REPORT OF
THE JOINT COMMISSION ON HEALTH CARE

STUDY OF HIGH RISK POOLS PURSUANT TO SJR 337 OF 1997, AND OTHER RELATED HEALTH INSURANCE ISSUES

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 25

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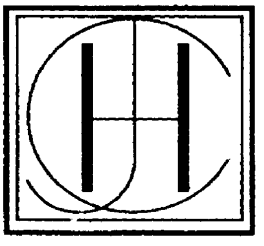

Preface

Senate Joint Resolution 337 of the 1997 Session of the General Assembly directed the Joint Commission on Health Care to study the feasibility of implementing a high risk insurance pool for persons who are uninsurable due to high risk medical conditions.

In addition to studying the issue of a high risk pool, this report includes discussion and follow-up analysis of three other insurance-related matters that were addressed by the Joint Commission in 1996. These other issues are: (i) whether the Bureau of Insurance's regulatory authority should be extended to other policies which are issued out of state, but cover Virginia residents; (ii) a review of technical amendments to Virginia's legislation which implements the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996; and (iii) an assessment of community rating requirements and pre-existing condition limitations.

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

- Twenty-five states administer high risk pools as a means of insuring persons who are uninsurable due to high risk medical conditions. Participation in high risk pools and funding sources vary from state to state. Because high risk pools segment high risk persons into one pool, premiums are very expensive. Virtually all states impose a cap on premiums charged to enrollees. Most states assess insurance carriers a fee to offset the losses incurred by the pool.

- "Open enrollment" programs are another mechanism for covering high risk persons. These programs are administered in 11 states, including Virginia. Trigon BlueCross and BlueShield and Blue Cross Blue Shield of the National Capital Area (BCBSNCA) are Virginia's open enrollment carriers. Through this program, these two carriers must issue a health insurance policy to all individuals, regardless of their health status. The Commonwealth imposes a lower premium tax on these two carriers to help offset losses incurred as a result of the open enrollment program.

- A key policy issue regarding high risk pools in Virginia is whether such an arrangement would provide a better and more cost effective "safety net" for uninsurable persons than the current open enrollment program. Further study of this issue and an analysis of Virginia's high risk

population would provide useful information regarding the feasibility of implementing a high risk pool in Virginia.

- Regarding the Bureau of Insurance's regulatory authority, Virginia currently exercises very limited authority over accident and sickness insurance policies which are issued out of state but cover Virginia residents.

- Some level of extraterritorial authority over certain health insurance policies which are issued out of state but cover Virginia residents would result in more consistent regulation of the insurance market, and provide greater consumer protections for the insurance buying public. The Bureau of Insurance drafted a proposal to extend its authority only in limited circumstances to "non-qualifying groups" which do not meet certain criteria. This approach would ensure that policies issued to persons with only tenuous group affiliation are subject to review by the Bureau. Some insurers which market group coverage to individuals through certain "non-qualifying groups" will oppose such an approach.

- With respect to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Virginia, as well as all other states, had a very limited period of time to adopt conforming legislation to implement the federal reforms. Due to the short period of time to draft Virginia's HIPAA legislation (HB 2887/SB 1112 of the 1997 Session of the General Assembly), a number of technical corrections and clarifying changes are needed to ensure full compliance with the federal requirements.

- In addition to the technical corrections, Virginia's HIPAA legislation inadvertently excluded a limited number of "eligible" individuals from the guaranteed issue protections of the reforms. To correct this situation, legislation is necessary to provide this small number of individuals an additional period of time after January 1, 1998 to obtain coverage under the guaranteed issue provisions of HIPAA.

- The final issue included in this report is an analysis of whether all health insurance policies should be required to use "pure" community rating when calculating premiums, and whether policies should be prohibited from including any pre-existing condition exclusions or limitations.

- Like most states, Virginia already has enacted "modified" community rating in the small group market and placed some limits on pre-existing condition exclusions. "Pure" community rating requires healthy persons to subsidize fully the cost of coverage for less healthy persons. If healthy

persons leave the market due to higher rates, the premiums for the remaining persons become even higher. Modified community rating provides a more moderate approach to spreading risks and costs than "pure" community rating.

- Prohibiting pre-existing condition exclusions ensures that persons can obtain health insurance benefits for their medical conditions from the beginning of their coverage. However, persons can "game the system" by not purchasing coverage until a medical condition necessitates obtaining insurance. If persons purchase coverage only when needed, premiums will increase for everyone. Limits on pre-existing conditions exclusions, rather than prohibitions, represents an incremental approach that seems to "strike the right balance."

Policy options were offered for consideration by the Joint Commission regarding the four major issues addressed in this report. These policy options are discussed on pages 31-33. At its January 6, 1998 meeting, the Joint Commission voted to introduce legislation which: (i) broadens the Bureau of Insurance's regulatory authority over certain insurance policies that are issued out-of-state but cover Virginia residents; (ii) makes technical corrections to 1997 legislation to implement the provisions of the Health Insurance Portability and Accountability Act (HIPAA); (iii) provides an additional period of time for certain individuals to obtain coverage under the guaranteed issue provisions of HIPAA; (iv) extends the requirements for modified community rating of the Essential and Standard plans to groups with 26-50 employees; and (v) directs the Joint Commission to conduct further study of high risk insurance pools.

Our review process on this study 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 summarized at the end of this report, provided additional insight into the various topics covered in this study.

Jane N. Kusiak
Executive Director

January 8, 1998

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I.
Introduction and Authority for Study

During the past several years, the Joint Commission on Health Care has initiated a number of health insurance market reforms to improve the availability and affordability of coverage for small groups and individuals. In addition, the Joint Commission has conducted a number of health insurance studies in recent years in response to study resolutions adopted by the General Assembly.

During 1997, the Joint Commission conducted a major study of how the Commonwealth can improve access to health insurance coverage and health care services for the indigent and uninsured pursuant to Senate Joint Resolution (SJR) 298. As part of this study, several policy options are being considered to further reform the health insurance market to make coverage more available and affordable for uninsured persons. Another health insurance-related study being conducted by the Joint Commission in 1997 examines whether health maintenance organizations (HMOs) should be required to include a "point-of-service" option in their HMO plan offerings. This study is being conducted pursuant to SJR 297 and House Joint Resolution (HJR) 631.

Four Health Insurance-Related Issues Are Addressed In This Issue Brief

This issue brief addresses four additional health insurance-related issues. Two of the four issues were studied last year by the Joint Commission. This report provides follow-up information on the analysis conducted last year. The other two issues are specific study directives of the 1997 Session of the General Assembly.

Follow-up analysis is presented on the following two topics: (i) whether the Commonwealth should adopt legislation which broadens the Bureau of Insurance's regulatory authority to certain health insurance policies currently not regulated by the Commonwealth; and (ii) an overview of technical corrections that are needed in the legislation passed last year (House Bill 2887/Senate Bill 1112) to implement the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The two General Assembly study directives included in this report are: (i) a study of community rating and pre-existing condition exclusions; and (ii) a study of the feasibility of establishing a high risk pool in Virginia for uninsurable persons.

Bureau Of Insurance Authority To Regulate Health Insurance Policies That Are Issued Out-of-State But Cover Virginia Residents: Last year, pursuant to House Bill (HB) 1026, the Joint Commission studied whether additional insurance reforms should be enacted in the individual market. One of the specific issues addressed in the HB 1026 study was 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. One of the conclusions of the study was that if additional individual market reforms were to be adopted, consideration should be given to extending the reforms to out-of-state group trusts and associations by expanding the Bureau of Insurance's regulatory authority to these products. These insurance policies, although issued outside of Virginia, cover Virginia residents and are not subject to Virginia's insurance laws and regulations. This report presents additional information on whether the Bureau of Insurance should have some regulatory oversight of certain insurance policies that are issued outside of Virginia but insure Virginia residents.

Technical Amendments to Virginia's Legislation Which Implements the Federal Health Insurance Portability and Accountability Act (HIPAA)of 1996: Last year, the Joint Commission, with the assistance of the Bureau of Insurance, drafted legislation (HB 2887/SB 1112) to implement the federal health insurance reforms included in HIPAA. This legislation was passed by the 1997 Session of the General Assembly.

To meet the requirements of HIPAA, Virginia's legislation had to be drafted in a very short period of time to avoid federal preemption of the Commonwealth's pertinent insurance laws. In fact, HB 2887/SB 1112 had to be drafted before federal regulations were issued. Due to the limited amount of time available to draft Virginia's legislation and the lack of federal regulations/guidance, a number of technical amendments are needed in Virginia's legislation to ensure compliance with HIPAA. This report briefly summarizes the needed technical changes, and addresses one policy concern regarding a limited number of individuals eligible for certain HIPAA protections who are not covered under Virginia's current statutes.

Study of Community Rating and Pre-Existing Conditions: Senate Bill (SB) 1181, which was introduced during the 1997 Session of the General Assembly, would have required pure community rating on all health insurance policies in the Commonwealth, and would have prohibited health insurance carriers from including pre-existing conditions exclusions or limitations in any policy. SB 1181 was not passed by the

General Assembly. However, the Senate Commerce and Labor Committee requested that the Joint Commission on Health Care study the desirability and effects of: (i) prohibiting the use of pre-existing condition exclusions in all health care coverage plans subject to regulation by the Commonwealth; and (ii) requiring community rating in all health are coverage plans subject to regulation by the Commonwealth.

Study of High Risk Pools: Senate Joint Resolution 337 of the 1997 Session of the General Assembly directs the Joint Commission to study high risk pools and the feasibility of establishing such a pool in the Commonwealth. The Bureau of Insurance was directed to provide technical assistance to the Joint Commission in this study. A copy of SJR 337 is attached at Appendix A.

II.
Bureau Of Insurance Regulation Of Certain Insurance Policies That Are Issued Outside Of Virginia, But Cover Virginia Residents

The Joint Commission on Health Care's 1996 Study Of Additional Individual Market Reforms Addressed The Issue Of Whether Certain Policies That Are Issued Out-of-State But Cover Virginia Residents Should Be Subject To Virginia Insurance Laws And Bureau Of Insurance Regulation

Last year, the Joint Commission on Health Care conducted a study pursuant to House Bill (HB) 1026 to determine whether additional insurance reforms should be implemented in the individual health insurance market. One of the specific issues included in the HB 1026 study was whether guaranteed issue and modified community rating should be required in the individual market. As part of the analysis of this issue, the study examined whether the Commonwealth should exercise "extraterritorial authority" over accident and sickness policies that are issued out of state, but cover Virginia residents.

This is an important issue in light of the fact that a significant portion of the individual market is comprised of "group" policies or contracts that are issued to a group trust or association located outside of Virginia with "certificates of coverage" being issued to individual Virginia residents. Under this scenario, the insurance policies/contracts are required to comply with the laws of the state in which the policy is issued or delivered to the policyowner, and are not subject to Virginia's insurance laws, regulations or protections.

The key issue in last year's study regarding these out-of-state policies was that unless these policies are required to comply with any guaranteed issue or modified community rating reforms, insurance carriers issuing policies in Virginia will be at a significant competitive disadvantage. Moreover, given that out-of-state group trusts and association type policies make up a sizable portion of the individual market, if the reforms did not extend to these policies, they would have significantly less impact on the market.

Guaranteed issue and modified community rating reforms in the individual market were not pursued last year; thus, legislation was not introduced to seek extraterritorial authority over out-of-state group trusts

and associations. However, the issue of whether Virginia's insurance laws and regulations should extend to certain policies which are issued out-of-state but cover Virginia residents remains as a key policy issue. This is particularly true in those instances where group insurance is marketed through policies issued outside of Virginia that avoid Virginia's regulation, and in instances where group coverage is offered to individuals with tenuous group affiliation.

Virginia Currently Exercises Very Limited Extraterritorial Authority Over Accident and Sickness Insurance Policies Which Are Issued Out-of-State But Cover Virginia Residents

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 this Commonwealth...*" (emphasis added) 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 imposed by the state in which the policy is issued.

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 policies. The Bureau reported there are advantages (e.g., consumer protection and 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 respective states.

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, the Bureau's recommendations were not enacted.

Some Level Of Extraterritorial Authority Over Certain Health Insurance Policies Which Are Issued Out-Of-State But Cover Virginia Residents Would Result In More Consistent Regulation Of The Insurance Market, And Provide Greater Consumer Protections For The Insurance Buying Public

As identified by the Bureau of Insurance's 1988 study, there are disadvantages to establishing extraterritorial authority over policies issued out-of-state. Requiring carriers to comply with multiple states' regulations and insurance laws can be burdensome and add to the carrier's administrative costs, which ultimately are passed on to the consumer. In analyzing the costs and benefits of such regulation, if extraterritorial authority is enacted, it should be done in such a way that: (i) provides the greatest benefit in terms of consumer protection; and (ii) minimizes administrative costs. Moreover, the extraterritorial authority should be focused on that portion of the market in which the need for consumer protection is the greatest.

The Bureau of Insurance Has Developed For Consideration By The Joint Commission A Proposal To Provide Extraterritorial Authority For Certain Policies That Are Issued Out-of-State But Cover Virginia Residents

With recognition of the issues examined in last year's study of individual market reforms, specifically, whether extraterritorial authority should be adopted to extend market reforms and other insurance laws to out-of-state group trusts and associations, the Bureau of Insurance developed for consideration by the Joint Commission the framework of a proposal for such extraterritorial authority.

The Proposal Under Consideration Would Provide Extraterritorial Authority Only In Certain Circumstances: Rather than adopt extraterritorial authority that requires all out-of-state insurance policies/contracts covering Virginia residents to comply with Virginia insurance laws and regulation, the Bureau's proposal to the Joint Commission would require such compliance only in those instances when policies of group insurance are issued to "non-qualifying groups." When coverage is sold to a "qualifying group" (as defined in the proposal), the policy would not be subject to Virginia's insurance laws and regulations (i.e., no extraterritorial authority). However, the sale of group policies to "non-qualifying groups" in Virginia would be prohibited unless they are approved by the Bureau of Insurance. This would ensure that when someone purchases group accident and sickness insurance through an

entity other than a qualifying group, such coverage will comply with Virginia law.

The key provisions of the proposal under consideration are as follows:

- group accident and sickness insurance policies could be issued in the Commonwealth only to the following types of "qualified" groups: employer groups, creditor/debtor groups, labor union groups or similar employee organizations, certain trusts (i.e., multiple employer welfare arrangements [MEWAs]), association groups that meet specific criteria, and credit union groups;
- group accident and sickness insurance issued to "qualified groups," as defined above, located outside of Virginia could be offered to Virginia residents without prior approval of the Bureau (i.e., no extraterritorial authority);
- an insurer offering group accident and sickness insurance to a resident of the Commonwealth under a group policy issued to a group other than those identified above (i.e., a "non-qualifying group") would have to document approval by a state with similar legislative requirements or obtain approval by the Bureau (this would address the issue of "group" coverage being issued to individuals with tenuous group affiliation);
- insurers seeking approval of group coverage to be offered to residents of the Commonwealth through a "non-qualifying" group would have to submit certain documentation for review by the Bureau; if the carrier is unable to provide certain documentation, the policy would have to be approved as meeting all the requirements included in title 38.2 of the Code of Virginia; and
- persons marketing "non-qualifying group" coverage (i.e., certificates of coverage) to individuals must hold a valid agent license.

The Bureau's Proposal Is Based On A Model Developed By The National Association of Insurance Commissioners (NAIC): The approach proposed by the Bureau for consideration by the Joint Commission is very similar to (in many instances the same as) model legislation developed by NAIC for states to consider when formulating extraterritorial authority statutes.

To Address The Same Concerns In The Group Life Insurance Market And For Consistency Of Insurance Regulation, The Proposal Under Consideration Would Place The Same Requirements On Group Life Insurance Policies Issued Pursuant To Chapter 33 of Title 38.2

In many instances, group life insurance policies are marketed and sold along with group health insurance. To address the same concerns as noted in the above discussion on group health insurance and to assure consistency of regulation in both life and health markets, the proposal under consideration would place the same requirements on group life insurance products.

Some Insurers Which Market Group Coverage To Individuals Through Certain "Non-Qualifying Groups" Will Oppose Such An Approach

The approach outlined above provides less extraterritorial authority than that recommended by the Bureau in 1988 following its study of this issue. It requires carriers to comply with Virginia insurance laws and regulations only in a limited number of instances. Nonetheless, insurers which market group coverage to individuals through certain types of groups that will be subject to Bureau review and approval likely will oppose any attempt to exercise any level of 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.

While certain insurers will oppose this proposal, it would provide more consistent regulation of the insurance market and extend Virginia's consumer protections to more residents of the Commonwealth.

III.
Technical Amendments To Virginia's Legislation To Implement The Federal Health Insurance Portability And Accountability Act of 1996

Last year, Congress passed the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This federal law included several health insurance reforms in both the group and individual markets. In response to this federal law, the Joint Commission on Health Care introduced legislation (House Bill 2887/Senate Bill 1112) in the 1997 Session of the General Assembly to implement the provisions of HIPAA in Virginia.

As noted earlier in this report, Virginia, as well as most other states, had a very short period of time in which to adopt legislation to conform its insurance statutes to the provisions of HIPAA. In addition to the limited timeframe, federal regulations promulgated as part of HIPAA were not finalized until well after most states had passed their respective HIPAA legislation.

Several Technical Corrections And Clarifications To Virginia's HIPAA Legislation Are Needed

Due to the short amount of time to draft Virginia's HIPAA legislation and the limited amount of guidance from federal agencies, a number of technical corrections and clarifying changes need to be adopted to ensure compliance with the federal requirements. Staff from the Joint Commission on Health Care and the Bureau of Insurance have formed a task force composed of representatives from several insurance carriers, HMOs, the Health Insurance Association of America, and the Virginia Association of Health Maintenance Organizations to draft the necessary technical amendments and clarifying changes. Legislation will be introduced during the 1998 Session of the General Assembly to adopt these technical changes.

Following The Passage Of Last Year's HIPAA Legislation, It Was Determined That A Limited Number Of Individuals Inadvertently Were Excluded From The Guaranteed Issue Protections For "Eligible" Individuals

The HIPAA legislation includes reforms in the group market and the individual market. The individual market reforms, which include

guaranteed issuance of coverage, apply only to "eligible" individuals. As provided in the federal act, Virginia's HIPAA legislation defines "eligible" individuals as persons who:

- have had 18 or more months prior continuous coverage in the group market;
- have not had a break in coverage for more than 63 days;
- are ineligible for other group coverage; and
- if eligible for extended coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA), have accepted and exhausted such coverage.

Virginia's guaranteed issue provision for "eligible" individuals requires carriers to guarantee the issuance of all policies offered in the individual market.

Group HIPAA Reforms Were Effective July 1, 1997; Individual Reforms Become Effective January 1, 1998: As required under the federal act, the group market reforms in Virginia's HIPAA legislation became effective July 1, 1997. However, as allowed under the federal legislation, Virginia's individual market reforms become effective January 1, 1998. The decision to have a later effective date for the individual reforms was in response to carriers' concerns that they would not be able to implement the guaranteed issue provisions prior to that date.

Virginia's HIPAA Legislation Inadvertently Excludes A Limited Number Of "Eligible" Individuals From The Guaranteed Issue Protections: An unintended consequence of the decision to have the group reforms become effective on July 1 and the individual reforms become effective on January 1, 1998, is that those individuals who lose eligibility for group coverage between July 1 and the end of October, who otherwise would have been "eligible" for the guaranteed issue requirements, will have a lapse of coverage for 63 or more days; and, thus, will lose their status as an "eligible" individual. The Bureau of Insurance has been contacted by a limited number of such persons expressing concern about their ineligibility for HIPAA protections.

To correct this situation, legislation is necessary to provide this small number of individuals an additional period of time after January 1, 1998 to obtain coverage under the guaranteed issue provisions of HIPAA. In developing its legislative package for the 1998 Session of the General Assembly, the Joint Commission should include in its deliberations whether or not to draft and introduce legislation to correct this problem.

IV.
Community Rating And Pre-Existing Condition Exclusions

Senate Bill 1181 of the 1997 Session of the General Assembly would have required community rating on all health insurance policies issued in the Commonwealth, and would have prohibited the use of pre-existing condition exclusions or limitations in any policy. Senate Bill 1181 was not passed by the General Assembly. However, the Senate Commerce and Labor Committee requested the Joint Commission on Health Care to study these issues and report its findings to the Governor and 1998 Session of the General Assembly.

Many Health Insurance Policies Are "Experience Rated" Based On The Claims Experience And/Or Demographics Of The Insured Person(s)

Most group health insurance policies are "experience rated" meaning that the premium for a given group is based primarily on the claims "experience" of the group along with other factors such as the group's demographics (e.g., the age, gender, occupation of the group members). In the individual market, persons generally are placed in a certain pool for rating purposes; premiums for each individual can vary according to the characteristics of the person (e.g., age, gender, occupation, etc.).

Under these rating practices, some groups and individuals will have very favorable claims experience/demographics, and will pay low or moderate premiums. However, there also are groups and individuals who, because of a high risk medical condition or other "risk" factor, must pay very high premiums or are not able to afford coverage at all.

When Insurance Policies Are "Community Rated," All Insured Persons Pay A Similar Premium Rate Regardless Of Their Claims Experience

Whereas policies which are "experience-rated" result in some groups/individuals paying a higher or lower rate depending on their claims experience, under a "community-rated" system, all insured persons pay a similar premium, regardless of their health status or claims experience. There are two basic types of community rating, "pure" and "modified" community rating.

"Pure" Community Rating: In a "'pure" community rating system, the premium charged by the carrier is the same for all persons. There are

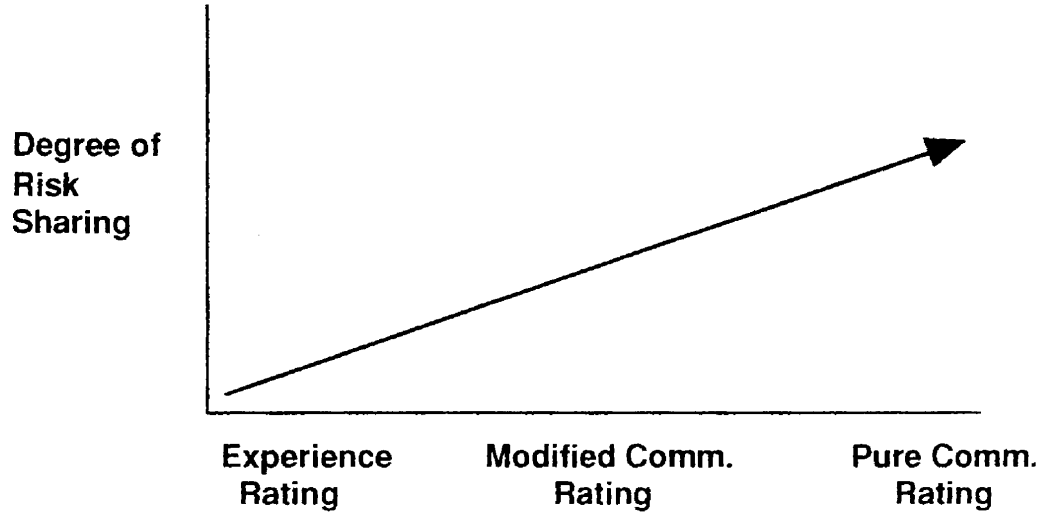
no adjustments to the premiums for age, gender, occupation, health status or any other factor. (Rates can vary based on whether the policy is for a single person or a family.)

"Modified" Community Rating: In a "modified" community rating system, the community rate essentially is calculated first as a "pure" community rate; however, the community rate then is "modified" to some degree to account for variations in certain rating factors among the groups or individuals being rated. Generally, there are limits placed on the degree to which the community rate can be "modified."

The key distinguishing feature of the various rating systems is the amount of "risk sharing" among the groups and/or individuals insured by a given carrier. In other words, the defining characteristic is the degree to which a certain group or individual is required to bear the full cost of the medical claims anticipated to be paid by the insurance (i.e. experience rating) or how much of the cost is shared among all groups or individuals covered by the carrier, irrespective of who incurs the cost (i.e., community rating). Figure 1 illustrates how these rating systems compare to one another along the continuum of risk sharing.

Figure 1

Experience, Pure Community and Modified Community Rating Practices: Level of Risk Sharing



Source: Joint Commission on Health Care Staff Analysis

Senate Bill (SB) 1181 Of The 1997 Session Of The General Assembly Would Have Required Pure Community Rating For Health Insurance Policies, And Prohibited The Use Of Pre-Existing Condition Exclusions Or Limitations

Pure Community Rating Provisions: The provisions of SB 1181 would have required every new or renewal premium rate for any individual or group health insurance policy issued in Virginia to be based on community rating. As defined in SB 1181, the required rating methodology would have been "pure" community rating in that no adjustments to the rates would have been allowed for "age grouping, gender, health status, duration of coverage, industry classification, claims experience or other rating factors which might be used."

Pre-Existing Conditions Provisions: SB 1181 would have prohibited an insurer from imposing any type of pre-existing condition exclusion or limitation (including waiting periods for such conditions) on any individual or group health insurance policy.

Virginia Law Provides For Modified Community Rating Of Two Standard Health Insurance Policies In The Primary Small Group (2-25) Market, And Places Limits On Pre-Existing Condition Exclusions In The Group And Individual Markets

Modified Community Rating Provisions: The small group reforms that were adopted in Virginia several years ago include a requirement that, in the primary small group (2-25 employees) market, carriers use a modified community rating methodology when calculating premiums for two standardized health benefits plans (Essential and Standard Plans). Carriers are allowed to "modify" the community rate 20% higher or 20% lower depending on the health status of a specific group.

Thus far, Virginia has not enacted any rating reforms in the individual market. In 1996, the Joint Commission drafted legislation to enact guaranteed issue and modified community rating of the Essential and Standard Plans in the individual market. However, based on the concerns expressed by the insurance industry regarding the unknown impact of such reforms, the legislation was not introduced.

The Joint Commission on Health Care currently is considering whether to seek legislation during the 1998 Session of the General Assembly to extend the modified community rating requirement in the primary small group market to: (i) other health insurance products; (ii)

self-employed/sole proprietors; (iii) the individual market; and (iv) larger sized groups (e.g., 26-50 employees).

Limits on Pre-Existing Condition Exclusions: As a result of past Virginia insurance reforms and the recent passage of the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, limits have been placed on the degree to which insurers can exclude coverage of certain services due to a pre-existing medical condition. For both the group (all sized groups) and individual markets, Virginia law now prohibits insurers from imposing a pre-existing condition waiting period for longer than 12 months. In determining whether a pre-existing condition exists, only those conditions for which medical advice, diagnosis, care or treatment was recommended or received within the previous six months (for groups) or 12 months (for individuals) can be excluded under the waiting period.

In addition to the 12 month limit on pre-existing condition waiting periods, Virginia law also requires carriers to provide credit for any waiting periods served in previous coverage. This requirement, which prevents persons from having to serve multiple waiting periods, applies to both the group and individual markets.

For a small number of "eligible" individuals, as defined in HIPAA, no pre-existing condition exclusions can be imposed.

Most States Have Enacted Rating Reforms In The Small Group Market; The Health Insurance Portability and Accountability Act of 1996 Requires States To Limit Pre-Existing Condition Exclusions For All Groups

Community Rating Requirements for Small Groups: Like Virginia, nearly all states (46) have implemented small group market reforms, including some degree of rating reform. These rating reforms generally are part of a larger package of reforms, including guaranteed issue of certain products, guaranteed renewability of coverage and limits on pre-existing condition exclusions.

Few, if any states, have adopted rating reforms for larger groups. The primary reason for this is that most larger groups are self-funded; and, thus, are exempt from state insurance regulation due to the Employee Retirement Security Act (ERISA). Also, it is the small group market which faces the most difficulty in obtaining affordable insurance. Accordingly,

states have focused their efforts primarily on reforming this segment of the insurance market.

Nearly all of the states which have adopted rating reforms require some form of "modified" community rating. Very few states' laws provide for pure community rating. Most states have adopted "rating bands" as recommended in model legislation adopted by the National Association of Insurance Commissioners (NAIC). These rating bands limit premiums to a range of 2:1 for experience, health status or duration of coverage. About five states have adopted "very tight" rating bands which operate similarly to the NAIC bands, but allow for only very limited variation in rates due to experience, health status or duration of coverage. About 15 states have community rating laws which prohibit the use of experience, health status or duration of coverage; most of these states allow for variation in rates based on demographic factors.

Limits On Pre-Existing Condition Exclusions For Small Groups: While most states, including Virginia, already had adopted limits on pre-existing condition exclusions in the small group market, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 set minimum standards that all states must meet. HIPAA prohibits pre-existing condition exclusions to exceed 12 months for any sized group. In addition, credit must be given for any waiting periods served in previous coverage.

States are allowed to have more restrictive limits on pre-existing condition exclusions than that provided in HIPAA. Indeed, twelve states have established more restrictive waiting period limits in their respective small group markets: two states have established a 9 month maximum waiting period; eight states have a 6 month maximum waiting period; and two states have a 3 month maximum.

Fewer States Have Enacted Rating Reforms And Limits On Pre-Existing Condition Waiting Periods In The Individual Market; HIPAA Has A Very Limited Impact On The Individual Market

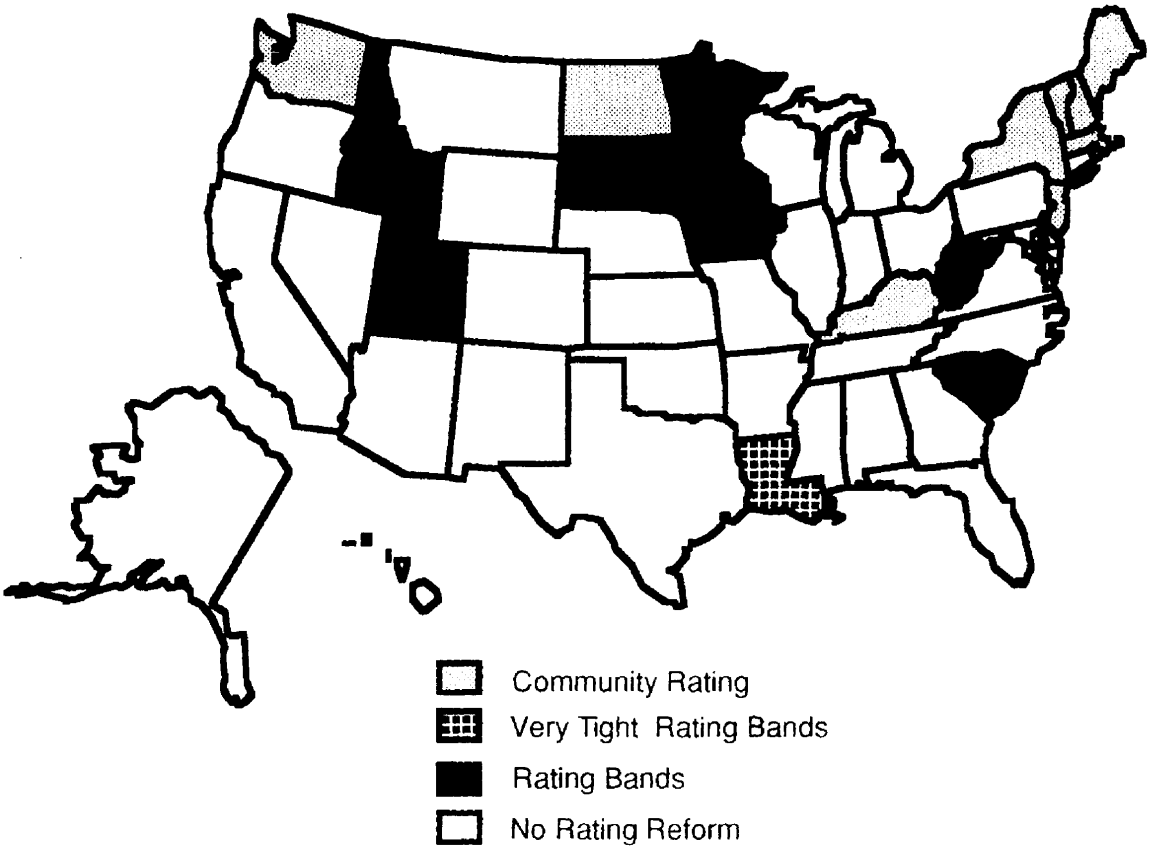
Community Rating in the Individual Market: There are only 17 states which have enacted some form of rating reform in the individual market. Seven states have established rating bands that limit carriers' use of experience, health status or duration of coverage in setting premium rates for individuals which are similar to the NAIC small group model legislation. Only one state imposes "very tight" rating bands on carriers. Nine states require community rating that prohibits the use of experience

health status or duration of coverage in setting premium rates. These nine states require "modified" community rating which allows for some variation based on factors other than experience or health status (e.g., age, gender, geography, etc.). New Jersey formerly required "pure" community rating, but now allows adjustments based on age.

Figure 2 illustrates the states which have enacted rating reforms in the individual market.

Figure 2

States Which Have Enacted Rating Reforms In The Individual Market



Community Rating: laws which prohibit use of experience, health status or duration of coverage; allow for variations based on other factors
Very Tight Rating Bands: laws which permit only a very limited adjustment for experience, health status or duration of coverage
Rating Bands: laws which limit use of experience, health status or duration of coverage

Source: Blue Cross Blue Shield Association, 1996

Limits On Pre-Existing Condition Exclusions In The Individual Market: Twenty-five states, including Virginia, have enacted laws which place limits on pre-existing condition waiting periods in the individual market. Of these states, most, like Virginia, prohibit waiting periods to exceed 12 months. One state limits the maximum waiting period to nine months; three states have a six month maximum; and one state has a three month maximum. Only Rhode Island prohibits carriers from imposing any pre-existing condition waiting periods.

HIPAA prohibits carriers from imposing any pre-existing condition exclusions for a limited number of "eligible" individuals. However, unlike the broad reforms in the group market, HIPAA has little impact in the individual market.

Individual Market Reforms In Some States Have Caused Market Disruption And Unintended Negative Consequences

Nearly all individual market reforms have been enacted within the past few years. Accordingly, there is little information on the experiences of the states regarding the impact of the reforms on the number of persons covered and premium stability. Those states which have taken more incremental steps in reforming their markets generally have not faced any significant problems. However, the reforms in a few states have caused some market disruption and unintended negative consequences.

Much has been written, both positive and negative, about New Jersey's individual market reforms (primarily pure community rating). There have been significant increases in premiums charged by some carriers, while other carriers, particularly HMOs, have had relatively stable premiums. In response to the concerns over the rate increases imposed by some carriers, New Jersey moved from pure community rating to modified community rating.

The state of Kentucky has experienced perhaps the most severe problems resulting from the reforms enacted in its small group and individual markets. However, the negative impact in the individual market has been the most pronounced. Citing problems associated with Kentucky's guaranteed issue, modified community rating and pre-existing condition reforms, 45 insurance companies have abandoned the individual policy market. The Kentucky legislature recently held a special session to resolve the severe market problems; however, the session adjourned without any resolution. Action is expected in the upcoming annual session to rectify these problems.

Requiring Community Rating And Prohibiting Pre-Existing Condition Exclusions or Limitations Pose Difficult Public Policy Issues

Requiring community rating and prohibiting pre-existing condition exclusions, as provided in SB 1181, pose difficult public policy issues. Such provisions clearly are well-intended and are geared to make health insurance more available and affordable to persons by spreading risk to a larger pool of insureds (community rating) and ensuring that persons receive coverage for their medical conditions (limits on pre-existing condition exclusions). While the intent of such reforms is to improve the health insurance market, they also can have unintended consequences.

Policy Issues Regarding Community Rating: Community rating, particularly "pure" community rating, in which no adjustments to the community rate are allowed, requires healthy groups/individuals to subsidize the cost of coverage for less healthy groups/individuals. To the degree this subsidization occurs, the premiums for the less healthy persons will be lowered. This clearly is a positive aspect of community rating. However, this subsidization results in healthier persons' premiums increasing, perhaps substantially.

In the event that healthier persons' premiums increase substantially, it is very likely that some will decide to discontinue their coverage. As healthy persons leave the market, the premiums for those remaining in the market increase even more. This cycle can continue causing more and more persons to exit the market; thus, increasing the premiums for those who stay.

Requiring that <u>all</u> policies be rated only on a "pure" community rating basis, as provided in SB 1181, increases the likelihood that the scenario described above would occur. A more incremental approach, such as "modified" community rating applied only to certain segments of the market, lessens the chance of unintended negative consequences.

Policy Issues Regarding Pre-Existing Condition Exclusions: As with community rating, prohibiting pre-existing condition exclusions ensures that persons can obtain insurance benefits for their medical conditions from the outset of purchasing health insurance. While this certainly has the positive effect of providing coverage for any covered service from the beginning of the policy, it also allows persons to "game the system" by not purchasing coverage until a medical condition arises which prompts the person to purchase coverage. Moreover, the person

then could drop coverage to avoid paying premiums until such time as another medical condition warranted insurance coverage. In this scenario, the insurer does not have the benefit of collecting premiums while the person is well; premiums are collected only when claims are going to be incurred. The result is that premiums must be increased for everyone.

To strike the proper balance between ensuring that persons have coverage for their medical conditions and protecting insurers (and other consumers) from possible "gaming of the system," states have enacted limits on the pre-existing condition exclusions, rather than eliminating them altogether. Requiring that credit be provided for waiting periods served in previous coverage (as in Virginia) prevents insurers from imposing multiple waiting periods and excluding coverage for an extended period of time. Limits on pre-existing condition exclusions, rather than prohibitions represent an incremental approach that seems to "strike the right balance."

V.
High Risk Insurance Pools

Senate Joint Resolution 337 of the 1997 Session of the General Assembly directs the Joint Commission on Health Care to study high risk insurance pools and the feasibility of establishing such a pool in the Commonwealth.

Risk Pools Provide Health Insurance Coverage For Persons Unable To Purchase Health Insurance For Medical Reasons; Most Persons Enroll For A Limited Period of Time

Risk pools are state-created, nonprofit associations that provide health insurance to high risk persons and/or small groups who have been unable to purchase health insurance because of medical reasons. Risk pools that have been established in other states largely serve the self-employed, employees of small businesses, and farmers who are not part of a large group health insurance plan. (Comprehensive Health Insurance for High-Risk Individuals, 1996.)

Based on the experiences of other states that operate high risk pools, these mechanisms provide a temporary stopping point for individuals who are denied health insurance for medical reasons. While some people enroll in high risk pools for an extended period of time, many enroll for a limited time and then disenroll when other coverage becomes available. The average time an individual spends in a high risk pool is approximately 30 months.

An "Open Enrollment Program" Is Another Mechanism Used By Some States To Provide A "Safety Net" For High Risk Persons

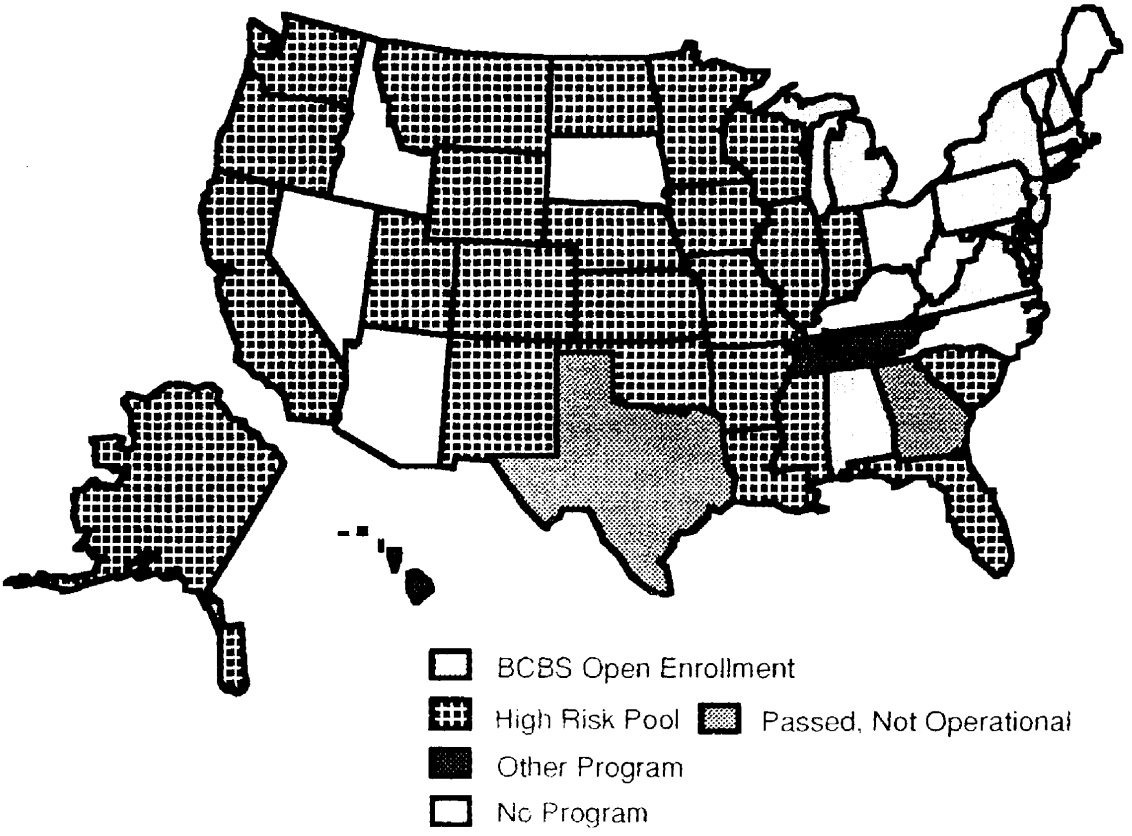
While high risk pools provide a "safety net" for otherwise uninsurable persons, some states, including Virginia, have instituted "open enrollment" programs to ensure that these high risk individuals have access to health insurance coverage. Open enrollment programs are administered by Blue Cross and Blue Shield (BCBS) plans operating in the respective states. In these programs, the BCBS plans provide coverage to high risk individuals, and generally receive some type of compensation from the state to offset their underwriting losses. (Information regarding Virginia's open enrollment program is presented later in this section.)

Currently, 25 States Administer A High Risk Pool

Figure 3 illustrates the various "safety net" programs in effect in states throughout the country. As seen in Figure 3, 25 states operate a high risk pool. High risk pool legislation has been passed in an additional two states; however, the programs are not yet operational. Open enrollment programs are in effect in 11 states and the District of Columbia. Ten states have not implemented any type of safety net program. Two states have implemented other programs to cover the uninsurable.

Figure 3

States Which Have Implemented High Risk Pools And Other "Safety Net" Programs



Source: Comprehensive Health Insurance for High-Risk Individuals, Communicating for Agriculture, 1996

Participation in High Risk Pools Varies Widely By State

For those state high risk pools that have been in operation for at least two years, the number of persons participating in the pools varies widely. Based on 1995 statistics, participation ranged from a low of 179 persons in Alaska (operational since 1993) to a high of 30,470 persons in Minnesota (operational since 1976). Of the 23 high risk pools in operation in 1995, 9 states reported fewer than 1,000 enrollees; 11 states reported between 1,000 and 5,000 enrollees; one state had between 5,000 and 10,000 enrollees, and two states reported more than 10,000 enrollees.

Funding Sources To Cover The Losses Of High Risk Pools Vary Among The States

Premiums collected from high risk enrollees generally cover only about 50% of the cost of administer the plan. Through the years, states have established a variety of funding sources to cover the losses associated with high risk pools. Most states (19) assess participating insurers in proportion to the amount of health insurance premiums written in the state. In some of these states, carriers are allowed to offset their premium tax payments by the amount of the assessment; this results in the state ultimately paying the cost of the program. Four states directly allocate state funds to offset plan losses. Two other states use other funding sources.

Assessments vary from state to state and from year to year depending on the number of enrollees, their claims experience and several other factors. In 1995, assessments ranged from $1.2 million in New Mexico (858 enrollees) to $48 million in Minnesota (30,470 enrollees).

High Risk Pools Typically Offer Comprehensive Benefits; However, Nearly All Include Lifetime Benefit Maximums And Some Plans Exclude Coverage For Certain Conditions

High risk pools typically offer comprehensive benefits including both inpatient and outpatient care, as well as diagnostic tests, and prescription drugs. Most plans offer different levels of deductibles ranging from as little as $200 to as much as $10,000. Nearly all of the high risk pools include a maximum lifetime benefit, with a few also including an annual limit. The lifetime maximums range from $250,000 to $1 million. Some plans exclude coverage for certain services such as maternity, dental and vision care.

Virtually All States Impose A Cap On The Premiums Charged To High Risk Pool Enrollees

High risk pools by their nature enroll only persons who cannot otherwise obtain health insurance due to a medical condition. Consequently, the premiums charged to enrollees can be very expensive. To control these prices, virtually all of the states have imposed premium caps that limit the premiums to a fixed percentage above the standard premium charged by private carriers to lower risk individuals in the state. Most states' premium caps limit premiums to be no more than 125% to 150% of the standard premium in the private market; a few states allow premiums to be as much as 200% or more of the standard rate.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 Affects The Need For High Risk Pools In The Small Group Market, And Permits States to Use High Risk Pools As An "Acceptable Alternative Mechanism" For "Eligible" Individuals

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that all carriers guarantee the issuance of all products offered in the small group market (2-50 employees) regardless of the health status of the group members. As such, the need to have a high risk pool or other safety net mechanism for small groups is diminished.

HIPAA also includes reforms in the individual market. For a limited number of "eligible" individuals, states must provide guarantee issue of coverage. HIPAA provides states with several options for meeting this requirement. One of the options allows states to use their high risk pool as a means of covering these individuals.

In implementing HIPAA, Virginia chose one of the other available options. Virginia's HIPAA legislation (HB 2887/SB 1112) requires carriers to guarantee issue all products marketed in the individual market. In this way, "eligible" individuals are offered a wide range of benefit options.

Virginia's Open Enrollment Program Provides Coverage For Individuals With High Risk Medical Conditions

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. There are two open enrollment carriers in Virginia, Trigon BlueCross BlueShield (Trigon) and Blue Cross and Blue Shield of the National Capital Area (BCBSNCA).

Prior to the passage of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Virginia's open enrollment program included small groups (2-49) and individuals. However, because of the guaranteed issue provisions for small groups in HIPAA, legislation was passed by the 1997 Session of the General Assembly that removed small groups from the open enrollment program.

In 1995, the two open enrollment carriers reported a total of approximately 11,300 individuals (excluding small groups) as being covered under the open enrollment program. The vast majority of these enrollees were covered by Trigon. It is not known how many of these enrollees are uninsurable due to high risk medical conditions; however, the number certainly is somewhat less than 11,300.

Because open enrollment carriers operate as an "insurer of last resort," the Commonwealth imposes a reduced license/premium tax on taxable premiums derived from individual policies to offset their underwriting losses. Open enrollment carriers pay a premium tax of 0.75%, whereas all other carriers pay a 2.25% tax. Based on the 1995 taxable premiums derived from individual policies reported by the two open enrollment carriers, this tax differential amounted to approximately $5.2 million for taxable year 1995.

There Are Advantages And Disadvantages To High Risk Pools

Advantages: One advantage to high risk pools is that carriers are better able to project their risks over time as opposed to experiencing wide fluctuations from year to year. Another advantage noted by some carriers is that by removing the sickest people from the mainstream, the pools are the best way to cover persons with serious medical conditions without driving up the cost for everyone else.

In those states where assessments are made on the carriers to offset underwriting losses of the pool, the cost of covering uninsurable persons is spread evenly across the industry rather than a disproportionate share being placed on a limited number of carriers. Moreover, in those states where offsets against state premium taxes are not provided to cover the cost of the assessments, the state's liability is significantly lowered.

Disadvantages: According to model legislation drafted by the National Association of Insurance Commissioners (NAIC), high risk pools are expensive to establish. The NAIC also cautions that if plan losses are assessed against insurers, the plan's cost effectiveness can be substantially impaired unless contributions from both insured and self-funded plans can be secured. NAIC notes that without the inclusion of self-funded plans, the financial base necessary to support the pooling mechanism may be insufficient. The provisions of the Employee Retirement Income Security Act (ERISA) currently preclude states from assessing self-funded plans.

Another disadvantage of high risk pools is the high cost of coverage. Because the persons in the pool all have high risk medical conditions, premiums typically are significantly higher than other insurance products. Lastly, the benefits in high risk pools have lifetime maximums and other limitations.

The Key Policy Issue Regarding High Risk Pools In Virginia Is Whether Such An Arrangement Would Provide A Better And More Cost Effective "Safety Net" For Uninsurable Persons Than The Current Open Enrollment Program; Further Study of These And Other Issues Would Provide Useful Information In Addressing This Issue

There clearly is a portion of the population which is uninsurable due to high risk medical conditions. The key policy issue for Virginia is whether a high risk pool provides a better mechanism for insuring these persons than the current open enrollment program. In analyzing this issue, there are several important considerations. What would be the better program for high risk persons in terms of benefits and costs? Which program is better for the insurance market as a whole? Which program provides the Commonwealth with the better approach to insuring these individuals?

Analysis Of Virginia's High Risk Population Is Needed: Addressing these and other issues regarding high risk pools requires further information and analysis of both the high risk pool and open enrollment programs. Moreover, a thorough analysis of the number and types of persons in Virginia with serious medical conditions is needed to determine how these individuals currently are obtaining coverage, and what premiums they are having to pay for the coverage. Clearly, there is some number of individuals who now must pay exorbitant premiums to obtain coverage while some are not able to secure coverage at all because of the high premiums. Analyzing the best approach for ensuring these

persons can obtain affordable coverage would be a key component of any further study.

Impact Of HIPAA Reforms Is Not Known: Another matter related to the issue of establishing a high risk pool is the recent enactment of HIPAA. Virginia's small group reforms became effective July 1, 1997; the individual market reforms do not take effect until January 1, 1998. Given that these reforms are just beginning to have an impact in the health insurance market, further study of how Virginia's HIPAA reforms relate to and affect the need for a high risk pool seems appropriate. In fact, the third enactment clause of Virginia's HIPAA legislation (HB 2887/SB 1112) directs the Bureau of Insurance and the Joint Commission on Health Care to monitor the impact of the reforms in the individual market, and to recommend any revisions or improvements.

Given that the individual reforms are not effective until January 1, 1998, this review will have to take place during 1998, and possibly into 1999. As part of this review, should it be determined that the individual market reforms need to be revised, high risk pools should be considered as an alternative. This issue also could be incorporated into any follow-up study on how best to cover high risk persons.

VI.
Policy Options

The following policy options are offered for consideration by the Joint Commission on Health Care regarding the four major issues presented in this issue brief: (i) the Bureau of Insurance's regulatory authority over certain insurance products issued out-of-state; (ii) revisions to last year's legislation implementing the Health Insurance Portability and Accountability Act (HIPAA) of 1996; (iii) community rating and pre-existing conditions; and (iv) high risk pools. The policy options under each topic do not represent the entire range of actions that the Joint Commission may wish to pursue.

Options Regarding The Bureau of Insurance's Regulatory Authority Over Certain Insurance Policies

- **Option I:** Take No Action.

- **Option II:** Introduce Legislation To Broaden The Bureau Of Insurance's Regulatory Authority Such That Group Accident And Sickness Insurance Offered To A Resident Of The Commonwealth Under A Group Policy Issued Out-of-State To "Non-Qualifying" Groups Would Have To Be Approved By The Bureau. The Legislation Also Would Require That Persons Marketing "Non-Qualifying Group" Coverage To Residents Must Hold A Valid Agent License. For Consistency Of Application, Consideration Also Should Be Given To Including The Same Provisions In Chapter 33 Of Title 38.2 Regarding Group Life Insurance Policies.

Options Regarding Revisions To Virginia's Legislation Implementing The Health Insurance Portability And Accountability Act (HIPAA) Of 1996

- **Option III:** Introduce Legislation To Make Technical And Clarifying Amendments To The Insurance Reforms Included In Virginia's HIPAA Legislation Enacted Last Year.

- **Option IV:** Introduce Legislation To Provide An Additional Period Of Time After January 1, 1998 For A Small Number Of Individuals To Obtain Coverage Under The Guaranteed Issue Provisions Of HIPAA For Which They Currently Are Not Eligible Due To An Unintended Result Of Last Year's HIPAA Legislation.

Options Regarding Community Rating And Pre-Existing Condition Exclusions

- **Option V:** Take No Action.

  (Options VI through VIII regarding potential expansion of community rating in the health insurance market are the same options presented in the first phase of the Indigent/Uninsured study conducted pursuant to SJR 298.)

- **Option VI:** Introduce Legislation To Expand The Guaranteed Issue And Modified Community Rating Reforms To The Self-Employed And Sole Proprietors.

- **Option VII:** Introduce Legislation To Extend The Modified Community Rating Reforms, Which Currently Apply Only To The Essential And Standard Plans Issued To Primary Small Groups (2-25), To Other Types Of Coverage And/Or To Groups Up To 50 Employees.

- **Option VIII:** Introduce Legislation To Extend The Guaranteed Issue And Modified Community Rating Reforms To The Individual Market.

- **Option IX:** Introduce Legislation To Reduce The Maximum Waiting Periods That Insurers Can Impose On Group And Individual Health Insurance Policies From 12 Months To 6 Months.

- **Option X:** Introduce Legislation To Reduce The Pre-Existing Condition "Look-Back" Provision In The Individual Market From 12 Months To 6 Months Which Would Make This Limitation The Same As The Group Market Limitation.

Options Regarding High Risk Pools

- **Option XI:** Take No Action.

- **Option XII:** As Part Of The Review Of The Guaranteed Issue Provisions Under HIPAA To Be Conducted By The Joint Commission On Health Care And The Bureau Of Insurance, Consider High Risk Pools As A Potential Alternative Should Changes To The Existing Provisions Be Warranted.

- **Option XIII:** Introduce A Joint Study Resolution Directing The Joint Commission On Health Care To Conduct Further Study On The Issue Of Establishing A High Risk Pool. The Study Would Include A Detailed Comparison Of The PROs And CONs Associated With High Risk Pools And Virginia's Current Open Enrollment Program, As Well As A Cost-Benefit Analysis Of Each Approach. The Study Also Would Assess Problems Encountered By High Risk Individuals In Obtaining Affordable Health Insurance Coverage To Help Determine What Type Of "Safety Net" Program Would Best Serve Their Needs.

APPENDIX A:

Senate Joint Resolution 337

SENATE JOINT RESOLUTION NO. 337

Directing the Joint Commission on Health Care to study high risk insurance pools and the feasibility of establishing such a pool in the Commonwealth.

Agreed to by the Senate, January 30, 1997
Agreed to by the House of Delegates, February 10, 1997

WHEREAS, Virginia currently has over 800,000 citizens without health insurance coverage; and

WHEREAS, the percentage of those Virginians without health insurance coverage is 13.9 percent, a figure that is below the national average of 17.3 percent, but still represents a large number of citizens who are not covered by health insurance; and

WHEREAS, 28 other states have established Comprehensive Health Insurance Plans (CHIPS), which have provided in these states an affordable solution for those uninsured citizens who have a medical condition that precludes their obtaining health insurance coverage; and

WHEREAS, a high risk insurance pool is a better solution to the problem than more radical reforms that disrupt an otherwise healthy insurance market; and

WHEREAS, while any shortfalls in the high risk insurance pool are paid through health insurer assessments, these assessments generally average less than five-tenths of a percent of a company's annual premium; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care be directed to study high risk insurance pools and the feasibility of establishing such a pool in the Commonwealth.

Technical assistance shall be provided to the joint commission by the Bureau of Insurance.

All agencies of the Commonwealth shall provide assistance to the joint commission for this study, upon request.

The Joint Commission on Health Care shall complete its work in time to submit its findings and recommendations to the Governor and the 1998 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B:
SUMMARY OF PUBLIC COMMENTS

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS: HEALTH INSURANCE ISSUES

Individuals/Organizations Submitting Comments

A total of 8 individuals and organizations submitted comments in response to the Health Insurance Issue Brief.

American Association of Retired Persons
American Medical Security, Inc.
Council for Affordable Health Insurance
Golden Rule
Time Insurance Company
Trigon BlueCross BlueShield
Virginia Association of HMOs
Virginia Association of Health Underwriters/Va. Association of Life Underwriters/Association of Health Insurance Agents

Policy Options

The following policy options are offered for consideration by the Joint Commission on Health Care regarding the four major issues presented in this issue brief: (i) the Bureau of Insurance's regulatory authority over certain insurance products issued out-of-state; (ii) revisions to last year's legislation implementing the Health Insurance Portability and Accountability Act (HIPAA) of 1996; (iii) community rating and pre-existing conditions; and (iv) high risk pools. The policy options under each topic do not represent the entire range of actions that the Joint Commission may wish to pursue.

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Options Regarding Revisions To Virginia's Legislation Implementing The Health Insurance Portability And Accountability Act (HIPAA) Of 1996

- **Option III:** Introduce Legislation To Make Technical And Clarifying Amendments To The Insurance Reforms Included In Virginia's HIPAA Legislation Enacted Last Year.

- **Option IV:** Introduce Legislation To Provide An Additional Period Of Time After January 1, 1998 For A Small Number Of Individuals To Obtain Coverage Under The Guaranteed Issue Provisions Of HIPAA For Which They Currently Are Not Eligible Due To An Unintended Result Of Last Year's HIPAA Legislation.

Options Regarding Community Rating And Pre-Existing Condition Exclusions

- **Option V:** Take No Action.

(Options VI through VIII regarding potential expansion of community rating in the health insurance market are the same options presented in the first phase of the Indigent/Uninsured study conducted pursuant to SJR 298.)

- **Option VI:** Introduce Legislation To Expand The Guaranteed Issue And Modified Community Rating Reforms To The Self-Employed And Sole Proprietors.

- **Option VII:** Introduce Legislation To Extend The Modified Community Rating Reforms, Which Currently Apply Only To The Essential And Standard Plans Issued To Primary Small Groups (2-25), To Other Types Of Coverage And/Or To Groups Up To 50 Employees.

- **Option VIII:** Introduce Legislation To Extend The Guaranteed Issue And Modified Community Rating Reforms To The Individual Market.

- **Option IX:** Introduce Legislation To Reduce The Maximum Waiting Periods That Insurers Can Impose On Group And Individual Health Insurance Policies From 12 Months To 6 Months.

- **Option X:** Introduce Legislation To Reduce The Pre-Existing Condition "Look-Back" Provision In The Individual Market From 12 Months To 6 Months Which Would Make This Limitation The Same As The Group Market Limitation.

Options Regarding High Risk Pools

- **Option XI:** Take No Action.

- **Option XII:** As Part Of The Review Of The Guaranteed Issue Provisions Under HIPAA To Be Conducted By The Joint Commission On Health Care And The Bureau Of Insurance, Consider High Risk Pools As A Potential Alternative Should Changes To The Existing Provisions Be Warranted.

- **Option XIII:** Introduce A Joint Study Resolution Directing The Joint Commission On Health Care To Conduct Further Study On The Issue Of Establishing A High Risk Pool. The Study Would Include A Detailed Comparison Of The PROs And CONs Associated With High Risk Pools And Virginia's Current Open Enrollment Program, As Well As A Cost-Benefit Analysis Of Each Approach. The Study

Also Would Assess Problems Encountered By High Risk Individuals In Obtaining Affordable Health Insurance Coverage To Help Determine What Type Of "Safety Net" Program Would Best Serve Their Needs.

Summary of Public Comments

American Association of Retired Persons

William L. Lukhard and Mary H. Madge submitted comments in support of Options II - IV, VI - X, and XIII. With regard to Option XIII, they recommended that the Joint Commission do an indepth study and consider the feasibility and practicality of having both a high risk pool and an open enrollment program.

American Medical Security, Inc.

Richard L. Ryman and Amy McGee Polasky expressed opposition to establishing community rating and prohibiting the use of pre-existing condition exclusions on health insurance. They commented in support of the establishment of a high risk pool.

Council for Affordable Health Insurance

Joseph T. Holahan expressed strong support for the establishment of a state high risk pool to guarantee coverage for uninsurable persons. Mr. Holahan stated that the impact of guaranteed issue and community rating on consumers, especially in the individual market, has been disastrous. He believes that the current requirements of Virginia law regarding exclusions for preexisting conditions strike the proper balance between ensuring reasonable access to coverage and protecting responsible consumers who purchase insurance when they are healthy and maintain it.

Golden Rule

Brent C. Embrey commented in support of the concept of high-risk insurance pools. He stated that a properly crafted high risk pool bill would not have a fiscal impact, and that delay in the name of "detailed analysis" is not necessary. Mr. Embrey urged the Joint

Commission to dismiss any proposal to expand community rating and preexisting conditions limitations.

Time Insurance Company

Kerry W. Smith expressed support for a high-risk pool as an effective and equitable mechanism for providing health insurance coverage to uninsured Virginians.

Trigon BlueCross BlueShield

Leonard L. Hopkins, Jr., stated that Trigon supports the introduction of legislation to broaden the Bureau of Insurance's regulatory authority over certain insurance products issued out-of-state. Also, Trigon offered support for the introduction of a bill to make technical and clarifying amendments to Virginia's legislation implementing HIPAA. Mr. Hopkins recommended further study and closer examination of the policy options on guaranteed issue, community rating, pre-existing condition exclusions and high risk pools. Trigon expressed support for Options XI or XII, but noted that the study contemplated in Option XIII is not needed.

Virginia Association of HMOs (VAHMO)

Mark C. Pratt stated that the VAHMO supports the introduction of legislation to make technical and clarifying amendments to Virginia's legislation implementing HIPAA. With regard to the policy options on community rating, pre-existing conditions exclusions and high risk pools, VAHMO recommended a closer examination of the issues. Mr. Pratt also asserted that perhaps the most important consideration in addressing the issue of the uninsured is recognizing what not to do.

Virginia Association of Health Underwriters/Va. Association of Life Underwriters/ Association of Health Insurance Agents

Susan Maley Rash and Richard Herzberg commented in support of extending the Bureau of Insurance's regulatory authority to certain policies issued out of state (Option II). They also commented in favor of revisions to the Health Insurance Portability and Accountability

Act (Option IV), and changes to the "look-back" provisions for pre-existing conditions limitations in the individual market (Option X). They expressed opposition to "pure" community rating and Option IX.

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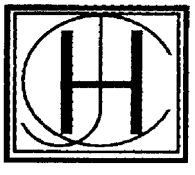

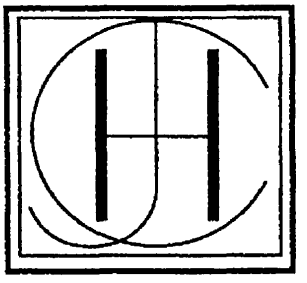

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