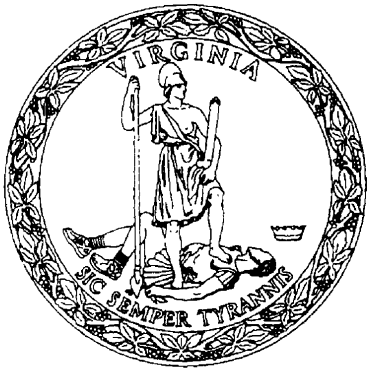
REPORT OF THE
STATE CORPORATION COMMISSION'S
BUREAU OF INSURANCE ON

MEASURES THAT INCREASE ACCESS TO AFFORDABLE HEALTH CARE COVERAGE FOR INDIVIDUALS AND THEIR FAMILIES

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA



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STATE CORPORATION COMMISSION

November 15, 1995

To: The Honorable George Allen
Governor of Virginia
and
The General Assembly of Virginia

We are pleased to transmit this Report of the State Corporation Commission on Measures That Increase Access to Affordable Health Care Coverage for Individuals and Their Families pursuant to Senate Joint Resolution No. 332.

Respectfully submitted,

Preston C. Shannon
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Table of Contents

I. Executive Summary

Senate Joint Resolution No. 332 requested the State Corporation Commission's Bureau of Insurance (Bureau), in cooperation with the Joint Commission on Health Care (JCHC), to examine individual and conversion health care coverage. The Bureau was requested to determine measures that increase access to affordable health care coverage for individuals and their families.

The majority of Virginians are insured for health care by employer-based coverage. Those Virginians covered by individual health contracts face higher costs, fewer choices, and more market uncertainty.

In accordance with Senate Joint Resolution No. 332, the State Corporation Commission's Bureau of Insurance makes the following recommendations:

(1) Insurers in the individual market should be required to offer the essential and standard health plans, developed by the Essential Health Services Panel, to all applicants;

(2) Contracts sold in the individual market should be offered on a guaranteed renewal basis; and

(3) Essential and standard plan contracts issued in the individual market should be subject to a modified community rating similar to the requirements for primary small employers and riders that reduce or eliminate coverage for specified conditions should be prohibited for the essential and standard contracts.

For the purpose of this report and its recommendations, the individual health contracts that provide coverage for accident only, credit, disability, Medicare supplement or long-term care insurance, dental only or vision only, specified disease, hospital confinement indemnity coverage, coverage issued as a supplement to liability insurance, workers' compensation, automobile medical payments or automobile medical expense coverage are excluded. The recommendations also do not apply to contracts for coverage of Medicare services, or federal employer health plans.

The Bureau recommends the above incremental actions based upon a review of activities in other states and on the national level. The recommended reforms, when combined with House Bill 2043 (Chapter 522, 1995 Acts of the Assembly), passed by the 1995 General Assembly, will parallel the reforms currently in place in Virginia's small employer market.

The Bureau believes that it is important to continue reforms on the state level, but that reforms in the individual market should not be dissimilar to those in the small group market. There is a potential for shifting of the potential insureds from one market

to the other to obtain what is viewed as more favorable treatment when the requirements in the two markets differ substantially.

The Bureau also believes that individual contracts issued as conversions from a group policy should be issued on a guaranteed renewal basis. The essential and standard plan contracts should be offered as options to those converting to individual coverage, and if the individual chooses one of those plans, it should be subject to modified community rating as provided for primary small employer groups in § 38.2-3433.

The Bureau recognizes that the recommendations contained in this report will not extend to those individuals converting from self-insured benefit programs because of pre-emption by federal law. We also recognize that these reforms will not assure access to health coverage for every individual in Virginia. We believe, however, that the implementation of these recommendations will continue the incremental improvements that will make health care coverage accessible to many Virginians currently without access to coverage.

II. Introduction

Senate Joint Resolution No. 332, adopted by the 1995 General Assembly, requested the State Corporation Commission's Bureau of Insurance (Bureau) in cooperation with the Joint Commission on Health Care (JCHC) to examine individual and conversion health care coverage. The resolution requested the Bureau to determine measures that increase access to affordable health care coverage for individuals and their families. The recommendation for this study followed legislation that instituted reforms in the small employer group market in 1992 and 1994.

Additionally, House Bill 2043 (Chapter 522, 1995 Acts of Assembly), passed by the 1995 General Assembly, now requires new contracts issued in the individual market to reduce the maximum length of pre-existing conditions periods to one year and to provide credits for pre-existing conditions periods that were served under prior policies.

III. Background

The majority of Virginians covered by health insurance are insured by group contracts. The cost of group coverage is usually less expensive than individual contracts because of the economies of mass marketing, servicing, and purchasing that can be utilized. It costs less to sell, enroll, administer, and service a group. Premiums are often collected by payroll deduction. Those covered by individual insurance, less than 20% of those insured in 1986 in Virginia, face higher costs, fewer choices, and market uncertainty because of insurers changing their market strategies.

A number of insurers withdrew from the individual health insurance market as claims costs rose in the 1970's and 1980's. As the health care dilemma grew, insurers sold business, merged, and redirected their efforts in the market in attempts to remain profitable. In the 1993 calendar year in Virginia, 33 of the 87 largest writers of accident and sickness insurance in Virginia issued only group coverage, according to responses of insurers to the annual filing required on the cost and utilization of mandated benefits and mandated providers.

Individual health insurance is primarily purchased by people whose employers do not provide such coverage. Many of the employers are small, use unskilled workers, or have a heavy concentration of temporary employees.

Senate Joint Resolution No. 332 continues the study of health insurance market reform by the Bureau of Insurance. In recognition of the problems in the market for small employer groups, and after the study conducted pursuant to the 1991 General Assembly's Senate Joint Resolution 181, the Bureau recommended in 1992 Senate Document No. 9: A Feasible Proposal to Establish a Small Business Risk-Sharing Pool with Insurance Reforms to Improve Access and Moderate Rate Increases and an Evaluation of Options for Monitoring Costs and Rates of Health Insurance Carriers:

(1) the adoption of small group health insurance market reforms designed to increase access and affordability, place limits on premiums that can be charged, limit the use of pre-existing condition restrictions, and require disclosure of specified rating practices and provisions regarding renewability of coverage;

(2) the establishment of a small employer group health insurance risk-sharing program to aggregate the experience of small businesses in order to purchase health insurance more economically; and

(3) the establishment of a small employer group health reinsurance association to spread the cost of high-risk groups among all insurers in the small employer group market.

The recommendations were not designed to solve all of the problems in the small employer group market. The recommendations were envisioned as a first step in addressing some of the problems confronting small employer groups in the health insurance market. The Bureau acknowledged that other related issues, problems, and remedies may need to be addressed in the future.

Legislation enacted as a result of the Bureau study included 1992 Senate Bill 505 (Chapter 800, 1992 Acts of Assembly), which took effect on July 1, 1992. Senate Bill 505 included small employer group market reform provisions that limited the use of pre-existing condition restrictions, required guaranteed renewability of coverage, and required that coverage be extended to the entire group if a group were accepted by a carrier.

The Bureau recommendations that would have guaranteed availability and restrict premium rates were not proposed in 1992. The Joint Commission on Health Care (JCHC), then known as the Commission on Health Care for all Virginians, decided to delay action on the issues of guaranteed availability and premium rate restrictions until an operational plan for a reinsurance association could be developed and reviewed.

House Bill 1345 (Chapter 303, 1994 Acts of Assembly) passed in 1994 required the offering of the essential and standard health plans to all primary small employers. It allowed small employer carriers to continue to offer other plans as well. The legislation also required that modified community rating be used for those plans. The essential and standard health plans were developed pursuant to 1992 Senate Bill 506 (Chapter 847, 1992 Acts of Assembly). The plans were developed by a panel of citizens and experts and recommended to the 1992 General Assembly. The plans were adopted by regulation of the State Corporation Commission with a March 1, 1995 effective date. Insurers participating in the market were required to have their contracts approved by October 28, 1995.

IV. Methodology

The Bureau reviewed the options available for reforming the individual market. The Bureau surveyed all states to determine (i) how many states have enacted reforms, and (ii) how many states are considering or studying the implementation of reforms in the individual market. Follow-up surveys were also sent to states with reforms in place to obtain information about the actual impact of their efforts.

The Bureau also reviewed studies and reports on the impact of insurance reforms in the individual and small group markets in other states.

The Bureau reviewed the work of the National Association of Insurance Commissioners (NAIC) in this area. Federal activity was also reviewed and assessed for the possible implications for Virginia.

A survey of insurers active in the individual market was conducted to obtain information regarding the current market practices and the possible effects of market reforms.

Additionally, assistance was obtained from one of the actuarial firms used by the Bureau on a consulting basis.

V. National Activity

A. Federal Health Insurance Reform Proposals

President Bill Clinton formally proposed to Congress on November 20, 1993, sweeping reform of the American health care system that included considerable health insurance reforms. These reforms were packaged into the American Health Security Act (Act). Proposals in the Act called for a guaranteed benefit package that would be available to all citizens, elimination of pre-existing conditions periods, and community rating. The plan also would have provided a budget for healthcare spending and required national standards for quality and consumer protection. Additionally, penalties would have increased or been instituted to toughen efforts against fraud and abuse. Malpractice laws were also included in the massive overhaul of the health care system.

Congress failed to pass the Clinton proposal last year. The opponents of the proposal were numerous and vigorously stated their concerns. However, the health care issue remains an important one that affects everything from the daily lives of most Americans to the federal deficit. As a result, numerous proposals have been introduced in the 104th Congress. Some of the proposals that impact the areas addressed by this study are summarized in this section.

H.R. 995 ERISA Targeted Health Insurance Reform Act of 1995

The bill requires that insurers make available to small employers (2 to 50 employees) general coverage with a fee-for-service option. If the insurer offers a managed care or point-of-service option, those options must also be made available. Insurers must also offer catastrophic coverage and "medisave coverage." Medisave coverage is defined for the purposes of the bill as health insurance coverage that has benefits available when costs exceed a catastrophic deductible amount and that provides a cash benefit that can be used for deductibles, cost-sharing, and other expenses specified under the coverage. This bill also requires guaranteed renewal.

The bill requires each insurer offering the general, catastrophic or medisave coverage in the small group market to accept every small employer and every eligible individual. There are exemptions for health maintenance organizations related to their service areas and adequate capacity. Insurers are also allowed exemptions if they have inadequate financial reserves.

H.R. 995 also amends the Employee Retirement Income Security Act of 1974 (ERISA) and pre-empts a number of state insurance laws including: small group health insurance requirements; mandated benefit provisions; provider network requirements; and restrictions on insurers' ability to negotiate rates and payments with providers. The bill also pre-empts state laws on limits of participation of providers and utilization review statutes.

The types of arrangements that qualify under ERISA as single employer plans and collective bargaining arrangements are significantly increased. This extends the ERISA exemption. The bill sets claims requirements for self-funded employer-based plans. The requirements include time limits for approval or denial of claims and review after initial denial. Deadlines are also included for pre-authorization of services and emergency treatment. Plans are also required to have thresholds, an open enrollment period, and to meet minimum reserve requirements. Legal action in federal court is the final appeal option available to those covered by the plans. Courts can require plans to cease and desist operation, to pay interest, and attorney fees.

The bill limits ERISA plans to pre-existing conditions limitations of six months after coverage. Small employer coverage may impose limits for pre-existing conditions from six to twelve months for a condition not diagnosed between three and six months before coverage. The bill requires that plans provide credits for previously satisfied pre-existing conditions periods.

H.R. 995 allows premium variations in the small group based on age, geography, family composition, benefit design, less restrictive pre-existing conditions exclusions, administrative expenses, employer wellness programs, and claims experience after issue. Insurers that pool the experience of associations are not allowed to vary their rates based on classes of business.

The bill includes the National Association of Insurance Commissioners (NAIC) in the development of the premium variation limitations, and development of standards for provider networks.

States have the option of enforcing the federal health insurance rating standard. Insurers have to file actuarial certification that their rates comply with the requirements. There is a three-year exemption from the loss ratio requirements for states that now have more restrictive requirements.

State insurance departments can petition the National Labor Relations Board for a determination of whether a non-Multiple Employer Welfare Arrangement (MEWA) ERISA plan has violated the National Labor Relations Act (NLRA).

The bill includes a process for certification and regulation of MEWAs. Any self-funded MEWA covering at least 1,000 participants, or at least 2,000 employees for participating employers, may operate while an application for certification is pending.

H.R. 996 Targeted Individual Health Insurance Reform Act

The bill's purpose is described as "to improve portability, access, and fair rating for health insurance coverage for individuals." The bill defines the individual market as including the health insurance that individuals obtain on behalf of themselves, and their dependents, that is not provided on the basis of employment. The bill was developed to coordinate with H.R. 995 and also sets out three types of coverages that are required to be available: general coverage; catastrophic coverage; and medisave coverage.

General coverage is health coverage that does not include limited benefit, long-term care, Medicare supplement, and other limited kinds of coverage. Catastrophic coverage benefits are available for one year to the extent covered expenses exceed a deductible amount of $1,800 for single coverage or $3,600 when there is a dependent. Medisave coverage benefits are available for one year when covered expenses exceed a catastrophic deductible. The medisave cash benefit coverage provides a fixed dollar amount that can be used for deductibles, cost-sharing and other expenses.

All eligible individuals must be accepted by insurers. The bill does allow insurers to deny coverage to individuals expected to incur "disproportionately high health care costs." Risk adjustment mechanisms, high-risk pools or other mechanisms are to be developed by the NAIC with assistance from the American Academy of Actuaries.

H.R. 996 provides that insurers in the individual market can use pre-existing conditions exclusions only for conditions diagnosed or treated within six months before coverage begins and the limitations cannot exceed twelve months. The bill provides that insurers that do not use pre-existing conditions limitations may use an "affiliation

period" of 90 days for those first eligible for coverage and 180 days for late enrollees. Insurers must give a month-for-month credit for previously served pre-existing conditions periods and policies must be guaranteed renewable. The bill also provides standards for provider networks, for reasonably prompt access, emergency care, and requirements for entering the provider network. Utilization Review programs, if used, must also meet standards.

Premium rates are permitted to vary by age, geographic area, family class, benefit design, pre-existing conditions surcharge and administrative categories. Association members may be treated as separate pools. Premiums are also allowed to vary based on classes of business and other objective characteristics, including claims experience. The initial premium rates of a class may vary based on prior claims experience, health status, occupation and other characteristics if the highest rate within a class does not exceed the base rate by more than 200% for the first two years.

States that opt to enforce the standards in the Act must submit a report to the Secretary of Health and Human Services on the program they establish to implement and enforce the standards. Penalties of up to $25,000 may be imposed for each violation.

States are prevented from enforcing standards different from the bill in the individual market. State laws that are pre-empted include mandated benefit requirements, "any willing provider laws," laws regarding reimbursement rates, laws inconsistent with provider network standards, and some utilization review requirements

Employer Group Purchasing Reform Act of 1995

Senate Bill 1062 introduced by Senator James Jeffords (R-VT) and Senator Sam Nunn (D-GA) amends Title I of the Employee Retirement Income Security Act of 1974 (ERISA).

The Employer Group Purchasing Reform Act of 1995 is designed to increase the purchasing power and affordability of health insurance for small employers; to crack down on the fraud and abuse in self-funded MEWAs; and provide increased security for more than 114 million Americans who receive health care benefits from private employers.

The legislation changes the Employee Retirement Income Security Act (ERISA) to clarify state jurisdiction over multiple employer welfare plans. It prohibits health care purchasing coalitions from self-funding.

Health Insurance Reform Act of 1995 (Senate Bill 1028)

The bill applies to health insurance polices sold to employers with at least two employees and to self-insured plans. The state insurance commissioners are to

enforce the legislation with regard to health insurers and the U.S. Secretary of Labor is to enforce the requirements that apply to self-insured ERISA plans.

The bill requires insurers and employers offering group health coverage to cover all employees regardless of their health status, medical history or condition, or claims experience. Insurers are allowed to deny enrollment to new individuals only if they do not have adequate financial or provider capacity. Employees may change their enrollment status or health plan if their family or employment status changes and no penalties may be applied. Discounts are allowed for wellness programs.

The bill also requires the guaranteed renewability of group plans unless there is nonpayment of premiums, fraud or misrepresentation, or termination of the plan. Insurers may withdraw from the market after giving 180 days notice, but will not be allowed to re-enter the market for five years.

The bill also limits pre-existing conditions exclusions to 12 months for conditions diagnosed or treated 6 months prior to an employee's enrollment. The pre-existing conditions limitation does not apply to newborns covered within 30 days of birth, or to pregnancy. Pre-existing conditions for late enrollees may be excluded for 18 months. There is also a provision for a month-to-month credit towards the pre-existing period for previous periods covered under a prior health plan. States are allowed to require shorter pre-existing periods.

Health Maintenance Organizations (HMOs) and others that do not use pre-existing conditions limitations may use a 60-day waiting period for new enrollees and a 90-day waiting period for late enrollees. The plan will not have to provide benefits during this period and premiums will not be charged.

The bill requires individual plans to guarantee coverage to individuals who have had continuous coverage for 12 months, were not terminated from a group plan for fraud or nonpayment of premiums, and are not eligible for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Discounts for wellness programs are permitted. Insurers are required to disclose their rating, renewal, and pre-existing conditions practices to employers upon request.

Individual policies must also be guaranteed renewable except where there is fraud, misrepresentation, or nonpayment of premiums. Insurers may withdraw from the individual market after giving 180 days notice. They may not re-enter the market for five years after withdrawing.

States that in the future enact reforms at least as effective as those in this bill, will be allowed to apply their individual reforms.

The U.S. Secretary of Health and Human Services, the NAIC, and the American Academy of Actuaries are to report to Congress on (i) the most appropriate way to

ensure the availability of reasonably priced individual health insurance, (ii) the need for federal standards that limit the variation in insurance premiums for individuals and groups, and (iii) the effect of this bill and state insurance reforms.

The bill includes changes to COBRA to improve access for the disabled and to allow newborns and adopted children to be added immediately.

The bill also provides for the formation of health plan purchasing coalitions. The coalitions allow individuals and employers to form a private and voluntary group that can then negotiate with insurers and (or) providers. The coalitions must register with the U.S. Secretary of Labor and must be governed by a board of directors. The coalitions must accept all individuals and employers.

H.R. 2220

This bill requires health insurance portability. It includes all workers, including those in small businesses and churches, and extends their eligibility under COBRA to 36 months.

The bill also establishes lower cost COBRA options that would offer the same coverage with higher deductibles. After COBRA coverage ends, employees would be eligible to choose individual policies at standard rates without pre-existing conditions limitations. The bill also encourages states to establish risk pools and medical savings account provisions.

Observations

The Kassebaum and Kennedy "Health Insurance Reform Act of 1995" is viewed as the reform legislation most likely to pass this Congress. The reforms in the bill are incremental and extend to the individual market the requirements that most states have put in place for small employer groups: guaranteed renewability; limits on pre-existing conditions exclusions; portability; and guaranteed issue for many individuals. The bill goes beyond what states can require because it would also regulate self-insured plans.

The impact on self-insured plans, along with the extended debate on the national budget and revamping of the Medicare program, are considered impediments to the passage of even this incremental reform legislation. It is likely that states will continue to enact legislation because of the absence of federal progress on these issues.

B. National Association of Insurance Commissioners' Position

The National Association of Insurance Commissioners (NAIC) is developing a model act to apply to individual health insurance reform. The NAIC plans to adopt a model in March, 1996. At this point the NAIC direction is consistent with its Small

Employer Health Insurance Availability Model Act. Exceptions are that the individual pre-existing condition definition will be 12 months for individual coverage and 6 months for small group coverage. The current draft advises states to have the same rating scheme in place for the small group and individual markets. The draft Act requires guaranteed renewability, guaranteed issue of all products including at least two benefits plans (the basic and standard plan), and credits for previously served waiting periods for pre-existing conditions. Carriers that do not impose pre-existing conditions may impose an "affiliation period." An affiliation period is defined as a period of no more than 60 days during which no premiums are paid and coverage is not effective. Carriers are not allowed to modify coverage, to restrict or exclude coverage for specific disease, medical conditions, or services covered otherwise.

The guaranteed issue requirement is presented in two options. Under the first option, the open enrollment requirement is 365 days per year and the pre-existing limitation period allowed may be up to 12 months. Under the second option, the open enrollment period is 30 days per year. The open enrollment period is based on the applicant's month of birth. The pre-existing limitation period may also be 12 months but, if the individual had previous coverage, the carrier must issue a plan to the individual if he applies for coverage within 31 days of the end of the prior coverage. The adjustment in the rate for age may be in one-year increment brackets after age 19.

Carriers are not required to cover individuals covered by, or eligible for coverage under, employer plans.

The model act also includes two options for risk-spreading mechanisms. One option requires that carriers participating in the small group market must also write in the individual market. This option includes a cap on the number of high-risk individuals each carrier must accept based on the total number of individuals that the carrier insures. The second option makes an assessment against the carriers that do not write their proportionate share of the individual market. The assessment covers losses and administrative expenses. This option is similar to the approach utilized in New Jersey.

A number of issues have not yet been decided, including the possibility of a third risk-spreading mechanism, the transition to the requirements, further rating restrictions and loss ratio concerns, and conversion plans.

VI. State Reform Efforts in the Individual Market

State efforts to reform the individual market have increased in recent years. The majority of the reforms include some combination of the following requirements: portability, guaranteed renewability, pre-existing conditions limitations, guaranteed issue, and rating restrictions. There are at least 10 states that have some type of guaranteed issue requirement in this market. Fourteen states require guaranteed renewability, eighteen have portability requirements, and at least eleven have rating

restrictions. Another six states are currently studying this area. Most of the reforms were effective in 1993 or 1994. Therefore, information about the actual impact of the reforms is limited. However, guaranteed issue requirements were effective in 1992 in the states of Vermont, New York, and New Jersey. There is some data about the results of reform in those states.

A. Vermont

Section 4080b of Title 8 of the Vermont insurance law contains reform for non-group plans. The requirement applies to persons not eligible for coverage by group health insurance. It does not apply to disability insurance, accident indemnity or expense policies, long-term care insurance, student or athletic or indemnity policies, Medicare supplement, or dental policies.

Carriers must give six months notice to withdraw from the market. They must accept any individual for any plan that is offered by the carrier. They must also accept any dependent. Exceptions are made for HMOs regarding those persons outside their service area, or if the HMO does not have the capacity to cover the person.

Carriers must offer two or more of the health care plans approved by the State Commissioner of Insurance (Commissioner). At least one plan must be a low cost "common" health care plan that may provide for deductibles, co-insurance, managed care, cost-containment provisions, and other provisions consistent with Vermont insurance laws that will help make the plan affordable.

Carriers are allowed to use a 12-month pre-existing conditions exclusion with a 12-month look back. Carriers must waive this exclusion if there was continuous coverage nine months previously. The plan rate structure must differentiate between single person, two person, and family rates.

Individual carriers must use community rating acceptable to the Commissioner. Prohibited rating factors are demographic (including age and gender), geographic, industry, medical underwriting and screening, experience rating, tier rating, and durational rating.

There was a phase-in period for the rating provisions. From July 1, 1993, the rate could not deviate from the community rate by more than 40%. After two years the rate could not deviate more than 20%. Rate increases above 20% in one year are prohibited with an exception for consideration of the financial soundness of the insurer. The anticipated loss ratio must be at least 70% for initial or revised rates. Rates must be guaranteed for 12 months. A reinsurance pool may be formed when the plan for the pool is approved by the Commissioner.

Section 4808c requires the Secretary of Administration of Vermont to make coverage available for individuals who lose coverage because of their insurer withdrawing from Vermont, or failing to register as a carrier. Coverage must also be provided by Vermont for individuals who lose group coverage because they are terminated or laid off, if they are not eligible for group coverage. This coverage begins after federal or state continuation of coverage has been exhausted.

Vermont's individual legislation is parallel to its small group reform legislation.

Vermont's experience has been characterized as mixed. According to the Vermont Department of Insurance, there were approximately 15 to 20 carriers in the individual market prior to the institution of the guaranteed issue requirement. They currently have eight carriers in the individual market. The uninsured population was 10 percent prior to the requirement and the current level of health coverage is not known. The average amount of rate increase in the individual market has been approximately 15 to 20 percent. Vermont cautions that this is an estimate only. The coverage offered now differs from what was available prior to reform.

B. New Jersey

Sections 17:B-27 A-1 through 17:B-27 A-54 of the New Jersey Insurance Code contain the requirements of the Individual Health Reform Act (Act). All carriers issuing health benefit plans must offer individual health benefit plans. All plans must be offered on an open enrollment, community rated basis. In lieu of offering individual plans, a carrier may pay an assessment to satisfy its obligation under the Act.

Each carrier must offer an eligible person a choice of five individual plans. One plan must be a basic plan, one must be a managed care plan, and three plans must include enhanced benefits. HMOs are allowed to offer a basic plan instead of the five plans.

The basic health benefit plan is set by law and is contained in the insurance code. The maximum amount of deductibles and coinsurance are also set out in the law, although a carrier may modify the coverage or provide alternative benefits if they are consistent with the Individual Health Reform Act. All plans must be guaranteed renewable. Riders may also be offered with the plans.

Individual conversion contracts issued after the effective date of the Act must also comply with it unless the premium is partially paid by or subsidized by the group policy from which the conversion policy is issued.

The Board of the New Jersey Individual Health Coverage Program (Board) is required to establish the forms and benefit levels to be made available in the plans. The plans may include cost containment measures, including utilization review, case

management, selective contracting with providers, and reasonable differences in payment to participating providers.

Plans are limited to a 12-month pre-existing conditions limitation. No pre-existing limitation is allowed if there was prior coverage with no lapse, and there was treatment or diagnosis for a condition under the previous coverage or if the insured satisfied a 12-month pre-existing conditions limitation under that coverage.

Rates are required to meet an anticipated minimum loss ratio of at least 75% of the premium. The carriers must submit supporting actuarial information.

Board consists of nine representatives. Four are to be appointed by the Governor, four members are to represent carriers (to be elected by the members). The Commissioner, or his designee, is the ninth and an ex officio member of the Board. Ninety days after appointment, the board is to submit a plan of operation to the Commissioner who may disapprove the plan. If a suitable plan is not submitted, the Commissioner may adopt a temporary plan. The operating plan is to include procedures for handling monies, fiscal reporting, collecting assessments, approving the coverage of plans, interest for late payments, and other matters.

There should be an equitable sharing of program losses among members based on their market share. Carriers must file annual loss statements.

All members are liable for an assessment to reimburse carriers that have net losses unless the member is exempt because it enrolls or insures the minimum number of non-group persons on an open enrollment, community rated basis. (Non-group persons include individually enrolled persons, and those with conversion policies.) Financially impaired members may request a deferment from an assessment but remain liable to the program for the amount that is deferred.

The minimum number of non-group persons shall equal the total number of community rated and modified community rated, individually enrolled or insured persons of all carriers subject to the act at year end, multiplied by the proportion that the carrier's new earned premium bears to the net earned premium of all carriers for that calendar year, including those carriers that are exempt from the assessment. If a carrier does not enroll the minimum number of non-group persons established by the Board, the carrier will be assessed on a pro rata basis for any differential between the minimum number established by the Board, and the actual number enrolled or insured by the carrier.

The Board is to determine whether any carrier has a disproportionate share of substandard risks and make recommendations to the legislature to minimize any disproportion.

New Jersey had one carrier in the individual market prior to implementing its reform. There are now 28 carriers in that market. The state does not have data on the level of health coverage or on the average amount of insurance increase. The reforms have been viewed by many as successful because only Blue Cross and Blue Shield was writing individual business in New Jersey before the reforms were implemented.

C. New York

New York § 3233 "Stabilization of health insurance markets and premium rates" gives the Superintendent of Insurance authority to implement §§ 3231 and 4317 and require open enrollment and community rating in the small group and individual health insurance markets.

Section 3231 requires that all individual and group policies covering three to fifty employees be community rated. The law requires that all individuals, employees or group members and dependents of employees or members must be accepted at all times throughout the year. Individuals and small groups may not be terminated because of claims experience. The law also applies to out-of-state group trusts covering less than 50 employees. As used in New York statute, "Community rated means a rating methodology in which the premiums for all persons covered by a policy or contract form is the same based on the experience of the entire pool of risks covered by that policy or contract form without regard to age, sex, health status, or occupation."

Companies are allowed to have different rates for single coverage and family coverage. Different rates are also allowed for individuals and small groups. Companies are allowed to use geographic regions as a rating factor. Companies must file 12-month rates. The rate approval process is to consider the insurer's prior experience, projections of claims costs, utilization, and administrative expenses.

The anticipated minimum loss ratio for premium increases or decreases shall not be less than 75% of the premium. The insurer must submit a certification by a member of the American Academy of Actuaries or other individual acceptable to the Superintendent as to compliance with the requirement.

Each calendar year insurers must return at least 75% of all the aggregate premiums in the form of paid claims. A dividend or credit must be issued to policyholders if the loss ratio is not at least 75%.

New York also requires in § 3232 that individual and group policies credit the time a person was covered under previous coverage when applying pre-existing conditions provisions. For HMOs, any prior waiting period must also be credited when applying a new waiting period. Pre-existing conditions limitations may not exceed twelve months with a six-month look back.

The New York law allows for reinsurance mechanisms, pooling, and risk-sharing if recommended by a technical advisory committee and proposed by the Superintendent. Section 4317 makes the law applicable to non-profit medical corporations.

The New York Insurance Department did not supply information on the number of uninsured before or after market reform in response to our survey. New York reports that they had "a limited number of carriers" writing comprehensive coverage prior to market reform. There are now three commercial insurers, seven not-for-profit carriers, and thirty HMOs writing individual coverage. The department did not supply information on the change in the average annual premium after reform.

VII. Current Market Practices in Virginia

The Bureau surveyed 56 insurers with individual accident and sickness premiums in Virginia, and all 24 health maintenance organizations licensed in Virginia in 1994 to determine their current underwriting and pricing practices in the individual market. A total of 80 companies were surveyed and 61 responded by September 1, 1995.

Not surprisingly, of the 61 respondents, only 22 are currently writing major medical or medical expense contracts that provide comprehensive coverage. There are 31 of the insurers writing other types of individual coverages, usually specializing in certain lines such as disability income policies, or specified disease policies. Eight of the HMOs have not entered the individual market.

A. Insurers

The majority of the responding insurers medically underwrite the contracts that they issue. The rating factors most commonly used are age, gender and geography. Individual lifestyle, duration and past claims were used by less than half of the respondents. The majority of respondents (twelve) used attained age rating with one-year rate brackets being most common (seven).

Eleven insurers use riders to exempt certain conditions or injuries from coverage. All eleven companies attach riders that exclude coverage permanently for some conditions.

Only two companies community rate a significant amount of their individual business.

The Bureau's survey asked questions about the other states in which companies operate to obtain information about the companies' responses to reform initiatives in

other states. Seven insurers indicated that they had withdrawn, or planned to withdraw from a state or states with guaranteed issue requirements. Vermont and Kentucky were the states mentioned most with four insurers withdrawing from Vermont and five from Kentucky.

B. Health Maintenance Organizations

Health maintenance organizations are entering the individual market increasingly in Virginia and other states. Five of the thirteen HMOs responding to the survey are in the individual market.

Four of the five HMOs medically underwrite the individual contracts that they issue. The rating factors most commonly used are age and gender (four of five and three of five, respectively). Health status and past claims are rating factors used by two of the HMOs.

Two respondents did not answer the question on use of attained age rates, two responded positively, and one HMO reported that it does not use attained age rates. Three of the HMOs use five-year age brackets after age 30.

None of the HMOs use riders to exclude coverage for specific conditions. Four of the five HMOs use community rating. None of the HMOs operate in a state that has a guaranteed issue requirement.

The responses to the survey indicate that rating restrictions on the use of age and gender will have the greatest impact on the insurers currently writing in the individual market. Some of the insurers have indicated their previous willingness to withdraw from states imposing guaranteed issue requirements (seven of seventeen insurers), although restrictions in the states most often withdrawn from are generally regarded as being very restrictive. New York, for example, requires "pure community rating;" Kentucky's law requires insurers to issue only set plans; and Vermont phases in restrictive rate bands. Survey results indicate that there may be some impact on the number of carriers in the individual market if extensive reforms are enacted.

VIII. Bureau Recommendations for Market Reform

There are a number of alternatives for individual reform in Virginia. They may be classified broadly as (i) waiting for federal legislation; (ii) proceeding with extensive reforms; or (iii) continuing incremental reform.

Most Congressional observers do not anticipate substantial federal legislation being passed during the current year. Incremental reform(s) may be passed, but would

likely contain exceptions for states that have reforms in place. It is, therefore, not necessary to wait for federal action before proceeding in Virginia.

Extensive reforms include requiring the guaranteed issue of all plans and modified or pure community rating. The enactment of reforms of this type has been criticized as too severe, resulting in considerable market place disruption with disagreement on the actual impact on access to coverage.

It is important to recognize that the reforms in the individual market will also impact the small group market. Many states, Vermont, New Jersey and New York included, have the same or similar legislation in place in both the small group and individual markets. The NAIC also recommends that similar individual and small group reforms be enacted. Many of the proposals before Congress also contain the same or similar provisions for individual and group coverage.

Many actuaries believe that restrictions in the individual market may push people currently paying the lower than average premiums in that market to seek other coverage without similar restrictions. For example, if there are lesser or no restrictions in the small group market, a 20-year old with no health problems might try to join an association or other small group to avoid the impact of reforms on his premium. Conversely, small groups could seek coverage through individual contracts to avoid reforms in the small group market. Many knowledgeable parties tend to agree that regulation in the small group market should at least be proportional to what is required in the individual market. This lessens the likelihood of groups or individuals attempting to alter their true status to avoid restrictions. It is the healthier or lower premium groups and individuals that would benefit most from avoiding reform; encouraging them to accept their true status is helpful to the others obtaining their coverage in that market.

The majority of the states that have enacted some variation of a guaranteed issue requirement do not have data on the change in the level of health coverage since their laws went into effect. Respondents to our follow-up state survey either had data on their uninsured prior to the law or after the law was enacted.

Information from other sources conflicts regarding the effect of guaranteed issue and community rating requirements in states like New York. One study, "The Impact of Guaranteed Issue and Community Rating in the State of New York," by Milliman and Robertson, Inc. determined that:

- The number of persons covered by insurance decreased by 500,000 after reform was effective;

- The average annual premiums decreased a few percent in the small group market and 20% in the individual market; and

- The cost of average claims has increased by 6% for the small group market and 46% for the individual market.

The New York Insurance Department disagreed with those findings and believes the actual impact on premiums and coverage has been more moderate. The Intergovernmental Health Policy Project's "Special Report Community Rating: States' Experience" cites an overall decline in coverage of 1.2% during the first nine months the New York law was effective. The report's findings include the following:

> The impact of community rating on total coverage in the five states with a year's experience has been mixed so far, with more states reporting favorable than unfavorable experience. As predicted, there are anecdotal reports of improved availability among firms that had previously had difficulty obtaining coverage, offset by complaints from firms with relatively young and healthy workers. Vermont and New Jersey appear to have improved coverage in the markets where they began their rating reforms, the small group market and individual market respectively. New York, where full community rating in three markets was abruptly implemented as a single date certain, has experienced a decline in individual coverage only partially offset by increases in small group and Medicare supplemental coverage, although the insurance department questions the significance of the drop. Average deductibles have risen as individuals seek policies with relatively low premiums.
>
> Information on individual and small group markets alone may not be adequate to measure whether there has been an overall improvement in coverage in a state, since information about coverage under the regulated policies does not capture shifts occurring outside these plans. Without population-based surveys and hospital data, it is difficult to tell what the net impact of the changes is 1) on coverage rates for the population as a whole and 2) on coverage for health care encounters (by shifting coverage to persons likeliest to need health care). In addition, of the states with information on the numbers covered, none had analyzed it according to the characteristics of covered and non-covered individuals to determine whether the predicted aging of the risk pool was taking place.

The report makes the following suggestion for states considering community rating:

(1) Phase-in rate restrictions to avoid extreme and abrupt rate changes;

(2) Develop a mechanism for risk-sharing, either a pool or assessment features of some type; and

(3) Integrate individual and small group markets.

The report concludes in part:

> The early tests of community rating (with its associated insurance reforms) suggest that it is making insurance more available and affordable to those who could not obtain it before, while raising prices for others. The overall impact on coverage seems to depend on how the program is designed and implemented, with Vermont and New Jersey experiencing net gains and New York experiencing a loss in coverage in affected plans during the first year of implementation. Since all state estimates are based on counts of policies sold, not population surveys, the true impact on overall coverage is unknown. No states have attempted to measure the impact on overall costs.
>
> The short-term success of the plans varies with specified design features, and states are continuing to experiment and learn from one another. However the long-term consequences of these choices cannot yet be assessed.

The information obtained and reviewed by the Bureau leads us generally to agree with the assessment of the Intergovernmental Health Policy Project. It is still too soon to tell which reform approach works best. Either a phase-in or incremental approach should be attempted to mitigate the possible negative consequences of reform. The Bureau has always acknowledged that as Virginia moves to improve access and affordability, there will be changes that mean higher premiums for some individuals and groups. There may be a need for some type of risk-sharing mechanism, but not all states have considered them necessary and Virginia proceeded with small group reform without a risk-sharing feature. The Bureau agrees that the individual and small group markets are closely associated, and while we do not believe that they should be integrated at this point, we believe that they should have similar restrictions.

The Bureau therefore recommends that incremental reform in Virginia, if chosen, could follow what is in effect in the primary small group market:

(1) guaranteed renewal of all individual policies and guaranteed issue of the essential and standard plans with carriers allowed to market other plans;

(2) modified or adjusted community rating of the essential and standard plans. This rating would allow carriers to continue to rate age, gender, and geographic area. The community rate restrictions would apply to claims experience, health status, and duration of coverage and would limit the variation for those factors from 20% above to 20% below the community rate as required in § 38.2-3433 for the essential and standard plans issued to primary small employers; and

(3) include a guaranteed renewability requirement for conversion contracts and the offering of the essential and standard plans. If the essential or standard plans are selected, they should also be subject to modified community rating.

Section 38.2-3541 of the Code of Virginia requires that group policyholders, usually employers, be offered two options for group members leaving the group. The policyholder can elect to continue group coverage for the employees for 90 days or allow the employees to convert their group coverage to an individual policy. Group members do not have to satisfy insurability requirements. The section also provides that the premium is to be at the insurer's then customary rate (i) for such policies, (ii) for the class or risk the individual belongs and, (iii) at his or her age at the policy effective date. Including these contracts in reform proposals is therefore recommended.

We also recommend a one-year residency requirement before individuals qualify for individual coverage under these reforms. This will decrease the likelihood of individuals from other states moving to Virginia to obtain coverage.

Additional consideration can be given to limitations on the use of age as a rating factor. The NAIC draft model on individual reform restricts the range for age factors to 3:1. The variance from the highest age factor cannot be more than 200% of the lowest factor. A five-year transition period is allowed in the model and can be considered for Virginia if age limitations are included. Consideration of this variance from the current small group reforms is warranted because of the impact a person's age can have on an individual's policy premium. Access to coverage can be limited greatly by the premium impact of age as a rating factor.

IX. Conclusion

The Bureau recommends the adoption of incremental reforms in the individual health insurance market. The Bureau recommends guaranteed renewal of all individual contracts and guaranteed issue of the essential and standard plans on a guaranteed renewal basis. The Bureau also recommends that the essential and standard plans sold in the market should be subject to modified community rating. The reforms recommended for the individual market should include the individual contracts issued as conversions from group contracts.

The Bureau recognizes that the institution of these reforms will not address all of the problems of access and affordability in the purchase of individual insurance. However, the Bureau believes that it is important to have reforms in place in the individual market that are similar to those in the small group market to avoid migration from one market to the other.

APPENDIX

SENATE JOINT RESOLUTION NO. 332

Requesting the State Corporation Commission's Bureau of Insurance to study individual and conversion health care coverage and market reform.

Agreed to by the Senate, February 7, 1995
Agreed to by the House of Delegates, February 22, 1995

WHEREAS, health insurance market reforms enacted in 1992, 1993 and 1994 are aimed at improving the access and affordability of health care benefit programs in the small group market; and

WHEREAS, nearly one million Virginians are uninsured, many of whom have limited or no access to group health insurance programs; and

WHEREAS, there are differences between the small group and individual markets such as form and rate filings and other regulatory issues, and there also are many similarities such as the need for access to coverage, portability of coverage, guaranteed renewability, guaranteed issue of essential health care benefit programs, and modified rating requirements; and

WHEREAS, affordability is a particular issue with conversion policies; and

WHEREAS, comprehensive national health care reform was not enacted by Congress and any future national reforms likely will be directed at insurance industry reforms including the individual market; and

WHEREAS, since 1991, fourteen states have enacted various individual market reforms which include portability of coverage, guaranteed issue, guaranteed renewability, rating reforms, and minimum loss ratios; and

WHEREAS, legislation is being introduced during the 1995 Session of the General Assembly as recommended by the Joint Commission on Health Care to limit waiting periods for pre-existing conditions, and provide credit for waiting periods served in previous coverage; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the State Corporation Commission's Bureau of Insurance, in cooperation with the Joint Commission on Health Care, be requested to examine individual and conversion health care coverage and market reform possibilities to determine measures which increase access to affordable health care coverage for such individuals and families.

The State Corporation Commission's Bureau of Insurance shall complete its work in time to submit its findings and recommendations to the Governor and the 1996 Session of the General Assembly in accordance with the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.