	$0	$0	$0	$0
Paid by Feds:	$0	$0	$0	$0	$0
Premium:	$0	$6,814	$6,527	$6,700	$6,829
Membership:	39,000	20			

Total Cost per Member for Current Non-Medicaid Membership					
	Current	Medicaid Buy-In			
	Cost of Care	Current Plan	Prototype A	Prototype B	Prototype C
Cost per Member:	$0	$10,316	$10,316	$10,316	$10,316
Copays:	$0	$53	$683	$342	$47
Paid by Colorado:	$0	$0	$0	$0	$0
Paid by Feds:	$0	$0	$0	$0	$0
Premium:	$0	$10,263	$9,633	$9,975	$10,270
Membership:	0	214			

Total Cost for Current Medicaid Membership					
	Current	Medicaid Buy-In			
	Cost of Care	Current Plan	Prototype A	Prototype B	Prototype C
Total Cost:	$3,083,326	$3,083,934	$3,083,934	$3,083,934	$3,083,934
Copays:	$8,480	$9,088	$57,638	$28,819	$7,723
Paid by Colorado:	$1,537,423	$1,537,423	$1,537,423	$1,537,423	$1,537,423
Paid by Feds:	$1,537,423	$1,537,423	$1,537,423	$1,537,423	$1,537,423
Premium:	$0	$0	-$48,550	-$19,731	$1,366
Membership:	140	140			

Total Cost for Current Non-Medicaid Membership					
	Current	Medicaid Buy-In			
	Cost of Care	Current Plan	Prototype A	Prototype B	Prototype C
Total Cost:	$0	$2,205,729	$2,205,729	$2,205,729	$2,205,729
Copays:	$0	$11,338	$146,071	$73,036	$9,973
Paid by Colorado:	$0	$0	$0	$0	$0
Paid by Feds:	$0	$0	$0	$0	$0
Premium:	$0	$2,194,391	$2,059,658	$2,132,693	$2,195,756
Membership:	0	214			

Total Cost for All Membership					
	Current	Medicaid Buy-In			
	Cost of Care	Current Plan	Prototype A	Prototype B	Prototype C
Total Cost:	$3,083,326	$5,289,663	$5,289,663	$5,289,663	$5,289,663
Copays:	$8,480	$20,427	$203,709	$101,855	$17,696
Paid by Colorado:	$1,537,423	$1,537,423	$1,537,423	$1,537,423	$1,537,423
Paid by Feds:	$1,537,423	$1,537,423	$1,537,423	$1,537,423	$1,537,423
Premium:	$0	$2,194,391	$2,011,108	$2,112,963	$2,197,121
Membership:	140	353			

Revenue to Offset to Premium:				
	Current Plan	Prototype A	Prototype B	Prototype C
Annual Enrollment Fee:	$0	$70,688	$35,344	$0
Disability Determination Fee:	$0	$32,071	$21,381	$10,690
Total Fees:	$0	$102,759	$56,725	$10,690
Remaining Premium Required:	$2,194,391	$1,908,349	$2,056,238	$2,186,431

Total Cost for All Membership PMPM					
	Current	Medicaid Buy-In			
	Cost of Care	Current Plan	Prototype A	Prototype B	Prototype C
Total Cost PMPM:	$1,840.13	$1,247.19	$1,247.19	$1,247.19	$1,247.19
Copays:	$5.06	$4.82	$48.03	$24.02	$4.17
Paid by Colorado:	$917.54	$362.49	$362.49	$362.49	$362.49
Paid by Feds:	$917.54	$362.49	$362.49	$362.49	$362.49
Fees:	$0.00	$0.00	$24.23	$13.37	$2.52
Premium:	$0.00	$517.39	$449.95	$484.82	$515.51
Membership:	140	353			