INTERIM REPORT OF THE
JOINT SUBCOMMITTEE STUDYING THE

Health Insurance Coverage Available in the Commonwealth For Individuals With Chronic Health Problems

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

House Document No. 17

COMMONWEALTH OF VIRGINIA
RICHMOND
1985

MEMBERS OF COMMITTEE

Joan H. Munford, Chairperson
Frank W. Nolen, Vice-Chairperson
Frank D. Hargrove
Mary Sue Terry
E. M. Holland
Robert C. Scott
B. Michael Herman
Stephen L. Pohl, MD

STAFF

Legal and Research - Division of Legislative Services

C. William Cramme', III, Senior Attorney
Terry Mapp, Research Associate
Cleola G. Wilkerson, Secretary

Administrative and Clerical

Office of Clerk, House of Delegates

Interim Report of the Joint Subcommittee Studying the Health Insurance Coverage Available in the Commonwealth for Individuals with Chronic Health Problems

To: Honorable Charles S. Robb, Governor
and
The General Assembly of Virginia

INTRODUCTION

In recent years, individuals with chronic health problems have found it increasingly difficult to obtain health insurance coverage as insurance companies have found it necessary to change the manner in which they underwrite risks because of dramatic increases in health care costs. Several states have attempted to solve the "uninsurability" problem through the implementation of health insurance pooling mechanisms which provide comprehensive hospital and medical coverage for these high risk individuals.

In an effort to learn more about the health insurance coverage available in Virginia for

individuals who are significant health and thus underwriting risks and to consider the feasibility of the Commonwealth's implementing a health insurance pooling mechanism, a joint subcommittee was established, pursuant to House Joint Resolution No. 69 of the 1984 General Assembly, a copy of which is attached to this report as Appendix I.

Delegate Joan H. Munford of Blacksburg served as Chairperson of the subcommittee. Other members of the House of Delegates appointed to serve were: Frank D. Hargrove of Glen Allen and Mary Sue Terry of Stuart.

Senator Frank W. Nolen served as Vice-Chairperson of the subcommittee. Other members of the Senate appointed to serve were: E. M. Holland of Arlington and Robert C. Scott of Newport News.

Mr. B. Michael Herman with Blue Cross and Blue Shield of Southwest Virginia from Roanoke and Dr. Stephen L. Pohl, Assistant Professor in the Department of Internal Medicine at the University of Virginia School of Medicine, from Charlottesville were appointed citizen members of the joint subcommittee.

C. William Cramme', III and Terry Mapp, Research Associate, with the Division of Legislative Services served as legal and research staff to the subcommittee. J. Lester Fitzgerald, Deputy Clerk of the House Clerk's Office, provided administrative and clerical duties for the subcommittee.

WORK OF THE SUBCOMMITTEE

In an effort to hear as much testimony as possible regarding the problems individuals with chronic health conditions have in obtaining health insurance, the health insurance coverage available in Virginia for such individuals, and the feasibility of the Commonwealth's implementing a health insurance pooling mechanism, the joint subcommittee held three meetings in 1984. The meetings were held on July 11, October 3, and November 15.

Prior to the subcommittee's first meeting, its staff furnished each member with a copy of a staff report which provided a brief overview of the health insurance coverage available in Virginia for individuals with chronic health problems, health insurance pooling mechanisms, and other states' experiences with such pools. A copy of this report minus its lengthy appendices is attached to this report as Appendix II.

The joint subcommittee heard a large amount of oral testimony during their meetings and also received position papers and other written materials from a number of organizations including: the Bureau of Insurance, AETNA Life and Casualty, Prudential Insurance Company, Blue Cross and Blue Shields of Virginia and Southwest Virginia, Blue Cross and Blue Shield Association in Washington, Metropolitan Life Insurance Company, the Health Insurance Association of America, American Heart Association, American Lung Association, American Cancer Society, Juvenile Diabetes Foundation, American Diabetes Association, National Foundation for Ileitus and Colitis, Mental Health Association of Virginia, "We Care", Virginia Alliance for the Mentally Ill, Association of Retarded Citizens in Virginia, Independent Resource Center of Charlottesville, Friends of Endependence Center in Northern Virginia, Supported Work Services Employment Project, Richmond Psychiatric Society, and the Department for the Visually Handicapped. A number of telephone calls from various other health associations were received by the subcommittee's staff.

During one of the subcommittee's meetings, the patron of the resolution, Delegate C. Richard Cranwell of Roanoke, testified that the genesis for the resolution was the number of people who had informed him that many people with chronic health conditions were unable or felt that they were unable to obtain health insurance coverage which would help defray the costs of a catastrophic medical problem in the event that one would occur. Mr. Cranwell explained that the resolution was introduced to encourage the Commonwealth to look at the problems these people are having as they have the right function normally in society without the fear of having their financial resources depleted because of their health care costs.

The subcommittee heard from several health associations concerning the problems and concerns of their members regarding insurance and pooling mechanisms. Testimony revealed that some people, because of their chronic conditions, have not been able to obtain coverage or have not been able to afford it and that many of those who have health insurance through their employers or their spouses' feel they are locked into their positions as they may not be able to obtain coverage through a new employer. Other concerns expressed were that an individual would lose his coverage if he had to stop working because of his condition and that even if an individual had insurance, one lengthy illness could exhaust this coverage and his own and his family's financial resources. It was stated that patients in state-supported hospitals continue to receive care even after their insurance runs out, yet the hospitals will not absorb these costs until they have taken the patient and his family through the courts for payment. It was pointed out that those who cannot obtain insurance have to live with the anxiety of not having the means to pay for medical care in the event of a serious illness or accident.

The Association of Retarded Citizens expressed its concern over the mentally retarded being inappropriately classified, for insurance purposes, with those who have medical conditions. It was explained that mental retardation is not a medical problem but a deficit at which one acquires skills. They also expressed concern over families who wish to adopt retarded children not being able to obtain insurance for the children and therefore not being able to complete the adoption process. The Virginia Alliance for the Mentally Ill testified that insurance coverage for the mentally ill is grossly inadequate.

The health associations indicated that they support pooling as it would be a means through which their members would have comprehensive health coverage and that their members would

more than likely be happy to pay higher premiums for coverage which would prevent them from exhausting their financial resources.

Representatives of private insurance companies testified that they provide health insurance to many individuals who have physical impairments and that they believe they are classifying risks in a non-discriminatory manner based on an equitable appraisal of the risks such individuals represent. They explained that individuals with chronic health problems present additional risks to them and that the insurance companies must determine the amount of risk they are willing to assume in order to set fair and competitive premiums. They stated that this cannot be accomplished without careful selection and classification of risks and explained that the selection and classification process is based on a number of factors including medical history, physical condition, and type of employment and that many decisions are based on the results of morbidity studies. They explained further that depending on the degree of risk, they may charge an additional premium, may limit benefits, or in extreme cases, may not offer insurance at all.

The joint subcommittee learned that exclusion waivers are used in those cases where an additional premium would not be enough to cover the amount of risk involved. It was pointed out that those individuals with the most severe conditions who have had recent illnesses cannot be covered at all because their long run medical expenses will be greater than those contemplated by the highest rates and that the use of exclusion waivers would be impractical as such conditions often lead to other complications. The insurance representatives stated that their premiums for high risk individuals which generally range between 125 and 200 percent of the average group rate depend on the type and severity of the conditions.

One of the major concerns of the subcommittee members of whether a child (diabetic, for example) who was no longer covered under his parent's policy would be able to obtain health insurance was addressed by several insurance representatives. They stated that if the parents' had their policy with their company, the child could, within thirty days, convert to an individual policy without having to show evidence of insurability. They noted, however, if the child's parents policy was not with their company the child most likely would not be accepted. They explained that the child would be able to obtain insurance through Blue Cross and Blue Shield yet would be subject to a twelve-month waiting period. It was pointed out that the child could apply for Blue Cross and Blue Shield coverage one year prior to the date when he would no longer be eligible for coverage under his parents' policy which effectively would provide him with continuous coverage since his parents' policy would be in effect during the waiting period.

Regarding the pooling mechanisms, the insurance representatives pointed out that there was no need for such a mechanism as Blue Cross and Blue Shield of Virginia acts as an insurer of last resort and accepts all applicants regardless of their physical condition. They stated that the pool premiums in other states ranged from 125 to 200 percent of the standard individual rate which was higher than what Blue Cross and Blue Shield would charge. They explained that if a pooling mechanism was used to solve this social problem, it would translate back into higher insurance rates for those who already have coverage, and that the Commonwealth would have to share in the responsibility by foregoing premium taxes from insurance companies or by subsidizing the pool in some other way. They indicated that the Health Insurance Association of America endorses pooling provided it is designed in certain ways and that their companies are generally supportive of the pooling arrangements in other states.

The Bureau of Insurance informed the joint subcommittee that it had no opinion on pooling. They pointed out that with the recent establishment of HMOs and PPOs, a new competitive era in health care has begun. They stated that they had received very few complaints about the availability of insurance but many about the affordability.

Blue Cross and Blue Shield testified that they are the "insurer of last resort" in Virginia as they will accept anyone, regardless of his physical condition, at the standard individual rate during open enrollment periods subject only to any applicable waiting period. It was pointed out that Blue Cross and Blue Shield of Virginia offers open enrollment year-round and that Blue Cross and Blue Shield of Southwest Virginia currently offers it during certain periods yet is working on a year-round plan. They explained that the rationale behind the waiting period was that, if there was none, people would wait until they needed insurance to obtain it. Blue Cross and Blue Shield explained that they have offered this as a community service since 1941 as a justification for their tax-exempt status.

Blue Cross and Blue Shield testified that although the National Association of Insurance Commissioners came out with a model pooling bill, a copy of which is attached to this report as Appendix III, the Association evidenced its own misgivings about the pools by attaching the following two caveats to its model:

-Adoption of the model bill does not constitute NAIC endorsement of the pooling concept, nor is it recommended for enactment in all states. Each state is urged to determine, through independent study, whether a pooling mechanism is needed, and whether enactment of the model would be cost-effective.

-Enactment of the model bill by states is not recommended unless and until a viable solution is secured, through federal law or otherwise, under which pools for uninsurables can operate on a universal basis including all health care financing mechanisms (self-insureds).

Blue Cross and Blue Shield explained that if a state has an insurer of last resort that provides adequate coverage at, or near, the standard rate and with little or no underwriting, there is no need for a pool. They stated that pools help only a very small percentage of people and that those in other states have only a small number of members. They explained that pools do not hold down health care costs yet add to the cost of coverage of existing insureds and that pools only guarantee product availability but do nothing to assure that people can afford to participate. They pointed out that, in most cases, it is the affordability of coverage that is prohibitive not the availability and that the major problem regarding the availability issue is the lack of information to consumers about where they can obtain coverage.

During its final meeting the joint subcommittee discussed and carefully considered the recommendations to make to the 1985 General Assembly. After reviewing the joint subcommittee's recommendations, the Bureau of Insurane indicated in a memorandum that they support the joint subcommittee's recommendations and suggested additional legislation which they felt would more fully address the "availability" problem. The study group included the Bureau's suggestions in their recommendations.

RECOMMENDATIONS

The subcommittee offers the following recommendations to the General Assembly:

1. Further study of health insurance pooling mechanisms is not needed as a source of health insurance coverage for people with chronic health problems exists in Virginia.

Testimony received during the meetings revealed that Blue Cross and Blue Shield of Virginia acts as the "insurer of last resort" in Virginia as they will accept anyone at anytime regardless of his physical condition and that the average premiums of pools in other states are greater than those charged by Blue Cross and Blue Shield. Testimony also revealed that a pooling mechanism would translate back into higher insurance rates for those who already have coverage, and that the Commonwealth would have to share in the responsibility by foregoing premium taxes or by subsidizing the pool in some other way. The joint subcommittee determined, therefore, that further study of health insurance pooling mechanisms at this time was unnecessary.

2 - Blue Cross and Blue Shield plans should be required by law to have open enrollment programs under which at all times any resident of Virginia, regardless of his physical condition, can obtain health insurance coverage. Contracts issued pursuant to the program and any related advertising shall advise purchasers that coverage is available for anyone.

Blue Cross and Blue Shield of Virginia testified that this would put into law their practice since 1941. The joint subcommittee felt that the inavailability problem resulted from the lack of communication by the insurance industry and Blue Cross and Blue Shield that such coverage is available and that by putting this into law and by encouraging health associations and insurance

brokers to inform people of this coverage, much of the availability problem would be cured.

3. Blue Cross and Blue Shield plans should be required to notify certain state and local agencies of the availability of health insurance through their open enrollment programs.

Notification by the Blues, through their contracts or any advertising related to the programs, would not be adequate enough to reach those individuals with no knowledge of the Blues open enrollment program. The study group, therefore, felt that the Blues should be required to notify all state and local agencies whose regular course of business includes working with individuals with health problems of their open enrollment programs.

4. Commercial insurers should be required to inform those who are rejected for health insurance coverage of the availability of insurance through the open enrollment programs.

In addition to requiring the Blues to provide and the advertise open enrollment programs and to notify certain state and local agencies of such programs, the joint subcommittee felt that in order to ensure that information regarding the open enrollment programs reaches as many people as possible commercial insurers, through their adverse underwriting decision notification, should inform the people who are being turned down for insurance coverage that health insurance coverage is available through open enrollment programs of the Blue Cross and Bleu Shield plans.

Enclosed as Appendix IV of this report is a copy of the legislation recommended by the subcommittee to effect the additions of recommendations 2, 3 and 4 to the Code.

5 - The study should be continued to monitor the dissemination of information about the coverage provided by Blue Cross and Blue Shield and to look into additional areas such as rate structures and waiting periods which were brought to the subcommittee's attention as needing study.

The joint subcommittee felt that the dissemination of information should be monitored to ensure that people become aware of the open enrollment program.

Testimony received during the meetings revealed that additional study is needed in other related areas, including rate structures and waiting periods. Several people pointed out that even if insurance is available, many people will not be able to afford it and that while waiting for a twelve-month waiting period to expire all or most of an individual's financial resources could be depleted. As explained earlier in the report, the Bureau of Insurance has received many complaints about the affordability of insurance coverage.

Enclosed as Appendix V of this report is a copy of the resolution recommended by the subcommittee to accomplish this.

CONCLUSION

The joint subcommittee expresses its appreciation to all parties who participated in this study. The study group's recommendations have been offered only after careful and thorough study of the information. The subcommittee believes that its recommendations are in the best interests of the Commonwealth, and it encourages the General Assembly to adopt its recommendations.

Respectfully submitted,

.....

Joan H. Munford

.....

Frank W. Nolen

.....

Frank D. Hargrove

.....

Mary Sue Terry

.....

E. M. Holland

.....

Robert C. Scott

.....

B. Michael Herman

.....

Stephen L. Pohl

LD4168406

HOUSE JOINT RESOLUTION NO. 69

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Rules on February 12, 1984)

(Patron Prior to Substitute—Cranwell)

Requesting the establishment of a joint subcommittee to study health insurance coverage available for people in the Commonwealth with significant risks and the feasibility of the Commonwealth's implementing health insurance pooling mechanisms.

WHEREAS, in recent years, the cost of health care has risen an alarming fifteen to twenty percent annually; and

WHEREAS, this dramatic increase in health care cost has led insurance companies to re-evaluate how they underwrite risks; and

WHEREAS, such changes have resulted in many Americans, especially those with chronic health problems such as diabetes, no longer being able to obtain health insurance; and

WHEREAS, although Congress has debated the feasibility of some form of national health insurance, it has focused primarily on insuring against catastrophic losses; and

WHEREAS, many states have taken initiatives to overcome the uninsurability problem by implementing health insurance pooling mechanisms; and

WHEREAS, there is a need for Virginia to look into the uninsurability problem, since it affects many of its citizens; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That a joint subcommittee be established to study health insurance coverage available for people in Virginia who may be significant underwriting risks and the feasibility of the Commonwealth's implementing health insurance pooling mechanisms. The joint subcommittee shall be composed of eight members, five of whom shall be appointed by the Speaker of the House, and three of whom shall be appointed by the Senate Committee on Privileges and Elections. The appointments shall be made from among the membership of the House Committee on Corporations, Insurance and Banking and the Senate Committee on Commerce and Labor as well as from among persons representing commercial insurance and prepaid health plans, health care providers, and organizations concentrating on the study of such chronic health problems.

The Bureau of Insurance and the Department of Health are requested to assist the joint subcommittee in its study.

The joint subcommittee shall complete its work by and make any recommendations it deems appropriate to the 1985 Session of the General Assembly.

All direct and indirect costs of this study are estimated to be $15,700.

Initial Staff Study for the Joint Subcommittee Studying the Feasibility of the Commonwealth Implementing a Health Insurance Pooling Mechanism

Prepared by

Terry Mapp

Division of Legislative Services

Contents

AUTHORITY FOR STUDY

Pursuant to House Joint Resolution No. 69 of the 1984 General Assembly a joint subcommittee was established to study health insurance coverage available for people in the Commonwealth with significant health risks and the feasibility of the Commonwealth's implementing health insurance pooling mechanisms. A copy of this resolution is attached as Appendix 1 to this report.

OBJECTIVES

It would appear that the joint subcommittee should strive to achieve the following objectives:

(1) A clear understanding of health insurance coverage available in the Commonwealth for individuals with significant health risks;

(2) An understanding of how health insurance pooling mechanisms work and how they can be implemented to solve the uninsurability problem;

(3) An understanding of other states' experience with pooling mechanisms; and

(4) The drafting of appropriate legislation to effect any changes in or additions to the law which the joint subcommittee deems appropriate.

SCHEDULE

The subcommittee will hold its first meeting of the year at 10 a.m. July 11 in House Room C, General Assembly Building and is requested to complete its work by November 15.

House Joint Resolution No. 69 states "the joint subcommittee shall complete its work by and make any recommendations it deems appropriate to the 1985 Session of the General Assembly." If the subcommittee concludes its deliberations by November 15, its staff will have ample time, prior to the beginning of the 1985 Session, to draft any legislation or reports desired by the subcommittee and its members will have more time to devote to their other studies.

GENERAL OVERVIEW

Individuals with chronic health problems such as diabetes have found it increasingly difficult in recent years to obtain health insurance as insurance companies have found it necessary to change the ways in which they underwrite risks because of dramatic increases in health care costs.1 Those individuals who are able to obtain coverage often have to pay very high premiums or have trouble getting their insurers to pay for important expenses.2

People who do not have access to insurance face possible harm from:

1. foregoing necessary medical care in order to meet everyday living expenses;
2. losing opportunities for gainful employment because of problems stemming from their lack of medical attention; and
3. living with the anxiety of not having the means to pay for medical care in the event of a serious illness or an accident.3

AVAILABLE COVERAGE

Currently coverage is available if one is employed, old enough, poor enough, disabled enough, has access to extensive resources, or lives in a state which has a pooled-risk insurance plan.4 A chart outlining the types of coverage available is attached to this report as Appendix 2.

Many group insurance policies offered through work are open to all employees regardless of preexisting medical

conditions.5 Most insurance companies however require that the group consist of at least ten employees. For groups of fewer than ten, insurance companies require that each individual demonstrate evidence of insurability. Group policies usually can be converted to individual plans without evidence of insurability within a specified time period (usually one month) at the standard rate regardless of condition. Thereafter, the person may not be able to obtain coverage or may have to pay exorbitant premiums.

A relatively new type of group insurance, health maintenance organizations, provide a wide range of medical services for a fixed fee, yet may not be the answer for high risk individuals. One of the drawbacks of HMOs is that a member can use only the doctors and facilities connected with it. Therefore, if an individual needs to see a particular type of specialist, and there is none on the HMO staff, he will have to pay to see one. The fact that an individual has a preexisting condition may affect his ability to join an HMO and could raise his fee.6

People over 65 years old or who are disabled are eligible for federal health insurance under Medicare. Medicare, however, covers only a portion of hospital and doctors' bills, and other expenses. Low-income families may qualify for Medicaid, a federal and state assistance program.7

Pooled-risk insurance is available for those who are having difficulties in obtaining coverages in several states. This concept is discussed later in this report.

All of the types of coverage listed in Appendix 2 except for pooled risk insurance are available in Virginia. In order to determine the actual coverage available through private insurers for high risk individuals, information was obtained through conversations with agents and managers of some of the companies represented in Virginia. Table 1 consists of a brief summary of the information. From the information received one can make the following generalizations concerning insurance coverage available for such high risk individuals:

1 - Insurance companies will usually consider insuring people with preexisting conditions. Some look at each case individually and others have specific standards (lists) they follow.

2 - With individual plans, the preexisting condition is excluded from coverage for a certain length of time (usually varies between ninety days to twelve months).

3 - Premiums generally depend on the type and severity of the condition. They, however are not necessarily higher than standard premium, yet may be as high as 250 percent of the standard rate

4 - Coverage is available for groups of ten and greater (fifteen and more in some cases) regardless of any preexisting conditions its members may have if they enroll in the plan during the enrollment period. If coverage is not obtained during this period, the employee must show evidence of insurability in order to be accepted. Some companies have waiting periods on

TABLE 1

	Travelers	Prudential	Mutual of Omaha	Life of Virginia	Blue Cross Blue Shield
Individual Coverage	.In many cases will consider people with preexisting conditions. .Look at each case individually - the experience, severity medication taken, duration. .May exclude condition from coverage for a certain length of time (usually 1 year) .Do not charge extra premiums	.Have individual qualifying criteria .Condition treated within 2 years of application not covered. If individual received no actual treatment within 2 years may be covered .May charge higher premiums	.Coverage depends on degree of illness .if bad enough - rejected .may exclude condition from coverage .may cover condition after certain length of time - depends on type of condition .Premium depends on condition - not necessarily higher than standard rate 110% of standard for moderate condition 125% for more severe 150% for multiple conditions 250% for multiple conditions in 12 mos.	Do not offer	"Insurer of last resort" in Virgini .Will cover anyone, any group .Premiums are community based. Risk is spread across the communit .Have a 1 year waiting period on preexisting conditions (base coverage) .with major-medical 90 day waiting period
Group Coverage	Groups of 2 to 15 (old coverage) 2-10 (new coverage) must fill out limited medical questionnaires (see Individual coverage) Groups of more than 15 old coverage or more than 10 - new coverage - all accepted	Groups of 2-9 subject to individual qualifying criteria may not accept all or may charge higher premiums for some Groups of 10+ All accepted regardless of preexisting conditions	Groups of 2 to 9 evaluated on an individual basis. Have no rate-write ups or exclusions - Accept at standard coverage rate or reject Groups of 10+ - No individual evaluation - accept all, have a 90 day preexisting clause	Groups of 3 to 15 evaluated on an individual basis Groups of 16+ preexisting conditions is limited to $500 at first-if have not been sick due to condition for 3 to 6 months (depending on type of condition) it will be covered if have been covered for 12 mos. condition is automatically covered	

preexisting conditions (like those on individual policies) for group policies.

5 - Members of groups containing less than ten members, (in some cases fifteen) are evaluated on an individual basis. Not all members are necessarily accepted.

6 - Most group policies are convertible to individual policies, if done so within a thirty-one day period. After the expiration of the period, acceptance is based on insurability. Mutual of Omaha offers continuous policies. For example, if an nineteen year old diabetic decides not to go to college, he is no longer covered by his parents' Mutual of Omaha policy, yet through Mutual of Omaha's continuous policy plan, he may obtain his own policy at a standard adult rate regardless of his condition.

7. Many companies have no loss, no gain provisions which means that if a group transfers its coverage from one company to another, they will not lose any benefits because of the switchover.

It is evident from this information that an unemployed person who is trying to obtain health insurance from a private insurer may not have very much success.

HEALTH INSURANCE POOLING MECHANISMS

Although Congress has debated the feasibility of some type of national health insurance it has focused primarily on insuring against catastrophic losses. Several states, however, have taken the initiative in solving the "uninsurability" problem by creating health insurance

pooling mechanisms. These mechanisms "provide comprehensive hospital and medical coverage for persons who are unable to obtain adequate standard health insurance in the private market due to physical or mental disability."[8] Thus far, six states, Conneticut, Indiana, Minnesota, North Dakota, Wisconsin, and Florida have implemented some type of pooling mechanism.[9]

Prior to the enactment of its health pooling mechanism in 1981, North Dakota's Legislative Council's Health Care Committee conducted an interim study on uninsurable pooling mechanisms.[10] A copy of the minutes taken during several of their meetings and of the 1981 Legislative Council Report is attached as Appendix 3.

The pooled risk insurance programs which have been implemented in the six states are very similar. Table 2 contains a summary of what the state and model programs offer.

General provisions of these programs include:

1 - The establishment of a state association or pool in which providers of health insurance and self-insurers are members. Every participating insurer shares in the administering expenses and losses on an equitable proportinate basis. Most of the states subsidize their programs through income or premium tax credits to offset the shortfalls in revenues needed to meet claims expenses.

2 - Coverage consisting of very broad comprehensive benefits. Applicants have the choice of high or low

TABLE 2

STATE COMPREHENSIVE HEALTH CARE PLANS

STATE/MODEL	NO. OF POOLS	POOL COMPOSITION	HMOs	SELF-INSURED	GOVERNING BOARD	POOL ADMINISTRATOR	POOL ASSESSMENTS
NAIC MODEL	ONE	All insurers (including HMOs), and insurance arrangements (METs self insurance	YES	YES	7 members; 4 elected by members; 3 appointed by NIS Ins. Com.; 1 must be non-profit.	Selected by Board from competitive bids.	Insuror's portion is fraction of premium in force to total state premiums. Self insureds on separate basis.
HIAA MODEL	ONE	All insurers (including HMOs, IPAs) Not fixed indemnity, credit or worker's comp.	YES	Voluntarily in state bill. Fed. bill to require.	Determined by Pool members with Commissioner approval	May be one or more. Selected by Board with Commissioner's concurrence.	Carriers earned premium as a percent of total state HI premium. Self insureds at 110% of benefits period.
CONNECTICUT	TWO	All insurers, self-insureds	NO	YES	Selected by Assoc. with Commissioner approval.	Selected by Assoc. (Travelers)	Apportioned proportionate to marketplace.
FLORIDA	ONE	All health insurers, doing business in state.	YES	YES	7 members, 3 yr term. 4 elected by Assoc. 3 appointed by NIS Ins. Com.',	Selected by Board from competitive bids for 3 years.	Based on percentages - insurors premiums to total HI premium in state.
INDIANA	ONE	All accident and sickness insurors, HMOs, and self-insureds not exempted by Federal law.	YES	YES/NO	9 members selected by Assoc. members.	One carrier selected by Board on competitive bid basis with NIS Ins. Com. approval. Mutual of Omaha	Insurors premium income as percentage of total premium. Assessments can be credited against state tax liability.
MINNESOTA	ONE	All insurors, self-insureds, fraternals, and HMOs.	YES	YES	7 members selected by Assoc. members with NIS Ins. Com. approval	One carrier selected by Assoc. for 3 years with NIS Ins. Com. approval. Northwestern Nat'l Life	As percentage of premiums in force. Allows tax offset.
NORTH DAKOTA	ONE	All A & H insurors with premiums in excess of $100,000.	NO	NO	Top 10 insurors.	By Board based on competitive bids. Blue Cross - Blue Shield	Based on percentage of market.
WISCONSIN	ONE	All A & H insurors conducting business in state HMOs, self-insureds.	YES	YES	9 members appointed by NIS Ins. Com; 2 non-profit; 2 profit; 3 public; 1 department; 1 health department.	One carrier selected by Board for 3 years. Mutual of Omaha	Based on insuror's percentage of total state premiums.

TABLE 2 continued

STATE COMPREHENSIVE HEALTH CARE PLANS

STATE/MODEL	POOL PRODUCTS	GROUP/NON-GROUP	MEDIGAP	UNDERWRITING RESTRICTIONS	PRICING	RATING	ELIGIBILITY
NAIC MODEL	$500, 1,000, 1,500 or 2,000 deductible. 20% co-pay; Max. out-of-pocket, 1,500/3,000	Non-group only	Allows Medicare carve out.	May exclude pre-existing condition up to 12 months.	Capped at 150% of standard risk.	Allows age, sex and geographical	State resident, spouse; dependents to age 19; former spouse; Rejected by 2 insurors.
NIAA MODEL	Min. $1,000 deductible; Max. 2,500 20% co-pay; Max. out-of-pocket, 3,500/5,000	Non-group	Secondary to any federal programs.	To be set by Board.	150% of standard risk initially. Not larger than 200%.	Age, geographical.	Eligibility determined by Board.
CONNECTICUT	$200, 500, 750 deductible; 20% co-pay; 1,000/2,000 max. liability.	Allows small groups (3).	Not allowed	Pre-existing conditions exempted for 1 year.	Minimum 125% Maximum 150% of standard.	Age, sex and geographical.	Any resident not eligible for Medicare.
FLORIDA	$1,000, 1,500 deductible; 20% co-pay; (N&M 50/50); Max. out-of-pocket $3,000.	Non-group only	Allows Medicare product.	May exclude pre-existing condition for 1 year.	150 to 200% of standard.		Individuals w/ 2 rejections, or cost in excess of pool; Medicaid eligible excluded.
INDIANA	$200, 500, 1,000 deductible; 20% co-pay; $1,000/ 4,000 out-of-pocket max.	Non-group only	NO	6 months pre-existing condition.[1]	135% ~~150%~~ of standard risk	Age, sex.	State resident; rejected by 2 insurors, or due to premium increase. No Medicare
MINNESOTA	$100, 300, 500, 1,000 or 2,000 deductible; 20% co-pay; $3,000 ind. max.	Non-group only	YES	6 months pre-existing condition.	125% of standard risk	Age, sex.	Individuals refused coverage, experiencing reduced coverage or substantial rate increase.
NORTH DAKOTA	$500, 1,000, 1,500 deductible; 20% co-pay; Max. out-of-pocket $3,000.	Non-group only	NO	Up to 6 months pre-existing condition.	135% of average premium charged by state's 5 largest insurers		Rejection by 2 insurors, or or offered restricted coverage
WISCONSIN	$1,000 deductible; 20% co-pay.	Non-group only	NO	30-day pre-existing condition.	150 ~~130~~% of standard risk	Age/sex and community rated.	Rejection by 2 insurors or 50% premium increase.

[1] Waiver of 6 month period if surcharge of 10% paid

[2] Rejection of 2 insurers not necessary if have certain conditions.

10/83

deductibles.

3 - Limited lifetime benefits range from $250,000 in North Dakota and Wisconsin to $1,000,000 in Connecticut.

4 - Limited cost of coverage range from 135 to 200 percent of standard rates.

5 - Coverage limited to the residents of the state who are under sixty-five years old. Additional eligibility requirements exist in four of the six states.

6 - Coinsurance of twenty percent until the insured has paid the maximum out-of-pocket expenses (from $500 to $3,000), after which the plan covers 100 percent.

7 - Preexisting clauses. In Minnesota, North Dakota and Wisconsin conditions treated within three months (MN & ND) and six months (Wis.) prior to acceptance into the plan are excluded from coverage for six months. Connecticut and Florida have twelve month exclusion periods. Indiana had an exclusion period identical to Wisconsin, but found that its subscribers were unhappy with it. To resolve this problem, they allow the condition to be covered immediately if a surcharge of ten percent is paid. The surcharge, however, is in effect for the duration of the coverage.

8 - The selection of the administering carrier through bids in four of the six states.

Most of the plans cover the usual and customary charges for the following services:

Services Prescribed by a Licensed Physician

..Hospital services

.. Basic medical-surgical services including both in-hospital and out-of-hospital medical and surgical services, diagnostic services, anesthesia services and consultation services

..In-hospital treatment for 30 days per calendar year for alcoholism and drug abuse and 60 days for mental and nervous disorders

..Outpatient services for alcoholism, drug abuse and mental and nervous disorders (to a maximum of $3,000 per year)

..Prescription drugs

..40 home health care vistis per year (365 visits for persons on Medicare when combined with Medicare benefits)

..Radium or other radioactive materials

..Oxygen

..Anesthetics

..Prosthesis other than dental

..Durable medical equipment other than eyeglasses and hearing aids

..Diagnostic X-rays and laboratory tests

..Some oral surgery

..Physical therapy

..Ambulance service

..30 days of skilled nursing care following a hospitalization (120 days for persons on Medicare)

..Processing charges for blood

Other Services

..Chiropractic services [11]

However, most plans will not cover:

..Experimental treatment

..Cosmetic treatment

..Custodial care

..Private room if not medically necessary

..Eyeglasses and hearing aids

..Dental care

..Routine physical exams

..Illness or injury due to acts of war

..Replacement fees for the first three pints of blood

..Charges in excess of usual and customary charges

..Charges for care which is not medically necessary

..Expenses incurred before effective date of coverage

..Expenses for which benefits are payable under a worker's compensation or other similar law

..Expenses for which benefits are payable under other insurance policies or government programs, such as Medicare or the U.S. Veterans' Administration.[11]

Pamphlets describing the state plans more completely are attached as Appendix 4 and copies of the legislation enacted by the states are attached as Appendix 5.

Included in Minnesota's Comprehensive Health Insurance Act is a catastrophic illness program which is designed to cover infrequent and costly illnesses. The state/insurance

company pays a certain percentage of "qualified" medical expenses above a certain figure which depends on the individual's income. Five other states and numerous insurance companies have implemented catastrophic illness programs.[13]

UPDATE ON THE HEALTH POOLING PROGRAMS

Indiana has encountered some problems with its program since it has been in effect. As originally drafted, its law called for a six month coverage exclusion for conditions diagnosed or treated within six months prior to acceptance into the program. When Indiana began enrolling people into the program they found that subscribers were not happy with the preexisting condition clause. In order to resolve this problem they made immediate coverage available if subscribers pay a surcharge of ten percent. The surcharge, however, remains in effect for the duration of the coverage. The success of this solution has yet to be determined as it has not been in effect long enough to determine its financial impact.

Indiana's other problem involved its eligibility requirements. In order to be eligible for coverage, applicants had to be "turned down" for coverage by two insurance companies. Applicants were having trouble getting turned down because agents were prohibited from sending applications in for review if they knew the applicant had a certain condition. To resolve this problem, Indiana has developed a "laundry list" of health conditions, a copy of which is attached as Appendix 6. If an applicant suffers

from any of the conditions on the list he is eligible to obtain coverage without having to submit the two rejection notices. This has allowed applicants to obtain coverage more quickly and easily.[14]

In 1982, Wisconsin's Health Insurance Risk Sharing Plan's Board of Directors sent questionnaires to all of its plan's subscribers in order to learn about their characteristics and satisfaction. The results indicated that sixty percent of the respondents were satisfied with the coverage and felt the plan was affordable. One third of the respondents noted their concern over the high cost of the plan and only a small number of respondents indicated they had filed claims. A copy of survey and results is attached as Appendix 7. Although most of the replies to the survey revealed overall satisfaction with the plan, the Board of Directors felt that additional study was warranted by the number of negative comments.

Minnesota experienced some problems concerning the legality of its plan. Included in Appendix "B", pp. 3-5 of the North Dakota minutes (Appendix 3 of this report) is a more complete explanation of their problems.

Connecticut currently has 30,000 policies in force; Wisconsin 1,798; North Dakota 365, Minnesota 6610, and Florida 158. In 1983, Wisconsin experienced a forty-one percent increase in the number of policies issued over the previous year, however they also experienced a 439 percent increase in the number of policies terminated. The increase in cancellations was contributed to their rate increase,

from 130 percent of the standard rate to 150 percent, and to plan modifications. A copy of the 1982 Annual Report of Wisconsin's Health Insurance Risk - Sharing Plan is attached as Appendix 8.

Several major points of concern have beeen raised concerning the pools. These are:

"1. Pools provide a ready means for insurers to avoid the natural, adverse consequences of their way of doing business. By selecting only the better risks and engaging in rigid underwriting practices, many commercial carriers have tended to create substantial social problems. Public policy should be directed not at accommodating those practices, but toward altering them. Decision-makers might more properly focus on providing incentives for insurers to address the problem of uninsurables as a part of their normal line of business.

2. Pools do not deal effectively with the affordability issue, which may be the major impediment to coverage for the unemployed, poor, near poor, left dependents and others.

3. By addressing only one symptomatic aspect of the problem, there may be a tendency to ignore the causes, including insurance industry practices and dramatic rises in the cost of health care.

4. Equal apportionment of risk by the pools may penalize responsible and desirable corporate behavior. It would be questionable public policy, for example, to treat carriers with open enrollment or very minimal underwriting standards the same as carriers writing only group coverage with strict underwriting rules. Good public policy would apportion pool liability in a manner consistent with the contributing cause, and should recognize and reward those carriers whose operations tend to contribute to the solution, not to the problem.

5. State proposals should remain flexible to adequately meet the differing state needs and contributing factors to the problem of the uninsured population without inadvertently prompting federal preemption."[15]

CONCLUSION

In June 1983 the National Association of Insurance Commissioners adopted a model health insurance pooling act, a copy of which is attached as Appendix 9. The adoption of the bill did not constitute NAIC endorsement of the concept, nor does the NAIC recommend its enactment in all states. The NAIC urges each state to determine "whether a pooling mechanism is needed and whether enactment of the model would be cost effective. Its cost effectiveness can be substantially impared in the absence of universal participation, for without the inclusion of self-insured plans, the financial base necessary to support the pooling mechanism will tend to progressively diminish." They do not recommend enactment of the model bill by states "unless and until a viable solution is secured, through federal law or otherwise, under which pools for uninsurables can operate on a universal basis including all health care financing mechanisms ."[16]

In their March 19, 1984 Legal Affairs Bulletin on pooling mechanisms for uninsurables, Counsel for Blue Cross and Blue Shield emphasized that "where plans (or other carriers) already provide a reasonable level of benefits with little or no medical underwriting on a direct pay basis and with liberal open enrollment opportunities, there is little or no justification for a pool arrangement."

MODEL HEALTH INSURANCE POOLING MECHANISM ACT

adopted June, 1983

Table of Contents

BE IT ENACTED BY THE STATE OF (insert state).
(adapt caption and formal portions to local requirements and statutes)

Statement of Principles

The State and Federal Health Insurance Legislative Programs (B6) Task Force was charged to develop model state legislation for the establishment of health insurance pooling mechanisms for uninsurables. The Task Force has developed the attached Model State Health Insurance Pooling Mechanism Bill and recommends its final adoption by NAIC subject to the following principles:

1. Adoption of the model bill does not constitute NAIC endorsement of the pooling concept, nor is it recommended for enactment in all states. Each state is urged to determine, through independent study, whether a pooling mechanism is needed and whether enactment of the model would be cost effective.

2. Enactment of the model bill by states is not recommended unless and until a viable solution is secured, through federal law or otherwise, under which pools for uninsurables can operate on a universal basis including all health care financing mechanisms.

These recommendations and principles are consistent with NAIC strategy for alternatives to national health insurance which embrace the interrelated goals concerning the federal ERISA preemption problems, state pooling mechanisms, adequate health insurance availability and cost containment. The interrelationship of these initiatives is exemplified by the ERISA barrier to universal participation in such pools and overall concerns about health care cost containment.

Although much has been accomplished with the enactment of P.L. 97-473 subjecting multiple employer trusts to state jurisdiction, and by the adoption of the NAIC model "Jurisdiction to Determine Jurisdiction" bill, these measures will not, in and of themselves, establish universal participation in state pools for uninsurables.

145-1

Uninsurable pools may not be needed in every state, nor present the most effective answer to questions of availability of health insurance in every state. The establishment of such programs is costly and their cost effectiveness should be weighed in relation to whether there is a demonstrated need for a pool in a given state. Their cost effectiveness can be substantially impaired in the absence of universal participation, for without the inclusion of self-insured plans, the financial base necessary to support the pooling mechanism will tend to progressively diminish. The purpose of the attached model bill is to establish a mechanism through which adequate levels of health insurance coverages can be made available to residents of the state who are otherwise considered uninsurable. The bill would establish a state "association" or pool in which all health care financing mechanisms (insurers, nonprofit service plan corporations, HMOs and self-insurers) would be members.

The pool coverage consists of very broad comprehensive benefits with a choice of a "high" and a "low" deductible. Each state is cautioned that the scope of coverage may not be appropriate. In such case, the benefit levels should be adjusted, or the bill should include the Alternative Section 6 under which the Commissioner is authorized to establish by regulation actual pool benefits commensurate with the prevailing levels of group coverages provided in that state.

By definition, a pool consisting of uninsurable risks will necessitate premium rates substantially greater than applicable for standard risks. The bill establishes an initial minimum rate at 150% of applicable standard risk rates. Thereafter rates are expected to fluctuate according to experience, however, in no event shall rates exceed 200% of standard risk rates. The minimum rate of 150% is admittedly inadequate for the risks insured, and the 200% maximum will prevent the rates from becoming prohibitive. Pool losses in excess of the 200% maximum rate will be assessed to each member of the pool in proportion to the volume of business done in the state. Eligibility for pool coverage is not established by criteria such as the incurring of a catastrophic condition, the expenditure of a prescribed amount of earnings for health care, or the rejection of the applicant by any specified number of health insurance carriers. Such criteria may not apply equitably to all uninsurables and may neither be cost efficient nor practical to administer. Practical considerations of price will serve to discourage individuals from buying pool coverage when it is available to them in the standard marketplace at a lesser rate.

For obvious cost containment reasons, the pool coverage is the coverage of "last resort" and it does not duplicate coverages from any other source, private or public. The mechanics of the pool, its operations and functions must all be established under a plan approved by the Commissioner. The pool is subject to the requirements of the insurance code and has the general powers and authority of an insurer licensed to transact health insurance.

Section 1. Definitions.

(1) "Pool" means the State Health Insurance Pool as created in Section 2 of this Act.

(2) "Board" means the Board of Directors of the pool.

(3) "Insured" means any individual resident of this state who is eligible to receive benefits from any insurer or insurance arrangement as defined in this section.

(4) "Insurer" means any insurance company authorized to transact health insurance business in this state, any (reference state nonprofit health care service plan act and if appropriate HMO law).

1452

(5) "Insurance arrangement" means any plan, program, contract or any other arrangements under which one or more employers, unions or other organizations provide to their employees or members, either directly or indirectly through a trust or third party administrator, health care services or benefits other than through an insurer.

(6) "Health insurance" means any hospital and medical expense incurred policy, nonprofit health care service plan contract and health maintenance organization subscriber contract. The term does not include short term, accident, fixed indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(7) "Medicare" means coverage under both part A and B of Title XVIII of the Social Security Act, 42 USC 1395 et seq., as amended.

(8) "Physician" (reference applicable state laws)

(9) "Hospital" (reference applicable state laws)

(10) "Health maintenance organization" (reference applicable state laws)

(11) "Plan of operation" means the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to Section 3 of this act.

(12) "Benefits plan" means the coverages to be offered by the pool to eligible persons pursuant to Section 6 of this act.

(13) "Department" means the Insurance Department.

(14) "Commissioner" means the Insurance Commissioner.

(15) "Member" means all insurers and insurance arrangements participating in the pool.

Section 2. Operation of the Pool.

(1) There is hereby created a nonprofit entity to be known as the (State) Health Insurance Pool. All insurers issuing health insurance in this state and insurance arrangements providing health plan benefits in this state on and after the effective date of this Act shall be members of the pool.

(2) The Commissioner shall give notice to all insurers and insurance arrangements of the time and place for the initial organizational meetings. The pool members shall select the initial board of directors and appoint one or more insurers to serve as administrator. Both the selection of the board of directors and the administering insurer(s) shall be subject to approval by the Commissioner. The Board shall at all times, to the extent possible, include at least one domestic insurance company licensed to transact health insurance and one domestic nonprofit health care service plan.

(3) If, within sixty (60) days of the organizational meeting, the board of directors is not selected or the administering insurer is not appointed, the Commissioner shall appoint the initial board and appoint an administering insurer.

(4) The pool shall submit to the Commissioner a plan of operation for the pool and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the pool. The Commissioner shall, after notice and hearing, approve the plan of operation provided such is determined to be suitable to assure the fair, reasonable and equitable administration of the pool, and provides for the sharing of pool gains or losses on an equitable proportionate basis. The plan of operation shall become effective upon approval in writing by the Commissioner consistent with th the date on which the coverage under this Act must be made available. If the pool fails to submit a suitable plan of operation within 180 days after the appointment of the board of directors, or at any time thereafter fails to submit suitable amendments to the plan, the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the Commissioner or superseded by a plan submitted by the pool and approved by the Commissioner.

(5) In its plan the pool shall,

(a) Establish procedures for the handling and accounting of assets and monies of the pool.

(b) Select an administering insurer in accordance with Section 4 of this act, and establish procedures for filling vacancies on the Board of Directors.

(c) Establish procedures for the collection of assessments from all members to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board, pursuant to Section 5 of this act. Assessment shall occur at the end of each calendar year. Assessments are due and payable within 30 days of receipt of the assessment notice.

(d) Develop and implement a program to publicize the existence of the plan, the eligibility requirements, and procedures for enrollment, and to maintain public awareness of the plan.

(6) Powers and Authority of the pool. The pool shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact the kinds of insurance defined under Section 1.(1)(6) and in addition thereto, the specific authority to:

(a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the approval of the Insurance Commissioner, to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(b) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against pool members;

(c) Take such legal action as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

145-4

(d) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas and any other actuarial function appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices.

(e) Assess members of the pool in accordance with the provisions of this section, and to make advance interim assessments as may be reasonable and necessary for the organizational and interim operating expenses. Any such interim assessments to be credited as offsets against any regular assessments due following the close of the fiscal year.

(f) Issue policies of insurance in accordance with the requirements of this Act.

(g) Appoint from among members appropriate legal,actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the pool.

Drafting Note - Optional Paragraph

A state may wish to provide members of the pool with the option of utilizing their existing distribution systems for the issuance of pool coverage. If so, such a provision should authorize the establishment of specific rules under which the pool would approve and serve as a reinsurer for coverage issued by members in their own names. Paragraph (h) is designed to allow states to implement this option.

(h) Establish rules, conditions and procedures for reinsuring risks of pool members desiring to issue pool plan coverages in their own name. Such reinsurance facility shall not subject the pool to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers.

Drafting Note - Section 3

It is intended that only those unable to purchase health insurance coverage in the marketplace at a reasonable price will apply for pool coverage. The higher cost of pool coverage should accomplish this result. However, to assure that the pool coverage does not compete with available coverage in the marketplace, a state may desire to include as a criterion for pool coverage the requirement of rejection of coverage by a specified number of health insurance carriers. This question is discussed fully in the attached Synopsis.

Section 3. Eligibility.

(1) Any individual person, who is a resident of this state shall be eligible for pool coverage, except the following:

1455

(a) persons who have on the date of issue of coverage by the pool coverage under health insurance or an insurance arrangement.

(b) any person who is at the time of pool application eligible for health care benefits under (references state Medicaid law).

(c) any person having terminated coverage in the pool unless twelve months have lapsed since such termination.

(d) any person on whose behalf the pool has paid out $1,000,000 in benefits.

(e) inmates of public institutions and persons eligible for public programs.

(2) Any person who ceases to meet the eligibility requirements of this section may be terminated at the end of the policy period.

(3) Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium and who is not eligible for conversion, may apply for coverage under the plan. If such coverage is applied for within 60 days after the involuntary termination and if premiums are paid for the entire coverage period, the effective date of the coverage shall be the date of termination of the previous coverage.

Section 4. Administering Insurer.

(1) The board shall select an insurer or insurers through a competitive bidding process to administer the pool. The board shall evaluate bids submitted based on criteria established by the board which shall include:

(a) The insurer's proven ability to handle individual accident and health insurance.

(b) The efficiency of the insurer's claim paying procedures.

(c) An estimate of total charges for administering the plan.

(d) The insurer's ability to administer the pool in a cost efficient manner.

(2) (a) The adminstering insurer shall serve for a period of 3 years subject to removal for cause.

(b) At least 1 year prior to the expiration of each 3-year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding 3-year period. Selection of the administering insurer for the succeeding period shall be made at least 6 months prior to the end of the current 3-year period.

(3) (a) The administering insurer shall perform all eligibility and administrative claims payment functions relating to the pool.

(b) The administering insurer shall establish a premium billing procedure for collection of premium from insured persons. Billings shall be made on a periodic basis as determined by the board.

145-6

(c) The administering insurer shall perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:

1. Making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission shall be made.

2. Evaluating the eligibility of each claim for payment by the pool.

(d) The administering insurer shall submit regular reports to the board regarding the operation of the pool. The frequency, content, and form of the report shall be as determined by the board.

(e) Following the close of each calendar year, the administering insurer shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the board and the department on a form as prescribed by the commissioner.

(f) The administering insurer shall be paid as provided in the plan of operation for its expenses incurred in the performance of its services.

Section 5. Assessments.

(1) Following the close of each fiscal year, the pool administrator shall determine the net premiums (premiums less administrative expense allowances), the pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Health insurance premiums and benefits paid by an insurance arrangement that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments.

(a) Each insurer's assessment shall be determined by multiplying the total cost of pool operation by a fraction the numerator of which equals that insurer's premium and subscriber contract charges for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges written in the state and 110% of all claims paid by insurance arrangements in the state during the preceding calendar year.

(b) Each insurance arrangement's assessment shall be determined by multiplying the total cost of pool operation by a fraction the numerator of which equals 110% of the benefits paid by that insurance arrangement on behalf of insureds in this state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges and 110% of all benefits paid by insurance arrangements made on behalf of insured in this state during the preceding calendar year. Insurance arrangements shall report to the board claims payments made in this state on an annual basis on a form prescribed by the commissioner.

(2) If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.

(3) (a) Each member's proportion of participation in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the member with it.

(b) Any deficit incurred by the pool shall be recouped by assessments apportioned under subsection (1) of this section by the board among members.

(4) The board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in subsection (1) of this section. The member receiving such abatement or deferment shall remain liable to the pool for the deficiency for 4 years.

Drafting Note - Section 6

Section 6 deals with the coverage to be issued by the pool. The original draft bill established a comprehensive and specific plan of coverage. However, this plan may not be appropriate to the needs of all states. Thus, the model bill provides two alternative approaches to Section 6.

Alternative 1 specifically establishes a broad, comprehensive plan of coverage in the form of a detailed schedule of benefits, exclusions, limits,deductibles and coinsurance factors.

Alterantive 2 vests authority in the Commissioner to promulgate, with the advice and recommendations of the pool members, a level of pool coverage determined to be commensurate with those typically provided by a representational number of large employers in the state.

It should be pointed out that most carriers will be members of the pools in more than one, and perhaps all, of the states that enact pooling legislation. The administration of these pools will be greatly facilitated if those provisions of the model bill dealing with pool formation, operation and administration remain uniform. This uniformity will allow each state pool to benefit from the operational experience of the others and will facilitate monitoring of the efficiency of pooling mechanisms. There is not the same necessity, however, regarding the actual plan benefits or coverage and the scope of coverage could vary according to individual state needs.

ALTERNATIVE 1

Section 6. Minimum Benefits - Availability.

(1) The pool shall offer major medical expense coverage to every eligible person who is not eligible for Medicare. Major medical expense coverage offered by the pool shall pay an eligible person's covered expenses, subject to limits on the deductible and coinsurance payments authorized under paragraph (4)(d) of this section, up to a lifetime limit of $1,000,000 per covered individual. The maximum limit under this paragraph shall not be altered by the Board, and no actuarial equivalent benefit may be substituted by the Board.

145-8

(2) Covered Expenses. Covered expenses shall be the prevailing charge in the locality for the following services and articles when prescribed by a physician and determined by the pool to be medically necessary.

(a) Hospital services.

(b) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, which are rendered by a physician, or by other licensed professionals at his direction.

(c) Drugs requiring a physician's prescription.

(d) Services of a licensed skilled nursing facility for not more than 120 days during a policy year.

(e) Services of a home health agency up to a maximum of 270 services per year.

(f) Use of radium or other radioactive materials.

(g) Oxygen.

(h) Anesthetics.

(i) Prostheses other than dental.

(j) Rental of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the condition for which is prescribed.

(k) Diagnostic X-rays and laboratory tests.

(l) Oral surgery for excision of partially or completely unerupted, impacted teeth or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(m) Services of a physical therapist.

(n) Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition.

(o) Services for diagnosis and treatment of mental and nervous disorders, provided that an insured shall be required to make a 50 percent copayment, and that the payment of the pool shall not exceed $4,000 for outpatient psychiatric treatment.

(3) Exclusions. Covered expenses shall not include the following:

(a) Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect to restore normal bodily functions.

(b) Care which is primarily for custodial or domiciliary purposes.

(c) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician.

(d) That part of any charge for services rendered or articles prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality or for any charge not medically necessary.

(e) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institituion or individual providing the services or articles.

(f) Any expense incurred prior to the effective date of coverage by the pool for the person on whose behalf the expense is incurred.

(g) Dental care except as provided in subsection (3)(1) of this section..

(h) Eyeglasses and hearing aids.

(i) Illness or injury due to acts of war.

(j) Services of blood donors and any fee for failure to replace the first 3 pints of blood provided to an eligible person each policy year.

(k) Personal supplies or services provided by a hospital or nursing home, or any other nonmedical or nonprescribed supply or service.

(4) Premiums, Deductibles, and Coinsurance.

(a) Premiums charged for coverages issued by the pool may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage.

(b) Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks.

(c) The pool shall determine the standard risk rate by calculating the average individual standard rate charged by the five largest insurers offering coverages in the state comparable to the pool coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for pool coverage shall not be less than 150% of rates established as applicable for individual standard risks. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall pool rates exceed 200% of rates applicable to individual standard risks. All rates and rate schedules shall be submitted to the Commissioner for approval.

145-10

(d) The pool coverage defined in Section 6 shall provide optional deductibles of $500 or $1,500 per annum per individual, and coinsurance of 20%, such coinsurance and deductibles in the aggregate not to exceed $3,500 per individual nor $5,000 per family per annum. The deductibles and coinsurance factors may be adjusted annually according to the Medical Component of the Consumer Price Index.

(5) Preexisting Conditions.

Pool coverage shall exclude charges or expenses incurred during the first twelve months following the effective date of coverage as to any condition, which during the six-month period immediately preceding the effective date of coverage, (i) had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or (ii) for which medical advice, care or treatment was recommended or received. Such preexisting condition exclusions shall be waived to the extent to which similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated; provided, that application for pool coverage is made not later than thirty-one (31) days following such involuntary termination and, in such case, coverage in the pool shall be effective from the date on which such prior coverage was terminated.

(6) Nonduplication of Benefits.

(a) Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or Federal law or program except Medicaid.

(b) The insurer or the pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not coverage expenses. Benefits due from the pool may be reduced or refused as a set-off against any amount recoverable under this paragraph.

ALTERNATIVE 2

Section 6. Minimum Benefits - Availability.

(1) The pool shall offer major medical expense coverage to every eligible person who is not eligible for Medicare. The coverage to be issued by the pool, its schedule of benefits, exclusions and other limitations, shall be established through regulations promulgated by the Commissioner taking into consideration the advice and recommendations of the pool members.

(2) In establishing the pool coverage, the Commissioner shall take into consideration the levels of health insurance provided in the state, medical economic factors as may be deemed appropriate and promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with health insurance provided through a representative number of large employers in the state.

(3) Pool coverage established under this Section shall provide both an appropriate "high" and a "low" deductible to be selected by the pool applicant. The deductibles and coinsurance factors may be adjusted annually according to the Medical Component of the Consumer Price Index.

(4) Premiums and Assessments.

(a) Premiums charged for pool coverage may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing the coverage. Separate schedules of premium rates based on age, sex and geographical location may apply for individual risks.

(b) The pool shall determine the standard risk rate by calculating the average individual standard rate charged by the five largest insurers offering coverages in the state comparable to the pool coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for pool coverage shall not be less than 150% of rates established as applicable for individual standard risks. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall pool rates exceed 200% of rates applicable to individual standard risks. All rates and rate schedules shall be submitted to the Commissioner for approval.

(5) Preexisting Conditions.

Pool coverage shall exclude charges or expenses incurred during the first twelve months following the effective date of coverage as to any condition, which during the six-month period immediately preceding the effective date of coverage, (i) had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or (ii) for which medical advice, care or treatment was recommended or received as to such condition. Such preexisting condition exclusions shall be waived to the extent to which similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated; provided, that application for pool coverage is made not later than thirty-one (31) days following such involuntary termination and, in such case, coverage in the pool shall be effective from the date on which such prior coverage was terminated.

(6) Nonduplication of Benefits.

(a) Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or Federal law or program except Medicaid.

(b) The insurer or the pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a set-off against any amount recoverable under this paragraph.

145-12

Section 7. Collective Action.

Neither the participation in the pool as members, the establishment of rates, forms or procedures nor any other joint or collective action required by this Act shall be the basis of any legal action, criminal or civil liability or penalty against the pool or any of its members.

Section 8. Taxation.

The pool established pursuant to this Act shall be exempt from any and all taxes.

Drafting Note - Optional Section

A state may wish to provide for some form of offset against applicable taxes in the amount of the assessments incurred by the members of the pool. If so, such a provision should allow appropriate reductions in assessments as to pool members not subject to the taxes against which offsets are allowed.

Section 9. Effective Date.

The provisions of this Act shall become effective _____.

D12/27/84 Mapp

SENATE BILL NO. ..... HOUSE BILL NO. .....

A BILL to amend and reenact § 38.1-57.13 of the Code of Virginia, and to amend the Code of Virginia by adding sections numbered 38.1-818.2 and 38.1-818.3, providing for open enrollment for Blue Cross and Blue Shield plans; notification.

Be it enacted by the General Assembly of Virginia:

1. That § 38.1-57.13 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding sections numbered 38.1-818.2 and 38.1-818.3 as follows:

§ 38.1-57.13. Notice of adverse underwriting decision; furnishing reasons for decisions and sources of information.

A. In the event of an adverse underwriting decision, including those which involve policies referred to in paragraph (1) of subsection (c) of § 38.1-371.2 and in paragraph (3) of subsection (f) of § 38.1-381.5, the insurance institution or agent responsible for the decision shall give a written notice in a form approved by the commissioner of insurance which:

1. Either provides the applicant, policyholder, or individual proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing or advises such person that upon written request he may receive the specific reason or reasons in writing; and

2. Provides the applicant, policyholder, or individual

proposed for coverage with a summary of the rights established under subsection B of this section and §§ 38.1-57.11 and 38.1-57.12 ~~.~~ ; and

3. Provides, in the event of an adverse underwriting decision involving a policy relating to accident and sickness insurance as defined in § 38.1-5, written notification of open enrollment programs as described in § 38.1-818.2.

B. Upon receipt of a written request within ninety business days from the date of the mailing of notice or other communication of an adverse underwriting decision to an applicant, policyholder or individual proposed for coverage, the insurance institution or agent shall furnish to such person within twenty-one business days from the date of receipt of such written request:

1. The specific reason or reasons for the adverse underwriting decision, in writing, if such information was not initially furnished in writing pursuant to paragraph 1 of subsection A of this section;

2. The specific items of personal and privileged information that support those reasons ~~; provided~~ , however:

a. The insurance institution or agent shall not be required to furnish specific items of privileged information if it has a reasonable suspicion, based upon specific information available for review by the Commission, that the applicant, policyholder, or individual proposed for coverage has engaged in criminal activity, fraud, material misrepresentation, or material nondisclosure, and

b. Specific items of medical-record information supplied by a medical-care institution or medical professional shall be disclosed either directly to the individual about whom the information relates or to a medical professional designated by the individual and licensed to provide medical care with respect to the condition to which the information relates, whichever the insurance institution or agent prefers; and

3. The names and addresses of the institutional sources that supplied the specific items of information given pursuant to paragraph 2 of subsection B of this section; however, the identity of any medical professional or medical-care institution shall be disclosed either directly to the individual or to the designated medical professional, whichever the insurance institution or agent prefers.

C. The obligations imposed by this section upon an insurance institution or agent may be satisfied by another insurance institution or agent authorized to act on its behalf.

D. When an adverse underwriting decision results solely from an oral request or inquiry, the explanation of reasons and summary of rights required by ~~paragraph~~ subsection A of this section may be given orally.

§ 38.1-818.2. Open enrollment.--A corporation licensed under this chapter, and subject to § 38.1-828, shall make available to citizens of the Commonwealth an open enrollment program under the terms set forth in this section. The program shall be available at all times to any person

residing in Virginia, regardless of the person's health history. The subscription charge for contracts issued pursuant to the program shall be the current standard individual rate. Any contract issued pursuant to the program, and any advertising related to the program, shall, in a prominent fashion, advise the purchaser that the coverage provided is available to anyone who applies, subject only to payment of subscription charges and applicable waiting periods, if any. Contracts issued pursuant to the program may include waiting periods for up to twelve months following enrollment during which time no benefits are available for pre-existing medical conditions manifesting signs or symptoms prior to the effective date of coverage.

If a corporation licensed under this chapter elects to discontinue its program for individuals it may do so only after giving written notice to the Commission at least twelve months in advance of the effective date of termination. Upon termination of the individual program, § 38.1-828 shall no longer be applicable to such corporation, and such corporation shall be subject to the provisions of § 58.1-2501.

§ 38.1-818.3. Notification of open enrollment programs to state and local agencies.--Every corporation licensed under this chapter, and subject to § 38.1-828, shall notify all state and local agencies whose regular course of business includes working with individuals with health problems of the availability of insurance through open

enrollment programs as described in § 38.1-818.2.

#

D 12/13/84

APPENDIX V

HOUSE JOINT RESOLUTION NO.....

Continuing the joint subcommittee of the House Committee on Corporations, Insurance and Banking and the Senate Committee on Commerce and Labor studying the health insurance coverage available in Virginia to people with chronic health problems.

WHEREAS, House Joint Resolution No. 69, passed by the 1984 Session of the General Assembly, established a joint subcommittee to study the health insurance coverage available to Virginia residents with chronic health problems and the feasibility of the Commonwealth's implementing a health insurance pooling mechanism; and

WHEREAS, the joint subcommittee met several times in 1984 to hear from various health associations and insurance companies regarding the availability and pooling issues; and

WHEREAS, testimony revealed that although health insurance coverage is available in the Commonwealth for anyone, regardless of his physical condition, it is not very well known; and

WHEREAS, testimony also revealed additional issues, including rate structures and waiting periods, that needed to be studied; and

WHEREAS, the joint subcommittee determined that further study of pooling mechanisms is not needed since there is a source of health insurance coverage for people with chronic

health problems, yet further study is needed for other insurance-related issues such as rate structures and waiting periods; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the joint subcommittee of the House Committee on Corporations, Insurance and Banking and the Senate Committee on Commerce and Labor studying the health insurance coverage available to Virginia residents with chronic health problems is hereby continued. The present members of the joint subcommittee shall continue to serve and any vacancies in the membership shall be filled in the manner provided in House Joint Resolution No. 69 of the 1984 Session of the General Assembly.

The joint subcommittee shall conclude its work and submit any recommendations it deems appropriate to the 1986 Session of the General Assembly.

The costs of this study, including direct and indirect costs, are estimated to be $16,410.

#