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HOUSE BILL NO. 403

Offered January 11, 2006

Prefiled January 6, 2006

A BILL to amend the Code of Virginia by adding in Title 38.2 a chapter numbered 63, consisting of sections numbered 38.2-6300 through 38.2-6312, relating to the Virginia Health Insurance Risk Pool.

Patron—Dance

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Title 38.2 a chapter numbered 63, consisting of sections numbered 38.2-6300 through 38.2-6312, as follows:

CHAPTER 63.

VIRGINIA HEALTH INSURANCE RISK POOL.

§ 38.2-6300. Definitions.

As used in this chapter, the term:

"Benefit plan" means coverage offered by the pool to eligible persons.

"Board" means the board of directors of the Virginia Health Insurance Risk Pool created under this chapter.

"Covered person" means any individual resident of this state, excluding dependents, who is eligible to receive benefits from any insurer.

"Creditable coverage" and "eligible individual" have the same meaning as specified in §§ 270l and 2741 of the federal Public Health Service Act, 42 U.S.C. §§ 300gg and 300gg-41, except that a person shall not be an eligible individual under this chapter if such person is eligible for or has declined any continuation or conversion coverage or has terminated any such coverage prior to its exhaustion.

"Dependent" means a spouse or unmarried child under the age of 18 years residing with the individual and a child who is a full-time student.

"Family member" means a parent, grandparent, brother, or sister.

"Health insurance" means any hospital or medical expense incurred policy, nonprofit health care services plan contract, health maintenance organization, subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services, whether by insurance or otherwise, when sold to an individual or as a group policy. This term does not include limited benefit insurance policies. For the purposes of this section, the term "limited benefit insurance" means accident and sickness insurance designed, advertised, and marketed to supplement major medical insurance. The term "limited benefit insurance" includes accident only, CHAMPUS supplement, dental, disability income, fixed indemnity, long-term care, Medicare supplement, specified disease, vision, limited benefit, or credit insurance; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical-payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, and includes any other accident and sickness insurance other than basic hospital expense, basic medical-surgical expense, and comprehensive major medical insurance coverage.

"Health insurance issuer"' and "health maintenance organization" have the same meaning as specified in § 2791 of the federal Public Health Service Act, 42 U.S.C. § 300gg-92.

"Insurance arrangement" means a plan, program, contract, or other arrangement through which health care services are provided by an employer to its officers, employees, or other personnel, but does not include health care services covered through an insurer.

"Insured" means a person who is a resident of this state and a citizen of the United States and who is eligible to receive benefits from the pool. The term "insured" may include dependents and family members.

"Insurer" means any entity that is authorized in this state to write health insurance or that provides health insurance or pays medical claims in this state. For the purposes of this chapter, the term includes any insurer proposing to issue an individual or group hospital policy or major medical policy in the Commonwealth; each corporation proposing to issue an individual or group hospital, medical or major medical subscription contract; and each health maintenance organization providing a health care plan for health care services, fraternal benefits society, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation.

"Medicare" means coverage provided by Part A and Part B of Title XVIII of the federal Social

Security Act, 42 U.S.C. § 1395c, et seq.

"Payer" means any person or entity that contributes financially toward the operation of the pool.

"Plan of operation" means the plan of operation of the pool and includes the articles, bylaws, and operating rules of the pool that are adopted by the board.

"Pool" means the Virginia Health Insurance Risk Pool.

"Resident" means: (i) an individual who has been legally domiciled in Virginia for a minimum of 90 days; (ii) an individual who is legally domiciled in Virginia on the date of application to the pool and who is eligible for enrollment in the pool as a result of the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191; or (iii) an individual who is legally domiciled in Virginia on the date of application to the pool and is eligible for the credit for health insurance costs under § 35 of the federal Internal Revenue Code of 1986.

§ 38.2-6301. Virginia Health Insurance Risk Pool established.

A. There is created a body corporate and politic to be known as the Virginia Health Insurance Risk Pool that shall be deemed to be a political subdivision of the Commonwealth. The Virginia Health Insurance Risk Pool shall have perpetual existence and any change in the name or composition of the plan shall in no way impair the obligations of any contracts existing under this chapter.

B. The pool shall be governed by board of directors consisting of the Commissioner, the Secretary of Finance, and nine citizen members to be appointed as follows: (i) two citizens at large, appointed by the Governor, subject to confirmation by the General Assembly; (ii) four citizens at large appointed by the Speaker of the House; and (iii) three citizens at large appointed by the Senate Committee on Rules. Members of the board shall be appointed for six-year terms. The citizen members shall have knowledge of health insurance issues. If a vacancy occurs on the board, the person or officer who made the original appointment to the board shall fill the vacancy for the unexpired term with a person who has the appropriate qualifications to fill that position on the board.

C. The Commissioner shall designate one of the appointees to the board to serve as chairman. The chairman shall serve at the pleasure of the Commissioner.

D. A member of the board shall not be liable for an action or omission performed in good faith in the performance of the powers and duties under this chapter and a cause of action shall not arise against a member for such action or omission.

§ 38.2-6302. Plan of operation for the pool.

A. The initial board of the pool shall submit to the Commissioner a plan of operation for the pool that will assure the fair, reasonable, and equitable administration of the pool.

B. In addition to the other requirements of this chapter, the plan of operation shall include procedures for:

1. Operation of the pool;

2. Selecting an administrator;

3. Creating a fund, under management of the board, for administrative expenses;

4. Handling, accounting, and auditing of money and other assets of the pool;

5. Developing and implementing a program to publicize the existence of the pool, the eligibility requirements for coverage under the pool, enrollment procedures, and to foster public awareness of the plan;

6. Creation of a grievance committee to review complaints presented by applicants for coverage from the pool and insureds who receive coverage from the pool; and

7. Other matters as may be necessary and proper for the execution of the board's powers, duties, and obligations under this chapter.

C. After notice and hearing, the Commissioner shall approve the plan of operation if it is determined that the plan is suitable to assure the fair, reasonable, and equitable administration of the pool.

D. The plan of operation shall become effective on the date it is approved by the Commissioner.

E. If the initial board fails to submit a suitable plan of operation within 180 days following the appointment of the initial board, the Commissioner, after notice and hearing, may adopt all necessary and reasonable rules to provide a plan for the pool. The rules adopted under this subsection shall continue in effect until the initial board submits, and the Commissioner approves, a plan of operation as provided under this section.

F. The board shall amend the plan of operation as necessary to carry out this chapter. All amendments to the plan of operation shall be submitted to the Commissioner for approval before becoming part of the plan.

G. By not later than December 1, 2007, the board shall report to the Governor, the President of the Senate, and the Speaker of the House the results of an actuarial study conducted by the board to determine:

1. The impact that the creation of the plan will have on the small group insurance market and the individual market on premiums paid by insureds. This shall include an estimate of the total anticipated aggregate savings for all small employers in the state;

2. The number of individuals the pool could reasonably cover at various premium levels; and

3. An analysis of various sources of funding and a recommendation as to the best source of funding for the future anticipated deficits of the pool.

H. Coverages available under the Virginia Health Insurance Risk Pool shall be made available not later than January 1, 2007.

§ 38.2-6303. Powers of the pool.

A. The pool is authorized to exercise any of the authority that an insurance company authorized to write health insurance in this state may exercise under the laws of this Commonwealth.

B. As part of its authority, the pool shall have the authority to:

1. Provide health benefits coverage to persons who are eligible for that coverage under this chapter;

2. Enter into contracts that are necessary to carry out its powers and duties under this chapter including, with the approval of the Commissioner, entering into contracts with similar pools in other states for the joint performance of common administrative functions or with other organizations for the performance of administrative functions;

3. Sue and be sued, including taking any legal actions necessary or proper to recover or collect assessments due the pool;

4. Institute any legal action necessary to avoid payment of improper claims against the pool or the coverage provided by or through the pool, to recover any amounts erroneously or improperly paid by the pool, to recover any amount paid by the pool as a mistake of fact or law, and to recover other amounts due the pool;

5. Establish appropriate rates, rate schedules, rate adjustments, expense allowance, agents' referral fees, and claim reserve formulas and perform any actuarial function appropriate to the operation of the pool;

6. Adopt policy forms, endorsements, and riders and applications for coverage;

7. Issue insurance policies subject to this chapter and the plan of operation;

8. Appoint appropriate legal, actuarial, and other committees that are necessary to provide technical assistance in operating the pool and performing any of the functions of the pool;

9. Employ and set the compensation of any persons necessary to assist the pool in carrying out its responsibilities and functions;

10. Contract for stop loss insurance for risks incurred by the pool;

11. Borrow money as necessary to implement the purposes of the pool;

12. Issue additional types of health insurance policies to provide optional coverages that comply with applicable provisions of state and federal law;

13. Provide for and employ cost containment measures and requirements including, but not limited to, preadmission screening, second surgical opinion, concurrent utilization case management, disease-state management, and other risk reduction practices for the purpose of maximizing effectiveness and cost savings to the pool, its insureds, and payers;

14. Design, utilize, contract, or otherwise arrange for delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations and health maintenance organizations;

15. Provide for reinsurance on either a facultative or treaty basis, or both; and

16. Develop through research and surveys of insurers offering individual health insurance coverage in the Commonwealth reasonable guidelines for acceptance of risk in the individual health insurance market.

C. The board shall promulgate a list of medical or health conditions for which a person shall be eligible for pool coverage without applying for health insurance. The list shall be effective on the first day of the operation of the pool and may be amended from time to time as may be appropriate and as treatment outcomes and disease state management practices change due to advances in medicine.

D. Not later than October 1 of each year, the board shall make an annual report to the Governor, the General Assembly, and the Commissioner. The report shall summarize the activities of the pool in the preceding calendar year, including information regarding net written and earned premiums, plan enrollment, administration expenses, and paid and incurred losses.

§ 38.2-6304. Administration of the pool.

A. After completing a competitive bidding process as provided by the plan of operation, the board may select one or more insurers or a third-party administrator certified by the Bureau to administer the pool.

B. The board shall establish criteria for evaluating the bids submitted. The criteria shall include:

1. An insurer's or third-party administrator's proven ability to handle individual accident and sickness insurance;

2. The efficiency of an insurer's or third-party administrator's claims paying procedures;

3. An estimate of total charges for administering the pool;

4. An insurer's or third-party administrator's ability to administer the pool in a cost-efficient manner; and

5. The financial condition and stability of the insurer or third-party administrator.

C. The administering insurer or third-party administrator shall perform such functions relating to the pool as may be assigned to it, including:

1. Perform eligibility and administrative claims payment functions for the pool;

2. Establish a billing procedure for collection of premiums from persons insured by the pool;

3. Perform functions necessary to assure timely payment of benefits to persons covered under the pool, including:

a. Providing information relating to the proper manner of submitting a claim for benefits to the pool and distributing claim forms; and

b. Evaluating the eligibility of each claim for payment by the pool;

4. Submit regular reports to the board relating to the operation of the pool; and

5. Determine after the close of each calendar year the net written and earned premiums, expense of administration, and paid and incurred losses of the pool for that calendar year and report this information to the board and the Commissioner on forms prescribed by the Commissioner.

§ 38.2-6305. Additional powers and duties of board.

The Commission may by rule and regulation establish additional powers and duties of the board and may adopt other rules and regulations as are necessary and proper to implement this chapter. The Commission by rule and regulation shall provide the procedures, criteria, and forms necessary to implement, collect, and deposit assessments made and collected under this chapter.

§ 38.2-6306. Rates.

A. Rates and rate schedules may be adjusted for appropriate risk factors, including age and variation in claim costs, and the board may consider appropriate risk factors in accordance with established actuarial and underwriting practices.

B. The pool shall determine the standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. The initial pool rate may not be less than 125% and may not exceed 150% of rates established as applicable for individual standard rates. Subsequent rates shall be established to provide fully for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described in this subsection; however, in no event shall pool rates exceed 150% of rates applicable to individual standard risks.

C. All rates and rate schedules shall be submitted to the Commissioner for approval, and the Commissioner must approve the rates and rate schedules of the pool before use by the pool. The Commissioner in evaluating the rates and rate schedule of the pool shall consider the factors provided for in this section.

§ 38.2-6307. Eligibility; pool participation.

A. Any individual person who is and continues to be a resident of Virginia and a citizen of the United States shall be eligible for coverage from the pool if evidence is provided of:

1. A notice of rejection or refusal to issue substantially similar insurance for health reasons by two insurers. A rejection or refusal by an insurer offering only stop loss, excess loss, or reinsurance coverage with respect to the applicant shall not be sufficient evidence under this subsection;

2. A refusal by an insurer to issue insurance except at a rate exceeding the pool rate;

3. Diagnosis of the individual with one of the medical or health conditions listed by the board in accordance with subsection C of § 38.2-6303. A person diagnosed with one or more of these conditions shall be eligible for pool coverage without applying for other health insurance coverage;

4. In the case of an individual who is eligible for coverage under the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, the individual's maintenance of health insurance coverage for the previous 18 months with no gap in coverage greater than 63 days of which the most recent coverage was through an employer-sponsored plan;

5. In the case of an individual who is eligible for coverage under the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, the individual's maintenance of health insurance coverage through an open enrollment program under § 38.2-4216.1 at a rate exceeding the pool rate; or

6. Legal domicile in Virginia and eligibility for the credit for health insurance costs under § 35 of the federal Internal Revenue Code of 1986.

B. Each dependent of a person who is eligible for coverage from the pool shall also be eligible for coverage from the pool unless that person is enrolled in or is eligible to enroll in any form of health insurance or insurance arrangement, whether public or private. In the case of a child who is the primary insured, resident family members shall also be eligible for coverage if they are the siblings,

parents, or guardians of the child.

C. A person may maintain pool coverage for the period of time the person is satisfying a preexisting waiting period under another health insurance policy or insurance arrangement intended to replace the pool policy.

D. A person is not eligible for coverage from the pool if the person:

1. Has in effect on the date pool coverage takes effect, or is eligible to enroll in, health insurance coverage from an insurer or insurance arrangement;

2. Is eligible for other health care benefits at the time application is made to the pool, including COBRA continuation, except;

a. Coverage, including COBRA continuation, other continuation, or conversion coverage, maintained for the period of time the person is satisfying any preexisting condition waiting period under a pool policy; or

b. Individual coverage conditioned by the limitation described by subdivisions A 1, A 2 or A 3.

3. Has terminated coverage in the pool within 12 months of the date that application is made to the pool, unless the person demonstrates a good faith reason for the termination;

4. Is confined in a county jail or imprisoned in a state prison;

5. Has premiums that are paid for or reimbursed under any government-sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider, except as provided in subdivision A 6;

6. Has had prior coverage with the pool terminated for nonpayment of premiums or fraud; or

7. Has voluntarily terminated coverage outside the pool within six months of the date that application is made to the pool unless the person demonstrates a good faith reason for the termination.

E. Pool coverage shall cease:

1. On the date a person is no longer a resident of this state, except for a child who is a full-time student and who is financially dependent upon the parent, a child for whom a person may be obligated to pay child support, or a child of any age who is disabled and dependent upon the parent;

2. On the date a person requests coverage to end;

3. Upon the death of the covered person;

4. On the date state law requires cancellation of the policy;

5. At the option of the pool, 30 days after the pool sends to the person any inquiry concerning the person's eligibility, including an inquiry concerning the person's residence, to which the person does not reply;

6. On the thirty-first day after the day on which a premium payment for pool coverage becomes due if the payment is not made before that date; or

7. At such time as the person ceases to meet the eligibility requirements of this section.

F. A person who ceases to meet the eligibility requirements of this section may have his coverage terminated at the end of the policy period.

§ 38.2-6308. Pool coverage.

A. The pool shall offer pool coverage consistent with major medical expense coverage to each eligible person who is not eligible for Medicare. The board, with the approval of the Commissioner, shall establish:

1. The coverages to be provided by the pool;

2. At least two health benefit products to be offered by the pool;

3. The applicable schedules of benefits; and

4. Any exclusions to coverage and other limitations.

B. The benefits provisions of the pool's health benefits coverages shall include the following:

1. All required or applicable definitions;

2. A list of any exclusions or limitations to coverage;

3. A description of covered services required under the pool; and

4. The deductibles, coinsurance options, and copayment options that are required or permitted under the pool.

C. The board may adjust deductibles, the amounts of stop loss coverage, and the time periods governing preexisting conditions to preserve the financial integrity of the pool. If the board makes such an adjustment, it shall report in writing that adjustment together with its reasons for the adjustment to the Commissioner. The report shall be submitted not later than the thirtieth day after the date the adjustment is made.

D. Benefits otherwise payable under pool coverage shall be reduced by amounts paid or payable through any other health insurance or insurance arrangement and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile insurance, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or

program.

E. The pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the pool may be reduced or refused as an offset against any amount recoverable under this subsection.

§ 38.2-6309. Preexisting conditions.

A. Except as otherwise provided by this section, pool coverage shall exclude charges or expenses incurred during the first 12 months following the effective date of coverage with regard to any condition for which medical advice, care, or treatment was recommended or received during the six-month period preceding the effective date of coverage.

B. The preexisting conditions limitation provided in this section shall be reduced by aggregated creditable coverage that was in effect up to a date not more than 63 days before application for coverage in the pool.

C An eligible individual who is eligible for enrollment in the pool as a result of the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, and has 18 months of prior creditable coverage, the most recent of which is employer-sponsored coverage, shall be eligible for coverage without regard to the 12-month preexisting conditions limitation.

D. An eligible individual who is eligible for the credit for health insurance under § 35 of the federal Internal Revenue Code of 1986 shall be eligible for coverage without regard to the 12-month preexisting conditions limitation only if he had three months of prior creditable coverage as of the date on which the individual seeks to enroll in pool coverage, not counting any period prior to a 63-day break in coverage.

§ 38.2-6310. Pool funding.

A. The General Assembly shall appropriate the funds necessary to carry out the powers and duties of the pool.

B. If the General Assembly should fail in any year to appropriate sufficient funds necessary to carry out the powers and duties of the pool, the board, by July 1 of that year, shall assess insurers in accordance with subsection C an amount necessary for the continued operation of the pool for the next fiscal year. Assessments shall be due not less than 30 days after the end of each calendar quarter and shall accrue interest at a rate not to exceed 12% per annum on and after the due date.

C. Each insurer shall be assessed in an amount established by the risk pool board not to exceed $2 per covered person insured by each insurer per month. Health insurance and health plans established by federal, state, or local governments shall not be included in such assessments.

D. To the extent not otherwise prohibited by law, each insurer may itemize the cost of this assessment in statements or invoices to employers or insureds.

E. The board shall make reasonable efforts designed to ensure that each covered person is counted only once with respect to any assessment. For that purpose, the board shall require each insurer that obtains excess or stop loss insurance to include in its count of covered persons all individuals whose coverage is insured, including by way of excess or stop loss coverage, in whole or in part. The board shall allow an insurer to exclude from its number of covered persons those who have been counted by the primary insurer or by the primary excess or stop loss insurer for the purposes of determining its assessment under this section.

F. Each insurer's assessment may be verified by the board based on annual statements and other reports deemed to be necessary by the board. The board may use any reasonable method of estimating the number of covered persons of an insurer if the specific number is unknown.

G. If assessments and other receipts by the pool, board, or administering insurer exceed the actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the board to offset future losses or to reduce plan premiums. Future losses shall include reserves for claims incurred but not reported.

H. The Commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any insurer that fails to pay an assessment. As an alternative, the Commissioner may levy a forfeiture on any insurer that fails to pay an assessment when due. Such forfeiture may not exceed 5% of the unpaid assessment per month, but no forfeiture shall be less than $100 per month.

I. Each insurer and excess or stop loss carrier assessed under this section shall be allowed a tax credit to the extent of that insurer's or excess or stop loss carrier's liability to pay the gross premium tax.

J. Notwithstanding other limitations, each insurer's and excess or stop loss carrier's assessment shall not exceed that insurer's or excess or stop loss carrier's net premium tax due for the previous calendar year.

K. If the board has established or is in the process of establishing an alternative funding mechanism other than assessments of insurers for future anticipated deficits of the pool as a result of recommendations pursuant to subsection G of § 38.2-6302, such funding mechanism shall be used in

lieu of assessments of insurers as soon as is reasonably practicable.

§ 38.2-6311. Grievance procedures.

An applicant or participant in coverage from the pool is entitled to have complaints against the pool reviewed by a grievance committee appointed by the board. The grievance committee shall report to the board after completion of the review of each complaint. The board shall retain all written complaints regarding the pool at least until the third anniversary of the date the pool received the complaint.

§ 38.2-6312. Audits.

The Auditor of Public Accounts shall conduct annually a special audit of the pool. The Auditor of Public Accounts shall report the cost of each audit conducted under this chapter to the board. The board shall then promptly remit that amount to the Auditor of Public Accounts for deposit to the general fund.