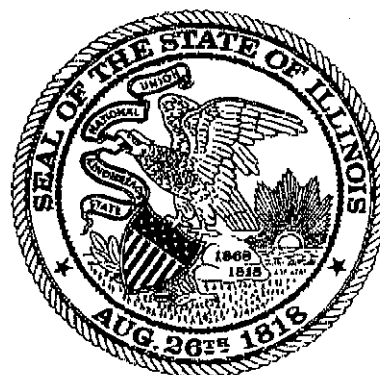


**ILLINOIS  
COMPREHENSIVE  
HEALTH  
INSURANCE  
PLAN**



**Feasibility Study of  
Establishing a Small  
Employer Health  
Insurance Pool**

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# Illinois Comprehensive Health Insurance Plan

## Feasibility Study of Establishing a Small Employer Health Insurance Pool

### Overview

One of the primary sources of health coverage in the United States is coverage provided through employers for their current employees. According to data from the Insurance Component of the Medical Expenditure Panel Survey (MEPS), conducted by the Agency for Healthcare Research and Quality, approximately 63 million of the 114 million employees from the private sector are enrolled in a health insurance plan sponsored by their employers.

Many factors are correlated with whether an employee has access to a health insurance plan sponsored by his or her employer and, if so, whether the employee enrolls and what the employee ultimately contributes toward the cost of this coverage. Employer characteristics commonly acknowledged to correlate with characteristics of employer-sponsored health insurance include the size of the employer, the industry, the presence of a union, and the level of employee compensation.

In 2000, more private-sector employees obtained family coverage health insurance through their employers than single self-only coverage. According to the MEPS, those employers with family coverage contributed both a larger dollar amount and a larger percent of the total premium for their coverage than did employees with single coverage.

Beginning in earnest about two decades ago, many states sponsored various programs in an effort to retard steep premium increases for small employers with high claim experience. By the early 1990s, however, many of these programs lost traction as a result of the burgeoning discussions of national health insurance reform.

The extensive reform proposals put forth by the Clinton administration never came to fruition. Nevertheless, these efforts led to the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPPA), which requires guaranteed issue of group coverage and renewal of individual coverage but addresses neither the cost of coverage nor the insurers' rating practices in the group or individual markets.

Resultantly, many states are beginning to revisit the concepts of stabilizing rates and expanding coverage. Specifically, many states are examining the merits of re-insurance in order to spread risk in insurance markets, improve the predictability of claims, and reduce the mark-up of premiums that insurers charge as a buffer against unanticipated claims. While as many as 21 states currently utilize reinsurance pools, many of these programs have very low enrollment or are even inactive. Among the programs of note, Connecticut, Idaho, New Mexico, and Massachusetts currently use reinsurance to support small-group coverage, improve individual access to coverage, or both. Arizona and New York also operate reinsurance programs that subsidize health insurance for small groups or low-income workers. Additionally, Maine operates a plan that attempts to maximize federal funds in order to free up additional funding for health insurance subsidization.

## **Other States' Experience in Establishing Small Employer Health Insurance Pools**

### **→ Connecticut's Small Employer Health Reinsurance Pool:**

This pool reinsures all small-group carriers in the State. These insurers are required to guarantee issue coverage to groups of 1 to 50. Any small-group insurer in the state is allowed to reinsure individual covered workers, dependents, or entire small groups within 60 days of issuing coverage.

Only full-time employees working a minimum of 30 hours per week are eligible for the program. Insurers pay a \$5,000 deductible per reinsured life with the reinsurance pool covering claims in excess of that amount. Premiums are based solely on demographics (i.e. rating for tobacco use is prohibited.)

The pool is funded by the reinsurance premiums paid by insurers who cede risk to the pool in addition to an annual assessment on all licensed health insurers based on their proportional share of the small-group market.

To date, 37 carriers have enrolled nearly 30,000 employees and dependents in the pool. As of October 2004, 3,100 were enrolled with an average annual reinsurance premium of approximately \$4,500.

### **→ Idaho's Small-Group and Individual Reinsurance Pools:**

The Small Employer Health Reinsurance Program has been operational since 1994 and, in essence, participation is mandatory as all carriers may be assessed a fee in order to fund any net losses accruing to the program. A small-group insurer has 60 days in which to notify the program of intent to reinsure.

The small group carrier is responsible for the first \$12,000 per claimant annually and 10% of the next \$13,000 (basic). Most recently available data indicates that Idaho reinsured eligible employees and dependents in 44 small-group plans.

Also, since 2001, the State has operated an Individual High-Risk Reinsurance Pool. This program reinsures the "high risk pool plans" that all individual (non-group) carriers are required to offer. Each carrier is responsible for the initial \$5,000 of benefits paid per enrollee per calendar year as well as 10% of the next \$25,000. Above this amount, the pool fully insures the individual. Most recently available data indicate that the high risk pool plans covered nearly 1,400 individuals. This program has been fully funded by the reinsurance premiums as well as a portion of the state premium tax.

### **→ The New Mexico Health Insurance Alliance:**

The Alliance was created in 1994 and partners with insurance carriers to make coverage available to employers in small groups (defined as 50 or fewer employees who work a minimum of 20 hours per week), self-employed workers

and individuals who have lost coverage involuntarily. The program currently contracts with 11 carriers to cover about 4,000 lives.

The program operates by providing reinsurance to participating carriers which is funded through an add-on to premiums paid to the carriers. Each year, the reinsurance fund pays participating carriers the amount by which incurred claims and reinsurance add-ons exceed 75 percent of earned premiums. Any annual loss that exceeds the fund's resources triggers an assessment on all carriers' premium income so as to make whole the participating carriers. This claims loss assessment has been triggered in each year of the program's operation.

→ **Massachusetts' Small Group Health Reinsurance Plan:**

In operation since 1992, this program reinsures all commercial small-group health coverage written in the state and accepts only full-time workers in firms with 50 or fewer employees, sole proprietors and dependents.

Small-group insurers are allowed to cede whole groups or specific, eligible workers or dependents within groups within 60 days of their enrollment in a small-group product. However, the program mandates that the insurer enroll a minimum of 75 percent of reinsurance eligible employees in the small group. The intent of this requirement is to minimize adverse selection.

Insurers ceding risk to the pool must pay the first \$5,000 in covered claim expense and 10 percent of the next \$50,000. The reinsurance covers all claims in excess of \$55,000. Premiums per individual per month vary from \$300 to \$2,100. In 2004, the average monthly premium has been between \$800 and \$1,000. These relatively high premiums are established to avoid otherwise assessing commercial insurers for unanticipated program losses and are perhaps the primary reason enrollment has been extremely low – less than 100 lives.

→ **Health Care Group of Arizona:**

The Health Care Group (HCG) contracts with insurers to offer coverage to small firms and self-employed individuals; HCG then reinsures that coverage. There are no income criteria for participating employees. In order to reduce adverse selection, HCG requires high employee participation in order for a group to qualify. For groups with fewer than 6 employees, 100 percent of employees must participate; larger groups must have a participation rate of 80 percent. No employer contribution is required.

Participating carriers must guarantee coverage to all HCG applicants, including self-insured workers and their families who are not guaranteed coverage in the commercial market. In return HCG absorbs the highest costs. The medical losses incurred by HCG are funded by an annual state appropriation of approximately \$4 million. HCG covers nearly 12,000 lives.

→ **Healthy New York:**

This program, established in 2001, is directed towards employers of middle-to-low-income workers. This targeted plan stipulates that employers with 50 or fewer employees may participate if at least 30 percent of their employees earn less than \$32,000 (adjusted annually) and the employer did not offer or did not contribute substantially (\$50 per month) to comprehensive group coverage in the prior year. Additionally, in an attempt to keep adverse selection in check, the program requires at least half of eligible employees to participate and for the employer to contribute at least half the premium.

The program's reinsurance strategy employs a risk corridor that allows participating carriers to receive reimbursement for 90 percent of claims between \$5,000 and \$75,000 for any member during a calendar year. In 2003, state payments for this corridor reinsurance amounted to \$12 million. Approximately 70,000 individuals have enrolled in this relatively popular program.

→ **Dirigo Health – Maine:**

This program is substantially different than the aforementioned plans. The program is in its initial year which, when combined with its distinctive approach, may help explain the low enrollment.

The plan is targeted to small businesses of between 2 and 50 individuals and provides for a benefit package equivalent to the healthcare plan provided to state employees. Employees contribute to the cost of the program although these contributions may be reduced or eliminated based on poverty levels. The unique nature of the plan is the manner in which the state attempts to mitigate its costs by maximizing federal funds available through its Medicaid program.

## **Assessment of the Need for a Small Employer Health Insurance Pool in Illinois**

Other than Medicaid, there are no programs in Illinois that directly address working poor households. Further, even when an insurance benefit is offered through an employer, there still exists a substantial range in out-of-pocket employee cost. For this reason it is essential to not only assess the incidence of available employer-sponsored health insurance but also to determine whether or not out-of-pocket expenses, including premiums, of such insurance are beyond the reach financially of the typical low-income worker.

Data provided through the Medical Expenditure Panel Survey (MEPS) illustrates the significant change that has occurred in health insurance pricing over the past few years. MEPS data collected for firms with fewer than 50 employees indicate that, over the most recent five year period, the average total single premium per employee increased 32%. Over that same time period the total family premium per employee was even more price sensitive, increasing 43%. As would be expected, employees felt the brunt of these increases. Over this same time period, the average employee contribution (out-of-pocket costs) for single coverage increased 30%. Meanwhile, the average employee contribution for family coverage experienced a substantial increase of 51%.

Next, for this analysis it is essential to determine if these rising costs affect all workers in the same manner. Data provided by the Current Population Survey (CPS) may provide some insight into this question. CPS data breaks out insurance status, stratified by employee income, for small businesses. In 2003, the data indicate that 72% of small business employees within the income range of 100% - 124% FPL lacked insurance. Examining further up the income strata reveals that 47% of the employees within the income range of 125% - 175% FPL lacked coverage while only 26% of the employees between 176% - 199% FPL lacked coverage.

Thus, the available data indicates that, in the case of accessible healthcare coverage, a definitive clustering occurs at the higher end of the employee income spectrum. That is, it would appear low-income workers are more price-sensitive to these ever-growing healthcare expenses than are their higher-earning counterparts to whom healthcare out-of-pocket expenses represent a smaller proportion of their overall income. While there are certainly many other contributing factors, there appears to be a clear correlation between employee compensation and accessibility to healthcare insurance.

## **CHIP-Developed Options for Increasing Insurance Coverage for Low-Income Workers of Small Employers and Sole Proprietors**

CHIP staff, working in conjunction with outside actuaries, explored several options for establishing a health insurance pool for low-income workers of small employers and sole proprietors. Each of the different scenarios requires some level of state subsidy. Cost estimates are included for each option.

### **GENERAL PARAMETERS**

In order to target the intended population as efficiently and effectively as possible, the following overarching constraints will be applied:

- ▶ Program will be subsidized by the State to promote affordability.
- ▶ Small employers with 30% of employees below the poverty threshold (200% of the Federal level) and sole proprietors below the poverty threshold are eligible but individuals are not.
- ▶ The group must have been uninsured for the prior 12 months.
- ▶ Small group participation requirement is 75%.
- ▶ Small employer contribution requirement is 50% of single rate.
- ▶ Rates will vary by age, sex and area **but not health**.
- ▶ Twelve month pre-existing limitation.
- ▶ Dependents can be covered.
- ▶ Maternity will be included.
- Benefits should be reasonably comprehensive but some concessions may be allowed to promote affordability.

In order to estimate overall plan costs, an average expected adult claim cost level needed to be derived (note: very few children are expected to be covered by a program of this nature since KidCare already offers comprehensive medical benefits to children up to 200% of the federal poverty level). CHIP actuaries established an average state-wide 2006 adult claim cost. This calculation was accomplished by taking base data obtained from an October 2003 survey of small group rates, applying an inflation factor while also adjusting for demographic and geographic differences.

Costs for the following scenarios are based on an enrollment assumption of 10,000 adults. This is done in large part to standardize the measure for cost comparison purposes. Actual enrollment figures could vary significantly depending on the eventual design of the program as well as macro factors such as the overall health of the Illinois economy.

### **Scenario #1 - State as the Insurer**

#### Assumptions:

- Model benefits and program per current IL CHIP Section 15 plan.
- Product is issued and insured by the State.

- Benefits – PPO with \$500 deductible and 80%/60% in/out coinsurance. RX is at 80% and no deductible.
- State Subsidy – 15% of gross premium rate.
- Administrative load – 10%.
- Margin load – 0% - Since the plan needs to be as reasonably priced as possible.

For every 10,000 individuals, this plan would annually cost the State **\$5.7 million**. Average monthly premiums for a male age 45 – 49 would be **\$244**.

### **Scenario #2 – State as the Insurer, Rx not covered**

#### Assumptions:

- Model benefits and program per current IL CHIP Section 15 plan.
- Product is issued and insured by the State.
- Benefits – PPO with \$500 deductible and 80%/60% in/out coinsurance. *No RX benefit.*
- State Subsidy – 15% of gross premium rate.
- Administrative load – 10%.
- Margin load – 0% - Since the plan needs to be as reasonably priced as possible

For every 10,000 individuals enrolled, this plan would cost the State **\$4.7 million**. Average monthly premiums for a male age 45 – 49 would be **\$198**.

### **Scenario #3 – State as the Insurer, Rx not covered, higher deductible**

#### Assumptions:

- Model benefits and program per current IL CHIP Section 15 plan.
- Product is issued and insured by the State.
- Benefits – PPO with *\$1000 deductible* and 80%/60% in/out coinsurance. No RX benefit.
- State Subsidy – 15% of gross premium rate.
- Administrative load – 10%.
- Margin load – 0% - Since the plan needs to be as reasonably priced as possible

For every 10,000 individuals enrolled, this plan would cost the State **\$4.3 million**. Average monthly premiums for a male age 45 – 49 would be **\$183**.

**Scenario #4 – New York Model**

## Assumptions:

- Model benefits and program per after Healthy New York plan.
- Product is issued and insured by insurance carriers.
- Benefits – in network only plan with \$0 deductible, \$20 office visit co-pay, \$50 ER co-pay, \$75 outpatient surgical center co-pay, and 20% co-pay for surgical professional fees. Rx - \$100 deductible and \$10/\$20 generic/brand co-pay and \$3,000 annual maximum.
- State Subsidy – State reinsures 90% of claim cost between \$30,000 and \$100,000 per person per annum.
- Premium basis – Claims net of State reinsurance divided by .70.

For every 10,000 individuals enrolled this plan would cost the State **\$4.3 million**. Average monthly premiums for a male age 45 – 49 would be **\$336**.

**Scenario #5 – New York Model, additional reinsurance liability**

## Assumptions:

- Model benefits and program per after Healthy New York plan.
- Product is issued and insured by insurance agents.
- Benefits – in network only plan with \$0 deductible, \$20 office visit co-pay, \$50 ER co-pay, \$75 outpatient surgical center co-pay, and 20% co-pay for surgical professional fees. Rx - \$100 deductible and \$10/\$20 generic/brand co-pay and \$3,000 annual maximum.
- State Subsidy – State reinsures 90% of claim cost between \$10,000 and \$100,000 per person per annum.
- Premium basis – Claims net of State reinsurance divided by .70.

For every 10,000 individuals enrolled, this plan would cost the State **\$11.1 million**. Average monthly premiums for a male age 45 – 49 would be **\$264**.

## **Conclusion and Recommendation**

One of the primary sources of health coverage in the United States is coverage provided through employers for their current employees. Nevertheless, a large proportion of employees currently lack health insurance. While there are many contributing factors to this deficiency, there is a clear correlation between employee compensation and accessibility to healthcare insurance.

Many States are moving aggressively in an effort to develop programs providing increased accessibility to healthcare insurance for low-income workers. Many of these programs rely on subsidization on the part of the State in order to reduce employee out-of-pocket costs to a level whereby the insurance becomes attractive to the worker.

Other than Medicaid, there are no programs in Illinois that directly address working poor households. In response to this, CHIP staff, working in conjunction with outside actuaries, explored several options for establishing a health insurance pool for low-income workers of small employers and sole proprietors. Each of the different scenarios requires some level of state subsidy.

Therefore, it is recommended that CHIP staff continue to explore this issue, working with all pertinent parties, including the Governor's Office of Management and Budget, in order to determine, given the State's economic climate, if there is a viable plan that can be developed at this time.