Colorado Uninsurable Health Insurance Plan

Review of the Financial Projections and the Impact of State and Federal Legislation on the Plan

July 2000

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Members of the Legislative Audit Committee:

This report includes the results of our review of the financial projections and the impact of State and federal legislation on the Colorado Uninsurable Health Insurance Plan, which Ernst & Young LLP conducted on behalf of the Colorado Office of the State Auditor. This audit was conducted pursuant to Section 2-3-103, CRS, which authorizes the State Auditor to conduct performance audits of all departments, institutions, and agencies of State government.

This document presents our findings, conclusions, and recommendations, and the response of the Colorado Uninsurable Health Insurance Plan. This report is intended solely for the information and use of the Legislative Audit Committee and the Office of the State Auditor.

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Report Summary

July 2000

Authority, Purpose, and Scope

Ernst & Young LLP (E&Y) conducted this review on behalf of the Colorado Office of the State Auditor. This audit was conducted pursuant to Section 2-3-103, CRS, which authorizes the State Auditor to conduct reviews and audits of all departments, institutions, and agencies of State government. Information presented in this report was accumulated through interviews, document review, and analysis of data supplied by the Colorado Uninsurable Health Insurance Plan (CUHIP). In addition, we have included duly noted citations from CUHIP's November 1, 1999 Report to the Joint Budget Committee. Our review was performed from April to June 2000.

Based upon the findings resulting from our review, we provide recommendations for improving the operations of CUHIP. The following summary highlights our comments and recommendations.

Background

CUHIP is a state-sponsored high-risk pool (health insurance plan). Colorado is one of twenty-eight states to have such a plan. It was created in 1990 and started operation in 1991. It provides health insurance to individuals who are unable to purchase health insurance at affordable rates from commercial insurance companies. As of April 2000, CUHIP covered 1,389 individuals. In 1999, the Plan had revenues of about $9 million (including premiums, investment income, and state subsidies), expenditures of almost $5 million, and a fund balance of about $24 million.

Fund Balance Projections

We reviewed the fund balance projections provided by CUHIP in its November 1999 report for the Joint Budget Committee. We believe the tools and data used to develop these projections produce reasonable, if not somewhat conservative, results. We did not verify the accuracy of the historical data used in the projections beyond basic tests of reasonableness.

While the 20% increase in claim cost per year assumed in the projections prepared by CUHIP appears conservative based upon historical experience, the premium trend assumption of approximately 15% appears to be aggressive given the Board's history of holding rates. While the claim trend and premium trend assumptions used in the projection do not appear reasonable when considered individually, the combination of the two assumptions employed in the projection appears to produce reasonable results when compared with independent projections we developed.

All the projections resulted in an expectation that CUHIP will become insolvent between August 2002 and July 2005 if no additional funding is secured. The following sections discuss specific impacts on CUHIP's financial situation as well as CUHIP's planned approach to address the funding shortfall and other funding options that CUHIP should pursue.

Impact of SB00-057

This law revises the process by which abandoned property is collected, retained as a liability, and distributed by the State Treasurer. The law repeals the Abandoned Property Fund, the Unclaimed Insurance Moneys Fund, and the Business Associations Unclaimed Moneys Fund and, subsequently, eliminates the transfer of moneys from these funds to the General Fund, the Special Fund for Industrial Bank Moneys, and the CUHIP Cash Fund. The law creates the Unclaimed Property Trust Fund and specifies that the moneys in the trust fund, as an ongoing State liability, are exempt from State spending considerations for TABOR.

The investment earnings from the Unclaimed Property Trust Fund will be transferred to the CUHIP Cash Fund as the State subsidy of CUHIP. SB00-057 will decrease CUHIP funding approximately $4,000,000 for the period July 1, 2001 to June 30, 2004. After that, SB00-057 will produce equivalent and then progressively more than the pre-SB00-057 subsidy.

CUHIP as the Health Insurance Portability and Accountability Act Insurer

The federal Health Insurance Portability and Accountability Act (HIPAA), passed by Congress in 1996, mandates that people who have had group health insurance coverage have access to continued coverage in the individual market if they leave their employer or other source of group coverage and meet certain requirements.

CUHIP is considering proposing legislation to become the HIPAA insurer for Colorado. This means that individuals who lose their coverage and want individual coverage would get that coverage from CUHIP instead of from individual insurance carriers. Currently, in Colorado, individual insurance carriers are required to offer such coverage to HIPAA-qualified individuals but the cost of such coverage is not regulated.

The main benefit of CUHIP becoming the HIPAA insurer is that individual HIPAA coverage would be more affordable to Colorado residents because CUHIP limits the premium it charges to no more than 150% of the average comparable commercial premium.

Commercial insurance carriers do not want high-risk individuals if they can avoid covering them and so charge 300% or more of the average premium to discourage enrollment. However, if CUHIP becomes the HIPAA insurer for the State, its costs will increase and the fund balance will be negatively affected. The cost increase will come from the increased membership because the premium from those members will not cover the cost of their claims and related administration cost.

Funding Alternatives

Based on the November 1999 projections provided by CUHIP management, CUHIP will become insolvent in the year 2004. For a new funding mechanism to be considered, it must be flexible, equitable, and inexpensive to administer. Some of the available funding alternatives are presented below. Each of these options is discussed in more detail later in this report:

- Assess insurers
- Institute a hospital surcharge
- Use unclaimed property proceeds
- Appropriate General Fund moneys
- Reinstate the income tax surcharge
- Levy a "sin tax"
- Raise premiums

While the financing projections are subject to significant uncertainty, **we recommend that CUHIP pursue additional funding to avoid insolvency. In particular, the assessment approach favored by CUHIP (assessing insurers) has the advantages of being an accepted and proven approach that spreads the cost widely and has the benefit of already being tested in other states.**

CUHIP Operations

Based on our review, we believe that the executive director is experienced and knowledgeable about health insurance, managed care and cost containment. The part-time utilization review individual is also an experienced health care professional who is knowledgeable about methods and techniques for managing the cost of health care. However, we also believe that there are opportunities for improvements in CUHIP's operations, as described below.

Cost Containment

We found that CUHIP uses several cost-containment activities, such as using a PPO to get a discount on provider charges and managing high-cost cases to control hospitalization costs. However, as a high-risk pool, CUHIP's members consume more health care services, on average, than commercially insured individuals, which creates a greater opportunity for cost

containment. Additional activities that CUHIP could consider are a program to proactively manage chronic diseases, more aggressive management of mental health hospitalization cases, and the promotion of cost-saving techniques by CUHIP members, such as the use of generic and lower-cost brand name drugs. In addition, CUHIP can improve cost-containment efforts by obtaining and using more detailed management reports from the PPO administrator. Examples include reports on hospital and emergency room utilization rates and percentages of claims from non-network providers. CUHIP should weigh the benefit of additional reporting against the costs of each report. **We recommend that CUHIP increase its cost-containment activities including the use of increased management reporting.**

Administration Costs

As part of our analysis of CUHIP's operations, we compared CUHIP's administration costs, which include the fees charged by OASYS (the PPO administrator), the administration fees charged by Kaiser, and CUHIP personnel costs, with those of over two dozen other state high-risk pools (see Appendix B). We observed that for the years 1996 through 1999 CUHIP administration costs, on a per-member basis, were always significantly above the average of the state high-risk pools. For 1998, the year for which the most complete comparative data were available, CUHIP's administrative cost per member was $62.48, almost double the average ($33.96) of all 25 other states.

We were unable to determine from the data provided by other states if CUHIP is doing more than other state high-risk pools or pays more for administration services than other states. However, given the significant differences in CUHIP's admistrative costs relative to other states, **CUHIP should evaluate its costs to ensure that it is operating as efficiently and cost-effectively as possible.**

Summary of Responses

CUHIP agreed with the recommendations and has begun analysis of the statutory changes needed to become HIPAA compliant as well as seeking a proposal from a medical management company to improve its management reporting and cost containment efforts.

Recommendation Locator

Rec. No.	Page No.	Recommendation Summary	CUHIP Response	Implementation Date
1	19	CUHIP should pursue additional funding sources to remain solvent.	Agree	1/2001 Introduce Legislation
2	22	CUHIP should increase its cost-containment activities.	Agree	9/2000
3	23	CUHIP should evaluate its administration costs, which are high compared to other state high-risk pools.	Agree	9/2000

Description of the Colorado Uninsurable Health Insurance Plan

In 1990, the Colorado Legislature determined that the State had a role to fill in providing access to health insurance for uninsurable individuals. It created the Colorado Uninsurable Health Insurance Plan. In 1991, the Colorado Uninsurable Health Insurance Plan ("CUHIP" or the "Plan") began offering access to:

- Individuals who are unable to buy health insurance because of a present or previous health condition (76% of 1998 CUHIP participants);
- Individuals who can only buy health insurance at a rate exceeding that which is offered by CUHIP (12% of 1998 CUHIP participants);
- Individuals whose preexisting medical condition has been excluded from coverage for more than six months (6% of 1998 CUHIP participants); and
- Individuals whose health insurance has been involuntarily terminated for any reason other than nonpayment of a premium (6% of 1998 CUHIP participants).

The legal status of CUHIP is set forth at Section 10-8-504, CRS, which states:

> There is hereby created a nonprofit unincorporated public entity known as the Colorado uninsurable health insurance plan. The operation of such plan shall be governed by the board of directors of the Colorado uninsurable health insurance plan created pursuant to section 10-8-505. The Colorado uninsurable health insurance plan is an instrumentality of the state; except that the debts and liabilities of a plan shall not constitute debts and liabilities of the state, and neither the plan nor the board shall be an agency of state government.

CUHIP is regulated by the Division of Insurance, as are many other insurance carriers. The statute indicates that the operation of the Plan is governed by the Board of Directors. However, because its excess losses are currently subsidized by the State and appropriated funds can only be given to a State agency, CUHIP contracts with the Executive Director's Office of the Department of Regulatory Agencies (DORA) so that its appropriated funds can pass through that agency. No employee or voting Board member of CUHIP is an employee of DORA or of the State, and the Executive Director of DORA has no lawful policy-making role with respect to CUHIP and its operations. Thus, the CUHIP Board retains full policy-making and administrative responsibility for the Plan, subject in some respects to the approval and regulation of the Commissioner of Insurance.

CUHIP is a nonprofit organization which is governed by an eight-member volunteer board of directors, six of whom are chosen by the Governor of Colorado, to ensure that health care provider, insurance, and consumer interests are represented. A member of the General Assembly sits on the Board, as does the Commissioner of Insurance (in an ex officio

capacity). A Denver-based executive director and administrative assistant supervise operations of the Plan, provide a number of services to potential participants and enrollees, and staff the Board.

CUHIP covered 1,389 individuals as of April 2000. In 1999 it paid $4,981,055 in claims and administration costs, had revenue from premium and investment income of $9,099,987 and at the end of 1999 had a financial surplus fund of $24,503,392.

The Plan offers its members medical and prescription drug coverage either through a preferred provider organization (PPO) or through an HMO (Kaiser).

Chapter 1. Financial Projections

In November 1999, CUHIP presented a report to the Joint Budget Committee in accordance with a requirement in House Bill 1999-215. This report contained a projection of the CUHIP fund balance for State fiscal years 2001 through 2005. The financial projection used actuarial techniques to estimate future membership, medical costs, and revenue. The purpose of the projection was to estimate the CUHIP fund balance over the next five years and to identify alternative ways to supplement CUHIP's revenue. The following are the principal assumptions that were used to develop the projections which resulted in the conclusion that CUHIP would become insolvent in calendar year 2004:

Claim Trend (the annual rate of increase in claim costs):	20%
Administration Fee Annual Increase:	5%
Premium Rate Increases:	7.5% (15% per year)
Membership (net increase per month):	40 (20 PPO, 20 HMO)

As part of this review, we evaluated the November 1999 projections and reviewed the projection methodology and assumptions. We also prepared independent projections and compared those with the November projections.

Evaluation of the Claim Trend and Rate Increases Used by CUHIP

While similar pools in other states have experienced high claim trends, the 20% annual increase in claim cost employed by CUHIP actuaries for projection purposes is unusually high, especially given the addition of the HMO option which should dampen utilization trends. Historical claim trends for the CUHIP PPO appear low at approximately 7% per year. However, these historical trends include the aging of the population, the shifting of some members to the HMO (including some HIV+ members due to the richer Rx benefits) from the PPO, and the addition of a block of new members with potentially different characteristics than those of the existing members. While trend analysis on a small population such as this is subject to large random fluctuations, it does appear that recent trends are lower than the 20% assumed by CUHIP.

Recent premium trends for this block of business have been flat to negative, indicating the absence of any recent rate increases. CUHIP has its actuarial firm perform periodic commercial premium rate comparisons for the purpose of setting the CUHIP rates. According to these comparisons, the rates for CUHIP, which were once approximately 50% higher than the standard risk rate, have decreased relative to the standard risk rate and are now 15% to 20% higher than similar benefit offerings in the Colorado individual market.

The lower rate of premium increase for the CUHIP coverage in comparison to the premium increases for commercial health insurance makes that coverage more affordable to a larger number of individuals. These lower rates (relative to the commercial market) mean more

members for CUHIP. These members are likely to be healthier because the sicker individuals who are eligible for CUHIP probably would have already purchased coverage.

Evaluation of Membership Growth

Total CUHIP plan membership for some recent periods is shown below:

Period Ending:	Number of Total Members in Force at the End of the Period	Change (#)	Change (%)
1st Quarter 2000	1,288	268	26%
Dec. 31, 1999	1,020	77	8%
Dec. 31, 1998	943	(115)	(11%)
Dec. 31, 1997	1,058	(169)	(14%)
Dec. 31, 1996	1,227	(345)	(22%)
Dec. 31, 1995	1,572	N/A	N/A

Source: Leif and Associates

Part of the recent growth in membership is probably due to the relative decrease in rates for CUHIP (mentioned in the previous section). Another reason for the membership growth, which affected only the HMO membership, was a change in how Kaiser rated its individual commercial policies. Kaiser changed from a community rate to age-banded rates and gave existing members the opportunity to undergo medical underwriting. Those members who could not pass medical underwriting found that it was cheaper to move to CUHIP's Kaiser coverage than to stay with their existing Kaiser coverage. When Kaiser notified its members of rate increases at the end of 1999, it also provided information on the CUHIP program. It was not apparent at the time of our review whether migration from Kaiser's insured population to CUHIP would continue.

Projection Scenarios

In developing our independent projections, we developed nine sets of assumptions or scenarios. The nine scenarios consist of three alternative situations (CUHIP as it existed prior to SB00-057, CUHIP after SB00-057, and CUHIP with SB00-057 and as the HIPAA insurer for Colorado), each with three outlooks with respect to future cost and membership trends (low, medium, or high rates of increase for medical cost trend, premium increases and membership growth). These scenarios are further explained below and the projections themselves are in Appendix A.

Scenario 1: CUHIP before SB00-057. These scenarios are provided as a reference for the impact that will result from SB00-057 and from making CUHIP the HIPAA insurer (if the State Legislature chooses to do that).

- 1L: With low rates of increase for medical costs, premium and membership. The rates for this scenario are at the low end of a reasonable range of rates considering historical plan experience and commercial health plan experience. The discussion on pages 10 and 11 provides the specific rates and percentages used.

- 1M: With moderate rates of increase for medical costs, premium and membership. The rates for this scenario would be the median of a reasonable range of rates.

- 1H: With high rates of increase for medical costs, premium and membership. The rates for this scenario are at the high end of a reasonable range of rates.

Scenario 2: CUHIP after SB00-057 but without CUHIP being the HIPAA insurer for the State.

- 2L: The rates for this scenario are at the low end of a reasonable range of rates considering historical plan experience and commercial health plan experience.

- 2M: The rates for this scenario would be the median of a reasonable range of rates. This is the most likely outcome if CUHIP does not become the HIPAA insurer.

- 2H: The rates for this scenario are at the high end of a reasonable range of rates.

Scenario 3: CUHIP after SB00-057 and with CUHIP being the HIPAA insurer for the State.

- 3L: The rates for this scenario are at the low end of a reasonable range of rates considering historical plan experience and commercial health plan experience.

- 3M: The rates for this scenario would be the median of a reasonable range of rates. This is the most likely outcome if CUHIP becomes the HIPAA insurer.

- 3H: The rates for this scenario are at the high end of a reasonable range of rates.

Of the three outlooks with respect to future costs and membership changes, we believe that the moderate outlook, depicted in charts 2M and 3M, is the most likely. However, it is difficult to predict the future. The actual results the CUHIP will experience will be affected by the health care environment, the health insurance market, the economic environment and health care legislation. So, we have provided the high and low outlook as a reasonable range of possible outcomes.

Projection Assumptions

This section describes the basis for the assumptions used in our projections:

- Values for 1997–1999: All of the numbers for 1997, 1998 and 1999 in the financial projections (see Appendix A) come from the CUHIP financial statements.

- Medical cost increase: We developed three scenarios for medical cost increase: 8%, 12% and 16% for the PPO with the HMO being 2% less. Long-term health care cost increases have been about 10% per year. This increase has been offset by benefit reductions that average about 2%. So, an 8% annual trend is reasonable for commercial

business. However, the CUHIP population has higher health care costs because they are less healthy than the average individual. Therefore, CUHIP members tend to have higher rates of increase in medical costs because they are more likely to need and use new procedures (e.g., MRIs) and new drugs. HMOs have been able to hold costs down better than PPOs by virtue of better provider discounts and better utilization management. So, we feel using a lower rate of increase for the HMO members is reasonable.

- Starting medical costs: We analyzed the experience for both the PPO and the HMO to develop a starting medical cost. For a January 2000 starting cost we used $470 per member, per month (PMPM) for the PPO (including the drug coverage) and $400 PMPM for the HMO.

- Membership increase: To estimate membership growth we looked at the membership growth of CUHIP in the past and that of other state high-risk pools. We developed three scenarios for each situation. The three scenarios for the continuation of the CUHIP as a no-HIPAA plan are a growth of 20, 40 or 60 members per month divided evenly between PPO and HMO. The plan has experienced a significant increase in membership since December 1999. Some of this growth was caused by Kaiser changing its individual health insurance rating practices. There are several possible reasons for the rest of the rapid growth including insurance carriers being more aggressive in raising their individual premium rates, making CUHIP rates more attractive.

- Other funds: We used the information contained in the legislative fiscal note for SB00-057 prepared by the State Treasurer's Office. We contacted the State Treasurer's Office to confirm that the projections are still valid. Data from the fiscal note are included on page 13.

- Premium increase: Generally, commercial premium increases have to approximately match medical cost increases after changes in benefits. We assumed that premium increases will be 2% to 4% less than the medical claim cost.

- Interest income: We assumed a rate of 6% on the average fund balance. Historically, interest income has averaged 6% of the fund balance. This same rate of return was also used in the SB00-057 fiscal note projections.

- Administration cost increases: We assumed a 5% annual increase in administration expense. Administration costs are correlated with the volume of claims which we assumed to be increasing faster than the average cost of living.

- HIPAA membership: CUHIP already covers many members who are HIPAA-eligible individuals. We believe that HIPAA will see additional growth if it becomes the HIPAA insurer. We estimate this to be 50% more members per month equally divided between PPO and HMO. As we describe in Chapter 3, we believe that CUHIP is covering many

HIPAA-eligible individuals now. If CUHIP becomes the HIPAA insurer for Colorado, then those individuals who are HIPAA eligible will probably be classified as HIPAA members and the HIPAA membership will see a rapid increase while the non-HIPAA membership without the addition of the HIPAA-eligible members will see little or no growth (see Appendix C for HIPAA data).

- HIPAA costs: To get an estimate of the cost difference between HIPAA enrollees and non-HIPAA enrollees we interviewed individuals at other high-risk plans which track HIPAA and non-HIPAA membership and costs separately. Based on those interviews and other data we concluded that HIPAA members in high-risk pools have approximately the same cost as non-HIPAA members (see Appendix C for HIPAA data).

Conclusion: As a result of our review of the November 1999 projection methodology and assumptions, along with a comparison to our independent projections, we conclude that the projections contained in the November 1, 1999 report to the Joint Budget Committee are reasonable with respect to the CUHIP fund balance. However, we disagree with the level of the assumptions about premium increase and claim cost increase, as described on page 8. Because those premium increase and claim cost increase assumptions offset each other, the fund balance projection is reasonable.

Chapter 2. Impact of Senate Bill 2000-57

A fundamental principle of all state high-risk pools is that the premium collected from the members is subsidized in some way so that a larger number of high-risk individuals can afford the coverage. Colorado has subsidized its high-risk pool in a variety of ways (see Chapter 4). Colorado is implementing another change to how CUHIP is subsidized. This spring the legislature passed and the Governor signed into law SB00-057. This law changes the State subsidy of CUHIP, as described below.

Before SB00-057

Since 1993 and until the effective date of SB00-057, CUHIP received an annual allocation of $2.5 million from the Business Association Unclaimed Moneys Fund (BAUMF). In addition, in 1995 CUHIP began receiving approximately $1.5 million annually from the Industrial Bank/Unclaimed Insurance Moneys Fund. These funding methods continue until July 1, 2001. The Treasurer's Office has estimated that the subsidy for the fiscal year July 1, 2000 to June 30, 2001 will be $3,500,000.

Subsidy Under SB00-057

This law revises the process by which abandoned property is collected, retained as a liability, and distributed by the State Treasurer. The law repeals the Abandoned Property Fund, the Unclaimed Insurance Moneys Fund, and the Business Associations Unclaimed Moneys Fund and, subsequently, eliminates the transfer of moneys from these funds to the General Fund, the Special Fund for Industrial Bank Moneys, and the CUHIP Cash Fund. The law creates the Unclaimed Property Trust Fund and specifies that the moneys in the trust fund, as an ongoing State liability, are exempt from State spending considerations for TABOR. The investment earnings from the Unclaimed Property Trust Fund will be transferred to the CUHIP Cash Fund as the State subsidy of CUHIP.

The following table shows the estimated impact of SB00-057 on the CUHIP Cash Fund:

Fiscal Year	Unclaimed Property Trust Fund Beginning Balance	Unclaimed Property Trust Fund Ending Balance	Investment Earnings Payable to CUHIP	Impact to CUHIP Revenue (Compared to Current Funding)
2001–2002	$13,595,000	$27,047,000	$1,274,000	($2,226,000)
2002–2003		$41,306,000	$2,109,000	($1,391,000)
2003–2004		$56,420,000	$2,993,000	($507,000)
2004–2005		$72,442,000	$3,931,000	$432,000
2005–2006		$89,424,000	$4,925,000	$1,425,000

Source: Analysis of SB00-057 prepared by the State Treasurer's Office

The preceding table projects that SB00-057 will decrease CUHIP funding approximately $4,000,000 for the period July 1, 2001 to June 30, 2004. After that, SB00-057 will produce equivalent and then progressively more than the pre-SB00-057 subsidy.

Conclusion: SB00-057 will have a negative short-term impact on the fund balance. Based on our projections and comparing the projection of the CUHIP fund balance before SB00-057 with the fund balance after SB00-057, the projected fund insolvency will occur about five months sooner than it would have without SB00-057. See Appendix A and Charts 1H, 1M, 1L, 2H, 2M, and 2L.

The alternatives to address the funding shortfall are described in Chapter 4.

Chapter 3. CUHIP as the Health Insurance Portability and Accountability Act Insurer

The federal Health Insurance Portability and Accountability Act (HIPAA), passed by Congress in 1996, mandates that people who have had group health insurance coverage have access to continued coverage in the individual market if they leave their employer or other source of group coverage and meet certain requirements.

For people who previously have had continuous group coverage and are seeking coverage in the individual market, state governments had a number of options they could use to meet the HIPAA portability requirements. States could choose to enact the "federal fallback" portability requirements which require individual insurers to cover any qualified applicant without imposing a pre-existing condition. However, there is no restriction on what the insurers can charge. The other mechanisms include using a state high-risk pool, enacting either the NAIC Small Employer and Individual Health Insurance Availability Model Act or the NAIC Individual Health Insurance Portability Model Act, or other methods that meet the access and portability requirements. The NAIC Model Acts are model legislation prepared by the National Association of Insurance Commissioners.

Of the twenty-eight states with high-risk pools, twenty-two have chosen to use their pools for HIPAA compliance. Colorado is one of the six states with a high-risk pool that does not explicitly use it for HIPAA compliance. However, CUHIP is considering proposing legislation that would establish the Plan as the HIPAA insurer for Colorado. This means that individuals who lose their coverage and want individual coverage would get that coverage from CUHIP instead of from individual carriers. Currently, in Colorado, individual carriers are required to offer such coverage to HIPAA-qualified individuals but the cost of such coverage is not regulated.

For CUHIP to become the HIPAA insurer, the Legislature would have to pass legislation that changes the current Colorado insurance law, removing the responsibility for commercial individual insurance carriers to offer coverage to HIPAA-eligible individuals. The insurance law would also have to be modified to place responsibility upon CUHIP.

The main benefit of CUHIP becoming the HIPAA insurer is that individual HIPAA coverage would be more affordable to Colorado residents because CUHIP limits the premium it charges to no more than 150% of the average comparable commercial premium. Commercial insurance carriers do not want high-risk individuals if they can avoid covering them and so charge 300% or more of the average premium to discourage enrollment. In addition, in other states, commercial insurers have accepted an assessment to subsidize the high-risk pool as a trade-off for the high-risk pool providing the HIPAA individual coverage. The principal argument against CUHIP becoming the HIPAA insurer is the added cost to the Plan of doing so.

If CUHIP became the HIPAA insurer, CUHIP membership would likely increase. Based on our research with other state high-risk pools, we believe that the claim cost for the average

HIPAA member is the same as that for non-HIPAA members. HIPAA places a limit on the amount that a high-risk pool can charge for a premium to a HIPAA member. This limit is 200% of the rate for a standard risk (usually measured by a survey of individual insurance carrier rates). Most high-risk pools charge the HIPAA members the same as non-HIPAA members. If CUHIP also charges HIPAA members the same rate, the financial impact on CUHIP of becoming a HIPAA insurer is the same as having an increase in membership.

CUHIP is already covering some HIPAA-qualified individuals by virtue of these individuals meeting the eligibility requirements. HIPAA individuals who apply for individual commercial coverage and who are quoted a commercial premium rate that exceeds the rate that CUHIP charges are eligible to be covered by CUHIP. So, the impact of HIPAA becoming the exclusive individual HIPAA insurer is mitigated by the fact that it is already a HIPAA insurer.

In estimating the additional membership that CUHIP would get if it became the HIPAA insurer, we looked at the experience other states had when their risk pools became the HIPAA insurers. We estimate that CUHIP will see 50% more members over the projection period if it becomes the HIPAA insurer.

Conclusion: If CUHIP becomes the HIPAA insurer for the State, its costs will increase and the fund balance will be negatively affected as shown in projections 3L, 3M, and 3H. The cost increase will come from the increased membership because the premium from those members will not cover the cost of their claims and related administration cost. The next chapter discusses options for funding to offset these additional costs as well as the overall funding shortage projected for CUHIP.

The alternatives to address the funding shortfall are described in Chapter 4.

Chapter 4. Funding Alternatives

The CUHIP November 1999 report contained a comprehensive description of subsidy alternatives. That description is summarized here.

Because its participants are members of a high-risk pool, the individual premium payments received by CUHIP have always been inadequate to fund its losses. This is the basic reason why all high-risk pools must have supplemental funding to remain solvent. The public policy question is whether the supplement comes from insurance industry assessments or some broader risk-spreading entity such as state government.

Choosing an alternative funding mechanism for CUHIP must be guided by two considerations. First, because CUHIP's losses are not easily predictable from year to year, the funding method must be flexible. A mechanism that provides funding in proportion to CUHIP's losses is preferred to a mechanism which produces a flat amount of funds. Second, the TABOR amendment makes difficult any proposed general tax upon a constituency in Colorado.

Of the 28 states with uninsurable health insurance plans, 20 states pay for the excess of costs over premiums by assessing insurers who do business in their state. Sixty-four percent of those states offer companies an income or premium tax offset for such assessment, while thirty-six percent do not. Other funding mechanisms include the following:

- California uses proceeds from a "sin tax" on tobacco.

- Louisiana uses three funding sources, a hospital bed tax, a general fund appropriation and industry assessments, to support their HIPAA plan.

- Oregon, Wyoming and Wisconsin have levied assessments against reinsurers, as well as insurers, in order to broaden the spreading of the risk.

In the past, Colorado has always found unique mechanisms to fund CUHIP's losses. For its first three years, CUHIP was funded by an income tax surcharge of $2 for a single filer and $4 for joint filers. Beginning in 1993, this was replaced by an annual allocation of $2.5 million from the Business Associations Unclaimed Moneys Fund, and in 1995 CUHIP began receiving approximately $1.5 million annually from the Industrial Bank/Unclaimed Insurance Moneys Fund. This funding changed again with SB00-057. Starting in July 1, 2001, CUHIP will receive the investment income from a new Unclaimed Property Trust Fund created by SB00-057.

The following are the alternatives for supplementing CUHIP's revenue that were presented in the November 1999 report to the Joint Budget Committee:

1. Assess Insurers: Assessing insurers is most equitable if the base upon which the assessments are levied is as broad as possible. One problem states have encountered is that self-funded plans are generally exempt from state laws through the operation of the

federal Employee Retirement Income Security Act (ERISA). Most self-funded plans purchase reinsurance so that the plan will not have to bear losses in excess of a certain amount. Including reinsurers (or stop-loss carriers) in the assessment base therefore indirectly assesses self-funded plans. The Oregon, Wyoming and Wisconsin high-risk pools have included reinsurers within their assessment bases. The Oregon State court found that the state's assessments on reinsurers were not preempted by ERISA.

2. Assess a Hospital Surcharge: Another option is to add a per diem for services received and/or stays in hospitals. The surcharge could be assessed against all patients except private pay patients and patients covered by a subsidized public program. Federal, psychiatric or chemical dependency hospitals could be exempted from the surcharge. The rationale behind the hospital surcharge is that it reaches self-funded plans otherwise exempt from state law, state fee collection and state taxation (through the application of ERISA).

3. Continue BAUMF and the Unclaimed Insurance Fund Allocations to CUHIP: The $2.5 million allocation from BAUMF has been distributed to CUHIP since 1993. Unclaimed Insurance Funds account for approximately $1.5 million in revenue to CUHIP each year.

4. Appropriate General Fund Moneys: Three states (Illinois, Louisiana, and Utah) pay a portion of the cost of their high-risk pool shortfalls through General Fund appropriations. A variety of mechanisms are used, including: a set dollar amount for each plan year, with or without an accompanying cap on enrollees; and an appropriation requested annually and based on actuarial estimates of the amount required to cover the Plan's losses. Many legislators feel that the costs of providing health care to uninsurable individuals is a matter of interest to all state citizens and should therefore be spread over all taxpayers. In addition to being widely equitable, an appropriation from the General Fund is also efficient. The disadvantage associated with requesting a General Fund appropriation is that the State's appropriation process may not be well suited to funding a program whose funding needs vary from year to year according to its losses.

5. Reinstate the Income Tax Surcharge: CUHIP was initially funded by an income tax surcharge ($2/individual return, $4/joint return). This mechanism was apparently used to provide a short and quick infusion of capital into CUHIP's surplus fund, and was not chosen by the Legislature to be the primary funding source for the Plan. Although it shares many of the advantages of a General Fund appropriation, it is more difficult to apply today because of the TABOR amendment.

6. Levy a "Sin Tax": California currently funds its uninsurable health plan from the proceeds of a state cigarette tax. The allure of using a cigarette tax, or a tax on alcohol or other analogous "sin tax," is that the consumption of those products may be directly related to higher health care costs. In addition, a tax on those products may deter their consumption, thereby producing a positive social effect.

7. Raise Premiums: One way to decrease the difference between premiums collected and claims paid is to increase premiums paid by covered members. Premiums are set by the CUHIP Board of Directors and are now approximately 115% of the standard commercial risk rate although, by statute, CUHIP may charge as much as 150% of the

standard risk rate. The rationale behind increasing premiums is that those who benefit from the uninsurable health plan should be the ones primarily responsible for its solvency. The argument against increasing premiums is that CUHIP is already unaffordable to many individuals who earn too much to be eligible for Medicaid, yet not enough to afford CUHIP premiums, and increasing premiums further will only exacerbate that situation. Also, as premiums increase, it is likely that the healthier covered members will discontinue coverage, while the less healthy individuals will remain. This will increase the Plan's losses, which will increase premiums and, eventually, the Plan will become untenable.

CUHIP Has a Plan to Deal with the Shortfall in Funding

As the various projection scenarios show, CUHIP is going to encounter a funding shortage between August 2002 and July 2005. Based on the projections of revenues and assessment of funding alternatives contained in the November 1999 report, CUHIP has developed a plan to deal with the shortfall in funding. However, this plan depends on enabling legislation. CUHIP intends to request legislation to be effective July 1, 2001 that would supplement the current State subsidy with an assessment of insurers and reinsurers. This approach is described as alternative # 1, above.

We believe the funding options identified by CUHIP are comprehensive and the one preferred by CUHIP is reasonable. The approach of assessing insurers and reinsurers for any annual shortfall in revenue is favored by the CUHIP executive director and is already in place in Oregon. Therefore, Oregon's enabling legislation, processes, and procedures can be considered as a guide for implementation in Colorado. This approach also spreads the risk over most of the health plans to which HIPAA applies, including group insured and self-funded plans. Although it is unlikely that the insurance industry will encourage an assessment approach, insurance companies have accepted assessments in other states with high-risk pools.

Recommendation No. 1:

CUHIP should pursue additional funding to avoid insolvency. In particular, the assessment approach favored by CUHIP (assessing insurers) has the advantages of being an accepted and proven approach that spreads the cost widely and has the benefit of already being tested in other states.

CUHIP Response:

Agree. In September of 1999 over 20 major insurance companies were invited to attend a meeting to discuss the future funding needs of CUHIP. At that time, the carriers agreed that the CUHIP program was necessary and should continue. The necessity for implementing a "special fee" was discussed with the carriers to fund increased losses and keep the program solvent. A majority of the carriers indicated

an acceptance of the fee assuming CUHIP becomes the HIPAA alternative for Colorado and all carriers, including the stop loss carriers, were treated equally.

Analysis of the changes needed in the existing statute to become HIPAA compliant has already begun to prepare for the introduction of legislation in the 2001 session.

Chapter 5. CUHIP Operations

As part of the performance audit we conducted a high level review of how CUHIP was being managed and operated. To do this we interviewed CUHIP management and staff, interviewed personnel involved in plan administration at Kaiser (the HMO administrator), and at OASYS (the PPO administrator). We looked at the reports CUHIP obtains from OASYS that could be used to manage the Plan. We also compared the claim and administration costs with those of other state high-risk pools.

The executive director is experienced and knowledgeable about health insurance, managed care, and cost containment. The part-time utilization review individual is also an experienced health care professional and knowledgeable about methods and techniques for managing the cost of health care. While CUHIP is generally doing a good job, there are additional things that they could do to improve the efficiency or effectiveness of the Plan's operation.

Cost-Containment Activity

Currently, CUHIP employs a number of cost-containment strategies. These include using a PPO to get a discount on provider charges, having a utilization review program to reduce unnecessary care, and having a high-cost case management program to try to reduce the cost of hospitalizations. As a high-risk pool, CUHIP's average member consumes more health care services than the average commercially insured individual. We feel that this presents a greater opportunity for cost-containment activities. Among the additional activities that CUHIP could consider are a disease management program, which involves proactive management of chronic diseases, increased case management activity, such as more aggressive management of mental health hospitalizations, and changing the design of the benefit coverage to encourage more cost consciousness on the part of the CUHIP member, such as using a three-tier drug copay to encourage the use of generic drugs and lower-cost brand name drugs.

One way CUHIP can improve cost-containment efforts is to obtain, and use, more detailed management reports from its PPO administrator. Currently, CUHIP receives reports that show cash disbursements, claims by certain types of procedures or diagnosis, and claim service reports from OASYS on a monthly basis. These reports are used to monitor customer service and adherence to the administration contract. However, improved management reporting would give CUHIP management the information it needs to identify areas to focus cost-containment efforts and to measure the results of such efforts. Examples of such reports include hospital utilization rates, emergency room utilization rates, and percentage of claims from non-network providers. We recognize that requiring such reports from its administrator would generate additional costs to the Plan. CUHIP should evaluate the benefit of the additional information in comparison to the costs of each report.

We believe that the management reporting should be improved so that CUHIP management has the information it needs to monitor the utilization of health care services and cost of health care services.

Recommendation No. 2:

CUHIP should increase its cost-containment activities by considering a disease management program, more aggressive case management of hospitalizations and changing the design of the benefit coverage to encourage more cost consciousness on the part of the CUHIP member, and improving management reporting by the PPO administrator.

CUHIP Response:

Agree. CUHIP staff has contacted, interviewed and received preliminary proposal information from ACCESSHealth Group/McKesson, a full-service medical management company based in Broomfield, Colorado. ACCESS currently covers over 35 million people in a variety of programs.

ACCESS is willing to offer CUHIP an "a la carte" array of services ranging from nurse triage intervention to disease management, case management, etc. billed on a per-member, per-month basis. CUHIP will begin studying the insured population to evaluate the efficacy of these services for our insured versus the cost of the services and the savings potential. We are also working with other states to aggregate a population large enough to negotiate discounts from ACCESS.

Administration Costs

As part of our analysis of CUHIP's operations, we compared CUHIP's claim and administration costs with those of over two dozen other state high-risk pools (see Appendix B). The CUHIP administration costs include the fees charged by OASYS (the PPO administrator), the administration fees charged by Kaiser, cost for the CUHIP staff, and the cost for brochures, enrollment forms, and other plan expenses. For State Fiscal Year 1999 the administration costs totaled $783,723. Most of the administration costs are proportional to membership so that as membership increases administration costs will change in the same way. We observed that for the years 1996 through 1999 the CUHIP administration fees, on a per-member basis, were always significantly above the average of the state high-risk pools.

For 1998, the year for which the most complete comparative data were available, CUHIP's administrative cost per member was $62.48. Only 2 of the 25 states in the comparison had higher per-member costs, and CUHIP's cost was almost double the average ($33.96) of all 25 other states.

We were unable to determine from the data provided by other states if CUHIP is doing more than other state high-risk pools or paying more for administration services than other states. It is also possible that there are undisclosed subsidies of some of the other state high-risk pools' administration costs. However, given the significant differences in CUHIP's

administrative costs relative to other states, we believe CUHIP should evaluate its costs to ensure it is operating as efficiently and cost-effectively as possible.

Recommendation No. 3:

CUHIP should evaluate its administration costs to identify any areas in which increased efficiencies may be possible.

CUHIP Response:

Agree. CUHIP is continually looking for ways to keep administrative costs at a minimum. We are currently participating in a working subgroup of the National Association to compare costs and operations with eight other high-risk plans nationally. Additional efforts can be made to look at the type of services we provide compared to comparable plans. Finally, CUHIP staff is looking at ways to reduce costs by purchasing common services with other states.

Appendix A

Projections

Colorado Uninsurable Health Insurance Pool Financial Projection

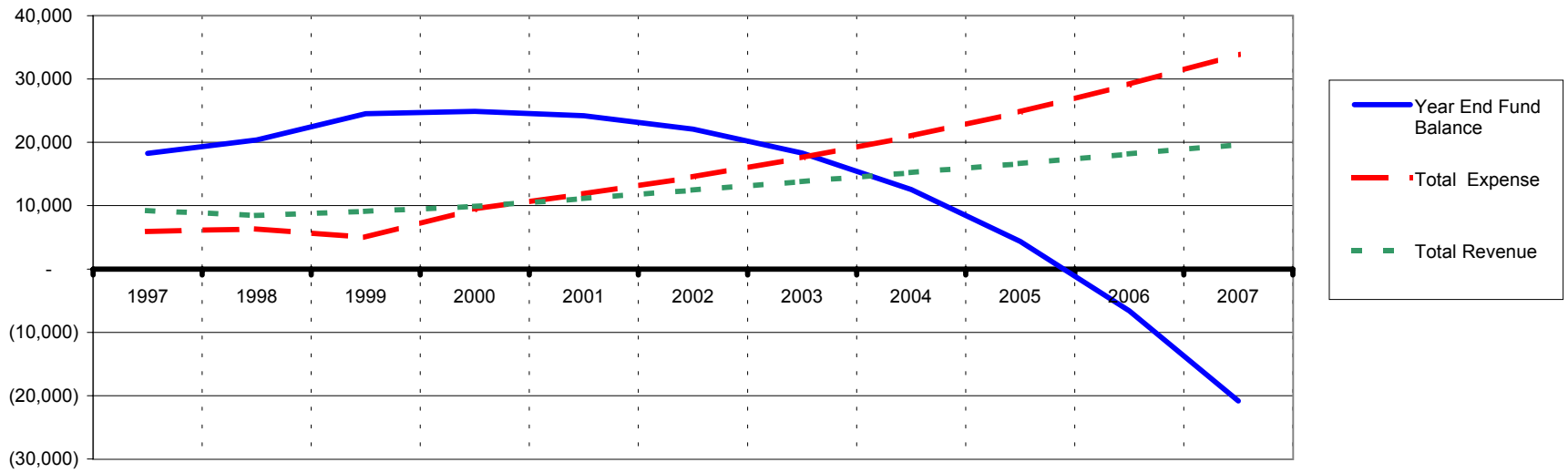
Pre-SB 00-57; Without HIPAA; With Low Growth in Membership and Claims

(Unless indicated, in $000's)

Scenario 1L:
Funding: pre-SB00 057
Member Growth: no HIPAA, low growth
Claim Trend: Low @ 8% for PPO

	Annual Rate of Increase			Member
	Claims	Premium	Admin	Count
PPO	8%	6%	5%	10
HMO	6%	4%	N/A	10

Calendar Year	Average Members	Earned Premium	Premium PMPM	Other Funds	Interest On Fund	Total Revenue	Incurred Claims	Claims PMPM	Admin Expense	Admin PMPM	Total Expense	Operating Gain (Loss)	Year End Fund Balance
1997	1,138	3,531	258.63	4,803	890	9,225	5,221	382.41	683	50.00	5,904	3,321	18,252
1998	975	3,178	271.54	4,147	1,129	8,455	5,592	477.75	731	62.48	6,323	2,132	20,384
1999	995	3,049	255.28	4,789	1,262	9,100	4,197	351.48	784	65.63	4,981	4,119	24,503
2000	1,499	5,034	279.87	3,500	1,348	9,882	8,472	471.00	998	55.50	9,471	412	24,915
2001	1,759	6,265	296.80	3,500	1,370	11,135	10,683	506.10	1,177	55.76	11,860	(724)	24,191
2002	2,019	7,614	314.27	3,500	1,330	12,445	13,185	544.19	1,367	56.42	14,551	(2,106)	22,084
2003	2,279	9,092	332.45	3,500	1,215	13,807	16,010	585.42	1,574	57.56	17,584	(3,777)	18,307
2004	2,539	10,712	351.57	3,500	1,007	15,219	19,195	630.00	1,800	59.07	20,995	(5,776)	12,531
2005	2,799	12,482	371.61	3,500	689	16,671	22,779	678.18	2,045	60.90	24,824	(8,153)	4,378
2006	3,059	14,414	392.66	3,500	241	18,155	26,805	730.22	2,312	62.99	29,117	(10,962)	(6,584)
2007	3,319	16,521	414.81	3,500	(362)	19,659	31,321	786.41	2,602	65.33	33,923	(14,264)	(20,848)



Colorado Uninsurable Health Insurance Pool Financial Projection

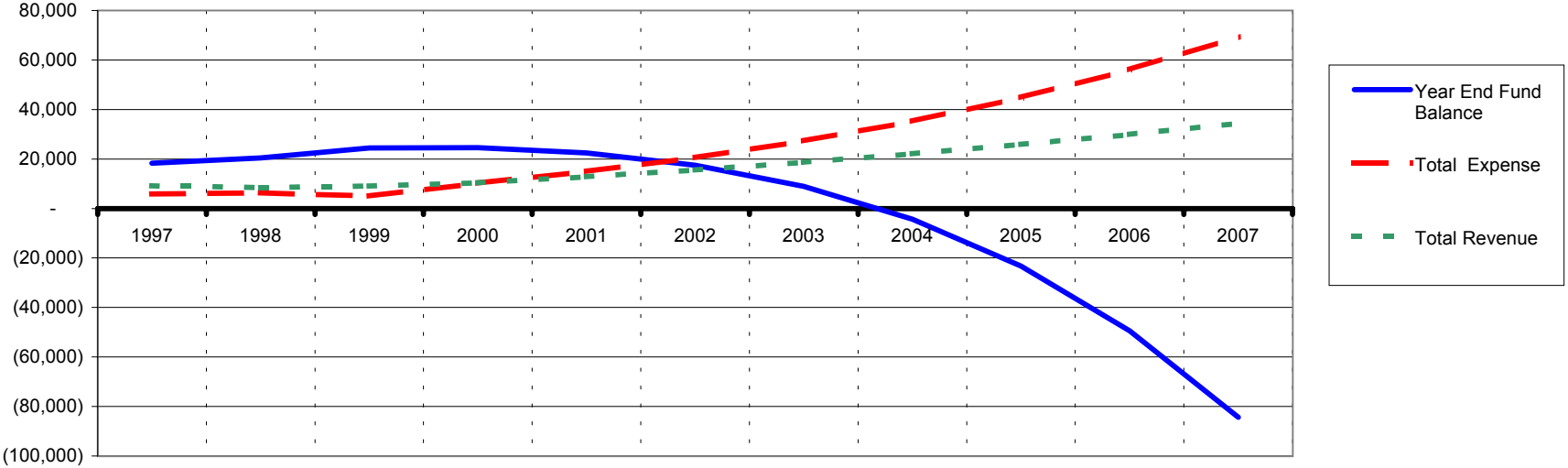
Pre-SB 00-57; Without HIPAA; With Moderate Growth in Membership and Claims

(Unless indicated, in $000's)

Scenario 1M:
Funding: pre-SB00 057
Member Growth: no HIPAA, moderate growth
Claim Trend: Moderate @ 12% for PPO

	Annual Rate of Increase			Member
	Claims	Premium	Admin	Count
PPO	12%	9%	5%	20
HMO	10%	8%	N/A	20

Calendar Year	Average Members	Earned Premium	Premium PMPM	Other Funds	Interest On Fund	Total Revenue	Incurred Claims	Claims PMPM	Admin Expense	Admin PMPM	Total Expense	Operating Gain (Loss)	Year End Fund Balance
1997	1,138	3,531	258.63	4,803	890	9,225	5,221	382.41	683	50.00	5,904	3,321	18,252
1998	975	3,178	271.54	4,147	1,129	8,455	5,592	477.75	731	62.48	6,323	2,132	20,384
1999	995	3,049	255.28	4,789	1,262	9,100	4,197	351.48	784	65.63	4,981	4,119	24,503
2000	1,609	5,499	284.80	3,500	1,348	10,347	9,236	478.34	1,047	54.25	10,283	64	24,567
2001	2,129	7,975	312.16	3,500	1,351	12,827	13,594	532.10	1,350	52.83	14,944	(2,117)	22,450
2002	2,649	10,860	341.64	3,500	1,235	15,595	18,871	593.65	1,677	52.75	20,548	(4,953)	17,497
2003	3,169	14,208	373.62	3,500	962	18,671	25,226	663.35	2,035	53.53	27,261	(8,591)	8,906
2004	3,689	18,093	408.71	3,500	490	22,083	32,844	741.94	2,428	54.85	35,272	(13,190)	(4,283)
2005	4,209	22,572	446.91	3,500	(236)	25,837	41,940	830.37	2,857	56.57	44,798	(18,960)	(23,243)
2006	4,729	27,724	488.54	3,500	(1,278)	29,946	52,762	929.75	3,326	58.61	56,088	(26,142)	(49,385)
2007	5,249	33,633	533.95	3,500	(2,716)	34,417	65,595	1,041.39	3,837	60.92	69,433	(35,016)	(84,401)



Colorado Uninsurable Health Insurance Pool Financial Projection

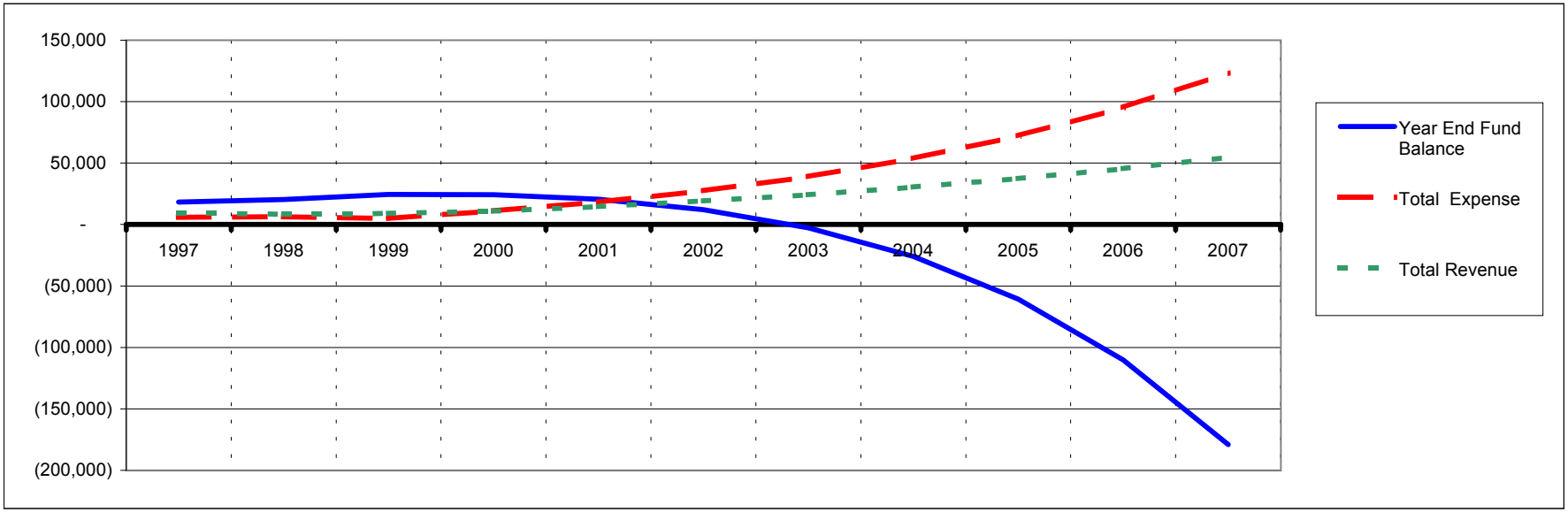
Pre-SB 00-57; Without HIPAA; With High Growth in Membership and Claims

(Unless indicated, in $000's)

Scenario 1H:
Funding: pre-SB00 057
Member Growth: no HIPAA, high growth
Claim Trend: High @ 16% for PPO

	Annual Rate of Increase			Member
	Claims	Premium	Admin	Count
PPO	16%	12%	5%	30
HMO	14%	11%	N/A	30

Calendar Year	Average Members	Earned Premium	Premium PMPM	Other Funds	Interest On Fund	Total Revenue	Incurred Claims	Claims PMPM	Admin Expense	Admin PMPM	Total Expense	Operating Gain (Loss)	Year End Fund Balance
1997	1,138	3,531	258.63	4,803	890	9,225	5,221	382.41	683	50.00	5,904	3,321	18,252
1998	975	3,178	271.54	4,147	1,129	8,455	5,592	477.75	731	62.48	6,323	2,132	20,384
1999	995	3,049	255.28	4,789	1,262	9,100	4,197	351.48	784	65.63	4,981	4,119	24,503
2000	1,719	5,973	289.54	3,500	1,348	10,821	10,026	486.03	1,096	53.15	11,122	(302)	24,202
2001	2,499	9,794	326.61	3,500	1,331	14,626	16,786	559.77	1,523	50.77	18,309	(3,683)	20,519
2002	3,279	14,475	367.88	3,500	1,129	19,104	25,501	648.08	1,987	50.49	27,487	(8,383)	12,135
2003	4,059	20,169	414.08	3,500	667	24,337	36,631	752.05	2,497	51.26	39,128	(14,791)	(2,655)
2004	4,839	27,087	466.47	3,500	(146)	30,441	50,739	873.78	3,056	52.63	53,795	(23,354)	(26,009)
2005	5,619	35,417	525.25	3,500	(1,430)	37,487	68,506	1,015.99	3,669	54.42	72,175	(34,689)	(60,698)
2006	6,399	45,402	591.26	3,500	(3,338)	45,564	90,759	1,181.94	4,340	56.52	95,099	(49,535)	(110,233)
2007	7,179	57,325	665.42	3,500	(6,063)	54,763	118,499	1,375.53	5,072	58.88	123,571	(68,808)	(179,041)



Colorado Uninsurable Health Insurance Pool Financial Projection

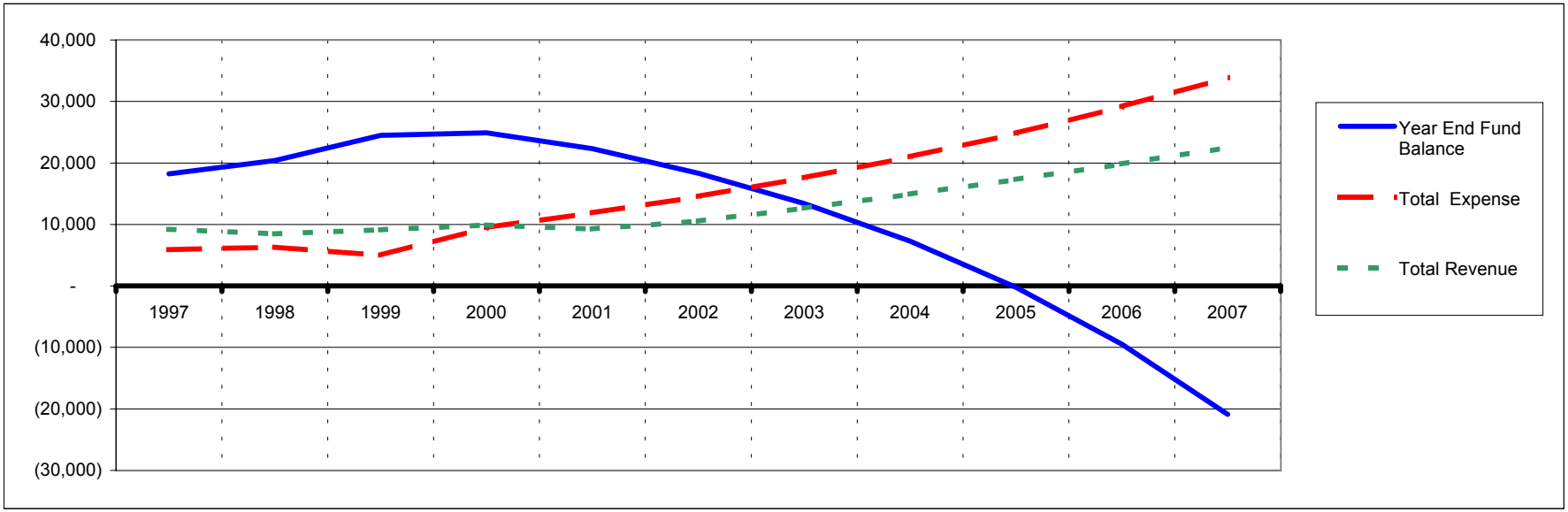
With SB 00-57; Without HIPAA; With Low Growth in Membership and Claims

(Unless indicated, in $000's)

Scenario 2L:
Funding: SB00 057
Member Growth: no HIPAA, low growth
Claim Trend: Low @ 8% for PPO

	Annual Rate of Increase			Member
	Claims	Premium	Admin	Count
PPO	8%	6%	5%	10
HMO	6%	4%	N/A	10

Calendar Year	Average Members	Earned Premium	Premium PMPM	Other Funds	Interest On Fund	Total Revenue	Incurred Claims	Claims PMPM	Admin Expense	Admin PMPM	Total Expense	Operating Gain (Loss)	Year End Fund Balance
1997	1,138	3,531	258.63	4,803	890	9,225	5,221	382.41	683	50.00	5,904	3,321	18,252
1998	975	3,178	271.54	4,147	1,129	8,455	5,592	477.75	731	62.48	6,323	2,132	20,384
1999	995	3,049	255.28	4,789	1,262	9,100	4,197	351.48	784	65.63	4,981	4,119	24,503
2000	1,499	5,034	279.87	3,500	1,348	9,882	8,472	471.00	998	55.50	9,471	412	24,915
2001	1,759	6,265	296.80	1,637	1,370	9,272	10,683	506.10	1,177	55.76	11,860	(2,587)	22,328
2002	2,019	7,614	314.27	1,692	1,228	10,534	13,185	544.19	1,367	56.42	14,551	(4,017)	18,310
2003	2,279	9,092	332.45	2,551	1,007	12,650	16,010	585.42	1,574	57.56	17,584	(4,934)	13,376
2004	2,539	10,712	351.57	3,462	736	14,910	19,195	630.00	1,800	59.07	20,995	(6,085)	7,291
2005	2,799	12,482	371.61	4,428	401	17,311	22,779	678.18	2,045	60.90	24,824	(7,513)	(222)
2006	3,059	14,414	392.66	5,452	(12)	19,854	26,805	730.22	2,312	62.99	29,117	(9,263)	(9,485)
2007	3,319	16,521	414.81	6,519	(522)	22,518	31,321	786.41	2,602	65.33	33,923	(11,405)	(20,890)



Colorado Uninsurable Health Insurance Pool Financial Projection

With SB 00-57; Without HIPAA; with Moderate Growth in Membership and Claims

(Unless indicated, in $000's)

Scenario 2M:
Funding: SB00 057
Member Growth: no HIPAA, moderate growth
Claim Trend: Moderate @ 12% for PPO

	Annual Rate of Increase			Member
	Claims	Premium	Admin	Count
PPO	12%	9%	5%	20
HMO	10%	8%	N/A	20

Calendar Year	Average Members	Earned Premium	Premium PMPM	Other Funds	Interest On Fund	Total Revenue	Incurred Claims	Claims PMPM	Admin Expense	Admin PMPM	Total Expense	Operating Gain (Loss)	Year End Fund Balance
1997	1,138	3,531	258.63	4,803	890	9,225	5,221	382.41	683	50.00	5,904	3,321	18,252
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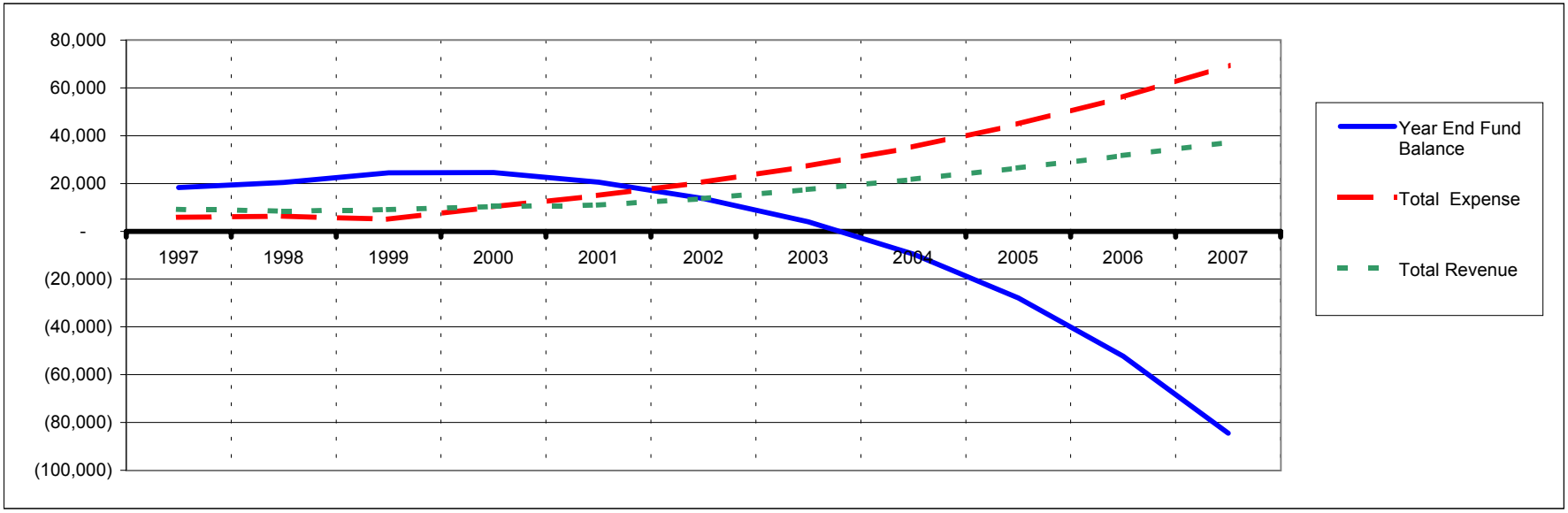
1999	995	3,049	255.28	4,789	1,262	9,100	4,197	351.48	784	65.63	4,981	4,119	24,503
2000	1,609	5,499	284.80	3,500	1,348	10,347	9,236	478.34	1,047	54.25	10,283	64	24,567
2001	2,129	7,975	312.16	1,637	1,351	10,964	13,594	532.10	1,350	52.83	14,944	(3,980)	20,587
2002	2,649	10,860	341.64	1,692	1,132	13,684	18,871	593.65	1,677	52.75	20,548	(6,864)	13,723
2003	3,169	14,208	373.62	2,551	755	17,514	25,226	663.35	2,035	53.53	27,261	(9,747)	3,976
2004	3,689	18,093	408.71	3,462	219	21,774	32,844	741.94	2,428	54.85	35,272	(13,499)	(9,523)
2005	4,209	22,572	446.91	4,428	(524)	26,477	41,940	830.37	2,857	56.57	44,798	(18,321)	(27,843)
2006	4,729	27,724	488.54	5,452	(1,531)	31,645	52,762	929.75	3,326	58.61	56,088	(24,443)	(52,286)
2007	5,249	33,633	533.95	6,519	(2,876)	37,276	65,595	1,041.39	3,837	60.92	69,433	(32,157)	(84,443)



Colorado Uninsurable Health Insurance Pool Financial Projection

With SB 00-57; Without HIPAA; With High Growth in Membership and Claims

(Unless indicated, in $000's)

Scenario 2H:
Funding: SB00 057
Member Growth: no HIPAA, high growth
Claim Trend: High @ 16% for PPO

	Annual Rate of Increase			Member
	Claims	Premium	Admin	Count
PPO	16%	12%	5%	30
HMO	14%	11%	N/A	30

Calendar Year	Average Members	Earned Premium	Premium PMPM	Other Funds	Interest On Fund	Total Revenue	Incurred Claims	Claims PMPM	Admin Expense	Admin PMPM	Total Expense	Operating Gain (Loss)	Year End Fund Balance
1997	1,138	3,531	258.63	4,803	890	9,225	5,221	382.41	683	50.00	5,904	3,321	18,252
1998	975	3,178	271.54	4,147	1,129	8,455	5,592	477.75	731	62.48	6,323	2,132	20,384
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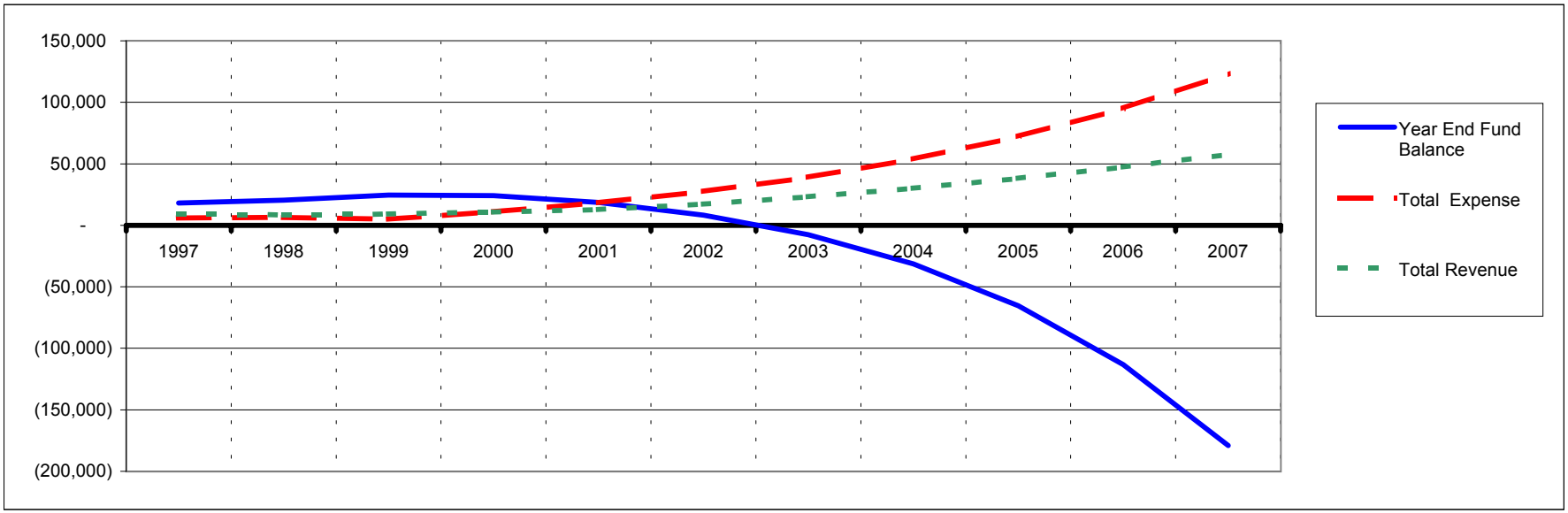
2000	1,719	5,973	289.54	3,500	1,348	10,821	10,026	486.03	1,096	53.15	11,122	(302)	24,202
2001	2,499	9,794	326.61	1,637	1,331	12,763	16,786	559.77	1,523	50.77	18,309	(5,546)	18,656
2002	3,279	14,475	367.88	1,692	1,026	17,193	25,501	648.08	1,987	50.49	27,487	(10,294)	8,361
2003	4,059	20,169	414.08	2,551	460	23,180	36,631	752.05	2,497	51.26	39,128	(15,947)	(7,586)
2004	4,839	27,087	466.47	3,462	(417)	30,132	50,739	873.78	3,056	52.63	53,795	(23,663)	(31,249)
2005	5,619	35,417	525.25	4,428	(1,719)	38,126	68,506	1,015.99	3,669	54.42	72,175	(34,049)	(65,298)
2006	6,399	45,402	591.26	5,452	(3,591)	47,263	90,759	1,181.94	4,340	56.52	95,099	(47,836)	(113,134)
2007	7,179	57,325	665.42	6,519	(6,222)	57,622	118,499	1,375.53	5,072	58.88	123,571	(65,949)	(179,083)



Colorado Uninsurable Health Insurance Pool Financial Projection

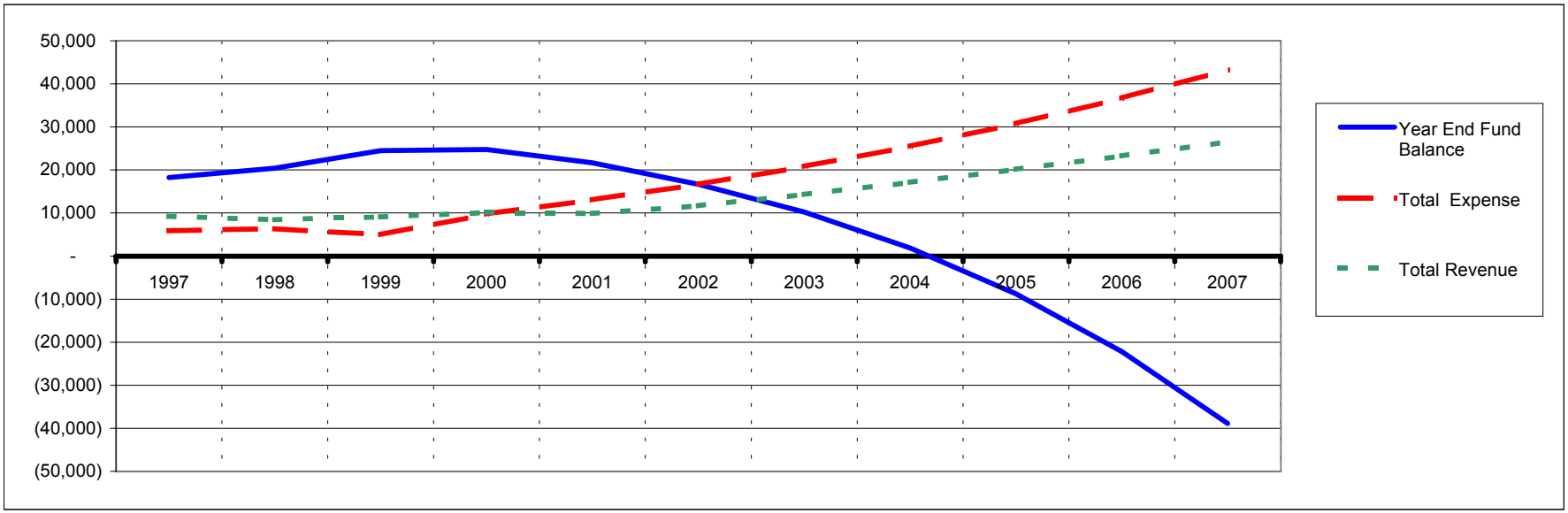
With SB 00-57; With HIPAA; With Low Growth in Membership and Claims

(Unless indicated, in $000's)

Scenario 3L:
Funding: SB00 057
Member Growth: HIPAA, low growth
Claim Trend: Low @ 8% for PPO

	Annual Rate of Increase			Member
	Claims	Premium	Admin	Count
PPO	8%	6%	5%	15
HMO	6%	4%	N/A	15

Calendar Year	Average Members	Earned Premium	Premium PMPM	Other Funds	Interest On Fund	Total Revenue	Incurred Claims	Claims PMPM	Admin Expense	Admin PMPM	Total Expense	Operating Gain (Loss)	Year End Fund Balance
1997	1,138	3,531	258.63	4,803	890	9,225	5,221	382.41	683	50.00	5,904	3,321	18,252
1998	975	3,178	271.54	4,147	1,129	8,455	5,592	477.75	731	62.48	6,323	2,132	20,384
1999	995	3,049	255.28	4,789	1,262	9,100	4,197	351.48	784	65.63	4,981	4,119	24,503
2000	1,554	5,222	280.04	3,500	1,348	10,070	8,772	470.42	1,023	54.85	9,795	275	24,778
2001	1,944	6,926	296.90	1,637	1,363	9,926	11,760	504.12	1,263	54.16	13,023	(3,097)	21,681
2002	2,334	8,800	314.19	1,692	1,192	11,684	15,157	541.18	1,522	54.34	16,679	(4,995)	16,686
2003	2,724	10,857	332.13	2,551	918	14,326	19,010	581.56	1,805	55.21	20,815	(6,489)	10,197
2004	3,114	13,116	351.00	3,462	561	17,139	23,370	625.40	2,114	56.57	25,484	(8,345)	1,852
2005	3,504	15,590	370.78	4,428	102	20,121	28,293	672.86	2,451	58.30	30,744	(10,623)	(8,771)
2006	3,894	18,297	391.56	5,452	(482)	23,267	33,841	724.20	2,819	60.33	36,660	(13,393)	(22,164)
2007	4,284	21,254	413.44	6,519	(1,219)	26,554	40,083	779.70	3,220	62.63	43,302	(16,748)	(38,913)



Colorado Uninsurable Health Insurance Pool Financial Projection

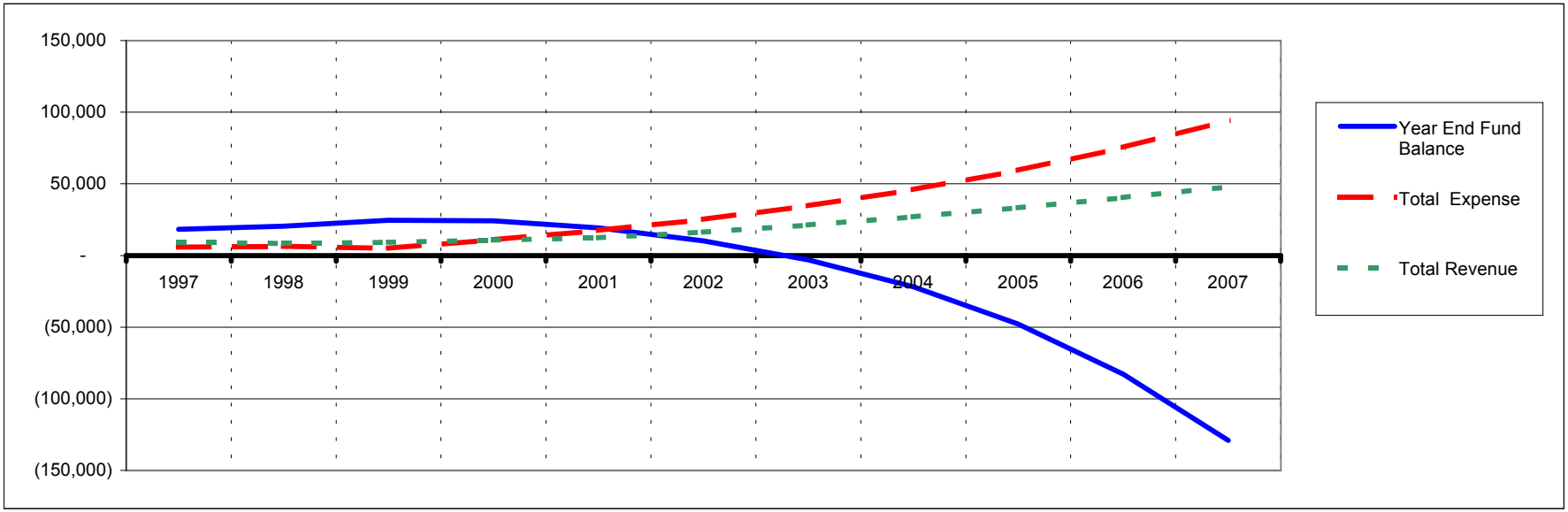
With SB 00-57; With HIPAA; With Moderate Growth in Membership and Claims

(Unless indicated, in $000's)

Scenario 3M:
Funding: SB00 057
Member Growth:HIPAA, moderate growth
Claim Trend: Moderate @ 12% for PPO

	Annual Rate of Increase			Member
	Claims	Premium	Admin	Count
PPO	12%	9%	5%	30
HMO	10%	8%	N/A	30

Calendar Year	Average Members	Earned Premium	Premium PMPM	Other Funds	Interest On Fund	Total Revenue	Incurred Claims	Claims PMPM	Admin Expense	Admin PMPM	Total Expense	Operating Gain (Loss)	Year End Fund Balance
1997	1,138	3,531	258.63	4,803	890	9,225	5,221	382.41	683	50.00	5,904	3,321	18,252
1998	975	3,178	271.54	4,147	1,129	8,455	5,592	477.75	731	62.48	6,323	2,132	20,384
1999	995	3,049	255.28	4,789	1,262	9,100	4,197	351.48	784	65.63	4,981	4,119	24,503
2000	1,719	5,884	285.22	3,500	1,348	10,732	9,850	477.51	1,096	53.15	10,947	(215)	24,288
2001	2,499	9,371	312.51	1,637	1,336	12,345	15,879	529.51	1,523	50.77	17,402	(5,057)	19,231
2002	3,279	13,451	341.85	1,692	1,058	16,201	23,221	590.15	1,987	50.49	25,208	(9,007)	10,224
2003	4,059	18,202	373.69	2,551	562	21,315	32,108	659.19	2,497	51.26	34,604	(13,289)	(3,065)
2004	4,839	23,730	408.66	3,462	(169)	27,024	42,807	737.18	3,056	52.63	45,863	(18,839)	(21,904)
2005	5,619	30,123	446.75	4,428	(1,205)	33,347	55,629	825.01	3,669	54.42	59,298	(25,951)	(47,855)
2006	6,399	37,492	488.26	5,452	(2,632)	40,313	70,934	923.77	4,340	56.52	75,274	(34,961)	(82,816)
2007	7,179	45,964	533.54	6,519	(4,555)	47,928	89,140	1,034.73	5,072	58.88	94,212	(46,284)	(129,101)



Colorado Uninsurable Health Insurance Pool Financial Projection

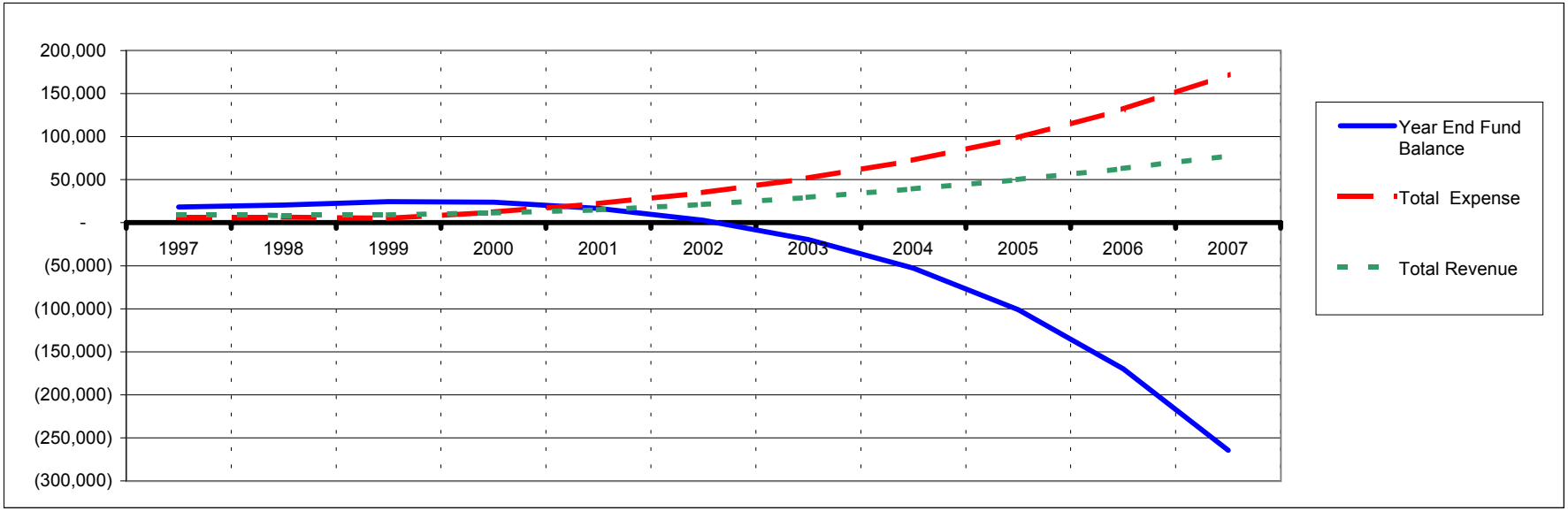
With SB 00-57; With HIPAA; With High Growth in Membership and Claims

(Unless indicated, in $000's)

Scenario 3H:
Funding: SB00 057
Member Growth:HIPAA, high growth
Claim Trend: High @ 16% for PPO

	Annual Rate of Increase			Member
	Claims	Premium	Admin	Count
PPO	16%	12%	5%	45
HMO	14%	11%	N/A	45

Calendar Year	Average Members	Earned Premium	Premium PMPM	Other Funds	Interest On Fund	Total Revenue	Incurred Claims	Claims PMPM	Admin Expense	Admin PMPM	Total Expense	Operating Gain (Loss)	Year End Fund Balance
1997	1,138	3,531	258.63	4,803	890	9,225	5,221	382.41	683	50.00	5,904	3,321	18,252
1998	975	3,178	271.54	4,147	1,129	8,455	5,592	477.75	731	62.48	6,323	2,132	20,384
1999	995	3,049	255.28	4,789	1,262	9,100	4,197	351.48	784	65.63	4,981	4,119	24,503
2000	1,884	6,561	290.19	3,500	1,348	11,409	10,969	485.16	1,170	51.75	12,138	(730)	23,774
2001	3,054	11,985	327.04	1,637	1,308	14,930	20,414	557.03	1,782	48.62	22,196	(7,265)	16,508
2002	4,224	18,659	368.12	1,692	908	21,259	32,672	644.56	2,451	48.36	35,123	(13,864)	2,644
2003	5,394	26,809	414.18	2,551	145	29,506	48,414	747.96	3,189	49.26	51,602	(22,097)	(19,452)
2004	6,564	36,742	466.46	3,462	(1,070)	39,134	68,459	869.12	3,999	50.77	72,458	(33,323)	(52,775)
2005	7,734	48,736	525.13	4,428	(2,903)	50,262	93,802	1,010.71	4,887	52.66	98,689	(48,427)	(101,203)
2006	8,904	63,149	591.02	5,452	(5,566)	63,036	125,650	1,175.97	5,860	54.85	131,510	(68,474)	(169,677)
2007	10,074	80,398	665.06	6,519	(9,332)	77,585	165,465	1,368.74	6,925	57.28	172,390	(94,805)	(264,482)



Appendix B

Comparison of State High-Risk Pool Data

Summary of State High Risk Pools 1996

State	# of Enrollees	Average PMPM Premium	Average PMPM Claims	Admin Cost PMPM
Colorado	1,227	$ 272.92	$ 311.28	$ 51.85
Alabama	NA	NA	NA	NA
Alaska	194	$ 252.95	$ 540.21	$ 144.25
Arkansas	401	$ 93.34	$ 38.24	$ 9.14
California	19,200	$ 201.82	$ 326.39	$ 19.22
Connecticut	1,477	$ 255.08	$ 515.78	$ 24.09
Florida	1,418	$ 306.43	$ 382.79	$ 26.08
Illinois	4,986	$ 315.63	$ 576.33	$ 42.79
Indiana	4,313	$ 296.79	$ 595.32	$ 30.11
Iowa	810	$ 391.01	$ 430.55	$ 25.45
Kansas	952	$ 137.38	$ 198.15	$ 17.19
Louisiana	677	$ 205.13	$ 526.84	$ 54.65
Minnesota	27,552	$ 147.97	$ 265.28	$ 15.30
Mississippi	1,250	$ 193.54	$ 286.48	$ 23.70
Missouri	1,076	$ 371.03	$ 549.18	$ 20.48
Montana	458	$ 179.42	$ 230.22	$ 23.07
Nebraska	3,627	$ 191.42	$ 339.56	$ 16.37
New Mexico	811	$ 320.34	$ 450.39	$ 39.63
North Dakota	1,302	$ 187.18	$ 269.33	$ 17.80
Oklahoma	119	$ 23.74	$ 1.22	$ 9.51
Oregon	4,139	$ 187.78	$ 303.11	$ 17.51
South Carolina	964	$ 367.39	$ 379.25	$ 46.76
Texas	NA	NA	NA	NA
Utah	680	$ 214.92	$ 410.16	$ 40.51
Washington	712	$ 174.62	$ 719.24	$ 41.39
Wisconsin	8,099	$ 239.59	$ 464.81	$ 20.05
Wyoming	279	$ 162.84	$ 320.08	$ 6.39
Colorado	**1,227**	**$ 272.92**	**$ 311.28**	**$ 51.85**
Average	**3,469**	**$ 227.61**	**$ 377.21**	**$ 31.33**
Median	**1,076**	**$ 205.13**	**$ 379.25**	**$ 23.70**
First Quartile	**680**	**$ 179.42**	**$ 286.48**	**$ 17.51**
Fourth Quartile	**3,627**	**$ 296.79**	**$ 515.78**	**$ 40.51**
Colorado Rank (25)	**12**	**8**	**17**	**3**

Source: Comprehensive Health Insurance for High-Risk Individuals, 13th edition, 1999, Communicating for Agriculture

Summary of State High Risk Pools 1997

State	# of Enrollees	Average PMPM Premium	Average PMPM Claims	Admin Cost PMPM
Colorado	1,137	$ 258.78	$ 370.95	$ 50.00
Alabama	NA	NA	NA	NA
Alaska	258	$ 220.69	$ 508.77	$ 98.27
Arkansas	588	$ 146.45	$ 139.84	$ 15.93
California	19,919	$ 200.33	$ 328.14	$ 20.08
Connecticut	1,290	$ 147.84	$ 700.85	$ 28.57
Florida	1,095	$ 317.67	$ 398.23	$ 37.91
Illinois	5,438	$ 301.84	$ 558.45	$ 43.90
Indiana	3,997	$ 310.96	$ 679.03	$ 31.90
Iowa	482	$ 407.77	$ 585.53	$ 52.77
Kansas	976	$ 124.21	$ 266.21	$ 20.87
Louisiana	747	$ 230.77	$ 649.96	$ 60.27
Minnesota	26,314	$ 150.32	$ 287.83	$ 15.44
Mississippi	1,700	$ 190.78	$ 278.87	$ 18.56
Missouri	1,032	$ 379.14	$ 576.48	$ 22.87
Montana	704	$ 196.87	$ 267.28	$ 26.04
Nebraska	3,977	$ 200.20	$ 351.23	$ 17.49
New Mexico	792	$ 307.58	$ 497.05	$ 28.79
North Dakota	1,328	$ 187.95	$ 267.45	$ 14.40
Oklahoma	355	$ 99.27	$ 95.59	$ 9.48
Oregon	4,461	$ 168.26	$ 308.46	$ 19.44
South Carolina	943	$ 360.27	$ 458.42	$ 53.27
Texas	NA	NA	NA	NA
Utah	714	$ 226.23	$ 449.99	$ 38.47
Washington	766	$ 162.59	$ 686.41	$ 39.44
Wisconsin	7,318	$ 281.00	$ 448.24	$ 22.42
Wyoming	349	$ 173.08	$ 348.88	$ 6.66
Colorado	**1,137**	**$ 258.78**	**$ 370.95**	**$ 50.00**
Average	**3,467**	**$ 230.03**	**$ 420.33**	**$ 31.73**
Median	**1,032**	**$ 200.33**	**$ 398.23**	**$ 26.04**
First Quartile	**714**	**$ 168.26**	**$ 287.83**	**$ 18.56**
Fourth Quartile	**3,977**	**$ 301.84**	**$ 558.45**	**$ 39.44**
Colorado Rank (25)	**11**	**9**	**14**	**5**

Source: Comprehensive Health Insurance for High-Risk Individuals, 13th edition, 1999, Communicating for Agriculture

Summary of State High Risk Pools 1998

State	# of Enrollees	Average PMPM Premium	Average PMPM Claims	Admin Cost PMPM
Colorado	970	$ 267.88	$ 405.98	$ 62.48
Alabama	841	$ 187.44	$ 293.98	$ 12.10
Alaska	258	$ 245.00	$ 594.00	$ 108.00
Arkansas	974	$ 193.00	$ 214.00	$ 22.00
California	19,995	$ 277.00	$ 354.00	NA
Connecticut	1,400	$ 290.00	$ 860.00	$ 27.00
Florida	916	$ 318.79	$ 690.83	$ 40.21
Illinois	6,561	$ 289.71	$ 560.86	$ 43.40
Indiana	4,208	$ 308.60	$ 795.98	$ 28.55
Iowa	346	$ 339.86	$ 553.05	$ 66.36
Kansas	1,019	$ 213.12	$ 306.60	$ 18.55
Louisiana	898	$ 207.27	$ 522.36	$ 32.34
Minnesota	24,954	$ 159.37	$ 159.37	$ 17.21
Mississippi	1,775	$ 240.29	$ 375.09	$ 18.46
Missouri	879	$ 401.67	$ 631.90	$ 22.09
Montana	706	$ 215.34	$ 345.94	$ 27.50
Nebraska	4,359	$ 215.43	$ 418.29	$ 19.27
New Mexico	849	$ 226.46	$ 411.54	$ 37.19
North Dakota	1,346	$ 196.49	$ 296.25	$ 12.76
Oklahoma	783	$ 200.22	$ 307.74	$ 20.67
Oregon	4,184	$ 204.09	$ 379.74	$ 27.22
South Carolina	1,046	$ 364.75	$ 602.34	$ 62.23
Texas	2,946	$ 128.44	$ 287.05	$ 40.23
Utah	888	$ 270.80	$ 385.53	$ 39.80
Washington	808	$ 150.96	$ 650.02	$ 49.31
Wisconsin	7,401	$ 219.46	$ 420.48	$ 22.16
Wyoming	429	$ 191.38	$ 274.44	$ 5.75
Colorado	**970**	**$ 267.88**	**$ 405.98**	**$ 62.48**
Average	**3,398**	**$ 241.59**	**$ 448.05**	**$ 33.96**
Median	**974**	**$ 219.46**	**$ 405.98**	**$ 27.36**
First Quartile	**845**	**$ 198.36**	**$ 307.17**	**$ 19.62**
Fourth Quartile	**3,565**	**$ 283.36**	**$ 577.43**	**$ 40.23**
Colorado Rank (27)	**15**	**10**	**14**	**3**

Source: Comprehensive Health Insurance for High-Risk Individuals, 13th edition, 1999, Communicating for Agricultu

Summary of State High Risk Pools 1999

State	# of Enrollees	Average PMPM Premium	Average PMPM Claims	Admin Cost PMPM
Colorado	995	$ 263.75	$ 405.91	$ 65.63
Alabama	1,309	$ 241.00	$ 372.00	$ 9.00
Alaska	342	NA	NA	NA
Arkansas	1,360	NA	NA	NA
California	21,429	NA	NA	NA
Connecticut	2,213	NA	NA	NA
Florida	851	NA	NA	NA
Illinois	7,199	NA	NA	NA
Indiana	4,246	NA	NA	NA
Iowa	356	NA	NA	NA
Kansas	1,115	$ 274.79	$ 397.19	$ 25.77
Louisiana	NA	NA	NA	NA
Minnesota	25,703	NA	NA	NA
Mississippi	1,823	NA	NA	NA
Missouri	NA	NA	NA	NA
Montana	1,343	$ 133.70	$ 186.96	$ 16.60
Nebraska	4,653	NA	NA	NA
New Mexico	933	NA	NA	NA
North Dakota	1,354	$ 199.84	$ 317.75	$ 11.54
Oklahoma	1,195	$ 231.63	$ 314.73	$ 20.21
Oregon	5,822	$ 165.95	$ 283.86	$ 19.56
South Carolina	1,117	NA	NA	NA
Texas	4,929	NA	NA	NA
Utah	983	NA	NA	NA
Washington	826	NA	NA	NA
Wisconsin	NA	NA	NA	NA
Wyoming	510	$ 210.85	$ 373.87	$ 5.49
Colorado	**995**	**$ 263.75**	**$ 405.91**	**$ 65.63**
Average	**3,859**	**$ 215.19**	**$ 331.53**	**$ 21.73**
Median	**1,326**	**$ 221.24**	**$ 344.88**	**$ 18.08**
First Quartile	**971**	**$ 191.37**	**$ 307.01**	**$ 10.90**
Fourth Quartile	**4,348**	**$ 246.69**	**$ 379.70**	**$ 21.60**
Colorado Rank	**17**	**2**	**1**	**1**

Source: Comprehensive Health Insurance for High-Risk Individuals, 13th edition, 1999, Communicating for Agriculture

Appendix C

HIPAA Experience

HIPAA versus Non-HIPAA Membership and Claim Experience

Membership

	1998			1999		
State	Non-HIPAA	HIPAA	HIPAA/ non-HIPAA	Non-HIPAA	HIPAA	HIPAA/ non-HIPAA
Connecticut	1,123	277	25%	1,239	487	39%
Illinois	5,037	1,008	20%	5,120	2,079	41%
Indiana	N/A	N/A		4,070	176	4%
Kansas	N/A	N/A		857	258	30%
Mississippi	N/A	N/A		1,441	382	27%
Oregon	1,242	170	14%	2,605	506	19%
South Carolina	N/A	N/A		732	350	48%
Utah	N/A	N/A		735	248	34%
Total	7,402	1,455	20%	16,799	4,486	27%

Claim Experience (Loss Ratio)

	1998			1999		
State	Non-HIPAA	HIPAA	HIPAA/ non-HIPAA	Non-HIPAA	HIPAA	HIPAA/ non-HIPAA
Illinois	196%	163%	0.83	195%	163%	0.84
Mississippi				117%	141%	1.21
Oregon	187%	74%	0.40	192%	158%	0.82
Average	192%	119%	0.61	168%	154%	0.96

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