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

Extraterritorial Authority Over Accident and Sickness Insurance Policies Issued Out-of-State

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 28

COMMONWEALTH OF VIRGINIA
RICHMOND
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December 29, 1988

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

We are pleased to transmit this Report of the State Corporation Commission on Extraterritorial Authority Over Accident and Sickness Insurance Policies Issued Out-of-State.

The study was initiated and the report prepared pursuant to House Joint Resolution No. 85 of the 1988 Session of the General Assembly of Virginia.

Respectfully submitted,

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EXECUTIVE SUMMARY

Legislative Request

The 1988 General Assembly passed House Joint Resolution 85 which requested the State Corporation Commission's Bureau of Insurance to determine if, and to what extent, group accident and sickness insurance policies issued for delivery in other states but covering Virginia residents should provide the same benefits that are required of policies issued in Virginia.

Nature of the Problem

Most Virginians who have health insurance are covered under group, as opposed to individual, accident and sickness insurance policies. Many of these policies are issued to groups located outside of the Commonwealth, and therefore, the policies do not fall under the jurisdiction of Virginia's insurance statutes and regulations. Some of these out-of-state policies do not contain provisions similar to those required of policies issued in the Commonwealth. Consequently, some Virginia residents are not receiving legislated health insurance benefits intended and designed by the General Assembly as consumer protection. This situation may be a cause of confusion and hardship for residents who find that they cannot be reimbursed for the same health care services that are being reimbursed for a friend or neighbor who is covered by a policy issued in Virginia.

Background of Study

Group accident and sickness insurance policies delivered or issued for delivery in Virginia are required to meet specific provisions of the insurance code. These provisions are determined and enacted into law by the Virginia General Assembly. Similar activity occurs in all states, with legislators responding to the needs of their citizens by passing laws that will offer consumers insurance protection deemed necessary in their respective states.

Traditionally, group accident and sickness insurance policies are required to comply with the the laws of the state in which the policy is to be issued or delivered to the policyowner. In the interest of consumer protection, however, some states have begun to extend their requirements to policies covering state residents, regardless of where the policy is issued. The 1988 Virginia General Assembly

enacted legislation that extended the insurance code provision prohibiting subrogation to policies providing for payment of benefits to or on behalf of persons residing in or employed in this Commonwealth. Current Virginia law allows all other provisions and benefits in out-of-state policies to comply solely with the requirements of the state of issuance.

Findings and Conclusions

In determining whether out-of-state policies should be brought under Virginia regulatory authority, the insurance requirements of other states were reviewed. Many of Virginia's standard policy provisions and criteria for unfair trade practices and privacy protection are frequently included in the insurance statutes of other states. The inconsistencies between state laws became most apparent in relation to mandated benefits. Mandated benefits are those provisions requiring that reimbursement for certain services or coverage be included in the policy or offered to the policyowner.

The results of the study revealed that no state has all of the same requirements that are mandated for accident and sickness insurance policies issued in Virginia. Over half of the states, however, require mandated benefits that are not found in Virginia's insurance statutes. This means that Virginia residents covered by out-of-state group policies may not receive all of the benefits deemed important as consumer protection by the Virginia General Assembly, but some Virginia residents covered by these policies may receive more or different benefits depending on the state of issuance.

A second area reviewed was the type of groups that are being issued insurance. Traditionally, group accident and sickness insurance policies have been less heavily regulated by state insurance departments than individual policies. There is a presumption that large groups are able to negotiate with insurance companies for their group insurance coverage and have the necessary insurance knowledge and sophistication to obtain appropriate coverage at competitive rates. Given the increasing variety of "groups" that have developed over the years, however, that presumption does not hold true in all cases.

Virginia insurance statutes do not define the specific types of groups that may be issued insurance. Some other states do. Because policies issued to groups out-of-state are not required to be filed in Virginia, little is known about the types of groups that are providing insurance to Virginia residents. During the course of the study, almost 300 consumer complaint files from the Bureau of Insurance's

Consumer Services Division were reviewed in an attempt to locate copies of policies issued to groups out-of-state. Three such policies, covering more than 12,000 Virginians, were located and examined. Between a review of these policies and the current literature on group insurance generally, several scenarios were established illustrating the many different types of groups that are providing insurance to Virginia residents. "True" groups, such as employer groups, frequently provide the Virginia group member with a buffer between the insurer and the insured by negotiating terms for the group to lessen any arbitrary provisions in the master contract. Other groups have been created, however, for the sole purpose of selling insurance. These groups not only offer policies that would not be approved for issuance in Virginia but they also appear to offer little direct service and assistance to the Virginia group member.

Implications of Extraterritorial Authority

Many states claim some type of extraterritorial authority over accident and sickness insurance policies issued out-of-state but covering residents of their state. This authority ranges along a continuum from requiring any policy covering residents of the state to meet the same statutory provisions as required of policies issued in-state to limiting the extraterritorial authority to certain specified provisions.

Requiring all accident and sickness insurance policies covering Virginia residents to meet all Virginia regulatory requirements would have the positive effect of:

1) providing all Virginia residents with the same benefits. (The General Assembly specifically mandated certain benefits for the protection of Virginia residents but current law only provides those benefits to "some".)

2) protecting Virginia consumers against "fictitious" groups. (Many of these groups are formed only to market insurance; they sometimes are of questionable reputation and they have been known to forum shop for the state with the least stringent requirements; their products would not be approved under Virginia requirements.)

3) avoiding substantial confusion for Virginia resident beneficiaries as well as Virginia health care providers with regard to scope of coverage questions.

On the negative side, mandating that all policies covering Virginia residents meet all Virginia requirements would have the effect of:

1) increasing the cost of coverage. (The increase in levels of contractual benefits as well as administrative support by companies may increase the cost of the affected health plans.)

2) hindering multi-state employers' efforts to contain costs. (Many employee health benefit plans are established through collective bargaining; such attempts would be impeded if Virginia employees were to be treated differently than the rest.)

3) expanding the number of self-insured plans. (The increase in cost of health insurance has led to an exodus from the traditional market which means that more individuals are being covered under plans that are exempt from state regulation through ERISA. Instead of protecting Virginia citizens, the effect could be to place more of them beyond our regulatory oversight.)

Recommendation

The study concluded that it does not appear to be either necessary or prudent for the Commonwealth to exert extraterritorial jurisdiction over all out-of-state issued group policies. There does, however, appear to be a need to extend state authority to include certain groups where the potential for abuse is greater.

In effect, the issuance of a group accident and sickness insurance policy providing coverage to Virginia residents should be prohibited unless the master policy: (i) complies with all Virginia requirements; (ii) is issued to a Virginia group; or (iii) is issued to an out-of-state group that is specifically exempted because it has been determined that the rights of Virginia residents will be adequately protected.

The State Corporation Commission's Bureau of Insurance would work with the insurance industry to draft an appropriate bill that would provide a workable solution to the problems outlined in the study, and would present the final proposal to the 1990 General Assembly for consideration.

1988 SESSION

HOUSE JOINT RESOLUTION NO. 85

Requesting the Bureau of Insurance to study extraterritorial jurisdiction over group accident and sickness insurance policies issued outside of Virginia.

Agreed to by the House of Delegates, February 16, 1988
Agreed to by the Senate, February 25, 1988

WHEREAS, the Virginia General Assembly has enacted several laws requiring that certain benefits be provided under group accident and sickness policies; and

WHEREAS, these laws are only applicable to policies issued or issued for delivery in Virginia; and

WHEREAS, many Virginians are insured under group accident and sickness insurance policies issued or issued for delivery outside of Virginia; and

WHEREAS, many of the other states where these group policies are issued or issued for delivery do not have the same requirements that are applicable to policies issued in Virginia; and

WHEREAS, providers of health-care services are delivering medical treatment to Virginians believing that such services are covered under a group accident and sickness insurance policy when in fact such services may not be covered; and

WHEREAS, considerable hardship occurs when an insurance policy does not cover these services and the insured unexpectedly has higher than anticipated out-of-pocket expenses or does not seek the needed service; and

WHEREAS, it appears inequitable that some Virginians are covered by laws of Virginia and others are not solely covered because of where the group policy is issued or issued for delivery; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Bureau of Insurance is requested to study and determine whether, and to what extent, group accident and sickness insurance policies providing coverage to Virginia residents should provide the same benefits to all Virginia residents regardless of where the group policy is issued.

The Bureau shall report to the Governor and the General Assembly of Virginia prior to the 1989 Session as provided in procedures of the Division of Legislative Automated Systems.

INTRODUCTION

Purpose of Study

Residents of the Commonwealth are receiving differential treatment under their group accident and sickness insurance policies depending on whether their policy is issued in or out of Virginia. This situation is occurring because, under current Virginia law, any accident and sickness insurance policy issued to a group (employer, association, etc.) that is located in another state, but that has some of its membership living in Virginia, has only to meet the insurance regulatory requirements of the other state. Virginia health insurance statutes and regulations would not apply to these out-of-state policies even though Virginia residents are involved and even though the other state may not have the same requirements and mandated benefits as Virginia.

The Virginia General Assembly has enacted several statutes mandating that certain benefits be included in accident and sickness insurance policies that are issued in Virginia. Nevertheless, Virginia residents covered by an accident and sickness insurance policy issued to a group located outside of Virginia may not be provided with those benefits whereas their neighbor, friend, or relative covered under a Virginia-issued accident and sickness insurance policy would be reimbursed for such services. This uneven distribution of benefits means that some Virginians cannot take advantage of General Assembly-enacted statutes intended and designed as consumer protection and may be a cause of confusion and hardship for Virginia residents.

Traditionally, insurance companies write group insurance policies to comply with the laws of the state in which the policy is to be issued or delivered to the policyowner. This approach has been accepted generally both by industry and by the state regulatory agencies which have the charge of administering the insurance laws. Some states, however, have begun to extend their filing and mandated benefit requirements to certificates, evidencing coverage, which are delivered to individuals in their state insured under the group contracts. When those individuals are residents of the mandating state but are insured under a contract delivered to a group policyowner in another state, the effect is an extraterritorial application of the mandating state's law on an out-of-state contract.

House Joint Resolution 85, passed by the 1988 Virginia General Assembly, requested the State Corporation Commission's Bureau of Insurance to determine if, and to what extent, group accident and sickness insurance policies

issued for delivery in other states but covering Virginia residents should provide the same benefits that are required of policies issued in Virginia.

Outline of the Report

The following report discusses the question in the context of:

1) reviewing the traditional concept of group insurance;

2) contrasting Virginia's health insurance requirements with the laws of other states;

3) assessing potential hardship and confusion for Virginia residents not covered by Virginia-issued policies;

4) examining the extent of extraterritorial jurisdiction claimed by other states, including an overview of relevant court cases;

5) discussing the implications of seeking extraterritorial authority; and

6) formulating a recommendation that addresses the major concerns identified in this report.

THE TRADITIONAL CONCEPT OF GROUP INSURANCE

Characteristics of Group Insurance

Group accident and sickness insurance policies cover the same types of losses as do individual policies. Medical, hospital and surgical expenses, loss of income due to disability, loss due to accidental death or dismemberment, and dental and vision care expenses are all available as coverages under group accident and sickness insurance policies. In fact, most Virginians who have health insurance are covered under group, rather than individual, policies.

An accident and sickness insurance policy is a contract under which the insurance company will reimburse payment for certain health care services or indemnify for certain losses due to an accident or illness. An individual accident and sickness insurance policy is a contract that covers one person, and perhaps that person's dependents. In contrast, a group policy provides coverage for many people and their dependents under one contract, called a master contract. By insuring groups of people under one contract, group insurance policies allow for savings on an insurance company's administrative costs which helps to lower the cost of premiums needed to pay for coverage. Therefore, one characteristic of group insurance is that it is usually less expensive than an individual policy providing comparable coverage.

With individual accident and sickness insurance, the person insured is the policyowner; that is, he applies for and owns the contract for coverage. The policyowner in the case of group insurance is the employer or other official representative of the group purchasing the group policy. This characteristic of group insurance means that the individual people who are insured are not usually recognized as legal parties to the master contract, although certificates stating the amount of coverage, describing the principal provisions of the master contract, and identifying the beneficiary are given to each participant.

Group Elements

The theory of group accident and sickness insurance is based on underwriting groups of people which, as a whole, meet a certain predictable rate of morbidity (the relative incidence of sickness and injury occurring among given groups of people). This morbidity rate reflects the normal activities of the group as well as the age and sex distribution of the group. If the size of the group is small, the insurer may require the individual members of the

group to submit evidences of insurability. In evaluating the risk, the insurer will then review all of the information available to determine if it will insure the group.

The selection of a group as a risk is only as theoretically sound as the size and the homogeneity of that group. To ensure this soundness, certain essential elements should be inherent in the group itself. If any of these elements are lacking, the insurance company runs the risk of adverse selection by group members. Underwriting considerations for groups, therefore, sometimes involve the following criteria:

1. The group should be a bona fide group, formed for some purpose other than the opportunity to gain low-cost insurance. If the group has no common interest other than the gaining of insurance, it could be composed mostly of poor risks seeking insurance. Some states require the group to have been in existence for a period of time, such as two years, before seeking insurance for its members.

2. A high percentage of the eligible people in the group should be insured. Only in this way can an insurance company gain a safeguard against adverse selection by group members. Lacking a high degree (e.g., 75 percent or more) of participation, the insurance company may require some individual underwriting on a medical basis.

Types of Groups

Traditionally group accident and sickness insurance policies have been less heavily regulated by state insurance departments than individual policies. There is a presumption that large groups are able to negotiate with insurance companies for their group insurance coverage and have the necessary insurance knowledge and sophistication to obtain appropriate coverage at competitive rates. Given the increasing variety of "groups" that have developed over the years, however, that presumption does not hold true in all cases.

The types of groups eligible for group insurance coverage within most states have broadened significantly during the last 50 years. Group insurance is permitted today for categories of groups that did not even exist in the early days of the product. By far, the dominant type of group is the employer group. This group consists of the employees of a single employer, with the employer being the policyowner. "Employer" is frequently interpreted as a sole proprietorship, a partnership, or a corporation.

A second type of group is a labor union group. Members of labor unions may be covered under a group contract issued to the union itself. This insurance must be for the benefit of persons other than the union or its officials.

Professional and other association groups make up a third type of group. These groups consist of members of a specific organization. The organization is the policyowner and the members are the persons insured. Some examples of association groups are professional organizations, such as those consisting of doctors, accountants, lawyers, or teachers; college alumni associations; veterans groups; and fraternal groups.

A fourth type of group emerges from collective bargaining processes which often lead to group contracts being written on multiple-employer groups and issued to the trustees of a fund created through the bargaining process. This fund is typically established by two or more employers in the same or a related industry, by one or more labor unions, or jointly by employers and labor unions.

The last type of group is a debtor-creditor group which has become an increasingly popular form of group insurance in our credit-oriented society. The policyowner in such plans is a creditor, such as a bank, a small loan company, credit union, or even a business that relies heavily on credit card customers. This type of group is different from most because the insurance benefits are payable to the policyowner (creditor) rather than to the individuals insured or their beneficiaries.

Some states include specific definitions in their insurance statutes of those groups that may be issued insurance in that state. Other groups that do not fall under these categories are often called discretionary groups. They are referred to as such because the state insurance commissioner may, in his or her discretion, allow a policy to be issued to such a group even though the group is not specifically defined under the state's laws.

Although Virginia statutes do not define specific types of groups that may be issued insurance, groups being issued accident and sickness insurance policies in Virginia must meet the following general criteria:

1. The members eligible for insurance under the policy shall be members of the group, or all of any class or classes of the group. However, an insurer may exclude or limit coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer.

2. A group accident and sickness insurance policy shall cover at least two persons, other than spouses or minor children, at the issue date and at each policy anniversary date.

In addition, one or more eligible groups may be insured under one group accident and sickness insurance policy issued to a trustee or trustees.

VIRGINIA ACCIDENT AND SICKNESS INSURANCE POLICY REQUIREMENTS

Standard Provisions

Group accident and sickness insurance policies delivered or issued for delivery in Virginia are required to meet specific provisions of the insurance code. The Virginia General Assembly has enacted, for instance, certain standard provisions that set out the legal rights and obligations of the insurer and the policyowner that must be included in all group accident and sickness policies.

Most states include similar standard policy provisions in their insurance statutes. In Virginia, these include the following:

- grace period - the policyowner is entitled to a grace period of not less than 31 days for the payment of any premium due except the first premium; during the grace period, coverage shall continue in force unless the policyowner has given the insurer written notice of discontinuance.

- incontestability - the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years.

- entire contract - the policy, and any application of the policyowner, and any individual applications of the persons insured shall constitute the entire contract between the parties; a copy of any application of the policyowner shall be attached to the policy when issued; all statements made by the policyowner or by persons insured shall be deemed representations and not warranties; no written statement made by any person insured shall be used in any contest unless a written copy of the statement is furnished to the person or to his beneficiary or personal representative.

- evidence of insurability - each policy shall contain a provision setting forth any conditions under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability.

- additional exclusions and limitations - the policy shall contain a provision specifying all additional limitations and exclusions applicable

under the policy for any disease or physical condition which existed prior to the effective date of the policy.

- misstatement of age - any policy where the premiums or benefits vary by age shall contain a provision that an equitable adjustment of premiums, benefits or both shall be made if the age of the person has been misstated.

In addition, group insurance policies are regulated by many of Virginia's unfair trade practices and privacy protection insurance statutes. These statutes are also common among most states.

Finally, all accident and sickness insurance policies or contracts issued in Virginia are required to provide insureds with certain benefits or coverages, termed "mandated benefits". The requirement of mandated benefits has been the most debated of all of the accident and sickness insurance-related provisions appearing in the Virginia insurance code.

Background of Virginia's Mandated Benefits

The introduction of mandated benefits legislation started in 1976 with a law mandating coverage of newborn children. During the same legislative session, a law mandating coverage for mental disorders was passed. In 1977 this law was amended to require the offering of outpatient psychiatric benefits in most accident and sickness insurance contracts. At the same time, a bill was enacted requiring health insurers to offer coverage for inpatient and outpatient care for alcoholism and drug addiction. By the beginning of 1982, there were eight statutes in the Virginia insurance code mandating that particular benefits be provided in accident and sickness insurance policies, including the reimbursement for certain providers, and four statutes mandating that specific benefits be made available by insurers for purchase by policyowners.

Several reasons existed for the increase in mandated benefit legislation during the 1970s. Society's concept of health and health care needs was expanding. Private health insurance coverage was thought by some to contain some unacceptable gaps. Society was also beginning to alter its opinion of its responsibility concerning individual risks that should be minimized through public or private insurance. Mandating expanded insurance coverage in the private sector had proved to be a useful means of shifting the service and cost for certain health-related problems away from public programs. Finally, the continually expanding number of both licensed practitioners and types of

health service licenses contributed significantly to the increase in legislatively mandated benefit initiatives. Facilitating the consumer's freedom of choice of nontraditional provider services was believed by some to lower the cost of specialized health care services.

Proponents of mandated benefits have argued that such provisions are essential if the citizens of the Commonwealth are to be assured of adequate health care coverage. Some individuals have continued to argue that additional health care coverages should be mandated by the General Assembly.

As the number of mandated benefit laws increased in the 1970s, however, a growing number of people began to articulate the concern that mandated benefit laws might be a significant factor in the tremendous increase in health care costs being experienced in the Commonwealth. Some individuals expressed the opinion that Virginia's existing mandated benefit laws should be repealed or that a statutory "freeze" against the adoption of any further mandates should be enacted.

Past and present critics of mandated coverage laws claim that the requirements usurp the prerogative of the individual insurance companies to determine which risks they wish to insure and to what extent they wish to insure them, while increasing the cost of the insurance protection to the consumer. Mandated benefit laws are thought to result in higher rates of utilization, contribute to the use of more expensive services rather than the substitution of less expensive and equally effective ones, and lead to a greater use of expensive technology. An additional criticism is that while such legislation mandates coverage for certain services, it places no limitations on the charges which health care providers may make for these services. Mandated benefit laws may also have the negative effect of limiting the flexibility of employers and unions in choosing the mix of health care coverage to be provided by employee benefit plans. These laws require employers and unions to purchase specific coverage that may be unwanted and unneeded, thereby contributing to the increased cost of the health insurance plan and reducing the number of dollars available for other more desired benefits. Some groups choose the option of buying no health insurance at all but instead become self insured rather than bear the cost of unwanted coverages.

In 1979, the Bureau of Insurance requested an independent consultant to examine the effect of mandated benefits on the cost, quality of care, and structure of the health care care delivery system in the Commonwealth. Upon completing the study, the consultant concluded that individual mandated benefit legislation had been so disjointed that additional problems were being generated and the real deficiencies in the health care system were not

being addressed. He recommended that a moratorium be placed on mandating additional benefits or coverage and urged a comprehensive evaluation of the adequacy of health coverage in Virginia.

The Virginia Commission to Study the Containment of Health Care Costs was created by the General Assembly to further examine the health care issue in the Commonwealth. In 1982, after four years of study, the Commission suggested that the mandated insurance provisions be repealed. This recommendation was included in the Commission's final report to the General Assembly but was accompanied by dissenting opinions from the Commissioner of Insurance, the Commissioner of Mental Health and Mental Retardation (both ex officio members of the Commission), and four legislative members of the Commission. As a compromise to the Commission recommendation, legislation was enacted in 1982 requiring that any coverage, benefits, or services mandated on or after July 1, 1982, only be offered as options for any new or renewed policies or contracts from that date forward. Mandated benefits first required prior to that date were not affected.

A subsequent legislative study conducted pursuant to 1982 Senate Joint Resolution 90 examined the concerns surrounding mandated benefits and reconfirmed the conclusion reached in the compromise to the Health Care Cost Containment Commission's recommendation. Since 1982, there have been no additions of mandated benefits to the insurance code other than the addition of social workers and professional counselors to the list of providers whose services are to be reimbursed.

Table 1. identifies the benefits that currently are required to be included or required to be offered to the group policyowner under accident and sickness policies issued in Virginia.

In addition to these requirements, the insurance code prohibits accident and sickness insurance policies issued in Virginia from containing any provision providing for subrogation of any person's right to recovery for personal injuries from a third person. This statute was modified by the 1988 General Assembly to apply to policies that provide "for payment of benefits to or on behalf of persons residing in or employed in this Commonwealth", thereby making it the only mandated provision in the Virginia insurance statutes that extends the Commonwealth's authority to policies issued out-of-state but that cover individuals living or working in the Commonwealth.

TABLE 1.

Virginia Mandated Benefits

Benefits Required To Be Included in Policies

1. Reimbursement of covered services provided by:

   a. chiropractors
   b. optometrists
   c. professional counselors
   d. psychologists
   e. clinical social workers
   f. podiatrists
   g. physical therapists
   h. chiropodists

2. Coverage for mentally retarded or physically handicapped children of the insured beyond normal termination of coverage date for dependents.

3. Coverage for services provided by a dentist if such services would be covered if performed by a physician.

4. Coverage for newborn children from the moment of birth for injury or sickness including care and treatment of medically diagnosed congenital defects and birth abnormalities.

5. Coverage for inpatient treatment for mental, emotional, and nervous disorders for at least 30 days per policy year.

6. Prohibition against including a provision in a group policy for coordinating benefits with respect to individually underwritten and individually issued accident and sickness policies for which the individual insured has paid the premium.

7. Provision allowing an individual whose eligibility terminates under the group policy to convert to an individual policy without evidence of insurability.

8. Coverage for pregnancy followed by an act of rape, provided certain reporting conditions are met.

Benefits Required To Be Offered In Policies

1. Coverage for outpatient treatment of mental, emotional, and nervous disorders, at various levels of benefits.

2. Coverage for inpatient and outpatient treatment for alcohol and drug dependence.

3. Coverage for obstetrical services.

4. Offer of at least one, if not more, options for deductibles and coinsurance.

COMPARISON OF VIRGINIA MANDATED BENEFITS WITH OTHER STATES

Mandated Benefit Legislation Nationwide

For the purposes of this study, a review of the mandated benefits of other states is necessary. Hypothetically, if most states had the same, or even similar, requirements as Virginia, extraterritorial jurisdiction over accident and sickness insurance policies issued in other states but covering Virginia residents might not be necessary. Under those circumstances, the question of where a policy is issued would not be as critical because the requirements would be relatively the same. Such does not, however, appear to be the case.

Mandated benefit legislation requiring coverages and offers of coverage in accident and sickness insurance policies have all been enacted by the Virginia General Assembly for the express purpose of protecting the Virginia consumer. Similar legislative activity has taken place in states across the country. Virginia's mandated benefit laws fall somewhere in the middle in comparison to the number and extent of mandated benefits enacted nationwide. Some states have more mandated benefits and some have fewer than those required in Virginia. Some states have several of the same provisions and some states just have very different requirements.

No other state has all of the same requirements as Virginia. This is not surprising considering that each state's insurance laws are developed to meet the specific needs of its citizens. For example, the Virginia requirement that at least one option for deductibles and coinsurance be offered to policyowners was a direct result of the previously mentioned Commission to Study the Containment of Health Care Costs. The required coverage for pregnancy following an act of rape was introduced because of a specific concern of a Virginia legislator. The required offer of coverage for obstetrical services is viewed by many states as being included under major medical coverage and is, therefore, not specifically stated as a mandated benefit. These three mandated benefits are Virginia-specific.

On the other hand, several states have enacted mandated benefit legislation which they believe are important protection for their residents but which have not been included in the Virginia insurance code. A few states, for instance, have mandated coverage for home health care, hospice care, long term care, mammographies and pap smears, in vitro fertilization, leukemia, and chemotherapy. Mandated

provider reimbursement legislation has been enacted in some states for marriage and family therapists, registered nurses, and midwives. Other services required in a few states include pediatric preventative care, second surgical opinions, ambulance services, and pre-admission testing.

Survey Results

One component of the research for this study included a survey to all state insurance departments to determine what mandated benefit laws have been enacted in each state. The survey results revealed the degree of similarity between Virginia mandated benefit requirements and those required in other states. Forty-seven states responded to the survey.

The data from the surveys can be examined in two ways. First, the figures in Table 2 identify the extent to which each of Virginia's mandated benefits are required in group accident and sickness insurance policies issued in other states overall. Briefly, this information reveals that:

- inpatient treatment of mental, emotional, and nervous disorders as specified in the Virginia insurance code is only required in 17 (36%) of the states that responded (an additional 11 states require such coverage to be offered, only);

- less than 1/2 of the states (49%) require coverage to be offered for the treatment of alcohol and drug dependence as specified in the Virginia insurance statutes (12 of the states require the offer of coverage for alcohol treatment, but do not cover drug dependence);

- less than one fourth (23%) of the states responding require that the services of a professional counselor be reimbursed (percentages of other provider reimbursement mandates include 40% for clinical social workers, 36% for physical therapists, and 38% for chiropodists);

- almost all states (96%) require coverage for newborn children and 77% require coverage for handicapped children.

Note that 64% of the states responding to the survey have more mandated benefits than those required in Virginia. This figure places in perspective the Commonwealth's relative standing on legislative mandates compared to other states and is important when considering the true need for requiring policies issued out of state to meet Virginia requirements.

The second approach to analyzing the data is to identify which states vary the most from Virginia's benefit requirements. Such information could indicate which states might be used by some companies to "forum shop", or seek out the state with the least stringent requirements.

TABLE 2

Total Number of States
With Virginia Mandated Benefits
(47 states responding)

Virginia Mandated Benefit	Total of States W/ Benefit	Percent of States W/ Benefit
1. Reimbursement for covered services		
a. chiropractors	42	89%
b. optometrists	40	85%
c. professional counselors	11	23%
d. psychologists	40	85%
e. clinical social workers	19	40%
f. podiatrists	35	75%
g. physical therapists	17	36%
h. chiropodists	18	38%
2. Coverage for handicapped children	36	77%
3. Coverage for services provided by a dentist	37	79%
4. Coverage for newborn children	45	96%
5. Coverage for mental, emotional and nervous disorders	17	36%
6. Coverage for alcohol and drug treatment	23	49%
7. Preclude COB provision	31	66%
8. Require continuation of coverage	35	75%
9. Other mandated benefits	29	64%

Table 3. identifies how many of the 15 Virginia mandated benefits (each mandated provider is counted separately) is found in each state's insurance statutes. Three Virginia mandated benefits (coverage for pregnancy following an act of rape, offer of coverage for obstetrical services, and offer of options for deductibles and coinsurance) were not included in this count because they are Virginia-specific.

As noted in Table 2, 64% of the other states have mandated benefits that are in addition to those required by Virginia. Some insurance companies doing multi-state business have chosen to issue group insurance policies in jurisdictions with stringent requirements so that other insurance departments will not question such a policy covering residents of their state. Other companies, however, look to states with relatively more lenient requirements to be the state of issuance for their group policies. This activity is frequently called "forum shopping".

Such group policies are at the heart of this study because they would more frequently be disapproved if the same coverage was being sought for issuance in Virginia. Of particular concern in Table 3, therefore, are those states such as Alabama, Mississippi, and Washington, D. C. that have few Virginia requirements and no additional mandated benefit statutes. In informal conversations with representatives from several companies, during the course of this study, those two states and Washington, D.C. were confirmed as being considered "easy" states by insurance companies doing multi-state business.

A more complete chart specifically identifying which states require group policies to provide the same benefits as those mandated in Virginia can be found in Appendix A.

TABLE 3

Number of Virginia Mandated Benefits (out of 15) Required in Other States

State	Number of VA Benefits	Additional Benefits	State	Number of VA Benefits	Additional Benefits
AL	7	no	MS	7	no
AK*			MT	13	no
AR	9	yes	NE	8	yes
AZ	9	yes	NV	14	yes
CA	12	yes	NH	9	yes
CO	9	yes	NJ	7	yes
CT	11	yes	NM	8	no
DC	4	no	NY	11	yes
DE	2	yes	NC	11	no
FL	9	no	ND	6	yes
GA	9	no	OH	9	yes
HI	7	yes	OK	10	yes
IA	9	no	OR*		
ID	12	no	PA	11	no
IL	15	no	RI	4	yes
IN*			SC	8	no
KS	13	no	SD	12	yes
KY	5	yes	TN	11	no
LA	11	yes	TX	10	yes
MA	9	yes	UT	13	no
MD	14	yes	WV	8	yes
ME	7	yes	WY	12	no
MI	9	yes	VT	6	yes
MN	11	yes	WA	13	yes
MO	11	no	WI	12	yes

*States did not respond to survey

EXTRATERRITORIAL AUTHORITY

Overview

As noted earlier in this study, the various state statutes are not in complete agreement as to the types of groups that may be written for group accident and sickness insurance, or the specific benefits that should be required. Nevertheless, the legal doctrine of comity (the courtesy by which states recognize and give effect within their own territory to the institutions or laws of another state) and full faith and credit among the states has traditionally permitted a group insurance policy properly written in a given jurisdiction to cross over state lines and provide insurance for residents of another state. The group insurance policy must be filed with and approved by the insurance department in the state in which the policy is issued and delivered to the policyowner. The laws of the state of delivery determine the legal requirements for policy issue as well as the laws which govern the group contract.

While the jurisdiction of states over the regulation of insurance has been traditionally confined to state boundaries, state regulatory authorities are increasingly concerned about the marketing of insurance on a basis involving several states through the creation of multiple employer or association trusts and the coverage of individuals resident in several states under a single group master policy delivered in only one state. This concern has prompted attempts to enact state legislation that would give state regulatory authorities jurisdiction over the insurance being written on individuals domiciled in their state even though the master group contract is delivered in another state.

Such attempts are of considerable concern to the insurance industry because a group accident and sickness insurance policy delivered to a corporation with its main office in one state can often cover employees of that corporation who are employed and domiciled in another state or states. Especially in the case of a plan of benefits negotiated by a union with an employer, it is important that the provisions of the benefits contract be uniform for all covered employees, regardless of the state in which they are employed or domiciled.

Most group insurance policies insure persons residing in several states having different laws and legal requirements. Opponents to extraterritorial authority over group accident and sickness insurance policies argue that the laws of some of the states may not recognize or permit insuring the type of group desired. Alternatively, such laws

may have different requirements concerning such matters as minimum enrollments, premium contribution requirements, required extended benefits, and required conversion rights.

Extraterritorial Authority In Other States

In the previously mentioned survey mailed to all state insurance departments, 33 of the 47 states responding (71%) claimed some type of extraterritorial authority over accident and sickness insurance policies issued out-of-state but covering residents of their state. This authority ranges along a continuum, from requiring any policy covering residents of the state to meet the same statutory provisions as required of policies issued in-state, to limiting the extraterritorial authority to certain specified provisions.

A chart briefly identifying the type of extraterritorial authority claimed by those 32 states can be found in Appendix B. Most statutes fall into one of four categories: (i) treating out-of-state policies as in-state policies; (ii) requiring approval of certificates; (iii) applying extraterritorial authority for only select insurance statutes; and (iv) limiting extraterritorial authority to the regulation of discretionary groups. Examples of these different categories are found below.

Examples of Treating Out-of-State Policies As In-State Policies

North Carolina insurance statutes provide an example of the full requirement. Section 58-28 of the North Carolina insurance code states: "All contracts of insurance on property, lives, or interests in this State shall be deemed to be made therein, and all contracts of insurance the applications for which are taken within the State shall be deemed to have been made within this State and are subject to the laws thereof."

Connecticut's 1988 legislative session enacted a law (Public Act No. 88-110) that specifically extends that state's regulatory authority to cover individuals employed in the state. The new statute requires every group accident and sickness policy "delivered, issued for delivery, renewed or continued in any other state on or after October 1, offered by an employer, shall provide to covered employees of such employer employed in this state coverage which meets the requirements of [mandated benefits] whenever, on the initial effective date of such policy or any renewal or continuance date thereafter, fifty-one per cent or more of the covered employees under such policy of such employer are employed in this state."

Rhode Island Regulation XXIII (Minimum Standards for Health Benefit Plans) applies to "all health benefit plans issued, delivered or offered for sale in Rhode Island to the extent that such plans cover Rhode Island residents".

Examples of Requiring Approval of Certificates

Some states require policies or certificates to be filed and approved before covering a resident in that state. **Arkansas** section 23-79-109, for example, specifically states that no policy shall be "issued, delivered, or used as to a subject of insurance resident, located, or to be performed in this state" unless the form has been filed and approved by the commissioner. The statute also states that "[a]s to group insurance policies effectuated and delivered outside this state but covering persons resident in this state, the group certificate to be delivered or issued for delivery in this state shall be filed with and approved by the commissioner." Section 26.1-30-19 of the **North Dakota** statues specifically state that certificates must be filed and approved by the commissioner as does Art. 3.42 of the **Texas** insurance code. Certificate is included in the definition of "policy" in the **Oklahoma** statutes, section 3602.

Example of Applying Extraterritorial Authority Only For Select Insurance Statutes

Some states limit their extraterritorial authority to certain types of policies or for the reimbursement of specific benefits. **California**, for instance, requires that statutes pertaining to medicare supplement policies apply to insurance provided to "residents of this state under a group policy ... regardless of the situs of the contract" (California insurance code section 10195). **Nebraska** also applies extraterritorial authority to medicare supplement policies as well as to long term care policies.

New Mexico brings "alien and foreign insurers delivering or issuing for delivery in New Mexico any certificate or other evidence of coverage" under that state's unfair trade practices statutes. Section 33-22-701 of the **Montana** insurance code included in the scope of the chapter pertaining to coverage for mental illness, alcoholism, and drug addiction "all group policies of accident and health insurance ... for the care and treatment of mental illness, alcoholism, and drug addiction offered to Montana residents by insurers, health service corporations,

and all employees' health and welfare funds that provide accident and health insurance benefits to residents of this state."

Example of Limiting Extraterritorial Authority To Discretionary Groups

A fourth way that other states have claimed extraterritorial authority over group policies issued out-of-state but covering residents of that state is to define the specific types of groups that may be issued insurance in their state. **Florida** statute section 627.6515 requires "any group health insurance policy issued or delivered outside this state under which a resident of this state is provided coverage shall comply with the provisions of this part in the same manner as group health policies issued in this state ... [t]his part does not apply to a group health insurance policy issued or delivered outside this state under which a resident is provided coverage if the policy is issued to [employer, labor union or association group as defined in the statute]." No policy of group health insurance may be delivered in **Missouri** unless it conforms to one of the definitions of a group policy provided in Missouri insurance code, section 376.421. No such group health insurance coverage may be offered in Missouri by an insurer under a policy issued in another state unless the Missouri commissioner or the other state has determined that the group definition is met.

New York requires all policies delivered or issued for delivery in the state to first be filed and approved by the commissioner. A certificate for group accident and sickness insurance evidencing coverage on a resident of New York, regardless of the actual place of delivery, is deemed to have been delivered in New York unless the insured group is of the type defined in the insurance statute (New York insurance code, section 3201).

The state of **Washington** includes in its statutory definition of unfair trade practice, any insurer effecting health insurance coverage on individuals in that state under a group policy delivered in another state when the policy does not (i) provide that claims will be processed for chiropodists, optometrists, registered nurses, chiropractors, psychologists,and dentists; (ii) meet the mandated benefit requirements; and (iii) meet the loss ratio standards applicable to group insurance. This rule is not applicable to insurance coverage provided by group policies for specifically defined groups (Washington insurance code, section 284-30-600).

Extraterritorial Authority in Virginia

The 1988 Virginia General Assembly amended and re-enacted Section 38.2-3405 (Certain subrogation provisions and limitations upon recovery in hospital, medical, etc., policies forbidden). That insurance statute's prohibition of subrogation provisions in policies is now extended to include policies "providing for payment of benefits to or on behalf of persons residing in or employed in this Commonwealth".

A second bill was introduced in the 1988 General Assembly Session (Senate Bill 123) that would have extended the application of Section 38.2-3541 (Conversion or continuation on termination of eligibility) to any group accident and sickness insurance policy "sold in this Commonwealth". This bill was carried over and will be re-addressed in the 1989 Session.

The only other attempt by the Virginia legislature to obtain extraterritorial authority over group accident and sickness insurance policies issued in another state was a 1982 proposal (House Bill 272) that would have extended the full protection of Virginia's insurance laws and regulations to all group certificateholders in the Commonwealth, regardless of where the policy was issued. This bill received strong opposition particularly because large multi-state groups such as the employer groups would have been placed in a position where employees from the Commonwealth would be provided with benefits differing from those provided to employees in other states. The bill was not enacted into law.

Court Cases

The regulatory power of a state with respect to insurance is based upon the state's inherent police power, an area of broad discretion. The exercise of the police power is subject to the general limitation that the inference with individual liberty, or with the right of an owner of property to use it as he sees fit, must have a reasonable relation to the accomplishment of the legislative purpose and must not be unreasonable in degree in comparison with the probable public benefit.

The following are just some examples of cases where courts have evaluated the legitimacy of a state's interest in protecting its citizens with respect to insurance afforded them under contracts issued outside of the state.

Until recently only a few states have attempted to apply their group insurance statutes to contracts issued in other jurisdictions. At one time, the general rule was that the situs of a multi-state group policy is the state in

which the policy was delivered rather than the residence state of an individual insured under the policy. Boseman v. Connecticut General Life Ins. Co., 301 U.S. 196 (1937). By application of contract law principles, this results in the laws of the state of delivery controlling questions arising under the contract. This principle has been ingrained in most state laws relating to group insurance by their application, in terms of the statute, to "policies delivered or issued for delivery in this state".

In more recent years, however, some courts have construed this language to include certificates of coverage issued in the state. See, e.g., Guardian Life Ins. Co. of America v. Insurance Commissioner of Maryland, 293 Md. 629, 446 A.2d 1140 (1982). This case involved a multiple employer trust arrangement which the court held was a trust "in name only, an artifice which serves no legitimate purpose..." . See also New England Mutual Life Ins. Co. v. Gray, 590 F. Supp. 615 (E.D. Mich. 1984), in which the court held "as a matter of law that when an insurer issues a group disability policy, beneficiaries of which live and are employed in [this state], and sends a certificate of insurance to the beneficiaries/employees of this state, it has "issued or delivered" a policy of insurance in this state..."

By the late 1950s, it was apparent that Boseman might not be the basis of a constitutional defense against the assertion of a state's insurance laws on an out-of-state contract covering its residents. In 1943, the Supreme Court in Hoopeston Canning Co. v. Cullen, 318 U.S. 313, 317 (1943), had written "[i]n determining the power of a state to apply its own regulatory laws to insurance business activities, the question in earlier cases became involved by conceptualistic discussion of theories of the place of contracting or of performance. More recently, it has been recognized that a state may have substantial interests in the business of insurance of its people or property regardless of these isolated facts. This interest may be measured by highly realistic considerations such as the protection of the citizen insured or the protection of the state from the incidents of loss."

In Eubanks v. National Federation Student Protection Trust, 290 Ark. 541, 721 S.W.2d 644 (1986), the Supreme Court of Arkansas addressed a case involving an Insurance Commissioner's Bulletin delineating when a student accident insurance plan, issued to a trust in another state, could and could not coordinate benefits with other insurance companies or declare itself "excess". The complaint, brought by the insurance company, stated a variety of grounds for

injunctive relief, one being that the Commissioner's Bulletin is arbitrary and capricious. The court found that the Bulletin was issued as a consumer-protection measure and that one of the Commissioner's responsibilities has been to safeguard the interest of the consumers who buy insurance. The Bulletin was not invalid on its face as the Commissioner has the authority to protect the parents who purchase insurance.

The Supreme Court of the State of Nevada decided in Daniels V. National Home Life Assurance Co., 747 P.2d 897 (Nev. 1987), that an insurance contract which does not provide for notice prior to termination for failure to pay a premium when due is against the public policy of Nevada and thus unenforceable even though the policy was issued in Missouri where the law does not require notice of termination before cancellation of a policy becomes effective. The court noted Nevada's overriding concerns of protecting its citizens and insuring that they are afforded fair and equitable treatment by insurers as evidence by passage of insurance statutes such as the one requiring written notice to a policyholder prior to the effective date of a policy cancellation.

On the issue of extraterritorial jurisdiction, the court indicated that it was not persuaded by the insurance company's argument that the policy in question was a group policy which should be governed by the law of Missouri, the state in which the master policy was delivered. Although veterans may be a group, "group policies" are directed at a limited number of persons affiliated with an organization. The cases National cited in support of its position do not involve such a diverse group as veterans, but concern either employees of a single employer, or recognized professional organizations such as the American Dental Association. In a typical group policy made available through an employer as a benefit, the employer provides a buffer between the insurer and the insured. The employer usually negotiates terms for the group to lessen any arbitrary provisions in the master contract. Also, the employer assures that the policy will remain in force, often provides information concerning coverage to its employees, collects premiums, and resolves any disputes with the insurer. Where, as here, there is no employer or organization to negotiate on behalf of the insured and provide a buffer against overreaching by the insurer, it is all the more compelling to construe (the insurance code) in a manner which affords the greatest protection to the insured.

In Blue Cross Blue Shield of Kansas City v. Bell, 798 F.2d 1331 (10th Cir. 1986), the court applied a balancing test of "whether the state interest in legislation requiring all health policies covering Kansas residents to provide

certain mandated benefits is substantial in order to overcome the incidental extraterritorial effect." Although witnesses for Blue Cross offered testimony on the increase in actual costs for provider reimbursement to Missouri residents and administrative costs to set up new contract groups comprised of Missouri residents employed in Kansas, the court held that the increased insurance protection was a public benefit which outweighed the minimal economic impact on Blue Cross, and was not in violation of due process.

The court also found that the Kansas statute regulating health insurance policies for individuals residing or employed in Kansas did not offend the contract clause. Because the statute applies to contracts of insurance issued or renewed, there was no sudden, totally unanticipated, and substantially retroactive hardship on contractual obligations. Contractual relationships were not burdened by the legislation and it does not offend the contract clause.

POTENTIAL IMPACT OF EXTRATERRITORIAL AUTHORITY ON VIRGINIA RESIDENTS

Determining the potential impact that extraterritorial authority over accident and sickness insurance policies issued out-of-state would have on Virginia residents is difficult. Few consumer problems related to the lack of extraterritorial authority over group accident and sickness policies reach the Bureau of Insurance's Consumer Services Division, which handles consumer insurance-related complaints. Consumers may not realize what benefits are required for Virginia-issued policies, and therefore, may not call the Bureau just because their policy does not cover a Virginia mandated benefit. In addition, because administrative record keeping is often delegated to the group policyowner, insurance companies that write groups often fail to have the name and addresses of all certificateholders insured under a group accident and sickness policy, so there is no quick way to determine how many Virginia residents are covered under group policies issued out-of-state.

Position Statements from Industry and Consumer Groups

This study examined two possible avenues for uncovering the potential impact of extraterritorial jurisdiction over group accident and sickness insurance policies. First, 18 trade associations, 3 state agencies, and the 2 Blue Cross Blue Shield plans operating in Virginia - representing insurers, providers, employers, and consumers across the Commonwealth - were identified as potentially having a direct interest in the outcome of this study. Representatives from each group were asked to offer a position statement on the question of extraterritorial authority over accident and sickness insurance policies issued in another state but covering Virginia residents. They were also asked to provide, if possible, specific examples supporting their argument. Fourteen organizations responded. Their full position statements can be found in Appendix C.

Arguments For Extraterritorial Authority

Arguments for extraterritorial authority over group accident and sickness insurance policies were supported in the position papers by examples of the need for services by Virginia citizens. The Virginia Department of Mental Health, Mental Retardation, and Substance Abuse, which oversees services for citizens of the Commonwealth with mental disabilities, is governed by a statute that prohibits refusal of services to individuals solely based on financial

considerations. The Department indicated that the "degree of success of [the HJR 85 study] has a direct bearing on the amount of financial assistance that is required through appropriations from the General Assembly." They went on to endorse "any measures that will afford citizens of Virginia an increased means through insurance to pay for services provided by this Department and/or reduce possible burdens on the taxpayer."

The National Association of Social Workers and the Virginia Society for Clinical Social Work both represent licensed Clinical Social Workers providing services in Virginia. These associations were instrumental in having the clinical social worker added to the Virginia mandated provider insurance statute that lists the providers whose services must be reimbursed. Both organizations take the position that "group insurance policies covering Virginia residents, regardless of where the policy is issued, should be required to to provide the same coverage as required of Virginia-issued policies, assuring consistency of coverage for all citizens of the Commonwealth". They provided several examples of problems that Virginia consumers have had because their insurance was issued to a group located out-of-state. They also noted their concern that "sometimes we are the only mental health providers in particular regions of the state. If any of these regions were dominated by employers who are based out-of-state, the result would be disastrous for the mental health and well-being of the entire region."

The Virginia Academy of Clinical Psychologists has on file a number of reports from Virginia residents who have employed the services of a clinical psychologist, believing that the psychologist's services were covered by their policy, only to find that the policy covers a group based out-of-state and the insurance company refuses to reimburse the clinical psychologist.

The Virginia Optometric Association states that "no Virginia carrier has been able to demonstrate to this association that subscriber costs have increased with the inclusion of optometry." They went on to state that "[w]ith the advent of legislation to permit optometrists to obtain certification to treat eye disease by use of medication, Virginia residents --- particularly in rural areas where optometrists are the only available vision care provider --- will seek care by their local optometrist. Failure to address extraterritorial application will require those patients to obtain care from a provider not specialized in vision care or require great travel distance and delay of treatment."

The Virginia Nurses Association, the Medical Society of Virginia, the National Insurance Consumer Organization,

and the Virginia Department of Health all expressed general support for attempts to provide all Virginians with the same mandated coverage.

Arguments Against Extraterritorial Authority

Some of the organizations argued that extraterritorial authority would have a negative impact on the citizens of the Commonwealth because of increased administrative burdens for the insurers and conflicting plans for employer groups. The American Council of Life Insurance (ACLI), representing 423 insurance companies doing business in the Commonwealth, stated that "[a]s extraterritorial extension of mandated benefits, in essence, constitutes a 'super' state mandate, by imposing all of the mandating state's laws on an out-of-state contract, the ACLI position, with respect to such extraterritoriality, in Virginia or any other state, is one of general opposition."

In addition to the concerns about increased administrative burdens, the ACLI discussed the impact of extraterritoriality on group - particularly employer group - plans. " ... it is highly possible, particularly with a group plan insuring employees in several states, that a single contract will be subject to laws which either differ or conflict. For example, mandated benefits, with respect to coverage of treatment for alcoholism and mental illness, vary tremendously. Some states mandate coverage of inpatient care, but not outpatient care; some states mandate the opposite; some require coverage only for care rendered in specialized treatment facilities; others do not; different states have different benefit limits and coinsurance features." The reasons supporting their position stem from experiences of their member insurers writing group policies for multi-state groups.

The ACLI also pointed out that payment of different benefits to employees, in like company positions but residents in different states, may not only cause administrative complexities but may be counter to an employer-policyowner's personnel policy or to a collective bargaining agreement.

Blue Cross/Blue Shield of the National Capital Area serves subscribers in a multi-jurisdictional environment, where the account commonly is in one of the three principal jurisdictions they serve, with employees living in each of them. Their major concern is that "[t]he administrative costs and burden of using employees' residence addresses to determine their health care benefits would be prohibitive and would result in an additional charge that would have to be passed on to our subscribers."

Blue Cross/Blue Shield of Virginia concurred and added, "[I]n requiring different benefit plans within the same employer-sponsored health benefit program, we perceive the real potential for operating discriminatory plans and thus causing a conflict with the federal laws that are imposed on employers offering employee benefit programs."

The Virginia Manufacturers Association stated its firm belief that "these benefits (like all employee benefits) should be decided by the employers ... and ... where collective bargaining is involved, for instance, and an employer can afford to offer wages and benefits at a certain level, then the choice of what benefits to be offered and accepted should be decided through the collective bargaining process."

The American Association of Retired Persons (AARP) believes that imposing extraterritorial authority would "destroy the character and efficiency of group insurance and would severely retard the ability of group sponsors to design unique and coherent programs for their members on a national basis, and to bargain effectively with insurers so that coverage can be provided for members at the lowest possible cost."

Structural Organization of Groups Issued Out-Of-State Policies

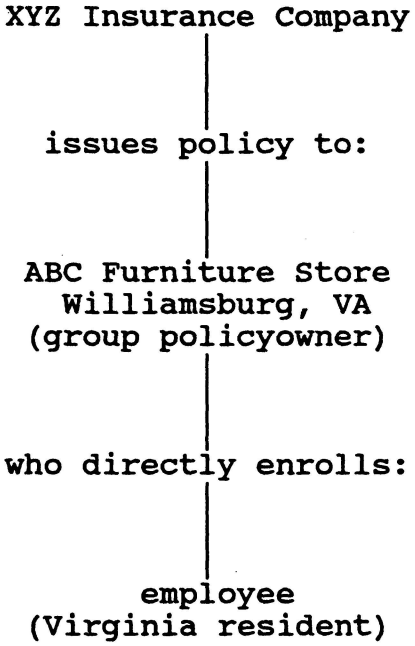
The second avenue for uncovering the potential impact of extraterritorial jurisdiction over group accident and sickness insurance policies came from a review of consumer complaints made to the Bureau of Insurance's Consumer Complaints Division. Almost 300 files from 1987 and the first half of 1988 were evaluated. The consumer complaints, themselves, were not directly related to the lack of extraterritorial application of Virginia's health insurance laws but, in reviewing the files, an attempt was made to locate copies of policies issued out-of-state. These policies are not required to be on file with the Bureau of Insurance. Originally, the purpose of reviewing these files was to provide examples of the types of coverage being provided to Virginia residents through policies issued out-of-state. In examining these policies, however, another area of concern became apparent. The structural organization of some of the groups (that is, the relationship between the insurer, the group, the state of issuance, and the Virginia resident) revealed such disorder and confusion that could lead to potential trouble for the Virginia resident.

Of the files that were reviewed, only some involved out-of-state groups that were issued insurance and only some of those files that were related to such groups contained actual copies of the policies. The review of the files,

however, did produce three policies that were identified as being issued out-of-state but covering Virginia residents. These three policies cover more than 12,000 Virginians, and each one demonstrates a different type of organizational structure.

As stated earlier, group insurance has traditionally been marketed to single groups pursuant to a group insurance policy issued in the state where the group is located. For example, ABC Furniture Store, located in Williamsburg, Virginia, buys a group policy from XYZ Insurance Company. ABC Furniture Store is the group policyowner. The policy is issued in Virginia where the group is located, and Virginia laws apply. The employees of the Furniture Store are then enrolled under the group policy by the employer.

This traditional scenario can be illustrated as follows:

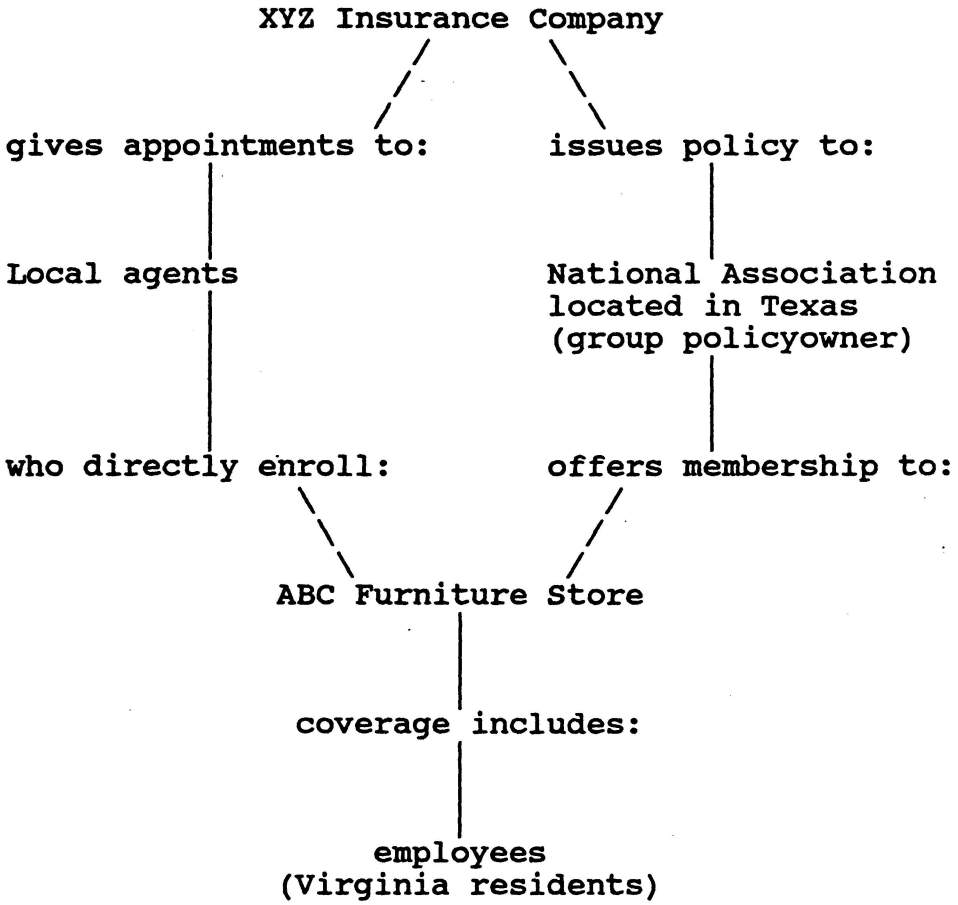


The three policies identified from the consumer complaint files demonstrate variations on this traditional arrangement.

Variation #1

A national association obtains a group accident and sickness insurance policy for the benefit of its members. The policy must meet the insurance requirements of Texas where the association is located. Association members are contacted directly by local agents in their state to choose one of three plan options available. The association has 120,000 members that are insured under this group policy. The association was unable to determine from its files how may of those individuals are Virginia residents.

The illustration for this scenario is only somewhat modified from the first:

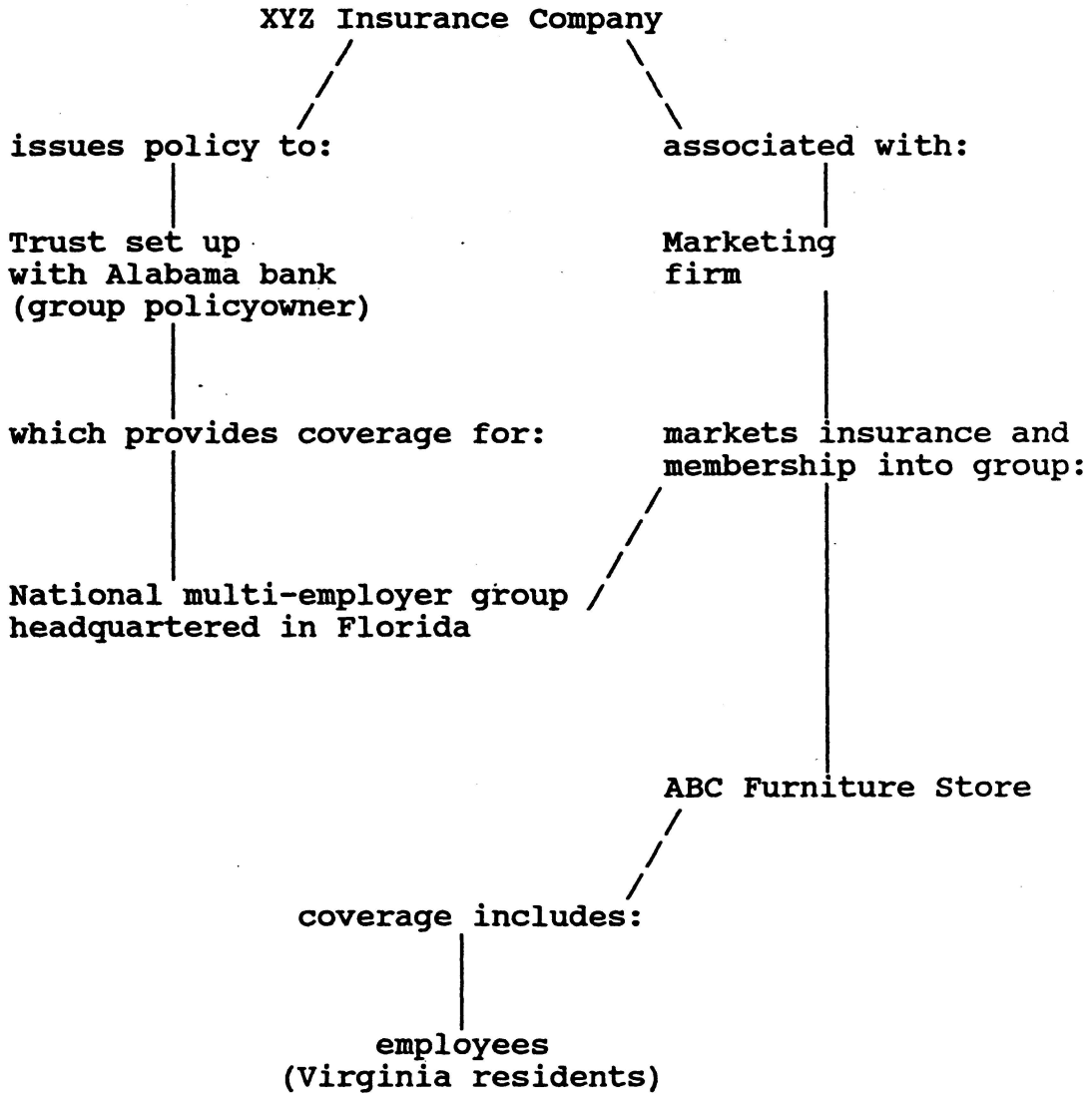


This policy would not have been approved if issued in Virginia because it specifically excludes coverage for mental or nervous disorders and treatment for alcohol or drug addiction. The policy also does not provide for conversion to an individual policy, nor does it provide for reimbursement of all of Virginia's mandated providers.

Variation #2

A second variation of the traditional approach adds another dimension. A national marketing and administrator firm solicits applications for insurance from small employers. The firm is directly affiliated with XYZ Insurance Company. The firm creates an association for the purposes of marketing insurance. The group is located in Florida where the marketing firm is also located. A group policy for the association is issued by the insurance company to a bank in Alabama which agrees to be the trustee and policyowner of the group contract. Under this arrangement, Alabama law applies.

An illustrated example of this arrangement is as follows:

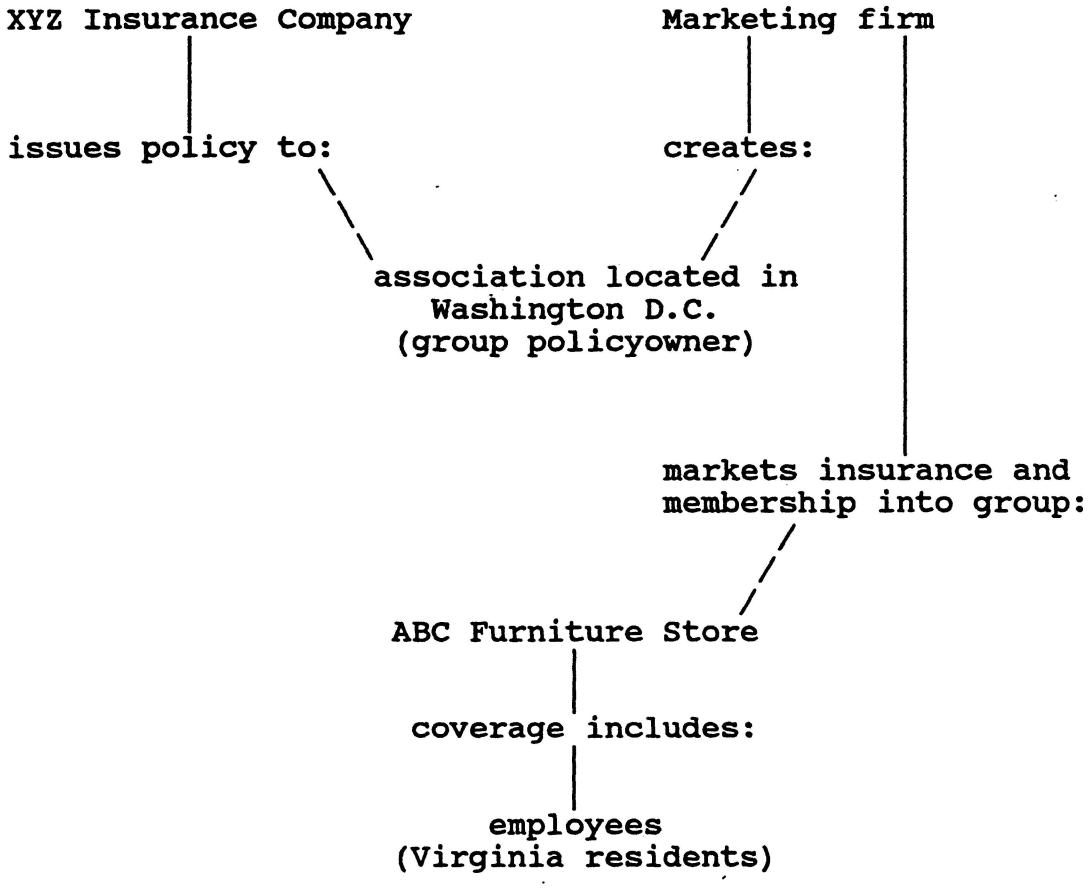


This policy covers about 15,000 groups nationally of which approximately 15% are located in Virginia. The average group consists of seven members; therefore, approximately 5,250 Virginia residents are covered under this group policy. This policy also does not provide for mental health treatment, alcohol and drug abuse treatment, coordination of benefits, and continuation of coverage and would not be approved for issuance in Virginia.

Variation #3

The third scenario involves a similar national marketing arrangement whereby an insurance marketing firm forms an association. The marketing firm--this time a separate entity from the insurance company--is based in Texas, but the association is located in Washington, D.C. No trust is established. The group policy is issued to the association, and the laws of Washington D.C. apply to the policy requirements. Individual employers and employees are directly solicited by the marketing firm to enroll in the group. Approximately 7,000 Virginia residents are covered under this group policy.

The illustration for this scenario is as follows:



This policy does not provide for reimbursement of treatment for mental or nervous disorders or for most of Virginia's mandated providers. The policy also does not provide for continuation or conversion of coverage.

Of the three policies, only the first involves a "true" association group where the association appears to serve a valid function for its members and was formed for purposes other than the purchasing of insurance. Although the policy does not offer all of the requirements mandated by Virginia, the plan was negotiated by the association for the benefit of its members. The association serves as a direct contact between the Virginia group member and the insurer. Only the names of members interested in purchasing insurance are provided to local agents who contact the group members in Virginia. Because local agents are used rather than direct response solicitation (through the mail), the agents must be licensed in Virginia, and their activity is regulated by the State Corporation Commission's Bureau of Insurance.

The second variation specifically creates an association for the purpose of marketing insurance. The marketing firm is directly associated with the insurance company. As demonstrated in the illustrated example, the Virginia group member has little contact with the association and is directly approached by the marketing firm. In addition, the policy is issued to a trust set up with a bank in Alabama, a state which has no connection with the association and, as identified in Table 3, has relatively lenient statutory requirements.

The last variation also demonstrates no direct contact between the association and the Virginia group member. In fact, of particular concern with this arrangement was the discovery that while the association was "located" in Washington, D.C., closer scrutiny revealed that only a Post Office box number is in Washington, D.C. The phone number listed in the association brochure is the same phone number as the insurance marketing agency located in Texas. Washington, D.C., was identified in Table 3 as one of the possible "forum shopping" states because of the relatively lenient insurance requirements.

The last two policies, therefore, demonstrate the types of groups covering Virginia residents that appear to be particularly vulnerable to hardship and confusion because they do not fall under Virginia regulatory requirements. These two policies cover over 12,000 residents of the Commonwealth.

SUMMARY OF POTENTIAL IMPACT OF EXTRATERRITORIAL AUTHORITY

There are very strong arguments both for and against the extension of Virginia's insurance regulatory authority beyond state boundaries. The reasons cited by those in favor center on the need for consumer protection. The Virginia General Assembly has enacted several mandated benefit statutes for the purpose of protecting citizens of the Commonwealth. Some of these benefits are not provided for by many other states. Therefore, any policy issued to a group located in another state may not provide these coverages to Virginia residents who are group members.

This concern is exacerbated by the creation of many different types of multi-state groups that are making health insurance coverage available as a membership benefit. While most of these groups are considered to be "true" groups (that is, they were formed for reasons other than obtaining insurance and they serve a valid and useful purpose for their members), there is a growing belief among some state regulators that these groups are being developed specifically to circumvent state regulation. The example provided earlier in the report about the association that is "located" in Washington D.C. but in fact only has a Post Office box number there, leads to the concern that some groups that are providing insurance coverage for Virginia residents may not be looking out for the best interests of their members.

On the other hand, those opposed to extraterritorial jurisdiction over accident and sickness insurance policies focus their concerns on the potential increase in health care costs. Insurance companies may be faced with higher administrative costs if required to meet multi-state insurance requirements. They would have to keep current with law changes in each state and then make and implement required changes in policy and certificate forms, employee booklets, advertising, and claim procedures, and obtain the necessary approvals, all of which they maintain tends to be overwhelming.

The volume and diversity of multi-state mandated coverage laws can also place heavy demands on employers with employees in more than one state. A group benefit plan that covers employees in two or more states can be brought into compliance with extraterritorial benefit laws only if provisions are rich enough to meet the most severe requirements of each state in which the participants reside or are employed. Those opposed to extraterritorial authority over group accident and sickness insurance policies argue that the multiplying effect of multi-state requirements

could generate an extremely rich plan at a disproportionately high cost.

As group accident and sickness insurance has become more and more expensive, business and industry have sought cheaper alternatives to the costly health plans traditionally offered to their employees. Self-insurance has developed as one alternative that takes several forms and has the potential to impact the state's income. Such a movement can result in loss of premium tax income to the states, loss of control over the substance and solvency of uninsured plans, and loss of insured business by traditional insurers. Possibly of greater concern is that the ability to protect the consumer covered under such plans is taken out of the hands of the state insurance regulators. The number of groups in Virginia that have turned to self-insured plans is unknown but the estimates are growing. Nationally, two-thirds of employer groups have become self insured.

Range of Regulatory Options

There are a range of regulatory options that could be considered for overseeing health insurance policies issued out-of-state but covering Virginia residents. On one end of the spectrum, extraterritorial jurisdiction could be sought over all health insurance policies providing coverage to Virginia residents regardless of where the policy is issued. Requiring all accident and sickness insurance policies covering Virginia residents to meet all Virginia regulatory requirements would have the positive effect of:

1) providing all Virginia residents with the same benefits. (The General Assembly specifically mandated certain benefits for the protection of Virginia residents, but current law only provides those benefits to "some".)

2) protecting Virginia consumers against "fictitious" groups. (Many of these groups are formed only to market insurance; they sometimes are of questionable reputation and they have been known to forum shop for the state with the least stringent requirements; their products would not be approved under Virginia requirements.)

3) avoiding substantial confusion for Virginia resident beneficiaries as well as Virginia health care providers with regard to scope of coverage questions.

At the other end of the spectrum, extension of Virginia regulatory authority to group health policies issued out-of-state but covering Virginia residents could be rejected.

Requiring all policies covering Virginia residents to meet all Virginia requirements would have the negative effect of:

1) increasing the cost of coverage. (The increase in levels of contractual benefits as well as administrative support by the companies may increase the cost of the affected health plans.)

2) hindering multi-state employers' efforts to contain costs. (Many employee health benefit plans are established through collective bargaining; such attempts would be impeded if Virginia employees were to be treated differently than the rest.)

3) expanding the number of self-insured plans. (The increase in cost of health insurance has led to an exodus from the traditional market which means that more individuals are being covered under plans that are exempt from state regulation through ERISA. Instead of protecting Virginia citizens, the effect could be to place more of them beyond our regulatory oversight.)

Protection of all Virginia residents can be considered a laudable goal, but it could also be highly impractical. The negative effects of extraterritorial authority over group accident and sickness insurance policies issued in another state could have serious side effects on the availability and affordability of health insurance for many Virginia citizens, thereby nullifying much of the positive effect.

Possibly a more balanced approach could be taken to limit the extraterritorial authority to those out-of-state groups where abuse or potential for abuse is most likely. Such groups are those described earlier in the report by the Nevada Supreme Court as having no employer or true organization to negotiate on behalf of the insured and to provide a buffer against overreaching by the insurer. These groups are often broadly referred to as "discretionary groups". Therefore, the most pragmatic solution might be to provide extraterritorial authority only for certain types of groups that include Virginia residents under policies issued out-of-state.

RECOMMENDATION FOR HJR 85

House Joint Resolution 85 requested that the State Corporation Commission's Bureau of Insurance determine if, and to what extent, group accident and sickness insurance policies issued for delivery in other states but covering Virginia residents should provide the same benefits that are required of policies issued in Virginia. Two major points were identified during the course of the study.

1) No other state has all of the same requirements that are mandated for accident and sickness insurance policies issued in Virginia.

   a. Virginia residents covered by out-of-state group policies may not receive all of the benefits deemed important as consumer protection by the Virginia General Assembly.

   b. Some Virginia residents covered by out-of-state group policies may receive more or different benefits depending on the state of issuance.

2) Many different types of groups are providing insurance to Virginia residents.

   a. "True" groups such as employer groups appear to provide the Virginia group member with a buffer between the insurer and the insured by negotiating terms for the group to lessen any arbitrary provisions in the master contract.

   b. Other groups have been created for the sole purpose of selling insurance and appear to offer little direct service and assistance to the Virginia group member; these groups have the potential for providing little benefit for the Virginia group member and causing hardship and confusion.

The study concluded that while extraterritorial authority over each and every out-of-state issued group policy may be neither necessary nor advisable, such authority appears to be needed with regard to those specific less-defined groups where the potential for abuse is greater.

The State Corporation Commission's Bureau of Insurance recommends that all group accident and sickness policies, unless exempted, comply with Virginia requirements equally.

The same requirements will apply as long as a resident of Virginia is covered, regardless of whether the policy is issued or delivered in Virginia or outside of Virginia.

The following exemptions should be included:

1. Employer groups where less than a majority of the persons covered on the effective date of the policy are residents of Virginia.

2. Labor Union groups where less than a majority of the members covered on the effective date of the policy are residents of Virginia.

3. Credit Union groups where less than a majority of the persons covered on the effective date of the policy are residents of Virginia.

4. Debtor groups where less than a majority of the persons covered on the effective date of the policy are residents of Virginia.

In addition, it is recommended that all group accident and sickness policies providing coverage to residents of the Commonwealth be made specifically subject to Chapter 5 of Title 38.2 (Unfair Trade Practices Act) and Chapter 6 (Privacy Protection Act).

The State Corporation Commission's Bureau of Insurance further recommends that the State Corporation Commission be authorized to promulgate and develop regulations that provide additional criteria for granting additional exemptions to extraterritorial jurisdiction and for the administration of extraterritorial authority.

In order to properly draft appropriate legislation, the State Corporation Commission's Bureau of Insurance recommends that a proposed bill be presented to the 1990 General Assembly. In the interim, the State Corporation Commission's Bureau of Insurance will work with the insurance industry to draft a bill that will provide a workable solution to the problems outlined in this study.

APPENDIX A

SURVEY RESULTS

VIRGINIA MANDATED BENEFITS

REQUIRED IN OTHER STATES

SURVEY RESULTS

VIRGININIA MANDATED BENEFITS FOUND IN OTHER STATES

	AL	*AK	AR	AZ	CA	CO	CT	DC	DE	FL
Reimbursement for services										
a. chiropractors	X		X	X	X	X	X		X	X
b. optometrists	X		X	X	X	X	X			X
c. professional counselors										
d. psychologists	X		X	X	X	X	X	X		
e. clinical social workers					X			X		
f. podiatrists	X		X	X	X	X	X			X
g. physical therapists					X					
h. chiropodists				X	X		X			X
Coverage for handicapped children			X	X	X		X			X
Coverage for services provided by a dentist	X		X	X	X	X	X			X
Coverage for newborn children	X		X	X	X	X	X	X	X	X
Coverage for mental, emotional and nervous disorders						X	X			X
Coverage for alcohol and drug treatment			X					X		
Preclude COB provision	X				X	X	X			
Require continuation of coverage			X	X	X	X	X			X
Other mandated benefits			X	X	X	X	X		X	

* did not respond to survey

SURVEY RESULTS (Cont.)

	GA	HI	IA	ID	IL	*IN	KS	KY	LA	MA
Reimbursement for services										
a. chiropractors	X		X	X	X		X	X	X	X
b. optometrists	X	X	X	X	X		X	X	X	X
c. professional counselors				X	X					
d. psychologists	X	X		X	X		X		X	X
e. clinical social workers				X	X		X		X	X
f. podiatrists	X		X	X	X		X		X	X
g. physical therapists				X	X		X		X	X
h. chiropodists	X		X	X	X		X			
Coverage for handicapped children	X	X		X	X			X	X	
Coverage for services provided by a dentist	X	X	X	X	X		X		X	
Coverage for newborn children	X	X	X	X	X		X		X	X
Coverage for mental, emotional and nervous disorders		X			X		X			X
Coverage for alcohol and drug treatment		X	X		X		X			X
Preclude COB provision			X	X	X		X	X	X	
Require continuation of coverage	X		X		X		X	X		
Other mandated benefits		X						X	X	X

* did not respond to survey

SURVEY RESULTS (Cont.)

	MD	ME	MI	MN	MO	MS	MT	NE	NV	NH
Reimbursement for services										
a. chiropractors	X	X	X	X	X	X	X	X	X	X
b. optometrists	X		X	X	X	X	X	X	X	X
c. professional counselors	X						X		X	
d. psychologists	X	X	X	X	X	X	X	X	X	X
e. clinical social workers	X	X					X		X	
f. podiatrists	X		X	X	X		X	X	X	X
g. physical therapists	X								X	
h. chiropodists	X						X		X	
Coverage for handicapped children	X		X	X	X	X	X	X	X	X
Coverage for services provided by a dentist	X		X	X	X	X	X	X	X	X
Coverage for newborn children	X	X	X	X	X	X	X	X	X	X
Coverage for mental, emotional and nervous disorders	X	X		X	X		X			X
Coverage for alcohol and drug treatment	X	X	X	X	X		X		X	
Preclude COB provision			X	X	X	X		X	X	
Require continuation of coverage	X	X		X	X		X		X	X
Other mandated benefits	X	X	X	X				X	X	X

SURVEY RESULTS (Cont.)

	NJ	NM	NY	NC	ND	OH	OK	*OR	PA	RI
Reimbursement for services										
a. chiropractors	X	X	X	X		X	X		X	
b. optometrists	X	X	X	X		X	X		X	
c. professional counselors										
d. psychologists	X	X	X	X		X	X		X	
e. clinical social workers							X			
f. podiatrists		X	X	X		X	X		X	
g. physical therapists			X	X			X		X	
h. chiropodists							X			
Coverage for handicapped children	X	X	X	X	X	X			X	
coverage for services provided by a dentist	X	X	X	X		X	X		X	
Coverage for newborn children	X	X	X	X	X	X	X		X	X
Coverage for mental, emotional and nervous disorders					X					
Coverage for alcohol and drug treatment			X	X	X				X	X
Preclude COB provision	X		X	X	X	X	X		X	X
Require continuation of coverage		X	X	X	X	X			X	X
Other mandated benefits	X		X		X	X	X			X

* did not respond to survey

SURVEY RESULTS (Cont.)

	SC	SD	TN	TX	UT	WV	WY	VT	WA	WI
Reimbursement for services										
a. chiropractors	X	X	X	X	X	X	X		X	X
b. optometrists	X	X	X	X	X		X		X	X
c. professional counselors			X		X		X	X	X	X
d. psychologists		X	X	X	X	X	X	X	X	X
e. clinical social workers		X	X	X	X		X		X	X
f. podiatrists	X	X	X	X	X	X	X			
g. physical therapists		X			X		X	X	X	
h. chiropodists		X			X	X	X		X	
Coverage for handicapped children	X	X	X	X	X		X	X	X	X
Coverage for services provided by a dentist	X	X		X		X	X		X	X
Coverage for newborn children	X	X		X	X	X	X	X	X	X
Coverage for mental, emotional and nervous disorders			X			X				X
Coverage for alcohol and drug treatment			X		X				X	X
Preclude COB provision	X	X	X	X	X				X	X
Require continuation of coverage	X	X	X	X	X	X	X	X	X	X
other mandated benefits		X		X		X		X	X	X

APPENDIX B

SURVEY RESULTS

STATES CLAIMING EXTRATERRITORIAL AUTHORITY

OVER GROUP ACCIDENT AND SICKNESS INSURANCE POLICIES

STATES CLAIMING EXTRATERRITORIAL AUTHORITY OVER GROUP ACCIDENT AND SICKNESS INSURANCE POLICIES

AL - no extraterritorial authority

AK - did not respond

AZ - no extraterritorial authority

AR - yes (code cite 23-79-109)

No policy shall be issued delivered or used as to a resident located in this state unless the form has been filed with the Arkansas insurance department. As to group insurance policies effectuated and delivered outside this state but covering persons resident in this state, the group certificates to be delivered or issued for delivery in this state shall be filed and approved by the Commission.

CA - yes (code cite 10195)

Applies to med sup policies only; applies to insurance provided to residents of this state under a group policy . . . regardless of the situs of the contract.

CO - no extraterritorial authority

CT - yes (public act no. 88-110)

Every group health insurance policy delivered or issued for delivery offered by an employer shall provide to employees employed in this state coverage which meets the [mandated benefit requirements]; (code cite 38-174m, 38-174x) medicare supplement and long term care statutes apply to certificates delivered or issued for delivery in the state.

DC - no extraterritorial authority

DE - no extraterritorial authority

FL - yes (code cite 627.6515)

Any group health policy issued or delivered outside this state under which a resident of this state is provided coverage shall comply with the provisions of this [set of provisions] in the same manner as group health policies issued in this state; this part does not apply to policies that are issued to "true" groups.

GA - yes

No cite or explanation given.

HI - no extraterritorial authority

IA - yes (code cite 509.1)

Standard discretionary law; no policy shall be delivered in the state unless it conforms to one of the following descriptions [definitions of true groups]; out-of-state discretionary groups may provide coverage to IA residents following specific criteria.

ID - no extraterritorial authority

IL - no extraterritorial authority

IN - did not respond

KS - yes (senate bill 668)

Group policies issued or renewed in another state but with the certificate holder being either a resident of or employed in the state must provide certain mandated benefits.

KY - yes (code cite 304.18-110)

Persons insured under group policies which affect residents no matter where the policy is issued, have the right of continuation of coverage upon termination of group membership.

LA - yes (code cite 611)

General chapter on insurance contract applies to any group policy covering residents of the state, regardless of where it was issued or delivered.

ME - yes (code cite 2808)

Group health insurance offered to a resident of this state under a policy other than one described as true group must meet specific criteria, plus the policyholder must be a bona fide group formed for purposes other than procurement of insurance.

MD - yes

Several statutes have been written with extraterritorial application, applying to certificates delivered or issued for delivery in the state; or to persons who live or work in MD; applies to health care provider benefits, and mental health coverage.

MA - yes

Several statutes have been written with extraterritorial application, applying to agreements between the insurer and the policyholder, within or without the commonwealth.

MI - yes

No code cite given but Michigan claims insurance authority extends to insurers and agents

MN - yes

Minnesota has various extraterritorial provisions which are found throughout its statutes

MS - no extraterritorial authority

MO - yes (code cite 376.421)

Applies to discretionary groups only; defines requirements for true groups.

MT - yes (code cite 33-22-701)

Requires all group accident and sickness policies that are offered to Montana residents to provide for the care and treatment of mental illness, alcoholism, and drug addiction

NE - yes (code cite 44-4511)

Only applies to medicare supplement and long term care policies.

NV - yes (code cite 689B.026)

Prohibits group health insurance policies from being delivered or issued for delivery to a group formed for the purpose of purchasing one or more policies of group health insurance unless specific approval from Commission is granted

NH - yes (code cite 415:18)

Requires certificates to be approved prior to use; all certificates must comply with all state requirements regardless of where policy is issued

NJ - yes (code cite 17B:29-7f and 17B:27-50(b)

Only with respect to credit insurance and psycholgists (reimbursent shall not be denied because the policy was delivered or issued for delivery outside of this state provided the covered individual is a resident of the state or employed in the state)

NM - yes (code cite 59A-16-1)

Unfair trade practices statutes apply to all insurers doing business in the state as well as alien and foreign insurers delivering or issuing for delivery in NM certificates or other evidences of coverage.

NY - yes (code cite 3201)

A group health certificate evidencing insurance coverage on a resident of this state shall be deemed to have been delivered in this state, regardless of the place of actual delivery unless the insured group is of the type described in [exempts true groups]

NC - yes (code cite 58-28)

All contracts of insurance or applications for insurance which are taken within the state shall be deemed to have been made within this state and are subject to the laws thereof

ND - yes (code cite 26.1-30-19)

Requires approval of certificates that are issued for delivery or delivered in the state and approval of applications used with such certificates

OH - yes

Several statutues have been written with extraterritorial application, applying to any certificate furnished by an insurer in connection with a policy used in this state.

WY - no extraterritorial authority

Provides that group insurance policies carried out and delivered outside this state but covering persons resident in this state, must have the certificates filed with the commissioner,at his request, for his information only

VT - no extraterritorial authority

WA - yes (Reg. 284-30-600)

It shall be an unfair practice for any insurer to effect [life or] disability insurance covrage on persons in this state under a group policy which is delivered outside this state when: the out-of-state policy does not provide for reimbursement of mandated providers; meet mandated benefit requirements; this shall apply to coverage offered to all groups except those specifically defined.

WI - yes (code cites 600.01 and 632.897)

Insurance provisions do not apply to group insurance covering risks in this state if the policyholder exists primarily for purposes other than to procure insurance; no more than 25% insureds are resident of the state. If such policy has at least 150 insured that are residents of the state, certain benefits are required.

OK - yes (code cite 3602)

Policy is defined to include contract of or agreement for effecting insurance, or the certificate thereof...; no policy form may be used unless filed with and approved by the Commissioner

OR - did not respond

PA - yes

Code cite not given; applies extraterritorial authority because licensed agents are required to sell approved products.

RI - yes (Regulation XXIII)

Regulation XXIII was developed to make coverage available to persons residing in state; the reg applies to all health benefits plans issued, delivered or offered for sale in RI to the extent that such plans cover RI residents

SC - yes (code cite 38-71-750)

Prohibits group a&s policies from being extended to residents under a policy issued outside of state which does not provide in substance the provisions required by S.C.

SD - no extraterritorial authority

Do not have e.t. authority but group being insured must be a recognized group; a discretionary group is not recognized and must obtain coverage through individual policies

TN - yes*

*Attorney General's Opinion interpreted the statute on payment to chiropractors to apply extraterritorially

TX - yes (art. 3.42)

Policies and applications delivered, issued or used in the state must be filed prior to use for approval

UT - no extraterritorial authority

WV -no extraterritorial authority

APPENDIX C

POSITION STATEMENTS FROM INDUSTRY AND CONSUMER GROUPS

STATEMENT OF THE AMERICAN COUNCIL OF LIFE INSURANCE RELATING TO HJR 85, EXAMINING WHETHER, AND TO WHAT EXTENT, GROUP HEALTH INSURANCE POLICIES, PROVIDING COVERAGE TO VIRGINIA RESIDENTS, SHOULD PROVIDE THE SAME BENEFITS TO ALL VIRGINIA RESIDENTS, REGARDLESS OF WHERE THE GROUP POLICY IS ISSUED.

Historically, the ACLI has had a general policy of opposition to state mandates. As extraterritorial extension of mandated benefits, in essence, constitutes a "super" state mandate, by imposing all of the mandating state's laws on an out-of-state contract, the ACLI position, with respect to such extraterritoriality, in Virginia or in any other state, is also one of general opposition.

It should be noted that, as a general rule, many of the large group insurers already are recognizing intra state laws in connection with the issuance of coverage under Multiple Employer Trusts (MET's). In fact, these carriers very often administer benefits, payable under MET's, based upon the principal location of the employer or member. Consequently, while extraterritoriality is not desirable under any circumstances, it would be acceptable if its application, in Virginia, were to be limited to groups, formed for the purpose of obtaining insurance, and to employers (not employees), principally located in Virginia, and participating in the group plan.

While acceptable in the context of MET's, extraterritoriality continues to be extremely undesirable in the traditional group situation. The ACLI opposes mandated benefits and their extraterritorial extension in the traditional group context for a variety of reasons, which are as follows:

(1) Because of the lack of uniformity in state group health insurance laws, their extraterritorial application to

group health insurance policies has the potential of severely disrupting the efficient administration of these policies.

(2) The increased levels, of required contractual benefits and administrative support, necessarily arising as a result of extraterritoriality, increase the cost of affected group health insurance plans, causing some employers to go uninsured and others to go self-insured.

(3) Because self-insured plans are not subject to state mandates, there is an unequal playing field, between insured and self-insured plans, which gives the latter an unfair competitive advantage.

(4) Group insurance is typically a benefit of employment. Consequently, the expectations of the parties (i.e., the insurer, the employer and the employee) is that the law of the state, where the contract was issued, typically the law of the state of the employer's domicile, will govern the benefits to which the employee is entitled.

Because of the tremendous variation in state mandates, regarding the types and extent of health insurance benefits required, extraterritorial extension of these benefits has the potential of "balkanizing" the regulation of group health insurance policies and causing them serious administrative disruption. Not only do group insurers often fail to have the names and addresses of all certificateholders, insured under a group health insurance plan, but even if, at the inception of the contract, the insurer is provided with this information, the

claims process is complicated by the need to maintain a record of each certificateholder's current address and to calculate different benefits, depending upon state of residence. This process is further complicated by the fact that it is highly possible, particularly with a group plan, insuring employees in several states, that a single contract will be subject to laws, which either differ or conflict. For example, mandated benefits, with respect to coverage of treatment for alcoholism and mental illness, vary tremendously. Some states mandate coverage of in-patient care, but not out-patient care; some states mandate the opposite; some require coverage only for care rendered in specialized treatment facilities; others do not; different states have different benefit limits and coinsurance features.

Also, payment of different benefits to employees, in like company positions, but resident in different states, may not only cause administrative complexities, but may be counter to an employer-policyholder's personnel policy or to a collective bargaining agreement, which requires payment of uniform benefits to employees, in like company positions, regardless of their state of domicile. Finally, because of the numerous differing state requirements and procedures, for the filing and approval of group polices and certificates, and also because many of these requirements are cumbersome and time-consuming, the effect of extraterritoriality, in these respects, is to further complicate the development, introduction and administration of these plans.

The increased levels of benefits and administrative support, required as a result the application of extraterritoriality, give

rise to increased costs, which destroy the administrative economies inherent in group insurance. It should be recalled that inherent to the idea of group coverage is the concept that reduced administrative costs and increased efficiencies will be passed on to consumers in the form of lower premiums. As a result of the numerous complexities, associated with extraterritoriality, administrative costs will be increased and efficiency decreased, causing premiums to rise.

As the cost of premiums rise, some employers will decide to go uninsured or self-insured. Mandates and the increased costs, associated with them, have been the cause of rapid increase in self-insured plans. These plans are not subject to state mandated benefits laws. In addition, some of these plans are under-capitalized, as a result of which they may be unable to honor claims when due. Consequently, the net result of the increased cost, necessarily associated with extraterritoriality, may be to accomplish the very opposite of that which is intended. The purpose of making Virginia group health insurance laws extraterritorial would be to ensure that Virginia residents, insured under group policies, receive the benefits required by Virginia law, regardless of the state in which their group policy was issued. Under current law, even if a Virginia resident is insured under a group plan, issued in a state, with less stringent requirements than those of Virginia, that resident is still insured under a plan, subject to some state requirements. If Virginia's group health insurance laws become extraterritorial, causing premiums for group health insurance coverage to increase,

some employers will decide to go uninsured, leaving their Virginia employees with no coverage at all. Other employers will decide to go self-insured. Some of these plans will be undercapitalized and unable to pay claims. Those which are adequately capitalized still will not be subject to any state mandates. Therefore, the net result of extraterritoriality very well may be that Virginia residents do not receive more benefits and are left with no coverage or with less coverage than they currently have.

Because self-insured plans are not subject to state mandates, they are not subject to the extraterritorial extension of these mandates, thereby exacerbating the existing lack of parity between insured and self-insured plans. Therefore, extraterritoriality serves to further self-insured plans' unfair competitive advantage over insured plans, and to perpetuate growth of this form of coverage.

Group health insurance is typically a benefit of employment. Insurers, employers and employees reasonably expect such benefits, like other benefits of employment, to be governed by the state, where the employer and the insurer entered into the contract for such benefits. This expectation is not based on a desire to evade state mandated benefits laws. It is based on a desire to have a contract, which provides benefits and can be administered in the most efficient and fair manner possible.

For the reasons noted above, the ACLI and its membership generally are opposed to the extraterritorial extension of mandated benefits in the traditional group situation and consequently would be opposed to such an extension of Virginia

mandated benefits in the traditional group situation. As noted at the outset of this Statement, extraterritoriality, though not desirable under any circumstances, would be acceptable only if limited, in its application, to the context of MET's. Moreover , any application of extraterritoriality should be made prospective to avoid extensive excess costs and administrative problems with existing plans.

Blue Cross
and
Blue Shield
of the National Capital Area

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Chartered by the Congress of the United States

88 AUG 22 A 11:50

August 19, 1988

EXPRESS MAIL

Stephen J. Kaufmann
Deputy Commissioner
Bureau of Insurance
State Corporation Commission
P. O. Box 1157
Richmond, Virginia 23209

Re: HJR 85 Study

Dear Steve:

Thank you for your letter of August 1, 1988 asking for our views on extraterritoriality to assist in the Bureau's study as required by HJR 85. It is our understanding that the Bureau is charged with examining "...whether, and to what extent, group accident and sickness insurance policies providing coverage to Virginia residents should provide the same coverage to all Virginia residents regardless of where the group policy is issued."

Adoption of this concept by the Commonwealth would, of course, require that insurance policies issued in other states conform to Virginia law. This would assure that Virginia residents would consistently be entitled to benefits and other aspects of insurance programs as required by Virginia statute and regulation. It would also create a number of problems for employers and insurance carriers doing business in Virginia.

We offer the following comments for your consideration, and ask that they be addressed as part of the Bureau's examination of the extraterritoriality concept:

* BCBSNCA AREA BUSINESS ADVERSELY AFFECTED

  BCBSNCA has always served subscribers in a multi-jurisdictional environment. The most common employment and residence situation we encounter is that of an account which is located in one of the three principal jurisdictions we serve, and which has employees residing in each of them. We have for many years utilized the employer's headquarters address or actual business location to determine which mandated benefits and regulations would apply. The administrative costs and burden of using employees' residence addresses to determine their health care benefits would be prohibitive and would result in an additional charge that would have to be passed on to our subscribers.

* BCBSNCA REGIONAL BUSINESS ADVERSELY AFFECTED

A problem also exists with respect to the numerous accounts in which we participate as a regional Blue Cross and Blue Shield Plan. For example, under existing national account arrangements, a Blue Cross and Blue Shield Plan in another state agrees to provide the coverage for a national organization (with employees and offices in many states). Many Blue Cross and Blue Shield Plans are called upon to administer those benefits according to a national account contract with standardized benefits negotiated and originating in that other state. Should we find that we cannot accommodate the contract because one jurisdiction will not permit it to apply to their residents as written, the result will be a costly administrative problem, in addition to the potential problems for the employer where benefits have been negotiated pursuant to a labor agreement.

* WOULD PROMOTE SELF-FUNDED ARRANGEMENTS

This kind of state action fosters a regulatory environment (as we have seen with state mandated benefits) that has caused many employers to elect self-funded arrrangements to meet their health care insurance needs in order to avoid state regulatory requirements. The majority of large employers throughout the nation now have self-insured programs and are not subject to state insurance laws and regulations.

* NEGATIVE EFFECT UPON STATE TAX REVENUE

The current trend towards self-funded arrangements may be expected to continue to have an adverse impact upon state premium tax revenue, and the state's ability to regulate the business of insurance.

* PERCEIVED AS ANTI-BUSINESS IN NATURE

Under the present administration, the Commonwealth has done an outstanding job in fostering a pro-business environment. Interfering with some employers' (primarily small employers) health care programs by requiring them to conform to Virginia law will be costly, administratively burdensome, and thereby may be perceived as anti-business in nature.

* INCREASE IN BUREAU OPERATING EXPENSES

The operating expenses of the Bureau should be expected to increase based upon the cost of the additional review and enforcement activities that would have to be undertaken as a result of such an enactment. This, of course, is funded by insurance carriers, and again, would be a pass-through charge to an insurer's policyholders.

* NEGATIVE IMPACT UPON CONCEPTS OF GROUP INSURANCE

  Two of the basic premises of group insurance, uniformity in standards and benefits, and mass grouping of risks, which are essential to the successful group coverage concept, will be adversely affected by such an enactment.

* OTHER STATES' NEGATIVE REACTION AND RECIPROCITY

  Extraterritoriality in place in Virginia might be viewed with disdain in neighboring states. Passage of reciprocal statutes in Maryland, West Virginia, or North Carolina would be a possibility, and most likely would not be favorably received by the Virginia Business Community.

* REDUCTION IN BENEFITS FOR SOME RESIDENTS

  A number of Virginia residents are presently employed by Maryland employers and (due to our practice of providing benefits based upon the account's domicile) enjoy a greater level of mandated benefits than would be applicable if Virginia benefits were required. These citizens would experience an actual reduction in benefits with such an enactment.

* NEGATIVE EFFECT UPON EMPLOYERS IN VIRGINIA AND ELSEWHERE

  Any Maryland employers, having Virginia residents as employees, could easily find themselves in the position of having to offer two types of federally required HMO coverage to all employees, all of Maryland's mandated benefits to some employees, and Virginia mandated benefits to Virginia residents as the result of such an enactment. Should Maryland pass a similar enactment, Virginia employers with Maryland residents as employees would face the same problems. This situation becomes even more complex if other neighboring jurisdictions follow suit with their own extraterritorial enactments.

* FEDERAL REGULATION

  The overall burden of the confusion, administrative difficulty, and expense experienced by business interests in attempting to comply with multi-jurisdictional requirements, particularly when those requirements cannot be aligned or administered uniformly, may well become a catalyst in the continual battle for preemptive Federal regulation of insurance.

We urge the Bureau to avoid the extraterritorial concept as a recommendation to the General Assembly.

Thank you for the opportunity of providing you with this information and participating in the Bureau's study efforts. If I might answer any questions or provide any further information, I may be reached at (202) 479-8386.

Very truly yours,

Richard A. Cook

Richard A. Cook
Vice President
Legal and Legislative Affairs

Blue Cross
Blue Shield
of Virginia

Joan M. Gardner
Government Affairs Counsel

2015 Staples Mill Road
Post Office Box 27401
Richmond, Virginia 23279
804/359-7288

August 11, 1988

REVISED August 18, 1988

Ms. Lisa DiNunno
Regulatory Policy Division
State Corporation Commission
Bureau of Insurance
P. O. Box 1157
Richmond, Virginia 23209

Re: HJR 85 Study

Dear Ms. DiNunno:

I am writing in response to Steve Kaufmann's letter of July 18, 1988 requesting a position statement from Blue Cross and Blue Shield of Virginia regarding the issue of extraterritorial jurisdiction over group health insurance policies by the Virginia Bureau of Insurance. We appreciate the opportunity to participate in the Bureau's study of this issue and we would like to provide the following comments:

1. As Blue Cross and Blue Shield of Virginia is licensed as a health care services plan only in Virginia, one might assume that we would be in favor of extraterritorial application of our mandated benefits statutes on the theory that such a step would "level the playing field" among our competitors. Quite the opposite is true. Issues of state regulatory authority over entities not licensed to do business within the state cannot be analyzed on a "level playing field" basis.

If state regulators begin moving en masse toward extraterritoriality, we believe that it would not be long before the federal government stepped in to eliminate the confusion. We would take the position of opposing any measure which would ultimately result in states relinquishing their authority to the federal government to regulate the insurance industry. It is our opinion that the states are in the better position to regulate the business of insurance within their borders than is the federal government.

2. Statutes granting extraterritorial jurisdiction could be attacked on a variety of constitutional grounds, including violations of the contract clause, the commerce clause, as well as the provision of due process. In the handful of states that have passed such laws, we understand that constitutional challenges have been made. We hope that the Bureau of Insurance would research this issue

carefully during its study. We feel that the argument remains strong that under constitutional and traditional conflict of law principles, contracts for goods or services are governed by the laws of the state in which the contract was issued.

As a side note, we are curious about how regulatory bodies administer similar laws and police each health care program of every state resident to assure compliance with mandated benefits. Also, since policies are issued by employers and third party administrators as well as by insurers, would the regulatory body direct its policing efforts toward the insurer, the administrator, or the contract holder of any non-complying form?

3. We also would like to raise the issue of the impact of an extraterritorial jurisdiction statute on certain federal employee benefits laws governing programs such as COBRA, continuation policies and employer's benefit level responsibilities under Section 89. In requiring different benefit plans within the same employer-sponsored health benefit program, we perceive the real potential for operating discriminatory plans and thus causing a conflict with the federal laws that are imposed on employers offering employee benefit programs.

4. Last, but certainly not least in the minds of group health benefit program administrators, are the administrative costs associated with the burden of providing for multi-levels of mandated benefits. Administrative costs are passed on directly to group subscribers and their members. These members are paying for a benefit which in the best judgment of the purchaser of the benefit was not appropriate for the group program, as a whole. We do not follow the logic of imposing layers of regulation on insurers, and in essence on employers, when there is questionable benefit to the group subscriber and individual group members.

If we are to support and promote the concept of group insurance, there is no alternative but to promote the concept of groups contracting for goods and services in accordance with the laws of the state in which that contract is consummated. The business of insurance is transacted between purchaser and seller. Purchasers and sellers are regulated by the laws of the state in which the insurance transaction occurs. Regulating a group health insurance transaction at the beneficiary's level makes little sense from a public policy perspective, makes less practical sense, and makes no economic sense whatsoever. We would hope that the research strategy established for this study would encompass surveys of employer groups operating on a multi-state basis in order to get a firsthand account of their concerns with administering employee health benefit programs within a scheme of multi-level mandated benefits.

Thank you for the opportunity to comment. Please feel free to contact us if you would like to discuss any of these issues in more detail. We will follow with interest the progress of and the ultimate report resulting from the HJR 85 Bureau of Insurance Study.

Sincerely,

Joan M. Gardner

JMG/bb

cc: Gerald L. Good

VIRGINIA MANUFACTURERS ASSOCIATION
Ninth & Main Streets, P.O. Box 412, Richmond, Virginia 23203, 804-643-7489

August 12, 1988

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* Denotes Executive Committee

VMA General Counsel
FRANK TALBOTT III, Danville

Mr. Stephen J. Kaufmann
Deputy Commissioner of Insurance
State Corporation Commission
P. O. Box 1197
Richmond, Virginia 23209

Dear Steve:

Thank you for your letter of July 18, 1988 with regard to the study authorized by HJR 85.

The Virginia Manufacturers Association has consistently opposed state mandated health benefits. The Code of Virginia has been revised over the years to expand the mandates for group health insurance coverage. We firmly believe that these benefits (like all employee benefits) should be decided by employers and that state intrusion in this field is totally unwarranted and disruptive to the employer/employee relationship. Where collective bargaining is involved, for instance, and a employer can afford to offer wages and benefits at a certain level, then the choice of what benefits to be offered and accepted should be decided through the collective bargaining process.

Businesses with multi-state facilities may have the majority of these employees located in states other than Virginia with perhaps only a fraction of that total employment in Virginia. In such cases, it would be perfectly reasonable for the employer to provide group health coverage purchased from an insurance company located and doing business in a state other than Virginia and having fewer mandated requirements than is required under Virginia law. This should be permitted regardless of the number of employees involved, the percentage of total employees located in Virginia, and without regard to where a business is incorporated or headquartered.

It is our firm belief and strong recommendation that current Virginia law should not be changed with regard to group health insurance policies issued in another state.

Thank you for the opportunity to comment and if you have any questions on this matter, please let me know.

Very truly yours,

Z. C. Dameron, Jr.

ZCD:ml

August 15, 198

Stephen J. Kaufman
Deputy Commissioner
Regulatory Policy Division
Commonwealth of Virginia
State Corporation Commission
Bureau of Insurance
Box 1157
Richmond, VA 23209

Dear Steve:

We thank you for the opportunity to comment whether, and to what extent, group health insurance policies providing coverage to Virginia residents should provide the same benefits to all Virginia residents regardless of where the group policy is issued.

We would oppose making group insurance programs subject to the mandated benefit laws in each state. To do so would destroy the character and efficiency of group insurance and would severely retard the ability of group sponsors to design unique and coherent programs for their members on a national basis, and to bargain effectively with insurers so that coverage can be provided for their members at the lowest possible cost.

Group sponsors desire to provide the same coverage options to all their members, regardless of geographic location, so as to assure equitable treatment, to control the cost of coverage, and to permit the design of unique and innovative coverage packages. This innovation includes experimentation with new benefit options and cost control features. Requiring compliance with a variety of widely differing state benefit mandates would directly impede the coherence and rationality of such programs, making these goals far more difficult to achieve. Operating a program with a myriad of benefit configurations and requirements would make it almost impossible to identify and respond to adverse trends and administrative problems. It could even compromise the ability of such groups to continue offering such coverage and very possibly impact negating the credibility and integrity of these knowledgeable and effective group policy holders.

Requiring compliance with each state's mandated benefit laws also would substantially reduce the administrative efficiency of group programs. Not only would a program need different certificates, brochures, and claim forms for each state, but it would also bear the increased cost of monitoring and complying with existing as well as new and ever changing benefit mandates for each state. Claims administration also become complex and expensive. Of course, these increased costs are borne by the group sponsor and its members.

The principle of group insurance is that groups - employers, unions, bona fide associations - are intelligent insurance purchasers who can ably negotiate with insurers on behalf of group members. While these groups clearly are subject to the minimum benefit requirements governing their master policy, other states traditionally have relied on the regulation of the state where the master policy was issued, as well as on the ability and strong desire of the group policyholder to protect group members. This system is effective and worthwhile.

Most Americans are covered by low cost, high quality health insurance programs. Requiring all group programs to meet Virginia's mandated benefit rules can only increase the cost of group coverage in the state.

Sincerely,

Ron Hagen /dpk

Ronald D. Hagen
Director, Insurance Services

cc: Greg Merrill
Frank Forbes
Lisa DiNunno

COMMONWEALTH of VIRGINIA

DEPARTMENT OF

Mental Health, Mental Retardation and Substance Abuse Services

IOWARD M. CULLUM
COMMISSIONER

MAILING ADDRESS
P.O. BOX 1797
RICHMOND, VA 23214
TEL. (804) 786-3921

August 24, 1988

Stephen J. Kaufmann, Deputy Commissioner
Regulatory Policy Division
State Corporation Commission
Bureau of Insurance
P.O. Box 1157
Richmond, Va 23209

Dear Mr. Kaufmann:

Thank you for giving me an opportunity to provide the Bureau of Insurance information relative to HJR 85.

There are several areas that are similar to HJR 85 that the Department of Mental Health, Mental Retardation and Substance Abuse Services is pursuing. I have developed a study group to research in general with the objective of determining new and/or expanded ways of providing coverage for citizens of Virginia with mental disabilities. In addition within the past year I have directed my staff to study the services that Medicaid in Virginia will cover.

House Joint Resolution #85, is of interest to the Department of Mental Health, Mental Retardation and Substance Abuse Services from a funding perspective. You are probably aware that the Department actively pursues payments from insurances to offset the cost of providing care to the patients and residents served. The degree of success of these efforts has a direct bearing on the amount of financial assistance that is required through appropriations from the General Assembly. I endorse any measures that will afford citizens of Virginia an increased means through insurance to pay for services provided by this Department and/or reduce possible burdens on the taxpayer.

Your staff has indicated that you are particularly interested in situations where an individual was refused or elected not to pursue treatment due to limitations created by differences in insurance laws of out-of-state carriers. It is important that you are aware that the Department of Mental Health,

Mental Retardation and Substance Abuse Services is governed by a section of the Code of Virginia [37.1-105 et al.] that prohibits refusal of services to individuals solely based on financial considerations. Therefore, the possibility of a scenario as indicated above is extremely remote.

If you have any additional questions regarding insurance issues relative to the Department of Mental Health, Mental Retardation and Substance Abuse Services, please contact me or John Jackson, who is the Reimbursement Director for the Department, at (804) 786-6157.

Sincerely,

Howard M. Cullum

Howard M. Cullum
Commissioner

HC/are

COMMONWEALTH of VIRGINIA

C.M.G. BUTTERY, M.D.
COMMISSIONER

Department of Health
Richmond, Virginia 23219

July 28, 1988

Mr. Stephen J. Kaufman
Deputy Commissioner
Regulatory Policy Division
Bureau of Insurance
State Corporation Commission
Box 1157
Richmond, Virginia 23209

Dear Mr. Kaufman:

Thank you for your July 18, 1988, letter concerning the State Corporation Commission study pursuant to HJR 85. I have shared your letter with my staff. I regret that the information you gave us about extraterritorial application of Virginia statutes was too vague for us to develop an opinion.

Emotionally, we feel that Virginia citizens should be treated equitably. However, you did not provide enough information about potential inequities and whether Virginians would be treated better or worse, or in what ways. You did not provide potential solutions or alternatives.

In the absence of any relevant data, our position on insurance is that a broad enough range of options should be open to Virginians of all income groups to ensure availability of basic health services. We also believe that information about the benefits and deficits of various kinds of insurance should be stated in clear simple English that will allow any applicant for insurance to choose wisely from the options.

I hope this information is useful to you.

Sincerely yours,

C. M. G. Buttery, M.D., M.P.H.
State Health Commissioner

CMGB:bcl

copy: Maston T. Jacks, Esquire
Deputy Commissioners
Legislative Analyst

NATIONAL INSURANCE
CONSUMER ORGANIZATION

July 20, 1988

Mr. Stephen J. Kaufmann
Deputy Commissioner
Regulatory Policy Division
State Corporation Commission
Bureau of Insurance
Box 1157
Richmond, VA 23209

Dear Mr. Kaufmann:

This is in response to your letter of July 18, 1988 in which you ask for NICO's input as to whether and what extent group health insurance policies providing coverage to Virginia residents should provide the same benefits to all Virginia residents regardless of where the group policy is issued.

They should be required to provide <u>at least</u> this level (same coverage as required of Virginia issued policies).

<u>Reason:</u> Large firms (employers) could engage in unfair competition by seeking policies in the least coverage states. States then might compete for premium taxes by adopting lax coverage standards, to the detriment of its citizens.

Thank you for the opportunity to express NICO's position on this matter.

Yours very truly,

J. Robert Hunter
President

JRH/ljb

88 JUL 25 AM 11:51

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TELEPHONE 615-637-4311

July 29, 1988

FILE NO. 30850.1

DIRECT DIAL NO. 804 788- 8289

Mr. Steven J. Kaufman
Deputy Insurance Commissioner
State Corporation Commission
Box 1157
Richmond, Virginia 23209

Dear Steve:

Jim Moore, the Executive Vice President of the Medical Society of Virginia, has asked me to respond to your letter of July 18 asking for the Society's views on the question whether group health policies written out of state, but providing coverage in state, should provide the same benefits as in state policies. While there has been no formal consideration of the issue presented, I believe I speak for the Medical Society in taking the position that to the extent the State has elected to mandate health insurance benefits, it is desirable that those mandated benefits cover all Virginia residents, regardless where the contract may have originated. It seems logical that our articulated state policy should not be subject to being avoided simply by having the contract executed out of state. Further, application of the statute to all Virginia residents will avoid substantial confusion for Virginia resident beneficiaries as well as Virginia health care providers with regard to scope of coverage questions.

I recognize there may be a substantial legal question as to the ability of the state to extend mandated benefits to contracts executed out of state. To the extent that you can get comfortable that you have the authority to do so, it seems to me that the policy justifications all point toward the exercise of that authority.

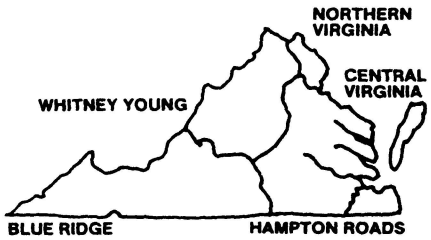
Please let me know if you have any questions regarding this matter.

Most sincerely,

Allen C. Goolsby, III

cc: Mr. James L. Moore, Jr.

VIRGINIA CHAPTER
NASW
NATIONAL ASSOCIATION OF SOCIAL WORKERS INC.



1500 Forest Avenue, Suite 224
Richmond, Virginia 23288
804/282-0788

August 23, 1988

Mr. Stephen J. Kaufmann, Deputy Commissioner
Bureau of Insurance
State Corporation Commission
P. O. Box 1157
Richmond, Virginia 23209

Dear Commissioner Kaufmann:

On behalf of NASW, I want to thank you for the opportunity to provide information concerning the study directed by House Joint Resolution 85. NASW is very much concerned about the issues of extraterritorial application of Virginia statutes to group health insurance policies covering Virginia residents.

Many of our members are Virginia licensed Clinical Social Workers (LCSW) attempting to provide quality clinical psychotherapy services to the citizens of the Commonwealth. Virginia citizens who are employed in industries which have group health insurance policies issued in another state are denied access to Licensed Clinical Social Workers as providers of health care. This unequal application of the Virginia Insurance Code denies citizens free choice and access to qualified licensed providers.

A specific example of this is in the Shenandoah Valley. A large pharmaceutical company, Merck, Sharpe and Dohme, Inc., has its main corporate officers in Pennsylvania. Most of these workers do not have access to Licensed Clinical Social Workers for their mental health needs even though a large number of the providers in this rural community are Licensed Clinical Social Workers. NASW takes the position that group insurance policies covering Virginia residents, regardless of where the policy is issued, should be required to provide the same coverage as required of Virginia-issued policies, assuring consistency of coverage for all citizens of the Commonwealth.

We thank you again for the opportunity to comment during this process. If we may be of further service, I trust you will contact us.

Sincerely yours,

R. Michael Marsh

R. Michael Marsh, Ph.D., ACSW
President

RMM/JGL/cn

EQUAL ACCESS TO ALL MANDATED HEALTH CARE SERVICES AND HEALTH CARE PROVIDERS FOR ALL CITIZENS

A POSITION PAPER FROM THE VIRGINIA SOCIETY FOR CLINICAL SOCIAL WORK, INC

AUGUST 15, 1988

Since the enactment of legislation to provide availability of health care services from a broad variety of health care providers, the citizens of Virginia have benefited greatly The legislative mandate for equal access not only provided parity among health care providers, it also allowed the citizens of Virginia the right to choose among health care providers without risking noncoverage of certain professionals by their group health insurance Clinical social workers have observed that many patients who might have previously chosen other mental health professionals due to lack of insurance coverage for clinical social workers are now choosing clinical social workers This is gratifying to everyone involved Everyone seems to benefit Everyone benefits except for one unfortunate and previously invisible group - those Virginia citizens whose group health insurance plans are written in states which do not mandate the services and providers mandated in Virginia

Many Virginia citizens, who are employed within Virginia, work for corporations with corporate headquarters in other states In many instances, these companies may have group health insurance plans which are written in other states If the state where the plan is written does not have the same coverage that is mandated in Virginia, the company may choose to disregard the mandate in Virginia As a result, the Virginia employee does not have the same equal access as his neighbor who is employed by a Virginia based company This is not fair This is not equitable This situation denies equal access This situation denies the equal protection of the law This situation causes unnecessary hardship Both Louisiana and California added language to their parity laws to prohibit circumvention of the mandate

We can only speculate regarding how widespread a problem the circumvention of the Virginia mandate may be But we have provided four examples of such problems and we suggest that if the situation is not corrected now, circumvention of the mandate will grow and expand as more and more multinational corporations move into Virginia It is unfair for worker A to have access to all services and all providers while it is denied to worker B It is unfair for the mandate to cover the Virginia based company but not the company based out of state As clinical social workers, we are concerned that sometimes we are the only mental health providers in particular regions of the state If any of these regions were dominated by employers who are based out of state, the result could prove disastrous for the mental health and well being of the entire region

The Virginia Society for Clinical Social Work unequivocally supports the position that group health insurance policies issued outside of Virginia but covering Virginia residents should be required to provide the same coverage as required of Virginia issued policies

Respectfully submitted,

R. Reese Harris

R Reese Harris, LCSW
President

RRH/ljl

EXAMPLES OF PROBLEMS PATIENTS HAVE EXPERIENCED
DUE TO HAVING OUT-OF-STATE INSURANCE

General Electric Insurance, Philadelphia, Pennsylvania

The patient was a 16 year old female who was admitted to a psychiatric hospital in Richmond and who was seen by an LCSW several times a week for six months' inpatient stay Prior to admission the hospital had talked with the insurance company and were told that LCSW's were covered

Reimbursement was sent to the LCSW for his sessions, but then the company began to question the reimbursement and said they paid the claim by mistake. They indicated they thought the patient was being treated in Maryland - not Virginia - and since Maryland's law did mandate coverage they would have covered the LCSW services there but not in Virginia since they weren't under the law here When the man in charge of the insurance claims department for G E was told we did have a vendorship law for LCSW's in Virginia, he stated that any state could make a law but that didn't mean they had to pay attention to it and implied that in order to get reimbursement the matter may need to go to court The amount in question was in the range of $4,000-$5,000 In this case the patient's family would either be burdened with the bill that they did not expect or contract for, or the LCSW would be unpaid for six months' of therapy The patient is a Virginia citizen

McKee Baking Company, Nashville, Tennessee

The patients were a couple and their two children who wished to be seen on an outpatient basis The couple was going through a very adversarial divorce and both did agree that the children were being affected and that counseling was indicated However, there was some problem agreeing on a therapist to see them, and finally with court intervention the two lawyers agreed for their clients on a therapist, an LCSW An appointment was made for them, and when they came in their insurance information was reviewed The insurance booklet stated that "Eligible charges under the plan include treatment by a licensed psychologist and psychiatrist but not by a social worker " The therapist phoned the insurance company to explain that in Virginia LCSW's were considered reimbursable providers, but was told that the McKee insurance plan did not have to abide by Virginia's laws since they were in Tennessee. The patients were Virginia citizens and had to go through the whole process once again of agreement on a therapist, which delayed the needed services

(continued)

Food Lion Insurance Plan, North Carolina

The patient was a woman who was experiencing depression due to a recent loss and who sought outpatient services from an LCSW She saw the therapist for only a couple of sessions before learning that her insurance would not cover the LCSW, and since she could not afford to pay the full fee out of pocket, she withdrew from therapy The LCSW did call the company, describing the Virginia law, and he was told that they did not have to provide coverage since they were based in North Carolina instead of Virginia This was a patient who had been timid about seeking counseling in the first place and it was felt unlikely that she would seek further counseling She was a Virginia citizen

Hospital Corporation of America, Aetna Plan written in Tennessee

The patient was a human services employee of an HCA hospital in the Richmond area The LCSW and the patient assumed that Aetna would cover outpatient mental health services because it routinely covers such services in all of its plans. However, upon submitting the first claim, the patient and therapist were shocked to find that the claim was denied because the plan is written in Tennessee which has no vendorship law covering clinical social workers The patient is a bright, articulate, assertive human services professional who complained to her hospital administration Her hospital administration used their clout as a large group and demanded that Aetna cover those and all comparable services provided by LCSWs However, a less assertive patient with a less assertive superior would have never received services

VIRGINIA ACADEMY CLINICAL PSYCHOLOGISTS

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August 10, 1988

Stephen J. Kaufman
Deputy Commissioner
Regulatory Policy Division
State Corporation Commission
Bureau of Insurance
Box 1157
Richmond, Virginia 23209

Dear Mr. Kaufman,

The Virginia Academy of Clinical Psychologists has received your letter of July 18, 1988 concerning the existant group health insurance policies providing coverage to Virginia residents regardless of where the group policy is issued. The Welfare and Reimbursement Committee of the VACP and the membership at large have been concerned about this problem for a number of years. We have in our files a number of reports from Virginia residents who have employed the services of a clinical psychologist and believed that the psychologist's services were covered by their policy, only to find that the carrier, based out-of-state, refused to reimburse the clinical psychologist. Clearly, such a situation imposes needless hardship on the Virginia resident. First, many residents subscribe to plans believing that the services of a clinical psychologists are covered only to find that their policies do not cover the services they need. Secondly, residents who prefer the services of a clinical psychologist are unable to exercise the "freedom of choice" which is their right as citizens of the Commonwealth.

Over the years a number of instances have come to our attention which Virginia residents have contracted for the service first and then found that he/she was not covered by their group health policy because an out-of-state insurance company would not observe Virginia law. Recently, two prominent clinical psychologists have worked with patients who found that their policies did not cover psychologists or needed to have a psychiatrist

"sign off" on their bill. These two instances involved patients whose coverage came from carriers with house offices in the adjacent states of Delaware and West Virginia.

Other examples we have encountered over the years include a Virginia resident who wanted to use the services of a clinical psychologist was unable to do so because his out-of-state carrier refused to cover psychological service. In another case, the patient was seen by the clinical psychologist, but the patient paid for service "out-of-pocket" at some financial hardship.

The Virginia Academy of Clinical Psychologists strongly supports House Joint Resolution 85, 1988 session recommending the study of the extent to which accident and sickness insurance policies providing coverage to Virginia residents should provide the same benefits to all Virginia residents regardless of where the group policy is issued. It seems grossly unfair to some residents to leave the situation <u>status quo</u>. We are recommending that all residents be protected when health and accident insurance is concerned. We suggest the same benefits be mandatory for those who have group policies from a carrier whose is based out-of-state as those who have coverage from Virginia companies. Such coverage would be 30 days in-patient for alcohol and substance abuse as well as the availability of the subscriber buying, if desired, a minimum of $1,000 of out-patient mental health coverage. If we can be of any help to you in working on developing future legislation that will address this problem, please feel free to contact us.

Samuel S. Rubin
Chairman, Welfare and Reimbursement

VIRGINIA NURSES' ASSOCIATION
1311 HIGH POINT AVENUE • RICHMOND, VIRGINIA 23230 • 804-353-7311

August 12 1988

Stephen J Kaufmann
Commonwealth of Virginia
State Corporation Commission
Bureau of Insurance
Box 1157
Richmond, Virginia 23909

Dear Mr Kaufmann

Thank you for soliciting our position regarding the matter of extraterritorial application of Virginia statutes to group health insurance policies covering Virginia residents. Providing the same benefits to all Virginia residents is a worthy goal, implementation could be unwieldly.

The Virginia Nurses' Association supports any system which benefits the consumer of health care Any mechanism which provides the consumer with accurate information regarding the limitations of an individual health coverage policy is appropriate in terms of self-determination

Encouraging in-state employers and all insurers to stipulate the limitations of coverage being provided could be one such mechanism A warning or statement to the effect that various policies may differ from the requirements of the home state might help alleviate a lapse in coverage.

Another means of transmitting this information is through such publications as we mail to our membership We would be pleased to assist in this way at any time.

Sincerely

Jan M. Johnson
Executive Director

Virginia Optometric Association

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August 2, 1988

Lisa DiNunno, Research Staff
Regulatory Policy Division-Bureau of Insurance
State Corporation Commission
Box 1157
Richmond, VA 23209

RE: HJR 85 (1985 session)

Dear Ms DiNunno:

The Virginia Optometric Association, representing over 85% of all actively practicing Virginia doctors of optometry, is pleased to provide comments regarding the Bureau's study on the extraterritorial application of Virginia statutes to group health insurance policies covering Virginia residents.

Our figures indicate over 1,000,000 Virginia residents annually obtain vision care services, both routine and non-routine, from state licensed optometrists. Traditionally, "major medical type" insurance policies exclude routine services such as refraction. However, Virginia law requires coverage for non-routine vision care services such as diagnostic and treatment services related specifically to patient complaints or symptoms of a non-routine nature, when rendered by a physician or a doctor of optometry. Studies indicate that annually over $5 million is incurred by Virginia residents for non-routine diagnostic and treatment services rendered by Virginia optometrists that are of a "non-routine" nature.

Optometric patient problems encountered are somewhat unique to those of other health care professions in that most every state in the nation has adopted "patient freedom of choice" statutes affecting the optometric profession. The problems encountered are a result of state variances whereby a "freedom of choice" statute may be only applicable to one

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particular type of policy in one state and another type policy in a different state. Conversely, optometric service coverage is addressed in Virginia accident and sickness policies, non-profit group health plans such as the "Blues", preferred provider organizations and health maintenance organizations.

Adding to public confusion for Virginia residents is the situation where the state in which a policy is written does not recognize optometric services in certain plans yet that carrier subcontracts the in-state administration to a Virginia carrier. Thus patient and provider alike are led to believe that the policy was written in Virginia and must comply with Virginia statutes.

Historically, inclusion of optometry under Virginia's "freedom of choice" statutes has shown an increase in provider pool without increasing costs. Largely due to the cost effectiveness of optometry and a conservative style of practice, no Virginia carrier has been able to demonstrate to this association that subscriber costs have increased with the inclusion of optometry. Indeed, some carriers have opted to include optometric fee profiles with that of ophthalmology and consequently end with a slight reduction in overall fee profiles for particular vision related services. One must question why Virginia residents with group policies written outside of the state may not reap the same financial benefits, particularly when the public demands cost effective health care.

In general, it is most difficult for a health care provider to attempt to explain the patient must absorb costs for services simply because their group policy was not written in Virginia and consequently Virginia statutes are not applicable. Obviously the patient's first response is "I'm a Virginia resident and Virginia laws should apply."

With the advent of legislation to permit optometrists to obtain certification to treat eye

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disease by use of medication, Virginia residents--- particularly in rural areas where optometrists are the only available vision care provider, will seek treatment care by their local optometrist. Failure to address extraterritorial application will require those patients to obtain care from a provider not specialized in vision care or require great travel distance and delay of treatment. Most likely, Virginia residents placed in such situations (rural locations) will obtain care from their local optometrist but bear the cost out of pocket.

For these and other reasons, the Virginia Optometric Association encourages revision of Virginia statutes so that policies issued to a group located in another state but with some members of the group living in Virginia meet the insurance requirements of that other state as well as Virginia's requirements. The need for assuring consistency of coverage for all Virginia residents is not only a question of fairness and patient convenience but is justified by its benefits in controlling the escalating costs of health care borne by Virginia citizens.

In considering proposals we suggest language such as: "Application of Statutes- Provisions related to group accident and sickness insurance policies, group non-profit health insurance policies, group preferred provider organization policies, and group health maintenance organization policies shall be applicable whether or not the contract policy or health care benefits plan is executed and/or delivered in or outside of the state or for use within or outside the state by or for any individuals who reside or are employed in this state." For the same reasons applicable to group health insurance plans, we suggest that any extraterritorial application of Virginia statutes include <u>all</u> types of group health related insurance policies.

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The Virginia Optometric Association and the Virginia citizens served by the optometric profession are most appreciative of the opportunity to provide these comments.

Sincerely,

Bruce B. Keeney
Executive Director

BBK/lsc

cc: VOA Executive Committee
Affiliated Local Society Presidents
VOA Third Party Care Committee
Dr. Robert Greenburg, Chm.
VOA Third Party Care