REPORT OF THE
SPECIAL ADVISORY COMMISSION
ON MANDATED HEALTH INSURANCE BENEFITS ON

THE MANDATED OFFER OF CONVERSION OR CONTINUATION OF COVERAGE PURSUANT TO SECTION 38.2-3416 OF THE CODE OF VIRGINIA

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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SENATE OF VIRGINIA

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To: The Honorable L. Douglas Wilder
Governor of Virginia
and
The General Assembly of Virginia

The report contained herein has been prepared pursuant to Sections 9-298 and 9-299 of the Code of Virginia.

This report documents a study conducted by the Special Advisory Commission on Mandated Health Insurance Benefits to assess the social and financial impact and the medical efficacy of the mandated offer of conversion or continuation of coverage pursuant to § 38.2-3416 of the Code of Virginia.

Respectfully submitted,

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Special Advisory Commission on
Mandated Health Insurance Benefits

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TABLE OF CONTENTS

INTRODUCTION

Sections 38.2-3416 and 38.2-3541 of the Code of Virginia require insurers to offer group policyholders the option of allowing individuals covered under the policy or subscription contract (i) to convert to an individual accident and sickness policy or contract without evidence of insurability upon termination of group coverage eligibility or (ii) to continue coverage for a period of ninety days at the existing group rate. However, if a person is insurable under a replacement group policy that does not impose additional waiting periods or preexisting condition limitations, then the conversion or continuation of coverage is not required. In addition, a conversion policy need not contain the same level of benefits as the group policy. Section 38.2-3416 was enacted in 1984.

Insurers having an applicable policy in effect before January 1, 1985 may be exempted from offering a conversion policy. However, in the absence of a conversion alternative, a person whose eligibility under the group policy is terminated may elect to continue coverage under the group plan at the group rate as long as the affected person elects or as long as the insurer is not required to offer an acceptable conversion policy.

The Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) reviewed the mandated offer of conversion or continuation of coverage in 1993. The Advisory Commission held a public hearing during its October 4, 1993 meeting to receive comments regarding the conversion or continuation offer. Written comments were received from two parties. No interested parties offered oral comments.

REQUIREMENTS FOR A CONVERSION POLICY

Section 38.2-3541 specifies that the following requirements must be met regarding the issue of a conversion policy:

1. The application for the policy shall be made, and the first premium paid to the insurer within thirty-one days after the termination;

2. The premium on the policy shall be at the insurer's then customary rate applicable: (i) to such policies, (ii) to the class of risk to which the person then belongs, and (iii) to his or her age on the effective date of the policy;

3. The policy will not result in over-insurance on the basis of the insurer's underwriting standards at the time of issue;

4. The benefits under the policy shall not duplicate any benefits paid for the same injury or same sickness under the prior policy;

5. The policy shall extend coverage to the same family members that were insured under the group policy; and

6. Coverage under this option shall be effected in such a way as to result in continuous coverage during the thirty-one day period for such insured.

FINANCIAL IMPACT OF THE CONVERSION OR CONTINUATION MANDATE

Results of a study conducted in 1989 on behalf of Blue Cross and Blue Shield of Virginia (BCBSVA) by KPMG Peat Marwick indicate that the cost per member month for the conversion mandate was $1.19 in 1988. During that year, BCBSVA experienced claims for benefits under this mandate of approximately $9,400,000 or 2.28% of total claims.

In 1989, the State Corporation Commission's Bureau of Insurance also conducted a study of the impact of mandated benefits and mandated providers. Results of the Bureau's initial survey indicated that on average insurers added about $3 to the premium charged for single coverage under a group contract to cover the cost of conversion. On average $5 was added to the premium for family coverage. Three insurers reported that they did not add an amount to the group premium to cover the cost of conversion. Instead they charged a flat fee to the group policyholder for each conversion. The fee varied from $200 to $500 per conversion.

In 1992, the State Corporation Commission (SCC) issued its first annual report on the financial impact of mandated benefits and mandated providers pursuant to § 38.2-3419.1 of the Code of Virginia (1993 House Document No. 9). Insurers were only required to submit data for the fourth quarter of 1991 for this initial report. Therefore, the results reported in 1993 House Document No. 9 may not be truly representative of insurer experience. Subsequent reports, however, will cover full calendar years. The results printed in the SCC's initial report are as follows:

Amount Added to the Annual Premium of a Group Policy Per Unit of Coverage to Cover the Cost of Conversion

GROUP	
Single	Family
$11.45	$27.55

FEDERAL LEGISLATION

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires group health plans, whether insured or self-

funded, to continue coverage for employees and dependents at group rates for up to 36 months upon losing eligibility for coverage under the group plan as a result of a "qualifying event." If coverage is lost because the employee's employment has been terminated or as a result of a reduction in hours then coverage may be continued for up to 18 months. COBRA does not apply to church or government plans or to employers with less than 20 employees. The continued coverage granted under COBRA must be identical to that provided under the group plan. At the end of the period of continued coverage, a person must be allowed to convert to an individual policy without evidence of insurability, if the employer plan includes a conversion provision.

LEGISLATION IN OTHER STATES

According to the Health Benefits Letter and a publication of the Intergovernmental Health Policy Project at George Washington University, at least 33 states require that group contracts contain the right to convert to an individual policy.

EVALUATION OF § 38.2-3416 BASED ON REVIEW CRITERIA

Social Impact

a. The extent to which the treatment or service is generally utilized by a significant portion of the population.

The conversion or continuation options are available to be utilized by most individuals covered by group health insurance. One of the options would be available to individuals who are no longer employed by the present employer and would not be joining another group covered by health insurance. The options also cover family members that were insured under the prior policy.

These privileges could generally be used by many Virginians. Over 80% of Virginians with health coverage obtain that coverage through employment. The possibility of being unemployed or needing to change jobs affects many adults and their families.

b. The extent to which insurance coverage for the treatment or service is already available.

Conversion or continuation options are currently available because the mandated option has been available since 1979. the options are offered to the group policyholder.

c. If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatments.

The options are available because of mandate. In the event the group policyholder selects the option of 90-day coverage and the individual employee does not obtain replacement coverage after the 90-day period, some health care could possibly be postponed.

d. If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment.

The coverage is generally available because of the mandate. Lack of such coverage would leave some individuals uninsured for the cost of health care.

e. The level of public demand for the treatment or service.

Not applicable. The mandate is not limited to a particular treatment or service.

f. The level of public demand and the level of demand from providers for individual and group insurance coverage of the treatment or service.

The Advisory Commission did not receive comments from the public or providers on this issue. However, consumers are generally in favor of this type of benefit.

g. The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts.

No information regarding the interest of collective bargaining organizations on this issue was presented to the Advisory Commission.

h. Any relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.

No findings were presented to the Advisory Commission from other state agencies.

Financial Impact

a. The extent to which the proposed insurance coverage would increase or decrease premiums or the cost of services over the next five years.

The mandated offer of conversion or continuation is not expected to have any significant impact on the cost of a conversion policy or a 90-day continuation of coverage. Conversion policy costs are largely based on the insurer's customary rate for a person of the risk class.

b. The extent to which the proposed insurance coverage might increase the appropriate or inappropriate use of the treatment or service.

Not applicable. The mandate is not specific to any particular treatment or service and, therefore, would not be expected to significantly affect the appropriate or inappropriate use of health care services.

c. The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service.

Not applicable. The mandate is not specific to any particular treatment or service.

d. The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next five years.

The mandated offer of conversion or continuation is not expected to have any impact on the number or types of providers in the next five years.

e. The extent to which insurance coverage might be expected to increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.

The greatest expenses associated with mandates are generally incurred when a mandate is enacted. The ongoing cost for this mandate is not expected to be substantial. In 1992, insurers reported an average annual premium cost of $11.45 for single coverage and $27.55 for family coverage as a result of this mandate.

f. The impact of coverage on the total cost of health care.

The mandate requires the offer of health coverage for those who have previously had coverage. It does not mandate a new benefit or provider. The mandate provides for health care coverage and should not impact the total cost of health care significantly.

Medical Efficacy

a. The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service.

Not applicable.

b. If the legislation seeks to mandate coverage of an additional class of practitioners:

1) The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered.

Not applicable.

2) The methods of the appropriate professional organization that assure clinical proficiency.

Not applicable.

Effects of Balancing the Social, Financial and Medical Efficacy Considerations

a. The extent to which the benefit addresses a medical or a broader social need and whether it is consistent with the role of health insurance.

The conversion or continuation privileges address social and medical needs. Some health care could be delayed or not received because of a lack of coverage resulting from gaps in employment.

b. The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders.

The cost of coverage has been shown to be relatively small

and the benefit is thought to be very important for those individuals who must leave a group health plan and may have difficulty in obtaining immediate coverage.

c. The extent to which the need for coverage may be solved by mandating the availability of the coverage as an option for policyholders.

The mandate allows the insurer and group policyholder some flexibility already. Because the mandate involves a guarantee of access to coverage, it is important that all groups be subject to its requirements. Otherwise, access would not necessarily be guaranteed to all of those in need.

RECOMMENDATIONS

The Advisory Commission voted to recommend that the mandated offer of conversion or continuation be retained. The Advisory Commission members were unanimous in their vote. No written or oral comments were received that requested the repeal of the mandate. The mandate does not significantly add to the cost of health care coverage and provides considerable consumer protection.

CONCLUSION

The Advisory Commission believes that the retention of the currently required offer of conversion or continuation is advisable. The conversion and continuation privileges provide a safety net to many Virginians who could go without health care coverage in the event of unemployment or some other situation not within the individual's control. Federal legislation was enacted after the Virginia statute was put into place that also provides protection in this area. The Advisory Commission believes that even with the federal legislation, Virginia's mandate is desirable.

APPENDIX

§ 38.2-3416. Conversion on termination of eligibility; insurer required to offer conversion policy or group coverage.--A. Before an insurer who delivers or issues for delivery in this Commonwealth or who renews, reissues or extends if already issued, any group hospital, medical and surgical or group major medical policy, the insurer shall be required to be able to offer without evidence of insurability to residents of this Commonwealth who are covered under the policy, whose eligibility may terminate under the policy, and who may elect Option 1 under § 38.2-3541 a nongroup policy of accident and sickness insurance, either individual or family, whichever is appropriate, pursuant to the provisions of § 38.2-3541 unless such termination is due to termination of the group policy under circumstances in which the insured person is insurable under the replacement group coverage or health care plan without waiting periods or preexisting conditions under the replacement coverage or plan.

B. Any insurer who has in effect prior to January 1, 1985, any group policy described in subsection A of this section, may be exempted from the provisions of subsection A of this section. However, for persons affected by the termination of eligibility, the insurer shall be required to continue coverage under the existing group policy, without evidence of insurability and at the insurer's current rate applicable to the group policy, for as long as the affected persons elect or as long as the insurer is not required to offer an acceptable conversion policy. (1984, c. 300, § 38.1-348.10:1; 1986, c. 562; 1988, c. 551.)

§ 38.2-3541. Conversion or continuation on termination of eligibility. -- Each group hospital policy, group medical and surgical policy or group major medical policy delivered or issued for delivery in this Commonwealth or renewed, reissued or extended if already issued, shall contain, subject to the policyholder's selection, one of the options set forth in this section. These options shall apply if the insurance on a person covered under such a policy ceases because of the termination of the person's eligibility for coverage, prior to that person becoming eligible for Medicare or Medicaid benefits unless such termination is due to termination of the group policy under circumstances in which the insured person is insurable under other replacement group coverage or health care plan without waiting periods or preexisting conditions under the replacement coverage or plan.

1. Option 1: To have the insurer issue him, without evidence of insurability, an individual accident and sickness insurance policy in the event that the insurer is not exempt under § 38.2-3416 and offers such policy, subject to the following requirements:

a. The application for the policy shall be made, and the first premium paid to the insurer within thirty-one days after the termination;

b. The premium on the policy shall be at the insurer's then customary rate applicable: (i) to such policies, (ii) to the class of risk to which the person then belongs, and (iii) to his or her age on the effective date of the policy;

c. The policy will not result in over-insurance on the basis of the insurer's underwriting standards at the time of issue;

d. The benefits under the policy shall not duplicate any benefits paid for the same injury or same sickness under the prior policy;

e. The policy shall extend coverage to the same family members that were insured under the group policy; and

f. Coverage under this option shall be effected in such a way as to result in continuous coverage during the thirty-one day period for such insured.

2. Option 2: To have his present coverage under the policy continued for a period of ninety days immediately following the date of the termination of the person's eligibility, without evidence of insurability, subject to the following requirements:

a. The application for the extended coverage is made to the group policyholder and the total premium for the ninety-day period is paid to the group policyholder prior to the termination;

b. The premium for continuing the group coverage shall be at the insurer's current rate applicable to the group policy; and

c. Continuation shall only be available to an employee or member who has been continuously insured under the group policy during the entire three months' period immediately preceding termination of eligibility. (1979, c. 97, § 38.1-348.11; 1982, c. 625; 1984, c. 300; 1986, c. 562; 1988, c. 551.)