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# Medicaid and Adults Without Dependent Children

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An Examination of Various Policy Options  
Regarding Medicaid Expansion for Adults without  
Dependent Children

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# Executive Summary

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In 2009, the Colorado State Legislature passed the Colorado Health Care Affordability Act (CHCAA.) This Act imposed a tax on hospitals, known as the Hospital Provider Fee. This tax was to pay for the expansion of Medicaid coverage to ineligible populations by 2012. The Act called for the state to expand Medicaid eligibility to adults without dependent children (AwDC) who had incomes at or below 100 percent of the federal poverty level (FPL.)

Eventually the Department of Health Care Policy and Financing (HCPF), as well as various stakeholders<sup>1</sup> determined that the funding source (the hospital provider fee) for the expansion was insufficient and would not allow the state to expand to the expected 100 percent FPL. HCPF determined that the funding to expand eligibility to a limited 10,000 AwDC would be available and distributed using a lottery system for individuals at or below 10 percent FPL.

The Patient Protection and Affordable Care Act (ACA, also known as federal health care reform), requires all states to expand Medicaid coverage to AwDC who fall at or below 133 percent of the FPL. This expansion is set to be implemented in all states in 2014, and states will receive 100 percent federal matching until 2016, at which point the federal matching percentage will be reduced to 90 percent for the years 2016-2019, followed by another reduction in 2019 to 75 percent federal matching.<sup>2</sup>

The passage of the ACA changed the way Colorado approached implementing Medicaid expansion. One major difference between Colorado Law and the ACA is that the ACA calls for an Essential (minimum) Benefits Health Plan (EBHP) that insurance companies (public insurance included) in every state will be required to offer. At this point, the federal government has yet to release guidelines on what this will require. It is expected that the federal government will require less coverage than what Colorado defines as full Medicaid benefits. However, Colorado statute does not require a specific benefits package. Once the federal coverage definition is implemented, states will have the option of offering more benefits under Medicaid than what the federal government outlines. States that offer above and beyond coverage options will be responsible for paying for those benefits.

Today, Colorado is faced with deciding to what extent the state should provide Medicaid coverage to AwDC. This paper will examine three policy alternatives that should be considered when addressing this issue;

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<sup>1</sup> Stakeholders include HCPF (the state,) hospitals and medical providers and childless adults.

<sup>2</sup> Supreme Court hearings regarding the constitutionality of the ACA begun on March 26. A Decision is expected to be made in June and could change aspects of the ACA currently set for implementation in 2014.

- ❖ The Status quo: expand Medicaid to 10,000 AwDC in Colorado who fall at or below 10 percent FPL and offer them full Medicaid benefits
- ❖ Alternative one: offer a “benchmark” or limited benefits package to a larger population of AwDC
- ❖ Alternative two: do nothing at all and wait for the federal government to implement coverage in 2014

**Problem Definition:**

Due to the Colorado Health Care Affordability Act and the Patient Protection and Affordable Care Act, the state must decide to what extent it should provide Medicaid benefits to adults without dependent children.

## **Introduction and Problem Definition**

Health care is important to everyone. For many it is provided through their employer, but for those who are unemployed, do not work enough hours to receive health coverage, or cannot afford it, Medicaid makes it possible to receive the health care needed to stay healthy. The Medicaid program is the third largest health insurance program in the United States, following employer based health insurance and Medicare.<sup>3</sup> Enacted under the 1965 Social Security amendments, Medicaid is responsible for three areas of coverage; (i) health insurance for low income families with dependent children and people with disabilities; (ii) long term care for older Americans and individuals with disabilities and; (iii) supplemental coverage for low income Medicare beneficiaries for services not covered by Medicare.<sup>4</sup>

This analysis seeks to examine the cost burden that one group, AwDC, places on the state, hospitals, client advocacy organizations, and the privately insured, because they currently do not qualify for Medicaid, and cannot afford private insurance. Due to the Colorado Health Care Affordability Act (CHCAA) and the Patient Protection and Affordable Care Act (ACA), the state must decide to what extent it should provide Medicaid benefits to AwDC.

This analysis seeks to examine three possible policy solutions that address the issue as well as the feasibility of each solution. For a more in depth discussion on the feasibility of each alternative, please see page 32.

- ❖ The status quo: expand Medicaid to a limited 10,000 individuals, at or below 10 percent FPL in this population and offer full Medicaid benefits. This option is scheduled to be implemented in Colorado during the spring of 2012.
- ❖ Alternative one: Limit the benefits package offered and expand to a larger population.
- ❖ Alternative two: do nothing until 2014, and leave expansion up to the federal government.

<sup>3</sup> [www.cms.gov/medicaidgeninfo](http://www.cms.gov/medicaidgeninfo), "Medicaid Program – General Information", Overview.

<sup>4</sup> [www.cms.gov/medicaidgeninfo](http://www.cms.gov/medicaidgeninfo), "Medicaid Program – General Information", Overview.

This analysis will also examine the states of Oregon and Maine and their experiences with providing coverage to this population, as well as the similarities and differences between the two states and Colorado. Please see below for a chart depicting these differences.

State	Enrollment System	Benefits Offered <sup>5</sup>
<b>Oregon</b>	Lottery System Selection of 10,000 individuals	General Medicaid Benefits package but Not full
<b>Maine</b>	Coverage of 60,000 AwDC	Benchmark (limited) Medicaid benefits package
<b>Colorado</b>	Lottery system 10,000 individuals selected	Full Medicaid benefits to be offered

This analysis focuses on two major policy issues. The first has to do with the uninsured being considered a drain on society, for example, the cost-shift to the privately insured when the uninsured seek uncompensated care. The skyrocketing cost of health insurance in Colorado is what has contributed greatly to the number of uninsured in this state. In 2009, the most recent year with per-person spending state specific data, Colorado spent \$21.7 billion on health care, which represents \$4,717 per person or 11.1 percent of the gross state product (GSP.) In 2009, the average annual premium for private insurance for a single person was \$4,570.<sup>6</sup> For a more in depth discussion on cost shifting, please refer to page 24. The second issue this analysis will focus on is the value of pilot programs.

### *Overview of Medicaid*

Within federal Medicaid guidelines, states have the ability to determine:

- ❖ Who is eligible for Medicaid
- ❖ What benefits they receive

<sup>5</sup> Please note it is beyond the scope of this paper to analyze the specific services that each benefits package option offers

<sup>6</sup> Byron L. Dorgan, Chairman, Democratic Policy Committee, Special Report, "Health Care Reform: The Cost of Doing Nothing in Colorado, Soaring Health Care Costs are Unsustainable for Families and Individuals, Businesses, and All Levels of Government", June 2009.

- ❖ How much to pay medical providers who serve these enrollees
- ❖ Whether or not to use a managed care approach<sup>7</sup>
- ❖ How the program is organized and administered
- ❖ State policy priorities such as covering AwDC.

States and the federal government jointly fund Medicaid. The federal government guarantees federal matching funds to states for qualifying Medicaid expenditures. Federal matching assistance percentages (FMAPs) are proportional to a states average personal income, relative to the national average. For example, states with *higher* personal incomes have *lower* FMAPs.<sup>8</sup>

Medicaid provides funding for a range of health care providers in communities across the United States. It provides support for jobs and income. The impact of Medicaid on the economy is greatly affected by the federal matching formula. At a minimum states draw a dollar of federal funding for every dollar spent on Medicaid. The federal Medicaid dollars represent the largest single federal grant to states, accounting for around 43 percent of all grants. On average states spend about 16 percent of their own funds on Medicaid, making it the second largest program in most states general funds, following spending for K-12 education.<sup>9</sup>

Most states have additional state-only programs, which provide medical assistance to low-income or medically frail individuals that do not qualify for Medicaid. One group that is traditionally not covered is AwDC. This population consists of adults who either do not have children, or have children who are no longer dependent upon them. Most of this population is made up of people who have part time jobs and do not work enough hours to qualify for employer-based health insurance, they have seasonal jobs and do not make enough money to buy private insurance, or they are all together unemployed.

Uninsured AwDC creates both a cost shifting and equity issue. They are responsible for a cost shift to the privately insured. This means that the privately insured pay for the care received by the uninsured. It is estimated that on average the privately insured pay around 47 percent of uncompensated care received by the uninsured.<sup>10</sup> This in turn leads to an equity issue, many assert it is not fair for the privately insured to pay for the uncompensated care received by the uninsured. Others argue that it is not within the scope of

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<sup>7</sup> **Managed Care** refers to efforts to coordinate, rationalize, and channel the use of services, to achieve desired access, service, and outcomes in health care, while controlling costs.

<sup>8</sup> Veron K. Smith, Kathleen Gifford, Eileen Elis, Robin Rudowitz, Laura Snyder, Kaiser Commission on Medicaid and the Uninsured, "Moving Ahead Amid Fiscal Challenges: A look at Medicaid Coverage, Spending and Policy Trends, Results from a 50- State Medicaid Budget Survey for State Fiscal Years 2011 and 2012", October 2011.

<sup>9</sup> Smith et al, "Moving Ahead Amid Fiscal Challenges."

<sup>10</sup> Smith et al, "Moving Ahead Amid Fiscal Challenges."

government responsibility to fund health care for those who cannot afford private insurance. All agree that something must be done to address these issues in an effort to curb the growth of health care spending.

### *Medicaid in Colorado*

In Colorado, the Department of Health Care Policy and Financing (HCPF) is responsible for administering Medicaid. It is responsible for determining state eligibility standards and benefits for the Medicaid program. HCPF's goal is to improve access to cost effective quality health care services for Coloradans.<sup>11</sup>

In Colorado, between 2006 and 2009 the number of Medicaid enrollees increased from 550,000 individuals to 650,000 individuals. In 2006, the total amount of money spent on Medicaid in the state was \$2.8 billion. The federal government contributed \$1.4 billion (around 50% of the total) while the state contributed a little less than \$1.4 billion (it was almost a 50/50 match between the state and federal government). In 2009, (the most recent year with Medicaid spending data available) the total amount of money spent on Medicaid in Colorado was \$3.5 billion. The federal government contributed \$2.1 billion (around 60% of the total) and the state contributed \$1.4 billion (around 40% of the total.)<sup>12</sup> Recent data shows that the state's share of total Medicaid spending has decreased since 2006. One reason for this could be that the rate of unemployment in Colorado has increased, resulting in a larger number of residents who are able to qualify for Medicaid, a lower average personal income and a larger federal match.

The eligibility requirements for Medicaid in Colorado are very similar to that of the minimum federal requirements. In order to qualify a person must be a low-income child<sup>13</sup> or adult. Adults must be parents with dependent children, pregnant women, persons who are blind, persons with disabilities or elderly.

### *The Colorado Health Care Affordability Act*

The CHCAA passed in 2009. It called for Colorado to expand Medicaid coverage to AwDC who fall between 0 and 100 percent of FPL by early 2012.<sup>14</sup> CHCAA dictated that HCPF would collect the

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<sup>11</sup> [www.colorado.gov/hcpf](http://www.colorado.gov/hcpf), Five Year Strategic Plan.

<sup>12</sup> [www.medicaid.gov/Medicaid-Chip-Program-Information/By-State/colorado.html](http://www.medicaid.gov/Medicaid-Chip-Program-Information/By-State/colorado.html).

<sup>13</sup> Children as well as pregnant women are covered under the Child Health Plan Plus portion of Medicaid. As of October 2011, The State of Colorado had 66,841 children and 1,925 pregnant women enrolled in CHP+. Weekly incomes to qualify are as follows; less than \$525 a week for a family of 1, less than \$708 for a family of two, less than \$892 for a family of 3, less than \$1,067 for a family of 4, less than \$1,260 for a family of 5, less than \$1,446 for a family of 6. [www.chhpplus.prg](http://www.chhpplus.prg).

<sup>14</sup> The Colorado General Assembly, HB09-1293, "The Colorado Health Care Affordability Act."

hospital provider fee. This fee was intended to generate a larger federal match for state Medicaid dollars in an effort to expand coverage to specific populations.<sup>15</sup>

The costs of expanding Medicaid coverage in Colorado to AwDC who fall between 0 and 100 percent of FPL were severely underestimated. In the spring of 2012, Colorado will begin to expand coverage to this population, of which many possibly have ailing health issues due to limited or no access to care, this will impact costs.<sup>16</sup> It is estimated that the state will have generated enough money from the hospital provider fee to finance expanded coverage to 10,000 AwDC who fall between 0 and 10 percent FPL, through a lottery system. This expansion will leave an additional 39,511 adults who fall between 0 and 10 percent FPL uninsured, and 190,000 between 10 and 133 percent uninsured until 2014.<sup>17</sup>

This analysis examines three policy options when considering Medicaid expansion to AwDC. The status quo of offering full Medicaid benefits and expanding coverage to 10,000 AwDC who fall between 0 and 10 percent of the FPL through a lottery system. Second would be to offer a ‘benchmark’ limited benefit package and cover a larger portion of the population. Third would be to do nothing at all, leaving Medicaid as is and wait for the federal mandate to be implemented in 2014.

It is important to note that FMAPs for the new expansion will differ from those currently used. Once the federal mandate starts in 2014, states will receive 100 percent FMAP for health care provided to this newly eligible group. State costs for covering this population under Medicaid will be 100 percent federally funded in 2014, 2015, and 2016, and the federal matching rate will then phase down to 90 percent for 2017, 2018, 2019 followed by 75 percent in 2020 and in subsequent years.<sup>18</sup> For AwDC, rather than traditional FMAPs the match is a set percentage of what the state spends on the newly eligible population. For example, after 2016 should a state spend \$1 million on Medicaid the federal government will match that spending with \$900,000. If Colorado were to spend another \$1million in 2020, the federal government would match that spending with \$750,000.

### *Overview of the Patient Protection and Affordable Care Act*

The Congressional Budget Office has determined that the ACA will provide coverage to 94 percent of Americans while staying under the established \$900 billion dollar limit. This is less than what was spent

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<sup>15</sup> [www.colorado.gov/hcpf](http://www.colorado.gov/hcpf), The Hospital Provider Fee.

<sup>16</sup> The Kaiser Commission, Focus on Health Reform, “Expanding Medicaid: Coverage for Low-Income Adults under Health Reform”, February 2010.

<sup>17</sup> The Colorado Health Institute, “Colorado Adults’ Health Insurance Status: 2011 Update, A profile of Colorado’s Uninsured, Low – Income Adults Without Dependent Children”, 2011.

<sup>18</sup> [www.cbpp.org](http://www.cbpp.org), The Center on Budget and Policy Priorities, Moving Forward with Health Reform, “No Need to Wait until 2014: States can Cover Low-Income Adults in Medicaid Now”, April, 2010.

in 2008 on total health care expenditures.<sup>19</sup> The Act contains nine titles, one of which addresses the role of public programs, which is associated with expanding Medicaid to populations who are currently ineligible. One of these populations includes AwDC who fall between 0 and 133 percent FPL.<sup>20</sup> States were allowed to begin coverage of this population as early as April 1 2010, even though the mandate does not apply until January 1, 2014. States also have the ability to expand eligibility to an income level below 133 percent FPL before 2014, as long as they do not cover higher income individuals before covering lower income individuals.<sup>21</sup> Colorado is one of many states implementing the mandate prior to 2014. It is important to note that the ACA prohibits states from rescinding any and all eligibility requirements as they stood in 2010. This provision known as maintenance of effort (MOE) is why this analysis does not examine scaling back on eligibility requirements.

## Methods

### *Evaluation and Criteria for Success*

This analysis will examine Maine's Medicaid program, which covers 60,000 AwDC through a Medicaid waiver. It will also look at the state of Oregon, which recently expanded health insurance coverage to 10,000 AwDC through a lottery system. Through examination of these expansions, Colorado could determine to what extent it should provide Medicaid to AwDC who fall between 0 and 133 percent FPL, and at what capacity they should do this before 2014.

An element critical to the evaluation of this issue is the high costs associated with emergency room utilization for routine care by the uninsured. Some experts have forecast cost savings by reducing this improper utilization through early enrollment of AwDC into Medicaid. These cost savings will be the criteria for success for each alternative. For example, if the state can prove that expansion to this population does in fact create cost savings then it can be viewed as a model of success. It is hoped that in the future, health outcomes for this population can also be looked at as a metric of success. Many health care studies look at health outcomes in order to determine the success or failure of a particular policy.

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<sup>19</sup> [Dpc.senate.gov/healthreformbill](http://Dpc.senate.gov/healthreformbill), "The Patient Protection and Affordable Care Act, A Detailed Summary"

<sup>20</sup> [Dpc.senate.gov/healthreformbill](http://Dpc.senate.gov/healthreformbill), "The Patient Protection and Affordable Care Act, A Detailed Summary."

<sup>21</sup> [www.cbpp.org](http://www.cbpp.org).

### *Why Examine AwDC*

Under our current health care system many low-income AwDC remain ineligible for Medicaid. The new health reform law includes a minimum Medicaid eligibility standard that will allow millions of uninsured low-income adults to qualify for Medicaid. Coverage will be provided to all AwDC with incomes at or below 133 percent FPL, an income of \$29,400 for a family of four and a little less than \$10,000 for an individual.<sup>22</sup> Two states that have already been covering this population are Maine and Oregon. Maine first implemented expansion to AwDC in the early nineties. Oregon recently enrolled 10,000 AwDC into Medicaid through a lottery system, and reported the effects in a study done by the National Bureau of Economic Research (NBER).

Oregon's expansion policies differ from Maine's in important ways. Oregon expanded Medicaid to low-income adults with assets equal to or less than \$2,000 to a limited number of individuals in 2008, while also offering a relatively comprehensive benefits package. Maine has been covering this population consistently through Medicaid since 2002 and has been able to cover those who fall between 0 and 100 percent FPL with a minimum benefits package. The following sections will discuss the expansions in Oregon and Maine.

### *Medicaid Expansion to AwDC in Oregon*

Oregon has been working on this issue for quite some time, and it recently implemented a policy very similar to the status quo for Colorado. It offered Medicaid expansion to a limited 10,000 individuals through a lottery system. Much of what led Colorado to consider that policy option is the research conducted on Oregon's Medicaid policies

Oregon began experimenting with low-income health care coverage for AwDC in the 1980s. In 1994, as part of legislation aimed at making public health insurance available to a broader population, it obtained a Medicaid 1115 waiver to cover all individuals at or below 100 percent of the FPL. Policies were implemented that made general Medicaid coverage available to all low-income AwDC.<sup>23</sup> Through a state developed mandatory Medicaid managed care delivery system the expansion known as the Oregon Health Plan (OHP) was able to cover a larger population.<sup>24</sup>

In 2001, Oregon faced a substantial economic downturn, and realized that it could no longer afford to provide Medicaid coverage to the entire population it had expanded to, especially while offering a

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<sup>22</sup> Coverageforall.org, 2012 Federal Poverty Level Index.

<sup>23</sup> Tanya Alteras, "Childless Adult Coverage in Oregon", State Report, Economic and Social Research Institute, 2004.

<sup>24</sup> Alteras, "Childless Adult Coverage in Oregon."

somewhat generous benefit package. In 2002, the plan was changed. The goal of the new plan, known as OHP 2, was to cut costs by reducing coverage for AwDC and give the state the authority to cap enrollment into the program. It did not reduce benefits offered.

In February of 2003, due to an increase in premiums from \$6 to \$20 dollars a month to keep the program in place, enrollment in Medicaid coverage for AwDC dropped by almost half, nearly 50,000 individuals.<sup>25</sup> In 2004, the OHP Standard option was closed to new enrollment due to budgetary short falls, and by 2008 attrition had reduced enrollment to about 19,000 individuals.<sup>26</sup>

In 2008, Oregon decided to provide coverage through a lottery system to AwDC. The lottery provided the state with the opportunity to look at the effects of expanding access to public health insurance on health care use, financial strain and the health of low-income adults using a randomized controlled design. The state decided on opening enrollment to those in this category who would apply for Medicaid to 10,000 individuals. There were 90,000 individuals that signed up for the lottery, and those who did not receive coverage were placed on a waiting list.<sup>27</sup>

Recently NBER completed an analysis of the Oregon lottery based expansion. NBER examined the impact of health insurance on increased health care utilization, as well as the impact of health insurance on health and financial strain for individuals and the state. The findings of this study will be discussed in the issue analysis section of this paper.

### *Medicaid Expansion to AwDC in Maine*

Maine has attempted to cover the AwDC population since the 90's, when it began a state-funded program that offered Medicaid-like coverage. In 1995 the program was terminated due to a lack of funding and resources. In 2002 the state submitted a waiver request to the federal government to expand Medicaid to AwDC with incomes at or below 125 percent of FPL. The waiver request was approved, and as of October 2003, Maine had enrolled nearly 16,854 AwDC into the expansion program.<sup>28</sup>

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<sup>25</sup> Kaiser Commission on Medicaid and the Uninsured, Stan Dorn, Sharon Silow-Carroll, Tanya Alteras, Heather Sacks, Jack A. Meyer, "Medicaid and Other Public Programs for Low-Income Childless Adults: An Overview of Coverage in Eight States", Economic and Social Research Institute, 2004.

<sup>26</sup> Amy Finkelstein, Sarah Taubman, Bill Wright, Mira Bernstein, Jonathan Gruber, Joseph P. Newhouse, Heidi Allen, Katherine Baicker, The Oregon Health Study Group, "The Oregon Health Insurance Experiment: Evidence from the First Year", The National Bureau of Economic Research, Working Paper 17190, July 2011.

<sup>27</sup> Finkelstein et al, "The Oregon Health Insurance Experiment."

<sup>28</sup> Tanya Alteras, Sharon Silow-Carroll, "Childless Adult Coverage in Maine", State Report, Economic and Social Research Institute, 2004.

Maine began the expansion by only offering coverage to AwDC at or below 100 percent FPL. For a single person the income limit was \$749 a month and for a couple it was \$1,010 a month. Maine also limited eligibility levels by implementing an asset test.<sup>29</sup> An individual could not have more than \$2000 dollars in assets and a couple, no more than \$3000 dollars in assets.<sup>30</sup>

At first, those who were deemed eligible for Medicaid in Maine received full comprehensive benefits. However, as of today those benefits have been limited.<sup>31</sup> Limitation of benefits is what allows the state to continue to cover a larger population. While there is no premium under Medicaid, there are nominal co-payments charged on a sliding scale between one and three dollars with a cap as to how much an enrollee can spend out-of-pocket on specific services each month.<sup>32</sup>

In their waiver proposal, the state originally estimated that there would be around 11,000 AwDC enrolled. However, within a year, of implementation there were 16,854 newly eligible AwDC enrolled. As of 2009, Maine had an estimated 370,000 individuals enrolled in Medicaid. The total amount of money spent on Medicaid that year was \$2.5 billion. The state contributed \$700 million to that total (around 27% of the total amount paid.) The federal government contributed \$1.8 billion to that total (around 73% of the total amount paid).<sup>33</sup>

Eight months after the expansion, hospital and medical provider industry spokespersons in the state of Maine claimed that the AwDC expansion had increased health care costs due to an increase in outpatient and specialty service utilization. This was because AwDC could visit primary care physicians and obtain referrals to see specialists, which they were previously incapable of doing. What this did was offer more services, while allowing for higher reimbursement rates in order to write off additional charity care. The formerly uninsured population was receiving care that was previously inaccessible.<sup>34</sup> Ultimately, Maine concluded that it is more cost effective to pay for coverage of this population than for society to pay the numerous costs resulting from lack of care.<sup>35</sup>

Maine and Oregon took very different approaches in creating policy regarding coverage for AwDC. One state went with the option of covering a more limited number of people and offering a more general package, another state chose to offer a lesser package and cover a larger portion of the population. Both provide helpful insight into Colorado's mission to expand Medicaid.

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<sup>29</sup> An asset test is a test that looks at household income or assets in order to determine Medicaid eligibility.

<sup>30</sup> Alteras et al, "Childless Adult Coverage in Maine."

<sup>31</sup> Alteras et al, "Childless Adult Coverage in Maine."

<sup>32</sup> Alteras et al, "Childless Adult Coverage in Maine."

<sup>33</sup> [www.cms.gov/Medicaid-CHIP-Program-Information/By-State](http://www.cms.gov/Medicaid-CHIP-Program-Information/By-State).

<sup>34</sup> Alteras et al. "Childless Adult Coverage in Maine."

<sup>35</sup> Alteras et al, "Childless Adult Coverage in Maine."

One similarity between the two states is that neither chose to offer full Medicaid benefits to this population. Meaning both states offered ‘benchmark’ packages. While Oregon did offer more benefits within its package than Maine, it did not offer every benefit available. It is important to have some background information on how these states implemented the expansion, as Colorado has the chance to learn from their experiences. The issue analysis section will discuss what we have learned from these two states and how we can apply those lessons to the decisions we make in this state.

## Issue Analysis

This section will discuss the importance of Medicaid expansion. It will provide some general information on the AwDC population as well as the statistics and costs associated with their lack of insurance on both a national and state level. This section will also provide insight on the lessons learned from the attempts made in Oregon and Maine regarding Medicaid expansion, and how these efforts can be considered or eliminated as alternatives in Colorado. Lastly, it will provide a brief economic analysis of the issue.

### *The importance of Medicaid Expansion and Stakeholder Input*

Due to the costs associated with this expansion, many have asked what the importance of expanding Medicaid coverage to AwDC in Colorado is. First, because of the passage of CHCAA in 2009 there is an expectation from the legislature that the state expand coverage to a percentage of this population. Second, while Colorado cannot expand to this population up to 100 percent of FPL for AwDC, due to budget constraints, the minimal expansion will be valuable as a pilot program, in which the state can build upon. The minimal expansion will also allow HCPF to prepare providers and doctors both technologically and financially for the inflow of Medicaid patients they will be required to serve in 2014.<sup>36</sup>

Many people who are uninsured have a chronic condition, and are unable to purchase health care. Much of this is because of preexisting conditions for which the private market is not obligated to provide coverage for. If these people had children, they would be covered under Medicaid, which raises a policy concern as having or not having children dictates one’s health care options.

There are a number of private organizations that serve AwDC that are concerned with the issue of Medicaid coverage. These include organizations such as the Colorado Aids Project, the National MS Society Colorado-Wyoming Chapter, the Colorado Coalition for the Medically underserved, and the Colorado Coalition for the Homeless.

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<sup>36</sup> Susan Mathieu, Program Development Specialist, Department of Health Care Policy and Financing, Interview conducted in November 2011.

Two organizations that will see the largest enrollment in the spring of 2012 under the status quo lottery system are the Colorado Aids Project and the Colorado Coalition for the homeless. This would lead one to think that each organization is supportive of the expansion. However, the Colorado Aids Project has some reservations. First, those living with HIV/AIDS qualify for the Colorado Indigent Care Program (CICP) and are mainly treated at no cost at safety net and infectious disease clinics. Their care is managed on a daily/weekly/monthly basis. There is a concern that with enrollment into Medicaid these patients will be responsible for their own care for the first time in their lives. This could lead clients to feel they need to work harder for their care. For example, those who seek care at an infectious disease clinic have someone who manages their medication for them. With enrollment into Medicaid, this client will have to seek care at an accountable care collaborative such as Denver Health where their medications will not be managed for them, and rather they do it on their own. This could be problematic should individuals not be apt to take on the personal responsibility of their care, therefore also impacting costs. For example, someone with HIV/AIDS who qualifies for Medicaid under the expansion would not have the infectious disease clinic calling them and reminding them to come in for their meds. That person might forget to take their meds two weeks in a row, and could wind up having an episode in which they are hospitalized, therefore driving up the cost of care. There is also a concern that with mandatory enrollment into the accountable care collaborative,<sup>37</sup> clients will have to gain the trust of a new primary care provider, and discussing chronic disease can be a difficult issue for many people, especially those living with HIV/AIDS.<sup>38</sup>

Despite these concerns, these organizations do not oppose the lottery-based expansion. They argue that expansion will provide an opportunity to educate people who have not had access to care before on the importance of routine doctors' visits, check-ups, etc. Many of the advocacy organizations feel that this expansion brings opportunity to inform people who for many years have let the system take care of them, how to take care of themselves.<sup>39</sup>

Expansion to this population is important because it will help begin to reduce the costs incurred by those who are insured, hospitals and the state for emergency room visits as well as care received at safety net clinics and community health centers. For example, between January and December of 2010 Denver Health had 53,365 emergency room visits made by the uninsured. The Medical Center of Aurora had 48,590 visits, University Hospital had 64,600 and Memorial Health Systems in Colorado Springs had

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<sup>37</sup> The Colorado State Waiver to expand Medicaid to this new population in 2012 automatically enrolls individuals in an accountable care collaborative.

<sup>38</sup> Ruth Pederson, Executive Director Colorado Aids Project, Interview Conducted in December 2011.

<sup>39</sup> Ruth Pederson, Executive Director of The Colorado Aids Project and Sharon O'Hara, Vice President of the National MS Society, Colorado-Wyoming Chapter, Interview conducted in December 2011.

132,175 emergency room visits, the most out of any hospital in Colorado. There are an additional 24 hospitals in Colorado none of which had less than at 2,000 emergency room visits by the uninsured.<sup>40</sup> It is estimated that on average in 2008, expenses for a visit to the emergency room for uninsured adults under the age of sixty-five were \$1,203 per person, with a median cost of \$453. Those with private insurance paid 47 percent of that cost.<sup>41</sup> The costs of the uninsured in Colorado are a major factor for combating increasing health care spending. In 2009, before the passage of the CHCAA there was an estimated \$2.1 million spent on uncompensated emergency room procedures in Colorado.<sup>42</sup>

Nationally, health care expenditures grew to \$2.1 trillion dollars or 16 percent of the gross domestic product in 2006. State and local government spending on health care reached \$265 billion in the same year. In Colorado, in the fiscal year of 2008, the general fund appropriation for HCPF was \$1.5 billion, which is equivalent to 20 percent of the general fund budget.<sup>43</sup> Today that appropriation has reached 24 percent of the general fund.

The importance of expanding Medicaid coverage to AwDC relates directly to costs incurred by the state, hospitals and those with private insurance that become responsible for their bills when they cannot pay. If, on average 47 percent of uncompensated medical costs are paid by those with private insurance, they are covering an estimated \$7.5 billion of the uninsured emergency room medical care in this state.<sup>44</sup> By expanding coverage, Colorado will eliminate these costs in the long run, hopefully, creating savings for the state, hospitals and the privately insured.<sup>45</sup>

### *Data Pertaining to AwDC*

In the United States there are 17.1 million uninsured AwDC at or below 133 percent of FPL. About half have family incomes below 50 percent of FPL. This is equivalent to an annual income of \$5,415 for an individual.<sup>46</sup> Young adults are the most likely to be uninsured, and most of them have reported cost and access to care as the major barrier to purchasing coverage. More than three quarters of these people work. However, they work for small firms where health benefits are less likely to be offered or they are part time workers who do not qualify for health insurance and do not earn enough to afford private insurance.

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<sup>40</sup> [www.cha.org](http://www.cha.org), The Colorado Hospital Association.

<sup>41</sup> Stephen Machlin, "Expenses for Hospital Emergency Room Visits", Statistical Brief #111, Medical Expenditure Panel Survey and Agency for Healthcare Research and Quality, January 2006.

<sup>42</sup> HB 1293 Oversight and Advisory Board Uncompensated Cost Analysis, 2009.

<sup>43</sup> The Department of Health Care Policy and Financing, State department functions piece 2008/2009.

<sup>44</sup> Number was obtained by multiplying how much was spent on uncompensated care with the passage of HB 1293 by the .47 it estimated those with private insurance pay to cover those who are uninsured.

<sup>45</sup> The Department of Health Care Policy and Financing, State department functions FY2008-09.

<sup>46</sup> The Department of Health Care Policy and Financing, State department functions FY2008-09.

They are less likely than those with insurance to receive preventative care and services for major health conditions and chronic diseases. People in this population are also at a higher risk for preventable hospitalizations.<sup>47</sup>

### *Colorado Specific Data for AwDC*

The Census Bureau estimated that 799,000 individuals or almost 17 percent of Colorado's population were uninsured between 2005 and 2007. Today that number has reached 829,000 people of which 201,728 are AwDC. Additionally 66 percent (97,000) of this population are male, 87 percent are single, 58 percent have a high school diploma or less and 12 percent have a bachelor's degree or higher.<sup>48</sup> It has been estimated that 42 percent of low-income adults without dependent children are unemployed, and 64.5 percent are between the ages of 19 and 35. A majority of this population lives in Adams, Arapahoe, Denver, Jefferson or El Paso Counties.<sup>49</sup>

While actual income levels of this population in Colorado are unknown, it is estimated that those who fall between 0 and 10 percent of FPL make \$91 dollars a month. A single person at 100 percent of FPL makes anywhere between \$10,891 and \$12,741 a year, around \$910 to \$1,062 per month. There are 74,809 people who fall between 0 and 60 percent FPL, 44,295 who fall between 61 and 100 percent FPL and 28,933 between 101 and 133 percent FPL.<sup>50</sup>

It is imperative that the costs and benefits of providing (or not providing) coverage to this population be examined closely in order to determine if Colorado is perusing the most cost effective Medicaid coverage policies.

### *Current and Previous Attempts to Cover AwDC*

In the past, non-disabled AwDC have been largely excluded from public safety net programs such as Medicaid. As a result, the only way to cover this group of people was through one (or both) of two policy options; first, Medicaid waiver programs and initiatives; second, policies that rely on state-only funding. The waivers allow states to use federal matching funds under Medicaid or State Children's Health Insurance Programs (SCHIP) in ways currently prohibited by law, such as covering AwDC. Waivers

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<sup>47</sup> The Henry J. Kaiser Family Foundation, "Kaiser Commission on Medicaid and the Uninsured; Five Facts about the Uninsured", September 2011.

<sup>48</sup> Colorado Health Institute Insurance Status, 2011 Update, A profile of Colorado's low-income Uninsured Adults without dependent children.

<sup>49</sup> The Colorado Health Institute, "Colorado Adults' Health Insurance Status: 2011 Update, A profile of Colorado's Uninsured, Low – Income Adults Without Dependent Children", 2011.

<sup>50</sup> Colorado Health Institute, Center for the Study of the Safety Net, Issue Brief, "Health Insurance Coverage among Low-Income Adults in Colorado", April 2010.

must be budget neutral, meaning federal costs must not exceed a state's projected federal spending baseline. This indicates that a state must make room for expanded coverage by doing one of two things; (i) redirecting unspent federal dollars such as SCHIP or disproportionate share hospital (DSH) funds; or (ii) reducing other Medicaid costs.<sup>51</sup>

The second approach is to develop a state-only program for covering AwDC. This approach is funded through state dollars only and allows the state complete flexibility in the policies adopted and the structure of the program including eligibility, benefits and cost sharing. The downside of state-only programs is that they are subject to the constraints of available state funding.<sup>52</sup> History has shown that state-only programs have not proven successful.

Oregon learned after some trial and error that state only funding options were not a sustainable way for it to cover AwDC. This is a main reason why in 2008, when considering expanding coverage once again, Oregon decided on an experiment to cover only a limited number of people through a lottery, utilizing a Medicaid waiver.<sup>53</sup> The NBER study of the Oregon lottery system found significant benefits from the program.

NBER concluded that having health insurance is associated with three tenths of a standard deviation increase in reported compliance with recommended preventative care such as mammograms, cholesterol monitoring, and prostate screenings. This resulted in earlier detection of diseases and a healthier population, leading to lower costs for the state, hospitals and private insurance payers. This also resulted in decreased exposure to medical liabilities and out-of-pocket costs for AwDC, as well as a 25 percent decline in the probability of having an unpaid medical bill. Out-of-pocket medical expenditures for these 10,000 individuals decreased by 35 percent once enrolled in Medicaid.<sup>54</sup>

Today, the OHP standard Medicaid option in Oregon, which is offered to those in this population, provides a relatively general benefits package to individuals who qualify, along with no cost sharing. However, this benefits package is still more limited than that which Colorado plans to offer to AwDC. OHP has monthly premiums in place ranging from \$0 to \$20 dollars depending on income, and the

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<sup>51</sup> Stan Dorn, Sharon Silow-Carroll, Tanya Alteras, Heather Sacks, Jack A Meyer, Economic and Social Research Institute, Kaiser Commission on Medicaid and the Uninsured, "Medicaid and Other Public Programs for Low-income Childless Adults: An Overview of Eight States", August 2004.

<sup>52</sup> Dorn et al, "Medicaid and Other Public Programs", August 2004.

<sup>53</sup> Finkelstein et al, "The Oregon Health Insurance Experiment."

<sup>54</sup> Finkelstein et al, "The Oregon Health Insurance Experiment."

average annual state expenditure is about \$3,000.<sup>55</sup> At the present time Colorado does not plan to put any premiums into place when covering this population.

The Oregon participants demographic characteristics were as follows: 56 percent female, the average age of the individual participating was 41, 92 percent had the preferred language of English. Four percent were black, 12 percent were Hispanic, and almost one-fifth had less than a high school education. Another half of the population had only a high school diploma or GED. Over half of those chosen to participate were not working and many were in poor health. For example, 18 percent reported having been diagnosed with diabetes, 28 percent with asthma, 40 percent with high blood pressure, and 56 percent screen positive for depression. Another 70 percent reported incomes below the eligibility cut-off of 100 percent FPL.<sup>56</sup>

NBER found that obtaining insurance is associated with an increase in the probability of a hospital admission. However, 35 percent of those admissions do not originate in the emergency room, which means the patient is seeking primary care, and some sort of hospitalization is recommended at that time. It is important to note that on average the services obtained in the hospital by those who were receiving regular primary care were less costly than those that waited until a life-threatening condition caused a hospital admission.

The study also examined hospital utilization for seven chronic conditions. Those conditions included heart disease, diabetes, skin infections, mental disorders, alcohol and substance abuse, back problems, and pneumonia. There was a statistically significant increase in utilization by those individuals with heart disease. The study did try to look at whether or not insurance was associated with a change in the proportion of patients going to public versus private hospitals. However, they were unable to detect any substantial changes in where this population received their care.<sup>57</sup>

Individuals on average reported better health upon receiving Medicaid coverage. Seven different measures were used in examining the effects of coverage on health. Those measures included: (i) self-reported health; (ii) quantitative examination of self-reported health; (iii) whether the self-reported health status is about the same or has gotten better over the last six months versus gotten worse; (iv) the number of days the individual reported having good physical health; (v) the number of days not impaired by poor physical health in the last 6 months; (vi) the number of days not impaired by poor mental health in the last month and; (vii) whether or not the individual screened negative for depression. Given the subjective

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<sup>55</sup> Finkelstein et al, "The Oregon Health Insurance Experiment."

<sup>56</sup> Finkelstein et al, "The Oregon Health Insurance Experiment."

<sup>57</sup> Finkelstein et al, "The Oregon Health Insurance Experiment."

nature of the responses individuals provided to researchers, it became difficult for them to judge whether the results reflected an actual improvement in physical health.<sup>58</sup>

Additionally, the Oregon study showed a statistically significant increase in prescription drugs and outpatient use, an increase in annual spending with insurance (around \$778 increase in spending), and an overall increase in health care utilization. The study did show a decline in medical debt collections by collection agencies. However, not all collections were reported to the credit bureaus that the researchers used to conduct this study. The study looked at four measures of financial strain and impact on the individuals which included; out-of-pocket medical expenditures in the last six months; money for other medical expenses; the borrowing of money or denial of paying other bills in order to pay medical expenses; and refusal of medical treatment because of medical debt in the last six months. There were statistically significant declines in all of these measures of financial strain.<sup>59</sup>

Overall, the NBER study on Medicaid for AwDC in Oregon over a one-year period provided researchers with evidence of increased hospital, outpatient, and drug utilization, increases in compliance with preventative care, declines in exposure to substantial out-of-pocket medical expenses and medical debts, and evidence of improved self-reported mental and physical health measures.

The results of this study are important as Colorado plans to implement the same policy that Oregon implemented with only one difference. Due to the passage of the ACA Colorado must begin implementation incrementally from the bottom-up (income level), while Oregon was able to implement coverage with fewer restrictions. For example, they did not have to start implementation of expansion with those at the lowest income levels.

Overall Oregon had excellent results in demonstrating that providing Medicaid coverage to this population was worth the immediate cost. While the demographics between the two states are different, Colorado should assume that it too would see some success and *eventual* cost savings. However, when we examine those who were eligible in Oregon in terms of income and who will be eligible in Colorado, the state faces some serious risks in concluding that a similar approach will work. There is a reasonable concern that stakeholders will have no way of notifying those who are chosen that they are now eligible for Medicaid, as this population is transient and often out of reach. This leaves many policy makers and stakeholders asking if we will be paying to keep people in the program and occupying spots when they are not actually utilizing it.

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<sup>58</sup> Finkelstein et al, "The Oregon Health Insurance Experiment."

<sup>59</sup> Finkelstein et al, "The Oregon Health Insurance Experiment."

Maine is another state that, for more than a decade, has been leading the nation when it comes to Medicaid expansion to AwDC, yet the future of its program between now and 2014 when the ACA mandate begins is not so certain. Much of this has to do with costs and the fact that the Governor has argued that Maine's entitlement system is a "runaway train." He is proposing contentious cuts to the Medicaid program. In December 2011, he proposed a plan to reduce Medicaid enrollees in the state by 18 percent of the total population enrolled. He seeks to make childless adults and all 19-20 year olds ineligible for Medicaid for the next two years.<sup>60</sup> It is unknown whether this proposal will be enacted.

Maine implemented a program very different from Oregon and that of what Colorado intends to do. It decided that rather than implement policy that limited the number of AwDC who could enroll in Medicaid it would limit the benefits offered. Because of the policies implemented in Maine, they are currently able to cover an estimated 60,000 to 65,000 individuals within this population.

#### *The significance of Demographic and other Factors in Examining Medicaid Expansion to AwDC*

While it is difficult to determine how successful the Oregon expansion policy will be in Colorado, conclusions can be drawn based on a comparison of the demographics in the two states. For example, in Oregon one-fourth of the population was between the ages of 50-64 with an average age of 41, in Colorado 65.5 percent of the entire childless adult population is between the ages of 19 and 35. One can draw the conclusion that a younger population might be a healthier population, therefore reporting better health on average. In Oregon, about 20 percent had a high school diploma or less. In Colorado 58 percent, over half of the childless adult population, has a high school diploma or less. Research has shown there is a direct correlation between a lack of education and enrollment in the Medicaid system.

Additionally, 56 percent of the population enrolled into Medicaid in Oregon was female; in Colorado, two-thirds of the entire population is male. In Oregon over 50 percent of the population chosen to participate was unemployed, in Colorado 42 percent of the entire AwDC population is unemployed. Research shows that a majority of those at or below 10 percent FPL in this state will be homeless, meaning that approximately 90 -100 percent of those 10,000 individuals will be unemployed, almost double that of Oregon. Colorado has decided to stay away from an income based monthly premium with the state expansion, as most in this income bracket would not be able to afford a monthly premium.

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<sup>60</sup> [www.nytimes.com](http://www.nytimes.com), Abby Goodnough, "Medicaid Cuts are Part of a Larger Battle in Maine", The New York Times, U.S. Politics, December 2011.

The comparison of demographics between Maine and Colorado are more similar than that of Colorado and Oregon. Maine has a majority of male enrollees, and an average enrollee age of 39. When strictly comparing demographics, it would seem that Maine's option would be a much better fit in Colorado than that of Oregon. However, due to ACA provisions allowing for state flexibility in developing their EHBP, Colorado has opted for one more closely resembling that of Oregon. All insurance companies in every state as well as Medicare and Medicaid will be required to offer certain benefits to its enrollees. At this point, no one knows what the EHBP mandated by the federal government would look like, and HCPF staff felt it would be easier to scale back on benefits once the EHBP is released by the feds, rather than to implement a benchmark plan and have to add to the benefits offered. For this same reason the department decided to put more energy into examining the policies for expansion implemented in Oregon. The feeling among many at HCPF was that much more could be learned from Oregon because they offered a more comprehensive package, and because the research examined the effects of those benefits on a limited 10,000 individuals.

After examining the demographic and other comparisons, HCPF decided that Oregon presented promising data relevant to providing health insurance to AwDC in terms of costs and benefits. Maine has not, at this time, conducted any research that can provide us with that evidence. This is important, as it would be helpful to show the effects of providing a 'benchmark' package compared to Oregon's general package. HCPF is further concerned with Maine's Medicaid program as it has been considered the primary reason for why the state is experiencing budget shortfalls. Maine is however an important state to keep in mind as they have been providing coverage to AwDC for a considerable amount of time. In fact, Maine has, in the past, seen much success with their policies regarding Medicaid coverage for AwDC that HCPF plans to examine the policies of Maine more closely once the EHBP is released. HCPF hopes that with more guidance from the federal government it can implement a similar benchmark package to that of Maine.<sup>61</sup>

### *What Can Colorado Learn from Other States as it comes to Medicaid Expansion?*

Today, Colorado is presented with many of the same challenges that Oregon and Maine have faced. Each state had to decide whether to expand Medicaid to AwDC, and then whether or not to apply for a Medicaid 1115 waiver or test the waters with state-only funding options. Each state also determined how to generate the state's share of the funds, and whether or not it was cost effective to spend that money on this population, rather than on policies in other areas such as education.

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<sup>61</sup> Susan Mathieu, HCPF.

No matter what the demographics, studies have shown that on average in any state AwDC tend to have much poorer health than any other population.<sup>62</sup> This is mainly due to limited or no access to care.

Oregon and Maine chose similar options to those evaluated for Colorado, Oregon implementing a cap of 10,000 AwDC and offering a general Medicaid benefit package. While Oregon spent many years amending policy and retooling their program, they eventually saw much success in covering AwDC, and were a key state used to conduct research to show the effects of offering coverage to this population. The state found itself contributing to only 26 percent of the total amount spent on Medicaid in 2010. Oregon's findings showed that while there was an increase in health care utilization, there was a substantial decrease in out-of-pocket costs, as well as uncompensated hospital care, and an increase in self-reported health. The state as well as NBER determined the expansion in Oregon was a success.

Maine took quite a different approach. Maine offered a more limited package and allowed for coverage of a larger percentage of AwDC. In looking at states that have been successful in covering this population for the longest period of time, Maine stands out. While attempts in the 90's might not have been as successful as hoped for, by the early 21<sup>st</sup> century the state had determined how to implement policy that allowed for the sustainability of coverage for AwDC. Despite recent attempts to terminate coverage in Maine, it is considered a leading state in implementation of Medicaid coverage to this population. As of 2009 Maine had 370,000 individuals enrolled in Medicaid, 60,000 of which were AwDC and it only paid 27 percent of the total costs, as opposed to Colorado's 40 percent.

It is important for Colorado to implement the policy alternative that has the best chance of eventually curbing the cost for Medicaid. Currently Medicaid makes up 25 percent of the general fund budget and 32 percent of the entire state budget. This is the second largest state funded program, next to education. For FY 2012-13 education received a major cut in state spending because of the need to increase spending in Medicaid. If the state of Colorado fails to enact a policy that will truly curb the cost of public health care, by 2025, Colorado will have no money left for anything other than Medicaid and K-12 education. It will also be dealing with a failing education system due to the constant need to cut education and add more money to Medicaid.<sup>63</sup>

One thing that can be agreed upon by policy makers and stakeholders involved in Medicaid expansion in all states, is that no matter how much research is done, the needs of this population will almost definitely be drastically underestimated. Colorado has already underestimated the costs of covering this population.

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<sup>62</sup> The Henry J. Kaiser Family Foundation, "Kaiser Commission on Medicaid and the Uninsured; Five Facts about the Uninsured", September 2011.

<sup>63</sup> Focus Colorado: Economic and Revenue Forecast, Colorado Legislative Staff Economics Section, September 2011.

This is a reason why the state should consider the experiences of both Oregon and Maine, as Colorado should implement policy that leaves room for further research and defines the needs of this population, in order to control cost.

### *The Economics of Expansion and Cost Shifting*

Over the past few years, the health care sector has been one of the few bright spots in the economy, experiencing a boom while other businesses have stagnated, shrunk and in some cases disappeared. Unfortunately, the success of the industry has been partially responsible for the struggles many Coloradoans face as it comes to access to, and receiving care, and costs associated with that care. The growth has led to higher health care costs, putting strain on business, families and the state budget. A recent study confirmed that the economic and social costs of failing to fix Colorado's health care system are very high.<sup>64</sup> Without reform, the number of uninsured will increase while businesses, privately insured individuals and the government will face increasingly higher costs, this is known as a cost shift. Many argue that without some sort of reform employer health care contributions, premium costs per worker, and uncompensated care costs, which typically result in higher prices for services, will all increase tremendously.

Uncompensated care is defined as care provided to the uninsured and underinsured for which providers are not compensated by the patient. This uncompensated care leads to higher health care costs and insurance premiums for the privately insured. Currently the private payer pays an estimated 47 percent of the cost of care received by someone who is uninsured. The state and the hospital pay the remaining 53 percent. For example, currently in Colorado, there is an estimated 201,728 AwDC. In 2010, these individuals cost the state an estimated \$2.5 million in uncompensated care. They cost medical providers and hospitals a total of approximately \$3.3 million in uncompensated care, totaling an estimated \$5.8 million.<sup>65</sup> The private insurer pays for the rest of that care, an additional 47 percent or just over \$5 million. The prevalence of cost shifting has played an important role in the health policy debate, and it does allow hospitals to recoup some of the loss they incur for treating the uninsured. Medicaid coverage for AwDC will reduce the amount of uncompensated care and therefore reduce the cost shift to the privately insured as well as allow hospitals to receive payment for the care they give to this population. This will then in turn lead to a lower share of state spending on the uninsured population.<sup>66</sup>

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<sup>64</sup> "The Future of Colorado Health Care: An Economic Analysis of Health Care Reform and the Impact on Colorado's Economy", Sponsored by the Colorado Trust, The Colorado Health Foundation, New Foundation America and University of Denver, Center for Colorado's Economic Future, 2010.

<sup>65</sup> The Department of Health Care Policy and Financing, CACP Annual Report FY2010-11.

<sup>66</sup> "The Future of Colorado Health Care."

There are other costs associated with the coverage, or lack thereof, of AwDC. One of those is the cost incurred by the client. Not all AwDC receive care in an ER or elsewhere at no cost. In fact, it is only those at the lowest income levels who have the ability to receive care without any compensation, all others pay something for services obtained. On average, uninsured AwDC pay an estimated \$700 a year for health care. A single childless adult at 50 percent FPL earns on average \$5,585 annually. This means that an estimated 13 percent of their annual income is going towards health insurance. A childless adult at 25 percent FPL earns an estimated \$2,793 annually and contributes 25 percent of their income to health care each year.<sup>67</sup>

There are reasonable benefits associated with examining health care reform and Medicaid expansion. Those benefits are both quantifiable and qualitative. Quantifiable benefits include additional output and economic activity, some benefits such as federal matching and reimbursement from public spending on expansion, additional household spending on health care and increased demand, which will help to create new jobs.<sup>68</sup>

Qualitative benefits include improved health, improved productivity as a result of improved health, gains to family members of the newly insured including the economic value of saved partners, parents or children, as well as benefits to the state and federal government for the cost of saved survivor benefits. Communities will also experience some sort of benefits due to reduced stress on the safety net.<sup>69</sup> The strategic recommendation portion of this analysis will address these factors in more depth.

## **Analysis of Proposed Solutions**

This section will examine each alternative proposed and the extent to which they address or solve to problem of deciding to what extent Colorado should adopt policies and provide benefits to AwDC before 2014.

There are three alternatives examined:

- ❖ The Status Quo: expand Medicaid to 10,000 AwDC at or below 10 percent of FPL, through a lottery system, offering full Medicaid benefits (similar to Oregon)
- ❖ Alternative one: develop a ‘benchmark’ limited benefit package and expand coverage to a larger population (similar to Maine)

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<sup>67</sup> CoverageForAll.org, 2012 Federal Poverty Level Index.

<sup>68</sup> “The Future of Colorado Health Care.”

<sup>69</sup> “The Future of Colorado Health Care.”

- ❖ Alternative two: Do nothing over the course of the next two years and wait for the federal government to expand coverage to this population

There have been and continue to be many stakeholders involved in the process of implementing this early expansion. Those stakeholders include the state; its taxpayers, medical providers (hospitals and safety net clinics, as well as primary care physicians and specialists), clients (childless adults who will be eligible to receive benefits in either 2012 or 2014) and client advocacy organizations that currently help serve the population.

*Status Quo: Expand Medicaid to 10,000 AwDC and offer full Medicaid Benefits*

Once HCPF realized funding from the hospital provider fee was not sufficient to cover this population up to 100 percent FPL they decided the best option was to expand coverage to a limited number of those AwDC at or below 10 percent of FPL, via a lottery system.

Not only did individuals eligible for this expansion need to be at or below 10 percent FPL, but they also would have an income of \$91 dollars a month or less. The 10 percent FPL income requirement was determined because the ACA mandated that all states that implement early expansion must expand coverage to those at a lower percentage of FPL before those a higher percentage.

This alternative leaves an estimated 191,728 AwDC without insurance. It does help to curb some of the costs for example, to those stakeholders involved in the process such as the state, as well as hospitals and medical providers. The state will see an estimated savings of \$487 million beginning in 2012 due to coverage of 10,000 AwDC. Medical and hospital providers will see an estimated savings of \$43 million beginning in 2012.<sup>70</sup>

Conversely, HCPF analysts have estimated that over the next three years expanding coverage to the limited 10,000 enrollees will cost the state \$190 million, or a little over \$63 million a year<sup>71</sup>. The AwDC will cost hospitals an estimated \$788 million over the next three years or around \$262 million annually. The cost to individuals enrolled in this expansion program will remain at \$0 consistently as they will be at such a low percentage of the federal poverty level Medicaid will cover all costs for care. There will also be an additional \$2.3 million given to the three largest counties in the state during the initial roll-out

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<sup>70</sup> Please see appendix A for all calculations and references for numbers mentioned in this section.

<sup>71</sup> This cost of \$ 63 million annually does not include what the state spends on Medicaid for already eligible individuals. It also does not include what the state will continue to spend on the Colorado Indigent Care Program or Charity Care for those who do not qualify for the expansion

period to help with IT, enrollment and coverage services. This money will be matched 50/50 between state and federal funds.<sup>72</sup>

Clearly, this is a limited solution and it does not address the issue in a permanent way. However, proponents argue that a pilot program allows the state to study AwDC in a way that has never been done before in Colorado. The state will be able to evaluate the health needs and costs of this population over the next two years and get a realistic idea of those costs and benefits rather than rely on estimates. It will allow the state to evaluate coverage options when the 2014 mandate begins. Similar to Oregon, implementation of this alternative will also give the state the opportunity to track the health outcomes of this population once they have access to care, and it will allow Colorado to examine the differences in out of pocket costs and medical debt of those who receive coverage.

There are many benefits to setting up pilot programs when it comes to determining health outcomes and reducing costs. In order to evaluate the effects of a health care program that program must have a determinable impact on the health of the target population. When the effect of the program is to improve health, the problem is to decide whether the improvement justifies the program. If the effect of the program is to reduce the cost of health care, the problem is to decide if that program really is helping to eliminate the cost born by all involved. There are two suggested analytic approaches when it comes to determining the effects of a pilot program, and those two approaches are cost benefit analysis and cost effectiveness analysis.<sup>73</sup> In many ways, the insufficient funding of the hospital provider fee may have been a good thing for Colorado because it gives policy makers the ability to realize the effects of providing coverage to this population, both on health outcomes and on cost savings. It also allows the state to design the most practical benefits program for its AwDC population. A pilot program will allow state flexibility and provide knowledge to establish an efficient expansion program.

AwDC are a costly population to Colorado for various reasons. One reason is lack of insurance; AwDC have higher uninsured rates than any other population in the state.<sup>74</sup> In 2008 hospitals spent an estimated \$201 million on uncompensated care. HCPF analysts as well as the CHCAA advisory committee have provided evidence that suggests once the CHCAA is implemented and Medicaid is expanded, uncompensated care costs will be reduced to an estimated \$158 million, a difference of \$43 million

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<sup>72</sup> Please see appendix A for Calculations.

<sup>73</sup> George W. Terrance, Warran H. Thomas, David L. Sackett, "A Utility Maximization Model for Evaluation of Health Care Programs", Health Services Research , 1972.

<sup>74</sup>Colorado Health Institute Insurance Status, 2011 Update, A profile of Colorado's low-income Uninsured Adults without dependent children.

annually over a three-year period.<sup>75</sup> As of 2009 there were 201,728 AwDC in the state. Expansion to only 10,000 people and the implementation of a pilot program will allow the state to effectively confirm or deny the findings and estimates that HCPF analysts have projected. Enrolling the limited number of individuals will give the state an accurate idea of how much this population will utilize services available to them, and how much those services will cost. Due to lack of care received by this population before this expansion, it is quite possible that many of these people will have complicated health needs. Setting up a pilot program will allow Colorado to better define what type of services and benefits will best serve them. The implementation of a pilot program will give Colorado the ability to work off its own numbers related to the cost of health care utilization.

Limited expansion of Medicaid and the implementation of a pilot program will have an effect on the information technology system in Colorado as well. The status quo will better prepare the Center for Medicare and Medicaid Services as well as other enrollment systems for the influx of individuals who will be enrolled into the system in 2014. Early expansion will ensure that we will not see a system overload or breakdown in 2014. It will help to guarantee that the state does not experience failure on the providers' side at figuring out how to best serve this population, as they will have had experience with a limited number of AwDC for two years prior to federal expansion.<sup>76</sup>

The status quo allows Colorado to learn what the best way to fix this problem is, and what the best benefits to offer this population are. While this option is not a permanent fix to the problem, examination of the two remaining alternatives will provide insight into why policy makers in Colorado decided that a temporary fix is the best policy to proceed with at the present moment.

*Alternative One: Offer a benchmark benefits package and expand Medicaid to a larger percentage of AwDC*

This alternative examines expanding Medicaid to more than 10,000 AwDC and offering a benchmark benefits package. This alternative is similar to that which Maine implemented and would require more work on behalf of both the policy and economic research analysts at HCPF, as well as stakeholders to determine which of the recommended benchmark benefits are most applicable to AwDC in the state of Colorado. It is hard to determine exactly what the costs and benefits of this option would be as we do not know which benefits best fit the needs of AwDC. Maine is able to cover 60,000 AwDC and the

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<sup>75</sup> The Department of Health Care Policy and Financing, The Colorado Health Care Affordability Act and the Adults without Dependent Children Advisory Board Committees.

<sup>76</sup> Susan Mathieu, HCPF.

examination of this alternative will assume that a benchmark benefits package would allow Colorado to cover 60,000 individuals as well.

With coverage of 60,000 individuals, the state of Colorado will spend approximately \$193 million per year on this population between now and 2014, and it will see a benefit of \$82 million per year with the limited coverage option.<sup>77</sup> The hospitals and medical providers will see a cost of \$274 million per year between 2012 and 2014 and a benefit of \$116 million per year. However, the stakeholders that will benefit the most in this process will be the clients. As mentioned the state of Colorado has 201,728 childless adults who will be eligible for Medicaid under federal expansion guidelines set to be implemented in 2014.<sup>78</sup> If the state were to implement this alternative of expanding to a larger population, 60,000 AwDC, while offering less benefits, 141,728 individuals will be left without coverage as opposed to the 191,728 left without coverage under the status quo. Those clients will accrue the largest benefit under this expansion option, \$2,550,000 per year between now and 2014.

Stakeholders and policy makers alike, who are supportive of Medicaid expansion, would argue in favor of this alternative, as it covers a larger percentage of childless adults. However, it is important to address how this alternative effectively solves or provides the state with the information needed to solve the problem. HCPF made a conscious decision to steer away from this option for two reasons. First, there was a feeling among many that whether Colorado has similar demographics to that of Maine or not, it will be difficult to implement the same exact benefits package, as we do not know what the comparison of health between the two states looks like. For example, Maine could have a much healthier population than Colorado; therefore we might learn that in order to meet the needs of this population in our state, we need a more comprehensive benefits package. On the other hand, Maine might have a sicker population than that of Colorado, therefore leading us to discover that we do not need to provide our population with the same, or as many benefits. Second, is the issue of providing a benchmark package that the state could later find out did not fit within the federal guidelines for EHBP that Medicaid would be required to offer.

In considering the three policy alternatives, this is a weaker solution to the problem. It might require many changes over time based on what we learn about the AwDC population in Colorado as we implement coverage. In addition, this alternative heavily relies on what the federal government tells us must be offered within the EHBP. We also do not have as much data on what Maine has experienced in terms of the costs and benefits of providing coverage to AwDC. While we do know that it has been doing

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<sup>77</sup> Please see Appendix A for Calculations.

<sup>78</sup> Colorado Health Institute, "A profile of Colorado's Uninsured."

this for quite some time, we also know that its extensive coverage has recently caused the state tremendous budget problems.

### *Alternative Two: Do Nothing*

This alternative is the simplest to understand and may seem like the most cost effective. Many assume that doing nothing does not cost anything, but this is not the case. This option actually presents the largest cost to all stakeholders involved

In FY 2009-10 the state spent approximately \$1billion on health care for AwDC, in FY 2010-11 that number rose to \$1.5 billion.<sup>79</sup> That is an estimated 50 percent increase from FY 2009-10 to FY 2010-11.<sup>80</sup> Information for FY 2011-12 is not yet available.<sup>81</sup> The Colorado Indigent Care Program (CICP) provides a partial solution to the health care needs of the states medically indigent population, but does not provide a comprehensive benefits package. CICP is not an insurance program, rather a financial vehicle for providers to recover some reimbursement for providing medical services to those in the state that do not qualify for Medicaid, but cannot afford private insurance. Currently CICP is the means through which most AwDC in this state receive care, and is how those between 11 and 100 percent FPL will receive care if the state goes through with expanding to only 10,000 individuals at or below 10 percent FPL in spring of 2012.<sup>82</sup>

Beyond what was paid for CICP in 2009-10 and 2010 -11 the alternative of doing nothing brings some hefty costs to Colorado, as well as hospitals and medical providers alike. In 2008-09, the state was responsible for paying hospitals and medical providers \$233 million<sup>83</sup> in CICP reimbursements.<sup>84</sup> In 2009-10, that payment did actually decrease to \$192 million, and in 2010-11 that payment increased to \$231 million. This averages out to be an annual change of 19 percent over each year. Using that percent change, the state can estimate that in 2012 the cost of doing nothing will be approximately \$275 million.<sup>85</sup>

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<sup>79</sup> The Department of Health Care Policy and Financing, Medically Indigent and Colorado Indigent Care Program, Fiscal Year 2010-11, Annual Report.

<sup>80</sup> See Appendix A for Calculations.

<sup>81</sup> These as well as following numbers comes from the amount spent on the Colorado Indigent Care Program (CICP.)

<sup>82</sup> The Department of Health Care Policy and Financing, Medically Indigent and Colorado Indigent Care Program, Fiscal Year 2009-10, Annual Report.

<sup>83</sup> The Department of Health Care Policy and Financing, Medically Indigent and Colorado Indigent Care Program, Fiscal Year 2010-11, Annual Report.

<sup>84</sup> This payment would be considered the cost to the state of doing nothing.

<sup>85</sup> The Department of Health Care Policy and Financing, Medically Indigent and Colorado Indigent Care Program, Fiscal Year 2010-11, Annual Report.

The actual cost of doing nothing for hospitals and medical providers in the state for 2012 is estimated to be \$395 million.<sup>86</sup> Clients would experience a cost of \$141 million in just one year. Conversely, they will experience \$0 benefit. This is because some will continue to seek care and not pay for it and others will seek care and go into debt because they cannot pay their medical bills. The worst scenario in this situation is that some will not seek care until it is life threatening. This delay in care will then spike the costs to the state and hospitals, as well as the privately insured, increasing the cost shift.

Continuing to ignore the issue of cost shifting and not provide coverage to a population that contributes to such a large portion of uncompensated care costs is unsustainable. The cost shift to the privately insured does not seem an adequate way to address this problem. However, there are some credible arguments in favor of doing nothing that should be considered. First, many argue that Medicaid is already a costly, unsustainable, broken program that must be fixed. Much of the “brokenness” of Medicaid is attributed to low provider payments and patient crowd out. Many patients who use Medicaid currently find it difficult to find doctors who will see them since many doctors will only see a certain percentage of Medicaid patients. For patients who are lucky enough to obtain a doctor who is accepting new Medicaid patients, the doctors tend to see an overwhelming number of patients. This means that quality care is not provided and rather providers are incentivized with a fee for service payment system. The reason doctors do not want to take too many Medicaid patients above and beyond what is required of them is because of the low provider payments they receive for providing services, which may also incentivize them to practice defensive medicine and therefore bill more for unnecessary services.<sup>87</sup>

Many are concerned that the expansion of Medicaid, whether it is implemented early by the state or in 2014 by the federal government, will only contribute to this existing problem. Full expansion of Medicaid in Colorado alone will add another 201,728 patients to the “broken” Medicaid system. This leads many policy makers involved to ask if early expansion and any sort of provision of Medicaid benefits is really the answer to curbing the states costs for the uninsured. They attest that waiting for 2014 is a way to address the issue as it will be the federal government that spends the money in the first three years, rather than the state putting funding into a program that we have no concrete evidence will work.

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<sup>86</sup> See Appendix A for Calculations.

<sup>87</sup> Jane Norman, Washington Health Policy Week in Review, “A Wave of Medicaid Patients is on the Way, but Who Will Treat It?” April, 2011.

### *Feasibility of Proposed Solutions*

While this analysis does focus heavily on the costs and cost savings associated with the proposed solutions, it is important to take into consideration the feasibility of implementing each possible alternative in the state of Colorado. The feasibility and sustainability of public programs has played a big role in the health care policy debate. Many argue that the current public insurance system is already unsustainable, at both the state and federal level, and expansion to currently ineligible populations will not help solve that issue.

The feasibility of alternative two, do nothing and wait for the federal mandate to be implemented in 2014 is not clear. While it does play to the idea that the Medicaid system is broken and expansion will not fix that, it does not address one of the major themes of this analysis, that the uninsured are considered a burden on the rest of society. Alternative two does not address the financial burden put on the private payer, nor does it address the costs incurred by the stakeholders involved. It makes no attempts to learn about the population, nor does it begin to decipher to what extent the state should offer benefits to AwDC. It is for these reasons that alternative two is the least feasible of the three proposed solutions.

Alternative one, to expand to a larger population and offer a lesser benefits package does begin to address these issues. However, due to a lack of data from states that provide benchmark packages, a lack of data on the population to be covered in terms of health care needs, and a *to-be-determined* EHBP, alternative one would be risky to implement at this time. There are currently too many moving parts and lack of information associated with the implementation of alternative one. Thus, while it is more feasible than alternative two, it is not the most feasible out of the three proposed solutions.

The status quo essentially sets up a pilot program that will be offered to a limited number of people at a very low percentage of FPL. The only thing that changes for the client with this alternative is that they now have better access to care. Once covered by Medicaid the client will have the opportunity to see a primary care physician as well as specialists if needed where previously their only option was to utilize a safety net clinic or the emergency room. This alternative seems to be the moderate solution. It lies right in the middle of the two extremes. Some policy makers do not want to expand Medicaid at all, while others argue that if we were to expand to all who could not afford private insurance we would see eventual savings. Implementation of this alternative admits that we do not know what the needs of this population will be. Although we can make projections, we have no fixed numbers, therefore, expanding to a large population might put the state in a financial hole, and doing nothing has the same potential given the amount spent on uncompensated care and the cost shift from the uninsured to the private payer.

Given the potential to learn and gather data on this population, the status quo is the most feasible and sustainable solution proposed.

## **Cost Benefit Analysis<sup>88</sup>**

The objective of this cost benefit analysis is to compare the costs and benefits of implementing the status quo to a limited number of individuals while offering full Medicaid benefits. Also included are the alternatives of limiting the benefits offered and expanding to a larger population and not expanding at all. This cost benefit analysis is broken up over a three-year period and considers the costs and benefits for 2012, 2013 and 2014. It is important to note that all figures are estimates based on the number of childless adults in Colorado, the amount of money HCPF has estimated they as well as hospital and medical providers have spent on uncompensated care, and the health care inflation rate of 4 percent.

*Figure 1* highlights the costs and benefits incurred by all stakeholders in the year 2012. It indicates that the status quo is the only proposed solution with a positive net present value. It also demonstrates that the state receives the most benefits in the initial year with implementation of the status quo, which could prove helpful as we are recovering from the great recession. However, AwDC benefits are restricted to qualitative measures only since their quantitative participation remains unchanged. Hospitals and medical providers only receive minimal benefits in 2012 with implementation of the status quo. Alternative one provides minimal benefits to the state, but substantial benefits to clients as well as hospitals and medical providers. However, there is not a considerable difference between the costs and benefits for either stakeholder. The CBA also reflects that there are no benefits for any stakeholder under alternative two, yet extensive costs for all involved.

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<sup>88</sup> Please see Appendix A for all CBA Calculations.

Figure 1-2012

Stakeholders:	Status Quo 10,000 Adults <sup>89</sup>	Alternative 1: Benchmark Benefits for 60,000 <sup>90</sup>	Alternative 2: Do Nothing <sup>91</sup>
<b>Benefits</b>			
HCPF (The State)	\$487,500,000	\$82,020,000	\$0
Hospitals/Medical Providers	\$43,166,721	\$116,220,000	\$0
Clients (AwDC)	\$0	\$350,000,000	\$0
Advocacy Organizations	? <sup>92</sup>	?	?
<b>Total Benefits</b>	<b>\$530,666,721</b>	<b>\$548,240,000</b>	<b>\$0</b>
<b>Costs</b>			
HCPF (The State)	\$163,333,333	\$193,742,176	\$275,805,540
Hospitals/Medical Providers	\$262,771,107	\$274,527,136	\$390,700,855
Clients (AwDC)	\$0	\$99,209,600 <sup>93</sup>	\$141,209,600
Advocacy Organizations	?	?	?
<b>Total Costs</b>	<b>\$426,104,440</b>	<b>\$567,478,912</b>	<b>\$807,715,995</b>
<b>Total Net Present Value</b>	<b>\$104,562,281</b>	<b>(\$19,238,912)</b>	<b>(\$807,715,995)</b>

<sup>89</sup> Status Quo: Medicaid expansion to 10,000 individuals at or below 10 percent FPL offering full Medicaid benefits.

<sup>90</sup> Alternative one: Medicaid expansion to 60,000 individuals offering a limited benefits package.

<sup>91</sup> Alternative two: Do not implement early Medicaid expansion and wait for the federal mandate to be implemented in 2014.

<sup>92</sup> Client Advocacy organizations are represented with a question mark as they are a very important stakeholder but the data available does not represent the costs/benefits incurred by these organizations properly.

<sup>93</sup> 50,000 of the 60,000 individuals covered under alternative two will incur some sort of cost, this number is representative of what that cost might look like.

Figure 2 highlights the costs and benefits associated with the year 2013. Once again, the status quo is the only alternative with a positive net present value. Additionally, the state again receives the most benefits under the status quo in 2013 while incurring fewer costs. Clients as well as hospitals and medical providers see the most benefits under implementation of alternative one. Once again, all stakeholders incur extensive costs in this year under alternative two.

Figure 2-2013

Stakeholders:	Status Quo 10,000 Adults	Alternative 1: Benchmark Benefits for 60,000	Alternative 2: Do Nothing
<i>Benefits</i>			
HCPF (The State)	\$507,000,000	\$85,300,800	\$0
Hospitals/Medical Providers	\$44,893,389	\$120,868,800	\$0
Clients (AwDC)	\$0	\$364,000,000	\$0
Advocacy Organizations	?	?	?
<b>Total Benefits</b>	<b>\$551,893,389</b>	<b>\$570,169,600</b>	<b>\$0</b>
<i>Costs</i>			
HCPF (The State)	\$169,866,666	\$570,169,600	\$341,336,936
Hospitals/Medical Providers	\$273,281,951	\$285,508,221	\$487,594,667
Clients (Childless Adults)	\$0	\$103,177,984	\$146,857,984
Advocacy Organizations	?	?	?
<b>Total Costs</b>	<b>\$443,148,617</b>	<b>\$590,178,068</b>	<b>\$975,789,587</b>
<b>Total Net Present Value</b>	<b>\$108,744,772</b>	<b>(\$20,008,468)</b>	<b>(\$975,789,587)</b>

Figure 3 highlights the benefits associated with providing coverage to the AwDC population once the federal mandate is implemented in 2014. Note that there are no costs incurred by any stakeholders in this year, as the federal government will provide 100 percent FMAP for costs from 2014-2016.

Figure 3-2014

Stakeholders:	Status Quo 10,000 Adults	Alternative 1: Benchmark Benefits for 60,000	Alternative 2: Do Nothing
<i>Benefits</i>			
HCPF (The State)	\$527,280,000	\$88,712,832	\$354,990,413
Hospitals/Medical Providers	\$46,689,124	\$125,703,552	\$507,098,453
Clients (AwDC)	\$0	\$378,560,000	\$152,732,303
Advocacy Organizations	?	?	?
<b>Total Benefits</b>	<b>\$573,969,124</b>	<b>\$592,976,384</b>	<b>\$1,014,821,169</b>
<i>Costs</i>			
HCPF (The State)	\$0	\$0	\$0
Hospitals/Medical Providers	\$0	\$0	\$0
Clients (Childless Adults)	\$0	\$0	\$0
Advocacy Organizations	?	?	?
<b>Total Costs</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>Net Present Value</b>	<b>\$573,969,124</b>	<b>\$592,976,384</b>	<b>\$1,014,821,169</b>

*Sensitivity Analysis<sup>94</sup>:*

While a cost benefit analysis is essential in guiding the decisions made by policy analysts, it is important to consider the level of variability associated with the number of people covered when considering the alternative of a limited benefit package and expansion to a larger population. Policy makers must address the following question: would alternative one be the chosen alternative if the state were able to limit the

<sup>94</sup> Calculations for the sensitivity analysis are included with the CBA calculations.

benefits package enough to cover 65,000 people rather than 60,000? The following sensitivity analysis attempts to answer that question for the years of 2012 and 2013.

Figure 4 highlights that if the number of individuals covered under a benchmark plan was increased by just 5,000 the net present value for this alternative becomes positive. It still reflects the same degree of costs and benefits associated with each stakeholder, for example, clients as well as hospitals, and medical providers reap more benefits than the state. Changing this number does result in larger total benefits than that of the status quo. However, the net present value for the status quo is still considerably larger. While this sensitivity analysis may prompt policy analysts to further research offering lesser more relevant benefits, it still shows, at least until the federal expansion mandate is implemented in 2014, that the status quo is the best policy alternative for the state of Colorado to implement.

Figure 4

2012

2013

Stakeholders:	Alternative 1: Benchmark Benefits for 65,000	Stakeholders:	Alternative 1: Benchmark Benefits for 65,000
<i>Benefits</i>		<i>Benefits</i>	
HCPF (The State)	\$88,850,000	HCPF (The State)	\$92,404,000
Hospitals/Medical Providers	\$125,905,000	Hospitals/Medical Providers	\$130,941,200
Clients (AwDC)	\$385,000,000	Clients (AwDC)	\$400,400,000
Advocacy Organizations	?	Advocacy Organizations	?
<b>Total Benefits</b>	<b>\$599,755,000</b>	<b>Total Benefits</b>	<b>\$623,745,200</b>
<i>Costs</i>		<i>Costs</i>	
HCPF (The State)	\$186,907,176	HCPF (The State)	\$194,383,463
Hospitals/Medical Providers	\$264,842,136	Hospitals/Medical Providers	\$275,435,821
Clients (Childless Adults)	\$97,709,600	Clients (Childless Adults)	\$101,617,984
Advocacy Organizations	?	Advocacy Organizations	?
<b>Total Costs</b>	<b>\$549,458,912</b>	<b>Total Costs</b>	<b>\$571,437,268</b>
<b>Total Net Present Value</b>	<b>\$50,296,088</b>	<b>Total Net Present Value</b>	<b>\$52,307,932</b>

## Strategic Recommendations

In this time of fiscally constrained state government, it is important to implement policy that will help to relieve the burden that AwDC places on the Medicaid system, hospitals, and most importantly the state. The methods section of this analysis outlined the criteria for success of each alternative as cost savings, and eventual health outcomes. After evaluating the three different proposed solutions, and considering the policies implemented in Oregon and Maine, this analysis finds the status quo to be the most beneficial and cost effective alternative to pursue.

As discussed above, alternative two, is the least feasible, and the cost benefit analysis shows that for the years of 2012 and 2013 there are virtually no cost savings. This alternative also does not have the potential to increase eventual health outcomes for this population in the immediate future.

The main reason for this issue analysis is to determine how Colorado can best provide coverage for AwDC while creating cost savings for all stakeholders over the next two years. However, another motive for analysis is to determine how we can contribute less state money to the Medicaid federal match percentage once the federal government stops contributing to a bulk of the costs associated with expanding Medicaid coverage. This ties directly to the eventual better health as part of the criteria for success for this analysis. A healthier AwDC population will mean that less services will be needed, which in turn will lead to less money being spent by clients, medical providers and the state. Alternative two does not provide any cost savings between now and 2014, nor does it attempt to improve the health of those who will qualify for this expansion.

Alternative one does attempt to address the problem by implementing coverage for 60,000 people. This alternative does meet the criteria set forth concerning improvement of health outcomes. While it is not quantifiable in the immediate future, it can be concluded that since this alternative will be extended to the largest number of AwDC and allow better access to care, it will have the best health outcomes. However, the cost benefit analysis shows that there are no cost savings associated with implementation of this alternative in 2012 or 2013 and the alternative produces a negative net present value. More importantly, there are some risks and uncertainties associated with implementation of this alternative.

The first of these uncertainties is the lack of data we have concerning the health needs of this population and the ability to determine which specific benefits best fit those health needs. Another uncertainty associated with implementation of this alternative has to do with the lack of guidance from the federal

government regarding the required EHBP. The state could potentially take on a huge risk in developing a benchmark package because there is a chance that the package will not match the benchmark package the federal government mandates. This could lead to a complete retool of benefits provided to this population.

While it would seem that coverage of the largest number of people possible would result in the largest cost savings, this is not the case. The cost benefit analysis shows that the status quo meets the criteria for success outlined for each year that is considered. While it does not provide the most cost savings in 2014, 2014 is an interesting year as all costs will be covered by the federal government, and is used to show that coverage of this population will result in benefits for all stakeholders involved.

It is 2012 and 2013 that are the most important years to pay attention too. In those two years, the status quo of expansion to a limited 10,000 AwDC meets the criteria for success of cost savings. While it may not improve health outcomes for more than 10,000 AwDC over the next two years, it will create the model by which AwDC enrolled up to 133 percent FPL will receive Medicaid benefits by 2014 therefore working to improve health. The status quo is the only alternative out of the three proposed that does address both pieces of criteria for success that have been outlined. The limited expansion also comes with the possibility to expand to more people over the next two years if the state has overestimated the costs associated with their coverage.

In addressing the issue, we must also consider qualitative factors while deciding which alternative should be implemented in Colorado. Those qualitative factors include the following: improved health; improved productivity as a result of improved health; gains to the family members of the newly insured, including the economic benefit those family members receive from the value of a saved partner, parents or child and; the benefit communities experience due to reduced stress on safety net clinics. While the implementation of alternative one would better address these qualitative factors, it is essential for the purposes of this analysis that the chosen alternative addresses both the qualitative and quantitative factors. The chosen alternative would also provide in some way benefits to family members of the newly insured, and reduce the stress on safety net clinics in communities. In addition, the chosen alternative should address one of the two major policy issues associated with this analysis: the cost shift of the care received by the uninsured to the privately insured, what some would consider a drain on society. The status quo is the only alternative that addresses all of these variables. It is for that reason that this analysis recommends the state of Colorado continue with the implementation of that policy option. Additionally implementation of a limited pilot program will allow Colorado to accurately study the costs, demographics, characteristics and health needs of this population, therefore becoming a leading state in Medicaid expansion.

## Weakness and Limitations

There are two major weaknesses within this analysis. First is the inclusion of mostly quantitative measures. These measures, such as the cost of providing health care to this population, hospitals and medical providers, and the state make it easy to conduct a cost benefit analysis but they do not represent the entire issue. For example, the quantified benefit to the client for expansion under the status quo is \$0. It is quantified as \$0 because currently (without expansion) the client does not pay any money for care they receive because they cannot afford it. This will not change once expansion is implemented therefore resulting in a benefit of \$0. However, there is a qualitative benefit to the client, and that is the benefit of health care. Qualitative measures are very important to consider as it comes to health care research and outcomes, and the sole reliance on quantitative measures within this analysis presents a limitation in accurately portraying the issue. Second, the NBER Oregon study puts an emphasis on self-reported measures of health in conducting their research. The issue with relying on these self-reported measures is that a person might not report their own health accurately, therefore creating unreliable results. Examination of the status quo within this analysis did rely on the research done by NBER in Oregon and it should be noted that the self-reported measures cannot be heavily depend upon in terms of accuracy.

Additionally, the lack of data from Maine as well as other states regarding the cost of benchmark benefit packages within Medicaid, and the benefits they produce presents another weakness within this analysis. Due to that lack of information as well as a lack of data on the AwDC population health needs it became difficult to determine what a benchmark benefits package would look like in Colorado. Due to that absence of figures, the costs and benefits for alternative one for each year are just estimates based the current monetary value of uncompensated care received by AwDC. Much of this uncertainty is what led to disregarding alternative one as the recommended alternative to pursue in Colorado. Another weakness associated with the examination of alternative one is that at the time this analysis was written, there was little to no guidance from the federal government on what the EHBP would look like. It is now known that individual states will have some control over what the EHBP should encompass. This is just one moving part that created limitations in the examination of alternative one.

There are also some issues pertaining to the efficiency of pilot programs that could be seen as a weakness or limitation of the analysis of the status quo. There are too many factors susceptible to change that could affect the results of a pilot program. For example, the commitment of the staff involved in implementing the program, the ability of a program to become weaker as it gets larger and the problem researchers face regarding survivor bias results. This weakness is associated directly with the provision of health care to the poor, which could have a major effect on the outcomes of the status quo. Compliance rates with health care coverage among low-income adults tend to be low. Additionally, many low-income persons

move around a lot and become hard to reach therefore dropping out of the system. This results in research conducted on unusually compliant and stable people therefore creating a bias within the results of the pilot program.<sup>95</sup>

Furthermore, this analysis mentions client advocacy organizations as a major stakeholder in expansion to AwDC, yet they are represented with a question mark in the cost benefit analysis. This is because there is a lack of data around how much client advocacy organizations spend on financial assistance for the AwDC population specifically. Therefore, the costs and benefits of expansion for these organizations could not be quantified within the examination of the issue.

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<sup>95</sup> Megan McArdle, "The Value of Health Care Experiments", The Atlantic, January 2011.

## Appendix A – Cost Benefit Analysis:

**Key Assumptions:** There are a few key assumptions made within this cost benefit analysis that must be noted. First, it is assumed that quantitative measures represent the whole issue. Second, it is assumed that on examining alternative two there is enough money to expand to 60,000 AwDC. Third, it is assumed that the cost of doing nothing for this population is represented by the amount of money spent on the Colorado indigent care program each year. This assumption was made due to information obtained from HCPF analyst Matt Haynes.

**Inflation Rate:** The health care inflation rate of 4 percent was used to project costs for all alternatives for the years 2013 and 2014. This inflation rate was obtained by averaging the current health care inflation rate of 3.6 percent with February 2012's inflation rate of 3.5 percent, 2011's average health care inflation rate of 2.92 percent and the long term health care inflation rate of 5.58 percent resulting in a 4 percent average inflation rate.

**Evaluation Period:** Most health care projects are evaluated over a longer period of time in order to obtain information on health outcomes of those who will be effected. For the purpose of this analysis, the costs and benefits are evaluated over a three-year period in total. Each year's costs and benefits are looked at separately rather than over all. Much of this is due to the implementation of the federal mandate in 2014.

### **Projections for cost and benefits to all stakeholders for Alternative Two:**

*HCPF:* The cost to the state for doing nothing is obtained by looking at what the state spends annually on the Colorado Indigent Care Program each year. Costs were obtained by looking at what was spend in 2009/09 2009/10 and 2010/11. The percent change from year to year was then calculated and averaged in order to project costs for 2012,2013 and 2014.

In 2008/09 the total amount paid into CICIP was \$436,186,367, hospitals paid \$202,662,534. In order to figure out how much the state reimbursed of that total spend subtract 202,662,534 from 436,186,367 = \$233,523,833 paid by the state.

2009/10 = 503,236,051-310,879,689 = \$192,356,353 paid by the state

2010/11 = 557,353,408-325,584,046 = \$231,769,362 paid by the state

Percent change of payments from 07/09 to 08/09 = 56%

08/09-09/10= 18%

09/10-10/11= 20%

Averaged out the percent change for these three years is equal to 19%.

To project for 2012 that \$231,769,362 paid by the state in 2010/11 must be multiplied by multiply 19%:

$$231,769,362 * 1.19 = \$275,805,540 \text{ projected cost to the state in 2012.}^{96}$$

For 2013 the same step must be repeated, however the average health care inflation rate must also be accounted for. So the projected 2012 cost (\$275,805,540) is then multiplied by 1.19 (19%) = 328,208,593 \* 1.04 (4% health care inflation rate) = \$341,336,936. The same step is again repeated in order to project costs for 2014.

The benefits of alternative two to HCPF for both 2012 and 2013 are reflected as \$0. This is because they would see no savings under this alternative. In 2014, as there are no costs to HCPF for covering this population, since the federal government will cover all costs that year, those benefits are calculated by multiplying the 2013 cost by the 4% health care inflation rate, assuming that those projected costs for 2014 would be seen as a cost saving (benefit).

*Hospital/Medical Providers:* In order to obtain costs, CICIP payments made by hospitals, as well as hospital provider fee payments were examined.<sup>97</sup> Once again percent changes year over year were averaged in order to project costs for 2013 and 2014,

2008/09 CICIP Net provider payments = \$202,662,534 % change from 07/8 = 4.1

2009/10 = \$310,879,968 % change from 08/09 = 53

2010/11 = \$325,584,066 % change from 10/11 = 4.7

Average percent change = 20%

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<sup>96</sup> HCPF CICIP Reimbursement rates – CICIP annual reports

<sup>97</sup> Matt Haynes, HCPF Analyst – Hospitals consider CICIP payments to be the cost of doing nothing.

Projected 2012 Cost =  $325,584,066 * 1.20 (20\%) = \$390,700,355$ . In order to determine costs for 2013 the 2012 cost was multiplied by the 20% average change, and then by the 4% average health care inflation rate. The same step was repeated for 2014.

Once again benefits to hospitals and medical providers for 2012 and 2013 are reflected as \$0 since there is not cost saving associated with this alternative.

*Clients:* There are 201,728 AwDC in Colorado, on Average they pay \$700 each per year in health care costs.<sup>98</sup>

Costs:  $201,728 * 700 = \$141,209,600$  per year for the entire population. This number was multiplied by the 4% average health care inflation rate to calculate costs for 2013. Costs for 2014 will be \$0 as the federal government will pay for 100 percent of the expansion that year.

Benefits: Benefits to clients under alternative two are \$0 as they do not see an cost savings without expansion.

### **Projections for costs and benefits to all stakeholders for Alternative one:**

*HCPF:* Costs and Benefits to the state as well assumes that the state will be able to cover 60,000 childless adults with this alternative.

Costs: Without expansion the state spends  $\$275,805,540/201,728$  AwDC in Colorado<sup>99</sup> = \$1,367 per person.  $201,728 - 60,000$  AwDC who will be covered = 141,728 not covered.<sup>100</sup>

$\$1,367$  per person \* 141,728 AwDC not covered = \$198,742,176. In order to obtain costs for 2013 \$198,742,176 was multiplied by the 4% health care inflation rate. Costs for 2014 will remain at \$0 as the federal government will fund 100% of the expansion in that year.

Benefits:  $\$1,367 * 60,000$  covered = \$82,202,000 saved by the state each year. In order to obtain benefits for 2013 \$82,202,000 was multiplied by the 4% health care inflation rate, in order to calculate benefits for 2014 the same step was repeated.

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<sup>98</sup> Karyn Schwartz and Tanya Schwartz, "Uninsured Young Adults: A Profile and overview of Coverage Options", Kaiser Commission on Medicaid and the Uninsured, June 2010.

<sup>99</sup> Colorado Health Institute, "A Profile of Colorado's Uninsured."

<sup>100</sup> CICIP Annual Reports.

*Hospitals/Medical Providers:* Costs and benefits to hospitals and medical providers assume the state will be able to cover 60,000 individuals.

Costs: Hospitals spend \$390,700,855 on 201,728 AwDC who have no insurance.  $\$390,700,855/201,728 = \$1,937$  per person.  $201,728 - 60,000$  covered = 141,728 not covered with alternative one.  $141,728 * \$1,937$  per person = \$274,527,136 spent by hospitals per year.<sup>101</sup> \$274,572,136 was then multiplied by the 4% health care inflation rate in order to obtain costs for 2013. Costs for 2014 are \$0 as the federal government will cover everything.

Benefits: \$1,937 per person (see Hospital/Medical Provider cost for calculation) 60,000 will be covered =  $1,937 * 60,000 = \$116,220,000$  saved.

*Clients (AwDC):* On average AwDC pay \$700 per year on health care. 10,000 of those people will pay \$0 as they are at such a low-income level.

Costs:  $201,728 \text{ AwDC} - 60,000 = 141,728$  not covered.  $141,728 * \$700$  (average cost per year spent by clients) = \$99,209,600 per year. In order to obtain costs for 2013 \$99,209,600 was multiplied by the 4% health care inflation rate. Costs for 2014 remain at \$0 the federal government will cover everything.

Benefits: 10,000 AwDC will pay \$0 as they are at such a low-income level. This equals  $\$700 * 10,000 = \$7,000,000$  saved by the client per year. In order to obtain benefits for 2013 \$7,000,000 was multiplied by the 4% health care inflation rate. This step was repeated in order to calculate benefits for 2014.

### **Projections for Costs and benefits to all stakeholders Status Quo:**

*HCPF:*

Costs: Total projected costs to the state for enrollment of 10,000 individuals is estimated to be \$190 million between enrollment (2012) and when the federal health mandate is implemented (2014.)<sup>102</sup>

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<sup>101</sup> CICIP Annual Reports.

<sup>102</sup> Information obtained from HCPF Analysts Matt Haynes.

$190,000,000/3 = \$63,333,333$  per year over the next three years.  $\$63,333,333$  is then multiplied by the 4% average health care inflation rate in order to obtain costs for 2013. Costs remain at \$0 in 2014 as the federal government will pay for expansion in that year.

Benefits: It is estimated that Medicaid expansion will save the state \$3.9 billion between now and 2019.<sup>103</sup>

$3,900,000,000/8 = \$487,500,000$  → benefit each year, over the next 8 years.  $\$487,500,000$  is then multiplied by the 4% inflation rate in order to calculate benefits for 2013. 2013's result is then again multiplied by again by the 4% average inflation rate to calculate benefits for 2014.

*Hospitals and Medical Providers:* The Colorado Health Care Affordability Act was implemented in 2009 with the intent to expand Medicaid coverage to adults without dependent children. The Hospital Provider Fee was the funding mechanism that was implemented through CHCAA in order to pay for the expansion. The following costs and benefits are calculated by examining fees collected from hospitals.

Total fees collected for 2009/10: \$340,870,000

Total Hospital Payments: \$427,362,000

Net Earnings to Hospitals: \$86,493,000

In 2009 before implementation of the hospital provider fee, hospitals paid \$201,979,242 in uncompensated care after implementation of the hospital provider fee hospitals paid \$158,972,078 a difference of \$43,007,078.

Costs:  $427,362,000 + 201,979,242 + 158,072,078 = \$788,313,320/3$  (for an average yearly cost) =  $\$262,771,107$  per year.<sup>104</sup>  $\$262,771,107$  is then multiplied by the 4% health care inflation rate in order to calculate costs for 2013. Costs for 2014 are \$0 as the federal government will fund 100% of the expansion in 2014.

Benefits:  $43,007,164 + 86,493,000 = \$129,500,164/3$  (for an average yearly benefit) =  $\$43,166,721$  per year.  $\$43,166,721$  is then multiplied by the 4% health care inflation rate in order

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<sup>103</sup> "The Future of Colorado Health Care, An Economic Analysis of Health Care Reform and the Impact on Colorado's Economy" The University of Denver, The Colorado Trust, The Colorado Health Foundation, New America Foundation, 2010.

<sup>104</sup> The Department of Health Care Policy and Financing, Colorado Health Care Affordability Act, FY 2009-10 Fees and Payments by Hospital by Region.

to project benefits. The same step is repeated in order to obtain 2014's benefit, using 2013's projected benefit.

*Clients Costs and Benefits:* Both will be \$0 as these clients are at such a low FPL, they already do not pay anything, and will not pay anything with coverage so costs and benefits will remain at \$0.

**Total Cost and Benefits:** Total costs and benefits for all years were calculated by adding the costs for each policy option and the benefits for each policy option.

**Net Present Value:** The net present value for each alternative was calculated using the following formula:  $NPV = PV(B) - PV(C)$  → The present value of all benefits minus the present value of all costs.

**Sensitivity Analysis:** Calculations for the sensitivity analysis are the same as the CBA calculations for alternative one, except 60,000 was substituted with 65,000 in order to obtain the costs and benefits for 2012 and 2013.

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