



## Gov. Blagojevich's Illinois Covered Choice Healthcare Plan

### Key provisions for employers and comment

#### ERISA Implications:

Employers that believe they are protected by ERISA preemption should be aware of the following provisions in the Governor's proposal.

- ❖ Healthcare tax on all employers with over 10 full-time equivalent employees whether ERISA exempt or otherwise;
- ❖ Extension of the new Office of Patient Protection to any "healthcare plan" regarding complaints about claim denial;
- ❖ The severability clause found in Part 7 Section 50-701 requires that each court decision regarding the legality of the proposal are stand alone decisions and every plaintiff must separately make their case for the legal standing of the law.

#### Healthcare Tax on Income:

**What employers are affected:** Employers of 10 or more fulltime equivalent employees are subject to 3% payroll tax up to \$7,500 on a single employee; full-time equivalent is defined as the lesser of the number of employees at any time during the taxable year and the total number of hours worked by all employees divided by 1500 (7.2 full-time equivalents); public sector employers are exempt; applies to wages paid on or after 7/1/08

**How tax will be collected:** Payment of the tax will be required at the same time the employer remits its employee income tax withholding to the Illinois Department of Revenue; No payment of the tax is required if the employer paid more than 4% of its total payroll costs on healthcare benefits during the 12 months preceding the taxable year; a partial credit up to an additional 1.5% (limiting the payroll tax to 1.5%) if an employer provides between 2.5% and 4% of payroll costs for healthcare benefits

**Comment:** *We oppose the healthcare tax. It's especially egregious that private employers are held to a higher responsibility than public employers on providing healthcare benefits to its employees. Depending on how many employers are able to meet the 4% test, over 200,000 employers in the state could generate as much as \$2 billion in payroll taxes for healthcare expansion and subsidies. We prefer to use Medicaid reform savings and federal grant monies to pay for healthcare expansion to the uninsured.*

## **Group Health Insurance Requirements:**

**Expanding Dependent Coverage to Age 30:** The Governor's proposal will require all group health insurance policies and group HMO plans that provide dependent coverage to offer dependent coverage up to age 30.

In order to qualify, a person under age 30 must be unmarried, a resident of the state or enrolled in college, and not otherwise covered by insurance. The premium for dependents added to a group policy pursuant to this change can be no more than 105% of a regular dependent premium. An employer sponsoring the group coverage is not required to contribute any portion of the premium associated with the dependent.

**Comments:** *The proposal caps any premium contribution to 105% of the premium previously paid for that dependent's coverage. That is unacceptable as it locks in premium with no more than a 5% increase over as many as 12 years. Employers also are required to provide notice of availability of coverage. A change in dependent age coverage is an issue the Illinois Chamber is willing to consider but not this approach.*

**Employer Requirement to Provide Cafeteria Plan:** All employers of 10 or more in the state as of 1/1/09 will be required to provide a Section 125, Cafeteria Plan to its employees.

**Comment:** *The Chamber opposes this mandate. Not only will this mandate increase costs for employers such as establishing and administering the 125 plan, these type of plans are not the only programs that employers and employees can use to achieve tax advantages. Many employers and individuals are turning to health savings accounts as a means of taking significant advantage of income tax adjustments.*

**Health plan discrimination:** The Governor's proposal prohibits discrimination between employees with respect to the amount an employer contributes for health insurance for an employee unless a collective bargaining agreement exists. An employer also must offer its group policy to all full-time employees.

**Comment:** *This would result in the same employer subsidy for: 1) employees who choose single and family coverage (families will be hurt); 2) employees who meet healthy life style incentives and those who don't; 3) employees who meet disease management strategies and those who don't. This is inconsistent with other provisions and not good policy.*

**Expanding Mental and Emotional Disorder Coverage:** Current law establishing an appeal process for denial of claims based on an insurer's determination that a given treatment is not medically necessary is removed. Two new sections, the "serious mental and emotional disorder provisions of the Illinois Insurance Code and Section 45 of the

Managed Care & Patients Rights Act, will provide a new framework for denied mental health claims. A new definition of "medically necessary" with respect to treatment of

mental and emotional disorders is created. It extends the same definition requirements for individual policies providing any form of mental and emotional disorder coverage. An additional appeal to the new Office of Patient Protection (OPP) when an internal and external review process is denied is created. The OPP decision is unappealable. The new process will make it more difficult for plans to deny mental health services.

**Comments:** *We oppose these changes and believe they will encourage the use of unnecessary services and the over-utilization of services leading to higher health insurance costs for employers.*

### **Illinois Covered Rebate Program:**

Establishes a premium assistance program for persons aged 19-64, with income below 400 percent of poverty (over \$80,000 for a family of 4) who are U.S. citizens, documented legal permanent immigrants, or documented non-immigrants who have been granted legal entry to the United States will be eligible under the program.

Assistance will be available to persons who have access to employer-sponsored coverage and individuals who do not have access to employer coverage. Note that premium assistance for individual coverage is only available for the Illinois Covered Plan .

**Comment:** *The Chamber supports the concept but wants specifics in the statute to define what qualifies as “employer-sponsored insurance”. Maintaining and encouragement of private coverage must be a priority. Our support also is contingent on agreeable funding source(s).*

### **Illinois Covered Choices Program**

The Governor’s proposal creates a new program that offers individuals and small businesses a health insurance option. The Illinois Covered Choices plan is to be available on January 1, 2009.

All insurers with established managed care networks must participate in the program and offer plans that have benefits approved and defined by the Department of Healthcare and Family Services (“HFS”) with lower co-pays and deductibles for participants at lower-income levels. Insurers will be required to offer Covered Choices through existing network arrangements.

Plans shall allow for only in-plan benefits, with the exception of emergency care or where a plan provider cannot provide needed services. Participants may choose to purchase separate dental or vision coverage.

HFS in collaboration with the Division of Insurance will determine the benefits in the suitable small group and individual Covered Choice products, including co-pays and deductibles, but long-term care and infertility treatment will not be included.

**What employers are eligible:** Illinois based, small employers of not more than 25 employees, if the employer pays a minimum amount of the premium; to participate in the first year, at least 2/3rds of employees must earn less than 400% federal poverty level. Although an employer may opt for a lower threshold, an eligible employee is one who works at least 25 hours per week.

## **“Suitable Managed Care Plan” requirements:**

**Employer requirements:** An employer must offer participation in the plan to all eligible employees. Employers are required to make the same percentage contribution to premium regardless of employee class. If an employer wishes to extend the plan as an option for employees, at least 50% of eligible employees must be insured. A pro-rata contribution will be required for part-time employees. Employers will have the option of whether to extend dependent coverage to employees. Suitable coverage must include coverage for mental and emotional disorders as defined and amended by the Governor’s proposal (215 ILCS 5/370c). Deductibles are limited to the maximum allowed under the Insurance Code. HMO’s: “Deductibles shall be either for a specific dollar amount or for a specific percentage of the cost of the health care service. No single deductible or copayment for health services may exceed 25% of the usual and customary fee of the service to the HMO and must be waived when, in a calendar year, deductibles and copayments paid for the receipt of health care services exceed \$500 per enrollee.” From Sec. 5421.131 of the Administrative Code. On the HMO side, there also are limits on the combination of deductibles and copayments for basic health care services to 50% of the usual and customary fee of the service and \$1,500 per enrollee or \$3,000 per family.

**Individual eligibility:** Unemployed, works less than 25 hours per week, self-employed, or the individual’s employer has not offered group health insurance during the eighteen months prior to the individual’s application for enrollment; for the first year of Illinois Covered Choices (January 1, 2009 – December 31, 2009) no income restrictions thereafter, the individual has personal or family income of less than 400% FPL; not be eligible for Medicare; Illinois resident.

The income restrictions do not apply to veterans not on active duty or honorably discharged.

Individual eligibility requirements other than income do not apply:

- When coverage is terminated due to the death of a family member;
- Change of residence and insurance is not available through an employer; or
- When there is a change in marital status that ends health insurance.

**Pre-existing conditions:** Although pre-existing conditions cannot be used for premium-setting purposes or to deny access to Illinois Covered Choices, the HFS will determine to what extent the cost for care of a pre-existing condition limitation can be applied. Pre-natal care must be covered without consideration of pregnancy as a pre-existing condition. Waiver of deductibles or copays may be used for participation in chronic care management or wellness and prevention programs.

**Guaranteed issue:** Any applicant for an Illinois Covered Choice product is guaranteed issue of coverage. (Section 10-15 (s))

**Rate regulation:** Insurers may develop a base rate factoring only:

- (A) Place of residence; The highest rate for any geographic area may not exceed the lowest rate by more than 30%.
- (B) Age; age variations cannot be smaller than 5-years, beginning at 20 and ending with 65, except for dependents. Individuals, sole-proprietors, and employees under 20 are to be treated as age 20.
- (C) Smoking or non-smoking status;
- (D) Participation in wellness or chronic disease management activities; premium discounts up to 10% for participation when actuarially justified.
- (E) Claims experience for groups and individuals must be combined for rating .

**Rate Bands:**

- (A) The highest age group rate shall not exceed the lowest age group rate by 25% for the first year of Covered Choices, and 20% thereafter with the Division of Insurance able to modify the allowed variance.
- (B) The highest rate for any small employer group cannot exceed the lowest rate by more than 25%.

All base rates for Illinois Covered Choice products will be subject to prior approval, and the Division of Insurance will approve, reject or modify a proposed rate.

- (1) rates must reflect the stop loss program;
- (2) rates cannot be excessive, inadequate or unfairly discriminatory;
- (3) rate evaluation will consider loss experience (past, prospective, in-state and out of state);
- (4) rate evaluation will consider actuarial support, enrollment, premium volume, risk-based capital, and ratio of incurred claims to earned premium.

**Reinsurance:** HFS will determine at what level qualified, catastrophic claims are reimbursed, including the reimbursement point or points and the percentage that will be paid by the state. Beginning 1/1/09, reimbursement is 80% of claims paid and will be subject to appropriation.

**CHIP assessments:** Health insurers also will be assessed at a rate that equals the average assessment, as a percentage of gross premium volume, from 2004-2008 in ICHIP. This calculation will establish a baseline assessment of \$XX million base that the assessment will not be lower than in the future.

**Provider reimbursement:** Reimbursement rates will be no lower than “base Medicare”. 105% of base Medicare for critical access hospitals; 112% of base Medicare for all other hospitals. Reimbursement may be higher for medical research, medical education, highly

complex medical care and disproportionate share hospitals. Where Medicare base can not be calculated reimbursement will be 90% of the lowest rate paid by an insurer.

Reimbursement rates under this program can not be used for other plans or used as usual and customary levels for hospitals.

**Provider requirement:** All providers who participate in a managed care network must also participate in the Illinois Covered Choice product(s) offered by the insurer.

**Consumer guide:** Insurers must share cost of publishing and distributing consumer shopping guides for the Illinois Covered plan.

**Comments:** *There are too many critical issues that are left to rule-making. The Chamber needs to be assured through statute what size employers will be eligible, what employees will be eligible; what benefits will constitute a “suitable managed care health plan”; specifically how the pre-existing condition provision will operate; and how specifically the reinsurance will be structured and funded.*

*We are concerned about the level of subsidy required to support the Covered Choice Plan and how the CHIP assessment change will impact the small group market.*

*We oppose the prior approval rate regulation components.*

## **Creation of More Bureaucracy**

A new state agency, the Office of Patient Protection (Office), is created within the Division of Insurance to adjudicate consumer grievances on healthcare policy disputes.

The Office will help consumers understand their rights and will, when appropriate, act on their behalf. The Office will have authority to investigate claims practices, order the

payment of a claim, and/or call a hearing to determine whether an insurer or HMO is complying with applicable law. The Office will also implement the Division’s new power to review medically necessity determinations. The Director of the Division can overturn any determination that is arbitrary and capricious or that demonstrates disregard for patient well-being or contractual terms.

**Comment:** *These provisions attempt to extend the authority of the Office to ERISA health plans.*

**Health plan appeals rights expansion:** Expands a right to an internal appeal process and an independent external review process provided to HMO participants under The Managed Care Reform and Patient Rights Act to other health insurance plans such as PPOs and indemnity plans. Requires all health insurers, like HMOs, to systematically report to the Division of Insurance complaints made to the insurance company and the resolution of those complaints.

A consumer will be allowed to bypass the internal appeal process and move directly to an independent external review if the enrollee, plan, and provider agree; or if the Office explicitly allows.

**Comment:** *We oppose the unnecessary creation of a new bureaucracy that will duplicate the responsibilities currently of the Illinois Division of Insurance. The Division has had a long-term reputation of protecting consumers and professionally regulating the insurance industry. Funding should be increased for the Division. Extension of certain rights to health insurance consumers currently provided to HMO patients could be supported as part of an overall package. We believe that the current Managed Care & Patients Rights protections for consumers have been working and do not need further expansion. For example, the extension from 30 to 180 days the amount of time to initiate an independent external review is unnecessary.*

## **Health Information Exchange and Technology**

The proposal creates a new public/private partnership to implement the recommendations of the Electronic Health Records Task force which promote the development of electronic health records in Illinois.

**Comment:** *Our support is contingent on the funding and implementation of the current statute regarding transparency and the consumer guide by the Illinois Department of Public Health.*

## **Reducing Administrative Costs in the Overall Healthcare System**

A common claims and procedures work group will be formed with representatives from healthcare providers, insurers and state agencies to review current systems and to make recommendations for improvements. This initiative is modeled after Vermont's initiative in this area.

**Comment:** *Our support is contingent on the funding and implementation of the current statute regarding transparency and the consumer guide by the Illinois Department of Public Health.*

## **Medicaid and Public Program Expansion**

The Governor's proposal seeks to expand access for FamilyCare, the Health Benefits for Workers with Disability Program and creates the Illinois Covered Assist to provide state sponsored healthcare coverage for adults whose family income is below the poverty level and who do not currently qualify for other state sponsored programs.

- ❖ Disabled employed up to 350% of federal poverty level;
- ❖ Caretaker relatives up to 400% federal poverty level

***Comment: The first priority for Medicaid is to make it more efficient, cost-effective and appropriately funded. Provider reimbursements should be increased and paid more promptly. Performance incentives similar to those being implemented for Medicare should be adopted. Funding for expansion and over-emphasis on placing individuals into public coverage are key concerns.***

## **Building Healthcare Capacity & Workforce Planning Group, Etc**

The Governor's proposal increases appropriations for recently initiated proposals to assure access to affordable health insurance for all Illinoisans. The proposal creates a Council to review state healthcare workforce efforts, develop 25-year workforce need projections and develop a five-year comprehensive workforce development plan.

Establishes a loan repayment program to encourage physicians (primary care and specialists) and dentists to serve underserved areas and underserved populations.

A new community health center program is created, with grants targeted to expansions of services in areas (by geography and/or specialty) identified by State health agencies as most needed to serve targeted populations (i.e., uninsured, underserved, Illinois Covered).

Creates a consensus process to develop a "roadmap to health." The roadmap will include the creation of a chronic care infrastructure designed to where possible prevent chronic illnesses and where chronic illnesses exist to manage such diseases in a manner that utilizes clinical best practices and integrates information technology initiatives so as to more cost effectively address chronic illnesses. Based on input from healthcare professionals, insurers and other experts, a strategic plan shall be developed to effectuate the integration of such a system across state programs including the Illinois Covered Choice program with the goal of diffusing across the healthcare system generally.

## **Individual Coverage Mandate**

By 1/1/08, a taskforce of consumer will be created to analyze the effects of establishing an individual mandate to purchase health insurance and its effects on current insurance premiums, its effects on lifetime healthcare costs, the issues of affordability of health insurance, the barriers to insurance that exist today and the remedies for such barriers, what entities currently incur costs due to individuals being uninsured and what an appropriate enforcement mechanism for such a mandate might be.