The Department of Health Care Policy and Financing (HCPF)

Passed in 1965, Medicaid was designed to help finance medical services for people unable to care for themselves due to poverty or disability. In 1993, the Colorado Department of Health Care Policy and Financing (HCPF) was created to oversee the operation of the Colorado Medicaid program and provide a central point of contact with federal Medicaid authorities.

Originally designed to collect and disburse the moneys allocated to the Medicaid program and to ensure that Colorado Medicaid abides by federal law, the Department's expanded mission now states that it will create "a novel model of public insurance and to promote health, function and self-sufficiency as its core goals."

Originally designed to collect and disburse the moneys allocated to the Medicaid program and to ensure that Colorado Medicaid abides by federal law, the Department's expanded mission now states that it will create "a novel model of public insurance and to promote health, function and self-sufficiency as its core goals." The public insurance will "reach beyond the clinical setting and into community settings where healthy behaviors are shaped."[1]

The Department proudly asserts that it "covers over 550,000 clients, over 10 percent of the state's population, and spends over 20 percent of the state's budget to administer its health insurance programs."[2] The Joint Budget Committee (JBC) report shows that it requested $4.58 billion in state and federal funding for FY 2010-11. It expects slightly more than 60 percent of its budget to come from the federal government.

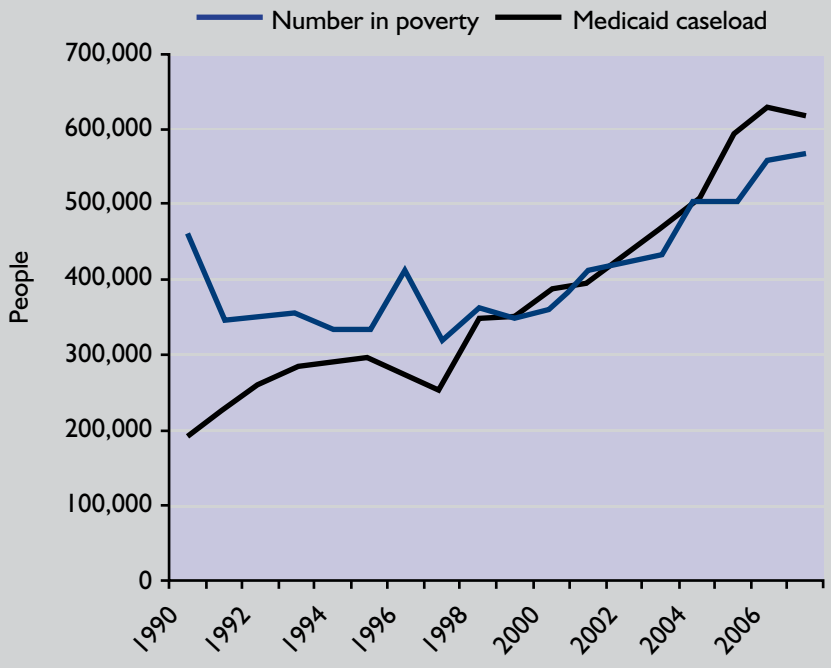
Department publications state HCPF is "responsible for the provision of all health care" for people enrolled in federal matching fund programs. Despite significant evidence suggesting government entities of all kinds do a poor job of providing health care when they control it, the Department apparently believes that it can manage its novel health care system well enough to provide care that is "medically necessary, appropriate to the population, and cost-effective." It fails to address the fact that health care appropriate to "the population" is not necessarily the same as curing or ameliorating the ills of a specific individual.

In recent years state officials have supported the Department in its drive to develop a state-run medical system. Programs have been shaped to favor certain kinds of health care providers and delivery systems. Rather than treat all physicians, hospitals and medical practices equally, officials have begun to pick winners and losers. They have supported new taxes levied only on those who pay for their own health care, and directed government funds to favored private groups. Officials have even supported a foundation plan to force physicians to report individuals' most private health information to a state-run data base. Information from that database will be used to control the type and amount of treatment that people can receive. State employees also have cooperated with private foundations interested in using Colorado citizens to promote their health care agendas.

Rather than treat all physicians, hospitals and medical practices equally, officials have begun to pick winners and losers.

The end of federal stimulus funding likely will open an annual shortfall of $252 million in the HCPF budget that will have to be backfilled by state funds. Reversing expensive decisions made within the past three years could save over $200 million per year. The Department plans future increases in eligibility for state programs that could increase annual costs by another $490 million per year. Its capitated mental health programs are expensive and their

Figure 1
Colorado: Number of People in Poverty Versus Medicaid Caseload



efficacy is unknown. They should be subjected to critical review.

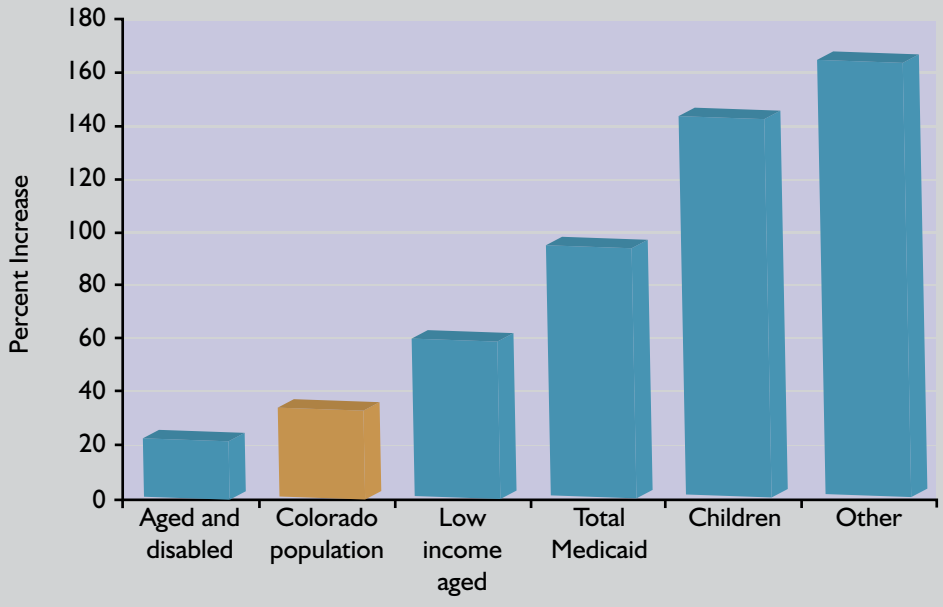
Major HCPF Programs and Spending: Medicaid

Medicaid was initially designed to pay for health care for impoverished families, the disabled and the impoverished elderly. On paper, Medicaid offers more benefits than the most generous corporate plan in America. It covers all medical costs. Co-pays, when they are collected, are generally capped at $5 per visit. Medical transportation, drugs, durable medical equipment, rehabilitative therapies, some over-the-counter medications and long-term care are covered.

States that choose to participate in Medicaid must develop medical assistance programs that pay for certain mandatory services for specifically defined groups of people. States have the option to add certain services and groups of people to their Medicaid programs. The federal government matches each dollar that a state spends on eligible programs and populations with a dollar of its own. State medical assistance for people who are not eligible for the Medicaid program does not qualify for federal matching funds.

Medicaid eligibility depends on income, usually expressed as a percentage of the income defined as the federal poverty level (FPL). Unless the percentage of

Figure 2
Medicaid Caseload Increase
FY 1995 to FY 2009-10 (projected)



people at or below the federal poverty level declines, one would expect Medicaid caseloads to expand along with the state's population. In Colorado, the Medicaid caseload has expanded faster than the state's population, and faster than the proportion of the state's population in poverty because the state has continuously expanded Medicaid eligibility.

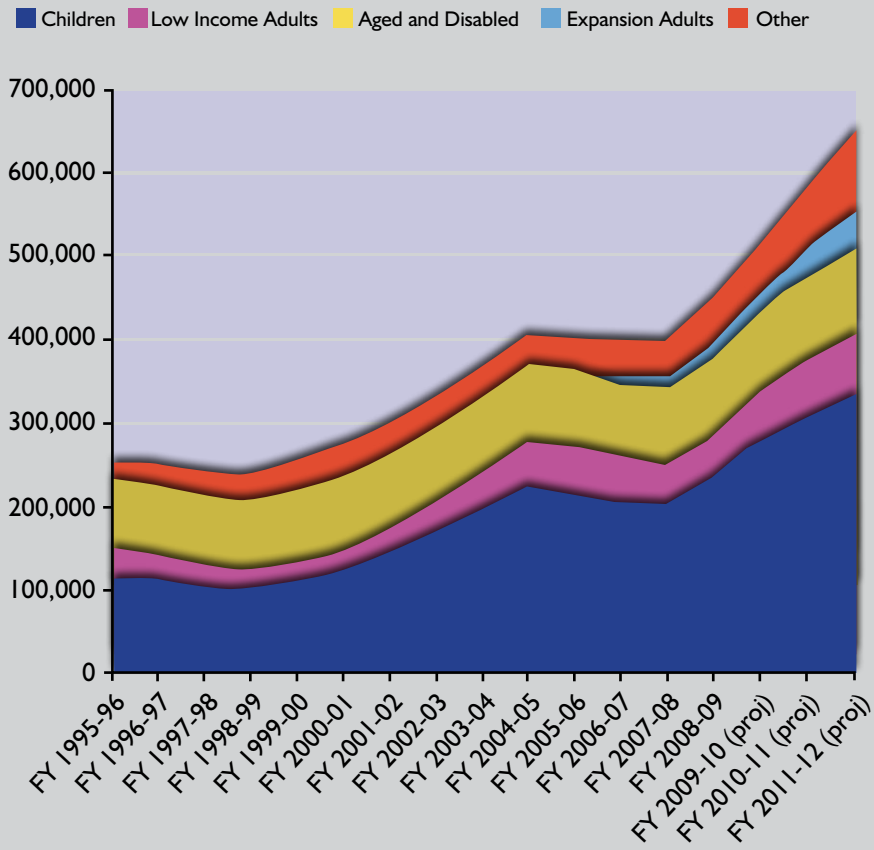
As figure 3 shows, children's eligibility began to expand in FY 1999-2000. Overall enrollment increased sharply in FY 2008-09, as eligibility for adults was expanded. Childless adults in good health historically have been ineligible for Medicaid except at very low levels of income. The assumption is that single adults in good health can work to pay for their own care. If they become seriously ill, their income would fall and they would automatically become eligible for Medicaid.

In the 2009 expansion, the legislature expanded Medicaid eligibility for parents of eligible children from 60 percent of the federal poverty level ($8,742 for two people) to 100 percent of the federal poverty level ($14,570 for two people). This increased caseloads by 11.4 percent in 2009. Cases are expected to increase by an additional 11.1 percent in 2010-11. In FY 2009-10 the state appropriated $4.3 billion dollars for Medicaid. The state share was $1.77 billion.

Between 1995 and 2009-10, the increase in the people who used to be the primary focus of Medicaid, the aged and disabled, has been smaller than the state's population increase. One would expect the percentage of low-income aged to grow faster than the population as the Baby Boom ages. In fact, the growth in the Medicaid caseload has been much more rapid than that of the population, and it has been led by the number of children and "others" enrolled.

Public statements by officials tend to ignore the role that eligibility expansions have played in Medicaid growth. They suggest that caseloads grow only as a result of greater "need." As figure 4 suggests, the Department's own research shows that caseload growth has not been well correlated with the state's business cycle. Caseloads grew throughout the 1990s both as unemployment rose and as unemployment fell. Caseloads fell both in Colorado and

Figure 3
Colorado Medicaid Caseload Composition



across the country after July 2006, likely a result of a new federal law requiring that states verify U.S. citizenship before allowing Medicaid enrollment.

The FY 2010-11 Medicaid budget passed at the end of the regular 2010 legislative session was $4.6 billion. The state share of that spending will be $1.86 billion.[3]

Colorado Medicaid is growing faster than private sector health spending. Figure 5 compares state Medicaid expenditures in FY 2006-07 with what they would have been had that year's totals been increased by the private sector medical cost trend. As the chart shows, maintaining the FY 2006-07 caseload in FY 2008-09 would have reduced state spending by $218 million after allowing for medical cost inflation.

Since 1995 Colorado's Medicaid program has provided mental health services via a separate Medicaid mental health program. It operates under a waiver from the federal government. The state contracts with "Behavioral Health Organizations." They provide all mental health care for eligible Medicaid clients living in their geographic areas. In exchange, the state pays the monopoly Behavioral Health Organization a set monthly fee (the "capitated cost") for each eligible Medicaid client in that area. The fee is determined through negotiation. It is paid whether or eligible people actually use the services.

Although the number of people eligible for the Medicaid mental health program fell, expenditures rose. The FY 2010-11 appropriation for the program is $247.6 million.[4] The Department does not appear to have published studies on the cost-effectiveness of its mental health arrangements.

Rather than take a hard look at the state fiscally unsustainable Medicaid growth, the state used funds from the American Recovery and Reinvestment Act (ARRA) of 2009 to maintain existing program expansions. ARRA has been extended to June 2011. According to a JBC staff analysis, once the ARRA funding expires the worst case scenario is that the state will have to find an additional $252 million in order to continue funding Colorado Medicaid at FY 2009-10 levels.[5] This estimate includes money from the Health Care Expansion Fund. It is funded by new taxes on hospital bills. This year the tax proceeds were diverted to fund

Figure 4

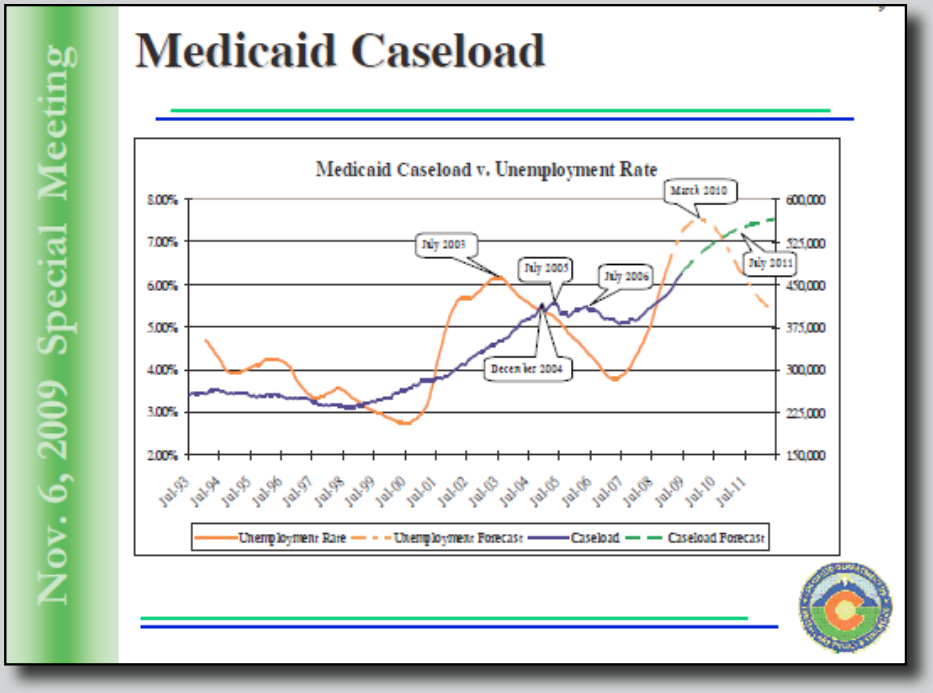
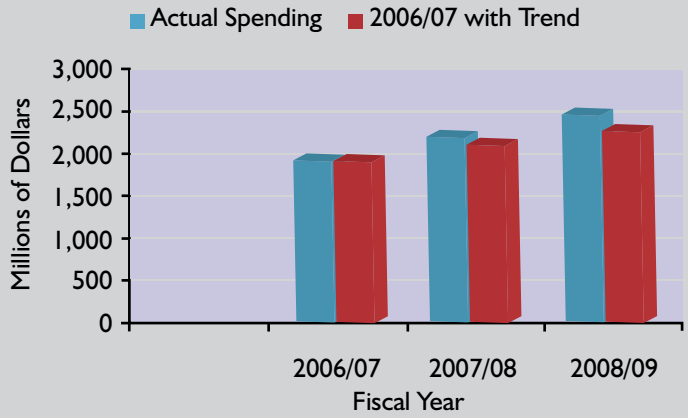


Figure 5
The $218 Million Dollar Difference: Actual Medicaid Spending Versus 2006/07 Spending Increased by the Milliman Medical Cost Trend



existing Medicaid programs rather than the planned eligibility expansions

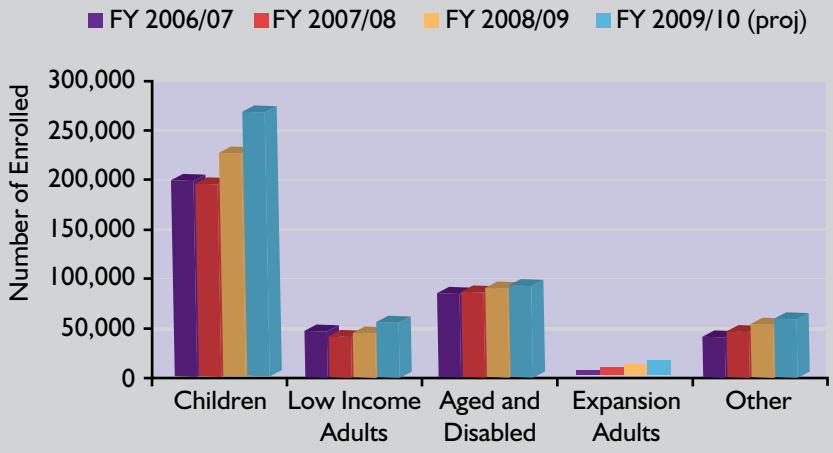
Despite its budget problems, state officials are in the process of further expanding Medicaid eligibility:

- The legislature voted to allow continuous 12-month eligibility *for children regardless of household income after enrollment.* This is a caseload expansion because low-income adults currently spend an average of 8.8 months on the program, while eligible children are enrolled for an average of 8.6 months.[6]
- Continuous 12-month eligibility *for adults* is estimated to be $75.9 million in FY 2012-13.
- Adults whose children are eligible either for Medicaid or CBHP, will be eligible as long as their household income is less than the federal poverty level. Costs for this expansion are estimated to be $140.5 million in FY 2012-13.
- Adding childless adults, or adults without a child in the home, will be eligible for Medicaid if they "earn" less than 100 percent of the federal poverty level at an estimated state cost of $197.3 million in 2012-13. Officials ignored the fact that many retirees "earn" less than poverty income because they collect reasonable incomes from Social Security, pensions and investments.
- Disabled adults and children with earned incomes up to 450 percent of the federal poverty level (household income of $65,565 for two) will be eligible. The estimated cost to state taxpayers will be $75.8 million per year.

MAJOR PROGRAMS AND SPENDING: THE CHILDREN'S BASIC HEALTH PLAN (CBHP)

Although it began as a small state program funded by "gifts, grants,

Figure 6
Medicaid Caseload: Four Years of Expansion



and donations" in 1990, the Colorado Children's Basic Health Plan (CBHP), now costs state taxpayers $63 million a year. Under the federal State Children's Health Insurance Program (SCHIP), and the federal government matches every state dollar spent in the CBHP with two federal dollars. As one would expect, the large federal match has encouraged state spending. Officials aggressively expanded CHBP eligibility by raising the income limit for the means-tested program's eligibility. Caseloads increased by 6.5 percent in FY 2006-07 jumped by 23 percent in FY 2007-08, rose 6.6 percent in FY 2008-09, and rose again by 14 percent in FY 2009-10.[7]

From June 2005 to June 2006, enrollment in Colorado's children's health insurance program rose 32.4 percent, the largest percentage increase in the country.

The vigorous enrollment expansion in CBHP has added to Colorado's budget woes. From June 2005 to June 2006, enrollment in Colorado's children's health insurance program rose 32.4 percent, the largest percentage increase in the country. State officials expanded eligibility from 185 percent of the federal poverty level to 200 percent of the federal poverty level.

In FY 2009-10, the Department initially appropriated $164.4 million for the CBHP. The state spending share was $57.8 million. The appropriation underestimated actual expenditures by almost 10 percent. A JBC analysis notes that although the Department initially estimated the hospital tax-funded Health Care Expansion Fund balance would be "$78.2 million at the end of FY 2009-10, it is instead anticipated to be insolvent by FY 2011-12."[8]

The program fixes proposed by the Department suggest the state's managed care network needs better management.[9] The Department remains committed to managed care even though it told the JBC in December 2006 that managed care did not save money. Specifically, it wrote:

> Although managed care organizations should experience savings over fee-for-service due to their improved ability to reduce unnecessary hospitalizations, emergency room visits, and other overutilization, there are also extensive administrative costs for care management, utilization management, providing networking to ensure access, and other processes such as bill paying and risk management.[10]

Families pay just $35 a year to enroll two or more children in CBHP, $25 for one child. Co-pays for office visits range from $2 to $5. Emergency room and hospital visits have maximum co-pays of $15. There are no co-pays for check-ups or prenatal care visits.

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Enrollment is good for 12 months. According to the HCPF website, in FY 2010-11 a pregnant woman with an annual income of up to $35,432 after childcare costs, medical expenses, dental expenses, and child support would have been eligible for CBHP. Families of four with residual incomes of up to $55,128 also qualified.[11]

Determination of eligibility is generally based on the previous month's income, supported by a pay stub. The state cannot vet reported income. People may hold multiple jobs and receive various forms of unreported income. Officials plan to check reported income against tax records, but tax records do not contain information on people who are paid in cash or do not file.

The income definition used for CBHP

eligibility is generous. It ignores most types of government aid. Child care costs are subtracted from gross income as are medical expenses, dental expenses, health insurance premiums, and child support and alimony payments. Income-augmenting subsidies like the earned income tax credit, housing subsidies, food stamps or energy assistance are not added. In all, eligibility standards disregard income supplements such as food stamps and housing that can add more than $20,000 a year to consumption income.[12]

In 2010, 225 percent of the federal poverty level was equivalent to an annual income of $49,613 a year (about $21 an hour) for a family of four. The Census Bureau estimates that median household income in Colorado in 2006-08 was $56,574, that average family size was 3.14 people, and that average household size was 2.54 people. At the current 225 percent of FPL means-tested limits, an eligibility limit reduced from the previous 250 percent level due to the state budget shortfall, CBHP has reached the point where ***half of the households in the state are expected to bear all the medical expenses for the other half's children.***

...CBHP has reached the point where half of the households in the state are expected to bear all the medical expenses for the other half's children.

In a widely-cited study of the effect of SCHIP on private coverage, Gruber and Simon used federal longitudinal surveys to estimate that six out of 10 new SCHIP enrollees previously had private insurance and that the rate at which SCHIP "crowds-out" private coverage rises as income eligibility levels has expanded."[13]

As the income level for eligibility is raised, parents are more likely to drop private coverage to enroll their children in CBHP simply because families with higher incomes are more likely already to have private health insurance coverage. With 60 percent crowd-out, the CBHP does an exceptionally poor job of targeting people who really need help.

Though state officials claim that health insurance is unaffordable, Bundorf and Pauly used various definitions of affordability to conclude that "while 36 percent of individuals in families with income of two times poverty level or less are uninsured, 44 percent have coverage." With incomes at or above 175 percent of the poverty line, 51 percent of the uninsured could have afforded coverage."[14]

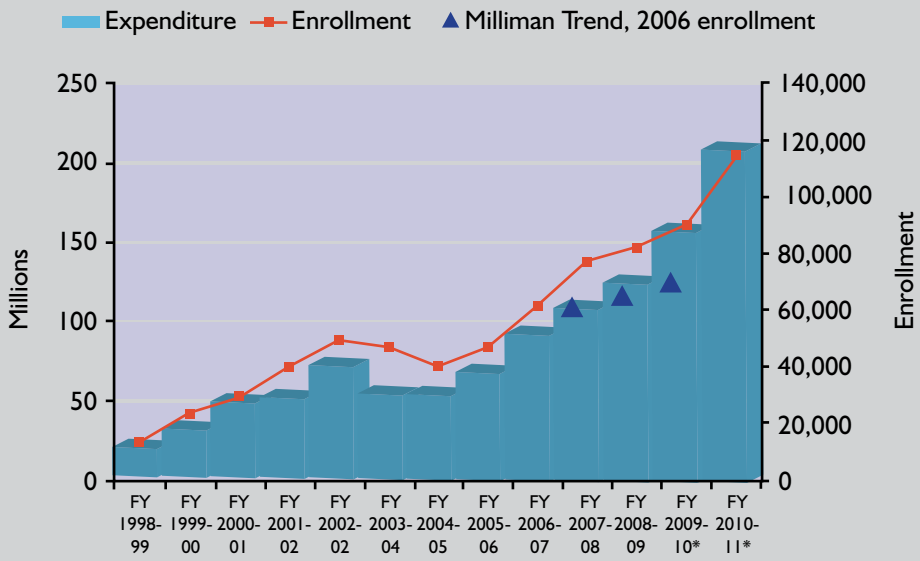
State officials could prevent at least some crowd-out by making the $35 CBHP enrollment fee more realistic.

State officials could prevent at least some crowd-out by making the $35 CBHP enrollment fee more realistic. In 2009, the average employee cost for a family policy in an employer-based group health plan was $3,515. The average annual employee cost for health insurance without dependent coverage was $779.[15] The annual premium for a family health insurance policy in Colorado's individual market was $5,939. The average annual premium for coverage of a single adult was $2,777.[16]

One way to estimate the cost of CBHP caseload expansion since 2006 is to apply standard trend estimates for increases in medical costs to 2006 CBHP caseloads. This analysis produces conservative estimates of the effect of caseload increases for two reasons: The population covered by the CBHP is relatively healthy, and the state claims to control provider reimbursement increases.

If state CBHP expenditures in 2006 had followed overall medical cost trend increases, the state share of expenditures would have risen from roughly $40 million to $46 million as shown by the triangles. Instead, the state expanded eligibility and expenditures rose from $40 million to $57.8 million. If national estimates of crowd-

Figure 7
Colorado Children's Plan Expenditures and Enrollment
(*projected)



out apply to Colorado, they suggest that between 2007 and 2009 Colorado spent about $6 million in state funds to provide CBHP health coverage for people who already had it.

Undeterred by the expense, the Department's FY 2010-11 Strategic Plan has made future enrollment increases in the CBHP part of its performance goals. Past and future targets are shown below in table 1.

The Department believes it did not reach its FY 2008-09 enrollment goals because "a higher number of children migrated to Medicaid who were previously eligible for the CBHP. This migration was the result of a drop in the incomes of families who initially qualified for the Plan, thus making their children eligible for Medicaid." It believes "The increased enrollment numbers in Medicaid support this trend."[17]

What the report does not say is that any migration that occurred caused both the Medicaid caseload and the CBHP caseload to continue to expand.[18] It also neglects to mention that the Department was worried about a caseload decrease. When budget cuts reduced its $2,700,000 FY 2007-08 CBHP advertising budget to $500,000 in FY 2010-11, the Department decided the remaining $500,000 was not "sufficient to drive large increases in caseload," and therefore the funding should be redirected "toward retention of existing eligible clients."[19]

The obvious question, of course, is whether it is in the best interest of the taxpayer to spend millions of dollars to market programs designed to encourage people that are paying for their own health care to depend instead on state taxpayers.

Table 1. CBHP Enrollment Increase Goals

	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11
Targeted Increase	9,000	10,000	7,000	12,839
Actual	11,299	4,039	--	--

Source: State of Colorado, Department of Health Care Policy and Financing Strategic Plan FY 2010-11 Budget Request, November 6, 2009, page C-24.

Table 2. CBHP and Medicaid caseloads expand, 2006-2009

Caseload (Children)	FY 2006-07	FY 2007-08	FY 2008-09
Medicaid	206,170	204,022 (-2.0%)	235,129 (15.2%)
CBHP (increase from previous year)	47,047 (6.5%)	57,795 (22.8%)	61,582 (6.6%)

Table 3. SCHIP Health Insurance Enrollment Fees, 2006				
	Colorado	Kansas	Iowa	New Hampshire
Annual Income of 151-200%FPL: ($21,856-$29,140 for a 2 person family in 2010)	$25-35 dollars per family per year	$20-$30 per family per month	$20 per family per month	$25 per child per month, family maximum of $100 per month
Source: Vernon Smith and Jason Cooke. May 2007. SCHIP Turns 10: An Update on Enrollment and the Outlook on Reauthorization from the Program's Directors. Kaiser Commission on Medicaid and the Uninsured.				

Though state control over Medicaid co-pays is limited, the state has considerable control over the enrollment fees and co-pays for the CBHP. As table 3 shows, CBHP enrollment fees are much lower than those in some other states.

With a FY 2008-09 CBHP caseload of roughly 61,582 children, simply collecting an additional $35 per child per year would increase state revenues by $2.1 million. Switching to the New Hampshire formula of $25 per child per month would generate more than $18 million a year—a net gain of more than $16 million assuming that every CBHP enrollee already pays $25 a year. CBHP enrollment fees also should be indexed for inflation. Adjusted for inflation, a $35 fee in 1999 would be worth almost $46 in 2010.

One of the major problems with medical assistance programs is that state officials have steadfastly refused to seriously consider programs designed to make the people aided by them feel as if they are spending their own money. For example, increases in co-pays have been shown to significantly reduce health service use without any effect on health. This is especially true of charges for emergency room use. Yet CBHP co-pays remain absurdly low relative to the program's income eligibility limits and the real cost of medical care.

According to its web page, in August 2010 the CBHP program charged $2 to $5 per visit for medical care and prescriptions, $3 to $15 per visit for emergency services, and $5 for most dental services. When Medicaid was authorized it was designed to provide coverage for the poor. Congress set the maximum co-pay at $5. In inflation-adjusted terms, a $5 co-pay in 1965 would be $34.60 in 2010.

Although state officials and private sector interest groups maintain that further CBHP expansion is required in order to take care of children who are not receiving proper medical care, officials have yet to show that any CHBP spending has improved the actual health of children. Measures published by the Department generally monitor service utilization rather than actual health.

Although state officials and private sector interest groups maintain that further CBHP expansion is required in order to take care of children who are not receiving proper medical care, officials have yet to show that any CHBP spending has improved the actual health of children.

Also of concern is the state's routine underestimation of CBHP cost. When eligibility was expanded from 200 percent to 205 percent of the federal poverty level in 2008, expenditure growth was "significantly higher" than estimated in the fiscal note that accompanied the enacting legislation. Growth in expenditures for the supplemental expansion children in FY 2009-10 was also "much higher than the Department's November 2009 forecast."

There is little evidence that the state provides coverage at a lower price than companies that offer private health insurance on the individual market. The Department reported that the FY 2009-10 per capita expenditure for the CBHP was $1,929. This amount includes the cost of the insurance paid by the state to insure itself against extremely expensive illnesses.[20] It does not include managerial resources covered in other sections of the state budget, things like auditing, detecting and prosecuting fraud, or the cost of maintaining the tax system that collects the money used to underwrite the CBHP.

There is little evidence that the state provides coverage at a lower price than companies that offer private health insurance on the individual market.

In mid-2010 the cost of insuring a 10-year-old Denver child by purchasing individual health insurance was $2,094 for a Kaiser-Permanente plan with a $35 co-pay. A Humana plan that qualified for a health savings account (HAS) and included childhood vaccinations and regular checkups cost $1,124 a year for with a $3,000 deductible. This means that after well child care and immunizations, the parents would pay the first $3,000 and the plan would pay everything after that.

If the CBHP were modeled after HSA qualified plans, the state could purchase the Humana plan and put $805 into a health savings account for the child. At most, parents would be liable for the $3,000 deductible minus the $805 that could be used to help pay for expenses, or $2,195 in the first year. The CBHP limits total family expenditure to 5 percent of family income in a year. At 185 to 200 percent of the federal poverty level, annual family health expenditures are therefore capped at 5 percent of income. This is between $1,347 and $1,457 a year.

Under the HSA plan, a worst case scenario would have families paying $542 to $652 more in their first year with the HSA. But if the state allowed balances to build up in the HSA account, families would have less financial exposure than with CBHP in less than three years even if parents spent $400 a year on dental visits, drugs and acute care visits. In addition to allowing parents to accumulate funds for their children's future health expenses, a HSA-type plan would allow people to see whatever physician they found most convenient.

People spend their own money more carefully than they spend other people's money, and mounting evidence indicates that plans structured around HSAs substantially reduce expenditures on health care without harming health. In May 2009, The American Academy of Actuaries estimates consumer-directed plans reduced expenditures 4 to 15 percent in their first year, and the expenditure growth rate by 3 to 5 percent in the years thereafter.[21] A 5 percent reduction in the state share of spending on the CBHP would reduce expenditures by about $5 million a year. A 5 percent reduction in the state share of Medicaid spending would save almost $90 million a year.

People spend their own money more carefully than they spend other people's money, and mounting evidence indicates that plans structured around HSAs substantially reduce expenditures on health care without harming health.

Despite the demonstrated savings, the Department has shown a surprising reluctance to consider this type of plan design. It may believe the federal government is unlikely to approve such plans. This is unfortunate. Because they properly align incentives, it is clear consumer-directed health plans save money by reducing unnecessary service use. As the Robert Wood Johnson Cash & Counseling experiments have shown, consumer-directed plans also improve health and reduce long-term expenditure by allowing people dependent on state programs to spend their money on the health care they

know they need rather than on the health care bureaucrats think they should have.

Without remodeling the program for savings, it is clear that in FY 2010-11 Colorado will spend $76.1 million in state funds on the $216.4 million CBHP. Though Arizona has more people under 18 years old than Colorado has, it spends much less on its SCHIP program. Arizona was spending $22.9 million a year before it canceled its SCHIP program on June 15, 2010, to help fill its $2.6 billion budget deficit.[22] Colorado could save up to $76.1 million by doing the same thing.

There is some question whether the Obama Care "maintenance of effort" requirement gives the federal government the power to prevent Colorado from dropping out of the SCHIP program in even the most dire fiscal emergency. But if Obama Care works as advertised, all people will have health insurance and all health insurance that covers parents will automatically cover their children. The CBHP should not be needed any longer.

The Indigent Care Program (CICP) program enrolls people with incomes up to 250 percent of the federal poverty level.

Major Programs and Spending: The Indigent Care Program (CICP)

The Indigent Care Program (CICP) program enrolls people with incomes up to 250 percent of the federal poverty level. They are assigned a co-payment amount that depends on income and family size, and is very low compared to private insurance. CICP co-payments are capped at 10 percent of income in a 12-month period.[23]

The co-payment fee structure strongly favors emergency room and outpatient clinic care. Adults in CICP are charged far higher co-pays than adults with similar incomes who are eligible for CBHP or Medicaid.

In practice, the Department directs CICP payments to hospitals and clinics that agree to cooperate with other state coverage programs.

In theory, CICP compensates hospitals and clinics for providing care to people who do not pay for it. In practice, the Department directs CICP payments to hospitals and clinics that agree to cooperate with other state coverage programs. Publicly- and locally-owned hospitals receive preferential funding, as do pediatric teaching hospitals, hospitals that treat more Medicaid patients, community health clinics, rural hospitals, and the Denver Health Medical Center. This politically-directed favoritism has little to do with the efficiency with which a hospital or clinic operates, the quality of its care, or whether people in the program like using it.

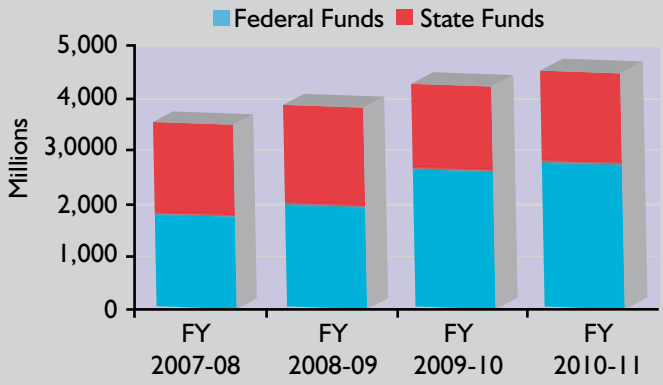
Overall expenditures rose from $308.7 million in FY 2006-07 to $325.8 million in FY 2009-10, or $15.1 million in four years. This is an increase of just 6 percent, an amount far below medical inflation or the increases in spending on relatively healthy children and adults in the same period.

Major Programs and Spending: The Comprehensive Primary Care Program

The Comprehensive Primary Care Program (PCP) was created when Amendment 35 passed in 2004. Amendment 35 increased taxes on tobacco products with the goal of expanding certain kinds of health programs. Implementation gave additional funding only to those providers in which adding the number of uninsured or indigent patients to the number enrolled in Medicaid or the CBHP exceeded 50 percent of total patient caseload. In essence, the General Assembly used the money to increase support for institutions that cooperated in its healthcare programs.

The Amendment language allowed the funds to be diverted to other uses upon a two-thirds majority vote of the General Assembly, the case in the past two years.

Figure 8
The Federal and State Share of HCPF
HCPF Appropriations



Does the HCPF Work for the Federal Government or Colorado Citizen?

As figure 8 shows, the Department ambitiously pursues federal funding. Over the last two decades, this pursuit has shifted Medicaid from its traditional focus on the care of the acutely and chronically ill poor to funding programs that provide state-run health care for basically healthy people at higher levels of income. The programs the Department designs are copies of those in other states. In those states they have produced much higher than expected costs, retarded medical innovation, and degraded service quality with no measurable gains in health.

Although state officials are fond of claiming that federal matching funds allow them to "leverage" state dollars, they ignore the fact that Colorado taxpayers must pay federal taxes—taxes that fund increased federal matching dollars. In order to create sensible health care policy, it is crucial to understand that any increase in the receipt of federal matching funds always requires an increase in spending by the State, that federal funds often come with expensive federal strings attached, and that the programs popular in Congress may not be the same as those that would provide needed help to the sick and disabled in Colorado.

Despite Departmental claims of poverty, figure 9 shows the state share of expenditures on Medicaid have continued to increase in good times and bad. Simply rolling expenditures back to the FY 2006-07 level would save about $500 million in state funds each year.

In 2009, the legislature imposed a tax on every hospital bill in the state. Because new taxes without a public vote are unconstitutional under TABOR provisions, both the Department and the legislature took care to call the new tax a "fee" in the legislation and in public communications. The Act hid the cost increase from patients by making it illegal for hospitals to list the extra charge on their bills.

The pretense came to a halt when the Department sought the required federal approval for the new tax. In a letter[24] the Department states: "The non-federal share of the proposed Medicaid inpatient hospital and DSH payments will be funded solely with fees assessed on hospital pro-

Figure 9
Medicaid Total Spending
Colorado Medicaid Expenditure

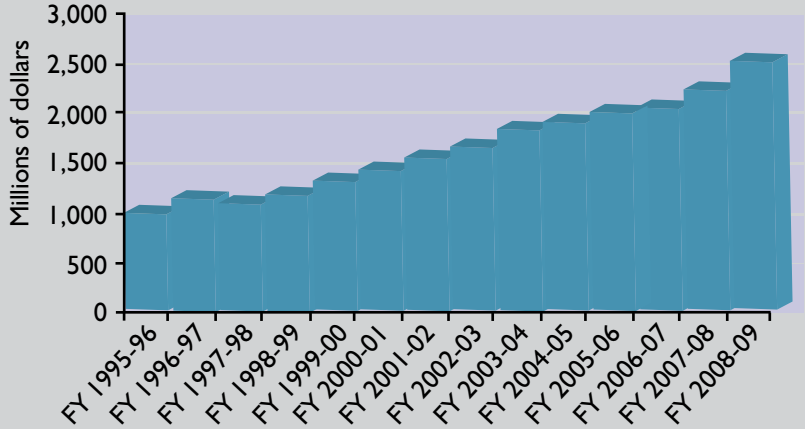
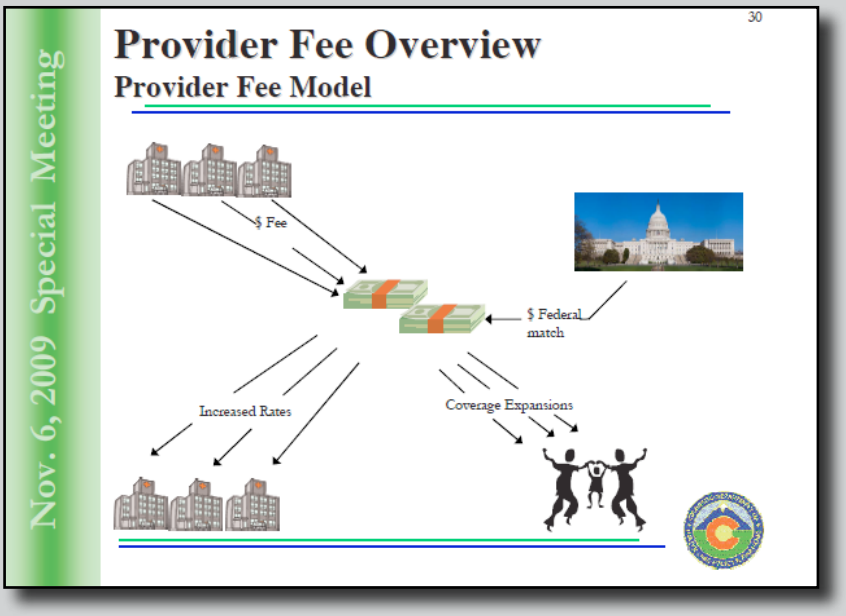


Figure 10



viders, which is designated as a provider tax under 42 CFR §433.68."[25]

The "fee" increase was done to gain more federal funding along with private taxes. People who pay for their own health care end up paying the state an additional $20 "fee" for the privilege of being sick enough to need hospitalization in Colorado.

Figure 10 comes from the November 6, 2009, Special Provider Meeting for the Colorado Indigent Care Program held by the Department of Health Care Policy & Financing. It provides insight into how Department employees view the new tax and the funds it raises. The only people in the figure jump for joy at the prospect of receiving coverage under a state health care expansion. Taxpayers are nowhere to be seen. According to the diagram, actual people do not have to give up anything because the money used to fund the Department's programmatic expansions will come only from hospital and U.S. government buildings.

The Department does not provide cost-benefit analyses of its expansion proposals or any data showing that past expansions have actually improved either the health of individual citizens or general population health. There is little evidence from other sources supporting the notion that the proposed coverage expansions make health care better or more affordable, and no evidence showing that taxing hospital care purchased by private payers improves health. The only thing clear is that the institutional behaviors required to maximize federal funding are not necessarily consistent with those required to maximize the welfare of the people of Colorado.

Obama Care and Colorado Medicaid Spending: Should Colorado Drop Out?

If the recent federal health care legislation remains as it currently exists, citizens and states might be better off exiting Medicaid and letting the federal government pay for health insurance for eligible Colorado citizens.

In FY 2013-14, the federal healthcare law forces states to expand Medicaid eligibility to people with incomes up to 133 percent of the federal poverty level (equivalent to an annual income of $19,378 for two people in 2010). The Department estimates the mandate will increase Colorado caseloads by 130,000 people at a cost of $625 million per year. The federal government will subsidize the state for the increased Medicaid spending in the first years of the program. After that, the Department estimates Obama Care will increase state Medicaid expenditures by $31.0 million in 2017, $39.1 million in 2018, $48.2 million in 2019, and $72.3 million in 2020. The total spending increase in those four years alone would be $190.6 million.

Although the Department's estimates of future state Medicaid spending under Obama Care are somewhat lower than the estimates of independent experts, all agree that Obama Care will significantly increase state Medicaid costs.

Edmund Haislmaier of the Heritage Foundation estimates that Obama Care will increase Colorado's Medicaid spending by $637.3 million between 2014 and 2020.[26] At the historic match rate of 50 percent, this analysis means the state share of Medicaid spending will rise by $318.6 million in six years. At a match rate of 57.4 percent, the state share of Medicaid spending will rise by $271.5 million.

Estimates produced by John Holahan and Irene Headen for the Kaiser Family Commission on Medicaid and the Uninsured, long a strong advocate for the program expansions embodied in the Obama Care law, also suggest the Department has underestimated future Medicaid spending. They conclude that spending on low-income adults will by itself increase by a minimum of $286 million between 2014 and 2019, an estimate close to the one produced by the Heritage Foundation analysts.[27] Under different assumptions, the Kaiser Family Foundation estimates spending will balloon by $470 million.

The looming spending increases are so large that Haislmaier and Smith make a persuasive case that states could make almost all of their citizens better off simply by pulling out of Medicaid.

The looming spending increases are so large that Haislmaier and Smith make a persuasive case that states could make almost all of their citizens better off simply by pulling out of Medicaid. They argue that exiting Medicaid likely would benefit the low-income people currently dependent upon it because Obama Care provides direct federal subsidies of up to $20,000 a year for the purchase of health insurance for a family of four provided that family is not enrolled in a state Medicaid program. If a state maintains such a program, Obama Care forces the state to enroll the family in Medicaid rather than in a private insurance plan. Numerous studies suggest the privately insured receive better and more convenient health care. If Colorado were to exit Medicaid, everyone on the state program would be eligible for federal health insurance subsidies. They could replace often spotty and inconvenient Medicaid coverage with private health insurance.

Assuming that Colorado uses roughly $2 billion of the money saved by pulling out of Medicaid in 2013 to continue paying for long-term care for people currently getting it under Medicaid, Haislmaier and Smith estimate state government could save $7.4 billion from 2013 to 2019.[28] Their estimate assumes the state also drops out of the SCHIP, as the CHBP would be no longer necessary with the subsidies provided for purchasing medical insurance.

Fiscal prudence and a sincere concern for the well-being of citizens dictate that both the state leaders and the Department give serious consideration to withdrawing from Medicaid.

Health Policy Changes Directed by Lobbies

For the last 20 years, the executive branch of Colorado government actively has cooperated with private foundations intent on reshaping health care.[29] In 1992, Governor Roy Romer received a $566,999 grant from the Robert Wood Johnson Foundation's State Initiatives in Health Care Financing Reform Program.

In return for the grant, the governor's office agreed to champion ColoradoCare, a state-run, single-payer health care program. The Colorado Trust coordinated its efforts with those of the Robert Wood Johnson Foundation, adding an additional $100,000 to

the ColoradoCare project and using its resources to produce favorable publicity and build a statewide coalition. In 1993, project director Alan Weil helped create the Department of Health Care Policy and Financing. He demonstrated how long-term government policy could be changed by using grant funds to hire people dedicated to passing legislation, and, once the legislation was passed, rewarding them with state jobs. Mr. Weil moved from the grant-funded CoverColorado project to the state payroll and became the first Executive Director of the Department.

The history of CBHP shows how small receipts of private grant money can be used to create new tax-funded programs that take on a life of their own.

The history of CBHP shows how small receipts of private grant money can be used to create new tax-funded programs that take on a life of their own. Along with grants, the Robert Wood Johnson Foundation aided friendly state officials[30] by hosting meetings, providing experts to testify in favor of its legislative agenda, conducting retreats, and offering help in producing favorable publications. Its efforts are detailed on its State Coverage Initiatives web page.[31]

To understand the extent to which private foundations have influenced Colorado's state health policy with grant-funded staffing and legislative support, consider that although Colorado's Center for Improving Value in Health Care Steering Committee (CIVHC) ostensibly was established by Governor Ritter by Executive Order,[32] it is listed as one of AcademyHealth's programs on the AcademyHealth website.[33] The Robert Wood Johnson Foundation is a major supporter of AcademyHealth.

As it did when the Robert Wood Johnson Foundation funded ColoradoCare, the Colorado Trust immediately "leveraged" the AcademyHealth CIVHC program by providing the money that HCPF used to plan, create, and staff CIVHC steering committee meetings. Eight members of the steering committee (the "Chicago eight") were then sent to a meeting hosted by The Commonwealth Fund and Academy Health. After the meeting they "assisted [HCPF] Department staff in creating a draft action plan for the Chicago team to use as a working document during the kick-off meeting."[34]

As of April 10, 2010, state documents suggest the CIVHC team planned to formulate new plans to control how physicians are paid, to expand palliative and hospice care in Medicaid and private care, to collect data on every health care encounter for every individual in the state, and to mount a public relations campaign to market its work.[35] CIVHC also plans to aggressively seek federal funding that, under Obama Care, exists to create pilot and demonstration programs to serve as platforms for the incubation of new tax-supported health care initiatives.

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It is unlikely the "Chicago eight" effectively represented viewpoints uncongenial to the Department or to the Robert Wood Johnson Foundation ideas about health care, ideas that have remained essentially unchanged since its support for single payer in the early 1990s. Of the nine members of the State Quality Improvement Institute Team listed by AcademyHealth, three are from HCPF and the rest come from entities that either receive substantial state funding or have an interest in expanding government control of health care.

The narrow viewpoint that grant-funded staffing has created within the Department has important implications for the state budget. The passage of Obama Care made large amounts of federal funding available for various initiatives. The federal money comes with strings attached, and most of the programs are designed to expand government control of health care. They will expand state spending on health care projects of questionable utility, and may endanger both state government fiscal stability and the stability of its private medical care system.

Minnesota Governor Tim Pawlenty recognizes the danger that federal control of health care poses to state treasuries. On August 31, 2010, he signed an Executive Order directing Minnesota state agencies to decline all discretionary participation in Obama Care pilots and demonstration programs. The Order notes that Obama Care contains a "multitude of programs and demonstration projects intended to speed the transition to federally-controlled health care." It states that "no application shall be submitted to the federal government in connection with requests for grant funding for programs and demonstration projects deriving from the Patient Protection and Affordable Care Act … unless otherwise required by law, or approved by the office of the Governor."[36]

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Poor Management, Crony Capitalism, and Excessive Spending at the Executive Director's Office

The Executive Director's Office directs Departmental programs. Its appropriations have grown from a FY 2006-2007 appropriation of $38.8 million for a staff of 231.8 full-time equivalent employees (FTEs) to $52.9 million for a staff of 294.8 FTEs in FY 2010-11.[37] In just five years, the Executive Director's Office budget grew by more than a third and the amount spent per full-time employee increased from $167,385 to $179,444. These increases occurred at a time when state tax revenues fell from $8,936 million in FY 2006-07 to $8,231 million in FY 2008-09.[38]

Although the Department plans to create its "novel model of public insurance and to promote health, function and self-sufficiency as its core goals" to "reach beyond the clinical setting and into community settings where healthy behaviors are shaped,"[39] it is having trouble managing its existing programs.

In 2008, the State Auditor reviewed 52 of 852,400 claims made under the CBHP. Errors were found in 52 percent of the claims. Overpayments equaled $54,800. Underpayments equaled $20. One of the claims was for abortion services in spite of both federal regulations and the Colorado Constitutional prohibitions on taxpayer abortion funding.[40] A separate 2008 audit of 203 applications for the CBHP found that 10 percent of those enrolled lacked adequate documentation, and that 16 people who were enrolled were ineligible. The errors cost taxpayers $48,300. The Department "lacked adequate controls to ensure that all enrollment fees are collected," exhibited an "overall lack of effective management and oversight," and did not ensure that its marketing and outreach for the program was "cost-effective, as required by statute."[41]

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As Colorado does not publish regular Medicaid performance audits, it is impossible for taxpayers to ascertain whether Department management practices have improved. The Department also appears to have difficulties determining appropriate

Table 4. Comparison of Private and Medicaid Reimbursement Rates				
	Wheelchair	Pediatrician	Chest X-ray	Ambulance
Private	$532.60	$115.94	$53.61	$700.05
Medicaid	$571.23	$86.21	$30.21	$131.91

payments for services provided under its medical assistance programs. Although it has determined that managed care is more costly, it remains committed to it despite the fact that capitated rates are determined by actuaries and negotiations, rather than by the actual fees paid for actual people for actual medical care.

The problem is that actuarial estimates are not necessarily accurate estimates. In 1995, the Department neglected to include care for foster care children in its mental health capitation estimates. The Department recognized its error in 1998. Between April 2001 and November 2004 the Department unilaterally increased payments to the managed care mental health providers by about $24 million. In November 2004, the federal government directed the Department to stop making those supplemental payments.[42]

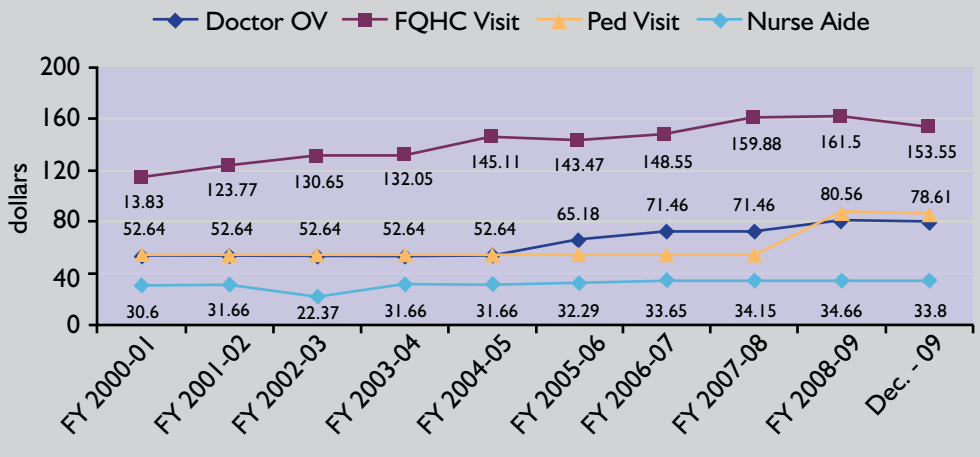
In a December 21, 2009, response to questions from the JBC, the Department provided some information about its Medicaid reimbursement rates. Table 4 compares standard commercial reimbursement rates provided by United Health Care and Ingenix.

Although the data in this table suggest Medicaid pays less for medical care than private insurers, they do not tell the whole story. In recent years the Department has made extensive use of Federally Qualified Health Centers (FQHC) and FQHC look-alikes in its managed care network. Denver Health's family health centers are FQHCs. The Colorado Community Managed Care Network consists of 12 FQHCs. It is a corporate member of Colorado Access. Colorado Access is one of the entities favored in the Department's efforts to enroll Medicaid and CBHP members in managed care.[43] As of 2009, an estimated 30 percent of Colorado's Medicaid population receives care in FQHCs.[44]

The FQHCs are very well paid compared to the reimbursements offered private physicians because federal law requires that Medicaid and Medicare reimburse all FQHCs for "reasonable costs." By steering patients to the more expensive FQHC clinics, the Department ensures taxpayers pay top dollar for primary care visits in its medical assistance programs, and it discriminates against Colorado's private physicians and hospitals. This discrimination makes both Medicaid clients and taxpayers worse off.

Since federal law requires payment of reasonable costs, only private physicians are harmed when the Department cuts reimbursement

Figure 11. Selected Medicaid Payments



rates. State law does not trump federal law and the bottom lines of Department contractors are protected.

The Department also discriminates against private health care by paying for FQHC equipment, buildings, offices and staff through its Comprehensive Primary and Preventive Care Grant Program.[45] Physicians and nurses practicing at the FQHCs enjoy special malpractice protections, and the nonprofit clinics enjoy favorable tax treatment. When all subsidies are included, and adjustments are made for the possibility that the clinics' mid-level practitioners see fewer patients per unit of time than private physicians do, it is possible the Department pays more for medical care than it would if it depended less on FQHCs and more on reasonable reimbursements rates for private physicians.

Determining the adequacy of the Department's capitated payments is also a problem. As required, the Department relies on actuarial calculations to determine the rates it will pay for capitated care. But without adequate competition in medical markets and arrangements that allow Medicaid patients to choose between fee-for-service and managed care, it is impossible to determine what health care really costs and whether capitated providers are actually providing the care for which they are being paid.

Access to care is a particular concern in capitated health care systems, particularly in view of evidence that Medicare clients with chronic illnesses are more likely to switch to Medicare's fee-for-service system in order to access care. The Department says it protects the quality of care with its measurement programs. It relies on its Healthcare Effectiveness Data and Information Set (HEDIS) measures of program quality. Unfortunately, most HEDIS measures monitor medical processes rather than medical care. HEDIS counts child immunizations, routine baby care visits, annual dental visits, asthma medication use, procedure frequency, hospital days and average use of antibiotics. Its composite measures, such as "Children's Access to Care" or "Adult Access to Care," are based on whether adults and children had various elective well-care visits or were continuously enrolled (thereby generating continuous capitation payments) with a particular provider.

HEDIS does not measure the time from seeking care to diagnosis to adequate treatment. It does not measure how long someone has to wait for an appointment, which is an important driver in emergency room overuse. It does not measure how difficult it is to access specialty care within the state's managed care plans.

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Despite its 2006 finding that managed care does not save money, the Department's 2010-11 performance measures require increasing the number of high-need clients in managed care. The new Colorado Regional Integrated Care Collaborative plans to put people into untested "medical homes" and "focal point of care" arrangements. These are HMOs by another name, and as one would expect, managed care giant Kaiser-Permanente has been extremely influential in the creation and design of the Collaborative.

Despite evidence to the contrary, the Department describes the "fee-for-service" health care system as difficult to manage and claims, without evidentiary support, that the 24 percent of clients in the fee-for-service system would be better served by managed care.

A number of programs of dubious provenance that benefit specific providers are included in the Department's Appropria-

tions Highlights for FY 2010-11. These include:

- An additional $1.3 million for the administrative costs of instituting "evidence guided" utilization controls on hospital stays and to monitor emergency room visits. Evidence-based utilization controls are favored by large HMOs and some private insurers. In government-controlled systems like the United Kingdom's National Health Service, they provide a "cover" for denying care that others might consider necessary and reasonable.

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- A spending increase of $772,095 to fund the Accountable Care Collaboration project managed care pilot program. Of that, $635,097 is for administrative costs, including money to develop pay-for-performance indicators. Pay-for-performance indicators provide a tool that government officials can use to reduce health spending by forcing physicians to provide only the care that is approved by government utilization guidelines.

- A spending increase of $257,183 and 0.9 FTE for the administrative costs associated with implementing "payment reform," which increases overall spending by $3.6 million. Payment reform seeks to get rid of fee-for-service medicine in favor of capitated care provided by managed care organizations that use pay-for-performance and utilization controls.

The general strategy for fueling future expansions in the Department's fiscally unsustainable government-run healthcare empire has three parts. The first requires coverage expansions whether or not the state can afford them. The idea is that people will be nominally covered even though the state may cut provider reimbursements, impose utilization controls, or otherwise make medical care difficult to access.

Proponents calculate that taxpayers can be goaded into approving tax increases as long as officials and their rent-seeking allies mount extensive publicity campaigns claiming that a refusal to increase taxes denies medical care to the poor and the sick. To expand their share of state revenues, favored non-profits that provide Medicaid services also have been successful in lobbying for provider taxes and other programs that increase the state funds flowing to them at the expense of those who pay for their own care.[46]

State programs already provide poorly targeted subsidies to large numbers of people who either can pay for their own health care or can afford to contribute much more than they do. Rather than focusing on reducing the cost of running a healthcare business, the Department has helped increase the number of people who demand services by supporting taxes on privately-provided care and promoting regulations that are expensive, ill-conceived and without evidentiary support.

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The second part of the strategy requires controlling the public message about how well existing state programs work compared

to the system they are supposed to replace. At present, the Department ignores its own findings on managed care, preferring instead to repeat the mantra that managed care reduces cost. It depends on allied foundations to fund extensive "technical support" programs and to create various small institutions that can be relied on for friendly staffing of proliferating committees, commissions and boards that make it increasingly difficult to pinpoint who is actually making policy within the Department. The small foundation-supported institutions also can be relied upon to join coalitions that provide political cover for state officials intent on transferring more money and power from private sector health programs to public ones.

Life in the cozy foundation cocoon has tended to blind Department officials to evidence and results that are not in accord with foundation claims.

Life in the cozy foundation cocoon has tended to blind Department officials to evidence and results that are not in accord with foundation claims.[47] The sheer number of rent-seeking special interests also makes it difficult for state officials to properly consider whether the suggestions being made are well thought out and well supported by actual evidence. The Department webpage on "Boards and Committees" lists 20 different groups of people who determine health policy for Colorado. Many of them represent the very same special interests that have done so much to design, develop, finance and expand the state's current collection of fiscally unsustainable, poorly managed and poorly conceived health programs.

The third part of the strategy is to cooperate with federal officials in making the citizens of Colorado submit to the requirements of Obama Care. When the federal government offered increased funding, Governor Ritter and the Department immediately began developing an insurance plan to cover uninsured residents with pre-existing medical conditions.

They elected to spend scarce State resources developing the transitional high-risk pool program even though Colorado already has a state plan to cover people with pre-existing conditions. Cover Colorado is funded by the unclaimed property fund and taxes on health insurers. The actuary for the Centers for Medicare and Medicaid Services predicted the $5 billion the federal government allocated nationally for the new state plans will run out as early as next year, so accepting the federal funds will likely increase future state spending. In addition, all of these efforts and all of this tax money will be wasted. The new insurance plan will, by law, be dismantled in 2014.

Responsible governors in other states refused to participate. They knew the relatively few people who need such insurance could join the federal insurance pool that will be operated by the federal government for people living in states that do not offer such insurance. The governors noted that designing such pools is an "enormously complicated undertaking," that there were few people who were uninsured, and that the lack of funding put their taxpayers at risk.[48]

In New York, Massachusetts, Kentucky and Tennessee, ill-considered expansions of poorly managed foundation-designed medical assistance programs have brought state government to the brink of bankruptcy.

In New York, Massachusetts, Kentucky and Tennessee, ill-considered expansions of poorly managed foundation-designed medical assistance programs have brought state government to the brink of bankruptcy. Colorado appears to be only a few years behind. Prudent management requires an immediate reconsideration of the state's medical assistance arrangements. In an era in which Obama Care essentially allows the federal government to control state medical assistance budgets, state healthcare access, and the type of medi-

cal treatment that may be offered, citizens would be better served by a Department that is skeptical of federal claims than by one that is eager to swallow them.

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Merrill Matthews offered insights, improvements and corrections to the work. He is a resident scholar at the Institute for Policy Innovation and specializes in health policy. Dr. Matthews served for 10 years as the medical ethicist for the University of Texas Southwestern Medical Center's Institutional Review Board for Human Experimentation, has contributed chapters to several books and has been published in numerous journals and newspapers. He writes the Right Directions column for Forbes.com, was an award-winning political analyst for the USA Radio Network, and provided a daily commentary on Sirius-XM for several years. He received his Ph.D. in Humanities from the University of Texas at Dallas.

ENDNOTES

[1] State of Colorado. Joint Budget Committee Hearing Agenda, Department of Health Care Policy and Financing FY 2010-11, December 21, 2009, pg. 38.

[2] Written responses to the questions on the Joint Budget Committee hearing agenda, December 21, 2009.

[3] Joint Budget Committee, State of Colorado, Appropriations Report: Fiscal Year 2010-11. These amounts do not include supplemental appropriations or changes in the budget that occurred after the 2010 regular legislative session. *State share calculated as total appropriation minus federal funding from summary tables of the Joint Budget Committee Appropriations Report FY 2007-08.

[4] Joint Budget Committee, State of Colorado, Appropriations Report: Fiscal Year 2010-11, pg. 124.

[5] Ibid. For another estimate see the NCSL Letter to Congress: FMAPExtension and the Impact on States, May 6, 2010.

[6] State of Colorado FY 2010-11 Budget Request Cycle: Department of Health Care Policy and Financing. Medicaid Caseload, p. MC-6.

[7] Joint Budget Committee, State of Colorado. Appropriations Report: Fiscal Year 2010-11, pg. 126.

[8] Melodie J. Beck. June 21, 2010. *Interim Supplemental Request for FY 2009-10, Department of Health Care Policy and Financing*, Working Document, Joint Budget, Colorado General Assembly, p. 3.

[9] Colorado General Assembly, Joint Budget Committee. *Interim Supplemental Request for FY 2009-10*, Department of Health Care Policy and Financing, June 21, 2010. http://www.state.co.us/gov_dir/leg_dir/jbc/hcpf2-06-21-10.pdf.

[10] FY 07-08 Joint Budget Committee Hearing, pg. 55, accessed October 16, 2007. For more discussion, see Linda Gorman, "It's Official: Managed Care Does Not Save Money," October 24, 2007, http://old.i2i.org/main/article.php?article_id=1418.

[11] State of Colorado, Child Health Plan Plus website, online version accessed August 17, 2010. Eligibility. Incomes effective May 1, 2010, to March 31, 2011.

[12] Douglas J. Besharov, *Measuring Poverty in America*, testimony before the Subcommittee on Income Security and Family Support, Committee on Ways and Means, U.S. House of Representatives, August 1, 2007. American Enterprise Institute for Public Policy Research.

[13] Jonathan Gruber and Kosali Simon, *Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?* National Bureau of Economic Research Working Paper no. 12858 (January 2007), pg. 28. For an expanded examination of crowd-out estimates, see Paul Winfree and Greg D'Angelo, SCHIP and "Crowd-out": The High Cost of Expanding Eligibility. Web Memo No. 1627, Heritage Foundation, September 19, 2007.

[14] M. Kate Bundorf and Mark V. Pauly, *Is Health Insurance Affordable for the Uninsured?* National Bureau of Economic Research Working Paper no. 9281 (October 2002), pgs. 29-30.

[15] Gary Claxton et al. *Employer Health Benefits: 2009 Annual Survey*, The Kaiser Family Foundation and Health Research and Educational Trust (2009), pg. 2, accessed August 17, 2010.

[16] AHIP Center for Policy and Research, Individual Health Insurance 2009, pg. 6.
[17] State of Colorado, Department of Health Care Policy and Financing Strategic Plan FY 2010-11 Budget Request, November 6, 2009, pg. C-25.
[18] State of Colorado, Joint Budget Committee. Appropriations Report: Fiscal Year 2010-11. Part III, pgs. 123, 127.
[19] State of Colorado FY 2010-11 Budget Request Cycle: Department of Health Care Policy and Financing, Schedule 13, Change Request for FY 2010-11Budget Request Cycle, pg. S 3.7.
[20] State of Colorado FY 2010-11 Budget Request Cycle: Department of Health Care Policy and Financing, Schedule 13, Change Request for FY 2010-11Budget Request Cycle, pg. S 3.15.
[21] American Academy of Actuaries, Consumer-Driven Health Plans Work Group, *Emerging Data on Consumer-Drive Health Plans* (May 2009), online version.
[22] Joyce Frieden, "Arizona Cancels SCHIP Program for Lack of Funds," *Medical News Today,* March 19, 2010.
[23] See the Colorado Indigent Care Program Fiscal Year 2009 Manual, Section IV: CICP Regulations.
[24] The letter was written by HCPF Budget and Finance Director John Bartholomew to Richard C. Allen of the Centers for Medicare and Medicaid Services.
[25] Letter from John Bartholomew to Richard C. Allen, March 26, 2010, http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobheadername1=Content-Disposition&blobheadername2=MDT-Type&blobheadervalue1=inline%3B+filename%3D107%2F553%2FSPA+TN+09-039+All+Documents+03+26+2010.pdf&blobheadervalue2=abinary%3B+charset%3DUTF-8&blobkey=id&blobtable=MungoBlobs&blobwhere=1251624798363&ssbinary=true.
[26] Edmund Haislmaier, "Reconciliation Bill Increases Obama Care Medicaid Costs for Twenty Eight States," March 25, 2010.
[27] John Holahan and Irene Headen, *Medicaid Coverage and Spending in Health Reform: National and State-byState Results for Adults at or below 133$ FPL*, Kaiser Commission on Medicaid and the Uninsured (May 2010).
[28] Dennis G. Smith and Edmund F. Haislmaier, *Medicaid Meltdown: Dropping Medicaid Could Save States $1 Trillion*, Web memo 2712, The Heritage Foundation, December 1, 2009.
[29] For an overview, see Brigid McMenamin, "Trojan Horse Money," *Forbes* (December 16, 1996), pp. 123-24; Linda Gorman, "National Puppet Masters Pull Strings for Local Health Reform Groups," Independence Institute opinion-editorial, March 5, 2009; *Paying Twice for Government Health Care: The Robert Wood Johnson Foundation: How Its Grants Pay for Colorado State Health Policy*, Capital Research Center, 2000.
[30] See http://www.statecoverage.org/node/5, the Technical Assistance portion of the State Coverage Initiatives web page.
[31] Ibid.
[32] Executive Order D 005 08, February 13, 2008.
[33] http://www.academyhealth.org/Programs/content.cfm?ItemNumber=3220.
[34] AcademyHealth. State Quality Improvement Institute, Colorado Action Plan, The Center for Improving Value in Health Care, September 10, 2008, http://www.academyhealth.org/files/SQII/ColoradoActionPlanSeptember08.pdf.
[35] AcademyHealth. State Quality Improvement Institute, Email Updates, April 2010. http://www.academyhealth.org/files/SQII/ColoradoApril10.pdf.
[36] Office of the Governor, State of Minnesota, Executive order 10-12, August 31, 2010, http://www.governor.state.mn.us/priorities/governorsorders/executiveorders/PROD010117.html.
[37] State of Colorado, Joint Budget Committee, Appropriations Report: Fiscal Year 2010-11, pgs. 135-36; and Fiscal Year 2007-08, pg. 120.
[38] State of Colorado, *Comprehensive Annual Financial Report for the Fiscal Year Ended June 30, 2009*, pg. 228.
[39] State of Colorado, Joint Budget Committee Hearing Agenda, Department of Health Care Policy and Financing FY 2010-11, December 21, 2009, pg. 38.
[40] State of Colorado, Report of the State Auditor, *State of Colorado Statewide Single Audit, Fiscal Year Ended June 30, 2008*, pgs. 293-97, online version..
[41] State of Colorado, Report of the State Auditor, *Children's Basic Health Plan Department of Health Care Policy and Financing, Performance Audit* (May 2008), online version.
[42] Office of Inspector General, Department of Health and Human Services, *Review of Colorado Medicaid Mental Health Capitation and Managed Care Program*, A-07-06-04067, October 2008.
[43] Colorado Access, Colorado Community Managed Care Network, Web page accessed August 20, 2010.
[44] Health Services Advisory Group, Inc., *Colorado Medicaid HEDIS 2009 Results*, Statewide Aggregate Report (October 2009).
[45] See, for example, the Fiscal Year 2006-07 Annual Report for the Comprehensive Primary and Preventive Care Grant Program.
[46] Colorado Access and Kaiser Permanente have received money for a pilot program covering 2,800 Medicaid recipients as a part of the Center for Health Care Strategies (a Robert Wood Johnson Foundation creation) Rethinking Care Program. Rethinking Care rethinks care only in the context of tightly managed HMO gatekeeper care. Given the choice, most Americans have chosen other types of health care arrangements. According to a May 13, 2008, press release, Colorado Access is sponsored by The Children's Hospital, Colorado Community Managed Care Network and University of Colorado Hospital/University Physicians, Inc. and the Rethinking Care Program is in partnership with the Department of Health Care Policy and Financing.
[47] Some of the myths propagated by foundation sources include the claim that the uninsured lack access to care, the claim that the lack of health insurance leads to thousands of deaths a year, the claim that people without insurance lack health care, and the claim that expanding public programs to cover the uninsured will lower costs for people with private coverage.
[48] David S. Hilzenrath, "18 states refuse to run insurance pools for those with preexisting conditions," *Washington Post*, May 4, 2010, http://www.washingtonpost.com/wp-dyn/content/article/2010/05/03/AR2010050304072.html.

COLORADO'S PENSION LIABILITY

The Public Employees Retirement Association (PERA), created in 1931, is the state's largest pension plan with more than 441,000 members in 2009. Although PERA boasts assets with market value of $32.9 billion,[1] its total liabilities were nearly twice that amount – $56.3 billion – even after the legislature adopted the latest PERA bailout: Senate Bill 1 (2010). That legislation reduced PERA's long-term liabilities and increased contributions from both taxpayers and employees by as much as $160 million annually.[2]

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A pension plan's "funding ratio" is an estimate of the actuarial value of a plan's assets versus its liabilities. At one extreme, a ratio of 0 percent would mean a plan has promised a benefit and has no assets to pay for it. A ratio of 100 percent would mean a plan is on track to have the actual assets needed to pay out the benefits when they come due. From 1970 to 2000, PERA's funding ratio steadily climbed from 55 percent to a high of 105 percent. As PERA's funding improved, state lawmakers and the PERA Board of Directors backed various policy changes that increased benefits, allowed members to purchase additional years of service at below cost, and reduced the employer contribution rate from 12.15 percent to 10.15 percent.

The market retrenchment of the early 2000s cost PERA an estimated $6.8 billion in investment assets through 2004. In the wake of the 2008 credit crisis, PERA lost another $12.3 billion in market assets. In just eight years, the market value of PERA's assets had fallen to less than 52 percent of its liabilities — a shortfall of $27.5 billion. The steady fiscal improvement that the plan had made over a 30-year period was wiped out in just eight years. Now, the costs of the extra benefits that were added during a time when the plan was just becoming fully funded are exacerbating the problem.

Even PERA began to acknowledge drastic changes were needed: "The combination of the dramatic losses due to the financial markets along with the cumulative effect of contribution shortfalls in the last five years and benefit enhancements in the 1990s, bring into question the long-term sustainability of the (fund)."[3]

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Prior to 2008, PERA officials routinely brushed off assertions that its ability to pay members' benefits was in jeopardy, although independent actuaries had told PERA, "If there is not a sufficient recovery in the investment markets in the near future, the long-term ability of (PERA) to support the benefits will be challenged ...."[4] As late as October 2009, PERA spokeswoman Katie Kaufmanis told the Associated Press that PERA has $32 billion in assets and will still be able to pay benefits for many years.

Within three months, however, PERA was singing a different tune. Sponsors of the PERA-supported Senate Bill 1 (2010) warned that without significant changes, including immediate benefit reductions, the fund could go broke within 20 years.[5]

Senate Bill 1 made some long overdue changes:

- For the first time, PERA's legal staff abandoned the contention that certain benefit enhancements, like cost of