



# Colorado Medicaid: Options for Cost Containment



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# Introduction

Medicaid is a publicly funded program that provides health insurance coverage for low-income parents, children, individuals with disabilities and elders. This safety-net program for Colorado's most vulnerable residents is under extreme financial strain as costs and enrollment increase while state funding struggles to keep pace.

The growth rate of Medicaid costs must be contained for the program to be sustainable in Colorado and across the nation. At the same time, providing care for these populations can prevent the need for more expensive care later. For example, taking medicine to control a chronic health condition is less expensive than a hospital admission. It is important to find the balance between controlling growth and investing in preventive care.

Meanwhile, as the single largest source of federal funding to Colorado's state budget, Medicaid has a substantial impact on the state's economy by generating services, supplies and jobs.

As policy leaders continue the important but challenging task of retooling Medicaid for a new era, understanding basic concepts and sharing new strategies are imperative. This report is an overview of how Medicaid works in Colorado, the traditional mechanisms for managing its cost, and innovative approaches being tested to deliver more coordinated and patient-centered care. Finally, Medicaid cost-containment approaches in other states are summarized.

## Medicaid: At-a-Glance

- Provides health insurance for about 600,000 low-income Coloradans, including children, some parents, people with disabilities, and people 65 and older\*
- Is expected to account for about one-fifth of the Colorado General Fund Budget in FY 2011-12
- Added \$2.8 billion in federal funding to the Colorado state budget in FY 2010-11<sup>i</sup>
- Will be expanded in 2014 under the federal Patient Protection and Affordable Care Act (ACA), paving the way for an estimated 150,000 new enrollees, according to a report to the Colorado Health Benefit Exchange by Jonathan Gruber and Wakely Consulting.

\* As of first quarter of 2011-12<sup>ii</sup>



# Medicaid in Colorado

Currently, Colorado Medicaid primarily serves low-income:

- Children
- Pregnant women
- Parents with dependent children
- Individuals with disabilities
- Elderly individuals (65+).

It is estimated that Medicaid will serve about one of 10 Coloradans in FY 2011-12. Specifically, Colorado Medicaid provides health insurance coverage for approximately:<sup>iii</sup>

- Two of five births
- One of four children
- Six of 10 nursing home residents.

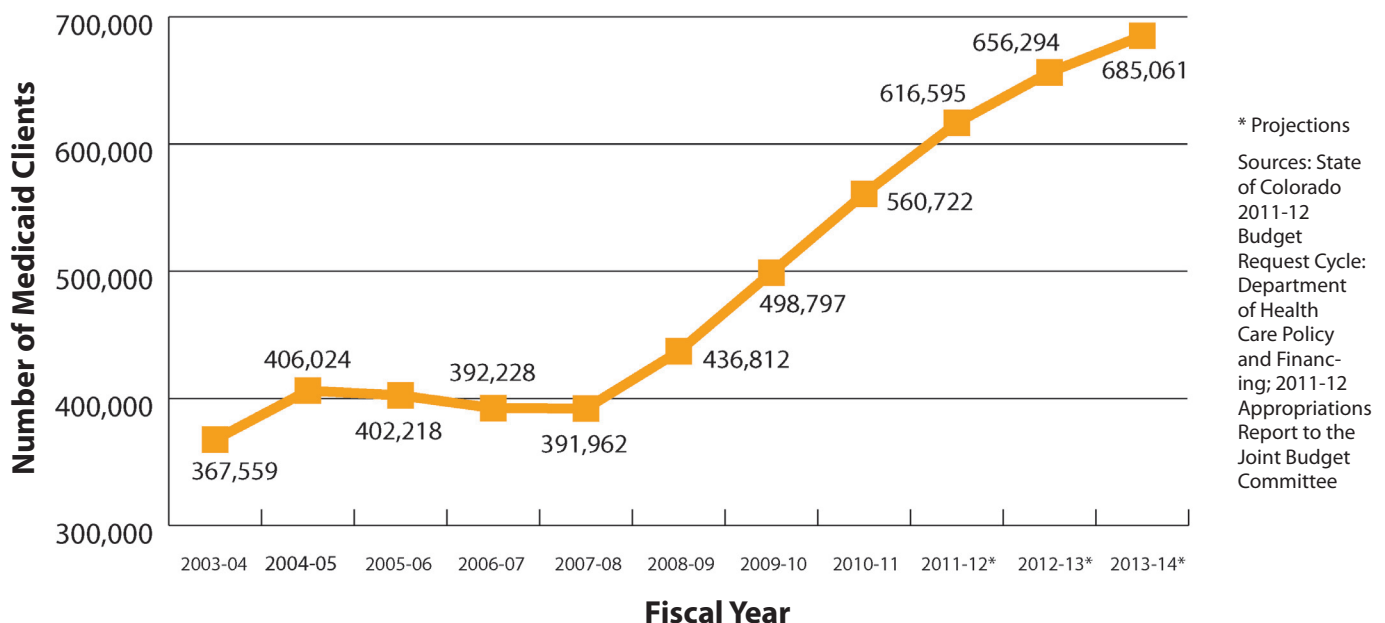
To be eligible for Medicaid, people must meet certain income requirements based on federal poverty level guidelines (FPL). Different groups must meet different eligibility standards. For example, children ages 0-5 are eligible for Medicaid if their family incomes are 133 percent<sup>iv</sup> of FPL or below, but elderly individuals without disabilities are eligible only if they are at 73 percent<sup>v</sup> of FPL or below.

## Changes in eligibility

Colorado is scheduled to expand Medicaid coverage to low-income adults without dependent children in March 2012. The Colorado Department of Health Care Policy and Financing (HCPF), the agency in Colorado, which administers the Medicaid program, announced that it will limit initial enrollment to 10,000 such adults with family incomes up to 10 percent FPL, or about \$90 a month. The program will gradually expand to include adults without

**Continued on Page 7**

**Graph 1. Colorado's Medicaid Caseload**



# The Cost of Medicaid: Key issues

## Increasing Enrollment

The number of people eligible for Medicaid continues to grow due to state health care reform, an aging population and the weak economy. Medicaid is a means-tested program; people must meet income requirements to be eligible. The weak economy has resulted in more Coloradans with an income low enough to qualify for Medicaid. Colorado estimates a 10 percent increase in the number of Medicaid clients between FY 2010-11 and FY 2011-12, reaching 616,595. Medicaid is an entitlement program, which means that anyone who is eligible can enroll. The size of the program cannot be capped due to budgetary constraints.

## Increasing Cost

Medicaid costs have been increasing, and are expected to continue to increase, at a higher rate than the rest of state government because:<sup>vi</sup>

- The number of people enrolled is increasing faster than general population growth.
- An aging population means the need for long-term services and supports is growing.
- Advancements in medicine lead to new treatment options and demands, which raise the cost of medical care.
- Health care inflation is higher than general inflation.

## Strained Budgets

One of the challenges of a means-tested program is that demand for services increases when the economy is doing poorly and tax revenues are sluggish. As a persistently high unemployment rate makes more people eligible for Medicaid, it also limits state and federal funds available to support the program.

**Table 1. Medicaid Spending Growth: Comparing Colorado's Rate to the National Rate**

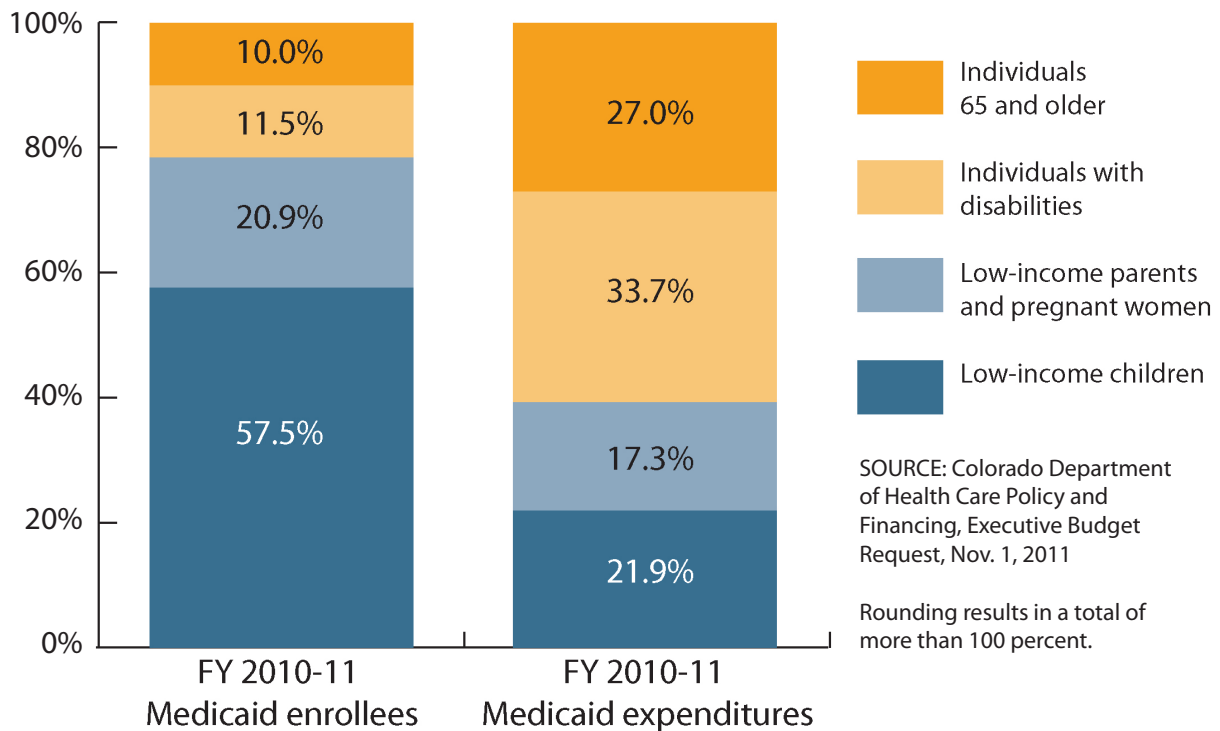
	CO %	U.S.%
FY 1990-2001	13.4%	10.9%
FY 2001-2004	7.0%	9.4%
FY 2004-2007	3.6%	3.6%
FY2007-2009	10.2%	7.1%

**Notes:** All spending includes state and federal expenditures. Growth figures reflect increases in benefit payments and disproportionate share hospital payments; they do not include administrative costs, accounting adjustments or costs for the U.S. Territories.

**Sources:** Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from CMS-64 reports.

Source: Kaiser Family Foundation

**Graph 2. Medicaid Enrollees and Expenditures, Colorado, FY 2010-11**



dependent children up to 100 percent FPL. Expanding Medicaid eligibility to this group was part of the Colorado Health Care Affordability Act (HB09-1293), which was signed into law on April 21, 2009.

HB09-1293 expanded CHP+ eligibility for children and pregnant women up to 250 percent of FPL beginning in 2010. In addition, the bill authorized the Medicaid Buy-In program in which individuals with disabilities can return to work and contribute to the cost of their Medicaid coverage without losing it. Individuals with incomes up to 450 percent FPL will be eligible. The program, originally scheduled for a 2011 roll-out, has been delayed by HCPF while it works out the mechanics of collecting monthly premiums.

These expansions will better align Colorado Medicaid eligibility with new federal standards. Under the ACA, starting in 2014, the federal government will require states to expand Medicaid eligibility to individuals with family incomes at or below 133 percent of FPL.

## How Is Medicaid Funded?

Medicaid spending reached \$3.3 billion in Colorado in FY 2010-11. Medicaid is a partnership between the federal government and the states. While states administer the program, it is funded by state and federal money. States are not required to participate in Medicaid, but they all do. Participating states are required to provide federally mandated services to people who meet federal eligibility requirements.

Historically, Colorado has received a 50/50 matching rate for Medicaid services: For every dollar that Colorado invested in Medicaid, the federal government contributed a dollar. The federal contribution to Medicaid was temporarily increased as part of the federal stimulus package, however. From 2008 through June 2011, the federal money covered between 60 and 62 percent of Colorado's Medicaid costs. This amounted to about a \$1 billion increase in federal support for Medicaid during these three years. As of July 1, 2011, the federal matching rate returned to 50 percent.

## Reducing the Cost of Medicaid

Efforts to control Medicaid costs that focus on efficient and effective care for elders and people with disabilities are likely to be most effective, since the bulk of Medicaid money is spent on elders and people with disabilities.

- Individuals with disabilities and people age 65 and older account for almost one-quarter of Medicaid enrollees in Colorado, but they account for nearly two-thirds of the spending.
- Colorado spent about \$1.1 billion in long-term services and supports in 2010-11, about 30 percent of the state's total Medicaid medical services costs of \$3.3 billion.<sup>vii</sup> Nationally, long-term care accounts for about 42 percent of all Medicaid dollars spent.<sup>viii</sup>

There are three basic ways to control how much money is spent on Medicaid: Reducing eligibility, reducing benefits or reducing how much health care providers are paid.

## Colorado's Other Publicly Funded Health Programs

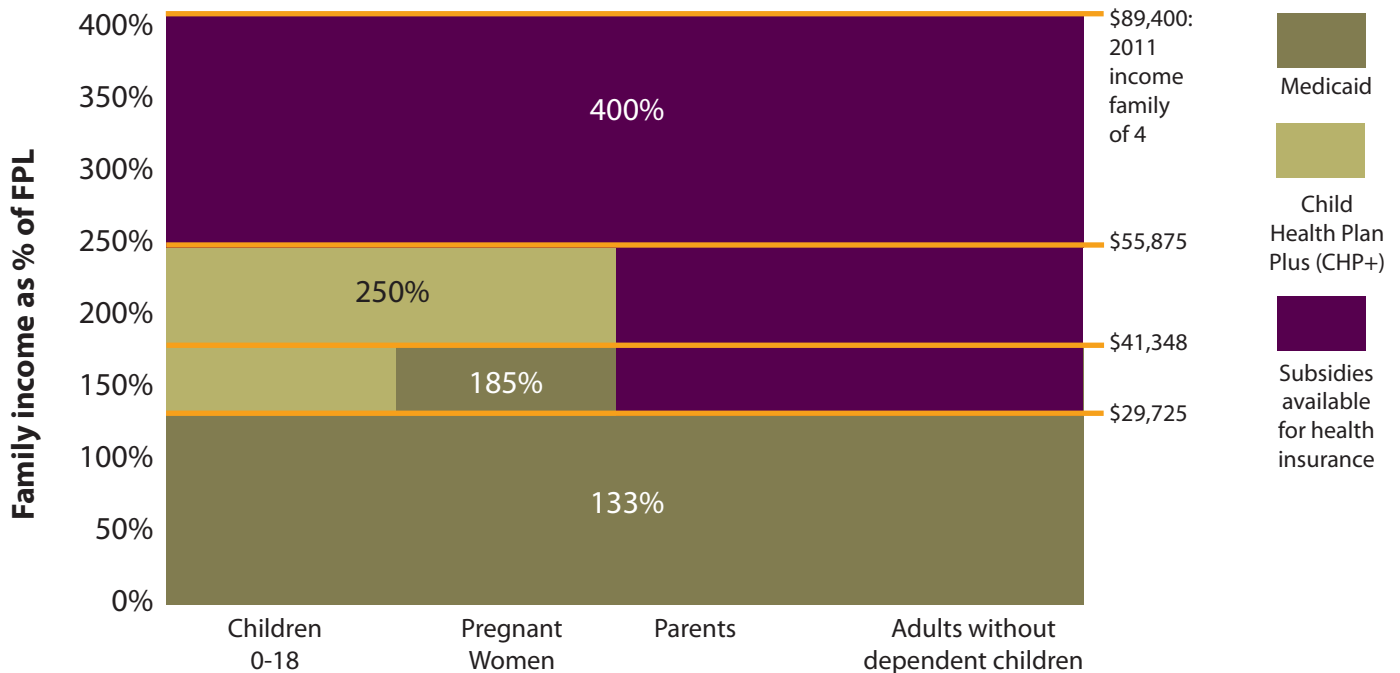
### Child Health Plan Plus (CHP+)

Created in 1997 to serve low-income children and pregnant women who are not eligible for Medicaid, CHP+ is jointly financed by the federal government and the state. Participating families pay an enrollment fee.

### Colorado Indigent Care Program (CICP)

This is not an insurance program. Rather, it partially compensates clinics and hospitals for care provided to uninsured and underinsured individuals whose incomes are at or below 250 percent of the FPL. CICP is financed with federal and state funds.

Graph 3. Eligibility Standards in Colorado After State and Federal Health Reforms



**Notes:** Federal health reform does not make changes to Medicaid eligibility for elders and people with disabilities. CICP will likely continue to serve individuals who do not qualify for Medicaid or CHP+ or are uninsured or underinsured.





# Traditional approaches to control Medicaid costs

## Reducing Eligibility

Medicaid eligibility is determined by income and individual characteristics such as age, pregnancy and disability. Federal law requires certain populations to be covered. States have the option to make additional groups eligible for Medicaid, but federal law sets a limit on how much states can reduce eligibility, requirements that are generally referred to as “maintenance of effort.”

Reducing eligibility means that fewer people can get Medicaid insurance. It saves the state money, but because Medicaid funding is provided by the state and the federal government, a reduction in eligibility results in less federal money coming into the state. A reduction in eligibility can also lead to more uncompensated care provided by clinics and hospitals and more expensive care being required after health conditions have gone untreated for too long.

### *Eligibility in Colorado*

In addition to the populations required under federal law, Colorado chooses to cover some others,

## Colorado Options

**Colorado has little flexibility to reduce Medicaid eligibility. Most of the expansions to Medicaid eligibility that Colorado has added in the past few years will be required under the ACA starting in 2014.**

called “optional” eligibility groups (see table on Page 10). Colorado has 11 waiver programs serving a variety of populations beyond the core federal eligibility.<sup>ix</sup> Some of these optional groups have been recently added by changes in Colorado law.

Federal health reform simplifies Medicaid eligibility. Under the ACA, anyone at or below 133 percent of FPL will qualify for Medicaid, regardless of age, health or whether they have dependent children. One of the most significant changes included in the ACA was adding adults without dependent children. The Colorado Health Care Affordability Act has Colorado starting to move toward the new federal standards in 2012.



**Table 2. Some of the “Optional” Medicaid Groups Covered by Colorado Medicaid:**

“Optional” Eligible Group	Financial Requirement *	Colorado Law That Added This Optional Group	Effective Date	Required Under ACA in 2014?	Notes
Low-income parents	29% to 100% of FPL	Colorado Health Care Affordability Act	2010	Yes	Federal law requires coverage below 29% of FPL.
Adults without dependent children	Up to 100% of FPL (launching program at 10% of FPL)	Colorado Health Care Affordability Act	Early 2012	Yes	
Working adults with disabilities	Adults who have a qualifying disability and are working will be able to buy in to Medicaid up to 450% of FPL. Buy-in premiums will be on a sliding-fee scale, based on income.	Colorado Health Care Affordability Act	March 2012	No	
Disabled individuals with long-term care needs (also known as “300 percenters”)	Individuals between 74% and 219% of FPL or 300% of the SSI standard and who need a nursing facility level of care can qualify for long-term care services.	<ul style="list-style-type: none"> <li>• C.R.S. 25.5-6-301-313, as amended; 42 C.F.R. 441.300 – 310</li> <li>• Department of Health Care Policy and Financing, 10.C.C.R. 2505-10, Section 8.485</li> </ul>	1991	No	
Children ages 6-18	100% to 133% FPL	SB11-008	2013	Yes	These children are currently covered under CHP+. Moving them to Medicaid is anticipated to save \$2.3 million in FY 2013-14 and \$10.4 million in FY 2014-15
Pregnant women	134%-185% FPL	SB11-250	May 27, 2011	No.**	These women are currently eligible for CHP+. Moving them to Medicaid was a federal requirement to receive additional federal CHP+ money to increase coverage.

\* Lower limit of financial requirement indicates what is required by federal law.

\*\* This law was required to gain additional CHP+ funding to cover pregnant women.

## Reducing Benefits

As with eligibility, federal law requires some health care benefits to be covered by Medicaid. States have some flexibility in the duration and scope of other services. For example, how many ultrasounds should be covered during a normal pregnancy? States may also decide to include optional benefits in their Medicaid programs.

### Colorado Options

Colorado provides fewer optional services than many other states. Many of those offered by Colorado Medicaid, such as pharmaceutical drugs, are designed to save money. Without needed drugs, for example, many enrollees would have much higher inpatient hospitalization rates, a significant driver of Medicaid costs. Still, there are optional Medicaid services that could be reduced. For example, the Colorado legislature in the 2010-11 session voted to eliminate circumcision services, for which the state paid \$373,000 in FY 2009-10. Other examples of optional services include home and community-based services, private duty nursing, podiatry services, insulin pumps and transplants. Again, immediate savings associated with elimination of optional services would need to be balanced against potential longer-term costs.<sup>x</sup>

## Reducing Payments

Reducing the amount that health care providers are paid for providing Medicaid services has been the primary tool used by the Colorado General Assembly to contain the cost of Medicaid in recent years. Colorado is one of 36 states that reduced Medicaid provider payments in FY 2010-11.<sup>xi</sup> From 2009 through FY2011-12, Colorado has reduced provider rates by more than 6 percent.

Federal law requires states to set reimbursement rates high enough to ensure that people enrolled in Medicaid can receive care that is comparable to people enrolled in private insurance programs. If Medicaid payments to providers are too low, then providers will not accept patients with Medicaid, and those patients may not be able to gain access to care. In April 2011, the Centers for Medicare & Medicaid Services proposed a regulation that would provide guidance to states on how to evaluate access to care for Medicaid enrollees.<sup>xii</sup>

Starting in 2013, states will be required to raise Medicaid reimbursements for primary care physician fees to the same level as that paid by Medicare. This law will remain in effect through 2014. Federal funds will cover 100 percent of the cost for 2013 and 2014.<sup>xiii</sup>

### Colorado Options

Colorado could continue to reduce the amount that providers receive for Medicaid services to decrease the cost of Colorado's Medicaid program. The extent to which payment reductions impact the number of providers accepting Medicaid clients should be monitored.



# Innovative Approaches: Current Colorado Investments in Reform

Two pilot programs under way are attempting to change how Colorado's Medicaid program delivers and pays for care.

## Accountable Care Collaborative (ACC)

The Accountable Care Collaborative (ACC) is a Medicaid initiative that aims to contain costs and improve health outcomes through coordination of care. The idea is that better coordination will help reduce unneeded, duplicative and inappropriate use of health care resources. In turn, the hope is that this will reduce spending and improve care by helping patients get the care they actually need. The goal is to encourage and reward quality of care and health outcomes, as opposed to rewarding a high volume of services. This program is the foundation of the state's Medicaid reform efforts.

### ACC: Three Components

- **Regional Care Collaborative Organizations (RCCOs):** Seven RCCOs cover the state. (Go to <http://1.usa.gov/rsN5a8> to view the regional map and county alignment.)
- **Primary Care Medical Providers:** Primary care providers will be affiliated with a RCCO. The primary care provider will provide a "medical home" for patients by coordinating and managing their health needs not only for primary care, but also across specialized services.
- **Statewide Data and Analytics Organization (SDAC):** The SDAC will collect and manage ACC data from across the state, creating a repository for Medicaid claims. It will build and maintain a Web portal for use by stakeholders, including providers, and create reports using health care analytics collected. The portal will provide data and analysis

to better align provider payments with health outcomes and to identify interventions designed to improve the health of Medicaid clients.

### ACC: Three Kinds of Payments

- **Fee-for-service payments:** Care providers will be paid for each service rendered. Most Medicaid services are billed this way in Colorado now.
- **Per-member-per-month payments (PMPM):** The General Assembly authorized a maximum of \$20 per member per month - \$17 PMPM to cover the RCCOs, primary care medical providers and incentive payments, and \$3 for SDAC.<sup>xiv</sup>
- **Incentive payments:** Initial goals to be rewarded by incentive payments include lowering emergency room visits among clients, reducing hospital readmissions and cutting the number of outpatient services and MRIs, CT scans and X-rays.

### Timeline

The ACC program began to enroll Medicaid clients with an existing Primary Care Medical Provider relationship in May 2011. The goal is to enroll 123,000 Medicaid clients in the first year. Eligible recipients are being "passively enrolled," meaning they are automatically enrolled, but may opt out if they don't want to participate. The enrollees will receive services using the fee-for-service model.<sup>xv</sup>

### Evaluation

Proposed savings are \$1.8 million in FY 2012-13 and \$4.1 million in FY 2013-14. Questions surround how to measure and evaluate the results, including whether the savings are significant enough and whether patient care and outcomes improve. Also, with seven organizations, practices that work in one region may not be entirely generalizable to other regions or the state as a whole.

## CO-ACTS: Colorado's "Money Follows the Person" Demonstration Program

Colorado Access to Community-based Transition and Services (CO-ACTS) aims to help Medicaid-eligible residents of all ages transition from nursing facilities back into the community and access the services and support they need. This includes improving access to home- and community-based services and streamlining the long-term care system to make it more consumer-oriented. The program is only for people who want to move back into a community setting and are able to do so.

CO-ACTS is designed to make money as easily available for care in the community as it is for care in a nursing home. CO-ACTS funding can be used to pay for a variety of services provided at home or in the community, including adult day care, home modifications, meal preparation services, skilled nursing services, home health care, transportation and other services. Additional services will be offered under the CO-ACTS demonstration grant during an individual's 12-month transition period. The goal is to support the transition of 490 Medicaid-eligible clients from nursing facilities back into the community with the necessary supports and services. The funding may cover home modifications, meal preparation services, skilled nursing services, caregiver supports and transportation services, among other assistance. Demonstration services will include supports such as life skills training, employment skills training, home delivered meals and intensive case management.<sup>xvi</sup>

### Reducing Medicaid costs

Providing more long-term care in a community setting would help reduce Medicaid costs, since institutional care is generally far more expensive than care in a community setting. It would also improve the quality of life for many people who need long-term care but would prefer to stay in their own homes or other community placements. In 2009, 68 percent of nursing home residents in Colorado expressed a desire to return to the

## What Is "Money Follows the Person"?

The "Money Follows the Person" model is a way to pay for long-term care that makes it more patient driven and community based, rather than focused on institutions such as skilled nursing facilities. Federal "Money Follows the Person" grants are designed to:

- Increase the use of home- and community-based services and reduce the use of institutionally based services;
- Eliminate barriers in state law, state Medicaid plans and state budgets that restrict or prevent the use of Medicaid funds to help eligible individuals receive long-term care in the setting of their choice;
- Strengthen the ability of Medicaid programs to continue providing home- and community-based services to individuals who choose to transition out of an institutional setting; and,
- Ensure that procedures are in place to provide quality assurance for home and community services.<sup>xvii</sup>

community and receive long-term care in that setting.<sup>xviii</sup>

### Timeline

This demonstration project is funded by a \$22 million "Money Follows the Person" grant from the CMS. CMS started funding some state "Money Follows the Person" demonstration projects in 2005.<sup>xix</sup> Funding for these programs was expanded and extended under the ACA, and Colorado received the grant for CO-ACTS in February 2011. The grant began April 1, 2011, and runs through March 31, 2015.

The first year of the grant will focus on hiring and training, service and benefit design, and information technology system changes. Community transitions through CO-ACTS are expected to begin in June 2012.



## More Changes in the Works

Other changes to Colorado’s Medicaid program that focus on long-term care payment models are still in the planning phases. These include:

### The State Balancing Incentive Payment Program

Funded under the ACA, this federal program was scheduled to go into effect October 1, 2011. It is available to states spending less than half of their total Medicaid long-term care money on home- and community-based services. Colorado spent 46% of Medicaid long-term care money on home- and community-based care in FY 2010-11, making it eligible for this program.<sup>xx</sup>

Federal matching payments for home and community-based long-term care services will be enhanced. Participating states must adopt administrative changes

to streamline access to home- and community-based care as well as the ability for consumers to access all long-term care services through a single point.

### Study of Potential Alternative Care Facility (ACF) Rate-setting Methods

The Colorado Legislature in 2010 passed a bill (HB 10-1053) that called for a study of how alternative care facilities, also known as assisted-living residences, are paid. The study will look at whether replacing flat-rate payments with a more flexible tiered structure could keep some residents from being transferred to more expensive nursing homes. Flexible payments would allow the alternative care facilities to charge higher rates for residents with more complicated care needs.



## The National Conversation

### What Are Other States Doing?

Most states are facing increasing Medicaid costs and enrollment. Some of the most common actions that states have taken to control the cost of Medicaid are:

- Increasing the number of Medicaid participants enrolled in managed care programs. Managed care has long been seen as a way to contain health care costs. Florida has passed several laws that propose enrolling all Medicaid participants in managed care programs. This proposal is controversial and cannot proceed without federal approval. It is being reviewed by CMS.<sup>xxi</sup>

- Cutting provider payments.
- Reducing benefits.
- Controlling pharmacy costs by subjecting more drugs to prior authorization, implementing or expanding preferred drug lists, and seeking new or enhanced supplemental rebates.
- Addressing long-term services and supports costs by providing more services in the home or community.





# What Is Happening at the Federal Level?

In 2010, Medicare, Medicaid and the Children's Health Insurance Program (CHP+ in Colorado) accounted for 21 percent of the federal budget, or \$732 billion. More than one-third of that amount – \$280 billion – went toward Medicaid and CHP+.<sup>xxii</sup> The prolonged economic recession, political gridlock and controversy around the federal health care reform law have focused attention on containing Medicaid costs.

As noted earlier, the ACA expands eligibility requirements for Medicaid starting in 2014, when millions of people are expected to be added to the program. The federal government will cover all of the increased cost for the first three years. Federal funds will taper off until they cover 90 percent of these costs in 2020 and beyond.

Options being considered for containing federal Medicaid costs include:

## *Block Grants*

The federal government would give annual lump-sum payments to states, limiting the federal financial commitment to Medicaid. Currently, federal Medicaid support to the states is open-ended because the federal government and the states share the cost and Medicaid is an entitlement program.

States would have more freedom to operate the Medicaid program, but they would be responsible for all Medicaid costs not covered by the federal block grant.

*Arguments in favor:* Proponents favor the reduced federal spending and the reduced federal requirements, which would give states more autonomy, including deciding which populations to cover and what services to provide.

*Arguments against:* Opponents are concerned that

reduced federal funding and requirements would result in loss of health care coverage for millions of people who are low income, elderly and/or have poor health status. Many believe that block grants would not keep pace with Medicaid costs. Because states would be responsible for all costs not covered by the block grant, and would not have to follow current federal law about Medicaid coverage, it is likely that they would provide fewer services to fewer participants to contain costs.

## *Blended Rates*

A "blended rate" would calculate a single, simplified federal matching rate that would be the Federal Medical Assistance Percentage for all Medicaid and CHP+ enrollees.

*Arguments in favor:* Proponents argue it would simplify administration of federal money for Medicaid and CHP+ and remove incentives for states to focus enrollment on populations offering a higher federal matching rate. For example, in Colorado the federal matching rate for Medicaid is 50 percent, but 65 percent for CHP+.<sup>xxiii</sup> For those newly eligible Medicaid enrollees under the ACA, the federal government will pay 100 percent for the first three years. Many proponents believe that a blended rate would also save the federal government money by reducing the total federal funding going to the states.

*Arguments against:* Opponents fear it would shift costs to the states by providing less federal money while doing nothing to reduce the total costs of Medicaid. Also, there would almost certainly be significant controversy over calculating a blended rate. The calculations would depend on a number of assumptions about Medicaid and CHP+ enrollment and expenditures, including how many people would be eligible under the ACA, how many would enroll and how much care they would use.

The number of people eligible and enrolled would be particularly difficult to estimate because of the continuing weak economy and the new health care law provisions that increase eligibility.

### *Repealing ACA “Maintenance of Effort” Requirement*

The ACA requires states to maintain their current eligibility levels for Medicaid and the Children’s Health Insurance Program in place as of March 2010. This requirement was aimed at preventing

states from reducing their Medicaid rolls before 2014. Beginning then, anyone at 133 percent of FPL or below will qualify for Medicaid, regardless of age, health status or whether they have dependent children.

Across the country, many governors and members of Congress have called for the maintenance-of-effort requirement to be repealed. They argue that an inability to restrict Medicaid eligibility imposes an unacceptable financial burden on states, particularly during difficult economic times.



## Conclusion

Colorado has launched innovative changes to the Medicaid program. While it is too soon to measure their impact, CHI will monitor the extent to which these alterations affect access to care and cost of health care services. The stakes are high as an aging population requires more long-term services and supports, the costs of health care continue to

increase and Medicaid enrollment expands under federal health reform. With state budget constraints a constant reality, the federal government struggling to address fiscal imbalances and health care consuming such a significant portion of public resources, it is crucial for the Medicaid program to be as cost-effective and efficient as possible.

For more information, see CHI’s paper, *Long-term Services and Supports in Colorado*.



## Endnotes

- <sup>i</sup> Colorado General Assembly Joint Budget Committee. (2010). "FY 2011-12 Staff Budget Briefing Department of Health Care Policy and Financing." (Available at: [http://www.state.co.us/gov\\_dir/leg\\_dir/jbc/hcpbrf1.pdf](http://www.state.co.us/gov_dir/leg_dir/jbc/hcpbrf1.pdf)).
- <sup>ii</sup> Department of Health Care Policy and Financing FY 2011-12 Medical Premium Expenditure and Caseload Report <http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251733908820&ssbinary=true>
- <sup>iii</sup> Colorado General Assembly Joint Budget Committee. (2010).
- <sup>iv</sup> 133% of FPL for a family of four is an annual income of \$29,725.50 under 2011 Federal Poverty Guidelines.
- <sup>v</sup> 73% of FPL for a family of four is an annual income of \$16,315.50 under 2011 Federal Poverty Level gGuidelines.
- <sup>vi</sup> Colorado General Assembly Joint Budget Committee. (2010).
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