

**AHCTF – Department of Insurance Presentation
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Bob Wagner (Bob.Wagner@ins.state.il.us)
Illinois Department of Financial and Professional Regulation
Division of Insurance
320 W. Washington
Springfield, IL 62786
Phone: (217) 782-4515

4 Topics

- A. Overview of Illinois Insurance Marketplace**
 - B. ERISA**
 - C. Federal proposals; SMART Act and AHP's**
 - D. State Planning Grant activities**
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A. ILLINOIS INSURANCE MARKETPLACE

Companies offering products in the Illinois Individual market based on filings submitted by FEIN:

2000 - 34
2005 - 42

Companies offering products in the Illinois Association Group market based on filings submitted by FEIN:

2000 - 13
2005 - 22

Companies offering products in the Illinois Small Group market based on certification submitted as required by the Small Employer Health Insurance Rating Act (SEHIRA)

2001 - 54
2005 - 51

(This looks larger than expected because under SEHIRA each company under a holding company must individually submit actuarial certifications. As such there are three United filings, two Aetnas, etc. The point is the relative stability of the number of entities offering small group coverage.)

In 2003 (from the site) Illinois ranked 17 among the 50 states in the number of persons covered by employer coverage (59%), ranked 15 for the number of persons with individual coverage (5%) and ranked 22 for the number of uninsured (14%).

Percentage Point Change Among Nonelderly by Coverage Type, 2000-2003 (incl. under 18)

Percentage drop for individuals losing employer sponsored coverage was 2.8%; nationally the loss was 4.1%.

Percentage drop for individuals gaining individual coverage was .4%; nationally the gain was .2%.

Percent of Private Sector Establishments That Offer Health Insurance to Employees, 2003

U.S. - 56.2%
IL - 55.0% Rank - 25

Percent of Private Sector Establishments That Offer Health Insurance to Employees, by Firm Size, 2003 - Firms with Fewer Than 50 Employees

U.S. - 43.2%
IL - 40.2% Rank - 31

Percent of Private Sector Establishments That Offer Health Insurance to Employees, by Firm Size, 2003 - Firms with 50 Employees or More

U.S. - 95.4%
IL - 95.7% Rank - 25

B. ERISA

1. Background
 - Stands for Employee Retirement Income Security Act
 - Passed by U. S. Congress in 1974 in response to abuses and mismanagement in the private pension system. (Problems still exist today).

- But law addressed both “pension plans” and “welfare plans” (i.e., medical, hospital, accidental death and disability - broadly health insurance).
- Fact that this federal law addressed health plans or insurance was and is remarkable because
- Historically and currently - insurance is regulated at state level. There is no federal insurance regulator and no federal insurance agency.
- To extent federal government is involved in health insurance thru ERISA, it does so through the D.O.L.

2. Benefits and Concerns regarding ERISA plans

- When established carefully, competently and in accord with federal and state law, can provide sound mechanism for providing health benefits to employees.
- Just as health care utilization is volatile and difficult to predict, so is health insurance.

ERISA health plans are thus subject to financial problems.

Limited ability of state insurance regulators to assist consumers due to federal jurisdiction.

If financial failure, no state Guaranty Fund protection.

- Because federal law controls the contents of plans: policies need not be approved by state regulators.

State coverage requirements (mandates) need not be included.

- Financial regulation less extensive than state-regulated entities.

Finally: Preemption

Much of state insurance law is superseded (preempted) by federal ERISA law, but not all. Complicated.

Present reality:

Estimates are that up to half, maybe more, of employees are in ERISA plans (though they often don't know it) rather than commercial marketplace.

Thus, discussions about increasing access to health insurance must at least consider the ERISA phenomena.

C. Federal Proposals

1. SMART Act

- Stands for State Modernization and Regulatory Transparency Act.
- Not yet an introduced bill, but hearings have been held.
- What does it do:

This legislative proposal is very complex and lengthy, with 17 separate titles covering a broad range of state insurance regulatory practices such as producer licensing, company licensing, commercial and personal rate supervision, reinsurance, surplus lines insurance, regulatory information sharing, access to FBI criminal data files, life insurance, viatical transactions, and health insurance. In each area, the SMART Act requires that states adopt uniform regulatory practices that meet specific federal requirements, with federal government oversight and involvement to assure that states comply with the Act's required standards. The SMART Act is a collection of many different regulatory goals combined under the umbrella of a central federal enforcement mechanism that preempts conflicting state laws and regulations.

- State Regulatory Concerns:

1. The SMART Act would substantially and negatively impact state regulatory authority to supervise property/casualty, life, and health insurance, as well as reinsurance, by establishing federally-mandated standards and preempting state laws that disagree with them.
2. The SMART Act would create unhealthy regulatory confusion in insurance markets by subjecting state regulations and orders to

second-guessing and possible interference by a new federal entity called the State-National Insurance Coordination Partnership. In addition to raising a host of serious legal and practical concerns regarding its composition, powers, and administration, this Partnership would encourage time-consuming and expensive litigation by those who disagree with state regulatory actions, during which the legitimacy of state actions would hang under a cloud of doubt until a final resolution is reached in federal courts.

3. The SMART Act would remove the ability for independent judgment and action by state regulators to protect consumers under state laws and regulations in such important areas as supervising rates as conducting market conduct exams. Even though Illinois has often been cited by SMART Act proponents as the model rate system for all states, the Act would undercut or negate important provisions of Illinois law that make its rate system work.
4. In general, the time limits for states to implement the SMART Act's requirements are too short, and many of the Act's provisions seem impractical, unworkable, or detrimental to state consumer protection efforts.
5. Federal legislation is generally not needed to implement the various provisions of the NAIC regulatory modernization Roadmap. However, federal legislation would be welcome to enable access by all state insurance regulators to the FBI criminal database, to enable sharing of confidential regulatory information, and to grant states equal receivership powers with the federal government.

D. State Planning Grant

History and Update

Under the auspices of a grant from the U.S. Department of Health and Human Services, Health Resource and Services Administration (HRSA), Illinois developed a multi-tiered plan to: (1) identify the qualitative and quantitative demographic

characteristics and needs of the uninsured population in the state, and (2) through a consensual and participatory process to develop policies and procedures that would allow all individuals in the state access to affordable health insurance. The Illinois Department of Insurance (DOI) served as the lead agency and coordinated with other key agencies and organizations including the Illinois Department's of Public Health, Public Aid, Commerce and Community Affairs, Human Services, and the Illinois Comprehensive Health Insurance Plan (high risk pool).

Research for the grant was undertaken by two major universities: Southern Illinois University at Carbondale (SIUC), in conjunction with Program Evaluation for Education and Communities, completed a compilation and synthesis of 27 focus groups and 15 key informant interviews; and the University of Illinois-Chicago (UIC), in collaboration with the Health Research and Policy Centers and the Survey Research Laboratory (at UIC), developed and administered a random digit dial population based survey of the uninsured and newly insured population. Both institutions divided the state into five stratified regions: Northwestern, Central, Southern, Cook County and the Collar Counties of Cook County.

The Behavioral Risk Factor Surveillance System (BRFSS) and the Illinois Center for Health Statistics in the Illinois Department of Public Health provided an expansion of ongoing research and data analysis pertaining to the uninsured population in the state. The staff of the State Planning Grant (SPG) developed a three volume Research Guide containing: original review articles of topical interest (crowd-out, purchasing pools, tax credits, etc.), and articles relating to public and private sector initiatives in other states or localities considered to be of specific interest to the Illinois project; a collection and organization of the works of other researchers working on the grant; and an analysis of public programs in twenty plus states. Short stories were written or adapted to provide insights into the plight of the uninsured, a "Must Read" list was developed, and a website was created for ease of communication with constituents.

Highlights of Research Results

The rate of uninsurance in the State of Illinois falls between 9.7% and 13.4%. According to the UIC random digit dial survey there are fewer uninsured persons in the state (9.7%) than reported in the U.S. Census Current Population Survey (13.4%). This conclusion is supported by BRFSS research, which indicated that 9.8% of adults aged 18 to 64 are uninsured.

Approximately 64% of the uninsured are currently employed and nearly half of the working uninsured does not have employer-sponsored health insurance available. Almost 61% of the uninsured are employed by firms with fewer than 50 employees and are most likely to work in service occupations in service industries. Seasonal and part-time employees frequently do not have access to employer-sponsored insurance, and some employees have not been with an employer long enough to qualify for employer-sponsored insurance. The uninsured tend to be low to very low-income persons or families.

Cost/affordability is the single most important reason given for failing to acquire employer-sponsored or private health insurance. The uninsured state that premiums, co-payments, and/or deductibles make health insurance costs prohibitive. Other reasons include: limitations on eligible health care providers; perceptions that pre-existing conditions limit qualification for employer-sponsored insurance; plan quality; and lifestyle choices.

Awareness of public programs is a major issue for individuals and families who are eligible and fail to take-up public health insurance. Additional considerations include: perceptions of "taking charity"; perceptions of "poor quality"; perceptions of or previous experience of being poorly treated; a complex and burdensome application process; little or no access to health care providers; cultural barriers or documentation issues; and a belief of lack of need.

The uninsured are obtaining their medical needs through emergency rooms, various community health centers, charity from doctors, and home remedies.

The Illinois' SPG project has been focusing on designing an affordable product for Small Business owners (25 or less employees) who do not currently provide health coverage.

HMA's approach has been in designing a community based three-share concept for employer sponsored health coverage, with premium costs shared by the employer, employee and a community subsidy.

The Southern Illinois Healthcare Foundation (SIHF), which operates 20 health clinics (in 4 counties) and two hospitals (Touchette in Centreville and Kenneth Hall in East St. Louis), sponsored a series of community meetings to determine if a need existed. Representatives from the community (which include local units of government, employers, labor unions, social service advocates, insurance agents and healthcare providers, including medical practitioners) formed a committee to design a benefits package and to explore options for the community subsidy. The consensus of the group was that a need for low cost employer sponsored health coverage for St. Clair County did indeed exist. With the help and support of the SIHF the committee then met several times from March to December and was able to design a modest benefits package. At each meeting both representatives from HMA and the Illinois Department of Insurance were present and active participants providing education and technical assistance services.

We are currently working with an Actuary with considerable experience to identify alternate financing mechanisms for coverage. This activity includes researching other state programs and designing a model, such as a reinsurance pool, for Illinois. If structured properly, this type of model could possibly work in conjunction with the expansion of the three-share model.

On December 1, 2003 a broker was selected, Crossroads Consulting and Brokerage, Inc. representing Pan American Life and Health Insurance (PALHI). Coverage will be written through the PALHI American Worker Plan. Crossroads was successful in meeting most of the requirements set forth in the RFP for the benefits package and with meeting the premium level.

After the selection of the carrier Southern Illinois Healthcare Foundation (SIHF) began the process of building a provider network in St. Clair County and developing a non-profit 501(c) (3) organization to administer the plan. This entity will be responsible for the day-to-day operations of the plan, including marketing the plan to local small business owners within St. Clair County.

The next phase of the project is designed to expand the 3-share model into two additional Illinois counties, one metro and one rural. The selection process began in December 2004. The Division of Insurance, State Planning Grant, issued a Request for Information and it was sent to each county and municipal health centers. Eight responses were received. The criteria that was established for measuring responses included; 1.) Community characteristics, 2.) Demographics, 3.) Number of community groups willing to participate, 4.) Major employers, 5.) Local units of government willing to participate, and 6.) Other relevant community information. Once received the responses they were evaluated and ranked.

As for the alternate financing mechanisms and the reinsurance pool project phase, we will continue to identify the characteristics of the target population, identify the alternative reinsurance paradigms; identify potential sources for subsidies to reduce the cost of the reinsurance and develop a model to determine that cost. The target population will be a subset of all high cost individuals. First a high cost individual will be defined and a cost level after which reinsurance will cover claims will be recommended.

Additional research will focus on the Dirigo program in Maine, the Connecticut Small Employer Reinsurance Pool and other similar models. Our Actuary has in contact with a consultant who specializes in alternate financing mechanisms. They will work

together to research the features of these programs and determine if they can be applied to Illinois.

In March 2005, the Illinois Division of Insurance, in concert with the Illinois Department of Public Health (IDPH), applied for the HRSA Limited Competition Planning Grant. The grant application seeks support for IDPH to develop and promote consensus on new policy options for expanding health care coverage in Illinois, as outlined in the Health Care Justice Act (Public Act 93-0973). The request also seeks funding to develop an evaluation tool for the Illinois three-share model. We anticipate receiving notification, regarding funding availability, by September.