REPORT OF THE
SPECIAL ADVISORY COMMISSION ON MANDATED
HEALTH INSURANCE BENEFITS

THE ESSENTIAL AND STANDARD HEALTH BENEFIT PLANS

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

COMMONWEALTH OF VIRGINIA
RICHMOND
2004

January 6, 2004

To: The Honorable Mark R. Warner
Governor of Virginia
And
The General Assembly of Virginia

The report contained herein has been prepared pursuant to §§ 2.2-2504 and 2.2-2505 and § 38.2-3431 of the Code of Virginia.

This report documents a review conducted by the Special Advisory Commission on Mandated Health Insurance Benefit on the Essential and Standard Health Benefits Plans.

Respectfully submitted,

Stephen H. Martin
Chairman
Special Advisory Commission on
Mandated Health Insurance Benefits

SPECIAL ADVISORY COMMISSION ON
MANDATED HEALTH INSURANCE BENEFITS

Stephen H. Martin, Chairman
R. Lee Ware, Vice-Chairman

Martin E. Williams
Kathy J. Byron
Bradley P. Marrs
Clarke N. Hogan
Phyllis L. Cothran
Ken Faulkner
Joe Kelliher
Jennifer Adkins

Stephen P. Long, M.D.
Janet Melton
Radyln Mendoza
Fred M. Rankin, III
John L. Roper, IV
Alfred W. Gross
Robert B. Stroube, M.D.

TABLE OF CONTENTS

Executive Summary

Section 38.2-3431 of Title 38.2 of the Code of Virginia requires that the State Corporation Commission (SCC) modify the regulations establishing the essential and standard plans to incorporate any revisions to the plans submitted by the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission). The regulation governing the essential and standard plans is based primarily on the work of the Essential Health Service Panel (Panel). The Panel was composed of a group of health care professionals and citizens appointed by the Governor and the Chairman of the Commission on Health Care for All Virginians.

House Bill 2234 was introduced in the 2003 Session of the General Assembly by Delegate Albert C. Pollard. The bill was passed and became effective on July 1, 2003. The bill revises the provisions in the small employer group provisions and the essential and standards plans. The bill specifically includes the ability of carriers to include cost-sharing features in the plan including co-payment, co-insurance, deductible or other cost-sharing arrangements. The bill exempts the plans from the mandated provider requirements of § 38.2-3408.

The essential and standard plans were discussed at the July 9, 2003 meeting of the Advisory Commission and a public hearing on the plans was held on September 15, 2003. Information on the development of the plans, the experience of the plans in Virginia and other states, and previous recommendations for changes was presented. Comments were made by the Virginia Association of Health Plans (VAHP), the Health Insurance Association of America (HIAA), the Virginia Chamber of Commerce (VCC) and the National Federation of Independent Businesses (NFIB).

The second alternative offered by the Bureau of Insurance was preferred by the VAHP. The alternative requiring three different versions of the essential plan was considered a costly and unnecessary option. The Bureau of Insurance subsequently suggested the use of the second alternative combined with the ability of the carriers to offer the plan with different levels of co-payments and deductibles. This option was offered as a means of including flexibility in the plans that is similar to other products in the market.

The interested parties preferred the second alternative combining reductions in dental, vision, and prescription drug coverage with flexibility in deductibles and co-payments. However, all parties agreed that the changes would not guarantee that in the future the plans would be the choice of more small employers. It was also acknowledged that the suggested changes would require administrative changes and costs to insurers.

On November 17, 2003, the Advisory Commission voted unanimously (9-0) to recommend that no changes be made to the essential and standard health benefit plans. The Advisory Commission members expressed concern that a legislatively created product was difficult to modify to compete in the rapidly changing health insurance market. Advisory Commission members were also concerned that the recommended changes would not result in increased sales of the plans.

Background

Section 38.2-3431 of the Code of Virginia requires that the State Corporation Commission (the Commission), modify the regulations establishing the essential and standard plans to incorporate any revisions to the plans submitted by the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission). The regulation governing the essential and standard plans is based primarily on the work of the Essential Health Service Panel (Panel). The Panel was composed of a group of health care professionals and citizens appointed by the Governor and the Chairman of the Commission on Health Care for All Virginians.

The legislation that created the Panel specified its makeup as follows:

- 3 primary care physicians
- 1 obstetrician/gynecologist
- 1 physician/specialist
- 2 citizen members knowledgeable but not involved in the health care system in Virginia
- 1 expert in mental health
- 1 nurse
- 1 pharmacist with a background in clinical pharmacy
- 1 medical ethicist (not a physician) and
- 1 health care provider, (not a physician), regulated by a health regulatory board pursuant to Title 54.1 of the Code of Virginia.

The Panel determined that *essential health services* means "age-appropriate preventive, diagnostic and treatment services required to maintain good health and to return individuals to good health."

The Panel developed a draft proposal which was submitted to the Advisory Commission for its review. The Advisory Commission recommended that the Panel incorporate the Advisory Commission's proposal for mental health coverage, in addition to other recommendations. The Panel acknowledged the Advisory Commission's recommendations but did not incorporate them into the essential and standard plans.

The recommendations of the Panel were then forwarded to the Governor and the General Assembly as well as the Joint Commission on Health Care (formerly the Commission on Health Care for All Virginians).

House Bill 2353, passed by the 1993 General Assembly, added provisions to the Insurance Title of the Code of Virginia for Small Employer Groups. The legislation included the following language in § 38.2-3431 D of the Code of Virginia:

> The Commission shall adopt regulations establishing the essential and standard plans. Such regulations shall incorporate the recommendations of the Essential Health Services Panel, established pursuant to Chapter 847 of the 1992 Acts of the Assembly.

One of the distinctive features of the plans is the required modified community rating. The impact on premiums of health status, claims experience, and duration of coverage is limited for the essential and standard plans, in accordance with § 38.2-3433. The rating can be described simplistically as follows:

- A Health issuer may use demographic rating (including age and gender) and geographic area rating.

- A Health issuer may not use health status, claims experience, duration or other risk factors, except that premiums charged by a health issuer may deviate from the health issuer's community rate by not more than 20% above or below the community rate for claims experience, health status and duration for groups within a similar demographic risk classification for the same or similar coverage.

- A Health issuer must apply rating factors consistently to all small employers in a similar demographic risk classification.

- Adjustments in rates for claims experience, health status and duration may not be applied individually. Any adjustment must be applied to the rate charged for all participants of the small employer. [1]

The days of inpatient hospitalization were increased to 365 days during a 12-month period by legislation in 1997. The change was suggested because the 21 days of inpatient coverage was seen as a substantial barrier to acceptance of the plans by the market.

EXPERIENCE OF ESSENTIAL AND STANDARD PLANS IN VIRGINIA

Sales of the essential and standard plans in Virginia have been less than anticipated. Some industry observers believe that this may be attributable to the fact that small employers are opting to purchase benefit packages that are more typical in the marketplace, at a cost that is only marginally different than the cost for the essential or standard plans. This appears to have been substantiated by a review of existing rate filings in Virginia, which indicated that there was little difference in the premium structures between the standard and essential plans and other plans offered to small employers.

The coverage under the plans in the past seven years appears below:

	ESSENTIAL		STANDARD	
Year	# of Groups	# of Persons	# of Groups	# of Persons
1996	42	284	67	336
1997	196	1578	94	717
1998	233	1935	77	506
1999	146	2851	64	411
2000	73	450	227	1317
2001	124	796	167	1193
2002	140	859	289	2158

* Prior to July 1, 1997, the plans were required to be offered only in the "primary small employer market" (less than 26 employees). After July 1, 1997, the requirement applied to groups with up to 50 employees. [2]

In June, 1998, the Bureau of Insurance (the Bureau) requested a review of the essential and standard benefit plans by its consulting actuarial firm, William M. Mercer, Inc., (Mercer). According to Mercer, price is often the predominant factor in the sale of health insurance in the small employer market. The existing essential and standard plans cover the full array of benefits typically included in employee plans. The costs of these plans, therefore, are not significantly different from other plans in the market.

Mercer presented benefit options that would produce more affordable premiums for the essential and standard benefit plans. The options were:

- Utilize Higher Deductibles and Out-of-Pocket Limits;

- Utilize Higher Deductibles and Patient Visit Payments for HMO Coverage;

- Limit Dental Benefits to Routine Checkups, and Cleaning for Children, or Eliminate Entirely; and

- Increase Cost-Sharing for Prescription Drugs.

Mercer also acknowledged the impact of federal legislation on the increased availability of other plans in the small group market as well as the fact that the marketing efforts of carriers might also be a factor in slow sales of the standard and essential plans.

Essential and Standard Work Group

At the direction of the Chairman of the Advisory Commission, a work group was formed to review the plans and discuss possible modifications to make them more attractive to consumers. The work group included representatives from the Virginia Chamber of Commerce, the National Federation of Independent Businesses, the Virginia Association of Health Plans, the Health Insurance Association of American, the Medical Society of Virginia, the Virginia Association of Family Physicians, the Virginia Hospital and Health Care Association, and the Health Department. A representative of the Virginia Association of Life Underwriters and a representative of a number of health care provider groups joined the meeting, along with the Executive Director of the Joint Commission on Health Care. The group met on November 8, 1999.

The group concluded that, although the plans were not selling well, there was a need for these types of products, particularly for small groups with one or more unhealthy members. Many group members felt that the modified community rating of these plans remained an important and necessary feature, even though the federal Health Insurance Portability and Accountability Act (HIPAA) requires that all products sold in the small group market be available to all small groups.

The group concluded that health insurance premiums would continue to increase and that products like the essential and standard plans may become more attractive as this trend of increasing premium costs continued. The group suggested that the plans be retained with the modified community rating. Members suggested that the Advisory Commission focus on changes to the essential plan and particularly pointed to dental, vision, and prescription drug coverage as areas for reduction in coverage.

PREVIOUS RECOMMENDATION

The Advisory Commission recommended to the State Corporation Commission that revisions be considered to the essential plan for the dental, vision, and prescription drug coverage's. The package of "essential" benefits should be those that are "medically essential." The Advisory Commission members were concerned that the benefit package may be more costly than what was anticipated when the objectives of the plan were originally set.

Bureau Recommendations

It was subsequently determined that any recommendations for changing the benefit structures of the plans should be formally recommended by the Advisory Commission prior to beginning the process of revising the Rules Governing the Standard and Essential Health Benefit Plans. The Bureau recommended that the Advisory Commission consider the following possible alternatives:

Alternative #1 - Require insurers to offer the following 3 versions of the essential plan or one of the 3 versions:

Essential Plan 1

- Currently required coverage

Essential Plan 2

- Generic Prescription Drugs Only (No exceptions)
- Dental examinations, cleaning, and fluoride treatments only (For children)
- Vision examination only

Essential Plan 3

- No dental coverage
- No vision coverage
- No prescription drug coverage

Alternative #2

- Dental Coverage (For children)
  Two cleanings, fluoride treatments; two examinations; x-rays;
  Emergency treatment

- Vision coverage
  Examination only

- Prescription Drug Coverage
  Higher Co-payment for No*n*-generic drugs
  Lower Co-payment for mail-order supply of drugs
  Lower Co-payment for 90-day supply

- Alternative for Prescription Drugs.
  Require at least 30/90-day supply for all maintenance drugs

House Bill 2234

House Bill 2234 was introduced in the 2003 Session of the General Assembly by Delegate Albert C. Pollard. The bill, which passed and became effective on July 1, 2003, revises provisions in the small employer group provisions and the essential and standard plans. The bill specifically provides for the inclusion of cost sharing features in the plans, including co-payment, co-insurance, deductible or other cost-sharing arrangements. The bill exempts the plans from the mandated provider requirements of § 38.2-3408 of the Code of Virginia.

Current cost-sharing requirements in the essential and standard plans are limited by 14 VAC 5-234-80 in the Rules Governing the Essential and Standard plans. The current requirements are:

INDEMNITY COVERAGE

- Individual Coverage
  Deductible no more than $500.00 per contract/calendar year
  Out-of-pocket limit no more than $3,000 per contract/calendar

- Other than Individual Coverage
  Deductible no more than $1,000 aggregate per contract/calendar year
  No more than $500 per person
  Out-of-pocket limit no more than $6,000 per contract/calendar year

- Lifetime Maximum of $1 million per covered person

- Carriers co-insurance percentage of at least 70% of allowable charges

PREFERRED PROVIDER COVERAGE

- No more than $400 inpatient hospital deductible per admission. Carrier's co-insurance of at least 70% of allowable charges after deductible for in-network benefits.

- $500 inpatient deductible per admission and carrier's coinsurance of at least 50% of allowable charges after the deductible for out-of-network benefits.

- Inpatient hospital deductible expenses are to be included in the out-of-pocket limit.

- $15 co-pay per provider visit for at least 4 annual visits per contract/calendar year or no more than 30% of allowable charges for in-network benefits.

- No more than 50% of allowable charges for out-of-network benefits.

- Carriers coinsurance of at least 70% of allowable charges for in-network benefits; 50% for out-of-network benefits including prescriptions or $10 for up to a 90-day supply.

- Individual Coverage in-network and out-of-network out-of-pocket limit of no more than $5,000 per contract/calendar year.

- Other than individual coverage out-of-pocket limit of no more than $15,000 per contract/calendar year.

- Lifetime maximum of $1 million per covered person in-network and $250,000 per covered person out-of-network.

HMO – NOT FEDERALLY QUALIFIED

- Co-pays of no more than:
    - $20 per visit for PCP
    - $20 per visit physician inpatient hospital services
    - $20 per outpatient laboratory services
    - $10 per prescription, up to 90-day supply
    - $400 per inpatient hospital admission

- Individual coverage out-of-pocket limit of no more than $5,000 per contract/calendar year.

- Other than individual coverage out-of-pocket limit of no more than $15,000 per contract/calendar year.

- Lifetime maximum of $1 million per covered person.

HMO – FEDERALLY QUALIFIED

- Co-pays of no more than:
    - $20 per outpatient visit
    - $20 for lab or diagnostic tests per visit
    - $20 per visit for x-rays
    - $10 per prescription, up to 90-day supply

- Individual coverage out-of-pocket limit of no more than $5,000 per contract/calendar year.

- Other than individual coverage out-of-pocket limit of no more than $15,000 per contract/calendar year.

- No deductibles or limits on hospital stay.

POINT-OF-SERVICE PRODUCTS

Benefits must comply with out-of-network limits for PPO out-of-network limit. [3]

State Experience with Standardized Plans in the Small Group Health Insurance Market

In 2003, updated information on the requirements and the experience of states' small group plans was obtained from the National Association of Insurance Commissioners, the National Insurance Law Services, numerous state insurance department websites, and phone conversations with insurance department personnel. All states have some type of small group health insurance requirements. Some states, including Virginia, enacted reforms in the small group market prior to federal actions. Many states enacted requirements to comply with the federal Health Insurance Portability and Accountability Act (HIPPA).

By 2003, approximately 27 states, including Virginia, had developed a specific plan or plans of benefits and provisions that are required offerings in the small group market. At least four states, (Iowa, Kansas, Nevada and South Dakota) have repealed or are in the process of repealing their standard plans.

Information on small group standard plans sales was requested from every state contacted. Two states, Maryland and New Jersey, have experienced considerable sales of the prescribed benefit plans. New Jersey's five standardized plans are the only plans allowed to be sold in the state's small group market. The plans sold in New Jersey cover approximately 999,000 lives. In Maryland, the standard plan established by the Maryland Health Care Commission (MHCC), is the only plan allowed for issue in the

small group market. Information from MHCC indicated that over 450,000 lives are covered by the standard plan.

Other states providing coverage numbers reported low sales. Florida, for example, reported that only 2% of the covered lives in the small group market were covered by the standard and basic plans, (approximately 23,701 lives), at year end 2000 . Some states reported that as few as four plan contracts sold in the latest reporting year. [4]

Small Employer Carrier Survey

A survey was sent to the insurers and health maintenance organizations that were currently registered with the Bureau as small employer carriers in June, 2003. Small employer carriers were asked to provide information about dental, vision, and prescription drug coverage's in their most commonly purchased small employer plans, areas previously identified by the Advisory Commission for possible change.

Twenty-one companies responded to the survey by the deadline of July 2, 2003. All of the respondents indicated that they marketed other products in the small group market in addition to the essential and standard plans. The respondents had, in total, approximately 501,000 covered lives in the small group market.

Five companies included dental coverage in their most popular small group contract. At least three of the remaining 16 companies offered dental coverage by rider. Companies including dental coverage provided the following:

- 3 Level Plan
  100%/80%/50%
  $50/150 Deductible
  $1,500 Annual Maximum

- $50 Deductible
  $1,000 calendar year benefit

- In-Plan Out-of-Plan
  100%/90%/80% 100%UCR/50%/50%
  $25 per member and $75 per member contract year deductibles

Maximum $1,000 per member per contract year
(From two respondents)

- $50/100 Deductible
  100% Co-insurance
  $75/$1,000/1,250/1,500 Out-of -pocket
  (Most popular option is $1,000 Out-of pocket)

Prescription drug coverage was included by all but two of the twenty-one companies. One of the two not including the coverage noted in their responses that they do offer it by rider. Seventeen of the nineteen companies provide three-tiered prescription drug coverage in their most popular plans. The variations of co-payments were considerable. In general, the co-payment for the first tier of coverage was $10, but one company offered a $6 co-payment. The second tier co-payment was most frequently $20, and the third tier co-payment varied from $18 to $50. The individual responses are displayed at the end of this summary.

Vision coverage was included in the most popular small group plan of only eight of the twenty-one respondents. All of the eight companies providing vision coverage covered annual examinations. One company applied a co-payment of $35 for a non-specialty examination and a $40 co-payment for a specialty examination. Co-payments in the other companies' plans ranged from $10 to $29. One company provided coverage for discounted frames and lenses. [5]

Prescription Drug Coverage
Cost Sharing Arrangements and Benefit Maximums in Popular Plans in the Small Group Market

$10/30/50	with 20% Co-insurance
$10/20/35	No maximum
$10/20/35	0 deductible
$10/25/40 or	$20/50/80 Mail Order
$10/30/50	with 25% Co-Insurance
$10/20/40	with 25% Co-Insurance
$10/25/45	with 25% Co-Insurance
$10/20/35	
$6/12/18 or	20%/30%/50%
$10/20/35	No deductible, No maximum
$10/25/40	
$10/20/45	
$10/20/40 or	30% Mail Order 3x Retail $0/200/400 Deductible
$10/20/40	2.5x for Mail Order
$15/25 + 10%/40+20%	

The essential and standard plans were discussed at the July 9, 2003 meeting of the Advisory Commission and a public hearing on the plans was held on September 15, 2003. Information on the development of the plans, the experience of the plans in Virginia, and other states and previous recommendations for changes was presented. Comments were made by the Virginia Association of Health Plans, the Health Insurance Association of America, the Virginia Chamber of Commerce and the National Federation of Independent Businesses.

The second alternative offered by the Bureau, (*see* Bureau Recommendations), was preferred by the VAHP. The alternative requiring three different versions of the essential plan was considered a costly and unnecessary option. The Bureau subsequently suggested the use of the second alternative combined with the ability of carriers to offer the plan with different levels of co-payments and deductibles. This option was offered as a means of including flexibility in the plans that is similar to other products in the market.

The interested parties preferred the second alternative combining reductions in dental vision and prescription drug coverage with flexibility in deductibles and co-payments. However, all parties agreed that the changes would not guarantee that more small employers would purchase these plans in the future. It was also acknowledged that the suggested changes would require administrative changes and costs to insurers.

The health insurance market experiences rapid changes in product offerings. There was acknowledgement of the problems associated with any type of plan that was static in design.

Recommendation

On November 17, 2003, the Advisory Commission voted unanimously (9-0) to recommend that no changes be made to the essential and standard health benefit plans. The Advisory Commission members expressed concerns that a legislatively created product was difficult to modify to compete in the rapidly changing health insurance market. Advisory Commission members were also concerned that the recommended changes would not result in increased sales of the plans. There was also recognition of the cost to insurers to redesign and market the plans after receiving regulatory approval.

End Notes

1. Code of Virginia, Title 38.2 – Section 38.2-3433.

2. Reports to State Corporation Commission, Bureau of Insurance, May 1997 – May 2003.

3. Chapter 234, Rules Governing Essential and Standard Health Benefit Plan Contracts.

4. Survey of State Insurance Departments, May 2003.

5. Survey of Small Employers Carriers, June 2003.