



HEALTH INSURANCE REFORM in ILLINOIS



Overview of Federal Health Insurance Reform Requirements

Illinois Department of Insurance Implementation Planning

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May 2010

Overview

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- This presentation is limited to major provisions related to private health insurance.
- Many specific details are yet to be determined by the U.S. Department of Health and Human Services (HHS) through regulations or directives.
- We/Illinois are participating directly and through the National Association of Insurance Commissioners (NAIC) with the development of HHS regulations and directives.
- The effect of reform will be different across states, depending on existing statutory and regulatory requirements and current market structure.
- Use caution when reading reform summary documents or news stories from non-public entities; many misinterpretations and inaccuracies have been published.

Illinois' Broken Health Insurance Marketplace

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Illinois' families and businesses will significantly benefit from national health insurance reform.
Current Illinois law:

- Does not restrict health insurance rate increases.
- Does not require health insurance rates to be actuarially justified.
- Unlike most states, does not vest the Department with any rate review or approval authority.
 - The "[Individual Major Medical Health Policy Rate Filing Report](#)" posted on the Department's website shows explosive rate increases dating back to 2005.
- Allows an insurance company to deny an individual health insurance for any reason other than "race, color, religion, or national origin."
- Allows insurers to impose annual and lifetime benefit limits on any individual, either through a group plan or an individual policy.
- Does not require insurers to expend on health care a defined percentage of hard-earned premium dollars paid by families and employers. Illinois currently has an exclusively for-profit health insurance market.
- Limits annual out-of-pocket costs for HMO plans, but non-HMO plans can include deductible, co-pay and other cost-shifts to consumers without regard to the financial burden shifted to a family.
 - Two-thirds of personal bankruptcies result from unanticipated medical expenses. Of those individuals who file bankruptcy due to medical expenses, 75% actually have "insurance."

Illinois' Broken Health Insurance Marketplace

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- **Allows health insurers unrestricted range when charging an individual more due to health status, gender or policy duration.**
 - Current Illinois law does not limit the gender disparity in premium cost. Some companies charge women as much as 57% more than a man of the same age, health status and geography—exclusive of maternity benefits.
- **Allows a health insurer to investigate an individual's medical history after the individual pays a premium and to rescind an individual or family policy if a claim filed within two years of the policy issuance would have resulted in either: denial of the application, exclusion of a preexisting condition, or charging more to the policyholder.**
 - By pure volume, Illinois has more rescissions than any state in the United States and, per capita, is second only to New Mexico.
- **Requires a health insurer to offer a policy to a small group (2-50 employees) but allows a health insurer to deny coverage – at any price – to a large group (50+ employees).**
- **Requires health insurance policies to cover certain preventive benefits such as mammograms and other cancer screenings while other important preventive services may not be covered or may be subject to significant co-pays or co-insurance amounts.**

Key Health Insurance Provisions

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- Comprehensive health insurance market reforms (see slide below):
 - Varying requirements for group and individual plans, and “grandfathered” plans that existed at the time the Affordable Care Act was enacted;
 - Many provisions also apply to self-insured employer plans.
- Development of uniform coverage documents and standardized terms.
- Consumer ombudsman program like the Illinois Office of Consumer Health Insurance.
- Temporary high risk pool like the Illinois Comprehensive Health Insurance Plan (ICHIP).
- Reinsurance program for early retirees.
- Creation of State-based Health Insurance Exchange.
- Requirement to purchase health insurance, with subsidies for eligible individuals to assist with the cost.
- Requirements for large employers to provide insurance coverage, and assistance for small employers.

Early Insurance Market Reforms

Reforms Effective Within 6 months (September 23, 2010)

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- Pre-existing condition exclusions prohibited for children up to age 19 (Federal clarification to be issued shortly).
- Rescissions prohibited (except for fraud or intentional misrepresentation).
- Internal and external appeals processes for enrollees
- Coverage of dependents up to age 26 without applying any criteria other than age or familial relationship (builds upon existing Illinois law).
- No lifetime benefit limits.
- Restrictions on allowable annual benefit limits (to be determined by HHS).
- Benefits for preventive and wellness services required, with no cost-sharing.
- Coverage for emergency services at in-network cost-sharing level; no prior authorization requirements.
- May not discriminate in premiums against employees based on salary. (Does not apply to self-insured plans)

Early Insurance Market Reforms

Reforms Effective Within 6 months (September 23, 2010)

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HEALTH PLAN DISCLOSURE AND TRANSPARENCY REQUIREMENTS

All plans are required to disclose the following information:

- Claims payment policies and practices;
- Periodic financial disclosures;
- Enrollment and disenrollment data;
- Claims denial information;
- Data on rating practices;
- Information on cost-sharing and payments with respect to out-of-network coverage;
- Other information to be determined.

Early Insurance Market Reforms

Reforms Effective Plan Year 2010

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PREMIUM RATE REVIEW

- The Department of Insurance in conjunction with HHS will review unreasonable premium rate increases:
 - Health plans must provide to HHS and the Department a written explanation of unjustified rates and post explanation on health plan's website;
 - The Department will review rate increases, determine reasonableness;
 - States must provide reports to HHS.
- HHS will distribute \$250 million in grants over 5 years to cover state costs; \$1-\$5 million to each state based on population and number of health plans in state.
- Given the absence of rate approval authority, the availability of grant funds in Illinois remains unclear.

Early Insurance Market Reforms

Reforms Effective Plan Year 2010/2011

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MEDICAL LOSS RATIO REQUIREMENTS

- Effective in Plan Year 2010, health plans must report to the Department of Insurance and HHS information on medical loss ratios.
- Report must provide percentage of premium revenue spent for:
 - Reimbursement of clinical services;
 - Activities that improve health care quality;
 - All other non-claims expenses excluding state and federal taxes, licensing or regulatory fees.
- Calculations and reporting requirements to be developed by HHS in consultation with the Department of Insurance and other states through the NAIC.
- Beginning in Plan Year 2011, rebates must be provided to consumers if health plans do not meet minimum loss ratio of 85% for large group plans or 80% for small group and individual.

Early Insurance Market Reforms

HHS Request for Information

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On April 14, 2010, the U.S. Departments of HHS, Labor, and Treasury published two separate Requests for Comments from Insurance Regulators/Stakeholders.

Medical Loss Ratios. Feedback requested regarding:

- Definition of activities that improve health care quality;
- Standardized methodologies for calculating loss ratios (by line, product type, plan size, geographic considerations);
- Variability and special considerations for smaller plans, types of plans, newer plans.

Rate Review. Feedback requested regarding:

- Existing state rate review requirements;
- Considerations and variations for types of plans;
- Methodologies for evaluating rate reasonableness and justification;
- Public disclosure practices and suggestions.

STATE REGULATOR ACTION

- Through the NAIC, provided feedback to both requests (available [here](#)).
- Continue to actively participate in NAIC work groups.
- Awaiting federal regulations regarding regulatory responsibilities and financial impact.
- Working to implement reforms so that Illinois' consumers receive much-needed protections.

Insurance Market Reforms

Required within 2 years

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Health plans must comply with uniform requirements for summary of benefits and explanation of coverage documents.

- **Must include the following information:**
 - Description of coverage and cost sharing for each category of essential benefits and other benefits;
 - Exceptions, reductions and limitations in coverage;
 - Renewability and continuation of coverage provisions;
 - Coverage facts label that describes common benefit scenarios;
 - Statement of whether the plan provides minimum essential benefits;
 - Statement that summary is only an outline;
 - Phone number for consumers to call for additional information.

- **Health plans must use standardized definitions for certain policy terms.**
- **Standards must be published within 12 months; health plan compliance within 24 months.**

STATE REGULATORY ACTION: The Department will continue to participate in Federal efforts to develop standards directly and through the NAIC.

Insurance Market Reforms

Effective January 1, 2014

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- **Guaranteed issue of all group and individual health insurance plans.**
 - No medical underwriting, no discrimination based on health status.
- **Elimination of preexisting condition exclusions.**
- **Elimination of all annual limits on coverage (with some exceptions to be determined by HHS).**
- **Waiting periods for group plans limited to 90 days.**
- **Limitation on deductibles in small market (\$2,000 individual, \$4,000 for family coverage).**
- **Rating restrictions for group and individual market: may only rate based on age (variations limited to 3: 1), family composition, geography, and tobacco use (variations limited to 1.5:1).**
- **Minimum benefit standards for small group and individual plans.**
- **Small employer redefined from 2-50 to 1-100 employees (by 2016).**
- **No discrimination based on health status, including individuals who participate in clinical trials (insurers must cover routine care that would otherwise be covered).**
- **All plans sold (inside and outside of Exchange) are considered a single individual or small group risk pool for rating purposes.**

Office of Consumer Health Insurance

Effective Immediately

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Provides grants to states to create health insurance consumer assistance or health ombudsman program:

- Serves as an advocate for consumers;
- Assists with insurance-related complaints and appeals, educates consumers on their rights and responsibilities;
- Assists consumers with enrollment in health plans;
- Resolves problems with obtaining premium subsidies beginning in 2014;
- Collects, tracks and quantifies consumer problems and insurance inquiries; must submit reports to HHS as required;
- \$30 million in funds will be distributed to states, HHS will provide instructions, qualifications for funds.

STATE REGULATOR ACTION: The Department's Office of Consumer Health Insurance currently performs many of these activities and will seek additional federal funds to supplement its consumer assistance functions.

Temporary High Risk Pool

Effective Within 90 Days

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Directs states to establish a temporary high risk insurance pool program for individuals with pre-existing conditions:

- No preexisting condition exclusions;
 - Out-of-pocket costs limited to no greater than limits for high-deductible health plans; (Currently \$5,950 for individuals and \$11,900 for families)
 - Must use adjusted community rating with maximum rate variation for age limited to 4:1;
 - Premiums must be set at 100% of the “standard rate.”
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- Eligible individuals must be uninsured for 6 months or longer.
 - Secretary may contract with states or non-profit entities (including existing high risk pools) to provide coverage.
 - Federal funding of \$5 billion allocated to fund eligible enrollees until 2014 (Illinois estimated to receive \$196 million), when state Exchange health plans will be available.
 - HHS working with states to develop program participation guidelines, allocation of funds.

Consumer Web Portal

Operational July 1, 2010

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Requires the establishment of a website through which residents or small businesses can identify health insurance options that may be available in each state (Medicaid, Medicare, ICHIP, or private insurance options).

- Within 60 days, HHS must establish a standardized format for presenting and comparing information about different insurance products.
- At a minimum, this information must include medical loss ratio, eligibility, availability, premium rates, and cost sharing.

STATE REGULATOR ACTION: The Department intends to develop its own site providing HHS with information regarding insurance coverage options available within Illinois.

Electronic Health Care Transactions

Multiple Implementation Dates

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Simplifies health insurance administration by requiring compliance with standards for certain electronic health care transactions.

- Enhances existing requirements under HIPAA by imposing new, earlier deadlines for federal HHS rules and implementation:
 - Requires use of a single set of operating rules for eligibility verification and claims status (January 2013);
 - Electronic funds transfers and health care payment and remittance (January 2014);
 - Health claims or equivalent encounter information (January 2016);
 - Enrollment and disenrollment in a health plan (January 2016);
 - Health plan premium payments (January 2016);
 - Referral certification and authorization (January 2016).

State Health Insurance Exchange

Operational by January 1, 2014

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Directs states to establish American Health Benefit Exchanges for individuals and Small Business Health Options Program (SHOP) for small businesses (and expand to large employers in 2017).

- Failure to establish Exchange will result in HHS establishing an Exchange within any non-participating state.
- State must be able to demonstrate by January 1, 2013, that it will have Exchange operational by January 1, 2014.
- Exchange must be operational by January 2014; HHS must work with NAIC, states, stakeholders to develop regulations applicable to Exchange.
- Exchange must be administered by governmental agency or non-profit organization.
- Grants will be available from HHS to Illinois to develop and implement the exchange.

State Health Insurance Exchange

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Health Insurance Exchange Features:

- **Provides one-stop insurance shopping for individuals and small businesses:**
 - Offers enrollees a selection of “Exchange qualified” plans that meet minimum standards for coverage and affordability;
 - Creates administrative mechanism for enrollment;
 - Standardizes presentation of insurance options for plan comparability; provides a “rating” system for plans and significant transparency provisions;
 - Redefines small businesses as 1-100 employees; states may limit to 50 until 2016.
- **All plans sold in the Exchange must be certified by the Department as meeting minimum federal benefit standards:**
 - Four options of benefit plans: bronze (least generous), silver, gold, platinum (most generous);
 - Catastrophic plans available to individuals under age 30 or those exempt from insurance requirement;
 - Insurers must offer children-only plans, and may offer stand-alone dental plans.

State Health Insurance Exchange

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Health Insurance Exchange Features (continued):

- Exchange must contract with “navigators” to assist consumers.
- Exchange must provide a seamless application and enrollment process for individuals who qualify for subsidies, requiring coordination for enrollment in public programs if eligible.
- Federal funding: HHS will distribute implementation grants to states within one year after date of enactment of legislation.

STATE ACTION: The Department will continue to work with HHS and other public and private stakeholders on establishing a health insurance exchange in Illinois. The Department is leading NAIC’s efforts regarding Exchange development and implementation.

Transitional Reinsurance

Effective January 1, 2014

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States are required to establish transitional reinsurance for the small group and individual markets to help stabilize premiums during first three years of Exchange when risk of adverse selection is greatest.

- States must establish a nonprofit reinsurance entity by 2014.
- HHS and the states, through the NAIC will establish provisions for program.
- Reinsurer collects payments from group insurers (including Third Party Administrators) and provides reinsurance payments to individual insurers that cover high-risk individuals (2014-2016).

Other Provisions of Significance

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- **CO-OPS.** Consumer Operated and Oriented Plan (CO-OP) program to foster creation of non-profit member-run health insurance companies to offer qualified health plans within Exchange. Funds of \$6 billion allocated to finance grants and loans to entities to establish CO-OPs by July 1, 2013.
- **Multi-State Plans.** Permits states to form health care choice compacts that would allow multi-state insurance sales in participating states with joint agreement. Consumer protection provisions prevail in state where enrollee resides. If state wants to participate, must enact law (January 2016).
- **Merge Markets.** Allows states to merge individual and small group markets (January 2014).
- **Employer-based Wellness Programs.** Permits employers to offer rewards of up to 30% of the cost of premiums for participating in wellness programs that meet certain standards; provisions included for non-discrimination. Creates a 10-state pilot program to allow similar programs in individual health plans.

Individual Requirement to Purchase Coverage

Effective January 1, 2014

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- Individuals (US citizens and legal residents) required to obtain qualifying coverage that meets federal standards.
- Can enroll in either an individual or group health plan, but that plan must be certified to meet certain benefit and other requirements.
- Exemptions for individuals below tax filing threshold (currently \$12,050 for individual and \$18,700 for couple), people with religious objections, members of Indian tribes, people not covered for less than three months.
- Subsidies for families/individuals up to 400% of federal poverty level (approx \$43,000 individual, \$88,000 family of 4) to apply towards premium costs.

Individual Requirement to Purchase Coverage

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- **Penalties for non-compliance:**
 - Greater of \$95 or 1% of income per person in 2014;
 - Greater of \$325 or 2% of income per person in 2015;
 - Greater of \$695 or 2.5% of income per person in 2016.
- **Enforcement:** individuals required to file with IRS must include IRS form to verify they have qualifying coverage. Individuals exempt from filing taxes also exempt from insurance requirement.
- **Individuals who do not submit form will receive notice from IRS in June of each year, notifying them that they need to file the required information or request exemption.**

Employer Requirement to Offer Health Coverage

Effective January 1, 2014

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Small Employers

- Small employers with 50 or fewer FTE employees are not required to offer insurance and are not subject to penalties.
- Part-time workers (work less than 30 hours per week) are counted for purposes of determining number of FTEs:
 - Add total number of hours worked by part-time employees and divide by 120 to determine number of FTEs;
 - Example: 10 part-time employees working total of 600 hours per month; $600 \div 120 = 5$ additional FTEs.
- No employer is required to offer coverage to or pay penalties on part-time workers.

Employer Requirement to Offer Health Coverage

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Small Employers (continued...)

- Tax Credits available for some small employers who do offer insurance:
 - Small Employers, with less than 25 employees and average annual wages of less than \$50,000, that do offer coverage receive tax credit of up to 35% of their premium payments on behalf of employees; credit increases to 50% in 2014;
 - Credits phase out gradually for firms with average wages between \$25,000-\$50,000 and for firms with 10-25 FTE workers.

Employer Requirement to Offer Health Coverage

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Large Employers

- **Employers with more than 50 full-time employees must offer insurance meeting certain cost requirements or pay penalties:**
 - Large employers who do not offer insurance and whose employees receive public subsidies pay 1/12 of \$2,000 per FTE per month, with a waiver for first 30 FTEs;
 - Large employers who offer insurance but have employees who receive premium assistance because they cannot afford the insurance (affordability is 9.5% of income) pay the lesser of 1) 1/12 of \$3,000 per FTE receiving subsidy per month, or 2) 1/12 of \$2000 per month for the total number of full-time employees with a waiver for first 30 FTEs;
 - Penalties calculated monthly based on number of applicable employees.
- **Employers with 200 or more workers who offer coverage must automatically enroll new employees and continue enrollment of current employees; employees may choose to opt-out.**

Reform's Impact on Market and Consumers

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- In Illinois, due to total absence of rate oversight, insurers have imposed explosive rate increases on families and businesses – even high deductible premiums have increased more than 30%.
- Nationally, consumers may begin to see premium changes within the next six months; some will see increases, others will see decreases.
- Some premium cost increases may be mitigated by minimum loss ratio requirements, but it's too early to predict market impact.
- Uninsured individuals with preexisting conditions may be able to obtain coverage through the temporary insurance risk pool at rates comparable to what is available in the commercial market.
- Significant impact on small and individual market due to rating requirements and guarantee issue.
- Likely to eliminate need for ICHIP after 2014.

Reform's Impact on Illinois Market and Consumers

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- Grandfather provision for plans in effect on the date of enactment; all plans issued going forward must meet federal requirements but consumers with insurance before passage of the law can continue under their current plan.
- Employers with existing group plans can continue to enroll new employees and eligible dependents.
- Insurers will continue to market private insurance plans but all plans sold after March 23, 2010, must comply with new benefit provisions.

STATE REGULATOR ACTION: The Department will continue all regulatory activities, including company and agent licensing, consumer protection, market conduct and financial oversight, enforcement, policy form review and approval.

Premium Tax Credits for Individuals and Families

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- Premium tax credits will be available to citizens and legal residents in families with incomes between 133% and 400% of poverty who purchase coverage through a state insurance Exchange.
- The tax credit will be refundable (available to a person even if he or she has no tax liability) and advanceable (available at the time insurance is purchased rather than after an annual tax return is filed).
- The tax credit varies based on a person's income such that the premium the person will have to pay will not exceed a specified percentage of her income, from 2% for an income level up to 133% of FPL to 9.5% for an income level between 300% and 400% of FPL.

Cost Sharing Subsidies

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- **Cost-sharing subsidies will be available to reduce out-of-pocket costs for families with incomes between 100% and 400% of poverty. These subsidies will reduce the maximum allowable out-of-pocket expenses allowed for plans sold on the exchange by:**
 - $\frac{2}{3}$ for income levels between 100% and 200% of FPL;
 - $\frac{1}{2}$ for income levels between 200% and 300% of FPL;
 - $\frac{1}{3}$ for income levels between 300% and 400% of FPL.
- **Additional cost-sharing subsidies will be available to reduce out-of-pocket costs for families with incomes at or below 250% of poverty. These subsidies will increase a health plan's share of total allowed costs of benefits provided under a plan to:**
 - 94% in the case of income levels between 100% and 150% of FPL;
 - 87% in the case of income levels between 150% and 200% of FPL;
 - 73% in the case of income levels between 200% and 250% of FPL.

Impact on the Department

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- Aggressive timeline for initial market reforms required by September 23, 2010.
- Approve all policy filings necessary to bring health plans into compliance with new policy provisions beginning in 6 months.
- Identify staffing and training needs, both short term and long term (technical, legal, administrative, Information Technology).
- Prepare for and aggressively implement new regulatory responsibilities, such as rate review requirements.
- Continue oversight and regulation of existing grandfathered plans as well as all new plans issued under reform provisions.
- Identify required legislative and rule changes and propose legislation and new rules.

Impact on the Department

(Continued...)

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- Establish internal processes and procedures to monitor and provide input in development of federal regulations, NAIC standards, and state law changes.
- Evaluate internal agency needs to ensure coordination of implementation activities across programs.
- Hold public stakeholder meetings to discuss implementation, obtain input on legislative and regulatory changes and new filing requirements.
- Maintain web page (www.insurance.illinois.gov/hiric) for regular updates on health reform activities, summary documents, and Q&As for frequently asked questions.
- Lead the establishment of health insurance Exchange in Illinois.

Department Implementation Planning

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- Developing detailed implementation plans and timelines to address immediate needs and long-term needs.
- Plan and conduct Public Stakeholder meetings.
- Some activities/decisions will depend on HHS directives and regulations; timelines may change based on federal decisions.
- Established Department workgroups, coordinate with corresponding NAIC workgroups.
- Fiscal estimates will be developed and reviewed continually as HHS regulations and directives are released, enabling the Department to develop accurate cost estimates.

Implementation Challenges

- Provisions effective within first 6 months will require aggressive implementation effort.
- Significant legislation and rules required; availability and timing of federal regulations will impact the Department's implementation planning and execution.
- Implementation and long-term management of varying regulatory requirements for grandfathered plans, Exchange plans, non-Exchange plans, multi-state plans; and plans within each market segment (individual, small group and large group).
- Consumer education and assistance.
 - Massive public education and information effort, coordinated across state agencies.
 - Staffing and training.
- Health care provider workforce and network adequacy; impact on existing healthcare infrastructure and ability to manage new insured.
- Long term fiscal planning as new HHS regulations are issued periodically during next four years.

Contact Information

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For more information please visit the Department's website (<http://insurance.illinois.gov>) or call the Office of Consumer Health Insurance toll-free at (877) 527-9431