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STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

March 1, 1985

ADMINISTRATIVE
LETTER 1985-6

TO: All Health Maintenance Organizations Licensed in Virginia

RE: Copayment Requirements

Section 38.1-863 of the Code of Virginia defines "copayment" as a nominal payment required of enrollees as a condition of the receipt of specific health services. During the past few months, many HMOs in Virginia have made filings or expressed in meetings with the Bureau of Insurance the position that HMOs should be allowed to market "low option" benefit packages which contain copayment amounts far above those normally contained in the benefit package of an HMO and far above what may reasonably be construed as "nominal". This has led the Bureau to a review of its requirements in this area. The following guidelines are offered to clarify what will be accepted by the Bureau of Insurance as being "nominal" copayments as required by Section 38.1-863 of the Code of Virginia, as amended.

It should be emphasized that these copayment requirements apply only to the basic benefits outlined below, and not to any supplemental health care services. It is our position that since supplemental health care services are not required to be provided by a health maintenance organization, no minimum standards for copayments for these services should be imposed.

The following is a listing of specific services and maximum copayment amounts that will be deemed to be in compliance with Section 38.1-863 of the Code of Virginia.

	Specific Services	Maximum Copayment
1.	physician services, including consultation and referral services;	lesser of 20% of the cost of the service provided, or $25.00.
2.	inpatient hospital services;	lesser of 10% of the total cost of the inpatient services for the hospital stay, regardless of the length of stay, or $100.00.
3.	outpatient medical services; (including surgery)	lesser of 20% of the cost of the service provided, or $25.00.
4.	diagnostic laboratory and diagnostic and therapeutic radiologic services;	included in the other specific services listed.
5.	preventive health services, including well-child care from birth, periodic health evaluations, immunizations, services for infertility, family planning, and eye and ear examinations for children 17 and under; and	lesser of 20% of the cost of the service provided, or $25.00.
6.	emergency health care services, including but not limited to, ambulance and out-of-area services	lesser of 20% of the cost of the service provided, or $25.00.
	Total Aggregate Copayments for Basic Health Care Services for the Calendar Year	$500.00 for each member.

Supplemental Health Care Services

No maximum copayment requirements.

The Evidence of Coverage issued by an HMO must provide for a specified dollar copayment amount for each specific basic health care service for which the HMO will require a copayment. Copayment amounts may not be expressed as a percentage of the cost of the service provided. Aggregate copayment amounts shall be expressed in the Evidence of Coverage.

These requirements will make it necessary for all HMOs licensed in Virginia to review their group agreements and evidences of coverage (whether issued on a group or individual basis) to make sure that they are in compliance with these requirements.

1. As of the date of this letter, the Bureau of Insurance will not approve any HMO policy forms, agreements, or evidences of coverage that do not conform to the copayment requirements set forth in this letter.

2. Effective 90 days from the date of this letter, any group agreements or evidences of coverage not in compliance with these requirements will be considered to be disapproved and cannot be marketed subsequent to that date. In view of this, those HMOs with forms that do not meet these requirements must withdraw them from use and file forms in compliance with these requirements within this 90 day period.

3. With regard to group contracts already in force, these may remain in force only until the anniversary date next following the expiration of 90 days from the date of this letter. At that time, all group agreements must be brought into compliance with these requirements.

4. Any evidence of coverage marketed on an individual basis prior to the expiration of 90 days from the date of this letter may stay in force, or may be amended, subject to the consent of all parties, using a form approved by the Bureau of Insurance.

Each health maintenance organization licensed in Virginia is requested to review the contents of this letter and its policy forms to ensure compliance. Please acknowledge receipt of this letter, and direct any questions concerning its contents, in writing, to:

Robert L. Wright, CLU
Supervisor
Forms and Rate Section
Life and Health Division
State Corporation Commission
Bureau of Insurance
P. O. Box 1157
Richmond, Virginia 23209

Sincerely,

James M. Thomson
Commissioner of Insurance

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