REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

HEALTH INSURANCE ISSUES STUDY PURSUANT TO HJR 555, HJR 601, HB 2708, HB 2304 (1995), SJR 489, AND SB 1235/HB 871

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 94

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Preface

This report responds to several study directives approved by the 1999 Session of the General Assembly. These study directives, all of which relate to health insurance issues, include:

- Senate Joint Resolution (SJR) 489 regarding pooled purchasing of health insurance coverage for small employers;
- Senate Bill 1235/House Bill 871 regarding the issue of whether insurance carriers should be required to provide direct reimbursement to providers who do not participate in their provider networks;
- House Joint Resolution (HJR) 555 regarding certain issues related to Medicare managed care plans and Medigap insurance coverage for disabled persons;
- HJR 601 regarding the feasibility of offering group insurance to self-employed individuals; and
- House Bill 2708 regarding the feasibility of licensing self-insurance associations to offer health insurance coverage to holders of medical savings accounts.

In addition to the above study directives approved by the 1999 Session of the General Assembly, this report also represents the third and final component of a three-year study required by HB 2304 (1995) regarding the impact of managed care on the availability and quality of ancillary medical services.

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

SJR 489 (Pooled Purchasing of Health Insurance)

- Health insurance purchasing cooperatives (HIPCs) have not: (i) achieved many of their original goals; (ii) significantly reduced the number of uninsured persons; (iii) established a critical mass of enrollees in other states; nor (iv) lowered premiums for employers when compared to premiums for coverage outside of the HIPC.
- An actuarial analysis conducted by William M. Mercer, Inc. as part of the SJR 489 study concluded the "best case scenario" savings of a HIPC would be about 3.5% and that the cost of creating a public HIPC seems to outweigh the potential benefits.

SB 1235/HB 871 (Direct Reimbursement to Non-Participating Providers)

- There are little or no empirical data to gauge the impact on the availability and cost of health insurance of requiring carriers to provide direct reimbursement to non-participating providers. Two independent actuaries opined that the impact would be minimal.

- Some, but not all, provider groups support requiring carriers to provide direct reimbursement. The health insurance and business communities indicate that such a provision would eliminate a key incentive for providers to join networks.
- A survey of other states indicates that only one state (Georgia) has adopted a similar law.

HJR 555 (Medicare Managed Care/Medigap Coverage for the Disabled)

- In 2000, it is anticipated that only about one-third of Virginia Medicare enrollees will have access to Medicare+Choice plans. Many seniors are confused about the Medicare managed care programs. Currently, there is limited funding for state-supported programs geared toward assisting seniors to understand their Medicare managed care options.
- The number of carriers offering Medigap coverage for the disabled is significantly smaller than the number of carriers offering such coverage to other Medicare enrollees. The premiums charged for disabled Medicare enrollees is 30%-115% greater than for other Medicare enrollees. Legislation that would have required community rating and required carriers to offer the same products to the disabled as those over age 65 was suggested by the Bureau of Insurance in 1995. Due to concerns expressed by the insurance industry, legislation was not introduced.
- There are four Medicaid assistance programs for low-income Medicare beneficiaries. These Medicaid programs (Qualified Medicare Beneficiary, Specified Low Income Medicare Beneficiary, Qualified Individual-1 and Qualified Individual-2) are designed to assist low-income Medicare beneficiaries with the cost-sharing requirements of Medicare.
- It is estimated that 55,000 persons eligible for the Medicaid assistance programs for low-income Medicare beneficiaries are not enrolled. The primary reasons include: (i) limited outreach, (ii) the stigma associated with Medicaid, and (iii) the lengthy application.
- The number of persons participating in the Medicaid assistance programs for low-income Medicare beneficiaries could be increased by modifying some of the participation requirements and the regulations regarding how these programs are administered by the Department of Medical Assistance Services.

HB 2708 (Group Self-Insurance Associations Offering Health Insurance to Holders of Medical Savings Accounts)

- A group self-insurance association (GSIA) is an association of two or more employers that pool their liability under the Workers' Compensation Act.

- The Bureau of Insurance, which provided assistance to the Joint Commission on this study, concluded that licensing GSIAs to offer health insurance to holders of medical savings accounts (MSA) would not be feasible due to: (i) financial solvency issues; (ii) joint and several liability of participating self-employed persons; and (iii) MSA/GSIAs would be subject to federal and state laws governing multiple employer welfare arrangements (MEWAs) and would require licensure as an insurance carrier.

HJR 601 (Group Insurance for the Self-Employed)

- Virginia's small group insurance laws apply to groups of 2-50 employees. Coverage is available for the self-employed in the individual market, including guaranteed issue products offered by two carriers (Trigon BlueCross BlueShield and Blue Cross and Blue Shield of the National Capital Area).
- Most insurance reforms (e.g., guaranteed renewability, limits on pre-existing condition waiting periods, and credits for waiting periods served in previous coverage) apply to both the group and individual markets.
- The advantages of including the self-employed in the definition of "small group" include: (i) more carriers and plan options would be available to the self-employed; (ii) all products in the small group market are "guaranteed issue;" (iii) modified community rating of the essential and standard products; and (iv) more favorable rating for self-employed. The disadvantages of including the self-employed in this definition include: (i) adverse selection in the small group market which would increase costs for small groups; and (ii) the potential for volatility in the individual market.
- Other states which include the self-employed in the definition of a small group report mixed results in terms of the impact on the small group and individual markets. Two independent actuaries consulted by the Joint Commission staff cautioned that including the self-employed could increase adverse selection in the small group market.

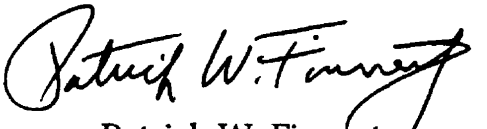
HB 2304 (Ancillary Medical Services)

- A survey of state employees and Medicaid recipients was conducted by Virginia Commonwealth University's Survey and Evaluation Research Laboratory (VCU/SERL) to determine managed care enrollees' views regarding the impact of managed care on the quality and availability of ancillary medical services.
- The VCU/SERL survey found that: (i) enrollees are satisfied with the quality and availability of ancillary medical services; and (ii) few differences exist between the responses of persons enrolled in HMO and non-HMO health insurance plans.

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the various issues discussed in this report. The policy options are presented throughout the report following the discussion and analysis of each topic.

Our review process 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 J) 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 Department of Medical Assistance Services, the Department of Personnel and Training, the Virginia Association of Health Plans, Trigon BlueCross BlueShield, Virginia Commonwealth University's Survey and Research Laboratory, the Medical Society of Virginia, the Virginia College of Emergency Physicians, the Virginia Hospital & Healthcare Association, the Coalition of the Public and Physicians (CoPPsUSA), and the Virginia Poverty Law Center for their cooperation and assistance during this study. I especially would like to thank the State Corporation Commission's Bureau of Insurance for their assistance and significant contributions to the completion of this report.



Patrick W. Finnerty
Executive Director

December, 1999

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I.
Background/Organization of Report

This report addresses six separate health insurance-related studies requested of the Joint Commission on Health Care (JCHC). Five of the studies were directives from the 1999 Session of the General Assembly. The sixth study is the final phase of a three-year study regarding the impact of managed care on the quality and availability of ancillary medical services. The ancillary medical services study was included in legislation passed by the 1995 Session of the General Assembly. Figure 1 identifies the six studies that are included in this report.

Figure 1

Health Insurance-Related Studies Included In This Report

Study Directive	Description
SJR 489 (1999)	Pooled Purchasing for Small Employers
HJR 601 (1999)	Group Insurance for the Self-Employed
HJR 555	Medicare Managed Care/Medigap Insurance for Disabled Persons
SB 1235/HB 871 (1999)	Assignment of Health Insurance Benefit Payments
HB 2708 (1999)	Feasibility of Licensing Self-Insurance Associations to Offer Certain Types of Health Insurance Coverage
HB 2304 (1995)	Impact of Managed Care on Ancillary Medical Services

Source: Joint Commission on Health Care Staff Summary

This report is organized into six sections with one section being devoted to each of the specific issues identified in Figure 1. Rather than devoting a separate section to potential policy options, as is done with most JCHC staff reports, the various policy options are included at the conclusion of each section.

II.
Pooled Purchasing For Small Employers

Senate Joint Resolution 489 of the 1999 Session of the General Assembly Directed The Joint Commission On Health Care To Develop A Pooled Purchasing Model For Small Employers

This section of the report responds to the study directive contained in Senate Joint Resolution (SJR) 489 of the 1999 Session of the General Assembly. SJR 489 directs the Joint Commission on Health Care (JCHC) to develop a pooled purchasing model for health insurance to determine if pooled purchasing could improve the affordability and availability of health insurance for small employers in the Commonwealth. The resolution called for the JCHC to hire an actuary to complete the analysis. Specifically, SJR 489 directs that the study will:

(i) identify any insurance market reforms or other statutory or regulatory changes necessary to support a pooled purchasing arrangement;
(ii) include alternative benefit designs which could be offered through the purchasing arrangement;
(iii) calculate estimated costs of the alternative benefit designs, and;
(iv) compare the estimated costs for small employers to purchase coverage through the pooled purchasing arrangement with the costs of purchasing similar coverage in the marketplace.

In addition to the actuarial analyses identified above, the resolution also directed the JCHC to form a panel of experts from the insurance, business, provider, consumer, and insurance agent communities to review and respond to the actuary's pooled purchasing model in terms of the potential for a pooled purchasing arrangement to increase the affordability and availability of coverage for small employers. As part of its review of the pooled purchasing model, SJR 489 also directed that the panel make recommendations on other possible actions to improve the affordability and availability of coverage for small employers. A copy of SJR 489 is attached at Appendix A.

Pooled Purchasing of Health Insurance Has Been Studied in the Past by the Joint Commission on Health Care as a Means of Improving the Availability and Affordability of Coverage for Small Employers

Historically, small employers (2-50 employees) have faced greater difficulty in purchasing health insurance coverage for their employees than large employers, primarily due to cost. Past surveys of the insurance status of

Virginians have shown that small employers have a significantly higher percentage of employees who are uninsured. Pooled purchasing arrangements, sometimes called health insurance purchasing cooperatives (HIPCs), have been implemented in several other states in an attempt to make coverage more affordable for small employers.

The principal objective of a HIPC is to pool the purchasing power of numerous small employers in an effort to gain greater purchasing clout in the marketplace. By joining together in a HIPC, the desired outcome is that small employers will realize many of the same purchasing advantages of a larger employer, namely: (i) more stable premiums, (ii) lower administrative costs; (iii) and a greater choice of benefit plans for employees.

Past Joint Commission on Health Care Studies: Over the past several years, the Joint Commission has conducted studies on various aspects of HIPCs to determine the feasibility of implementing such an arrangement in Virginia. The first such study was conducted in 1993 with the results being published in the Joint Commission's annual report. The Joint Commission continued its study of HIPCs in 1994 pursuant to SJR 132 of the 1994 Session of the General Assembly. The results of the 1994 study were published in 1995 Senate Document 21. The most recent study was conducted last year in response to SJR 124/HJR 202 of the 1998 Session of the General Assembly. House Document 51 (1999) contains the results of the 1998 study.

While Past Studies Analyzed Numerous Aspects Of HIPCs And Examined the Feasibility of Implementing A Purchasing Pool In Virginia, These Studies Did Not Include An Actuarial Analysis Of What Savings Could Be Realized Through Such An Arrangement

Past JCHC studies examined various aspects of HIPCs and reviewed the experiences of other states which had implemented purchasing pools. However, none of the previous studies included an actuarial analysis of the savings that could potentially be realized by small employers if they purchased coverage through a HIPC as compared to purchasing the same coverage on their own in the marketplace. Following last year's study, it was determined that, until such an analysis is completed, the true benefits of pooled purchasing could not be identified nor could an informed decision be made on the advisability of creating a pool in Virginia.

The Primary Focus Of This Year's Study Is To Develop Some Concrete Evidence On The Potential Cost Savings That Small Employers Could Realize When Purchasing Coverage Through A HIPC As Compared To Purchasing Coverage On Their Own In The Marketplace; The Bureau of Insurance Engaged Its Actuary To Conduct The Study

In response to the limitations of previous studies, the primary focus of this year's analysis is to move the debate beyond theoretical discussions of the value of a HIPC, and develop some concrete evidence of the potential cost savings that may be realized by small employers. As previously noted, SJR 489 directed the Joint Commission to hire an actuary to conduct this analysis. It was estimated that $75,000 would be required to pay for the necessary actuarial work. While a budget amendment was introduced during the 1999 Session of the General Assembly requesting the needed funds, the amendment was not approved.

Although funding for the actuarial analysis was not approved, in order to respond to the SJR 489 study directive, the Bureau of Insurance engaged its actuary, William M. Mercer, Inc. (Mercer) to perform the required actuarial services. The Joint Commission and the Bureau provided funding from their respective operating budgets to pay for Mercer's actuarial work. Due to the limited funding available to conduct the analysis, the actuarial services provided by Mercer necessarily were limited to addressing the fundamental question of the study: *what are the potential cost savings for small employers who purchase health insurance coverage for their employees through a pooled purchasing arrangement as compared to purchasing coverage on their own in the current marketplace?*

Mercer Submitted A Detailed And Comprehensive Report To The Bureau of Insurance And the Joint Commission Staff; This Report Summarizes The Key Findings And Conclusions

Mercer completed a detailed analysis of the issues contained in SJR 489 and submitted a 62-page report to the Bureau of Insurance and JCHC staff. The following paragraphs summarize the key findings and conclusions of the Mercer study.

Mercer Concluded That While HIPCs Have Had Some Successes, They Have Not Been Able To Deliver On Many Of Their Original Goals

For the purposes of its report, Mercer defined a "HIPC" as follows:

> *"A HIPC is a mechanism for small employers to join together in a larger pool of purchasers to contract with multiple insuring carriers (commercial carriers, Blue plans and HMOs) to provide a choice of medical plans underwritten by*

different carriers. In a HIPC, eligibility is open to any small employer meeting the statutory definition. While the HIPC is responsible for certain administrative functions, it does not accept any insurance risk associated with the various medical plans, and the products being offered the small groups are fully insured."

Mercer examined the results and accomplishments of HIPCs that have been formed across the nation. The following summarizes Mercer's key findings and conclusions regarding the overall performance of these pooled purchasing entities.

- HIPCs clearly have satisfied the goal of increasing employee choice of benefit plans.
- The experience in other states shows that HIPCs have been an excellent vehicle to introduce managed care to the small group market.
- HIPCs have not significantly reduced the number of uninsured persons across the country. However, there is some evidence that HIPCs have increased the number of very small employers (less than 5 employees) that offer coverage.
- The American Academy of Actuaries indicated previously that, for a HIPC to be successful in a given state, it would need to have 220,000 members or a 34% market share, whichever was greater. However, Mercer found that none of the HIPCs it had examined have achieved this critical mass.
- The premium rates for the HIPCs reviewed by Mercer were not significantly different from the premium rates outside of the HIPC.
- One of the major differences in administrative costs between large and small groups is that the level of commissions is significantly higher for small groups. Some HIPCs hoped to reduce this cost by eliminating the use of agents. However, HIPCs have discovered that agents play a critical role in the acceptance and success of a HIPC. When agents' commissions are removed as a source of savings, the potential for other significant savings is lowered.
- The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instituted a number of the market changes (e.g., guaranteed issue of products, guaranteed renewability, limits on pre-existing conditions, etc.) that HIPCs originally were conceived to accomplish.

Mercer Offered Several Recommendations For Establishing A HIPC Should Virginia Decide To Do So

While much of the experience of other states indicates that HIPCs have not achieved many of their original goals, Mercer, nonetheless, provided the following recommendations for implementing a HIPC should Virginia decide to do so.

- Experience shows that HIPCs function best in a small group market that requires the same modified community rating techniques inside and outside of the HIPC. Virginia has no modified community rating requirements other than for the Essential and Standard plans. Mercer recommended if Virginia elects to create a publicly funded HIPC, that the Commonwealth require a transition from its current rating practices to modified community rating over a period of several years. The HIPC could not be implemented until the transition was complete.
- Any HIPC should be voluntary.
- Significant capital will be required to fund the start-up costs and ongoing operations until such time that the HIPC is self-supporting. These funds could be in the form of a loan.
- The number of carriers participating in the HIPC should be limited to maximize the potential for economies of scale and minimize the potential for adverse selection. The number of benefit plans also should be limited.

Mercer Estimated That, In A "Best Case Scenario," The Maximum Savings That HIPCs Could Generate Would Be Approximately 3.5%

Based on its model of a successful HIPC, which follows the recommended actions described above, Mercer estimated that, under a "best case scenario," a HIPC would generate savings of only about 3.5%. Mercer indicated that "it is uncertain whether this savings is of sufficient magnitude to justify the costs of creating a HIPC and the resulting possible change or disruption in the marketplace. Furthermore, these savings are for a 'best case scenario.' There is a great deal of evidence that HIPCs do not result in any savings to the employer in many cases."

Mercer identified claims administration (1%), marketing costs (1%), and "contribution to surplus and risk" (1%) as the primary areas of potential cost savings that could be attributable to HIPCs.

Mercer Concluded That The Costs Of Creating A Public HIPC Seem To Outweigh The Potential Benefits

Mercer concluded its report by stating that the historical success of HIPCs has been disappointing in general. Enrollments in other states have never reached the expected levels required to enable the HIPCs to be significant negotiators in the market, and the anticipated cost savings have not materialized. Given the limited potential savings (3.5%) in a "best case scenario," Mercer concluded that "it would seem the costs of creating a public HIPC outweigh its potential benefits. In a post HIPAA environment, the time and need for HIPCs may have passed."

A Panel of Experts Reviewed And Responded to the Mercer Report

As required by SJR 489, JCHC staff formed a panel of experts from the insurance, business, provider, consumer and insurance agent communities to: (i) review and respond to the actuary's report; and (ii) make recommendations on other possible actions to improve the affordability and availability of coverage for small employers. JCHC staff sent a copy of Mercer's report to representatives of the following organizations: Virginia Hospital & Healthcare Association; the Virginia Chapter of the National Federation of Independent Business; the Virginia Chamber of Commerce; the Virginia Association of Health Plans; Trigon, BlueCross BlueShield; the Virginia Manufacturers Association; Kaiser Permanente; the Virginia Chapter of AARP; and the Virginia Association of Health Underwriters. Responses to the Mercer report were received from four of the organizations: the Virginia Association of Health Plans, the Virginia Association of Health Underwriters, the Virginia Chamber of Commerce, and the Virginia Manufacturers Association. The following paragraphs summarize the responses of these four groups.

Virginia Association of Health Plans (VAHP): In its response to the Mercer report, VAHP stated that it remains very concerned about the affordability and availability of health care coverage for small businesses. However, VAHP is not convinced that a state-mandated HIPC is the appropriate solution for addressing this problem. VAHP noted that the Mercer report provides compelling information about the lack of historical success in other states with HIPCs and that it concurs with Mercer's analysis that the costs of creating a public HIPC outweigh its potential benefits. VAHP further commented that the better policy direction for the Commonwealth would be to refrain from enacting mandated benefits which drive up the cost of health insurance for small businesses and their workers, and, ultimately add to the rolls of the uninsured.

Virginia Chamber of Commerce: The Chamber noted that while it is disappointed in the Mercer findings, it believes that the large number of uninsured Virginians and the continued difficulties experienced by small group purchasers in the current market justified the exercise. The Chamber indicated that the conclusions of the report beg the question: "if not this, then what?" The Chamber concluded its response by stating that this is the most serious health care issue in Virginia, and deserves the focused attention of the Joint Commission.

Virginia Manufacturers Association (VMA): The VMA commented that HIPCs have not lived up to their promise of facilitating inclusion of health insurance in the compensation programs of small employers, and have not stemmed the increase in the uninsured population. VMA stated that government should not prohibit the creation of HIPCs, and may even encourage it, but should not force or fund their establishment. Public policy should allow the market to determine the appropriate balance between coverage and affordability.

Virginia Association of Health Underwriters (VAHU): Representatives of VAHU commended the thoroughness of the Mercer report and commented that it was particularly encouraged to see the report's affirmation of the role of agents. VAHU restated its reservations regarding the success and potential savings presumed to be generated by HIPCs and indicated that the Mercer report confirms their conclusions. VAHU offered the following as issues to be considered by the Joint Commission in addressing the availability and affordability of health insurance for small employers:

- refrain from passing more mandates; mandates raise costs of insurance for all insureds while often benefiting few;
- work towards tax credits or subsidies for small employers (beginning with groups of 2-10 employees);
- do not expand the small group market to include groups of one, or, at a minimum, allow groups of one to be charged higher premiums than small groups;
- consider allowing part-time employees to buy into their employers' group coverage (this may require contribution and participation requirements);
- consider allowing HMOs to have deductible and copay plans with more affordable and flexible options;
- consider offering medical savings accounts (MSAs) as an option to all groups; this could be implemented initially as a pilot program with the approval of the Heath Care Financing Administration (HCFA); also, as

part of this approach the state may consider waiving some premium taxes for the commercial carriers to participate in the pilot program;
- eliminate the law that requires carriers to mail printed provider directories to all members; instead, the directory should be made available upon request; and
- encourage carriers to be flexible in their plan offerings.

Legislation Has Been Introduced In Congress To Allow The Formation of "HealthMarts"

Legislation was introduced in the U.S. Congress on September 30, 1999 which would provide for the formation and administration of "HealthMarts." H.R. 2990, referred to as the "Quality Care for the Uninsured Act of 1999," includes various provisions regarding access to health insurance coverage. Title XXVIII of the legislation would provide for the formation of "HealthMarts" which would function in many respects like a HIPC. A HealthMart would provide coverage to all small employers and eligible employees. One of the key provisions of the proposed legislation is Section 2802 (b) which provides that state laws regarding benefit mandates (e.g., requirements regarding coverage for specific providers, services or conditions, or amount, duration or scope of benefits) would not apply to HeathMarts. This would give HealthMarts a significant advantage over other carriers in a given state who must comply with various benefit mandates.

As of November 11, 1999, the House had not acted on H.R. 2990. JCHC staff will continue to monitor the status of this proposed legislation.

Two Policy Options Are Offered For Consideration By The Joint Commission on Health Care

Given the conclusions of the Mercer report and the responses of the expert panel that reviewed the actuarial analysis, at this time, only two policy options are offered for consideration by the Joint Commission regarding HIPCs. Clearly, the following two options do not represent the range of potential actions that could be taken by the Joint Commission.

- **Option I:** Take no action
    - JCHC staff would continue to monitor the status of the HealthMart legislation introduced in Congress.
- **Option II:** Introduce legislation and an accompanying budget amendment to establish a state fund which would provide some start-

up funding to assist private HIPCs that are established in Virginia and meet certain criteria and requirements. The start-up funds could be provided in the form of a loan to be repaid after the HIPC becomes operational.

- This option was offered in last year's study of HIPCs. Essentially, this option would provide a revolving loan fund that would be used to help with the start-up costs associated with implementing a private HIPC. In this way, the Commonwealth would not be operating the HIPC, but would be establishing a public-private partnership by providing some financial support for privately sponsored HIPCs.

III.
Group Insurance For The Self-Employed

House Joint Resolution 601 of the 1999 Session of the General Assembly Directed The Joint Commission On Health Care To Examine Ways To Provide Group Insurance For Self-Employed Individuals

This section of the report responds to the study directive contained in House Joint Resolution (HJR) 601 of the 1999 Session of the General Assembly. HJR 601 directs the Joint Commission on Health Care (JCHC) to "study efficient and economical ways to provide group health insurance coverage for self-employed individuals." The resolution directs the Bureau of Insurance to provide technical assistance. A copy of HJR 601 is attached at Appendix B.

The *Code of Virginia* Provides That "Group" Health Insurance Is Available To Groups Of Two Or More Employees; Group Coverage Is Not Available To Self-Employed "Groups of One"

As suggested by the term "group coverage," the *Code of Virginia* requires that at least two persons, excluding spouses or minor children (unless the spouse or child is determined to be an eligible employee of the employer), be covered under a "group" health insurance policy. Accordingly, group coverage is not available to self-employed persons who often are referred to as "groups of 1."

While Coverage Is Available To Individuals, There Are Fewer Carriers Participating In The Individual Market Than In The Small Group Market

Currently, self-employed individuals must purchase coverage in the "individual" market. In Virginia, there are several health insurers licensed in Virginia that offer individual coverage. In addition to the carriers licensed in Virginia that offer individual policies, there also are health insurance policies offered to individuals through "association type" plans. Often, coverage available through an association is issued to a group or association in another state with "certificates of coverage" provided to persons living in other states who are covered under the policy. Because of this type of "association" coverage that is issued outside of Virginia, the Bureau of Insurance cannot determine the total number of carriers who offer coverage in Virginia's individual market. However, the Bureau indicates that the number of carriers in the individual market is significantly less than the number of carriers selling coverage in the group market. The Bureau estimates that approximately 75 carriers market to small groups (2-50 employees).

"Open Enrollment" Carriers: In the individual market, carriers offering insurance policies medically underwrite persons applying for coverage. Persons who do not pass medical underwriting can be denied coverage. However, there are two "open enrollment" carriers in Virginia, Trigon BlueCross BlueShield and Blue Cross Blue Shield of the National Capital Area (BCBSNCA), which must issue coverage without the imposition of underwriting criteria. BCBSNCA's service area is limited to Northern Virginia; Trigon's service area includes the entire state except that portion serviced by BCBSNCA. Because the open enrollment carriers do not impose medical underwriting, the program provides a source of coverage to many persons who otherwise would not be able to purchase coverage elsewhere in the market. Figure 2 illustrates the number of persons covered through the open enrollment program in calendar year 1997. As seen in Figure 2, the open enrollment program provides coverage to nearly 21,000 Virginians.

Figure 2

Virginia's Open Enrollment Program:
Number of Enrollees, 1997

Type of Open Enrollment Subscriber	Number of Subscribers
Individuals	10,510
Medicare-Extended [1]	9,915
Conversions[2]	573
Total	20,998

[1] Persons under age 65 who are eligible for Medicare due to disability
[2] Persons who converted from group to individual coverage

Source: Annual Open Enrollment Reports Submitted by Trigon and BCBSNCA to SCC

The coverage available to individuals through the open enrollment program is comprehensive and includes: (i) inpatient and outpatient medical services; (ii) laboratory tests and x-rays; (iii) mental health and substance abuse treatment; and (iv) prescription drugs. Trigon offers both an indemnity and HMO plan as its open enrollment coverage. BCBSNCA offers its open

enrollment subscribers a preferred provider organization (PPO) plan. Both carriers offer various deductible/co-insurance options.

Sections 38.2-4216.1 and 38.2-4217 of the *Code of Virginia* authorize the open enrollment program. In return for issuing coverage to all eligible persons without medical underwriting, the Commonwealth imposes a lower premium tax on these carriers to offset any plan losses that result from insuring persons with costly or high risk medical conditions.

The primary benefit afforded the Commonwealth through the open enrollment program is the ability of any individual to obtain health insurance coverage, regardless of their health condition. While the rates typically exceed those of other individual policies, the additional cost reflects the higher risk of insureds in the pool.

In The Small Group Market, There Are More Carriers And A Greater Selection Of Policy Choices

The principal reason why some self-employed persons want to be eligible for small group coverage is that the small group market offers a greater choice of carriers and policy choices. In addition, whereas in the individual market, only the open enrollment carriers are required to guarantee the issuance of coverage to eligible individuals, as a result of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, all products offered by all carriers in the small group market must be sold on a "guaranteed issue" basis.

Another statutory provision that applies only in the small group market is the requirement that carriers offer two standardized products and rate them differently than other products. Sections 38.2-3431 and 38.2-3433 of the *Code of Virginia* require carriers in the small group market to offer two standardized health plans, the Essential and Standard Plans; and to rate these products on a modified community rating basis. These products must be offered in addition to any other products marketed by the carrier. However, the number of Essential and Standard policies sold in the Commonwealth is extremely small. Neither of the standardized products nor the modified community rating requirement are required of carriers in the individual market.

Most Other Insurance Market Reforms Apply To Both The Individual And Small Group Markets

Beyond guaranteed issue of all products in the small group market and the requirements associated with the Essential and Standard plans, most of the other insurance reforms have been enacted in both the individual and small group

markets. While there are minor variations in the specific language, the reforms in each market include: (i) policies must be issued on a guaranteed renewable basis; (ii) policies must adhere to limits on pre-existing condition waiting periods; and (iii) credits must be provided for waiting periods served in previous coverage.

Including The Self-Employed (i.e., "Groups Of 1") Within The Definition of "Small Group" Would Extend The Advantages of the Small Group Market To These Individuals; However, There Are Potential Problems Associated With This Action

Including the self-employed or "groups of 1" in the definition of "small group" would provide certain advantages to these individuals, namely: (i) additional choice of carriers; (ii) additional policy choices; (iii) access to the Essential and Standard plans and the associated rating reforms; and (iv) potentially more favorable rating experience.

Potential Adverse Impact in Small Group and Individual Markets: While there are advantages for the self-employed when included in the definition of "small group," there also are potential problems for other small groups and those remaining in the individual market. JCHC staff interviewed two actuaries about the feasibility of including the self-employed in the definition of "small group." Both actuaries warned that, due to greater adverse selection associated with self-employed individuals as compared to groups of 2 or more, including the self-employed in the small group market likely would increase the rates paid by existing small groups. The actuaries also cautioned that, because the self-employed tend to be the better risks among those covered in the individual market, the degree to which these persons moved into the small group market could result in a more volatile individual market and higher rates for those who continue to purchase coverage in the individual market.

In its study of pooled purchasing for small employers discussed in Section II of this report, William M. Mercer, Inc. (Mercer) indicated that if the self-employed are included among those small groups eligible to participate in a HIPC, they should be rated higher than other groups. While this would control the potential negative impact on the other groups, it also defeats one of the main reasons for including the self-employed in the small group market, which is lower premiums. Furthermore, there still would be the potential adverse impact on the individual market.

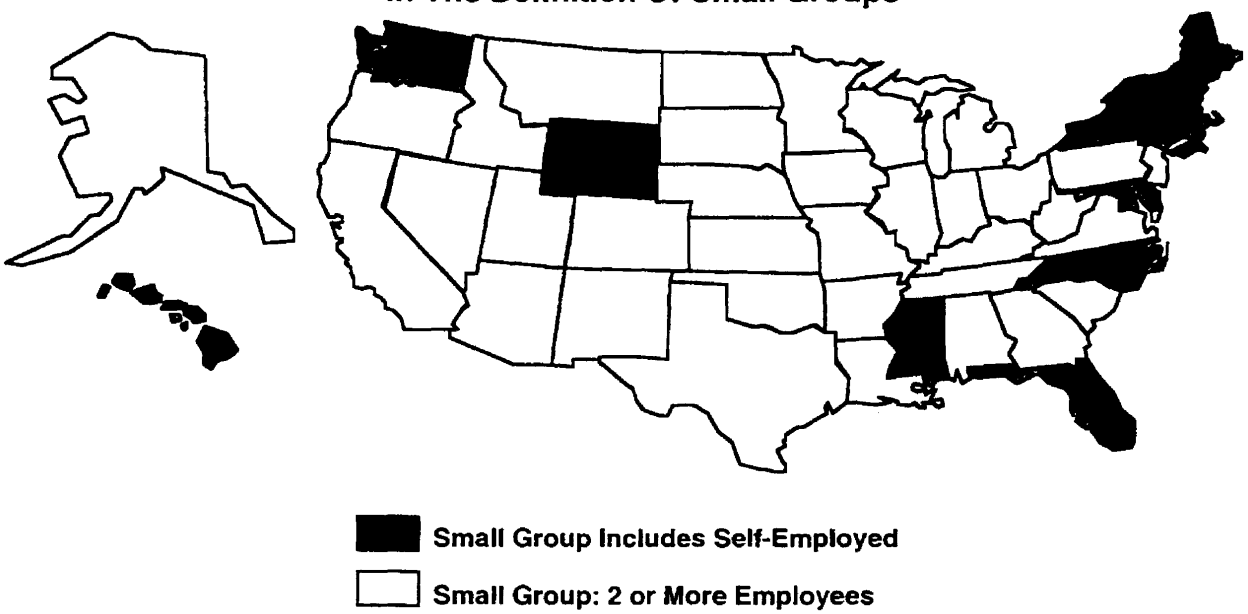
Insurance Agents Oppose Including The Self-Employed In The Small Group Market

The Virginia Association of Health Underwriters (VAHU) writing in response to the Mercer report indicated that it opposes inclusion of the self-employed in the small group market for the same reasons identified by Mercer. VAHU indicated that if the self-employed are included in the definition of "small group," they should be rated higher than groups with 2 or more employees.

Several Other States Include The Self-Employed In Their Definition Of "Small Group;" The Experience Of Other States That Include Self-Employed Persons In The Definition of "Small Group" Is Mixed

According to the National Blue Cross Blue Shield Association, 15 other states include the self-employed in their definition of "small group." Figure 3 identifies these states. JCHC staff completed telephone interviews with insurance department representatives from 10 of the 15 states. About one-half of the respondents described positive effects resulting from their statutory definition concerning the self-employed, and believe that this type of approach is advisable for other states. Others described some negative consequences associated with this public policy decision.

Figure 3
States Which Include Self-Employed Persons In The Definition Of Small Groups



Source: National Blue Cross Blue Shield Association, 1998

Five of the respondents (WA, NC, CT, MA, and DE) cited positive benefits, primarily greater access to health insurance coverage on the part of self-insured individuals, and no negative effects, as a result of their statutory provision. For example, the representative from Massachusetts stated that small group products in that state provide a greater range of prices and benefit options than do individual policies. The respondent from Delaware noted that, although the impact has been positive overall, there are still many uninsured individuals in the state.

One other state, Florida, cited both positive and negative aspects of this type of statutory change. According to the respondent, it was beneficial in that it promoted increased access to health insurance on the part of certain individuals. However, it was also negative in that it "created havoc" among carriers who claim that it has resulted in adverse selection. In Florida, carriers have gone so far as to change the commission schedules of their agents in order to discourage the writing of small group coverage for the self-employed. Many insurance agents in Florida reportedly now earn next to nothing for writing health insurance contracts for very small groups.

In Maryland, the representative indicated that some insurance agents have presented data that show including the self-employed in the small group market has resulted in a "tremendous" amount of adverse selection and that the state's largest carrier has data which show a loss ratio of 135-140% for the self-employed. The representative also noted that, while it is difficult to document, some carriers indicate they have left the market due to this issue. Maryland is reviewing the information presented by the agents and carriers to determine if any state action is warranted.

Only one respondent, from New Hampshire, expressed the opinion that this type of statutory change is not advisable. According to the respondent, this type of provision (1) promotes adverse selection, (2) places pressure on community rating, and (3) requires carriers to write policies for very small groups, which is quite difficult to do. This respondent did state that his personal opinion was probably different from the official position of the department.

The respondent from Maine stated that the department of insurance originally proposed including the self-insured exclusively in individual market, in order to strengthen that market. However, the industry wanted the flexibility to include the self-employed in the small group market, since many insurance agents believed that small group products were better for their clients. The respondent from Rhode Island did not make a clear statement regarding the advisability of this approach. Three respondents, Maine, New Hampshire and

Rhode Island, were unable to attribute any specific positive or negative impact to this type of statutory change.

There is some variation in terms of whether self-employed individuals may be rated differently than groups of two or more individuals. Four of the respondents (FL, WA, NC, and NH) prohibit different rating structures. However, four other states (RI, CT, MA, and ME) allow it. In Connecticut, Maryland and Massachusetts, insurers are permitted to adjust rating structures based on a number of factors, including the size of the group.

There is also some variation among the states in terms of whether self-employed individuals may purchase coverage in either the individual market or the small group market. In seven of the 10 states, self-employed individuals can purchase coverage in either the individual or small group market. In Massachusetts, however, 1996 legislation mandated that the self-employed may not purchase health insurance in the individual market. Maine is also somewhat of an exception, in that carriers have discretion in whether to sell a self-employed individual an individual or a small group policy. In Maine, each carrier has the option of including self-employed individuals in a small group, or placing them in the individual market.

Information Provided By VAHU Confirms The Reports Of Other States Regarding The Mixed Results Of Allowing Groups Of One

VAHU provided information to JCHC staff from the National Association of Health Underwriters (NAHU) that indicates the impact of allowing "groups of one" has been mixed. NAHU reports that while several states have experienced various problems including adverse selection in the group market and significant premium increases, others have not.

The National Association of Insurance Commissioners' Model Small Group Reform Act Includes "Self-Employed" As An Option For States To Consider

The Model Small Group Reform Act developed by the National Association of Insurance Commissioners (NAIC) provides guidance to states on how to structure their small group markets. One of the "options" listed for states is to include the self-employed in the definition of "small group." NAIC staff indicated that it does not recommend how states should address this issue; states need to decide what is best for their respective markets.

Three Policy Options Are Offered For Consideration By The Joint Commission on Health Care

The following policy options are offered for consideration by the Joint Commission regarding including self-employed persons in the definition of "small group."

- **Option I:** Take no action

- **Option II:** Introduce legislation to amend the *Code of Virginia* to include self-employed persons in the definition of "small group."

- **Option III:** Introduce legislation to amend the *Code of Virginia* to include self-employed persons in the definition of "small group." The legislation would include a provision that permitted self-employed persons or "groups of 1" to be rated higher than groups of 2 or more employees.

IV.
Medicare Managed Care And Medigap Policies

House Joint Resolution 555 of the 1999 Session of the General Assembly Directed The Joint Commission On Health Care To Examine Medicare Managed Care Programs and Medigap Insurance in Virginia

This section of the report responds to the study directive contained in House Joint Resolution (HJR) 555 of the 1999 Session of the General Assembly. HJR 555 directs the Joint Commission on Health Care (JCHC) to examine insurance options for Medicare beneficiaries in Virginia, including: (i) the availability of Medicare managed care products; (ii) the availability of Medigap policies for Medicare beneficiaries who are not yet age 65; (iii) increasing utilization of available Medicaid coverage for low-income Medicare beneficiaries; and (iv) other issues as may seem appropriate. A copy of HJR 555 is attached at Appendix C.

Medicare Provides Important Medical Security For The Elderly And Disabled

Medicare is a Federal health insurance program established in 1965 for people 65 years of age and older, certain younger disabled people, and people with kidney failure. It is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Employers and employees contribute to the Hospital Insurance (Part A) fund, while payments for Part B benefits derive from federal dollars and from monthly premiums from most beneficiaries. Most retired elderly and their spouses are eligible for Medicare Part A. A small percentage who have worked less than ten years must pay a monthly premium in order to receive benefits. Figure 4 illustrates the benefits and cost sharing in both Medicare Part A and Part B.

Medicare Only Pays For About Half Of Beneficiaries' Health Costs, And Sets No Limit On Yearly Out-Of-Pocket Expenses; It Does Not Pay For Prescription Drugs

Part B does not include coverage for routine physicals, most dental care, dentures, routine foot care, hearing aids, and most prescription drugs.

Figure 4

Benefits and Cost Sharing in Traditional Medicare	
Medicare Premiums and Covered Services	*What Beneficiaries Pay*
Medicare Part A	
Premium	$0
Inpatient hospital	$768 deductible per benefit period $0 coinsurance days 1-60 $192 per day for days 61-90 $384 per day for 60 lifetime reserve days
Skilled nursing facility	$0 coinsurance for days 1-20 $96 per day for days 21-100 Full cost for care beyond 100 days
Home health	$0
Hospice	Small payments for outpatient drugs and inpatient hospice care
Medicare Part B	
Premiums	$45.50 per month
Physician and other medical services	$100 deductible 20% coinsurance, plus up to 15% in excess of Medicare-approved services Doctors who accept assignment, and most do, cannot charge more than 100% of Medicare's approved charge.
Outpatient hospital care	20% of hospital charges
Ambulatory surgical services	20% of Medicare-approved amount
Home health	$0
Clinical diagnostic laboratory services	$0
Outpatient mental health services	50% of Medicare-approved amount
Preventive services	No deductible for annual mammograms and pap smears. No coinsurance for certain services including flu shots and pap smears.

Source: Health Care Financing Administration

Moreover, Medicare does not limit beneficiaries' total payments for cost sharing. As a result, out of pocket expenses (deductibles, co-pays, and costs of necessary services not covered by the program) can run from several hundred to many thousands of dollars per year. In 1997, the average out-of-pocket expense per beneficiary was $2,150 dollars, or 19% of average yearly income. (This does not include the cost of home health care or nursing facility services.) The proportion of income spent on health care is much higher for the poor or near poor who may spend up to 35% of their income on health care.

Medigap Supplemental Insurance Policies Help With Yearly Out-Of-Pocket Expenses, But Most Policies Do Not Result In More Services To The Beneficiary

Medigap policies are offered by private insurance companies to help defray the costs of health care not covered by Part A and Part B of Medicare. These supplemental policies are available in ten different benefits packages set according to Federal regulations. (See Appendix D for details about the different benefit options.) Yearly costs (1998 data) to elderly Medicare beneficiaries for these policies vary from about $500 for the most basic, to about $2,000 for the most comprehensive. In most states, including Virginia, rates go up with age, or if the beneficiary has Medicare due to disability. As of 1997, 62% of all elderly Medicare beneficiaries had a supplemental insurance policy. About half of these were provided by employers as part of retirement benefits.

The average cost of such a policy in 1998 was $997 per year. [Sources: Commonwealth of Virginia Bureau of Insurance; AARP Public Policy Institute] Given that most individuals with Medigap policies do not have a high-cost/high-benefit type of policy (the great majority of policies sold do not cover prescriptions, for example), it is fair to say that Medigap doesn't afford the average beneficiary more services, but rather it provides peace of mind by setting a limit on out-of-pocket expenses for many health services.

Managed Medicare Was Introduced By Congress In 1982 And Showed Considerable Growth During The Middle Of This Decade

The Health Care Financing Administration (HCFA) allowed private insurance companies to accept a risk-contract option and offer Medicare "managed care" policies beginning in 1982. Insurance companies receive 95% of the usual funds expended by HCFA for an individual living in a particular county, in return for assuming the entire risk for that individual's health care. From the government's perspective, this offers the prospect of cost savings (5% withhold), and, given good care management, enhanced health benefits to the

consumer (such as prescription coverage). As a protection against excessive profits from this arrangement, the government requires companies to return any excess funds (after reasonable expenses) to HCFA, or offer enhanced benefits to members. In practice, only the latter is used. [Source: Physician Payment Review Commission, Annual Report to Congress, 1997]

Medicare Managed Care Has Grown Considerably in Recent Years

While the initial growth of managed Medicare was modest, the rate of growth accelerated in the early 1990s. Two factors seem responsible for this trend: (i) managed care plans in the general commercial market were rapidly growing at the same time, and (ii) insurance companies who were early participants in managed Medicare found that the capitation payments in their selected markets allowed for reasonable profits. Given the historical rate of increases in the AAPCC (Adjusted Average Per Capita Cost - the rate paid by HCFA per month per person in a given county), linked to FFS (Fee for Service), plans expected to have an opportunity for continued successful business operations. In some cases, employer groups pushed for plan participation in managed Medicare so that this option was available for retirees. Other health plans saw managed Medicare as a means to increase enrollment and thereby gain leverage in negotiations with provider networks.

In Return For A Restricted List Of Providers And Other "Care Management" Features, Individuals Choosing A Managed Medicare Plan Can Receive More Services With Less Out Of Pocket Expense

Until recently, two-thirds of managed Medicare plans charged the beneficiary only the usual monthly Part B premium. In these plans, beneficiaries received significantly improved health services compared to those remaining in FFS Medicare at no added out-of-pocket cost. Increased benefits available through managed Medicare plans include additional coverage for hospital services, medications at no cost or with nominal co-pays, eye exams, ear exams, foot care, dental care, and preventive care. In 1997, the average Medicare beneficiary in FFS paid $2,454 for out-of-pocket expenses. Beneficiaries in Medicare HMOs paid an average of $1,775, and received more total benefits. [Source: AARP Policy Institute]

The Payment Formula From HCFA To Medicare Managed Care Companies Had Widely Varying Rates, And May Also Have Overpaid Because Of A Tendency For Healthier People To Choose Managed Care Options

Medicare risk contract payments are set according to anticipated costs for fee-for-service participants in the same county, adjusted for certain demographic

factors (risk adjusters) - age, sex, disability status, institutional status, Medicaid enrollment, and status as working aged. They reflect historical norms for volume and cost of medical services in a county. Disparities in payments to various counties can have an impact on the availability of managed care plans, or the quality of benefits offered by companies that offer managed care options.

The cost and volume of health services provided to Medicare beneficiaries in urban and suburban areas are greater than the national average. Demographic composition, health status, provider distribution and practice patterns, patient preferences, and funds earmarked for hospitals (graduate medical education and disproportionate share payments) contribute to an enormous range of average payment per member per month. In 1997, rural counties in Nebraska showed monthly payments of $221 (the AAPCC), while Richmond County (Staten Island), New York and Dade County, Florida had monthly payments of $767. There is also great range across metropolitan areas, with Portland, Oregon and Minneapolis, Minnesota having average rates of about $390, while New York City has an average of $680. It is important to point out that differences in costs of services account for only 13% of the variation in the AAPCC.

Wide Variations In AAPCC, Along With Great Variability In "Managed Care Penetration" In The Greater Marketplace, Have Resulted In An Uneven Distribution Of Managed Medicare Availability, And Great Variance In The Benefit Packages Offered By Those Plans

Managed Medicare plans have the biggest market presence in Washington state, California, New York, Florida, and selected metropolitan areas in other states with high managed care penetration and/or high AAPCCs. No mid-Atlantic states had counties with Medicare plan enrollment of greater than 5% of the Medicare population as of 1995. By 1998, selected counties in Southwest Virginia, Tidewater, greater Richmond, and Northern Virginia had plan enrollments of greater than 5% of the Medicare population. The point here is that managed Medicare plans have been available in Virginia in relatively limited parts of the state, and are relatively recent additions. As of 1996, enrollment in managed Medicare plans in Virginia stood at 2% of those eligible, compared to a national average of 10%. This has significance for the decisions by some plans to withdraw from managed Medicare (see BBA discussion below).

Differences In Health Status Of Beneficiaries Enrolled In Fee For Service Medicare And Managed Medicare Plans Is A Key Variable Affecting Enrollment

A final issue relates to the impact of differences in the health status of beneficiaries enrolled in fee-for-service Medicare vs. those in managed plans.

Enrollment in managed Medicare is voluntary, and studies have shown that, in all age groups, healthier people are more likely to choose a managed care option than are sicker people. Some have suggested that health plans also employ strategies to select for healthier enrollees (Neuman P, et al, Health Affairs July/August 1998;17(4):132-139). For whatever reason, the consequence is that sicker Medicare beneficiaries who generate more health costs are over-represented in the FFS population, thereby accelerating the growth in the AAPCC. Health plans with risk contracts thereby derive an even higher payment for their members, who are relatively healthier and utilize fewer services. [Source: Physician Payment Review Commission, Annual Report to Congress, 1997]

The Balanced Budget Act (BBA) Of 1997 Seeks To Control The Rate Of Increase In Medicare Costs And To Address The Problems In The Payment Formula

Given the apparent selection of healthier Medicare beneficiaries to managed Medicare plans, the General Accounting Office (GAO) stated that "many managed care enrollees would have cost Medicare less if they had stayed in the FFS sector" (GAO Report #99-91: Medicare Managed Care Plans, April, 1999). The Physicians Payment Review Commission estimated that this case selection resulted in overpayments of as much as $2 billion annually. Congress took steps to address this problem, the disparity in payment rates to various counties, and the rate of increase in Medicare expenses with the Balanced Budget Act (BBA) of 1997.

"The BBA substantially changed the method used to set the payment rates for Medicare managed care plans. As of January 1, 1998, plan payments for each county are based on the highest rate resulting from three alternative methodologies: (i) a minimum payment amount, (ii) a minimum increase over the previous year's payment [2%], or (iii) a blend of national and local FFS spending....[T]he establishment of a minimum payment rate was meant to encourage plans to offer services in rural areas." (GAO 99-91) HCFA also plans to make changes in the risk-adjustment process for determining the AAPCCs, and these plans as currently stated will reduce aggregate payments by $11 billion over the next five years. The BBA also created the "Medicare+Choice program," which allowed more kinds of managed care organizations to participate, and allowed beneficiaries to utilize medical savings accounts. However, plans participating in this new program are required to implement new and more comprehensive quality improvement programs, and must collect and report on more information to HCFA and to beneficiaries.

Significant Number Of Companies Have Withdrawn Their Managed Care Products In Response To The Changes In The BBA of 1997, But HCFA Sees This As A "Market Correction" And Does Not Currently Intend To Alter Its Payment Plans

In the Fall of 1998, nearly 100 managed Medicare plans (out of approximately 350) announced that they would withdraw entirely, or reduce their service area, citing cost concerns and increased administrative burdens under the BBA. The GAO report of April, 1999 characterizes the withdrawal of health plans from managed Medicare as a "market correction" whereby "weaker" plans decided to withdraw due to higher levels of competition and insufficient enrollment. They point out that there are many applications for new plans under the Medicare+Choice option (although none are in Virginia). The report acknowledges, however, that plan withdrawals were much more likely to occur in higher-payment rate counties, "because they anticipated that these counties will receive below-average payment increases in the coming years." The GAO also speculates that the high rate of plan withdrawal in 1998 may have resulted in part from a technicality in regulations of the BBA that allowed plans to withdraw before the Medicare+Choice plan was implemented, and be exempt from the usual 5-year wait for reentry into the same market. HCFA shares these GAO perspectives, and also emphasizes that managed care plans of all types are having a difficult time maintaining profits.

HCFA believes that the initiatives of the BBA remain justified and intends to stay the course for now. HCFA's latest report on the topic, "Medicare+Choice: Policy Concerns, Implications, and Prescription for Change" (September 24, 1999) recognizes that, "plans will restructure benefits in ways that increase enrollee out-of-pocket costs and limit coverage, particularly in relation to prescription drugs." HCFA also states that GAO studies continue to suggest that "causes other than payment rates appear to play a large role in business decisions to participate in Medicare + Choice in 2000." Seniors seem to be increasingly wary of managed Medicare as a result of these rapid changes. Even in localities where a Medicare + Choice option remains available, half of beneficiaries who were disenrolled from their Medicare + Choice plan chose to return to FFS Medicare in 1998. Such skepticism may also be part of a more general "managed care backlash."

Although the BBA tried to address the inequities in payments to rural localities, "access to managed care in rural areas will decline in 2000." In addition, "only 4% of beneficiaries in rural areas will have access to prescription drug coverage through a Medicare + Choice plan in 2000."

HCFA states that President Clinton has proposed reforms to the current Medicare plan. These changes would: (i) ensure that plans receive full payment of market-based rates, (ii) guarantee that all beneficiaries have access to affordable prescription drug coverage whether or not they live in areas where Medicare + Choice plans have chosen to provide care; and (iii) increase protection for beneficiaries when plans withdraw from the program. Current assessments are that these proposals have little or no chance of passing in this session of Congress.

The Health Insurance Industry Believes That The Rate Reductions Are Too Severe, That The New "Risk Adjustment" System Is Complex And Unfair, And That Other New Reporting Requirements Create Significant New Administrative Costs

In their response to the GAO report, the Health Insurance Association of America took issue with the conclusions, stating that "this is just the beginning of a very significant squeeze on plan rates." Their actuaries estimate that Medicare+Choice per capita payments will be down to an average of 83% of original Medicare payments, with even greater reductions in very high cost counties. They also claimed that the research on selection of healthier people into HMOs was "flawed." Overall, they saw the report as "seriously deficient in that it fails to alert Congress that, on its present course, the future of the Medicare+Choice program is in jeopardy." The American Association of Health Plans concurred with this criticism, noting also the difficulty in establishing or maintaining provider networks in the face of falling reimbursement. [Source: GAO Report 99-91, Appendices IV and V]

Provider consolidation makes this a bigger problem for health plans. As independent hospitals join forces, they gain countervailing leverage with health plans and may simply refuse to accept the lower rates and the risk associated with Medicare + Choice plans, when FFS Medicare is a ready alternative. In rural areas, hospitals are typically the only such providers in town, and so have a similar negotiating advantage.

Health plans are concerned their message that Medicare+Choice is in trouble is being interpreted by HCFA and Congress as simply a desire for higher payments. They see no indication of significant action in response to their concerns.

Virginia Health Plans Share The Views Of The National Organizations; Two Major Carriers In Virginia Have Decided To Withdraw Entirely From Medicare Managed Care; Only Three Carriers Will Continue To Offer Managed Medicare Plans

The Virginia Association of Health Plans concurs with the perspectives and concerns expressed by the national associations. As noted above, many of Virginia's managed Medicare plans were new in the market, and had few enrollees in some counties and cities. These factors, along with overall concerns about falling reimbursement and increased administrative costs, led Virginia Beach-based Optima Health Plan and Richmond-based Trigon BC/BS to withdraw entirely from Medicare managed care effective December 31, 1999, affecting 16,665 enrollees in the Tidewater and greater Richmond areas. About 14,000 have no other Medicare + Choice option and must return to FFS Medicare (with the option of purchasing additional Medigap insurance). Cigna continues to offer Medicare + Choice products in both the Richmond and Northern Virginia areas. Kaiser Permanente continues with a plan in Northern Virginia, and John Deere Health Plan is available in a limited area of Southwest Virginia.

Appendix E shows the AAPCC rates for selected Virginia counties and cities in which managed Medicare plans operated in 1997. The tables indicate that from 1997 to 1998, payments to hospitals in these selected counties dropped by an average of 10%, while payments for Part B increased by an average of 26%. Part B includes both physician services and home health care. The AAPCC rates reflect very slight increases in payments of 2-3% in 1999. The increases certainly were less than the increase in costs for hospitals and other providers during this time. The projected rates for 2000 for these selected counties and cities show an increase of 4% and 7% for Parts A and B, respectively. The rate changes in Tidewater were no worse than for Richmond or Northern Virginia, so it appears that the decisions by Cigna and Kaiser to stay in might be a reflection of their national, rather than regional presence.

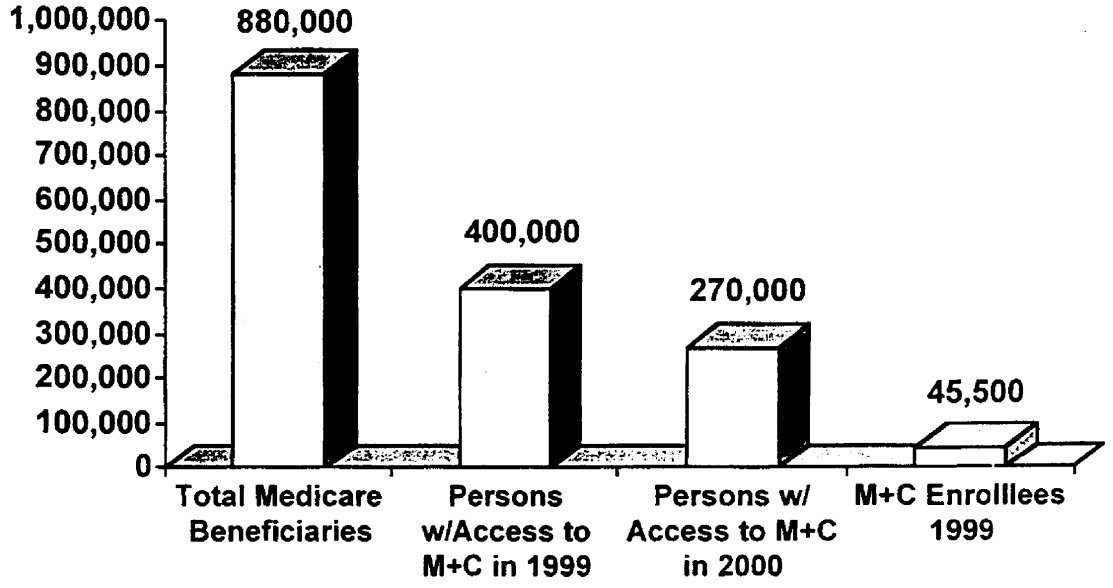
This Year, Nearly Half Of All Medicare Beneficiaries In Virginia Had The Option Of Choosing A Managed Care Plan. Because Of Plan Withdrawals (Particularly In Tidewater), That Proportion Will Drop To About 30%. Currently About 11% Of Those With Access To A Medicare + Choice Plan Have Chosen To Enroll

As seen in Figure 5, Virginia has approximately 880,000 people enrolled in Medicare. About 17,000 more are added each year. However, in 1999 only 400,000 Virginians live in counties or cities with access to managed Medicare plans. The number of Virginians with access to Medicare + Choice plans will decrease to 270,000 on January 1, 2000. As of July, 1999, only 45,500 of those with

access (11%) had selected a managed Medicare plan from one of five insurance companies offering these policies. The declining access to Medicare + Choice plans in Virginia (that is, the number who no longer have access vs. the total number previously enrolled in any Medicare + Choice plan) was 31% - among the highest in the nation.

Figure 5

**Total Medicare Enrolled in Virginia vs.
Persons With Access to Medicare + Choice Plans And Actual Enrollment**



Source: Health Care Financing Administration, Bureau of Insurance

Virginia Has Several Programs In Place That Can Respond To The Questions And Concerns Of Citizens Enrolled In Or Considering Managed Medicare Plans

Elderly and disabled beneficiaries are confused by the complexity of the options before them, and by the changes in costs and benefits in both the Federal and private insurance plans. HCFA has responded by including educational information in its new Medicare website (www.medicare.gov), and by setting up offices in each state with toll-free "800" numbers to advise Medicare beneficiaries on insurance choice. In Virginia, this State Health Insurance Assistance Program (SHIP) resides in the Department for the Aging as the Virginia Insurance Counseling and Assistance Program (VICAP). HCFA has $15 million to support these programs in all 50 states.

VICAP subcontracts with Virginia regional Area Agencies on Aging (AAA) offices to deliver this program. Because of the limited funding, the AAAs only receive $5,600 each for this program, and must rely upon considerable input from local volunteers in order to serve the counseling needs of local elderly and disabled. VICAP estimates it served about 3,000 clients last year. HCFA is currently planning additional nationwide educational programs, and may increase funding for state counseling programs.

The newly created Managed Care Ombudsman within the Bureau of Insurance helps any Virginian with a problem related to health care within a managed insurance plan. There is no age restriction on this service, so one may anticipate that the majority of those helped will be non-Medicare enrollees. The service is too new to gauge the impact on the Medicare managed care problem. The Bureau also provides free information to the public on Medigap policy options and rates. Upon request, the Bureau makes available copies of HCFA's "Guide to Health Insurance for People with Medicare."

The Virginia Department for the Aging has 25 Area Agencies on Aging throughout the Commonwealth. They deliver numerous services, including the Virginia Insurance Counseling and Assistance Program (VICAP) in which volunteers counsel the elderly and disabled on insurance questions and problems.

The Arlington Area Agency on Aging received a two-year grant from the Arlington Health Foundation to create the Northern Virginia Medicare Managed Care Ombudsman Program. This program "helps Medicare beneficiaries to resolve problems with managed care plans, and in turn helps the health care system to function more effectively." (Ms. Terri Lynch, Director, Arlington AAA) In addition to extensive one-on-one advising and problem-solving, the ombudsman conducts numerous local and regional workshops, and serves as a technical advisor to other AAAs in the state. The Arlington AAA estimates that the ombudsman saved local beneficiaries about $30,000 in a six-month period in 1999. This program appears to be the only one of its kind in the nation.

Policy Options

Because Medicare is a federal government program, state policy decisions can have only a limited affect on improving the availability of Medicare + Choice plans. Despite the uncertainties in the managed Medicare market, consumers may want to consider those options that remain in Virginia because of the rapidly rising costs of Medigap insurance and the increasing out-of-pocket expense in FFS Medicare. Specific policy options are offered at the end of this

section of the report addressing potential ways to increase consumer awareness and education about Medicare managed care.

Given The High Out Of Pocket Expenses Associated With Medicare, Disabled Beneficiaries In Virginia Need Options For Controlling Those Costs

As stated earlier, "Medigap" (Medicare supplemental insurance) policies were an initiative of private insurance companies to offer coverage and limit risk to beneficiaries under Medicare Parts A and B. Federal standards were first established in 1980 that covered guidelines for marketing, penalties for abuses, and expected loss ratios (payouts/premiums). Further legislation in 1988 required insurers to report their loss ratios to the states, and OBRA 1990 standardized and set a maximum of 10 types of Medigap policies (see Appendix D).

There are no Federal requirements that insurance companies must offer Medigap policies to Medicare beneficiaries under 65 without medical underwriting. The only Federal regulations that pertain are those that (i) make managed Medicare plans (where available) open to enrollment by Medicare beneficiaries under 65 under the same conditions as elderly Medicare enrollees, (ii) mandate that all Medicare beneficiaries who disenroll from a Medicare + Choice plan due to plan withdrawal or to moving out of a service area must have access to at least a basic Medigap policy, and at the same rate regardless of age, sex, or health status, and (iii) mandate that disabled Medicare beneficiaries who reach age 65 have a 6-month open enrollment period for obtaining a Medigap policy, and that they are issued a Medigap policy regardless of disability or other health reasons. [Source: HCFA's 1999 Guide to Health Insurance for People with Medicare]

Although 62% of Medicare beneficiaries nationwide have some kind of Medigap policy, recent trends in premiums raise concern about the ability of both individual and group purchasers (i.e., employers) to afford such coverage. For example, premiums for community-rated, guaranteed issue policies offered through AARP rose 26% in 1996, and another 13% in 1997. [Source: Physician Payment Review Commission, 1997 Annual Report to Congress]

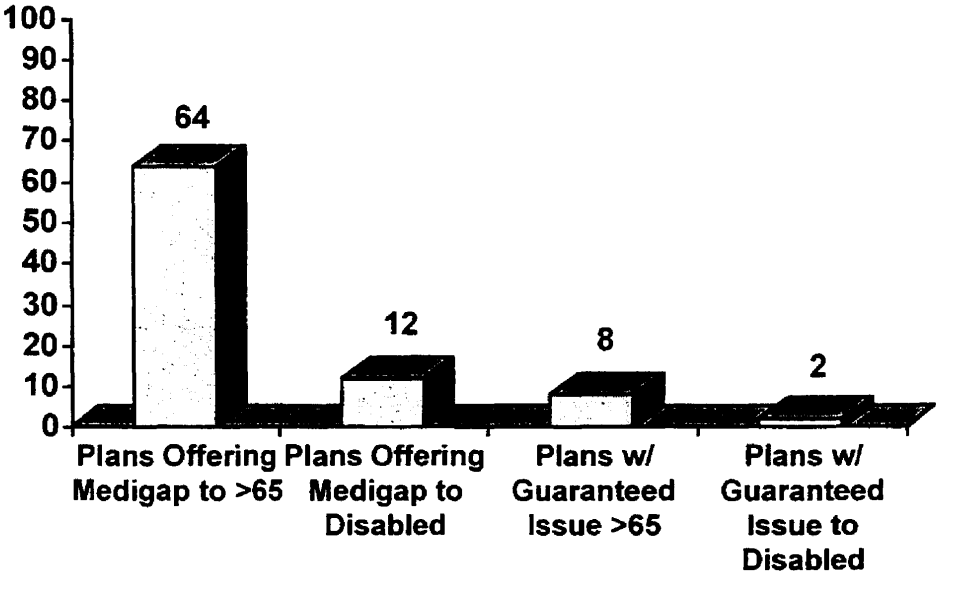
About a third of disabled Medicare beneficiaries are also enrolled in Medicaid, either through eligibility for supplemental security income [SSI] payments, or because their high medical expenses enable them to qualify as a "medically needy" individual. The remainder must consider options of Medigap insurance, managed Medicare (where available), or using FFS Medicare.

Disabled Virginians On Medicare Have Far Fewer Options For Medigap Policies, And Must Pay A Significantly Higher Premium Than Their Elderly Counterparts For The Same Type Of Policy

HCFA data for July, 1998, indicate that approximately 122,000 disabled Virginians were enrolled in Medicare Part A. The 10 Medigap policy options described in Appendix D can be offered to disabled Medicare beneficiaries. However, few companies offer these products. As of October, 1999, 64 companies offered Medigap policies in Virginia to Medicare beneficiaries over 65, and 8 offered policies without medical underwriting ("guaranteed issue"). Only 12 of these companies offered Medigap policies to Medicare beneficiaries under 65, and only two offered guaranteed issue options (Figure 6).

Figure 6

Health Plans Offering Medigap Policies



Source: Health Care Financing Administration, Bureau of Insurance

Premiums vary by company, plan type, age of beneficiary, use/non-use of medical underwriting, and whether the beneficiary has Medicare due to disability. The two plans that offer guaranteed issue Medigap policies for those under 65 and disabled are BC/BS of the National Capital Area (BCBSNCA) and Trigon BC/BS. These policies are offered as part of the "open enrollment"

program in Virginia. BCBSNCA markets its policies in Northern Virginia; Trigon markets throughout the remainder of the state. As such, there is only one guaranteed issue Medigap product for disabled persons in each area of the Commonwealth. The BCBSNCA and Trigon policy types and rates are shown in Figure 7, with comparison to the same companies' rates charged to older beneficiaries for the same policy types (again with no medical underwriting).

Figure 7

Premiums for BCBSNCA and Trigon Medigap Policies Offered on Guaranteed Issue Basis

	1999 Annual Premium		
Company Name/Type Policy	**Policy A**	**Policy C**	**Policy F**
BC/BS NCA, Age 65	$1,134	$1,821	$1,834
BC/BS NCA, Age 75	$1,195	$1,917	$1,931
BC/BS NCA, Disabled	$1,588	$2,549	$2,568
Trigon BC/BS, Age 65	$600	$1,164	$1,176
Trigon BC/BS, Age 75	N/A	N/A	$1,956
Trigon BC/BS, Disabled	N/A	N/A	$2,532

Source: Trigon, BCBSNCA, Bureau of Insurance

Figure 7 shows that BCBSNCA has higher rates for disabled Medigap than for Medigap at 65 or at 75. Their average rates for Policy options A, C, and F for the disabled are 40% higher than the same policies sold to 65-year-olds, and 33% higher than those sold to 75-year-olds.Trigon has fewer policy options (only one option with no medical underwriting for the disabled or older elderly), and charges 29% more to a disabled Medicare beneficiary than to one aged 75, and 115% more than that charged to a beneficiary at age 65. The major reason for the large differences in premiums is that the disabled category includes those who have Medicare because of end-stage renal disease (kidney failure), and expenses for these individuals are much higher each year than for any other Medicare group.

Companies must apply for and receive approval for rate changes from the State Corporation Commission's Bureau of Insurance. By Federal statute, the Bureau of Insurance must ensure that the "loss ratio" (Payouts/Premiums) is kept above 65% for individual Medigap policies, and above 75% for group Medigap policies, regardless of whether they are being sold to the elderly or to the disabled.

Rates For All Medigap Policies Have Increased By At Least 10% Per Year In Recent Years; Medigap Coverage Can Consume A Significant Portion Of A Disabled Person's Monthly Income; No Medigap Policy Available To The Typical Disabled Virginian Affords Any Coverage For Medication Costs

Rates for Medigap policies in Virginia typically increased by 9-10% between 1998 and 1999, with some policies increasing by 20 or 30%. No Medigap policies for the disabled in Virginia offer any coverage for prescription drug costs, regardless of medical underwriting, except for the Mennonite Mutual Aid Association, which restricts its polices to members. [Source: Commonwealth of Virginia, Bureau of Insurance]

Chronically disabled persons with no other source of income receive monthly payments that vary according to age at onset of benefit, prior yearly earnings, and whether the disabled has a spouse and dependents. They range from $797 per month for a 25 year old who was making $20,000 per year to $2,262 per month for that same individual if previously making $62,700 per year and supporting a spouse and child. These benefits continue so long as the disabled person is unable to do "substantial" work (that is, independently earn at least $500 per month). [Source: Social Security Administration]

For a disabled individual receiving $797 per month, a Medigap policy in Virginia offered with no medical underwriting would cost $132 per month for the most basic coverage (Part A and Part B coinsurance expenses), and $211per month for a policy that added coverage for deductibles, skilled nursing coinsurance, and foreign travel emergencies. Medically underwritten policies could be significantly less. With the exception of the Mennonite coverage noted earlier, none of these policies would pay for any prescription costs.

Disabled Virginians on Medicare can enroll in a managed Medicare plan if one is available. Such plans cannot discriminate among enrollees based on disability or any other prior conditions once the post-enrollment waiting period (no more than six months) has expired. However, should such an individual lose coverage by a Medicare +Choice policy due to plan withdrawal, that individual must be offered a Medigap policy by the same company, and at the same rate charged to elderly beneficiaries.

Some States Require Yearly Open Enrollment For Medigap Policies, And A Few Require "Community Rating," So That All Enrollees Pay The Same Rate Regardless Of Their Age Or Disability

About 15 states mandate an open enrollment period of six months every year for disabled persons seeking Medigap policies. This is in contrast to the procedure followed by Virginia and the majority of other states which offer open enrollment: (i) at the time of first receiving Medicare due to disability, (ii) upon reaching age 65, or (iii) upon losing coverage from a Medicare + Choice plan (all of which are Federal mandates). States with open enrollment still generally allow differential charges for disabled Medigap policies vs. Medigap for the elderly.

Six states (New York, Washington, Minnesota, Massachusetts, Maine and Connecticut) require community rating for all Medigap policies, which means that the disabled pay the same for a Medigap policy as do elderly of any age. It is generally believed that while this approach reduces the cost for disabled persons, its increases the cost for the elderly. Whether this would represent higher costs for the elderly over the life of the policy is not known at this time, but could be determined with further study. At least one state – Pennsylvania – takes a "middle ground" approach and requires that Medigap policies offered to the disabled be priced the same as those offered to 65-year-olds, but allows for higher premiums for the older elderly. The office of the insurance commissioner for Pennsylvania was not aware of any negative reaction to this statute from consumers or insurance companies.

In 1995, The Bureau Of Insurance Suggested Legislation Be Considered To Require Carriers To Offer the Same Range Of Policy Options To The Disabled As The Over Age 65 Population And To Require Community Rating For All Medigap Policies; The Insurance Industry Opposed The Community Rating Proposal

A community-rating proposal was made in 1995 by the Virginia Bureau of Insurance, as well as a proposal requiring the same range of policy options for both the elderly and the disabled. At that time, the Bureau anticipated certain effects on the public and on the insurance industry as noted in the following 1995 statement: "Those eligible for Medicare by reason of disability would have available to them a far greater choice of Medicare supplement coverage at premiums which are less expensive than now charged. Persons eligible for Medicare by reason of age would pay somewhat increased premiums. The industry would need to change their method of making available Medicare supplement coverage and their methodology for determining premiums."

The Joint Commission on Health Care requested public comment on the Bureau's proposal in 1995. Several insurers and insurance organizations expressed concern about the proposal. The Health Insurance Association of America (HIAA), the Virginia Association of HMOs (VAHMO), now the Virginia Association of Health Plans, Trigon, and BCBSNCA indicated that charging one premium (i.e., the community rating proposal) would increase premiums for the largest Medicare segment – the elderly. HIAA and VAHMO suggested further study of the impact. BCBSNCA did not oppose making the same plan types available to both the elderly and the disabled, but did oppose community rating. Trigon did not oppose the proposal. No legislation was introduced, and to date no further study has occurred.

The Elderly Poor Pay A Very Large Portion Of Their Monthly Income On Medical Expenses, And Nearly Half Of Virginia's Medicare Beneficiaries Are Low Income

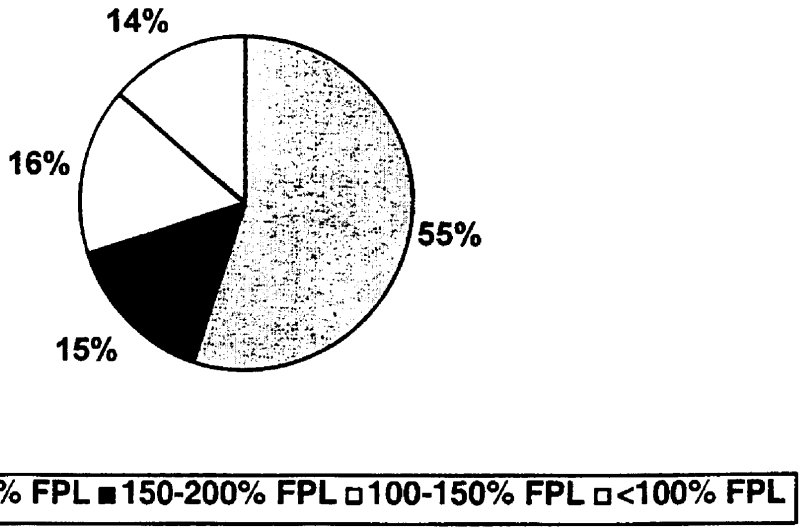
Medicare pays for only about half of all medical costs for beneficiaries. As indicated earlier, out-of-pocket expenses can amount to 35% of total income for the poor, and consume about 22% of income for near poor and low income individuals. Of the 880,000 Medicare beneficiaries in Virginia, about 400,000, or 45%, have monthly incomes below 200% of the federal poverty level. Low income beneficiaries are especially vulnerable; they are nearly twice as likely to report their health status as only fair or poor. [Source: Kaiser Family Foundation] Figure 8 illustrates the percentage of Medicare beneficiaries (national numbers) in relation to the federal poverty level.

Low Income Medicare Beneficiaries Are Less Likely To Have Private Supplemental Coverage Than Are Medicare Beneficiaries Overall; They Are Less Likely Than Higher Income Medicare Beneficiaries To Be Offered Employer-Sponsored Retiree Coverage, And Individual Medigap Policies Are Often Prohibitively Expensive; However, There Are Federal/State Programs That Can Help A Portion Of The Low Income Elderly With Medical Expenses

Congress created the Qualified Medicare Beneficiary (QMB) Program in 1988 that required states to "buy in" to Medicare Part A and Part B for Medicare beneficiaries who had minimal resources and incomes below the poverty level. Congress expanded this program in 1993 by creating an additional state buy-in requirement for individuals with slightly higher incomes and minimal resources:

Figure 8

Medicare Population by Poverty Level



Note: "Poverty level" in 1999 is defined as $687 per month for individuals and $922 for couples.
Source: Kaiser Family Foundation

the Specified Low Income Medicare Beneficiary (SLMB) Program, which pays for Part B premiums only. Finally, under the BBA of 1997, Congress created a five-year block grant providing funds for states to pay all or part of the Part B premium for two additional groups of qualifying individuals (QIs). Beneficiaries can also qualify for full Medicaid support if they are SSI beneficiaries or "Medically Needy." Figure 9 summarizes the eligibility requirements for these programs and their benefits.

Figure 9

Medicaid Eligibility for Low-Income Medicare Beneficiaries

Beneficiaries Receiving Full Medicaid Benefits		
	Income Test	**Resource Test**
SSI Beneficiaries*	<=$500/mo for individual <=$751/mo for couple	<=$2,000 for individual <=$3,000 for couple
Medically Needy	State sets income standard; individual may "spend down" to qualify by deducting incurred medical expenses from income.	State sets resource standard; individual may not "spend down" or dispose of resources to qualify.

Beneficiaries Receiving Medicaid Assistance with Premiums and Cost Sharing				
Category	**Family Income**	**Resource Test**	**Medicaid Pays**	**Entitle-ment?**
QMB	<100% FPL	$4,000 individual $6,000 couple	All Medicare premiums and cost sharing	Yes
SLMB	100-120% FPL	$4,000 individual $6,000 couple	Medicare Part B monthly premium	Yes
QI-1	120-135% FPL on a first come, first served basis	$4,000 individual $6,000 couple	Medicare Part B monthly premium	No (subject to annual Federal cap)
QI-2		$4,000 individual $6,000 couple	Portion of monthly Part B premium ($1.14 per month)	No (subject to annual Federal cap)

*Virginia is one of 11 states (so called "209b states") that does not automatically qualify SSI individuals for Medicaid, but rather uses somewhat more restrictive standards. This also requires Virginia to establish a Medically Needy pathway for Medicaid eligibility.
Note: "Poverty level" in 1999 is defined as $687 per month for individuals and $922 for couples.
Source: Kaiser Family Foundation

A Significant Proportion Of Those Eligible For These Programs Are Not Enrolled

"Although the state QMB and SLMB buy-in programs do not result in Medicaid coverage per se (such as coverage for prescription drugs and long-term care), they do aid in the financial well-being of low-income Medicare beneficiaries." (AARP Policy Institute) However, not all who are eligible are enrolled. Using data from multiple studies, the number of Medicare beneficiaries eligible in Virginia for full or partial assistance from Medicaid vs. the number enrolled in these programs is illustrated in Figure 10.

Figure 10

Low-Income Medicare Beneficiaries In Virginia Eligible For and Receiving Full or Partial Assistance From Medicaid

Characteristic	Estimated Number in Virginia
Total Medicare beneficiaries	880,000
Number at or below 120% FPL	230,000
Number enrolled in QMB/SLMB/QI	140,000
Number enrolled in other DMAS programs[1]	35,000
Eligible but not enrolled in QMB/SLMB/QI	55,000

Notes:
[1] This estimate includes elderly and disabled on Medicaid and in institutions (eg, nursing homes), non-institutional on Medicaid, and Medically Needy
* Some numbers differ from figures published by the AARP Policy Institute and by Families USA
Source: HCFA, US Census, and Virginia DMAS

Various Studies Have Suggested Multiple Barriers To Enrollment; Barriers To Enrollment In Virginia Include Lack Of Public Awareness, No Organized Outreach Programs, And A Complex Enrollment Process

Various studies have suggested different possible reasons for low enrollment in Medicaid assistance programs for low-income Medicare beneficiaries including: (i) lack of knowledge about the program; (ii) lack of understanding about the benefits of the program; (iii) stigma associated with

applying for a Medicaid ("welfare") benefit; and (iv) barriers in the application process, such as lengthy and complex application forms.

JCHC staff are not aware of any survey data specific to Virginia on this issue. However, interviews with individuals in DMAS, the Department for the Aging, and advocacy groups for the elderly suggest the following:

- There is no specific statutory requirement for outreach activities towards this population by DMAS or any other state agency.
- Because Virginia is like the majority of states and continues to require means-testing for QMB, SLMB, and QI programs, the same eligibility form is used that evaluates eligibility for full Medicaid benefits. This form is 14 pages long, and counselors from state AAA offices say that it can take up to three hours of their time to assist an individual to complete the application.
- Rural counties have a relatively higher proportion of poor, and therefore eligible, Medicare beneficiaries, yet the local Departments of Social Services serving these counties may have fewer resources for intake, much less outreach activities.

Other States Have Used Several Strategies To Address Barriers To Enrollment

Outreach by mass mailing to all Medicare beneficiaries is expensive and appears to be relatively ineffective. An alternative used by 19 states (including Maryland, North Carolina and South Carolina) is to obtain a data base called "QMB leads data." HCFA screens newly entitled Medicare beneficiaries to determine whether their income from Social Security is within the income standards of the QMB program. The data base is updated monthly and shows the potential QMB eligibles' Medicare claim number, Social Security number, name, address, and county code. This allows for directed mailings to individuals most likely to qualify.

Outreach Messages: To be effective, outreach messages need to address the psychological barriers to enrollment. The most successful have two basic messages:

- The QMB/SLMB programs can put much needed money back into a family's pocket to pay for other essentials, such as prescription drugs, food, and rent.
- The QMB/SLMB programs provide a benefit that people have earned by working hard all their lives; it is not a government "handout." [Source: AARP Public Policy Institute]

Grassroots Outreach: These efforts appear to be the most effective in educating and informing people about the programs. In some other states, local

AAAs, using the equivalent of the VICAP program, are staffed to perform aggressive local outreach and enrollment activities. This often requires one-on-one work with eligibles.

State government officials acknowledge that states lack incentives to support the QMB/SLMB programs. States are currently faced with other priorities in their Medicaid programs, including implementation of CHIP programs, welfare reform, and Medicaid managed care.

Virginia Medicaid Costs Would Increase If More Who Are Eligible Actually Enrolled, But It Is Also Possible That The Resulting Improved Access To Basic Health Care Could Reduce State Costs In The Long Run

There is some uncertainty about the number of eligibles but not yet enrolled in Virginia; JCHC staff estimate a figure of 55,000 for this report. It is unrealistic to expect that all of them would enroll, even with the most comprehensive and aggressive outreach and enrollment programs. It is estimated that an effective outreach program would result in perhaps 50% of the 55,000 eligible but not enrolled persons enrolling in the program. Most of those eligible but not yet enrolled are in the SLMB category (perhaps 75% of the total), which costs the state about $273 per person per year. Each added QMB might cost the state about $1,000 per year. With these assumptions, the estimated cost to the state (not including added administrative costs) for enrolling approximately 27,500 individuals in the QMB/SLMB program is about $12.5 million annually.

It is possible that because QMB/SLMB coverage removes barriers to care, enrollees would more likely receive preventive care and other primary care services, which may lead to future reductions in hospitalizations, and delays in nursing home care (which is financed largely by Medicaid). If eligibles are enrolled in QMB, they may not be forced to spend down their resources due to uncovered hospital expenses, which may in turn keep them off the role of full Medicaid beneficiaries. Finally, by "buying in" to Medicare Parts A and B, the state Medicaid program is no longer the payor of first resort for providers. Unfortunately, there are no studies available which explore how much these forces actually reduce Medicaid costs.

DMAS Is Considering Options For Improving Public Awareness Of The QMB/SLMB Programs

There have been very limited outreach initiatives in the past; however, DMAS is participating in new HCFA activities on this topic. DMAS will be distributing about 50,000 brochures to VICAP, SSA, and DSS offices explaining

the program and encouraging enrollment. HCFA has set a target of increasing state-level enrollment in QMB/SLMB/QI programs by 4% per year. HCFA is also working to develop strategies for outreach, enrollment, and eligibility simplification, in part by identifying best practices in collaboration with the states. Virginia DMAS personnel will be appraised of these suggestions through participation in ongoing conferences and by direct mail and phone contact with HCFA officials. The Social Security Administration is also conducting trials of new strategies to increase enrollment. [Source: Interviews with DMAS officials; GAO Report HEHS-99-61]

AAAs and their VICAP counselors are aware of the need to encourage enrollment among poor elderly clients, and incorporate this into their routine contacts with these individuals. Some of the AAAs utilize local papers and group functions to educate the public about the QMB and SLMB programs. AARP reports that it plans to begin an outreach program on the Eastern Shore of Virginia regarding the QMB/SLMB programs and other public benefit programs.

Current State Policies May Create Delays In Enrollment For Some Of Those Eligible For The QMB Program

Some elderly individuals have not worked a sufficient number of calendar quarters in Social Security-covered employment to qualify for free Part A premiums. Their monthly cost to buy Part A will be $170 if they worked 30-40 calendar quarters, and $309 if they worked fewer than 30 quarters. Many of these individuals are likely to rely on SSI, whose payment is only about 75% of the FPL. For such individuals, the monthly premium for Part A is prohibitive. The QMB program requires Part A participation for eligibility. Therefore, these individuals may qualify for full Medicaid services, yet not receive Medicare coverage for Part A services.

Individuals who cannot afford Part A can still enroll in Part A by allowing the state to complete their QMB application. However, federal regulations only allow for such individual enrollment during the 7 months surrounding the 65th birthday, and between January and March every year thereafter. HCFA allows for an exception to this regulation if the state is buying the Part A premium (as part of a QMB program), but only if the state has an agreement with HCFA to do so. Virginia is one of 12 states that have no such agreement. This means that an individual who qualifies for the QMB program may wait as long as 16 months for the full benefits of that program. This delay may discourage some from enrolling. Expanding the enrollment period as is done in most other states may have a fiscal impact on the Medicaid program; however, further analysis is needed to develop an accurate estimate.

Virginia Employs Stricter Criteria For Medicaid Eligibility Among Supplemental Security Income (SSI) Recipients Than Most Other States

Aged and disabled persons who qualify for SSI may not qualify for Medicaid because Virginia, as a "209b state," uses more restrictive resource requirements for Medicaid eligibility for these individuals than it uses for SSI eligibility. Specifically, Virginia counts more contiguous property for those applying for Medicaid with SSI, than does the Social Security Administration (SSA) in determining eligibility for SSI. On the other hand, Virginia allows for a larger set-aside for burial expenses for these individuals than does the SSA.

The "Medically Needy" Option For Obtaining Medicaid Coverage Requires A "Spend Down" Of Income To 37% Of The Federal Poverty Level

Virginia is one of 35 states that allows individuals to qualify for Medicaid on the basis of being "medically needy," even though their monthly income is higher than SSI. However, these individuals must "spend down" their income (not their resources) in order to qualify. The level of net income they need to reach – the "Medically Needy Income Level" (MNIL) - in Virginia is set at between $216 and $400 per month, depending upon where the individual lives, and whether the income supports one or two people. These income levels are about 37% FPL.

During the 1999 Session of the General Assembly, Senator Maxwell introduced SB 1333 which would have established a new category of Medicaid eligibility for aged and disabled individuals with incomes up to 100% of the FPL. (The SSI income level is approximately 75% of the FPL.) A fiscal impact statement prepared during the 1999 Session estimated the state's share of such a change to be approximately $25 million annually. SB 1333 was not approved by the General Assembly. If there is a desire to increase the number of aged and disabled persons eligible for Medicaid, consideration could be given to setting a new category of eligibility at a level somewhat below that which was proposed by SB 1333, such as 80% of FPL. This would increase the amount of income an eligible aged or disabled person could have by about $33 per month above current levels. To determine the cost of such an approach would require further analysis; however, given that the estimated cost of establishing the new category at 100% of FPL (SB 1333) was $25 million; the cost of setting the eligibility level at 80% of FPL likely would be approximately $5 million.

Several Policy Options Are Offered For Consideration by the Joint Commission on Health Care In Addressing The Issues Of Medicare Managed Care, Medigap Policies And Increasing Utilization Of Available Medicaid Coverage For Low-Income Medicare Beneficiaries

The following Policy Options are offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this section of the report. The options do not represent the entire range of potential actions that could be taken by the Joint Commission.

Medicare Managed Care Issue

- **Option I:** Take no action

- **Option II:** Introduce a budget amendment to provide funding for additional managed care ombudsmen at selected AAAs throughout the Commonwealth to provide counseling services and other information for Medicare beneficiaries.

- **Option III:** Introduce a budget amendment (language and funding) directing the Department for the Aging to develop a public information campaign, in cooperation with the local Area Agencies on Aging, specifically geared toward assisting Medicare enrollees understand their Medicare plan options.

Medigap Supplemental Insurance Issue

- **Option I:** Take no action

- **Option II:** Introduce legislation to require Virginia insurers to offer the same range of Medigap policy options to all Medicare beneficiaries, regardless of whether the prospective purchaser has Medicare by reason of age or disability.

- **Option III:** Introduce legislation to require Virginia insurers to community rate all Medigap policies, regardless of whether the prospective purchaser has Medicare by reason of age or disability.

- **Option IV:** Introduce legislation to require Virginia insurers to use the same rates for policies offered to 65-year-olds and disabled, but allow higher rates for the elderly over age 65 at the time of policy purchase.

- **Option V:** Introduce legislation providing an annual six month open enrollment period for all Medigap policies, regardless of whether the prospective purchaser has Medicare by reason of age or disability.

Medicaid Assistance for Low-Income Medicare Beneficiaries

- **Option I:** Take no action

- **Option II:** Introduce a budget amendment (language only) directing DMAS to utilize "QMB leads" data to target mailings to potentially poor elderly Virginians who may be eligible for Qualified Medicare Beneficiary (QMB) benefits through Medicaid.

- **Option III:** Introduce a budget amendment (language only) directing DMAS to examine the possibility of using a simplified form for determining eligibility for the QMB/SLMB/QI programs.

- **Option IV**: Introduce a budget amendment (language only) directing DMAS to report to the Governor and General Assembly on how it plans to achieve the Federal targets of increasing QMB/SLMB enrollment by 4% each year during the next biennium.

- **Option V:** Introduce a resolution encouraging Virginia's aging community, the faith community, and other advocacy and provider organizations to include information in their publications and activities that would educate their members about Medicaid assistance programs for low-income Medicare beneficiaries.

- **Option VI:** Introduce a budget amendment (language and funding) directing the Department for the Aging to develop a statewide outreach program, in cooperation with the Department of Medical Assistance Services and local Area Agencies on Aging, for educating Virginia's poor elderly about the Medicaid assistance programs for low-income Medicare beneficiaries.

Other Issues Regarding Medicaid Assistance for Low-Income Elderly and Disabled Virginians

- **Option I:** Take no action

- **Option II:** Introduce a budget amendment (language only) directing DMAS to establish an agreement with HCFA that would extend the current annual three-month enrollment period for enrolling in Part A coverage through the QMB program.

- **Option III:** Introduce a budget amendment (language only) directing DMAS to assess the financial and programmatic impact on the Medicaid program of discontinuing its "209B" status.

- **Option IV:** Introduce a budget amendment (language and funding) to establish a new category of Medicaid eligibility for the aged and disabled with incomes up to a given level such as 80% of FPL.

V.
Assignment of Health Insurance Benefits

Senate Bill 1235 and House Bill 871 of the 1999 Session of the General Assembly Direct The Joint Commission On Health Care To Examine The Impact Of Prohibiting Health Insurance Carriers From Refusing To Accept Assignment of Benefits

During the 1999 Session of the General Assembly, legislation was passed which contained a number of managed care-related provisions. Included in the provisions of Senate Bill 1235/HB 871 was a requirement that health insurance carriers accept assignment of benefits. This provision is contained in proposed §38.2-3407.15 of SB 1235/HB 871 as follows:

§38.2-3407.15 (A): "No insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, no corporation providing individual or group accident insurance subscription contracts, no health maintenance organization providing a health care plan for health care services, and no dental services plan offering or administering prepaid dental services shall refuse to accept or make reimbursement pursuant to an assignment of benefits made to a health care provider or hospital by an insured, subscriber, or plan enrollee, provided that if the health care provider or hospital obtain such an assignment of benefits, then the health care provider or hospital shall accept the reimbursement under such assignment as payment in full for the services covered by such assignment and shall not charge or bill the insured, subscriber, or plan enrollee any further amount except for the amount of any applicable deductible, copayment or coinsurance."

§38.2-3407.15 (B): "For the purpose of this section, "assignment of benefits" means the transfer of health care coverage reimbursement benefits or other rights under an insurance policy, subscription contract or health care plan by an insured, subscriber or plan enrollee to a health care provider or hospital."

§38.2-3407.15 (C): "This section shall not apply to an assignment of benefits made to a dentist or oral surgeon."

Study Mandate: While the above language was included in SB 1235/HB 871, the fourth enactment clause of the legislation stated that these provisions would not become effective unless reenacted by the 2000 Session of the General Assembly. The enactment clause also stated that "Prior to the 2000 Session of the General Assembly, the Joint Commission on Health Care and the Bureau of

Insurance shall review the financial impact that the enactment of these sections will have on health care costs, health insurance premiums, and the availability of health care in the Commonwealth." A copy of §38.2-3407.15 and the study language incorporated into SB 1235/HB 871 is attached at Appendix F.

Dental Services/Benefits Are Not Included in Study: As noted above, §38.2-3407.15(C) states that the provisions of this section do not apply to an assignment of benefits made to a dentist or oral surgeon. As such, this review of the impact of this section does not address dental issues. (SB 1235/HB 871 included a separate provision [§38.2-3407.13] which prohibits carriers from refusing to accept assignment of benefits made to a dentist or oral surgeon. This provision does not include a "no balance billing" requirement that is part of the §38.2-3407.15 language related to medical and hospital benefits.)

Providers Who Participate In Network Plans Agree To Accept The Insurer's Reimbursement As Payment In Full And Do Not "Balance Bill" Patients For Amounts That Exceed The Plan's Reimbursement

Health insurance plans (e.g., health maintenance organizations [HMOs], preferred provider organizations [PPOs], and point-of-service plans [POS]) provide direct reimbursement to those providers who participate in their provider network(s). Providers who participate in networks agree to accept the plan's reimbursement as payment in full, and not bill patients for any amount of charges that exceeds the plan's reimbursement. When plan enrollees receive services from a non-participating provider, some plans provide an "out-of-network" level of reimbursement to the provider; others send the appropriate benefit amount to the enrollee who then is billed by the provider for the services. In many instances, enrollees who receive services from non-participating providers are "balanced billed" for the amount of the provider's charge that is not covered by the insurer's reimbursement amount.

Impact of Networks on Providers: For providers, one of the advantages of participating in a provider network is being able to receive direct reimbursement from the plan rather than having to bill patients for payment. While the reimbursement amount generally is lower than the providers' normal charge for a service, receiving direct reimbursement is an important consideration for many providers. Further, participation in provider networks also increases patient volume which helps offset any reduction in reimbursement agreed to as part of the network participation contract. While providers receive direct reimbursement from carriers and have increased patient volume by participating in networks, they also must agree to comply with various contractual obligations such as credentialling requirements, utilization review,

referrals and pre-authorization for certain services, and other care management requirements.

Impact of Networks on Enrollees: For enrollees, one of the most significant advantages of receiving services from a participating provider is the financial protection of not being billed for any charges above the plan's reimbursement amount. Because a provider's charge often can exceed the plan's level of reimbursement by a significant amount, receiving services from a participating provider is an important financial safeguard for patients. Other advantages of receiving services from network providers include: (i) not having to file claims for reimbursement, (ii) knowing that network providers have been credentialled by the plans; and (iii) having referrals and pre-authorizations handled by the provider. However, some enrollees resent having to see network providers in order to receive the highest level of benefits afforded by their health insurance plan. For those enrollees whose provider does not participate in their plan's network, they either must switch to a provider in the network or receive a lower level of reimbursement for receiving care outside of the network. (In closed panel HMOs, enrollees receive no benefit outside of the network except in the case of an emergency or other special circumstance.)

The "Assignment Of Benefits" Provision of SB 1235/HB 871 Would Require Health Insurance Plans To Provide Direct Reimbursement To Non-Participating Providers

Assignment of benefits is a process whereby the patient agrees to transfer or "assign" the payment of any insurance benefit to the provider rather than receiving the benefit directly and then paying the provider. Section 38.2-3407.15 of SB 12235/HB 871 would require health insurance plans to accept an enrollee's "assignment of benefits," and provide such direct reimbursement to all providers, including those with whom the plan has no contractual agreement. As noted above, providing direct reimbursement to providers is one of the key advantages of participating in a network. According to insurance companies, having to accept an enrollee's "assignment of benefits" to a non-participating provider would eliminate one of the key benefits of joining a network and could affect adversely their ability to form viable provider networks.

There Are No Empirical Data To Show The Potential Impact Of the "Assignment of Benefits" Provision of SB 1235/HB 871; JCHC Staff Were Unable To Find Any Previous Studies on This Issue

The study mandate for the Bureau of Insurance and the JCHC is to review the financial impact that §38.2-3407.15 will have on health care costs, health insurance premiums and the availability of health care in the Commonwealth.

Inasmuch as §38.2-3407.15 is not yet effective, there are no Virginia-specific data available that can be used to estimate the impact of this provision.

JCHC staff contacted several organizations to determine if any previous studies on this issue had been conducted. Staff contacts included the National Association of Insurance Commissioners (NAIC), the American Association of Health Plans (AAHP), the National Conference of State Legislatures, the National Governor's Association, the National Academy for State Health Policy, the American Medical Association, and the American Hospital Association. None of these organizations had conducted or were aware of any studies on this specific issue. In addition, a literature search produced no previous studies or reports on this specific issue. (Numerous studies, reports and articles have been published on POS requirements, any willing provider laws and freedom of choice laws; however, none specifically address the assignment of benefits issue.)

A Survey of Other States Indicates That Only A Few States Have Passed Laws Regarding Assignment of Benefits

The Bureau of Insurance surveyed all 49 other states to determine how many have enacted similar assignment of benefits laws. A total of 26 states responded to the Bureau's survey. JCHC staff contacted the remaining 23 states which had not responded to the Bureau.

In total, responses were obtained from 31 states. Of these 31 states, 26 indicated that they had not passed laws similar to §38.2-3407.15 in SB 1235/HB 871. Four states, Alaska, Maine, Missouri, and Tennessee responded that their statutes included a provision requiring plans to accept assignment of benefits but that the requirement was limited to network providers. One state, Georgia, responded that its legislature recently passed a similar law to Virginia; however, regulations have not been promulgated and the law is not yet in effect.

It must be noted that, in some instances, it was difficult to determine exactly what statutory provisions exist in other states due to the complexity of insurance laws and the variations in terminology used across the country. Nonetheless, based on the survey conducted by the Bureau and the JCHC staff, it appears that there has been little legislative activity in this area across the nation.

The Medical Society of Virginia Supports The "Assignment of Benefits" Provision of SB 1235/HB 871

Representatives of the Medical Society of Virginia (MSV) indicated that it believes medical providers should be able to receive assignment of benefit payments directly from carriers when filing insurance claims on behalf of the

patient regardless of the provider's network participation status. At the MSV's recent annual meeting, the following resolution was passed regarding this matter.

> *"RESOLVED, that the Medical Society of Virginia support legislation in Virginia that physicians or other health care providers who file insurance for their patients and who have an appropriately executed Assignment of Benefits directly receive insurance reimbursement for their medical services from the payer whether or not they are participating providers with the insurance plan. And be it further*
> *RESOLVED. Additionally, the MSV delegation to the AMA should address this issue nationally."*

The MSV resolution does not specifically reference §38.2-3407.15 or the reenactment of this provision; however, it is clear from the resolution that the MSV supports reenactment of the assignment of benefits language in SB 1235/HB 871. The MSV resolution also is silent on the issue of prohibiting "balance billing" by providers.

Emergency Room Physicians Indicate The "No Balance Billing Provision" Of §38.2-3407.15 Has A Particularly Adverse Effect On Their Practices

Representatives of emergency room (ER) physicians interviewed by JCHC staff indicate that the "no balance billing" provisions of §38.2-3407.15 will have a particularly adverse impact on their ER practices. In most respects, ER physicians work very similarly to other physicians. However, one distinguishing characteristic that applies only to ER physicians is that they must treat emergency patients in accordance with a federal law that requires ER physicians to treat all patients who need care, regardless of their ability to pay or insurance coverage.

Federal EMTALA Provisions: The federal law referenced above, often referred to as the "anti-dumping law," is part of the Emergency Medical Treatment and Labor Act (EMTALA). This law was passed by Congress in 1985 to prevent hospitals/ER physicians from refusing to treat patients or transferring them to other hospitals because they are unable to pay or are covered by Medicare or Medicaid. EMTALA requires ER physicians to: (i) provide a medical screening examination to determine whether an emergency medical condition exists; and (ii) provide treatment to stabilize the patient if an emergency medical condition exists. EMTALA provisions also require that this care not be delayed by questions about methods of payment or insurance coverage. ER physicians indicate that because of the EMTALA provisions, the

"no balance billing" provision of §38.2-3407.15 places an additional burden on them because they cannot turn individuals away.

The principal concern of the ER physicians is that the out-of-network reimbursement paid to them by insurance plans is too low, and that they need to be able to balance bill patients in order to receive an appropriate level of reimbursement. (JCHC staff were unable to analyze the level of out-of-network reimbursement for ER physicians in comparison to other types of providers.) Currently, ER physicians balance bill patients who are enrolled in plans that they do not participate with. Given that EMTALA prohibits ER physicians from re-directing patients to other providers when they do not have a contract with the patient's health plan, ER physicians indicate that they will have more patients than other providers for whom they cannot balance bill. As such, ER physicians are opposed to reenacting the current provisions of §38.2-3407.15. They argue they should be able to receive direct reimbursement and balance bill patients. If not able to receive direct reimbursement and balance bill, ER physicians would prefer that §38.2-3407.15 not be reenacted, or that they be exempted from this provision as are dentists and oral surgeons.

The Virginia Hospital & HealthCare Association Believes Assignment of Benefits Is Not an Area in Which State Law Should Apply

The Virginia Hospital & HealthCare Association indicated in an interview with JCHC staff that assignment of benefits is a contractual matter between health plans and individual providers and that it is not an area where state law should apply. VHHA staff indicated that it believes §38.2-3407.15 should not be reenacted.

The Business Community Has Concerns Regarding The Potential Impact That The Assignment of Benefits Provision May Have On the Cost of Health Care and Health Insurance Premiums

JCHC staff interviewed representatives of the Virginia Chamber of Commerce and the Virginia Chapter of the National Federation of Independent Business (NFIB) to obtain their input into this issue. The Chamber expressed concern that the assignment of benefits provision of SB 1235/HB 871could hinder health insurers' ability to establish cost-effective provider networks, and that if the balance billing provision is deleted, the financial impact on consumers would be significant. The NFIB representative expressed concern regarding the impact on consumers if the "balance billing" provisions is deleted.

AARP Also Expressed Concern Regarding The Potential For Eliminating The "No Balance Billing" Provision

As noted by the business representatives, AARP also expressed concern regarding the impact on consumers if the "no balance billing" provisions were to be deleted in any reenactment of §38.2-3407.15. AARP indicated that the network protection against balance billing is an important issue for consumers and helps to hold down costs.

Insurers Indicate That The Current Provisions of §38.2-3407.15 Will Have A Negative Impact on Their Ability to Form Effective Provider Networks, And That The "No Balance Billing" Provision Is The Most Critical Issue

Representatives of the Virginia Association of Heath Plans (VAHP) expressed concern that the assignment of benefits provisions of §38.2-3407.15 will adversely affect their ability to develop cost-effective provider networks. As stated earlier, offering direct reimbursement to providers is one of the key incentives used by health plans to encourage provider participation in networks. Few managed care health insurance plans accept an assignment of benefits made to a non-participating provider. Provider contracts typically involve physicians, hospitals, and others agreeing to accept a lower level of reimbursement than their normal charges in return for increased patient volume and the ability to be paid directly by the carrier for services rendered to plan participants. However, if required to provide direct reimbursement to all providers, including those who do not participate with the plan, health plans argue that a significant advantage of network participation is removed, and, as a result, providers will be less inclined to participate. Moreover, the plans indicate that they effectively would be functioning as a "collection agent" for those providers with whom they have no other contractual relationship.

The plans posed the following question to illustrate their concern: *"why would a provider want to participate in a network and adhere to the contractual requirements of participation such as discounted fees, credentialling, and utilization review when they can get one of the most significant advantages (i.e., direct reimbursement) without having to join?"* This concern is similar to that raised in health plans' opposition to "any willing provider" laws which require plans to include in their networks any provider willing to accept the terms and conditions of network participation.

Quality Aspects of Provider Networks: The plans noted that networks provide a level of assurance to their enrollees that the providers from whom they receive care are credentialled and meet certain quality standards that non-participating providers may not meet. Should fewer providers participate in

their networks as a result of the assignment of benefits provision, enrollees will be receiving care from a greater number of providers who have not met these quality standards. Moreover, the plans point out that, to the degree they are less able to develop networks, they also will be less able to respond to several provisions of §32.1-237.1 et. seq. of the *Code of Virginia* that relate to holding plans accountable for health outcomes. The argument here is that should fewer providers participate in their networks as a result of §38.2-3407.15, the plans will have less ability to "assess, measure and improve the health status of covered persons" as required in §32.1-137.2(C) of the *Code of Virginia*.

Balance Billing: The greatest concern expressed by the health plans was the possibility that the "no balance billing" provision would be deleted from §38.2-3407.15. While the carriers indicated that §38.2-3407.15 would adversely affect their ability to develop effective provider networks, they believe the current provisions likely would not directly increase costs to any significant degree as long as the "no balance billing" provision remained in force. Currently, the vast majority of Virginians are covered under insurance plans that do not allow participating providers to balance bill for charges that exceed the plan's level of reimbursement. Therefore, extending direct reimbursement to non-participating providers along with a "no balance billing" provision is not expected to increase costs in any significant way. However, the plans argue that if the "no balance billing" provision is deleted and non-participating providers are able to bill patients for amounts that exceed their charges, there would be a significant impact on costs, and that the impact would be on consumers. Figure 11 illustrates the differences in consumer payments when receiving services from a provider who can balance bill.

The plans argue that if §38.2-3407.15 is reenacted and the "no balance billing" provision is deleted, consumers will be faced with greater health care costs. The plans' basis for this argument is that if non-participating providers can receive direct reimbursement from the plan (albeit lower than that of a participating provider) and balance bill patients, there will be little financial incentive for a provider to join a network. It is true that enrollees today are faced with the same type of balance billing when they decide to receive services outside of the network as illustrated in Figure 11. However, the plans argue that reenactment of §38.2-3407.15 without the balance billing prohibition will cause more providers to decide not to participate in networks resulting in enrollees having to receive more and more services from non-participating providers. The end result would be an overall increase in balance billing and increased costs for enrollees.

Figure 11

Potential Impact of Balance Billing

	Participating Provider	Non-Participating Provider
Provider Charge	$500	$500
Plan Allowance	$400	$400
Amount Paid by Plan	$320 (80% of allowance)	$240 (60% of allowance)
Amount Paid by Enrollee	$80 (20% of allowance)	$160 (40% of allowance)
Amount of Balance Bill	$0 (not permitted)	$100 (difference between plan allowance and provider charge)
Total Paid by Enrollee	$80	$260

Note: The amounts shown above are for illustrative purposes only

Source: JCHC Staff analysis of typical PPO benefit plan

Two Independent Actuaries Indicated That The Potential Impact of §38.2-3407.15 on Health Care Costs, Insurance Premiums and Availability of Health Care Would Be Minimal

JCHC staff and the Bureau of Insurance each consulted an independent actuary regarding the potential impact of the assignment of benefits provision in SB 1235/HB 871. Both actuaries indicated that, as presently written, the assignment of benefits provision likely would have a minimal impact on the cost of health care, health insurance premiums, and the availability of care. The actuaries pointed to the fact that because a significant portion of Virginia's health insurance market already functions in the manner envisioned by §38.2-3407.15, that the impact would be minimal. Both actuaries did note, however, that removing the "no balance-billing" provision could increase the cost to consumers as cautioned by the health plans.

Three Policy Options Are Offered For Consideration By The Joint Commission on Health Care

The following policy options are offered for consideration by the Joint Commission. The options presented below do not represent the entire range of potential actions that could be taken by the JCHC.

- **Option I:** Take no action.

  (This option would result in §38.2-3407.15 not being reenacted unless another member of the General Assembly introduced the legislation.)

- **Option II:** Introduce legislation to reenact §38.2-3407.15 as contained in SB 1235/HB 871 of the 1999 Session of the General Assembly with no changes.

- **Option III:** Introduce legislation to reenact §38.2-3407.15 as contained in SB 1235/HB 871 of the 1999 Session of the General Assembly, and include emergency room physicians among those providers to whom the section does not apply.

VI.
Licensing Group Self-Insurance Associations To Offer Health Insurance Coverage to Holders of Medical Savings Accounts

House Bill 2708 of the 1999 Session of the General Assembly Directs The Joint Commission On Health Care To Study the Feasibility of Licensing Group Self-Insurance Associations To Offer Health Insurance Coverage to Holders of Medical Savings Accounts

During the 1999 Session of the General Assembly, legislation (HB 2708) was passed which allows a bank, insured savings institution or credit union to act as a trustee or custodian of medical savings accounts (MSAs). The second enactment clause of HB 2708 directs the Joint Commission on Health Care (JCHC), with assistance of the Bureau of Insurance and the Department of Taxation, to "examine the current provisions of federal and state taxation and insurance laws to determine the feasibility of licensing group self-insurance associations that will pool their liabilities for the purpose of offering high-deductible, catastrophic health insurance coverage to holders of medical savings accounts." A copy of HB 2708 is attached at Appendix G.

The Impetus Behind This Study Request Was To Determine Whether There Is A Way Of Providing High-Deductible Insurance Plans For Persons With MSAs Without The Involvement of an Insurance Carrier

JCHC staff interviewed the individuals who were instrumental in getting the study language added to HB 2708. These individuals indicated concern that insurance carriers are charging excessive premiums for high deductible catastrophic plans. Moreover, these individuals expressed a desire to find a means of providing health insurance to persons with MSAs that would limit the degree to which carriers become the intermediary between provider and patient. Lastly, these individuals indicated that the overall health system would better serve patients and providers if patients had greater access to the providers of their choice and the providers could interact directly with their patients without the restrictions and limitations imposed on them by managed care insurance plans. Group self-insurance associations were identified as a potential vehicle for achieving these objectives, and, thus, are the focus of this review.

Given the legal, regulatory, and insurance-related aspects of this topic, the Bureau of Insurance conducted the research regarding this issue, and wrote this section of the report.

Medical Savings Accounts (MSAs) Are Authorized In Federal And State Law

Medical Savings Accounts (MSAs) are authorized in Chapter 56 of Title 38.2 of the *Code of Virginia*. Section 38.2-5601 states that "[u]pon the passage of federal legislation authorizing the components of the Plan, the Departments of Medical Assistance Services, Workers' Compensation, and Taxation and the Bureau of Insurance shall develop the Virginia Medical Savings Account Plan." Section 38.2-5602 further states "[u]pon the authorization in federal law to establish medical savings accounts and upon development and enactment of the Plan described in § 38.2-5601 of this chapter, medical savings accounts may be established in the Commonwealth." State regulation of MSAs is therefore based on enabling federal authority, which is found at Section 301 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

Four-Year MSA Demonstration Project: To fully understand MSAs, therefore, one must review the enabling federal law. MSAs were created as a four-year demonstration program by HIPAA. The current demonstration program is scheduled to end in 2000. A December 15, 1997 "Comprehensive Study of the Medical Savings Account Demonstration Task Order 97-2 - Insurer Survey, Phase I Final Report" completed by the U.S. General Accounting Office describes MSAs as follows. "MSAs are tax-favored trusts or custodial accounts that are used in conjunction with qualified high-deductible health insurance plans (qualified plans) for paying for approved medical expenses. Qualified plans are comprehensive health insurance products that meet certain conditions concerning annual deductible amounts, maximum out-of-pocket limits and coverage of state-mandated preventative care benefits."

Since current Virginia statutes regarding MSAs defer to federal law, any MSA in Virginia must be established in accordance with the federal requirements. Federal tax law regarding MSAs can be found in Section 220 of the Internal Revenue Code (IRC Sec. 220), which was added by HIPAA. Section 220 specifies deductibility of MSA contributions, eligibility of individuals, limitation of the number of MSAs, etc. In order to be eligible for a deduction, an MSA must be used by an eligible individual in conjunction with a high-deductible health plan, which is also defined in IRC Sec. 220. Federal law states that only "self-employed individuals and employees of small businesses with 50 or fewer employees" can participate in a MSA.

The Current Demand For MSAs Has Been Far Less Than Anticipated

In November 1998, the U.S. General Accounting Office published a second report, "Comprehensive Study of the Medical Savings Account Demonstration Task Order 97-2 - Insurer Survey, Final Report". Several "key findings" were listed in the Executive Summary. These findings include: (i) consumer demand has been lower than expected, (ii) there are approximately 50 insurance companies which offer qualifying high-deductible products, and (iii) in some instances, premiums associated with qualifying plans dropped from 1997 to 1998. According to GAO, the number of MSAs opened in the United States as of June, 1998 was fewer than 40,000, well below the HIPAA-allowed maximum limit of 750,000.

The federal law created MSAs as a four-year demonstration project, with a general cut-off date of October 1, 2000. Unless an individual meets the definition of an "active MSA participant" before the close of the cut-off year, or becomes covered under a high-deductible plan of an "MSA-participating employer" which was in existence before the close of the cut-off year, they will not meet the eligibility requirements for participating in an MSA account. Legislation has been adopted in both Houses of Congress to extend the MSA demonstration project; however, as of November 10, 1999, final legislation had not been passed. Federal legislation also is pending that would eliminate the current demonstration project limits regarding numbers of eligible participants, the restrictions placed on eligible members and reduce the minimum annual deductions.

A Group Self-Insurance Association (GSIA) Is An Association of Two or More Employers Having a Common Interest That Have Entered into Agreements to Pool Their Liability Under The Worker's Compensation Act

The State Corporation Commission's "Rules Governing Group Self-Insurers of Liability under the Virginia Workers' Compensation Act" (14 VAC 5-370-10 et seq.), define a group self-insurance association (GSIA) as an association organized by two or more employers having a common interest that have entered into agreements to pool their liabilities under the Virginia Workers' Compensation Act. There are currently 14 active, licensed GSIAs in Virginia. The common interest requirement has resulted in GSIAs for businesses such as automobile dealers, contractors, municipalities, restaurants and loggers.

Licensing GSIAs to Offer High-Deductible Catastrophic Insurance Coverage Does Not Appear To Be Feasible Under Current Insurance Laws and Regulations

Based on a review of the current insurance laws, it is not feasible to license a GSIA for the purpose of offering high-deductible, catastrophic health insurance coverage to holders of medical savings accounts. The current laws and regulations governing GSIAs are Chapter 8 of Title 65.2 and 14 VAC 5-370-10 et seq. There are numerous provisions in the current laws and regulations that would prohibit or make it very difficult for a GSIA to offer high-deductible, catastrophic health insurance.

As mentioned, the statutory provision for GSIAs is Title 65.2 of the Code of Virginia, which is the Workers' Compensation Act as opposed to the Insurance Code, Title 38.2. According to §65.2-802 A, GSIAs can only pool liabilities under the Virginia Workers' Compensation Act. This Act pertains to workers' compensation benefits which may arise under the laws of any other jurisdictions and other types of employers' liabilities for the death or disablement of, or injury to, their employees. It does not appear that high-deductible, catastrophic health insurance coverage would meet the definitions found in §65.2-802 A or 14 VAC 5-370-10 et seq. as mentioned above.

Financial Solvency Issues: The State Corporation Commission cannot license a GSIA or grant authorization for an employer to become a member of such GSIA unless it receives satisfactory proof of the solvency of any such employer. This provision, required by §65.2-802 B and 14 VAC 5-370-50, can be hard to regulate. The GSIA members (i.e., small businesses operating throughout Virginia) often have a difficult time preparing a complete set of financial statements to be submitted and can be reluctant to disclose such data. MSA participants (i.e., employees of a small business and self-employed persons) could find the preparation of financial statements even more difficult than small businesses. Further, individuals may also be rather reluctant to disclose their personal financial position.

Joint and Several Liability: Although the financial statements are a sensitive issue, they are an imperative part of GSIA regulation. Section 65.2-802 C requires members of a GSIA to execute a written agreement under which each agrees to jointly and severally assume and discharge any liability of employers party to such agreement. In order to ensure the employer members of a GSIA have the financial capability to pay an assessment, they must demonstrate solvency via a financial statement. The GSIAs have no minimum surplus requirements, so assessments, in addition to paid premium, are occasionally necessary to ensure the GSIA can meet its obligations. The issue of joint and

several liability is another matter that could cause problems if GSIAs were used in conjunction with MSAs. One has to consider if allowing private citizens of Virginia to join an entity in which they could be assessed an unlimited amount of money to meet insurance obligations is in their best interest. Further, §65.2-802 C goes on to provide the State Corporation Commission with the right to independently enforce, on behalf of the GSIA, the joint and several liability of its members if the GSIA fails to enforce such rights. It would be quite awkward for the State Corporation Commission to be in the position of taking legal action against private citizens.

Workers' Compensation Notification Requirements: Since the GSIAs are designed for workers' compensation coverage, there are several Workers' Compensation Commission notification requirements that are certainly not relevant for high-deductible, catastrophic health insurance. Section 65.2-804 A 1 requires every employer who has cancelled his membership in a licensed GSIA to immediately notify the Workers' Compensation Commission of such cancellation, the date thereof and the reasons therefor. Every GSIA shall in a like manner notify the Workers' Compensation Commission immediately upon the cancellation of any membership agreement. Further, §65.2-804 B and 14 VAC 5-370-140 state that no membership in a GSIA shall be cancelled or nonrenewed by the GSIA except on thirty days' notice to the employer and the Workers' Compensation Commission, unless the employer has obtained other insurance.

Premium Contribution Requirements: There are also numerous examples of premium contribution requirements that are clearly designed for workers' compensation coverage. According to 14 VAC 5-370-110 A 1, GSIA members shall make contributions based on annual payrolls for all employees of each member. 14 VAC 5-370-100 7 requires payroll verification of all members of the GSIA to be conducted within 180 days after the close of the plan year and additional amounts due to be collected within 30 days. Contribution (premium) based on payroll and payroll audits are indicative to workers' compensation as opposed to high-deductible, catastrophic health insurance coverage.

There Have Been Previous Legislative Proposals To Permit Medical Savings Account Group Self-Insurance Associations

During the 1998 and 1999 sessions of the Virginia General Assembly, legislation was introduced to establish medical savings account group self-insurance associations ("MSA GSIA"). The most recent legislation was SB 954, which was introduced but failed during the 1999 session. While the legislation would have resulted in an addition to Chapter 56 of Title 38.2, much of the wording was identical to §65.2-802. There were several provisions in the proposed legislation that would make the financial viability and feasibility of

MSA GSIAs questionable. First and foremost is the issue regarding joint and several liability and the State Corporation Commission's authority to enforce such. While this issue has been previously addressed, the impact of private citizens being in a position of unlimited assessment and having a state regulatory agency taking action against them must be carefully considered.

The previous legislation appears to lack clarity on the issue of member financial condition. Subsection 4 of the bill's proposed §38.2-5604 B stated the MSA GSIA could not discriminate based on financial status. However, §38.2-5605 A stated the State Corporation Commission shall not grant authorization for any person to become a member of the MSA GSIA unless it receives proof of the solvency of any such person and of the financial ability of each to meet his obligations as a member.

The underwriting standards of MSA GSIAs could potentially lead to financial problems. The proposed legislation allowed the members to voluntarily enroll for and disenroll from coverage. This easy enrollment could result in adverse selection which is the tendency for the unhealthy to seek insurance and for others to neglect or postpone it. It would obviously be more advantageous for an individual facing a catastrophic condition to join an MSA GSIA. Should more unhealthy individuals join an MSA GSIA it would be financially disastrous not only for the licensed entity but also for the members that are jointly and severally liable.

The proposal also stated that the catastrophic health care insurance coverage provided by the MSA GSIA is to be community rated, although it may furnish minimal rate adjustments based on age, and may provide health-based discounts for subscribers related to the use of tobacco, alcohol and nonprescribed controlled substances. To ensure its solvency, the MSA GSIA should have the flexibility to charge adequate rate adjustments not only for the age but also for the general health of the insured.

According to the proposed legislation, the MSA GSIA's financial records, including its records of all expenditures, are available to the public. The public nature of the financial records appears too broad. "All expenditures" could be construed to include individual claim information, which would be inappropriate. Further, personal financial statements of the members could potentially be included in this definition.

MSA/GSIAs Would Be Subject To Federal and State Laws Governing Multiple Employer Welfare Arrangements (MEWAs); These Laws Would Require That Such an Entity Be Licensed as an Insurance Company, Health Services Plan, HMO, or Dental or Optometric Plan

Any future MSA GSIA would also be subject to federal and state laws regarding multiple employer welfare arrangements (MEWAs). Pursuant to 29 USCS § 1002 (40)(A), a MEWA is an employee welfare benefit plan, or any other arrangement which is established or maintained for the purpose of offering or providing benefits to the employees of two or more employers including one or more self-employed individuals. An employee welfare benefit plan is defined in 29 USCS § 1002 (1) as any plan, fund, or program established for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, or hospital care or benefits. Since the MSA GSIA would be offering high-deductible, catastrophic health insurance to employees of two or more small employers and self-employed individuals, the entity would be deemed a MEWA pursuant to 29 USCS § 1002 (40)(A). By virtue of the proposed MSA GSIA meeting the definition of a MEWA, it is also subject to additional state regulation as provided by 29 USCS § 1144 (6)(ii).

The state regulations regarding MEWAs can be found in the State Corporation Commission's "Rules Governing Multiple Employer Welfare Arrangements" (14 VAC 5-410-10 et seq.) The MSA GSIA would not be deemed to be a fully insured MEWA in accordance with 14 VAC 5-410-30 because its covered benefits are not insured on a direct basis by an insurance company licensed in Virginia. Therefore, as the regulation and laws are currently written, the MSA GSIA would have to become a licensed company pursuant to 14 VAC 5-410-40 A, which indicates a MEWA that is not fully insured shall not operate in Virginia without first meeting the criteria and becoming appropriately licensed as an insurance company, health maintenance organization, health services plan, or a dental or optometric services plan pursuant to Title 38.2 of the Code of Virginia.

Combining MSAs and GSIAs Is Problematic Given Current Federal and State Laws

Given the limitations placed upon the establishment of MSAs by federal law, and the limitations placed upon the establishment of GSIAs under existing Virginia law, it appears that the concept of combining an MSA and a GSIA is problematic. MSAs are limited to individuals, where as GSIAs are limited to associations of employers. Secondly, GSIAs are limited to providing workers' compensation and related insurance, where MSAs have been established to provide funds to pay general health expenses. Finally, the federal and state laws

regarding MEWAs would prohibit an MSA GSIA from operating unless the entity became a licensed insurance company or health maintenance organization.

Whether based on existing laws for GSIAs or the implementation of previously proposed additional language to Chapter 56 of Title 38.2, the concept of MSA GSIAs is not currently feasible. There are already high-deductible, catastrophic policies available for use with MSAs. As previously mentioned, as of December 31, 1997, less than 50,000 MSAs existed across the country. With so few medical savings accounts, there does not appear to be a significant demand for MSA GSIAs.

Policy Options

Given the current restrictions in federal and state law regarding GSIAs and MSAs, the Bureau of Insurance could not identify any workable policy options for addressing the specific issue of licensing GSIAs to offer high-deductible health insurance policies to holders of MSAs.

VII.
Impact of Managed Care on the Quality and Availability of Ancillary Medical Services

House Bill 2304 of the 1995 Session of the General Assembly Directed The Joint Commission On Health Care To Conduct A Three-Year Study of the Impact of Managed Care on the Quality and Availability of Ancillary Medical Services

The 1994 Session of the General Assembly passed HB 840 which enacted a "freedom of choice" law for pharmacy and ancillary medical services. In short, this law provided that health insurers and HMOs issuing policies or contracts requiring the use of network providers could not prohibit an enrollee from receiving pharmacy or ancillary medical services from the provider of his/her choice so long as the provider accepted the insurer/HMO's reimbursement as payment in full.

The 1995 Session of the General Assembly passed HB 2304 which repealed the "freedom of choice" provisions that pertained to ancillary medical services. However, the third enactment clause directed the Joint Commission on Health Care (JCHC) to conduct a three-year study of ancillary medical services insofar as the availability and quality of these services are affected by managed care. A copy of the study mandate contained in HB 2304 is attached at Appendix H.

Information Regarding This Issue Was Included in Past JCHC Annual Reports

As directed by HB 2304 (1995), the JCHC included information on this issue in its past annual reports. Because there has been little or no empirical research on the impact of managed care on the quality and availability of ancillary medical services, the information presented in previous reports consisted primarily of secondary data regarding complaints filed with state agencies, and the respective positions and arguments of ancillary medical providers and insurers. The key findings of the previous reports included:

- Due to methodological limitations, measuring the true impact of managed care on the availability and quality of ancillary medical services is difficult at best;
- While managed care has limited the number of ancillary service providers from whom enrollees receive services, there are little or no quantitative data

to suggest that the availability or quality of ancillary medical services have been adversely affected;

- Many ancillary service providers believe the quality of care is less under managed care insurance plans; managed care organizations argue there has been no diminution in access or quality;
- Managed care organizations, the Virginia Department of Health, and the Department of Medical Assistance Services, which administers the Medicaid program, reported having received very few complaints about ancillary medical services; and
- Ancillary medical service providers believe the "freedom of choice" law should be reinstated; the managed care industry believes the law should not be reinstated.

The previous reviews of this issue were included in the JCHC's 1996 Annual Report (1997 SD 29) and 1998 Annual Report (1999 HD 62).

The Analysis Included in this Report Summarizes the Results of a Survey of Consumers Regarding Their Views on the Quality and Availability of Ancillary Medical Services

The May, 1999 Joint Commission on Health Care (JCHC) meeting included a discussion of this issue as part of a staff presentation of the JCHC's 1998 Annual Report. During the presentation, several members requested that JCHC staff survey consumers of ancillary medical services to determine their views on the quality and availability of these services. This section of the report summarizes the results of a consumer survey that was conducted this Fall.

Survey Contractor: JCHC staff contracted with Virginia Commonwealth University's (VCU) Survey and Evaluation Research Laboratory (SERL) to conduct the survey. SERL staff drafted the survey instrument, designed the sampling strategy, mailed the surveys, and analyzed the results of the survey responses.

Survey Participants: Both the Department of Personnel and Training (DPT) and the Department of Medical Assistance Services (DMAS) developed random samples of participants for the survey according to a sampling strategy approved by SERL. DPT generated samples of state employees enrolled in HMO plans and employees enrolled in the Key Advantage plan, which is a point-of-service (POS) preferred provider organization (PPO). As seen in Figure 12, a total of 600 state employees were surveyed. DMAS also generated two samples, one of Medicaid recipients enrolled in the mandatory Medallion II HMO plan, and one of recipients enrolled in the Medallion primary care case management plan. DMAS' samples also were drawn according to the SERL approved

protocols. A total of 900 Medicaid recipients were surveyed. (The number of DMAS participants was greater than DPT participants because DMAS was able to identify a certain number of recipients who had received ancillary medical services in the recent past. Inasmuch as SERL, JCHC and DMAS staff expected the number of respondents who actually had used ancillary medical services to be very low, it was decided to increase the number of DMAS participants to ensure a sufficiently large sample.)

At the outset of the project, JCHC staff asked the Virginia Association of Health Plans (VAHP) if its member plans would participate in the survey by providing a random sample of enrollees. However, the VAHP questioned the need for the survey and had reservations about participating. As such, the survey population did not include any "commercial" plan enrollees. While this is a limitation of the project, the DPT population was considered to be a reasonable measure of a typical managed care plan population.

Figure 12

Ancillary Medical Services Consumer Survey Sampling Plan

	Medicaid Participants	State Employee Participants	TOTAL
HMO	450*	300	750
Non-HMO	450*	300	750
TOTAL	900	600	1,500

* Included 350 who had used DME in past 12 months

Source: VCU SERL

It was assumed that the DMAS list would cover a portion of the state's population that is in the lower income group and more likely to be out of work, while the DPT list would represent people in the state who are generally earning higher incomes and are, by definition, employed. Conceptually at least, the entire sampling frame could be seen as a reasonable effort to represent Virginians primarily aged 18-64, and who are covered by some sort of health insurance plan. In this way, the sampling frames combined to cover approximately 568,000

of an estimated 5,160,000 adults in Virginia (U.S. Census estimate, 1996), or about 11% of the adult population of the state.

It should be noted, however, that the sampling plan cannot strictly be said to represent anyone other than those comprising the sampling frames – that is, Medicaid enrollees and state employees. The extent to which the respondents differ from other Virginians is unknown. It is assumed for the purpose of this research that the differences would not be unacceptably large.

Survey Process: The survey instrument was designed by SERL staff and reviewed by JCHC, DMAS and DPT staff. A first draft was piloted with a small convenience sample which resulted in several refinements to the survey instrument. Surveys were mailed to all those included in the DPT and DMAS samples with a cover letter from the Executive Director of the JCHC. A copy of the survey form is attached at Appendix I. Also included in the survey packet was a description of the term "ancillary medical services" and a listing of the types of services and products that were included under the definition. For the purposes of this report, the definition of "ancillary medical services" was limited to "durable medical equipment (DME) and supplies."

As seen in Appendix I, the survey asked respondents: (i) whether their insurance plan had paid for any ancillary medical services during the past several months; (ii) about their views on the quality and availability of ancillary medical services; (iii) about their level of satisfaction regarding ancillary medical services; (iv) how easy it is to get information and help regarding ancillary medical services; and (v) certain demographic questions. The survey form also invited respondents to include any additional comments or thoughts they may have regarding ancillary medical services. All survey participants were given a telephone number to call if they had any questions about the survey. Lastly, a postage-paid envelope was provided to return their completed survey form.

Mailing Procedure: All packets were mailed by first class U.S. mail in JCHC envelopes. A unique identification number was printed on each mailing label, cover letter and survey instrument. This allowed for quality control in the preparation of packets, and for follow-up with non-responders. Returned surveys were logged by identification number in the mailing database. Each person on the mailing list received the initial survey mailing. About one week later, a post card was mailed to all people on the list. The post card content was generic (non-personalized) and thanked those who had responded and urged those who had not to respond today. After about two weeks, a second survey mailing was sent to all current non-responders.

Data Entry: The data from all completed survey forms were entered into an electronic data file for processing and analysis, in SPSS format. Standard SERL coding rules were used. Open-ended responses were not coded or entered verbatim. There was a variable for each case that indicated the presence or absence of open-ended data, however. Quality control reviews were performed on 10% of the cases entered by each data entry clerk. Mistakes found during these checks were corrected. If problems were noted, further reviews were conducted until the problems were corrected or it was determined that no pattern existed. While every effort was made to assure a clean dataset, it is likely that some small number of random keying errors remain in the dataset.

Sampling Error: Questions answered by the entire sample of DME users are subject to a sampling error of +/- 5.5% at the 95 percent level of confidence. That means that in 95 out of 100 samples like the one used here, the results obtained should be no more than 5.5 percentage points above or below the figure that would be obtained by interviewing all adult Medicaid enrollees and state employees who have valid mail service. Where the answers of subgroups are reported, the sampling error would be higher.

Caveats: As noted above, while the logic of the sampling plan was to represent Virginians with health insurance plans as broadly as possible, the survey results can strictly be said to apply only to those Virginians represented in the sampling frames – that is, those who are Medicaid enrollees and those who are state employees. To the extent that Virginians outside the reach of the sampling frames differ from those in the sampling frames, the survey results will differ from how the rest of the population would have responded. The extent of these differences is unknown.

Most of the data obtained from DME users came from Medicaid enrollees, because they could be targeted for DME use and the DPT list could not be. There may be some evidence that this population is "easier to please" than are the DPT users of DMEs. If that is the case, it could have an important impact on the findings of the survey. Also as noted above, surveys are prone to biases and errors that are difficult or impossible to measure. This is even more likely to be the case in a survey such as this one that does not rely on previously validated or thoroughly tested items. While every effort is made to identify and reduce such problems, the results of surveys should be used with caution.

A Total Of 683 Responses Were Received And Analyzed

Of the 1,500 total surveys mailed out, 683 were returned and analyzed for a response rate of 46%. The responses included 382 (56% of total) Medicaid

enrollees and 301 (44% of total) state employees. In terms of plan type, 316 responses (46% of total) were from persons enrolled in an HMO; and 367 responses (54% of total) were from persons enrolled in other "non-HMO" type plans (Medallion for Medicaid enrollees, and Key Advantage for state employees).

The Responses Included Very Few State Employees Who Had Used DME Services; As Such, The Analysis Of HMO vs. Non-HMO Responses Essentially Reflects The Opinions of Medicaid Enrollees

As anticipated, very few state employees responded that they had used DME equipment or supplies. Only 35 (13%) state employee respondents reported having used DME equipment or supplies, as compared to 198 (75%) Medicaid enrollees. (The overall percentage of persons who had used DME was 44%). When these responses are subdivided into HMO and non-HMO groups for the purposes of analyzing and comparing responses of persons enrolled in more tightly managed health plans, there were only 17 state employee respondents in the HMO group and 18 in the non-HMO group. As such, the number of state employee respondents using DME equipment and supplies is just too small to make any reasonable comparisons among state employees and Medicaid enrollees. Furthermore, while the analysis that follows comparing HMO to non-HMO respondents includes both state employees and Medicaid enrollees, the results are driven primarily by Medicaid enrollees.

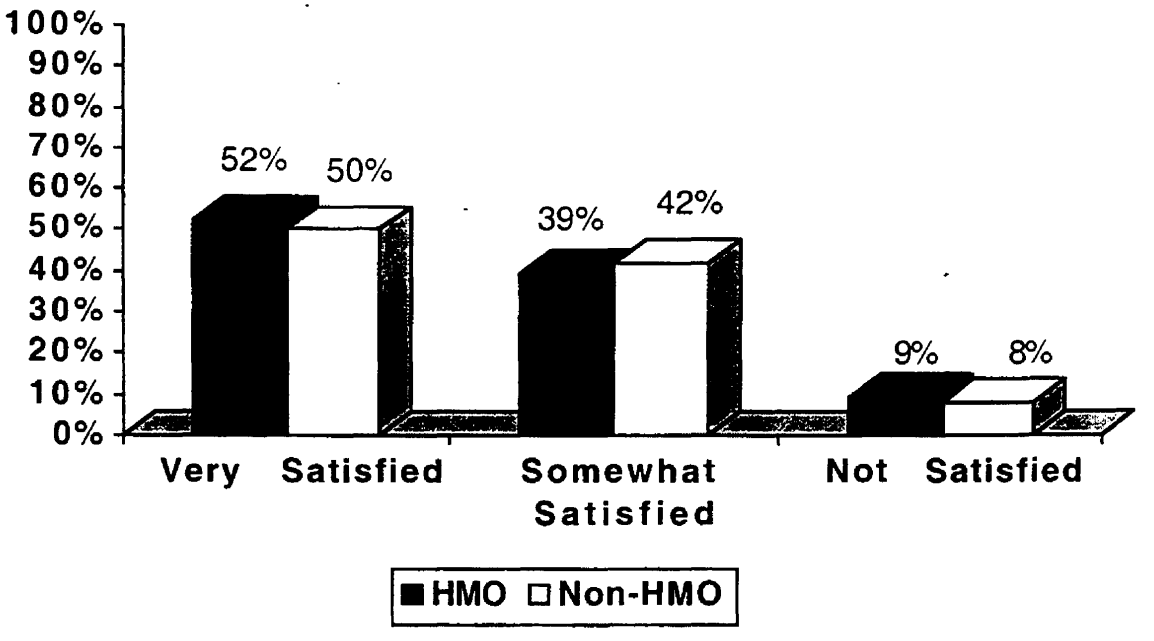
The Results of the Survey Indicate That Enrollees Are Generally Satisfied With The Quality And Availability of Ancillary Medical Services; There Appear To Be Few Differences of Opinion Between HMO and Non-HMO Enrollees

The survey results indicate that consumers are generally satisfied with the availability and quality of ancillary medical services (DME equipment and supplies). While numerous questions were asked of the respondents, the following pages summarize responses to several key questions.

Figure 13 illustrates the responses to the question: "How satisfied are you with the number of choices where you can get medical supplies and equipment?" As seen in Figure 13, the responses of HMO enrollees and non-HMO enrollees indicate a high level of satisfaction.

Figure 13

Survey Responses to the Question:
"How Satisfied Are You With The Number Of Choices Where You Can Get Medical Supplies And Equipment?"

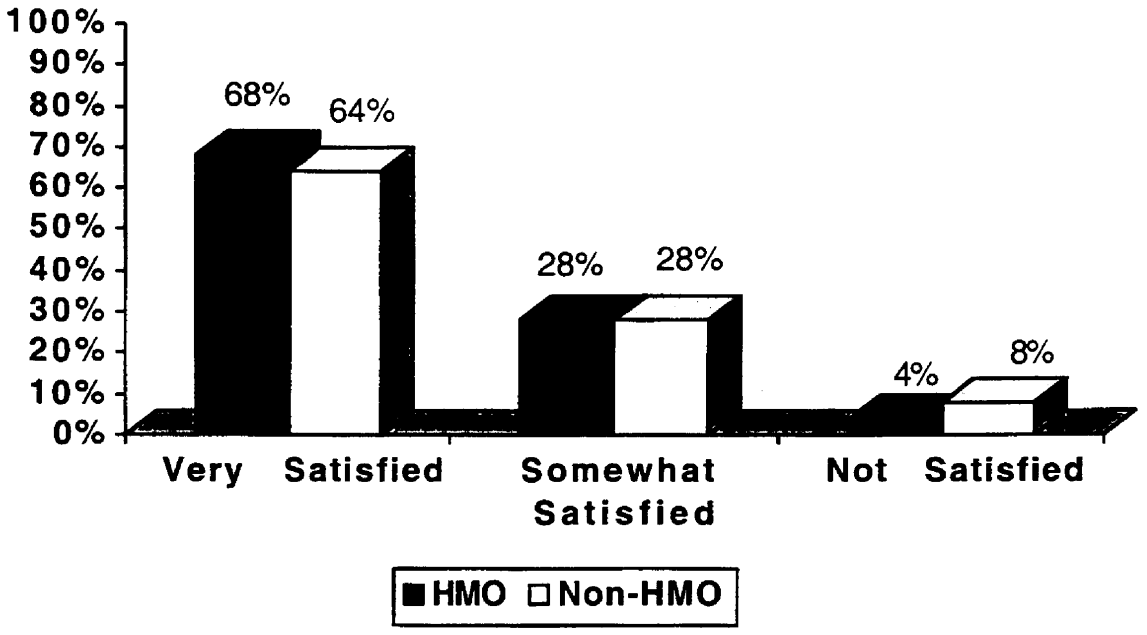


Source: VCU SERL Analysis of Survey Responses

Survey respondents also were asked "how satisfied are you with the places you have gotten medical supplies and equipment?" As seen in Figure 14, again, the level of satisfaction was high, and there was very little difference between the responses of HMO and non-HMO respondents.

Figure 14

Survey Responses to the Question:
"How Satisfied Are You With The Places You Have Gotten Medical Supplies And Equipment?"

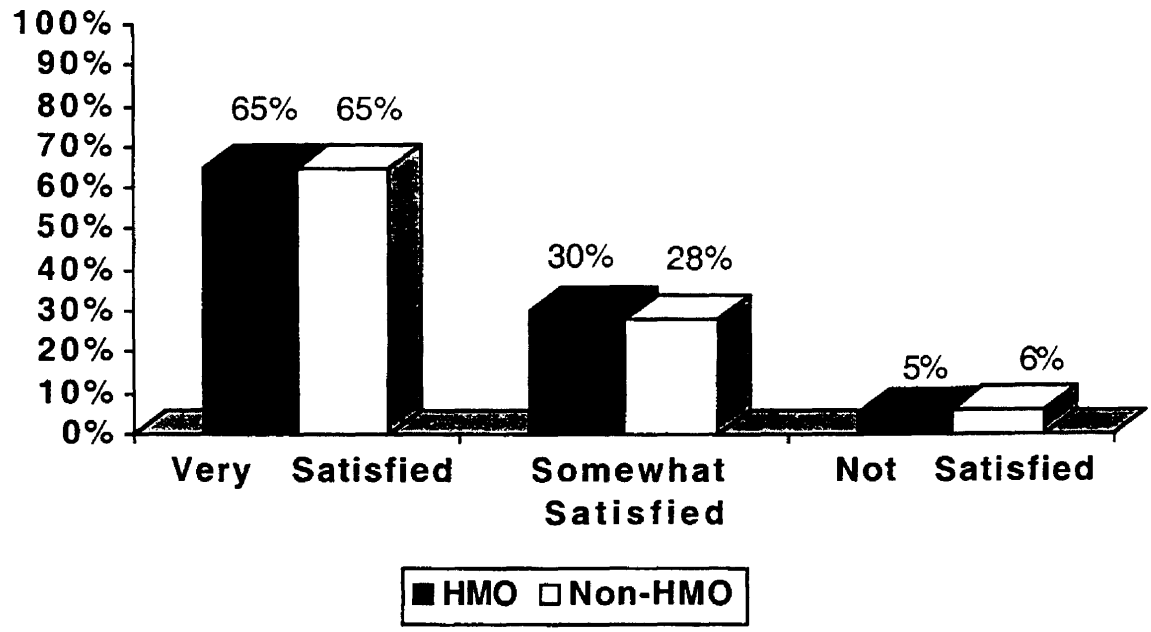


Source: VCU SERL Analysis of Survey Responses

Figure 15 illustrates the responses to the survey question: "how satisfied are you with the quality of the medical supplies and equipment you used?" The responses of HMO and non-HMO respondents were nearly identical.

Figure 15

Survey Responses to the Question:
"How Satisfied Are You With The Quality Of The Medical Supplies And Equipment You Used?"

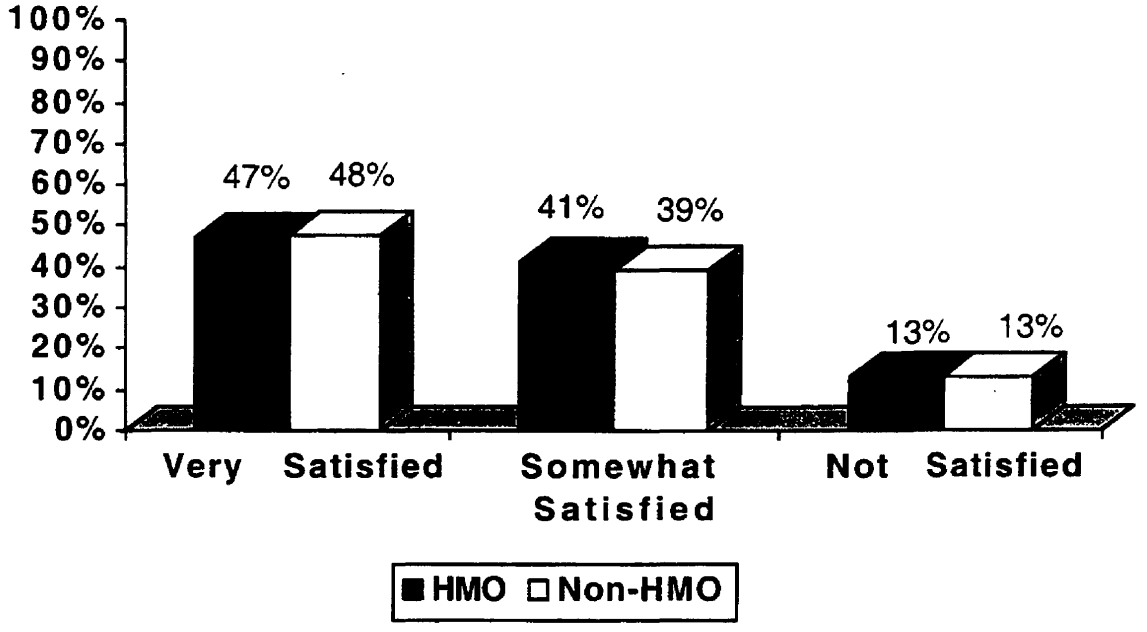


Source: VCU SERL Analysis of Survey Responses

Figure 16 presents the responses to the question: "how satisfied are you with the number of choices of types or brands of medical supplies and equipment?" As in the responses to the previous questions, the responses of the HMO and non-HMO group were very similar.

Figure 16

Survey Responses to the Question:
"How Satisfied Are You With The Number of Choices of Types or Brands of Medical Supplies and Equipment?"

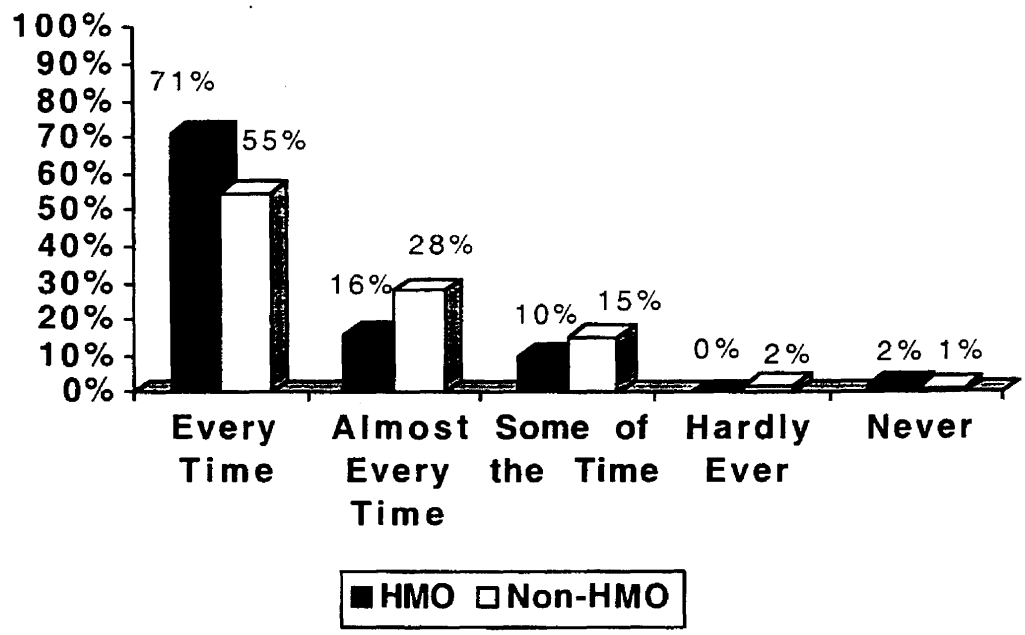


Source: VCU SERL Analysis of Survey Responses

In addition to questions regarding respondents' satisfaction with the quality of ancillary medical services, respondents also were asked about the availability of services. Figure 17 illustrates the responses to the survey question: "have medical equipment and supplies, paid for by your insurance company, been easily available?"

Figure 17

Survey Responses to the Question:
"Have Medical Equipment And Supplies, Paid For By Your Insurance Company, Been Easily Available?"



Source: VCU SERL Analysis of Survey Responses

While There Was An Insufficient Number of Responses To Assess Differences Between State Employee And Medicaid Enrollees By HMO and Non-HMO Plan Enrollment, The Data Do Suggest There Likely Are Differences

As previously noted, there were only 17 state employees in the HMO group and 18 state employees in the non-HMO group who had used DME; this precludes any statistical analysis of any differences that may exist within the state employee population and any differences that may exist between the state employee and Medicaid populations. However, the limited state employee data suggest that some differences may exist. In general, it appears that the responses of state employee HMO respondents had a somewhat less favorable opinion about the availability and quality of ancillary medical services than their Medicaid HMO counterparts. For instance, on the question regarding "satisfaction with the number of choices where you can get medical supplies and

equipment," state employee responses were much different than Medicaid responses. Fifty-two percent of Medicaid HMO respondents and 50% of non-HMO Medicaid respondents indicated they were "very satisfied." However, for state employees, only 27% of HMO respondents indicated they were "very satisfied" as compared to 50% of the non-HMO respondents. Another example is the responses to the question "have medical equipment and supplies, paid for by your insurance, been easily available?" Seventy-seven percent of Medicaid HMO respondents answered "every time." However, only 43% of state employee HMO respondents answered "every time."

While there are differences between the Medicaid and state employee populations, the number of state employee responses is simply too small to make statistically valid comparisons between the two groups.

Three Policy Options Are Offered For Consideration By The Joint Commission on Health Care

The following policy options are offered for consideration by the Joint Commission . The options presented below do not represent the entire range of potential actions that could be taken by the JCHC.

- **Option I:** Take no action.

- **Option II:** Introduce a resolution requesting the Virginia Department of Health and the Bureau of Insurance's Managed Care Ombudsman to track consumer complaints regarding the availability and quality of ancillary medical services and report their findings to the Joint Commission on Health Care.

- **Option III:** Introduce legislation to reenact the "freedom of choice" provision in the *Code of Virginia* pertaining to ancillary medical services.

APPENDIX A

SENATE JOINT RESOLUTION NO. 489

Directing the Joint Commission on Health Care, in cooperation with the Bureau of Insurance, to develop a pooled purchasing model for health insurance to determine if such a pooled purchasing arrangement could improve the affordability and availability of insurance for small employers in the Commonwealth.

Agreed to by the Senate, February 4, 1999
Agreed to by the House of Delegates, February 15, 1999

WHEREAS, a 1996 survey of the insurance status of Virginians found that approximately 13 percent, or 858,000 persons, are uninsured; and

WHEREAS, the percentage of Virginia's uninsured adults who are employed full time has increased from 41 percent in 1993 to 57 percent in 1996; and

WHEREAS, small employers have a significantly higher percentage of employees who are uninsured than larger employers; and

WHEREAS, when purchasing health insurance, small employers generally are more price-sensitive than larger employers, pay higher administrative costs, have less negotiating power with insurance carriers, often experience wide fluctuations in premiums from year to year, and generally are able to offer less of a choice of benefit plans to their employees; and

WHEREAS, pooled purchasing arrangements enable small employers to "pool" their purchasing power, a practice which provides them with many of the same purchasing advantages of larger employers; and

WHEREAS, a number of states have enacted laws to establish state-sponsored health insurance purchasing pools or encourage the development of private pools; and

WHEREAS, the purchasing pools in other states have produced mixed results with some being successful in making coverage more affordable for small employers while others have been disbanded; and

WHEREAS, the Joint Commission on Health Care studied the feasibility of implementing a pooled purchasing arrangement in the Commonwealth pursuant to Senate Joint Resolution No. 124 and House Joint Resolution No. 202 of the 1998 Session of the General Assembly; and

WHEREAS, there continues to be disagreement between interested parties as to the ability of pooled purchasing arrangements to lower premium costs and make insurance coverage more affordable for small employers; and

WHEREAS, actuarial analysis is needed to develop a specific pooled purchasing model that would identify alternative benefit designs and estimated costs that can be compared to the level and cost of coverage that can be purchased in the marketplace without such a pooled purchasing arrangement; and

WHEREAS, without such an actuarial analysis there will continue to be unanswered questions regarding the potential benefits of such a purchasing arrangement for small employers; 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 develop a pooled purchasing model for health insurance to determine if such a pooled purchasing arrangement could improve the affordability and availability of insurance for small employers in the Commonwealth. As part of its deliberations, the joint commission shall hire an actuary to develop a specific model of pooled purchasing which shall: (i) identify any insurance market reforms or other statutory or regulatory changes necessary to support a pooled purchasing arrangement; (ii) include alternative benefit designs which could be offered through the purchasing arrangement; (iii) calculate estimated costs of the alternative benefit designs; and (iv) compare the estimated costs for small employers to purchase coverage through the pooled purchasing arrangement with the costs of purchasing similar coverage in the marketplace; and, be it

RESOLVED FURTHER, That the Joint Commission on Health Care shall form a panel of experts from the insurance, business, provider, consumer, and insurance agent communities to review and respond to the actuary's pooled purchasing model in terms of the potential for a pooled purchasing arrangement to increase the affordability and availability of coverage for small employers. In its review of the pooled purchasing model, the panel also shall make recommendations on other possible actions to improve the affordability and availability of coverage for small employers.

All agencies of the Commonwealth shall provide assistance to the Joint Commission on Health Care and its staff, upon request. Actuarial work, estimated to cost $75,000, will be required for the Joint Commission on Health Care to complete the study. Such expenses shall be funded by a separate appropriation from the General Assembly.

The Joint Commission on Health Care shall complete its work in time to submit its findings and recommendations to the Governor and the 2000 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

HOUSE JOINT RESOLUTION NO. 601

Directing the Joint Commission on Health Care to study efficient and economical ways to provide group health insurance coverage for self-employed individuals.

Agreed to by the House of Delegates, February 5, 1999
Agreed to by the Senate, February 18, 1999

WHEREAS, current Virginia law requires at least two persons, excluding spouses or minor children, be covered under group health policies unless such spouse or minor child is determined to be an eligible employee of the employer to whom the policy is issued; and

WHEREAS, as a result, group policies may not be issued to self-employed individuals, as is the case in some neighboring states; and

WHEREAS, such a restriction prevents many hard working self-employed Virginians from obtaining affordable health care; and

WHEREAS, requiring all insurance companies to offer the same "open enrollment" and lower rates to self-employed persons as is offered in neighboring states is a fair requirement and will prove to be ultimately profitable to the insurance companies once the requirement is imposed on all companies; and

WHEREAS, providing such an affordable means of health care coverage will allow self-employed Virginians to continue making valuable contributions to the Commonwealth's economy while having the security of available, affordable health care coverage for themselves and their families; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care be directed to study efficient and economical ways to provide group health insurance coverage for self-employed individuals. 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 shall complete its work in time to submit its findings and recommendations to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

WHEREAS, actuarial analysis is needed to develop a specific pooled purchasing model that would identify alternative benefit designs and estimated costs that can be compared to the level and cost of coverage that can be purchased in the marketplace without such a pooled purchasing arrangement; and

WHEREAS, without such an actuarial analysis there will continue to be unanswered questions regarding the potential benefits of such a purchasing arrangement for small employers; 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 develop a pooled purchasing model for health insurance to determine if such a pooled purchasing arrangement could improve the affordability and availability of insurance for small employers in the Commonwealth. As part of its deliberations, the joint commission shall hire an actuary to develop a specific model of pooled purchasing which shall: (i) identify any insurance market reforms or other statutory or regulatory changes necessary to support a pooled purchasing arrangement; (ii) include alternative benefit designs which could be offered through the purchasing arrangement; (iii) calculate estimated costs of the alternative benefit designs; and (iv) compare the estimated costs for small employers to purchase coverage through the pooled purchasing arrangement with the costs of purchasing similar coverage in the marketplace; and, be it

RESOLVED FURTHER, That the Joint Commission on Health Care shall form a panel of experts from the insurance, business, provider, consumer, and insurance agent communities to review and respond to the actuary's pooled purchasing model in terms of the potential for a pooled purchasing arrangement to increase the affordability and availability of coverage for small employers. In its review of the pooled purchasing model, the panel also shall make recommendations on other possible actions to improve the affordability and availability of coverage for small employers.

All agencies of the Commonwealth shall provide assistance to the Joint Commission on Health Care and its staff, upon request. Actuarial work, estimated to cost $75,000, will be required for the Joint Commission on Health Care to complete the study. Such expenses shall be funded by a separate appropriation from the General Assembly.

The Joint Commission on Health Care shall complete its work in time to submit its findings and recommendations to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX C

HOUSE JOINT RESOLUTION NO. 555

Directing the Joint Commission on Health Care's Long-Term Care Subcommittee to examine Medigap and Medicare managed care programs in Virginia.

Agreed to by the House of Delegates, February 5, 1999
Agreed to by the Senate, February 18, 1999

WHEREAS, Medicare is a health care financing program authorized by Title XVIII of the Social Security Act and funded by payroll taxes; and

WHEREAS, Medicare provides the primary sources of health insurance coverage for an estimated 12 percent of Virginians; and

WHEREAS, Medicare provides coverage both to persons age 65 and older and to certain disabled persons under age 65; and

WHEREAS, Medicare has traditionally been a fee-for-services program that does not require recipients to choose a health plan; and

WHEREAS, there are important gaps in Medicare coverage, particularly regarding prescription medications; and

WHEREAS, Medigap policies provide supplemental health insurance for Medicare recipients; and

WHEREAS, Medicare managed care plans are a relatively new option for Medicare recipients that may offer additional benefits beyond those offered in the standard fee-for-services Medicare program; and

WHEREAS, there has been a nationwide trend of health plans discontinuing Medicare managed care products; and

WHEREAS, in addition, certain disabled persons receiving Medicare who are not yet 65 are reporting difficulty in obtaining Medigap policies; and

WHEREAS, limited Medicaid coverage for low-income Medicare beneficiaries is available, but underutilized; and

WHEREAS, the Joint Commission on Health Care has formed a Long-Term Care Subcommittee to address various long-term care and aging issues; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care's Long-Term Care Subcommittee be directed to examine insurance options for Medicare beneficiaries in Virginia, including (i) the availability of Medicare managed care products, (ii) the availability of Medigap policies for Medicare beneficiaries who are not yet 65, (iii) increasing utilization of available Medicaid

coverage for low-income Medicare beneficiaries; and (iv) other issues as they may seem appropriate.

The Joint Commission shall report its findings and recommendations to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX D

Medigap Plan Types and Benefits

Every company offering Medigap insurance must offer Plan A. In addition, companies may have some, all, or none of the other plans.

Basic Benefits - Included in all plans:

- Hospitalization: Part A coinsurance plus coverage for 365 additional days during beneficiary's lifetime after Medicare benefits end
- Medical expenses: Part B coinsurance
- Blood: First 3 pints of blood each year

	Medigap Policy Types									
Medigap Benefits	**A**	**B**	**C**	**D**	**E**	**F***	**G**	**H**	**I**	**J***
Basic Benefits	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part A: Inpatient Hospital Deductible		✓	✓	✓	✓	✓	✓	✓	✓	✓
Part A: Skilled Nsg Facility Coinsurance			✓	✓	✓	✓	✓	✓	✓	✓
Part B: Deductible			✓			✓				✓
Foreign Travel Emergency			✓	✓	✓	✓	✓	✓	✓	✓
At-Home Recovery			✓				✓		✓	✓
Part B: Excess Charges						100%	80%		100%	100%
Preventive Care					✓					✓
Prescription Drugs								Basic Coverage	Basic Coverage	Extended Coverage

Note: Plans F and J also have a high deductible option. Beneficiaries choosing this option must pay $1,500 out-of-pocket expenses per year before the plans pay anything. Insurance policies with a high deductible option generally cost less than those with lower deductibles

Source: HCFA

APPENDIX E

HCFA's AAPCC Rates, Selected Virginia Counties and Cities, 1997-2000

	1997					
	Part A-E	Part B-E	Part A-D	Part B-D	Wt. Avg.	
Chesterfield	274	144	223	119	408	
Fairfax	245	156	223	161	399	
Henrico	266	150	268	146	416	
Norfolk City	293	149	266	134	436	
Richmond City	301	152	328	145	456	
Virginia Beach	268	157	264	157	424	
Washington	230	108	140	89	323	
Wise	336	162	187	118	472	
Average	277	147	237	134	417	

Note: Weighted average combines Part A and B and takes into account the relative proportion of elderly and disabled in the state. Changes in AAPCC from year to year split out A and B changes and show rates for elderly only, since they make up the majority of beneficiaries.

	1998					Change (%) 97-98	
	Part A-E	Part B-E	Part A-D	Part B-D	Wt. Avg.	Part A-E	Part B-E
Chesterfield	245	181	205	162	418	-11%	26%
Fairfax	235	174	219	173	407	-4%	12%
Henrico	244	181	236	186	425	-8%	21%
Norfolk City	259	191	228	180	444	-12%	28%
Richmond City	265	196	270	212	464	-12%	29%
Virginia Beach	249	185	240	189	433	-7%	18%
Washington	211	156	205	162	367	-8%	44%
Wise	292	215	205	162	488	-13%	33%
Average	250	185	226	178	431	-10%	26%

	1999					Change (%) 98-99	
	Part A-E	Part B-E	Part A-D	Part B-D	Wt. Avg.	Part A-E	Part B-E
Chesterfield	249	185	215	160	426	2%	2%
Fairfax	239	178	229	171	415	2%	2%
Henrico	249	185	247	184	434	2%	2%
Norfolk City	264	196	239	178	454	2%	3%
Richmond City	270	201	282	210	474	2%	3%
Virginia Beach	254	188	251	187	441	2%	2%
Washington	218	162	215	160	379	3%	4%
Wise	297	221	215	160	499	2%	3%
Average	255	190	237	176	440	2%	3%

	2000					Change (%) 99-00	
	Part A-E	Part B-E	Part A-D	Part B-D	Wt. Avg.	Part A-E	Part B-E
Chesterfield	263	201	214	182	455	6%	9%
Fairfax	261	200	223	190	454	9%	12%
Henrico	263	201	237	202	461	6%	9%
Norfolk City	267	204	230	195	465	1%	4%
Richmond City	277	212	272	231	491	3%	5%
Virginia Beach	263	201	262	205	464	4%	7%
Washington	228	174	214	182	401	5%	7%
Wise	299	229	214	182	510	1%	4%
Average	265	203	233	196	463	4%	7%

APPENDIX F

§ 38.2-3407.15. Refusal to accept assignments prohibited.

A. No insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis, no corporation providing individual or group accident and sickness subscription contracts, no health maintenance organization providing a health care plan for health care services, and no dental services plan offering or administering prepaid dental services shall refuse to accept or make reimbursement pursuant to an assignment of benefits made to a health care provider or hospital by an insured, subscriber, or plan enrollee, provided that if the health care provider or hospital obtains such an assignment of benefits, then the health care provider or hospital shall accept the reimbursement under such assignment as payment in full for the services covered by such assignment and shall not charge or bill the insured, subscriber, or plan enrollee any further amount except for the amount of any applicable deductible, copayment or coinsurance.

B. For the purpose of this section, "assignment of benefits" means the transfer of health care coverage reimbursement benefits or other rights under an insurance policy, subscription contract or health care plan by an insured, subscriber or plan enrollee to a health care provider or hospital.

C. This section shall not apply to an assignment of benefits made to a dentist or oral surgeon.

4. That § 38.2-3407.15 and the amendments to §§ 38.2-4214, 38.2-4319 and 38.2-4509 citing § 38.2-3407.15 shall not become effective unless reenacted by the 2000 Session of the General Assembly. Prior to the 2000 Session of the General Assembly, the Joint Commission on Health Care and the Bureau of Insurance shall review the financial impact that the enactment of these sections will have on health care costs, health insurance premiums, and the availability of health care in the Commonwealth.

APPENDIX G

CHAPTER 331

An Act to amend the Code of Virginia by adding in Chapter 1 of Title 6.1 a section numbered 6.1-2.9:8, relating to medical savings accounts; study.

[H 2708]

Approved March 22, 1999

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Chapter 1 of Title 6.1 a section numbered 6.1-2.9:8 as follows:

§ 6.1-2.9:8. Medical savings accounts.

To the extent allowed by federal law, a bank, insured savings institution, or credit union may act as a trustee or custodian of medical savings accounts established with financial institutions under § 220 of the United States Internal Revenue Code of 1986, as amended from time to time. Contributions may be accepted and interest thereon retained by such institution pursuant to forms provided by it and may be invested in accounts of the institution in accordance with the terms upon which such contributions were accepted. The financial institution shall administer such accounts in accordance with the requirements of federal law.

2. That the Joint Commission on Health Care, assisted by the Bureau of Insurance of the State Corporation Commission and the Department of Taxation, shall examine the current provisions of federal and state taxation and insurance laws to determine the feasibility of licensing group self-insurance associations that will pool their liabilities for the purpose of offering high-deductible, catastrophic health insurance coverage to holders of medical savings accounts. The Joint Commission on Health Care shall complete its work in time to submit its findings and recommendations to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX H

CHAPTER 467

An Act to amend and reenact §§ 38.2-3407.7, 38.2-4209.1, and 38.2-4312.1 of the Code of Virginia, and to repeal §§ 38.2-3407.8, 38.2-4209.2, and 38.2-4312.2 of the Code of Virginia, relating to pharmacies and ancillary service providers; freedom of choice.

[H 2304]

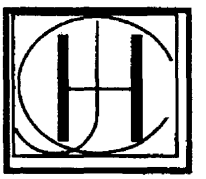
Approved March 20, 1995

Be it enacted by the General Assembly of Virginia:

3. That the Joint Commission on Health Care shall conduct a three-year study of ancillary medical services insofar as the availability and quality of the same are affected by managed care, and shall include its findings thereon in its 1996, 1997 and 1998 reports to the Governor and the General Assembly.

APPENDIX I

AVAILABILITY AND QUALITY OF MEDICAL EQUIPMENT AND SUPPLIES FOR VIRGINIANS COVERED BY HEALTH INSURANCE PLANS



Commonwealth of Virginia
Joint Commission on Health Care

THANK YOU for taking time to do this survey. The Joint Commission on Health Care is interested in how things are going for Virginians who use medical equipment and supplies ***that were paid for by their health insurance plans***. Are the equipment and supplies available without too much trouble? Are they of high quality? Are people satisfied?

For this survey, medical equipment and supplies are defined as things such as bandages and dressings, tubes and pumps, IV supplies, incontinence products, ostomy products, special beds and bedding supplies, communication devices used for medical reasons, apnea monitors, canes, crutches, walkers, wheelchairs and wheelchair accessories, dialysis supplies and so forth. This does **NOT** include medicines, x-rays, lab tests, etc. A list of things included in this survey is enclosed on a separate sheet of paper.

Remember, the survey only covers medical equipment and supplies *that were paid for by your health insurance plan* and that you used since April 15, 1999.

Your opinions are confidential. Your name will never be connected with your answers. We value your opinions and we thank you for your time.

Please use the enclosed business reply envelope to return the survey. If you have any questions about the survey, please contact Jim Ellis at:

Survey and Evaluation Research Laboratory
Virginia Commonwealth University
901 W. Franklin St.
P.O. Box 843016
Richmond VA 23284-3016
Phone 804-828-8813

1. Are you currently covered by a health insurance plan?

☐ Yes
☐ No (skip to #15)
☐ Don't know (skip to #15)

2. Have you been covered by a health insurance plan since April 15, 1999?

☐ Yes
☐ No (skip to #15)
☐ Don't know (skip to #15)

3. Since April 15, 1999 did you have any interruption of coverage OR did you switch to a different health insurance plan? (check all that apply)

☐ Yes, interruption of coverage (skip to #15)
☐ Yes, switched plans (skip to #15)
☐ No (had same plan since April 15, 1999)

4. Since April 15, 1999, have you used any medical equipment or supplies *that were paid for by your health insurance plan*?

☐ Yes
☐ No (skip to #13)
☐ Don't know (skip to #13)

5. Since April 15, 1999, would you say that you have used medical supplies and equipment for a *temporary condition* (one that has ended or will end soon), or for a *chronic condition* (one that will continue into the future)?

☐ Used them only for a temporary condition
☐ Used them only for a chronic condition
☐ Used them for both temporary and chronic conditions
☐ Don't know

6. The following questions are about the choices you have under your health insurance plan. Please think only about the medical supplies and equipment you have used since April 15, 1999 that were paid for by your health insurance plan. Check the box under the best answer for each item. Use "DK/NA" for "Don't know" or "Not applicable."

NUMBER OF CHOICES	Many	Some	Few	DK/NA
a. How many choices do you have for where you can get the medical supplies and equipment you used?	☐	☐	☐	☐
b. How many choices do you have for the types or brands of the medical supplies and equipment you used?	☐	☐	☐	☐
SATISFACTION	**Very satisfied**	**Somewhat satisfied**	**Not satisfied**	**DK/NA**
c. How satisfied are you with the ***number of choices*** you have for ***where you can get*** the medical supplies and equipment you used?	☐	☐	☐	☐
d. How satisfied are you with the ***number of choices*** you have for ***types or brands*** of the medical supplies and equipment you used?	☐	☐	☐	☐

e. How satisfied are you with the ***actual places*** where you have gotten the medical supplies and equipment you used?	☐	☐	☐	☐
f. How satisfied are you with ***the quality of the actual medical supplies and equipment*** you used?	☐	☐	☐	☐

7. Since April 15, 1999, about *how long* does it usually take you to receive your medical equipment and supplies?

- ☐ The same day they are prescribed
- ☐ Within 2-4 days
- ☐ Within 5-7 days
- ☐ More than 1 week
- ☐ Don't know (skip to #9)

8. To meet your needs, is this length of time:

- ☐ Too quick
- ☐ About right
- ☐ Too slow
- ☐ Don't know

9. You may talk with different people about your medical equipment and supplies. Please tell us how well the following people explain things to you about getting, using or paying for your medical equipment and supplies. Check the box under the best answer for each item. Use "DK/NA" for "Don't know" or "Not applicable."

PEOPLE YOU MAY TALK WITH	Very clearly	Somewhat clearly	Not too clearly	DK/NA
a. The people at the doctor's office explain how to use the equipment and supplies . . .	☐	☐	☐	☐
b. The people at the places where I get my supplies explain how to use the equipment and supplies . . .	☐	☐	☐	☐
c. The people at my health insurance plan explain my coverage for medical equipment and supplies . . .	☐	☐	☐	☐

10. Please tell us how easy it is for you to get the following things done. Check the box under the best answer for each item. Use "DK/NA" for "Don't know" or "Not applicable."

THINGS YOU MAY NEED DONE	Very easy	Somewhat easy	Not easy	DK/NA
a. Completing paperwork to get medical equipment or supplies	☐	☐	☐	☐
b. Picking up medical equipment or supplies	☐	☐	☐	☐
c. Getting medical equipment or supplies delivered	☐	☐	☐	☐
d. Getting medical equipment or supplies that work correctly	☐	☐	☐	☐
e. Getting quick help with problems	☐	☐	☐	☐
f. Getting effective help with problems	☐	☐	☐	☐
g. Getting high quality medical equipment or supplies	☐	☐	☐	☐

11. Thinking about the medical equipment and supplies that have been paid by your health insurance plan and you have used since April 15, 1999, have they been *easily available*:

☐ Every time
☐ Almost every time
☐ Some of the time
☐ Hardly ever
☐ Never
☐ Don't know

12. Thinking about the medical equipment and supplies that have been paid by your health insurance plan and you have used since April 15, 1999, has their *overall quality* been:

☐ Excellent
☐ Very good
☐ Good
☐ Fair
☐ Poor
☐ Don't know

13. Since April 15, 1999, have you been *denied* any medical equipment or supplies by your health insurance plan?

☐ Yes
☐ No (skip to #15)
☐ Don't know (skip to #15)

14. Please explain briefly what the equipment or supply was and what reason was given for denying the request:

_____

Now some questions to group your answers.

15. Are you male or female?

☐ Male
☐ Female

16. In what county or independent city do you live? Please indicate "county" or "city."

_____

17. Are you Hispanic or Latino/a?

☐ Yes
☐ No
☐ Don't know

18. Would you call yourself:

☐ White or Caucasian
☐ Black or African-American
☐ Asian
☐ Multi-racial
☐ Something else

19. What is your age? _____ years

20. Are you (please only one):

☐ Employed full-time
☐ Employed part-time
☐ Temporarily out of work/ laid off/ looking
☐ Retired
☐ Homemaker
☐ Something else

21. In what kind of area do you live?

☐ Urban
☐ Suburban
☐ Rural
☐ Small town
☐ Don't know

APPENDIX J

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS: HEALTH INSURANCE ISSUES STUDY (SJR 489 Pooled Purchasing)

Organizations Submitting Comments

A total of four organizations submitted comments in response to the SJR 489 report on pooled purchasing of health insurance for small employers.

- Virginia Association of Health Plans (VAHP)
- Trigon, BlueCross BlueShield
- Virginia Hospital & Healthcare Association (VHHA)
- Judith Clarke Consultants

Policy Options Included in the SJR 489 Issue Brief

- **Option I:** Take no action

- **Option II:** Introduce legislation and an accompanying budget amendment to establish a state fund which would provide some start-up funding to assist private health insurance purchasing cooperatives (HIPC) that are established in Virginia and meet certain criteria and requirements. The start-up funds could be provided in the form of a loan to be repaid after the HIPC becomes operational.

Overall Summary of Comments

Trigon, the VAHP and the VHHA all supported Option I. Essentially, the three commenters pointed to the actuary's report as the reason for recommending the Joint Commission on Health Care take no action. Judith Clarke supported Option II.

SUMMARY OF PUBLIC COMMENTS: HEALTH INSURANCE ISSUES STUDY (HJR 601 Group Insurance for the Self-Employed)

Organizations Submitting Comments

A total of four organizations submitted comments in response to the HJR 601 report on group insurance for the self-employed.

- Virginia Association of Health Plans (VAHP)
- Trigon, BlueCross BlueShield (Trigon)
- Virginia Hospital & Healthcare Association (VHHA)
- Health Insurance Association of America (HIAA)

Policy Options Included in the HJR 601 Issue Brief

- **Option I:** Take no action

- **Option II:** Introduce legislation to amend the *Code of Virginia* to include self-employed persons in the definition of "small groups."

- **Option III:** Introduce legislation to amend the *Code of Virginia* to include self-employed persons in the definition of "small groups." The legislation would include a provision that permitted self-employed persons or "groups of 1" to be rated higher than groups of 2 or more employees.

Overall Summary of Comments

All four commenters supported Option I. Trigon, VAHP and HIAA all expressed concern about the potential impact that Options II and III could have on the small group and individual markets.

SUMMARY OF PUBLIC COMMENTS:
HEALTH INSURANCE ISSUES STUDY
(HJR 555 Medicare Beneficiary Issues)

Medicare Managed Care Issues

Organizations Submitting Comments

A total of seven organizations submitted comments in response to the section of the report regarding Medicare managed care issues.

- Jefferson Area Board on Aging (JABA)
- Virginia Hospital & Healthcare Association (VHHA)
- Virginia Poverty Law Center (VPLC)
- Virginia Primary Care Association (VPCA)
- Arlington Agency on Aging (AAA)
- Virginia Association of Nonprofit Homes for the Aging (VANHA)
- Northern Virginia Aging Network (NVAN)

Policy Options

- **Option I:** Take no action

- **Option II:** Introduce a budget amendment to provide funding for additional managed care ombudsmen at selected AAAs throughout the Commonwealth to provide counseling services and other information for Medicare beneficiaries.

- **Option III:** Introduce a budget amendment (language and funding) directing the Department for the Aging to develop a public information campaign, in cooperation with the local Area Agencies on Aging, specifically geared toward assisting Medicare enrollees understand their Medicare plan options.

Overall Summary of Comments

VANHA supported Option I. Six commenters (JABA, VHHA, VPLC, VPCA, AAA, and NVAN) all supported Option II. Five commenters (JABA, VPLC, VPCA, AAA, and NVAN) supported Option III.

SUMMARY OF PUBLIC COMMENTS: HEALTH INSURANCE ISSUES STUDY (HJR 555 Medicare Beneficiary Issues)

Medigap Supplemental Insurance Issues

Organizations Submitting Comments

A total of seven organizations submitted comments in response to the section of the report on Medigap supplemental insurance issues.

- Trigon BlueCross BlueShield (Trigon)
- Jefferson Area Board on Aging (JABA)
- Virginia Association of Health Plans (VAHP)
- Virginia Poverty Law Center (VPLC)
- Health Insurance Association of America (HIAA)
- Virginia Association of Nonprofit Homes for the Aging (VANHA)
- Virginia Chapter of Arthritis Foundation (VCAF)

Policy Options

- **Option I:** Take no action

- **Option II:** Introduce legislation to require Virginia insurers to offer the same range of Medigap policy options to all Medicare beneficiaries, regardless of whether the prospective purchaser has Medicare by reason of age or disability.

- **Option III:** Introduce legislation to require Virginia insurers to community rate all Medigap policies, regardless of whether the prospective purchaser has Medicare by reason of age or disability.

- **Option IV:** Introduce legislation to require Virginia insurers to use the same rates for policies offered to 65-year-olds and disabled, but allow higher rates for the elderly over age 65 at the time of policy purchase.

- **Option V:** Introduce legislation providing an annual six month open enrollment period for all Medigap policies, regardless of

whether the prospective purchaser has Medicare by reason of age or disability.

Overall Summary of Comments

Option I was supported by three commenters (Trigon, VAHP, and HIAA). Option II was supported by VPLC. Trigon, VAHP and HIAA voiced opposition to Option II due to concerns over the impact in the Medicare market. JABA did not specifically express opposition, but expressed concern about impact on premiums. Options III and IV were not supported by any of the commenters and was opposed by Trigon, VAHP and HIAA. JABA did not specifically express opposition, but expressed concern about the impact on premiums. Option V was supported by four commenters (VCAF, JABA, VPLC, and VANHA). It was opposed by Trigon, VAHP and HIAA.

SUMMARY OF PUBLIC COMMENTS: HEALTH INSURANCE ISSUES STUDY (HJR 555 Medicare Beneficiary Issues)

Medicaid Assistance for Low-Income Medicare Beneficiaries

Organizations Submitting Comments

A total of seven organizations submitted comments in response to the section of the report regarding Medicaid assistance for low-income beneficiaries.

- Virginia Chapter of Arthritis Foundation (VCAF)
- Jefferson Area Board on Aging (JABA)
- Virginia Hospital & Healthcare Association (VHHA)
- Virginia Poverty Law Center (VPLC)
- Virginia Primary Care Association (VPCA)
- Arlington Agency on Aging (AAA)
- Virginia Association of Nonprofit Homes for the Aging (VANHA)

Policy Options

- **Option I:** Take no action

- **Option II:** Introduce a budget amendment (language only) directing DMAS to utilize "QMB leads" data to target mailings to potentially poor elderly Virginians who may be eligible for Qualified Medicare Beneficiary (QMB) benefits through Medicaid.

- **Option III:** Introduce a budget amendment (language only) directing DMAS to examine the possibility of using a simplified form for determining eligibility for the QMB/SLMB/QI programs.

- **Option IV**: Introduce a budget amendment (language only) directing DMAS to report to the Governor and General Assembly on how it plans to achieve the Federal targets of increasing QMB/SLMB enrollment by 4% each year during the next biennium.

- **Option V**: Introduce a resolution encouraging Virginia's aging community, the faith community, and other advocacy and provider

organizations to include information in their publications and activities that would educate their members about Medicaid assistance programs for low-income Medicare beneficiaries.

- **Option VI:** Introduce a budget amendment (language and funding) directing the Department for the Aging to develop a statewide outreach program, in cooperation with the Department of Medical Assistance Services and local Area Agencies on Aging, for educating Virginia's poor elderly about the Medicaid assistance programs for low-income Medicare beneficiaries.

Overall Summary of Comments

All seven commenters expressed support for Options II-VI citing each as a means of increasing the number of low-income Medicare beneficiaries who could benefit from these Medicaid assistance programs.

SUMMARY OF PUBLIC COMMENTS: HEALTH INSURANCE ISSUES STUDY (HJR 555 Medicare Beneficiary Issues)

Other Issues Regarding Medicaid Assistance for Low-Income Elderly and Disabled Virginians

Organizations Submitting Comments

A total of three organizations submitted comments in response to the section of the report regarding Medicaid assistance for low-income elderly and disabled Virginians.

- Jefferson Area Board on Aging (JABA)
- Virginia Poverty Law Center (VPLC)
- Virginia Association of Nonprofit Homes for the Aging (VANHA)

Policy Options

- **Option I:** Take no action

- **Option II:** Introduce a budget amendment (language only) directing DMAS to establish an agreement with HCFA that would extend the current annual three-month enrollment period for enrolling in Part A coverage through the QMB program.

- **Option III:** Introduce a budget amendment (language only) directing DMAS to assess the financial and programmatic impact on the Medicaid program of discontinuing its "209B" status.

- **Option IV:** Introduce a budget amendment (language and funding) to establish a new category of Medicaid eligibility for the aged and disabled with incomes up to a given level such as 80% of FPL.

Overall Summary of Comments

The Jefferson Area Board on Aging and the Virginia Poverty Law Center supported Options II-IV; the Virginia Association of Nonprofit Homes for the Aging supported Options II and IV.

SUMMARY OF PUBLIC COMMENTS: HEALTH INSURANCE ISSUES STUDY (SB 1235/HB 871)

Organizations Submitting Comments

A total of eight individuals/organizations submitted comments in response to the issue of assignment of health insurance benefits.

- Trigon BlueCross BlueShield
- Medical Society of Virginia (MSV)
- Virginia Association of Health Plans (VAHP)
- Virginia Hospital and Healthcare Association (VHHA)
- Virginia College of Emergency Physicians (VCEP)
- Chesapeake Emergency Physicians (CEP)
- Dr. Kenneth Frunkin
- Virginia Chamber of Commerce

Policy Options Regarding Assignment of Benefits

- **Option I:** Take no action.

  (This option would result in §38.2-3407.15 not being reenacted unless another member of the General Assembly introduced the legislation.)

- **Option II:** Introduce legislation to reenact §38.2-3407.15 as contained in SB 1235/HB 871 of the 1999 Session of the General Assembly with no changes.

- **Option III:** Introduce legislation to reenact §38.2-3407.15 as contained in SB 1235/HB 871 of the 1999 Session of the General Assembly, and include emergency room physicians among those providers to whom the section does not apply.

Overall Summary of Comments

All of the commenters, except the Medical Society of Virginia, supported Option I. The Medical Society of Virginia supported Option III.

Trigon and the VAHP commented that providing direct reimbursement to providers is a key incentive for a provider to participate in a network. They also stated that Option II or III would adversely affect health plans' ability to form cost-effective networks.

The VCEP, CEP, and Dr. Frunkin commented that because of the low reimbursement paid by many managed care organizations, ER physicians must be able to balance bill patients in order to recover their costs of providing care. These three commenters also stated that the federal EMTALA provisions make reenactment of Section 38.2-3407.15 particularly problematic for ER physicians.

SUMMARY OF PUBLIC COMMENTS: HEALTH INSURANCE ISSUES STUDY (HB 2708)

Organizations Submitting Comments

One individual submitted comments in response to the issue of group self-insurance associations offering catastrophic health insurance to holders of medical savings accounts.

- Dr. Robert K. Su

Policy Options Regarding Assignment of Benefits

Given the current restrictions in federal and state law regarding group self-insurance associations and medical savings accounts, no workable policy options could be identified.

Overall Summary of Comments

Dr. Su, who submitted comments on behalf of the Coalition of the Public and Physicians (CoPPsUSA), indicated that while the analysis correctly focused on group self-insurance associations (GSIAs) as required by HB 2708, the report did not address other potential ways of allowing self-insurance pools for holders of medical savings accounts. Dr. Su stated that the report misunderstands the proposed pools and other avenues of developing them that would not conflict with federal and state laws. Dr. Su provided an outline for the creation of publicly-controlled, nonprofit catastrophic self-insurance pools for further review and analysis.

SUMMARY OF PUBLIC COMMENTS: HEALTH INSURANCE ISSUES STUDY (HB 2304, 1995)

Organizations Submitting Comments

Comments were submitted by two organizations in response to the issue of the impact of managed care on the availability and quality of ancillary medical services.

- Trigon, BlueCross BlueShield
- Virginia Association of Health Plans

Policy Options Regarding Ancillary Medical Services

- **Option I:** Take no action.

- **Option II:** Introduce a resolution requesting the Virginia Department of Health and the Bureau of Insurance's Managed Care Ombudsman to track consumer complaints regarding the availability and quality of ancillary medical services and report their findings to the Joint Commission on Health Care.

- **Option III:** Introduce legislation to reenact the "freedom of choice" provision in the *Code of Virginia* pertaining to ancillary medical services.

Overall Summary of Comments

Both commenters supported Option I and cited the results of the JCHC survey of managed care enrollees as evidence that consumers are satisfied with the quality and availability of ancillary medical services. Both commenters noted there is no need to reenact the "freedom of choice" provisions for ancillary medical service providers.

JOINT COMMISSION ON HEALTH CARE

Executive Director

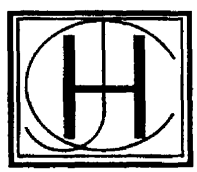
Patrick W. Finnerty

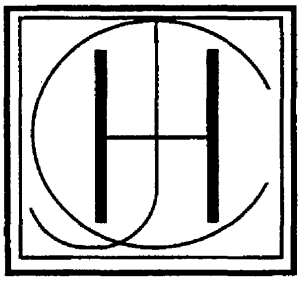
Senior Health Policy Analysts

Joseph J. Hilbert
William L. Murray, Ph.D.
E. Kim Snead

Office Manager

Mamie V. White





Joint Commission on Health Care
Old City Hall
1001 East Broad Street
Suite 115
Richmond, Virginia 23219
(804) 786-5445
(804) 786-5538 (FAX)

E-Mail: jchc@leg.state.va.us

Internet Address:

http://legis.state.va.us/jchc/jchchome.htm