2007 SUNSET REVIEW

Colorado Department of Regulatory Agencies
Office of Policy, Research and Regulatory Reform

Assessments Imposed upon Insurance Carriers to Fund the CoverColorado Program

October 15, 2007

STATE OF COLORADO

DEPARTMENT OF REGULATORY AGENCIES
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Bill Ritter, Jr.
Governor

D. Rico Munn
Executive Director

October 15, 2007

Members of the Colorado General Assembly
c/o the Office of Legislative Legal Services
State Capitol Building
Denver, Colorado 80203

Dear Members of the General Assembly:

The mission of the Department of Regulatory Agencies (DORA) is consumer protection. As a part of the Executive Director's Office within DORA, the Office of Policy, Research and Regulatory Reform seeks to fulfill its statutorily mandated responsibility to conduct sunset reviews with a focus on protecting the health, safety and welfare of all Coloradans.

DORA has completed the evaluation of the special fees assessed upon insurance carriers to fund the CoverColorado program. I am pleased to submit this written report, which will be the basis for my office's oral testimony before the 2008 legislative committee of reference. The report is submitted pursuant to section 24-34-104(8)(a), of the Colorado Revised Statutes (C.R.S.), which states in part:

> The department of regulatory agencies shall conduct an analysis of the performance of each division, board or agency or each function scheduled for termination under this section...
>
> The department of regulatory agencies shall submit a report and supporting materials to the office of legislative legal services no later than October 15 of the year preceding the date established for termination…

The report discusses the question of whether the assessment provided under Section 530(1.5) of Article 8 of Title 10, C.R.S., serves to protect the public health, safety or welfare. The report also discusses the effectiveness of the assessment in fulfilling the intent of the statute and makes recommendations for statutory changes in the event this funding mechanism is continued by the General Assembly.

Sincerely,

D. Rico Munn
Executive Director

2007 Sunset Review
Assessments Imposed upon Insurance Carriers to Fund the CoverColorado Program

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Executive Summary

Quick Facts

What is CoverColorado? The CoverColorado Program (Program) is a non-profit entity created in 1991 to offer health insurance coverage to the uninsurable: those unable to secure private health insurance in the individual market without restrictive exclusions or extremely high premiums, usually due to a pre-existing health condition.

How Many People are Enrolled in the Program? Over the past five years, there has been an average of 4,700 people enrolled in the Program at any given time.

Who Pays for the Program? The Program is funded in a variety of ways, including participant premiums, allocations from the Unclaimed Property Fund, federal grants, and special fees assessed upon insurance carriers.

Who is Subject to the Assessment? All regulated insurance carriers providing group or individual health benefit plans in Colorado, as well as those providing stop-loss, excess-loss, and reinsurance coverage to self-insured group health plans are subject to the assessment.

When are the Special Fees Assessed? The CoverColorado Board (Board) may only assess the special fees if, after taking into account all other funding sources, a budget shortfall is still projected.

How is the Amount of the Assessment Calculated? Insurance carriers are charged a per capita fee for each individual covered by one of their health plans. The Board determines the per capita amount by dividing the total projected budget shortfall by the total number of covered lives in the state. The per capita amount is then multiplied by the total number of individuals insured by a given carrier. For example, if the per capita amount is $5, a carrier reporting 1,000 covered lives would be assessed $5,000.

Has the Assessment Ever Been Charged?
The assessment has been charged twice:

- In August 2003, the per capita amount was $7.45 and the total fees assessed equaled $9,252,203.
- In May 2004, the per capita amount was $26.37 and the total fees assessed equaled $29,829,718.

Where Do I Get the Full Report? The full sunset review can be found on the internet at:
http://www.dora.state.co.us/opr/oprpublications.htm

Key Recommendations

Continue the authority to assess special fees upon insurance carriers to fund the CoverColorado Program.
CoverColorado exists to ensure access to healthcare coverage for the uninsurable. A simple change in circumstances—the diagnosis of a serious illness or the loss of a job or employer-provided health insurance—could force any Coloradan into the ranks of the uninsurable. For this reason, the Program is critical to the public health and safety of Coloradans, and must be funded. Although the assessment is currently neither the sole nor the primary funding mechanism for the Program, it has historically been effective in sustaining the Program when other funding sources are depleted. Therefore, the assessment should be continued.

Remove the sunset provision for the assessment from the statute.
The sunset statutory criteria were devised specifically to evaluate licensing boards and programs, so these criteria do not provide an effective means of evaluating a funding mechanism for a non-profit instrumentality of the state. Further, the assessment could not reasonably be allowed to repeal without putting another funding mechanism in its place.

Create a task force to develop long-term, permanent funding solutions for CoverColorado.
The assessment was originally devised with the input of insurance carriers, representatives of state government, health care experts, and uninsurable individuals. In light of the current focus on Colorado health care reform, now is the time for stakeholders to reconvene and develop a proposal for funding the Program for at least the next 10 years. An 11-member task force, appointed by the Governor, should be created to develop such a funding plan and present it to the General Assembly.

Major Contacts Made During This Review

Colorado Association of Health Plans
Colorado Division of Insurance
CoverColorado
CoverColorado Board
Office of the Colorado Attorney General
Office of the Colorado State Treasurer

What is a Sunset Review?

A sunset review is a periodic assessment of state boards, programs, and functions to determine whether or not they should be continued by the legislature. Sunset reviews focus on creating the least restrictive form of regulation consistent with protecting the public. In formulating recommendations, sunset reviews consider the public's right to consistent, high quality professional or occupational services and the ability of businesses to exist and thrive in a competitive market, free from unnecessary regulation.

Sunset Reviews are Prepared by:
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Background

The Sunset Process

Regulation, when appropriate, can serve as a bulwark of consumer protection. Regulatory programs can be designed to impact individual professionals, businesses or both.

As regulatory programs relate to individual professionals, such programs typically entail the establishment of minimum standards for initial entry and continued participation in a given profession or occupation. This serves to protect the public from incompetent practitioners. Similarly, such programs provide a vehicle for limiting or removing from practice those practitioners deemed to have harmed the public.

From a practitioner perspective, regulation can lead to increased prestige and higher income. Accordingly, regulatory programs are often championed by those who will be the subject of regulation.

On the other hand, by erecting barriers to entry into a given profession or occupation, even when justified, regulation can serve to restrict the supply of practitioners. This not only limits consumer choice, but can also lead to an increase in the cost of services.

There are also several levels of regulation. Licensure is the most restrictive form of regulation, yet it provides the greatest level of public protection. Licensing programs typically involve the completion of a prescribed educational program (usually college level or higher) and the passage of an examination that is designed to measure a minimal level of competency. These types of programs usually entail title protection – only those individuals who are properly licensed may use a particular title(s) – and practice exclusivity – only those individuals who are properly licensed may engage in the particular practice. While these requirements can be viewed as barriers to entry, they also afford the highest level of consumer protection in that they ensure that only those who are deemed competent may practice and the public is alerted to those who may practice by the title(s) used.

Certification programs offer a level of consumer protection similar to licensing programs, but the barriers to entry are generally lower. The required educational program may be more vocational in nature, but the required examination should still measure a minimal level of competency. Additionally, certification programs typically involve a non-governmental entity that establishes the training requirements and owns and administers the examination. State certification is made conditional upon the individual practitioner obtaining and maintaining the relevant private credential. These types of programs also usually entail title protection and practice exclusivity.

While the aforementioned requirements can still be viewed as barriers to entry, they afford a level of consumer protection that is lower than a licensing program. They ensure that only those who are deemed competent may practice and the public is alerted to those who may practice by the title(s) used.

Registration programs can serve to protect the public with minimal barriers to entry. A typical registration program involves an individual satisfying certain prescribed requirements – typically non-practice related items, such as insurance or the use of a disclosure form – and the state, in turn, placing that individual on the pertinent registry. These types of programs can entail title protection and practice exclusivity. Since the barriers to entry in registration programs are relatively low, registration programs are generally best suited to those professions and occupations where the risk of public harm is relatively low, but nevertheless present. In short, registration programs serve to notify the state of which individuals are engaging in the relevant practice and to notify the public of those who may practice by the title(s) used.

Finally, title protection programs represent one of the lowest levels of regulation. Only those who satisfy certain prescribed requirements may use the relevant prescribed title(s). Practitioners need not register or otherwise notify the state that they are engaging in the relevant practice, and practice exclusivity does not attach. In other words, anyone may engage in the particular practice, but only those who satisfy the prescribed requirements may use the enumerated title(s). This serves to indirectly ensure a minimal level of competency – depending upon the prescribed preconditions for use of the protected title(s) – and the public is alerted to the qualifications of those who may use the particular title(s).

Licensing, certification and registration programs also typically involve some kind of mechanism for removing individuals from practice when such individuals engage in enumerated proscribed activities. This is generally not the case with title protection programs.

As regulatory programs relate to businesses, they can enhance public protection, promote stability and preserve profitability. But they can also reduce competition and place administrative burdens on the regulated businesses.

Regulatory programs that address businesses can involve certain capital, bookkeeping and other recordkeeping requirements that are meant to ensure financial solvency and responsibility, as well as accountability. Initially, these requirements may serve as barriers to entry, thereby limiting competition. On an ongoing basis, the cost of complying with these requirements may lead to greater administrative costs for the regulated entity, which costs are ultimately passed on to consumers.

Many programs that regulate businesses involve examinations and audits of finances and other records, which are intended to ensure that the relevant businesses continue to comply with these initial requirements. Although intended to enhance public protection, these measures, too, involve costs of compliance.

Similarly, many regulated businesses may be subject to physical inspections to ensure compliance with health and safety standards.

Regulation, then, has many positive and potentially negative consequences.

The authority to assess special fees upon insurance carriers to fund the CoverColorado Program (Program) in accordance with section 10-8-530(1.5), Colorado Revised Statutes (C.R.S.), shall terminate on July 1, 2008, unless continued by the General Assembly. During the year prior to this date, it is the duty of the Department of Regulatory Agencies (DORA) to conduct an analysis and evaluation of the assessment pursuant to section 24-34-104, C.R.S.

The purpose of this review is to determine whether the assessment should be continued for the protection of the public and to evaluate the efficacy of the assessment in the funding of the Program. During this review, the Program must demonstrate that the assessment serves to protect the public health, safety or welfare. DORA's findings and recommendations are submitted via this report to the legislative committee of reference of the Colorado General Assembly. Statutory criteria used in sunset reviews may be found in Appendix A on page 26.

It is important to note that the Governor's Blue Ribbon Commission for Health Care Reform[1] (Commission) is currently in the process of evaluating comprehensive statewide health care reform options and developing specific recommendations to improve the health care system in Colorado. The Commission will present its findings to the General Assembly in January 2008. Any resultant legislation could have a substantial effect on the Program and its funding.

Methodology

As part of this review, DORA staff conducted a literature review; interviewed staff of the DOI, the Office of the State Treasurer, and the Program; reviewed records and minutes of the CoverColorado Board; interviewed stakeholders in the health insurance and stop-loss insurance industries; reviewed Colorado statutes, DOI rules, and Program policies; and reviewed the laws of other states.

[1] Because the Commission was created with the passage of Senate Bill 06-208, it also known as the 208 Commission.

Profile of the Program

The Program was created to address the needs of a unique population: the uninsurable.

According to 2005 statistics, among Colorado's insured population, most individuals—about 70 percent—secure health insurance in the group health insurance market through their employers. Roughly 21 percent are insured via Medicare, Medicaid, or other public programs, and the remaining 8 percent purchase insurance in the individual market. [2]

Colorado law requires carriers in the group health insurance market to provide coverage to all group members, their spouses, and their dependents, regardless of health status. The individual health insurance market, however, is not subject to these requirements. Insurance carriers in the individual market medically underwrite their health insurance plans and are free to decline any applicant on the basis of health status.

Coloradans who are ineligible for public programs (e.g., Medicaid) and do not have access to the group insurance market—because they are unemployed, self-employed[3], or their employers do not offer a group health insurance plan—often end up seeking health coverage in the individual insurance market. The result is that many individuals with pre-existing health problems—from serious illnesses like cancer and lupus to chronic diseases like diabetes—have difficulty obtaining health insurance in the individual market, and if they do obtain it, the coverage offered can be limited and the premiums high. These individuals, distinct from the uninsured, are deemed "uninsurable." The Program was created to offer health insurance to this population.

The Program is a high-risk pool, which can be broadly defined as a non-profit association created by state government to provide comprehensive health insurance for Colorado's uninsurable residents.[4] High-risk pools are frequently referred to as "safety nets" for the uninsurable or "insurers of last resort." Thirty-three states currently operate high-risk pools.

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[2] *State Health Facts Online, 2004-2005,* Kaiser Family Foundation, downloaded from http://www.statehealthfactsonline.org/profileind.jsp?ind=125&cat=3&rgn=7 on September 20, 2007.
[3] Certain self-employed individuals meeting the criteria for a "business group of one" as defined in section 10-16-102(6), C.R.S., may be eligible for coverage in the small group insurance market.
[4] *Issue Brief: High-Risk Health Insurance Pools*, Families USA, May 2006, p. 1.

High-risk pools are predicated on the notion that bringing more people—even those with serious health problems—into the ranks of the insured makes financial sense for these reasons:

- Catastrophic medical costs are a leading cause of personal bankruptcy in the United States.[5] Because uninsurable people often have serious health problems, they are at particular risk for major personal losses in the event of a health crisis.

- Every year, hospitals lose billions of dollars on uncompensated care, defined as an overall measure of hospital care provided for which no payment was received from the patient or insurance carrier.[6] In a 2005 survey of 4,936 registered community hospitals, the American Hospital Association found that hospitals lost a total of $28.8 billion, or 5.6 percent of their expenses, to uncompensated care.[7] Health care providers partially recoup these losses by raising the rates on hospital services for insured patients, or "cost-shifting," which contributes to a rise in health insurance premiums.[8] If more people receiving hospital services are insured, hospitals are likely to receive more direct payment for their services, reducing the potential for cost-shifting.[9]

- High-risk pools increasingly offer case management services for participants, which can help contain health care costs by placing an emphasis on preventive and coordinated care resulting in fewer expensive emergency procedures.

- High-risk pools provide a critical safety net for very sick individuals, frequently at a lower cost to the consumer than other mechanisms, such as mandated guaranteed issue for the individual market. Such mandates, which require insurance carriers in the individual market to issue policies to all applicants regardless of health status, are much less likely to place a cap on premium rates than are high-risk pools. Further, some representatives of the health insurance industry suggest that high-risk pools are also less costly for carriers.[10]

[5] "Medical Bills Leading Cause of Bankruptcy, Harvard Study Finds," *Consumer Affairs*, February 3, 2005, downloaded from http://www.consumeraffairs.com/news04/2005/bankruptcy_study.html on June 27, 2007.
[6] *Uncompensated Hospital Care Cost Fact Sheet,* American Hospital Association, October 2006, p. 1.
[7] Ibid, p. 4.
[8] *Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis*, Twentieth Edition, 2006/2007, National Association of State Comprehensive Health Insurance Plans, p.13.
[9] *State of Ohio High-Risk Pool Feasibility Study*, Leif and Associates, June 2005, p. 40.
[10] *State Health Insurance Index 2006: A 50 State Comparison of the Nation's Health Insurance Market*, Council for Affordable Health Insurance, 2006, p. 3.

High-risk pools are also a popular way for states to offer health insurance to individuals eligible under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). A key provision of this sweeping legislation was to increase availability of health coverage for people who change employers. A typical example of a HIPAA-eligible individual would be a worker who loses his or her job and elects to continue purchasing group health benefits via the Consolidated Omnibus Budget Reconciliation Act (COBRA) for the maximum period allowed by law, typically 18 months. If, at the end of that 18-month period, the worker has not been able to secure health insurance through another means, HIPAA compels states to offer those workers a means of purchasing health insurance, either by requiring insurance carriers to offer at least one health plan regardless of health status (guaranteed issue) or by making health insurance available via an "alternative mechanism," e.g., a high-risk pool. Twenty-seven states currently use high-risk pools to comply with HIPAA.

By offering health insurance to federally eligible individuals, as well as those ineligible for public programs and unable to secure health coverage in the individual market, high-risk pools like the Program fill an important niche.

The perennial challenge of high-risk pools, however, is in funding them. Since the population they serve is made up of high-risk individuals, the number and cost of claims is high. The average loss ratio of high-risk pools illustrates this. A loss ratio is an actuarial calculation representing the percent paid out in claims for every dollar collected in premiums. A typical insurance company can expect a loss ratio of 75 to 85 percent, meaning the company pays out $0.75 to $0.85 in claims for each premium dollar collected. The Program's loss ratio is 140 to 160 percent, meaning it pays out $1.40 to $1.60 in claims for every dollar collected. The loss ratio for high-risk pools nationwide varies considerably, starting as low as 120 percent and soaring to as high as 300 percent in some states.[11]

Participants pay monthly premiums that cover a portion of these costs, but funding high-risk pools' operating expenses entirely through premiums would make the programs prohibitively expensive for participants. In fact, premium rates for high-risk pools are typically capped by law, at anywhere from 150 to 200 percent of the standard market rate. The intent of these caps, plus a number of low-income subsidy programs, is to increase uninsurable individuals' access to health coverage.

[11] *State of Ohio High-Risk Pool Feasibility Study*, Leif and Associates, June 2005, p. 38.

The imbalance between premiums paid in and claims paid out means that states have to seek additional funding elsewhere to sustain high-risk pools. States make up the difference using a variety of funding sources, including federal grants, assessments on hospital gross revenues, allocations from general state revenues, tobacco settlement funds or other special state funds, and assessments upon insurance carriers.[12]

In Colorado, participant premiums cover roughly 60 percent of the Program's costs. Colorado makes up the shortfall with allocations from the Unclaimed Property Trust Fund (UPF), federal grants, premium tax credits, and assessments upon insurance carriers.

History of Regulation

In 1990, the General Assembly passed House Bill 90-1305 (HB 1305), the Colorado Uninsurable Health Insurance Plan Act (Act). The Act created a non-profit, unincorporated instrumentality of the state responsible for guaranteeing health insurance coverage for Coloradans unable to secure private health insurance due to restrictive exclusions or prohibitively high rates. Before the Act was put in place, there was no safety net for individuals who were both 1) unable to secure health insurance on their own, and 2) ineligible for federal programs like Medicaid or Supplemental Security Income (SSI): they simply went without health insurance. The Colorado Uninsurable Health Insurance Plan (CUHIP) was placed under the governance of a seven-member board comprised of representatives of state government, the insurance and health care industries, and individuals eligible for coverage in the CUHIP. The CUHIP began providing comprehensive medical insurance coverage to 598 high-risk individuals in April 1991.

The CUHIP received funding from a variety of sources. To cover its original implementation costs, HB 1305 included a clause authorizing an appropriation from the General Fund to be split between the Division of Insurance (DOI) and the Department of Revenue. The clause stipulated that this appropriation was to be repaid within eight months. Additionally, the bill established three sources of ongoing funding: the CUHIP cash fund; a compulsory charge ($2 per single return and $4 per joint return) on each state income tax return reporting an adjusted gross income of $15,000 or more; and premiums paid by plan participants.

[12] *Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis*, Twentieth Edition, 2006/2007, National Association of State Comprehensive Health Insurance Plans, p.35.

In 2001, the General Assembly passed House Bill 01-1319, which changed the name of the CUHIP to "CoverColorado" and—in response to the growing financial needs of the program—granted the Program the ability to assess special fees upon insurance carriers. The assessment provision was the outcome of negotiations among representatives of the Program, the DOI, and health insurance carriers. The assessment is widely viewed as a compromise: insurance carriers agreed to pay an assessment to fund the Program, and in exchange, they could deny coverage to individual applicants based on health status. The bill established under what circumstances the fees may be assessed and the methodology for calculating the fees. It also contained a provision requiring insurance carriers to recoup the cost of their assessment; this provision was removed two years later via House Bill 03-1163.

The assessment was charged for the first time in August 2002 for $9.8 million, and again one year later for over $28 million. Responding to concerns in the insurance industry, House Bill 03-1164 added a section stating that while the assessment mechanism stabilized the finances of the Program, it should not be considered the "exclusive remedy" and mandated that other funding options be explored. Section 2 of the bill also contained language compelling the Program to consider a reduction in benefits to enrollees before assessing any special fees upon insurance carriers. This provision was later removed by Senate Bill 06-180.

In 2004, the General Assembly passed House Bill 04-1206 (HB 1206) and Senate Bill 04-211 (SB 211), which together diminished the need for a future assessment.

House Bill 1206 created a provision allowing qualified insurance carriers—those subject to the assessment—to contribute funds to the Program and deduct the amount of such contribution from their premium tax liability. The law allows up to $5 million aggregate per year in tax-deductible contributions, effective through tax year 2014.

Senate Bill 211 authorized the State Treasurer to transfer the principal balance and interest earnings from the UPF—less unclaimed property claims, reserve, and administration expenses—to the Program. The amount of this transfer is adjusted annually based on actuarially substantiated projections for claims, administrative expenses, and reserves prepared by the Program. The appropriation is paid in quarterly installments. The way the law now stands, the Program must consider in its projections several funding sources—premiums, grants and donations, and the yearly allocation from the UPF—before assessing any special fees. If, after taking all these funding sources into consideration, a budget shortfall is still projected, the Program may proceed with calculating and collecting an assessment from insurance carriers.

Legal Framework

The assessment is governed by Colorado state law, Division of Insurance (DOI) rule, and CoverColorado Program (Program) policy.

The ability of the Program to assess special fees is created in section 10-8-530(1.5), Colorado Revised Statutes (C.R.S.). The section outlines the circumstances under which the Program can assess the special fees, the methodology for calculating the fees, rulemaking and reporting requirements, and other administrative matters. The DOI promulgated Regulation 4-2-22 ("Insurer Assessments for CoverColorado") to further clarify these procedures. The CoverColorado Board (Board) implemented policies establishing internal procedures for collecting assessments and correcting or adjusting assessment amounts.

The Program is considered to be adequately funded if it has enough money to pay projected claims and administrative expenses for 24 months into the future, while retaining a surplus equal to 10 percent of projected claims.[13] Every year, the Board is required to submit to the State Treasurer a detailed analysis of the Program's finances. If the analysis projects a shortfall, the projected deficiency becomes the basis for requesting an appropriation from the Unclaimed Property Trust Fund (UPF). The amount of the requested allocation must be subjected to two actuarial evaluations before any money can be transferred from the UPF. [14]

If, after taking all other revenue streams into account—including the UPF appropriation— a shortfall is still projected, the Board may determine to move forward with the assessment of special fees.[15] The amount of the proposed assessment must be subjected to two actuarial evaluations before the Board can proceed with the assessment.[16] The Board must give insurance carriers notice of the assessment at least 12 months before the due date. The special fees may be assessed no more than two times in a calendar year. [17]

[13] §10-8-530(1.5)(a), C.R.S.
[14] §10-8-530(1.5)(c), C.R.S.
[15] Rule 4-2-22, Section 4C.
[16] Rule 4-2-22, Section 4D.
[17] Rule 4-2-22, Section 6A.

To facilitate a potential assessment, the Program collects annual data from insurance carriers providing group or individual health benefit plans in Colorado, as well as those providing stop-loss, excess-loss, and reinsurance coverage to self-insured group health plans. On March 1 of every year, carriers report to the Program the total number of individuals enrolled in all of their health benefit plans as of December 31 of the previous year. This total number includes those covered under group and individual policies but excludes dependents. Carriers offering stop-loss, excess loss, or reinsurance coverage to self-insured health plans report the total number of individuals covered by such policies, but may exclude from their counts individuals who have been already counted by their primary carriers.[18]

The Program calculates the per capita fee by dividing the Program's total projected deficiency by the total number of insured lives in the state of Colorado. The special fee assessed to each insurance carrier equals the number of covered lives reported to the Program multiplied by the per capita amount.[19]

The Program mails each insurance carrier a notice of assessment that includes the per capita amount, a calculation of the assessment due, and a summary of the underlying assumptions and financial projections supporting the need for the assessment in general and the per capita amount in particular. Insurance carriers must pay the assessment within 13 months of the notice issue date.[20] No later than 30 days after the due date, Program staff must forward to the DOI a list of all carriers who have not paid.[21] The Commissioner of Insurance is responsible for enforcing payment of the special fees.[22]

An insurance carrier able to prove that paying the assessment would compromise its ability to fulfill its contractual obligations to the people it insures may submit a letter to the DOI requesting the fees be waived. The rules also define certain circumstances where insurance carriers might be eligible for a credit against the assessment: for example, if a carrier offers health plans to individuals with presumptive conditions.[23]

Public programs such as Medicare, Medicaid, the Children's Basic Health Plan, and the Federal Employers Benefit Health Plan are not subject to the assessment.[24] Under the federal Employee Retirement Income Security Act of 1974 (ERISA), self-insured groups are also exempt,[25] but carriers that sell stop-loss, excess-loss, and reinsurance coverage to such groups are not.

[18] Rule 4-2-22, Section 5A.
[19] Rule 4-2-22, Section 5 B2.
[20] Rule 4-2-22,Section 6C.
[21] CoverColorado Policy on Collection of Assessments.
[22] §10-8-530(1.5)(a), C.R.S.
[23] Rule 4-2-22, Section 7C.
[24] §10-8-530(1.5)(g), C.R.S.

Program Description and Administration

Governance

Section 10-8-501, *et seq.*, Colorado Revised Statutes (C.R.S), establishes the CoverColorado Program (Program) as a non-profit, unincorporated instrumentality of the state governed by a board of directors. Neither the Program nor its Board of Directors (Board) is considered an agency of state government.[26]

The Board consists of:[27]

- Four representatives of insurance carriers, of which there is at least:
  - One representative of a health maintenance organization;
  - One representative of a sickness and accident insurance carrier; and
  - One representative of a stop-loss or excess loss insurance carrier.
- One medical professional who specializes in chronic disease;
- Two individuals who currently are insured or who have been insured under the Program and who are not associated with the medical profession, any hospital, or any carrier; and
- Three *ex officio* nonvoting members:[28]
  - The Commissioner of Insurance or his or her designee;
  - The State Treasurer or his or her designee;
  - A member of the General Assembly.

The Board meets six times a year. The Board's responsibilities include establishing premium rates, establishing health benefit plans with cost-containment controls, creating low-income subsidy programs, developing the list of medical or health conditions the existence or history of which presumptively makes an individual eligible for the Program, and assessing special fees upon insurance carriers to provide for the Program's continuous operation.[29]

[26] §10-8-504, C.R.S.
[27] §10-8-505(2)(a), C.R.S.
[28] §10-8-505(3), C.R.S.
[29] §10-5-506, C.R.S.

The Board is charged with contracting with a third-party administrator to perform all administrative tasks relating to the Program, including evaluating applications for eligibility, billing, and paying claims. This contract is subject to a competitive bidding process every three years. Currently, the Board contracts with PacifiCare Life and Health Insurance Company (PacifiCare) to perform these functions. The Board also contracts with Common Sense Medical Management 2 (CSM2) for case management services.

Eligibility

To be eligible for the health benefit plans offered by the Program, an individual must currently reside in Colorado and have been a continuous resident for at least six months, and meet one of the following conditions:[30]

- Have applied to a carrier for a health benefit plan and the application has been:[31]
    - rejected or refused because of the health or medical condition of the applicant;
    - accepted, but at a premium exceeding the premium available through the Program; or
    - accepted with a reduction or exclusion of coverage for a preexisting medical or health condition for a period exceeding six months.
- Have a history of any of the following medical or health conditions:[32]

AIDS/HIV+
Alcohol/Drug Abuse
Alzheimer's Disease
Anorexia
Bipolar Disorder
Cancer, Metastatic
Cerebral Palsy
Cirrhosis of the Liver
Cleft Palate
Crohn's Disease
Cystic Fibrosis
Diabetes, Insulin Dependent
Emphysema
Hemophilia
Hepatitis, Chronic Active
Primary Polycythemia
Schizo Affective Disorder
Schizophrenia
Hodgkin's Disease
Huntington's Disease
Kidney Disease Requiring Dialysis
Leukemia
Lou Gehrig's Disease
Lupus Erythematosus Disseminate
Major Depressive Disorder
Malignant Tumor, within last four years
Multiple or Disseminated Sclerosis
Muscular Dystrophy
Myasthenia Gravis
Panic Disorder
Paraplegia or Quadriplegia
Parkinson's Disease
Specific Obsessive Compulsive Disorder
Stroke

[30] §10-8-513(1), C.R.S.
[31] §10-8-513(1)(a), C.R.S.
[32] §10-8-513(1)(b), C.R.S. The list is subject to change at the discretion of the Board pursuant to section 10-8-506(1)(g.5), C.R.S.

- Have had a health benefit plan involuntarily terminated for any reason other than nonpayment of a premium or premiums.[33]
- Be federally eligible[34] through the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), meaning he or she meets the following requirements:[35]
    - Most recent coverage was not terminated as a result of non-payment of premiums or fraud;
    - Has 18 or more months of previous creditable coverage, with the most recent coverage under a group plan, governmental plan or church plan;
    - Has elected and exhausted any continuation coverage available under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or a similar state program;
    - Is not currently eligible for Medicare or Medicaid or covered under any other health insurance; and
    - His or her prior insurance has not been lapsed for more than 90 days.
- Be federally eligible under the Trade Act of 2002, which created a tax credit to subsidize private health insurance coverage for certain displaced workers and for individuals receiving benefits from the Pension Benefit Guaranty Corporation.[36]
- Be eligible for coverage by a qualified state high-risk pool under any other federal law.[37]

Applicants are required to submit proof of residency as well as evidence documenting that they meet one of the above conditions. The residency requirement is waived for any individual who has been enrolled in a high-risk pool in another state and who applies for coverage under the Program within 30 days of relocating to Colorado.

During the 2007 session, Senate Bill 49 was passed, creating a special coordination of benefits plan intended to provide supplemental insurance for certain individuals eligible for Medicare. To be eligible for the coordination of benefits plan, an individual must be:[38]

- Under age 65;
- Eligible for Medicare by reason of disability;
- Enrolled in parts A and B of Medicare; and

[33] §10-8-513 (1)(c), C.R.S.
[34] §10-8-513.5(1), C.R.S.
[35] §10-16-105.5(1), C.R.S.
[36] §10-8-513.5(1)(a)(II), C.R.S.
[37] §10-8-513.5(1)(a)(III), C.R.S.
[38] §10-8-513(1)(d), C.R.S.

- Applying to the Program outside of the open enrollment period for a Medicare supplement policy.

The administration, benefits, and costs of the coordination of benefits plans are identical to those of the traditional health benefit plans offered by the Program.

Table 1 shows the number of CoverColorado participants for the five fiscal years indicated.

Table 1
Number of Participants

FY 01-02	FY 02-03	FY 03-04	FY 04-05	FY 05-06
3,886	4,914	4,801	4,896	5,169

Several factors contributed to the spike in the number of participants from fiscal year 01-02 to fiscal year 02-03. In July 2001, the Program became the alternative mechanism for providing health insurance to HIPAA-eligible individuals. This greatly expanded the pool of potential participants.

This time period also correlates with Colorado's economic slowdown, when more people were losing their jobs and their health benefits. Some insurance carriers tightened their underwriting standards, leading to more applications being denied. Other carriers left the state.[39]

Just at the time that enrollment was increasing due to the economic slowdown, Colorado's own economic troubles led to slashes in funding, which necessitated an increase in Program premiums to make up the difference.

The lack of growth in enrollment from fiscal year 02-03 through 04-05 is likely due to the fact that premiums were higher during that period: House Bill 03-1164 mandated that premiums be fixed at 150 percent of the standard risk rate, which was prohibitively high for some individuals. Subsequent legislation allowed premiums to range from 100 to 150 percent of the standard risk rate, which resulted in a decrease in premiums and a correlated rise in the number of participants. A premium discount program, offering reduced premiums based on household income, was also expanded in 2006, making the Program affordable to more eligible individuals.

[39] Fletcher, Amy, "Safety Net Health Plan May Lose Support," *Denver Business Journal*, January 16, 2004.

Current projections for the Program anticipate the number of participants will continue to grow at just over 100 per month for the rest of 2007, but decrease to about 60 per month thereafter. The new coordination of benefits plan is expected to be in place in September 2007 and attract 20 participants per month for the first two years. The number of participants thereafter is projected to remain stable.[40]

Costs

The Program offers a statewide major medical plan via the PacifiCare Preferred Provider Organization (PPO) Network, with eight annual deductible levels to choose from: $1,000, $1,500, $2,000, $3,000, $5,000, $7,500, and $10,000. There is a lifetime benefit maximum of $1 million.[41]

Premiums for the various health benefit plans are based on the standard risk rate, which is calculated by averaging the rates charged by the five largest carriers in the state for comparable plans. [42] Program premiums must not be lower than the standard risk rate, nor in excess of 150 percent of the standard risk rate.[43] Within this range, the Program fine-tunes premiums based on the participant's age, gender, tobacco use, and county of residence.

Premiums range from $62.48 per month for a female non-smoker in her late teens living in Mesa county ($10,000 deductible plan) to $1,103.37 per month for a male smoker in his sixties living in Eagle county ($1,000 deductible plan). A schedule of premiums for Program participants is included as Appendix B on page 27.

Since 1999, CoverColorado has offered a premium-discount program to eligible individuals. There are discounts available to two income categories:

- Individuals whose annual household income is **$40,000 or less** are eligible for a discount of up to 34 percent on their premiums.

- Individuals whose annual household income is between **$40,000 and $50,000** are eligible for a discount of up to 20 percent on their premiums.

Applicants must provide proof of income, e.g., a tax return, when they apply. Individuals may only apply with their initial application to the Program or at the end of every year during the Program's open enrollment period.

[40] Memorandum from Leif Associates, Inc., to CoverColorado Board of Directors, July 16, 2007, p.2.
[41] §10-8-515 and §10-8-525, C.R.S.
[42] §10-8-512(1)-(2), C.R.S.
[43] §10-8-512(3)(a), C.R.S.

The Program considers the applicant's liquid assets in tandem with his or her yearly income when calculating the premium discount. For example, if an applicant has an income of $30,000 per year but holds liquid assets of $15,000, the discount will be adjusted accordingly. Sixteen percent of participants are currently enrolled in the premium-discount program.

Table 2 shows the expenses of the Program for the five fiscal years indicated.

Table 2
Expense History

	FY 01-02	FY 02-03	FY03-04	FY 04-05	FY 05-06
Claims Paid	$16,116,796	$25,487,163	$31,482,711	$31,778,537	$34,527,196
Administrative Carrier Fees	$1,083,975	$1,557,613	$1,565,740	$1,148,121	$605,796
Other Administrative Costs	$543,327	$1,544,029	$1,457,147	$1,414,422	$1,565,886
Total Expenses	$17,744,098	$28,588,805	$34,505,598	$34,341,080	$36,698,878

The remarkable increase in claims paid from fiscal year 01-02 to 02-03 corresponds to the increase in participants during that period.

Funding

Currently, the Program is funded by participant premiums, allocations from the Unclaimed Property Trust Fund (UPF), premium tax credits (limited to $5 million aggregate per year), federal grants, and assessments upon insurance carriers.

Table 3 shows the revenue history of the Program for the five fiscal years indicated.

Table 3
Revenue History

	FY 01-02	FY 02-03	FY03-04	FY 04-05	FY 05-06
Premiums Paid	$9,380,110	$17,064,208	$21,361,177	$21,405,515	$23,878,912
Unclaimed Property Trust Fund	$6,797,110	$648,284	$1,245,335	$1,805,668	$7,232,579
Carrier Assessments	$0	$2,093,432	$32,131,036	$53,951	$10,074
Premium Tax Credits/Grants	$0	$0	$7,026,974	$3,470,961	$5,472,812
Interest	$1,347,023	$785,836	$439,755	$938,124	$1,515,334
Total Revenue	$17,524,243	$20,591,760	$62,204,277	$27,674,219	$38,109,711

The funding from the UPF dropped off dramatically from fiscal year 01-02 to 02-03 due to an unexpected financial challenge. Colorado was in the midst of a budget crisis, and in 2002, the General Assembly voted to transfer monies from a number of state cash funds—including the UPF— into the General Fund to pay for general government expenses. As a result, interest income from the UPF declined precipitously. This dramatic reduction in revenue was to play a major role in the Board's decision to assess fees upon insurance carriers twice in subsequent years.

The amount of money received from the UPF rose again once legislation passed entitling the Program to the principal—as well as the interest—on the UPF.

"Premium Tax Credits/Grants" in Table 3 includes tax-deductible contributions from qualified insurance carriers (up to $5 million per year) as well as federal grants.

Past Assessments

The special fees to fund the Program have been assessed twice.

Table 4 shows the details of the two assessments.

Table 4
Assessment History

	First Assessment	Second Assessment
	August 2003	May 2004
Total Assessment Amount	$9,252,203	$29,829,718
Total Insured Lives Reported to the Program	1,241,240	1,131,199
Per Capita Amount	$7.45	$26.37

When the principal from the UPF was transferred to the General Fund, one of the Program's critical funding sources—second only to participant premiums—took a major and unexpected hit. The decline in UPF funds led to a considerable shortfall in the Program's funding and was largely responsible for the remarkable increase in the per capita amount of the special fees from the first assessment to the second. Had the interest on the UPF remained steady, the funding for the Program would have remained relatively stable. An assessment might have been required in any case, but the amount of such an assessment would likely have been significantly less.

Estimates for the timing of the next assessment are as follows:[44]

- **Most conservative:** June 2010
- **Most likely:** December 2011
- **Least conservative:** Far into the future

Although the number of participants and the rising costs of health care unquestionably have a significant impact on the Program's financial outlook, the likelihood of an assessment is still very much dependent on the balance of the UPF. Current projections show the Program's share of the UPF—estimated at over $100 million for fiscal year 07-08—will be diminished to about $50 million by fiscal year 09-10.

[44] Memorandum from Leif Associates, Inc., to CoverColorado Board of Directors, July 16, 2007, p.3.

Analysis and Recommendations

Recommendation 1 – Continue the authority to assess special fees upon insurance carriers to fund the CoverColorado Program.

The statutes governing the CoverColorado Program (Program) are located within the insurance statutes at section 10-8-501, *et seq.*, Colorado Revised Statutes (C.R.S).

Any discussion of the Program's continued funding is rooted in the assumption that the Program is necessary to protect the public health, safety, and welfare and therefore should be funded. In conducting this review, the Department of Regulatory Agencies (DORA) found that the Program, by offering health insurance to individuals unable to secure health coverage in the individual market, as well as to those eligible for coverage under federal law, provides protection to some of Colorado's most vulnerable citizens in a way no other entity does. Thus, the funding of the Program is a matter of critical importance.

The funding sources for the Program are established in section 10-8-530, C.R.S. Section 10-8-530(1.5), C.R.S., grants the Program the ability to assess upon insurance carriers special fees as may be reasonable and necessary for the operation of the Program. The question at hand is whether the assessment has been effective and necessary for the operation of the Program.

Of the 33 states that operate high-risk pools, 29 assess insurance carriers to fund the programs. Typically, health insurance carriers are assessed in proportion to the amount of health insurance premiums written in the state. Insurance carriers are sometimes permitted to offset the amount of the assessment against state premium or income taxes, thereby depleting the General Fund, so this functions as an indirect way of using state funds. The flaw in the premium market share methodology is that the federal Employee Retirement Income Security Act (ERISA) prohibits states from imposing a premium assessment on self-insured plans based on share of premiums.[45] Since a significant proportion of the insured population is covered under ERISA plans—in Colorado, about 28 percent—a correspondingly significant share of the insurance market is exempt from the assessment. This exemption seems inequitable, given that some individuals leaving self-funded plans are not eligible for coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) and can end up seeking coverage from high-risk pools.

[45] *Issue Brief: Colorado's High-Risk Pool: Small but Important Part of the Health Insurance Market,* Colorado Health Institute, November 2006, p. 2.

The per capita methodology Colorado uses—assessing health insurance, stop-loss, excess loss, and reinsurance carriers based on number of covered lives—at least partially captures ERISA plans. Although the plans cannot be directly assessed, carriers that sell stop-loss, excess-loss, and reinsurance coverage to such plans can be.[46] Including such carriers creates a broader funding base and decreases the amount levied against any single insurance carrier, making the per capita method arguably more fair.

It is important to remember that insurance carriers were part of the original discussions when the assessment was devised. Insurance carriers benefit from the Program in that they are allowed to decline individual coverage to very sick applicants who are likely to make considerable claims. Guaranteed issue in the individual market—which compels some or all insurance carriers to offer at least one health policy to every applicant regardless of health status—can place intense financial pressure on insurance carriers. When New York implemented its guaranteed issue policy for the individual market, several smaller carriers disappeared from the market. Citing the hardship guaranteed issue causes in the insurance industry, the Council for Affordable Health Insurance (CAHI)—an association made up primarily of insurance carriers—has come out against it, advocating instead for high-risk pools.[47] High-risk pools like the Program allow insurance carriers to decline coverage to very sick people in the individual market. In exchange, carriers pay the assessment.

The assessment is not the Program's sole, or even primary, source of revenue. Other funding sources include participant premiums, principal and interest from the Unclaimed Property Trust Fund (UPF), premium tax credits, and federal grants. A many-pronged funding approach makes sense because any single funding source has its limitations: allocations from the General Fund are susceptible to state economic woes; special funds like tobacco settlement funds and the UPF are finite; and assessments upon insurance carriers can place an undue burden on small business and harm the economy.

[46] One such carrier, Great West Life, filed a lawsuit against the State contending that the per capita methodology is inequitable and that assessment itself is in violation of the TABOR Amendment. See *Great-West Life & Annuity Insurance Company v. Doug Dean, in his capacity as Commissioner of Insurance for the State of Colorado, Colorado Division of Insurance and CoverColorado*, Case No. 03-CV-10136 (District Court, City and County of Denver, 2003). The lawsuit is still open.

[47] *CAHI Issues: High Risk Pools*, Council for Affordable Health Insurance, downloaded from http://www.cahi.org/cahi_contents/issues/article.asp?id=489 on July 31, 2007.

The Program has benefited from this funding approach. Despite some periods where enrollment was flat due to higher premiums, the Program has never been forced to raise premiums higher than 150 percent of the standard risk rate. The Program has never had to take the more drastic measures some states have, such as curtailing benefits and capping enrollment. California has limited participants to 36 months of continuous enrollment; the Florida high-risk pool was closed to new applicants permanently in 1991 due to lack of funding. Not only has Colorado's pool survived, it has provided a consistent level of care to its members.

Insurance carriers have also benefited. Despite the significant fees assessed in 2003 and 2004, Colorado insurance carriers have not borne the same financial burdens as insurance carriers in other states because the assessment currently functions as a stopgap measure rather than a steady funding stream. For example, an assessment upon insurance carriers is the primary funding source for Washington's high-risk pool, which has just over 3,000 participants (compared to Colorado's 5,000). Using the per capita methodology, the Washington State Health Insurance Pool assessed carriers an average of $26.3 million per year from 2001 to 2005.

That said, the assessment as it exists now is less than perfect. The timing of the assessment has proven challenging to both insurance carriers and the Program. Though this long timeframe was intended to give insurance carriers time to collect the money for the assessment before paying it out, insurance carriers seem to agree that it is still not long enough to build the expense into premiums. Another complication arises around the annual reporting of covered lives. If an insurance carrier reports having 1,000 covered lives as of December 31, 2007, this becomes the basis for the per capita calculation in 2008. If an assessment were noticed in June 2008, payment would be due in July 2009. In the ensuing months, the carrier could lose a major contract, decreasing the number of covered lives, but the carrier would still be held to the December 31, 2007 figure.

The Program encounters a similar problem when trying to determine the need for an assessment. The Program bases the need for an assessment on a projected shortfall that will occur 24 months in the future. Much could happen in that 24-month period: claims could dip, health care costs could rise, legislation causing an influx of participants could pass, and administrative expenses could skyrocket or plummet. The longer the timeframe, the less likely it is that the actuarial projections will accurately reflect the Program's financial needs at the time the assessment comes due. Because of the long wait between noticing the assessment and collecting the fees, the Program is also compelled to keep a large cash reserve on hand. Because the longer timeframe is not serving the intended purpose, it might make sense to shorten it and mitigate some of these other problems.

There are also no rules or policies governing how insurance carriers may recover the assessment. Some carriers treated the expense as an administrative cost and incorporated it into premiums; others placed the assessment on employers' and individual subscribers' bills as a line item. However insurance carriers handle it, they inevitably pass the cost of the assessment on to employers, either as a pass-through or in the form of higher premiums. This effectively penalizes small businesses that choose to provide health insurance for their employees, while relieving those employers who do not of any responsibility.

Despite these flaws, it is indisputable that monies collected via the assessment sustained the Program during Colorado's economic struggles. Had the assessment not been in place, the Program would not have remained solvent. During the two-year period—after the UPF had been depleted to the point where interest could no longer cover expenses, but before the Program was made the primary beneficiary of the UPF—the assessment is what allowed the Program to survive.

Although enrollment in the Program is relatively low—representing less than one percent of the insured population—it is conceivable that most Coloradans could find themselves in a situation where the "insurer of last resort" becomes the only avenue for obtaining health insurance. A diagnosis of a serious illness, the loss of a job, or simply the loss of health benefits could lead someone to enroll in the Program, if only temporarily. The money collected via the assessment funds a program that any Coloradan may need someday. In the absence of another alternative mechanism for federally eligible individuals, federal law compels Colorado to keep the Program afloat.

Assessments upon insurance carriers are a typical funding mechanism for high-risk pools nationwide. The per capita methodology Colorado uses spreads the assessment across a broader funding base than do other methods, which is generally beneficial. Although the assessment has not been collected in several years, and some aspects of the administration and collection are flawed, it remains a critical part of the Program's funding. It would be impossible to terminate the assessment without coming up with another viable funding mechanism to replace it. Therefore, the authority to assess fees upon insurance carriers to fund the Program should be continued.

Recommendation 2 – Remove the sunset provision for the assessment from the statute.

The sunset provision specific to the assessment is located at section 10-8-530(1.5)(h), C.R.S. Continuing to evaluate the efficacy of the assessment apart from the "big picture" of the Program's funding would to be to postpone development of a meaningful, long-term solution. Elimination of the assessment would make the Program primarily dependent on premiums and the UPF, an inevitably short-lived funding scenario since the law caps premiums at 150 percent of the standard risk rate and the UPF will eventually be depleted. Sunsetting the assessment without changing the other funding mechanisms for the Program is simply not a viable option. Unless alternative funding sources are established via new legislation, there would be little choice in future sunset reviews other than to continue the assessment, calling into question the purpose of such reviews.

Further, the sunset criteria at section 24-34-104, C.R.S., are geared toward professional and occupational licensing boards. Evaluating the assessment—a single funding mechanism for a non-profit instrumentality of the state—based on the same criteria used to evaluate entities such as the Division of Real Estate or the Board of Medical Examiners might not be the most effective way of analyzing the law. The sunset provision for the assessment should be removed, and emphasis placed on long-term funding proposals.

Recommendation 3 – Create a task force to develop long-term, permanent funding solutions for CoverColorado.

The Governor's Blue Ribbon Commission for Health Care Reform[48] (Commission) is currently evaluating the portability, sustainability, and availability of health care, topics of critical relevance to the Program. The Commission's recommendations could become the basis for legislation affecting the Program: an alternative health care funding mechanism could be established, eliminating the need for the assessment; another state program could be created to fill the niche the Program currently occupies.

That said, the substance of the Commission's findings and any resultant legislation are unknown. The fact remains that the future financial health of the Program must be assured for the sake of the vulnerable population it serves. The stakeholders interviewed for this review agree on this point: the Program needs a stable, predictable, broad-based funding source.

[48] Because the Commission was created with the passage of Senate Bill 06-208, it also known as the 208 Commission.

The assessment mechanism came out of a series of meetings among stakeholders in 2001. Another assessment is unlikely to be needed for several years. With the current interest in health care reform both locally and nationally, the time seems ripe for stakeholders to reconvene and develop a long-term funding solution for the Program that meshes with the evolving health care environment.

An 11-member task force, appointed by the Governor, should be formed consisting of the following:

- The Executive Director of the Program;
- The Commissioner of Insurance or his or her designee;
- The State Treasurer, or his or her designee;
- The Chair of the CoverColorado Board;
- Two representatives of the health insurance industry;
- One representative of the stop-loss insurance industry;
- One representative of the hospital industry;
- One Colorado licensed physician working as a general practitioner; and
- Two representatives of the uninsurable population.

The composition of this task force provides a balance of administrative, budgetary, and industry expertise, while giving a voice to those who rely on the services the Program provides. These representatives largely reflect those who were involved in the development of the original assessment, with representatives of the hospital industry and physicians being critical additions. These additional representatives could be affected by changes in the Program's funding mechanisms, so must be included in the discussion.

The task force should report back to the General Assembly by March 31, 2009, with a detailed plan for the Program's funding over a minimum of 10 years. In their deliberations, the task force should, at a minimum, consider the following:

- **Establishing an all-payer system.** Hospitals offer a unique way to spread costs over a broad population. Maryland's high-risk pool is funded via an "all-payer" system: an assessment of 0.73 percent is added to the rates of all regulated inpatient and outpatient facilities in Maryland. This assessment is spread among all insurance carriers and payers who use these facilities. [49] Because an all-payer system could conceivably charge fees on private practice as well as hospitals, a physician is also included. An all-payer system is an option worth considering because it could dramatically broaden the funding base, reducing the burden on any single payer.

[49] *Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis*, Twentieth Edition, 2006/2007, National Association of State Comprehensive Health Insurance Plans, pp. 37, 130.

- **Increasing the premium tax credit.** The task force should also consider raising the limit on the premium tax credit for donations to the Program. Insurance carriers have embraced the premium tax credit option, donating the maximum amount ($5 million aggregate) for the past two years. Although this tax credit affects the balance in the General Fund, it also helps to reduce the need for an assessment upon insurance carriers. Even a modest increase in the maximum aggregate amount might be worthwhile.

- **Revising the methodology/administration of the assessment.** The task force should specifically address the role, if any, the assessment upon insurance carriers will play in the future funding of the Program. If the assessment is retained, any concerns regarding the methodology, administration, and collection should be addressed and reflected in the final plan.

A bill implementing the recommendations of the task force should be introduced in the 2009 session. Even if the most conservative actuarial projections—placing the next assessment in June 2010—come to fruition, an alternative plan should be in place by the time any subsequent assessment is noticed under the current law.

Appendix A – Sunset Statutory Evaluation Criteria

(I) Whether regulation by the agency is necessary to protect the public health, safety and welfare; whether the conditions which led to the initial regulation have changed; and whether other conditions have arisen which would warrant more, less or the same degree of regulation;

(II) If regulation is necessary, whether the existing statutes and regulations establish the least restrictive form of regulation consistent with the public interest, considering other available regulatory mechanisms and whether agency rules enhance the public interest and are within the scope of legislative intent;

(III) Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures and practices and any other circumstances, including budgetary, resource and personnel matters;

(IV) Whether an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively;

(V) Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates;

(VI) The economic impact of regulation and, if national economic information is not available, whether the agency stimulates or restricts competition;

(VII) Whether complaint, investigation and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession;

(VIII) Whether the scope of practice of the regulated occupation contributes to the optimum utilization of personnel and whether entry requirements encourage affirmative action;

(IX) Whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest.

Appendix B – Premiums Matrix for CoverColorado

CoverColorado
PPO Monthly Rates

Effective July 1, 2007 through December 31, 2007

Calculating Your Monthly Premium

1. Select the deductible of the plan you want to purchase: $1,000, $1,500, $2,000, HSA $2,000, $3,000, $5,000, $7,500 or $10,000
2. In the appropriate Base Rate table below find the age bracket that contains your current age.
3. Look to the right of your age bracket and select the Base Rate for your gender and smoking status.
4. In the County Area Factors table to the right, find the County you live in and its Area Factor.
5. Multiply the appropriate County Area Factor by the appropriate Base Rate and the result is your monthly premium.

Base Rates

$1,000 In-network/$2,000 Out-of-network Deductible

Age	Male Nonsmoker	Female Nonsmoker	Male Smoker	Female Smoker
0 - 19	$159.51	$159.51	$202.29	$202.29
20 - 24	$152.17	$255.59	$192.97	$324.10
25 - 29	$175.11	$319.96	$222.06	$405.70
30 - 34	$199.51	$338.95	$252.97	$429.82
35 - 39	$237.32	$372.47	$300.95	$472.33
40 - 44	$290.12	$425.00	$367.92	$538.96
45 - 49	$365.57	$483.41	$463.56	$613.01
50 - 54	$468.83	$562.11	$594.50	$712.80
55 - 59	$624.31	$676.66	$791.65	$858.04
60 - 64	$798.29	$787.74	$1,012.27	$998.90

HSA-eligible $2,000 Deductible with Integrated Pharmacy

Age	Male Nonsmoker	Female Nonsmoker	Male Smoker	Female Smoker
0 - 19	$108.19	$108.19	$137.20	$137.20
20 - 24	$103.24	$173.36	$130.91	$219.85
25 - 29	$118.79	$217.02	$150.63	$275.19
30 - 34	$135.31	$229.91	$171.59	$291.53
35 - 39	$160.98	$252.67	$204.12	$320.38
40 - 44	$196.79	$288.27	$249.55	$365.55
45 - 49	$247.96	$327.88	$314.41	$415.79
50 - 54	$318.01	$381.29	$403.24	$483.49
55 - 59	$423.48	$458.98	$537.01	$582.00
60 - 64	$541.47	$534.33	$686.61	$677.59

$1,500 In-network/$3,000 Out-of-network Deductible

Age	Male Nonsmoker	Female Nonsmoker	Male Smoker	Female Smoker
0 - 19	$141.81	$141.81	$179.83	$179.83
20 - 24	$135.32	$227.23	$171.58	$288.16
25 - 29	$155.70	$284.45	$197.44	$360.70
30 - 34	$177.36	$301.35	$224.91	$382.12
35 - 39	$211.00	$331.19	$267.55	$419.94
40 - 44	$257.94	$377.84	$327.09	$479.14
45 - 49	$325.01	$429.77	$412.12	$544.99
50 - 54	$416.83	$499.77	$528.55	$633.73
55 - 59	$555.08	$601.61	$703.88	$762.84
60 - 64	$709.73	$700.37	$899.97	$888.15

$3,000 In-network/$6,000 Out-of-network Deductible

Age	Male Nonsmoker	Female Nonsmoker	Male Smoker	Female Smoker
0 - 19	$102.44	$102.44	$129.91	$129.91
20 - 24	$97.75	$164.15	$123.95	$208.16
25 - 29	$112.48	$205.48	$142.63	$260.56
30 - 34	$128.12	$217.69	$162.47	$276.04
35 - 39	$152.42	$239.24	$193.27	$303.35
40 - 44	$186.33	$272.94	$236.28	$346.12
45 - 49	$234.78	$310.45	$297.70	$393.69
50 - 54	$301.11	$361.02	$381.81	$457.79
55 - 59	$400.97	$434.59	$508.47	$551.06
60 - 64	$512.69	$505.93	$650.11	$641.57

$2,000 In-network/$4,000 Out-of-network Deductible

Age	Male Nonsmoker	Female Nonsmoker	Male Smoker	Female Smoker
0 - 19	$122.84	$122.84	$155.78	$155.78
20 - 24	$117.21	$196.84	$148.63	$249.61
25 - 29	$134.87	$246.40	$171.03	$312.45
30 - 34	$153.63	$261.04	$194.83	$331.01
35 - 39	$182.78	$286.88	$231.76	$363.76
40 - 44	$223.44	$327.30	$283.34	$415.04
45 - 49	$281.53	$372.28	$356.99	$472.09
50 - 54	$361.07	$432.92	$457.84	$548.95
55 - 59	$480.82	$521.13	$609.72	$660.80
60 - 64	$614.78	$606.68	$779.58	$769.34

$5,000 In-network/$10,000 Out-of-network Deductible

Age	Male Nonsmoker	Female Nonsmoker	Male Smoker	Female Smoker
0 - 19	$83.80	$83.80	$106.27	$106.27
20 - 24	$79.97	$134.28	$101.40	$170.29
25 - 29	$92.02	$168.11	$116.68	$213.15
30 - 34	$104.80	$178.09	$132.91	$225.81
35 - 39	$124.70	$195.70	$158.10	$248.17
40 - 44	$152.44	$223.28	$193.31	$283.15
45 - 49	$192.08	$253.98	$243.55	$322.06
50 - 54	$246.33	$295.35	$312.35	$374.50
55 - 59	$328.01	$355.51	$415.94	$450.83
60 - 64	$419.42	$413.90	$531.82	$524.85

$7,500 In-network/$15,000 Out-of-network Deductible

Age	Male Nonsmoker	Female Nonsmoker	Male Smoker	Female Smoker
0 - 19	$73.08	$73.08	$92.68	$92.68
20 - 24	$69.74	$117.10	$88.43	$148.51
25 - 29	$80.25	$146.60	$101.76	$185.88
30 - 34	$91.40	$155.31	$115.91	$196.92
35 - 39	$108.74	$170.66	$137.88	$216.42
40 - 44	$132.94	$194.72	$168.58	$246.93
45 - 49	$167.51	$221.49	$212.39	$280.86
50 - 54	$214.82	$257.57	$272.40	$326.59
55 - 59	$286.05	$310.03	$362.74	$393.16
60 - 64	$365.76	$360.96	$463.78	$457.71

$10,000 In-network/$20,000 Out-of-network Deductible

Age	Male Nonsmoker	Female Nonsmoker	Male Smoker	Female Smoker
0 - 19	$65.08	$65.08	$82.52	$82.52
20 - 24	$62.10	$104.27	$78.74	$132.24
25 - 29	$71.46	$130.54	$90.61	$165.52
30 - 34	$81.38	$138.29	$103.21	$175.35
35 - 39	$96.83	$151.97	$122.77	$192.71
40 - 44	$118.37	$173.39	$150.11	$219.88
45 - 49	$149.16	$197.23	$189.12	$250.10
50 - 54	$191.29	$229.35	$242.56	$290.81
55 - 59	$254.71	$276.07	$323.00	$350.09
60 - 64	$325.70	$321.41	$412.98	$407.57

Calculation of rates - Example: $7,500 deductible, 20 years old, Female, Non-smoker, Park county
$69.74 x 1.05 (Park county) = $73.23 monthly premium rate

County Factors

County	Area Factor
Adams	1.02
Alamosa	1.00
Arapahoe	1.02
Archuleta	1.00
Baca	1.00
Bent	0.96
Boulder	1.00
Broomfield	1.02
Chaffee	1.00
Cheyenne	1.00
Clear Creek	1.05
Conejos	1.00
Costilla	1.00
Crowley	0.96
Custer	1.00
Delta	1.00
Denver	1.02
Dolores	1.05
Douglas	1.05
Eagle	1.09
El Paso	0.96
Elbert	1.05
Fremont	1.05
Garfield	1.05
Gilpin	1.05
Grand	1.00
Gunnison	1.05
Hinsdale	1.00
Huerfano	1.00
Jackson	1.05
Jefferson	1.02
Kiowa	0.96
Kit Carson	1.00
Lake	1.00
La Plata	1.09
Larimer	1.00
Las Animas	0.96
Lincoln	1.00
Logan	1.05
Mesa	0.96
Mineral	1.00
Moffat	1.05
Montezuma	1.00
Montrose	1.00
Morgan	1.05
Otero	0.96
Ouray	1.00
Park	1.05
Phillips	1.05
Pitkin	1.09
Prowers	0.96
Pueblo	1.00
Rio Blanco	1.00
Rio Grande	1.00
Routt	1.05
Saguache	1.00
San Juan	1.00
San Miguel	1.00
Sedgwick	1.05
Summit	1.09
Teller	1.05
Washington	1.09
Weld	1.00
Yuma	1.05

Notes

1. Coverage after age 64 is only available if you are not eligible for Medicare. Call 303-863-1960 for more rates.
2. Select the smoker rate if you have used any tobacco product within the last 12 months.