Competition and Flexibility Key to Quality, Accessible Health Care in Illinois – A Minority Report in Dissent from the Majority Recommendation of the Illinois Adequate Health Care Task Force

The members of the Adequate Health Care Task whose signatures appear at the conclusion of this document do hereby dissent from the majority which has approved the final Hybrid Model Plan for consideration by the Governor and the Illinois General Assembly. We submit this Minority Report to express our deep concern regarding the provisions and recommendations contained in the majority- approved plan and the quality of the underlying data upon which those recommendations are based.

This minority report asserts that the plan advanced by the Adequate Health Care Task Force will, if implemented, increase health care costs, reduce consumer choice of health care coverage, have a negative effect on the quality of health care provided to the citizens of Illinois and restrain job growth.

I. Overview –

In August, 2004, the Illinois General Assembly passed the Health Care Justice Act, creating the Adequate Health Care Task Force under the banner of one worthy and ambitious goal: "It is a policy goal of the state of Illinois to ensure that all residents have access to quality health care at costs that are affordable." As members of the insurance and employee benefits industries, we were pleased to be invited to participate in the process, and we were impressed with the commitment of the General Assembly and the Department of Public Health to develop a fair and workable process. Today, after two years, one million dollars in taxpayer funds and hundreds of volunteer hours, the Task Force delivers its report back to the General Assembly. **Unfortunately, it is the opinion of the undersigned that the report jeopardizes the very goal articulated in the Act.**

It is important to note that the terms "health care" and "health insurance" have become virtually – and incorrectly - interchangeable in the public mind. Unfortunately, this false belief has served to cloud many of the issues related to reform of America's health system and covering the uninsured. In fact, this distinction is not clear in the recommendations of the Task Force nor was it clear during our deliberations. One of the guiding principles of our minority report and our recommendations to the Task Force is that health insurance is expensive because health care is expensive. **Sadly, the Task Force recommendations do absolutely nothing to address these costs. And, the recommended Hybrid Plan will add to administrative complexity – and costs – for employers, insurers and the State of Illinois.**

When considering the uninsured, this background cannot be ignored. Many people are uninsured because health care services are expensive. Illinois has one of the most competitive health insurance markets in the country. This helps keep administrative costs in check while providing consumers with dynamic and innovative health insurance products.

It must be said that we believe the Task Force did much valuable work. The public hearing process, where Illinois citizens were given the chance to express their strong views about our health care system, was eye-opening – often movingly so.

Throughout this minority report, we will outline our strong concerns regarding the process; the data and facts used – or ignored – during deliberations; specific concerns with the Task Force recommendations; and our suggestions for a more workable solution. We urge members of the Illinois General Assembly to reject the Task Force proposal, and we offer our assistance in developing real policy solutions that will fulfill the Health Care Justice Act's goal of increased access to quality care at costs that are affordable.

II. Process Concerns

Legislative

- The Illinois Health Care Justice Act was passed in 2004. The Act was initially drafted to move Illinois to a single-payer, government run health care system. As the bill was amended, the creation of the task force was added. However, the goals articulated in the Act directed the outcome to one that would rely heavily on an expansion of government to fully meet the goals enumerated in the Act.
- The task force was not appointed for more than one year after the Act was passed into law. During this year, consumer-directed health care, a movement to engage consumers more actively in health care decision-making, was gaining ground across the nation. It is likely that a Health Care Justice Act considered in 2005 would have taken a different approach to the problem of the uninsured.

Organizational

- The task force was appointed by each of the Legislative Leaders and the Governor. This structure was transplanted to the organizational structure of the task force. This was especially constraining given the development of a Steering Committee to direct the task force's efforts. Only one member appointed by each of the appointing authorities was allowed on the Steering Committee.
- Most of the meetings of the task force were conducted as a committee-of-the-whole limiting dialogue and input.
- Meeting topics and presenters were biased in favor of government expansion proposals. Private sector alternatives and considerations were only considered after they were demanded by the signers of this minority report.

Operational

- Discussion of critical issues was severely limited by the structure of the meetings. Meetings were almost exclusively seminars on different aspects of the health care system and discussion was limited.
- Critical issues that became embedded in the consultants' analysis were not discussed by the task force or were not determined by task force members. There was little discussion or attempts to reach agreements on the critical issues of employers mandates, individual mandates, measures to control health care costs, the role of government in providing and paying for health care and problems or opportunities with Medicaid.
- Most votes taken by the task force were articulated as straw polls. These straw polls were then used to determine the direction of the proposals. Few votes were recorded votes.
- The Steering Committee made decisions regarding analysis and development of proposals that did not reflect votes of the task force. The consultants were instructed to pursue development solely of the hybrid plan alternative despite desires by task force members to continue consideration of all proposals.

Analytical

- The consultants made decisions regarding relative importance of issues that had not been determined by the task force. Proposals were weighed against these consultant-derived standards. Example: Proposals were assessed for "proper load-sharing" a term that was neither defined by the task force nor by the consultants.
- Consultants ignored facts and statistics that conflicted with their world view. These facts were supported by multiple and reliable sources. They were unwilling to incorporate these facts into their analysis as an addition to their own data. The most egregious evidence of this was the use of administrative costs in both the public and private health care sectors that were sharply divergent from multiple alternative sources.
- Consultants consistently used data external to the state of Illinois even when data specific to Illinois was available and more valid. Illinois' health care and insurance markets are distinctly different from Maine, Massachusetts or New York, for example.
- Consultants did not provide any econometric analysis to support their recommendations or analysis. Recommendations to greatly increase the state's spending for health care or those to require businesses to shoulder a dramatic increase in costs should only be considered in tandem with possible outcomes.

III. Specific Concerns Regarding the "Hybrid" Plan Adopted by the Task Force

- The proposed hybrid model expands government through the employer system. The hybrid model also proposes significant cost increases from the employer community to pay for the changes. Employer fees or taxes are estimated to

increase by $1.5 billion with nearly $3.6 billion in additional spending from funding sources that have not yet been identified.

- The Hybrid Model fails to include options to engage consumers in the use of the health care system utilizing the recently enacted federal laws regarding Health Savings Accounts (HSAs). While these plans call for high deductible health plans in order to qualify for the tax-favored HSAs, they have been well-received by people who had been uninsured. More importantly, these plans are undergoing almost constant change with new provisions enacted in December, 2006 that are expected to make these plans even more attractive and cost-effective alternatives.

- The Hybrid Model seems opposed to the creation of plans that focus on wellness and consumer choice. The Hybrid Model provides very little insight as to how cost containment is addressed. The Hybrid Model's recommendations of "guaranteed" issue for insurance coverage and dramatic reductions in the small group rating bands arguably remove any incentive for individuals to engage in wellness behavior. These proposals in particular fail to encourage employees to practice more healthy lifestyles, which is an essential part of reducing the need for remedial heath care treatment and services and thus the cost of health care. The Hybrid Model uses the private sector as a smokescreen to accomplish dramatic increases in government intervention into the system of employer-provided health care benefits. By requiring a specific amount to be spent by an employer on health care benefits and defining a "standard health care benefit package", innovation and cost-effectiveness will be diminished. Employer needs for flexibility and innovation have driven plan design, and have proven to be more cost effective methods of providing health care benefits.

- While the Hybrid Model purports to spread the "pain" to all parties, the employer community is responsible to shoulder the bulk of the costs, to the tune of $1.5 billion in new fees or taxes for employers. Employers will likely also be called upon to pay for the lion's share of the $3.6 billion for which the Hybrid Model fails to provide funding. The plan does nothing to address health care costs or affordability. Rate restrictions are imposed on private insurers, but there are no cost-containment measures on the provider side. Cost containment needs to be spread across all participants in the healthcare industry, not just one constituent. Premium subsidies will help reduce employees' share of the cost of coverage, but do nothing to reduce the overall cost of coverage. Unless the subsidies are large enough to make coverage truly affordable, they will do nothing to increase employee participation.

- "Risk spreading strategies" such as the creation of a state-sponsored self-insured plan fail to spread risk and discourage innovation in the private sector. What incentive does a private plan have to provide guaranteed issue products if a state self-insured plan exists? What appeal is there for consumers to buy into a plan that relies on Medicaid providers and rates? Higher reimbursement rates are probably not enough to get more providers on board, creating access problems that would not exist under a private plan. The social stigma imposed by Medicaid may further limit consumer interest.

- The voluntary nature of the reinsurance program is counterproductive. A voluntary program provides no guarantees that an adequately- funded reinsurance program will exist, so carriers cannot base rate determinations on the assumption that reinsurance will act as stop-loss coverage. Without a reinsurance program, higher risk consumers will remain in the general insurance pool, preventing carriers from lowering rates. A plan- funded reinsurance program would have to create significant savings for carriers in order to make it worth participating in the program.

- The authors of this minority report do not support the individual mandate included in the Task Force's recommended plan. If health insurers are allowed to develop innovative, affordable products and to educate consumers on the value of health insurance, the authors believe that market forces will reduce the number of uninsured Illinois residents as an example, in 2004-2005, private insurance carriers provided new individual health insurance policies to 753,000 people across the country who previously had been uninsured.

- Given the number of state mandated benefits currently required in Illinois, the authors of this minority report are concerned that "affordable" products may not be available to every individual in Illinois. Further, because the proposed penalty on individuals who do not obtain coverage is minimal, it may not be an effective means of ensuring that every individual obtains health insurance coverage.

- The authors oppose the play-or-pay mandate on employers contained in the plan being recommended by the Task Force. Such mandates create a perverse incentive for small employers to escape compliance with the mandate through various means such as reducing wages, hiring independent contractors instead of full-time employees, or reducing the size of their workforce below the threshold for the mandate. As an alternative, the authors of this minority report support federal tax credits to encourage small employers to offer coverage to their workers.

- The play-or-pay mandate on employers also likely violates The Employee Retirement Income Securities Act (ERISA), the federal law that regulates voluntarily established employee benefit plans in the private market, including health care. The mandate requires employers to maintain a minimum plan of benefits, or face penalties. The sample assessment used in the 7th version of the Updated Coverage Expansion Model put forth by the Adequate Health Care Task Force would require employers to contribute at least 4.8 percent of payroll for their Illinois employees. These are the same type of legal requirements imposed on employee welfare benefit plans that were struck down by the Maryland federal district court in the recent legal challenge to the Maryland Fair Share Health Care Fund Act (also known as the Maryland "Wal-Mart" law, for its principal effect upon Wal-Mart.).[1]

  The Maryland law imposed several requirements on non-governmental employers of 10,000 or more people in that state. It required a for-profit employer failing to spend up to 8% of the total wages paid to employees in the state on health insurance costs to pay to the state an amount equal to the difference between what the employer spent for health insurance costs, and the 8% of total wages paid to Maryland employees. The Maryland law also required an employer to report annually its total number of employees in the state, the amount spent by the employer on health insurance costs, and the percentage of payroll the employer spent on health insurance costs.

  In general, ERISA preempts state laws relating to employee welfare benefit plans. The main objective of ERISA's preemption clause is to avoid different state legal obligations to permit nationally uniform administration of employee welfare benefit plans. In its decision, the Maryland federal court emphasized that because the purpose and impact of the Maryland law would be to require Wal-Mart to expand its ERISA health plan, thus interfering with the national uniform administration of the Wal-Mart plan, ERISA preempted the state law. Similarly, the current Task Force proposal requires employers to maintain a minimum plan of benefits (or face penalties) and to spend a certain percentage of payroll on employee benefits, and would similarly violate ERISA.

  - The authors of this minority report are concerned that the Adequate Health Care Task Force's health care reform plan could pose regulatory and operational issues for health plans through the Illinois Health Education and Referral Center (IHERC).
    - The IHERC approval process will likely commoditize products available to consumers, thus limiting choice in the marketplace.
    - It is very unclear what the funding source of IHERC will be. If IHERC is funded, in whole or in part, by insurer assessments, insurers' administrative costs will rise. Any such increase in cost will likely be passed down to consumers in the form of higher premium prices.

[1] Retail Industry Leaders Ass'n v. Fielder, Civil No. JFM-06-316 (July 19, 2006), found at http://www.mdd.uscourts.gov/Opinions152/Opinions/Walmartopinion.pdf

- The regulatory roles of the Division of Insurance and the IHERC are not yet clear, which may lead to confusion in the health insurance industry, postpone the introduction of new, affordable products to consumers, and provide for unnecessary dual regulation.

- The Hybrid proposal includes new insurance regulations including a provision called "guaranteed issue." Existing HIPAA Portability laws have accommodated for sick individuals who are not otherwise eligible for health insurance to obtain coverage through the State Health Insurance Pools. To implement another/different layer of "Guaranteed issue" in Illinois right now would be to add an inconsistent layer of regulation on our system and would impose a requirement that has proven ineffective in other states. For many reasons, "guarantee issue" of individual coverage has driven carriers out of the individual marketplace in many states. It allows people to wait until they are sick to buy insurance, thus driving up the cost of coverage. It is often compared to allowing people to buy homeowners insurance when their house is already on fire.

  While the concept of "guaranteed issue" appears to be attractive it has been found to, quite understandably, drive up insurance prices. Insurance then tends to become less attractive to everyone except those who have a serious health condition. The cycle continues as fewer healthy people purchase insurance, business dwindles and insurers leave the market. Ultimately, less competition and fewer insurers in the market push prices even higher. This has happened in every state that has experimented with "guaranteed issue."

IV. Positive Suggestions for Viable Change

The authors of this minority report presented a plan to the Adequate Health Care Task Force that met all of the requirements of the Health Care Justice Act and did so utilizing the savings realized through a mandatory managed care program for Medicaid to fund the costs of the program expansions contained therein. No new taxes or enhanced revenue streams are necessary to implement this plan. This minority report reasserts the position that the State of Illinois should consider its adoption. That plan is based on the following guiding principles:

- Preserve health plan and provider choice
- Build on the respective strengths of the private market and government
- Maximize the employment-based system of providing health insurance
- Engage consumers in taking a more active role in their health and utilization of health care
- Recognize the diversity of the uninsured

The plan itself presents the following framework for reducing the number of uninsured in Illinois:

1. **Medicaid reform and reaching the public program eligible:**

   - **HIFA waivers and block grants**: Through the use of HIFA waivers or block grants expand eligibility to the population of single childless adults with incomes at 100% or below of the federal poverty level and who have been uninsured for more than one year and have no access to some form of private insurance coverage.
   - **Increase portability of coverage** through vouchers that allow Medicaid eligible beneficiaries to enroll in their employers' plans.
   - **Personal Health Accounts (PHAs)** should be provided to Medicaid beneficiaries who enroll in a consumer-engaged (i.e. "consumer-driven") option, with the use of such accounts being restricted to the payment of health care expenses and health insurance premiums. This would empower these beneficiaries to manage some of their own health care dollars and get them more engaged in managing their health and utilization of health care.
   - **Managed care Medicaid**: Medicaid enrollees who choose not to enroll in a consumer-engaged option should "default" to enrollment in a state-run managed care Medicaid program.
   - **Long term care partnerships**: Implement long term care partnerships in Illinois in view of the recently passed (February, 2006) federal budget reconciliation law.
   - **Public program outreach**: Enroll eligible low-income individuals into currently available public programs to significantly reduce uninsurance among people who are eligible for coverage but are not currently enrolled. The State of Illinois should also research and evaluate the feasibility of implementation of an aggressive public education/outreach program as a means of maximizing public program participation.

2. **Reaching the non-afforders**: Public policy should be advanced that allows carriers to more readily develop coverage opportunities for small business and individuals who wish to purchase private coverage but for whom the cost is out of reach.
   - **Encourage the further development of Health Savings Accounts and Consumer Directed Health Care.**
   - **Provide tax incentives to individuals, employers and carriers to help make coverage more affordable**

3. **Reaching the voluntarily uninsured**:
   a. Encourage product innovation in the private sector to expand choices of lower-cost options.
   b. Develop a multi-faceted public awareness campaign to educate individuals on the availability of coverage, and to educate small employers on the tax treatment of insurance, rate protections, and the availability of coverage in our state on a guarantee issue basis (be it because of SEHIRA, or through CHIP and HIPAA-CHIP).

4. **Reaching the chronically uninsurable:**
   a. Maintain appropriate funding and management of Illinois' high-risk pools (HRPs).
   b. Limit coverage provided through HRPs and implement a mechanism to mainstream high-risk individuals into the private health insurance market.
   c. Require the two principal CHIP pools (Sections 7 and 15) to offer a CDHP (consumer-drive health plan) option that incorporates an HSA-compatible high deductible health plan (HDHP).

Improve Quality and Make Coverage More Affordable

5. **Improve quality of care and patient safety** - Accelerating adoption of health information technology (HIT) and establishing an HIT infrastructure are needed to improve quality, patient safety and efficiency.

    - Reduce treatment variation
    - Base more reimbursement on Pay-For-Performance
    - Improve health literacy

6. **Increase consumer involvement in health care decisions**

7. **Reduce excessive, unnecessary regulation and litigation**

8. **Consider the use of reinsurance pools as a means of achieving greater affordability of health insurance**: Evaluate the cost-effectiveness and feasibility of a voluntary, federally-subsidized individual and/or small group reinsurance pool set up strictly to handle the financial side of insuring high-risk individuals. Reinsurance pools, if administered correctly, have the potential to become important market-stabilizers.

Other

9. **Health savings accounts should be used as a "bridge" option for citizens moving from public to private programs**.

10. **Inventory current public insurance and medical assistance programs** to determine such things as 1) enrollment, 2) costs (overhead and costs of care), and 3) overlap with other programs, and determine which current state government-sponsored programs could be modified or even eliminated as part of an overall streamlining and consolidation initiative.

11. **"Health insurance and medical assistance" decision tree:** The Division of Insurance's Ombudsman program has a database application that phone counselors use in steering citizens to insurance, public health, and medical assistance programs that are available at state, county, and township levels in Illinois. It should web-enable this same application and provide a "health insurance and medical assistance" decision tree. Citizens should be able to enter information about themselves (e.g., name, address, date of birth, marital status, information about dependent children, gross household income, etc.), and receive a "report" showing ALL the programs they are eligible for that includes hyperlinks to websites, addresses, and phone numbers where one may turn for further assistance and counseling.

V. Conclusion

The Adequate Health Care Task Force was a noble effort to allow citizens across Illinois to express their concerns about the health care system and have their voices heard. Many people testified at the hearings in every Congressional district. None of them advocated the status quo, especially for Medicaid. The shortcomings of the Medicaid system were more than poor payments to medical providers. The shortcomings included a dearth of

providers willing to provide care, concern that the system is not responsive to patient needs and concerns that navigating the state's bureaucracy is difficult, and at times impossible.

The Hybrid Model adopted by the Task Force does not reflect the needs expressed by the people that testified. Instead, it preserves and enhances the Medicaid safety net as a safety net for providers. Illinois needs and deserves a Medicaid safety net for patients.

The task force report also overlooks the real – and potentially grave – effects on jobs and job growth in Illinois that can result from the assessment on employers. Apart from the questions of whether such a scheme can legally be accomplished, such a scheme should not have been considered without serious and sober discussion regarding the impact on Illinois jobs, the ability of employees to earn a decent living and whether businesses will be able to flourish with this new financial and administrative burden.

It goes without saying that the effects on the insurance industry – one that has been very vibrant in Illinois and that contributes more than $16 billion in Gross State Product (all insurers) to Illinois' economy – will be negatively impacted if the hybrid is enacted into law. The evidence is clear and convincing – in states that have enacted similar insurance regulations – the insurance market has suffered and premiums have escalated and insurance options narrowed.

Perhaps the gravest flaw of the final report is that it did not deliver on many of the very real deliverables contemplated by the Health Care Justice Act. It does not consider increasing cost-efficiency in the system and it does nothing to increase the availability of preventive services or wellness. It also does nothing to expressly add to the availability of health care resources, capital and technology. And, sadly, it does not provide consumers with choices of medical plans, medical providers or benefit packages.

It is for all of these flaws and failures that we, the undersigned, do hereby dissent from the majority recommendation of the Illinois Adequate Health Care Task Force.

Pamela Mitroff
DuPage County

Joe Roberts
Dekalb County

Michael R. Murphy
Sangamon County

Gregory S. Smith
Peoria County

Catherine Bresler
Cook County