REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

STUDY ON THE FEASIBILITY OF ESTABLISHING A HIGH RISK POOL IN VIRGINIA (PURSUANT TO SJR 126)

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 22

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Preface

Senate Joint Resolution (SJR) 126 of the 1998 Session of the General Assembly directed the Joint Commission on Health Care to continue its study of the feasibility of establishing a high risk insurance pool in Virginia.

Specifically, SJR 126 directed the Joint Commission's study to include an analysis of: (i) the problems encountered by high risk individuals in obtaining affordable health insurance coverage; (ii) whether the current "open enrollment" program, a high risk pool, or other mechanism would best serve the needs of persons with high risk medical conditions; (iii) which type of approach provides the best mechanism for insuring high risk persons in terms of its impact on the health insurance market; (iv) which type of program provides the Commonwealth with the best approach to insuring high risk individuals; and (v) the practicality of administering both an open enrollment program and a high risk pool.

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

- states have taken different approaches to covering persons with high risk medical conditions: (i) 27 states have established high risk insurance pools; (ii) 9 states have a guaranteed issue requirement in the individual market; (iii) 6 states, including Virginia, and the District of Columbia administer open enrollment programs; (iv) 2 states have adopted other programs for high risk persons; and (v) 6 states have not adopted any mechanism to cover high risk persons;

- Virginia's open enrollment program provides comprehensive health insurance to persons with high risk medical conditions; Trigon Blue Cross Blue Shield and Blue Cross and Blue Shield of the National Capital Area are the Commonwealth's two open enrollment carriers;

- overall, the level and cost of the health insurance coverage offered through Virginia's open enrollment program are comparable to that offered through high risk pools in other states;

- the open enrollment program provides reasonable access to coverage for persons with high risk medical conditions as

evidenced by the fact that, in 1997, there were approximately 21,000 Virginians enrolled in the program;

- the Commonwealth imposes a lower premium tax rate on open enrollment carriers (0.75%) than other carriers (2.25%) on premiums derived from individual subscriber contracts to subsidize the cost of the program; in 1997, this tax differential amounted to $5.4 million;

- because the cost and level of coverage available through Virginia's open enrollment program are generally comparable to high risk pools in other states, it would appear that the only reason to move away from the open enrollment program would be to change the manner in which the cost of covering uninsurable persons currently is shared among enrollees, the insurance industry, and the Commonwealth; and

- except in very limited circumstances, no state currently operates both a high risk pool and an open enrollment program; administering two programs in Virginia would be duplicative.

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. These policy options are listed on pages 31-32.

Our review process on this topic included an initial staff briefing, which comprises the body of this report. This was followed by a public comment period during which time interested parties forwarded written comments to us regarding the report. The public comments (attached at Appendix B) provide additional insight into the various issues covered in this report.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank the Bureau of Insurance, the Virginia Association of Health Plans, Golden Rule Insurance Company, Trigon Blue Cross Blue Shield, and Blue Cross Blue Shield of the National Capital Area for their assistance during this study.

Patrick W. Finnerty
Executive Director

February 3, 1999

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I.
Authority for Study/Organization of Report

In 1997, The Joint Commission On Health Care Conducted A Study On The Feasibility Of Establishing A High Risk Insurance Pool In Virginia

High risk insurance pools have been established in a number of other states as a means of providing health insurance to persons with high risk medical conditions which preclude them from obtaining coverage in the health insurance market. The Joint Commission on Health Care conducted a study on high risk insurance pools in 1997 pursuant to Senate Joint Resolution (SJR) 337.

Last year's study included an analysis of the 25 states which were operating high risk pools in 1996. In addition, the SJR 337 study also presented limited information on Virginia's "open enrollment" program which provides coverage for high risk persons. A key conclusion of the SJR 337 study was that more detailed analysis of high risk pools was necessary to determine if they provide any significant advantages over Virginia's current open enrollment program.

Senate Joint Resolution 126 Of The 1998 Session Of The General Assembly Directs The Joint Commission To Conduct Further Analysis Of High Risk Pools And The Commonwealth's Open Enrollment Program

Senate Joint Resolution (SJR) 126 of the 1998 Session of the General Assembly directs the Joint Commission on Health Care, in cooperation with the Bureau of Insurance, to continue its study on the feasibility of establishing a high risk insurance pool in Virginia. Specifically, SJR 126 requires that the Joint Commission's study include, but not be limited to, a more detailed analysis of:

- the problems encountered by high risk individuals in obtaining affordable health insurance coverage;
- whether the current open enrollment program, a high risk pool, or other mechanism would best serve the needs of persons with high risk medical conditions;

- which type of approach provides the best mechanism for insuring high risk persons in terms of its impact on the health insurance market as a whole;
- which type of program provides the Commonwealth with the best approach to insuring high risk individuals; and
- the practicality of administering both an open enrollment program and a high risk pool.

A copy of SJR 126 is attached at Appendix A.

This Report Is Presented In Five Major Sections

This first section discusses the authority for the study and organization of the report. Section II provides detailed information on the high risk insurance pools operating in 27 other states. Section III describes Virginia's open enrollment program for covering persons with high risk medical conditions and presents historical data on program administration, enrollment, and financing. Section IV analyzes both high risk pools and the open enrollment program in terms of which approach provides the better mechanism for insuring Virginia's uninsurable population. Section V presents a series of policy options the Joint Commission may wish to consider in addressing the issue of high risk insurance pools.

II.
High Risk Insurance Pools

High Risk Insurance Pools Provide Health Insurance Coverage For Persons Who Are Otherwise Uninsurable

In the individual market where persons buy coverage by themselves rather than through an employer-sponsored plan, persons with high risk medical conditions often cannot obtain health insurance coverage in the marketplace. Unless a state has enacted laws that mandate health insurance companies guarantee the issuance of coverage regardless of the health status of the applicant, very often persons with high risk medical conditions are denied coverage due to the high costs associated with insuring them.

High risk insurance pools have been established in 27 states as a means of providing health insurance for persons who otherwise are uninsurable due to high risk medical conditions. A high risk pool typically is a state-created, nonprofit association that offers comprehensive health insurance benefits to individuals with pre-existing health problems who have been denied coverage in the private market or who can only access restricted coverage.

Some States Have Established Open Enrollment Programs Or Enacted Laws Mandating Guaranteed Issuance Of Coverage As A Means Of Insuring High Risk Persons

High risk pools are not the only means of ensuring that high risk persons have access to health insurance coverage. Seven states, including Virginia, and the District of Columbia, have established open enrollment programs to insure persons with high risk medical conditions. 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 financial compensation from the state to offset their underwriting losses. (Information regarding Virginia's open enrollment program is presented in Section III of this report.)

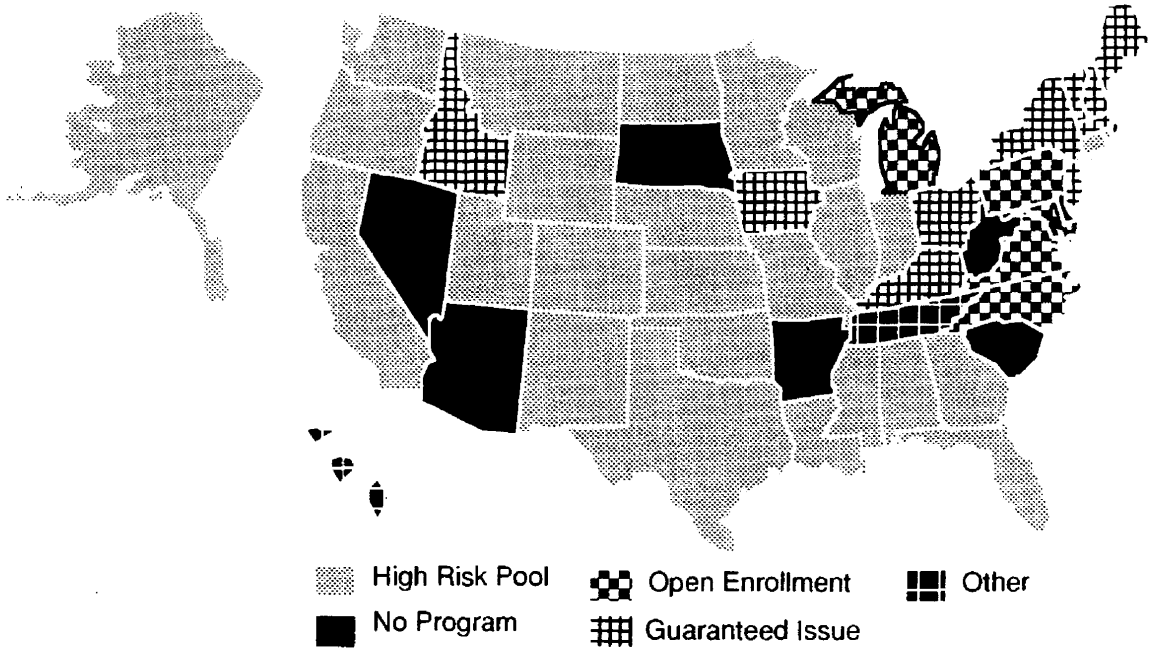
Nine states have enacted legislation mandating that health insurers guarantee the issuance of coverage in the individual market which ensures that persons with high risk medical conditions have access to coverage. However, without some type of rating reform to help hold down the

premiums charged to these enrollees, while coverage in guaranteed issue states may be available, for many, it may not be affordable. Two states (Tennessee and Hawaii) have established other programs that provide coverage for all citizens, including those with high risk medical conditions.

While most states have established some mechanism for insuring persons with high risk medical conditions, six states have not. Figure 1 illustrates the programs that have been established across the country to provide coverage to uninsurable persons.

Figure 1

States Which Have Established High Risk Pools And Other Mechanisms To Insure Persons With High Risk Medical Conditions



Source: Comprehensive Health Insurance For High-Risk Individuals, Communicating for Agriculture, 1998

High Risk Pools Typically Are Established As State-Created, Non-Profit Associations Which Work Closely With The State's Insurance Regulators

In the 27 states which have created high risk pools, the pool is established in state law and typically operates as a non-profit association. The pool works closely with the state's insurance regulators, and often must have various aspects of the plan operation approved by the state's insurance commissioner. The pools are overseen by an appointed board of directors, usually including representatives from the insurance industry, consumers, medical professionals, and legislators or agency directors. Often there is some supervision of the pool by the state's insurance department.

A private, third-party administrator handles the day-to-day operation of the pool. Blue Cross/Blue Shield plans operate the pools in many of the states. Administrative costs for operating a pool obviously depend in large part on the number of enrollees. The administrative costs reported by the high risk pool states for 1997 ranged from $30,000 in Wyoming (429 enrollees) to $4.9 million in Minnesota (26,314 enrollees). Fifteen of the high risk pools incurred administrative expenses of less than $500,000; four states' administrative costs were between $500,000 and $1 million; and six states had more than a $1 million in administrative costs. Two states (Alabama and Texas just began operations in 1998 and did not report administrative cost data.) Figure 2 includes some comparative data on the high risk pools operating in 1998.

High Risk Pools Often Serve As A Temporary Source Of Insurance

In many instances, high risk pools serve as a temporary source of insurance. While some persons enroll in a high risk pool for an extended period of time, many risk pool enrollees access coverage through the pool only until they become eligible for other sources of coverage such as employer-sponsored insurance. The average time an individual spends in a risk pool is 30 months.

The Health Insurance Portability And Accountability Act (HIPAA) Of 1996 Reduces The Need For A High Risk Pool In The Small Group Market And Permits States To Use High Risk Pools As An "Acceptable Alternative Mechanism" For Certain 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 risk pool or other safety net mechanism for small groups is diminished. Accordingly, high risk pools primarily serve the individual market. (Because of the guarantee issue provisions in HIPAA, Virginia's legislation to implement these reforms also revised the Commonwealth's open enrollment program to eliminate small groups from the program. Additional information regarding Virginia's open enrollment program is provided in Section III of this report.)

HIPAA also included reforms in the individual market. For a limited number of "eligible" individuals (i.e., persons who had at least 18 months of group coverage, exhausted any applicable COBRA benefits, and converted to individual coverage), there must be some form of "guaranteed issue" coverage. HIPAA provides states with several options for meeting this requirement. One of the options allows states to use their high risk pools as a means of covering these individuals. Alabama's high risk pool, which was implemented in 1998, is limited to only HIPAA eligible individuals.

In enacting its HIPAA legislation, Virginia requires carriers to guarantee issue all products marketed in the individual market. In this way, eligible individuals are offered a wider range of benefit options.

Enrollments In High Risk Pools Vary Widely By State

Enrollment in high risk pools is a function of many factors, including the total state population, the cost of coverage, the underwriting practices of the insurance market, and the risk pool's eligibility criteria. The high risk pools in five states, California, Florida, Illinois, Oklahoma, and Utah have the authority to place a cap on plan enrollments to limit pool losses.

In 1997 – 1998, participation in high risk pools ranged from as few 198 in Alaska to as many as 26,314 in Minnesota. As shown in Figure 3, of the 27 high risk pools operating in 1998, 12 reported enrollments of less than 1,000; 11 states had between 1,000 and 5,000 enrollees; 2 states reported between 5,000 and 10,000 enrollees, and 2 states reported more than 10,000 enrollees.

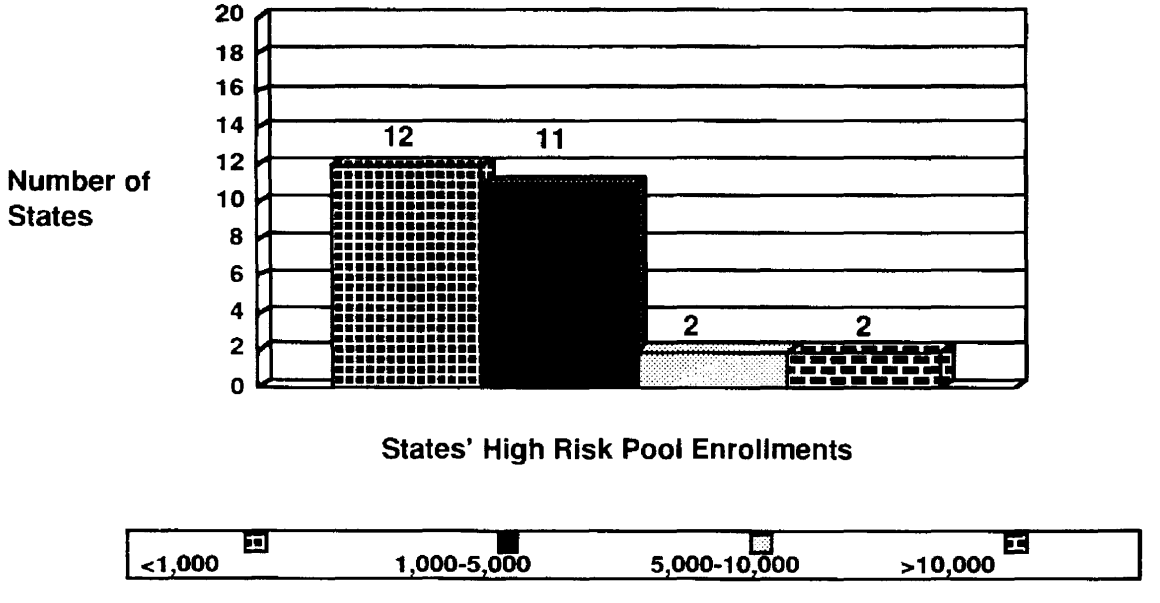
Due To The Poorer Health Status Of High Risk Pool Enrollees, The Cost Of Coverage Is Significantly Higher Than Coverage Available In The Market

High risk pools, by their very nature, provide coverage to enrollees with substantial health problems and very high medical costs. As such, the cost of covering these individuals is much greater than the cost of coverage available through other insurers. The total cost per person can be as much as 3-4 times more expensive than the premiums paid by healthier individuals who obtain coverage in the market.

Premium Caps: Due to the high cost of coverage and the inability of the enrollees to bear the full cost of their insurance, all of the state high risk pools set a cap on the amount of premiums that enrollees can be charged. Typically, the premium caps are between 125-150% of the premium charged in the private insurance market. Some states impose a graduated premium cap where the initial cap is one level (e.g., 125%) and subsequent caps are set at a higher level (e.g., 150 or 175%). Because the risk pools do not charge the enrollees the full price of their insurance coverage, each risk pool necessarily loses money. Accordingly, each risk pool requires some form of subsidy to cover pool losses.

Figure 3

High Risk Pools: 1997-1998 Enrollments



Source: Comprehensive Health Insurance For High-Risk Individuals, Communicating for Agriculture, 1998

While Most States Assess Insurance Carriers To Cover Their High Risk Pool Losses; Some States Appropriate General Funds To Subsidize Their High Risk Pool

Most states (21) assess their insurance carriers on a pro rata basis to cover the losses incurred by the high risk pool. In these states, any expenditures incurred by the pool that is not recovered through enrollee premiums is paid through these assessments. The amounts paid by the carriers through assessments include both claims expenditures and administrative costs. As seen in Figure 2, the amount of the pool assessments vary significantly, depending in large part on the level at which the enrollees' premiums are capped and the number of pool enrollees. Assessments for 1997 ranged from $0 in Alaska (200% premium cap and 198 enrollees) to nearly $48 million in Minnesota (125% premium cap and 26,314 enrollees).

Premium Tax Offsets of Assessments: Thirteen of the 21 states who assess carriers for pool losses provide a premium tax offset for their assessments. As such, while carriers in these states are assessed a pro rata share of pool losses, they are provided a premium tax credit to offset the assessment. When premium tax offsets are provided, the state ultimately is providing the subsidy to support the pool.

While most of the states which provide a premium tax offset provide a dollar for dollar credit to the carriers, some states limit the offset. For instance, Iowa offsets its assessments through a 20% tax credit each year over a 5-year period. Kansas limits its offset to 80% of the assessment; New Mexico's tax credit is limited to 30% of the assessment; and South Carolina limits its total tax credits to $5 million per year.

Several States Fund Their Risk Pools Through General Fund Appropriations And Other Revenue Sources

While most states assess insurance carriers to recoup pool losses, several states use general fund appropriations or other revenue sources. California, Colorado, Illinois, Louisiana and Utah use state appropriations. In addition, Louisiana is funded through service charges on hospital admissions ($2.00 per admission) and outpatient procedures ($1.00 per procedure). California appropriates $40 million a year from the state Cigarette and Tobacco Products Surtax Fund to subsidize pool losses. Illinois appropriated $15.3 million for the risk pool during the most recent fiscal year. The Louisiana high risk pool received $2 million in 1997 and requested an additional $2 million for 1998. The 1996 Utah legislature

appropriated $5 million each year to fund the high risk pool. While Minnesota utilizes carrier assessments, in 1997, the legislature also appropriated $15 million a year to help offset pool losses.

High Risk Pools Cannot Assess Self-Insured Or ERISA-Exempt Plans

One of the limitations of insurance carrier assessments is that states cannot assess self-insured plans that are exempt from state regulation due to the Employee Retirement Income Security Act (ERISA). Because self-insured plans cannot be assessed amounts to offset high risk pool losses, the burden of subsidizing pool losses falls entirely on the insured market. As more and more employers turn to self-insurance as a means of holding down insurance premiums, there will be a diminishing market base to fund the pool losses.

High Risk Pools Offer Comprehensive Health Insurance Benefits With Varying Cost-Sharing Provisions; Virtually All Include Lifetime Benefit Maximums; Most States Offer A Choice Of Plan Designs

High risk pools typically offer comprehensive health insurance benefits including both inpatient and outpatient care, as well as diagnostic tests and prescription drugs. All states except Indiana, include a lifetime benefit maximum. The lifetime maximums range from $300,000 to $2 million. Most states (15) have a $1 million lifetime maximum. (See Figure 2.)

Most of the high risk pools offer a choice of deductibles and out-of-pocket limits. Deductibles range from as little as $200 to as much $10,000. Many states offer two or three levels of deductibles (e.g., $500, $1,000, and $1,500).

In addition to choices of deductible and out-of-pocket limits, many of the high risk pools also offer enrollees a choice of plan design options, including traditional indemnity plans, health maintenance organizations, and preferred provider organizations.

The National Association Of Insurance Commissioners Has Adopted Model Legislation For Establishing A High Risk Pool

The National Association of Insurance Commissioners (NAIC) adopted model legislation for states to follow when establishing a state high risk pool. The NAIC urges states to determine through independent study whether a risk pool is needed. The NAIC model legislation

recommends an initial premium cap of 125-150% of the state's standard risk rates with increases thereafter limited to 200%.

The model bill also provides alternative means of funding pool losses, including carrier assessments, state appropriations, and service charges on hospital and surgical centers. The NAIC cautions states that if assessments on carriers are used to offset pool losses, the plan's effectiveness can be substantially impaired unless contributions from both insured and self-funded benefit plans can be secured. The NAIC also notes that, without the inclusion of self-funded plans, the financial base necessary to support the pooling mechanism may be insufficient.

III.
Virginia's Open Enrollment Program

Virginia's Open Enrollment Program Provides Health Insurance Coverage To Persons With High Risk Medical Conditions; Blue Cross and Blue Shield Of The National Capital Area And Trigon BlueCross BlueShield Are The Commonwealth's Two Open Enrollment Carriers

While many states have implemented a high risk pool to cover uninsurable persons, Virginia's "open enrollment" program provides coverage to a similar population. Section 38.2-4216.1 of the Code of Virginia establishes the Commonwealth's open enrollment program. Through this program, nonstock corporations are required to provide for issuance of open enrollment contracts without imposition of medical underwriting criteria whereby coverage is denied or subject to cancellation or nonrenewal due to the individual's age, health or medical history, or employment status, or, if employed, industry or job classification. Blue Cross and Blue Shield of the National Capital Area (BCBSNCA) currently is the only nonstock corporation functioning as an open enrollment carrier. BCBSNCA's service area is limited to Northern Virginia.

Section 38.2-4229.1 (D) of the Code of Virginia provides that any nonstock corporation that offers an open enrollment program shall, directly or through a subsidiary, continue to offer such program notwithstanding its conversion to a domestic mutual insurer. Further, §38.2-4229.1(D) requires any domestic mutual insurer which converts to a stock insurer to continue to offer its open enrollment program. These Code provisions were enacted by the General Assembly when Trigon BlueCross BlueShield (formerly Blue Cross and Blue Shield of Virginia) converted from a nonstock corporation to a domestic mutual insurer and eventually to a stock insurer. As such, these provisions apply only to Trigon. Trigon's service area includes the entire state except that portion of Northern Virginia which is served by BCBSNCA.

In Past Years, The Open Enrollment Program Included Coverage Provided To Small Groups And Individuals; Recent Statutory Changes Limit The Open Enrollment Program Only To Individuals

When first created, the open enrollment program included coverage made available to both small groups (2-49 employees) as well as persons purchasing coverage on their own (i.e., individual policies). The open

enrollment program formerly included small groups because they faced many of the same difficulties when purchasing coverage as did individuals.

However, as a result of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, insurance carriers participating in the small group market must guarantee the issuance of coverage to any small group, regardless of the group's health status. Inasmuch as all carriers must provide coverage to small groups regardless of health status, legislation introduced by the Joint Commission on Health Care and passed by the 1997 General Assembly to implement HIPAA also revised the open enrollment program to eliminate small groups from the types of open enrollment contracts. Accordingly, the open enrollment program now includes only coverage offered to individuals.

Virginia's Open Enrollment Program Provides Comprehensive Health Benefits To Persons Unable To Obtain Coverage Elsewhere In The Market

Because open enrollment carriers are required to issue coverage to persons regardless of their health status, the program provides a source of coverage to many persons who otherwise would not be able to purchase coverage elsewhere in the market. The open enrollment program provisions included in the Code require that the coverage offered to open enrollment subscribers be comprehensive accident and sickness insurance. Figure 4 presents a summary of the key provisions and requirements of the open enrollment program.

Trigon And Blue Cross Blue Shield Of The National Capital Area (BCBSNCA) Offer Comprehensive Coverage To Their Open Enrollment Subscribers

While the types of plans and coverage provisions vary, both of Virginia's open enrollment carriers, Trigon and BCBSNCA, offer comprehensive coverage to their open enrollment subscribers. The following paragraphs briefly describe the type and extent of the coverage.

Figure 4

Key Provisions And Requirements Of Virginia's Open Enrollment Program

- Coverage must be issued *without imposition of underwriting criteria* whereby coverage is denied or subject to cancellation or nonrenewal, in whole or in part because of a person's age, health or medical history, or employment status.

- Open enrollment contracts are *not available to any individual who is an employee of an employer which provides, in whole or part, health coverage to its employees.*

- Open enrollment contracts are *available on a year-round basis.*

- *Premiums charged for open enrollment coverage must be reasonable* in relation to the benefits and deductibles provided, as determined by the Commission.

- Each open enrollment carrier *must prominently advertise the availability of its open enrollment contracts* at least 12 times annually in a newspaper of general circulation. The content and format of such advertising must be generally approved by the State Corporation Commission.

- The State Corporation Commission *may prescribe minimum standards* to govern the contents of the coverage issued to open enrollment subscribers.

- Pre-existing conditions may not be excluded from coverage; however, *waiting periods for pre-existing conditions of up to 12 months are allowed.*

- If an open enrollment carrier elects to discontinue its open enrollment program, it may do so only with *24 months written notice* to the State Corporation Commission.

- Open enrollment carriers are required to *submit annual statements to the State Corporation Commission* regarding their open enrollment programs.

- Open enrollment carriers are required to *provide other public services* to the community including health-related educational support and training.

- Open enrollment carriers *pay a reduced premium tax* on the premium income derived from individual contracts.*

* Note: The open enrollment tax provisions are discussed in detail later in this report

Source: Sections 38.2-4216.1 and 38.2-4217 of the Code of Virginia

BCBSNCA Offers The "BluePreferred Plan" As Its Open Enrollment Coverage

BCBSNCA offers its open enrollment subscribers a preferred provider organization (PPO) plan called the "BluePreferred Plan". A separate Medicare Supplement Plan is offered to persons who qualify for Medicare due to disability. The "BluePreferred Plan" provides comprehensive coverage, including benefits for the following:

- inpatient medical and outpatient medical services;
- routine adult physicals;
- well-child care;
- laboratory tests and x-rays;
- mental health and substance abuse treatment (inpatient and outpatient); and
- prescription drugs (drug card program).

Exclusions include maternity care, dental services, eye exams, eyeglasses or hearing aids. There is no lifetime maximum benefit. Figure 5 illustrates the cost-sharing provisions, deductibles and out-of-pocket limits of the "BluePreferred Plan." The monthly premiums for the BCBSNCA open enrollment plan are as follows: self-only, $143; two-party (subscriber and child), $215; two-party (subscriber and spouse), $272; and family, $430.

Trigon Offers Both An Indemnity And HMO Plan As Its Open Enrollment Coverage

Trigon offers its open enrollment subscribers two plan options, a comprehensive major medical product (Virginia Standard) and an HMO product (HealthKeepers Individual Program). The HealthKeepers product is available only in the Tidewater and Richmond areas. In the Virginia Standard product, enrollees can receive care from any participating provider. In HealthKeepers, all services must be performed by a designated HMO provider. A separate Medicare Supplement Plan is offered to persons who qualify for Medicare due to disability.

Figure 5

BluePreferred Plan: Cost-Sharing, Deductibles And Out-of-Pocket Limits

Benefit Provision	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Cost Sharing	80%/20% coinsurance	60%/40% coinsurance
Calendar Yr. Deductible		
• ***Individual***	$750	$1,500
• ***Two-Party/Family***	$1,500	$3,000
Out-of-Pocket Limit		
• ***Individual***	$3,500	$7,000
• ***Two-Party/Family***	$7,000	$14,000

Source: BCBSNCA

Both the Virginia Standard and HealthKeepers products provide comprehensive coverage, including benefits for the following:

- inpatient medical and outpatient medical services;
- laboratory tests and x-rays;
- mental health and substance abuse treatment (inpatient and outpatient); and
- prescription drugs.

Virginia Standard Plan: The exclusions under the Virginia Standard product include maternity care, routine physicals, dental, hearing and vision services. (Riders can be purchased for an additional cost to provide coverage for dental and maternity services.) The Virginia Standard product has a $1 million lifetime benefit maximum. Once the subscriber meets his/her deductible ($750, $1,500 or $2,500), the Virginia Standard product pays 80% of covered services until the subscriber has incurred a maximum out-of-pocket expense of $5,000. (Deductibles do not

count toward the out-of-pocket maximum.) Once the maximum amount is incurred, the plan pays 100%. The premiums charged for the Virginia Standard product vary based on three factors: (i) age of the enrollee; (ii) the plan deductible; (iii) the enrollee's place of residence. Figure 6 illustrates the premiums for the Virginia Standard product.

In addition to the rates presented in Figure 6, Trigon also offers a $5,000 deductible plan with no co-insurance through the Virginia Standard Plan. The rates for this plan are slightly less than the rates for the $2,500 deductible plan listed in Figure 6.

HealthKeepers Individual Program: In addition to the basic coverage described above, HealthKeepers also provides coverage for maternity services as well as routine physicals, screening services and well-child care. The HealthKeepers product has no deductible (e.g., $750 or $1,000) and has no lifetime maximum benefit (e.g., $1 million). Copayments are required for preventive care, outpatient services, inpatient services and others (e.g., prescription drugs).

Figure 6
Trigon's "Virginia Standard" Product:
Monthly Premiums

	Area 1[1] Premiums			Area 2[2] Premiums			Area 3[3] Premiums		
Age	Deductibles			Deductibles			Deductibles		
	$750	$1,500	$2,500	$750	$1,500	$2,500	$750	$1,500	$2,500
0-25	$322	$286	$262	$293	$260	$238	$264	$235	$215
30	330	291	267	300	265	243	271	239	219
35	345	300	272	314	273	248	283	246	223
40	356	310	277	324	282	252	292	254	227
45	367	320	282	334	291	257	301	262	231
50	398	339	302	362	308	275	326	278	248
55	441	379	336	401	345	306	362	311	276
60	514	443	388	468	403	353	421	363	318

Notes:
[1] Area 1 generally includes urban areas (e.g., Richmond, Tidewater, portions of Northern Virginia)
[2] Area 2 generally includes somewhat less urban areas and localities adjacent to urban areas
[3] Area 3 generally includes more rural areas (e.g., Southwest Virginia)

Does not include coverage offered to Medicare extended enrollees.
Source: Trigon BlueCross BlueShield

Premiums for the HealthKeepers product are calculated differently than for the Virginia Standard Plan. As shown in Figure 7, HealthKeepers rates are calculated on "age group" (e.g., ages 30 – 39) rather than each specific age (e.g., age 35, age 46, etc.). Rates also are calculated by type of contract (e.g., single, subscriber + one, family).

Virginia's Open Enrollment Program Provides Coverage To Approximately 21,000 Virginians; Trigon Covers A Large Majority Of Enrollees

As of December, 1997, Virginia's open enrollment program was providing coverage to approximately 21,000 persons across the Commonwealth. As provided in the Code, open enrollment enrollees include: (i) individual subscribers, (ii) Medicare extended enrollees (persons under age 65 eligible for Medicare due to disability), and (iii) persons who converted from group coverage.

Figure 7
Trigon's "HealthKeepers Individual Program:"
Monthly Premiums

	Monthly Premiums				
Type of Contract	Age 29 & Under	Ages 30-39	Ages 40-49	Ages 50-59	Ages 60 & Over
Single	$205	$259	$320	$368	$423
Single + Minor	$310	$342	$402	$459	$555
Single + Multiple Minors	$486	$492	$516	$590	$678
Single + Spouse	$590	$597	$628	$716	$823
Family	$682	$689	$726	$827	$951

Notes

Premiums are rounded to nearest dollar.

Source: Trigon BlueCross BlueShield

As seen in Figure 8, the number of covered persons in the open enrollment program has declined from a total of 25,627 in 1994 to 20,998 in 1997, a decrease of approximately 18 percent. Individual subscribers represent approximately one-half of total enrollments; Medicare-extended enrollees represent a little less than one-half, and conversion enrollees make up only about 3 percent of total enrollments. Figure 8 also illustrates that a substantial majority of enrollees (78%) are covered through Trigon. BCBSNCA covers a relatively small portion of the state, it reported only 222 individual subscribers as of December, 1997.

Not All Open Enrollment Participants Are Uninsurable

The total number of open enrollment participants clearly includes many persons who would not be able to purchase coverage elsewhere in the market due to their high risk medical condition. However, not all participants should be considered to be uninsurable. There is an unknown number of participants who did not pass the open enrollment carrier's medical underwriting, yet likely could obtain some level of coverage from another carrier.

BCBSNCA And Trigon Provide Public Service Contributions As Part Of The Open Enrollment Program

As noted earlier, §38.2-4216.1(G) requires the open enrollment carriers to provide public services to the community including "health-related educational support and training for those subscribers who, based upon such educational support and training, may experience a lesser need for health-related care." Figure 9 presents information on the amount of community support the two plans have reported to the State Corporation Commission for the period 1994 through 1997. While a significant majority of the organizations and activities supported by the two carriers are health-related, some are not. The amount of community support reported by Trigon is far greater than BCBSNCA, however, Trigon's 1997 annual figure ($1.2 million) is only about one-half of the amount reported in 1994 ($2.2 million).

Open Enrollment Carriers Are Assessed A Lower License/Premium Tax Rate In Recognition Of The Services Provided To Uninsurable Persons

In recognition of the fact that open enrollment carriers serve as an "insurer of last resort," the Commonwealth imposes a reduced license/premium tax on a portion of the carriers' premium income.

Figure 8

Virginia's Open Enrollment Program: Enrollment Statistics, 1994-1997

	Number of Enrollees			
	CY 1994	**CY 1995**	**CY 1996**	**CY 1997**
Trigon				
Indiv. Subscribers	11,899	11,192	10,869	10,288
Medicare-Extend.	6,930	6,263	6,157	5,881
Conversions	1,095	699	461	283
Trigon Subtotal	**19,924**	**18,154**	**17,487**	**16,452**
BCBSNCA				
Indiv. Subscribers	130	92	64	222
Medicare-Extend.	4,998	4,385	4,338	4,034
Conversions	575	463	162	290
BCBSNCA Subtotal	**5,703**	**4,940**	**4,564**	**4,546**
Statewide				
Indiv. Subscribers	12,029	11,284	10,933	10,510
Medicare-Extend.	11,928	10,648	10,495	9,915
Conversions	1,670	1,162	623	573
Grand Total	**25,627**	**23,094**	**22,051**	**20,998**

Source: Annual Reports Submitted By BCBSNCA and Trigon BlueCross BlueShield To The State Corporation Commission

(Section 58.1-2501(4) applies to BCBSNCA; §38.2-4229.1(D) applies to Trigon.) Open enrollment carriers and other commercial carriers pay the same 2.25% license/premium tax on premiums derived in the group market. However, BCBSNCA and Trigon pay a 0.75% tax on premiums derived in the individual market, including their open enrollment contracts. Other carriers pay a 2.25% premium tax on these premiums. The reduced premium tax is provided to these carriers to help offset the losses incurred by insuring such a high risk population.

Figure 9

Public Service Contributions Provided By Open Enrollment Carriers: 1994-1997

	Public Service Contributions			
	CY 1994	**CY 1995**	**CY 1996**	**CY 1997**
BCBSNCA[1]	$24,360	$100,497	$135,665	$204,957
Trigon[2]	$2,155,497	$1,779,818	$1,653,134	$1,001,493
TOTAL	**$2,179,857**	**$1,880,315**	**$1,788,799**	**$1,206,450**

Notes:

1 Includes corporate contributions to area organizations, does not include employee contributions to the United Way and other organizations

2 Includes expenditures for public services to the community provided by Trigon's Department of Community Services as well as health-related educational support and training that were monetary and in-kind contributions

Source: Annual Reports Submitted By BCBSNCA and Trigon BlueCross BlueShield To The State Corporation Commission

The Reduced Premium Tax Amounts To Approximately $5.4 Million Each Year

Based on financial reports submitted by BCBSNCA and Trigon, the State Corporation Commission estimates the tax differential (i.e., the difference between 0.75% and 2.25% tax on individual premiums) to be

approximately $5.4 million annually. Because Trigon has a significantly larger base of individual premiums than BCBSNCA, the vast majority of the tax differential is attributed to Trigon. Based on 1997 taxable premiums, Trigon accounts for $5.2 million of the total $5.4 million tax differential; BCBSNCA accounts for the remaining amount.

The tax differential helps offset plan losses associated with the open enrollment population. Trigon reports that in CY 1997 it incurred an underwriting loss of $7.6 million (after accounting for interest earnings). When the reduced tax paid by Trigon ($5.2 million) is factored in, one can argue that Trigon's net loss on the open enrollment program in CY 1997 was $2.4 million. Comparable data was not immediately available from BCBSNCA.

IV.
Insuring Virginia's High Risk Population: Open Enrollment, High Risk Pool Or Other Mechanism

Senate Joint Resolution 126 directed the Joint Commission to assess whether a high risk pool, the Commonwealth's open enrollment program, or another mechanism is the best approach for providing insurance coverage to persons with high risk medical conditions. As reported in Section II of this report, high risk pools, open enrollment programs, and "guarantee issue" requirements in the individual market are the primary mechanisms that are being used across the country to ensure that persons with high risk medical conditions have access to health insurance coverage. While there may be other possible approaches to covering these persons, this section of the report assesses which of these three mechanisms represents the best course of action from the perspective of: (i) persons with high risk medical conditions; (ii) the health insurance industry; and (iii) the Commonwealth.

The Principal Concerns Of Persons With High Risk Medical Conditions Relate To The Availability Of Coverage, The Benefits That Are Offered, And The Cost Of Coverage; Open Enrollment, High Risk Pools And Guaranteed Issue Reforms All Would Ensure Coverage Is Available; The Cost Of Coverage Would Depend On Benefit Design And Funding/Subsidy Decisions

As with any health insurance purchaser, the principal concerns of persons with high risk medical conditions relate to: (i) the availability of coverage; (ii) the benefits that are offered; and (iii) the cost of coverage. The following paragraphs address each of these three concerns.

Availability of Coverage: Each of the three mechanisms (open enrollment, high risk pool and guarantee issue) provides access to comprehensive health insurance for persons with high risk medical conditions. While the coverage may vary somewhat, the benefits of the Commonwealth's open enrollment program and the high risk pools in other states are comparable. Moreover, benefit levels in high risk pools or the open enrollment program can be designed or revised to provide specific levels or types of benefits. Requiring carriers in the individual market to guarantee the issuance of coverage may broaden the number of different policies available to persons with high risk conditions. However, such a requirement also may have the unintended consequence of some carriers deciding to discontinue offering coverage in the individual

market. To the degree carriers leave the individual market, there may be an adverse impact on not just persons with high risk medical conditions, but the individual market as a whole.

Cost of Coverage: Because persons with high risk medical conditions inevitably incur higher claims expenditures, the cost to insure these persons necessarily will be greater than the cost of coverage for those without such conditions. However, the degree to which premiums of high risk persons exceed those paid by other persons depends on a number of key factors.

Comparing the cost of coverage through the current open enrollment program, a high risk pool or guaranteed issue reforms is difficult for two reasons. Firstly, the cost of coverage depends on the level of benefits and cost sharing provisions, the plan design (e.g., indemnity, HMO, etc.), and other demographic/geographic factors (e.g., age and sex of the participants, overall cost of living in the state, etc.). Secondly, the premium rates will depend a great deal on the degree to which the cost of coverage is subsidized by the Commonwealth, the insurance industry or both.

Under a guaranteed issue approach, it is assumed that each carrier would be allowed to offer various forms of coverage, as long as the policies conformed with Virginia's statutory and regulatory requirements. Accordingly, there are no data immediately available on the cost of the various coverages that would be made available through a guaranteed issue approach.

Figure 10 compares the cost of coverage (according to age) available through Virginia's current open enrollment program and the high risk pools operating in four other states. It must be noted that Figure 10 does <u>not</u> provide an "apples to apples" comparison of the two approaches. There are variations in the benefit designs, subsidy levels and demographic/geographic factors that have <u>not</u> been actuarially adjusted. The comparison of premiums is provided for illustrative purposes only.

Figure 10
Monthly Premium Comparisons: Virginia's Open Enrollment Program And Selected High Risk Pools

Age	Virginia Open Enrollment			Other State High Risk Pools			
	Trigon[1] Va. Stnd.	Trigon[2] HealthKe.	BCBS-NCA[3]	North Dakota[4]	Illinois[5]	Minne-sota[6]	Wiscon-sin[7]
<25	$286	$205	$143	$151	$203/254	$79	$126/126
30	$291	$259	$143	$183	$230/311	$87	$147/206
35	$300	$259	$143	$183	$253/345	$95	$167/224
40	$310	$320	$143	$207	$315/402	$107	$200/248
45	$320	$320	$143	$225	$394/465	$128	$254/291
50	$339	$368	$143	$252	$509/527	$158	$335/335
55	$379	$368	$143	$304	$673/597	$194	$438/383
60	$443	$422	$143	$380	$821/670	$217	$539/450
64	$495	$422	$143	$380	$821/670	$217	$539/450

Notes:

1 Indemnity; Deductible: $1,500, Coinsurance: 80/20; Maximum out-of-pocket: $6,500; Lifetime Maximum: $1 million; Area Rate: Urban

2 HMO; Deductible: $0, Coinsurance: Co-pays; Maximum out-of-pocket: $3,800 (co-pay max.); Lifetime Maximum: none; Area Rate: HealthKeepers areas only.

3 PPO "BluePreferred;" Deductible: $750 in network, $1,500 out-of-network, Coinsurance: 80/20 in –network, 60/40 out-of-network; Maximum out-of-pocket: $3,500 in network, $7,000 out-of-network; Lifetime Maximum: none; Area Rate: N/A

4 Indemnity (without optional chiropractic); Deductible: $1,000, Coinsurance: $2,000; Maximum out-of-pocket: $3,000; Lifetime Maximum: $1 million; Area Rate: N/A; Premium Cap: 135%

5 Indemnity; Deductible: $1,000, Coinsurance: 80/20; Maximum out-of-pocket: $2,500; Lifetime Maximum: $1 million; Area Rate: A/Cook County; Premium Cap: 125-150%; (Premiums are provided for male/female)

6 PPO; Deductible: $1,000, Coinsurance: 80/20; Maximum out-of-pocket: $4,000; Lifetime Maximum: $2 million; Area Rate: N/A; Premium Cap: 125-150%

7 Indemnity; Deductible: $1,000, Coinsurance: 80/20; Maximum out-of-pocket: $2,000; Lifetime Maximum: $1 million; Area Rate: Zone 1(Milwaukee); Premium Cap: 200%; (Premiums are provided for male/female)

Rates are for subscriber only coverage

Source: BCBSNCA ,Trigon; Comprehensive Health Insurance For High Risk Individuals, 1998

As seen in Figure 10, there is significant variation in the rates charged by Virginia's open enrollment carriers and the high risk pools operating in North Dakota, Illinois, Minnesota and Wisconsin. As previously noted, it is important to recognize that premiums are based on many factors, including: (i) underwriting philosophy, (ii) past claims experience, (iii) administrative costs; (iv) premium subsidies, (v) geographic cost variations, and (vi) demographic characteristics of the enrolled populations.

With respect to which program (open enrollment or a high risk pool) provides enrollees with the lower premiums, the answer varies depending on the age of the individual and the open enrollment product that is selected. In some instances, the cost of coverage through open enrollment is lower than that charged for comparable coverage in some states' high risk pools, and, in other instances, the cost is higher. The "bottom line" is that enrollees' premiums will depend in large part on the degree to which the cost of coverage is subsidized by the Commonwealth regardless of whether the coverage is offered through the existing open enrollment program or a high risk pool.

The Insurance Industry Has Mixed Views Regarding Whether Open Enrollment Or A High Risk Pool Provides The Best Mechanism For Covering Uninsurable Persons; Guaranteed Issue Reforms Are Not Supported By The Industry

The insurance industry has mixed views regarding which approach (open enrollment or a high risk pool) provides the best mechanism for covering uninsurable persons. However, the industry generally is opposed to enacting guaranteed issue reforms as a means of insuring these individuals. As argued by most insurance industry representatives, guaranteed issue requirements do nothing to address the issue of "affordability" of coverage. When guaranteed issue is combined with some form of modified community rating to hold down costs for persons with high risk medical conditions, industry representatives argue that such rating reforms will cause premiums to increase for many enrollees and will result in fewer healthier persons purchasing coverage. The end result, they claim, is that there will be a greater number of uninsured persons.

With respect to an open enrollment program or a high risk pool, there are mixed views. Under either approach, carriers (except open enrollment carriers) do not have to enroll persons with high risk medical conditions. In this respect, either approach is preferred to a guarantee issue requirement. Some carriers believe that a high risk pool is a more

efficient, more equitable means of insuring high risk persons. Even if there are assessments to recoup pool losses with no tax offset, some carriers still believe this is a more equitable approach in that assessments are made evenly among carriers. They also indicate that assessments typically amount to only one-half of one percent of premium, and, therefore, represent only a fractional increase in cost that can be spread across a carrier's book of business with little or no noticeable impact. Carriers who support high risk pools also point to the open enrollment programs in some other states which have only limited enrollment periods and which do not advertise the availability of coverage. (Virginia's open enrollment program has a 12 month enrollment period and requires BCBSNCA and Trigon to advertise the availability of coverage.)

Other carriers do not support a high risk pool and recommend leaving the current open enrollment program as Virginia's mechanism for covering high risk persons. Under the current open enrollment program, carriers are not charged assessments to cover program losses. Implementing a high risk pool, in all likelihood, would involve assessments which some carriers would prefer not to pay. Some carriers noted that, under a high risk pool arrangement, the inability to assess ERISA exempt plans insulates a large segment of the market from sharing in the cost of the pool which places a disproportionate share of the burden on the "insured" market. Those carriers which do not favor a high risk pool also point to the fact that the number of participants in the open enrollment program (20,998 in 1997) indicates that the Commonwealth already has a viable program that is serving Virginia's high risk population.

From The Commonwealth's Perspective, The Open Enrollment Program, A High Risk Pool, Or A Guaranteed Issue Mandate All Would Ensure Access To Insurance For Uninsurable Virginians, The Critical Issue Is How The Cost Of Coverage Is Shared Among The Enrollees, The Insurance Industry, And The Commonwealth

Assessing which type of program provides the Commonwealth with the best approach to covering high risk Virginians ultimately depends on the degree to which and the manner in which the cost of covering these persons is subsidized. All three approaches that have been addressed in this report (open enrollment, a high risk pool and a guaranteed issue mandate) will ensure that all high risk Virginians have access to coverage. The critical issue is how the cost of covering these individuals should be shared among the enrollees, the insurance industry and the Commonwealth.

Guaranteed Issue Approach: As noted earlier, a mandate that all carriers in the individual market must guarantee the issuance of coverage will ensure access to coverage. However, unless the cost of coverage is subsidized in some way, only those who can afford very high premiums would purchase coverage. If rating reforms are included in this approach, there are concerns that many healthy persons will discontinue their coverage leading to higher and higher premiums in the individual market.

With guaranteed issue, there would be no reason to continue the reduced premium tax break for the current open enrollment carriers. If these carriers were taxed at the same rate as other carriers (2.25%), an additional $5.4 million in general funds would be realized each year. This approach would effectively eliminate the Commonwealth's current subsidy of the open enrollment program unless a new mechanism was established for distributing this amount as a subsidy for high risk persons enrolling with various carriers. However, such a mechanism would be difficult and complex to establish and administer.

High Risk Pool: A high risk pool provides an alternative to the current open enrollment program. The benefits could be developed as desired by the Commonwealth. If a high risk pool is established in Virginia as in other states, and a bill is drafted in accordance with the model legislation drafted by the National Association of Insurance Commissioners (NAIC), there are additional administrative requirements (e.g., a board of directors, contract procurement and administration, finance/accounting responsibilities, etc.) that would have to be addressed by the pool that currently are handled by Trigon and BCBSNCA for the open enrollment program. Also, the Bureau of Insurance would have additional administrative duties related to administration of the pool.

The critical issue regarding a high risk pool is whether it provides the Commonwealth with a more preferable means of financing insurance for high risk individuals than is now the case with the open enrollment program. Through the tax preference provided to its open enrollment carriers, the Commonwealth currently provides a $5.4 million annual subsidy to the cost of covering these individuals.

Through a high risk pool approach, the Commonwealth could continue the same subsidy, increase it, or decrease it. If desired, the Commonwealth could assess pool losses to carriers and provide a maximum tax offset of $5.4 million annually. Because the current open enrollment tax break is $5.4 million annually, this would be a budget

neutral approach. Alternatively, the Commonwealth could decide to assess carriers and offer no tax offsets. In this scenario, the Commonwealth would realize a $5.4 million annual increase in general funds as a result of not providing a lower tax rate to open enrollment carriers. Finally, the Commonwealth could decide to subsidize the program by providing tax credits in an amount other than the current $5.4 million subsidy. The amount could be set at a specified amount or left unspecified.

Open Enrollment Program: Through the open enrollment program, the Commonwealth has established a viable means of providing coverage for persons who could not otherwise obtain insurance in the market. Through this program, the Commonwealth provides $5.4 million annually to help offset plan losses. Inasmuch as there currently are 20,998 persons enrolled in the program, it covers more persons than nearly all of the high risk pools established across the country. (However, as previously stated, some open enrollment participants likely could obtain some level of coverage from another carrier.)

From the Commonwealth's perspective, the key policy question seems to be as follows: is there a compelling reason to discontinue the current open enrollment program in favor of a high risk pool? In response to this question, it would appear that the only reason to move away from the open enrollment program would be to change the manner in which the cost of covering uninsurable persons currently is shared among enrollees, the insurance industry and the Commonwealth.

Except In Very Limited Circumstances, No State Currently Operates Both A High Risk Pool And An Open Enrollment Program; Administering Two Programs Would Be Duplicative

Senate Joint Resolution 126 directed the Joint Commission to analyze the practicality of administering both an open enrollment program and a high risk pool. Based on information available from states with high risk pools, except in very limited circumstances, no state currently operates both types of programs. In California, Blue Cross and Blue Shield offers an open enrollment program only for those persons on the high risk pool's waiting list.

Administering two different programs for the same population of high risk persons would be duplicative and more expensive to administer than either a high risk pool or an open enrollment program. None of the

various interested parties interviewed as part of this study identified any reason(s) for operating two programs.

V.
Policy Options

The following Policy Options are offered for consideration by the Joint Commission on Health Care. They do not represent the entire range of actions that the Joint Commission may wish to pursue.

Option I. Take no action

- This option is offered due to the fact that the current open enrollment program provides a viable mechanism for insuring persons with high risk medical conditions.

Option II. Introduce Legislation To Establish A High Risk Pool Based On The National Association Of Insurance Commissioners' Model High Risk Pool Legislation; The Current Open Enrollment Program Would Be Discontinued

- In considering this Option, it is assumed that health insurance carriers would be assessed pool losses. The following are alternatives regarding how much, if any, the Commonwealth would provide tax credits to offset carrier assessments:
-
    - **Budget Neutral:** In this scenario, the Commonwealth would provide tax credits up to an amount of $5.4 million annually.
    - **No Subsidy:** In this scenario, the Commonwealth would not provide tax credits. This would generate approximately $5.4 million annually in GF revenues as a result of discontinuing the current subsidy of open enrollment.
    - **Other Subsidy Level:** In this scenario, the Commonwealth would provide tax credits up to a specified amount other than $5.4 million annually.

Option III(A) Introduce Legislation To Require Guaranteed Issuance Of Coverage In The Individual Market With No Requirement For Modified Community Rating; Open Enrollment Program Would Be Discontinued And All Carriers Would Pay Current 2.25% Premium Tax On All Taxable Premiums

Option III(B) Introduce Legislation To Require Guaranteed Issuance Of Coverage In The Individual Market With Modified Community Rating; Open Enrollment Program Would Be Discontinued And All Carriers Would Pay Current 2.25% Premium Tax On All Taxable Premiums

APPENDIX A

SENATE JOINT RESOLUTION NO. 126

Directing the Joint Commission on Health Care, in cooperation with the Bureau of Insurance, to continue its study on the feasibility of establishing a high risk insurance pool in Virginia.

Agreed to by the Senate, February 13, 1998
Agreed to by the House of Delegates, March 12, 1998

WHEREAS, the Joint Commission on Health Care recently completed a study of high risk insurance pools and the feasibility of establishing such a pool in Virginia, pursuant to Senate Joint Resolution No. 337 (1997); and

WHEREAS, high risk pools have been established in 25 states as a means of providing health insurance coverage for small groups and individuals who, because of serious medical conditions, have been unable to purchase health insurance in the marketplace; and

WHEREAS, there are advantages and disadvantages to implementing a high risk pool; and

WHEREAS, "open enrollment" programs are used in 11 states, including Virginia and the District of Columbia, to provide coverage for uninsurable individuals; and

WHEREAS, in Virginia's open enrollment program, Trigon Blue Cross/Blue Shield and Blue Cross and Blue Shield of the National Capital Area function as open enrollment carriers and provide coverage to individuals regardless of health status; and

WHEREAS, Virginia's two open enrollment carriers reported a combined total of approximately 11,300 individuals being covered under the open enrollment program in 1995; and

WHEREAS, the actual number of uninsurable persons covered through the open enrollment program is unknown but is somewhat less than 11,300; and

WHEREAS, the Commonwealth imposes a reduced premium license tax on taxable premiums of open enrollment carriers derived from individual policies to help offset the carriers' underwriting losses incurred as a result of the open enrollment program; and

WHEREAS, the reduced license tax on open enrollment carriers amounted to approximately $5.2 million in taxable year 1995; and

WHEREAS, the Health Insurance Portability and Accountability Act of 1996 reduces the need for high risk pools or other "safety net" programs in the small group market; and

WHEREAS, a key policy issue regarding the feasibility of implementing a high risk pool in Virginia is whether such an arrangement would provide a better and more cost effective "safety net" for uninsurable person than the current open enrollment program; and

WHEREAS, 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; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care, in cooperation with the Bureau of Insurance, be directed to continue its study of the feasibility of establishing a high risk pool in Virginia. The Joint Commission's study shall include, but not be limited to, a more detailed analysis
of (i) the problems encountered by high risk individuals in obtaining affordable health insurance coverage; (ii) whether the current open enrollment program, a high risk pool, or other mechanism would best serve the needs of persons with high risk medical needs in terms of costs and benefits; (iii) which type of approach provides the best
mechanism for insuring high risk persons in terms of its impact on the health insurance market as a whole; (iv) which type of program provides the Commonwealth with the best approach to insuring high risk individuals; and (v) the practicality of administering both an open enrollment program and a high risk pool similar to the programs
operating in Colorado. The Joint Commission shall consult with various consumer advocates in conducting the study.

The Joint Commission shall complete its work in time to submit its findings and recommendations to the Governor and the 1999 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

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS: STUDY ON THE FEASIBILITY OF ESTABLISHING A HIGH RISK POOL IN VIRGINIA (SJR 126)

Individuals/Organizations Submitting Comments

A total of four individuals and organizations submitted comments in response to the draft issue brief on the feasibility of establishing a high risk pool in Virginia.

- Blue Cross and Blue Shield of the National Capital Area (BCBSNCA)
- Golden Rule Insurance Company
- Trigon, BlueCross BlueShield
- Virginia Poverty Law Center (VPLC)

Policy Options Included in the High Risk Insurance Pool Issue Brief

Option I. **Take no action**

Option II. **Introduce Legislation To Establish A High Risk Pool Based On The National Association Of Insurance Commissioners' Model High Risk Pool Legislation; The Current Open Enrollment Program Would Be Discontinued**

Option III(A) **Introduce Legislation To Require Guaranteed Issuance Of Coverage In The Individual Market With No Requirement For Modified Community Rating; Open Enrollment Program**

Would Be Discontinued And All Carriers Would Pay Current 2.25% Premium Tax On All Taxable Premiums

Option III(B) **Introduce Legislation To Require Guaranteed Issuance Of Coverage In The Individual Market With Modified Community Rating; Open Enrollment Program Would Be Discontinued And All Carriers Would Pay Current 2.25% Premium Tax On All Taxable Premiums**

Overall Summary of Comments

Trigon and BCBSNCA commented in favor of Option I. Golden Rule commented that if a high risk pool is not implemented now, a high risk pool should be considered the most reasonable alternative in the event either of the open enrollment carriers cease offering open enrollment coverage. The Virginia Poverty Law Center commented that additional study should be conducted to evaluate: (i) the degree to which the open enrollment program actually serves high risk individuals, and (ii) the high risk uninsured population and the various alternatives for providing them health insurance/health care.

Summary of Individual Comments

Blue Cross and Blue Shield of the National Capital Area (BCBSNCA)

Gail Thompson, Director of Government Affairs, commented that BCBSNCA supports Option I. Ms. Thompson noted that the open enrollment program in Virginia is an active and effective mechanism providing health insurance to persons unable to obtain coverage elsewhere. She commented that a high risk pool does not appear to provide significant benefits either as a substitute for, or in addition to, the existing open enrollment program. BCBSNCA indicated that a high risk pool would require a bureaucratic structure to maintain and operate the pool.

Ms. Thompson also stated that BCBSNCA does not support Option IIIA or IIIB due to concerns that, without a mandate for all Virginians to purchase coverage, guaranteed issue of individual coverage would result in a volatile market and would likely have a significant negative impact on the availability and affordability of coverage. Lastly, Ms. Thompson noted that before the Commonwealth undertakes a new and complicated program (i.e., high risk pool) or further market reforms, more information is needed to better understand why uninsured individuals do not seek coverage under the existing open enrollment program.

Golden Rule Insurance Company

Theodore F. Adams, III commented on behalf of Golden Rule Insurance Company. Mr. Adams stated that Golden Rule is pleased that some 10,000 Virginians obtain their health insurance through the open enrollment system. He noted that, demographically, that level of participation is about what is to be expected in any state operating either a high risk pool or open enrollment program. He commented that Golden Rule believes a high risk pool is the best long-term solution for uninsurable Virginians. He stated that should the Joint Commission choose not to recommend establishment of a high risk pool, Golden Rule urges that a high risk pool be considered the most reasonable alternative in the event that either of the open enrollment carriers ceases to offer open enrolment coverage.

Trigon BlueCross BlueShield

Leonard Hopkins, Vice President, Public Policy Officer, commented that, at this point, there is no compelling reason to discontinue the open enrollment program in favor of creating a new high risk pool or other mechanism. The current open enrollment program is overseen by the Bureau of Insurance and is effective in providing comprehensive coverage to a sizable number of Virginians regardless of their health status. Accordingly, Trigon supports Option I.

Mr. Hopkins commented that creation of a high risk pool would require establishment of a new bureaucratic structure to operate the program. He also noted that if the Commonwealth were to move to a

high risk pool, there would need to be appropriate transition provisions to protect the open enrollment carriers during the period in which they continued to cover persons enrolled under the current program. Mr. Hopkins stated that Trigon does not support Option III as it may have the unintended consequence of causing some carriers to leave the individual market.

Virginia Poverty Law Center (VPLC)

Jill A. Hanken, Staff Attorney, commented that while it is tempting to support Option I, she feels that it is premature to leave this issue at this time. Ms. Hanken indicated two concerns. First, the study was not able to determine how many open enrollment subscribers are actually high risk individuals who are otherwise uninsurable. She indicated that until there is more information on these persons, the value of the open enrollment product for high risk individuals cannot be truly understood. Secondly, she noted that the study did not attempt to develop data about the high risk population that is uninsured. Ms. Hanken indicated that until more is known about this population, an appropriate response cannot be designed.

Ms. Hanken recommended a different option . . . that the Joint Commission: (i) evaluate to what degree the open enrollment products actually serve high risk individuals; and (ii) evaluate further the high risk population to better understand who they are, their health care needs and the various alternatives for providing them health insurance/health care.

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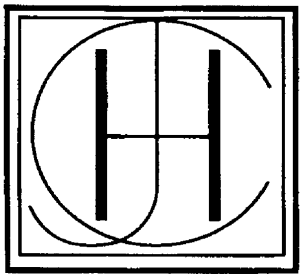

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