Schedule 13
Change Request for FY 2009-10 Budget Request Cycle

Decision Item FY 2009-10 ☑	**Base Reduction Item FY 2009-10** ☐	**Supplemental FY 2008-09** ☐	**Budget Amendment FY 2009-10** ☐
Request Title:	Children's Basic Health Plan Medical Premium and Dental Benefit Costs		
Department:	Health Care Policy and Financing	**Dept. Approval by:** John Bartholomew TB 10/23/08	**Date:** October 31, 2008
Priority Number:	DI-3	**OSPB Approval:**	**Date:** 10-24-08

	Fund	1 Prior-Year Actual FY 2007-08	2 Appropriation FY 2008-09	3 Supplemental Request FY 2008-09	4 Total Revised Request FY 2008-09	5 Base Request FY 2009-10	6 Decision/ Base Reduction FY 2009-10	7 November 1 Request FY 2009-10	8 Budget Amendment FY 2009-10	9 Total Revised Request FY 2009-10	10 Change from Base (Column 5) FY 2010-11
Total of All Line Items	**Total**	120,071,806	167,596,061	0	167,596,061	191,522,750	(17,562,527)	173,960,223	0	173,960,223	(21,833,067)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	4,736,447	0	0	0	0	4,270,540	4,270,540	0	4,270,540	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	283,367	59,154,048	0	59,154,048	67,574,080	(12,328,096)	55,245,984	0	55,245,984	(12,328,096)
	CFE/RF	41,525,827	30,328	0	30,328	92,421	4,595,238	4,687,659	0	4,687,659	4,595,238
	FF	73,526,165	108,411,685	0	108,411,685	123,856,249	(14,100,209)	109,756,040	0	109,756,040	(14,100,209)
(4) Indigent Care Program; H.B. 97-1304 Children's Basic Health Plan Trust	**Total**	6,671,262	406,045	0	406,045	488,936	4,198,723	4,687,659	0	4,687,659	(71,817)
	FTE	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	GF	4,736,447	0	0	0	0	4,270,540	4,270,540	0	4,270,540	0
	GFE	0	0	0	0	0	0	0	0	0	0
	CF	283,367	406,045	0	406,045	488,936	(71,817)	417,119	0	417,119	(71,817)
	CFE/RF	1,651,448	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**	104,684,790	154,739,207	0	154,739,207	177,141,049	(20,025,109)	157,115,940	0	157,115,940	(20,025,109)
	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	0	54,390,220	0	54,390,220	62,222,676	(11,648,629)	50,574,047	0	50,574,047	(11,648,629)
	CFE/RF	36,823,865	30,328	0	30,328	92,421	4,595,238	4,687,659	0	4,687,659	4,595,238
	FF	67,860,925	100,318,659	0	100,318,659	114,825,952	(12,971,718)	101,854,234	0	101,854,234	(12,971,718)

Schedule 13
Change Request for FY 2009-10 Budget Request Cycle

Decision Item FY 2009-10 ☑	**Base Reduction Item FY 2009-10** ☐	**Supplemental FY 2008-09** ☐	**Budget Amendment FY 2009-10** ☐
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:** October 31, 2008
Priority Number:	DI-3	**OSPB Approval:**	**Date:**

	Fund	1 Prior-Year Actual FY 2007-08	2 Appropriation FY 2008-09	3 Supplemental Request FY 2008-09	4 Total Revised Request FY 2008-09	5 Base Request FY 2009-10	6 Decision/ Base Reduction FY 2009-10	7 November 1 Request FY 2009-10	8 Budget Amendment FY 2009-10	9 Total Revised Request FY 2009-10	10 Change from Base (Column 5) FY 2010-11
(4) Indigent Care Program; Children's Basic Health Plan Dental Benefit Costs	**Total**	8,715,754	12,450,809	0	12,450,809	13,892,765	(1,736,141)	12,156,624	0	12,156,624	(1,736,141)
	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	0	4,357,783	0	4,357,783	4,862,468	(607,650)	4,254,818	0	4,254,818	(607,650)
	CFE/RF	3,050,514	0	0	0	0	0	0	0	0	0
	FF	5,665,240	8,093,026	0	8,093,026	9,030,297	(1,128,491)	7,901,806	0	7,901,806	(1,128,491)

Non-Line Item Request:	None
Letternote Revised Text:	[a] Of this amount, $25,612,252 shall be from the Children's Basic Health Plan Trust created in 25.5-8-105, C.R.S.; $21,735,684 shall be from the Health Care Expansion Fund created in 24-22-117 (2) (a) (I), C.R.S.; $2,744,447 shall be from the Supplemental Tobacco Litigation Settlement Account in the Children's Basic Health Plan Trust created in 25.5-8-105, C.R.S.; and $481,664 shall be from the Colorado Immunization Fund created in 25-4-2301, C.R.S. [b] Of this amount, $2,800,116 shall be from the Children's Basic Health Plan Trust created in 25.5-8-105, C.R.S.; $1,324,142 shall be from the Health Care Expansion Fund created in 24-22-117 (2) (a) (I), C.R.S.; and $130,560 shall be from the Supplemental Tobacco Litigation Settlement Account in the Children's Basic Health Plan Trust created in 25.5-8-105, C.R.S.
Cash or Federal Fund Name and COFRS Fund Number:	CF: Tobacco Master Settlement Funds, Children's Basic Health Plan Trust Fund 11G, Health Care Expansion Fund 18K, Supplemental Tobacco Litigation Settlement Account in the Children's Basic Health Plan Trust Fund, and Colorado Immunization Fund; FF: Title XXI
Reappropriated Funds Source, by Department and Line Item Name:	RF: Enrollment Fees of CBHP enrollees from Fund 11G; General Fund from Fund 11G.
Approval by OIT? **Yes:** ☐ **No:** ☐ **N/A:** ☑	
Schedule 13s from Affected Departments:	N/A

CHANGE REQUEST for FY 2009-10 BUDGET REQUEST CYCLE

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

SELECT ONE (click on box):

☒ Decision Item FY 2009-10
☐ Base Reduction Item FY 2009-10
☐ Supplemental Request FY 2008-09
☐ Budget Request Amendment FY 2009-10

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 decrease the total funds appropriation for the Children's Basic Health Plan Premium Costs by $20,025,109 from the FY 2009-10 Base Request of $177,141,049. This request also seeks to decrease the Children's Basic Health Plan Dental Benefit Costs appropriation by $1,736,141 from the FY 2009-10 Base Request of $13,892,765. The adjustments requested for FY 2009-10 are the net result of decreased caseload estimates and higher medical and dental costs. This request also seeks to decrease the appropriation of Cash Funds for annual enrollment fees into the Children's Basic Health Plan Trust Fund by $71,817 due to a lower projected caseload, as well as a General Fund appropriation to the Children's Basic Health Plan Trust Fund in the amount of $4,270,540 for FY 2009-10. The requested General Fund appropriation is from a Base Request of $0, and is required to balance the Trust Fund due to an eligibility expansion and increased expenditures for the fixed number of traditional clients funded through the Trust.

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 225% 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.

The FY 2008-09 Long Bill (HB 08-1375) appropriated $148,842,315 in total funds to the Children's Basic Health Plan Premium Costs. During the 2008 Legislative Session, this appropriation was increased by $5,896,892 to $154,739,207, with changes for the following two bills:

- 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.

In the 2008 Legislative Session, SB 08-022 was also passed to grant the Department overexpenditure authority for the Children's Basic Health Plan with a General Fund limit of $250,000. Due to the 12-month guaranteed eligibility for children in the Plan, the Department would not have been able to prevent an overexpenditure once it became apparent. This bill allows the Department to continue to provide health care to children and prenatal women and avoid drastic measures in attempt to prevent the overexpenditure at the end of the fiscal year.

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 FY 2008-09 Long Bill (HB 08-1375) appropriated $12,168,394 in total funds to the Children's Basic Health Plan Dental Benefit Costs. This appropriation was increased by $282,415 to $12,450,809 for SB 08-160, which expands eligibility for children to 225% of the federal poverty level effective March 1, 2009.

General Description of Request:

This request seeks:

- To adjust the projected enrollment for children and pregnant women in the Plan;
- To adjust the per capita costs for medical and dental services in accordance with actuarial projections, and;

- To adjust the Cash Funds appropriation to the Children's Basic Health Plan Trust Fund for a revised estimate of enrollment fees, as well as the General Fund appropriation to balance the Trust Fund in FY 2009-10.

I. Description of Request Related to Children's Premiums

Caseload Projections (Exhibit C.6)

Many factors caused unexpected volatility in the traditional children's caseload (up to 185% of the federal poverty level) in FY 2006-07 and FY 2007-08. 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 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. Second, marketing of the Children's Basic Health Plan began in April 1, 2006. The marketing campaign has been successful, and the Department believes that it has had a positive effect on caseload in both the children and prenatal programs. New television and radio campaigns have been running statewide, and have targeted low-income and Hispanic populations.

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 November 3, 2008 Budget Request, Exhibit B, page EB-1, the base Medicaid Eligible Children caseload is projected to grow by 15,220 children in FY 2008-09, a 7.46% increase over FY 2007-08. This caseload is projected to increase by an additional 2.61% in FY 2009-10.

Due to volatility in recent children's caseload history, the Department based its February 15, 2008 forecast for FY 2007-08 on growth experienced in FY 2001-02. This time period was used due to similar economic conditions and the presence of Children's Basic Health Plan marketing. The Department's February 15, 2008 forecast for traditional children was for a monthly average of 55,182 in FY 2007-08, and actual caseload was a monthly average of 54,008. This difference is largely due to the sudden decrease in average monthly growth beginning in February 2008. There is evidence that some of the March 2008 decrease was due to the implementation of the expansion to 205% of the federal poverty level (known as Supplemental Expansion Children). This would occur if a child had family income change to between 201-205% of the federal poverty level within their 12-month guaranteed eligibility period. This child, who prior to March 1, 2008 would have remained in the lower income level group due to the guaranteed period, is now being classified in the new income group.

Increases in the traditional children's caseload averaged 1,060 per month between July 2007 and January 2008. Caseload reversed trend after this, resulting in an average decline of 93 children per month from February to June 2008. The Department believes that there are three main factors behind this shift in trend. First, as discussed above, the

implementation of the expansion to 205% of the federal poverty level was partially responsible for the March 2008 decline. Second, the Department believes that economic conditions are also partially responsible for the slowdown in caseload growth. Lastly, the Department believes that its issuance of the final Deficit Reduction Act rules is responsible for the change in trend. This policy was effective January 1, 2008, and includes citizenship and identification requirements for children in the Children's Basic Health Plan. Thus, children who were made eligible for the Children's Basic Health Plan rather than Medicaid due to lack of Deficit Reduction Act documentation will now be required to present such identification for either program. While the Department does not know the magnitude of the caseload declines anticipated from this policy change, caseload is expected to continue to decline for at least one year from the date of implementation as all children that would be impacted undergo an annual redetermination. The Department believes that this change is also partially responsible for strong increases experienced in Medicaid during the same timeframe that the Children's Basic Health Plan has slowed.

Due to these factors, the Department anticipates that the traditional children caseload will continue to experience declines through March 2009, followed by moderate increases. Based on growth between November 2007 and August 2008, the Department forecasts traditional children's caseload to decline by an average of 0.76% per month for the remainder of the fiscal year beginning September 2008. This forecast incorporates a moderating trend through the end of the fiscal year as all children will have undergone an annual redetermination, and also includes monthly variations in growth based on the pattern from FY 2001-02. These monthly variations are due to things such as the distribution of annual redeterminations and seasonality in caseload caused by strong marketing around the beginning of the traditional school year.

In FY 2009-10, the Department anticipates the average monthly growth to increase from that in FY 2008-09. Because all children will have undergone an annual redetermination, the caseload impact of the policy change regarding the Deficit Reduction Act citizenship requirements should be completed in FY 2008-09. Growth in FY 2009-10 should be due to marketing and natural growth, owing to factors such as the economic conditions and

general population growth. The base Medicaid Eligible Children caseload is projected to increase by 7.46% in FY 2008-09 and 2.61% in FY 2009-10, which should result in moderate growth in the Children's Basic Health Plan children's populations. Based on growth experienced from July 2006 through August 2008, the Department forecasts that the traditional children caseload will increase by 0.34% per month in FY 2009-10. The Department believes that this is a moderate forecast given the current and anticipated levels of marketing and outreach for this program, funded by both the Department and community based organizations, and is in line with both the short-term and long-term trends.

The traditional and expansion populations have had policy changes that affected each group individually over the last two years. The large decrease in March 2008 indicates that the implementation of the Supplemental Expansion children affected this higher income group more than the traditional children. After accounting for these policy changes, monthly growth in the expansion children's caseload was approximately the same as that for the traditional children in FY 2006-07 and FY 2007-08. 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. However, children in this income range would have never been affected by the Deficit Reduction Act citizenship requirements, and the caseload trends appear to be diverging since the Department implemented its final rules. As such, the Department does not anticipate caseload declines in the expansion children. The projection for FY 2008-09 is based on the expansion children caseload trends between January 2007 and August 2008, omitting the growth in March 2008. This forecast results in average monthly growth of 0.81% per month for the remainder of the year beginning September 2008, with monthly variations based on experience from the traditional children in FY 2001-02. The Department anticipates that because the policy impacts will be completed in the traditional children in FY 2008-09, the caseload trends in these two populations will return to equivalent levels in FY 2009-10. As such, the expansion children caseload is forecasted to increase by an average of 0.34% per month in FY 2009-10, with the monthly variations retained.

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.

In the revised caseload forecast for this population, the Department used data provided by The Lewin Group. This data includes estimates of the number of uninsured, based on the Current Population Survey that has been adjusted for a Medicaid undercount. In addition, The Lewin Group has provided estimates for the number of individuals currently in private insurance that would opt to switch their health care due to an expansion in the public sector, known as "crowd-out". These crowd-out estimates assume voluntary health coverage and a six-month waiting period provision, and incorporate assumptions regarding the number of eligible individuals that would opt to enroll. Estimates of both the uninsured and crowd-out populations are split into demographic groups (i.e., children, parents, pregnant women, and childless adults), income level by federal poverty level, and citizenship status. Due to citizenship requirements for eligibility in Medicaid and the Children's Basic Health Plan, undocumented individuals are excluded from the analysis. In addition, legal non-residents in the United States less than 5 years are eligible for Medicaid or the Children's Basic Health Plan in very limited circumstances, so only 5% of this group is included in this analysis, along with all citizens and legal non-residents in the United States 5 years or longer.

Based on this analysis, the Department estimates that 1,880 children would ultimately apply and be found eligible for the Supplemental Expansion program (known as the 'ultimate enrollment level'). Caseload would not experience a one-time increase from this expansion, but would rather see a gradual increase as the program is established and the eligible individuals apply and enroll. The Department normally assumes that 40% of the ultimate enrollment level (90% of the uninsured in the eligibility range) would enroll

in the first year, 80% in the second year, and 100% in the third (known as 'phase-in rates'). This is based on analysis provided by The Lewin Group, however this schedule is not known at this time.

The Department's revised forecast for this population is a final caseload of 1,505 in FY 2008-09, or average monthly growth of 44 children for the remainder of the fiscal year. The FY 2009-10 forecasted caseload is 1,880, or growth of 21 children per month.

Caseload Adjustments

In addition to the base caseload outlined above, there are three bottom line adjustments to the children's caseload for the forecast period.

In its November 1, 2007 FY 2008-09 DI-3A, the Department requested and received an additional $1,400,000 for expanded outreach activities in the Children's Basic Health Plan to find and enroll more eligible but not enrolled children in the State. The Department estimated that an additional 8,000 children would be enrolled in the Children's Basic Health Plan through these efforts. In the Department's March 11, 2008 Figure Setting, the Joint Budget Committee approved the full amount of the Department's outreach request, but appropriated resources for an additional 5,358 children due to different assumptions used by Staff to estimate the increase. Because the Department was appropriated the entire amount that it requested for expanded outreach, the Department believes that the appropriate caseload adjustment is its original estimate of 8,000 in FY 2008-09. The FY 2009-10 base caseload growth rate is applied to the FY 2008-09 adjustment to estimate the FY 2009-10 adjustment. These adjustments are split between the income groups based on their share of the forecasted base caseload.

In its February 15, 2008 FY 2008-09 BA-A1A, the Department requested funding to implement a Medical Home initiative in the Children's Basic Health Plan to ensure that all children have a medical home by January 1, 2010. Providing children with a medical home is expected to increase retention in the Children's Basic Health Plan through continuity and increased quality of care, which would increase caseload. The

Department received the level of funding it requested for the medical home payments and is working with the Children's Basic Health Plan managed care organizations on disbursement of the incentives. The Department was only appropriated resources for medical and dental benefits for an additional 694 of the 1,410 children it had requested from this initiative. Because implementation of the program is being delayed, the Department is reducing its original adjustment of 1,410 by one-half to reflect the phase-in of the program in FY 2008-09. For FY 2009-10, the medical home program will be implemented, and the Department believes that the appropriate caseload adjustment is its original estimate of 1,506. These adjustments are split between the income groups based on their share of the forecasted base caseload.

In its February 15, 2008 FY 2008-09 BA-A1A, the Department also requested funding to increase eligibility in the Children's Basic Health Plan from 205% to 225% of the federal poverty level. SB 08-160 was passed during the 2008 Legislative Session, which provided the Department with the statutory authority to implement this expansion. Eligibility for children will be expanded effective March 1, 2009, and expansion for the prenatal program will be effective October 1, 2009. The adjustments for children from this expansion are 1,750 in FY 2008-09 and 5,333 in FY 2009-10.

Total Children's Caseload Projection

The total FY 2008-09 children's caseload forecast is 66,757, a 15.5% increase over the FY 2007-08 caseload of 57,795. The total FY 2009-10 children's forecast is 71,598, a 7.3% increase over the FY 2008-09 projection. Please see Exhibit C.6 for children's caseload history and detailed projections.

Children's Caseload Summary	**FY 2008-09 Appropriated Caseload**	**FY 2008-09 Revised Caseload**	**FY 2009-10 Requested Caseload**
Traditional Children (up to 185% FPL)	70,272	59,229	59,697
Expansion Children (186-200% FPL)	4,893	4,040	4,371
Supplemental Expansion Children (201-205% FPL)	237	1,738	2,197
SB 08-160 Children (206-225% FPL)	1,750	1,750	5,333
Final Caseload Forecast (Including Adjustments)	**77,152**	**66,757**	**71,598**

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. 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. 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 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.

For the development of the FY 2008-09 rate for children in the self-funded network, the Plan's contracted actuary assumed that health care costs would grow by an estimated 6.7% based on history, published surveys, and reports. In addition, the total administrative costs are projected to be $27.25. This amount includes $24.95 for the contracted claims and network administration costs per the new Administrative Services Organization contract and an estimated $2.30 in reinsurance costs per client per month in the self-funded program. The resulting FY 2008-09 base per month cost for each child in

the self-funded network is a total of $139.54, a 2.0% increase over the FY March 1, 2008 rate. This FY 2008-09 rate is lower than that previously reported in the Department's February 15, 2008 FY 2008-09 Budget Request BA-A3. When the original FY 2008-09 rate was developed, the actuarial analysis assumed that the Department would be lifting existing caps on physical, occupational, and speech therapies for all children under the age of three in compliance with SB 07-004 (Early Intervention Services), not just those with developmental delays. Because the original FY 2008-09 had already incorporated the cost of lifting the caps for all children, this update reflects the lower assumed utilization which results in a lower rate. In addition, the actual contracted amount for claims and network administration is $5.50 per member per month less than the original estimated amount.

The contracted actuary utilized historical Children's Basic Health Plan data in the FY 2008-09 HMO rate development. Based on claims costs incurred in 2005 and 2006, the contracted actuary assumed a cost trend of 6.9% for the HMOs, which is in line with other industry studies. The rates were also adjusted for the impacts of the 2007 legislation outlined above, as these costs were not already included in the claims costs from which the FY 08-09 costs are projected. Based on recent growth, administrative costs are projected to increase by 14.1% to $16.46 per member per month. The resulting FY 08-09 HMO rate is $111.32, a 2.5% decrease from the March 1, 2008 HMO rate of $114.22. This overall decrease is largely due to a projected reduction in costs for children under age 6, which comprise approximately 20% of children enrolled in the HMOs.

This FY 2008-09 rate is higher than that previously reported in the Department's February 15, 2008 FY 2007-08 Budget Request BA-A3 due to the final impact for SB 07-004 (Early Intervention Services). The current benefit package provides physical, occupational, and speech therapies only in cases where such therapy is medically needed due to illness or injury, and the benefits are limited to 30 visits. However, prior to SB 07-004, the benefit package specifically excluded "therapies for learning disorders, developmental delays, stuttering, voice disorders, or rhythm disorders". In estimating the fiscal note and the original FY 2007-08 rates for this benefit change, only the cost of

removing the cap on visits was included. The higher than estimated cost for adding these benefits is because the exclusion of developmentally delayed clients under age 3 is being removed, and unlimited therapies for these clients have been provided since November 1, 2007. The contracted actuary included the estimated cost for lifting the cap for all children in the original FY 2008-09 rate, and did not include any adjustment to the HMO rate. Thus, for the HMO rate, the cost for Early Intervention Services for children under three only represents a new addition to the rate, whereas this change represents a decrease in the self-funded network rate.

The Department estimates that approximately 41.0% of children will be served in the self-funded network in FY 2008-09 and the remaining 59.0% will be enrolled in an HMO. This is based on historical experience as well as the expectation that the growth in children new to the Children's Basic Health Plan will support a higher percentage of children in the self-funded network, as new children are often in the self-funded network for a number of months prior to enrolling in an HMO. Applying these weights to the actuarial rates yields a blended rate of $122.85 for all children in FY 2008-09. This is an increase of 0.14% over the final FY 2007-08 blended rate of $122.68 (effective March 1, 2008 and including all benefit changes from the 2007 Legislative Session), as calculated using the actual caseload mix between self-funded and HMO. See Exhibit C.5, page C.5-2 for calculations.

The Department's FY 2008-09 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 2007-08. 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 2008-09 blended capitation rate is used to project the FY 2008-09 per capita. The base growth of 0.14% is applied to the calculated FY 2007-08 per capita

to estimate a base per capita. In addition to the base, there are three required adjustments to the per capita costs for programmatic changes.

First, the Department was appropriated funding to implement a Medical Home initiative in the Children's Basic Health Plan through to the Department's FY 2008-09 BA-A1A ("Building Blocks"), with funding effective July 1, 2008. To estimate the per capita cost, the Department assumed that a managed care organization would be paid an additional $10 for each code that identifies a medical home procedure. Further, utilization targets of medical home for children in an HMO are 80% for children under age 2 and 60% for children older. The utilization target for children in the state's self-funded network is 20% for all ages, as most clients that pass through the network move quickly into an HMO, which artificially deflates the utilization of well-child visits. The resulting estimated per capita cost is $6.88 in each year (see the Department's February 15, 2008 BA-A1A, Table D.3-1, page S.1A-D5).

Second, SB 08-057 (Hearing Aids for Minors) mandates coverage for medically appropriate hearing aids for children whose hearing loss is verified by a physician or audiologist. The Children's Basic Health Plan currently limits annual benefits for hearing aids to $800. Effective January 1, 2009, the Children's Basic Health Plan will no longer cap the annual benefits for hearing aids, which is expected to increase the average cost as the Plan begins covering the entire cost of more expensive hearing aids. In addition, the Department will remove the requirement that the hearing impairment must be due to congenital defect or traumatic injury, which may increase the number of children receiving hearing aids. Based on analysis of encounter data from the Plan's managed care organizations, the Department's contracted actuary estimates that the per member per month rate will increase by approximately $0.13. In the fiscal note for SB 08-057, the Department estimated that this translates into a per capita cost of $0.87 in FY 2008-09 (adjusted for the partial year) and $1.77 in FY 2009-10.

Third, SB 08-160 (Health Care for Children) mandates mental health benefits in the Children's Basic Health Plan that are equivalent to those offered in Medicaid effective January 1, 2009. The Department's estimate for the per capita cost to provide expanded

mental health services is based on that for Medicaid Eligible Children. However, because children in the Children's Basic Health Plan will continue to receive mental health services through their physical health system rather than a dedicated behavioral health organization, the Department assumes that utilization will be 20% lower than that in Medicaid. The Department worked with its contracted actuary to identify mental health costs already included in the children's capitation rate, and removed this from the total cost. As outlined in the fiscal note for SB 08-160, the Department estimated the additional per capita cost for the enhanced mental health benefits to be $38.85 in FY 2008-09 (adjusted for the partial year) and $80.76 in FY 2009-10.

The final projected FY 2008-09 per capita, including the impacts of all the above programmatic changes, is $1,635.35. This is a 3.08% increase over the FY 2007-08 calculated per capita of $1,586.53, with most of the growth coming from changes in benefits.

Beginning with FY 2009-10, the Department and its contracted actuary are changing the schedule for developing capitation rates. Currently, rates are calculated one year in advance, which requires 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 are based on claims costs incurred in 2005 and 2006. The rate development will now begin 6 months later, which will allow 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. As a result of this change, the Department does not have FY 2009-10 base capitation rates developed.

To estimate the FY 2009-10 per capita trend, the Department analyzed the historical growth in the self-funded network and HMO rates. The Department has used a four-year average growth rate to project the FY 2009-10 HMO and self-funded rates separately. The blended rate is then calculated assuming that approximately 41.0% of children will be served in the self-funded network in FY 2008-09 and the remaining 59.0% will be enrolled in an HMO. This results in a base growth rate of 6.15% for FY 2009-10.

Similar to the FY 2008-09 per capita, the projected growth in the FY 2009-10 blended capitation rate is used to project the FY 2009-10 per capita. The Department applies the projected 6.15% growth to the base FY 2008-09 per capita of $1,588.75 to estimate a base FY 2009-10 per capita of $1,686.51. The base FY 2009-10 per capita requires adjustments for the same programmatic changes discussed for FY 2008-09 (see discussion on pages 16-17). The final projected FY 2009-10 per capita, including the impacts of all programmatic changes, is $1,775.92. This is a 8.60% increase over the FY 2008-09 projected per capita of $1,635.35, with most of the growth coming from changes in benefits.

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 Baby and Kid Care Program in Medicaid. In addition, the prenatal population was subject to the identification requirements of HB 06S-1023. With the passage of SB 07-211, the CHP+ prenatal population 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 Baby and Kid Care Program Adults in Medicaid, the traditional prenatal population experienced unusually strong growth in FY 2007-08. Pregnant women in Medicaid are required to provide proof of citizenship and identification under the Deficit Reduction Act. Strong growth in the Medicaid population indicates that the exemption of the prenatal population in the Children's Basic Health Plan from similar requirements under HB 06S-1023 is 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.

The Colorado Department of Public Health and Environment Family Planning Initiative was recently 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 moderating trends in the traditional prenatal population.

In its February 15, 2008 Budget Request, the Department forecasted that traditional prenatal would increase by an average of 1.00% per month in FY 2008-09. This was based on the growth experienced in FY 2006-07. The Department believes that this is a moderate forecast given the current level of marketing and outreach for this program, funded by both the Department and community based organizations, as well as the anticipated Family Planning initiatives discussed above. Marketing and outreach are expected to impact the prenatal population less than the children populations, as such efforts are targeting children specifically. Additionally, the Department does not anticipate the declines experienced in July and August 2008 to continue. Therefore, the Department is not changing the FY 2008-09 projected monthly growth from its February 15, 2008 forecast of 1.00% per month for the remainder of the fiscal year beginning in September 2008.

In FY 2009-10, the Department anticipates the average monthly growth to decrease from that in FY 2008-09. In addition to the reasons outlined above, monthly caseload is expected to increase at a slower rate as it approaches a saturation point. The Department's FY 2009-10 forecast assumes that the monthly growth rate will decrease by 11% from that in FY 2008-09, to 0.89% per month. This is based on the projected

reduction in monthly growth in Medicaid Baby Care Adults between FY 2008-09 and FY 2009-10.

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.

The Department does not anticipate that the negative trend experienced in FY 2007-08 in this population to continue given the growth trends in Medicaid Baby Care Adults and the Children's Basic Health Plan traditional prenatal, as well as the current level of marketing and outreach for this program, funded by both the Department and community based organizations. The caseload for this population has seen small increases in July and August 2008, which are anticipated to continue. The Department's forecast for the remainder of FY 2008-09 for expansion prenatal is based on the long-term trend experienced between July 2006 and June 2008, during which the monthly increases averaged 0.43%. The Department projects that this moderate growth will continue in FY 2009-10.

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.

Similar to the supplemental expansion children, the Department is using data provided by The Lewin Group to revise its forecast. This data includes estimates of the number of

uninsured, based on the Current Population Survey that has been adjusted for a Medicaid undercount. In addition, The Lewin Group has provided estimates for the number of individuals currently in private insurance that would opt to switch their health care due to an expansion in the public sector, known as "crowd-out". These crowd-out estimates assume voluntary health coverage and a six-month waiting period provision, and incorporate assumptions regarding the number of eligible individuals that would opt to enroll. Estimates of both the uninsured and crowd-out populations are split into demographic groups (i.e., children, parents, pregnant women, and childless adults), income level by federal poverty level, and citizenship status. Due to citizenship requirements for eligibility in Medicaid and the Children's Basic Health Plan, undocumented individuals are excluded from the analysis. In addition, legal non-residents in the United States less than 5 years are eligible for Medicaid or the Children's Basic Health Plan in very limited circumstances, so only 5% of this group is included in this analysis, along with all citizens and legal non-residents in the United States 5 years or longer.

Based on this analysis, the Department estimates that 180 pregnant would ultimately apply and be found eligible for the program (known as the 'ultimate enrollment level'). Caseload would not experience a one-time increase from this expansion, but would rather see a gradual increase as the program is established and the eligible individuals apply and enroll. The Department normally assumes that 40% of the ultimate enrollment level (90% of the uninsured in the eligibility range) would enroll in the first year, 80% in the second year, and 100% in the third (known as 'phase-in rates'). This is based on analysis provided by The Lewin Group, however this schedule is not known at this time.

The Department's revised forecast for this population is a final caseload of 104 in FY 2008-09, or average monthly growth of 10 women for the remainder of the fiscal year. The FY 2009-10 forecasted caseload is 178, or growth of 3 women per month.

Caseload Adjustments

In its February 15, 2008 FY 2008-09 BA-A1A, the Department also requested funding to increase eligibility in the Children's Basic Health Plan from 205% to 225% of the federal poverty level. SB 08-160 was passed during the 2008 Legislative Session, which provided the Department with the statutory authority to implement this expansion. Eligibility for prenatal women will be expanded effective October 1, 2009 to coincide with the renewal of the Health Insurance Flexibility and Accountability (HIFA) section 1115 demonstration waiver under which these clients receive services. The adjustment for the prenatal program from this expansion is 254 in FY 2009-10.

Total Prenatal Caseload Projection

The total FY 2008-09 prenatal caseload forecast is 1,847 clients, a 17.6% increase over the FY 2007-08 caseload of 1,570. The FY 2009-10 total prenatal forecast is 2,363 clients, a 27.9% increase over FY 2008-09. Please see Exhibit C.7 for children's caseload history and detailed projections.

Prenatal Caseload Summary	**FY 2008-09 Appropriated Caseload**	**FY 2008-09 Revised Caseload**	**FY 2009-10 Requested Caseload**
Traditional Prenatal (up to 185% FPL)	1,725	1,568	1,743
Expansion Prenatal (186-200% FPL)	277	175	188
Supplemental Expansion Prenatal (201-205% FPL)	19	104	178
SB 08-160 Prenatal (206-225% FPL)	0	0	254
Final Caseload Forecast	**2,021**	**1,847**	**2,363**

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. For the development of the FY 2008-09 rates, the contracted actuary did not have multiple years of claims experience to develop cost trends, so the growth in prenatal

rates is based on history and industry trend sources. The assumed growth in health care costs in FY 2008-09 is 6.7% for prenatal women in the self-funded network, up from a 4.7% trend in FY 2007-08. Utilization assumptions were retained from FY 2007-08, and the actuarial analysis assumes that 95% of all pregnant women in the prenatal program will have deliveries in the Children's Basic Health Plan, and that the average length of stay will be 7.8 months. As with the children's rates, the total administrative costs are projected to be $27.25, which includes $24.95 for the contracted claims and network administration costs per the new Administrative Services Organization contract and an estimated $2.30 in reinsurance costs per client per month in the self-funded program. (see Children's Rates, Section I). The FY 2008-09 base prenatal rate developed by the contracted actuary is $915.80, a 5.99% increase from the FY 2007-08 rate. The FY 2008-09 rate is lower than that previously reported in the Department's February 15, 2008 FY 2007-08 Budget Request BA-A3 because the actual contracted amount for claims and network administration is $5.50 per member per month less than the original estimated amount.

The Department's FY 2008-09 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 clients, and that other factors that may affect per capita costs remain constant from FY 2007-08, such as the length of stay in the program. Thus, the projected FY 2008-09 per capita is $12,015.85, a 5.99% increase over the FY 2007-08 per capita. There are no per capita adjustments for the prenatal program.

As discussed in Children's Rates in Section I, beginning with FY 2009-10, the Department and its contracted actuary are changing the schedule for developing capitation rates and the FY 2009-10 rates have not yet been developed.

To estimate the FY 2009-10 per capita trend, the Department analyzed the historical growth in the prenatal rates. The Department has used a three-year average growth rate to project the FY 2009-10 rate, which results in forecasted base growth of 5.53% for FY

2009-10. The projected FY 2009-10 per capita is $12,680.33. There are no per capita adjustments for the prenatal program.

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.

For the development of the FY 2008-09 dental capitation rate, the contracted actuary assumed a cost trend of 3.00%, based on historical dental claims data as well as industry publications. The FY 2008-09 actuarially developed dental rate is $14.66 per member per month, an increase of 5.92% over the FY 2007-08 rate. This rate assumes the continuation of the enhanced benefits package described above, as well as an estimated $1.09 in administrative costs per member per month.

The Department's FY 2008-09 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 2007-08. Base growth of 5.92% from the capitation rate is applied to the calculated FY 2007-08 per capita of $151.14, resulting in a projected FY 2008-09 per capita of $160.09.

As discussed in Children's Rates in Section I, beginning with FY 2009-10, the Department and its contracted actuary are changing the schedule for developing capitation rates and the FY 2009-10 rates have not yet been developed.

To estimate the FY 2009-10 per capita trend, the Department analyzed the historical growth in the dental rates. The Department has used a five-year average growth rate to project the FY 2009-10 rate, which results in forecasted base growth of 6.06% for FY 2009-10. The projected FY 2009-10 per capita is $169.79. There are no per capita adjustments for the dental program.

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

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

The Children's Basic Health Plan Trust Fund is funded primarily through Tobacco Master Settlement appropriations and General Fund (when necessary); however, enrollment fees from clients of the program and interest earnings on the Fund's balance also serve to subsidize the Trust. In FY 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.

The estimate of the FY 2008-09 Tobacco Master Settlement base allocation to the Trust Fund is $22,465,691. In addition, HB 07-1359 accelerated payments from the Strategic Contribution Fund in the Master Settlement Agreement, which increases the Trust's allocation further by $3,696,000. Accounting for the Trust's portion of the State Auditor's Office payment, the current forecasted FY 2008-09 Tobacco Master Settlement allocation to the Trust is $26,128,545. The current estimate for the FY 2009-10 allocation to the Trust is $26,686,343.

While the Trust Fund balance is expected to be sufficient for the FY 2008-09 program costs, the Trust Fund is forecasted to have a shortfall in FY 2009-10. Based on total projected program expenses of $179,011,337 for FY 2009-10 and total revenues (including the beginning balance, Health Care Expansion Fund monies, Supplemental Tobacco Litigation Settlement account funds, and federal matching funds) of $174,665,636, there would be a Trust Fund balance shortfall of $4,345,701 for FY 2009-10. Due to the fact that the funds would collect interest while in the Trust, the Department estimates a need of $4,270,540 in General Fund for FY 2009-10 to balance the Trust (see Exhibit C.1, line V).

There are two drivers behind the shortfall in the Trust Fund. First, the caseload funded from the Trust Fund for traditional children will be 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.

Second, SB 08-160, which expanded eligibility in the Children's Basic Health Plan to 225% of the federal poverty level, is funded primarily through the Trust Fund. While the Trust Fund was appropriated $5,564,404 in FY 2007-08 partially to fund this expansion, the medical and dental costs for these clients is currently projected to be $3,142,021 in

FY 2008-09 and $13,597,275 in FY 2009-10. The cumulative State cost of the expansion over the two years is estimated to be $5,884,427. Without including the medical and dental costs of the expansion clients, the Trust Fund would have a positive balance of approximately $1,400,000 at the end of FY 2009-10.

Consequences if Not Funded:

If this request is not funded, the Children's Basic Health Plan would have insufficient funding to support the projected caseload growth and per capita increases. As such, the Department would have to delay the implementation of the expansion to 225% of the federal poverty level. The medical and dental costs of the expansion clients over FY 2008-09 and FY 2009-10 are greater than the Trust Fund shortfall, so delaying this implementation would ensure that enrollment in the previously established program would not need to be capped.

Calculations for Request:

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 2008-09 Final Appropriation (Column 2)	$406,045	$0	$406,045
FY 2009-10 Base Request (Column 5)	$488,936	$0	$488,936
FY 2009-10 November 3, 2008 DI-3 (Column 6)	$4,198,723	$4,270,540	($71,817)
Total FY 2009-10 Revised Request (Column 9)	**$4,687,659**	**$4,270,540**	**$417,119**

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 2008-09 Final Appropriation (Column 2)	$406,045	$0	$406,045
FY 2009-10 Base Request (Column 5)	$488,936	$0	$488,936
FY 2009-10 November 3, 2008 DI-3 (Column 6)	$4,198,723	$4,270,540	($71,817)
FY 2010-11 Change from Base (Column 10)	**($71,817)**	**$0**	**($71,817)**

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 2008-09 Final Appropriation (Column 2)	$154,739,207	$54,420,548	$100,318,659
FY 2009-10 Base Request (Column 5)	$177,141,049	$62,315,097	$114,825,952
FY 2009-10 November 3, 2008 DI-3 (Column 6)	($20,025,109)	($7,053,391)	($12,971,718)
Total FY 2009-10 Revised Request (Column 9)	**$157,115,940**	**$55,261,706**	**$101,854,234**

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 2008-09 Final Appropriation (Column 2)	$154,739,207	$54,420,548	$100,318,659
FY 2009-10 Base Request (Column 5)	$177,141,049	$62,315,097	$114,825,952
FY 2009-10 November 3, 2008 DI-3 (Column 6)	($20,025,109)	($7,053,391)	($12,971,718)
FY 2010-11 Change from Base (Column 10)	**($20,025,109)**	**($7,053,391)**	**($12,971,718)**

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 2008-09 Final Appropriation (Column 2)	$12,450,809	$4,357,783	$8,093,026
FY 2009-10 Base Request (Column 5)	$13,892,765	$4,862,468	$9,030,297
FY 2009-10 November 3, 2008 DI-3 (Column 6)	($1,736,141)	($607,650)	($1,128,491)
Total FY 2009-10 Revised Request (Column 9)	**$12,156,624**	**$4,254,818**	**$7,901,806**

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 2008-09 Final Appropriation (Column 2)	$12,450,809	$4,357,783	$8,093,026
FY 2009-10 Base Request (Column 5)	$13,892,765	$4,862,468	$9,030,297
FY 2009-10 November 3, 2008 DI-3 (Column 6)	($1,736,141)	($607,650)	($1,128,491)
FY 2010-11 Change from Base (Column 10)	**($1,736,141)**	**($607,650)**	**($1,128,491)**

Cash Funds Projections:

Cash Fund Name	**Cash Fund Number**	**FY 2007-08 Expenditures**	**FY 2007-08 End of Year Cash Balance**	**FY 2008-09 End of Year Cash Balance Estimate ***	**FY 2009-10 End of Year Cash Balance Estimate ***	**FY 2010-11 End of Year Cash Balance Estimate ***
Children's Basic Health Plan Trust	11G	$120,907,223	$9,231,077	$5,463,582	($21,746,716)	($28,734,729)
Health Care Expansion Fund	18K	$76,441,702	$135,721,617	$111,499,132	$72,449,213	$32,395,800

* Cash Balance Estimates do not incorporate the impact of any Change Requests.

Assumptions for Calculations:

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

Assumptions for Children's Caseload Projections
FY 2008-09 and FY 2009-10 Enrollment Projection: Exhibit C.6

- The Department anticipates that the traditional children caseload will continue to experience declines through March 2009, followed by moderate increases. Based on growth between November 2007 and August 2008, the Department forecasts traditional children's caseload to decline by an average of 0.76% per month for the remainder of the fiscal year beginning September 2008. This forecast incorporates a moderating trend through the end of the fiscal year as all children will have undergone an annual redetermination, and also includes monthly variations in growth based on the pattern from FY 2001-02.
- The Department's FY 2009-10 forecast assumes that the monthly growth rate will increase to 0.34% per month, based on growth experienced from July 2006 through August 2008. Because all children will have undergone an annual redetermination, the caseload impact of the policy change regarding the Deficit Reduction Act citizenship requirements should be completed in FY 2008-09. Growth in FY 2009-10 should be due to marketing and natural growth, owing to factors such as the economic conditions and general population growth. The base Medicaid Eligible Children caseload is projected to increase by 7.46% in FY 2008-09 and 2.61% in FY 2009-10, which should result in moderate growth in the Children's Basic Health Plan children's populations.
- The growth rates between the two children's populations converged in FY 2006-07 and FY 2007-08, and the Department assumes that the expansion population has reached a level of maturity where large monthly increases are not expected simply due to the newness of the program. However, children in the expansion income range would have never been affected by the Deficit Reduction Act citizenship requirements, and the caseload trends appear to be diverging since the Department implemented its final rules. As such, the Department does not anticipate caseload declines in the expansion children. The projection for FY 2008-09 is based on the

expansion caseload trends between January 2007 and August 2008, omitting the growth in March 2008. This forecast results in average monthly growth of 0.81% per month for the remainder of the year beginning September 2008, with monthly variations based on experience from the traditional children in FY 2001-02.

- The Department anticipates that because the policy impacts will be completed in the traditional children in FY 2008-09, the caseload trends in these two populations will return to equivalent levels in FY 2009-10. As such, the expansion children caseload is forecasted to increase by an average of 0.34% per month in FY 2009-10, with the monthly variations retained.
- The Department is revising its forecast for the Supplemental Expansion children (201-205% of the federal poverty level) using data provided by The Lewin Group. Based on this analysis, the Department estimates that 1,885 children would ultimately apply and be found eligible for the program (known as the 'ultimate enrollment level'). Caseload would not experience a one-time increase from this expansion, but would rather see a gradual increase as the program is established and the eligible individuals apply and enroll. Based on this analysis, the Department's revised forecast for the Supplemental Expansion children's population is a final caseload of 1,505 in FY 2008-09, or average monthly growth of 44 children. The FY 2009-10 forecasted caseload is 1,880, or growth of 21 children per month.

Assumptions for Prenatal Caseload Projections (Exhibit C.7)

- In its February 15, 2008 Budget Request, the Department forecasted that traditional prenatal would increase by an average of 1.00% per month in FY 2008-09. This was based on the growth experienced in FY 2006-07. The Department believes that this is a moderate forecast given the current level of marketing and outreach for this program, funded by both the Department and community based organizations, as well as the Family Planning initiatives discussed above. Additionally, the Department does not anticipate the declines experienced in July and August 2008 to continue. Therefore, the Department is not changing the FY 2008-09 projected monthly growth from its February 15, 2008 forecast of 1.00% per month for the remainder of the fiscal year beginning in September 2008. In FY 2009-10, the Department anticipates

the average monthly growth to decrease from that in FY 2008-09. The Department's FY 2009-10 forecast assumes that the monthly growth rate will decrease by 11% from that in FY 2008-09, to 0.89% per month. This is based on the projected reduction in monthly growth in Medicaid Baby Care Adults between FY 2008-09 and FY 2009-10.

- Unlike the children's populations, the growth in the expansion prenatal population does not appear to be converging with that in the traditional population. 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. The Department's forecast for the remainder of FY 2008-09 for expansion prenatal is based on the long-term trend experienced between July 2006 and June 2008, during which the monthly increases averaged 0.43%. The Department projects that this moderate growth will continue in FY 2009-10.
- Similar to the supplemental expansion children, The Department is revising its forecast for the Supplemental Expansion prenatal (201-205% of the federal poverty level) using data provided by The Lewin Group. Based on this analysis, the Department estimates that 180 pregnant would ultimately apply and be found eligible for the program (known as the 'ultimate enrollment level'). Caseload would not experience a one-time increase from this expansion, but would rather see a gradual increase as the program is established and the eligible individuals apply and enroll. Based on this analysis, the Department's revised forecast for Supplemental Expansion prenatal population is a final caseload of 104 in FY 2008-09, or average monthly growth of 10 women for the remainder of the fiscal year. The FY 2009-10 forecasted caseload is 178, or growth of 3 women per month.

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 2007-08. 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. (2008) (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., (2008) *"Eligible person" means: (a) A person who is less than nineteen years of age, whose family income does not exceed two hundred twenty five percent of the federal poverty level, adjusted for family size…; or (b) A pregnant woman whose family income does not exceed two hundred five percent of the federal poverty level, adjusted for family size.*

25.5-8-107 (1) (a) (II), C.R.S. (2008) (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. (2008) *…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.