

Questions from Adequate Health Care Task Force (AHCTF) Members Regarding Navigant Consulting's Evaluation of Six Proposals Submitted to the AHCTF

During the July 25, 2006 Adequate Health Care Task Force meeting, the Task Force requested that the Navigant Consulting team respond to questions and concerns submitted by Task Force members and proposers regarding our evaluation of the six proposals, including the hybrid proposal. We have provided these questions and our responses below.

1. *If Single Payer becomes law, what happens to the insurance reserve funds? How much is there and can they be moved to the new system?* (Submitted by Jan Daker)

We assume that the insurance reserve funds identified above are the reserve funds set aside by health insurance carriers to cover future liabilities and reserve funds collected by employers and unions to cover current and future retiree health insurance costs included in company or union pension plans. In the case of reserve funds collected and managed by health insurance carriers, we assume that carriers would recover these funds, and in the case of publicly traded carriers, return these funds to their stockholders. In the case of reserve funds collected by employers and unions for pension plans, the treatment of these funds is less clear – for example, a company could return these funds to individual employees or the State could require that these funds be brought into the Single Payer system to cover initial program implementation costs.

2. *How much do businesses save if a Single Payer system is enacted over the long term?* (Submitted by Jan Daker)

While significant analyses would be needed to answer this question as it relates to Illinois, an extensive evaluation of a single payer plan that was introduced in the California legislature¹ indicated that the total change in spending for all private employers would be \$1.5 billion in 2006 (three percent increase in expenditures). Private employers who were providing coverage in 2004 would save \$7.9 billion in estimated 2006 expenditures (16 percent). For employers not providing health coverage as of 2004, spending for health coverage, due to new payroll taxes, would increase by \$9.4 billion. The report also found that California firms with 25-99 workers would see an increase in spending per worker under a Single Payer system, but all other firms would see a decrease in health spending per worker under the system. Also, most industries, with the exception of wholesale trade and the services industry, would see a decrease in spending per worker under the new system, with the transportation and manufacturing industries receiving the largest savings.

¹ Sheils, J.F. and Haught, R.A, The Lewin Group, "The Health Care for All Californians Act: Cost and Economic Impacts Analysis. Analysis Based Upon SB 921 as of April 30, 2004 With Clarifications Provided by Author's Staff," (January 19, 2005). Available online: <http://www.healthcareforall.org/lewin.pdf>.

3. *Is there the possibility of floating a bond for transitional costs that is backed up by a portion of a “premium” surcharge that goes away once the system has converted and the bonds are paid off?* (Submitted by Jan Daker)

Floating a bond to cover the transitional costs of a Single Payer system is one option the Task Force and the State could consider. For purposes of applying this approach to the Single Payer proposal in front of the Task Force, we assume that the State would add an additional surcharge to the payroll taxes collected to fund the system to repay the bond. The State would then remove this surcharge from the payroll tax once the State converts the bond.

4. *Please provide an estimate of the cost of IHERC.* (Submitted by Craig Backs)

We estimate that the cost of IHERC will range between \$3 million - \$4 million annually. We base this estimate on the cost of Maine’s Dirigo Health Agency. The Dirigo Health Agency is an independent agency that determines eligibility and enrollment in the Dirigo Health Plan, conducts enrollment, arranges for health care coverage and provides subsidies to eligible individuals. We anticipate that the creation of IHERC will allow for additional cost savings for the State because it will consolidate some of the functions of the Division of Insurance, the Department of Health and the Department of Healthcare and Family Services.

5. *Will you please provide the assumptions used to derive the administrative cost percentages used in the model?* (Submitted by selected members of the insurance industry)

Please see Attachment A for Milliman, Inc.’s response.

6. *Please comment on the impact of various proposed changes to the insurance market.* (Various Task Force members and proposers)

This section responds to a number of questions about the impacts of various insurance market reforms. These include:

- **Guaranteed issue** – Guaranteed issue is the requirement that all insurance carriers issue coverage of any product on demand. In a guaranteed-issue market, carriers may not deny coverage to any applicant, if they meet the contractual terms of coverage (for example, at least minimum employee participation in a group plan). By federal law, coverage for small groups (2-50) is guaranteed issue in every state, but each state determines whether individual coverage is guaranteed issue.
- **Community rating** – Community rating is the requirement that insurance carriers set premiums that do not vary by individual health status. In states that require community rating in the small-group and/or the individual market,

premiums may not reflect differences in health status among otherwise similar groups or individuals. In states that require *pure* community rating, premiums may not reflect differences in any circumstance or personal characteristic, although they may vary by benefit design, family type (e.g., individual, couple, individual and child/ren, couple and child/ren), and geographic location.

- **Rate bands** – Rate bands are the requirement that insurance carriers constrain how widely premiums vary to reflect specific risk factors or characteristics (such as age or health status). *Comprehensive rate bands* constrain rate differences for all characteristics taken together (so that the highest rate may not exceed some proportion of the lowest rate charged for the same product, in the same geographic location, for the same family type). Currently, Illinois has comprehensive rate bands of plus or minus 25 percent for small group coverage—that is, the premium cannot exceed 167 percent of the lowest premium for the same product sold to a small group in the same location. Premium increases cannot exceed medical trend plus 15 percentage points. In the individual market, Illinois does not restrict either the variation in premiums for specific rate factors or overall, nor does it restrict premium increases. Carriers may use any rate factors they choose to set premiums for individual coverage.

- a. *What have been the effects of guaranteed issue of individual coverage when health insurance is voluntary?*

Very few studies looking for impacts of insurance market reforms have focused directly on the individual market and also controlled for other concurrent reforms. With respect to voluntary individual coverage, these studies found that guaranteed issue apparently permitted individuals with relatively high medical cost into the market, where they had been denied coverage before. The end result of this change in states that have enacted guaranteed issue of individual coverage (controlling for differences in concurrent regulation) has been an apparent reduction in coverage. The presumed dynamic behind this result is an increase in premiums following guaranteed issue, reflecting both higher average medical cost and more conservative insurer reserving.²

However, at least one other research study did not find this result. In New Jersey, guaranteed issue (together with and pure community rating) in the State's Individual Health Coverage Program (IHCP) produced no early evidence of a change in coverage.³

² D.J. Chollet, K.I. Simon, and A.M. Kirk (2000), "What Impact HIPAA? State Regulation and Private Health Insurance Coverage Among Adults." Report to the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services [www.aspe.gov/].

³ K. Swartz and D.W. Garnick (1999), "Can Adverse Selection Be Avoided in a Market for Individual Health Insurance?" *Medical Care Research and Review* 56(3): 373-388. See also: K. Swartz and D.W. Garnick (February 2000), "Lessons from New Jersey." *Journal of Health Politics, Policy and Law* 25(1): 45-70.

With more consistent and robust participation (as would occur with an individual mandate for coverage), the dynamic that, in a voluntary market, would raise premiums and reduce coverage is unlikely to occur. That is, it is unlikely that guaranteed issue would introduce disproportionately high-cost individuals into the market. Regardless of health status or medical risk, individuals could leave the individual market only in favor of group coverage or public coverage, if it is available to them; the lowest-risk individuals could not forego coverage altogether.

- b. *What have been the effects of community rating and/or narrow rate bands in the small group market?*

Very few studies have examined the impact of regulation on insurance prices directly, in either the small group market or the individual market. The studies that have attempted to do so have appear only in the “gray” literature and are seriously compromised by inadequate controls for the many factors that affect price—including benefit design, risk selection, utilization, medical cost, and the net cost of insurance.

Recognizing these problems, the professional research literature has taken a different path, exploring the ultimate impact of community rating and/or rate bands on coverage. This literature assumes that (all else being equal) lower rates of coverage correspond to higher premium levels and that some small employers and/or employees would drop coverage if regulation caused an increase in premiums. However, even in this literature, how the regulatory variables are constructed strongly affects the findings. Moreover, all of the studies rely on very few observations of change.

Most early studies of small-group rate regulation found little or no effect of community rating on overall coverage in the small group market, and more recent studies have confirmed this overall finding.⁴ However, recent studies also have looked for and found some differences by risk group, concluding that:

- In states with community rating, higher-risk individuals (specifically, married women of childbearing years with children) may gain coverage.⁵

⁴ For example, T. C. Buchmueller and J. DiNardo (2002), “Did Community Rating Induce an Adverse Selection Death Spiral? Evidence from New York, Pennsylvania, and Connecticut.” *American Economic Review* 92(1): 280-294; and A. C. Monheit and B. Schone (2004), “How Has Small Group Reform Affected Employee Health Insurance Coverage?” *Journal of Public Economics* 88(1-2): 237-254.

⁵ K. I. Simon (2002), Did Small Group Health Insurance Reforms Work? op cited in: K. I Simon (2004), “What Have We Learned from Research on Small Group Insurance Reforms?” In *State Health Insurance Market Reform*, edited by A.C. Monheit and J.C. Cantor. New York: Routledge, pp. 21-45.

- High-risk workers are more likely to find or retain coverage when small group coverage is community rated, and especially in states that also have narrow rate bands overall.⁶

It is possible that community rating may increase premiums for healthier and younger groups and, all else being equal, would discourage employers from offering coverage to such groups. In turn, when employers require significant premium sharing, groups that are charged more due to community rating lower-risk workers may be more likely to decline coverage. Only one study has looked at this issue using appropriate methods and data. It concluded that low-risk workers (specifically, single men under age 36) in small firms are more likely to become uninsured in states with narrow rate bands. However, the magnitude of the effect was small.⁷

c. *What have been the effects of community rating and/or narrow rate bands in the individual market?*

All of the caveats with respect to direct observation of prices in the small group market (described above) apply to direct observation of prices in the individual market. However, even fewer studies have examined the potential effects of rating reforms in the individual market—although it is possible that community rating and/or narrow rate bands would have a much greater impact on premiums and coverage in the individual market.

Only two studies have examined these effects specifically with regard to individual coverage, accounting for other concurrent regulation. These studies found that:

- In a voluntary market, rate regulation can have complex effects. Specifically, narrower *rate bands on health* (including community rating) appear to raise coverage among some populations—lower-income healthy adults and adults with health problems. But narrow *comprehensive rate bands* (including pure community rating) may reduce coverage among healthy adults—particularly at low levels of income.⁸
- However, in New Jersey, pure community rating (combined with guaranteed issue) produced no early evidence of a change in coverage.⁹ While a more recent study observed that new enrollees to the State’s Individual Health

⁶ A.C. Monheit and B. Schone (2004), *op cit*.

⁷ Simon (2002), *op cit*.

⁸ This study controlled for the presence and size of a high-risk pool; studies without this control found no such effects on coverage. Chollet, D.J. and E. Schone (2002), “Expanding Health Insurance Coverage: High Risk Pools and Market Regulation.” Mathematica Policy Research Working Paper. Washington, DC.

⁹ K Swartz and D.W. Garnick (1999), “Can Adverse Selection Be Avoided in a Market for Individual Health Insurance?” *Medical Care Research and Review* 56(3): 373-388. See also: K. Swartz and D.W. Garnick (February 2000), “Lessons from New Jersey.” *Journal of Health Politics, Policy and Law* 25(1): 45-70.

Coverage Program (IHCP) were significantly older than earlier enrollees, it was unclear whether the apparent selection of risk was a result of pure community rating (together with guaranteed issue) or changes in group coverage that occurred during the same time period.¹⁰

7. *What is the source of information that Deborah Chollet used to discuss Illinois' individual health insurance market during the meeting on July 25, 2006?*

We obtained information for all carriers that filed in Illinois either as health companies or as life, accident, and health companies in 2004 from the National Association of Insurance Commissioners. We estimate that property casualty companies in Illinois accounted for less than 3 percent of the market, and did not obtain information for these companies. All health or life companies that reported either premiums earned or claims incurred associated with individual coverage (excluding Medicare Supplement or Medicare only) are reported in Exhibit 1 on the following page.

In Illinois, two large commercial carriers—Country Life Insurance Company and Unicare-Midwest—accounted for more than half of the individual market. Traditionally the largest carriers in the individual market, Blue Cross of Illinois and United Healthcare, had essentially left the individual market by 2004; United Healthcare remained with very low premium volume, and was operating in the individual market at a loss.

¹⁰ A.C. Monheit, J.C. Cantor, M. Koller, and K.S. Fox (2002). Community Rating and Sustainable Individual Health Insurance Markets: Trends in the New Jersey Individual Health Coverage Program. Unpublished manuscript. Center for State Health Policy, Rutgers University.

EXHIBIT 1
NONGROUP MAJOR MEDICAL CARRIERS IN ILLINOIS:
PREMIUMS, CLAIMS, AND MEDICAL LOSS RATIOS 2004

Company name	Premiums (\$ in millions)	Claims (\$ in millions)	Estimated medical loss ratio
<i>Health companies</i>			
United Healthcare Of IL Inc	\$1.0	\$1.2	1.19
<i>Life, accident and health companies^a</i>			
Country Life Ins Co	\$55.7	\$34.1	0.61
Unicare Health Ins Co Of The Midwest	\$39.4	\$26.7	0.68
Humana Ins Co	\$17.0	\$12.9	0.76
American Republic Ins Co	\$13.9	\$11.1	0.80
Washington Natl Ins Co	\$12.7	\$8.9	0.70
Bankers Life & Cas Co	\$8.7	\$6.2	0.71
Union Bankers Ins Co	\$5.8	\$4.3	0.74
All other carriers (n=28)	\$27.4	\$15.4	0.56
TOTAL	\$181.3	\$ 120.7	66.5%

Source: Mathematica Policy Research, Inc. Estimates derived from company annual statements, as compiled by the National Association of Insurance Commissioners (NAIC).

^a Premiums and claims for life, accident, and health companies are estimated from aggregated health-line information as reported by each company.

8. *Will you please provide a general discussion of employer “play or pay” initiatives?* (Submitted by Campaign for Better Health Care and Health & Disability Advocates)

Some of the proposals in front of the Adequate Health Care Task Force recommend an employer mandate. Generally speaking, an employer mandate requires that employers to pay a “health coverage” fee (per employee or as a percent of payroll) to the State. Employers who wish to provide health coverage directly to their employees can obtain a credit against this fee. The State uses the fees collected to provide coverage to State residents. We have listed key considerations below that Illinois should take into account if it decides to implement an employer mandate.

- **Which employers will be assessed the fee?**

The State should consider whether it will apply the mandate to all employers regardless of size, or exempt certain classes of employers (i.e., small and/or low-wage employers). While including all employers in a mandate would treat all employers the same and avoid placing a disproportionate burden on a particular employer group, those employers that do not currently offer coverage (typically small employers) may need full or partial relief from the new costs associated with the mandate.

- **What classes of employees will be used to determine an employer’s fee obligation?**

The State will need to consider whether the fee will be based on full- and part-time employees or just full-time employees. It also must decide how to define the applicable categories of employees (i.e., number of hours). Including part-time employees in the assessment (proportionate to payroll) will discourage the substitution of part-time for full-time workers. However, it will also increase the cost to employers of hiring on a part-time basis (relative to full-time workers whom already may have a health care expense associated with their positions), which could decrease the number of part-time positions available. The State may also want to consider limiting the amount of capping the per employee wages subject to the assessment reflecting the real world dynamic in which health care benefits represent a very small portion of total compensation for those with very high salaries.

- **What will the level and basis of the fee assessed be?**

The State should consider how the amount of the fee will affect employers’ willingness to provide health coverage. Ideally, the fee would be set so as to distribute the burden of employee health coverage fairly, yet maintain current levels of employer coverage (to preserve the efficiencies of group purchasing)

and not be too onerous for non-offering employers. The State will need to avoid making the fee so small that employers currently providing coverage may choose to pay the fee instead.

- **How will the credit against the fee be determined?**

The State must decide what type of coverage qualifies as a credit against the fee. This involves answering the following questions:

- a) How much will employers be required to contribute to health benefits for their employees?
- b) What type of benefit packages must the employers provide?
- c) What types of employees/dependents must receive an offer?
- d) Do employees need to be offered or to have taken the coverage for the employer to receive a credit?

- **How will the program interact with ERISA regulations?**

The federal Employment Retirement Income Security Act (ERISA) is a federal statute intended to provide relief from inconsistent state or local regulation of employee benefit plans, including health benefits for interstate employers. ERISA prevents states from directly regulating coverage arrangements established by employers. The act does not preclude states from regulating insurers and health plans with which employers contract. The structure of the pay-or-play mandate is designed to work around ERISA considerations since states are allowed to assess fees or taxes and the direct provision of coverage remains voluntary under the program. Nonetheless, the State would likely face a legal challenge in the event that such a program is introduced into law (see Massachusetts's experience with an employer mandate below).

Several states have implemented or attempted to implement employer mandates. We provide a brief description of these efforts in California, Hawaii, Maryland, Massachusetts and Vermont.

- **Massachusetts** recently enacted a law that requires employers with 10 or more employees to make a per worker "fair share" contribution equal to the cost of free care used by its employees. The State caps the contribution at \$295 per full time equivalent (FTE) employee. The law also requires employers with 11 or more employees to offer a Section 125 "cafeteria plan". Employers who do not offer insurance will be subject to a "free rider" surcharge if their employees

access free care a total of five times per year or one employee uses free care more than three times. The surcharge will range between 10 and 100 percent of the State's cost of the services provided, but the first \$50,000 per employer will be exempt.

- **Vermont's** newly developed Catamount Health Plan assesses \$365 per (FTE) employee from employers if employees are not offered coverage; if employers offer coverage but the employee is ineligible for coverage through the employer and if employees are offered coverage but choose not to enroll and are therefore uninsured.
- **Hawaii** implemented an employer mandate in 1974 that required nearly all Hawaiian employers to provide health insurance to employees who work 20 hours or more per week for four consecutive weeks. Hawaii has one of the highest rates of employer-sponsored insurance across the nation.
- **Maryland** passed a law in 2005 that would have required employers with 10,000 employees in the State to make expenditures on employee health insurance of at least eight percent of total compensation to their employees. This law would have only applied to Wal-Mart and two other very large employers. The U.S. District Court for the District of Maryland recently ruled against this law, ruling that the law conflicts with and is preempted by ERISA since it imposes on covered employers different health care obligations on employers for their employees in Maryland than those required for employees elsewhere in the country.
- **California** introduced an employer mandate in 2003 that would have required employers with 50 or more employees to either provide coverage or pay a fixed fee into a State fund for a public program to cover their workers. The State's voters rejected the law in 2004.

Attachment A

Milliman Inc.'s Response