REPORT OF THE
STATE CORPORATION COMMISSION'S
BUREAU OF INSURANCE ON

A Contingency Plan for Implementing a Health Insurance Pooling Mechanism In Virginia

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

House Document No. 21

COMMONWEALTH OF VIRGINIA
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COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

December 30, 1987

TO: The Honorable Gerald L. Baliles
Governor of Virginia
and
The General Assembly of Virginia

The report contained herein is pursuant to House Joint Resolution No. 329 of the 1987 Session of the General Assembly of Virginia.

This report represents the response of the State Corporation Commission's Bureau of Insurance to the legislative directive to study a contingency plan for implementing a health insurance pooling mechanism in Virginia.

Respectfully submitted,

Preston C. Shannon
Commissioner

Thomas P. Harwood, Jr.
Commissioner

REPORT OF THE STATE CORPORATION COMMISSION'S BUREAU OF INSURANCE

ON

A CONTINGENCY PLAN FOR IMPLEMENTING A HEALTH INSURANCE POOLING MECHANISM IN VIRGINIA

TO

THE GENERAL ASSEMBLY OF VIRGINIA

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The State Corporation Commission's Bureau of Insurance was requested by House Joint Resolution No. 329 to prepare a contingency plan for the implementation of a health insurance pool in Virginia. This request was made to provide alternative protection for individuals who are considered "uninsurable" for health coverage in the event that the open enrollment periods currently offered in Virginia by the Blue Cross and Blue Shield Plans are discontinued or reduced.

The information that was produced by the 1985 and 1986 studies on the Taxation of Insurance Companies, the 1984 joint subcommittee study of the feasibility of implementing a health pool in Virginia, and the 1986 study of the degree of health insurance coverage of Virginia were used in this study.

This report contains an overview of health insurance pools in other states and describes the rationale for the decisions that were made in the key areas. A draft of the legislation that could be introduced in Virginia in the event open enrollment coverage is no longer available is included as an appendix to this report. Also included is a draft regulation that could be circulated to interested persons prior to implementation of a health insurance pool in the Commonwealth.

The suggested legislation combines elements of the present National Association of Insurance Commissioners (NAIC) Model Act with provisions included in other state pooling laws and some of the provisions in the Virginia Property Insurance Association Chapter of the Insurance Code. The State Corporation Commission's Bureau of Insurance believes that this legislation will best serve the Virginia public should an insurance pool be needed.

The recommended pool would:

- be available to applicants refused coverage by two insurers;
- require members to be residents of Virginia for at least six months;
- have an initial premium of 150% of the average premium of the five largest insurers by market share offering health coverage in the state;
- be funded by assessments of insurers operating in Virginia if a deficit is produced;
- have a six month pre-existing condition exclusion;
- offer a choice of deductibles; and
- offer comprehensive coverage.

The State Corporation Commission's Bureau of Insurance believes that with this contingency plan in existence a health insurance risk pool could be operational within twelve months. This would allow sufficient time to provide a very viable alternative to those individuals in the Commonwealth that are considered uninsurable. The contingency plan should be activated in the event either of the Blue Cross and Blue Shield Plans operating in Virginia provides notice of its intention to discontinue its open enrollment program. The contingency plan adequately addresses the problem of availability of health insurance for the uninsurable. It does not address the affordability of that coverage.

GENERAL ASSEMBLY OF VIRGINIA -- 1987 SESSION

HOUSE JOINT RESOLUTION NO. 329

Requesting the Bureau of Insurance of the State Corporation Commission to study and prepare contingency plans for implementing a health insurance risk pool in Virginia.

Agreed to by the House of Delegates, February 4, 1987
Agreed to by the Senate, February 19, 1987

WHEREAS, as reported in House Document No. 17 of 1985, a health insurance risk pool is not needed in Virginia as long as Blue Cross/Blue Shield or another insurer continues to offer open enrollment; and

WHEREAS, 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; and

WHEREAS, 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; and

WHEREAS, nationwide, risk pools are viewed as a reasonable alternative to open enrollment, causing twenty-four states to have introduced risk pool legislation and, as a result, six risk pools are currently operating in the country; and

WHEREAS, if the open enrollment program in Virginia were terminated, appropriate enabling legislation would have to be adopted by the General Assembly to amend Title 38.2 of the Code of Virginia so that a risk pool plan could be established in Virginia; and

WHEREAS, before amending the Code, proposed regulations need to be drafted as part of the plan, and a number of important issues, including the organization of the pooling mechanism, the process of selecting insurers to participate in the plan, pool funding sources, eligibility requirements for enrollees, premiums, benefit levels, waiting periods, the extent of state regulation or oversight of pool administration and operation, and the type o. state subsidy, if any, for the pool, need to be resolved; and

WHEREAS, the changes to the statutes and the resolution of the issues that would be necessary would require time and planning; and

WHEREAS, it would be in the interest of the Commonwealth to have prepared a contingency plan to address this should the need arise; now, therefore, be it

RESOLVED by the House of Delegates. the Senate concurring, That the Bureau of Insurance of the State Corporation Commission is requested to study and prepare a contingency plan for implementing a health insurance risk pool in Virginia. The plan should include enabling legislation that would allow the General Assembly to establish a pool and suggestions to resolve the important issues that are inherent in establishing such a plan. Draft regulations should be included in the contingency plan so that those interested could determine how the plan would operate.

The Bureau is requested to report its findings and recommendations to the General Assembly by November 15, 1987.

INTRODUCTION

The State Corporation Commission's Bureau of Insurance was requested by the 1987 Session of the General Assembly to prepare a contingency plan for the operation of a health insurance pool in Virginia. This request was made as the result of the 1985 and 1986 studies by the Secretary of Finance that reviewed the taxation of insurance companies. Those studies focused on the differences in taxation of companies providing health coverage to Virginians. One of the areas that the Bureau was directed to investigate was the numbers and characteristics of high risk or uninsurable individuals whose health insurance coverage would be jeopardized if prepaid health care plans or health maintenance organizations were made subject to taxation. For the purposes of this report "uninsurables" refers to those individuals who are unable to obtain health insurance coverage in the voluntary market because of their health condition or health history.

Prior to the studies by the Secretary of Finance, the feasibility of establishing a health insurance pooling mechanism in Virginia was studied by a joint subcommittee of the General Assembly in 1984. As a result of that study, legislation was enacted requiring the Blue Cross and Blue Shield Plans operating in the Commonwealth to continue to maintain their open enrollment programs or lose their preferred tax status. During the open enrollment period the Blue Cross and Blue Shield Plans accept all applicants for coverage regardless of their health history, employment status, occupation, or geographical location. The legislation enacted as a result of the health insurance pool study also required any Blue Cross/Blue Shield Plan to give written notice to the State Corporation Commission (SCC) at least 12 months prior to ending its open enrollment program. The discontinuance of the open enrollment program will result in the taxation of that organization according to § 58.1-2501 which includes provisions for the taxation of accident and sickness insurers.

At the conclusion of the Secretary's study in 1985, the requirements of the open enrollment provisions of the Health Services Plan chapter of the insurance title that applies to the Blue Cross and Blue Shield Plans were modified. Section 38.2-4216.1, Open enrollment, now requires a health services plan to provide 24-months advance notice to the SCC before ending its open enrollment period. The 24-months notice provision allows adequate time for the institution of another means of providing health care coverage to "uninsurables".

SCOPE OF PROBLEM

The groups likely to apply for coverage in a pool are those presently uninsured because of refusal by insurers, present open enrollment subscribers, and those who become uninsurable because of some life threatening illness such as AIDs or a chronic illness.

A study conducted by the State Corporation Commission's Bureau of Insurance in 1986 revealed that 10 percent of Virginia's population is uninsured for health coverage. An additional 8 percent of the population is without comprehensive health coverage and is considered underinsured. Of the individuals surveyed, 7 percent of those underinsured indicated they were without protection because of rejection by insurers. The percentages translate into 1,040,400 underinsured individuals, and it estimated that over 83,000 of those individuals are without adequate coverage because they were rejected by insurers. Nationally, experts in the area have estimated that 1 percent of the general population is uninsurable because of chronic conditions or past illnesses.

The 83,000 Virginians without adequate coverage would be most likely to benefit from the creation of a health insurance pool. These individuals and their families are currently without adequate protection from the often severe economic consequences of chronic or serious illnesses, such as cancer, diabetes, heart disease, etc.

In testimony before the joint subcommittee studying a health pool in 1984, representatives from the American Heart Association, the American Lung Association, the American Cancer Society, the Juvenile Diabetes Foundation, American Diabetes Association, National Foundation for Ileitis and Colitis, Mental Health Association of Virginia, Virginia Alliance for the Mentally Ill, the Association of Retarded Citizens in Virginia, the Richmond Psychiatric Society and the Department for the Visually Handicapped described the situations of their members or constituencies. Representatives of those organizations spoke of members or constituencies who could not obtain health coverage because of their chronic conditions or who were unable to afford the cost of health coverage that is available to them. Representatives spoke of individuals with chronic illnesses who were unable to change employment because of the fear of losing health coverage or having a need for hospitalization that occurs during the period pre-existing conditions are not covered. For some individuals one lengthy period of illness could exhaust the family's savings and other resources. Some individuals receive assistance from state-supported hospitals, but there are financial and legal requirements that must be met before an institution will absorb the cost of an individual's care. Children with chronic illnesses facing adulthood without health care coverage was another of the concerns frequently mentioned.

The majority of the organizations testifying informed the subcommittee that they were unaware of the opportunity to obtain coverage from the Blue Cross/Blue Shield Plans through their open enrollment programs. In response to that problem, the Blue Cross and Blue Shield Plans are now required by law to advertise the availability of open enrollment at least twelve times a year.

According to the 1987 Taxation of Insurance Companies report, in 1985 the average number of Blue Cross and Blue Shield open enrollment individual contracts in force at one time was 31,109. It was estimated that a total of 62,218 individuals were insured under the open enrollment contracts at some time during the year. In addition, an average of 5,139 small group contracts that were not underwritten were issued by Blue Cross and Blue Shield. Although all of those subscribers with open enrollment contracts are not "uninsurable," the numbers covered during that year does provide some idea of the potential number of pool applicants. Approximately 39 percent of the individual open enrollment subscribers reported no high risk conditions when surveyed for the taxation study. Another 10 percent of open enrollment individuals have hypertension (high blood pressure) and could possibly obtain insurance coverage in the voluntary market at a higher than standard premium.

The impact of Acquired Immune Deficiency Syndrome (AIDS) must also be considered in the implementation of a health insurance pool. As of July, 1987, 38,808 Americans had been diagnosed as having the disease, and 22,328 of those diagnosed have died. The Centers for Disease Control in Atlanta estimate that the average cost for treating an AIDS patient from onset of the disease until death is $150,000. The United States Public Health Service predicts that there will be 270,000 AIDS victims by 1991. There are estimates that up to two million people in this country may be carrying the virus at this time.

Individuals suffering from the effects of AIDS, if unable to obtain coverage elsewhere, could find joining a pool preferable to spending their assets to pay the costs of their care. The existence of a pool would provide an alternative to medical indigency for those individuals and could prevent, or minimize, reliance on the Commonwealth's traditional providers of care to the indigent led by the Medicaid program and the state teaching hospitals. Although Virginia is not a high risk state, 516 AIDS cases have been reported here. Another AIDS implication must be considered. Individuals in states bordering Virginia could choose to relocate to Virginia if Virginia offered coverage through a pool that was unavailable in their home state.

EXISTING HEALTH INSURANCE POOLS

Fourteen states have enacted legislation to establish health insurance pools. Minnesota and Connecticut were among the first to do so. This year Iowa, Montana, Nebraska, and Tennessee will begin to operate health insurance pools. Maine, New Mexico, Oregon, and Washington passed legislation to organize pools in their most recent legislative sessions. The experiences of the pools vary but none have proved to be the answer to the affordability of health insurance coverage. Health pools do provide access to insurance for those who are uninsurable because of their medical history, but they do not provide health coverage to those who cannot afford the price of health coverage in the voluntary market.

Among the states where pools have been operating at least two years, the pool enrollment is not considered high when compared to estimates of the number of chronically ill individuals. The low enrollments are attributed to the cost of coverage. Another barrier to success for pools is the inability of states to require self-insurers to join. Although some pool legislation requires self-insurers to participate, the state laws are not enforceable because the Employee Retirement Income Security Act of 1974 (ERISA) preempts states from regulating self-insurers. ERISA prohibits states from regulating qualified employee benefit plans and, therefore, states cannot require employers who self-insure to participate. Federal legislation has been introduced this year that would require states to form health insurance pools. The federal legislation includes provisions that would give states a means for including self-insurers in pools.

The majority of the states that have pools are organized similar to the National Association of Insurance Commissioners' (NAIC) Model Bill. However, none of the states have adopted the model in its entirety. The NAIC Model was adopted in 1984, and suggestions for changes to the model are currently being considered. The suggested changes will broaden the authority of the state insurance regulator and the board of directors in the operation of the pool. Amendments to the model have also been proposed that will shorten the pre-existing conditions period from twelve months to three or six months. Additional consideration is being given to expanding the model to address the affordability of pool coverage.

Six states have pools which have been in operation for at least one year. Information from those states and the four that began operating this year is summarized in Appendix I to this report. The information in the appendix highlights the key areas of decision-making that are discussed below.

Pre-existing condition requirements

Most insurance contracts will not provide coverage until a certain time period has passed for a health condition that exists when the policy is purchased. These requirements are intended to decrease the likelihood of a person waiting until they need treatment to buy a policy.

The existing state pools vary considerably on this provision. Minnesota and North Dakota have a 90-day exclusion for pre-existing conditions, but Montana's

recently activated plan has a five-year exclusion. Indiana allows an applicant to pay an additional charge of 10% of the premium to reduce or eliminate the pre-existing condition period. The majority of the states have a six-month exclusion which provides more protection to the consumer than the 12-month exclusion that is often used in accident and sickness insurance. Opponents of a shorter exclusion say it would allow the postponement of elective surgeries until the pool would pay for the care. A shorter exclusion could then encourage prospective applicants to delay joining the pool.

Eligibility Requirements

The requirements for admission to the pool is one of the most important issues to be decided. The states with pools are not uniform in this area. Most require the applicant to have been rejected by one or two insurance companies, but Connecticut does not require rejection by an insurer. Additionally, three states require that the individual not be eligible for Medicare. Medicare is the federal program that covers most people 65 years old or older and some disabled persons that are under age 65. The Indiana pool will admit applicants that have a specific pre-existing condition that is listed as a prerequisite. Many pools also accept individuals who have been accepted by insurers but have been offered a policy with a pre-existing condition rider for more than twelve months, or have been refused coverage that is comparable to pool coverage or have been offered coverage with riders excluding certain conditions from coverage.

All pools are designed to assist those who have difficulty obtaining coverage in the voluntary market. The rationale is the same in all states although they differ in implementation. The decisions for some states have been intended to include more of the less sick of the uninsurables so as to enlarge the base of the pool. Opponents say that the adverse selection inherent in the pool cannot really be overcome in this manner.

Connecticut's pool will accept groups of up to ten members if at least one member of the group is uninsurable because of health status. There has been general belief that small groups that are underwritten have more difficulty obtaining insurance than larger groups. Allowing these groups to enter a pool increases the base of participants and adds individuals who are less likely to produce a high volume of claims to the pool.

Residency Requirements

The pool laws of all states require the applicant to be a resident of the state before being accepted into the pool. Nebraska and North Dakota require the applicant to have been a resident of the state for at least six months. Residency requirements are used to assure that those who live and work in the state and contribute to the state are served by the pool. The majority of states allow insurers a credit for assessments that reduce tax revenues, so the state is in effect paying part of the cost of the care.

Premium

The premiums charged are expressed as a percentage of the average individual standard premium that is charged by the five largest insurers by market share in the state. The maximum premiums allowed range from 125% of standard up to 400%. The majority of states have a maximum of 150%.

Wisconsin is the only state that currently directly subsidizes the costs of premiums for individuals. Individuals who are accepted into the pool with annual incomes of below $16,500 are eligible for reductions of the premiums ranging from 6% to 30%. Wisconsin also plans to begin to subsidize the cost of the deductibles for pool participants.

Premium caps are used to increase the accessibility of pool coverage. Without premium caps pool enrollments would most likely be even lower. Even with caps the premiums charged for a 50-year-old man per year range from $837 to $2,506 in pool states. The actuarially-determined premiums that pool coverage would generate would be significantly higher, as the sizeable pool deficits indicate. The assessments required by deficits in 1985 ranged from $590,000 in North Dakota to approximately $5 million in Minnesota.

Funding

Funds for expenses that exceed the total amount of premiums collected are obtained by assessing the insurance companies licensed to provide and providing accident and sickness benefits, health maintenance organizations and multiple employer trusts (METS) in the state. We recognize that it may be difficult to administer the requirement that METs belong to the pool, but feel it is equitable that they be members because of the coverage they provide. Assessments are levied in proportion to the volume of business that is conducted in the state. The pools in this instance are similar to the Virginia Property Insurance Association that is operated to provide coverage to those who cannot obtain protection for their property in the voluntary market.

Most states allow for a reduction of premium taxes based on the assessments that are paid by the insurers. In states where pooling has been studied and not implemented, opponents have pointed out that any assessments an insurer has to pay will be passed on in the form of higher premiums to those who are able to purchase insurance in the voluntary market. By allowing a tax credit, the states are indirectly assuming the excess cost of the pool. Because revenues to the state are reduced, the cost is not passed on to those who can obtain health insurance. Credits are utilized to avoid placing the total fiscal responsibility of a social concern on those in business. Connecticut and Wisconsin are the only states that do not allow insurers to receive some form of tax credit for the assessment they must pay.

Deductibles

The deductibles that individuals must pay out-of-pocket before the pool begins to pay benefits range from $150 in North Dakota up to $2,000 in Tennessee. Most states offer a choice of deductibles with higher premiums charged for the lower deductible. Every state has a deductible in some amount.

Deductibles have proven useful as a cost containment measure in all types of insurance. The use of deductibles helps to create a cost awareness among policyholders and encourages them to use services efficiently. Deductibles also assist in lowering the premium that must be paid for the coverage. Providing policyholders with a choice of deductible allows individuals to decide for themselves how much they can afford to pay at the time health care services are used.

Benefits

The benefits offered by most pools are fairly extensive. Most provider services are covered. Broad coverage is necessary to provide services that the majority of the chronically ill will need. For those with chronic illness, the overwhelming concern is that they have major medical coverage (coverage for hospital care and serious illness or injury) although basic medical and hospital coverage is also necessary. Many pools also have annual limits on the amount of money a pool member will have to pay towards claims.

Expenses for the following services are generally covered by state pools:

- hospital services;
- professional services for diagnosis or treatment of injuries, illness or conditions other than outpatient mental or dental, rendered by a physician or at the physician's direction;
- prescription drugs;
- skilled nursing facility care;
- services of a home health agency if medicare qualified;
- home health care;
- hospice care;
- outpatient services for mental or nervous disorders;
- use of radium or other radioactive materials;
- oxygen;
- anesthetics;
- prostheses other than dental;
- rental or purchase of durable medical equipment (other than eyeglasses or hearing aids);
- diagnostic x-rays and laboratory tests;
- oral surgery;
- physical therapy, speech therapy, occupational therapy;
- ambulance services;
- charges for blood.

RECOMMENDATIONS

The State Corporation Commission's Bureau of Insurance makes the following recommendations for a comprehensive health insurance pool (CHIP) for the Commonwealth. The recommendations are made in light of the accepted purpose of a pool which is making coverage available to those who cannot find it and are greatly in need of it.

Pre-Existing Conditions

The pre-existing conditions exclusion is one of the most important variables in the coverage of the pool. Many of the individuals testifying before the joint subcommittee that studied pooling in 1984 expressed considerable concern about the hardship imposed upon individuals by pre-existing conditions exclusions.

The NAIC Model bill is likely to be amended to reduce the length of this exclusion from twelve months to 90 days or six months. It is apparent that some pre-existing conditions exclusion must be included to encourage individuals not to delay joining the pool. However, in recognition of the difficulties associated with lack of care for an existing medical condition, an exclusion of only six months is recommended. A six-month period is felt to provide an adequate incentive without imposing a burden on the majority of potential applicants.

Residency

The states bordering Virginia (West Virginia, Maryland, the District of Columbia, and North Carolina) do not have health insurance pools at this time. Maryland studied health pools in 1986 and decided at that time it would not be advantageous to implement a pool. Because of the ease of changing residency from one state to another, Virginia could possibly attract a number of new residents from border states because of their need for health care. There should be a residency requirement of at least six months. This would not completely prevent individuals moving to Virginia from joining the CHIP, but it could discourage relocation for the specific purpose of joining the pool.

Eligibility

The eligibility requirement should not pose an undue burden on an individual who cannot find coverage in the voluntary market and who has no other means of coverage. If coverage is provided through Medicare, the individual is not necessarily uninsurable. The majority of individuals receiving Medicare benefits do so because they are over age 65. Congress is currently considering legislation that will expand Medicare coverage beyond the services currently covered. At this time, therefore, the State Corporation Commission's Bureau of Insurance recommends that those eligible for Medicare not be included. Those eligible for Medicaid coverage are already receiving comprehensive medical care because of their income status or because they

are "medically needy." The individuals covered by Medicare and Medicaid then are not uninsurable and are not in need of pool coverage.

Coverage will be available on both a family and an individual basis. This will allow other family members to obtain coverage as a unit in the event that the wage-earner in the household is the uninsurable individual. However, family coverage is not being required to eliminate the possibility of a family paying higher premiums than necessary in the event that lower coverage is available from other sources.

With regard to a requirement that the applicant to have received a certain number of rejections by those offering coverage in the voluntary market, two rejections should be sufficient. The inclusion of individuals who are less likely to generate large claims is a benefit to the pool, not a liability. The greater the number of participants in the pool, the larger the base over which to spread losses. However, one rejection alone may not adequately determine an individual's insurability and could preclude an individual from obtaining coverage in the voluntary market that may be available at a lower premium. The State Corporation Commission's Bureau of Insurance, therefore, recommends that two rejections be required. Rejection can be demonstrated by the applicant by either furnishing copies of Adverse Underwriting Decision notices or certifying rejection on the application form and listing the company names. The decision between these alternatives would be determined by the Board of Directors of the pool.

The State Corporation Commission's Bureau of Insurance also recommends that future consideration be given to including in the pool groups under ten. No Virginians should be without health coverage simply because they are employed by a small organization. However, at the present time the need for coverage of individuals is greater, and the existence of a pool may, in fact, assist the smaller groups in obtaining coverage that may be more affordable than pool coverage.

Premium

The purpose of the pool must be kept in mind when considering the amount of premium that should be charged. It is the primary purpose of a pool to make coverage "available" to individuals who otherwise could not obtain it. With pool enrollment hinging largely on the premium charged, a premium level of over 150% of standard premium could result in lower enrollment in Virginia than in other states. A higher premium could possibly attract only the most ill of the uninsurable thereby reducing the number of people to be insured and limiting the pool to those who would generate the highest losses. The State Corporation Commission's Bureau of Insurance, therefore, recommends 150% of the standard individual rate for the Virginia CHIP.

Funding

Although health pool experience typically results in losses, the expenditure should be viewed in terms of the total impact a health pool has on the state. Presently, there are individuals who after using all of their own resources to pay health care expenses turn to the Medicaid program to pay the cost of their care.

Other individuals may forego care that is needed because they have no means to pay for it. These individuals may eventually require more extensive and more expensive care if their medical conditions deteriorate. Some of these individuals rely on the teaching hospitals and other providers of care that are not compensated.

As previously mentioned, the Blue Cross and Blue Shield Plans operating in Virginia currently pay no premium tax on their subscriber fee income. In 1987, legislation was passed that resulted from the Taxation of Insurance Companies Study that will change the tax treatment of the Blue Cross and Blue Shield Plans. Beginning January 1, 1988, Blue Cross and Blue Shield will pay a tax of 0.75 of one percent. The tax rate for accident and sickness insurance will be changed in 1989 to 2 and 1/4 percent from 2 and 3/4 percent of direct gross premium income.

Should the Blue Cross and Blue Shield Plans end open enrollment, their license tax will increase from .75 of one percent to 2.25 percent. This would result in an addition to the general fund of approximately $18,000,000 per tax year without adjustments for any additional loss of business connected with a change to operation as a commercial insurer.

The State Corporation Commission's Bureau of Insurance recognizes that the existence of a pool may be beneficial to all entities that provide health coverage in the state and that there should be some participation by those insurers. It is therefore recommended that any losses of the CHIP that exceed premiums be recouped by assessing all entities regulated by the State Corporation Commission that provide health coverage in the state.

Because the CHIP provides a service that benefits the citizens of this Commonwealth, a reduction of the premium taxes paid into the general fund by insurers is appropriate. Health maintenance organizations (HMOs) do not pay a premium tax in this state. For-profit HMOs, however, pay a corporate income tax of six percent. It would therefore be equitable to reduce their corporate income tax by the amount of their assessment. There are currently twenty HMOs operating in Virginia. Fifteen of the twenty are for-profit and a number of the non-profit HMOs are in the process of requesting a change in their profit status.

A reduction of premium tax will be consistent with the current philosophy that reduces the taxes paid by the Blue Cross/Blue Shield Plans because of the services they provide to the Commonwealth. The increase to the general fund from taxes paid by the Blue Cross/Blue Shield Plans should offset, at least partially, the reduction in the taxes paid by all entities that belong to the pool.

Deductibles

The State Corporation Commission's Bureau of Insurance recommends that a range of deductibles be offered to individuals so that they can elect the coverage that best suits their needs. Recommendations on the amount of the deductibles offered are only tentative and will be subject to discussion. It is likely that the amounts will be

changed prior to a hearing on the regulation. It is important that there be one deductible that is low enough to provide coverage that is comparable to coverage now offered in open enrollment contracts.

Benefits

A review of the type of individual likely to be in need of pool coverage should be considered before deciding the benefits that should be payable in Virginia.

According to the 1987 Taxation of Insurance Companies study, the individuals that are currently open enrollment subscribers typically have one or more of the following medical conditions:

Heart Disease
Liver/Kidney Disease
Stroke/Paralysis
Diabetes
High Blood Pressure
Cancer/Tumors
Neurological Disease
Joint Disease
Nervous/Mental Disorder
Alcoholism/Drug Dependency

Individuals with these medical conditions will have a need for a considerable range of services; and, accordingly, comprehensive coverage is considered the most appropriate form of coverage for the pool. The services that are included in the NAIC Model Bill are similar to those covered under the Blue Cross and Blue Shield of Virginia Standard Plan, and the State Corporation Commission's Bureau of Insurance believes that these services should be offered to the individuals that join the pool.

The recommend coverages are:

- hospital services;
- professional services for diagnosis or treatment of injuries, illness or conditions other than outpatient mental or dental, rendered by a physician or at the physician's direction;
- prescription drugs;
- skilled nursing facility care;
- services of a home health agency if medicare qualified;
- home health care;
- hospice care;
- outpatient services for mental or nervous disorders;
- use of radium or other radioactive materials;
- oxygen;
- anesthetics;
- prostheses other than dental;
- rental or purchase of durable medical equipment (other than eyeglasses or hearing aids);

- diagnostic x-rays and laboratory tests;
- oral surgery;
- physical therapy, speech therapy, occupational therapy;
- ambulance services;
- charges for blood.

The State Corporation Commission's Bureau of Insurance recognizes that every possible medical need would not be covered, but believes that the benefits listed will provide coverage that is comprehensive enough to adequately protect the majority of uninsurables.

CONCLUSION

The State Corporation Commission's Bureau of Insurance recommends that the draft legislation contained in this report be introduced in the event that either Blue Cross/Blue Shield Plan provides notice of intent to end its open enrollment program. The draft legislation provides for the creation of a health insurance pooling mechanism that is under the direction of the Bureau of Insurance and the Board of Directors of the pool.

The pool will be open to residents of this state who have been refused by two insurers or who have been terminated by an insurer. The pool coverage will have an initial rate of 150% of standard premium with a maximum of 200%. A pre-existing condition exclusion of six months will also be included. The draft regulations that are included in this report provide for comprehensive benefits to be offered to pool participants.

The State Corporation Commission's Bureau of Insurance believes that through advertising and educating the public about the existence of the pool, the uninsurable individuals in the Commonwealth will have an opportunity to protect themselves from the high costs of health care. A notice will also be provided to individuals who are not accepted for coverage or who receive notice of non-renewals or cancellations from their health insurer.

This contingency plan does not provide for low-cost comprehensive coverage for those with chronic illnesses. Adequate premiums for those who are uninsurable might be very high. The actual premiums for pools presently operating vary considerably but none are less than 125% of standard premium. Future consideration can be given to the affordability of coverage. However, this plan adequately provides the benefits equivalent to those offered to Virginians by the open enrollment programs of the Blue Cross/Blue Shield Plans.

State	Waiting Period	Pre-Existing Condition	Residency Requirement	Uninsurable Requirement	Enrollment	Administration
Connecticut	12 mths.	6 mths.	State resident	Ineligible for Medicare	27,122	Travelers
Florida	12 mths.	6 mths.	State resident	Rejected by 2 carriers.	2,190	Mutual of Omaha
Indiana	6 mths.	6 mths.	State resident	Non-Medicare Eligible - rejected by 2 carriers or - specific pre-existing condition.	3,229	Mutual of Omaha
Iowa	6 mths.	6 mths.	State resident	Rejected by 1 carrier Less expensive coverage not available.	Began operation in 1987	Mutual of Omaha
Minnesota	6 mths.	90 days	State resident	Rejected by 1 carrier.	10,700	Blue Cross/ Blue Shield
Montana	12 mths.	5 yrs.	State resident	Rejected by 2 carriers in last 6 mths. or restrictive rider impossible by 2 carriers.	Began operation July, 1987	Blue Cross/ Blue Shield
Nebraska	6 mths.	6 mths.	State resident for 6 mths.	Rejected by 1 carrier. Non-Medicare or Medicaid eligible	65	Blue Cross/ Blue Shield
North Dakota	6 mths.	90 days	State resident for 6 mths.	Rejected by 1 carrier.	1,241	Blue Cross/ Blue Shield
Tennessee	6 mths.	6 mths.	State resident	Rejected by 1 carrier.	Began operation in 1987	Mutual of Omaha
Wisconsin	6 mths.	6 mths.	State resident for 30 days	Rejected by 2 carriers.	2,075	Mutual of Omaha

State	Max. Benefits	Premium	Deductibles	Fees	Funding
Connecticut	$1 million Lifetime	125% Minimum 150% Maximum	$400; $1,000; $1,500	Agent $20	Assessment of losses to participating insurers.
Florida	$500,000 Lifetime	150% Initial 200% Maximum	$1,000; $1,500 $1,200	Agent $75	Assessment with credit against premium and income taxes.
Indiana	Plan I - No Limit Plan II - $500,000 Lifetime	150% Maximum	$200; $500; $1,000	Agent $25	Assessment with credit against premium and income taxes.
Iowa	$250,000 Lifetime	150% Maximum	$500; $1,000; & any others designated by Board		Assessment with credit against premium and income taxes.
Minnesota	Regular Plan - $250,000 Medicare Plan - $100,000 Lifetime	125% Maximum	$500; $1,000	Agent $50 Admin. 12 1/2% maximum	Assessment with credit against premium and income taxes. (Repealed this year.)
Montana	$100,000 Lifetime Minimum	150% Initial 400% Maximum	Not to exceed $1,000	Agent $25 Admin. 12% maximum	Assessment with credit against premium tax.
Nebraska	$500,000 Lifetime	135% Initial 165% Maximum	To be determined by the Board		Assessment with credit against premium tax.
North Dakota	$250,000 Lifetime	135% Maximum	$150; $500; $1,000	Agent $25 Admin. 12 1/2% maximum	Assessment with credit against premium and income taxes.
Tennessee	$500,000 Lifetime	150% Maximum	$500; $2,000 & any others designated by Board	Agent $50	Assessment of losses with credit against premium tax.
Wisconsin	$250,000 Lifetime	150% Maximum	$1,000	Agent $35	Assessment plus special fund for subsidy to applicants.

Chapter 53.

Virginia Comprehensive Health Insurance Pool.

§ 38.2 - 5300. Definitions. — As used in this chapter:

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

"Administrator" means the entity authorized by the Board of Directors and the Commission to operate the Virginia health insurance pool.

"Benefits" plan means the coverages to be offered by the pool to eligible persons pursuant to § 38.2-5305 of this chapter.

"Board" means the Board of Directors of the pool.

"Bureau" means the Bureau of Insurance.

"Health maintenance organization" means any person who undertakes to provide or arrange for one or more health care plans.

"Insurance arrangement" means any plan, program, contract or any other arrangement under which one or more employers, unions or other organizations provide to their employees or members, either directly or indirectly through a trust, non-risk bearing preferred provider organization or third party administrator, health care services or benefits other than through an insurer.

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

"Insurer" means any insurance company authorized to transact accident and sickness business in this Commonwealth, any health services plan, preferred provider organization or health maintenance organization.

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

"Plan of operation" means the plan of operation of the pool, including articles, by laws and operating rules, adopted by the Board pursuant to § 38.2-5302.

"Pool" means the Commonwealth of Virginia Health Insurance Pool as created in § 38.2-5301.

§ 38.2-5301. Operation of the pool. — A. There is hereby created a nonprofit entity to be known as the Commonwealth of Virginia Health Insurance Pool. All insurers authorized to issue accident and sickness insurance in this Commonwealth and insurance arrangements providing health plan benefits in this Commonwealth on and after the effective date of this chapter shall be members of the pool.

B. The Commissioner shall give notice to all insurers and insurance arrangements of the time and place for the initial organizational meetings. The Commissioner shall select the initial Board of fifteen directors. The Board shall at all times, to the extent possible, include at least one domestic insurance company licensed to transact accident and sickness insurance, one domestic health services plan, one health maintenance organization, one or more public members, the Commissioner or the Commissioner's designee and other entities as the Commission deems necessary.

C. The Board shall submit to the Commission a proposed plan of operation for the pool and any amendments necessary or suitable to assure the fair, reasonable and

equitable administration of the pool. The Commission after notice and hearing, may revise the plan and shall approve a final plan of operation as is determined to be suitable to assure the fair, reasonable and equitable administration of the pool, and to provide for the sharing of pool gains or losses on an equitable proportionate basis. The final plan of operation shall become effective upon approval in writing by the Commission consistent with the date on which the coverage under this chapter must be made available. If the Board fails to submit a suitable proposed plan of operation within 90 days after the appointment of the Board, or at any time thereafter fails to submit suitable proposed amendments to the plan, the Commission may, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the Commission or superseded by a proposed plan submitted by the Board and approved by the Commission.

D. The plan of operation shall:

1. Establish procedures for the handling and accounting of assets and monies of the pool.

2. Select an administrator in accordance with § 38.2-5303 and establish procedures for filling vacancies on the Board.

3. Establish procedures for the collection of assessments from all members to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the Board, pursuant to § 38.2-5304. Assessment shall occur at the end of each calendar year. Assessments are due and payable within 30 days of receipt of the assessment notice.

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

The Board shall have the specific authority to:

1. Enter into contracts as are necessary or proper to carry out the provisions and purposes of this chapter, including the authority, with the approval of the Commisioner, to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

2. Sue, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against pool members;

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

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

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

6. Issue policies of insurance in accordance with the requirements of this chapter.

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

§ 38.2-5302. Eligibility. — A. Any individual person, who has been a resident of this Commonwealth for a period of at least six months, and has been rejected by two insurers for health insurance coverage comparable to the coverage offered by the pool shall be eligible for pool coverage, except the following:

1. persons who will have, on the date of issue of coverage by the pool, coverage under accident and sickness insurance or an insurance arrangement;

2. any person who, at the time of pool application, is eligible for health care benefits under Medicare, or Medical Assistance Services provided in § 32.1-310 et seq., Chapter 9;

3. any person having terminated coverage in the pool unless twelve months have lapsed since such termination;

4. any person on whose behalf the pool has paid out $1,000,000 in benefits;

5. inmates of public institutions and persons eligible for health or medical public programs.

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

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

§ 38.2-5303. Administrator. — A. The Board shall select an insurer, insurers, or other entity through a competitive bidding process to administer the pool. The Board shall evaluate bids submitted based on criteria established by the Board which shall include:

1. The administrator's proven ability to handle individual or group accident and health insurance or plans;

2. The efficiency of the administrator's claim paying procedures;

3. An estimate of total charges for administering the plan;

4. The administrator's ability to administer the pool in a cost efficient manner.

The administrator shall serve for a period of three years subject to removal for cause.

B. At least one year prior to the expiration of each three year period of service by an administrator, the Board shall invite all authorized insurers or other entities, including the current administrator to submit bids to serve as the administrator for the succeeding three year period. Selection of the administrator for the succeeding period shall be made at least six months prior to the end of the current three year period.

C. The administrator shall perform all eligibility and administrative claims payment functions relating to the pool.

The administrator shall establish a premium billing procedure for collection of premium from insured persons. Billings shall be made on a periodic basis as determined by the Board.

The administrator shall perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:

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

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

The administrator shall submit regular reports to the Board regarding the operation of the pool. The frequency, content, and form of the report shall be determined by the Board.

Following the close of each calendar year, the administrator shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the Board and the Bureau of Insurance in a form prescribed by the Commission.

The administrator shall be paid as provided in the plan of operation for its expenses incurred in the performance of its services that are determined to be reasonable by the Board.

§ 38.2-5304. Assessments. — A. Following the close of each license year ending June 30, the administrator shall determine the net premiums, premiums less administrative expenses allowances, the pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Health insurance premiums and benefits paid by an insurance arrangement that are less than an amount determined by the Board to justify the cost of collection shall not be considered for purposes of determining assessments.

1. Each insurer's assessment shall be determined by multiplying the total cost of pool operation by a fraction, the numerator of which shall equal the insurer's premium and subscriber contract charges for accident and sickness insurance written in the Commonwealth during the preceding calendar year, and the denominator of which shall equal the total of all premiums, subscriber contract charges written in the Commonwealth and 110% of all claims paid by insurance arrangements in the Commonwealth during the preceding calendar year.

2. Each insurance arrangement's assessment shall be determined by multiplying the total cost of pool operation by a fraction, the numerator of which shall equal 110% of the benefits paid by that insurance arrangement on behalf of insureds in this Commonwealth during the preceding calendar year, and the denominator of which shall equal the total of all

premiums, subscriber contract charges and 110% of all benefits paid by insurance arrangements made on behalf of insured in this Commonwealth during the preceding calendar year. Insurance arrangements shall report to the Board claims payments made in this Commonwealth on an annual basis on a form prescribed by the Commission.

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

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

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

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

§ 38.2-5305. Minimum benefits; availability; premiums and assessments; preexisting conditions. — A. The pool shall offer comprehensive medical expense coverage to individuals that meet the requiements of § 38.2-5302. The pool must also allow for the provision of family coverage. The coverage to be issued by the pool, its schedule of

benefits, exclusions and other limitations, shall be established through regulations promulgated by the Commision taking into consideration the advice and the recommendations of the pool members.

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

C. Pool coverage established in this section shall provide both an appropriate high and low deductible to be selected by the pool applicant. The deductibles and coinsurance factors may be adjusted by July 1 of each year according to the Medical Component of the Consumer Price Index.

D. 1. Premiums charged for pool coverage may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing the coverage. Seperate schedules of premium rates based on age, sex and geographical location may apply for individual risks.

2. The pool shall determine the standard risk rate by calculating the average individual standard rate charged by the five largest insurers by market share offering coverage in this Commonwealth comparable to the pool coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for pool coverage shall not be less than 150% of rates established as applicable for individual standard risks. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the

limitations described herein. In no event shall pool rates exceed 200% of rates established as applicable to individual standard risks. All rates and rate schedules shall be submitted to the Commission for approval.

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

§ 38.2-5306. Collective action. — Neither the participation in the pool as members, the establishment of rates, forms or procedures nor any other joint or collective action required by this chapter shall be the basis of any legal action, criminal or civil liability or penalty against the pool or any of its members.

§ 38.2-5307. Taxation. — The pool established pursuant to this chapter shall be exempt from any and all taxes.

§ 38.2-5308. Service of process. Service of any notice, proof of loss, legal process or other communication relating to the policy or any notice or order of the Commission shall be made upon the pool by service upon the pool's administrator.

§ 38.2-5309. Obligations not to be impaired in event of repeal of chapter. If the General Assembly repeals this chapter, the obligations incurred by the pool and the policies written by the pool shall not be impaired by the repeal and the pool shall be continued until it has fully performed its outstanding obligations.

§ 38.2-5310. Appeal from decision of pool. Any person aggrieved by any action or decision of the pool may appeal to the Commission within thirty days from the action or the decision. The Commission shall provide the aggrieved person and the pool an opportunity to be heard on not less than ten days' written notice. The Commission shall then issue an order (i) approving the action or decision, or (ii) disapproving the action or decision.

§ 38.2-5311. Reports, etc., not public documents. The reports and communications of the pool shall not be public information.

§ 38.2-5312. Offset premium tax liability. Any member subject to premium tax liability may offset assessments paid to the pool by such member in a calendar year against its premium tax liability. In the event the member pays no premium tax, an offset against the state income tax may be made.

§ 38.2-5313. Application of certain provisions of law. — No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-500, 38.2-600, 38.2-3408, 38.2-3410, 38.2-3412, 38.2-3413, 38.2-3415, 38.2-3418, 38.2-3419 shall apply to the operation of this pool.

COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

BUREAU OF INSURANCE

INSURANCE REGULATION NO.

RULES GOVERNING THE VIRGINIA COMPREHENSIVE HEALTH INSURANCE POOL

Effective Date:

RULES GOVERNING THE VIRGINIA

COMPREHENSIVE HEALTH INSURANCE POOL

Section 1. Authority.

This regulation is issued pursuant to the authority vested in the Commission under §§ 38.2-223 and 38.2-5302 of the Code of Virginia.

Section 2. Purpose.

The purpose of this regulation is to set forth rate, form and procedural requirements that the Commission deems necessary to carry out the provisions of Chapter 53 of Title 38.2 of the Code of Virginia.

Section 3. Effective Date.

This regulation shall be effective on _____.

Section 4. Definitions.

As used in this regulation:

"Administrator" means the administrator of the Commonwealth of Virginia Health Insurance Pool.

"Board" means the Board of Directors of the Commonwealth of Virginia Health Insurance Pool.

"Commission" means the State Corporation Commission.

"Contract" means the contract issued to eligible persons by the Virginia Comprehensive Health Insurance Pool.

"Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals.

(1) The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

(a) be an institution operated pursuant to law;

(b) be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and

(c) provide 24 hours nursing service by or under the supervision of registered graduate professional nurses (R.N.'s).

(2) The definition of the term "hospital" may state that such term shall not include:

(a) convalescent homes, convalescent, rest, nursing facilities;

(b) facilities primarily affording custodial, educational or rehabilitory care;

(c) facilities for the aged, drug addicts or alcoholics subject to te requirements of § 38.2-3412; or

(d) any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

"Insurer" means any company licensed to provide accident and sickness insurance, or any health service plan, health maintenance organization, preferred provider organization, or insurance arrangement that is licensed in this Commonwealth.

"Pool" means the Virginia Comprehensive Health Insurance Pool.

Section 5. Compensation to Agents.

Any agent who submits an application to the pool shall receive a fee of twenty-five dollars, and shall be prohibited from accepting any other fees for services rendered to eligible persons in connection with pool applications.

Section 6. Benefits.

The pool shall offer comprehensive medical expense coverage to every eligible person in a form approved by the Commission. Coverage offered by the pool shall pay an eligible person's covered expenses, subject to limits on the deductible and coinsurance payments authorized under this regulation, up to a lifetime limit of $1,000,000 per covered individual. The maximum limit under this paragraph shall not be altered by the Board or the administrator and no actuarial equivalent benefit may be substituted by the Board.

A. Covered expenses shall be the usual, customary and reasonable charge in the locality for the following services and articles when provided by a hospital or prescribed by a physician and determined by the pool to be medically necessary:

(a) Hospital services;

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

(c) Drugs requiring a physician's prescription;

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

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

(f) Use of radium or other radioactive materials;

(g) Oxygen;

(h) Anesthetics;

(i) Prostheses other than dental;

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

(k) Diagnostic x-rays and laboratory tests;

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

(m) Services of a physical therapist;

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

(o) Services for diagnosis and treatment of mental and nervous disorders.

B. Covered expenses shall not include the following:

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

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

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

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

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

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

(g) Dental care except as provided in paragraph (1) of this section;

(h) Eyeglasses and hearing aids;

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

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

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

Section 7. Premiums, deductibles, and coinsurance.

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

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

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

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

Section 8. Notice of pool availability.

Any insurer or agent who refuses to renew or cancels a policy of insurance that provides accident and sickness coverage to a policyholder must provide the policyholder with notification that coverage is available from the pool. The notice shall be given in a form approved by the Commission.

Section 9. Cost containment.

The Board may adopt cost containment provisions, subject to the approval of the Commission. The cost containment provisions shall not result in a lower standard of care for pool members.

Section 10. Penalties.

Any violation of this regulation shall be punished as provided for in § 38.2-218 of the Code of Virginia and any other applicable law of this Commonwealth.

Section 11. Severability.

If any provision of this regulation, or the application of it to any person or circumstances, is held invalid, such invalidity shall not affect other provisions of this regulation which can be given effect without the invalid provision or application, and to that end the provisions of this regulation are severable.