REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

STUDY OF ADDITIONAL REFORMS IN THE INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MARKET PURSUANT TO HB 1026 OF 1996

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 27

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Preface

House Bill (HB) 1026 of the 1996 Session of the General Assembly requires health insurers, health services plans and health maintenance organizations to guarantee the renewability of health insurance policies issued to individuals. This legislation continued the reforms begun in 1995 in the individual health insurance market when legislation was passed to reduce the maximum waiting periods for pre-existing conditions, and provide credit for waiting periods served in previous coverage.

The second enactment clause of HB 1026 directed the Joint Commission on Health Care, in cooperation with the Bureau of Insurance, to study additional reforms in the individual health insurance market, including, but not limited to, guaranteed issue and modified community rating for the Essential and Standard Health Benefits Plans. The bill also directed the Joint Commission to: (i) evaluate whether the Commonwealth has the authority to apply individual health insurance reforms to multiple employer welfare arrangements (MEWAs) and out-of-state group trusts and associations; and (ii) assess the impact of guaranteed issue reforms on the taxation of open enrollment carriers. In addition to the requirements of HB 1026, we also evaluated the results of the health insurance reforms previously enacted in the small group market.

Based on our research and analysis, we concluded the following:

- Thus far, the guaranteed issue and modified community rating reforms enacted in the primary small group (2-25 employees) market have had a minimal impact. Very few groups have purchased either the Essential or Standard Health Benefits Plans. A key reason for this is that the plans are difficult to market due primarily to the 21-day inpatient hospital benefit. To ensure that the plans are marketable today and in the future, a process for reviewing and updating the benefits and other features of the plans is needed.

- While Virginia has an open enrollment program for individuals to obtain coverage who may not be able to purchase coverage from other carriers, guaranteed issue and modified community rating of the Essential and Standard Plans in the individual market should expand access to coverage for some individuals.

- If guaranteed issue and modified community rating are required in the individual market, consideration should be given to extending these reforms to policies sold through out-of-state group trusts and associations. The provisions of the Employee Retirement Income Security Act (ERISA) precludes the Commonwealth from extending these reforms to all but one MEWA operating in Virginia.

- Open enrollment carriers (Trigon, BlueCross BlueShield and Blue Cross and Blue Shield of the National Capital Area (BCBSNCA)) pay a reduced premium tax in return for providing coverage to all individuals regardless of their health status. If guaranteed issue products are required of all carriers, the principal reason for giving open enrollment carriers a tax advantage would be eliminated. Thus, if guaranteed issue is required of all carriers in the individual market, consideration should be given to requiring open enrollment carriers to pay the same premium tax as other carriers on premiums derived from individual contracts.

- There is a discrepancy in the tax status of the two open enrollment carriers with respect to tax payments on premiums derived from primary small groups (2-25 employees). Trigon pays the full 2.25% tax while BCBSNCA pays the reduced tax (.75%). Inasmuch as the tax treatment should be consistent for all open enrollment carriers, consideration should be given to applying the 2.25% premium tax on the primary small group premiums of BCBSNCA.

The recent passage of the federal Health Insurance Portability and Accountability Act (HIPAA) includes a number of insurance reforms that Virginia will need to enact to be in compliance with federal law. However, the federal legislation does not address the affordability of coverage at all. Despite the important changes that will occur as a result of the HIPAA, it is clear that the Commonwealth still must wrestle with the issues of accessibility and affordability of coverage for many Virginians.

Policy options were offered for consideration by the Joint Commission regarding four major issues : (i) establishing a process for reviewing and updating the Essential and Standard Health Benefits Plans; (ii) deciding whether to implement guaranteed issue and modified community rating in the individual health insurance market; (iii) addressing the tax status of open enrollment carriers as it relates to premium income derived from primary small groups; and (iv) addressing the tax status of open enrollment carriers should guaranteed issue be implemented in the individual market. These policy options are discussed on pages 37-39.

Our review process on this topic included an initial staff briefing which you will find in the body of this report followed by a public comment period during which time interested parties forwarded written comments to us on the report. In many cases, the public comments, which are provided at the end of this report, provided additional insight into the various topics covered in this study.

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Executive Director

December 5, 1996

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I.
Authority for Study

House Bill (HB) 1026 of the 1996 Session of the General Assembly directs the Joint Commission on Health Care, in cooperation with the State Corporation Commission's Bureau of Insurance, to study additional reforms in the individual health insurance market, including, but not limited to guaranteed issue and modified community rating of the Essential and Standard health benefits plans as defined in §38.2-3431. Specifically, HB 1026 directs the Joint Commission to evaluate:

(i) whether the Commonwealth has the authority to apply individual health insurance reforms to fully insured and not fully insured multiple employer welfare arrangements and out-of-state group trusts and associations; and
(ii) the impact of guaranteed issue reforms on the taxation of open enrollment carriers.

A copy of HB 1026 is provided at Appendix A.

II.
Health Insurance Reform in Virginia

State Health Insurance Reforms Affect Only a Portion of the Health Insurance Marketplace in Virginia

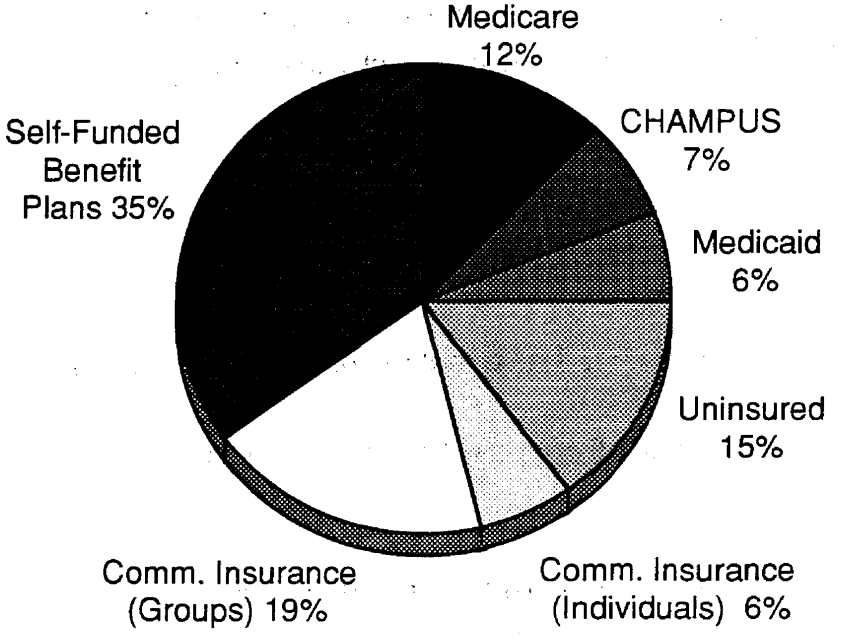
In Virginia and across the nation, insurance reforms enacted by state legislatures have been an attempt to increase the accessibility and affordability of health insurance coverage for the uninsured and underinsured. However, these reforms affect only a limited portion of the entire health insurance marketplace.

The only component of the marketplace that states directly impact through these reform initiatives is commercial insurance. Other publicly funded health insurance programs such as Medicare and CHAMPUS are subject to federal laws

and regulations. While states have some discretion in the design of their respective Medicaid programs, the federal government also plays a major role in how this program is administered. Self-funded plans, typically large employer groups, are not subject to state regulation because of an exemption provided through the Employee Retirement Income Security Act (ERISA). Accordingly, as illustrated in Figure 1, state health insurance reforms in Virginia affect only about 25% of Virginians (approximately 19% in commercial *group* insurance and 9% in commercial *individual* insurance). It is within this context that Virginia's health insurance reforms are discussed and analyzed in this report.

Figure 1

Health Insurance Status of Virginia's Population: 1992



Source: Virginia Commonwealth University, Survey Research Laboratory, U.S. Health Care Financing Administration, CHAMPUS Staff, Joint Commission on Health Care Staff

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A High Percentage of Small Businesses in Virginia Do Not Provide Health Insurance Benefits To Their Employees

Health insurance market reforms typically are targeted to those groups and individuals which have the most difficulty obtaining affordable and comprehensive health insurance. In Virginia, small businesses clearly fall within this category. According to information provided by the Small Business Advisory Board, while 81% of firms with 10 to 49 employees provide health insurance benefits, only 57.3% of firms with 10 or fewer employees provide benefits to their employees. These small employers have found it particularly difficult to obtain insurance coverage due to such factors as: (i) greater risk/uncertainty in predicting claims costs; (ii) higher administrative costs; and (iii) limited bargaining/negotiating power with carriers.

It is because of these demographics of Virginia's small business community that the Joint Commission on Health Care sponsored legislation over the past several years to reform the small group insurance market.

Market Research Indicates Small Employers Want to Provide Health Insurance and Are Willing to Pay a Reasonable Premium

Market research conducted last summer by the Williamson Institute of Virginia Commonwealth University indicated that small employers (2-25 employees) want to provide health insurance for their employees, and are willing to pay a reasonable premium for the coverage. Through focus groups and telephone surveys, the Williamson Institute found that cost and scope of coverage were among the most important factors in both employers' and employees' decisions to purchase coverage. A "consistent theme" among small businesses was that they had sophisticated knowledge of health insurance issues and wanted to make good purchasing decisions. Another consistent theme was that employers and employees understand the tradeoffs in coverage versus cost, and are willing to accept responsibility for their decisions. In sum, small businesses want to find a way to purchase health insurance coverage for their employees and are looking for affordable comprehensive coverage.

Virginia Has Implemented Several Reforms in the Small Group Health Insurance Market

Reforms for Small Employers (2-49 Employees): As noted above, small employers historically have had difficulty obtaining affordable, comprehensive health insurance. It is for this reason that Virginia has implemented a number of reforms in the small group (2-49) market. The Joint Commission on Health Care sponsored Senate Bill 505 which was enacted by the 1992 General Assembly and put in place several reforms for these small employers. This legislation: (i) reduced waiting periods for pre-existing conditions to a maximum of 12 months; (ii) required carriers to provide credit for waiting periods served in previous coverage; (iii) prohibited carriers from excluding certain individual members from the group; and (iv) required guaranteed renewability of all products, except in limited circumstances (e.g., non-payment of premiums, fraud, etc.).

In 1996, legislation (HB 700) was passed that extended these reforms to groups up to 99 employees.

Additional Reforms for Primary Small Employers (2-25 Employees): It is the smallest of employers who face the most difficulty obtaining affordable health insurance for their employees. In an attempt to provide even greater access to coverage for these groups, the Commonwealth enacted additional reforms in 1993 and 1994 that apply to primary small groups between 2 and 25 employees. House Bill 2353 of the 1993 Session and House Bill 1345 of the 1994 Session required carriers to: (i) guarantee the issue of the Essential and Standard health benefits plans; and (ii) set premium rates for these two benefits plans on a modified community rating basis. Once the carrier fulfills this requirement, they are allowed to market other products without the guaranteed issue or modified community rating requirements.

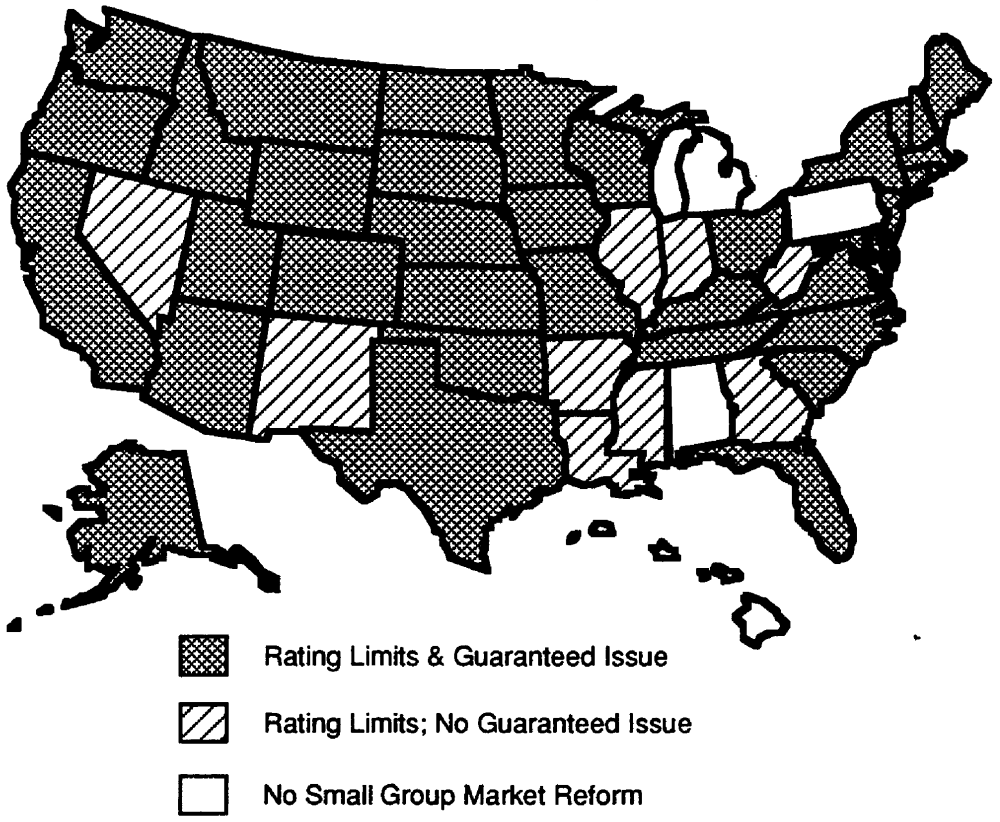
Virginia's Small Group Reforms Are Similar to Other States; However, Several States Have Passed More Extensive Reforms

Virginia's small group reforms, particularly the guaranteed renewability provision and the limits on pre-existing conditions are very similar to other states' reforms. According to a 1995 report by the Blue Cross and Blue Shield

Association, 45 states have enacted pre-existing conditions limits, while 43 states have enacted guaranteed renewability provisions. (See Figure 2)

Figure 2

Small Group Reforms In Other States (1995)



Source: Blue Cross and Blue Shield Association, 1995

As shown in Figure 2, Virginia is among 46 states which have enacted some form of rating reform, and among 37 states which have implemented guaranteed issue provisions. Most of these states are like Virginia in that their rating reforms include rating bands and/or some form of modified community rating. These reforms typically limit the degree to which carriers can rate small groups on the basis of their health status. In Virginia, carriers can vary their community rate due to health status by 20% above or 20% below the community rate. Some states have established tighter rating bands or more restrictive community rating by strictly limiting the number and/or "weight" of certain factors (e.g., health status, age, gender, geographic location, etc.) that carriers use in setting premiums.

Virginia's Primary Small Group Guaranteed Issue Provision Is Not as Extensive as 14 Other States

Virginia's guaranteed issue provisions apply only to the Essential and Standard health benefits plans. These two standardized plans were developed by the Essential and Standard Health Benefits Panel which was established pursuant to Senate Bill 506 of the 1992 General Assembly. As mentioned previously, carriers can market other products without the guaranteed issue or modified community rating requirements. Because carriers can market other products without these requirements, there is little incentive for a carrier to actively market the Essential and Standard plans.

There are 14 other states which require carriers to guarantee issue all products marketed in the small group market. These states are listed in Figure 3. Some states, such as Kentucky, prohibit carriers from marketing products other than standardized plans. Most of the 14 states allow carriers to develop and market their own products, but require them to guarantee issue all such products. In these states, there is little or no financial incentive for carriers not to market certain products. As such, the reforms in these states are more extensive and provide greater access to coverage for small employers.

Figure 3

States Which Require Guaranteed Issue of All Products in the Small Group Market

California	Florida
Kentucky	Maine
Maryland	Massachusetts
Minnesota	New Hampshire
New Jersey	New York
Oregon	Texas
Vermont	Washington

Source: Blue Cross and Blue Shield Association, 1995

There is Limited Information Available on the Impact of Virginia's Primary Small Group Reforms; Carriers Report Few Groups Purchasing the Essential and Standard Plans

Virginia's primary small group reforms were implemented only recently; therefore, there is limited information on the impact the reforms are having in the marketplace. The regulations establishing the Essential and Standard plans were promulgated by the Bureau of Insurance on May 1, 1995. Carriers had to register with the Bureau and have their Essential and Standard plans approved by October 28, 1995 in order to conduct business in the primary small group market. The Bureau reports that as of June 17, 1996, 87 carriers were registered as a Small Employer Carrier, with 64 of the 87 also registered as a Primary Small Employer Carrier.

The regulations promulgated by the Bureau require carriers to report by March 1 of each year the number of primary small employers covered by the Essential and Standard plans during the preceding calendar year. As of March 1 of this year, three carriers, two insurers and one Health Maintenance Organization, reported issuance of Standard and Essential benefits plans in the primary small group market. Fifteen primary small employer groups covering a total of 65 persons had purchased the Essential and Standard plans. The Bureau expected these numbers to be low due to the relatively short period of time the reforms had been in effect prior to the March 1 reporting date (November, 1995 through February, 1996).

Carriers will not report new data to the Bureau until March 1, 1997. However, carriers anecdotally have stated that there have been very few enrollments in the Essential and Standard plans. As of June 27, 1996, Trigon BlueCross BlueShield, the largest carrier in the state, had sold guaranteed issue products to only three groups covering 10 employees. Spokespersons for several carriers indicate that the plans are difficult to market due to the benefits offered and the manner in which the plans are designed. More detailed information is provided on the marketability of the Essential and Standard plans later in this issue brief.

In Addition to Small Group Market Reforms, A Pilot Program to Convert the Indigent Health Care Trust Fund Into a Program to Subsidize Health Insurance Coverage for Small Employers is Underway

As noted earlier, market research indicates that small business owners want to provide health insurance coverage for their employees, and that the cost of coverage is an important factor in their purchasing decisions. The small group reforms enacted in Virginia are aimed at addressing this need. In addition to these reforms, the Technical Advisory Panel of the Indigent Health Care Trust Fund is working on a pilot project to convert the fund into a program which subsidizes the cost of health insurance for the working uninsured in small businesses. This pilot program, which was initiated through legislation sponsored by the Joint Commission on Health Care, is designed to use voluntary contributions to the Trust Fund to offer subsidized insurance coverage for these employers and employees. The Essential and Standard plans are envisioned as being the coverage offered to these groups.

One hospital system, INOVA in northern Virginia, has expressed firm interest in making voluntary donations to the fund for a pilot site in northern Virginia. While some progress has been made on the pilot, much work remains to be done. The Department of Medical Assistance Services hopes to have the necessary regulations and other components of the program ready by April, 1997.

It is the intent of this pilot project that a model can be developed to convert the trust fund into a program that assists employers across the state purchase coverage. Through this effort and the reforms in the small group market, it is hoped that more small businesses will be able to purchase coverage for their employees.

Virginia Has Implemented Limits on Preexisting Conditions, Portability of Coverage and Guaranteed Renewability in the Individual Insurance Market

Following the enactment of reforms in the small group market, the Commonwealth began efforts to reform the individual insurance market. In 1995, House Bill 2043 was passed by the General Assembly which reduced the

maximum waiting periods for pre-existing conditions from 24 to 12 months. This legislation also required carriers to provide credit for any waiting periods individuals served in previous coverage. In addition, Senate Joint Resolution 332 was adopted by the General Assembly which directed the Bureau of Insurance to study additional reforms in the individual market.

Bureau of Insurance Study of Individual Market Reforms: The Bureau of Insurance study recommended that Virginia enact additional reforms in the individual market similar to those which have been implemented in the primary small group market. (The Bureau's study and recommendations were published in Senate Document 9 of the 1996 Session.) Specifically, the Bureau recommended that Virginia enact the following reforms: (i) require guaranteed issue and modified community rating of the Essential and Standard plans; (ii) require guaranteed renewability for all individual health insurance products; (iii) provide guaranteed renewability for individual contracts issued as conversions from group policies; and (iv) require that the Essential and Standard plans, with modified community rating, be offered as options to those converting to individual coverage.

Guaranteed Renewability Approved By 1996 General Assembly: A bill was drafted to implement the Bureau's recommendations. However, several carriers submitted public comments to the Joint Commission on Health Care on the draft bill expressing concern about the guaranteed issue and modified community rating provisions. In response to these concerns, the guaranteed issue and modified community rating provisions were removed from the bill, leaving only the guaranteed renewability requirement. Accordingly, House Bill (HB) 1026 was passed by the 1996 General Assembly requiring carriers to guarantee the renewability of all individual products, except in limited circumstances (e.g., non-payment of premiums, fraud, etc.).

In response to the insurance carriers' concerns regarding the guaranteed issue and modified community rating provisions, a second enactment clause was included in HB 1026 directing the Joint Commission on Health Care, in cooperation with the Bureau of Insurance, to study these issues. As noted earlier in this report, the language in HB 1026 specifically directs the Joint Commission to evaluate: (i) whether the Commonwealth has the authority to apply

individual health insurance reforms to fully insured and not fully insured multiple employer welfare arrangements and out-of-state group trusts and associations; and (ii) the impact of guaranteed issue reforms on the taxation of open enrollment carriers. The next section of this report addresses these specific issues.

III.
Guaranteed Issue In Virginia's Individual Health Insurance Market

Bureau of Insurance Survey Finds That Twenty-Two Carriers Currently Write Comprehensive Individual Health Insurance Policies

In its 1995 study of individual market reforms, the Bureau of Insurance surveyed the 56 insurers with individual accident and sickness premiums in Virginia and all 24 HMOs licensed in Virginia. Of the 61 plans which responded to the survey, only 22 currently write major medical contracts that provide comprehensive coverage in the individual market. There are 31 insurers writing other types of coverage, usually specializing in disability income policies or specified disease policies (e.g., cancer policies).

The majority of the companies responding to the survey medically underwrite their policies. Two carriers, Trigon BlueCross BlueShield and BlueCross Blue Shield of the National Capital Area, offer "open enrollment" contracts to individuals without medical underwriting. In return for serving as an "insurer of last resort," these plans pay a reduced premium tax.

Bureau of Insurance's Recommendation to Enact Guaranteed Issue of Essential and Standard Plans Was Supported by Many Groups; However, Several Carriers Raised Concerns

A number of groups and associations, including the Virginia Hospital and Healthcare Association, the League of Virginia Health Systems, the Virginia Chamber of Commerce, the Virginia Manufacturers' Association, and the Virginia Small Business Advisory Board submitted comments in support of the bill which was drafted to require guaranteed issue and modified community rating of the Essential and Standard Plans. However, each of the insurance carriers and insurance trade associations which commented on the draft bill expressed concerns about the guaranteed issue and modified community rating provisions. Some carriers commented that they oppose any form of guaranteed issue. Others commented that instead of a guaranteed issue requirement, a high-risk pool should be established for persons who cannot obtain insurance.

Other commenters indicated that some issues should be studied and resolved prior to implementing a guaranteed issue requirement. The following summarizes the major issues identified by these groups:

(i) Virginia should exercise extraterritorial authority and extend any requirement for guaranteed issue to out-of-state group trusts and associations (several insurance agent associations also urged the Joint Commission to extend the guaranteed issue requirement to Multiple Employer Welfare Arrangements (MEWAs));

(ii) guaranteed issue should not be implemented in the individual market until the impact of this reform in the small group market can be assessed;

(iii) guaranteed issue should not be extended to persons who are "eligible" for other insurance coverage; and

(iv) the rating bands (i.e., 20% above or below the community rate) should be broadened.

In addition to the above concerns identified through the Joint Commission's public comment process for draft legislation, several major carriers also indicated during interviews conducted as part of this study that the Essential and Standard plans are difficult to market in their present form due to certain aspects of the benefit design. Each of these concerns is addressed in the following sections.

A Key Issue is Whether Guaranteed Issue and Modified Community Rating Requirements Should Apply to Policies Issued by Out-Of-State Group Trusts and Associations

Group and individual health 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 General Assembly to ensure Virginians that insurance products meet certain minimum standards and are financially sound. However, these provisions do not apply to insurance policies which are issued to a contract holder in another state and purchased by a resident of Virginia. In these instances the policies are required to comply with the laws of the state in which the policy is issued or delivered to the policyowner.

As noted above, some of the comments received by the Joint Commission strongly urged that any legislation requiring guaranteed issue and modified community rating of the Essential and Standard plans should apply to out-of-state group trusts and associations. Out-of-state group trusts and associations are insurance arrangements where an insurer issues an insurance contract or policy to a contract holder located in a state other than Virginia. The trust or association then issues a "certificate" or evidence of coverage to persons in Virginia who purchase coverage. Currently, the policies of these out-of-state trusts and associations must comply with the insurance laws and regulations of the particular state in which they are issued, but are not subject to the insurance laws of Virginia.

Regarding guaranteed issue and modified community rating of the Essential and Standard plans, some argue that unless the out-of-state group trust and association policies are required to comply with these reforms, insurance carriers issuing policies in Virginia will be at a significant competitive disadvantage. Moreover, while the Bureau does not maintain records on the number of Virginians covered through out-of-state group trust and association policies, several carriers and some insurance agent associations have indicated that these policies comprise a significant portion of Virginia's individual health insurance market. Thus, if the reforms did not extend to out-of-state group trusts and associations, the reforms would have significantly less impact on the market.

Virginia Currently Exercises Very Limited Extraterritorial Authority Over Accident and Sickness Insurance Issued Through Out-Of-State Group Trusts and Associations

Virginia exercises extraterritorial authority over accident and sickness policies only with respect to prohibiting subrogation of insurance benefits. Section 38.2-3405 of the Code of Virginia prohibits accident and sickness insurance policies ". . . delivered or issued for delivery or providing for payment of benefits to or on behalf *of persons residing in or employed in* (emphasis added) this Commonwealth. . ." from including a provision providing for subrogation of any person's right to recovery for personal injury from a third person. 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.

Bureau of Insurance Study Recommended Expanding Extraterritorial Authority: In 1988, the Bureau of Insurance studied whether Virginia should expand its extraterritorial authority over accident and sickness insurance polices. The Bureau reported that there are advantages (e.g., consumer protection, consistency in benefits for all Virginians) and disadvantages (e.g. added administrative costs for plans, difficulty for insurers meeting numerous state requirements) associated with exercising extraterritorial authority over out-of-state health insurance policies. The study found that 33 of 47 states responding to a survey claimed some extraterritorial authority over policies that are issued out-of-state but cover residents of their states.

On the basis of its review, the Bureau recommended that all out-of-state group accident and sickness policies comply with Virginia' s insurance laws except employer groups, labor union groups, credit union groups and debtor groups where less than a majority of the persons covered under the policy are residents of Virginia. However, these recommendations were not enacted.

Nearly All States Which Require Guaranteed Issue in the Individual Market Extend This Requirement to Out-Of-State Group Trusts and Associations

As will be discussed in more detail later in this report, 10 states have implemented a guaranteed issue provision in their respective individual insurance markets. A survey of these states indicated that all but one apply this requirement, as well as other individual reforms, to out-of-state group trusts and associations. These states indicated that without such extraterritorial authority, a sizable part of their markets would not be subject to the reform requirements.

The National Association of Insurance Commissioners' Model Legislation for Small Group and Individual Insurance Reform Urges States to Extend These Provisions to Out-Of-State Group Trusts and Associations

In its model legislation released June 3, 1996, the National Association of Insurance Commissioners (NAIC) recommended that states apply their individual reforms to out-of-state group trusts and associations. Section 3 (S)(2) defines an individual health benefit plan to include *" a certificate issued to an eligible person that evidences coverage under a policy or contract issued to a trust or association or other similar grouping of individuals, regardless of the situs of delivery of*

the policy or contract, if the eligible person pays the premium and is not being covered under the policy or contract pursuant to continuation of benefits provisions applicable under federal or state law, except that 'individual health benefits plan' shall not include a certificate issued to an eligible person that evidences coverage under a professional association plan." (A professional association plan is one which serves a single profession which requires members to be highly trained or licensed and meets a list of 10 criteria listed in the act.)

The NAIC included a drafting note in the model legislation which states: "[I]n reforming the individual health insurance market, it is important that state insurance departments have jurisdiction over policies sold to individuals through trusts or associations situsedoutside the state."

Insurers Which Sell Individual Policies Through Group Trusts and Associations Likely Will Oppose Extending State Reforms to These Policies

Due to the additional administrative requirements of having to comply with various states' insurance laws, carriers which issue policies through group trusts and associations likely will oppose any attempt to exercise extraterritorial authority over these policies. They argue that the policies should only have to comply with the insurance laws that exist in the state where the policy is issued.

The Employee Retirement Income Security Act (ERISA) Limits States' Ability to Regulate Multiple Employer Welfare Arrangements (MEWAs)

Unlike a group trust or association, which is considered to be an association of individuals, a multiple employer welfare arrangement (MEWA) is considered to be an association of employers. The term MEWA means an employee welfare benefit plan or any other arrangement which is established to offer or provide benefits to the employees of two or more employers. (Federal law does not consider collective bargaining agreements, rural electric cooperatives and rural telephone cooperatives to be MEWAs.)

The Employee Retirement Income Security Act (ERISA) specifically addresses states' authority to regulate MEWAs. The degree to which states can regulate MEWAs depends on whether the MEWA is fully-insured or not fully

insured. Section 514(b)(6)(A)(i) of ERISA provides that for *fully-insured* MEWAs, only those state laws requiring the maintenance of specified levels of reserves and contributions can be applied. In the case of MEWAs that are *not fully insured,* ERISA §514(b)(6)(A)(ii) provides that any state insurance law can be applied as long as the law is not inconsistent with Title I of ERISA.

The Bureau of Insurance reports that there are 13 Virginia (domiciled in Virginia) fully-insured MEWAs, 227 Foreign (domiciled outside of Virginia) fully-insured MEWAs and one self-funded or not fully-insured MEWA operating in Virginia. Based on current ERISA provisions, Virginia may directly regulate the one self-funded MEWA. Virginia may indirectly impose individual market reforms on the 13 Virginia-domiciled MEWAs by imposing certain requirements on all insurance products delivered or issued for delivery in Virginia. However, the Commonwealth has no authority to extend individual market reforms to the 227 foreign MEWAs.

Some Carriers and the Virginia Association Of HMOs Believe Guaranteed Issue and Modified Community Rating Should Not Be Implemented in the Individual Market Until the Impact of These Reforms in the Primary Small Group Market Can Be Assessed

Virginia's guaranteed issue and modified community rating requirements in the primary small group market became effective when regulations were promulgated by the Bureau of Insurance on May 1, 1995. Carriers had to begin offering the Essential and Standard plans by October 28, 1995. Thus, these reforms have been in place for only several months. Consequently, there is little information upon which to gauge the success and impact of these reforms.

The Bureau of Insurance recommended guaranteed issue and modified community rating of the Essential and Standard plans in the individual market, in part, so that the reforms in the individual market will parallel those in the primary small group market. The Bureau noted that it is important to continue reforms on the state level and that ". . .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's concern regarding comparable reforms in the individual and small group markets is shared by the National Association of Insurance Commissioners (NAIC). In its "Small Employer and Individual Health Insurance Availability Model Act," the NAIC notes that "[S]tates should be mindful of the desirability of having consistent rating schemes in the small group and individual markets. Whatever the rating rules are for small employer health benefits plans in a state, they should be consistent for individual health benefits plans."

There Are Differing Opinions as to Whether Guaranteed Issue Coverage Should Be Extended to Persons Who Are "Eligible" For Other Coverage

The original draft of HB 1026 included language that provided carriers would not have to guarantee the issue of the Essential and Standard plans to persons already covered through other insurance. However, the guaranteed issue provision would have extended to persons who are uninsured but "eligible" for other coverage. The argument for extending the guaranteed issue provision to these persons is that it broadens the number of options available to them. Some carriers and insurance agent associations stated that the guaranteed issue provisions should not be extended to persons "eligible" for coverage. Their argument is that if persons are eligible to obtain other coverage and choose not to, but then elect to purchase the Essential or Standard plan, there will be adverse selection against the Essential and Standard plans which will raise the rates for these products. The NAIC model act excludes persons "eligible" for coverage from the guaranteed issue provision.

Should Virginia go forward with guaranteed issue in the individual market, consideration should be given to excluding persons "eligible" for coverage from this provision.

If Guaranteed Issue and Modified Community Rating Reforms Are Implemented, the Issue of Whether to Broaden the Rating Bands (i.e., 20% Above or Below the Community Rate) for the Essential and Standard Plans Needs to be Resolved

The original draft of HB 1026 included modified community rating provisions identical to that included in the primary small group reform. This

rating scheme would have allowed carriers to adjust the community rate 20% higher or 20% lower based on the health status of the individual. Some carriers commented that because the individual market is more volatile in terms of risk selection, the rating bands should be broadened (e.g., 30% or 40% above or below the community rate).

The principal reason for setting the rating bands at 20% was to have the same rating methodology in the individual and small group markets. As noted earlier, the NAIC encourages states to have similar rating methodologies to avoid any "gaming" of the two markets. With respect to consumers, the design issue here is that tighter bands (i.e.,+ - 20%) will hold down premiums more for persons with greater health risks, but will raise premiums more for healthy persons. Broadening the bands (i.e., + - 30 or 40%) would result in higher premiums for those with health risks but would require less subsidy from healthier persons. With respect to carriers, wider bands lessen the risk they assume for persons who purchase the Essential and Standard products.

One possible alternative to this issue would be to phase in tighter rating bands over a given time period. For instance, the bands for the first year could be 30% and then 20% in the second and succeeding years. However, maintaining similar rating structures in the small group and individual markets should be a priority.

Some Carriers and Insurance Agents Have Expressed Concern That the Essential and Standard Health Benefits Plans Have Limited Marketability and Need to be Revised Prior to Being Implemented in the Individual Market

The Essential and Standard plans were developed by the Essential Health Services Panel established pursuant to Senate Bill 506 of the 1992 General Assembly. As directed by SB 506, the panel was composed of 12 members, including five physicians, a mental health expert, a nurse, a pharmacist, a medical ethicist, a health care provider who is not a physician, and two citizens/consumers. The panel was moderated by former Delegate J. Samuel Glasscock. The panel was staffed by Norma E. Szakal of the Division of Legislative Services and Dr. Louis F. Rossiter, Ph.D., of the Department of Health Administration at Virginia Commonwealth University. As the benefit plans

were developed, the panel received input from a variety of sources including health care policy experts and insurance carriers.

As required by § 38.2-3431 (D) of the Code of Virginia, the State Corporation Commission adopted regulations establishing the Essential and Standard plans, and incorporated the recommendations of the Essential Health Services Panel in the regulations. The Commission also received public comments on the proposed regulations and made numerous changes to the regulations based on these comments. However, given the language in the Code that the Commission shall incorporate the recommendations of the Essential Health Services Panel, the Bureau believed it had limited authority to make substantive changes to the plans recommended by the panel.

Through interviews conducted as part of this study, several carriers expressed concern that the Essential and Standard plans have limited marketability, and, therefore, are not "selling" well in the market. This concern is shared by the insurance agent community. The most common concern identified by carriers and agents is the 21-day inpatient hospital benefit. In today's health care marketplace, inpatient stays rarely exceed 21 days. However, it is important to consumers to have the "security" of more extensive inpatient benefits to protect them against the catastrophic costs that can be associated with a lengthy hospital stay.

Other concerns identified by carriers are that the benefits of the Standard plan are too rich which results in the product being too expensive.

A Process for Reviewing and Updating the Essential and Standard Health Benefits Plans is Needed to Improve and Maintain The Marketability of These Products

Whether or not the Essential and Standard plans are marketable now, there is clearly a need to establish a process for reviewing and updating the plans to ensure the products are marketable in the future and meeting the needs of consumers. Current law does not assign responsibility to any entity to perform this function.

There are several alternative approaches to establishing a review process. One alternative would be to have the Bureau of Insurance assume this function as part of its current responsibility for promulgating the regulations that establish the plans. An advisory committee of insurers, employers, consumers and providers could be established to advise the Bureau. Another option would be to establish a separate committee (with appropriate stakeholder representation) which would have statutory authority to review the plans and make recommendations to the Bureau for revising the regulations. A third option would be to have the Commission on Mandated Benefits assume this responsibility. Under this option, the Bureau would issue regulations based on the plans recommended or adopted by the Commission.

A more immediate approach would be to have the Joint Commission on Health Care recommend to the 1997 General Assembly any pressing changes that are needed in the plan design. In this way, changes could be instituted more quickly. One of the other three options could also be pursued legislatively at the same time to institute a long-term process for keeping the plans marketable.

Benefit Plan Review Process in NAIC Model Act: The National Association of Insurance Commissioners' (NAIC) model act establishes a Health Benefit Plan Committee composed of representatives of carriers, small employers, consumers and health care providers to recommend standard benefit plans to the state's insurance commissioner. The model act also calls for the committee to study and report at least every three years to the commissioner on the effectiveness of the act in promoting rate stability, product availability and coverage affordability. Part of the committee's responsibility would be to recommend changes in the plan design as needed.

Other States' Review Process: All of the eight states which require carriers to guarantee the issue of standard benefit plans to individuals have a process for updating their standard plans. In most states, the department of insurance, often with the assistance of an advisory committee or council, reviews and updates the benefit plans. Two states report having a separate committee or authority which is responsible for this function.

IV.
Impact Of Guaranteed Issue On The Tax Status Of Open Enrollment Carriers

House Bill 1026 specifically directs the Joint Commission on Health Care to evaluate the impact of guaranteed issue reforms on the taxation of open enrollment carriers.

Virginia's "Open Enrollment" Program Provides Coverage for Persons Unable to Purchase Insurance From Other Carriers

Section 38.2-4216.1 of the Code of Virginia requires each non-stock corporation to make available an "open enrollment" program in which each carrier issues open enrollment contracts without the imposition of underwriting criteria whereby coverage is denied or subject to cancellation or nonrenewal because of an individual's age, health status, employment status or, if employed, industry or job classification. The open enrollment program applies to individuals, members of any group of 49 or fewer enrolled members, including multi-group, master group or association-type contracts providing coverage to individuals and members of organizations with 49 or fewer enrolled members.

Currently, there are two open enrollment carriers in Virginia, Trigon BlueCross BlueShield (Trigon) and BlueCross BlueShield of the National Capital Area (BCBSNCA). Section 38.2-4229.1, which provides a process for a nonstock corporation to convert to a domestic mutual insurer, includes a provision which requires a domestic mutual insurer to continue its open enrollment program. (This statute applies to Trigon which recently converted to a mutual insurer.)

Open enrollment statistics provided by Trigon and BCBSNCA to the Bureau of Insurance for calendar year 1995 indicate that Trigon issued a total of 9,127 policies to individual open enrollment subscribers covering 11,192 participants. The statistics provided by BCBSNCA indicate it issued individual open enrollment policies to only 92 subscribers in calendar year 1995.

Open Enrollment Carriers Pay a Lower Premium Tax

The open enrollment program provides a form of guaranteed issue for individuals and small groups in that open enrollment carriers must issue a policy regardless of the insured's health status. Because open enrollment carriers operate as an "insurer of last resort," the Commonwealth imposes a reduced license/premium tax to offset their underwriting losses. A secondary reason for the tax preference is that open enrollment carriers also are required to provide other public service to the community including health-related education and training.

Prior to 1988, open enrollment carriers were exempt entirely from premium tax. However, since 1988, open enrollment carriers have paid 0.75% of their direct gross subscriber fee income in premium taxes (§58.1-2501). This tax rate is substantially lower than the 2.25% rate imposed on the accident and sickness premiums collected by other carriers not subject to the open enrollment requirements. The lower tax rate applies to all subscriber income, not just premiums derived from open enrollment contracts. (As will be discussed later, Trigon now pays 2.25% of subscriber income derived from primary small groups.)

If Guaranteed Issue of the Essential and Standard Plans is Required of All Carriers in the Individual Market, the Primary Reason for Providing a Tax Preference to Open Enrollment Carriers Would Be Eliminated for This Market

Should the Commonwealth enact legislation requiring guaranteed issue of the Essential and Standard plans (and/or other plans) by all carriers in the individual market, the open enrollment carriers would no longer be the "insurers of last resort." Accordingly, the primary reason for providing a tax advantage to these carriers in this market would be eliminated. The impact of eliminating the tax preference of open enrollment carriers on premium income derived through individual policies is illustrated in Figure 4.

As seen in Figure 4, the difference between the current tax rate (0.75%) applied to premium income derived from individual contracts for open enrollment carriers and the full 2.25% rate paid by other carriers amounted to

$5,166,562 for calendar year 1995. Should the tax preference be eliminated as a result of guaranteed issue of the Essential and Standard plans, this is an estimate of the amount of additional taxes that would be paid by open enrollment carriers.

Figure 4

Impact Of Eliminating The Tax Preference For Premiums Derived From Individual Policies Issued By Open Enrollment Carriers

Open Enrollment Carrier	Taxable Ind. Premiums	Current Tax (0.75%)	Full Tax (2.25%)	Difference
Trigon	$329,700,674	$2,472,755	$7,418,265	$4,945,510
BCBSNCA	$14,736,816	$110,526	$331,578	$221,052
TOTAL	**$344,437,490**	**$2,583,281**	**$7,749,843**	**$5,166,562**

Source: Information provided to the Bureau of Insurance by Trigon and BCBSNCA, Joint Commission on Health Care Staff Analysis

There is an Inconsistency in Current Code Provisions Regarding the Premium Tax Rates Paid by Open Enrollment Carriers for Premiums Derived From Primary Small Groups

Legislation that was passed by the 1994 General Assembly Session established certain parameters by which a nonstock corporation could convert to a domestic mutual insurer. This legislation was requested by Trigon. Included in this legislation was a provision which changed the tax rate Trigon pays on the premium income derived from primary small groups (2-25 employees). Section 38.2-4229.1(D) provides that after taxable year 1994, a nonstock corporation which converts to a domestic mutual insurer will pay 2.25% on premium income from accident and sickness insurance issued to primary small employers and 0.75% on other premium income derived from accident and sickness insurance.

Accordingly, Trigon now pays the full tax on premium income derived from primary small groups. This provision was included as a result of the guaranteed issue reforms enacted in the primary small group market. However, a similar provision was not enacted to require the other open enrollment carrier (BCBSNCA) to pay the full 2.25% tax on primary small group premiums. According to information provided to the Bureau of Insurance by BCBSNCA, the plan reported a total of $15,955,136 in taxable premiums derived from primary small groups (2-25 employees) in 1995. The current tax rate of 0.75% would yield a premium tax payment of $119,663; the full 2.25% tax would have yielded a premium tax payment of $358,990, a difference of $239,327.

Given that both Trigon and BCBSNCA operate similar open enrollment programs, and no longer serve as the "insurer of last resort" in the primary small group market, the General Assembly should consider enacting legislation which requires all open enrollment carriers to pay the full 2.25% tax on premiums derived from primary small groups.

V.
Individual Insurance Reforms In Other States

Fewer States Have Implemented Reforms in the Individual Market Than in the Small Group Market

As seen in Figure 2, all but two states have implemented some reforms in their small group insurance markets. However, as illustrated in Figure 5, the number of states implementing reforms in the individual market is much smaller. Only about half of the states had implemented individual market reforms as of December, 1995.

Ten States Require Carriers to Guarantee Issue Certain Individual Health Insurance Plans

As seen in Figure 5, 10 states have implemented a guaranteed issue reform in their individual health insurance market. These 10 states have implemented various guaranteed issue requirements. Two states, Kentucky and New Jersey, require carriers to guarantee issue standardized plans (e.g., a Basic and Standard plan) developed by the state, and prohibit carriers from marketing any other plans. Three states, Maine, Vermont and Washington, require carriers to guarantee issue standardized plans and any other plans the carriers wish to market. Three states, Idaho, Iowa and Utah require carriers to guarantee issue standardized plans, but also allow the carriers to offer other plans on an underwritten basis. (This approach is similar to Virginia's guaranteed issue requirement in the small group market.) Lastly, two states, New Hampshire and New York, require carriers to guarantee issue any product they market, but do not require them to offer any standardized plans.

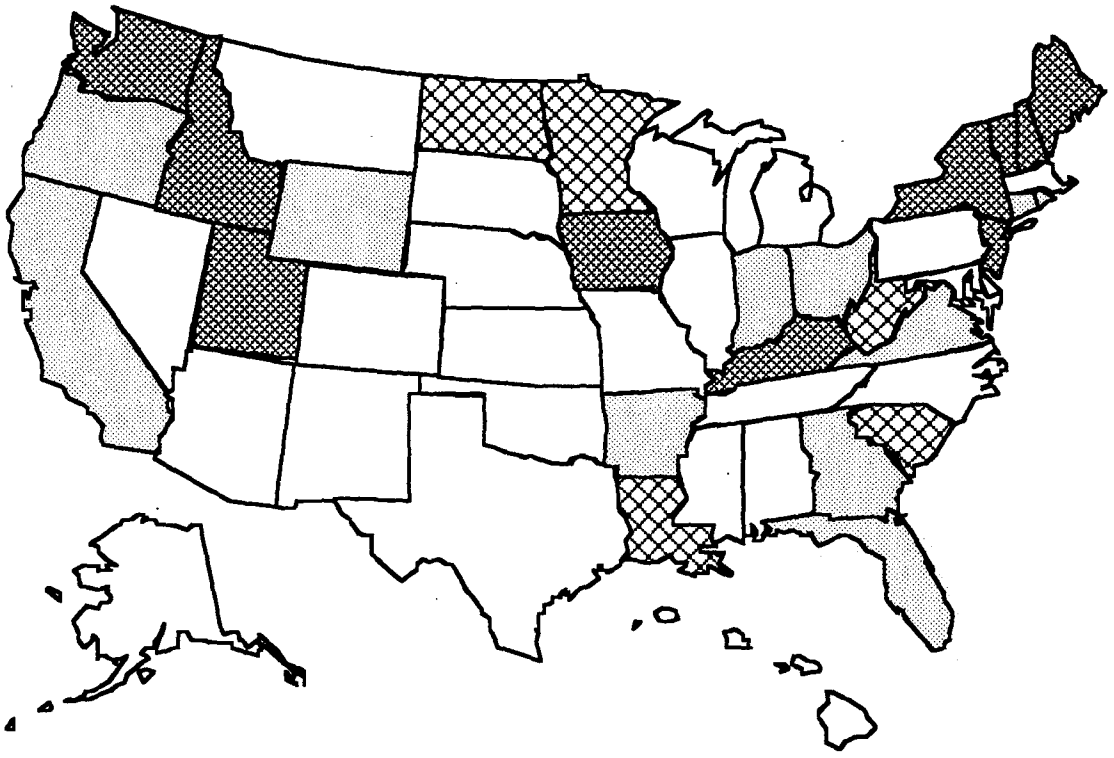
All States Requiring Guaranteed Issue of Standard Plans Have Established a Process for Reviewing and Updating the Plans

As noted earlier, all of the guaranteed issue states which have established standardized plans have instituted a process for reviewing and updating the benefit plans. In most states, the department of insurance, often with the assistance of an advisory committee or council, review and update the benefit

plans. Two states report having a separate committee or authority which is responsible for this function.

Figure 5

States Which Have Implemented Reforms In The Individual Health Insurance Market



Rating limits and Guaranteed Issue

Reforms Other Than Rating limits and Guaranteed Issue (i.e. renewal or pre-existing condition limits)

Rating limits; No Guaranteed Issue

No Individual Reform Laws

Source: Blue Cross and Blue Shield Association, 1995; State Individual Health Insurance Markets and Impacts of Federal Reform, Barents Group, LLC of KMPG Peat Marwick LLP, May, 1996; Joint Commission on Health Care Staff Analysis

All But One of the Guaranteed Issue States Extend This Requirement to Out-Of-State Group Trusts and Associations

All of the guaranteed issue states, except Iowa, indicated that this requirement applies to all individual coverages, including coverage provided through out-of-state group trusts and associations. A representative of the Iowa Department of Insurance reported that they are aware of the arguments for applying these reforms to out-of-state group trusts and associations; but, thus far, are not experiencing any problems.

All States Utilize Some Form of Community Rating for the Guaranteed Issue Products

All of the guaranteed issue states require carriers to use some form of community rating for these products. Six states, Kentucky, Maine, New Hampshire, New York, Vermont, and Washington require some form of modified or adjusted community rating where carriers can modify or adjust the community rate according to certain demographic factors (e.g., age, geography, industry, etc.). However, these states do not permit any adjustment based on the individual's health status.

Three states, Idaho, Iowa and Utah require modified community rating and allow some adjustment for health status. The adjustment for health status is in the form of "rating bands" similar to that used in Virginia's primary small group market rating reform. The range or "width" of the bands varies from state to state. Only New Jersey requires pure community rating with no adjustments of any kind. However, New Jersey is considering moving to a modified community rating methodology that would allow adjustments based on age.

Because Guaranteed Issue Requirements Are So Recent, There is Little Information Available Regarding the Impact of These Reforms

Like Virginia, other states have implemented reforms in the small group market first. For the most part, reforms in the individual market, particularly guaranteed issue, have been implemented very recently. Most states have implemented their guaranteed issue laws since 1993, with several being enacted

in 1994 and 1995. As such, in many states, guaranteed issue products have been in the marketplace a very short time.

Due to the recent enactment of these laws, there is little information available in the states regarding the impact of the reform with respect to the number of persons covered and premium stability. Most states report that some carriers have left the individual market but that these departures were by carriers with small market shares and that the departures did not cause major market disruptions.

New Jersey, New York and Vermont which implemented their laws in 1992 have more experience than other states. As reported in the Bureau of Insurance's study (House Document #9, 1996), the New York and Vermont insurance departments were not able to provide information on the number of uninsured before and after their reforms or the average annual premium before and after reform.

Much has been written, both positive and negative, about New Jersey's law. There have been significant increases in premiums charged by some carriers, while other carriers, particularly HMOs, have had relatively stable premiums. New Jersey insurance department officials report that since the guaranteed issue reform was enacted, the number of uninsured persons in the state has declined. A recent report by the New Jersey insurance department also notes that ". . . the implementation of the reform laws has not been without disruption to carriers and policyholders, in terms of rate fluctuations and plan choices. At the same time, individuals and small employers that had been shut out of the health insurance market prior to 1993 . . . have a broad array of choices in these markets. Carriers continue to offer affordable rates in both markets."

In response to concerns over the significant rate increases imposed by some carriers, the insurance department is sponsoring a "summit" meeting of consumers, carriers, and other interested parties to discuss ways of stabilizing premiums. The summit is being held on July 1, 1996. As noted earlier, insurance department officials report that a likely change will be a move from pure community rating to modified community rating.

Maryland Has Included Self-Employed "Groups of 1" Under Its Small Group Reforms

Maryland has taken a different approach to expanding access to health insurance coverage for individuals. Rather than implement reforms in the individual market, the Maryland legislature passed legislation extending its small group reforms to self-employed persons. The legislation, which takes effect on July 1, 1996, extends the guaranteed issue, community rating and other small group reforms to "groups of 1." In this way, the reform is more narrowly focused on a segment of the individual market which is considered by some to be a "lower risk" than other individuals who are not employed.

The National Association of Insurance Commissioners Recently Adopted a Small Group and Individual Health Insurance Availability Model Act

On June 3, 1996, the National Association of Insurance Commissioners (NAIC) adopted a small group and individual health insurance availability model act for states to use when reforming their respective markets. The 28-18 vote to adopt the act indicates some disagreement among the commissioners on the provisions of the act. Some insurance commissioners complained that the model act would lead to higher premium costs. Others defended the act as offering a flexible range of approaches that have proven effective in many states.

The key provisions of the model act regarding guaranteed issue in the individual market are outlined below:

* all carriers shall, as a condition of transacting business with individuals, actively offer to individuals all (emphasis added) health benefits plans it actively markets to individuals including at least two health benefits plans (a basic and standard plan developed by a health benefit plan committee);
* premium rates must be developed on an adjusted community rating basis and may be adjusted only for geographic area, family composition and age;
* guaranteed issue is not required for persons who are covered or eligible for other coverage;
* pre-existing condition waiting periods cannot exceed 12 months;

* two options for risk-spreading across the guaranteed issue market are suggested; Option I provides a "play or pay" approach, and assesses carriers that do not write their proportionate share of the individual market; Option 2 provides for a reinsurance program;
* guaranteed issue, modified community rating and other provisions apply to out-of-state group trusts and associations (except professional associations);
* a health benefit plan committee, composed of representatives of carriers, small employers, providers, and consumers recommends the form and level of coverage for the basic and standard plans; and
* a periodic market evaluation shall be conducted by the health benefit plan committee and others every three years and reported to the insurance commissioner for ensuring the effectiveness of the reforms.

VI.
Status Of National Health Insurance Reforms

Kassebaum/Kennedy Bill Was Recently Passed by Congress and Signed by President Clinton; Legislation Will Implement a Number of Insurance Market Reforms

Senate Bill 1028, introduced by Senators Kassebaum and Kennedy, recently was passed by Congress and signed by President Clinton. Most provisions of the bill will take effect on July 1, 1997. However, a number of federal regulations must be revised to implement certain provisions.

The bill expands access to coverage for groups and individuals, but does not address the *affordability* of coverage at all. While there is still uncertainty about some provisions of the legislation, key provisions of the bill as they relate to the group market include: (i) prohibits group health plans (self-insured or insured) from excluding an employee or his/her dependent or charge differential premiums based on health status; (ii) provides guaranteed issue in the small group (2-50) market and guaranteed renewability in the large and small group market; (iii) limits exclusions for preexisting conditions to a 12 month maximum, and (iv) requires credit for waiting periods served in previous coverage.

In the individual market, the key provisions of the bill provide guaranteed issue and renewability of coverage regardless of health status for individuals who: (i) have had 18 or more months prior continuous coverage in the group market, (ii) are ineligible for other group coverage, and (iii) have accepted and exhausted COBRA coverage. No preexisting condition exclusions would be imposed on these individuals.

The legislation provides states with flexibility in implementing these reforms. For example, the federal requirements for individual reform shall not apply to states in which:

(i) all eligible individuals (with at least 18 months of creditable coverage) are provided a choice of health insurance coverage;

(ii) such coverage does not impose any preexisting condition exclusion;

(iii) the choice of coverage includes at least one policy that is comparable to comprehensive health insurance coverage offered in the individual market; and

(iv) the state is implementing one of the NAIC models (i.e., a qualified high risk pool or alternative mechanism which includes risk adjustment).

Medical Savings Account (MSAs) Provisions: The legislation allows MSAs and catastrophic coverage for small businesses (<50 employees) and self-insured individuals up to a national limit of 750,000 policies over a 4-year demonstration period. Allows minimum/maximum deductibles of $1,500/$2,250 for individuals, $3,000/$4,500 for families; and a total out-of-pocket exposure limit of $3,000 and $5,500 respectively.

Tax Deductibility of Premiums for Self-Employed: The bill increases the deductibility of premiums for the self-employed from the current rate of 25% to 40% in 1997, to 45% in 1998-2002; and, then, increasing annually to 80% in 2006 and thereafter.

Even though the bill has been signed, there still is uncertainty as to exactly what impact it will have on the insurance markets in the various states. There is confusion on various aspects of the bill that likely will not be resolved for several weeks or months. The Bureau of Insurance is reviewing the legislation to determine how the provisions of the bill will impact Virginia.

VII.
Conclusions

Virginia's Small Group Market Reforms are Similar to Those in Other States; However, the Guaranteed Issue Requirement is Not as Extensive as That in Several Other States

Virginia's small group market reforms, particularly the pre-existing condition limits, guaranteed renewability and no group exclusions are similar to most other states. While Virginia now requires guaranteed issue of the Essential and Standard plans in the primary small group (2-25) market, this provision is less extensive than 14 other states which require all plans to be marketed on a guaranteed issue basis. Typically, when carriers can market medically underwritten plans in addition to one or two standardized plans, there is less incentive for the carriers to actively market the standardized plans. This may be contributing to the limited number of groups which have purchased the Essential and Standard plans thus far.

A Process for Reviewing and Updating the Essential and Standard Plans is Needed to Ensure the Plans Are Marketable

Several carriers and insurance agents have indicated that the Essential and Standard plans are not marketable, due primarily to the 21-day inpatient hospital benefit. To ensure that the plans are marketable today and in the future, a process for reviewing and updating the plans is needed. While there are several different approaches to establishing such a process, it must include input from the key stakeholders, including the Bureau of Insurance, carriers, providers, employers and consumers.

Guaranteed Issue and Modified Community Rating of the Essential and Standard Plans in the Individual Market Should Expand Access to Coverage

While Virginia currently has an open enrollment program for individuals whereby persons can obtain coverage from one of the two open enrollment carriers, guaranteed issue of the Essential and Standard plans should expand access and increase choice among carriers. Such reforms would be consistent with the recommendations of the Bureau of Insurance and the National

Association of Insurance Commissioners both of which suggest that similar reforms be adopted in the small group and individual markets.

Consideration should be given to excluding persons "eligible" for other coverage from the guaranteed issue provisions and to phasing in the rating bands used to community rate individuals. However, the goal should be to have the same rating bands in the primary small group and individual markets.

If Guaranteed Issue and Modified Community Rating Are Required in the Individual Market, Consideration Should Be Given to Extending the Requirements to Out-Of-State Group Trusts and Associations; Requirements Cannot Extend to Most MEWAs

All but one of the states which require guaranteed issue in the individual market exercise extraterritorial authority over policies/coverage provided through out-of-state group trusts and associations. The National Association of Insurance Commissioners (NAIC) urges states to exercise this authority. While there are no definitive statistics on the percentage of Virginia's individual market that is covered under these policies, it is believed to be significant. Consideration should be given to extending individual market reforms to out-of-state group trusts and associations.

Out-of-state group trusts and associations and the carriers which market through these entities likely will oppose this provision. However, the key reasons for including these types of coverage under the reform are to provide a "level playing field" for all carriers/insurers, and to provide the benefit of guaranteed issue/modified community rating to all Virginians.

The Employee Retirement Income Security Act precludes the Commonwealth from extending these reforms to all but one MEWA operating in Virginia.

If Guaranteed Issue Products Are Required in the Individual Market, Consideration Should Be Given to Requiring Open Enrollment Carriers to Pay the Same Premium Tax as Other Carriers on Premiums Derived From Individual Contracts

The principal reason for the reduced premium tax (0.75%) paid by open enrollment carriers is that they serve as an "insurer of last resort" for persons unable to obtain coverage from other carriers which pay the full 2.25% premium tax rate. If a guaranteed issue reform is enacted in the individual market, all carriers will have to issue coverage to persons, regardless of their health status; and the open enrollment carriers would no longer function as the "insurer of last resort." Accordingly, consideration should be given to imposing the full 2.25% premium tax rate on open enrollment carriers' premiums derived from individual policyholders. Legislation passed in 1994 effected this change for premiums derived from primary small groups (2-25 employees) by Trigon BlueCross BlueShield.

There Is a Discrepancy in the Tax Status of the Two Open Enrollment Carriers With Respect to Premium Tax Payments on Premiums Derived From Primary Small Groups; Consideration Should Be Given to Resolving This Discrepancy

Currently, the Code of Virginia requires a nonstock corporation which converts to a domestic mutual insurer (Trigon) to pay the full 2.25% premium tax on premiums derived from primary small groups. This legislation is in recognition of the fact that all carriers in the primary small group market now have to issue the Essential and Standard plans to primary small employers, and that Trigon no longer serves as an "insurer of last resort" in this market. However, the other nonstock corporation (BCBSNCA) continues to pay a 0.75% premium tax on premiums derived from primary small groups. Inasmuch as the tax treatment should be consistent for all open enrollment carriers, consideration should be given to applying the 2.25% premium tax on the primary small group premiums of the other open enrollment carrier (BCBSNCA).

While Federal Health Insurance Reforms Will Have a Positive Impact, Access and Affordability Issues Still Remain; the Full Impact on States Is Not Known

The Kassebaum/Kennedy health insurance reform legislation contains important group and individual market reforms. The reforms expand availability of insurance to some but not all groups and individuals. Moreover, it does not address the affordability of coverage at all. The full impact of this legislation on the states is not yet known. However, it is clear that the Commonwealth still must wrestle with the issues of accessibility and affordability of coverage for many Virginians.

The Joint Commission may want to request the Commissioner of Insurance to present an overview of the legislation as soon as there is a clearer understanding of its impact on Virginia and the actions the Commonwealth must take to be in compliance with its requirements.

VIII.
Policy Options

Options are offered for consideration by the Joint Commission on Health Care regarding four major policy issues: (i) establishing a process for reviewing and updating the Essential and Standard health benefits plans; (ii) deciding whether to implement guaranteed issue and modified community rating in the individual health insurance market; (iii) addressing the tax status of open enrollment carriers as it relates to premium income derived from primary small groups; and (iv) addressing the tax status of open enrollment carriers should guaranteed issue be implemented in the individual market.

Options for Reviewing and Updating the Essential and Standard Health Benefits Plans

Option I: Introduce Legislation to Assign Responsibility to the State Corporation Commission's Bureau of Insurance to Review and Update the Essential and Standard Plans With Input From an Advisory Committee Established by the Bureau and Composed of Representatives of Insurance Carriers, Providers, Employers and Consumers.

Option II: Introduce Legislation to Establish a Separate Committee Composed of Representatives of Insurance Carriers, Providers, Employers and Consumers to Review the Essential and Standard Plans, and Make Recommendations to the Bureau of Insurance for Updating the Plans.

Option III: Introduce Legislation to Expand the Statutory Authority of the Commission on Mandated Benefits to Review the Essential and Standard Plans and Make Recommendations to the Bureau of Insurance for Updating the Plans.

Option IV: Introduce Legislation to: (I) Make Specific Benefit Changes to the Essential and Standard Plans in 1997; and (II) Implement Option I, II, or III as a Long-Term Approach to Updating the Plans.

Options for Implementing Guaranteed Issue and Modified Community Rating in the Individual Health Insurance Market

Option I: **Status Quo.**

Under Option I, no action would be taken in the 1997 General Assembly Session to implement guaranteed issue and modified community rating in the individual market. This issue would be reviewed during 1997 along with further review of the impact that these reforms are having in the primary small group market. The impact of Federal reform legislation would also be studied to determine which actions Virginia should take in response to these national reforms.

Option II: **Introduce Legislation to Implement Guaranteed Issue and Modified Community Rating of the Essential and Standard Plans in the Individual Market Similar to That Implemented in the Primary Small Group Market.**

If it is decided to pursue this option, several issues regarding the specific provisions of the legislation would need to be resolved (e.g., providing guaranteed issue to persons "eligible" for coverage, and the modified community rating bands). More importantly, two major issues would need to be addressed: (i) whether it would be appropriate to include a delayed effective date to allow time for the Essential and Standard plans to be reviewed and possibly updated prior to implementation; and (ii) whether the reforms should extend to out-of-state group trusts and associations.

Options for Addressing the Tax Status of Open Enrollment Carriers as it Relates to Premium Income Derived From Primary Small Groups

Option I: **Status Quo.**

Under Option I, no action would be taken to revise the current tax status of open enrollment carriers.

Option II: Introduce Legislation to Equalize the Tax Treatment of Open Enrollment Carriers Regarding the Tax Rate Imposed on Premium Income Derived From Primary Small Groups

Under Option II, legislation would be introduced to equalize the tax treatment of open enrollment carriers by imposing on all open enrollment carriers the 2.25% license tax on premium income derived from primary small groups (2-25 employees).

Options for Addressing the Tax Status of Open Enrollment Carriers Should Guaranteed Issue Be Implemented in the Individual Market

Option I: Status Quo.

Under Option I, should guaranteed issue be implemented in the individual market, no action would be taken to revise the tax status of open enrollment carriers.

Option II: If Guaranteed Issue Is Required of All Carriers in the Individual Market, Introduce Legislation to Require Open Enrollment Carriers to Pay the Full 2.25% Tax Rate Imposed on Premium Income Derived From Individual Policies

Should guaranteed issue be required of all carriers in the individual market, the open enrollment carriers would no longer be "insurers of last resort" in this market. Option II would impose the full 2.25% tax on the premium income that open enrollment carriers derive from individual polices.

APPENDIX A

CHAPTER 550

An Act to amend and reenact §§ 38.2-4214 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3514.2, relating to individual accident and sickness insurance policies.

[H 1026]

Approved April 3, 1996

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-4214 and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3514.2 as follows:

§ 38.2-3514.2. Renewability of coverage.

A. Every individual policy, subscription contract or plan delivered, issued for delivery or renewal in this Commonwealth providing benefits to or on behalf of an individual shall provide for the renewability of such coverage at the sole option of the insured, policyholder, subscriber, or enrollee. The insurer, health services plan or health maintenance organization issuing such policy, subscription contract or plan shall be permitted to refuse to renew the policy, subscription contract or plan only for one or more of the following reasons:

1. Nonpayment of the required premiums by the insured, policyholder, subscriber, or enrollee, or such individual's representative;

2. In the event that the policy, subscription contract or plan contains a provision requiring the use of network providers, a documented pattern of abuse or misuse of such provision by the insured, policyholder, subscriber, or enrollee, continuing for a period of no less than two years;

3. Subject to the time limits contained in § 38.2-3503.2 or in regulations adopted by the Commission governing the practices of health maintenance organizations, for fraud or material misrepresentation by the individual, with respect to his application for coverage;

4. Eligibility of an individual insured for Medicare, provided that such coverage may not terminate with respect to other individuals insured under the same policy, subscription contract or plan and who are not eligible for Medicare; and

5. The insured, subscriber, or enrollee has not maintained a legal residence in the service area of the insurer, health services plan or health maintenance organization for a period of at least six months.

B. This section shall not apply to the following insurance policies, subscription contracts or plans:

1. Short-term travel;

2. Accident-only;

3. Disability income;

4. Limited or specified disease contracts;

5. Long-term care insurance; and

6. Short term nonrenewable policies or contracts of not more than six months' duration which are subject to no medical underwriting or minimal underwriting.

§ 38.2-4214. Application of certain provisions of law.

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, 38.2-1312, 38.2-1314, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3407.1 through 38.2-3407.6, 38.2-3407.9, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3425 through 38.2-3429, 38.2-3431, 38.2-3432, 38.2-3500, 38.2-3501, 38.2-3502, 38.2-3514.1, *38.2-3514.2*, 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3525, 38.2-3540.1, 38.2-3541, 38.2-3542, 38.2-3600 through 38.2-3607 and Chapter 53 (§ 38.2-5300 et seq.) of this title shall apply to the operation of a plan.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2 through 38.2-1309, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9, 38.2-3411.2, 38.2-3418.1, 38.2-3418.1:1, 38.2-3418.2, 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3433, 38.2-3500, 38.2-3514.1, *38.2-3514.2*, 38.2-3525, 38.2-3542, and Chapter 53 (§ 38.2-5300 et seq.) of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

D. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

2. That the Joint Commission on Health Care, in cooperation with the State Corporation Commission's Bureau of Insurance, shall study additional reforms in the individual health insurance market including, but not limited to, guaranteed issue and modified community rating for the essential and standard health benefit plans as defined in § 38.2-3431. The Joint Commission also shall evaluate: (i) whether the Commonwealth has the authority to apply individual health insurance reforms to fully insured and not fully insured multiple employer welfare arrangements and out-of-state group trusts and associations; and (ii) the impact of guaranteed issue reforms on the taxation of open enrollment carriers. The Joint Commission shall report its findings and recommendations to the Governor and the 1997 Session of the General Assembly by October 1, 1996.

APPENDIX B

Joint Commission on Health Care

Summary of Public Comments on Draft Issue Brief 2: Health Insurance Reform in Virginia

Comments regarding the Health Insurance Reform in Virginia Issue Brief were received from the following 11 interested parties:

BlueCross BlueShield of the National Capital Area
Golden Rule Insurance Company
Kaiser Permanente
Medical Society of Virginia
State Corporation Commission Bureau of Insurance
Trigon BlueCross Blue Shield
Virginia Association of Health Maintenance Organizations
Virginia Chamber of Commerce
Virginia Citizens Consumer Council
Virginia Hospital & Healthcare Association
Virginia Poverty Law Center

Policy Options Presented in Issue Brief

Options for Reviewing and Updating the Essential and Standard Health Benefits Plans

Option I: Introduce Legislation to Assign Responsibility to the State Corporation Commission's Bureau of Insurance to Review and Update the Essential and Standard Plans With Input From an Advisory Committee Established by the Bureau and Composed of Representatives of Insurance Carriers, Providers, Employers and Consumers.

Option II: Introduce Legislation to Establish a Separate Committee Composed of Representatives of Insurance Carriers, Providers, Employers and Consumers to Review the Essential and Standard Plans, and Make Recommendations to the Bureau of Insurance for Updating the Plans.

Option III: Introduce Legislation to Expand the Statutory Authority of the Commission on Mandated Benefits to Review the Essential and Standard Plans and Make Recommendations to the Bureau of Insurance for Updating the Plans.

Option IV: Introduce Legislation to: (I) Make Specific Benefit Changes to the Essential and Standard Plans in 1997; and (II) Implement Option I, II, or III as a Long-Term Approach to Updating the Plans.

Options for Implementing Guaranteed Issue and Modified Community Rating in the Individual Health Insurance Market

Option I: Status Quo.

Under Option I, no action would be taken in the 1997 General Assembly Session to implement guaranteed issue and modified community rating in the individual market. This issue would be reviewed during 1997 along with further review of the impact that these reforms are having in the primary small group market. The impact of Federal reform legislation would also be studied to determine which actions Virginia should take in response to these national reforms.

Option II: Introduce Legislation to Implement Guaranteed Issue and Modified Community Rating of the Essential and Standard Plans in the Individual Market Similar to That Implemented in the Primary Small Group Market.

If it is decided to pursue this option, several issues regarding the specific provisions of the legislation would need to be resolved (e.g., providing guaranteed issue to persons "eligible" for coverage, and the modified community rating bands). More importantly, two major issues would need to be addressed: (i) whether it would be appropriate to include a delayed effective date to allow time for the Essential and Standard plans to be reviewed and possibly updated prior to implementation; and (ii) whether the reforms should extend to out-of-state group trusts and associations.

Options for Addressing the Tax Status of Open Enrollment Carriers as it Relates to Premium Income Derived From Primary Small Groups

Option I: Status Quo.

Under Option I, no action would be taken to revise the current tax status of open enrollment carriers.

Option II: Introduce Legislation to Equalize the Tax Treatment of Open Enrollment Carriers Regarding the Tax Rate Imposed on Premium Income Derived From Primary Small Groups

Under Option II, legislation would be introduced to equalize the tax treatment of open enrollment carriers by imposing on all open enrollment carriers the 2.25% license tax on premium income derived from primary small groups (2-25 employees).

Options for Addressing the Tax Status of Open Enrollment Carriers Should Guaranteed Issue Be Implemented in the Individual Market

Option I: Status Quo.

Under Option I, should guaranteed issue be implemented in the individual market, no action would be taken to revise the tax status of open enrollment carriers.

Option II: If Guaranteed Issue Is Required of All Carriers in the Individual Market, Introduce Legislation to Require Open Enrollment Carriers to Pay the Full 2.25% Tax Rate Imposed on Premium Income Derived From Individual Policies

Should guaranteed issue be required of all carriers in the individual market, the open enrollment carriers would no longer be "insurers of last resort" in this market. Option II would impose the full 2.25% tax on the premium income that open enrollment carriers derive from individual polices.

Summary of Comments

Overall, insurance industry comments generally stated that further reforms would be premature, and recommended not taking action on guaranteed issue and modified community rating in the individual market until impact of federal reforms could be assessed.

Other commenters generally supported moving forward with reforms in the individual market and recommended these reforms be extended to out-of-state group trusts and associations.

Summary of Individual Public Comments

BlueCross BlueShield of the National Capital Area

Gail M. Thompson, Administrator, Government Affairs, stated it was important to understand the full impact of federal reform before taking further actions and stated it is premature to adopt any policy options at this time.

Golden Rule Insurance Company

Theodore F. Adams, III, Attorney with Christian & Barton, commented that federal reform legislation addresses many if not all of the insurance reform issues being examined by the Joint Commission. He suggested that Virginia should abandon efforts to design products for small employers and individuals and should not impose tighter rating bands in the small group market. He further stated that Virginia should unequivocally abandon any thoughts of enacting the NAIC Small Employer and Individual Health Insurance Availability Model Act. Mr. Adams also commented that any unresolved issues should be addressed through a high-risk pool and that Virginia should guarantee small employer carriers reasonable rating flexibility to accommodate new federal requirements.

Kaiser Permanente

Kathleen McNalty, Director of Government Relations, expressed strong support for universal health benefits coverage for all Americans but expressed opposition to expanding guaranteed issue to the individual market unless carriers are required to provide coverage to individuals as a condition of doing business. Ms. McNalty noted that utilization among individuals who purchase coverage on a guaranteed issue basis is higher than the risk of the general population of covered persons. She also stated

that extension of the small group reforms into the individual market, without requiring that all carriers participate and without protecting carriers that do, will significantly increase rates for individual coverage. She also stated that without a mandate to participate, carriers will leave or refuse to enter the individual market. Ms. McNalty suggested that the best way to affect wide spread coverage among small employers is to mandate that all plans in the small group market be subject to guaranteed issue.

Medical Society of Virginia

Madeline I. Wade commented in support of Option I for updating the Essential and Standard Plans but prefers Option II because it ensures balanced, unbiased composition of the committee. Ms. Wade opposed status quo on individual insurance reforms. She supported Option II and opposed wider rating bands but could support a 1-2 year phase in. Further, she suggested removing health status from the rating methodology and supported identical tax status for similarly situated carriers. Ms. Wade stated that license taxes and assessments for all plans should be reviewed. She supported Option II on equalizing the tax treatment of open enrollment carriers with three caveats: (1) tax incentives should reflect the degree to which the carrier markets open enrollment products; (2) tax incentives should be greater if additional products other than the Essential and Standard Plans are issued on a "guaranteed" basis; and (3) the Bureau of Insurance should explore the possibility of lowering taxes as incentive for more open enrollment carriers. Lastly, Ms. Wade stated that taxes should be adjusted equitably if guaranteed issue is to be implemented in the individual market.

State Corporation Commission Bureau of Insurance

Alfred W. Gross, Commissioner of Insurance, suggested that in light of the federal Kassebaum-Kennedy legislation, all efforts should be concentrated on incorporating the new federal requirements into law during the 1997 Session of the Virginia General Assembly in order to avoid federal pre-emption of Virginia law in this area. Specifically, Commissioner Gross stated that in regards to the options for reviewing and updating the Essential and Standard Health Benefit Contracts, the Bureau does not support Option I, II, III or IV. He recommended that an independent panel of experts be appointed to review and modify the Essential and Standard Plans. He emphasized leaving medical determinations in the hands of medical experts rather than those of insurance regulators. On the options for implementing guaranteed issue and modified community rating in the

individual health insurance market, Commissioner Gross stated that he recommended against Option I and again suggested moving forward to incorporate the new federal requirements into Virginia law to avoid federal pre-emption in this area. Concerning the tax status of open enrollment carriers regarding primary small groups, Commissioner Gross opposed Option I (status quo) and stated that since all carriers now must accept all primary small groups, it would be inequitable to permit only the "open enrollment" plans to continue to pay lower tax rates. Regarding options for addressing the tax status of open enrollment carriers should guaranteed issue be implemented in the individual market, Commissioner Gross stated that there would be no remaining justification for the differing tax treatment among "open enrollment carriers." He emphasized that while the Bureau of Insurance does not make recommendations on issues of tax policy, they believe that serious consideration should be given to Option II, which would call for all open enrollment carriers in the individual market to pay the full 2.25% premium tax rate.

Trigon BlueCross BlueShield

Wilda M. Ferguson, Director of Government and Public Affairs, recommended the Joint Commission include time at a future meeting to assess recent federal health insurance reforms. She also recommended delaying action on policy options until the impact of the federal reform is known. Trigon supported Option I for updating the Essential and Standard Plans should Virginia adopt a plan to implement federal legislation and continue these benefit plans.

Virginia Association of Health Maintenance Organizations (VAHMO)

Mark C. Pratt, Director of Policy, recommended Option I for updating the Essential and Standard Plans. He recommended "extreme caution" in considering reform in the individual market. Mr. Pratt stated that it is premature to implement guaranteed issue/modified community rating reforms in the individual market; however, if reforms are enacted, they should be extended to out-of-state group trusts and associations. Further, he recommended a more thorough analysis of existing open enrollment programs before legislation is enacted.

Virginia Chamber of Commerce

Sandra D. Bowen, Senior Vice President, commented that small groups and individuals have few choices in the marketplace and supported Option II and IV for updating the Essential and Standard Plans. She stated

that the small group market and the individual market should be subject to consistent "rules and regulations" and consideration should be given to requiring guaranteed issue of all products. She also stated that the reforms should be implemented extra-territorially. She recommended that the tax treatment of open enrollment carriers be equalized; the Joint Commission should look at the impact of lowering premium taxes.

Virginia Citizens Consumer Council

Jean Ann Fox, President, commented in support of legislation requiring guaranteed issue in the individual market and supported as narrow a rate band as possible, no more than ± 20%. Further, Ms. Fox expressed support for Option IV to have the Joint Commission recommend changes to the Essential and Standard Plans and implement a long-range review process.

Virginia Hospital & Healthcare Association

Katharine M. Webb, Senior Vice President, stated that despite state and federal reforms, research shows major gaps in coverage remain, and the number of uninsured is expected to increase. Ms. Webb endorsed any action to expand availability and affordability of coverage as quickly as possible. She also stated that the Essential and Standard Plans should be updated regularly. She did not endorse any specific option but felt that the process should involve stakeholders including the purchasing community.

Virginia Poverty Law Center

Jill A. Hanken, Staff Attorney for the Virginia Poverty Law Center, commented in support of tighter rating bands for small groups. She also recommended that guaranteed issue be required of all small group products and recommended Option IV for updating Essential and Standard Plans, including a long-range process with consumer input. Ms. Hanken recommended guaranteed issue and modified community rating in the individual market and extending reforms to out-of-state group trusts. She commented in support of extending guaranteed issue to persons "eligible for other coverage." She also recommended revising tax policies to assure uniformity and using any new tax revenues to enhance coverage for the uninsured.

JOINT COMMISSION ON HEALTH CARE

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