REPORT OF THE
SECRETARY OF FINANCE ON

The Taxation of Insurance

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

House Document No. 19

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RICHMOND
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HJR 155:
The Taxation of Insurance Companies in Virginia

December 1986

COMMONWEALTH of VIRGINIA

Office of the Governor
Richmond 23219

Stuart W. Connock
Secretary of Finance

December 22, 1986

TO: The Honorable Gerald L. Baliles
Governor of Virginia

and

The General Assembly of Virginia

The 1986 General Assembly passed House Joint Resolution 155, requesting that the Secretary of Finance continue the study of the taxation of insurance companies in Virginia. Enclosed for your review and consideration is the report prepared in response to this resolution.

Sincerely,

Stuart W. Connock

Stuart W. Connock

EXECUTIVE SUMMARY

Overview and Purpose of this Report

House Joint Resolution 155, passed by the 1986 session of the General Assembly, requested the Secretary of Finance to continue the study of the taxation of insurance companies in Virginia conducted pursuant to House Joint Resolution 311 of 1985. This continued study was necessary to respond to several issues that could not be resolved during the 1985 study, and to make specific recommendations for correcting inequities in the current tax treatment of insurance companies.

BC/BS plans are exempted from the gross premium tax because they offer a program of insurance that no other health insurance companies offer. This program--known as the "open enrollment" program--provides health insurance coverage to any Virginia citizen who applies for it regardless of health history, employment status, occupation, or geographical location.

The open enrollment program comprises a small proportion of the Blues' total book of business. In recent years, questions have been raised regarding the equity of providing an exemption from tax on all the Blues' premiums rather than just that unique portion known as open enrollment. In 1985, the HJR 311 Study of the Taxation of Insurance Companies in Virginia found that the majority of the Blues' business is very similar to that offered by commercial companies, and that preferential tax treatment for that portion of the business should be reconsidered. However, due to limited information on the extent of participation within BC/BS' open enrollment program, a final recommendation could not be made regarding the preferential tax treatment.

The objectives of this study are:

1. To present documentation of the numbers and characteristics of high risk or uninsurable individuals whose health insurance could be jeopardized if prepaid health care plans such as Blue Cross/Blue Shield (BC/BS) or health maintenance organizations (HMOs) are subject to taxation;

2. To identify the legal and regulatory requirements, if any, needed to protect health insurance subscribers or policyholders if changes to current tax laws are recommended;

3. To evaluate Virginia's policy of exempting certain types of insurance from taxation in light of federal reform actions to eliminate the tax-exempt status of these organizations;

4. To document the views of the Attorney General regarding Virginia's authority to tax self-insured groups under federal law; and

5. To propose specific revisions of the tax structure to rectify inequities in the current tax treatment of insurance companies.

Current Premium Taxation in Virginia

The gross premiums tax that Virginia levies on the insurance industry generated $131.2 million in fiscal year 1986, making it the fifth largest source of revenue in the Commonwealth's General Fund. Although the characteristics of the insurance industry have changed dramatically over the years, the rate structure has not changed from the original form adopted by The General Assembly in 1914. HJR 311, passed by the 1985 General Assembly, requested the Secretary of Finance to study the taxation of insurance companies in Virginia.

Findings of HJR 311 Study: The HJR 311 study concluded that Virginia's tax structure for insurance companies involves rates that are higher than most states. These comparatively high rates were viewed by industry representatives as one reason why the domestic insurance industry is relatively small in Virginia. Among domestic insurers, the highest relative tax burden is on property and casualty companies, mutual assessment fire companies, and the worker's compensation self-insured groups. Additionally, the study found that Virginia has a more complex, multi-tiered tax structure than most other states, and that there is little justification for the variation in amounts or application of annual license fees.

Tax-Exempt Status of Pre-Paid Health Plans and HMOs: Unlike commercial insurance companies, which pay a 2.75% tax on gross premiums, pre-paid health plans such as BC/BS and HMOs are exempt from the premium tax. The current tax-exempt status of these groups was a major issue discussed in the 1985 study. BC/BS plans maintain that they should retain their tax-exempt status because they provide a significant social benefit that other commercial insurers do not. Specifically, this benefit is the plans' open enrollment policy, whereby persons applying for individual or small group health insurance cannot be denied coverage for health reasons, and once enrolled cannot lose coverage due to high utilization of medical services. Certain other groups, deemed ineligible for coverage by some commercial carriers due to the occupational or industrial classification of the group, also benefit from the Blues' open enrollment program.

The Blues also state that, in addition to open enrollment, BC/BS plans provide other community services that further justify this tax-exemption. These community services include: sponsoring public education programs, developing health care cost containment programs, assisting localities in the planning of health care facilities and contributing cash and in-kind services to various community projects.

Although HMOs are exempt from the gross premiums tax, for-profit HMOs are subject to a corporate income tax. The corporate income tax imposes a lesser tax burden than would be the case if HMOs were subject to the gross premiums tax. HMO officials contend that the current tax treatment is appropriate for HMOs because they are health care providers, not insurers. HMO proponents also cite the General Assembly's decision to impose a corporate rather than a premium tax on for-profit HMOs as one way of allowing HMOs to establish themselves during their first years of operation in Virginia.

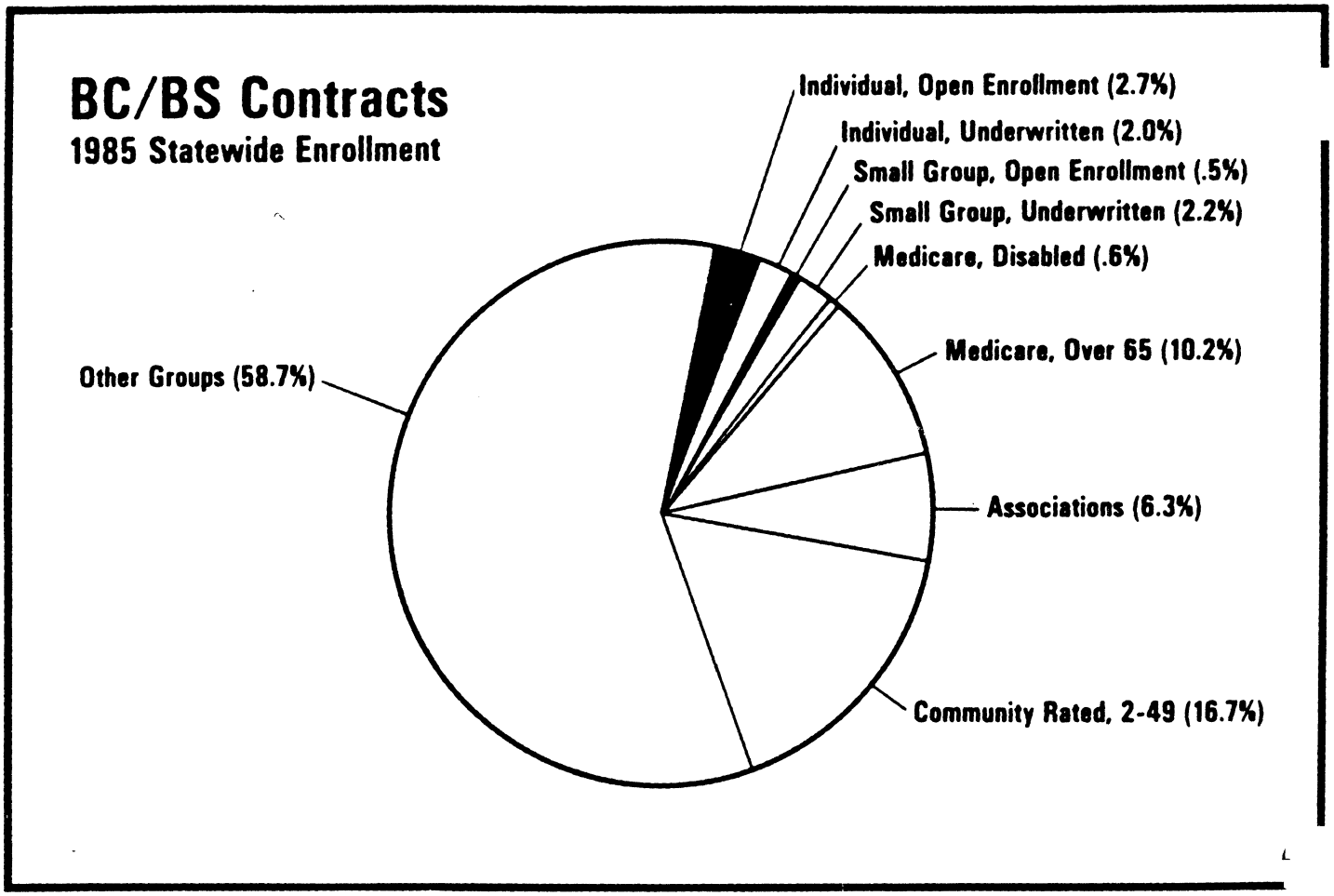
Commercial insurers in Virginia view the premium tax-exemption now enjoyed by BC/BS and HMOs as a distinct competitive advantage. These insurers contend that the activities of BC/BS plans and HMOs have become so like those of commercial insurers that tax-exemption is no longer appropriate.

BC/BS Health Plans in Virginia

In calendar year 1985, BC/BS plans collected $1.2 billion in total health insurance premiums from Virginia subscribers. Section 38.2-4226 of the Code of Virginia exempts BC/BS from the 2.75% premium tax that other insurers pay on their gross accident and sickness premium income. This exemption totalled approximately $33 million in 1985.

Currently there are two BC/BS plans operating in Virginia: BC/BS of Virginia (based in Richmond) and Blue Cross/Blue Shield of the National Capital Area (BCBSNCA, based in Washington, D.C.). Until March 1986, when it merged with BC/BS of Virginia, BC/BS of Southwestern Virginia operated as a third plan. Since the merger, BC/BS of Virginia now operates with two major divisions, Richmond and Roanoke. Figure 1 displays the percentage of subscribers (or contracts) insured under the various types of coverage offered by BC/BS.

Figure 1



SOURCE: BC/BS of Virginia, BCBSNCA

The average total enrollment for BC/BS plans in 1985 was about 1.1 million subscribers. A total of 36,248 subscribers (individual and small group) were covered under BC/BS' open enrollment program in 1985. As seen in Figure 1, these subscribers make up about 3.2% of all BC/BS subscribers. Unlike commercial carriers, BC/BS plans also provide non-group, Medicare-extended coverage to disabled persons under age 65. A total of 6,934 such contracts (.6% of all contracts) were in-force during 1985. Through open enrollment, the Blues also provide coverage to certain groups that are deemed ineligible for coverage by most commercial carriers.

The bulk of the Blues' business (nearly 70 percent) is derived from larger group contracts and Medicare-extended coverage to persons over 65. Industry experts state that the Blues' larger group policies, Medicare-extended policies (persons over age 65) and underwritten (individual and small group) policies are similar in most respects to policies offered by commercial carriers.

Reassessing the Tax-Exempt Status of BC/BS Plans

The study team analyzed the medical characteristics and insurability of both individual and small group open enrollment subscribers. The analysis of these groups was agreed to during the planning stage of the study by both BC/BS and the commercial companies which participated in the analysis of claims information. After the study team had completed its analysis of this portion of the Blues' business, BC/BS of Virginia and BCBSNCA identified, following their review of the exposure draft, additional categories of business which they wanted to have included in the scope of the open enrollment program.

The additional categories of business identified by the Blues include members of professional and trade associations (71,130 contracts), certain community-rated groups (ineligible groups: 29,112 contracts; community-rated groups of 2-9 employees: 16,000 contracts) and disabled Medicare-extended subscribers under age 65 (6,934 contracts). Due to the late submission of this information, the study team had limited time to analyze the characteristics of these subscribers. However, the team was able to collect sufficient information to develop general conclusions regarding the insurability of these categories of the Blues' business.

Characteristics of Open Enrollment Subscribers: A telephone survey of BC/BS individual open enrollment subscribers revealed that the primary reasons for participating in BC/BS plans are that subscribers simply converted from BC/BS group coverage (41%) or selected the coverage because they believed the benefits were better than other companies (20%).

The survey of individual subscribers also indicated that 61 percent of the open enrollment subscribers surveyed reported having a high risk condition. However, it cannot and should not be assumed that all of these subscribers would be unable to obtain commercial insurance. For instance, high blood pressure was defined for the purposes of this study to be a "high risk" condition. Because high blood pressure alone does not incur high benefit costs, persons applying to commercial companies with only this condition will likely face less difficulty obtaining insurance.

This finding was corroborated by the survey of commercial insurance companies. This survey demonstrates that comprehensive health insurance is available, although at a higher premium, to most persons with selected high risk medical conditions, particularly persons with only high blood pressure. Only those persons with the most serious medical conditions (alcoholism/drug abuse, stroke/paralysis), those with the more advanced stages of a disease, those with more than one high risk condition and those who have recently been treated for a high risk condition would likely be unable to obtain comprehensive insurance.

At the same time, it is important to note that open enrollment does offer comprehensive health insurance to some persons who, in all likelihood, would not be able to purchase similar coverage from commercial insurers. The underwriting practices of most commercial carriers often exclude high risk conditions from coverage or deny coverage altogether to most persons with serious medical problems. This finding is substantiated by a greater percentage of BC/BS open enrollment contracts with high risk claims, a larger percentage of the Blues' total benefits being paid for high risk claims, a higher average claim liability for open enrollment contracts, and the responses of commercial companies regarding their underwriting practices.

Conclusions Regarding Open Enrollment: The total number of open enrollment contracts in 1985, both individual and small group (2-10 subscribers), was 36,248, or 3.2% of all BC/BS contracts. Medicare-extended subscribers, who are under 65 and disabled, account for .6% of all BC/BS contracts. An additional 29,112 contracts, or 2.6% of the Blues' total contracts, are subscribers who are employed in groups (2-49 employees) the Blues contend are ineligible for coverage from most commercial companies because of the high risk nature of the group. Therefore, even without any analysis of the medical characteristics and insurability of these persons, this segment of the open enrollment program applies to a maximum of about 6.5% of the Blues' total business. These contracts provide the primary basis for justifying the Blues' total tax-exemption, estimated at $33 million in 1985.

The study team concludes that the medical characteristics and insurability of the individual open enrollment population can best be defined in a four-tiered description:

1. Approximately 39 percent of individual open enrollment subscribers, who reported no high risk conditions, would have little, if any, difficulty obtaining insurance from commercial carriers.

2. Those persons with only high blood pressure, about 10 percent of open enrollment subscribers, would likely have to pay additional premiums, but would be able to obtain health insurance from other insurers.

3. An unknown percentage of open enrollment subscribers who reported having other high risk medical conditions would likely have difficulty getting coverage; and if coverage was available, the person would likely pay higher premiums. Whether a commercial carrier would offer coverage to these persons would depend on the seriousness of the condition, and the time between the treatment or diagnosis of the condition and the time of application.

4. The remaining open enrollment subscribers, who have the most serious conditions or who have more than one high risk condition, would not be able to get insurance from any carrier other than BC/BS.

The team further concludes that although some groups are declared ineligible by most commercial carriers, very few groups are totally excluded from coverage by all companies. Due to the varying underwriting practices of commercial companies, the broad categories of groups identified by the Blues as being ineligible, and the difficulty in conducting a comprehensive search of BC/BS's computer files, the team was unable to identify a specific number of subscribers that would not be able to get coverage from other insurers. However, the team does conclude that the number of subscribers employed by these groups who cannot get commercial insurance is substantially less than the number reported by BC/BS (29,112).

The study team does not agree that every subscriber in each of the additional categories of business, identified by the Blues during their review of the exposure draft, is "at-risk" or is a direct beneficiary of the open enrollment program. However, if one were to assume that every subscriber in all of the categories identified by the plans is truly "at-risk" or benefits directly from the open enrollment program, these subscribers would still make up only about 14% of the Blues' total contracts (see Table II-1). The study team concludes the actual number of BC/BS subscribers that are "at-risk" is substantially less than the number reported by BC/BS.

Based on the analysis presented in this report, open enrollment and the related social benefits cited by BC/BS do not appear to be adequate justification for the Blues' total tax-exemption, estimated at $33 million in 1985. At the same time, some preferential tax treatment is justified because some persons and groups currently enrolled in BC/BS plans will find it difficult or impossible to obtain affordable coverage from commercial insurers and because of any underwriting losses which can result from insuring these enrollees.

Regulatory Mechanisms Available to Protect Uninsurable Persons

The Blues have maintained that, if subject to the gross premiums tax, they would possibly reduce or eliminate open enrollment. Under current Virginia law, BC/BS can elect to eliminate its open enrollment program, as long as BC/BS provides 12 months notice to the State Corporation Commission. If BC/BS did curtail or eliminate open enrollment, selected persons with high risk medical conditions would not be able to purchase comprehensive health insurance. Without insurance, some of these persons would likely be unable to pay their health care costs. As a result, hospital bad debt would increase and be passed on to other consumers or the Commonwealth through increased costs.

The study team examined several regulatory mechanisms as possible means for protecting health insurance subscribers whose coverage may be affected if changes in the current tax laws, or the Blues of their own volition, alter the availability of open enrollment. Among the alternatives examined by the team were: establishing a health insurance risk pool, offering tax credits or deductions to any insurer offering open enrollment, and taxing BC/BS at a reduced rate as an incentive for the Blues to continue open enrollment.

Health Insurance Risk Pools: Health insurance risk pools have been established in ten states to address the problem of uninsurable persons. Risk pools are currently operating in six states. Four additional states expect to implement risk pools in 1987. 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 uninsurable physical or mental conditions. Risk pool subscribers generally pay between 125 percent to 160 percent of the premiums charged to healthy individuals.

The costs of operating a risk pool that are not recovered through premiums paid by persons insured under the plan are proportionately assessed to all insurance companies operating in the state. Most states subsidize the cost of operating a risk pool by providing tax credits equal to the assessment paid by each company.

If a risk pool does become necessary in Virginia to insure high risk persons, Title 38.2 of the Code would have to be amended. Additionally, a number of important issues would have to be resolved, including: the organization of the pool, funding sources, eligibility requirements, benefit levels, premiums, the extent of state regulation, and the type of state subsidy (if any) for the pool. The SCC estimates that approximately one year would be needed to implement a health insurance risk pool in the Commonwealth.

Open Enrollment Criteria: The establishment of open enrollment criteria (e.g., year-round open enrollment, community-rated pricing, etc.) that, if met, would qualify any insurer for special tax rates, credits or deductions would "level the playing field", in that all insurers would have an opportunity to earn preferential tax treatment. Depending on the requirements that are established, this approach would likely require extensive monitoring by the Bureau of Insurance to ensure that companies seeking special tax treatment are indeed earning it.

This approach has not been implemented in any state. Furthermore, although the 1986 federal tax reform law established criteria for special tax treatment at the federal level, it appears that only existing BC/BS plans will qualify for this special tax treatment. If implemented in Virginia, this alternative would likely require that a risk pool be established as a safety net for uninsurable persons in the event no insurer chooses to offer open enrollment. Also, as recognized at the federal level, the financial impact of this option in terms of possible lost premium tax revenue is unknown.

Preferential Tax Treatment for BC/BS Plans: The analysis of BC/BS' open enrollment program and other community services, presented in Chapter II of this report, indicates a total tax-exemption for the Blues is not justified. However, the availability of insurance to high risk individuals and certain groups through open enrollment does warrant preferential tax treatment because no other insurer offers such a program. Based on the analysis presented in this report, the most practical and efficient mechanism for protecting uninsurable individuals would be for the Commonwealth to provide BC/BS a partial tax-exemption as an incentive for continuing open enrollment.

A change in tax status, phased in over time, would help offset the cost of insuring high risk enrollees, and, at the same time, would remedy the current inequity in the tax treatment of BC/BS and commercial insurers.

Regulation and Taxation of HMOs and Self-Insured Groups

Industry experts report that the traditional form of health insurance, in which patients are cared for by physicians of their choice and insurance companies reimburse the patient or provider on a fee-for-service basis, is disappearing. The establishment and rapid growth of health maintenance organizations (HMOs) and preferred provider organizations (PPOs) is quickly reshaping the health care delivery and health insurance industries. Industry experts predict even greater growth in both HMOs and PPOs into the 1990s.

In addition to the dramatic changes seen in the health care delivery and health insurance industries, there has been substantial growth in the numbers of companies, corporations and other groups that are turning to self-insurance as a means of reducing the cost of employee benefit plans. Self-insurance is effecting change not only in the provision of health insurance benefit plans, but also in workers' compensation benefits, property and casualty insurance and liability insurance.

There are no definitive statistics on the amount of premium tax revenue that is no longer collected since the advent of HMOs and self-insurance. However, there is little doubt that as these entities continue to grow, the Commonwealth will experience a commensurate reduction in revenues that otherwise would have been generated through taxing premiums associated with traditional forms of insurance.

Taxation of HMOs in Virginia: The Bureau of Insurance reports a total of 18 HMOs licensed in Virginia. Four HMOs are currently operating on a non-profit basis and therefore are tax-exempt. The other 14 HMOs are for-profit and are subject to a six percent corporate income tax. The current approach to regulation and taxation of HMOs in Virginia is largely the result of the 1979 Commission to Study the Containment of Health Care Costs (also known as the "Willey Commission"). The Commission concluded that encouraging the development of HMOs would inject competition into the health care system, and, in turn, would help combat escalating health care costs. The Willey Commission recommended that HMOs be regulated and taxed differently than BC/BS plans and that legislation specifically applicable to HMOs be adopted to encourage their development.

The 1980 General Assembly's decision to impose a corporate rather than a premium tax on for-profit HMOs was one way of recognizing HMOs as health care providers rather than insurers. It also acknowledged the vulnerability of this young industry and attempted to inject competition into the health care system. No HMO has been licensed under the current HMO legislation more than five years, although four were doing business before 1980 under prior Code provisions. The small market share held by HMOs is evidenced by the fact that 11 HMOs reported subscriber income of less than $5 million in 1985; seven had income of less than $500,000. BC/BS plans' enrollment was eight times greater than the total 1985 HMO enrollment; 1985 subscriber income for the Blues was 11 times greater than HMO subscriber income.

Reassessing the Tax Status of HMOs: The study team's reassessment of the tax status of HMOs indicates that the distinction between health care provider and insurer still exists with respect to the five Staff and Group model HMOs operating in the Commonwealth. These types of organizations employ or

contract directly with a group of physicians to provide health care for their membership. Moreover, physicians who contract with these HMOs typically deliver most covered services at facilities owned by the HMO. As such, the corporate income tax appears to be the appropriate form of taxation.

The 13 Independent Practice Association (IPA) model HMOs, on the other hand, function similarly to BC/BS plans in that they contract with a large number of physicians who practice in their own offices and generally treat a greater percentage of patients who are not affiliated with the HMO. However, as with Group and Staff model HMOs, IPA physicians assume risk through the prospective method of payment. Because IPA model HMOs are new and have a very small market share of the Virginia health care market, the imposition of a premium tax is not warranted at this time.

Self-Insurance: In recent years, significant numbers of employers have moved to replace traditional insurance coverage with self-insurance or self-funded plans in an effort to control costs. These arrangements have opened new business opportunities for insurance companies and independent management firms. By altering the distribution and assumption of risks, self-insurance plans also have important implications for state tax and regulatory policy.

The types of self-insurance plans can generally be grouped into three classes. The first is where the self-insured assumes all risks but contracts with other entities for administrative services such as claims handling and data processing. A second category of self-insurance is characterized by a sharing of risks between the self-insured party and an insurance company. The final type of self-insurance consists of plans which are totally self-funded and self-administered. Employee benefit plans provided by several large employers or unions fall into this class.

There is little data to accurately measure the volume of self-insurance. The major reason for this is that self-insurance plans are not subject to annual reporting requirements because they are not regulated by state insurance departments, like other forms of insurance. Moreover, the principal sources of information which are available do not cover all aspects of the self-insurance market.

Regulating and Taxing Self-Insured Groups: Current tax provisions for self-insurance seem to be based on the assumption that self-insurance is equivalent to no insurance. This is grounded in the fact that self-insurance does not involve an insurance contract. The arguments for placing a premium tax on these plans, however, are strong since these plans divert income away from insurance companies which would otherwise be included in the premium tax base.

Because of the disparity in tax treatment between insurers and self-insurers, the study team requested the Attorney General's Office to review whether or not Virginia had the authority to impose a premium tax on self-insurance plans. This review indicated that self-insurance associated with employee benefit plans was exempt from state taxation under the provisions of the Employee Retirement Income Security Act of 1974. The Attorney General's Office did indicate, however, that other forms of

self-insurance could be taxed. The merits of taking this action are difficult to assess because of the present lack of data on the size and scope of these plans. Clearly, more research is needed in the area of property and casualty self-insurance before current tax policy is changed.

Due to the continued growth of both HMOs and self-insurance, the Commonwealth will likely have to reevaluate its current tax policy regarding HMOs and self-insurance within the next few years. Furthermore, the ability of BC/BS plans and other insurance companies to change their operation and products in such a way that premium taxes can be substantially reduced, or avoided altogether, will also be a critical issue that the General Assembly will likely have to address in the upcoming years.

Recommendations

This study and the one conducted pursuant to HJR 311 of 1985 have identified a number of inequities in the manner by which insurance companies are taxed in Virginia. This report provides recommendations and alternatives for addressing these inequities. Three types of recommendations are presented. They include actions to redesign the tax structure, the tax base, and the administration of premium taxes and regulatory assessments.

Recommendations For Tax Structure Changes

Recommendation 1: The current premium tax rate imposed on property and casualty and accident and sickness insurance should be reduced to be more in line with the tax rate applied to life insurance.

Recommendation 2: The current tax-exemption provided prepaid health and Blue Cross/Blue Shield plans should be repealed. Instead, consideration should be given to the following:

- As long as an open enrollment program with the current features is maintained by the Blues, tax their entire premium income at a rate which is lower than that applied to commercial accident and sickness insurance;
- Tax BC/BS plans at the same rate as commercial accident and sickness insurance, but exempt a certain percentage or certain types of subscriber income from taxation; or
- Tax the premium income of all insurers (commercial and BC/BS plans) the same, but provide tax credits or reduced rates for that portion of any company's business that is derived from an open enrollment program.

Recommendation 3: The General Assembly should direct the Bureau of Insurance to prepare contingency plans for implementing a health insurance risk pool in Virginia.

Recommendation 4: The General Assembly should recommend an appropriate change to the federal charter of Blue Cross/Blue Shield of the National Capital Area (BCBSNCA) to allow that corporation to be subject to Virginia premium taxation.

Recommendation 5: If Recommendation 2 is adopted, the annual license fee which is imposed on prepaid health plans should be repealed.

Recommendation 6: The tax status of HMOs should not be altered at this time. However, the General Assembly should closely monitor the growth and internal operations of HMOs to determine if changes in taxation are warranted in the future.

Recommendations For Tax Base Adjustments

Recommendation 7: The members of both the Virginia Property and Casualty Insurance Guaranty Association and the Virginia Life, Accident and Sickness Insurance Guaranty Association should be allowed to deduct guaranty association assessments from premium taxes, but the amount of this deduction during any one year should be limited to a specified amount of premium income.

Recommendation 8: The premium income received by cooperative non-profit life benefit companies from policies not requiring legal reserves should be taxed at the rate presently imposed on these companies.

Recommendations For Administrative Reform

Recommendation 9: The General Assembly should direct the Bureau of Insurance to analyze and document those occupational classes or industries that are generally "red-lined" or deemed ineligible from obtaining health insurance from commercial carriers.

Recommendation 10: The premium tax return presently submitted by insurance companies should be modified to accurately account for amounts claimed for allowable deductions.

Recommendation 11: Fraternal benefit societies should be assessed for the cost of regulation.

Recommendation 12: The General Assembly should monitor the evolving changes within the insurance industry at frequent intervals to ensure tax equity among competing forms of insurance and to assess the revenue impact associated with these changes.

ACKNOWLEDGEMENTS

This report was prepared for the Secretary of Finance by staff from the Department of Planning and Budget. Principal contributors were Richard D. Brown, Patrick W. Finnerty and Billie K. Payne.

The following persons provided technical information and special assistance throughout the study: Stephen J. Kaufmann, Vickey Verwey, and Jill Ross of the State Corporation Commission; Ken Thorson, Gail Jaspen and Julia Hatcher, Office of the Attorney General; Dr. Louis F. Rossiter, Associate Professor of Health Economics at the Medical College of Virginia; Dr. Howard McCue, a retired cardiologist and past Executive Vice President of the Life Insurance Company of Virginia; and Scott Keeter and the staff of Virginia Commonwealth University's Survey Research Laboratory. Administrative support was provided by Van Nessa Davis, Helene Edwards and the staff of the DPB word processing center. Statistical analysis was provided by Peter L. Rikard of SYNERgistics.

The study team appreciates the efforts and cooperation of Blue Cross/Blue Shield of Virginia, Blue Cross/Blue Shield of the National Capital Area, The Life Insurance Company of Virginia, The Travelers Insurance Company, Metropolitan Life Insurance Company, Mutual of Omaha Insurance Company and The Prudential Insurance Company of America. The team would also like to acknowledge the assistance and information provided by the Health Insurance Association of America.

BC/BS of Virginia, Blue Cross/Blue Shield of the National Capital Area (BCBSNCA), and several commercial insurance companies submitted responses to the exposure draft of this report. These responses are on file in the library of the Department of Planning and Budget for persons interested in reviewing these documents.

TABLE OF CONTENTS

I. INTRODUCTION

Overview and Purpose of HJR 155

House Joint Resolution 155, passed by the 1986 session of the General Assembly, requested the Secretary of Finance to continue the study of the taxation of insurance companies in Virginia conducted pursuant to House Joint Resolution 311 of 1985. This continued study was necessary to respond to several issues that could not be resolved during the 1985 study, and to make specific recommendations for correcting inequities in the current tax treatment of insurance companies.

A key recommendation contained in the 1985 report was that the continued study should document the possible ramifications of imposing the gross premiums tax on exempt health care organizations, namely prepaid health plans such as Blue Cross/Blue Shield (BC/BS) plans and Health Maintenance Organizations (HMOs).

The objectives of this study are:

1. To present documentation of the numbers and characteristics of high risk or uninsurable individuals whose health insurance could be jeopardized if prepaid health care plans or health maintenance organizations are subject to taxation;

2. To identify the legal and regulatory requirements, if any, needed to protect health insurance subscribers or policyholders if changes to current tax laws are recommended;

3. To evaluate Virginia's policy of exempting certain types of insurance from taxation in light of federal reform actions to eliminate the tax-exempt status of these organizations;

4. To document the views of the Attorney General regarding Virginia's authority to tax self-insured groups under federal law; and

5. To propose specific revisions of the tax structure to rectify inequities in the current tax treatment of insurance companies.

This continued study was conducted by staff from the Department of Planning and Budget, with assistance from the Office of the Attorney General, the State Corporation Commission, the Department of Health Administration and the Survey Research Laboratory of Virginia Commonwealth University and the Department of Taxation. Throughout the course of the study, representatives of the insurance industry provided information and assistance.

Review of HJR 311 Study

The gross premium tax that Virginia levies on the insurance industry generated $131.2 million in calendar year 1986, making it the fifth largest source of revenue in the Commonwealth's General Fund. Although the characteristics of the insurance industry have changed dramatically over the years, the rate structure has not changed from the original form adopted by the General Assembly in 1914. HJR 311, passed by the 1985 General Assembly,

requested the Secretary of Finance to study the taxation of insurance companies in Virginia. The objectives of that study were:

- to examine the philosophy and derivation of the gross premium tax;
- to evaluate the rationale for applying different tax rates to gross premium income;
- to assess the tax burden and equity of taxing gross premium income; and
- to evaluate the criteria for exempting certain types of insurers from the gross premium tax.

Tax Inequities Identified: The HJR 311 study found that Virginia's tax structure for insurance companies (see Table I-1) involves rates that are higher than most states. These comparatively high rates were viewed by industry representatives as one reason why the domestic insurance industry is relatively small in Virginia. Among domestic insurers, the highest relative tax burden is on property and casualty companies, mutual assessment fire companies, and the worker's compensation self-insured groups. Additionally, the study found that Virginia has a more complex, multi-tiered tax structure than most other states, and that there is little justification for the variation in amounts or application of annual license fees.

The study concluded the present system could be restructured in the following ways:

1. Equalize the base of taxation;
2. Equalize license fees;
3. Require all companies to equitably bear the cost of regulation;
4. Reduce the tax burden for property and casualty companies; and/or
5. Move toward a simplified rate structure.

Several alternatives were proposed for addressing the tax inequities while maintaining current levels of revenue, but no recommendations were made. The options that were recommended are not mutually exclusive and are open to combination and refinement.

Tax-Exempt Status of Pre-Paid Health Plans and HMOs: Unlike commercial insurance companies, which pay a 2.75% tax on gross premiums, pre-paid health plans such as BC/BS and HMOs are exempt from the premium tax. The current tax-exempt status of these groups was a major issue addressed by the 1985 study. BC/BS plans have maintained that they should retain their tax-exempt status because they provide a significant social benefit that other commercial insurers do not. Specifically, this benefit is the plans' open enrollment policy, whereby persons applying for individual or small group health insurance cannot be denied coverage for health reasons, and once enrolled cannot lose coverage due to high utilization of medical services. The Blues state that another benefit of open enrollment is that coverage is offered to persons living in rural areas and to persons employed in certain types of high risk occupations.

TABLE I-1

TAX AND FEE STRUCTURE FOR INSURANCE COMPANIES IN VIRGINIA
1985

Classes of Insurance	Gross Premium Tax	Other License Fees	Insurance Bureau Assessment	Industrial Commission	Fire Programs	Corporate Income Tax
Life	(2.25%)	-	(.06%)	-	-	-
Accident & Sickness	(2.75%)	-	(.06%)	-	-	-
Property & Casualty[a/]	(2.75%)	-	(.06%)	(1.0%)	(.8%)	-
Cooperative Nonprofit Life Benefit	(1.0%)	$25	(.06%)	-	-	-
Cooperative or Assessment Life and Casualty	(1.0%)	-	(.06%)	-	-	-
Burial Societies	(1.0%)	-	(.06%)	-	-	-
Title Insurance	(2.75%)	-	(.06%)	-	-	-
Mutual Assessment Fire (4 counties or less)	-	-	(.06%)	-	(.8%)	-
Mutual Assessment Fire (More than 4 counties)	(1.0%)	-	(.06%)	-	(.8%)	-
Home Protection	(2.75%)	-	(.06%)	-	(.8%)	-
Prepaid Legal	(2.75%)	$50-200	(.06%)	-	-	-
Prepaid Hospital, Medical, Surgical, Dental, Optometric	-	$50-200	(.06%)	-	-	-
HMOs	-	$100	(.06%)	-	-	(6.0%)
Fraternal Benefit Societies	-	$20	-	-	-	-
Workers' Compensation - Self-Insured Groups	-	-	(.06%)	(1.1%)	-	-

[a/] Property and casualty tax and assessment excludes workers' compensation premiums. Industrial Commission 1% sales tax is assessed on workers' compensation premiums only.

SOURCE: State Corporation Commission, Bureau of Insurance.

Although HMOs are exempt from the gross premiums tax, for-profit HMOs are subject to a corporate income tax. The corporate income tax imposes a lesser tax burden than would be the case if HMOs were subject to the gross premiums tax. HMO officials contend that the current tax treatment is appropriate for HMOs because they are health care providers, not insurers. HMO proponents also cite the General Assembly's decision to impose a corporate rather than a premium tax on for-profit HMOs as one way of allowing HMOs to establish themselves during their first years of operation in Virginia.

Commercial insurers in Virginia view the premium tax-exemption now enjoyed by BC/BS and HMOs as a distinct competitive advantage. These insurers contend that the activities of BC/BS plans and HMOs have become so like those of commercial insurers that tax-exemption is no longer appropriate.

While open enrollment is a unique practice of BC/BS plans, a final recommendation concerning the plans' tax-exempt status could not be made in the 1985 study due to the lack of quantitative information on the number of persons that truly benefit from open enrollment in Virginia. The question of the proper tax treatment for HMOs was not addressed.

Because several critical decisions could not be made without additional information, a set of comprehensive tax policies could not be recommended. The central focus of the current study is to provide that missing information, most importantly the true extent of open enrollment, so that a comprehensive set of recommendations can be made to bring about equity in Virginia's taxation of insurance companies.

Methodology

As previously noted, the major analytical task of the current study is to document the number of persons whose health insurance may be jeopardized if prepaid health plans or HMOs are subject to the gross premiums tax. In order to estimate the number of persons who rely on BC/BS's open enrollment policy for health insurance, three major data collection activities were conducted:

1. Survey of BC/BS Individual Subscribers: Telephone interviews with a random sample of persons covered under BC/BS open enrollment were conducted to determine their medical characteristics, and to document any past or present difficulties obtaining insurance from other carriers.

2. Survey of Commercial Insurance Companies: Surveys were sent to 160 life insurance companies marketing accident and sickness insurance in Virginia. The survey collected information regarding companies' practices in approving applications for individual and small group health insurance and the medical characteristics of persons denied coverage.

3. Analysis of Health Insurance Claims: Each of the BC/BS plans operating in Virginia, in addition to five major commercial insurers that market similar health insurance in Virginia, provided information concerning the claims submitted by persons with individual and small group coverage so that the study team could identify and compare the medical characteristics of BC/BS and commercial policyholders.

In addition, several other analytical methods were employed during the study:

- Over thirty insurance associations and research organizations were contacted in an effort to identify existing data sources for information concerning the number and medical characteristics of persons who had been denied insurance or had their current coverage cancelled due to health reasons.

- Information on those states which have implemented health insurance risk pools as a means of insuring high risk or uninsurable persons was analyzed to determine how these mechanisms operate.

- Numerous interviews were conducted with representatives of BC/BS, commercial insurance companies and HMOs.

- A survey of all fifty states was conducted to determine if BC/BS fee structures and minimum benefit levels are more stringently regulated than commercial insurers.

- A review of 20 health insurance policies available through five of the major commercial health insurers operating in the Commonwealth was conducted to determine how the benefits of commercial health insurance policies compare to BC/BS coverage.

Report Structure

This chapter has presented a brief overview of the HJR 311 study and the issues that will be addressed by the current study. The next chapter analyzes the extent of BC/BS's open enrollment policy. Chapter III discusses health insurance risk pools and other regulatory options that may be used to protect high risk or uninsurable persons. Chapter IV assesses the regulation and taxation of HMOs, preferred provider organizations (PPOs) and self-insured groups. The final chapter provides specific recommendations for rectifying inequities in the current tax treatment of insurance companies. Additional information is contained in appendices to this report.

II. TAX-EXEMPT STATUS OF BLUE CROSS/BLUE SHIELD HEALTH PLANS

Overview

A major issue to be addressed by this study is a reassessment of the current tax-exempt status of Blue Cross/Blue Shield (hereafter called "BC/BS" or "the Blues") health plans. Section 38.2-4226 of the Code of Virginia exempts BC/BS from the 2.75% premium tax that other insurers pay on their gross accident and sickness premium income. In calendar year 1985, BC/BS plans collected a total of $1.2 billion in total health insurance premiums from Virginia subscribers, none of this amount was subject to taxation.

BC/BS plans are exempted from the gross premium tax because they offer a program of insurance that no other health insurance companies offer. This program--known as the "open enrollment" program--provides health insurance coverage to any Virginia citizen who applies for it regardless of health history, employment status, occupation, or geographical location. As stated in Section 38.2-4216 of the Code of Virginia, the only restrictions to the program are:

1) The persons shall not be employed by an employer which provides health coverage to its employees, and

2) that coverage shall be subject to a residency requirement and payment of subscription charges.

The open enrollment program comprises a small proportion of the Blues' total book of business. In recent years, questions have been raised regarding the equity of providing an exemption from tax on all the Blues' premiums, rather than just that unique portion known as open enrollment. In 1985, the HJR 311 Study of the Taxation of Insurance Companies in Virginia, found that the majority of the Blues' business is very similar to that offered by commercial companies, and that preferential tax treatment for that portion of the business should be reconsidered. However, due to limited information on the extent of participation within BC/BS' open enrollment program, a final recommendation could not be made regarding the preferential tax treatment.

This chapter presents a brief overview of the evolution of BC/BS health insurance, the plans' tax exemption, and the different types of health policies offered by the Blues. Approaches to taxation of BC/BS plans by the federal government and other states are also summarized here. The major component of this chapter is an analysis of the benefits of the plans' open enrollment policy and other community services. The chapter examines the central question surrounding the taxation of the Blues: Does the scope of the Blues' open enrollment program justify a tax-exemption on their total book of business?

Characteristics of Blue Cross/Blue Shield Health Plans

BC/BS plans are typically independent, non-profit, non-stock corporations that make payments to providers on a fee-for-service basis for surgical, medical, and hospital care. BC/BS plans first started in Virginia in the

1930s. They were originally established nationally in response to two factors-- the economic conditions of the 1930s and the growth of organized labor. During this time, many people were unable to pay their hospital bills and, as a result, many hospitals were in a state of financial crisis. At the same time, employers were offering fringe benefits as concessions to labor organizations which were demanding higher wages. The combined effect of these factors gave rise to prepaid hospital plans.

A study conducted in 1949 by the Virginia Advisory Legislative Council (VALC) concluded that the plans should be exempt from the gross premium tax because:

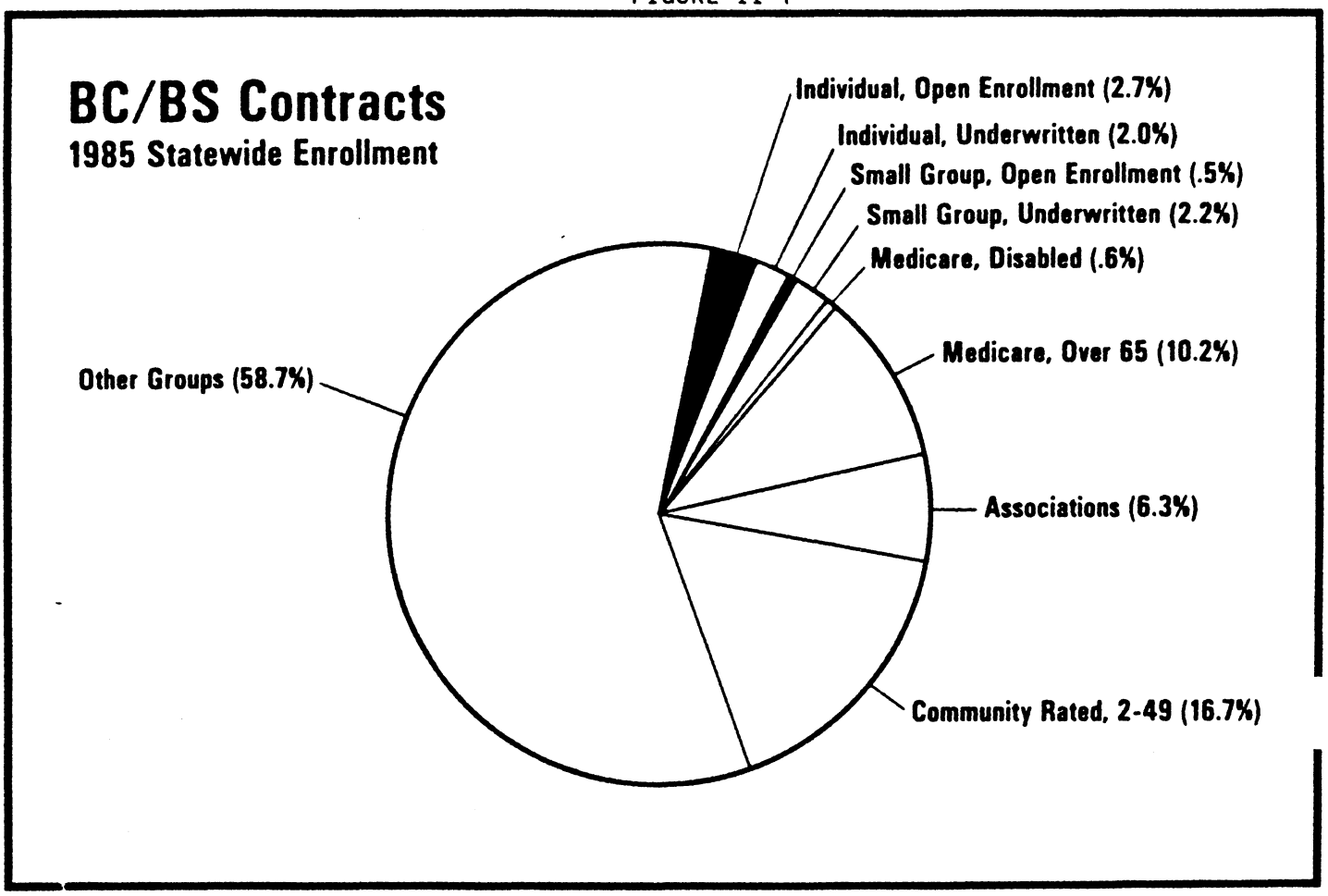
- The plans offered a means of providing hospital care for those who could not otherwise afford it;
- The plans were considered collecting and disbursing agencies for participants--not insurance companies;
- There were no profits to the association or its subscribers;
- The plans offered a viable alternative to the nationwide pressure for adoption of socialized medicine; and
- The plans attempted to balance income and outgo, and VALC believed that any tax would diminish reserves, decrease services, or increase rates.

Currently there are two BC/BS plans operating in Virginia: BC/BS of Virginia (based in Richmond) and Blue Cross/Blue Shield of the National Capital Area (BCBSNCA, based in Washington, D.C.). Until March 1986, when it merged with BC/BS of Virginia, BC/BS of Southwestern Virginia operated as a third plan. Since the merger, BC/BS of Virginia now operates with two major divisions, Richmond and Roanoke.

Both Virginia BC/BS plans market health insurance coverage for individuals, Medicare recipients, small groups (2-9, or 10 subscribers), and larger groups. BC/BS' average total enrollment for these types of policies in 1985 was about 1.1 million subscribers. Figure II-1 illustrates the percentage of contracts insured under the various types of coverage offered by BC/BS.

The study team analyzed the medical characteristics of the individual and small group open enrollment subscribers. These subscribers are represented by the two darkened segments of Figure II-1. These two categories of the Blues' business are considered to be the cornerstone of the open enrollment program. As displayed in Figure II-1, the total number of open enrollment contracts in 1985, both individual and small group, was 36,248, or 3.2% of all BC/BS contracts. Commercial companies do not offer similar coverage, so without this coverage sold by the Blues, some individuals would be unable to find health insurance coverage. It is these categories that are the central justification for preferential tax treatment.

FIGURE II-1



Source: BC/BS of Virginia, BCBSNCA; DPB Graphic Illustration.

Non-Group Health Policies: Both BC/BS plans offer three different types of comprehensive non-group individual policies: underwritten, non-underwritten and group conversions. Non-group policies are offered to persons who cannot get BC/BS group coverage, or who leave a group that had BC/BS coverage and convert their coverage. Policies that are underwritten by the Blues require that the applicant answer health-related questions and meet certain underwriting criteria prior to being approved for coverage. This type of policy is similar to those

marketed by commercial insurers. The average number of underwritten non-group contracts in-force by the Blues throughout 1985 was 23,050. As depicted in Figure II-1, these contracts made up approximately 2.0% of BC/BS's 1985 total statewide contracts. Both BC/BS plans indicated the total number of persons insured under BC/BS contracts can be calculated by doubling the number of contracts. Therefore, approximately 46,100 persons were insured through these underwritten contracts in 1985.

Persons insured through the underwritten policies offered by BC/BS of Virginia are termed "Healthy Virginians". This program offers comprehensive health insurance at a substantial discount to persons who meet prescribed underwriting criteria. BCBSNCA's underwritten policies provide some cost savings to the applicant compared to the cost of non-underwritten coverage. However, the major difference is the greater level of benefits provided by underwritten coverage, as will be discussed later in this report.

Persons who either do not apply for underwritten coverage, or who apply and do not meet the underwriting criteria, are offered coverage through the plans' non-underwritten policies. Persons insured under the Blues' non-underwritten policies and group conversions are considered "open enrollment" subscribers. The average number of open enrollment individual contracts during 1985 was 31,109 or 2.7% of BC/BS's total in-force contracts in 1985. An estimated 62,218 persons were insured under individual open enrollment contracts in 1985.

Small Group Policies: Both BC/BS plans also offer small group insurance policies. BC/BS of Virginia's Richmond and Roanoke divisions offer underwritten policies with premium discounts similar to individual policies. BCBSNCA does not market underwritten small group policies. Approximately 25,000 underwritten small group contracts were in-force during 1985. These contracts constitute 2.2% of the Blues' total in-force contracts for 1985. A total of approximately 50,000 persons were insured under these contracts.

The Richmond division of BC/BS of Virginia and BCBSNCA offer insurance to small groups without requiring medical underwriting. Small group coverage is available to groups with individuals who have high risk medical conditions as well as to high risk industries such as farming, mining and commercial fishing. The Roanoke division does not offer non-underwritten small group coverage. Because non-underwritten, small groups do not have to provide evidence of insurability, the Blues consider these groups as part of their open enrollment population. This segment of BC/BS's business averaged 5,139 contracts during 1985 and comprised 0.5% of BC/BS's total contracts.

Medicare-Extended Policies: Both BC/BS plans offer Medicare-extended coverage to persons over 65 to cover medical expenses not insured through Medicare. These policies do not provide comprehensive benefits like other BC/BS policies. A total of 115,734 Medicare-extended contracts were in-force during 1985. These contracts comprised about 10.2% of BC/BS' total contracts.

In addition to Medicare-extended coverage for persons over 65, the Blues also offer Medicare supplemental policies to disabled persons under age 65. A total of 6,934 contracts were in-force during 1985. These contracts made up about .6% of the total BC/BS contracts.

Community-Rated Groups (2-49): BC/BS plans community rate groups of 11-49 employees rather than base each group's premium rate on its respective claims experience. In addition to groups of 11-49 subscribers, BC/BS of Virginia also "grandfathered" a number of community-rated small groups (2-9 employees) into this program when the plan's small business (2-9 employees) program was established in 1984. A total of 16,000 subscribers that would normally be placed in the current small business program were grandfathered into the community-rated program. A total of 188,759 contracts insured through community-rated groups were in-force during 1985. As seen in Figure II-1, these contracts comprised 16.7% of all BC/BS contracts.

Associations: BC/BS of Virginia reported a total of 71,130 subscribers who are insured through professional and trade associations that contract with BC/BS to provide health care to their members. These contracts made up about 6.3% of all BC/BS contracts during 1985.

Other Group Policies: The majority of the persons insured by the Blues are covered under larger group policies. Industry experts generally agree that this segment of the Blues' insurance business is similar in most respects to policies marketed by commercial health insurers. BC/BS reports that an average of 662,934 such contracts were in-force during 1985.

Approximately 59% of the Blues' insurance contracts were persons insured through larger group policies. Excluding Medicare subscribers, the percentage of subscribers covered under Virginia BC/BS group policies (including small groups) is 95 percent. This percentage is slightly higher than national statistics published by the National BC/BS Association which indicate group subscribers make up 93.4% of all regular BC/BS subscribers.

BC/BS's Share of Health Insurance Market: According to the National Blue Cross/Blue Shield Association, BC/BS plans serve about 100 million people in the United States -- slightly less than one out of every two persons. These statistics include Medicare and Medicaid supplemental policies. This estimate is confirmed by health insurance premium statistics published by the Health Insurance Association of America (HIAA). HIAA reports that in 1983, 48 percent of all health insurance premiums in the United States were paid to BC/BS plans.

In Virginia, BC/BS health plans accounted for 56.7% of the combined 1985 direct accident and sickness insurance premimums and HMO income, as reported in the State Corporation Commission's (SCC) 1985 Statistical Report. Because the SCC report includes premiums earned from limited coverage policies, such

as cancer policies and excludes self-insured groups, this percentage is only an approximation. However, most industry experts agree that BC/BS health insurance plans account for approximately one-half of all traditional health insurance written in Virginia.

Additional Categories of Open Enrollment Identified by BC/BS

As noted earlier, the study team analyzed the medical characteristics and insurability of both individual and small group open enrollment subscribers. The analysis of these categories was agreed to at the outset of this study by both BC/BS and the commerical insurers as being the core of the open enrollment program. After the study team had completed its analysis of this portion of the Blues' business, BC/BS of Virginia and BCBSNCA identified, following their review of the exposure draft, additional categories of business which they believe to be part of the open enrollment program. These groups are analyzed in this section.

Medicare-extended coverage for disabled persons under age 65: While both commercial insurers and BC/BS plans offer Medicare-extended coverage to persons over age 65, BC/BS plans also offer non-group, Medicare-extended coverage to disabled persons under 65. Commercial insurers typically do not offer this type of policy; and therefore BC/BS considers these contracts as part of its open enrollment program. The average enrollment of disabled Medicare-extended subscribers under age 65 during 1985 was 6,934 contracts.

While the study team did not analyze this portion of the Blues' business, commercial insurers did indicate to the team that they typically do not offer this type of Medicare-extended coverage. Therefore, the team agreed that these contracts should be considered as part of open enrollment.

Ineligible Groups and Industries: In addition to medically underwriting individual and small group subscribers, most commercial insurers also identify certain industry classifications which are deemed ineligible for coverage due to the high risk nature of the industry. A total of 29,112 subscribers were identified by both BC/BS plans as being members of groups the Blues believe to be ineligible for coverage from commercial carriers. Included in this number are contracts which BC/BS of Virginia and BCBSNCA insure under their community-rated groups (11-49 employees) and underwritten small groups (2-9 employees). An analysis of these ineligible groups is presented later in this chapter.

Community-Rated (10 or Fewer Employees): As stated earlier, BC/BS of Virginia identified 16,000 subscribers which were covered under group policies (groups of less than 10) and which were located in the plan's community-rated program when the small business program was established in 1984. These groups were "grandfathered" into the community-rated program, even though under the current small business program (2-10 employees) they would be regarded as small business subscribers.

BC/BS of Virginia first identified these contracts in the plan's November 24, 1986 response to the study team's exposure draft of this report. Because the team was unable to analyze the medical characteristics of these

subscribers, no conclusions regarding the insurability of these subscribers can be made. However, it is very likely that some portion of these contracts would qualify for the Healthy Virginian program or commercial insurance coverage and therefore would not be considered part of open enrollment.

Associations: BC/BS of Virginia, in its November 24, 1986 response to the exposure draft, stated that open enrollment also applies to 21 trade and professional associations which contract with BC/BS of Virginia to provide health insurance to their members. The Virginia Farm Bureau Federation has established a similar program for its members. BC/BS of Virginia reports a total of 71,130 contracts insured through these associations. In its response to the exposure draft of this report, BCBSNCA did not identify associations as being part of its "at-risk" or open enrollment program.

BC/BS of Virginia maintains that only the long-standing, highly stable and low-risk associations are capable of obtaining insurance through commercial carriers. Due to the late submission of this information, the team did not have sufficient time to fully analyze the insurability of association members. However, the team did contact several representatives of commercial carriers to determine whether they insure associations. The Health Insurance Association of America indicated that commercial carriers do insure professional and general interest associations. For instance, The American Association of Retired Persons (AARP) is insured by Prudential and the American Medical Association is insured through Provident Life and Accident Insurance Company.

Because BC/BS of Virginia did not identify any of its currently enrolled associations except the Virginia Farm Bureau, the team was not able to determine the number of association members insured by the plan that would be unable to obtain insurance from commercial carriers. The Farm Bureau, which currently underwrites its membership, has the largest number of members (23,403 in 1985) insured through BC/BS of Virginia's association category of business and is one of the largest groups of any kind insured by BC/BS of Virginia. The team was advised by several representatives of the commercial insurance industry that, while the benefits and prices might vary from BC/BS coverage, there would be a number of commercial carriers interested in insuring a group of over 23,000 members.

Based on the information provided by BC/BS of Virginia and commercial carriers, the study team concluded that while some association members may be unable to obtain health insurance from commercial carriers, there is no means of estimating that number at this time. However, if there are association members who cannot get insurance through commercial carriers, the number is substantially less than 71,130, as reported by BC/BS of Virginia.

Total "At-Risk" Population: The study team does not agree that every additional contract identified by the Blues following their review of the exposure draft is "at-risk" or is a direct beneficiary of the open enrollment program. However, if one were to assume that every subscriber in all of the categories identified by the plans is truly "at-risk" or benefits directly

from the open enrollment program, these subscribers would still make up only about 14% of the Blues' total contracts, as seen in Table II-1. As will be documented later in this report, the study team concludes the actual number of BC/BS subscribers that are "at-risk" is substantially less than the number reported by BC/BS.

TABLE II-1

AT-RISK CONTRACTS IDENTIFIED BY BC/BS
AS A PERCENTAGE OF BC/BS TOTAL CONTRACTS

TOTAL BC/BS CONTRACTS		CONTRACTS IDENTIFIED BY BC/BS AS BEING AT-RISK		
CATEGORIES OF CONTRACTS	NUMBER OF CONTRACTS	CATEGORIES OF CONTRACTS	NUMBER OF CONTRACTS	PERCENTAGE OF TOTAL CONTRACTS
Individual, Open Enrollment	31,109	Individual, Open Enrollment	31,109 *	2.7%
Individual, Underwritten	23,050	-	-	-
Medicare-Extended (disabled, under 65)	6,934	Medicare-Extended (disabled, under 65)	6,934 **	.6
Medicare-Extended (over 65)	115,734	-	-	-
Small Group, Open Enrollment	5,139	Small Group, Open Enrollment	5,139 *	.5
Small Group, Underwritten	25,000	-	-	-
Community-Rated (2-49)	188,759	Ineligible Groups (2-49)	29,112 *	2.6
		Grandfathered Community Rated Groups (2-9)	16,000 *	1.4
Associations	71,130	Associations	71,130 *	6.3
Other Groups	662,934			
TOTAL CONTRACTS	1,129,789	TOTAL "AT-RISK" CONTRACTS	159,424	14.1%

* Study team agrees that certain contracts within the category are at-risk, but does not agree that all contracts within the category are at-risk.

** Study team agrees that all contracts within this category are at "at-risk".

SOURCE: BC/BS of Virginia, BCBSNCA

Federal and Other States' Approaches to BC/BS's Tax Exemption

BC/BS plans are currently tax-exempt from federal taxes under Sections 501(c) (3) and (4) of the Internal Revenue Code, which address charitable and social welfare organizations that serve a public, rather than a private purpose. As part of the current tax reform effort, the House Ways and Means Committee's bill in December 1985 addressed the issue of the plans' tax-exempt status. The Committee report noted concern that exempt charitable organizations such as BC/BS plans are engaged in insurance activities that so closely resemble commercial insurance that the tax-exemption is no longer appropriate. This concern led to a study of this issue by the General Accounting Office.

General Accounting Office (GAO) Study of BC/BS Plans: The Chairman of the Subcommittee on Health, Committee on Ways and Means requested the GAO to examine the impact which taxing BC/BS plans might have on the availability of health insurance. The study, completed in July 1986, compared the plans with commercial insurers to identify potential differences in the provision of health insurance, especially to persons with high risk medical conditions.

GAO compared health insurance offered to 129 high risk test cases identified by the plans in California, Connecticut, the District of Columbia (BCBSNCA), Illinois, Maryland, and New York to insurance available from five commercial companies--Prudential, Bankers Life and Casualty, Metropolitan Life, The Travelers, and Mutual of Omaha. Information on certain nationwide underwriting practices used by the plans and commercial companies was also analyzed.

GAO found more similarities than dissimilarities between the plans and commercial companies with regard to high risk individuals. GAO's major findings included:

- At least one commercial health insurance alternative was available for 67 percent of the plans' high risk test cases; the other one-third of the cases were rejected by all five commercial insurers;
- Commercial insurers and three of the six BC/BS plans offered high risk individuals less comprehensive coverage than other individuals;
- Both the plans and commercial insurers experience-rate their large groups, which constitute the majority of their business; and
- The BC/BS plans' pricing methods that set separate rates for high risk individuals have come to resemble the experience-rating methods used by commercial companies.

GAO concluded that taxation of the Blues should not affect the availability of health insurance for most Americans, who are insured as members of large, employer-paid groups. Any potential adverse impact on the availability of health insurance would be concentrated in the individual and small group markets. Furthermore, the adverse effects would be limited to high risk persons. Based on GAO's findings that alternative sources of insurance were available from at least one insurer in 67 percent of high risk test cases, the size of the effected population would be even further reduced.

BC/BS Association Comments: The National BC/BS Association provided comments regarding the GAO study. Specifically, the association expressed concern about:

1) the conclusion that BC/BS benefits for high risk subscribers are limited;

2) the conclusion that BC/BS pricing practices are similar to those of commercial companies;

3) the methodology used to verify information submitted by commercial insurers; and

4) the omission of certain practices of the BC/BS plans that assure widely available, affordable coverage.

In response to BC/BS comments, some minor modifications to the report were made. However, the GAO did not change any of their conclusions and maintained their methodology was appropriate.

The Tax Reform Act of 1986: Initially, the House and Senate disagreed on the issue of taxing BC/BS. However, following the GAO report, an agreement was reached which is now enacted into law. The Tax Reform Act of 1986 provides that BC/BS plans are:

- Taxable as stock property and casualty insurance companies;
- Allowed a deduction (not to exceed taxable income) equal to one quarter of the year's annual claims and administrative expenses less prior year's surplus for regular tax;
- Given a fresh start with respect to accounting methods, including loss reserves; and
- Exempt from the provision regarding unearned premiums of property and casualty insurance companies.

The Conference Report of the Tax Reform Act of 1986 states that the special tax provisions apply to other organizations if substantially all of the organization's activities are providing health insurance. Organizations other than existing tax-exempt BC/BS plans must meet the following criteria in order to receive special tax treatment:

- At least 10 percent of the health insurance must be provided to individuals and small groups (disregarding Medicare supplemental coverage);
- Full-year open enrollment (including conversions) for individuals and small groups must be available;

- Any individual seeking health insurance must be offered coverage which includes coverage of pre-existing conditions; coverage becomes effective within a reasonable waiting period (a reasonable waiting period is intended to be no more than three months);

- Coverage is to be provided without regard to age, income, or employment status of persons under age 65;

- At least 35 percent of the organization's health insurance premiums must be determined on a community rated basis; and

- The organization must be organized and operated in a manner such that no part of the net earnings inures to the benefit of any private shareholder or individual.

Other States' Taxation of BC/BS Plans: A telephone survey of all 50 states and the District of Columbia was conducted in 1985 as part of the HJR 311 study. This survey indicated that of the 25 states that impose a premium tax on BC/BS plans, 21 view the plans as insurance companies and subject them to the same taxation as a commercial insurer.

Tax rates among the states range from .044 to six percent, with 14 of the 25 states allowing some type of credit or deduction. Of the 25 states that tax the Blues, 12 states have a tax rate greater than two percent and seven of the 12 allow credits for in-state assets. Those states that currently impose a tax on the BC/BS plans reported no planned changes in their tax laws. Based on this 1985 survey, five states intended to introduce legislation to tax BC/BS.

BC/BS plans were not taxed in 26 of the 51 jurisdictions surveyed in 1985. Twenty-two of these states consider BC/BS plans non-profit, tax-exempt organizations. Three states have a state tax policy that exempts all health insurance from any form of taxation. BC/BS plans in Oregon are exempt because all domestic companies, regardless of the type of insurance, are exempt from premium taxes.

Analyzing BC/BS Open Enrollment in Virginia

The open enrollment policy of BC/BS is the cornerstone of the plans' justification for tax-exemption. As noted earlier in this report, open enrollment means that applicants cannot be denied health insurance for health or other reasons such as occupation or geographical location. Once enrolled, open enrollment subscribers cannot lose coverage or have rates increased due to higher than average utilization of medical services. That portion of the open enrollment program applicable to individual and small group comprehensive policies accounts for 3.2% of all subscribers covered by BC/BS plans in Virginia.

Open Enrollment Benefits: The open enrollment policies of BC/BS of Virginia and BCBSNCA are quite different with respect to the period of time open enrollment is offered and the benefits provided. BC/BS of Virginia offers full-year open enrollment for both non-group and small group

applicants. A 12-month waiting period is required for pre-existing conditions of all open enrollment applicants. However, major medical coverage is offered after a 90-day waiting period. BC/BS of Virginia's open enrollment policies provide the same level of benefits offered to persons with underwritten policies.

BCBSNCA offers open enrollment for non-group coverage only one month each year. However, as provided for in §38.2-4216 of the Code of Virginia, "a non-stock corporation may elect to have an open enrollment period of shorter time if credit is given toward any applicable waiting period for coverage of pre-existing conditions for the period of time a person has been continuously enrolled under a non-stock corporation's coverage immediately prior to the effective date of his open enrollment coverage". BCBSNCA provides this credit toward their ten month waiting period.

Unlike BCBSNCA's underwritten non-group policies, which offer Standard and Preferred Blue Cross and Blue Shield benefit levels and Major Medical Coverage, persons insured through open enrollment have no choice of benefit levels. Open enrollment subscribers receive the standard benefit package for both Blue Cross (hospitalization) and Blue Shield (medical care) coverage. Major Medical Coverage is not available to open enrollment persons. The unavailability of Major Medical coverage eliminates a number of important insurance benefits including:

- most office and home visits;
- prescription drugs;
- local ambulance service;
- durable medical equipment;
- outpatient psychotherapy;
- inhalation, occupational and physical therapy;
- allergy tests and shots;
- prosthetic appliances;
- cardiac rehabilitation program; and
- balances on basic services (e.g. hospital stays beyond that covered under Blue Cross).

Although BCBSNCA administratively separates group conversions from open enrollment contracts, conversions are not medically underwritten, and therefore are considered by the plan as part of their non-group open enrollment services. Group conversions (other than Federal Employee Program) are offered the same benefits as BCBSNCA's underwritten non-group contracts.

BCBSNCA offers open enrollment throughout the year to small groups of 2-9 subscribers. Small groups with 2-9 subscribers are offered standard Blue Cross coverage. However, two levels of Blue Shield benefits are offered. Major Medical Coverage is also offered.

As reported in the HJR 311 study, there is no quantitative data on the number of BC/BS subscribers who bought plan coverage because they were (or assumed they were) uninsurable by commercial carriers. In Virginia, there are two basic reasons for this lack of data. First, open enrollment subscribers do not have to answer health-related questions on their applications. Only

those persons applying for underwritten coverage answer health questions. Second, because BC/BS of Virginia has full year open enrollment rather than a limited period of time, there is no means of isolating those persons who enrolled during a specific "open enrollment period". Combined, these factors make it impossible to determine from BC/BS records the exact number of persons who are truly open enrollment subscribers, with "high risk" medical conditions which would make them uninsurable, from those who choose BC/BS for other reasons. Consequently, special data collection efforts were required to estimate the number and medical characteristics of open enrollment subscribers.

Definition of "High Risk" Individuals: Defining who should be considered a "high risk" or uninsurable individual is crucial to analyzing open enrollment. The study team consulted with a number of insurance and medical experts to arrive at a definition of what the insurance industry considers to be a high risk individual.

The team reviewed the health-related questions on a number of commercial insurers' application forms to develop a preliminary list of the medical conditions which have underwriting significance. The list of high risk medical conditions was then reviewed by the Medical Relations Board and Actuarial Department of the Health Insurance Association of America (HIAA), both BC/BS of Virginia and BCBSNCA, Dr. Louis F. Rossiter, a health economist at the Medical College of Virginia, several commercial insurance companies, and Dr. Howard McCue, a retired cardiologist and past Executive Vice President of the Life Insurance Company of Virginia. Based on the advice of these individuals and organizations, a final list of high risk conditions was developed. This composite of medical conditions was used throughout the analysis to identify high risk or uninsurable persons, and included:

- Heart Disease;
- Stroke or other paralysis;
- High blood pressure;
- Neurological diseases (such as epilepsy);
- Nervous and mental disorders;
- Other high risk conditions [1/] (diseases of the blood and respiratory system).
- Liver and kidney disease;
- Diabetes;
- Cancer and other tumors;
- Joint disease (arthritis);
- Alcoholism and drug dependency; and

Once the characteristics of high risk individuals were defined, three separate methods were used in analyzing the scope of BC/BS's open enrollment policy: a survey of commercial insurance companies, a survey of BC/BS individual subscribers, and an analysis of health insurance claims. The overall objective of these methods was to document the number and medical

characteristics of persons who must rely on the Blues' open enrollment policy for health insurance because of high risk medical conditions. Although there likely is no means of providing an exact number of persons who, without open enrollment, would be uninsurable, the data generated by these methods do provide as close of an approximation as possible of the benefits provided to the Commonwealth through open enrollment.

Survey of Commercial Insurance Companies: Prior to surveying individual insurance companies, the team contacted over thirty insurance trade associations and research organizations to document the number and medical characteristics of persons in Virginia who had been denied insurance or had their coverage cancelled for health reasons in 1985. Because none of the organizations could provide data specific to Virginia residents, it was necessary to survey individual companies.

Surveys were sent to 160 commercial life insurance companies which market health insurance in Virginia. These companies comprised nearly 98 percent of the total accident and sickness premiums collected by commercial companies in 1985. The objectives of the survey were:

- To determine the number and medical characteristics of individuals and small groups denied insurance or cancelled by commercial insurers in 1985; and

- To document the underwriting practices of commercial companies with respect to high risk individuals and small groups.

Of the 160 companies surveyed, 122 (76.25%) responded. Forty-five (36.9%) of the 122 companies market comprehensive individual or small group health insurance. The findings reported later in this chapter are based only on those companies marketing comprehensive health coverage similar to the Blues.

Survey of BC/BS Individual Subscribers: A telephone survey of BC/BS's open enrollment individual subscribers was conducted to meet several objectives:

- To determine the medical characteristics of persons insured under BC/BS open enrollment;

- To document the number of individual subscribers who have been denied health insurance by commercial companies, or who would have difficulty getting insurance from other carriers; and

- To document the number of persons insured by the Blues who have had insurance cancelled by commercial companies for health reasons.

The survey was conducted by the Virginia Commonwealth University Survey and Research Laboratory. A random sample of 401 individuals insured under the Blues' non-underwritten policies (including group conversions) were surveyed.

Each of the two plans were represented in the sample according to their percentage of the total statewide BC/BS individual open enrollment contracts. The sample size provides a 95 percent confidence level and a 5 percent error rate.

Analysis of Health Insurance Claims: Claims submitted in 1985 by Virginia residents insured through the Blues' individual and small group policies (underwritten and non-underwritten) were analyzed and compared to similar information developed by five commercial companies: The Life Insurance Company of Virginia, The Travelers, Mutual of Omaha, Prudential and Metropolitan Life Insurance Company. (Travelers was unable to provide claims information regarding individual policies.) The objective of the claims analysis was to document the percentage of BC/BS claims that involved high risk conditions, and to make comparisons to the percentage of high risk claims processed by commercial companies.2/

All claims incurred by Virginia residents in calendar year 1985 and paid through May 31, 1986 were analyzed. (This allowed the insurers to receive credit for claims that were incurred late in the year and could not be processed prior to the end of 1985.) Only those claims submitted for payment against basic hospital, medical, surgical and major medical expense insurance were included. Claims paid by strict indemnity, Medicare supplements, accident only coverage and specialized insurance were excluded.

Number and Medical Characteristics of Individuals Covered by BC/BS Open Enrollment

The following analyses of the medical characteristics of open enrollment subscribers includes individual and small group (2-10) subscribers who have comprehensive health insurance policies with BC/BS.

As noted in Figure II-1, open enrollment individual contracts comprise 2.7% of the Blues contracts, while open enrollment small group contracts make up 0.5%. Therefore, even without any analysis of the medical characteristics and insurability of these persons, a maximum of 3.2% of the Blues' total business is comprised of individual and small group open enrollment contracts. These contracts represent the primary basis for justifying the current tax-exemption, estimated at $33 million in 1985. The bulk of the plans' contracts are with persons insured through large groups.

General Characteristics of Individuals Covered by BC/BS Open Enrollment: Based on the survey of a representative sample of BC/BS individual subscribers;

- 84 percent of open enrollment subscribers have never had a health insurance policy with another insurer;
- a large number of subscribers (41%) simply converted from BC/BS group coverage;

- 20 percent of the respondents selected BC/BS coverage because they felt the benefits were better than other companies; and

- 8 percent of the respondents chose BC/BS coverage because they either had been denied insurance from another carrier, or felt that, because of health reasons, other insurance would not be available.

The age distribution of BC/BS individual open enrollment subscribers is depicted in Table II-2. Compared to the age distribution of the general population in Virginia, BC/BS open enrollment subscribers are considerably older. However, it should be recognized that the preponderance of persons included in the 0-29 age group of the general population are dependents who are insured through a parent's health policy. The reason why the percentage of BC/BS subscribers in the 0-29 range is so low is because dependents are not included. The BC/BS age distribution includes only those persons old enough to purchase their own policies.

TABLE II-2

AGE DISTRIBUTION OF BC/BS OPEN ENROLLMENT SUBSCRIBERS COMPARED TO VIRGINIA POPULATION

Age Range	Percentage of Respondents	Cumulative Percentage	Percent of Va. Population	Cumulative Percentage
0-29	12.3%	12.3%	46.8%	46.8%
30-39	14.1	26.4	17.2	64.0
40-49	12.6	39.0	12.2	76.2
50-59	28.0	67.0	9.2	85.4
60 and over	33.0	100.0	14.6	100.0

SOURCE: Department of Planning and Budget, Survey of BC/BS Individual Subscribers; DPB 1986 Population Projections.

As seen in Table II-2, 61 percent of all individual open enrollment subscribers are 50 years or older, as compared to only 23.8% of the state population. The significance of this older population is that the incidence of claims generally is greater as persons grow older. However, because BC/BS of Virginia premium rates are adjusted for age, the higher incidence of claims is offset by higher premiums. For example, a family subscriber age 0-29 pays $228.29 per month for standard coverage ($200 deductible); whereas a family subscriber, age 60 and over, pays $318.14 each month for the same coverage, a 39 percent increase. (Premium rates were effective October 1, 1986.) BCBSNCA does not currently adjust their premium rates based on the applicant's age.

Denials and Cancellations: Twenty-one percent (85 persons) of the 401 subscribers surveyed have applied to an insurance company other than BC/BS.

Of those who have applied for other insurance, 16 persons (19%) were denied coverage. In total, 4 percent of all survey respondents stated they have applied to another carrier and were denied insurance. However, as will be demonstrated later, 59 percent of those who have not applied to other carriers reported having a high risk medical condition.

While few subscribers have been denied commercial coverage, survey results also indicated that some open enrollment subscribers who have applied to other insurers have experienced adverse underwriting actions, other than denial of coverage. Of the 85 persons who have applied to commercial companies:

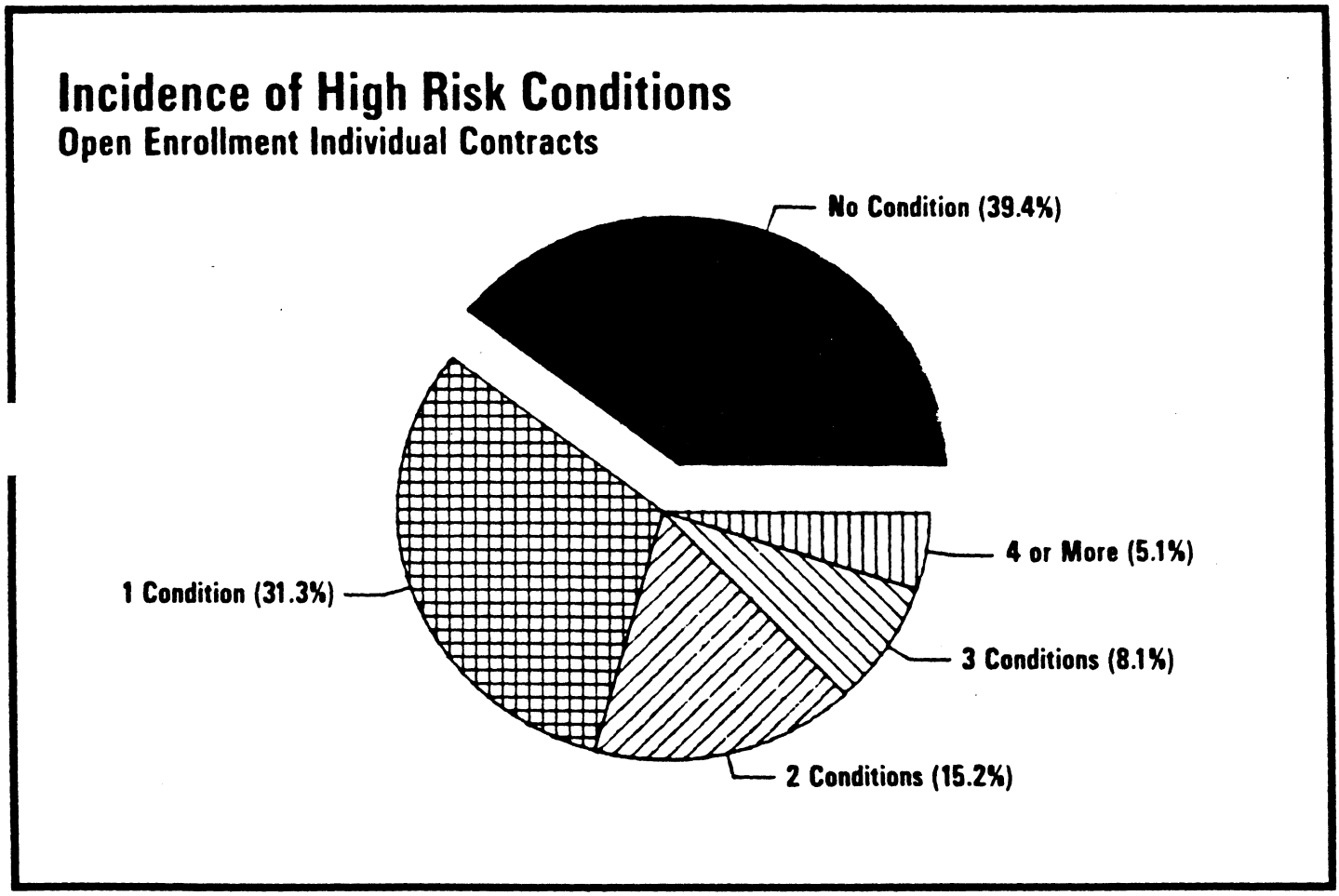
- Twenty-one percent (18 persons) were required to pay additional premiums due to health conditions;
- Thirteen percent (11 persons) paid additional premiums due to factors other than medical reasons; and
- Twenty-two percent (19 persons) had certain medical conditions excluded from coverage (ridered out).

Thirty-four subscribers (8.5% of persons surveyed) reported having been advised by an insurance agent that, because of medical problems, they would have difficulty getting insurance from commercial carriers.

A very small percent (2.5%) of survey respondents have ever had health insurance cancelled by commercial companies. (However, 84 percent of the respondents reported never having a policy with a commerical company.) Of the 11 respondents who have been cancelled by other insurers, only three persons (less than 1 percent of all respondents) reported that their health insurance had been cancelled due to health reasons.

Medical Characteristics of BC/BS Open Enrollment Subscribers: Overall, 39 percent of the survey respondents reported that no persons with any of the high risk conditions were insured under their policies. The remaining 61 percent indicated that at least one person with one or more high risk condition(s) was covered by their policy. Figure II-2 displays the incidence of high risk conditions in open enrollment contracts.

FIGURE II-2



Source: Department of Planning and Budget, Survey of Individual Subscribers.

Whereas 61 percent of BC/BS individual open enrollment policy holders reported having a high risk person covered by their policy, about 64 percent of the total persons insured (contract holders and dependents) have or have been diagnosed as having a high risk condition. Included in the 64 percent is some double-counting of persons with more than one high risk condition. Table II-3 presents, for each high risk condition, the percentage of open enrollment subscribers who reported that at least one person insured by their policy has the condition, as well as the total number of persons with each condition.

TABLE II-3

PERCENT OF OPEN ENROLLMENT CONTRACTS
WITH HIGH RISK MEDICAL CONDITIONS

High Risk Condition	Percent of Contracts Without Condition	Percent of Contracts With Condition	Total Persons With Condition	Percentage Of Total Persons Insured
° heart disease	85.3%	14.7%	58	8.6%
° liver/kidney disease	95.2	4.8	19	2.8
° stroke/paralysis	96.7	3.3	13	1.9
° diabetes	90.1	9.9	39	5.8
° high blood pressure	68.2	31.8	124	18.4
° cancer/tumors	87.3	12.7	49	7.3
° neurological diseases	97.4	2.6	9	1.3
° joint disease	78.3	21.7	84	12.5
° nervous/mental disorders	92.6	7.4	29	4.3
° alcoholism/drug dependency	98.0	2.0	8	1.2
TOTAL			432*	64.1*

* Totals include double counting of persons with more than one condition.

SOURCE: Department of Planning and Budget, Survey of Individual Subscribers.

High blood pressure (present in 18.4% of total persons insured) was the most frequently reported condition. Following high blood pressure, the most prevalent high risk conditions are joint disease (12.5% of total persons insured) and heart disease (8.6%). Alcoholism, neurological diseases and stroke/paralysis were the least reported conditions.

Comparable statistics on the incidence of these high risk conditions in the general population are available for high blood pressure, cerebrovascular disease (stroke), heart disease, cancer and diabetes. As seen in Table II-4, estimates published by various national data centers on the incidence of chronic health conditions indicate the percentage of BC/BS open enrollment subscribers with these health problems is somewhat higher than is present in the general population.

TABLE II-4

COMPARISON OF CHRONIC HEALTH CONDITIONS:
BC/BS OPEN ENROLLMENT SUBSCRIBERS AND GENERAL POPULATION

Chronic Health Condition	Percent of Open Enrollment Participants	Percent of General Population
° high blood pressure	18.4%	11.7%
° heart disease	8.6	7.4
° diabetes	5.8	2.5
° cancer	7.3	2.1
° cerebrovascular disease (stroke)	1.9	1.0

SOURCE: Department of Planning and Budget, Survey of Open Enrollment Subscribers; National Center for Health Statistics, National Health Interview Survey, 1982; American Cancer Society, 1986 Cancer Facts and Figures.

Analysis of Health Insurance Claims

The analysis of BC/BS open enrollment and commercial carrier claims indicates a greater percentage of high risk claims are submitted by BC/BS individual and small group open enrollment subscribers than persons insured by commercial companies. Table II-5 presents the percentage of contracts with incurred and paid claims in 1985, as well as the percentage of contracts with high risk claims.

TABLE II-5

CLAIMS ANALYSIS OF INDIVIDUAL CONTRACTS

		Percent of Individual Contracts		
	Total Contracts	Contracts: No Paid Claims	Contracts: Any Paid Claims	Contracts: Paid High Risk Claims
Blues: Open Enrollment	31,109	33%	67%	36%
Blues: Underwritten	23,050	53	47	22
Commercial Companies	14,436	75	25	9

SOURCE: Department of Planning and Budget, Analysis of Health Insurance Claims.

As Table II-5 illustrates, the percentage of open enrollment contracts with paid high risk claims is greater than the percentage of the Blues' underwritten contracts and commercial company contracts with high risk claims. The difference can be attributed to the fact that open enrollment persons with high risk medical conditions are not denied coverage. The presence of high risk conditions in medically underwritten contracts (both Blues and commercial companies) is likely due to these conditions appearing or being detected after the underwriting process, or the high risk condition was not serious enough to deny coverage. Strict interpretation of these findings is required. The claims analysis does not indicate that only 36 percent of open enrollment contracts are high risk or uninsurable. Rather, only 36 percent of these contracts had paid high risk claims incurred in 1985.

Although 36 percent of open enrollment contracts had high risk claims paid in 1985, these contracts account for 47 percent of the $40.8 million in total benefits paid to individual open enrollment subscribers in 1985. Table II-6 compares the percent of total benefits paid for high risk conditions by the Blues and the commercial companies. The analysis of paid benefits shows that a greater proportion of open enrollment benefits pay high risk claims (47%) than either BC/BS underwritten contracts (39%) or commercial company contracts (40%).

TABLE II-6

INDIVIDUAL CONTRACTS: BENEFITS PAID
FOR HIGH RISK CONDITIONS

	Total Benefits Paid	Percent Paid For High Risk Conditions
Blues: Open Enrollment	$40,819,977	47% ($19,185,389)
Blues: Underwritten	$15,500,796	39% ($ 6,045,310)
Commercial Companies	$ 4,216,272	40% ($ 1,666,225)

SOURCE: Department of Planning and Budget, Analysis of Health Insurance Claims.

The average benefit paid per contract (with incurred and paid claims) indicates that BC/BS open enrollment contracts are more costly to insure than the underwritten contracts of BC/BS and commercial carriers. In 1985, an average of $1,958 was paid in benefits to each open enrollment contract which had incurred and paid claims, as compared to $1,430 for BC/BS underwritten contracts and $1,168 for commercial company contracts. For those open enrollment contracts which had incurred and paid high risk claims, the average benefit paid per contract was $1,713, as compared to $1,192 for BC/BS underwritten contracts and $1,282 for commercial carrier contracts.

Table II-7 illustrates the percentage of total benefits paid for each of the high risk conditions by BC/BS and commercial companies.

TABLE II-7

INDIVIDUAL CONTRACTS: PERCENT OF TOTAL BENEFITS PAID FOR EACH HIGH RISK CONDITION

Condition	Percent of Total Benefits Paid: Blues: Open Enrollment	Blues: Underwritten	Commercial Companies
° heart disease	11%	8%	7%
° liver/kidney disease	5	6	4
° stroke/paralysis	2	2	0
° diabetes	2	1	1
° high blood pressure	1	0	1
° cancer/tumors	10	9	8
° neurological diseases	1	1	3
° joint disease	3	3	6
° nervous/mental disorders	8	7	6
° alcoholism/drug abuse	2	2	1
° other high risk claims[1]	1	2	2
° TOTALS[2]	47%	39%	40%

1 Includes diseases of the blood and blood forming organs and diseases of the respiratory system.

2 Totals may not add due to rounding.

SOURCE: Department of Planning and Budget, Analysis of Health Insurance Claims.

The claims analysis displayed in Table II-7 illustrates that, for open enrollment contracts, a greater percentage of benefits is paid for cancer, heart disease, and nervous/mental disorder claims than any other high risk condition. Combined, these conditions are present in 20.2% of the total persons covered under open enrollment (see Table II-3). However, these conditions account for approximately 29 percent of the total paid benefits. Liver/kidney disease is another medical condition that incurs a disproportionate share of paid benefits. This condition is present in 2.8% of open enrollment participants, yet consumes 5 percent of the total benefits. Therefore, approximately three-quarters of all high risk expenses incurred by BC/BS individual contracts are the result of four high risk conditions.

Whereas heart disease, cancer, nervous/mental disorders and liver/kidney disease incur high costs, high blood pressure claims account for a disproportionately small share of the total paid benefits. As shown in Table II-3, high blood pressure was the most prevalent of all high risk conditions, present in 18.4% of open enrollment participants. However, only 1 percent of the total benefits was paid for high blood pressure claims.

Another less costly condition is joint disease, which was present in 12.5% of open enrollment participants, yet accounted for only 3 percent of the total paid benefits. Finally, while diabetes was present in 5.8% of persons insured under open enrollment, this condition accounted for only 2 percent of the total paid benefits. Taken together, the three high risk conditions were found in approximately 37 percent of open enrollment participants, yet accounted for only 6 percent of all benefits paid.

Small Group Claims Analysis: The analysis of small group claims produced results similar to the analysis of claims submitted by individual subscribers. A smaller percentage of BC/BS open enrollment small group contracts had no paid claims (36%) than either BC/BS underwritten contracts (38%) or commercial small group contracts (65%). However, there is very little difference between the claims experience of BC/BS open enrollment and underwritten contracts. Therefore, there appears to be few differences in the medical characteristics of persons insured under the Blues' underwritten and non-underwritten small group policies. Table II-8 compares the claims experience of BC/BS open enrollment and underwritten contracts and commercial company contracts.

TABLE II-8

CLAIMS ANALYSIS OF SMALL GROUP CONTRACTS

		Percent of Small Group Contracts		
	Total Contracts	Contracts: No Paid Claims	Contracts: Any Paid Claim	Contracts: Paid High Risk Claims
Blues: Open Enrollment	5,139	36%	64%	34%
Blues: Underwritten	25,000	38	62	34
Commercial Companies	3,866	65	35	19

SOURCE: Department of Planning and Budget, Analysis of Health Insurance Claims.

An analysis of the benefits paid by BC/BS and commercial companies to small group contracts is presented in Appendix A. Although the total benefits paid are quite different, there is little difference in the percent of total benefits paid for high risk claims by BC/BS and commercial companies.

Profit/Loss Analysis of Open Enrollment Policy

An additional reason cited by BC/BS of Virginia as justification for the tax-exemption is the losses incurred due to open enrollment subscribers. BC/BS of Virginia maintains the high claims liability of individuals insured through open enrollment forces the plan to charge additional premiums to its larger group contracts. This income subsidizes the cost of insuring open enrollment subscribers. BC/BS of Virginia also indicates that the current tax-exemption helps offset the high cost of insuring these individuals.

BCBSNCA officials informed the study team that, while it is not the policy of BCBSNCA that one group of policyholders should subsidize the cost of another group's insurance, BCBSNCA lost an average of $1.4 million each year on group conversions during 1981-1985. BCBSNCA also reported an average loss of $845,500 each year on open enrollment subscribers during the period 1981 through mid 1986. Despite these losses, each of BCBSNCA's insurance groups (open enrollment, small groups, large groups) is expected to pay the full cost of its insurance. Losses and gains may be realized from year to year. However, over time the benefits paid to each group should equal the premiums paid.

BC/BS of Virginia Estimates of Open Enrollment Losses: The study team requested BC/BS of Virginia to provide documentation of the losses the plan incurred in 1985 due to the high claims liability of individual and small group open enrollment subscribers. BC/BS of Virginia stated that open enrollment losses were calculated in the following manner:

- Earned dues (income) were calculated from data collected to support rate development and financial forecasting activities.

- Incurred claims were calculated using the data from the analysis of health insurance claims (discussed earlier). Because the amounts used in the claims analysis reflected only payments through May 31, 1986, BC/BS contends that five percent of the total amount paid for claims incurred in 1985 were unaccounted for. Accordingly, the claim amounts were increased five percent to allow for the remaining payments.

- Administrative expenses were calculated using the "cost per subscriber" factor the plan uses for internal purposes. This factor is approximately eight percent of total claim payments.

Table II-9 displays the BC/BS of Virginia estimate of the losses incurred through open enrollment.

TABLE II-9

BC/BS OF VIRGINIA ESTIMATE OF 1985
OPEN ENROLLMENT LOSSES
($000 omitted)

	Individual Subscribers	Small Group Subscribers	Total
Earned Dues	$32,221	$3,332	$35,553
Incurred Claims	38,744	3,229	41,973
Administrative Expenses	3,009	202	3,211
Underwriting Gain (Loss)	(9,532)	(100)*	(9,632)*

*May not add due to rounding.

SOURCE: BC/BS of Virginia.

As shown in Table II-9, BC/BS of Virginia estimates open enrollment losses in 1985, for both individual and small group subscribers, to be $9.6 million. BC/BS reports that 1985 claim trends were about three percent lower than expected. According to BC/BS, claims experience was also lower in 1985 because the Roanoke Division was offering only 30-day open enrollment during a portion of 1985.

The Blues also offer supplemental health insurance policies to Medicare recipients to insure those costs not covered by Medicare benefits. Although most commercial insurers also offer Medicare extended coverage, BC/BS of Virginia states that BC/BS is the only source of Medicare extended coverage for non-group, disabled Medicare beneficiaries in Virginia under age 65. BC/BS of Virginia reports a total underwriting loss of $2.4 million in 1985 due to coverage offered to these disabled citizens.

Therefore, BC/BS of Virginia estimates the total underwriting loss attributable to all individual and small group open enrollment coverage and Medicare policies to be $12 million in 1985. When BCBSNCA's average annual losses are included, the total losses on these open enrollment subscribers was $14.2 million.

Insurability of BC/BS Open Enrollment Subscribers

As reported earlier, 45 life insurance companies marketing comprehensive health insurance in Virginia responded to a survey regarding their underwriting practices for individual and/or small group policies. Their survey responses were analyzed to determine the number and medical characteristics of individuals and small groups denied insurance or cancelled by insurers in 1985, and to document the underwriting practices of commercial companies with respect to high risk individuals and small groups.

Denials and Cancellations: Twenty-two companies were able to provide information specific to Virginia residents applying for non-group health insurance. Of the 12,459 applications for non-group health insurance received by these companies in 1985, 12 percent (1,493 persons) were denied coverage. Seventy percent of the applicants were approved as a standard risk, while 18 percent were approved as a substandard risk.

Two data limitations regarding the number of persons denied insurance must be noted. First, the number of denials includes only those persons who were denied after formally applying for coverage. There is an unknown number of persons who are advised by insurance agents that they likely would not meet underwriting criteria, and therefore do not apply to commercial carriers. A second data limitation concerns the varying underwriting standards used by commercial insurers. Due to differences in these standards, a person who is denied coverage by one carrier may be accepted by another. It was not possible to control for either of these two variables.

Thirty-one companies reported a total of 1994 applications from Virginia residents for small group health insurance. Eleven percent of the applicants were denied coverage; 83 percent were approved as a standard risk; six percent were approved as a substandard risk.

The denial rates documented by companies responding to the survey are similar to those reported in other studies conducted by the Health Insurance Association of America (HIAA). A study completed in 1985 by HIAA on denials in the state of New York found that 12 percent of persons applying for individual health insurance were denied coverage, while 72 percent were accepted as standard risks and 16 percent as substandard risks. HIAA reports these percentages are similar to studies completed in other states.

Nineteen companies provided information on both the number of non-group policies cancelled and the reasons for cancellation. These companies reported a total of 1,257 non-group policies were cancelled in 1985. Twenty-nine companies reported a total of 598 small group policies were cancelled during the same year. Virtually no policies were cancelled due to deteriorating health conditions of persons covered by the policy. Rather, failure to pay premiums was the primary reason for cancelling individual and small group policies.

Underwriting Practices of Commercial Companies: A key question regarding the insurability of BC/BS open enrollment subscribers is whether or not these individuals would be able to purchase insurance from other carriers. To address this important issue, commercial carriers were asked what underwriting decisions would be made, in the majority of cases, if evidence of a high risk condition existed at time of application. Companies were asked to select from five underwriting alternatives:

- Issue At Standard Rate: full coverage provided at a standard premium;
- Issue At Substandard Rate: full coverage provided at a higher premium;
- Standard Rate; Rider Out Condition: coverage provided at standard premium, but high risk condition is not covered;
- Substandard Rate; Rider Out Condition: coverage provided at higher premium and high risk condition is not covered; and
- Deny Coverage: coverage is not provided.

It should be noted that companies reported underwriting decisions that would be made in the majority of cases. There are a wide range of variables that are considered during the underwriting process, and the seriousness of the medical condition can vary greatly. However, the responses do provide a means of estimating the availability of health insurance for most persons with the listed high risk conditions.

Table II-10 identifies the underwriting decisions of 27 companies that responded to the survey and which market non-group, comprehensive, health insurance in Virginia. (Whereas 45 companies that responded to the survey market individual and/or small group health insurance, 18 companies market only small group coverage. Therefore 27 companies responded to questions regarding non-group underwriting practices.)

TABLE II-10

UNDERWRITING DECISIONS: INDIVIDUAL HEALTH INSURANCE POLICIES

	NUMBER OF COMPANIES				
CONDITION	ISSUE AT STANDARD RATE	ISSUE AT SUBSTANDARD RATE	STANDARD RATE; RIDER OUT CONDITION	SUBSTANDARD RATE; RIDER OUT CONDITION	DENY COVERAGE
° heart disease	0	5	6	3	13
° liver/kidney disease	0	7	7	3	10
° alcoholism/drug abuse	0	1	0	0	26
° stroke/paralysis	0	2	2	1	22
° nervous/mental disorders*	0	5	5	2	14
° diabetes	0	11	3	1	12
° high blood pressure	1	18	6	1	1
° cancer/tumors*	0	5	5	2	14
° neurological diseases	0	6	3	1	17
° joint disease	0	6	17	2	2

* Only 26 companies responded to these conditions.

SOURCE: Department of Planning and Budget, Survey of Commercial Insurance Companies.

Table II-10 illustrates that although many companies deny coverage for most high risk conditions, comprehensive health insurance is available from at least one company, at a substandard rate (higher premium), for most persons with any of the high risk conditions. Five or more companies offer insurance, at a substandard rate, to most persons with any of the high risk conditions except alcoholism and stroke/paralysis.

The underwriting practices of these companies show that persons with a history of alcoholism or stroke/paralysis would face the most difficulty getting insurance from other carriers. In contrast, 18 companies provide coverage for most persons with high blood pressure; 11 companies offer insurance to most persons with diabetes. Only one company indicated that most persons with high blood pressure would be denied coverage.

As reported earlier, 61 percent of the 401 open enrollment subscribers surveyed reported that at least one person covered under their policy has a high risk condition. Included in the 61 percent were 43 subscribers who reported having only high blood pressure. Although high blood pressure is present in 18.4% of all open enrollment participants, the analysis of BC/BS paid benefits indicated that only one percent of all benefits are paid for this condition.

The significance of this analysis is that the underwriting practices of commercial companies are based on the expected monetary liability of a particular type of condition. Because high blood pressure does not incur high benefit costs, persons applying to commercial companies with this condition alone will likely face less difficulty obtaining insurance. This is evidenced by the fact that 18 companies indicated they would offer insurance to most persons with high blood pressure, at a substandard premium. High blood pressure increases the cost of coverage, but does not preclude the individual from obtaining insurance.

In addition to providing underwriting decisions regarding high risk conditions in general, companies were also asked to indicate what underwriting decisions would be made regarding specific medical scenarios in which serious medical conditions existed. The scenarios described a fictitious applicant and included the person's age, height, weight, medical diagnosis, and treatment. Insurers selected from the same underwriting alternatives described earlier. Table II-11 summarizes the underwriting decisions regarding each of the scenarios.

TABLE II-11

UNDERWRITING DECISIONS: SCENARIOS OF INDIVIDUAL HEALTH INSURANCE APPLICANTS

SCENARIO	NUMBER OF COMPANIES: ISSUE AT STANDARD RATE	ISSUE AT SUBSTANDARD RATE	STANDARD RATE; RIDER OUT CONDITION	SUBSTANDARD RATE; RIDER OUT CONDITION	DENY COVERAGE
° chronic renal disease	0	2	2	1	22
° breast cancer, surgery 3 years ago	0	1	4	1	21
° breast cancer, surgery 6 years ago	0	6	8	3	10
° heart disease, bypass 3 years ago	0	3	3	3	18
° heart disease, bypass 6 years ago	0	5	5	4	13
° schizophrenia, employed	0	0	1	1	25
° schizophrenia, unemployed	0	0	0	0	27
° alcoholism, sober for 1 year	0	1	0	0	26
° alcoholism, sober for 3 years	4	5	0	1	17
° diabetic since age 37	0	12	2	2	11
° diabetic since age 12	0	3	2	1	21

SOURCE: Department of Planning and Budget, Survey of Commercial Insurance Companies.

The majority of companies indicated that persons with these serious medical conditions would be denied coverage. Insurance, at a substandard rate, is available from five or more companies in only four scenarios: breast cancer (surgery six years ago), heart disease (bypass six years ago), diabetes (since age 37) and alcoholism (sober for three years). However, insurance is available, at a substandard rate, from at least one company to each of the scenarios except schizophrenia. A critical factor considered in the underwriting process appears to be the length of time between treatment for the illness and the time of application.

Other Underwriting Factors: In addition to screening medical characteristics of applicants for individual and small group health insurance, companies also consider other factors when underwriting both types of policies. Most companies (20 of the 27 responding companies) look at an individual's occupation and employment status when underwriting individual policies.

The same two factors are considered by nearly all companies when underwriting small group policies. While the geographical location of a small group applicant is considered by 18 companies (67%), the geographical location of an individual applicant is considered by only six companies (22%). BC/BS open enrollment coverage is available to both non-group and small group applicants regardless of the applicant's occupation or geographical location.

In summary, comprehensive health insurance is available, although at a higher premium, to many persons with high risk medical conditions, particularly persons with only high blood pressure. Those persons with the most serious conditions, those who are in the more advanced stages of a disease, those who have recently received major treatment for the condition and those with two or more serious medical conditions would be unable to obtain comprehensive insurance.

High Risk Industries and Groups

Although commercial insurers generally do not medically underwrite individuals within groups of 11 or more employees, BC/BS states that certain groups and industries are declared "ineligible" by most commercial carriers because of the "high risk" nature of the group. BC/BS contends that because it does not reject these groups, this serves as further justification for the current tax-exemption.

BC/BS of Virginia supplied the study team with a list of high risk groups which it believes are generally denied coverage by most commerical carriers. BC/BS of Virginia states that although there are other types of groups which appear on some ineligibility lists, the list contained in Table II-12 is a core list of groups that is deemed ineligible for coverage from most commerical insurers. Table II-12 also includes the number of groups and employees that BC/BS of Virginia and BCBSNCA could identify as currently enrolled through BC/BS small group, underwritten and 11-49 group policies. It is difficult for the Blues to identify every group on their files that may be ineligible for coverage because of the disclaimers and exclusions that are included in some commercial companies' underwriting manuals. The 29,112 subscribers identified in Table II-12 as employees of "ineligible groups" represent about 2.6% of BC/BS's total statewide contracts.

TABLE II-12

HIGH RISK GROUPS IDENTIFIED BY BC/BS OF VIRGINIA;
NUMBER OF GROUPS AND EMPLOYEES COVERED BY BC/BS PLANS

GROUPS (2-49 EMPLOYEES)	NUMBER OF GROUPS COVERED BY BC/BS PLANS	NUMBER OF EMPLOYEES COVERED BY BC/BS PLANS
Farming	171	1090
Commercial Fishing	11	138
Mining, Quarries and Drilling	272	3766
Logging and Lumbering	128	1697
Explosive Chemicals and Exterminators	45	616
Local Transportation	25	428
Trucking	246	2683
Aviation Services	16	195
Junk Dealers and Salvage Yards	48	598
Restaurants, Bars, Taverns and Lounges	567	4456
Hotels and Motels	173	2234
Beauty Parlors and Barber Shops	139	607
Security Guards and Detective Agencies	14	173
Parking Lots	14	227
Amusement, Sports and Entertainment	152	1495
Hospitals, Nursing Homes and Ambulance Services	96	1895
Nonprofit and Religious Groups	306	3681
Public Employees and Government Entities	186	3133
TOTALS	2,609	29,112

SOURCE: BC/BS of Virginia, BCBSNCA

The study team contacted each of the five commerical companies which participated in the claims analysis to determine if the groups identified by the Blues are declared ineligible for health coverage. Commercial carriers were asked if they would insure these "high risk" groups of 11-49 employees. The combined responses of the five companies indicated that although some groups with 11-49 employees listed by the Blues are declared ineligible by some companies, coverage is available from at least one company for each of the general categories listed in Table II-12, except sports teams, selected amusement/entertainment groups and some taverns and bars. Some of the listed groups will pay additional premiums for coverage from some commerical carriers; however, coverage is available. At least three of the five carriers indicated that they would provide coverage to the following groups: farming, trucking, hotels and motels, and public employees and government entities.

Several of the groups listed by the Blues are combined into broad categories, and while one or two of the specific groups listed in a category may be ineligible for coverage, other groups listed in the category are eligible. For example, only one insurer reported that the entire category of restaurants, bars, taverns and lounges is ineligible for coverage. Three other insurers contacted by the team made a distinction between a first rate or full service restaurant (eligible) and certain bars or taverns (ineligible). Similar distinctions were also made by one or more companies with respect to certain groups within other categories.

In summary, most commerical companies identify certain groups or industries as ineligible for health insurance. As a result, some groups with 2-49 employees will have difficulty obtaining group health insurance from a commercial carrier, depending on the types of groups the carrier considers to be ineligible. Due to the varying underwriting practices of commerical companies, the broad categories of groups identified by the Blues, and the difficulty in conducting a comprehensive search of BC/BS's computer files, it is not possible at this time to identify the specific number of groups with 2-49 employees which cannot get coverage from any insurer other than BC/BS. However, the team does conclude that the number of groups which would not be able to obtain insurance from commercial carriers is substantially less than the number reported by the Blues.

Comparison of Benefits Offered by BC/BS and Commercial Carriers

The Department of Health Administration of Virginia Commonwealth University conducted an analysis of the benefits offered by BC/BS policies and four of the five companies which participated in the analysis of health insurance claims. Overall, 20 health insurance policies, including small group and non-group coverage, available in Virginia through the state's major insurers were reviewed. A total of 52 parameters of insurance coverage were reviewed. The categories of parameters included in the analysis were:

- the nature of coverage for pre-existing conditions;
- benefit waiting periods;
- continuation of coverage;
- conversion privileges;
- coordination of benefits; and
- benefit limits.

In general, the analysis indicated BC/BS coverage for pre-existing conditions, benefit waiting periods, and limits on benefits are superior to the other insurance companies' policies, when examined collectively. However, comparable coverage and, in a few instances, superior coverage is readily available and provided by each of the major insurance companies examined.

A notable exception to the comparability of BC/BS coverage and coverage available from commercial insurers is the lack of major medical coverage offered to BCBSNCA open enrollment subscribers.

Other Community Services Provided by BC/BS

The Blues state that, in addition to open enrollment, BC/BS plans provide other community services that further justify their tax-exemption. Documents prepared by the corporate counsel of BC/BS of Virginia and BCBSNCA (attached at Appendix B), include detailed descriptions of the community services provided by both plans. Examples of the community services offered by BC/BS plans include:

- Public Education Programs: BC/BS sponsors education programs designed to promote better nutrition and physical fitness, reduce drunk driving, and foster overall better health. Examples of such programs include: distributing films, booklets and other information, sponsoring health-related workshops, teaching classes in health-related topics, developing fitness and exercise programs, and sponsoring athletic events.

- Health Facilities Planning: The Blues provide assistance to localities in planning health care services and facilities. BC/BS also has given financial support to local health planning agencies and has assisted in the development of data bases for health planning. BCBSNCA conceived, designed and provided initial funding of $490,000 for a computerized metropolitan health care data system beginning in 1973.

- Hospital Cost Containment Program: BC/BS plans help sponsor energy management loan programs as an incentive for hospitals to develop energy conservation measures. Among other activities, BCBSNCA developed a uniform hospital cost reporting system in Northern Virginia and has contributed about $100,000 in support of a regional hospital group purchasing program.

- Health Care Cost Containment: BC/BS plans have initiated several programs to help control rising health care costs. These efforts include:

  1) reviewing claims for medical necessity or contractual issues;

  2) auditing health care facilities to uncover poor utilization practices;

  3) reviewing physician reimbursement rates;

  4) investigating fraudulent or abusive practices by providers; and

5) verifying the medical necessity of hospital admissions and lengths of stay through a pre-admission review program.

The Medical Affairs Unit of BC/BS of Virginia has primary responsibility for developing and administering the plan's cost containment efforts. The annual budget for this unit is approximately $2.5 million.

- Research and Pilot Projects: Through research and demonstration or "pilot" programs conducted with health care providers, BC/BS monitors developments in health care delivery with an eye toward implementing benefit programs that support services and levels of care that are less costly, but equally effective. Examples of services which have been studied include: skilled nursing facilities, home health care, second opinion surgery, and hospice care.

The corporate counsel of BC/BS of Virginia reported the plan's financial commitment to community services for 1986 will approach $800,000. Approximately $590,000 of this amount will be devoted to advertising open enrollment policies, financing public service announcements on substance abuse, sponsoring fitness events and making contributions to various organizations. The remaining $210,000 will be funded in-kind services.

BCBSNCA's financial contributions to community services in 1986 have exceeded $500,000. BCBSNCA's financial committment includes $60,750 to support the Health System Agency of Northern Virginia and $271,500 to underwrite an infant morbidity/mortality education program.

Community Services of Commercial Insurers: Commercial insurance companies also feel a sense of social responsibility to the citizens of the Commonwealth. Each of the commercial companies which participated in the analysis of health insurance claims was asked to provide the study team with information on relevant community services that each provides in Virginia.

Each of the insurers distributes literature, brochures, films and other materials on nutrition, exercise and other health-related matters. Commercial insurers also help in funding or co-sponsoring educational programs, workshops and health clinics. Recipients of cash contributions from these insurers include the Society to Prevent Blindness, Virginia Health Center, volunteer rescue squads, Big Brothers and Big Sisters, Virginia colleges and universities, and many others. Examples of some of the more notable community services provided by commercial health insurers include:

- The Life Insurance Company of Virginia has contributed computer equipment and other educational supplies to Richmond area public schools and non-profit organizations. The Life of Virginia Foundation provided a total $231,700 in cash contributions to non-profit organizations during the period of June 1985-1986.

- Metropolitan Life provided contributions to 22 Virginia colleges and universities in 1985 through its Matching Fund Program. Longwood College received a $22,000 grant from Metropolitan to develop an alcohol awareness program. Metropolitan also sponsors competitive award programs in health, nutrition and education.

- The Travelers sponsors a national Older American Program to improve the economic security and health care of the elderly. The Travelers also sponsors a matching gift program for funding educational programs.

The information provided by BC/BS plans indicates the Blues do provide a significant amount of community services. Most major corporations operating within the Commonwealth also possess a sense of social responsibility and fulfill this responsibility through community service. While the community services of BC/BS plans are perhaps more extensive than any single commercial insurer, these services, in conjunction with open enrollment, do not appear to justify the current tax-exemption.

Conclusions

The total number of open enrollment contracts in 1985, both individual and small group (2-10 subscribers), was 36,248, or 3.2% of all BC/BS contracts. These contracts provide the primary basis for justifying the current tax-exemption, estimated at $33 million in 1985. Medicare-extended subscribers, who are under 65 and disabled, account for .6% of all BC/BS contracts. An additional 29,112 contracts (2.6% of total contracts) are subscribers who are employed in groups the Blues contend are ineligible for coverage from most commercial companies. The 16,000 "grandfathered", 2-9 community-rated group subscribers comprises 1.4% of all BC/BS contracts. Therefore, even without any analysis of the medical characteristics and insurability of these persons, individual and small group open enrollment provisions apply to a maximum of about 7.8% of the Blues' total business. Even if one assumes that every contract identified by the Blues (including associations) is truly "at-risk", these contracts represent just 14.1% of the Blues' total business.

It is clear from the analysis presented in this chapter that without the BC/BS open enrollment program, some individuals would be unable to find any health insurance coverage; others would have to pay premiums substantially higher than average to acquire coverage; and still others would be unable to obtain coverage for certain medical conditions.

The open enrollment program sold by the Blues is a valuable component of the total health insurance spectrum in Virginia. As was pointed out by the subcommittee which studied the availability of health coverage for high risk persons, pursuant to HJR 69 of 1984, the Blues' open enrollment program is Virginia's answer to the concept of "risk pools". A health insurance risk pool is one mechanism which more and more states have turned to to provide coverage for individuals who could not obtain insurance through any established insurance company.

The proportion of business that should receive preferential tax treatment can never be precisely calculated. However, it is clear from the foregoing analysis that the percentage of contracts attributable to open enrollment is no greater than 14% of the Blues' total business. The open enrollment coverage that is unique to the Blues should receive unique tax treatment. However, the Blues' total premium income should not receive preferential tax treatment. Chapter III presents several alternatives for providing preferential tax treatment to the Blues.

FOOTNOTES:

1/ The category "Other High Risk Conditions" was included only in the analysis of health insurance claims. This category was not included in the survey of individual subscribers or the survey of commercial companies because of the difficulty in responding to multiple high risk conditions included in the category.

2/ Claims experience of the Blues and commercial companies were analyzed using the International Classification of Diseases (ICD) 9th Revision, Clinical Modification. Among other purposes, the ICD is designed for the indexing of hospital and other medical records by assigning a specific code or series of codes for each classification of disease. For example, the ICD-9 code for high blood pressure is 40 (Hypertensive Disease). These codes are used by nearly every major health insurer to classify insurance claims.

ICD-9 codes were used to identify claims submitted for each of the high risk conditions. The analysis focused on the number of contracts or policies that had incurred high risk claims, and the total benefits paid for these claims.

III. REGULATORY MECHANISMS AVAILABLE TO PROTECT UNINSURABLE PERSONS

Overview

Chapter II concluded that the benefits provided by BC/BS's open enrollment program and other community services are not adequate justification for the Blues' current tax-exemption. The Blues have maintained that, if subject to the gross premiums tax, they would possibly reduce or eliminate open enrollment. If BC/BS did curtail or eliminate open enrollment, selected persons with high risk medical conditions would not be able to purchase comprehensive health insurance. Without insurance, some of these persons would likely be unable to pay their health care costs; as a result, hospital bad debt would increase and be passed on to other consumers or the Commonwealth through increased costs. In extreme cases, health care providers might refuse complete care to uninsured, indigent persons.

Health insurance risk pools have been established in ten states to address the problem of uninsurable persons. 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 uninsurable physical or mental conditions. Both the National Association of Insurance Commissioners (NAIC) and the Health Insurance Association of America (HIAA) have established model health insurance pooling acts. For the most part, states which have implemented health risk pooling mechanisms have adopted the basic concepts of these models.

HJR 155 calls for an examination of the legal and regulatory requirements, if any, needed to protect health insurance subscribers whose coverage may be affected if changes in the current tax laws alter the availability of open enrollment. In this chapter, health insurance risk pools are analyzed as a possible alternative to open enrollment. The characteristics of health risk pools that have been implemented in other states are presented, as well as an analysis of how a risk pool might be implemented in Virginia. The chapter concludes with a discussion of other regulatory options for addressing the current inequity of the Blues' total tax-exemption while, at the same time, ensuring that high risk persons can get comprehensive health insurance.

Characteristics of State Health Risk Pools

Nationwide, 24 states have introduced risk pool legislation. Ten of those states enacted the legislation, and as a result, six risk pools are currently operating in the country. Four additional plans are expected to begin in 1987. In each of the ten states which have enacted risk pool legislation, there was no BC/BS plan offering open enrollment coverage. The oldest plans in existence, Minnesota and Connecticut, were both implemented in 1976. (Minnesota's enabling legislation became the test risk pool case in 1979, with the courts affirming the legality of operating a risk pool.) North Dakota and Wisconsin plans followed in 1981. Since that time, Indiana and Florida have begun plans and the states of Iowa, Montana, Nebraska, and Tennessee will have plans in effect in 1987. The characteristics of the ten state plans and the two risk pool models are generally very similar. Appendix C contains detailed comparisons of the ten state and two model risk pool plans.

Risk pool legislation was passed in South Dakota but it was vetoed by the governor and failed to pass in the following session. New York and South Carolina have carried over their legislation. Of the other eleven states that failed to establish risk pools, eight plan to reintroduce the bills.

Risk Pool Participants: All twelve risk pool plans (10 states, NAIC and HIAA model plans) require that all insurance carriers that provide health insurance coverage or services in the state participate in the plan. Every participating insurer shares in the administrative expenses and losses on an equitable, proportionate basis. Variations on this feature of risk pool plans are minimal. North Dakota taps only those companies with more than $100,000 in annual health insurance premiums for its pool. The HIAA model recommends excluding fixed indemnity coverage, while Nebraska specifically excludes indemnity and Medicare supplements. Connecticut is the only state that does not include HMOs, and Minnesota is the only state that specifies fraternal benefit societies as members.

Most states and both models include self-insurers as pool participants. This issue was challenged in Wisconsin courts when their state risk pool legislation was passed in 1981. Self-insurers in the state argued that under the federal Employee Retirement Income Security Act (ERISA) of 1974, the state of Wisconsin had no authority to include self-insured plans in the state pool. The state courts found in favor of the self-insurers, noting the preemptive authority of federal law. As a result of this ruling, both the NAIC and HIAA are strongly supporting federal legislation which would allow self-insurers to be included in state risk pool plans. Indiana and Montana include all health insurers in their pools except those exempted by federal law. Other states have included self-insured groups in their legislation in anticipation of changes at the federal level, but do not currently enforce the measure.

Enactment of the model bill is not recommended by NAIC until federal legislation that excludes self-insurers from participating in risk pool plans is amended to allow inclusion of all types of health insurers in the plans.

Governing Body and Administration: The governing body for each of the risk pool plans is a board rather than a state agency. The majority of the plans call for board selection by the insurers participating in the plan, often with the approval of the appropriate state commissioner. The boards consist of four to ten members, with nine members being the most common. The board composition varies among the plans, but the following are often included: a domestic insurer (chartered in the state), a foreign insurer (chartered outside the state), an HMO, a health care service plan (BC/BS), a non-profit insurer, a public representative, a health professional and/or a medical representative. Tennessee specifies that a risk pool enrollee sit on the board. Montana and North Dakota automatically take the largest health insurers in the state to comprise the board. Wisconsin calls for the insurance commissioner or his representative to sit on the board.

The day-to-day administration of the plans is carried out by a contracted administrator, usually an insurance company operating in the state. Seven states require a bidding process to select the plan administrator. The remaining plans allow the board or commissioner to select the administrator. Currently, Mutual of Omaha is administering plans in Wisconsin and Indiana, and is scheduled to begin in Florida. Blue Cross/Blue Shield is the administrator in Minnesota and North Dakota. Several states have established maximum administrative fees that can be charged by the plan administrator. Minnesota, Montana and North Dakota have set a ceiling of 12.5, 12, and 12.5 percent of the total annual paid premiums, respectively.

Nine states specify agent referral fees for the plans. Individuals, however, are not required to go through an agent to enroll in the plans. The fees range from a low of $25 per referral to a high of $75.

Assessments: Assessments are the costs of operating a risk pool that are not recovered through premiums paid by persons insured under the plan. The pool administrator typically calculates assessments by totalling the administrative costs and losses incurred (benefits paid minus premiums paid) each year or at several times during the year. This loss figure is then proportionately assessed to each of the participating insurers in order to keep the plan solvent.

All of the existing plans assess losses on a proportionate basis according to each insurer's share of the total health insurance premiums paid in the state. The formula for assessing insurance carriers generally calculates each insurer's share of the health insurance market by dividing the amount of each company's health insurance premium income in the state by the total premium income in the state. Each company is then assessed an amount proportionate to the company's market share. If Congress amends ERISA in such a way that self-insurers can be required to participate in a risk pool, the formula is adjusted so that self-insured groups are assessed on 110 percent of their benefits paid. (This adjustment is necessary because self-insurers typically do not report premium income.)

Assessments are usually levied on a quarterly, interim, or as needed basis. Eight states allow participating companies a credit against their premium tax liability for assessments paid to the pool. Credits are normally equal to the assessment paid by the company. Only Connecticut and Wisconsin do not provide the premium tax credit.

Eligibility Requirements: Commonalties between the plans appear in eligibility requirements and benefit levels. All twelve plans have a residency requirement. Ten plans require evidence of being denied coverage by one or two commercial carriers prior to enrollment. Indiana allows those individuals with proof of specific pre-existing conditions to forego the requirement of being denied coverage from commercial insurers. Montana also eliminates this step for those individuals who have paid increased premiums for high risk conditions, or have had conditions excluded from coverage by two commercial companies. Several states bar Medicare and Medicaid eligibles from participation. HIAA's position on eligibility requirements is that any individual willing to pay higher premiums, and unable to find adequate health coverage in the commercial market, should be entitled to coverage under the risk pool plan.

Benefit Levels: Most plans offer comprehensive benefit packages that cover usual and customary charges for:

- basic medical-surgical services, including both in-hospital and out-of-hospital medical and surgical services;
- prescription drugs;
- alcoholism and drug abuse services; and
- other services including ambulance service, physical therapy, diagnostic X-rays and laboratory tests.

Other features of most health risk pool plans include:

- Maximum Benefits: Maximum lifetime benefits range from $250,000 to $1,000,000. The majority of the plans have limits of $500,000 or less. Indiana is unusual, however, in that its two plans have no limit except a $50,000 limit on nervous/mental disorders.
- Deductibles: All plans except the HIAA model and Wisconsin offer the option of two or more deductibles. The amounts range from $250 to $2,000, with almost all plans providing $500 and $1,000 deductibles.
- Co-payment/Stop Loss Provisions: Most plans require a co-payment of 20 percent until the insured has paid the maximum out-of-pocket expenses (stop loss provision), after which the plan covers 100 percent of expenses. Stop loss provisions for individual policies range from $1,000 to $5,000 and from $2,000 to $5,000 for family coverage. Minnesota, Montana, Nebraska and North Dakota only allow for individual stop loss provisions. Six states offer stop loss rates based on the benefit plan selected. Those states that have Medicare supplement coverage usually require lower stop loss rates for these policies.

In most states the benefits available to health risk pool subscribers are not as comprehensive as the benefits currently available through BC/BS of Virginia's open enrollment program. However, if a risk pool were to be implemented in Virginia, the Commonwealth can establish benefit levels and premium rates according to its own desires.

Risk Pool Premiums: All plans mandate the maximum premium rate that may be charged by the plan. The premium rate is determined by one of two methods:

1) The state calculates the average premium rate of the five largest health insurance companies in the state for equivalent coverage and increases that rate by a specified percentage (i.e. 150%, 200%); or

2) The state develops a benefit package, has the package rated by an actuary, and then increases the rate by the pre-determined percentage.

Rates are set to ensure that the risk pool plans are utilized by high risk individuals only and do not compete with commercial insurance plans. The percentage used to determine the premium rates ranges from a minimum of 125 percent to a maximum of 400 percent. Nine plans have a maximum premium rate of 160 percent or less of what persons without high risk conditions would pay for equivalent insurance. Only the HIAA model plan (200%), Florida (200%) and Montana (400%) are higher.

Table III-1 presents the premiums paid by enrollees of five risk pool plans as compared to the annual premium paid by BC/BS of Virginia open enrollment subscribers. Premium rates are for a 41 year old single female.

TABLE III-1

PREMIUMS PAID BY SINGLE FEMALE, AGE 41: RISK POOL PLANS AND BC/BS OF VIRGINIA OPEN ENROLLMENT

State	$ Deductible	Annual Premium
North Dakota	$500	$1,080
Wisconsin	$1,000	$1,244 - $1,464[1]
Florida	$1,000	$1,947
Connecticut	$400	$1,920
Indiana	$500	$1,850 - $2,000[1]
BC/BS of Virginia	$500	$1,170[2]

[1] Premiums vary according to rating zones.
[2] Premium for open enrollment coverage; rate effective October 1, 1986.

SOURCE: Communicating for Agriculture, 1986 Risk Pool Survey; BC/BS of Virginia.

Table III-1 indicates that the premiums paid by risk pool enrollees are generally higher than BC/BS of Virginia open enrollment rates, in some cases the premiums are much higher. However, the premium paid by risk pool participants in North Dakota is less costly. Because of the differences in deductibles, the benefits offered by each state and variations in the cost of health care in each state, straight comparisons between other states' risk pool premiums and BC/BS are not conclusive.

Waiting Periods and Pre-existing Conditions: Waiting periods for pre-existing conditions are required by all plans. Five plans specify a waiting period of 12 months, while seven require six months. Nine define pre-existing conditions as those conditions which have appeared or have been treated in the prior six month period. Indiana allows for the waiting period to be waived if the individual agrees to pay an additional ten percent above the premium for the duration of coverage. (Many participants have selected this option.) Minnesota and North Dakota impose waiting periods on conditions diagnosed or treated within 90 days. Montana's 12 month waiting period applies to any condition identified in the past five years. The most common requirement is a six month waiting period for any condition identified in the prior six months.

BC/BS of Virginia requires a 12-month waiting period for pre-existing conditions which existed prior to the effective date of participation. BCBSNCA applies a 10-month waiting period for pre-existing conditions for which the subscriber either received care within one year prior to enrollment, or had symptoms of the condition prior to enrollment.

Operating Statistics for State Risk Pool Plans

Operating statistics (1985) which are available for most plans show significant variation among the six states currently operating risk pools. Minnesota, which has been in existence the longest, 10 years, served 10,139 persons in 1985. The total losses that were assessed to participating insurers was $5.5 million. In its sixth year of operation, the North Dakota plan covered 983 persons and assessed participating insurers a total of $600,000. Wisconsin, also in its sixth year, covered 1,919 persons; however, there were no assessments. Indiana's plan covered 3,276 persons in its fourth year, and $3.3 million in losses were assessed to participating insurers. Florida's plan insured 664 individuals in 1985, and no losses were incurred.

The differences seen in the losses each state must assess its participating insurers is due largely to varying benefit levels and premium rates. While enrollees profit from greater benefits and lower premiums, pool losses generally increase. As losses increase, state tax revenues decrease, assuming tax credits are provided to insurers.

It is difficult to draw conclusions from the state operating figures due to significant differences seen year to year. The Minnesota plan operated for five years before it reached assessments of $1,000,000 per year. Connecticut's plan functioned for eight years before reaching that point. Although Indiana's total individuals increased from 2,288 in 1983 to 3,305 in 1985, Indiana's assessments jumped from $10,601 in 1983 to $3,339,318 in 1985. Wisconsin's experience was very dissimilar--while total individuals increased slightly (1,798 in 1983 to 1,928 in 1985), assessments dropped from $2,000,000 in 1983 to no assessments in 1985. Florida's risk pool has had no assessments since its inception.

One reason for the large fluctuations in yearly assessments is the lack of actuarial data upon which to predict claims liability. Because risk pool plans are relatively new, data are just beginning to be collected for this purpose. In addition, there are no other comparable insurance populations (all high risk persons) that have been in existence long enough to project expected claims experience. This lack of critical actuarial information makes it extremely difficult, if not impossible, to precisely predict the cost of operating a risk pool.

The administrative costs charged by plan administrators to operate risk pools are largely estimates, as states have not generally seen a need to capture this data. The states of North Dakota, Minnesota and Wisconsin have included legal fees in their administration figures, which further dilutes the accuracy of these estimates. North Dakota appears to have the lowest administration costs ($56,758 in 1985), while the Wisconsin plan, which was implemented in the same year, has had much higher costs ($210,646 in 1985). Minnesota has the highest administrative costs, $984,154 in 1985, but this may be partially attributed to the fact it has been in operation for the longest period of time (1976), and has the largest number of enrollees. The wide range of administrative costs is due to the fact that these costs are calculated as a percentage of the premiums paid (see page III-3).

Risk Pools as an Alternative to Open Enrollment in Virginia

The question of whether a health risk pool is needed in Virginia to insure persons with chronic health conditions was addressed in 1984. HJR 69 of the 1984 session of the General Assembly established a subcommittee to study the availability of health insurance coverage for people in the Commonwealth who may be significant underwriting risks, as well as the feasibility of implementing a health insurance pooling mechanism. The subcommittee produced their report, House Document No. 17: Health Insurance Coverage Available in the Commonwealth For Individuals With Chronic Health Problems, for the 1985 session.

The subcommittee heard testimony from chronically ill individuals, commercial insurance companies, BC/BS, health associations, state agencies and health advocacy groups. The subcommittee found that the limited availability of health coverage for high risk individuals was compounded by the high cost of coverage that was available.

Testimony given by BC/BS confirmed that affordability is a key issue. The Blues testified that they act as the "insurer of last resort" and accept all applicants regardless of their physical condition. BC/BS officials noted they have offered this as a community service since 1941 as a justification for their tax-exempt status. BC/BS stated 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."

Insurance representatives testified that the Commonwealth would have to share in the responsibility of funding a pool by providing premium tax credits or by subsidizing the pool in some other way.

The subcommittee therefore concluded that further study of a health insurance pooling mechanism was not needed because BC/BS, as insurer of last resort, was filling this need, and because a pooling plan would require some form of state subsidy.

The subcommittee further concluded that BC/BS should be required to have year-round open enrollment and that BC/BS should inform consumers, as well as state and local agencies, that coverage is available to anyone. The subcommittee also recommended that commercial insurers should be required to inform those who are rejected for health coverage of the open enrollment programs, concluding that increased communication would solve much of the availability problem.

Implementing a Risk Pool in Virginia: As reported by the HJR 69 subcommittee, a risk pool is neither desirable nor necessary in Virginia as long as BC/BS or another insurer continues to offer open enrollment. However, if the Blues curtail or eliminate open enrollment, the availability of insurance to some persons with chronic health conditions would be reduced, if not totally eliminated. In this scenario, a health insurance risk pool would be the most likely alternative source of insurance for these individuals. As documented by the experiences of other states, risk pools do provide a reasonable alternative to open enrollment.

Should BC/BS elect to eliminate its open enrollment program, §38.2-4216 of the Code provides that BC/BS may do so only after giving written notice to the State Corporation Commission (SCC) at least 12 months in advance of the effective date of termination. Additionally, BC/BS non-group contracts contain a provision which provides that they can "non-renew" the contract if 30 days notice is given to the subscriber. In view of this, BC/BS could discontinue coverage to current open enrollment subscribers, as long as the subscriber is informed 30 days prior to the action.

If the open enrollment program is terminated, appropriate enabling legislation would have to be adopted by the General Assembly to amend Title 38.2 so that a risk pool plan could be established in Virginia. Other states have adapted the NAIC model bill to meet their unique needs, and this is a likely possibility for Virginia. According to the Bureau of Insurance of the SCC, several important issues would have to be resolved prior to enacting risk pool legislation, such as:

- The process of selecting insurers to participate in the plan. Of particular concern would be the inclusion of self-insured groups and HMOs;

- The organization of the pooling mechanism. Options include the Bureau of Insurance operating the pool, an association composed of health insurance industry and other officials appointed by the SCC, or another organizational structure;

- Pool funding sources, whether by assessment of participating insurers, a general appropriation from the state budget or some other means;

- Eligibility requirements for enrollees, premiums, benefit levels, and waiting periods for pre-existing conditions;

- Extent of state regulation or oversight of pool administration and operation; and

- Whether premium tax credits or some other form of direct subsidy would be offered to participating companies.

After legislation is passed, a regulation would need to be drafted and scheduled for a hearing before the Commissioners of the SCC. The regulation would need to include, among other things:

- The authority of the risk pool association, if one is utilized, or the Bureau's authority to utilize the services of an administrator to process claims;

- Guidelines for the premiums and deductibles under the pool; and

- Provisions for payment to agents referring enrollees to the pool.

Once the regulation is approved by the SCC, at least six months would probably be needed before the pool could be operational. During this time, decisions would need to be made as to the extent of advertising the pool to assure that the public is aware of its existence.

Cost of Operating a Risk Pool in Virginia: As shown in the operating statistics of other states, the cost of operating risk pools varies substantially from year to year. Not only is it difficult to estimate administrative and operational costs, it is equally difficult to predict other impacts of establishing a risk pool, such as the overall affect a risk pool may have on the cost of health care in Virginia.

The absence of actuarial data virtually eliminates accurate predictions of claims experience, as is done with large group policies. Without this data, assessments that will be levied against companies participating in a Virginia pool cannot be accurately estimated. Additionally, actual assessments cannot be calculated until certain decisions regarding how the pool is to be operated are made, such as:

- What form, if any, will the Commonwealth choose to subsidize the pool?

- If a tax credit is offered, what will be the amount?

° What insurance benefits will be offered at what premium cost?

° What administrative costs will be involved?

Communicating for Agriculture (CA), a non-profit national organization attempting to improve the quality of life in rural areas, is one of the most active groups involved in helping states examine the need for a risk pooling mechanism. Representatives from CA have testified before 27 state legislatures throughout the country and before the U.S. Senate and House of Representatives on the issue of health risk pools.

As part of their services, CA provides computer-generated cost estimates to states which are considering risk pools as a means of insuring persons with high risk medical conditions. CA cost estimates are based on the state's population and the limited historical data collected on persons insured and claims experiences of other states with operating pools. Assuming that current open enrollment subscribers are allowed to continue their BC/BS coverage, CA estimates that approximately one out of every 13,000 residents will enroll in a risk pool in the first year of operation. The loss incurred by each insured person is estimated at $450 per year (benefits paid minus premiums paid). Based on these assumptions, in Virginia, an estimated 440 persons would join the risk pool in the first year and the estimated losses or assessments would be $200,000.

The experiences of other states indicate that as more persons become aware of the availability of insurance through a risk pool, the number of enrollees increases rapidly. Approximately one out of every 5,336 residents would join the risk pool in the second year (1,068 in Virginia). The number of persons increases to one for every 2,312 residents by the third year (2,465 in Virginia). Expected losses per person also increase in the third year. This is largely due to waiting periods for pre-existing conditions which begin to expire, allowing persons to receive benefits for conditions which were excluded from coverage for the first year. CA estimates the losses incurred in the third year are generally the greatest ($700 per person). Rough estimates of Virginia's total risk pool assessments for the third year is estimated at approximately $1.7 million (2,465 persons times $700 per person). By the eighth year, losses per person level off at approximately $500 per insured. Because risk pool plans have been in existence only since 1976, there is no data to predict experiences beyond the tenth year.

If BC/BS discontinues coverage for current open enrollment subscribers, the number of persons enrolling in a Virginia risk pool and the resulting pool losses would likely be greater than CA estimates.

As noted earlier, BC/BS's current share of the health insurance market in the state is approximately 50 percent. Therefore, if risk pool participants are assessed pool losses proportionate to their market share, roughly half of the total losses would be assessed to the Blues. However, if participants are given tax credits equal to their assessments, BC/BS's tax liability would be reduced accordingly.

It must be noted that CA estimates are based on only six operational plans throughout the country, and that estimates of enrollees and losses are only rough approximations. CA points out the lack of actuarial data and the novelty of health risk pooling mechanisms severely limit the capability of predicting the costs of operating a pool. Before any final approximations of the cost to operate a pool in Virginia can be computed, the issues listed on page III-8 must be resolved.

Premium Costs: The cost of coverage that Virginians would pay for health insurance through a risk pool plan is also difficult to estimate. However, in order to present a rough estimate of risk pool premiums in Virginia, the study team computed premium estimates in the same manner that rates are calculated by a number of states operating risk pools.

The team received annual premium rates from three of the five commercial companies that participated in the analysis of health insurance claims, another major commercial company operating in Virginia and BC/BS of Virginia. Premium data reflect the cost of comprehensive health coverage with a $500 deductible (one company which offers only a $100 deductible was included) and marginal differences in benefits for a 41 year old single female. The commercial company policies included in the analysis are those policies identified by the Department of Health Administration as being similar to risk pool insurance offered in other states. The team computed an average rate and then increased the average by several different percentages.

The average annual premium cost of the five companies was $886. If increased 125 percent, the premium cost would be $1,107; a 150 percent increase results in a cost of $1,329; a 200 percent increase means risk pool enrollees would pay $1,772. A 160 percent increase, which is the highest premium charged by nine plans, results in an annual premium of $1,418.

Other Regulatory Options

A risk pool appears to be the only alternative means of providing health insurance to high risk persons if open enrollment is terminated by BC/BS. However, in addition to examining alternatives to open enrollment, the team also reviewed other regulatory options that address the inequity of exempting the Blues from premium taxes, without running the risk of BC/BS eliminating open enrollment. Specifically, the team looked at whether other states are regulating the fees and benefits of the Blues significantly different from other commercial insurers as a means of ensuring the Blues earn their preferential tax treatment. Another regulatory option reviewed by the team involves establishing open enrollment criteria, which if met by any carrier, would qualify the insurer for special tax treatment. The final regulatory option would be to tax BC/BS at a rate lower than other commercial insurers, provided the Blues continue open enrollment.

Regulation of Fees and Benefits by Other States: The Bureau of Insurance of the State Corporation Commission (SCC) conducted a survey of all 50 states to determine if BC/BS fee structures and minimum benefit levels are more stringently regulated than commercial insurers. Thirty-seven states responded. SCC staff researched and interpreted appropriate Code citations of those 13 states which did not respond so that all states would be included in the analysis.

The survey findings indicate that, like Virginia, other states generally do not regulate BC/BS fees and benefits more stringently than commercial companies' fees and benefits. In nearly all states that have laws or regulations requiring insurers to comply with minimum standards, both BC/BS and commercial carriers are subject to the requirements. Other states report that, for the most part, the Blues are also required to make available the same kind of benefits as commercial insurers. Nearly every state that requires BC/BS to make available a specific benefit also requires commercial companies to offer the benefit. The survey also revealed that other states which have laws or regulations requiring rate approval generally apply to both commercial insurers and BC/BS. The similarities between commercial carriers and BC/BS, with respect to benefit regulations and rate approval, generally exist both for individual as well as group policies.

Open Enrollment Criteria: Another possible alternative to the current tax policy of exempting only BC/BS for offering open enrollment would be to establish a set of open enrollment criteria, and offer certain tax credits or deductions to any insurer meeting the criteria. This approach was mentioned in the General Accounting Office (GAO) study discussed in Chapter II. GAO recommended that if the Congress decides not to continue the current BC/BS exemptions, and instead offers special tax treatment for insurers who provide coverage to high risk individuals by amending the tax code, specific criteria for granting such treatment should be established. The Federal tax reform bill provides special tax treatment to existing BC/BS plans. The special tax provisions also apply to other organizations substantially all of whose activities are providing health insurance. However, in order to earn special tax treatment, organizations other than existing tax-exempt BC/BS plans must meet several requirements. (These requirements are discussed on page II-10 of this report.)

There are few, if any, organizations that could satisfy the stringent requirements for earning special federal tax treatment. It is reported that reasons for imposing such stringent requirements were concern over the number of insurers which may seek the special tax treatment, the resulting cost for tax administration and potential loss of tax revenues. It appears that the practical result of the new federal legislation will be that only existing BC/BS plans will enjoy special tax treatment at the federal level.

A similar approach could be taken by the Commonwealth that would offer special tax treatment to any insurer meeting certain requirements. Such an approach would "level the playing field" in that all insurers would have an opportunity to earn tax credits. To implement this alternative, the Bureau of Insurance would have to identify the types of coverage which would qualify as open enrollment practices, such as non-underwritten individual policies and policies offered to groups deemed ineligible for coverage by commercial underwriting practices.

Depending on the requirements that are established for earning tax credits, this approach would likely require extensive monitoring by the Bureau of Insurance to ensure that companies seeking special tax treatment are indeed earning it.

Partial BC/BS Tax Exemption: The analysis of BC/BS's open enrollment program and other community services, presented in Chapter II of this report, does not support a total tax-exemption for the Blues. However, the analysis also illustrates there are certain high risk individuals and groups who, without open enrollment, would not be able to obtain comprehensive health insurance. Although a total tax-exemption is not justified, the availability of insurance to high risk individuals and certain groups through open enrollment does warrant recognition for the Blues.

Of all the alternatives discussed in this chapter to protect uninsurable individuals, a partial tax-exemption for BC/BS may be the most practical because no administrative monitoring would be required. Through open enrollment, the Commonwealth has a mechanism in place to insure high risk individuals. By providing a partial tax incentive to the Blues, and requiring BC/BS to continue open enrollment, the Commonwealth can avoid the administrative processes that would be involved in the other two alternatives: implementing and maintaining a risk pool, or offering tax incentives to all insurers which provide open enrollment.

An equitable means of recognizing the benefits provided to the Commonwealth through open enrollment would be to tax the Blues at a rate lower than other insurance companies which do not insure certain high risk individuals and groups. This tax break would provide financial relief to the Blues to help offset the cost of insuring high risk enrollees, and, at the same time, would remedy the current inequity in the tax treatment of BC/BS and commercial insurers.

Conclusions

If BC/BS is ultimately taxed and open enrollment is discontinued, a health insurance risk pool will be needed to provide health insurance for uninsurable persons. Risk pools have been successfully established in six states, and four other states expect to implement similar pools in 1987. These pools offer comprehensive health insurance at rates generally 125 percent to 160 percent of the premiums charged to healthy individuals.

Due to the absence of actuarial data, claims liability and risk pool losses cannot be accurately predicted. Therefore, an accurate estimate of the annual cost to operate a health insurance risk pool in Virginia is not possible. Based on rough approximations provided by CA, a Virginia risk pool would insure approximately 2,465 persons in the third year (one per 2,312 residents), with assessments of approximately $1.7 million. (This estimate assumes that existing open enrollment subscribers would continue their health coverage with BC/BS. If these subscribers are not allowed to continue their present coverage, an additional number of persons would likely enroll in the risk pool, and pool losses would likely increase.) If the Commonwealth were to provide tax credits equal to the total assessments, premium tax revenues would be reduced accordingly

It must be noted that CA estimates are based on only six operational plans throughout the country. However, if CA estimates are even remotely accurate, a $1.7 million annual loss in premium tax revenue does not even approach equalling the $33 million tax-exemption enjoyed by BC/BS in 1985.

If a risk pool does become necessary, Title 38.2 of the Code would have to be amended. Additionally, a number of important issues would have to be resolved including: the organization of the pool, funding sources, eligibility requirements, benefit levels, premiums, the extent of state regulation, and the type of state subsidy (if any) for the pool. The SCC estimates that approximately one year would be needed to implement a health insurance risk pool in the Commonwealth.

Two of the other regulatory options considered in this chapter, regulating BC/BS benefits and rates more stringently, and offering tax credits to any insurer meeting certain open enrollment criteria, do not appear to be the most practical or efficient means of rectifying the current inequity of exempting the Blues from premium income taxation. The survey of other states indicated that BC/BS benefits and rates are generally regulated in the same manner as commercial insurers, and that other states have not chosen increased regulation as a means of justifying preferential tax treatment for the Blues. Because open enrollment constitutes a small percentage of the Blues' total business in Virginia, increased regulation of the Blues still would not justify a complete tax-exemption.

The establishment of open enrollment criteria that, if met, would qualify any insurer for special tax credits or deductions has not been implemented in any state. Furthermore, although federal tax reformers have established criteria for special tax treatment at the federal level, it appears that only existing BC/BS plans will qualify for this special tax treatment. If implemented in Virginia, this alternative would likely involve a continuous and difficult monitoring process to ensure those companies seeking preferred tax status are meeting the required criteria. Additionally, a risk pool would likely have to be established as a safety net for uninsurable persons in the event no insurer chooses to offer open enrollment. Also, as recognized at the federal level, the financial impact of this option in terms of possible lost premium tax revenue is unknown.

The most appropriate mechanism for protecting uninsurable individuals would be for the Commonwealth to provide BC/BS a partial tax-exemption as an incentive for continuing open enrollment. The analysis of BC/BS's open enrollment and other community services, presented in Chapter II of this report, indicates a total tax-exemption for the Blues is not justified. However, the availability of insurance through open enrollment to high risk individuals, small groups (2-10 employees) and certain larger groups which are deemed ineligible by commercial carriers does warrant some financial relief for the Blues.

By providing a preferential tax treatment to the Blues, and requiring BC/BS to continue open enrollment, the Commonwealth can avoid the administrative processes that would likely be involved in the other two alternatives; implementing and maintaining a risk pool, or offering tax incentives to all insurers which provide open enrollment. A change in tax status, phased in over several years, would help offset the cost of insuring high risk enrollees, and, at the same time, would remedy the current inequity in the tax treatment of BC/BS and commercial insurers.

IV. REGULATION AND TAXATION OF HEALTH MAINTENANCE ORGANIZATIONS AND SELF-INSURED GROUPS

Overview

As reported in the 1985 study of the taxation of insurance companies, the insurance industry has changed dramatically over the past several years. Perhaps the most notable changes have taken place in the provision of health care and health insurance. Industry experts report that the traditional form of health insurance, in which patients are cared for by physicians of their choice and insurance companies reimburse the patient or provider on a fee-for-service basis, is diminishing. The establishment and rapid growth of health maintenance organizations (HMOs) and preferred provider organizations (PPOs) are quickly reshaping the health care delivery and health insurance industries. Industry experts predict even greater growth in both HMOs and PPOs into the 1990s.

In addition to the dramatic changes seen in the health care delivery and health insurance industries, there has been substantial growth in the numbers of companies, corporations and other groups that are turning to self-insurance as a means of reducing the cost of employee benefit plans. Self-insurance is effecting change not only in the provision of health insurance benefit plans, but also in workers' compensation benefits, property and casualty insurance and liability insurance.

Third party administrators (TPAs), administrative services only (ASO) arrangements and minimum premium plans (MPPs) all are means by which employers can become self-insured and avoid paying increasing insurance premiums. Like the shrinking of traditional health insurance, self-insurance is also decreasing state revenues that previously were collected through taxing premiums paid to insurance companies.

There are no definitive statistics on the amount of premium tax revenue that is no longer collected since the advent of HMOs and self-insurance. However, there is little doubt that as these entities continue to grow, the Commonwealth will experience a commensurate reduction in revenues that otherwise would have been generated through taxing premiums associated with traditional forms of insurance.

In this chapter, PPOs, HMOs, and self-insurance, the principal change agents reforming the health insurance industry, are described and analyzed. The brief history of these approaches to health care is discussed, along with industry experts' predictions of how certain of these entities will continue to grow in the future. Conclusions regarding the regulation and taxation for HMOs, PPOs, and self-insurance are discussed at the close of the chapter.

Preferred Provider Organizations (PPOs)

A PPO is a contractual arrangement between health care providers and third party payers. Generally, a PPO is made up of a group of physicians who

agree to provide services to a specific group of patients on a discounted fee-for-service basis. Subscribers, usually members of an employer group, are offered economic incentives if they receive their health care from the preferred providers. The economic incentives are normally reduced deductibles or co-payment rates. The providers are rewarded with an increased pool of patients and more rapid payment of claims. Financial risk is normally assumed by a third party payer, rather than the physicians.

A key difference between a PPO and an HMO is the method of payment. Most HMO physicians are paid on a prospective basis, whereas PPO physicians are paid on a fee-for-service basis. The other major difference is that in a PPO arrangement, patients do not have to be treated by preferred providers, whereas HMO patients must be treated by the HMO's physicians. PPOs are seen as a midpoint in health care delivery between traditional fee-for-service, where the patient has complete freedom to select a provider, and an HMO where patients are very restricted in the physicians they can choose from.

Many health care experts believe the PPO arrangement will be growing faster than any other form of health care delivery or health insurance. Although these arrangements now have only about one percent of the national health insurance market, experts predict that by 1995, PPOs will command a 25 percent market share. In July 1985, there were 334 PPOs operating in 34 states. Most of the national health insurers have established PPOs in various parts of the country, including Metropolitan, Aetna, Prudential, Travelers and others. BC/BS plans are also establishing PPOs. In July 1985, 31 of the nation's 90 BC/BS plans had set up PPOs. KeyCare is the PPO operated by BC/BS of Virginia.

PPOs can be organized and operated in a variety of ways. The basic distinction made by the Bureau of Insurance with respect to PPO regulation involves the assumption of an insurance risk. If there is no assumption of insurance risk, then the Bureau of Insurance considers the PPO not to be in the business of insurance and does not regulate it. If the PPO does assume insurance risk, then the entity assuming the risk must be licensed in Virginia as either an insurer or a BC/BS plan. Accordingly, PPOs that the Bureau considers to be insurance are regulated and taxed as the license of the entity holding the insurance risk requires by Virginia statute. Therefore, premium income of PPOs organized by commerical insurers is taxed at 2.75%, while premium income of PPOs sponsored by BC/BS plans is not currently taxed.

Because PPOs are regulated and taxed the same as other insurance products of the organization sponsoring the PPO, the future growth of PPOs should not result in the Commonwealth having to adjust its tax policy unless legislation is changed.

Health Maintenance Organizations (HMOs)

The HMO concept has been in existence in the United States since the 1920s. An HMO is an organization that provides a wide range of health care services, including preventive care for a fixed periodic payment. HMOs generally enroll only groups. The major distinctions between an HMO and a BC/BS plan are the breadth of services, the method of payment to providers, and choice of provider. HMOs offer a broader range of benefits, in that the preventive care provided to subscribers is generally not available under

BC/BS contracts. HMO physicians are paid a set fee on a prospective basis, in contrast to the traditional fee-for-service method of payment received by physicians who contract with BC/BS plans. BC/BS plans give subscribers broad flexibility in choosing their physicians and hospitals, while HMOs require subscribers to utilize specific providers.

HMO Cost Controls: The bedrock of the HMO concept is prospective payment, rather than the traditional fee-for-service method. The prospective method of payment pays providers a set fee or salary per patient, regardless of the number of operations or treatments performed. Through the prospective method of payment and the use of utilization controls, HMOs attempt to control the incentive to overuse health care services that exists under traditional health insurance. In addition, by providing for regular check-ups and preventive health care practices, the opportunity to diagnose early and treat a potentially major illness may be a factor in ultimately reducing total health care costs. For these reasons, HMOs are in an excellent position to control rising health costs.

The ability of HMOs to control health care costs has been documented by about 40 comparison studies which have found that HMOs reduce per capita health care costs between 10 and 40 percent. The reduction in overall costs is due largely to a 25 to 45 percent reduction in hospital use. Health care and research experts agree that a 1984 study conducted by the Rand Corporation is perhaps the best effort to-date in analyzing the effectiveness of HMOs in controlling health care costs. The study, published in a 1984 issue of the New England Journal of Medicine, found that the hospital admission rate of HMO enrollees was about 40 percent lower than the admission rate for enrollees of traditional fee-for-service insurance plans. The study also found the cost of all health care services was 25 percent less for HMO enrollees than fee-for-service insurance enrollees.

HMO Models: HMOs can be sponsored by the government, medical schools, hospitals, employers, labor unions, commercial insurers, and BC/BS plans. HMOs are generally organized and operated in one of four ways:

- Group Model: The HMO contracts with a group of physicians who practice together, and share facilities, medical equipment, records, and personnel;

- Staff Model: A type of group practice HMO in which the physicians are hired and employed by the HMO, as opposed to being partners in a group practice partnership. Staff model physicians provide health care services in facilities operated by the HMO;

- Network Model: A network HMO contracts with two or more group practices to provide care and may bring together features of a group, staff or IPA model HMO; and

- Independent Practice Association (IPA): Physicians are organized to provide services under a prepaid plan, but continue to practice in their own separate offices. The IPA may consist of a single association or a combination of associations, medical groups, staff and individual physicians, and other health professionals under contract with the HMO.

Growth of HMOs: Although HMOs have been in existence since the 1920s, the HMO concept did not begin to flourish until the early 1970s. In an effort to curb spiraling health care costs through increased health care competition, the Nixon administration worked with Congress to pass the Health Maintenance Organization Act of 1973. This act became the turning point for HMO development. The HMO Act of 1973 (amended in 1976 and 1981) spelled out several conditions an HMO needed to fulfill to qualify for federal approval. Becoming federally qualified was and continues to be an important distinction for HMOs. The federal Office of Prepaid Health Care (OPHC) reports that 377 active HMOs or 78.5% are federally qualified. The HMO Act:

- Gives Federal recognition to HMOs as legal entities;
- Authorizes limited funding for existing HMOs;
- Prescribes standards for HMO organization and the services offered;
- Overrides some state legislation that is a barrier to development of HMOs; and
- Requires employers to offer their employees the opportunity to select a qualified HMO as an alternative to their present employee health benefit plans if approached by an HMO that serves the area where at least 25 of their employees live.

During the 1970s, the federal government provided nearly $900 million of financial assistance to new federally qualified HMOs. HMO enrollment increased substantially during this period. For the five year periods of 1970-75, 1975-80, and 1980-85, the average annual growth rates were 14.7%, 9.9%, and 15.1%, respectively. During the last two years, HMO growth has exceeded 20 percent per year. The 1985 National HMO Census reported that, as of December 31, 1985, there were a total 480 HMOs nationwide with an enrollment of 21.1 million persons. More than half of the HMOs which responded to the census reported that they are now operating on a for-profit basis.

Interstudy, the research firm which sponsors the annual National HMO Census, estimates that, in June 1986, there were 550 HMOs and 23.5 million enrollees. Table IV-1 depicts the rapid growth of HMOs during the past two decades. Although not displayed in Table IV-1, IPA model plans have shown the largest increase, gaining 64 plans between June, 1985 and December, 1985. IPA plans now account for over 51 percent of all operational HMOs.

TABLE IV-1

GROWTH OF HMOs
SELECTED YEARS: 1970-1986

	All Plans - Totals			Plan Type			
				Staff, group/network plans (combined)		IPA Plans	
Year	Number of Plans	Enrollment (millions)	Percent of U.S. Population	Number of Plans	Enrollment (millions)	Number of Plans	Enrollment (millions)
1970*	26	2.9	1.4%				
1975*	178	5.7	2.6				
1980	236	9.1	4.0	139	7.4	97	1.7
1983	280	12.5	5.3	181	10.6	99	1.9
1984 (Jun)	306	15.1	6.4	180	12.2	126	2.9
1984* (Dec)	337	16.7	7.0				
1985	480	21.1	9.0	235	14.7	245	6.4
1986* (Jun)	550[1]	23.5[1]	9.8				

* Information on specific HMO models not available.
[1] 1986 figures are Interstudy estimates.

SOURCE: National HMO Census 1984, 1985 (Excelsior, Minnesota: Interstudy, 1985)
Statistical Abstract of the U.S., 1985.

Future Growth: Many health insurance experts believe that HMOs will continue to grow into the next century. Business Insurance, a weekly insurance industry newspaper, estimates that approximately 92 percent of all health care today is paid for through the traditional fee-for-service system, while just 7 percent is paid for through the HMO concept. However, by 1995 it is predicted that the market share of traditional insurance could decrease to 55 percent, while PPOs will grow to 25 percent and HMOs to 20 percent.

One reason given for the future growth of HMOs (and PPOs) is an oversupply of physicians. According to the Graduate Medical Education National Advisory Committee, a surplus of 60,000 doctors is likely by 1990.

Likely results of this oversupply of doctors will be: increased competition among physicians, greater emphasis on competitive group health care, and greater numbers of physicians seeking out HMOs and PPOs as reliable sources of patients.

Current Tax Status of HMOs Nationally

The dramatic growth of HMOs and the resulting changes in the health care delivery and health insurance industries have caused both the federal government as well as selected other states to reexamine the preferred tax status enjoyed by HMOs throughout most of the country.

Federal Actions: Federal taxation of HMOs is based on the profit/non-profit status of the organization. All for-profit HMO models are taxable. Non-profit Group and Staff models are tax-exempt as charitable organizations under Section 501 (c)(3) of the Internal Revenue Service (IRS) code. Non-profit IPA models are also tax-exempt as social welfare entities under section 501 (c)(4) of the IRS code.

Tax legislation passed by the House Ways and Means Committee in December 1985 would have removed the tax-exempt status of a non-profit HMO, unless it provided "health care to its members predominantly at its own facility through the use of health care professionals and other workers employed by the organization." The final House bill stated that "an organization described in sections 501 (c)(3) and (4) of the Code is exempt from tax only if no substantial part of its activities consists of providing commercial-type insurance." Although IPA model HMOs were not specifically identified, the final House bill would have removed the tax-exempt status of non-profit IPAs. The Senate did not endorse the House proposal to tax HMOs, and as part of the conference committee proceedings, the House proposal was killed. As a result, the Tax Reform Act of 1986 does not alter the tax-exempt status of health maintenance organizations (HMOs).

As reported earlier in this chapter, the Federal government pressed for the development of HMOs and invested nearly $1 billion during the 1970s as one method to increase competition and reduce the rate of increase in health care costs. The decision to continue the federal tax treatment of HMOs appears to be a commitment on the part of tax reformers to further encourage the growth of HMOs.

Other States' Taxation of HMOs: Because HMOs are relatively new, some states do not have any HMOs and several states are just now developing enabling legislation to regulate their operations. The 1985 study of insurance companies in Virginia found that approaches to taxation vary across the nation:

- Of the sixteen states that tax HMOS, 12 of those states treat HMOs as insurance companies and subject them to a premium tax.
- Indiana, Massachusetts and New Hampshire apply the premium tax to for-profit HMOs only.
- Oregon taxes foreign, for-profit HMOs only.

- Iowa allows a five year grace period before the two percent premium tax is imposed on HMOs. This delay is in place to provide sufficient start-up and development time for the organization.

- Kansas levies a staggered tax rate, no premium tax for the first two years, 0.5% for years three through five, and one percent after five years.

The tax rates for HMOs range from .044 to 3 percent, with rates for 13 states falling in the 2 to 3 percent grouping. The states that tax HMOs generally expect no changes to their HMO statutes.

The 1985 study also found that there were several reasons why 35 jurisdictions (including the District of Columbia) do not tax HMOs. The most prevalent reason was that HMOs are considered non-profit organizations. Other states, like Virginia, do not tax HMOs in an attempt to encourage their development within the state. HMOs are not taxed in four states because the state does not view HMOs as insurance companies.

Some states which do not currently tax HMOs are reexamining the tax exemption. In the states that now consider HMOs to be non-profit companies, three expect legislation to be introduced in the near future to propose a tax. One of those states that is currently attempting to encourage development of HMOs (Connecticut) is also considering levying a tax.

HMOs Operating in Virginia

The Bureau of Insurance reports a total of 18 HMOs licensed in Virginia. Four HMOs are currently operating on a non-profit basis, while the other 14 are for-profit. Five are Staff/Group model plans, while the remaining 13 are IPA model plans. Two HMOs operate as both an IPA and a Group model in different locations. (The statistics in this report concerning IPA model HMOs include the two HMOs operating as both an IPA and Group model plan.) All but two of the licensed HMOs are federally qualified.

HMOs operating in Virginia reported a total of $104.8 million in subscriber income during 1985, a 39 percent increase over 1984 subscriber income. The 1985 subscriber enrollment of 162,000 represents a 56 percent increase over 1984 enrollment figures (103,635). A total of 250,000 persons (subscribers and dependents) were enrolled during 1985.

Despite the growth in the number of persons enrolled in Virginia HMOs, the total number of persons insured through BC/BS plans (about two million) was nearly eight times greater than the total number of HMO enrollees (250,000) in 1985. BC/BS's 1985 subscriber income was 11 times greater than the 1985 HMO subscriber income. Table IV-2 displays the HMOs currently licensed in Virginia, along with other descriptive information.

TABLE IV-2
HMOs CURRENTLY LICENSED
IN VIRGINIA

HMO	MODEL TYPE	FEDERALLY QUALIFIED?	HMO LICENSE YEAR[1]	1985 SUBSCRIBER INCOME	PROFIT/ NON/PROFIT
Physicians Health Plan	IPA	YES	1985	$ -	PROFIT
Prudential Health Care Plan	GROUP	YES	1982	20,595,133	PROFIT
Optima Health Plan	IPA	YES	1984	3,048,967	NON-PROFIT
Southern Health Services	IPA	YES	1985	333,671	PROFIT
AETNA Healthcare	IPA	NO	1983	225,143	PROFIT
United Medical Plan	IPA	YES	1984	15,079,679	PROFIT
Kaiser Foundation Health Plan of Mid-Atlantic States	GROUP	YES	1981	25,792,292	NON-PROFIT
Virginia Health Maintenance Organization	GROUP& IPA	YES	1984	3,224,721	PROFIT
George Washington University Health Plan	STAFF	YES	1981	463,010	NON-PROFIT
Health Plus, Inc.	IPA	YES	1985	45,060	PROFIT
HealthAmerica Virginia	STAFF	YES	1984	1,169,440	PROFIT
Group Health Association	STAFF	YES	1981	25,612,743	NON-PROFIT
Network Health Plan	IPA	YES	1983	6,751,920	PROFIT
Humana Health Plan	IPA	YES	1985	-	PROFIT
Health Plan of Virginia	IPA	YES	1984	1,043,687	PROFIT
Healthkeepers of Virginia	GROUP& IPA	NO	1986[2]	94,218	PROFIT
Capital Care, Inc.	IPA	YES	1985	27,300	PROFIT
MD-Indivdiual Practice	IPA	YES	1985	268,426	PROFIT
TOTAL				$104,774,410	

[1] Year HMO was licensed under existing HMO legislation.
[2] Date of Merger with BC/BS of Virginia

SOURCE: Bureau of Insurance.

Virginia HMO Market: As seen in Table IV-2, the current HMO market in the Commonwealth is dominated by three Group/Staff model HMOs: Kaiser, Prudential Health Care, and Group Health Association. Combined, these three HMOs accounted for 70 percent of the total HMO subscriber income reported for 1985. The 13 IPA model HMOs made up the majority of the remaining 30 percent.

Within the IPA grouping, United Medical Plan, which reported subscriber income of $15.1 million, makes up more than 50 percent of the total IPA income for 1985. The other 12 IPA plans, or two-thirds of the HMOs licensed in the state, make up only 13 percent of all subscriber income. Nine of the 13 IPA plans reported less than $5 million in subscriber income in 1985; six IPAs reported less than $500,000.

Table IV-2 also illustrates how young the HMO industry is in Virginia. The enabling legislation for HMOs was enacted in 1980. No HMO has been licensed under the current legislation more than five years, although four were doing business before 1980 under prior Code provisions.

Virginia Taxation of HMOs: For-profit HMOs operating in Virginia are required to pay corporate income tax, while non-profit HMOs are tax-exempt. No HMOs realized any profits in 1984.

The current approach to regulation and taxation of HMOs in Virginia are largely the result of the 1979 Commission to Study the Containment of Health Care Costs (also known as the "Willey Commission"). The Commission, formed to study a number of topics related to the rising cost of health care, concluded that encouraging the development of HMOs would inject competition into the health care system, and, in turn, would help combat escalating health care costs.

The Commission noted that although HMOs were authorized in Virginia in 1972, the original statute resulted in HMOs being regulated similarly to BC/BS plans. However, the Commission defined HMOs as deliverers of health care services, and determined that HMOs were unlike BC/BS plans because the Blues are "basically a funding mechanism for an open pool of providers" that had "little control over the quality and cost of care since they merely pay for it."

The Report of the Commission to Study the Containment of Health Care Costs noted that HMOs are required to be cost-efficient in order to provide contracted services for the fee paid, and can exercise greater control over the type and quality of services available to its subscribers. Accordingly, the Commission proposed to the 1980 General Assembly that HMOs be regulated differently from BC/BS plans and that legislation specifically applicable to HMOs be adopted to encourage their development. The 1980 General Assembly's decision to adopt new HMO legislation and to impose a corporate rather than a premium tax on for-profit HMOs was one way of recognizing HMOs as health care providers rather than insurers. It also acknowledged the vulnerability of this young industry and attempted to inject competition into the health care system.

HMO representatives contacted during the 1985 insurance study noted that the current tax treatment is justified because of the differences between HMOs and other insurers:

- HMOs have a contractual obligation to provide or arrange for health services, while insurers simply pay for care;
- HMOs provide greater cost controls, and greater breadth of services;
- HMOs generally community rate all enrollees, while other insurers experience rate most enrollees so that "sicker" groups pay higher premiums; and
- HMOs retain smaller reserves than other insurers.

A more comprehensive comparison of commercial health insurers, BC/BS plans, and HMOs is displayed at Appendix D.

Reassessing the Tax Status of HMOs in Virginia

The current tax treatment for HMOs operating within the Commonwealth is based primarily on two factors: 1) the desire of the General Assembly to encourage the growth of a young, cost-efficient segment of the health care/insurance industry; and 2) the unique characteristics of HMOs, specifically, in the delivery of health care services. The study team's reassessment of the tax status of HMOs is grounded in these same two factors.

The unprecedented growth of HMOs within the past 20 years, coupled with predictions of continued future growth, clearly indicate this segment of the health care/insurance industry is firmly establishing itself across the country. In Virginia, the strong footing being established by HMOs is evidenced by a 56 percent growth in the number of subscribers in 1985 (162,282). Virginia subscriber income increased 39 percent from $75.5 million in 1984 to $104.7 million in 1985.

Despite the growth of HMOs, the HMO enrollment and subscriber income statistics are quite small in comparison to the number of subscribers insured by traditional forms of insurance and the premium income of traditional insurers. BC/BS plans' enrollment was eight times greater than the 1985 HMO enrollment; while 1985 subscriber income for the Blues was 11 times greater than HMO subscriber income. Furthermore, 12 of Virginia's 18 HMOs have been licensed only since 1984, and are still establishing themselves within the Commonwealth.

HMOs' unique characteristics are cited as one major reason for not taxing HMOs like insurance companies. Principal among the distinguishing features of HMOs has been that HMOs provide health care services rather than insure health care costs. This distinction still exists with respect to Staff and Group model HMOs. The Staff and Group models employ or contract directly with a group of physicians to provide health care for its membership. Physicians who contract with these HMOs typically deliver most covered services at facilities owned by the HMO. Because the distinction of being a provider of health care

has been a critical characteristic used by both the federal government and the Commonwealth to differentiate between HMOs and other insurers, the corporate tax appears to be appropriate for Staff/Group model HMOs.

On the other hand, IPA model HMOs appear to function similarly to BC/BS plans in that these HMOs contract with large numbers of physicians who practice in their own separate offices. Although there are no definitive statistics on the number of patients seen by IPA physicians, it is generally accepted that IPA physicians generally treat a greater percentage of patients who are not affiliated with the HMO than do physicians with Staff or Group HMOs. Also, physicians associated with IPA model HMOs typically do not deliver their services at facilities either owned or operated by the HMO. Thus, the critical distinction Virginia lawmakers used in 1980 to differentiate between HMOs and other forms of health insurance--that is HMOs are health care providers and not insurers-- does not appear to be as applicable to IPA model HMOs as to other models.

Despite the similarities between IPA model HMOs and BC/BS plans, the 13 IPA model HMOs reported only $30.1 million in subscriber income in 1985. This comprised only 29 percent of the total subscriber income reported by all HMOs in 1985. Within the IPA grouping, United Medical Plan makes about 50 percent of the total IPA income for 1985. The remaining subscriber income is split among the 12 other plans, nine of which reported subscriber income less than $5 million in 1985, and six had income of less than $500,000.

Although the IPA model HMOs appear to function more as insurers, these HMOs, with the possible exception of one, are still trying to establish themselves within the Commonwealth. Given the small market share held by these plans and their newness, a heavier tax burden on these organizations, which are the least able to bear additional taxes, could cause serious financial implications for this type of HMOs. Furthermore, IPA physicians, like Group and Staff model physicians, assume risk through the prospective method of payment. Therefore, despite the similarities that exist between IPAs and other insurers, a corporate income tax rather than the premium tax appears to be the more appropriate form of taxation for IPA plans at this time.

Whereas a corporate income tax is an appropriate method of taxation for HMOs at this time, the continued growth predicted for HMOs, particularly IPAs, will likely cause the Commonwealth to eventually reevaluate its tax policy. As HMOs continue to secure a greater share of the health care/insurance market by attracting more consumers and/or by traditional insurers funnelling more of their business into HMOs to avoid premium taxation, the Commonwealth will realize significant losses in revenue that otherwise would have been generated through premium taxes. As a result, the Commonwealth may wish to adjust its tax policy at some point in the future in order to maintain equity in the tax treatment of insurance companies and these other health care/insurance organizations.

If the Commonwealth eventually reconsiders its taxation of HMOs, IPA model plans, which operate more as insurers than other HMO models, should be given the closest scrutiny. If premium taxation is enacted for IPA and/or other HMO models, a tax that is phased in over several years, similar to the approaches taken by Iowa and Kansas, would make the transition less burdensome for the smaller, less established HMOs.

Self-Insurance Plans

The advent of health maintenance organizations is not the only development which has influenced trends in the insurance industry. In recent years, significant numbers of employers have moved to replace traditional insurance coverage with self-insurance or self-funded plans in an effort to control costs. These arrangements have opened new business opportunities for insurance companies and independent management firms. By altering the distribution and assumption of risks, self-insurance plans also have important implications for state tax and regulatory policy.

Technically speaking, the term "self-insurance" is a misnomer, because "insurance" is normally defined as an agreement to shift the risk of loss from one party to another for a consideration. As a result, there can be no insurance contract without two parties. The practical meaning given to the term appears to be aimed at distinguishing between entities which have no, or inadequate insurance coverage and entities which have adequate resources to cover an uninsured risk and have made a rational decision not to insure that risk. In this context, the term "self-insurance" is equally applicable to high deductibles contained in some insurance policies.

The types of self-insurance plans can generally be grouped into three classes. The first is where the self-insured assumes all risks but contracts with other entities for administrative services such as claims handling and data processing. This type of plan is called different names, depending on the nature of the organization providing the administrative support. Examples include ASO (administrative services only) when such services are supplied by an insurance company, ASC (administrative services contract) when such services are provided by a Blue Cross/Blue Shield company, and TPA (third-party administrator) when such services come from a management consultant other than a traditional insurance company.

A second category of self-insurance is characterized by a sharing of risks between the self-insured party and an insurance company. One form provides for the self-insured to assume a fixed percentage of claims while the insurance company insures against claims in excess of actuarial projections. Insurance companies refer to this arrangement as a "minimum premium plan" or MPP. A similar arrangement occurs where an entity self-insures but obtains conventional insurance against catastrophic claims. This type of insurance is commonly called excess-loss or stop-loss insurance.

The final type of self-insurance consists of plans which are totally self-funded and self-administered. Employee benefit plans provided by several large employers or unions fall into this class.

Self-Insurance Trends

There is little data to accurately measure the volume of self-insurance. The major reason for this is that self-insurance plans are not subject to annual reporting requirements because they are not regulated by state insurance departments like other forms of insurance. Moreover, the principal sources of information which are available do not cover all aspects of the self-insurance market. For example, the Health Insurance Association of America routinely publishes data on the ASO and MPP business of its member insurance companies, but it collects no data on self-insurance plans administered by independent TPAs.

Despite these limitations, rough estimates of self-insurance for health coverage have been developed based on benefit payments (see Table IV-3). While these estimates are somewhat dated, they do provide an indication of the relative importance of self-insurance and a feel for the trends which have been developing over time.

According to these estimates, the composition of health insurance has changed markedly during the last two decades. The national market share of commercial insurance and Blue Cross/Blue Shield policies, as measured by benefit payments, has steadily declined (from 93 to 76 percent) since 1965. This trend has been offset by a corresponding increase (from 7 to 24 percent) in the amount of claims processed by ASOs, TPAs, and HMOs.

Within the category of self-insurance, it should be noted that the market share of self-administered plans has changed little over time. One explanation for this is that these plans are primarily made up of larger employers and unions which were firmly established in the self-insurance market before the introduction of other third-party arrangements. This finding suggests that the real growth in self-insurance has occurred in the more moderate-sized businesses which do not have the resources to administer self-insurance internally. Thus, ASOs, TPAs, and MPPs have been instrumental in broadening the feasibility of self-insurance programs.

It is also no coincidence that the growth of self-insurance has paralleled increased awareness on the part of employers about the importance and costs of modern employee benefit plans. In this regard, self-insurance has several implications. Through self-insurance, companies can gain greater control over insurance costs and obtain access to claim reserves for business use. Furthermore, because self-insurance programs are exempted from State regulation by the Federal Employee Retirement Income Security Act of 1974, the multitude of state laws mandating specified benefit levels are not applicable. These aspects raise obvious regulatory concerns. More importantly for this analysis, the tenet that self-insurance is tantamount to no insurance has significant impacts for tax policy.

Taxation of Self-Insurance

In order to address the tax issues surrounding self-insurance, it is necessary to understand how the current tax treatment of self-insurance programs differs from that applicable to traditional forms of insurance. These differences are discussed below for income taxes and premium taxes.

Income Taxes: The Internal Revenue Code and Virginia law allow taxpayers to deduct all ordinary and necessary trade or business expenses. Expenses for group health plans are specifically included in the definition of trade or business expenses. As a result, an employer can deduct all of its costs for a group health plan, whether it pays a premium to an insurance company, pays its employees' health claims directly, or reimburses an administrator for claims and processing costs.

The only restriction on the deduction of premiums for health plan insurance is one which applies to all types of insurance. When the employer is an affiliate of the insurance company and the insurance company only insures property or employees of its affiliates, it is a "captive insurance company". The Internal Revenue Service does not allow a deduction for premiums paid to a captive insurer because there has been no effective shift of the risk of loss from the economic entity. However, when the captive insurance company insures unrelated entities as well as affiliates, the risk of loss has been shifted and premiums will be deductible provided they are reasonable in amount for the coverage obtained and are based on sound actuarial principles.

Some self-insured employers set up a trust to handle health plan claims or establish a reserve for anticipated claims. Contributions to a trust or reserve for claims are deductible only if the "all events" test is satisfied. The "all events" test requires that the employer's liability for the claim be certain and that the amount of the claim can be estimated with reasonable accuracy. The Federal Tax Reform Act of 1984 added a requirement that the deduction may only be claimed in the taxable year when the claim is paid. An exception is provided for claims paid within a reasonable time after the end of the taxable year in which the "all events" test is otherwise met.

A self-insured employer may not deduct payments to a trust or reserve which are the equivalent of the premium charged by an insurance company, or are based on actuarial assumptions about future claims, no matter how reasonable the estimates may be. Deductions must be based on medical expenses incurred by plan participants and actually paid during the taxable year or shortly after the end of the taxable year. The amount will fluctuate depending on the claims filed each year and could be more or less than the premium an insurance company would charge.

Some unions establish a multi-employer health plan under a collective bargaining agreement. Employer contributions to the plan are governed by the same rules as for trusts set forth above. However, if the collective bargaining agreement fixes the amount and time of payments into the plan and no refunds to the employer are possible under the agreement, then the payments to the plan will be deductible when paid by the employer regardless of the actual claims paid by the plan to the participants.

Insurance company premiums are based on actuarial assumptions about future claims and are collected in advance of the covered period. If an accident or illness occurs during the covered period, the insurance company might not actually pay any benefits for some time after the covered period. An employer would deduct a premium when paid (in advance) but a self-insured employer would deduct actual claims and administrative costs as they are paid.

Thus, for income tax purposes, the decision to self-insure may result in a smaller deduction for health plan costs because of cost savings. It may also result in a timing difference because some of the health plan costs will be deducted in a later taxable year.

Premium Taxes: Virginia imposes an annual license tax on the direct gross premium income of every insurance company which issues policies or contracts of insurance. An insurance company is defined in Title 38.2 of the Code as a company which is engaged in the business of making contracts of insurance.

An employer which contracts with a third party to administer a health plan has not entered into an insurance contract if the risk of loss is not shifted from the employer. Therefore, the payments to the plan administrator are not considered to be premiums for an insurance contract and are not subject to the premium tax.

Similarly, an employer which administers its own health plan has not entered into a contract with anybody except, of course, its own employees. The definition of an insurance contract cannot be stretched to include an employment contract merely because the compensation package includes a health plan.

Under Virginia law, a captive insurer is regulated as an insurance company. The premiums paid to a captive insurer would appear to be subject to the premium tax even though it is possible that the insured would not be allowed to deduct the premium for income tax purposes.

In summary, both federal and Virginia income tax law allow an employer to deduct almost all health plan costs in the taxable year that the cost is incurred and paid. However, the deduction for self-insured health plan costs is not an amount representing a premium or actuarial assumption about future claims, but is limited to actual claims received and paid during the taxable year.

On the other hand, insurance companies providing health insurance in Virginia are subject to a license tax on their direct gross premium income. An employer with a large number of employees may find that it is economically and actuarially feasible to self-insure the health plan it offers to its employees. The costs incurred by such a self-insured health plan are not subject to the premium tax whether the plan is administered by the employer or by a third party under contract.

Attorney General's Advice

Because of the disparity in premium tax treatment between insurers and self-insurers, the continued growth of self-insurance plans could cause Virginia to lose significant amounts of revenue from what would otherwise be collected in premium taxes. For this reason, the study team sought advice from the Attorney General's Office as to whether Virginia had the authority to impose a similar license tax on self-insured groups.

In an informal reply to the study team, staff from the Attorney General's Office pointed out that the states' power to tax any employee benefit plan had been pre-empted by federal law. The Employee Retirement Income Security Act of 1974 (ERISA) basically applies to any program established by an employer or by an employee organization for the purpose of providing its participants health care, disability, death, unemployment or vacation benefits, or other benefits including training programs, day care, scholarship funds, or prepaid legal services. This Act specifically provides that its provisions "shall supersede any and all state laws insofar as they...relate to any employee benefit plan" and that an employee benefit plan and any trust established under such plan shall not be "deemed to be an insurance company...or engaged in the business of insurance...for the purposes of any law of any State purporting to regulate insurance companies..."

The Attorney General's Office also reported that courts have repeatedly given a broad interpretation to ERISA's pre-emption provisions and have struck down state taxation statutes which directly or indirectly tax the funds of an employee benefit plan. In National Carriers' Conference Committee v. Heffernan, a state tax on a dental insurance plan in the amount of 2.75% of the benefits paid to state residents was held void and unenforceable insofar as it applied to an employee benefit plan covered by ERISA.

Similar reasoning was applied in General Motors Corp. v. California State Board of Equalization. In this case, two private employers maintained self-insured employees' disability and health care plans with excess risk coverage provided by a private insurance company for liability beyond a certain "trigger point." The excess insurer also processed many pre-trigger claims, drawing funds from the plans' account. California imposed a franchise tax on gross premiums received by the excess insurer which included the benefit payments made from plan funds. Despite the state's argument that the gross premium tax was an assessment against the insurer for doing business, the court held that the tax on the excess risk insurer in connection with the payment of benefits below the trigger point indirectly taxed benefit payments in violation of ERISA's preemption.

As for other types of self-insurance (liability, casualty, property, etc.), the Attorney General's Office indicated that some insurance programs which receive federal subsidy or assistance might be subject to specific provisions that pre-empt state taxation. As a general rule, however, the regulation and taxation of the business of insurance is delegated to the states. Therefore, these types of self-insurance plans could be subject to taxation based on benefit payments.

Reassessing the Tax Status of Self-Insurance Plans

The advice of the Attorney General's Office indicates that Virginia's options for changing the present tax treatment of self-insurance are limited. This is because self-insured employee benefit plans, perhaps the most prevalent form of self-insurance, are exempt from state taxation under the provisions of ERISA. It does appear, however, that the state could tax certain types of property and casualty self-insurance. The merits of this action are difficult to assess because of the current lack of data on the size and scope of these plans.

The above suggests that it would be inappropriate to change the current tax treatment of property and casualty self-insurers without further research. Should subsequent efforts indicate a need for change, two options should be considered. The first would place a license tax on property and casualty self-insurance based on the volume of claims. The second would restrict the amount of self-insured property and casualty losses which could be deducted from income taxes. Of these two approaches, the second may be easier to administer since it would follow present tax reporting procedures (e.g., income tax returns).

Conclusions

During the past decade, the insurance industry has undergone major changes. The establishment and rapid growth of health maintenance organizations and preferred provider organizations are quickly reshaping the health care insurance and delivery systems. In addition, there has been substantial growth in the numbers of corporations and other groups that are turning to self-insurance. There is little doubt that as these entities continue to grow, Virginia will experience a reduction in revenue from what would otherwise be collected through premium taxes.

HMOs operating in Virginia are taxed according to their profit or non-profit status. All for-profit HMOs are subject to corporate income taxation. This approach is used rather than premium taxes for two reasons: 1) the desire of the General Assembly to encourage the growth of a young, cost-efficient segment of the health care/insurance industry; and 2) the unique characteristics of HMOs, specifically that HMOs provide health care services rather than insure health care costs.

The study team's reassessment of the tax status of HMOs indicates that the distinction between health care provider and insurer still exists with respect to Staff and Group model HMOs. These types of organizations employ or contract directly with a group of physicians to provide health care for their membership. Moreover, physicians who contract with these HMOs typically deliver most covered services at facilities owned by the HMO. As such, the corporate income tax appears to be the appropriate form of taxation.

IPA model HMOs, on the other hand, function similar to BC/BS plans in that they contract with a large number of physicians who practice in their own offices and generally treat a greater percentage of patients who are not affiliated with the HMO. However, as with Group and Staff model HMOs, IPA physicians assume risk through the prospective method of payment. Because IPA model HMOs are new and have a small market share of the Virginia health care market, the imposition of a premium tax is not warranted at this time.

As for self-insurance, current tax provisions seem to be based on the assumption that self-insurance is equivalent to no insurance. This is grounded in the fact that self-insurance does not involve an insurance contract. The arguments for placing a premium tax on these plans, however, are strong since these plans funnel income away from insurance companies which would otherwise be included in the premium tax base.

Because of the disparity in tax treatment between insurers and self-insurers, the study team requested the Attorney General's Office to review whether or not Virginia had the authority to impose a premium tax on self-insurance plans. This review indicated that self-insurance associated with employee benefit plans was exempt from state taxation under the provisions of the Employee Retirement Income Security Act of 1974. The Attorney General's Office did indicate, however, that other forms of self-insurance could be taxed. The merits of taking this action are difficult to assess because of the present lack of data on the size and scope of these plans. Clearly, more research is needed in the area of property and casualty self-insurance before current tax policy is changed.

Due to the continued growth of both HMOs and self-insurance, the Commonwealth will likely have to reevaluate its current tax policy regarding HMOs and self-insurance within the next few years. Furthermore, the ability of BC/BS plans and other insurance companies to change their operation and products in such a way that premium taxes can be substantially reduced, or avoided altogether, will also be a critical issue that the General Assembly will likely have to address in the near future.

V. RECOMMENDATIONS AND ALTERNATIVE REVENUE ADJUSTMENTS

Overview

This study and the one conducted pursuant to HJR 311 of 1985 have identified a number of inequities in the manner by which insurance companies are taxed in Virginia. This chapter provides recommendations and alternatives for addressing these inequities. Three types of recommendations are presented. They include actions to redesign the tax structure, the tax base, and the administration of premium taxes and regulatory assessments.

Recommendations For Tax Structure Changes

Recommendation 1: The current premium tax rate imposed on property and casualty and accident and sickness insurance should be reduced to be more in line with the tax rate applied to life insurance.

Virginia's multi-tiered premium tax structure is complex, and nominal tax rates are high by national standards. The 2.75 percentage rate applied to property and casualty and accident and sickness insurance is especially high and the addition of other levies such as the fire tax results in property and casualty companies having the greatest tax burden.

This situation may have hindered the economic development of these types of insurers in Virginia because domestic companies must pay retaliatory taxes to other states where they do business. Retaliatory taxes equalize different tax treatments among the states. For example, if New York-based companies pay a higher rate in Virginia than in New York, then New York state imposes an additional tax (equal to the difference in the rates) on Virginia-domiciled companies doing business there. (For a more detailed discussion of retaliatory taxes, see House Document 22, Chapter III.)

The Virginia tax structure could be simplified by removing the 2.75% tier and taxing property and casualty and accident and sickness insurance such that the relative tax-burden on property and casualty insurers is more in line with that of life insurance. This action would also improve Virginia's competitive position with respect to retaliatory taxes.

Recommendation 2: The current tax-exemption provided prepaid health and Blue Cross/Blue Shield plans should be repealed. Instead, BC/BS plans should be taxed at a level which is more commensurate with their open enrollment and community service benefits. Other prepaid health plans should be taxed in a manner similar to commercial accident and sickness insurance.

The findings of this study indicate the open enrollment and related social benefits offered by BC/BS plans are not adequate to justify a total tax-exemption. At the same time, it is important to note that each of the three special methods used to analyze the number and medical characteristics of BC/BS subscribers indicates that open enrollment does offer comprehensive health insurance to some persons who, in all likelihood, would not be able to obtain similar coverage from commercial insurers. For this reason,

preferential tax treatment would appear to be warranted as an incentive to BC/BS plans for enrolling individuals and certain groups who could not get affordable coverage from commercial insurers and for the underwriting losses which often result from insuring these subscribers.

Preferential tax treatment could be implemented in any number of ways, including the following:

- As long as an open enrollment program with the current features is maintained by the Blues, tax their entire premium income at a rate which is lower than that applied to commercial accident and sickness insurance. This approach would recognize the unique nature of the Blues' business and would provide sufficient tax breaks to cover losses due to open enrollment. At the same time, the imposition of a premium tax would acknowledge that in many ways, the Blues' lines of business are similar to that offered by commercial insurers;

- Tax BC/BS plans at the same rate as commercial accident and sickness insurance, but exempt a certain percentage or certain types of subscriber income from taxation. This approach would preclude the taxation of that portion of the Blues' business that is considered to be open enrollment, and unique in the industry; or

- Tax the premium income of all insurers (commercial and BC/BS plans) the same, but provide tax credits or reduced rates for that portion of any company's business that is derived from an open enrollment program meeting established criteria, such as year-round open enrollment, major medical coverage, and aggressive advertising of open enrollment. This option would encourage all health insurers to share the bad risks with BC/BS plans and receive the same preferential tax treatment for doing so.

The options for providing preferential tax treatment to BC/BS are not mutually exclusive and are open to combination and refinement.

Other prepaid health plans (e.g., vision, dental plans) do not have open enrollment provisions to justify a tax-exemption. However, if these plans are taxed similar to commercial accident and sickness insurance, they should be given the option of organizing on a for-profit basis.

The imposition of a premium tax on the Blues should be phased in order to lessen the impact on existing BC/BS plans and other prepaid health plans and minimize any potential effect on subscriber rates.

Recommendation 3: The General Assembly should direct the Bureau of Insurance to prepare contingency plans for implementing a health insurance risk pool in Virginia.

Under current provisions of the Code, BC/BS plans could discontinue the open enrollment program if prior notice of 12 months is given to the SCC. For this reason, a health insurance risk pool may be needed to provide health insurance to uninsurable persons. Because the establishment of a risk pool will require adequate planning, the General Assembly should request the Bureau of Insurance to prepare contingency plans for implementing a risk pool in Virginia.

Recommendation 4: The General Assembly should recommend an appropriate change to the federal charter of Blue Cross/Blue Shield of the National Capital Area to allow that corporation to be subject to Virginia premium taxation.

Blue Cross/Blue Shield of the National Capital Area (BCBSNCA), the Northern Virginia BC/BS plan, is a federally chartered corporation. The present provisions of its charter exempt BCBSNCA from all state and local taxes other than taxes on real estate and unemployment compensation.

The General Assembly should pursue through formal resolution and contact with the Virginia congressional delegation the matter of having the federal government eliminate this pre-emption. Such action would be justified to promote tax equity among competing BC/BS plans. It would also be consistent with recent federal tax reform decisions to eliminate the tax-exempt status of BC/BS plans nationally.

Recommendation 5: If Recommendation 2 is adopted, the annual license fee which is imposed on prepaid health plans should be repealed.

Prepaid health plans are currently subject to an annual license fee. The fee is relatively inconsequential (ranging from $50 to $200) and should be repealed if Recommendation 2 is adopted. This action would be consistent with the provisions of Section 58.1-2508 of the Code, which states that the premium license tax shall be in lieu of all other state taxes, fees, licenses and levies.

The estimated revenue loss associated with this recommendation is -$1,000 per year.

Recommendation 6: The tax status of HMOs should not be altered at this time. However, the General Assembly should closely monitor the growth and internal operations of HMOs to determine if changes in taxation are warranted in the future.

The study team's reassessment of the tax status of HMOs indicates that a corporate income tax is an appropriate method of taxation for HMOs at this time. However, as HMOs continue to secure a greater share of the health care/insurance market by attracting more consumers and/or by traditional insurers funnelling more of their business into HMOs to avoid premium taxation, the Commonwealth will realize significant losses in revenue that otherwise would have been generated through premium taxes.

In addition, HMOs currently contract with a closed panel of physicians to provide medical services to subscribers on a prospective method of payment. If future changes alter this basic feature of HMOs, the current tax treatment may no longer be appropriate. As a result, the General Assembly will need to closely monitor the growth and operations of HMOs to determine if future changes in taxation are warranted.

Recommendations For Tax Base Adjustments

Recommendation 7: The members of both the Virginia Property and Casualty Insurance Guaranty Association and the Virginia Life, Accident and Sickness Insurance Guaranty Association should be allowed to deduct guaranty association assessments from premium taxes, but the amount of this deduction during any one year should be limited to a specified amount of premium income.

There are two guaranty associations in Virginia: one for life and accident and sickness insurance, and the other for all remaining kinds of insurance except title, fidelity and surety, and ocean marine insurance. If an insurance company operating in Virginia becomes insolvent, these two associations are obligated to cover claims of that company within certain limits. For this purpose, assessments are levied against other insurance companies as prescribed by law. The amount of any assessment on a life insurance company may be written off against premium taxes over a five year period. However, there is no provision for property and casualty companies to deduct any of these assessments.

The arguments against allowing property and casualty companies the privilege of this deduction rest on the logic that property and casualty companies are more volatile than life companies. As a result, there is a greater potential for a large bankruptcy to depress state revenues over an extended period if property and casualty companies are permitted this deduction.

On the other hand, it may be argued that the state should ultimately be responsible for claims against an insolvent insurance company because it is charged with licensing and regulating all insurance companies operating within its borders. Accordingly, the nature of these assessments render them a legitimate tax deduction which should be available to all insurance companies.

The recommendation proposed here represents a compromise between these two extremes. It allows all insurance companies a deduction for guaranty association assessments but limits the amount of the deduction that can be claimed in any one year to a fixed percent of premium income. Under this arrangement, the initial impact of a large assessment would fall on insurance companies until the assessment could be totally written off over a period of years. The state, in turn, would be protected from sudden losses in revenue but would gradually assume the full cost of these assessments over time.

Based on the historical size of these assessments, this recommendation would have no real impact because Virginia has had very few insurance company failures. The guaranty association assessments which have been levied to date are well below the proposed cap. (For a more detailed discussion of guaranty assessments, see House Document 22, Chapter III.)

Recommendation 8: The premium income received by cooperative non-profit life benefit companies from policies not requiring legal reserves should be taxed at the rate presently imposed on these companies.

When the Insurance Code was enacted in 1952, cooperative non-profit life benefit companies were allowed to retain certain types of insurance which did not have to comply with standard reserve requirements. The premiums associated with these policies were also exempted from taxation. The reason for this appears to be related to the historical nature of these companies. Originally, cooperative non-profit life benefit companies were similar to fraternal benefit societies in that they were non-profit entities without capital stock, which conducted business for the sole benefit of their members.

Regardless of the purpose, there appears to be little justification for exempting this income from premium taxes. This is especially true since cooperative non-profit life benefit companies are already afforded preferential tax treatment by being subject to a tax rate of only 1 percent.

The revenue gain associated with this recommendation is +$41,000, based on the income attributable to non-legal reserve policies during 1985.

Recommendations For Administrative Reform

Recommendation 9: The General Assembly should direct the Bureau of Insurance to analyze and document those occupational classes or industries that are generally "red-lined" or deemed ineligible from obtaining health insurance from commercial insurers.

BC/BS plans state that certain groups are "red-lined" or deemed ineligible for coverage by commercial carriers due to the occupational or industrial classification of the group. The study team concluded there are some groups that would likely have difficulty obtaining commercial insurance because of the high risk nature of the group. However, the team was not able to determine each group that is typically "red-lined" by commercial carriers.

The General Assembly should direct the Bureau of Insurance to determine which types of groups are deemed ineligible by commercial insurers. If the General Assembly decides to tax BC/BS and exempt that portion of the Blues' (and possibly other insurers') business that is derived from open enrollment practices, these groups will have to be identified in order to provide proper tax credits or deductions for insuring these "red-lined" groups.

Recommendation 10: The premium tax return presently submitted by insurance companies should be modified to accurately account for amounts claimed for allowable deductions.

Insurance companies are currently not required to itemize deductions on the premium tax return which they submit to the SCC. The inclusion of this data would make it easier for the state to monitor the total costs of allowable deductions.

Recommendation 11: Fraternal benefit societies should be assessed for the cost of regulation.

All states exempt fraternal benefit societies from premium taxation. Virginia, however, is one of the few states that does not levy a regulatory assessment. This situation should be changed so that fraternal benefit societies equitably share in the cost of regulation. The revenue gain associated with this recommendation is +$14,000.

Recommendation 12: The General Assembly should monitor the evolving changes within the insurance industry at frequent intervals to ensure tax equity among competing forms of insurance and to assess the revenue impact associated with these changes.

There has been no fundamental change in the Virginia premium tax structure since 1915. However, the insurance industry has changed dramatically over the years and industry experts predict even greater and more rapid change in the future.

The development and growth of alternative forms of insurance such as HMOs and self-insurance will cause traditional insurance and the revenues generated from taxing premium income to diminish accordingly. This reshaping of the insurance industry may also result in tax equity problems among competing forms of insurance. As these changes materialize, the General Assembly will have to re-examine Virginia's insurance tax policy.

APPENDICES

APPENDIX A

ANALYSIS OF SMALL GROUP
PAID BENEFITS

SMALL GROUP CONTRACTS: BENEFITS PAID
FOR HIGH RISK CONDITIONS

	Total Benefits Paid	Percent Paid For High Risk Conditions
Blues: Small Groups, Open Enrollment	$ 6,810,158	39%
Blues: Small Groups, Underwritten	$19,784,918	33%
Commercial Companies	$ 3,189,723	38

SOURCE: Department of Planning and Budget, Analysis of Health Insurance Claims.

APPENDIX B
Community Services of BC/BS of Virginia

The following text is a series of excerpts from BC/BS of Virginia correspondence regarding community services:

Unlike commercial insurers, Blue Cross has earned its exemption from the premium tax through a unique and extensive program of public and community services designed to improve the health care system in the Commonwealth. These community service programs are organized to fulfill two complimentary objectives, (1) to improve the health of residents of the Commonwealth; and (2) to promote efforts to contain health care costs. Loss of Blue Cross' exemption from the premium tax and the corresponding burden of regulatory and statutory restrictions may render Blue Cross unable to continue with such community service functions.

1. Community activities

Blue Cross and Blue Shield of Virginia has established a corporate objective of reaching 67% of the population of Virginia -- approximately 3,685,000 people -- with its community service programs during 1986. Management fully expects to meet this goal through statewide radio and TV broadcasts; programs made available to every junior and senior high school student in Virginia; health messages for 1.8 million Blue Cross customers; fitness events sponsorships; and work with health care organizations throughout the state.

Particular emphasis is focused on the needs of young people and the elderly. Youth programs include fitness and exercise instructional materials; anti-drunk driving efforts including the distribution of copies of the official Students Against Driving Drunk (SADD) film to every school division in Virginia; and drug abuse prevention campaigns. With particular emphasis on the substance abuse prevention programs, Blue Cross has developed a comprehensive two-year campaign against substance abuse. Objectives of this program are to prevent misuse of alcohol and drugs, and to make the public aware of the high costs of abuse in both economic and human terms. Programs for the elderly include the Golden Olympics, year-round open enrollment for Medicare supplemental benefits; claims filing help for nursing home residents; and staff and financial assistance for studies and long-term care needs.

The Plan's financial commitment to community service for 1986 will approach $800,000. Approximately $590,000 will be devoted to the following program:

(1) Advertising to increase public awareness of non-group and Medicare supplemental open enrollment policies, directed particularly to those in need of health care services who may not be able to find coverage elsewhere;

(2) Anti-drunk driving and other substance abuse radio, TV, and print messages;

(3) Fitness events; and

(4) Corporate contributions.

The remainder will be funded in-kind services; employee bonus time incentives for United Way giving; art and printing services for non-profit health organizations; and employee time specifically devoted to health promotion.

Blue Cross attempts to demonstrate in every facet of its corporate activities its dedication and commitment to community service. These efforts complement Blue Cross' traditional and historic mission in the Commonwealth. During the 1970's, Blue Cross took an early lead in the fitness movement. Today, the Company is launching an important offensive against alcohol and drug abuse as the major health problems in the 1980's. Continuously, Blue Cross is in the forefront of efforts to improve the health and well-being of residents of the Commonwealth.

2. Health care costs containment efforts.

Blue Cross and Blue Shield of Virginia is committed to controlling the rising cost of health care. The Plan has initiated many programs over the years including home health care and hospice care which are designed to ensure medically appropriate and cost effective use of the health care dollar. Most of these programs benefit not only each Blue Cross subscriber but also benefit all patients because providers typically adapt for convenience their practices and procedures in order to conform with those of Blue Cross. Blue Cross reserves and resources are committed to managing the benefit dollar for all of its Virginia subscribers.

Private commercial carriers do not sustain the same level of cost containment effort as does Blue Cross due to their unwillingness and inability to dedicate necessary resources in a local market. No other health insurer can claim the level of leadership that the Plan has had in leading the fight against health care inflation. While it is true that many of our activities are geared toward controlling our own costs, it is also true that we have helped to shape public policy and to develop innovative programs for use throughout the Virginia health care market and have thereby contributed significantly to the public interest. The health care cost containment programs developed under our leadership include Ambulatory Surgery, Outpatient I.V. Therapy, and Home Health and Individual Care Management programs.

The Medical Affairs Department of Blue Cross and Blue Shield of Virginia has primary responsibility for developing and administering the Plan's cost containment efforts. The department currently employs over seventy people,

including nearly forty trained medical professionals (doctors and nurses). The Medical Affairs annual budget is approximately $2.5 million dollars, and has realized consistent growth in recent years.

The following is a brief overview of some of the programs initiated by Blue Cross and Blue Shield of Virginia to help contain health care costs in the Virginia market. Some of those programs are superficially similar to programs conducted by some commercial insurers; however, their programs are normally conducted through vendors which deal with subscribers, not the provider community. Blue Cross is much more provider oriented and devotes its energy to direct interaction with providers in order to influence their patient care practices and utilization trends. This is done because our less restrictive approach to availability of coverage warrants a much more intensive effort to control costs, thereby benefiting the public interest, not just Blue Cross' direct interest in cost control. Blue Cross' cost control programs include:

(a) Medical Review and Individual Consideration.

Twenty nurses are dedicated to reviewing claims for medical necessity or contractual issues. The staff reviews medical records associated with a claim to help determine the appropriate level of payment. Each Plan subscriber benefits from individual case review.

(b) Provider Audits.

Twelve Plan nurses travel across the state and audit health care facilities in an attempt to uncover poor utilization practices and inaccurate or inappropriate billing procedures. These audits have an educational focus, and hospitals are monitored to ensure continued cooperation in reducing lengths of stay and accurate billing.

(c) UCR Administration.

Blue Cross and Blue Shield of Virginia consistently reviews physician reimbursement rates through the maintenance of its Usual, Customary, and Reasonable fee schedule. Constant editing of the schedule guarantees physicians a fair level of reimbursement by procedure and geographic location of the provider. Establishing and maintaining the physician provider network creates a level of control over reimbursement rates.

(d) Financial Investigation.

The Plan has committed five individuals to the investigation and recovery of funds appropriated to providers through fraudulent or abusive practices. Over one million dollars is recovered annually by the group. The existence of the Financial Investigations Unit helps to deter physicians from abusing the reimbursement system.

(e) Pre-Admission Review Program.

The program verifies up-front the medical necessity of a hospital admission and length of stay, thus, minimizing unnecessary but expensive days in a hospital. Participation in this program has a positive impact on utilization for a group and, therefore, results in a lower level of premium.

APPENDIX B
Community Services of BCBSNCA

The following text is a series of excerpts from BCBSNCA correspondence regarding community services:

- Public Education Programs -- Our public health education programs have been under way for nearly 20 years, and they have annually featured public media advertising messages in prime air time and space on such topics as coronary and respiratory disease; rectal, breast and cervical cancer; venereal disease; glaucoma; alcoholism and drug abuse; immunization and physical checkups for children; deafness; food and fitness; exercise; hypertension; stress; obesity; and drunk driving and use of automobile seatbelts. Television production and airing of these kinds of messages cost the Plan $217,000 in 1986 and $329,000 in 1985.

  In the area of the infant morbidity and mortality, the Plan has committed $271,500 to underwrite the largest, community-wide public education program to foster the use of early and continuing prenatal care by mothers-to-be that has ever been undertaken in a metropolitan region in the United States. This project is being carried out in partnership with the March of Dimes and WRC-TV.

  In health education films, BCBSNCA does not simply "distribute" such films. For example, we helped produce with Disney Productions films on fitness for all grade levels, placed the films in the film libraries of all local school systems in our region, including all those in Northern Virginia, and provided teacher guides and student materials to support the use of the films.

  We should note that these projects are just examples of activities we have carried out to address a public health education need -- a need determined to exist in the area we serve, including Northern Virginia. We do not simply pass out leaflets produced by some national office located elsewhere in the United States. Our messages are tailored to community needs the developed and distributed at our expense.

  No commercial insurer operating in Virginia can match the record of BCBSNCA for long-term and current activity in public health education.

- Health Facilities Planning -- While BCBSNCA financial support of health planning in the Washington region dates back to 1962, we began in 1972 to conduct independent studies and surveys of area health services needs and to participate directly in the certificate of need and plan development processes of Virginia, Maryland and the District of Columbia as soon as these processes got under way. In the hundreds of meetings and hearings in which we have offered our views on health planning issues since 1972, we have heard testimony from a representative of the commercial insurance industry on only one issue, and that was in 1986, on heart transplantation.

BCBSNCA financial support of a Northern Virginia health planning agency dates back to 1973, the year the Comprehensive Health Planning Council of Northern Virginia was activated. In 1973-74, our contributions to the Council totaled $35,000. Federal rules prohibited us from funding health planning activities between 1975 and 1982, but since this restriction was lifted, we have committed a total of $208,250 to the Health Systems Agency of Northern Virginia in the form of annual grants. Historically, these contributions have been important to the Agency in obtaining both federal and state matching funds to support its work programs.

During the period 1973-86, we believe you will find that commercial insurers' financial contributions to health planning in Northern Virginia have been nominal or nil.

BCBSNCA conceived, designed and provided initial funding of $490,000 for a computerized metropolitan health care data system, beginning in 1973. The Health Information System (HIS), formerly operated by the Metropolitan Washington Council of Governments (COG) and now administered by the Metropolitan Washington Area Council of Health Planning Agencies (MWACHPA), provides data which are essential for both community and institutional planning in our region. All Northern Virginia hospitals participate in HIS, and without the system both community and institutional planners would incur major expenses in data acquisition and evaluation efforts.

BCBSNCA financial support of HIS since 1973 has totaled more than $1,300,000. Commercial insurers' contributions to HIS have again been nominal or nil.

As for the health planning process itself, we believe that BCBSNCA support of the participation in health planning in Northern Virginia has been influential in a process which has avoided the unnecessary expenditure of nearly $80,000,000 for unneeded hospital beds in the region. Were those beds now in place, they would be producing annual operating costs of $32,000,000.

Yet commercial insurers have been virtually absent from any involvement in or support of this critical process.

- Hospital Cost Containment Programs -- BCBSNCA's community services include: development of a uniform hospital cost reporting system; financial support amounting to about $100,000 of a regional hospital group purchasing program; development and operation of a regional medical abstracting system for use in patient care evaluation and utilization review; financial support of a variety of hospital professional educational activities; support of a hospital-based metropolitan poison control center; and other activities.

  To our knowledge, commercial insurers in this region have offered no assistance of this nature to area hospitals.

- Health Care Cost Containment Programs -- Like Blue Cross and Blue Shield of Virginia, BCBSNCA routinely carries out review of claims for medical necessity and contractual issues; auditing of facilities to reveal poor utilization practices; review of physician reimbursement rates; investigation of fraudulent or abusive practices by both providers and subscribers; and pre-admission authorization of elective hospital admissions.

  However, we also conduct educational programs for subscribers and providers to limit unnecessary payments for outmoded medical procedures, routine hospital tests not ordered by a physician, inpatient care for surgical procedures safety done on an outpatient basis; respiratory therapy services; diagnostic imaging services; and others. Nearly all regional hospitals, including those in Northern Virginia, participate in a unique BCBSNCA program for concurrent review of the medical necessity of patient admissions and lengths of stay.

  We believe that no commercial insurer or the commercial insurance industry in general can match the record of the Blue Cross and Blue Shield organization in effective health care cost containment activity.

- Research and Pilot Projects -- Beginning in the 1960's BCBSNCA began the systematic evaluation and field-testing of benefits for new and/or underused health services -- especially services with the potential to become alternatives to the increasingly costly hospital inpatient setting. As the direct result of our research and field-testing activities, benefits for hospital-based outpatient surgery programs became available to all BCBSNCA subscribers in the late 1960's; for out-of-hospital prescription drugs in 1970; for dental health care in 1971; for home health care in 1977; for outpatient cardiac rehabilitation in 1980; and for hospice home and inpatient care for care in approved, free-standing ambulatory surgical facilities in 1984.

  BCBSNCA health services research activities are far more extensive than those of commercial insurers operating in our region. And significantly, our research and benefits implementation pursuits are addressed to the configuration of health services -- and the identified health care needs of the population -- in the region we serve, including Northern Virginia. The same cannot be said of the benefits design of commercial insurers.

- Other Contributions -- BCBSNCA makes many other contributions to health-related community activities and groups and some to community educational activities. We have committed $10,000 annually to the National Capital Area Health Care Coalition, an organization of more than 150 business, labor, and provider organizations committed to the control of health care costs in our region. We have supported local conferences on AIDS and many other public health issues, and regularly contribute to area drunk driver programs and educational efforts to control regional alcohol and drug abuse.

Including our grants to health planning bodies and the infant morbidity/mortality public education project described above, BCBSNCA community service financial contributions in 1986 have exceeded $500,000. We believe that no other underwriter of health care coverage operating in our region has even approached this level of community service.

CHARACTERISTICS OF STATE HEALTH RISK POOL PLANS

STATE/ MODEL	POOL COMPOSITION	ELIGIBILITY	MAXIMUM BENEFITS	DEDUCTIBLES	STOP LOSS (INDIVIDUAL/ FAMILY)	PREMIUM CAP	WAITING PERIOD/ PRE-EXISTING CONDITION	BOARD	ADMINISTRATOR	ASSESSMENTS	PREMIUM TAX CREDIT	FEES ALLOWED
MAIC	All insurers (including HMOs), and self-insurance. Recommend federal legislation to include self-insurance.	-resident -rejected by 2 carriers -non Medicaid eligible	$1,000,000	$500 $1,000 $1,500 $2,000	Maximum $1,500/$3,000 $3,500/$5,000	150% maximum	12 mos./ past 6 mos.	selected by members - at least 1 domestic insurance company and one domestic nonprofit health care service plan	Bid process	Based on company's proportion of total state health premiums. Self-insured or separate basis.	Optional	-
HIAA	All insurers (including HMOs, IPAs). Not fixed indemnity, credit or workers' comp. Recommend federal legislation to include self-insurance.	-resident -open to anyone willing to pay the higher premiums.	-	$2,500	Maximum $3,500/$5,000	150% initial 200% maximum	12 mos./ past 6 mos.	Selected by members	Selected by Board and Commissioner	Based on company's proportion of total state health premiums. Self-insured at 110% of benefits period.	Yes	-
CONN	All insurance, self-insurance, Not HMOs.	-resident -non Medicare eligible	$1,000,000	$400 $1,000 $1,500	$2,000/$4,000	125% minimum 150% maximum	12 mos./ past 6 mos.	7 members selected by participating members	Selected by Association (Travelers Ins. Co.)	Based on company's proportion of market.	No	Agent Referral Fee - $20
FLA	All health insurers doing business in State (including HMOs, self-insurance).	-resident -rejected by 2 carriers (Medicare supplement plan for Medicare eligibles)	$500,000	$1,000 $1,500 $2,000	Regular I $2,500/$4,000 II $3,000/$4,500 III $3,500/$5,000 Medicare I $1,500/$4,000 II $2,000/$4,500 III $2,500/$5,000	150% initial 200% maximum	12 mos./ past 6 mos.	7 members - 3 appointed by Commissioner (public, medical, health representative) 4 appointed by members (nonprofit, domestic, 2 optional)	Bid process (Mutual of Omaha)	Based on company's proportion of total state premiums. Maximum of 1% per year on premiums or greater than premium tax.	Yes	Agent Referral Fee - $75
IND	All accident and sickness insurers HMOs, and self-insurance not exempted by federal law.	-resident -non Medicare eligible -rejected by 2 carriers or -specific pre-existing conditions	Plan I - no limit Plan II - $50,000	$200 $500 $1,000	$1,000/$2,000	150% maximum	6 mos./ past 6 mos. (premium + 10% - waiting period waived)	5 to 9 members selected by members	Bid process (Mutual of Omaha)	Based on company's proportion of total premiums.	Yes	Agent Referral Fee - $25
IOWA	All carriers who provide health insurance or health coverage services in state.	-resident -rejected by 1 carrier -less expensive coverage not available	$250,000	$500 $1,000 Board rate	$1,500/$3,000 $2,000/$4,000	150% maximum	6 mos./ past 6 mos.	4-8 members selected by members and approved by Commissioner. 1 public member appointed by Commissioner.	Option of Association	Based on company's proportion of total premiums or other method as determined by association.	Yes	Agent Referral Fee - $25
MINN	All insurance (including self-insurance, HMOs and fraternals).	-resident -rejected by 1 carrier	$250,000 Regular $100,000 Medicare Supplement	$500 $1,000	Individual Regular - $3,000 Medicare Supplement - $1,000	125% maximum	6 mos./ past 90 days	9 members - 7 selected by members 2 appointed by Governor	Selected by Association and Commissioner (Blue Cross/ Blue Shield)	Based on company's proportion of premiums in force.	Yes	Maximum 12.5% Administration Agent Referral Fee - $50

STATE/ MODEL	POOL COMPOSITION	ELIGIBILITY	MAXIMUM BENEFITS	DEDUCTIBLES	STOP LOSS (INDIVIDUAL/ FAMILY)	PREMIUM CAP	WAITING PERIOD/ PRE-EXISTING CONDITION	BOARD	ADMINISTRATOR	ASSESSMENTS	PREMIUM TAX CREDIT	FEES ALLOWED
MONT	All insurers licensed to do business in State except those exempt by federal law.	-resident -rejected by 2 carriers in past 6 months or -restrictive rider imposed by 2 carriers	Not less than $100,000	Not to exceed $1,000	Individual $5,000	150% initial 400% maximum	12 mos./ past 5 years	8 members - 7 largest volume insurers 1 public appointee	Bid process	Based on company's proportion of state health insurance market.	Yes	Maximum 12% Administration Agent Referral Fee - $25
NEBR	All insurers authorized to issue health insurance in the state (excludes indemnity, Medicare supplement, and self-insurance).	-resident for 6 months -rejected by 1 carrier -non Medicare or Medicaid eligible	$500,000	$250 $500 $1,000	Individual $5,000	135% initial 160% maximum	6 mos./ past 6 mos.	9 members - 1 health care service plan 1 HMO 1 domestic insurance company 1 public 5 optional	Bid process	Based on company's proportion of state health insurance.	Yes	Agent Referral Fee - $25
N DAK	All accident and health insurers with premiums in excess of $100,000.	-resident for 6 months -rejected by 1 carrier	$250,000	$150 $500 $1,000	Individual $3,000	135% maximum	6 mos./ past 90 days	10 members - 10 largest volume insurers	Bid process (Blue Cross/ Blue Shield)	Based on percentage of market.	Yes	Max. 12.5% Admin. Agent Ref. Fee - $25
TENN	All health insurers in State.	-resident -rejected by 1 carrier (Medicare plan available)	$500,000	$500 $2,000 Board rate	$1,500/$2,500 $2,500/$3,500	150% maximum	6 mos./ past 6 mos.	9 members selected by Commissioner 1 domestic insurance company 1 foreign insurance company 1 non-profit health care service plan 1 HMO 1 health professional 1 public representative 1 risk pool insured	Bid process	Based on company's proportion of state insurance premiums.	Yes	-
WIS	All accident and health insurers conducting business in State (including HMOs and self-insurance.)	-resident -rejected by 2 carriers	$250,000	Plan I - $1,000 Plan II - Medicare Part A Deductible	Plan I - $2,000/$4,000 Plan II - $500	150% maximum	6 mos./ past 6 mos.	9 members - Commissioner 1 representative of Health Policy Council 2 non-profit insurers and 3 public members appointed by Commissioner 2 insurance companies	Selected by Board (Mutual of Omaha)	Based on company's proportion of total state premiums.	No	Agent Referral Fee - $35

APPENDIX D

ISSUE	COMMERCIAL CARRIERS	BLUE CROSS	STAFF & GROUP MODEL HMO's	IPA HMOs
Contractual obligation.	Indemnify policyholders or pay a percentage of claims for services rendered.		Obligation to provide or arrange services.	Obligation to provide or arrange services.
Minimum benefit requirements.	No group requirements except coverage for mental emotional or nervous disorders; alcohol and drug dependence; congenital anomalies of covered dependent children. No other group policy mandates to provide coverage. Reg. 19 establishes minimum requirements for individual policies, and specifies allowable limitations and exclusions.		State: Both individual and group policies must provide basic services with durational limits. Required services include: emergency services; inpatient hospital and physician care; outpatient medical services; lab and radiologic services; preventive health services; mental health; drug and alcohol dependence. Federal Law: Both individual and group policies must provide essentially same required services as State; most without durational limits.	
Rating methods required by law.	No requirement. Most use experience rating.	No requirement. Experience rating used predominantly. Small groups may be community rated.	Community rating required for federally qualified plans. State law allows setting rates based upon sound actuarial principles.	
Operation of health care facilities.	No.	No.	Yes. Staff and Group model HMOs typically deliver most covered services at their own facilities.	Sometimes, but usually do not.
Prepayment to providers.	No. Claims are reimbursed.	No. Claims are reimbursed	Yes.	Various possible payment arrangements including prepayment on a per capita basis or a fee-for-service reimbursement under which a portion of the fee is withheld.
Quality assurance.	No requirement.	No requirement.	Required by federal & state law.	Required by federal & state law
Deductibles and coinsurance.	Statute requires offering of one or more cost-sharing options specified at Sec. 38.2-3417, or "any other option containing a greater deductible, coinsurance or cost-sharing provision." Reg. 19, Sec. 8 contains numerous cost-sharing provisions. With the exception of major medical expense coverage, there are no caps on copayments.		Federal Requirement: No deductibles on basic benefits. Cost sharing on basic benefits capped at 200% of annual premium; 50% of cost of any single service; 20% of total cost of providing all basic services. State: Statute allows "reasonable requirements for copayments" on basic benefits. Proposed Bureau of Insurance regulations would cap copays at 100% of annual premium.	
Underwriting restrictions.	Statute allows insurers to exclude or limit coverage on any person in a group for whom evidence of individual insurability is not satisfactory. Reg. 19 specifies allowable pre-existing conditions, limitations and exclusions for individuals.		Federal law prohibits medical screening and waiting periods on pre-existing conditions for group enrollees. Proposed state regulations allow reasonable exclusions or limitations of services for pre-existing conditions at time of enrollment.	
Enrollment of individuals.	No requirement.	Required continuous open enrollment regardless of individual health history. Provisions for shorter open enrollments. Subscription charges must be reasonable in relation to benefits provided. Statute allows for waiting periods of up to 12 months.	Federally qualified HMOs can medically screen individuals, but accepted individuals must be enrolled in the federally mandated comprehensive benefit package at community rates; waiting periods on receipt of benefits coverage is prohibited. Proposed state regulations allow reasonable exclusions or limitations of services for pre-existing conditions at time of enrollment.	
Conversion coverage.	Required, but may provide at significantly less than group coverage.		Required. Federal law requires conversion at the mandated comprehensive benefit package and community rated group rate plus administrative cost. Proposed state regs would require conversion at the basic benefit package.	
Federal tax status.	Taxed.	Non-profit, but under federal tax reform bill, will be taxed.	For profits would be taxed. Non-profit group and staff are charitable (501)(c)(3).	For-profits are taxed. Non-profits are social welfare 501(c)(4).