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# HMA

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HEALTH MANAGEMENT ASSOCIATES



*Illinois Exchange Strategic and Operational  
Needs Assessment*

*Final Report*

SEPTEMBER 2011

*Research and Consulting in the Fields of Health and Human Services Policy, Health Economics  
and Finance, Program Evaluation, Data Analysis, and Health System Restructuring*

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## 1. Executive Summary

The Affordable Care Act (ACA) is a substantial, comprehensive reform of health care and health insurance in this country. A central element of the ACA is the creation of Health Insurance Exchanges. Exchanges are organized marketplaces for the purchase of health insurance by individuals and small businesses. Among the most challenging aspects of implementing health reform for states is planning for Exchange establishment and operation.

The ACA will substantially overhaul the individual and small-group insurance market in Illinois, require individuals to buy insurance, and incentivize employers to purchase insurance for their employees. The ACA also expands Medicaid eligibility and establishes new tax credits to subsidize the purchase of insurance for individuals who are low income but do not qualify for Medicaid. Those subsidies are only available to individuals who purchase insurance through an Exchange. There are currently 1.5 million uninsured individuals in Illinois. According to the State's most recent estimates, the reforms included in ACA will dramatically reduce the number of uninsured in the State.

The purpose of this report is to inform the process of Exchange planning in Illinois. The report provides background information on the federal law, analyzes the state's needs in setting up an Exchange, addresses mandatory Exchange services and functions, projects Exchange start-up and operating costs, and provides insights on policy decisions the state will need to make in designing its Exchange, coordinating it with the Illinois insurance market, and integrating it with existing Illinois public programs.

The process of Exchange planning involves both the Executive and Legislative branches. After passage of the ACA, Governor Pat Quinn issued an Executive Order establishing the Illinois Health Reform Implementation Council. The Council convened a series of public hearings during the latter part of 2010 and on November 15, 2010, sought public input on a series of explicit policy questions regarding the ACA implementation. The final report of the Council, titled *Health Care Reform Implementation Council: Initial Recommendations*, was made public on March 1, 2011. With the support of a federal Exchange planning grant, affected state agencies have established a variety of workgroups, commissioned this report, and conducted other background research efforts. The General Assembly, which created a Legislative Study Commission to study and provide recommendations on Exchange enabling legislation, also plays a crucial role in Exchange planning in Illinois. Overall the state of Illinois is deeply engaged in ACA implementation planning.

### **Exchange Planning and the Challenges of the ACA Timeline**

A primary consideration and constraint in planning for Exchange implementation is timing. Exchanges begin operating under new ACA rules on January 1, 2014. To begin providing coverage options on that date, Exchanges need to be operational for an initial open enrollment period beginning October 1, 2013. Substantial development, generally funded by the federal government, and careful testing of new IT infrastructure needs to be completed satisfactorily before the initial enrollment period. State Exchange plans must be submitted for federal approval in the fall of 2012 for approval by the Secretary of Health and Human Services (HHS) by January 1, 2013. Many of the policy decisions about how the Illinois

Exchange will operate in relation to the larger insurance market and how the Exchange will integrate with the state's existing Medicaid program are necessary well in advance of 2013. Finally, requirements for Exchange operations, most notably the need to integrate eligibility and enrollment systems with existing state Medicaid enrollment, necessitate action now to allow time for design, procurement, development, and deployment steps that must be taken before implementation.

We emphasize timing at the outset because it helps bring into sharp focus the issues faced by Illinois and every other state considering establishing an Exchange. We also emphasize two related points. First, the challenge of compressed timeframes impacts not only state government planners but also health insurance carriers that wish to be qualified to offer Exchange plans; they will have to undertake significant operational preparations. Second, preparations for ACA implementation are well underway in Illinois, with senior-level state staff organized, coordinated, and engaged in the day-to-day decisions needed to support the planning effort. However, final decisions on the myriad options confronting Illinois will be impossible without an established Exchange organization with an accountable governance structure. Given the priority placed on Exchange planning in Illinois, legislative action to establish an Exchange is a crucial next step.

### **Potential Policy Goals of an Exchange**

An important initial consideration for Illinois is to consider the goals that it seeks to prioritize in implementing an Exchange in the state. Informed by Illinois planning efforts to date, this report identifies potential policy goals for an Exchange and discusses methods to ensure that those goals are met. We recommend an early discussion about potential goals among decision-makers in Illinois to arrive at common understandings of priorities and of the trade-offs inherent in the setting of those priorities. On August 24, 2012 the Legislative Study Committee discussed potential goals of an Exchange with the support of a presentation drawn largely from the material in section 4.1 of this report.

### **Mandatory Exchange Decisions and Functions**

Initial projections are that the Illinois Exchange will enroll 486,000 individuals in 2014, the first year of operation. Of that total, 149,000 will enroll in the Small Business Health Options Program, or SHOP Exchange, and 337,000 as individual purchasers. Of the individual purchasers, 73% will receive some form of premium or cost-sharing tax credit. As the Exchange becomes well-established, enrollment is projected to grow, particularly over the first few years of operation. By 2016, the Illinois Exchange is projected to serve over 1 million customers.

Exchange enrollees will include: individuals without insurance and certain individuals in state programs today (many of whom will have access to subsidized coverage through the Exchange), people who purchase nongroup insurance today and will use the new Exchange market to purchase insurance, and people (some insured and others currently uninsured) who work for small employers who choose to use the SHOP Exchange.

A threshold question for Illinois is whether to build its own Exchange or to defer Exchange establishment in Illinois to the federal government. This report discusses both structural and organizational models for

an Exchange that are authorized under the ACA. Given the large number of new functions Exchanges must perform and the operational complexity of these functions, Illinois should consider design and organizational approaches to the Exchange that enable prompt decision-making and provide flexibility to adapt quickly to shifting market conditions. Board decisions will be difficult because they will directly affect a wide range of stakeholders, special-interest groups, consumers, and business interests. Given the importance of ensuring the public's trust in Exchange board decisions and of insulating, to the extent practical, members from political pressures, Illinois should prioritize competence and experience in defining its board membership rather than status as a representative of an identified interest group.

Operational expectations of Exchanges are substantial. This report reviews mandatory Exchange requirements and addresses, in fourteen separate domains, whether existing state infrastructure is available or could be leveraged to serve the function for Illinois. The functions of the Exchange can be grouped into the following fourteen domains:

- Eligibility determination
- Online shopping
- Enrollment, billing, and collections
- Customer service
- Producer management
- Navigator management
- Communications and outreach
- Plan specification and qualified health plan management
- Financial management
- Risk adjustment (if done by the Exchange)
- Oversight, governance, and program evaluation
- Mandate certification and eligibility appeals
- Consumer protections
- Reporting for federal and state oversight

In general, relatively little functionality is already in place in Illinois that could be adapted or expanded to serve the Exchange – a conclusion not altogether surprising or unique to Illinois. This report recommends potential approaches to acquiring or performing mandatory Exchange functions. A number of mandatory Exchange functions will require substantial investments in information technology infrastructure. A significant element of IT development, relating to eligibility and enrollment systems, is dealt with in a separate report produced by the HMA Team. This report also recommends a series of approaches for strategically approaching purchasing options in acquiring the various IT and operational needs of Exchanges.

Education and outreach is another important function for the Exchange. We treat the function as mandatory because we believe that well-conceived enrollment strategies are a critical element of success for the Exchange. The ACA and Exchanges will substantially change how health insurance is purchased by individuals and small businesses by streamlining and simplifying the process of shopping for and purchasing health insurance. As a new distribution channel that is expected to reform the

purchase of health insurance for the individual and small-group markets, there is a natural tension between the Exchange and the role of brokers, commonly known in Illinois as producers. If producers are hostile to the Exchange and have incentives to avoid sending business to it, their actions could threaten the success of the Exchange. At the same time, producers play an important and valued role in Illinois today for individuals and small business purchasing insurance. Because defining the role and compensation level of producers in the Exchange is a complicated and potentially controversial issue, we strongly recommend working with all stakeholders, including the producer community, to develop a policy and financial model that seeks to smooth the inevitable tension between an Exchange and producers.

Illinois also has a successful education and outreach resource targeted at supporting enrollment in public programs, All Kids Application Agents. The report compares the role and functions of producers and AKAAs to a new role created in the ACA and required to be funded by Exchanges, that of Navigators. Again, our recommendation is for working closely with stakeholders to define appropriate roles—a step that is necessary to ensure successful outreach strategies that work in the unique context of Illinois.

Finally, the ACA substantially reshapes the insurance marketplace in Illinois and, in doing so, creates substantial new obligations on Illinois insurance regulators at the Department of Insurance. As part of this needs assessment, we identify specific new regulatory functions and assess the resources that will be necessary to perform the regulatory work that is essential to the successful operation of health reform.

### **Exchange Finances**

Under the ACA, by 2015 Exchanges are required to be self-sustaining. In other words, Illinois needs to identify appropriate revenue to support its Exchange after the start-up and establishment funding currently being provided by the federal government is spent. The report includes a preliminary Exchange financial model to inform the state's planning effort.

Once operational, the per-member cost of running the Exchange, as well as the Exchange's cost as a percentage of premiums, will decline as enrollment grows. This is because the Exchange will be able to spread its fixed costs across a larger membership base.

While a range of potential revenue sources are possible, the financial model presented in this report assumes that the Exchange will be financed through an assessment on participating health carriers in order to provide a concrete illustration of potential costs and revenues. Based on the assumption that revenue is collected only from Exchange-participating plans and a range of potential enrollment scenarios, we estimate that the assessment required to finance the cost of running the Exchange, as a percent of premium, will be between 2.24% and 3.39%. We estimate that the cost of the Exchange on a per-member per-month (PMPM) basis will be between \$10.47 and \$16.83 in 2014 and between \$8.92 and \$13.47 in 2015. Both measures compare favorably with existing benchmarks. For example, in FY 2011, its fifth year of operations, the Health Connector in Massachusetts experienced PMPM expenses of \$11.16. The Health Connector has employed premium assessments between 3% and 4% of premium.

Illinois may consider other revenue-raising options, including by broadening the base on which any assessment is charged to the non-Exchange health insurance market. The policy justification for a broader assessment is that the Exchange, by increasing coverage and decreasing unreimbursed care, serves a role that benefits the entire market.

### **Other Structural Exchange Decisions**

In addition to mandatory Exchange functions, there are other decisions that Illinois could make that will have important and lasting impacts of the character and success of its Exchange.

One area concerns methods and actions Illinois can take to avoid adverse selection. Adverse selection is a general term referring to the negative consequences that result if more high-risk individuals actually enroll in insurance plans than the market or an individual health insurer anticipated. There are three general types of adverse selection, which involve selection against 1) the entire market, 2) the Exchange market as compared to the “outside” or non-Exchange market, or 3) a specific insurance carrier. The ACA contains a number of provisions intended to avoid adverse selection. Recognizing and building on those provisions of the ACA, we provide in this report specific recommendations about steps Illinois can take to avoid adverse selection.

The ACA also requires the expansion of the small-group market to employers with up to 100 employees in 2016. Until 2016, Illinois may retain its current definition of small group (up to 50 employees), or it may expand the definition to the higher level. The small-group market is served by the SHOP Exchange. Most published analysis of the issue argues for retaining the current restriction of the market, based on the concern that allowing businesses with 51-100 employees into the SHOP immediately could raise premiums because businesses with healthy workforces would choose to self-insure, while businesses with less healthy workforces would choose to take advantage of the coverage available through the SHOP. The analysis in this report finds that over 30% of the 50-100 employee size firms would need to self-insure before the SHOP would begin to be significantly impacted with increased premiums. The State should carefully consider options to prevent large groups between 50 and 100 from exiting the fully-insured marketplace (by either dropping coverage or self-insuring) to ensure that the state benefits from an early expansion of the Small Group Market.

Another option available to Illinois under the ACA is to combine its small-group and individual risk pools. In general, merging markets will equalize premiums. Based on actual historical data provided by Illinois carriers in the individual and small -group markets, we estimate that rates in the individual market would likely increase significantly, and rates in the small-group market would likely decrease minimally if the markets were merged in Illinois. It is important to emphasize that the results of our analysis are not intended to suggest that small-group premiums are expected to decrease under the ACA. The finding presented here with regard to the market merger is in isolation of other possible findings related to the ACA and should be viewed strictly in relation to if the markets were *not* merged.

Finally, we analyze and recommend against the early implementation of the substantial insurance market and consumer protection reforms that will become effective under in 2014, including the ACA’s prohibition on pre-existing condition exclusions and the ACA’s guaranteed issue and renewal rules. In

the circumstances, early implementation of those reforms without an individual mandate will cause pricing turmoil in the market and potential damage a larger group of currently insured than would benefit from the protections before 2014. Rather, we recommend focusing resources on careful planning to deal with the implementation challenges and market impacts of the ACA in 2014.

### **Medicaid and the Exchange**

Efficiently integrating an Exchange with existing Illinois state programs, most particularly the Medicaid program, will be an essential element of success for the state. There are both policy and operational dimensions to the integration of the Exchange with existing state programs, and our advice is to pay close attention at all turns to how Exchange decisions and actions will affect other state programs. We also emphasize that decisions of state agencies and circumstances in the Medicaid program may equally affect the Exchange. There is currently a strong working relationship between staff in the Medicaid program and the Department of Insurance working on Exchange implementation. We strongly recommend the development of a formal structure once an Exchange is established that continues this relationship, including the involvement of senior staff involved in both operational management and agency policy-setting.

The report also addresses existing state agency operational capacity. The increased caseload attributable to the ACA, in combination with the need for enhanced program integrity measures from the 2012 Illinois Medicaid reform law, cannot be handled with existing staffing levels given existing business processes. We recommend a focus on improved business processes as a component of the overhaul of eligibility IT systems, and a close monitoring of state agency staffing needs.

### **Medicaid Expansion Impacts**

In January 2014, the ACA expands Medicaid to cover individuals and families below 133% of the federal poverty level (FPL). Individuals above that income level (some of whom are served by state programs or Medicaid today) will have access to Exchange-based subsidized coverage. In Illinois, the Medicaid expansion will affect primarily two groups:

- Individuals with income at or below 133% FPL who do not meet categorical eligibility criteria.
- Individuals with disabilities and income at or below 133% FPL and above the current Medicaid threshold of 100% FPL.

Based on existing state enrollment and administrative data concerning growth, we project Medicaid enrollment between now and 2014 at an effective annual growth rate of 3.1%. After accounting for the eligibility changes created by the ACA, we estimate total Medicaid and Children's Health Insurance Program enrollment in FY2014 to be 3.1 million. Of that total (which covers only individuals receiving comprehensive benefits), 130,000 will be new enrollment from currently eligible individuals and 267,000 will be individuals newly-eligible under the Medicaid expansion – an important distinction because of the differential federal matching rates provided for the two groups under the ACA. We also estimate

that eligibility for 22,994 children and 39,524 non-elderly adults will be eliminated and those individuals will be eligible instead for federal subsidies through the Exchange.

Costs based on this new enrollment in Medicaid are estimated to be \$224.5 million in 2014. Savings attributable to the elimination of eligibility in Illinois are estimated to be \$115.1 million, for a net state cost to the state in 2014 of \$109.4 million. Our analysis addresses costs and savings from changes in Medicaid eligibility standards in 2014 and is not a comprehensive analysis of the cost of health reform in Illinois. The state should analyze other potential cost savings, including reductions in state spending for uncompensated care, to understand the overall impact of the ACA on the state budget.

### **The Basic Health Plan**

Illinois has the option of establishing a Basic Health Program (BHP) in lieu of Exchange coverage for people ineligible for Medicaid who have income at or below 200% FPL. Because the BHP allows the state flexibility in benefit design and cost sharing, it may be an opportunity to design a plan that is intended to address the needs of the low-income population and to improve continuity of care across transitions in coverage and within families who would otherwise be “split” between the Exchange and Medicaid. However, the financial structure of the BHP, which gives states 95% of what BHP enrollees would have received in subsidies on the Exchange, creates significant risk and uncertainty for Illinois. This report analyzes risks and benefits of the BHP in detail.

We also provide a financial model intended to demonstrate how the state can assess BHP financing analytically. Given substantial uncertainty across a variety of inputs to the cost and revenue model for the BHP, most especially available revenue to the state for the BHP, our model is primarily intended to provide a framework for illustrating a range of potential BHP financial scenarios.

### **Next Steps**

Many of the policy and operational decisions faced by the state and the Illinois General Assembly are addressed in detail in this report. We provide recommendations throughout the report for areas that deserve further inquiry, additional research, or ongoing monitoring. And we emphasize, in this summary and throughout the report, that: 1) the single most challenging aspect of implementing Exchanges and ACA in Illinois is meeting required timelines to achieve the 2014 implementation date; and 2) the single most crucial step the state could take support a successful implementation is to establish, through legislative action, an Exchange with appropriate authority over and responsibility for providing direction to the state’s implementation efforts.

## 2. Introduction

### 2.1 Contract Background and Approach

The State of Illinois received a planning grant from the federal government to support planning activities related to the creation and operation of health benefit Exchanges under the Affordable Care Act (ACA). Health Management Associates (HMA) was engaged by the state to provide assistance with this planning process.

The contract, through the Illinois Department of Insurance (DOI) on behalf of the state, was divided into two major related components. The first component was an “Exchange Organizational and Impact Assessment” intended to help the state identify business, organizational, and financial needs to establish an Exchange, and to assess the impact of the ACA and a state-based Exchange on the Illinois insurance market and on existing Illinois public programs. The second component involved information technology infrastructure to perform eligibility, verification, and enrollment (EVE) functions for an Exchange and for other existing Illinois health and human services programs. The EVE component was intended to review current state Information Technology (IT) systems and initiatives alongside new federal requirements, to develop options for an ACA-compliant solution, and to support the process of the state’s selection of an approach that would address new federal requirements and meet state strategic goals.

HMA recruited a team of individuals and organizations to support this work. The HMA Team includes two major subcontracting firms, CSG Government Solutions (CSG) and Wakely Consulting Group (Wakely). Wakely’s work has focused on the Strategic Needs Assessment, including actuarial and market analysis. CSG, an information technology firm, has focused on the EVE component of the contract. HMA has participated substantively in both components of the work and has managed the overall engagement, including a group of additional individual subcontractors.

The planning and analysis process has consisted of a range of activities and events. The HMA Team attended an executive-level briefing at the outset of the project. The contract called for a “mid-term oral report,” which took place in Chicago on June 15, 2011, with state executive leadership and legislative staff. After discussions with state project leadership, that oral report took the character of a general update on the status of the Team’s work combined with a detailed facilitated discussion of potential policy goals that could be served or supported as the state designs its approach to ACA and Exchange implementation. Throughout the engagement, the HMA Team has met regularly with state project leadership from DOI and the Illinois Department of Healthcare and Family Services (HFS) for the purpose of status reporting and to organize substantive discussions with appropriate state staff to inform the planning work. Research and data gathering activities conducted in preparation for this report are described more fully in the relevant sections of the report and in the supplemental EVE report.

For the EVE component, the HMA Team’s engagement with Illinois state staff and agency leadership was particularly important. The goal of that work was to identify a clear set of options and to help the state select a preferred option for a major system development project affecting multiple agencies and serving multiple programs. For that reason, the HMA Team worked with state project leadership to

design and conduct a series of facilitated discussions with a planning team composed of appropriate representatives of affected agencies, departments, programs, and business operations. The group, known as the EVE Planning Group, met regularly from May to July. HMA Team members also met individually with executives in affected agencies and presented at a Medicaid Advisory Committee meeting to discuss EVE planning.

This report and the materials accompanying it comprise the final report of the planning process. In recognition of the unique and technical nature of the EVE planning process, the HMA Team has created a separate final report for that component, which is a supplement to this report.

## 2.2 State Exchanges and Planning

### THE AFFORDABLE CARE ACT AND STATE EXCHANGE PLANNING

The ACA is a substantial, comprehensive reform of health care and health insurance in this country. The overall goals of the ACA are to:

- reform the individual and small-group health insurance market by instituting certain consumer protections, establishing limits on rate variation based on enrollee risk and other regulatory requirements, and defining basic benefit standards;
- require the purchase of insurance by individuals, enforced by tax penalties for non-purchasers;
- incentivize employers to purchase insurance using a variety of methods; and
- expand insurance coverage for lower-income individuals with subsidies, either through coverage in the Medicaid program or through Exchange-based premium and cost-sharing subsidies.

A central element of the ACA is the creation in states of Exchanges. The purpose of this report is to inform the process of Exchange planning in Illinois. That planning process includes both executive branch agencies and the legislative branch. While state agencies are appropriately directing research and doing implementation planning work, Exchanges are ultimately a creature of state law, so this report is intended to inform legislative decision-making as well as state agency planning. The report provides background information on the federal law, analyzes the state's needs in setting up an Exchange, addresses mandatory Exchange services and functions, projects Exchange start-up and operating costs, and provides insights on policy decisions the state will need to make in designing its Exchange, coordinating it with the Illinois insurance market and integrating it with existing Illinois public programs.

### HEALTH INSURANCE EXCHANGES

As envisioned in the ACA, the Health Insurance Exchange will be a major mechanism for expanding health coverage. A Health Insurance Exchange is an organized marketplace for the purchase of health insurance by individuals and small businesses.

The ACA requires that an American Health Benefits Exchange be available to individual consumers of health coverage and that a Small Business Health Options Program (SHOP) Exchange be available to small groups seeking coverage. The legislation mandates that Health Insurance Exchanges be available to residents in every state either as a state-established entity, or if a state decides not to create an Exchange or does not meet Federal requirements for Exchange development, through the Federal Department of Health and Human Services (HHS). States implementing an Exchange can create a single Health Insurance Exchange serving all the residents of the state, partner with neighboring states to create a regional Exchange, or create subsidiary Exchanges serving different regions within a state.

Health Insurance Exchanges are expected to fulfill the following functions:

- Certifying qualified health plans
- Administering premium tax credits and cost sharing
- Providing assistance to consumers for the purchase of health coverage
- Creating and maintaining a website designed to assist consumers to assess their eligibility and enroll in health insurance
- Coordinating Exchange eligibility and enrollment with Medicaid and the Children's Health Insurance program

The ACA requires Health Insurance Exchanges to be available to consumers seeking individual and small-group coverage by January 1, 2014. The legislation also authorizes the provision of federal premium and cost sharing subsidies to individuals with incomes between 133% and 400% of the Federal Poverty Level (FPL). These subsidies will be available only for coverage purchased through a Health Insurance Exchange.

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#### PLANNING EFFORTS IN ILLINOIS

After passage of the ACA, Governor Pat Quinn issued an Executive Order establishing the Illinois Health Reform Implementation Council. The Council, composed of representatives of the state agencies affected by the ACA, convened a series of public hearings during the latter part of 2010 and on November 15, 2010, sought public input on a series of explicit policy questions regarding the ACA implementation. Informed by that public comment, a second draft report was produced by the council in February 2011. The final report of the Council, titled *Health Care Reform Implementation Council: Initial Recommendations*, was made public on March 1, 2011.

We mention the Council's report here because it has been an important guide to our efforts, but also because it represents a significant undertaking to begin organized planning for health reform implementation. However, the work of the Council is far from the only implementation planning activity underway in Illinois.

In May 2011, the Illinois General Assembly passed, and in July 2011 Governor Quinn signed into law SB 1555, the Illinois Health Benefits Exchange Law (Public Act 97-0142). The law created a 12-member Legislative Study Committee to conduct a study regarding the implementation and establishment of an Illinois Exchange. The Committee is directed to address: 1) governance and structure of the Exchange;

2) financial sustainability of the Exchange; and 3) stakeholder engagement, including ongoing legislative oversight of the Exchange. The Committee will report its findings to the General Assembly and Governor by September 30, 2011.

Finally, it is important to recognize that Illinois state staff in multiple agencies are deeply engaged in the Exchange planning effort and are dedicating significant time and resources to planning for health reform implementation. Our hope is that this report will support the ongoing efforts in Illinois by the Quinn Administration and the General Assembly.

## 2.3 The Federal Environment

### EXCHANGE PLANNING CORE AREAS

In federal guidance concerning Exchange planning and establishment funding, the Center for Consumer Information and Insurance Oversight (CCIO) of the United States Department of Health and Human Services (HHS) has defined 11 Exchange planning core areas. Federal oversight of planning and implementation work will generally be organized by those core areas. Exchange planning and establishment core areas are in the table below.

**Table 1: Exchange Planning and Establishment Core Areas**

Exchange Planning and Establishment Core Areas
1. Background Research
2. Stakeholder Consultation
3. Legislative and Regulatory Action
4. Governance
5. Program Integration
6. Exchange IT Systems
7. Financial Management
8. Oversight and Program Integrity
9. Health Insurance Market Reforms
10. Providing Assistance to Individuals and Small Businesses, Coverage Appeals and Complaints.
11. Business Operations of an Exchange

Throughout Exchange development until 2015, these core areas will be the areas about which states are obligated to report progress and on which states will be judged in seeking additional federal funding support.

No organizational structure can avoid the fact that Exchange planning decisions about policy, financing, and operations are deeply interwoven and overlapping. For example, strategic decisions about Exchange priorities (discussed in section 4.2.2) influence potential information technology solutions (section 4.2.4 and a separate EVE report). Exchange costs (section 4.3) are influenced by decisions about Exchange (and other state agency) operational processes and approaches (sections 4.5 and 4.6). By identifying core areas at the outset we do not intend to imply that planning and development should proceed

within core area “silos.” In fact, to develop a successful Exchange in Illinois, state planners will need to integrate these areas in a comprehensive effort to meet the aggressive timelines required by the ACA.

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## FEDERAL FUNDING FOR EXCHANGE PLANNING

Costs associated with state efforts to design and implement a Health Insurance Exchange through December 31, 2014, will be fully funded by the federal government. In September 2010, the federal government made \$1.0 million Exchange planning grants to all states that applied for the purpose of supporting state planning efforts. These funds were to be utilized by states on early background research and Exchange design tasks.

In January, 2011, the Federal Office of Consumer Information and Insurance Oversight (now the Center for Consumer Information and Insurance Oversight [CCIIO]) issued a Federal funding announcement, describing the structure of federal financial support for Health Insurance Exchange establishment activities. Funding is available through two related grant mechanisms:

- **Level One Establishment Grants:** These funds are available to states that have already received Exchange Planning grants. States will enter into a cooperative agreement with the federal government in Exchange for one year of Exchange establishment funding. Eligible states must demonstrate progress in Exchange planning.
- **Level Two Establishment Grants:** These funds are available to states that received Exchange planning grants and met specified federal criteria. Funding is available to support all Exchange establishment costs incurred by a state until December 31, 2014. States must demonstrate the following to qualify for Level Two Establishment grant funds:
  - Legal authority to establish and operate an Exchange that complies with Federal requirements
  - Identified self-sustaining financing mechanism
  - Establishment of an Exchange governance structure
  - Submission of a complete Exchange budget through 2014
  - Submission of a plan outlining anticipated state efforts to combat waste, fraud, and abuse
  - Submission of a plan outlining anticipated state efforts to provide customer assistance to individuals and small groups purchasing coverage through the Exchange

Application deadlines for Level One Establishment grants are established on a quarterly basis up until December 2011. Illinois submitted a Level One application on June 30, 2011. On August 12, 2011, HHS announced grant awards for the June 30 grant cycle and awarded Illinois \$5,128,454 to support additional and ongoing planning efforts.

States may apply for more than one Level One grant. Application deadlines for Level Two Establishment grants are established on a quarterly basis up until June 2012.

### 3. Current Environment in Illinois and Background Research

The State of Illinois has a proud history of public program coverage initiatives to improve access to health care for the uninsured. In particular, in 2006, Illinois expanded its All Kids program for children to include coverage for all uninsured children, regardless of income, health status or citizenship status. Along with that coverage expansion, Illinois simplified enrollment processes for children and prioritized education and outreach to support enrollment of uninsured children. That experience and the infrastructure created by it will prove invaluable to the state as it embarks on implementation of the ACA. Today, the Illinois Medicaid program covers over 2.7 million individuals with comprehensive benefits. The impact of the ACA's Medicaid expansion in Illinois is dealt with in detail in this report.

The Illinois private insurance market is robust and relatively stable. Both the individual and small-group market will be significantly affected by the new underwriting and rating rules and other consumer protection requirements in the ACA.

There are over 1.5 million people without insurance coverage in Illinois. The number of uninsured in Illinois will drop dramatically as a result of the ACA. As Illinois prepares for potential implementation of an Exchange under the ACA, a description of the current state of insurance coverage and of the uninsured population is critical background information.

Concurrently with the HMA engagement, DOI contracted with a separate vendor to provide background research to inform Exchange planning. The outcome of that contract is a report on the current state of health insurance coverage in Illinois and the existing health insurance marketplace, including demographic analysis of the uninsured, underinsured, and insured populations, an assessment of barriers to coverage and insurance enrollment, including affordability, and a ten-year projection of Illinois coverage trends in public and private insurance.

The HMA Team has worked closely with the background research vendor, Deloitte LLC ("Deloitte"), to define responsibilities, coordinate approaches and share expertise. In substantial part, this report includes the Deloitte model's projections of Exchange enrollment in Illinois beginning in 2014. In areas that rely on these projections, this report adopts the Deloitte projections and defines ranges, of higher and lower Exchange enrollment, as appropriate to support the analysis. After discussions with the state, in one area this report provides an alternative methodology and analysis of a specific component of the research. The assessment of the cost of the Medicaid program expansion contained in section 4.5.1 requires estimates of both the number of uninsured and of the growth between now and 2014 of the uninsured and of the current Medicaid program. The Deloitte modeling approach required estimates of those same factors among many others, including economic and behavioral variables involving the effect of the ACA on the private insurance market.

The HMA Team developed a methodology focused solely on the impact of the ACA on Medicaid and other state programs. The approach is less robust and comprehensive than the Deloitte modeling approach, but more focused on using existing state administrative data to make projections about current state programs. Therefore, the analysis of Medicaid costs in section 4.5.1 presents alternative Medicaid growth projections. Taken together, the state could view these alternatives, which lead to

different projections of Medicaid growth and Medicaid costs under the ACA, as an upper and lower bound projection for planning purposes.

## 4. Impact Assessment and Operational Needs of an Exchange

*This section of the report, and the supplemental report concerning eligibility and enrollment IT system options, constitutes the bulk of the HMA Team's research and analysis. [Section 4.1](#) reviews potential goals that can be served by an Exchange. [Section 4.2](#) involves the mandatory activities of an Exchange, including required policy decisions and practical operational needs involved in Exchange and ACA implementation. [Section 4.3](#) addresses long-term financial sustainability of an Exchange. [Section 4.4](#) reviews certain optional considerations for an Exchange and how it relates structurally to the Illinois insurance market. [Sections 4.5 and 4.6](#) address a range of topics concerning the interactions between Medicaid, other state programs, and the Exchange.*

Establishing an Exchange in Illinois is a significant undertaking. This section of the report is meant to help define the challenges Illinois faces and provide guidance on the choices that Illinois must make. It is worth emphasizing that the Illinois Exchange will have a very large customer base. Projections from the Deloitte model adopted in this report estimate Exchange enrollment of 486,000 in 2014, the first year of operation. As the Exchange is established and becomes better known, enrollment is expected to grow, particularly over the first few years of operation. By 2016, the Illinois Exchange is projected to serve over 1 million customers.

Exchange enrollees will include: individuals without insurance and certain individuals in state programs today (many of whom will have access to subsidized coverage through the Exchange), people who purchase nongroup insurance today and will use the new Exchange market to purchase insurance, and people (some insured and others currently uninsured) who work for small employers who choose to use the SHOP Exchange. Those projections are summarized below.

**Table 2: Projected Exchange Enrollment in Illinois, 2014 (in thousands)**

Projected Exchange Enrollment in Illinois, 2014 (in thousands)	
Total Individual Exchange	337
Subsidy Eligible - <200% of FPL	106
Subsidy Eligible - 200%-399% of FPL	141
Not Subsidy Eligible	90
Small Group – SHOP	149
Total Projected SHOP and Individual Exchange Enrollment	486

## 4.1 Potential Policy Goals for the Illinois Exchange

*This section reviews potential policy goals that could be prioritized by an Exchange.*

In light of Illinois' ongoing Exchange planning process, we identify seven *potential* policy goals for Illinois' Exchange and discuss how an Exchange might advance these goals. There are challenges and trade-offs to pursuing each of these goals, which we discuss in each section below. As planning moves forward, Illinois should assess and prioritize Exchange policy goals. Developing a clear vision of the key policy goals for Illinois' Exchange can help guide decision-making around the many policy and operational issues that will need to be addressed in setting up the Exchange.

### 1. CREATE AN ATTRACTIVE, ACCESSIBLE, AND EASY-TO-USE WEBSITE FOR INDIVIDUALS AND THEIR FAMILIES TO COMPARE AND PURCHASE COMPREHENSIVE HEALTH INSURANCE COVERAGE

Private health insurance contracts are long and complicated and the products are highly variable. As a result, many people have difficulty comparing the value of various options, including small business owners when they are selecting coverage for their employees. An attractive and easy-to-use website can serve as a gateway to the Exchange and can greatly improve purchasers' ability to compare and shop for value in health insurance. Standardization of benefits can facilitate comparison shopping; the ACA will promote such comparison by defining the "essential health benefits" all plans must offer and by defining four standardized benefit plans that include all of the essential health benefits but differ by the amount of consumer cost sharing. Exchanges can further standardize plan offerings to simplify comparison shopping, for example, by specifying precisely how the four cost-sharing levels will be structured in terms of co-pay, deductibles, etc.

Although standardization makes it easier for consumers to compare plan value and thereby promotes competition among health plans, if the plans offering coverage outside the Exchange are trying to differentiate themselves by offering not only the required standardized plans but a larger variety of benefits structures, the Exchange might be at a competitive disadvantage. The experience of the Massachusetts Health Connector indicates that this is an issue that requires careful monitoring. The Connector began with a broad array of options designed by each carrier and, over time, standardized plans across carriers around the most popular designs (measured by sales volume).

### 2. USE ADVANCED CUTTING-EDGE TECHNOLOGY TO DETERMINE ELIGIBILITY FOR INDIVIDUAL TAX CREDITS AND ENROLL QUALIFIED APPLICANTS IN THE EXPANDED MEDICAID PROGRAM

The ACA requires a "no wrong door" eligibility process. This means that the Exchange and other "portals," such as Medicaid offices, are expected to direct an applicant to the right program, in real time, and on the first encounter. To do this, the Exchange will need advanced, cutting-edge technology to make timely and accurate eligibility determinations based on data provided by the applicant and matched against several external data sources—a real challenge, to be sure.

In addition to the ACA operational requirement, both the Exchange and the state have financial incentives to perform eligibility determinations quickly and effectively. Those households and small employers who are eligible for tax credits can access subsidies only through the Exchange, and they will likely represent the core of Exchange enrollment. Because the tax credit is paid by the federal government and is available only through the Exchange, these enrollees are “free” to the state and are highly likely to buy from the Exchange. Since Exchanges are scalable entities with relatively fixed costs, higher enrollments serve to reduce per enrollee administrative costs and are consistent with the mission of an Exchange to cover people.

### 3. DEVELOP A PROGRAM TO ENGAGE INDIVIDUAL CONSUMERS AND HELP THEM NAVIGATE THEIR INSURANCE OPTIONS

The Exchange should identify the impediments that could make it difficult for people in various target markets to enroll. People should find the process both easy and comfortable. Consumer-friendly, simplified comparison shopping tools are part of the solution. So are Navigators, a new educational resource created through Exchanges by the ACA, and producers, both of whom can first find potential enrollees and then talk them through their options and the application process. The state will also need to decide how best to use Navigators and producers to help enrollees with their purchase. Both decisions have policy implications that will need to be thoughtfully evaluated by the Exchange.

### 4. ENCOURAGE THE WIDEST POSSIBLE PURCHASE OF HEALTH INSURANCE COVERAGE

There are close to 1.5 million uninsured individuals in Illinois. Some will be added to Medicaid under health reform, others will receive subsidized coverage through the Exchange, and a significant number will remain uninsured. Although ACA requires nearly everyone to acquire coverage, it is likely that some people will not understand the requirement and will remain uncovered unless efforts are made to inform them and provide easily accessible paths for them to acquire coverage. This is part of the task of the Exchange. To effectively expand coverage in Illinois, the Exchange will need robust outreach and enrollment efforts, a broadly defined mass marketing campaign, an understanding of the needs and wants of both the currently uninsured and insured populations, and a convenient and user-friendly insurance “store” with multiple points of access (via web, telephone, and perhaps walk-in locations and clinical sites).

One potential obstacle to a focus on reaching some elements of the currently uninsured population is that the Exchange may be seen as a resource primarily for lower-income, subsidized people. De-stigmatizing premium subsidies and promoting small business-tax credits should be objectives within any marketing program, advertising campaign, or outreach effort. The Exchange will need to carefully balance the objectives of expanding access among the currently uninsured and appealing to a broader swath of the overall insurance market. One example of such an approach: In Massachusetts, the Red Sox partnered with the Health Connector to promote coverage availability. Sporting teams often transcend income, age, linguistic and cultural barriers in their ability to touch otherwise divergent populations.

## 5. FOSTER A COMPETITIVE HEALTH INSURANCE MARKETPLACE FOR MORE AFFORDABLE COVERAGE FOR INDIVIDUALS AND THEIR FAMILIES

One of the objectives that Exchanges are designed to achieve is more effective competition among health plans. Achieving that objective requires presenting prospective buyers with easily understood comparisons of plan benefits, prices, network availability, and quality—something like a healthcare Travelocity. Consumers like choice, particularly when presented in a visually appealing way, but it must be meaningful choice that does not overwhelm the uninitiated. Beyond such basics, the Exchange can actively promote competition by encouraging new plans to compete in the non-group and small-group markets. As a single point of access to a large population of insurance buyers, the Exchange can reduce the barriers to entry for new health plans, including Medicaid Managed Care organizations (MCOs) that wish to continue serving their enrollees as they migrate into eligibility for tax credits.

## 6. CREATE SYSTEMS THAT SUSTAIN CONTINUITY OF CARE FOR LOWER-INCOME POPULATIONS WHOSE INCOME AND ELIGIBILITY FOR MEDICAID AND PRIVATE INSURANCE LIKELY WILL CHANGE FREQUENTLY

The Exchange should anticipate both churning (frequent transitions between coverage programs as a result of income and family size changes) and a need to sustain safety-net providers. As to churning, some degree of movement between plans is inescapable, and Illinois should anticipate the need to transition enrollees smoothly between programs. To mitigate disruptions in coverage that can otherwise result from churning, some states may require or incentivize Medicaid MCOs to participate in the Exchange so that an individual who moves between a Medicaid program and an Exchange subsidy would not need to switch health plans (or providers) each time there is a change in eligibility.

Another possible solution to this challenge is for the state to consider offering a Basic Health Plan (BHP) to individuals and families with incomes between 133% and 200% FPL. As the ACA requires that the BHP be operated under the same rules as Medicaid, the state would be able to assure continuity of care across Medicaid and non-Medicaid programs. As noted by the Council, a properly designed BHP could provide more affordable and comprehensive coverage than commercial plans offered in the Exchange. Additionally, the state could provide Medicaid, All Kids, and BHP coverage for working families, thereby allowing them to keep the same medical providers if their income changes.

With respect to this potential goal, the HMA Team's scope of work calls for a specific discussion of methods to prevent churning and of the BHP. That discussion is in section 4.5.

## 7. PROVIDE SMALL BUSINESSES WITH COST-EFFECTIVE AND EASY-TO-ACCESS COMPREHENSIVE HEALTH INSURANCE COVERAGE OPTIONS

Any state that establishes an Exchange must also establish a Small Business Health Options Program or SHOP Exchange to help small businesses provide health insurance for their enrollees. Understandably, small businesses are primarily seeking rate relief. Meeting this expectation will be a challenge because there is nothing inherent in the Exchange structure that will immediately reduce costs, and any such unreasonable expectations will need to be managed. Nonetheless, the SHOP Exchange can serve small business and their employees by offering employee choice of health plans, including lower-cost select

network plans. In designing a SHOP Exchange, the state should understand small employer needs and respond to these needs by persuasively marketing what the SHOP can offer owners and their employees. A well-constructed SHOP could: improve price stability for employers and employees; expand employer and employee choice by providing varied benefit levels, provider networks and carriers; and offer administrative savings to small businesses that do not have access to benefit administrators that perform SHOP-like functions.

## OTHER GOAL-SETTING CONSIDERATIONS

Further dialogue with the state’s leadership will be required to decide what is feasible for Illinois and which goals to prioritize. For example, many policymakers see health reform as an opportunity to transform the delivery of medical care to achieve the ultimate goals of reducing costs, ensuring access, and improving quality. They aim for payment reform and development of coordinated care models, such as Accountable Care Organizations (ACOs), to encourage clinical integration. Reforming health care to this extent would present major hurdles, and overcoming them would require a significant, sustained commitment from the state’s political leadership. Only the state can determine if reforming health care delivery is a realistic goal for Illinois, either now or at some point in the future. Similarly, the state should prioritize the goals outlined above.

## 4.2 Mandatory Operational Needs of an Exchange

### 4.2.1 Exchange Design, Organizational Structure and Governance

*Section 4.2.1 addresses threshold design questions and reviews Illinois’ options for Exchange organizational and governance structure.*

### THRESHOLD EXCHANGE DESIGN OPTIONS

The ACA requires that states create an “American Health Benefits Exchange” for individuals and a “Small Business Health Options (SHOP) Exchange” for companies with 100 or fewer employees. Alternatively, states may let the federal government establish and administer Exchanges for their state. Thus, *the first key decision that a state must make is whether to build its own Exchange or let the federal government’s model be used in their state.* Clearly this is a threshold question for every state to address.

Given that the Illinois General Assembly has indicated its intent to establish an Illinois Exchange by virtue of the passage of SB 1555, and the Council’s initial recommendations that the state should establish its own Exchange, this report does not address in detail the implications of Illinois deciding not to establish and Exchange. Operating a state-based Exchange preserves state self-determination on a range of issues, including how the Exchange will relate to the external markets and to the state Medicaid program. However, concerning planning efforts for a federal Exchange, two points are worth emphasizing.

First, the character of a federal Exchange is unknown, and proposed federal rules shed very little light on how a federal Exchange will relate to a state. It is clear that relying on a federal Exchange would mean that Illinois would surrender control over a wide range of policy issues and a significant component of its insurance market. To the extent that the state identifies or prioritizes any of the potential policy goals of an Exchange (discussed in detail in section 4.1), deferring Exchange operations to the federal government would make it difficult to achieve a state's "own" goals. Second, state obligations under the ACA are significant irrespective of whether the state is operating an Exchange or not. For example, Illinois will need to do the work necessary to ensure a systematic relationship between its Medicaid eligibility and enrollment system and the Exchange, whether the Illinois Exchange is state-based or federally run. Similarly, Illinois insurance regulators will need to wrestle with risk-adjustment methodologies across individual and small-group markets and will need to understand how the Exchange market relates to the "outside" or remaining Illinois individual and small-group markets. This will be a different challenge if there is a federal Exchange, but it will be no less important and no less complicated. More generally, close coordination between the Exchange and existing state functions, including most obviously insurance oversight at DOI and Medicaid operational and policy issues, will be essential whether or not Illinois runs its own Exchange. While implementation planning pressures (and associated funding) would be lessened by a decision to opt for a federal Exchange, Illinois would still have significant responsibilities, related to operations, policy and finance, to perform to implement the law.

States may form multi-state Exchanges with other states. States may also allow more than one Exchange to operate within the state, as long as each "subsidiary" Exchange serves a distinct geographic area. It is important to note that a statewide Exchange could be designed with regional dimensions. For example, Illinois could establish regional rating areas, specifying regions for the purpose of qualifying health plans, and defining coherent regions through which to arrange for specified Exchange functions like outreach, consumer assistance, and services for small businesses obtaining coverage for their employees. These regions could be, in effect, "sub-units" of the statewide Exchange.

While the ACA requires that Exchanges be established to serve the individual and small-employer market, some states will determine that operating a combined Exchange is more efficient and manageable. Although ACA is not explicit about the parameters of a combined individual and SHOP Exchange, we believe there is considerable flexibility for a single Exchange to differentiate as appropriate between the individual and small-business markets, including by providing differential services and establishing different requirements depending on the market. Illinois could form one Exchange with separate risk pools for individuals and employees of small businesses.

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## ORGANIZATIONAL STRUCTURE FOR A STATE-BASED EXCHANGE

In terms of organizational structure, Illinois can establish an Exchange in an existing state government agency or establish a quasi-governmental or nonprofit organization to manage and operate the Exchange. Most states that have addressed this question have set up some form of a separate Exchange organization, almost always with an independent governing board. To operate an Exchange, Illinois

needs an entity that is capable of interacting with the commercial insurance market, providing services to consumers and insurance purchasers, and coordinating with existing state agencies and programs.

The structure of that entity is clearly an important question, but we recommend focusing not on form but rather on substance—that is, by reflecting on the basic purpose of an Exchange. In initial guidance to states considering establishing Exchanges, the Secretary of HHS gave this definition to Exchanges:

A mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality. By pooling people, reducing transaction costs, and increasing transparency, Exchanges create more efficient and competitive markets for individuals and small employers.<sup>1</sup>

Consistent with this general description of an Exchange as a marketplace for consumers, Exchanges are expected to be a distribution channel for commercial insurance for both individuals and small businesses, to work with small employers to aid them in offering coverage, and to interact with health plans that participate on the Exchange to ensure compliance with state and federal standards for reporting, marketing, and plan benefit design. These functions are deeply connected to the existing state-regulated commercial health insurance markets.

The ACA also obligates Exchanges to perform a variety of functions that are intertwined with other existing state programs. Exchanges will determine eligibility for federal tax subsidies that will be available to lower-income people buying through the Exchange. This function must be closely coordinated with the Medicaid eligibility and enrollment processes. Moreover, over time many individuals will move between the Exchange-based subsidized market and the Medicaid and Title XXI CHIP programs. Other functions of the Exchange, such as determining exemptions from the individual mandate, are more like traditional government functions than commercial activities, but they require less integration with existing state programs.

One final point concerning the timeline for implementing the ACA is worth emphasizing. Given the large number of new functions Exchanges must perform and the operational complexity of these functions, state implementation will proceed under extremely challenging time constraints and in an evolving regulatory environment. As a result, implementation structures that promote informed and transparent public input and prompt decision-making and provide flexibility to adapt quickly to shifting market conditions will be essential.

With those general observations as a background, this section addresses the advantages and disadvantages of the options relating to organization structure of an Exchange in the table below.

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<sup>1</sup> Letter from Secretary Kathleen Sebelius, “Initial Guidance to States on Exchanges,” November 18, 2010.

**Table 3: Organizational Options**

	<b>Advantages</b>	<b>Disadvantages</b>
<b>State Agency</b>	May allow some shared infrastructure. Direct ability to coordinate with other state agencies.	Restricted to state procurement practices. Restricted to state hiring practices including freezes. Decision-making and operations may be politicized. Financial resources of exchange could be entangled with annual legislative appropriation processes.
<b>New State Agency</b>	Single focus, avoids conflicting priorities and objectives within agency. Could include governing board.	Requires start-up of human and other resources. May not be influential with other agencies whose cooperation is required.
<b>Existing Agency in State Government</b>	Enables use of existing staff and skills, administrative systems and procedures.	New objectives may overwhelm or conflict with existing functions or objectives of host agency. Existing objectives may be prioritized over new Exchange mission objectives.
<b>New Quasi-Governmental Authority or Independent Public Agency</b>	Less politicized. Flexibility to use or not use state procurement and personnel rules for any or all purchasing or hiring. Maintains public accountability.	May be difficult to obtain cooperation of Medicaid and other state agencies. May be less transparent.
<b>New Nonprofit Organization</b>	Less politicized. More flexible in hiring and procurement practices. More independent and flexible.	No access to government purchasing or hiring advantages or processes. Less public accountability and transparency. Little ability to influence or gain coordination of state agencies

**GOVERNANCE CONSIDERATIONS**

An important element of Exchange structure is the makeup of an Exchange governing body. We assume for the purposes of this section that Illinois intends to establish an independent, appointed governing board to support its Exchange. Unless the Exchange is established in an existing state agency, Illinois will be required to establish such a board.

An important initial point is that whatever governing structure Illinois prefers needs to be defined in enabling legislation. As discussed more fully earlier in this report, a formal governance structure is one essential component of Exchange enabling authority that is required for the state to access implementation (Level Two) grants from HHS.

There will be federal standards that must be met in defining a governing board. Proposed rules issued on July 11, 2011, set those standards, which are excerpted below. Note that these are draft proposed

rules, and HHS requested public comments on a number of issues affecting governing board standards, so the state should monitor these rules as they are finalized.

**42 CRF §155.110 Entities eligible to carry out Exchange functions**

*(c) Governing board structure. If the Exchange is an independent State agency or a nonprofit entity established by the State, the State must ensure that the Exchange has in place a clearly-defined governing board that:*

- 1) Is administered under a formal, publicly-adopted operating charter or by-laws;*
- 2) Holds regular public governing board meetings that are announced in advance;*
- 3) Represents consumer interests by ensuring that overall governing board membership is not made up of a majority of voting representatives with a conflict of interest, including representatives of health insurance issuers or agents or brokers, or any other individual licensed to sell health insurance; and*
- 4) Ensures that a majority of the voting members on its governing board have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured.*

In general, the regulations give states significant discretion in structuring an independent agency or non-profit governing or oversight board. The rule does not specifically prohibit certain categories of board members, although a state could decide to do so. It does require that the board “represents consumer interests” by not having a majority of voting members “with a conflict of interest.” The examples provided in the rules are representatives of insurers or agent/brokers. The board must also have a majority of voting members with relevant experience in health benefits administration or other health care or health policy fields. An Exchange board must operate under a formal structure with public board meetings, by-laws, conflict of interest and financial disclosure standards.

The SHOP Exchange may have independent governance and administrative structures from the Exchange that manages the individual market aspect of the Exchange, or SHOP and individual market Exchange may share common governance and administration. In the case that both the individual and SHOP Exchanges are combined under one governance and administrative structure, the structure must have “adequate resources to assist individuals and small employers.”

Assuming the basic parameters of the proposed rule remains intact, the federal government establishes two basic standards – that the board represents consumer interests and that the board has individuals with relevant expertise. Illinois can decide who appoints board members and can establish appropriate terms. Federal standards are generally consistent with our recommendation that Illinois prioritize competence and experience in defining its board membership rather than status as a representative of an identified interest group. The HMA Team’s observations about the makeup of an Exchange board, and a review of similar state structures, are included in section 4.4.2.

## 4.2.2 Resources and Capabilities Needed for the Illinois Exchange

*In this section, we profile the functional requirements of an Exchange, including those of a Small Business Health Options Program or SHOP Exchange. As part of this needs assessment, we outline the capabilities and resources essential to operating the Exchange.*

The purpose of this section is to identify resources necessary to run an Exchange and the HMA Team's assessment of whether Illinois has those resources today or needs to acquire them. Where Illinois may already have capabilities or resources in place that might be repurposed or otherwise utilized for the Exchange, we note this. Finally, when Exchange needs cannot be met through existing assets, we offer recommendations on various approaches to either "build or buy new" the required functionalities to make an Exchange operational in time for open enrollment activities to commence in the late fall of 2013.

We found relatively little functionality already in place that could be adapted or expanded to serve the Exchange—a conclusion not altogether surprising or unique to Illinois. These initial findings were confirmed in interviews with senior staff in Illinois. We also reviewed documents identified by interviewees as being of particular importance or relevance. For example, the State of Illinois Framework Vision helps summarize why Illinois is not currently well positioned to look to existing resources and capabilities for the Exchange. This document suggests that Illinois has already thoughtfully evaluated its infrastructure and, independent of any consideration to Exchange development, has found it in significant need of broad based re-engineering to support existing social service programs.

Accordingly, Illinois will likely need to "buy or build new" many of the functional requirements of an Exchange. Sourcing suggestions are made throughout this section, and the state should expect to see additional "turnkey solutions" hit the market in the months ahead as vendors rush to fill various similar voids across many state governments.

Requirements for operating an Exchange come from ACA statutory requirements, regulatory requirements based on guidance issued to date by federal regulators, and operational requirements dictated by the functions needed for an Exchange to carry out its operations. The functions of the Exchange can be grouped into fourteen domains:

- Eligibility determination
- Online shopping
- Enrollment, billing, and collections
- Customer service
- Producer management
- Navigator management
- Communications and outreach
- Plan specification and qualified health plan (QHP) management

- Financial management
- Risk adjustment (if done by the Exchange)
- Oversight, governance, and program evaluation
- Mandate certification and eligibility appeals
- Consumer protections
- Reporting for federal and state oversight

In addition, efforts to prevent fraud, waste, and abuse—both in terms of built-in systemic controls and in terms of evaluation and retrospective review systems—should be built into all processes and functions.

We will discuss each of the domains in turn and elaborate on the requirements of the Exchange in each of these domains. Table 4 shows the functional requirements of an Exchange, including their relationship to the core areas defined by CCIIO for the federal Exchange grant application process.

**Table 4: Exchange Functional Requirements by Domain**

Domain	CCIIO Core Area	Functions
<b>Eligibility determination</b>	<b>Business operations</b>	Determine eligibility for Exchange subsidies, Medicaid, CHIP and other state and local programs, in real time for most shoppers Confirm eligibility, premium and cost-sharing subsidy levels and mechanism for appeals Establish system for updating information and re-determining eligibility
<b>Online shopping</b>	<b>Business operations</b>	Provide standardized information on QHPs Establish website to inform shoppers about eligibility criteria for Medicaid, Exchange subsidies and other state and local programs Provide cost calculator and display costs to SHOP employees Provide information about enrollee satisfaction Establish process for "grabbing" rates from carriers Create decision support tools for consumers
<b>Enrollment, billing, and collections</b>	<b>Business operations</b>	Enroll qualified individuals and families in QHPs Confirm plan selection, enrollment date, premium subsidy level, monthly enrollee premium (subsidized or unsubsidized), dollar flows, effective date of coverage, and fulfillment of enrollment process/materials by carrier Enable automated data exchange between enrollment and billing systems Generate bill Process electronic funds transfer (EFT) or credit card payment Generate receipts Establish open enrollment periods Provide notification and management of annual renewals Enable employer shopping, employee census management,

Domain	CCIIO Core Area	Functions
		<ul style="list-style-type: none"> <li>and secure employee access to website</li> <li>Establish systems for making mid-year adds/deletes, administering COBRA coverage</li> <li>Establish uniform policies across carriers for enrollment, billing cycle, collection, late payment and termination for non-payment</li> </ul>
<b>Customer service</b>	<b>Providing assistance to individuals and small businesses, coverage appeals, and complaints</b>	<ul style="list-style-type: none"> <li>Design customer service protocols (automated and in manuals)</li> <li>Provide customer tracking tools and database management</li> <li>Establish telephone hotline, in-person support and web-based support</li> <li>Hire and train customer service staff</li> <li>Establish peak-period tele-customer spillover capacity</li> <li>Design flexible Interactive Voice Response (IVR) system</li> </ul>
<b>Producer management</b>	<b>Business operations</b>	<ul style="list-style-type: none"> <li>Train and certify producers</li> <li>Establish advisory council</li> <li>Establish dedicated portal with account self-management</li> <li>Calculate and pay commissions</li> </ul>
<b>Navigator management</b>	<b>Business operations</b>	<ul style="list-style-type: none"> <li>Train and certify navigators</li> <li>Establish advisory council</li> <li>Establish dedicated portal for Navigators</li> <li>Provide telephonic customer service support</li> <li>Oversee contract performance</li> </ul>
<b>Communications and outreach</b>	<b>Business operations Stakeholder consultation</b>	<ul style="list-style-type: none"> <li>Perform marketing/sales functions</li> <li>Consult with stakeholders</li> </ul>
<b>Plan specification and QHP management</b>	<b>Business operations</b>	<ul style="list-style-type: none"> <li>Design benefits and plans</li> <li>Design QHP contracting/purchasing process</li> <li>Research customer needs, wants</li> <li>Rate QHPs on quality and value</li> <li>Update QHP premium rates</li> <li>Reconcile billings/collections monthly with QHPs (and Treasury)</li> </ul>
<b>Financial management</b>	<b>Financial management</b>	<ul style="list-style-type: none"> <li>Perform accounting functions with annual report to secretary</li> <li>Coordinate payments between feds/state/plans/enrollees</li> <li>Publish costs of licensing, regulatory fees, and other costs of Exchange</li> <li>Manage vendors and contracts</li> <li>Perform collections and disbursements</li> <li>Generate reports</li> <li>Develop/install general ledger</li> <li>Coordinate audits</li> </ul>
<b>Risk adjustment</b>	<b>Financial</b>	Implement risk corridors for QHPs (2014-2016)

Domain	CCIIO Core Area	Functions
	<b>management</b>	Implement reinsurance program (2014-2016) Implement risk adjustment (permanent)
<b>Oversight, governance, program evaluation</b>	<b>Governance Program Integration Oversight and program integrity</b>	Select staff and executive leadership  Establish Board Coordinate with other state agencies Evaluate Exchange
<b>Mandate certification and eligibility appeals</b>	<b>Providing assistance to individuals and small businesses, coverage appeals, and complaints</b>	Receive and process appeals of eligibility decisions Certify exemptions from mandate Notify employers when employees access Exchange subsidies
<b>Consumer Protections</b>	<b>Providing assistance to individuals and small businesses, coverage appeals, and complaints</b>	Monitor QHPs pricing and underwriting Design reporting system to track buying patterns, enrollee satisfaction and problems Coordinate with DOI on host of licensure and market oversight issues Establish formalized connection to Office of Consumer Health Insurance within DOI Address consumer complaints re QHPs
<b>Reporting for Federal and State Oversight</b>	<b>Oversight and program integrity, applications and notices</b>	Demonstrate to HHS capability to manage finances soundly Publish annual financial audit; respond state and federal audits as required Submit the required annual accounting report to HHS

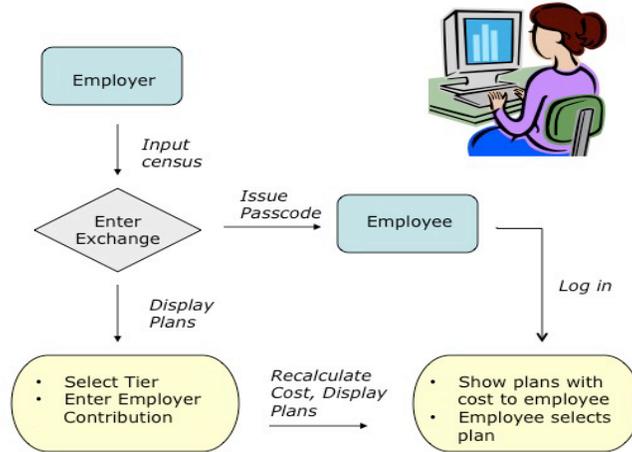
#### A. ELIGIBILITY DETERMINATION

This critical functional area for Exchange planning is dealt with comprehensively in the separate report regarding information technology infrastructure to perform Eligibility, Verification and Enrollment (EVE) functions.

#### B. ONLINE SHOPPING

Exchanges are required to establish a website that provides standardized comparative information on qualified health plans (QHPs). The Exchange must provide a cost calculator that calculates the cost of coverage after the application of a premium or cost-sharing tax credit. This means that the Exchange must have an interface for accepting rates from carriers. The Internet portal must also provide information about enrollee satisfaction. In addition, the Exchange should provide decision support tools to help consumers choose a plan. While not explicitly described in ACA, SHOP Exchanges will need to display for employees the coverage tier selected by their employer and the employee's cost of plans in that tier, taking into account the employer contribution (see Figure 1).

**Figure 1: Schematic of SHOP Exchange**



With regard to on-line shopping, Illinois does not have significant resources to draw on. The All Kids program offers an engaging, well designed website, but as the program offers only one benefit design, no “shopping” or comparison tools are featured. One Exchange-friendly feature is that the entire web site can be accessed in Spanish. The Illinois Comprehensive Health Insurance Plan (ICHIP), the high-risk pool program, also offers a website to enrollees, but the only Exchange-applicable feature on the site is a premium rate calculator with multiple variables. The calculator was developed in house by IT staff.

Illinois can buy on-line shopping functionality with decision support tools from a number of sources. There are several private-sector Exchanges and vendors with shopping tools for both non-group and small-group markets, as well as newly developed products which can demonstrate capabilities and customization options. Choice Administrators, eHealth, and Connecture are only a few of the many vendors that currently operate online Exchanges that could be utilized by Illinois. Plan rating resources include the National Committee for Quality Assurance and the Utilization Review Accreditation Commission. In our experience, buying a customized on-line shopping resource is likely to be more economical and faster than building one from scratch, so long as there are competing vendors in the private sector with plenty of experience, repeatable processes, and a business model that allows them to profit by serving the state Exchange.

### C. ENROLLMENT, BILLING, AND COLLECTIONS

As stated earlier, the HMA Team has produced a separate report that is a needs assessment for state Eligibility, Verification, and Enrollment (EVE) functions. We limit discussion in this section to billing and collections systems, which may or may not be integrated with enrollment functions both in terms of systems and vendors.

As a primary consideration, there should be automated data exchange between the eligibility, enrollment, and billing systems, so that consumers do not need to re-enter or re-transmit basic

information at each step. The Exchange will need to generate bills, process electronic funds transfer and/or credit card payments, and generate receipts, all with appropriate security protocols in place. Uniform policies should be established across carriers for enrollment, billing cycles, collections, late payments, and termination for non-payment.

The Illinois State Treasurer's Office currently utilizes the E-Pay system for more than 650 local governments and state agencies, and the All Kids programs uses it to allow enrollees to make on line payments. E-Pay is a self-service electronic payment program allowing payments to be made at any time online, by phone or over the counter. The system accepts Visa, MasterCard and E-checks, and users do not incur any additional charge for making payments on the secure site. An open issue is whether a credit card fee applies and, if so, what is the cost and who pays? This system may be compatible for some Exchange needs.

Outside of this payment resource, the Exchange will need to pursue either a buy or build approach for billing and collections. The level of complexity in the billing and collections funds flow are very different for the individual Exchange relative to the SHOP Exchange, so Illinois will need to be aware of such differences as they begin the assessment. For example, billing individuals is a straightforward one-to-one relationship, but in the SHOP Exchange, billing will be a many-to-many reconciliation due to the employee choice model required by the law. The Exchange will need a system sophisticated enough to aggregate employer payments, report amounts due to multiple carriers, bundle the payments by carrier across multiple employers, and reconcile the payments due to the carrier across multiple employers. Buy may be the preferred option, as billing and collection systems exist, either independently or in connection with existing private Exchanges. A considerable amount of customization, however, will be required for tracking/billing multiple sources and flows of premiums, such as those between U.S. Treasury and carriers, individuals and either the Exchange or carriers, and employers and the Exchange. Alternatively, billing and collection capabilities can be built by the state, albeit probably not as cost effectively or as quickly as buying and customizing an "off the shelf" system.

#### D. CUSTOMER SERVICE

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Exchanges are required to provide a toll-free telephone hotline for consumer assistance in addition to the website described. The ACA also directs the Secretary to establish an appeals process for eligibility determinations. Exchanges should consider the need for customer service to respond to individual, employer, and producer queries and any difficulties with website functionality or navigation, as well as problems in transmission of enrollment and premium information to plans.

To operate a customer service call center, the Exchange will need customer service protocols (automated and in manuals) and customer inquiry tracking tools and databases. Telephone and in-person staff will need to be hired and trained. In developing customer service support, the Exchange should consider accessibility of the Exchange to people whose primary language is not English and to people with disabilities, including the deaf and hearing impaired. Thus, the call center will need to be staffed with personnel fluent in Spanish and the other most commonly spoken non-English languages. To assist callers with less frequently spoken languages, the call center protocols and technology could accommodate "warm" telephone transfers to personnel in the Department of Insurance (DOI) where

existing staff can aid Polish, Korean, Japanese, Urdu, Hindi, and Bengali speaking consumers or to a translation assistance phone line. TTY/TTD services will need to be provided for hearing impaired callers.

Overall, Illinois appears to have limited experience with the multi-faceted customer service functions that will be necessary under the Exchange. While each state benefit program operates some type of customer service center, there is not a centralized resource that could be readily scaled up to take on the additional workload or interdependencies that will be generated by the Exchange. This conclusion is echoed by the Framework Vision findings. While Illinois can choose to build a tech-savvy call center, this too can be readily bought in the marketplace, generally more economically and faster than one can be built. Call centers are standardized, commoditized functions. Exchange and eligibility determination vendors, such as HP/EDS, Dell Perot, and Deloitte, are likely to offer call center options, or one can be contracted separately, in which case the vendor list is virtually endless. Moreover, external call centers generally have peak-volume back-up capacity, multiple sites from which to balance weather-related down times, and other features that a state would be hard-pressed to build on its own.

#### E. PRODUCER MANAGEMENT

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However Illinois decides to utilize producers in marketing their Exchange, producers will need training and certification, a dedicated portal to access Exchange services, and dedicated producer service support. In addition, the Exchange will need to calculate and may need to pay producer commissions depending on the financial model employed by the Exchange (see subsequent discussion regarding the role of producers in the Exchange). Moreover, the producers will have suggestions and demands for the Exchange and will want formal channels of communication. The Exchange should consider establishing a Producer Advisory Council, much as carriers often do, to solicit their input and to explain policy and policy changes. This council should include recognized leaders among the producers, distributed by geography.

The producer support and oversight process is a complicated one. The Exchange does some things that producers traditionally do, such as set forth plan options for buyers and provide comparative information. Producers typically work for and are paid by carriers as “producers,” but this model may not fit the Illinois Exchange. The ACA defines roles and compensation for “Navigators” (through grants) that do not fit traditional producer compensation schemes, and yet there is substantial overlap between the roles of producers and Navigators. Working with producers will be crucial to the success of the Exchange, and deciding how best to do so will require further exploration by the state. To be sure, understanding producers’ roles and relationships with carriers is a skill set not readily available outside the world of producers and carriers.

However the producer role is defined, this function is critical, especially for the SHOP Exchange, and the Exchange would be well served by hiring someone with strong carrier and producer relations experience to manage the function under the Chief Sales and Marketing Officer for the Exchange. Alternatively, the Exchange may want to outsource the producer function to one or more General Agencies (GA), much like carriers in Illinois do themselves. The GA system serves as a single point of contact between a carrier and the producer, and it provides the producer with information and support needed to sell new business and retain existing contracts. Typical GA services to the producer include: prospecting and

marketing plan assistance; product, policy, procedural and sales training; online quotes; and problem solving for claim, billing, and enrollment issues. General agencies in Illinois active in the small group and non-group markets include Midwest Insurance Brokerage Services, EBRM, Flexible Benefit Service Corp and Resource Brokerage. GAs are gearing up to work closely with Exchanges, and the state may be well served by outsourcing this function to an agency demonstrating strong producer support services, advanced technological capabilities, flexibility, and importantly, strong existing relationships with the producer community.

#### F. NAVIGATOR MANAGEMENT

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The ACA creates a Navigator program to help with education and outreach efforts for the Exchange. Navigators perform outreach, especially to hard-to-reach populations, provide information on reform to low-income populations, many of whom will qualify for Medicaid and CHIP/All Kids, rather than tax credits in the Exchange, and help clients through a sometimes daunting eligibility determination process. Effectively, Navigators are the field sales force for the non-group, subsidized market, which is likely to be the largest market segment for the Exchange. Exchanges will need to contract with Navigators and provide training as needed. A dedicated portal for Navigators may also be helpful, along with dedicated Navigator service support. The Exchange needs to encourage Navigators to pursue a broad range of outreach and educational services on health reform, and it needs to measure and provide oversight of Navigator performance, including productivity metrics. This requires classic return-on-investment (ROI) analyses. An essential tool for doing this will be a Navigator Management Information System (MIS) or Customer Relationship Management (CRM) tool, such as any carrier would deploy for its own sales force in business-to-consumer marketing. Potential vendors might include Salesforce.com, HealthPlanCRM, and Health Plan Sales Solution for Microsoft Dynamics CRM. The Exchange may want to consider measuring such productivity standards as sales leads generated, success rate in reaching leads, closing ratios, ability of Navigators to generate their own leads, enrollments per dollar spent on Navigators, and problem cases and re-work.

While the ACA defines a whole new role for “Navigators,” many states, including Illinois, have experience working with application facilitators and consumer advocates who play related roles with respect to Medicaid and CHIP/All Kids. For example, in Illinois, the Exchange may benefit from the experience of All Kids and their All Kids Application Agents (AKAA) program. Community-based organizations, medical providers of any kind in good standing with HFS, and others are permitted to enroll as AKAAAs. AKAAAs receive reports on results of applications submitted and ongoing updates on the application process. For compensation, most AKAAAs are eligible to receive Technical Assistance Payments (TAPs) of \$50 for each completed application that results in new coverage. See Section 4.2.2 for more discussion of Navigators and AKAAAs.

Illinois has an additional resource that might be useful to the Exchange, that being a network of almost 100 DHS Family Community Resource Centers (FCRCs) across the state, offices that can be thought of as “one stop” centers for medical assistance, food stamps, and job services. FCRCs do not have available staff time to devote to the Exchange. Nonetheless, the acquired expertise of staff in education and outreach to low-income populations should not be overlooked when Illinois develops a Navigator

approach for the Exchange. Similarly, the breadth and depth of the DHS office network also offers the Exchange extensive physical reach into literally every county in Illinois, as well as into most communities. The Exchange may be well served by attempting to harness the collective presence of state agencies, offices, and employees when attempting to “connect” with the uninsured along any of the touch points that occur when residents interact with state government for any reason. However, one innovation that might be considered is placing “online” kiosks in select local offices. Such consumer-friendly technology, placed in strategic locations, could capitalize on existing office space in local communities where lower-income individuals and families are already comfortable seeking assistance. In addition to online access to the Exchange website, the kiosk could be outfitted with toll free telephone service to allow the enrollee to contact a centralized Exchange customer service center.

## G. COMMUNICATIONS AND OUTREACH

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The Illinois Exchange will need communications and outreach programs to explain the role of the Exchange to Illinois residents, especially to hard-to-reach population segments. The SHOP Exchange will need to conduct outreach to small-group employers and employees, producers, and agents. In addition, the ACA specifies that Exchanges must consult with stakeholders, including representatives of small businesses and self-employed individuals.

The initial communication challenge will be publicizing the existence and purpose of the Exchange, as part of wider health reform, and making it as approachable as possible. This effort may be conceived in three parts: (1) outreach to lower-income, subsidy-eligible uninsured individuals, (2) outreach to small employers, especially those who are eligible for tax credits, and (3) broader marketing to full-pay customers. Much of the art in conceiving and executing this outreach will be in using various channels and methods of communication for both purposes. For example, lack of insurance among adults correlates with youth and lower income, and messages can be readily targeted at both segments. Nevertheless, a major thrust of outreach and education will be along the traditional lines used by Medicaid, and these elements of the campaign should be closely coordinated with HFS and its outreach efforts.

As for more conventional marketing, shopping for health insurance is not a “feel good” experience. It is a “grudge buy” and not something that the young and healthy in particular are eager to do. It is a major outlay, ranging from \$3,000 to \$15,000 per year, yet it carries great significance if the enrollee becomes sick or injured. Therefore, effective communications to a large population of potential Exchange customers is a critical function, and both the marketing message and venues must be selected with the limited attention span and low interest of the reluctant health insurance shopper in mind.

To conduct large scale communication and outreach campaigns leading up to the launch of the Exchange, with all the accompanying new rules and opportunities for coverage, the Exchange may want to sponsor a multi-media marketing mix featuring mass media including social media, paid advertising, creative private/public partnering, mass mailings, signage, press releases, public relations, media relations, website promotion, digital marketing, and outreach through legislators’ district offices. For more targeted marketing over time (to small employers and households) a different mix of tools will probably be more cost-effective and appropriate. In particular, social media and digital marketing to

households and the producer channel for small business can be utilized but on a smaller scale with more focused messaging. The Illinois Office of Communication and Information (IOCI) may be able to help the Exchange think through some options. But given the newness and particular challenges of Exchange marketing and communications, the Exchange may be better served by tapping private-sector resources with more advanced relevant skill sets. The Exchange will want to solicit competing proposals for a PR/marketing firm to develop and execute campaigns under the direction of the Chief Sales and Marketing Officer for the Exchange, a key management position. The process of soliciting and reviewing proposals is a good way to educate the entire Exchange management team about marketing options.

#### H. PLAN SPECIFICATION AND QHP MANAGEMENT

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The ACA requires Exchanges to certify, recertify, and de-certify plans as Qualified Health Plans (QHPs), based on standards that are established, in part, by the federal government. The SHOP Exchange will need to solicit bids and negotiate contracts with health plans to offer plans through the Exchange website. While the ACA is not specific on this point, Exchanges should also consider whether they wish to standardize benefits beyond the actuarial tiers specified in the ACA (for example, by limiting the cost-sharing options plans can use), and how selective they plan to be in the contracting process. The ACA also directs Exchanges to require health plans to submit justifications of premium increases. While not explicitly an Exchange function, there will need to be close coordination between the Exchange and the state regulatory agency responsible for such issues. An open question of considerable significance is the extent to which a state's SHOP Exchange will want to coordinate certification of QHPs with its nongroup Exchange if the two are organized separately.

Unlike several other Exchange functions, QHP management cannot be outsourced; rather, it must be built and continually managed as an Exchange core competency. Whether it chooses a "passive" or "aggressive" purchasing approach or somewhere in between, Illinois should develop an explicit purchasing strategy based on their policy goals. The Exchange has three major levers to influence the market: the QHP certification process, target populations to offer and enroll, and plan performance rating criteria. The Exchange must use these levers strategically to create carrier interest and achieve the goals of their procurement process.

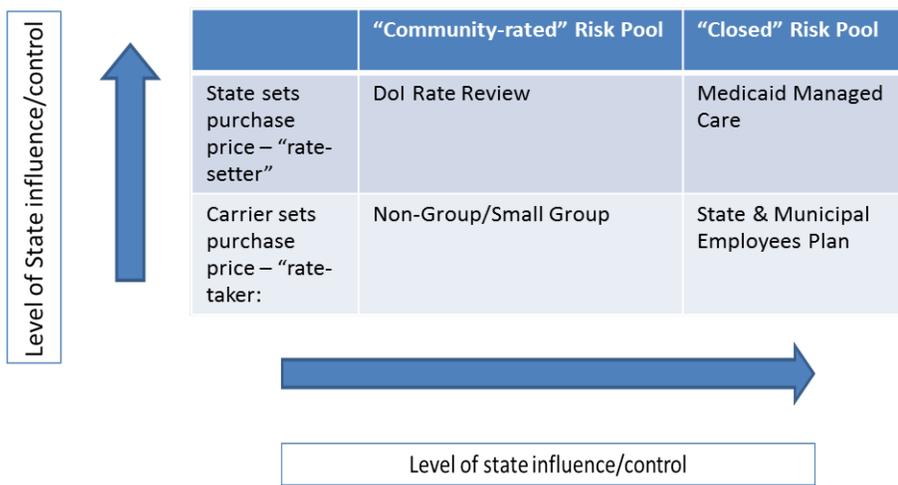
**Figure 2: Qualified Health Plan Purchasing**



There are at least four target populations to include: subsidized and unsubsidized elements within both the non-group and small group. Illinois might further consider expanding the overall market to include Medicaid (current and newly eligible) and All Kids enrollees, state and municipal employees and potentially other state programs. The greater the Exchange’s market size, the greater the leverage. The Exchange will need to assess how each population currently purchases health insurance.

The Exchange will need to determine whether they wish to pursue a “rate-setter” or “rate-taker” strategy. In concept, under a “rate-setter” strategy, the state sets the purchase price, whereas a “rate-taker” approach has the carrier setting the purchase price. The chart below demonstrates the level of influence or control the Exchange can exert, and provides general examples of typical activities or markets that represent those levels.

**Figure 3: Qualified Health Plan Procurement**  
**QHP Procurement Strategy**



The plan performance rating system is a significant lever. For example, it can be utilized to advance policy objectives (i.e., rankings can be developed for metrics such as the number of primary care office visits or customer service levels). The plan rating strategy can be more influential if extended to other populations (such as Medicaid). In any event, performance rating attributes should be built into QHP specifications, and QHPs with high scores can receive preferred placement on the website, special indicators, or be selectively awarded contracts.

The third lever is the QHP certification process itself. The analytical process needs to begin early. The Exchange should research populations served by carriers to determine ability to utilize common carriers and networks for similar populations (i.e., Medicaid and non-group, state employees, and small group). Benefit designs for each of the populations will need to be compared, as this will inform the level of standardization question. The procurement process should include a formal Request for Proposal (RFP), bidder’s conference to explain the terms of the RFP and answers to any questions, the development of scoring criteria for the RFP responses and a “selection committee” to review and score RFP responses. Realistically, the Exchange should also plan for more frequent procurements during the beginning of operations.

### I. FINANCIAL MANAGEMENT

An Exchange must account for all activities, receipts, and expenditures and provide an annual report to the HHS Secretary. An Exchange will be subject to audits and investigations. In addition to strong accounting and financial management reporting systems, Exchanges will need to be self-sustaining beginning in 2015, which means they will need to assess and collect an administrative fee. SHOP Exchanges will need to coordinate payments from employers to plans, producers, and vendors. Exchanges are required by the ACA to publish the costs of licensing, regulatory fees, and any other payments required by the Exchange. Exchanges will need data warehousing functions to manage these financial functions and be able to generate reports and receipts. Outsourcing and vendor-management

functions will also be needed. Periodically, the Exchange will need to reconcile billing and collections with QHPs and possibly the Treasury as well.

The Exchange will need to hire a Chief Financial Officer (CFO) as soon as the Executive Director is in place. The CFO should establish a financial management structure and begin hiring experienced accountant and audit staff that can assist with the development or purchase of accounting and financial reporting systems and take such basic first steps as setting up a general ledger, obtaining a Tax ID number, and establishing the corporation with the IRS and appropriate state authorities, and developing the necessary banking relationships to operate the Exchange. To meet the short-term needs of the Exchange, a simple off-the-shelf software program such as QuickBooks Pro will suffice. These programs are easy to install and learn and will provide the necessary functionality to allow the Exchange to reflect basic cash, receivable, and payable transactions.

Longer term, the Exchange should perform a more comprehensive assessment of its needs relative to accounting software. Given the expected enrollment in the Exchange, the need to manage multiple revenue streams such as carrier assessments, federal and state grants, and member premiums, it is likely that the Exchange will quickly outgrow a basic accounting package. The core functions of business accounting software include: a general ledger, accounts receivable, accounts payable, and a payroll and reporting module. One of the key decisions points in this area for the Exchange will be whether to purchase and implement an expensive enterprise resource planning (ERP) system that generally has a large collection of extra features and functionality, and corresponding complexity in installation and use, or, a more modest software package commonly in use by small business. Software packages offering more extensive capabilities include Sage Simply Accounting, NetSuite, Sage Peachtree, and CMS Professional (Cougar Mountain). QuickBooks has more powerful software called Premier and also has an ERP solution.

## J. RISK ADJUSTMENT

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The ACA creates three kinds of risk-adjustment programs: a temporary reinsurance program that assesses fees on all carriers and makes payments to individual plans enrolling high-risk individuals; a temporary risk corridor program for qualified health plans in the individual and small-group markets; and a risk-adjustment program for issuers offering plans in the individual and small-group markets. While it is not clear if these functions will be carried out by the Exchange or by another state entity, at a minimum, the Exchange will need to be able to coordinate closely with these programs. While further guidance from CMS is needed to more thoroughly address the needs of this domain, Illinois should tentatively plan on hiring technical consultants for advice on risk adjustment, and possibly external vendors who specialize in risk adjustment and who can work with the state on all three kinds of risk-adjustment programs. In our opinion, such external expertise will be needed, as there do not seem to be existing capabilities within state government that match the substantial level of expertise and claims collection, data cleansing, manipulation, and analysis required to do the comprehensive risk adjustment as currently envisioned under the ACA. This area will doubtless need to be revisited as federal guidance and standards are made more explicit.

## K. OVERSIGHT, GOVERNANCE, AND PROGRAM EVALUATION

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Staffing the Exchange with key management personnel will be one of the first critical tasks to initiate once the Exchange and governance structure is authorized. To assist the state in selecting qualified individuals for these positions, suggested qualifications and educational requirements are provided in ten job descriptions in Appendix A for the following key positions: Executive Director, Chief Financial Officer, Chief Information Officer, Chief Sales and Marketing Officer, Chief Operating Officer, Chief Communication Officer and Director of Public Education and Government Affairs, Deputy Director, Director of Human Resources, Director of Non-Group or Individual Plans, and Appeals Unit Manager.

The Exchange will be governed by a board, and Exchange staff will need to manage board relations so that the board is fully informed, works effectively, and maintains confidence and trust in the staff. Public board meetings often attract media coverage, so Exchange governance communicates a lot about the Exchange and reform more broadly. Coordination between the Exchange and other state agencies will also be important to assure effective implementation of health reform across the various involved state agencies. For example, in Massachusetts, the heads of Medicaid and the Department of Insurance were members of the Exchange board to help ensure coordination between the three entities. In addition to the financial oversight and reporting described above, Exchanges should develop multi-year strategic plans, annual operating plans, fraud detection procedures, and program evaluation tools to track performance over time, including take-up and enrollment levels of the target markets and consumer satisfaction. Exchanges should also monitor for unintended consequences such as crowd-out (reduced private insurance as a result of public insurance expansions) in the employer market or adverse selection.

Exchanges are expected to help buyers without purchasing power, specifically individuals and small employers, by creating meaningful choices and simplifying the distribution of insurance. Bylaws should further establish transparent rules consistent with state and federal requirements.

If an Exchange is to function like a private business and enroll members, it should have access to the business expertise it needs. In order to ensure the Exchange is viewed as trusted and independent by Exchange consumers it should be insulated from political influence and prevent even the appearance of any conflicts of interest. If it is to achieve policy objectives through tax-financed subsidies and some degree of regulation, it also must be publicly accountable. In short, the Exchange needs to be run like a publicly held corporation – goals must be set, metrics must be established and measured, and results should be regularly and publically reported to the governing board of directors, which is ultimately accountable for the stewardship of public funds and trust.

In our review of the Illinois Comprehensive Health Insurance Program (ICHIP) program, a possible model for Exchange governance consideration was identified. Both the Board composition and plan of operation (including articles, bylaws and operating rules) provided for in the ICHIP enabling legislation (215 ILCS 105/1 from Chapter 73, paragraph 1301) may be worthy of further study as they may well provide a suitable architectural home (with modifications as necessary) for the Exchange.

## L. MANDATE CERTIFICATION AND ELIGIBILITY APPEALS

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The ACA assigns the Exchange responsibility for certifying exemptions from the ACA requirement that all individuals have health insurance. While the Secretary of HHS is to establish an appeals process for eligibility determinations, it is likely that the Exchange will need to be able to implement this process. The Exchange will also need to be able to notify employers when an employee qualifies for subsidized coverage through the Exchange, thus potentially triggering an employer penalty. Carrying out these politically sensitive tasks efficiently, effectively, and with considerable flexibility will be necessary to maintain and build public support for the Exchange and health reform.

To carry out these activities, the Exchange will need to develop requirements for systems and program operations that include: accepting requests for exemptions, protocols for reviewing and adjudicating requests and notifying all concerned parties of outcomes, including HHS. Functionality related to adjudicating grievances and hearing appeals already exists at different levels in various state agencies, including the Attorney General's office, the Department of Insurance, ICHIP, and the Medicaid program. The Exchange can and should build this capability internally, borrowing techniques and expertise from sister state agencies. Within the Exchange, the functionality can reside either under the General Counsel or in Operations/Customer Service, but wherever it is located, the other department should have strong input.

## M. CONSUMER PROTECTIONS

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The ACA requires Exchanges to carry out a number of consumer protection functions. For example, Exchanges are directed to require health plans that seek to become QHPs to submit justifications for any premium increases. The statute directs Exchanges to collect and disclose information from plans seeking to be QHPs, including financial disclosures, data on enrollment and disenrollment, and data on denied claims. Exchanges are also required to post information about enrollee satisfaction on their websites.

Additional operational requirements include developing a reporting system to track buying patterns, enrollee satisfaction, and problems; developing a rating system for QHPs; coordinating with the appropriate Illinois agency(s) on a host of licensure and market oversight issues; updating and monitoring QHP premium rates and underwriting; and addressing consumer complaints regarding QHPs. Beyond statutory requirements, each state Exchange will no doubt exercise some discretion in deciding how proactive or interventionist it will be on consumer protections.

In Illinois, several units within the Department of Insurance (DOI) already provide consumer protection and education programs, as well as complaint intake, research, and resolution for consumers. Two of these units, the Office of Consumer Health Insurance (OCHI) and the Life, Accident and Health Complaint Unit (LAH) have been in place for years and have acquired consumer advocacy expertise with a cross-cultural, multilingual workforce that the Exchange would be hard pressed to either replicate quickly on its own or outsource to an external vendor. OCHI also manages the Uninsured Ombudsman Program, which educates uninsured Illinois residents about health insurance options and benefits and their rights under state and federal laws, clearly an area of expertise closely aligned with the mission of the Exchange. Other units within DOI provide additional consumer assistance and protections for the

citizens of Illinois. For example, the Managed Care unit oversees MCO registrations, compliance, and departmental relations with carriers; the Producer Regulatory Unit oversees producer licensing, communication and education, and complaint management; and the Department oversees carrier rate filings under the recently expanded Premium Review Project. The Exchange could formally tap into this multi-dimensional expertise through an intra-governmental subcontracting arrangement between the Exchange and the Department of Insurance. This type of synergistic arrangement is likely to be both cost effective and expeditious and would optimize the use of existing state government resources for the benefit of the Exchange.

#### N. REPORTING FOR FEDERAL AND STATE OVERSIGHT

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Managing funds is perhaps the most critical function performed by the Exchange, and a robust management structure must be put in place at the outset to ensure the Exchange is fully meeting its fiduciary obligations. The financial management of the Exchange is twofold: it must meet the administrative and financial needs of the entity itself (ensuring the Exchange has sufficient resources to pay staff, rent, and vendors), and it must provide the appropriate controls and reporting capabilities to manage state and federal funds. Taking the time to establish strong policies and procedures with respect to the management of funds at the outset will be critical to managing the rapid growth of funds under the custody of the Exchange. An important element to financial control will be ensuring that the Exchange has sufficient analytical and reporting capabilities to track and report on the funds under its control, including the ability to respond to required federal- and state-level audits and operational reviews, as well as publish all revenue, receivables, and expenditures consistent with state and federal reporting requirements.

As a hybrid public and private organization, the Exchange should look to existing government agencies for internal control models and reporting systems to evaluate. However, with the level of public scrutiny, transparency, and the number of federal and state audits the Exchange is likely to be subject to, looking to the private market for additional examples and models of best practices will be required. Regulations such as the U.S. Federal Sentencing Guidelines for Organizations of 2005, and the U.S. Sarbanes-Oxley Act of 2002, as well as professional organizations such as the Institute of Certified Public Accountants (AICPA) and the Association of Certified Fraud Examiners (ACFE), are good resources for information and guidance.

#### CONCLUSION

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As suggested in the previous sections, there are some capabilities that already exist in Illinois state agencies that could serve the needs of the Illinois Exchange. Any analysis of whether and how best to utilize such existing resources is complicated by the difficulties of “stitching together” functions and agencies that were formed for, and are driven by, different purposes. The Exchange will be carrying out a novel set of functions, in some ways more typical of a commercial carrier than a governmental entity. Not only is it difficult to “re-purpose” existing resources and skills in one part of state government—which may already be in short supply to meet the host agency’s own needs—but doing so across numerous agencies would hugely complicate start-up challenges and effective ongoing management of the Exchange.

Therefore, unless an existing agency resource is critical to the Exchange, otherwise hard to obtain, and exceptionally well developed in the agency, we recommend not laboring to find a way to incorporate it into the Illinois Exchange operations. For example, the consumer protection units within the DOI are a good example of exceptionally well developed expertise that should be leveraged by the Exchange. There are other examples of professional experience and subject matter expertise that can and should be tapped to benefit the Exchange. One way to do so might be to establish an Advisory Board of existing state talent that can be called upon by Exchange staff on an as-needed basis. Such an informal network of “in house” consultants recognizes the valuable contributions that existing employees can make to the Exchange but does not reassign any staff away from existing needs.

Even if existing resources were maximally leveraged, however, Illinois still would have significant needs in most of the functional domains. Much of the systems infrastructure (customer service, premium billing and collections, the enrollment web site) and some of the expertise can be purchased; other functions must be developed in house, perhaps with the help of external consultants and professionals. In particular, contracting with QHPs and promoting the Exchange to target population segments are central to the Exchange’s mission and success. Procurement and vendor oversight will also need to be core competencies.

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#### 4.2.3 Education and Outreach

*This section describes potential approaches to the education and outreach functions that the Exchange must perform.*

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#### ROLE OF PRODUCERS IN THE ILLINOIS EXCHANGE

A particularly important organizational and business issue for Exchanges concerns the role of brokers or agents, also known in Illinois as producers. This section addresses that issue and supports a general analysis with a specific discussion of a similar role that All Kids application agents perform in Illinois. It is expected that the concepts and issues identified in this paper will be further researched, evaluated, and assessed as Illinois transitions from the planning to the establishment phase of its health insurance Exchange.

Producers play an important role for consumers. In the highly fragmented, complicated, and confusing landscape that is the health insurance market today, producers can help bring order to the disorder of evaluating options and purchasing health insurance for individuals and small businesses. Producers provide a number of value-added services to individuals and small businesses—including providing health plan comparisons, explaining benefits and cost sharing provisions, and assisting with the application and enrollment process. Many individuals and small businesses rely on producers to provide health insurance options and assist in the purchasing process. This is evidenced by the sheer number of

licensed producers in Illinois today: 77,135 resident producers and 93,292 non-resident producers<sup>2</sup>. Many health insurance carriers in Illinois rely on producers, as well as the General Agency system, to reach individuals and small employers, a market dynamic confirmed in our phone interviews with the six health plans having the greatest overall market presence.

Producers often act as a trusted advisor for individuals and small business and can assume the additional role of a human resource function for small business owners. Producers assist the small business owner in explaining insurance options to employees, provide information on cost sharing provisions and availability of certain health care providers, assist in completing the required health plan paperwork for employer and employees, explain insurance laws and generally ensure that the entire purchasing process, beginning with plan comparisons through paying the first month's premium, is performed smoothly and efficiently.

The ACA and health insurance Exchanges are expected to substantially change how health insurance is purchased by individuals and small businesses by streamlining and simplifying the research and purchase function through the use of state-of-the-art technology, benefit standardization, and transparency. Yet, because of the prominent role of the producers in the current Illinois market, it is still important to analyze and assess the future role of the producers in an Exchange environment.

The ACA assigns a specific role to "Navigators," who perform functions similar to those now performed by producers. They are expected to play an important role in the new health insurance market post-2013. Section 1311 of the ACA defines Navigators as "Community and consumer-focused nonprofit groups; trade, industry, professional associations; commercial fishing industry organizations; ranching and farming organizations; chambers of commerce; unions; partners of the Small Business Administration; licensed insurance agents and brokers."

The role of the Navigator, as specified under ACA, is not too dissimilar to the role played by Medicaid outreach workers and state healthcare advocacy groups. More specifically, the duties of Navigators are expected to include activities such as:

- a. Conduct public education activities to raise awareness of the availability of qualified health plans.
- b. Distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402.
- c. Facilitate enrollment in qualified health plans.

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<sup>2</sup> Non-resident producers are licensed in their home state and afforded reciprocity in Illinois as part of their non-resident licensing application.

- d. Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or determination under such plan or coverage.
- e. Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange.

Understandably, producers are concerned about how the Navigator program will affect their role and about whether Navigators are being afforded an unfair competitive advantage in assisting prospective Exchange enrollees. Therefore, one of the first issues for the Illinois Exchange to consider will be defining the role of producers relative to that of its Navigator program. Although under ACA a broker/producer can be a Navigator, there are some practical differences in the role of each. For example:

- a. Navigators are required to be funded from the operations of the Exchange, while producer commissions are paid by health plans, employers, or consumers.
- b. Navigators are not allowed to receive compensation, either directly or indirectly from health insurance issuers, for enrolling individuals or employers in a health plan.
- c. Producers are required to have state licenses, while any certification or licensure requirement for Navigators is to be decided by Illinois.

Using establishment grant funding, Illinois will need to perform market research and involve relevant stakeholders to help answer important questions about Navigators and producers such as the following: (i) How should each of these roles be defined? (ii) What are fair and reasonable compensation levels for each? (iii) Should there be licensure or certification criteria for Navigators, and if so, what should they be? (iv) How will the effectiveness of producers and Navigators be measured or evaluated? (v) Should roles and compensation for Navigators and producers be different for the individual market and small-group markets?

As a new distribution channel that is expected to reform the purchase of health insurance for the individual and small-group markets, there is a natural tension between the Exchange and the producer community in Illinois. Therefore, it will be important for the policy-making process to engage all of the key stakeholders to determine the best course of action for Illinois. More specifically, Illinois will need to engage in stakeholder meetings with individual health insurance consumers, employer purchasers, producers, health care advocacy groups, and health plans. The goal of such meetings will be to address the questions noted above but also discuss how the Navigator program can best serve the target market segments, whether there are natural but different market segments for Navigators and producers to serve, and what value Navigators and producers can bring to each stakeholder.

## FINANCING CONSIDERATIONS

One of the more difficult finance issues that will confront the Illinois Exchange, in addition to the questions of whether and how they should continue to use producers, is how to compensate producers at reasonable commission rates while maintaining a low administrative cost structure. Whether to have commission parity inside and outside the Exchange will be an important policy decision. If the Exchange pays commissions below outside market rates, producers have an obvious incentive to write business, or “steer” prospective enrollees, outside the Exchange. A counter-balancing element is that individual enrollees and small businesses that are eligible for premium tax credits or cost sharing assistance cannot receive these subsidies unless they purchase coverage through the Exchange. However, for higher-income people not eligible for subsidies, a producer can in good conscience encourage purchase of coverage outside the Exchange, thereby causing the Exchange to lose business share.

A secondary concern is that the Exchange could become susceptible to “street underwriting” in which producers direct higher-risk enrollees to the Exchange and send healthier enrollees to carriers outside the Exchange, where commission levels are greater. The result would be adverse selection and higher cost in the Exchange compared to the outside market. Such activities by producers allegedly undermined the success of previous Exchanges, including PacAdvantage in California in 2006.<sup>3</sup> The ACA includes three risk-adjustment provisions to mitigate the occurrence of risk selection occurring against the Exchange. Although such provisions should provide the Exchange with some level of protection, risk-adjustment methodologies are imperfect.

The fact is that past experience suggests that if producers are hostile to the Exchange and have incentives to avoid sending business to it, their actions could threaten the success of the Exchange.

The level of compensation to be paid to producers by the Exchange will need to be carefully evaluated and assessed in the context of prevailing market norms in Illinois, expected enrollment take-up in the Exchange, and the revenue-generation options available to the Exchange. The chart below summarizes our findings regarding commission payment based on calls to six health insurance carriers made in May and June of 2011:

**Table 5: Producer Commission Averages**

Producer Commission Averages (expressed as a percent of premium)			
Market Segment	Average	Low	High
Small Group	6.0%	5.0%	6.8%
Non-Group	8.6%	7.4%	11.0%

In addition to this policy question of how much to pay producers, a number of other payment methodology issues will need to be carefully considered. For example:

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<sup>3</sup> SHOPping Around: Setting up State Health Care Exchanges for Small Businesses: A Roadmap. Terry Gardiner and Isabel Perera July 2011. Center for American Progress

- a. If the Exchange decides to pay producers, should the payment methodology be on a percent of premium or a fixed per member per month (PMPM) basis? Historically, producer payments have been largely based on a percentage of premiums. Recently a number of commercial carriers, as well as the two state-based Exchanges currently operating, Massachusetts and Utah, are paying producers on a fixed PMPM basis. Medicare Advantage health plans also pay a fixed fee. The rationale is that premium-based commissions provide producers with incentives to enroll individuals and employers in more expensive insurance policies. A fixed-dollar amount removes this incentive.

Also, percent-of-premium payments reward producers from one year to the next, not on the basis of greater productivity or better service, but on the annual increase in the cost of health care. Such built in “pay raises” are not sustainable over time and merely serve to escalate premium costs needlessly.

- b. Should commissions be greater in the first year than in renewal years? The logic to this practice is that the level of effort in an initial sale is much greater than renewals, justifying a higher level of reimbursement to cover the producer’s incremental expense. Additionally, this methodology could provide an incentive to write the business through the Exchange. Such a policy may increase producer interest and could be financially palatable to the Exchange, especially if renewal commissions are substantially lower. But this policy could encourage churning within the Exchange, could raise the concern of Qualified Health Plans (QHPs) regarding selection bias, notwithstanding the implementation of risk adjustment, and might generally be perceived as unsatisfactory customer service for Exchange enrollees. An alternative payment methodology for consideration, and one that is currently in use in Medicare Advantage, is to pay a higher rate of commission the *first time* a resident enrolls in a QHP through the Exchange but not if the enrollee then changes to another QHP offered through the Exchange.
- c. There are two primary approaches the Exchange could use in structuring producer commissions: (i) make the producer fee an explicit add-on to the premium quote, with the Exchange acting as a pass-through for payment from the enrollee to the producer, or (ii) include the producer fee in the premium quote without separately identifying it. Under the second approach, which is currently used by the Massachusetts Health Connector, the producer fee is a component of the total premium quote and is not visible to the enrollee. Assuming the Exchange generates revenue through an assessment on QHPs for enrollment through the Exchange, the Exchange includes the producer commission as part of the total assessment and pays producer from this revenue stream. This approach has the effect of making the Exchange assessment higher than it would otherwise need to be and removes the transparency of the transaction. In the first approach, the producer payment is being made directly by the insured, which has the benefit of full transparency regarding the cost of commission. However, it is a significant change in the way producers are paid in Illinois today. This type of model is currently employed by the Utah state Exchange.

Defining the role and compensation level of producers in the Exchange is a complicated and potentially controversial issue. What is clear from historical experience is that working with all stakeholders to develop a policy and financial model that seeks to smooth the inevitable tension between an Exchange and producers is in everyone's best interest. The financial advantages accruing to those who are eligible for subsidies only if they enroll through the Exchange (including those who move back and forth from Medicaid and the Exchange) are likely to offset any incentive that producers have to steer people to the outside market if the commission is higher there. But this effect does not apply to the small-group market. Although Illinois may benefit from reviewing the decisions of other states as they design roles, commission levels, and payment methodologies for producers, Illinois will most likely need to develop an approach that is uniquely informed by the local norms of its markets.

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### **ALL KIDS APPLICATION AGENT PROGRAM**

For more than twelve years, the Illinois All Kids (previously KidCare) Application Agent initiative has been very successful in promoting state health coverage programs to children and parents and in enrolling eligible families into these programs. All Kids Application Agents (AKAAs) are community organizations such as clinics, hospitals, other health providers, day care centers, religious organizations, schools, insurance agents and others that help parents, children, and pregnant women enroll in coverage through All Kids and FamilyCare. AKAAs are responsible for:

- identifying potentially eligible individuals and families;
- explaining program eligibility, benefits, cost-sharing, etc.;
- assisting applicants in completing an application, accurately answering all applications questions and gathering all required verification documents;
- submitting the complete application to the state electronically or by mail;
- complying with all confidentiality requirements; and
- following all other AKAA rules.

The state assures that AKAAs understand their duties and are knowledgeable about program provisions. Entities interested in becoming AKAAs submit a request on official letterhead to HFS. The request describes the organization, its regular duties, and how these duties put staff in a good position to encounter families likely to be eligible for All Kids or FamilyCare. HFS staff reviews the request, determines whether the entity can be approved as an AKAA, and sends an enrollment packet to approved entities. The packet contains an AKAA agreement for the entity to review, sign, and submit to HFS for the HFS Director to sign.

With an AKAA agreement signed by the community organization and HFS, the organization's staff attends AKAA training provided in English and Spanish. As part of training, AKAA staff receives an 83-page AKAA manual that explains in detail topics such as: AKAA procedures; AKAA payment requirements; benefits and cost-sharing for each program; eligibility requirements for each program;

service delivery options, including fee-for-service with primary care case management and managed care organizations; rules regarding what date coverage begins; eligibility rules for unique family circumstances; enrollee reporting requirements; how coverage is maintained by DHS and HFS staff; tips for successful applications; the renewal process; etc. In addition, the state maintains ongoing communications with AKAAs through a website and periodic AKAA updates.

AKAAs help families complete an application that is nearly identical to the application families can submit on their own. However, the AKAA application includes a checklist for the AKAA to complete to assure that they have completed all duties, answered all questions, and gathered all required verification documents. The checklist also includes a spot where the AKAA indicates organization name, staff name, and AKAA number. It is this checklist that indicates to state staff that the application came from an AKAA. If the checklist is complete, the application requires no follow-up, and if at least one individual from a family not already enrolled in state coverage is newly approved for All Kids or FamilyCare, the AKAA will receive a \$50 Technical Assistance Payment (TAP) for submission of a successful application. State provisions prohibit AKAAs from submitting multiple applications for individuals in the same family and other attempts to fraudulently earn TAP payments. Each AKAA also receives monthly data reports indicating the number of applications approved and eligible for TAP, the number approved and ineligible for TAP with the reason TAP was denied, the number of applications denied, etc.

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#### **COMPARISON OF AKAAS AND NAVIGATORS**

ACA requires state health insurance Exchanges to award grants to Navigators, organizations that will perform some of the same duties that AKAAs perform. Although Navigators are similar to AKAAs, some ACA provisions vary from AKAA policies. The following table compares ACA Navigator provisions with AKAA policies.

**Table 6: Comparing Navigator and ACAA Provisions**

	Navigator Provisions in ACA	ACAA Provisions in ACAA Manual
<b>Types of Entities</b>	<p>Entities that have existing relationships or could establish relationships with employers and employees; consumers, including uninsured and underinsured persons; and self-employed individuals likely to be eligible to enroll in the Exchange.</p> <p>Must include entities from at least two of the following categories: trade, industry and professional associations; community and consumer-focused non-profit groups; commercial fishing industry organizations, ranching, and farming organizations; chambers of commerce; unions; Small Business Administration resource partners; other licensed insurance agents and producers; and, other entities that can perform Navigator duties and meet standards set by the Secretary, including but not limited to Indian tribes, tribal organizations, urban Indian organizations, and State or local human service agencies.</p> <p>Navigators may not be health insurance issuers or receive direct or indirect consideration from insurers in connection with enrollment.</p>	<p>Community based organizations, including faith-based organizations, day care centers, local governments, unions, medical providers and licensed insurance agents.</p> <p>ACAAs include multiple social services organizations that provide outreach and application assistance to individuals in languages such as Chinese, Korean, Japanese, Arabic, Polish, Urdu, etc. Other ACAAs frequently work with individuals who are homeless and those with mental illness and addictions.</p>
<b>Duties</b>	<ul style="list-style-type: none"> <li>• Perform public education duties to raise awareness about qualified health plans.</li> <li>• Provide fair and impartial information about enrollment in qualified health plans following standards to be set by the Secretary of HHS.</li> <li>• Facilitate qualified health plan enrollment.</li> <li>• Provide referrals to appropriate entities for enrollees with grievances, complaints, or questions.</li> <li>• Provide culturally and linguistically appropriate information.</li> </ul>	<ul style="list-style-type: none"> <li>• Identify potentially eligible families (including use of a worksheet to identify the programs for which individuals may qualify).</li> <li>• Assist applicants in completing the application including getting all verification documents, answering all application questions and having applicants authorize the application.</li> <li>• Submit the completed application online or by mail.</li> <li>• Comply with confidentiality requirements.</li> <li>• Notify HFS of changes in organization or staff information.</li> </ul>
<b>Funding</b>	<p>Exchanges will provide grants to Navigators from Exchange operational funds. (Federal funds and enrollee cost sharing, no state dollars.)</p>	<p>ACAAs receive a \$50 Technical Assistance Payment (TAP) for each complete application that results in a new enrollment for a family not already covered by one of the programs. (50% federal, 50% state funds)</p>

The July proposed rules provided some further guidance on Navigators. However, additional standards are likely to be forthcoming, given the extent of the areas for which HHS is seeking comment.

Specifically, HHS is seeking comment on several topics including:

- whether HHS should propose additional conflict-of-interest provisions for entities receiving Navigator grant funds;
- whether additional conflict-of-interest provisions are required to address the potential conflict of agents and brokers (producers) being allowed to receive compensation for enrolling individuals, small employers, and large employers in non-QHPs while receiving Navigator grant funds;
- whether at least one of the two eligible entities to receive Navigator grant funds should be a community or consumer-focused nonprofit organization or whether Navigator grantees should be required to represent a broad cross-section of stakeholders;
- potential standards for state Exchanges to use when making Navigator grant awards and ways to ensure the information made available by Navigators is fair, accurate, and impartial;
- further specificity on standards for Navigators when providing information to populations such as those with limited English proficiency and individuals with disabilities; and
- requiring Exchanges to commence the Navigator program no later than the first day of the initial open enrollment period.

Additional questions not related to these areas for further comment that may be answered in future guidance include the following questions:

- What is involved in the Navigator duty to “*facilitate enrollment*”?
- Can Navigator grants be structured in a way to pay Navigators based on “new” approved applications they facilitated?
- Despite references to “qualified health plans,” are Navigators expected to work only with individuals and families likely to be eligible for Exchange qualified health plans? Or do ACA provisions for well-integrated Medicaid and Exchange eligibility and enrollment systems require that Navigators work with individuals or families eligible for Medicaid and CHIP too?
- What will be the enrollment and training requirements?

## ROLE OF AKAAS IN OUTREACH AND EDUCATION INITIATIVES

A recent report<sup>4</sup> on the state's All Kids website indicates that AKAAs have a 92% approval rate. This is an impressive measure of the contribution that AKAAs make in streamlining the application process for families. AKAAs also reduce workloads for DHS local office and HFS All Kids Unit staff by increasing the number of complete applications that do not require staff to request additional information. Combined with a well-integrated, easy-to-use EVE system, AKAAs can assist the state in handling the increased volume of applications that will be submitted when Medicaid eligibility is expanded to 133% of FPL for U.S. citizen and qualified immigrant non-elderly individuals on January 1, 2014.

Illinois' ACAA program could be the foundation on which the Exchange Navigator program is built as an integrated outreach and application assistance strategy for Medicaid and the Exchange. Unless federal guidance regarding Navigators would contradict this, the state could expand the ACAA program to incorporate additional types of entities included in the ACA as potential Navigators. It is likely that only a few of the currently enrolled AKAAs, such as insurance agents paid by insurers, would be prohibited from being Exchange Navigators. Since the state has designed an effective system for enrolling, contracting with, training, and paying application agents and this system has been successful in providing linguistically and culturally appropriate application assistance in the community with high application approval rates, lessons learned from the ACAA effort should be integrated with and applied to application assistance for Exchange eligible persons.

Illinois structures payments to AKAAs in a way that rewards entities for providing assistance that results in coverage for a new family that is not already enrolled in state health benefits coverage. This is the ultimate goal of outreach programs, to get people covered. Many outreach programs are successful in promoting a program and making the general public more aware of the program but do not result in more people with coverage. If federal guidance will permit, the state should consider a Navigator program that rewards the submission of complete, approved applications. Not all the families AKAAs work with complete the application process or provide needed verification documents. The ACAA may submit applications for four or five families before one of the applications is approved and a TAP payment earned. After 2014, it will be more likely that the low-income uninsured individuals or families that a Navigator works with will qualify for either Medicaid or subsidized Exchange coverage. Thus the proportion of completed and approved applications should be higher than what AKAAs experience today. For this reason, despite the fact that AKAAs may request an increase in the TAP amount, it may be fair to consider the current \$50 payment for an approved application an appropriate amount for the work Navigators will do to assist individuals and families in applying for Medicaid and the Exchange.

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<sup>4</sup> Source Allkids.com/assets/042611.pdf

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#### 4.2.4 Exchange IT Needs Assessment

*This section addresses the information technology functions of an Exchange specifically, with a focus on opportunities and strategies for developing, purchasing, and acquiring systems and infrastructure to serve those functions.*

This section addresses Exchange information technology needs and potential solutions in Illinois for the Exchange. The HMA team has conducted an information technology needs assessment for Illinois to supplement the Exchange planning needs assessment in section 4.2. We excluded from the assessment the important Exchange functions that will be addressed by the Eligibility, Verification, and Enrollment needs assessment, which is provided in a separate report.

Similar to the review of Exchange business functions, we find little information technology in place in Illinois that can or should be adapted or expanded to serve the IT needs of the Exchange. This is an entirely expected conclusion, since Exchanges will be expected to perform new functions that are not commonly state agency activities (with the exception of eligibility and enrollment functions). Given that, and after discussions with state project managers, our team has taken an operational and strategic business approach to this task rather than a technical one. This section describes emerging federal requirements, discusses the options to acquire technology that meets the requirements, and provides some information about what selected other states are planning. It also addresses some special considerations for the SHOP Exchange. This section is guided by three focusing questions:

1. How is the federal government supporting Exchange IT acquisition?
2. What does Illinois need to acquire to run an Exchange?
3. What are Illinois' options to acquire what it needs?

There is necessarily significant overlap between the business functions of an Exchange described in section 4.2.2 and the functions addressed here. Information technology is simply a business tool, so it is always difficult to address the two components separately. Moreover, while we leave a fuller analysis of eligibility, verification, and enrollment functions to a separate and more detailed report, when reviewing options for acquiring IT functionality, there are important practical and operational reasons to consider all of the IT functions of an Exchange, including EVE functions. We stress these overlapping considerations not to complicate matters or to try to explain away the organizational structure of an exceedingly large and complex final report. Rather, we believe that the most important of the business issues that the state of Illinois needs to grapple with is how, practically and strategically, it should go about purchasing and acquiring IT functions. This would be a challenging effort in any environment, but given the constrained timeframes of the ACA, it is even more important that potential approaches and implications are considered in advance of deploying a purchasing strategy.

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## THE FEDERAL ENVIRONMENT AND EXCHANGE IT NEEDS

Recognizing the challenges confronted by states planning and establishing Exchanges, the federal government is engaged in an ongoing process of defining IT standards for Exchanges in detail. CMS and CClIO are also providing significant funding for states to become compliant, including enhanced funding for certain required Medicaid eligibility system updates. The federal government is also building a data hub that state eligibility systems can access to verify of income, citizenship status, and other applicant information.

In addition to providing federal funding, distributing detailed guidance for accessing funding, and creating certain core functions for states to utilize, HHS has also recognized that assistance in the development and acquisition of technology is an important support for states establishing Exchanges. HHS has provided large grants to six Early Innovator states for Exchange IT development with a goal of disseminating the best practices and creating avenues for states to adopt models to their particular circumstances. CMS is also planning to establish “Learning Collaboratives” to help disseminate ideas and share best practices during Exchange implementation in the states.

It is important to note that, to receive federal funding to support systems-development efforts, states have to demonstrate that they have conducted “due diligence” in reviewing the system models being developed by “Early Innovator” states. States will be required to justify a decision not to use these models. We discuss Early Innovators and the prospects for Illinois later in this section. States also have to show how they will integrate the eligibility-determination functions between the Exchange and existing state agencies. On that score, as described in our separate EVE report, Illinois has a strong process underway.

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## KEY IT NEEDS OF THE EXCHANGE

The federal government has provided some initial draft guidance on structuring the information technology solutions that are needed to meet Exchange business requirements (*CMS Exchange Reference Architecture: Foundation Guidance*, draft v.0.99, March 2011). This guidance identifies six core business areas for Exchanges:

1. Eligibility and Enrollment
2. Plan Management
3. Financial Management
4. Customer Service
5. Communications
6. Oversight

Additional details, in the form of functional and technical requirements, have been or will be provided in relation to each of these core business areas. The detailed guidance is intended to provide the technical framework for Exchanges to use as they develop their IT solutions. Illinois should monitor closely the ongoing guidance associated with this framework.

Nevertheless, in terms of the Exchange’s need to sensibly and strategically acquire IT, not every core business area requires significant IT support. In our view, there are five primary IT systems or services

that the Exchange needs to develop, purchase, or acquire. They are listed below, and generally conform, as noted, to five of the functional domains laid out in section 4.2.2:

- Eligibility determination Section 4.2.2 (a)
- Web Portal Section 4.2.2 (b) (Online shopping)
- Enrollment, billing, and collections Section 4.2.2 (c)
- Customer service Section 4.2.2 (d)
- Financial management Section 4.2.2 (i)

Before discussing acquisition strategies, we make a few observations.

### THE EXCHANGE WEB PORTAL

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In this section of the report we use the term “web portal” to describe the online shopping function that the Exchange must build, for two reasons.

First, the development of a robust website is a hallmark of a successful state Exchange. Illinois should not shortchange this investment and should contemplate it at the initial planning stages as providing more than merely a shopping experience. Compared to the complex challenges and expense of updating existing eligibility systems, the state can spend relatively fewer dollars and realize large consumer rewards for this investment.

Second, using the term “web portal” emphasizes the important point that the website could (and in some cases must) be integrated with a range of Exchange functions. The point is important because it has purchasing implications. Illinois may want to purchase web portal functionality as a part of the Integrated Eligibility System (IES) described in the separate EVE report. Or Illinois could purchase website functionality from the same vendor that provides customer service functions to support the online shopping experience. The ACA also requires Exchanges to provide an “electronic calculator to determine the actual cost of coverage taking into account eligibility for premium tax credits and cost sharing reductions.” The need to have this important tool on the website crystallizes how core functions of the Exchange are expected to be integrated and presented in an accessible way to the consumer.

### PREMIUM BILLING, COLLECTIONS, AND ADVANCE PAYMENT OF TAX CREDITS

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Federal regulations on Exchanges are expected to address the options for states to manage the premium billing and collections from Exchange participants. As noted in section 4.2 (c), premium billing is significantly more complicated for SHOP Exchange customers than for individual purchasers. However, for individuals who qualify for premium tax credits, the Exchange will have to execute an advance-payment process that is complex and must be closely integrated with the eligibility-determination system. If Illinois opts to have health insurance carriers collect premiums, the Exchange will nevertheless have to develop or acquire an IT system that is capable of tracking the administration of the advance payments of Exchange subsidies to eligible enrollees, a core function for Exchanges.

## SHOP EXCHANGE CONSIDERATIONS

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The ACA requires every state that operates an Exchange to establish a SHOP Exchange. The SHOP Exchange is supposed to facilitate the purchase of coverage in qualified health plans for the employees of small-business employers that choose to purchase through the Exchange. Beginning on 1/1/2014, Small Business Health Care Tax Credits will be available only through the Exchange. There are forthcoming federal rules that will provide a framework for SHOP Exchanges, including options for how employers can provide contributions toward employee coverage that meet standards for small-business tax credits.

At a minimum, Illinois needs to consider the extra functionality that will be needed on the Exchange website for small businesses, which includes web enrollment for small businesses and their employees and a producer connection to the web for completing enrollments. In addition, Illinois will need to ensure that there is specialized attention for small businesses through its Exchange call center, particularly if the individual and SHOP Exchanges are combined.

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## ACQUISITION STRATEGIES

There are a number of approaches that Illinois can take to acquire its Exchange operating systems, from designing and building its own system to fully outsourcing a solution. Based on its own initial analysis, Illinois has largely decided not to attempt to build its own Exchange operating system or to modify any of its existing systems to address the Exchange's business needs. Instead, Illinois has proposed hiring a systems integrator to coordinate the design and development of an outsourced Exchange solution or series of integrated solutions.

As a result, we focus on outsourcing options. The first consideration is which phases to outsource: design, development, and/or ongoing operations. There may be different answers, depending on the business function (e.g., web portal vs. call center).

The next consideration is whether to outsource to one vendor or to multiple vendors. There are pros and cons to each approach. If the state outsources the work to one vendor, for a "turnkey" or full solution approach, a key risk is that the state has put "all of its eggs in one basket," and the vendor's failure would be hard to mitigate. If the state outsources components to multiple vendors (taking a modular approach, similar to the Minnesota RFP example discussed below), the state would need a strong system integrator to coordinate the components.

The grid below presents a logical framework for analyzing these needs and a sample approach for selected business functions. This grid is only for illustrative purposes. It is intended not to propose a specific approach but rather to illustrate how to apply a structured framework to represent the purchasing options that Illinois has.

**Table 7: Business Function Purchasing Options**

<b>Business Functions→</b>	<b>Web Portal</b>	<b>Call Center</b>	<b>Premium Billing</b>	<b>Financial Management: Accounting Systems</b>
<b>Phases:</b>				
<b>Design</b>	Enrollment UX 2014 Project	Vendor C (Turnkey for all phases)	Federal framework + System Integrator	Commercial Off The Shelf (COTS) vendor
<b>Development</b>	Vendor A	Vendor C	Vendor D	COTS vendor
<b>Ongoing Operations</b>	Vendor B	Vendor C	Vendor D	In-house

Vendors will doubtless convey an ability to provide multiple functions across all phases. As noted above, a vendor that develops the IES or EVE function (which is not included on the illustration above, but could be) may be capable of designing, developing, and even providing ongoing operations for other business functions. There are, conceptually, a virtually endless variety of scenarios that fit the pieces of this puzzle together. That does not mean that every variety is a good idea.

**CONSIDERATIONS FOR IMPLEMENTATION OF EACH OPTION AND ONGOING OPERATIONS**

There are some core considerations that Illinois should take into account in designing its acquisition approach, including:

- The availability of qualified staff resources.
- The availability of proven vendor solutions.
- The complexity of the project, particularly in areas that need to integrate with the IES project, such as premium billing.
- The degree of uniqueness that Illinois would like to have in the design of its Exchange web portal and operating systems (as compared to other states).
- The operation of state procurement rules that apply to the Exchange on particular scenarios (how many business functions can be bundled into one procurement?) and in general (how administratively cumbersome is the process, and timely?).

**PROCUREMENT LEVERAGE**

Illinois may be concerned about how to maximize its leverage during any Exchange IT procurement process since so many states will be competing for the same services. While this is admittedly a challenge, Illinois has a couple of options. States that issue RFPs early, while vendors are still “hungry,” will get better prices and may get more seasoned vendor staff. The state may also consider methods to make the project attractive to vendors by committing to a longer timeframe or providing financial incentives for performance.

Another approach would be to add scale by participating in a multi-state IT infrastructure procurement. While there are real (and difficult-to-quantify) transaction costs to an approach that includes other states, it is difficult to ignore that every state that is establishing an Exchange is purchasing similar, if not identical, functionality.

## LEVERAGING OTHER EXTERNAL RESOURCES

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Illinois is participating in a user design collaborative through the California Healthcare Foundation whose goal is to design the consumer interface for the Exchange web portal. This project provides an excellent opportunity for Illinois to incorporate best practices for consumers into its Exchange design, without committing significant resources and potentially doing so early enough to be useful. A key factor will be the timing of the project's results and therefore the ability to incorporate the design into any RFP that Illinois issues. The project appears to hold promise for the potential of collaboration among a number of participating states as well.

## FEDERAL RESOURCES

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The Early Innovator grant program designed by CCIIO is intended to provide states with access to development support and ultimately established, approved solutions. We see significant timing concerns with the concept, because, as described below, most Early Innovator states are now in the early phases of design and development. While the prospect is appealing, relying on not-yet developed systems for the Exchange, given the time constraints of Exchange planning, is a high-risk strategy—at least until practical outcomes become more clear. More generally, we think the state should expect ongoing developments from CCIIO about potential methods or solutions for IT infrastructure that are supported by the federal government. We recommend monitoring development with the Early Innovator states as well as other approaches that are offered by CCIIO. Obviously, much more detail will be needed to assess whether any such approach presents a viable option for Illinois.

## CONSIDERATIONS FOR A SYSTEM INTEGRATION VENDOR

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Procuring a system integration vendor to help manage the Exchange IT development is a good idea, especially in light of scarcity in staff resources at the state level, but a vendor does not substitute for the need for strong state oversight of the project. In addition, the system integration will need to happen across the overall health reform project, including the Integrated Eligibility System. In particular, we think that a system integrator can play a vital role in helping to manage the implementation of the Exchange's customer support center, which has many key interdependencies with other aspects of Exchange implementation. Finally, it is crucial that a system integrator or project management role coordinates very closely with the non-technical aspects of Exchange implementation.

## CONCLUDING OBSERVATIONS AND RECOMMENDATIONS

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**Call Center:** It makes sense to combine the development and operation phases of the call center into one contract. It gives the vendor the right incentives to do a good job on the development phase since they have to operate the results. To address both the need to give vendors incentives to bid on Illinois' work, combined with the desire to minimize procurement process time, a good option for the state to pursue for its call center and premium billing solutions (combined or separate) is a relatively short initial contract term (3 years) with potential extensions. The initial length of the contract, combined with the possibility of extensions, is enough to make the project worth the vendors' investment of resources, but it also gives the state the flexibility to exit if the vendor's performance is substandard. During that period, the Exchange will gain an identity and a great deal of experience and will learn from other states.

This will put the state in a position to better know what it wants and therefore refine its future procurement requests.

Web Portal: The website development and ongoing operations (such as hosting the site) are very different functions and can be easily split across vendors. Alternatively, the web portal can be designed in such a way that updates could be done by in-house Exchange staff.

Combined Contracts: Bundling the web portal and call center development is possible, but the state would need to be sure that vendors truly have strengths in each area. Often, vendors have a comparative advantage in one area; it is best if the state can play to their respective strengths. The state should be cautious when reviewing vendors who are subcontracting a great deal of the work—the state should get assurances that the teams have worked together before, and the state needs to ensure that the lead vendor is truly accountable for the results and has the capacity and expertise to step in if the subcontractor fails.

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## WHAT OTHER STATES ARE DOING

HMA is monitoring what other states are doing in terms of acquisition of Exchange technical systems that would have applicability to Illinois. Many, but not all, of the states are Early Innovator grantees.

### MINNESOTA

Minnesota is not an Early Innovator grantee, but it is one of the first states to be issuing a technical RFP. Minnesota recently issued an RFP for Health Benefit Exchange Technical Infrastructure prototypes, most of which are related to the Exchange's web portal functions. The state has taken a creative approach to managing technology planning in a deeply uncertain environment. Vendors are being asked to respond to a two-phased approach, in which they first share their prototype ideas and then receive funding to develop the prototypes more fully. The prototypes are meant to be stand-alone modules that can also be connected into a fully integrated solution.

The modules identified are as follows:

- Individual Eligibility and Exemption
- Individual Enrollment
- Small Employer Eligibility and Enrollment
- Health Benefit Plan and Navigator/Broker Certification and Display
- Provider Display
- Fund Aggregation and Payment
- Account Administration
- Mobile Application or Accessibility.

If the prototypes are accepted, the vendors are not guaranteed the funding to fully implement the prototypes. Minnesota declares that any implementation is contingent upon future federal funding and that it may implement a solution brought by another state or build an expanded solution from other state agencies.

## OREGON

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Oregon received \$48 million in Early Innovator grant funding and plans to use the funds to create a modular, reusable IT solution with commercially available, off-the-shelf software. The Exchange development is being linked to Oregon's "Self Sufficiency Modernization" effort, which is a major overhaul of its eligibility systems used in Medicaid and cash assistance programs. The state plans to issue an RFP for a system integrator for this project.

## MARYLAND

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The Maryland Department of Health and Mental Hygiene has modified its Early Innovator work plan. The state noted in its quarterly planning grant report that it had ended the contract of a software developer for assistance in creating the Exchange. The state reports a revision to their work plan to accomplish the following:

- A review of current technical infrastructure currently available.
- A review of Federal standards for minimum function of an Exchange.
- A comprehensive GAP analysis.

The report notes that the state is not ready to contract with a vendor for IT Exchange development until it has a clearer understanding of current Federal Exchange requirements.

Maryland further noted that it has merged Exchange development activities into planned IT eligibility and enrollment projects. It is our understanding that one reason for the modification of the original Early Innovator proposal was to incorporate the needs of the human services system—also an issue of particular interest to Illinois. Maryland plans on issuing a Request for Information (RFI) to assess technical capabilities available in the private sector for "back office" IT functions of the Exchange, including premium billing.

## MASSACHUSETTS/NEW ENGLAND

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Massachusetts is the lead state in a consortium of New England states that are looking to build upon the Exchange infrastructure that Massachusetts has already implemented. They are seeking to create a flexible IT framework for Exchanges that can be used by other states. We recommend monitoring the activities of the consortium closely, since the core functionality is further ahead of most states, and the lead state shares with Illinois a similar commitment to implementing health reform. The project is underway with an initial focus on assessing whether the current Exchange IT components comport with the ACA rules and whether they will be reusable for other states.

## NEW YORK

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New York is proposing to use its Early Innovator grant funds to build from its new MMIS system and develop its Exchange products. The state is expected to release an RFP for this work soon. The original grant proposal had envisioned using the vendor who completed the new MMIS to also complete the Exchange work. Adding the RFP process will lengthen the timetable, which makes it less feasible for Illinois to leverage New York's results in a relevant timeframe. Also, the project may be too state-specific or too focused on that state's MMIS to be usable for Illinois.

## WASHINGTON

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While not an Early Innovator grantee, Washington is one of the states that have passed Exchange legislation. Washington is taking a two-phased approach for the development of its Exchange IT system. The first is to build the foundational architecture of the Exchange, and the second is to build the actual Exchange business functions, such as eligibility and enrollment.

## WISCONSIN

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Wisconsin is a federal Early Innovator grantee and received an award of over \$37 million to build out its proposed website for all subsidized and non-subsidized health care programs. It is worth reviewing the core functionality, which has been deployed in a number of states and subsequently developed to accommodate the requirements of the ACA, closely.

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### 4.2.5 Mandatory Regulatory Functions

*This section addresses certain mandatory regulatory functions required under the ACA, primarily concerning insurance market regulation.*

As central as the Illinois Exchange will be to health reform implementation in Illinois, it is important to emphasize that there are other key provisions of the ACA that do not apply only to Exchange plans or Exchange purchasers. The law substantially reshapes the insurance marketplace in Illinois and in doing so creates substantial new obligations on Illinois insurance regulators at DOI. While Exchanges are intended to help organize, facilitate, and simplify choices for consumers, the broader market reforms regulate rating, underwriting, and marketing rules to protect consumers and to rationalize competition in the market. A particularly important regulatory activity, premium rate reviews, must be performed by DOI and the Illinois Exchange is required to consider rate increases and the DOI rate review process in certifying Exchange plans. Given the new mandatory regulatory activities that the state will need to perform, this section is intended to summarize the regulatory resources outside of the Exchange that will be needed in Illinois.

- Staff and resources to administer and monitor risk adjustment, reinsurance, and risk corridor programs.

The ACA establishes three distinct risk-sharing programs that will be largely state-administered. Risk corridors apply to all qualified health plans. Reinsurance relates to the individual market, and risk adjustment will take place across the individual and small-group markets. As noted earlier in this section, Illinois should plan on hiring technical consultants for advice on risk adjustment and possibly external vendors who specialize in risk adjustment and who can work with the state on all three kinds of risk-sharing programs. External expertise will be needed, as well as skilled resources to manage that work within DOI. In particular, risk adjustment will require a substantial level of expertise and claims collection, data cleansing, manipulation, and analysis. In addition, all three risk-sharing programs will need to be closely monitored by DOI as a part of its existing examination and oversight functions.

- Resources to enhance consumer assistance and external review functions.

The ACA required the establishment of Consumer Assistance Programs (in Illinois, housed at DOI) and the institution of new standards that govern the processes insurers need to have in place for internal appeals and external review of grievances. These provisions create new obligations on DOI for which the state has accessed federal grant money. Even so, as Exchanges are implemented, new public outreach and enrollment strategies and pathways will be devised, and DOI will need to devote time and resources to ensure that it is aware of Exchange strategies and that its consumer assistance work is well-coordinated with that of the Exchange.

- Staff and resources to perform rate reviews and monitor minimum loss ratios.

The Illinois DOI has embraced and received federal support for a significant new regulatory activity, premium rate review. This is a significant undertaking for DOI, and one for which interaction with the Illinois Exchange will be required. The Exchange must consider a carrier's justification for premium increases in determining whether to qualify a plan for Exchange participation.

The rate-review process works in conjunction with new rules that set standards for the minimum amount of collected premiums that insurers spend on medical care, with associated monitoring obligations on DOI. The state should carefully monitor the availability of federal grant support for these activities, which are ongoing and substantial, and determine whether supplemental staff and resources are required.

- Support for other individual and group market reforms in the ACA.

ACA market reforms will involve the creation of rating and underwriting standards that are not as comprehensively enforced in Illinois as they will be when the reforms take effect. New market and pricing standards will involve state legislative changes and require ongoing regulatory action in Illinois. Finally, there is a wide range of regulatory requirements in the ACA, generally associated with its overall scheme to make insurance more standardized for consumers. These requirements, including the creation of uniform enrollment forms, standard definitions of benefits and coverage, and uniform reporting requirements are or will be the subject of NAIC-led federal standards. However, review, monitoring and enforcement will largely be a matter for states. If Illinois wants to prioritize strong and efficient enforcement of the ACA's market reforms, the state should carefully review whether existing DOI resources are adequate to perform its significantly enhanced role.

## 4.3 Financing the Exchange

*This section estimates Exchange operating expenses, projects revenue based on a range of administrative fees and Exchange enrollment assumptions, and summarizes the detailed assumptions made in designing the model into 5-year budget projections for the Illinois Exchange.*

### SUMMARY

This section of the report provides a description of the estimated operating expenses that will be incurred by the Illinois Health Insurance Exchange during the five-year period from 2011 to 2015. These budget projections are intended to provide some guidance as to the type of expenses that the Exchange is likely to incur during this period, as well as to assist Illinois in determining the level of and sources for funding that will allow the Exchange to become self-sustaining by January 1, 2015, as required by the ACA. To facilitate this decision-making process, the projections described in this document estimate the actual dollar value for spending in both the start-up phase, 2011 through 2013, and for the first two years of operations, 2014 and 2015, as well as the total revenue that will be required to sustain the operations of the Exchange assuming low, moderate, and high take-up rates and membership. The major assumptions necessary to create the five-year budget projections are spelled out in the document. It is expected that such assumptions will evolve considerably, and the projections will become more refined and credible as Illinois progresses to the implementation phase and updated data becomes available, especially for key variable such as Exchange enrollment projections, premium levels, the cost of the IT design and build, and the level of outsourcing of core Exchange functions. For this draft, we have assumed a highly outsourced Exchange model.

### Key Messages

The key financial modeling conclusions for Illinois to consider at this phase in their Exchange development process include the following:

1. Once operational, the cost of running the Exchange, in absolute dollars, is tied to the level of enrollment, meaning that an Exchange that serves more people will cost more in absolute dollars. However, the per-member cost of running the Exchange, as well as the Exchange's cost as a percentage of premiums, will decline as enrollment grows. This is because the Exchange will be able to spread its fixed costs across a larger membership base.
2. Although other financing options exist, the model presented below assumes that the Exchange will be financed through an assessment on participating Qualified Health Plans (QHPs). Based on a range of potential enrollment scenarios, we estimate that the assessment required to finance the cost of running the Exchange, as a percent of premium, will be between 2.24% and 3.39%. This compares favorably with existing benchmarks. For example, the assessment employed by the Health Connector in Massachusetts has historically been between 3% and 4%.

3. We estimate that the cost of the Exchange on a per-member per-month (PMPM) basis will be between \$10.47 and \$16.83 in 2014, and between \$8.92 and \$13.47 in 2015. The middle of this range is comparable to benchmark PMPM expense amounts. For example, in FY 2011, its fifth year of operations, the Health Connector in Massachusetts experienced PMPM expenses of \$11.16, while performing fewer functions than the Illinois Exchange is expected to perform. PMPM costs in subsequent years are expected to be a function of enrollment, meaning that ongoing growth is expected to result in moderately lower PMPM cost levels than those seen in 2015.
4. We estimate that total start-up costs for the 2011-2013 period will be approximately \$92.3 million; it is anticipated that these funds will be provided via a federal Exchange establishment grant. The majority of this cost (roughly 80%) is related to the development of Exchange IT systems. The assumptions related to this cost estimate are discussed later in this section.

For planning purposes, we have developed two high-level expense subtotals: (1) Systems Development and Support and (2) Program Operations. The Systems Development and Support subtotal represents the estimated expenses for the work required to develop and operate the Exchange's four major IT systems: (i) Eligibility Determination and Enrollment, (ii) Website, (iii) Customer Service, and (iv) Premium Billing. The Program Operations subtotal includes the remainder of the administrative expenses for operating the Exchange. Examples of items included in this category include Salary and Benefits for Exchange staff, Consulting and Professional Support, General and Administrative, Marketing and Advertising, and the estimated cost to fund the Exchange Navigator program.

For the start-up phase, fiscal years 2011 through 2013, we estimate a cumulative total expense of \$92.3 million. The three years reflect only 27 months in total, as we have estimated that operations would not begin in earnest until October 2011, which is when Illinois is expected to begin receiving Level 1 Exchange establishment grant funding. The spending will be staggered such that approximately 6% will be incurred in 2011, 36% of the total by the end of 2012, and the remaining 59% of the budget in 2013. The Systems Development and Support subtotal is \$75.0 million, or approximately 80% of the total, with \$45.4 million estimated for the eligibility determination and enrollment system, \$15.8 million for a website, \$9.6 million to develop a customer service call center, and \$4.1 million for a premium-billing system. The Program Operations subtotal during the start-phase is \$18.9 million, with 94% of projected expenditures falling into three expense categories: (1) Facility and Related of \$809,959; (2) Salary and Benefits of \$8.4 million; and (3) Consulting and Professional Support of \$7.0 million.

For the operating phase, beginning in 2014, we developed estimated expenses that scale based on projected enrollment in the Illinois Health Insurance Exchange. We first developed an expected baseline expense on a per-member per-month (PMPM) basis, using historical data from the Health Connector in Massachusetts, after it had moved beyond start-up. We then adjusted that experience for a larger anticipated enrollment scale in Illinois, other circumstances specific to Illinois, and functions required by the ACA. We then projected expenses for low, moderate, and high enrollment scenarios, and calibrated the necessary percentage surcharge on premiums to generate sufficient revenue to achieve approximate break-even in both 2014 and 2015. Our model also provides the ability to model slow,

moderate, or fast ramp up of membership in year 1. To employ a level of conservatism, the figures in this report assume a slow ramp-up of membership in year 1 of operations.

For enrollment, we used estimates for baseline Exchange enrollment developed by Deloitte Consulting. The estimates and the sources of data are described in greater detail later in the document. We then assumed a range of enrollment around this baseline to test the impact on Exchange costs in the event that enrollment is lower or higher than anticipated. The low scenario was developed to allow for a level of conservatism so that Illinois could evaluate the level of premium assessment necessary to achieve break-even should enrollment in the Exchange fall well below expectations, while the high scenario was developed to ensure that systems and processes are sufficiently scalable to support higher levels of enrollment.

We estimate expenses in 2014 to be approximately \$16.83 PMPM in the low enrollment scenario, with a downward scale on a PMPM basis under the moderate and high enrollment scenarios, which are \$12.34 and \$10.47, respectively. Estimated 2014 expenses range from a low of \$32.1 million to a high of \$46.7 million. For 2015, the range of spending on a PMPM basis is estimated to be between \$13.47 PMPM for the low scenario and \$8.92 PMPM for the high scenario. The 2015 estimated range on a dollar basis is between \$57.3 million for the low estimate and \$88.6 million for the high estimate.

While alternative models for financing exist and are discussed below, the presumed financing structure assumed for modeling purposes is a percentage surcharge on QHPs participating in the Exchange as provided for in the ACA. The surcharge percentage required to approximate break-even during the first two years of operations (2014-2015) is estimated to be between 2.83% and 4.56% in 2014 and between 2.24% and 3.39% in 2015, depending on enrollment scenarios. The average surcharge percentage needed to approximate break even over the first two years in aggregate is estimated to be between 2.42% and 3.75%.

For modeling purposes, we have not allowed for a build-up of net assets, presuming the Exchange will target break-even performance in each year. However, our expectation is that HHS will allow for the development of some surplus while the Exchange transitions from being 100% federally funded during start-up to becoming fully self-sustaining in 2015 and will recognize that it will be prudent for the Exchange to develop moderately higher net asset totals to protect the entity's long term financial stability, supplemented with a line-of-credit or other means to raise revenue should enrollment estimates come in lower than expected, or actual expenses are higher than forecasted. 2014 will be a critical year in this regard, as the Exchange will be transitioning from grant funding for Exchange start up while beginning to generate its own revenue, and should explore options around developing a modest reserve from these revenue sources to weather future potential revenue volatility.

The estimates presented in this document are based on currently available data or, where data is incomplete, on proxy or benchmark data and will need to be refined as additional data becomes available or as material policy decisions are reached. Notwithstanding the preliminary nature of these projections, we believe that they do provide a useful baseline for the Illinois Health Insurance Exchange and state leaders in Illinois as they begin to develop their start-up and implementation planning and

prepare to initiate their request for additional Level 1 or Level 2 Exchange implementation funding from the United States Department of Health and Human Services (US HHS). Continuing to obtain establishment grants (Level 1 or Level 2) will be a critical next step for Illinois, and an initial financial blueprint should jumpstart the ongoing grant application process. The presentation of revenues, expenses, and net assets in this report is representative of a typical government financial statement preparation and does not conform with the eleven core areas identified by the Centers for Medicare and Medicaid Services' (CMS) Center for Consumer Information and Insurance Oversight (CCIIO) funding opportunity announcement (FOA) released on January 20, 2011. Restating the expenses to conform to the FOA grant application can be performed upon request.

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## BACKGROUND INFORMATION

This budget projection and narrative document is derived from the Wakely Exchange Financial Implementation Model or ExFIM. The ExFIM is a proprietary model that incorporates variables unique to each state, such as total targeted market size, premium rates, contract size, and expected enrollment ramp-up; it has been developed to work at various levels of detail, depending on data availability and client preference. For example, total Exchange revenue can be based off a simple, high-level composite premium estimate for the entire Exchange population, or we can refine the revenue estimates as more detailed data become available and assumptions are refined for premium level and annual trend, take-up rates, and net enrollment through the Exchange separately for subsidized non-group and small group and for the unsubsidized non-group and small-group Exchange. Eventually, both enrollment and premiums should be projected at the actuarial levels of Platinum, Gold, Silver, Bronze, and Catastrophic. This level of premium build-up provides more precision in calibrating the assessment necessary to fund the Exchange, which can be updated for actual experience and used as a business planning tool once the Exchange is operational.

For the budget estimates contained in the document, we have made assumptions that will need to be refined working with Illinois staff. Our assumptions for certain key variables are included at the end of this report, and we have used publicly available data wherever possible. We have run only three volume-based scenarios. However, if desired, we can provide the results for a broader array of scenarios resulting from changing the key assumptions, and we can perform empirical research and analyses for the development of more refined assumptions.

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## BUDGET DEVELOPMENT METHODOLOGY

To develop the five-year administrative budget, this analysis is organized as follows:

1. Expense Estimates
  - a. We developed different methodologies for expense estimates for the start-up phase, which we have defined as fiscal years 2011 through 2013, and for the first two years of operations, which are expected to be 2014 and 2015. The reason for this methodological difference is as follows:

- i. For start-up expenses, we developed actual dollar estimates using a granular, bottom-up approach based on expected staff hiring, consultant costs, and related facility and administration expenses using our direct experience implementing the health benefit Exchange in Massachusetts, our Exchange operational and IT planning work in other states, factors unique to Illinois, and common available metrics for general and administrative costs. In translating our Massachusetts-based benchmark for Illinois-specific estimates, we have reflected (1) cost-of-living differences between Massachusetts and Illinois; (2) complexities in implementing the reform law in Massachusetts compared to provisions of the ACA; (3) available data specific to Illinois; (4) the short start-up phase in Massachusetts as compared to the longer start-up and implementation period Illinois will experience in developing the Illinois Health Insurance Exchange; and (5) the significant IT design and development that will be undertaken by Illinois as part of the implementation of the ACA.
- ii. In estimating expenses for the first two years of operations, we developed a baseline per member per month (PMPM) expense estimate utilizing our experience and published data in Massachusetts. Additionally, as the size of the Exchange for the baseline data was approximately 200,000 covered lives, we have developed factors that allow the baseline PMPM to scale up or down depending on the low, moderate, or high enrollment scenarios based on the relative share of fixed and variable costs. This allows for a more refined expense estimate correlated to the size of the Exchange and allows for the assessment of cost at various assumed levels of enrollment.
- iii. We have also developed the functionality to adjust expenses using estimated contract size to convert expense estimates to a per subscriber per month (PSPM) basis, which will be important in assessing the impact of utilizing insurance producers as well as any future analyses that separate out the SHOP Exchange functionality from the individual Exchange.

## 2. Revenue Estimates

In developing revenue estimates for the Illinois Health Insurance Exchange, we incorporated the following elements into the ExFIM model:

- a. Potential total size of enrollment through the Illinois Health Insurance Exchange (the source and assumptions used to estimate enrollment are discussed in the next section, “Enrollment Estimates”)
- b. Estimated Illinois Health Insurance Exchange enrollment by each of the precious metal tiers and the catastrophic plan.
- c. Estimated premium levels at each of the precious metal tiers.

- d. Assumed that funding would be an assessment, expressed as a percentage of total premium revenue, on Exchange-only enrollment. For a discussion of potential additional funding arrangements for the Exchange that should be considered, please refer to the section titled Alternative Exchange Funding Options further in this report.

To estimate the premium levels for each of the precious metal tiers, we used premium data provided by Illinois carriers. We received 2010 premium data from carriers accounting for approximately 85% of the small- and non-group market in Illinois, and, of that market share, the data provided represented approximately 82% of the covered lives for the carriers polled, or approximately 70% of the small- and non-group market in total. The data was provided at the product level and arrayed by relative actuarial values in five percentage point increments from greater than 50% to 90% and above. We blended this more granular information to arrive at premium averages at the precious metal tier level for both small and non-group. In some cases, minor adjustments were made to correct for data irregularities and/or small cell sizes. Finally, an annual premium inflation factor of 8% compounded was applied to project these premium values from 2010 to 2014 and 2015.

In the following Tables, the Non-Group columns combine our take-up assumptions for the individual market, existing public programs, and uninsured populations.

**Table 8. Estimated Premium Level by Precious Metal Tier and Market Segment**

Estimated Premium Levels – PMPM				
	CY 2014		CY 2015	
	Non Group	Small Group	Non Group	Small Group
<b>Platinum (90% + AV)</b>	\$ 685.93	\$ 669.60	\$ 740.80	\$ 723.17
<b>Gold (80% - 90% AV)</b>	\$ 454.67	\$ 533.84	\$ 491.05	\$ 576.55
<b>Silver (70% - 80% AV)</b>	\$ 328.46	\$ 469.56	\$ 354.73	\$ 507.13
<b>Bronze (60% - 70% AV)</b>	\$ 283.94	\$ 453.63	\$ 306.66	\$ 489.92
<b>Catastrophic (&lt;60% AV)</b>	\$ 208.11	\$ 364.61	\$ 224.75	\$ 393.77
<b>Total</b>	\$ 283.02	\$ 499.00	\$ 305.67	\$ 538.92

**Table 9. Estimated Enrollment Distribution by Precious Metal Tier**

Exchange Enrollment Mix - (Moderate Enrollment Scenario)				
	CY 2014		CY 2015	
	Non Group	Small Group	Non Group	Small Group
<b>Platinum (90% + AV)</b>	-	745	-	1,015
<b>Gold (80% - 90% AV)</b>	3,370	7,450	4,890	10,150
<b>Silver (70% - 80% AV)</b>	304,985	110,260	442,545	150,220
<b>Bronze (60% - 70% AV)</b>	26,960	29,800	39,120	40,600
<b>Catastrophic (&lt;60% AV)</b>	1,685	745	2,445	1,015
<b>Total</b>	337,000	149,000	489,000	203,000

### 3. Membership estimates

In order to appropriately estimate the potential range of revenue and expenses of the Illinois Health Insurance Exchange, we developed a budget model that allows for various enrollment scenarios. Our approach is based on the following variables, which can be modified as more data becomes available.

- a. Total baseline estimated enrollment for the non-group and small group markets based on Deloitte population model estimates.
- b. Average contract size of each market.
- c. Average member duration for each market (allows for the calculation of annual subscriber months—i.e., the number of months a subscriber has been enrolled in a QHP for a given year).
- d. Estimates of enrollee take up by each of the precious metal tiers (Platinum, Gold, Silver, and Bronze) and the catastrophic plan.

**Table 10. Estimated Total Exchange Enrollment by Sub-Population (1,000s)**

	2014			2015		
	Low	Moderate	High	Low	Moderate	High
Small Group	89	149	209	122	203	284
Non-Group	202	337	472	293	489	685
<b>Total</b>	<b>292</b>	<b>486</b>	<b>680</b>	<b>415</b>	<b>692</b>	<b>969</b>

**Table 11. Exchange Take Up and Enrollment Scenarios by Sub-Population**

	CY 2014			CY 2015		
	Low	Moderate	High	Low	Moderate	High
<b>Market Mix:</b>						
Non Group	69.34%	69.34%	69.34%	70.66%	70.66%	70.66%
Small Group	30.66%	30.66%	30.66%	29.34%	29.34%	29.34%
<b>Total Enrollment</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>
<b>Members:</b>						
Non Group	202,200	337,000	471,800	293,400	489,000	684,600
Small Group	89,400	149,000	208,600	121,800	203,000	284,200
<b>Total Members</b>	<b>291,600</b>	<b>486,000</b>	<b>680,400</b>	<b>415,200</b>	<b>692,000</b>	<b>968,800</b>
<b>Subscribers:</b>						
Non Group	124,815	208,025	291,235	181,111	301,852	422,593
Small Group	45,381	75,635	105,888	61,827	103,046	144,264
<b>Total Subscribers</b>	<b>170,196</b>	<b>283,659</b>	<b>397,123</b>	<b>242,939</b>	<b>404,898</b>	<b>566,857</b>
<b>Wtd. Avg. Contract Size</b>	<b>1.71</b>	<b>1.71</b>	<b>1.71</b>	<b>1.71</b>	<b>1.71</b>	<b>1.71</b>
<b>Member Months:</b>						
Non Group	1,325,792	2,209,653	3,093,515	3,008,666	5,014,443	7,020,220
Small Group	586,181	976,968	1,367,756	1,248,996	2,081,660	2,914,325
<b>Total Member Months</b>	<b>1,911,973</b>	<b>3,186,622</b>	<b>4,461,270</b>	<b>4,257,662</b>	<b>7,096,103</b>	<b>9,934,545</b>
<b>Subscriber Months:</b>						
Non Group	818,390	1,363,984	1,909,577	1,857,201	3,095,335	4,333,469
Small Group	297,554	495,923	694,292	634,008	1,056,680	1,479,353
<b>Total Subscriber Months</b>	<b>1,115,944</b>	<b>1,859,907</b>	<b>2,603,869</b>	<b>2,491,209</b>	<b>4,152,016</b>	<b>5,812,822</b>

**EXPENSE CATEGORIES DETAIL**

The table below identifies the various expense line items estimated and the key assumptions we have developed for the start-up period. As noted previously, the start-up period was developed on a dollar-basis, utilizing baseline information from our experience in standing up the Exchange in Massachusetts and our work in other states in determining the level of spending in developing an Exchange under ACA, adjusted where appropriate for circumstances unique to Illinois and our understanding of Exchange requirements under ACA relative to the baseline.

A key driver of the start-up costs of the Exchange, accounting for roughly 80% of the cost during the 2011-2013 period, is the development of the core IT systems. The cost estimates included here assume a significant new development costs, consistent both with the plan for a substantial eligibility and enrollment development project and our findings that, outside of that integrated eligibility system, little existing state infrastructure could be leveraged to perform Exchange-specific functions. Because detailed specifications have not been developed for the Illinois Exchange, we relied upon benchmark information from other states that are similar to Illinois in size and expected IT build requirements. As

greater detail becomes available about the IT needs of the Exchange, the IT development cost estimates can become more refined.

**Table 12. Detailed Expense Line Items, Type of Expense, and Assumptions – Start up period:**

Expense Line Item	Key Assumptions
Eligibility Determination, Verification and Enrollment	Expenses used for this report were based on a detailed IT plan for a state with comparable features to Illinois in terms of size and expected IT build and complexity and allocated based on the share of each system associated with the development of Massachusetts Exchange. IT budget assumes a leveraged model, in which acquired systems would be configured and customized to meet the needs of Illinois, combined with the leveraging of solutions from early innovator states and the federal government.
Website	Expenses used for this report were based on a detailed IT plan for a state with comparable features to Illinois in terms of size and expected IT build and complexity and allocated based on the share of each system associated with the development of Massachusetts Exchange. IT budget assumes a leveraged model, in which acquired systems would be configured and customized to meet the needs of Illinois, combined with the leveraging of solutions from early innovator states and the federal government.
Customer Service/Call Center	Expenses used for this report were based on a detailed IT plan for a state with comparable features to Illinois in terms of size and expected IT build and complexity and allocated based on the share of each system associated with the development of Massachusetts Exchange. IT budget assumes a leveraged model, in which acquired systems would be configured and customized to meet the needs of Illinois, combined with the leveraging of solutions from early innovator states and the federal government.
Premium Billing	Expenses used for this report were based on a detailed IT plan for a state with comparable features to Illinois in terms of size and expected IT build and complexity and allocated based on the share of each system associated with the development of Massachusetts Exchange. IT budget assumes a leveraged model, in which acquired systems would be configured and customized to meet the needs of Illinois, combined with the leveraging of solutions from early innovator states and the federal government.
IT Infrastructure	This represents cost primarily for general IT services required by Exchange employees, such as data hosting, computer equipment, and software licensing. In operational period, IT infrastructure also includes the need for expanded data warehousing and analytical capabilities to support risk adjustment, appeals, and reporting.
Marketing and Advertising	Represents Marketing and Advertising expense for a commercial public relations firm.
Consulting and Professional	Represents purchased services primarily for auditing function, legal, actuarial, and independent contractors for short-term subject matter expertise.

Expense Line Item	Key Assumptions
Salary and Benefits	Assumes staff ramps up to approximately 48 FTEs by 2013 at an average salary of approximately \$85,000 in 2013, fringe factor of 35%, and annual inflation assumed at 3% per year. Salary and fringe estimates were based on employee salary and fringe information obtained from Illinois HFS. The Wakely staffing model divides staff into four levels – (1) Staff (2) Manager (3) Director and (4) Executive. For benchmarking purposes, the Kidcare Supervisor (salary ~ \$75,000) indicated by HFS was assumed to be equivalent to the Wakely Manager level in most instances, and a range up and down was developed for Staff, Directors, and Executives. For Senior Executive salaries, we assumed that, to attract highly qualified individuals, the Exchange would provide salaries at a level higher than the state employee payroll but lower than executive leaders earn in the private insurance industry. The range for executive salaries assumed in the model is between \$165,000 and \$235,000. To place this salary level in context, a review of executive compensation at selected Illinois insurance carriers indicates a range of compensation at the Vice President level and above between \$232,000 and \$1.8 million.
General and Administrative	Represents expenses primarily for office supplies, postage, printing, travel reimbursements, dues and subscriptions, etc. Where possible, we used budget assumptions from Illinois HFS (e.g., furniture and fixtures, telecommunications).
Facility and Related	Represents Rent and Utilities for approximately 50 staff, plus conference rooms, office furniture and fixtures, and property and casualty insurance.
Appeals Program	Assumes costs for development of an appeals program are incurred during the first year of operations, 2014.

One additional expense category, applicable to the Exchange starting in 2014, merits special comment. This is the cost of Navigators. For Navigators, we used a fairly modest estimate of approximately \$2.0 million to \$4.0 million, which was derived, based on a baseline from a comparable program utilized in Massachusetts and increased to account for (a) the increased complexities of the ACA requirements and (b) the larger scale of population in Illinois. We assume that Navigators will shoulder a considerable responsibility for outreach, education, and enrolling the (mostly subsidized) non-group population, a function that will be supported by the Exchanges marketing and outreach expenditures.

**Table 13. Navigator Program Expenses**

Expense Line Item	Key Assumptions
Navigators	<p>Developed a baseline PMPM amount utilizing the experience in Massachusetts in using consumer advocacy groups to assist the subsidized population in understanding and navigating the health care system. Adjusted baseline to account for enhanced ACA requirements and other differences unique to Illinois.</p> <p>The Massachusetts Exchange was one of a number of funding streams for “Navigators” in that state, so the figures represented in this budget were adjusted to reflect this difference.</p>

**ALTERNATIVE FUNDING OPTIONS FOR EXCHANGE**

State-based Exchanges are expected under ACA to be self-sustaining as of January 2015, and federal grants are available to finance start-up administrative costs, including part of the first-year costs of operations (2014). On a steady-state basis, ACA legislation anticipates that state Exchanges will levy a surcharge or assessment on Qualified Health Plans (QHP’s) to support the Exchange’s operations. As indicated above, employing such a methodology would provide for self-sustainability, with a carrier assessment range of between 2.42% and 3.75% of premium. Please note that this level of assessment does not take into account the potential role of insurance producers and whether significant volume of enrollment is drawn from producers. As was indicated earlier, producer fees, when added to the administrative expense, could have a material impact on the overall cost as a percentage of the premium and should be considered when considering the total cost of the Exchange.

Based on the relatively large expected volume of enrollment, a relatively low carrier surcharge of this kind appears likely to provide sufficient revenue to sustain Exchange operations. However, the level of assessment that is tolerable to stakeholders in Illinois will dictate whether this surcharge alone is sufficient, and it may be prudent for Illinois to explore alternative or supplemental funding levels. In addition to the conventional funding approach of an assessment on QHP enrollment through the Exchange, there are a number of alternative funding options that can work in combination with a QHP assessment or expand the QHP assessment across a larger part of the health insurance market. The discussion that follows identifies a number of such alternatives and where additional financial modeling will be necessary.

1. Leveraging the State Medicaid Program. Some states have elected to utilize the Exchange to determine eligibility for Medicaid and other public subsidized programs. In this arrangement, the Exchange incurs a cost that can be charged to the state’s Medicaid program. The Medicaid program can offset this cost utilizing its federal administrative cost match rate, thus lowering the total cost to the state of Illinois. In order to quantify the potential revenue accruing to the Exchange for providing this service, we will need to work with the appropriate state and federal personnel to develop a cost allocation methodology. The methodology will need to quantify areas such as: (a) the cost for the Exchange for determining eligibility; (b) the number of Medicaid applications processed by the Exchange; (3) the number of customer service calls

coming through the Exchange, but redirected to the Medicaid program; (4) any anticipated notifications sent to Medicaid enrollees by the Exchange; and (5) federal guidance.

In addition, by working closely with the Medicaid program, the Exchange and Medicaid program could potentially leverage scale economies such that the Exchange could assume certain additional administrative functions, minimizing redundant resources and providing for additional funding sources for the Exchange. Areas for Illinois to explore in this area include, member notifications, website integration, and call center functions.

In a similar vein, should the Exchange adopt the opposite approach of utilizing existing state eligibility determination systems, it may be able to take advantage of similar economies of scale to reduce its overall administrative cost footprint. This approach could also yield significant savings in the IT development and start-up phases by leveraging existing technology.

2. Exchange as a purchasing agent. Because the Exchange will be organizing the purchase of health insurance for a large and diverse population, the opportunity could exist to perform a similar function on behalf of other state programs such as the state employees plan and Medicaid Managed Care. Providing this service could result in a strong ongoing source of revenue for the Exchange. One of the core missions of the Exchange is to organize the purchase of health insurance for the individual and small-group markets. In performing this function, the Exchange will be developing core expertise in working with health insurance carriers, developing benefit designs, negotiating contracts, and influencing the price of insurance, all critical functions for which the entity could derive revenue from its “clients”, i.e., other state agencies. This alternative source of funding has the additional promise of lowering the overall cost to the state, as the resources required of the state employee’s plan or Medicaid Managed Care to support the purchasing function can be redirected to other functions, thereby lowering the administrative cost for those programs.
3. Broadening the QHP assessment. Another approach to consider is the expansion of the QHP assessment to apply to all members of a QHP, or to go even further, an assessment across all health insurance carriers whether or not they are participating in the Exchange. This may be controversial, the latter more so than the former, but should still be an option for Illinois to consider. The policy justification for a broader assessment is that the Exchange serves a role that benefits the entire market. The Exchange, by making coverage more affordable and accessible, reduces uncompensated care costs and limits the premium impact associated with unreimbursed care.

In broadening the enrollment to be assessed, the Exchange can project with a much higher degree of certainty its funding revenue. This would be especially important during the first few years of operations, when the expense load may be heavy due to start up and the revenue yield is uncertain as the Exchange transitions from federal funding to private market funding. Broadening the assessment base to a larger number of enrollees would allow the state to garner the same revenue from a smaller assessment per enrollee.

This approach would help to dampen the desire of carriers to enroll members directly, thereby avoiding paying the Exchange assessment, and could serve to encourage Exchange participation. Finally, the ACA requires that federal and state taxes and licensing and regulatory fees be excluded from premium revenue for carriers when they calculate their medical loss ratio (MLR). As a result of this provision, carriers may be more willing to go along with a broad-based assessment.

4. Service fee on consumers. Yet another approach is to charge consumers, individuals, and small employers who are purchasing health insurance through the Exchange a modest service fee. Although not as consumer friendly as other options that are available, this has the benefit of being transparent and user-based; it is currently in use in the Utah's state-based Exchange. In some markets such as Massachusetts, small employers are charged an add-on fee in addition to the monthly premium.
5. Other. There are additional mechanisms for the Exchange to generate revenue in addition to an assessment on QHP's. For example, the Exchange could decide to extend its product line beyond health insurance and begin selling complementary products such as dental, life insurance, and long-term care insurance. Alternatively, the Exchange could sell advertising space on its website. Yet another approach could be a dedicated sin-tax such as on tobacco, which would provide for dedicated revenue stream to the Exchange. Some of these ideas could be very controversial, and our inclusion of these concepts is not an endorsement of their viability, but simply to point out that alternative sources of funding could be sought or created.

FIVE-YEAR BUDGET FORECASTS

**Table A – Budget Pro-Forma: Low enrollment estimates; 4.56% Administrative Fee for 2014; 3.39% for 2015.**

Illinois Health Insurance Exchange  
Five-Year Projections  
Administrative Budget

	Start Up			Operations	
	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Members	0	0	0	291,600	415,200
Member Months	0	0	0	1,911,973	4,257,662
Total Exchange Premiums	\$ -	\$ -	\$ -	\$ 706,093,101	\$ 1,691,923,983
<b>Operating revenues:</b>					
QHP Administrative Fee	\$ -	\$ -	\$ -	\$ 32,197,845	\$ 57,356,223
User Fees				\$ -	\$ -
HHS Grant Funding - Exchange Est.	\$ 5,139,789	\$ 33,152,506	\$ 54,007,715	\$ -	\$ -
Total operating revenue	\$ 5,139,789	\$ 33,152,506	\$ 54,007,715	\$ 32,197,845	\$ 57,356,223
<b>Operating expenses:</b>					
Eligibility Determination & Enrollment Website	\$ 2,270,642	\$ 15,894,495	\$ 27,247,706	\$ 5,712,616	\$ 11,476,969
Customer Service	\$ 481,651	\$ 3,371,560	\$ 5,779,817	\$ 7,413,319	\$ 14,893,776
Premium Billing	\$ 206,422	\$ 1,444,954	\$ 2,477,064	\$ 3,205,170	\$ 6,439,368
<b>Subtotal - Systems Dev. &amp; Support</b>	<b>\$ 3,750,000</b>	<b>\$ 26,250,000</b>	<b>\$ 45,000,000</b>	<b>\$ 17,726,553</b>	<b>\$ 35,613,647</b>
IT Infrastructure	\$ 122,700	\$ 70,400	\$ 78,900	\$ 632,312	\$ 1,270,351
Marketing & Advertising	\$ 20,000	\$ 80,000	\$ 100,000	\$ 1,831,526	\$ 3,679,639
Consulting & Professional	\$ 810,931	\$ 3,243,722	\$ 2,967,976	\$ 1,700,703	\$ 3,416,807
Salary & Benefits	\$ 295,988	\$ 2,975,670	\$ 5,097,253	\$ 6,790,550	\$ 7,194,449
General & Administrative	\$ 52,629	\$ 246,166	\$ 327,716	\$ 352,627	\$ 506,637
Facility & Related	\$ 87,542	\$ 286,547	\$ 435,870	\$ 566,901	\$ 1,138,936
Appeals Program	\$ -	\$ -	\$ -	\$ 1,068,390	\$ 2,146,456
Broker Commissions	\$ -	\$ -	\$ -	\$ -	\$ -
Navigators	\$ -	\$ -	\$ -	\$ 1,504,468	\$ 2,398,857
<b>Subtotal - Program Operations</b>	<b>\$ 1,389,789</b>	<b>\$ 6,902,506</b>	<b>\$ 9,007,715</b>	<b>\$ 14,447,476</b>	<b>\$ 21,752,133</b>
<b>Total Operating</b>	<b>\$ 5,139,789</b>	<b>\$ 33,152,506</b>	<b>\$ 54,007,715</b>	<b>\$ 32,174,030</b>	<b>\$ 57,365,780</b>
	6%	36%	59%		
<b>Nonoperating revenue:</b>					
Investment income	\$ -	\$ -	\$ -	\$ -	\$ -
Total nonoperating revenue	\$ -	\$ -	\$ -	\$ -	\$ -
Increase in net assets	\$ -	\$ (0)	\$ 0	\$ 23,816	\$ (9,557)
Total net assets - beginning of fiscal year	\$ -	\$ -	\$ (0)	\$ 0	\$ 23,816
Total net assets - end of fiscal year	\$ -	\$ (0)	\$ 0	\$ 23,816	\$ 14,259

**Table B - Budget Pro-Forma: Moderate enrollment estimates; 3.34% Administrative Fee for 2014; 2.59% for 2015.**

Illinois Health Insurance Exchange  
Five-Year Projections  
Administrative Budget

	Start Up			Operations	
	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Members	0	0	0	486,000	692,000
Member Months	0	0	0	3,186,622	7,096,103
Total Exchange Premiums	\$ -	\$ -	\$ -	\$ 1,178,602,875	\$ 2,819,873,305
<b>Operating revenues:</b>					
QHP Administrative Fee	\$ -	\$ -	\$ -	\$ 39,323,179	\$ 73,041,573
User Fees				\$ -	\$ -
HHS Grant Funding - Exchange Est.	\$ 5,139,789	\$ 33,152,506	\$ 54,007,715	\$ -	\$ -
Total operating revenue	\$ 5,139,789	\$ 33,152,506	\$ 54,007,715	\$ 39,323,179	\$ 73,041,573
<b>Operating expenses:</b>					
Eligibility Determination & Enrollment	\$ 2,270,642	\$ 15,894,495	\$ 27,247,706	\$ 7,215,427	\$ 14,990,817
Website	\$ 791,284	\$ 5,538,991	\$ 9,495,413	\$ 1,762,547	\$ 3,661,879
Customer Service	\$ 481,651	\$ 3,371,560	\$ 5,779,817	\$ 9,363,531	\$ 19,453,732
Premium Billing	\$ 206,422	\$ 1,444,954	\$ 2,477,064	\$ 4,048,350	\$ 8,410,878
<b>Subtotal - Systems Dev. &amp; Support</b>	<b>\$ 3,750,000</b>	<b>\$ 26,250,000</b>	<b>\$ 45,000,000</b>	<b>\$ 22,389,856</b>	<b>\$ 46,517,307</b>
IT Infrastructure	\$ 122,700	\$ 70,400	\$ 78,900	\$ 798,654	\$ 1,659,289
Marketing & Advertising	\$ 20,000	\$ 80,000	\$ 100,000	\$ 2,313,343	\$ 4,806,216
Consulting & Professional	\$ 810,931	\$ 3,243,722	\$ 2,967,976	\$ 2,148,104	\$ 4,462,915
Salary & Benefits	\$ 295,988	\$ 2,975,670	\$ 5,097,253	\$ 7,314,712	\$ 8,322,752
General & Administrative	\$ 52,629	\$ 246,166	\$ 327,716	\$ 392,779	\$ 600,518
Facility & Related	\$ 87,542	\$ 286,547	\$ 435,870	\$ 716,035	\$ 1,487,638
Appeals Program	\$ -	\$ -	\$ -	\$ 1,349,450	\$ 2,803,626
Broker Commissions	\$ -	\$ -	\$ -	\$ -	\$ -
Navigators	\$ -	\$ -	\$ -	\$ 1,900,246	\$ 2,381,311
<b>Subtotal - Program Operations</b>	<b>\$ 1,389,789</b>	<b>\$ 6,902,506</b>	<b>\$ 9,007,715</b>	<b>\$ 16,933,323</b>	<b>\$ 26,524,266</b>
<b>Total Operating</b>	<b>\$ 5,139,789</b>	<b>\$ 33,152,506</b>	<b>\$ 54,007,715</b>	<b>\$ 39,323,179</b>	<b>\$ 73,041,573</b>
	<b>6%</b>	<b>36%</b>	<b>59%</b>		
<b>Nonoperating revenue:</b>					
Investment income	\$ -	\$ -	\$ -	\$ -	\$ -
Total nonoperating revenue	\$ -	\$ -	\$ -	\$ -	\$ -
Increase in net assets	\$ -	\$ (0)	\$ 0	\$ -	\$ -
Total net assets - beginning of fiscal year	\$ -	\$ -	\$ (0)	\$ 0	\$ 0
Total net assets - end of fiscal year	\$ -	\$ (0)	\$ 0	\$ 0	\$ 0

**Table C Budget Pro-Forma: High enrollment estimates; 2.83% Administrative Fee for 2014; 2.24% for 2015.**

Illinois Health Insurance Exchange  
Five-Year Projections  
Administrative Budget

	Start Up			Operations	
	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Members	0	0	0	680,400	968,800
Member Months	0	0	0	4,461,270	9,934,545
Total Exchange Premiums	\$ -	\$ -	\$ -	\$ 1,650,044,026	\$ 3,947,822,627
<b>Operating revenues:</b>					
QHP Administrative Fee	\$ -	\$ -	\$ -	\$ 46,713,795	\$ 88,595,438
User Fees				\$ -	\$ -
HHS Grant Funding - Exchange Est.	\$ 5,139,789	\$ 33,152,506	\$ 54,007,715	\$ -	\$ -
Total operating revenue	\$ 5,139,789	\$ 33,152,506	\$ 54,007,715	\$ 46,713,795	\$ 88,595,438
<b>Operating expenses:</b>					
Eligibility Determination & Enrollment Website	\$ 2,270,642	\$ 15,894,495	\$ 27,247,706	\$ 8,718,238	\$ 18,504,666
Customer Service	\$ 791,284	\$ 5,538,991	\$ 9,495,413	\$ 2,129,646	\$ 4,520,224
Premium Billing	\$ 481,651	\$ 3,371,560	\$ 5,779,817	\$ 11,313,744	\$ 24,013,688
<b>Subtotal - Systems Dev. &amp; Support</b>	\$ 206,422	\$ 1,444,954	\$ 2,477,064	\$ 4,891,530	\$ 10,382,389
IT Infrastructure	\$ 3,750,000	\$ 26,250,000	\$ 45,000,000	\$ 27,053,158	\$ 57,420,966
Marketing & Advertising	\$ 122,700	\$ 70,400	\$ 78,900	\$ 964,996	\$ 2,048,226
Consulting & Professional	\$ 20,000	\$ 80,000	\$ 100,000	\$ 2,795,160	\$ 5,932,794
Salary & Benefits	\$ 810,931	\$ 3,243,722	\$ 2,967,976	\$ 2,595,506	\$ 5,509,023
General & Administrative	\$ 295,988	\$ 2,975,670	\$ 5,097,253	\$ 8,080,342	\$ 9,062,822
Facility & Related	\$ 52,629	\$ 246,166	\$ 327,716	\$ 432,930	\$ 694,399
Appeals Program	\$ 87,542	\$ 286,547	\$ 435,870	\$ 865,169	\$ 1,836,341
Broker Commissions	\$ -	\$ -	\$ -	\$ 1,630,510	\$ 3,460,796
Navigators	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Subtotal - Program Operations</b>	\$ -	\$ -	\$ -	\$ 2,296,024	\$ 2,630,071
<b>Total Operating</b>	\$ 1,389,789	\$ 6,902,506	\$ 9,007,715	\$ 19,660,637	\$ 31,174,472
	6%	36%	59%		
<b>Nonoperating revenue:</b>					
Investment income	\$ -	\$ -	\$ -	\$ -	\$ -
Total nonoperating revenue	\$ -	\$ -	\$ -	\$ -	\$ -
Increase in net assets	\$ -	\$ (0)	\$ 0	\$ -	\$ -
Total net assets - beginning of fiscal year	\$ -	\$ -	\$ (0)	\$ 0	\$ 0
Total net assets - end of fiscal year	\$ -	\$ (0)	\$ 0	\$ 0	\$ 0

**Table D. PMPM Cost Table Low enrollment estimates; 4.56% Administrative Fee for 2014; 3.39% for 2015**

	PMPM Spending	
	FY 2014	FY 2015
Members		
Member Months		
Total Exchange Premiums	\$ 369.30	\$ 397.38
<u>Operating revenues:</u>		
QHP Administrative Fee	\$ 16.84	\$ 13.47
User Fees	\$ -	\$ -
HHS Grant Funding - Exchange Est.	\$ -	\$ -
Total operating revenue	\$ 16.84	\$ 13.47
<u>Operating expenses:</u>		
Eligibility Determination & Enrollment	\$ 2.99	\$ 2.70
Website	\$ 0.73	\$ 0.66
Customer Service	\$ 3.88	\$ 3.50
Premium Billing	\$ 1.68	\$ 1.51
<b>Subtotal - Systems Dev. &amp; Support</b>	<b>\$ 9.27</b>	<b>\$ 8.36</b>
IT Infrastructure	\$ 0.33	\$ 0.30
Marketing & Advertising	\$ 0.96	\$ 0.86
Consulting & Professional	\$ 0.89	\$ 0.80
Salary & Benefits	\$ 3.55	\$ 1.69
General & Administrative	\$ 0.18	\$ 0.12
Facility & Related	\$ 0.30	\$ 0.27
Appeals Program	\$ 0.56	\$ 0.50
Broker Commissions	\$ -	\$ -
Navigators	\$ 0.79	\$ 0.56
<b>Subtotal - Program Operations</b>	<b>\$ 7.56</b>	<b>\$ 5.11</b>
<b>Total Operating</b>	<b>\$ 16.83</b>	<b>\$ 13.47</b>

**Table E. PMPM Cost Table Moderate enrollment estimates; 3.34% Administrative Fee for 2014; 2.59% for 2015**

	PMPM Spending	
	FY 2014	FY 2015
Members		
Member Months		
Total Exchange Premiums	\$ 369.86	\$ 397.38
<u>Operating revenues:</u>		
QHP Administrative Fee	\$ 12.34	\$ 10.29
User Fees	\$ -	\$ -
HHS Grant Funding - Exchange Est.	\$ -	\$ -
Total operating revenue	\$ 12.34	\$ 10.29
<u>Operating expenses:</u>		
Eligibility Determination & Enrollment	\$ 2.26	\$ 2.11
Website	\$ 0.55	\$ 0.52
Customer Service	\$ 2.94	\$ 2.74
Premium Billing	\$ 1.27	\$ 1.19
<b>Subtotal - Systems Dev. &amp; Support</b>	<b>\$ 7.03</b>	<b>\$ 6.56</b>
IT Infrastructure	\$ 0.25	\$ 0.23
Marketing & Advertising	\$ 0.73	\$ 0.68
Consulting & Professional	\$ 0.67	\$ 0.63
Salary & Benefits	\$ 2.30	\$ 1.17
General & Administrative	\$ 0.12	\$ 0.08
Facility & Related	\$ 0.22	\$ 0.21
Appeals Program	\$ 0.42	\$ 0.40
Broker Commissions	\$ -	\$ -
Navigators	\$ 0.60	\$ 0.34
<b>Subtotal - Program Operations</b>	<b>\$ 5.31</b>	<b>\$ 3.74</b>
<b>Total Operating</b>	<b>\$ 12.34</b>	<b>\$ 10.29</b>
<u>Nonoperating revenue:</u>		
Investment income	\$ -	\$ -
Total nonoperating revenue	\$ -	\$ -
Increase in net assets	\$ -	\$ -
Total net assets - beginning of fiscal year	\$ 0.00	\$ 0.00
Total net assets - end of fiscal year	\$ 0.00	\$ 0.00

**Table F. PMPM Cost Table High enrollment estimates; 2.83% Administrative Fee for 2014; 2.24% for 2015**

	PMPM Spending	
	FY 2014	FY 2015
Members		
Member Months		
Total Exchange Premiums	\$ 369.86	\$ 397.38
<u>Operating revenues:</u>		
QHP Administrative Fee	\$ 10.47	\$ 8.92
User Fees	\$ -	\$ -
HHS Grant Funding - Exchange Est.	\$ -	\$ -
Total operating revenue	\$ 10.47	\$ 8.92
<u>Operating expenses:</u>		
Eligibility Determination & Enrollment	\$ 1.95	\$ 1.86
Website	\$ 0.48	\$ 0.46
Customer Service	\$ 2.54	\$ 2.42
Premium Billing	\$ 1.10	\$ 1.05
<b>Subtotal - Systems Dev. &amp; Support</b>	<b>\$ 6.06</b>	<b>\$ 5.78</b>
IT Infrastructure	\$ 0.22	\$ 0.21
Marketing & Advertising	\$ 0.63	\$ 0.60
Consulting & Professional	\$ 0.58	\$ 0.55
Salary & Benefits	\$ 1.81	\$ 0.91
General & Administrative	\$ 0.10	\$ 0.07
Facility & Related	\$ 0.19	\$ 0.18
Appeals Program	\$ 0.37	\$ 0.35
Broker Commissions	\$ -	\$ -
Navigators	\$ 0.51	\$ 0.26
<b>Subtotal - Program Operations</b>	<b>\$ 4.41</b>	<b>\$ 3.14</b>
<b>Total Operating</b>	<b>\$ 10.47</b>	<b>\$ 8.92</b>
<u>Nonoperating revenue:</u>		
Investment income	\$ -	\$ -
Total nonoperating revenue	\$ -	\$ -
Increase in net assets	\$ -	\$ -
Total net assets - beginning of fiscal year	\$ 0.00	\$ 0.00
Total net assets - end of fiscal year	\$ 0.00	\$ 0.00

## GENERAL OBSERVATIONS – FINANCE

In addition to the development of the five-year administrative budget projections, we have added below additional context for Illinois’s consideration in moving forward with their forecasts and estimations. This information is supplementary to the budget analysis above and is intended to help frame certain issues experienced by the authors in standing up an Exchange model. It may be helpful to the staff of the Illinois Exchange implementation team as they begin developing the Exchange business plan, infrastructure, and grant application budgets:

1. Negotiate vendor contracts and provisions within contract terms for scalability of costs.

Because of the number of systems that will most likely need to be developed for the Illinois Health Insurance Exchange, a major function will be procuring the services of a number of vendors. In doing so, it is important for the Exchange to dedicate resources to negotiate key legal and financial terms and to allow for ongoing vendor management and oversight once a contract has been signed. This area will be a major spending source for the Exchange and can be an area of inefficiency, misunderstandings, and excessive budget overruns. Areas where the Exchange may want to focus include negotiating financial terms that are scalable, such as on a per member or subscriber basis with floors and ceilings to protect the vendor from losses and therefore poor performance, as well as protecting the Exchange from overpayments driven by higher than expected enrollment.

2. Weigh carefully the pros and cons of augmenting Exchange staff with professional support.

Although the use of short-term professional support staff can be costly, it will be important for the Exchange to consider the ability to support fulltime staff with knowledgeable external help, especially during the start-up phase of the Exchange. To meet the challenging timelines and find and hire personnel with the multitude of skills required of Exchange staff, the Exchange should develop a cost/benefit analysis when considering the hiring of short-term professional staff. Also, as a new entity responsible for implementing a complex law, there may be short-term resource need which can be more cost-effectively resourced by contracting for a subject matter expert short-term, rather than hiring the expertise—only to discover that yet a different set of skills is needed once the original issue has been researched and addressed.

3. Budget discipline will be a critical core competency, especially during the beginning of operations.

The requirement of the Exchange to be a self-sustaining organization requires a high degree of fiscal responsibility and management. This is especially true if the source of revenue for the Exchange is tied to the level of enrollment in the Exchange. Key attributes of a budget model will be timely updates of both spending and enrollment projections, knitted closely with vendor negotiations and related financial terms. Developing a budget system that not only tracks actual expenses but is adept at forecasting both expenses and enrollment will allow the Exchange to

make informed decisions regarding the level of assessment, the scale and scope of vendor contracts, and the maintenance of effective cash flow to meet the ongoing business obligations.

4. Strong management reporting and financial systems.

Closely tied to the budget discipline function noted at #3 above, the development of the Exchange infrastructure needs to include a very strong system of management and financial reporting. Often overlooked when developing a start-up organization, the ability for the Exchange to have a strong accounting system, human resource function, accounts receivable and payable, consistent contract terms and obligations, cash flow management, and a host of other functions and data needs will be critical for the Exchange to be a strong fiduciary of the state and to convey a sense of competency for market participants looking to work with the Exchange.

5. Need to carefully manage expected spending in 2014/2015 as federal funding sunsets and the Exchange is expected to be self-sustaining.

This will be a particularly important timeframe from a financial perspective. Presumably, a significant amount of expenses will be committed to vendors by the Exchange as it rolls into operations in 2014. By year-end 2014, federal funding will cease, and it is expected that the Exchange will be generating enough revenue in 2015 to cover its operating expenses. Key areas on which the Exchange should focus include:

- a. Will US HHS allow the Exchange to develop some level of surplus during start up and the first year of operations?
- b. What is the range of enrollment estimates, and can the Exchange meet its expense obligations at the low end of the enrollment range?
- c. If enrollment is ramping up more slowly than expected, can vendor payment terms be adjusted?
- d. Can the Exchange establish a line of credit for meeting short-term cash flow issues?

Finally, it is worth reiterating that the projections in this report rest on a host of assumptions about market size, penetration rates, premium levels, consumer preferences, cost of technology, and so forth that are imperfect at this early stage but which can be refined over time, with research and experience. These assumptions will materially affect the results, and such research should be undertaken to make the model more accurate. Eventually, as the Exchange garners real experience, the model can be refined and used as a management tool. Nevertheless, we do believe that the range of administrative expenses and revenues shown here—on the order of % of premiums—is in the right ballpark.

It is important to emphasize that this model does not include funding from Exchange operating funds for the payment of producer commissions. As discussed in section 4.2.3, this is an important policy

consideration for the Illinois Exchange, and one which could significantly alter the overall financial picture of the Exchange. Producer commissions average 6% of premiums the small-group market at 8.6% in the small-group market.

This budget document also makes other assumptions about some key policy determinations, such as the level of Navigator subsidies, the surcharging of total premiums associated with Exchange enrollment (and of no other premiums or revenue sources), and the size of the “footprint” of the Exchange regarding full-time personnel. We have made these assumptions simply in order to proceed in the absence of more defined policy direction, and have attempted to “fill in the blanks” with plausible assumptions. We have no reason to believe that the Exchange will (or should) eventually make its own determinations in line with the same policy assumptions as we put into this model. Indeed, one of the future uses of this model may be to highlight and then draw out the financial implications of making some very different policy determinations than this model assumes.

#### START-UP STAFFING CHART

FTEs by Calendar Year				
	Annual Salary	CY 2011	CY 2012	CY 2013
<b>Leadership</b>				
<b>Sr. Executives :</b>		<b>3.0</b>	<b>5.0</b>	<b>8.0</b>
Executive Director	\$ 253,000	1	1	1
General Counsel	\$ 176,000			1
Chief Financial Officer	\$ 165,000	1	1	1
Chief Technologist	\$ 165,000		1	1
Chief Operating Officer	\$ 165,000		1	1
Chief Marketing Officer	\$ 165,000			1
Chief Medical Officer	\$ 220,000			1
Senior VP for Risk Adjustment	\$ 165,000	1	1	1
<b>Staff by Functional Area</b>				
<b>Administration</b>				
Manager	\$ 50,000	1	1	2
Assistant	\$ 33,000	1	2	3
<b>Appeals</b>				
Director	\$ 70,000			1
Manager	\$ 60,000			1
Specialist	\$ 50,000			
<b>Finance</b>				
Director	\$ 85,000	1	1	1
Manager	\$ 75,000	1	2	3
Analyst/Accountant	\$ 60,000		2	4
<b>HR</b>				
Director	\$ 65,000		1	1
Manager	\$ 55,000		1	1
Specialist	\$ 45,000			
<b>IT</b>				
Director	\$ 85,000	1	1	1
Manager	\$ 75,000		2	2
Specialist/Analyst	\$ 68,000	2	2	2
<b>Legal</b>				
Asst Gen Counsel	\$ 120,000			2
Attorney	\$ 100,000		1	2
Paralegal	\$ 60,000			
<b>Operations</b>				
		1	5	10

FTEs by Calendar Year				
	Annual Salary	CY 2011	CY 2012	CY 2013
Director	\$ 85,000	1	1	1
Manager	\$ 75,000		2	3
Specialist/Analyst	\$ 60,000		2	6
<b>Communications/Outreach</b>		<b>1</b>	<b>2</b>	<b>3</b>
Director	\$ 85,000	1	1	2
Manager	\$ 75,000			
Specialist	\$ 55,000		1	1
<b>Policy</b>		<b>1</b>	<b>1</b>	<b>3</b>
Director	\$ 85,000	1	1	1
Manager	\$ 75,000			1
Analyst	\$ 60,000			1
<b>Sales</b>		<b>0</b>	<b>1</b>	<b>2</b>
Director	\$ 85,000			
Manager	\$ 75,000		1	2
Specialist	\$ 55,000			
<b>Grant Administrator</b>		<b>1</b>	<b>1</b>	<b>1</b>
Director	\$ 70,000	1	1	1
Manager	\$ 60,500			
Specialist	\$ 45,000			
		<b>14.0</b>	<b>30.0</b>	<b>48.0</b>

OPERATIONAL STAFFING LOAD PROJECTIONS: FTES BY FUNCTIONAL AREA FOR HIGH, LOW, AND MODERATE ENROLLMENT SCENARIOS, 2014 AND 2015

	2014			2015		
	Low	Moderate	High	Low	Moderate	High
<b>Administrative</b>	2	2	3	2	3	3
<b>Appeals</b>	5	6	6	5	6	7
<b>Sr. Executives</b>	9	9	9	9	9	9
<b>Finance</b>	11	12	14	12	14	16
<b>Human Resources</b>	1	1	2	1	2	2
<b>IT</b>	5	6	6	5	6	7
<b>Legal</b>	4	4	5	4	5	5
<b>Operations</b>	15	16	17	16	17	19
<b>Outreach</b>	5	6	6	5	6	7
<b>Policy</b>	3	3	4	3	4	4
<b>Sales</b>	3	4	5	3	5	6
<b>Grant Administrator</b>	1	1	2	1	2	2
<b>Total</b>	<b>64</b>	<b>70</b>	<b>79</b>	<b>66</b>	<b>79</b>	<b>87</b>

## 4.4 Other Structural Considerations for Exchanges

### 4.4.1 Minimizing Adverse Selection under the Affordable Care Act

*This section discusses adverse selection, identifies the most important provisions of the ACA that address the risk of adverse selection, and recommends approaches the state can take in Exchange planning in general to address adverse selection issues.*

The Affordable Care Act (ACA) provides for the development of an insurance marketplace (Exchange) for the purchase of health insurance for individuals and small groups. It allows for states to expand the definition of small group to 100 employees. While the ACA has a very long list of provisions affecting various aspects of the insurance market, this portion of the report is focused on methods for minimizing adverse selection in the individual and small-group marketplace. Pending regulation may materially affect the issues and recommendations presented herein.

#### INTRODUCTION AND OVERVIEW

Adverse selection occurs when an insurance market or an individual insurer enrolls a disproportionate share of higher-risk, less healthy people who, because of their greater need for medical services, are more costly to insure than the average person in the population as a whole. Because the entity enrolling these more costly people is forced to raise premiums to cover the higher costs, lower-risk enrollees to flee to other forms of coverage where premiums are lower. Once begun, the process can result in a downward spiral of rising premiums and lost enrollment.

Avoiding and mitigating adverse selection is essential to the success of an Exchange, in order to keep coverage affordable for residents of Illinois, particularly those without access to subsidies.

The ACA provides for states to create an Exchange, but allows for the continuation of a market outside of the new Exchange. Multiple insurance companies would be expected to participate in the Exchange and outside the Exchange. There are three general types of adverse selection that can occur.

1. Adverse Selection against the market in total (“Market Adverse Selection”) occurs when a market enrolls relatively few healthier people and provides coverage for a disproportionate share of higher-risk people. The problem is exacerbated if market rules allow people to buy coverage with no penalty once they determine they need medical services. This type of adverse selection increases the average cost of insurance across the market.
2. Adverse Selection against the Exchange (“Exchange Adverse Selection”) occurs when the Exchange enrolls a higher proportion of higher-risk people than insurers operating outside the Exchange. This type of adverse selection increases the average cost of insurance inside the Exchange and decreases it outside of the Exchange.

3. Adverse Selection against a given insurer (“Insurer Adverse Selection”) occurs when some insurers attract a disproportionate share of higher-risk people. This type of adverse selection increases the average cost of insurance for some insurers and decreases it for others.

This section discusses the most important aspects of provisions of the ACA and of Exchange planning in general to address adverse selection issues.

It is important to understand the ACA recognizes the potential problems created by adverse selection and includes a number of crucial provisions to try to solve those problems, including requiring that everyone purchase coverage (the individual mandate) and requiring that Exchanges establish several types of risk-adjustment mechanisms. But we begin our discussion by looking at the rating and underwriting rules in Illinois, then move to a discussion of some of the ACA provisions that could cause adverse selection problems in the absence of provisions to mitigate them. We continue with an explanation of the ACA provisions to protect against adverse selection and then conclude with recommendations for Illinois.

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## CURRENT RATING AND UNDERWRITING RULES IN ILLINOIS

The current rating and underwriting rules in Illinois provide an important context for adverse selection issues under the ACA since underwriting and rating practices are employed to mitigate adverse selection. Current regulations in these areas are intended to provide particular consumer protections while allowing for health insurers to protect themselves against adverse selection. Regulations vary considerably by state. Illinois is generally more permissive than other states in terms of the practices insurers are allowed to employ to mitigate adverse selection.

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## INDIVIDUAL MARKET

Illinois currently allows individual health insurers to deny coverage to individuals with pre-existing conditions or other characteristics that the insurer deems to put them at high risk. Insurers can use a variety of methods to deny coverage including denying coverage for pre-existing conditions, attaching coverage riders, or using exclusion periods of up to 24 months. If a claim is made in the first 24 months, the insurer can review the individual’s history up to 24 months prior to application to check for pre-existing conditions and refuse the claim if the condition was pre-existing.

If an individual is eligible for HIPAA and is denied coverage from an insurer, he or she is able to join the Illinois Comprehensive Health insurance Plan (ICHIP, the state’s high risk pool).

There are no limits on the extent to which insurers can vary premiums based on the individual’s health status or other characteristics, but coverage cannot be cancelled because of an individual’s health condition. Rates can vary based upon age, health status, plan type, and family size. Renewal rates can reflect similar factors.

Illinois does not require standardized policies that must cover the same benefits but does require the inclusion of a number of state law-required policy provisions and coverage of certain benefits by all insurers under all plans, such as diabetes care and mammogram screenings.

## SMALL-GROUP MARKET

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Illinois currently defines small groups as employers with 2-50 employees. Insurers cannot deny coverage or cancel coverage for small groups because of health conditions of employees and dependents.

Premiums can vary based on enrollees' health status, gender, age, and risk. In the individual market, carriers are not constrained to the degree of variation incorporated in rating for health status, whereas in the small group market, carriers can vary rates based solely on health status up to 25%. Allowing a limit on health status variation generally has the effect of making premiums lower for the less healthy groups and making premiums higher for the healthier groups.

To be eligible for coverage, employers must meet minimum employee participation requirements set by the insurers; if they do not, the plan can be terminated. Insurers can also require that employers contribute a minimum specified percentage of the premium.

A policy/product that is sold to one group must be available to all other small groups. The benefits must be the same, but the premiums can vary by group.

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## ACA PROVISIONS THAT INCREASE POTENTIAL FOR ADVERSE SELECTION

The ACA includes a number of provisions generally designed to protect consumers that, in the absence of offsetting provisions that are part of ACA, could increase the potential for adverse selection in the individual and small-group markets:

1. Rating or underwriting based on health status based is not allowed. The only factors than can be used to vary rates are age and smoking status.
2. Age rating is allowed but is limited to a ratio of three to one for adults. Therefore, the highest rate (for the oldest person) cannot be more than three times the lowest rate (for the youngest person). Actual medical cost variations are much greater – with highest-cost age/gender rate cells being six to eight times more costly than the lowest-cost age/gender cells. Therefore, limiting the rating variation to a ratio of three to one means that the youngest members will be partially subsidizing the oldest members. Any time one group of individuals subsidizes another, there is risk of adverse selection, meaning that the market prices can move upward overall if the individuals subsidizing others choose to leave the market.
3. Subsidies available for specific populations. ACA provides subsidies to lower-income and moderate-income individuals (up to 400% of the federal poverty level) to be used to purchase health coverage. As the subsidies can be used to purchase coverage only within the Exchange, there will be a higher proportion of these individuals in the Exchange. If those who are eligible for subsidies are also higher-than-average risk, Exchange Adverse Selection may occur. (Whether this will be the case generally or in Illinois is not yet clear, as income correlates with both health and age, but age correlates negatively with health status and age-rating is constricted. That is, lower-income people tend to be sicker for their age, but younger people are more likely to be low-income than their older counterparts.) As discussed elsewhere in this

section, income should be considered as a risk-adjustment variable (if permitted by federal regulation).

4. Availability of plans outside Exchange. Plans outside the Exchange may be grandfathered such that they are allowed to remain in place as long as they meet requirements for maintaining their pre-reform benefit levels, co-pays, contribution levels, and covered services. Grandfathered plans are not subject to adjusted community rating rules. These plans would not be available within the Exchange. Depending on how prevalent grandfathered plans continue to be in Illinois, those that continue to exist may drive a different balance of risk between the population covered through the Exchange and those covered outside the Exchange.
5. A smoking adjustment of up to 50% of premium is allowed. Insurance regulators should monitor the application of this adjustment closely to ensure that it is not abused to “cherry-pick” favorable risks. In addition, if the smoking adjustment is excluded from the calculation of federal subsidies, permitting carriers to increase the rates for smokers, this significantly may lead to a substantial number of low-income state residents facing premiums that are unaffordable to them. In doing so, these individuals will be exempt from the requirement to purchase health coverage, and reduce the expansion in coverage experienced by the state.

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#### ACA PROVISIONS INTENDED TO AVOID OR MITIGATE ADVERSE SELECTION

The ACA includes key provisions intended to avoid or mitigate adverse selection:

1. Individual mandate. The ACA applies penalties if individuals who can afford to purchase coverage do not. The mandate is intended to avoid all three types of adverse selection. Because under ACA people cannot be denied coverage or charged more for poor health status, without a mandate many low-risk people would choose not to buy coverage initially, waiting until they anticipating needing expensive medical services to enroll in a plan. The result would be adverse selection: they would incur costs far in excess of the amount they contribute to the risk pool in premium payments. To the extent that the mandate prevents such behavior, it protects the market from this form of adverse selection. The penalties for failing to buy coverage are relatively small in relation to potential premiums. However, even a relatively modest penalty like that in Massachusetts has been shown to have a material effect on coverage. In fact, tax-based penalties in Massachusetts are lower than those that will be enforced under the ACA. The constitutionality of this particular provision of the ACA is being litigated in a number of courts and is likely to be decided ultimately by the Supreme Court.
2. Risk Corridor – The risk corridor program established by the ACA is meant to spread risk more evenly among health plans by projecting target health claims for each plan, and then providing payments to those that exceed the targeted health claim levels by more than 103%. In this way, plans that have significantly worse than expected experience will have their losses lessened, and plans that have experience that is significantly better than expected will have their profits lessened. Risk corridors protect somewhat against “Insurer Adverse Selection,” “Exchange

Adverse Selection,” and “Market Adverse Selection.” This protection extends only through 2016. Risk corridors apply to qualified health plans in the individual and small-group markets.

3. Reinsurance – Reinsurance provides protection against high-cost claims and applies to the Individual market only. Recently released proposed rules by HHS define the reinsurance program to be a more traditional approach that considers the actual costs for specific members (i.e., “Stop Loss reinsurance”). Reinsurance protects somewhat against “Insurer Adverse Selection,” “Exchange Adverse Selection” and “Market Adverse Selection.” However, it can be argued that reinsurance does not really protect against “Market Adverse Selection” since it is funded through assessments on the market in general. This protection extends only through 2016.
4. Risk Adjustment – The risk adjustment program is intended to provide a mechanism for assessing a charge on plans that incur lower-than-average risk and providing payments to those with higher-than-average risk. In this manner, plans that enroll high-risk members are likely to receive payments from plans that enroll low-risk members. Risk adjustment uses demographic characteristics and past claims history to determine the relative risk for each individual. Risk adjustment is budget neutral for the market in total. Therefore, it does not protect the market in general from adverse selection. Risk Adjustment protects against “Insurer Adverse Selection” and “Exchange Adverse Selection.”

Other provisions of the ACA that are intended to avoid or mitigate adverse selection, including the following:

1. Essential benefits. The ACA requires all non-grandfathered policies in the small-group and non-group markets to cover essential benefits (to be defined in detail by HHS), which represent a relatively comprehensive list of medical services. By requiring all policies to cover most medical services, health insurers cannot offer very lean benefit plans that exclude certain services (e.g., cancer treatment) to attract healthy individuals or exclude high-cost services such as maternity coverage.
2. Common benefit designs. Under the ACA, standardized benefit plans will be designated as Bronze, Silver, Gold, or Platinum. The covered medical services will be the same in all metal tiers, but the level of cost sharing will vary by specified percentages in terms of the proportion of claims costs that are covered. Insurers participating in the Exchange must offer both a Silver and Gold plan. Similar to the essential benefits, the requirement that plans offer a similar set of plans (though they can choose to also offer the Bronze and Platinum level plans) means that one insurer will not inherently attract a different population than another insurer offering a different plan. While this provision reduces Insurer Adverse Selection within the Exchange, if similar requirements are not set up outside the Exchange, there may still be Exchange Adverse Selection occurring.

## ADVERSE SELECTION RECOMMENDATIONS

This section lists specific risks and Wakely's recommendations for addressing these risks.

### 1. Overall Risk Mitigation

**Develop robust risk adjustment, reinsurance, and risk corridor methodologies with input from the health plans.**

**Allow insurers to offer individual and small-group coverage only through the Exchange<sup>5</sup>, or apply all of the same market rules to the Exchange and non-Exchange markets.** This includes many of the provisions that are outlined by ACA as well as additional requirements that can be set up by the state including network adequacy minimums, contracting with safety net providers, and prohibitions on marketing and benefit design practices intended to avoid high-cost individuals (similar to Medicare Advantage). Having the same rules inside and outside the Exchange eliminates the potential for adverse selection between the Exchange and the external market. The regulations can be set up so that the consumers are still offered a wide array of coverage alternatives and protections.

### 2. Avoid Individuals Only Seeking Coverage when they are Sick

If the individual mandate is successful, people will not be buying coverage only when they get sick. But if the mandate were to be overturned in the courts, then other protections would be necessary. Given the opportunity, individuals that are aware of upcoming health issues may choose to obtain or increase coverage specific to that condition only for the period of need. In order to mitigate this risk, the state could (*if permitted by federal law* because the mandate provision is overturned) limit opportunities for enrolling to an open enrollment period that is relatively short (one or two months). Exceptions should be allowed for life events such as birth, death, marriage, change in job, change in subsidy eligibility, and others affecting insurance coverage. The state may want to limit these exceptions to circumstances in which the individual or family had prior coverage. Another policy option that is similar and could be incorporated as an alternative would be a late enrollment penalty, such as that currently employed by the Medicare program.

**Require small employers to contribute a minimum share or amount of employees' premium for coverage purchased in the Exchange comparable to prevailing underwriting requirements of the carriers in the outside market.** The more that an employer contributes toward an employee's health premium, the more likely that employee will opt for insurance. This will result in more people choosing coverage as well as broaden the risk pool so that it includes both healthy and sicker individuals. The higher the burden of premiums on members, the more likely

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<sup>5</sup> If the Exchange is the only marketplace, undocumented immigrants would not have a marketplace to purchase insurance.

the healthiest will opt to forego coverage. (Again, this approach may not be necessary if the mandate requirement is effective.)

### 3. Avoid Adverse Selection for Groups of 51-100 Affecting Small-Group Risk Pool

While this paper separately discusses this issue and indicates that increasing the small-group market to 51-100 in 2014 may not significantly increase small-group premiums, any major change in the market can produce adverse selection issues. The possible danger is the higher-risk groups in this size category would choose Exchange coverage to save on premiums, while the lower-risk groups choose other forms of coverage. Groups larger than 50 employees have more options for coverage. Because they have more people in the risk pool than smaller employers, their average risk is likely to be more representative of the entire population; their risk will be less affected by the presence of one or two very high-risk individuals. They are also not subject to the same underwriting approaches that are used with groups under 50. As a result, they can often purchase relatively inexpensive coverage outside the Exchange. Additionally, groups that believe themselves to be a lower-than-average-risk group may choose to self-insure rather than purchase insurance through the Exchange or the external market. Defining stop loss insurance in state regulations will help to avoid selection issues (see later discussion). For example, if groups are able to obtain a significant amount of stop loss insurance, it will lessen their retained risk and provides further incentive for a group to self-insure and therefore not enter the insured market. Prohibiting insurers from selling stop-loss coverage to groups of 51 to 100 employees would eliminate this problem.

This issue extends into the “large group” (employers with 100 or more employees). Many of the same issues that are considered with the 51-100 groups are also present in the large groups, although the size of the impact can be much greater because of the size of the over-100 market.

### 4. Selection Against the Exchange

**Require all QHPs licensed to sell products in the individual and small-group market to offer Bronze, Silver, Gold and Platinum policies both inside and outside the Exchange.** This will ensure that insurers are offering similar option packages to all members and that no insurer can opt to offer only the benefit plans that would attract better risks. The state may take this protection further and standardize benefit packages beyond what ACA requires (essentially by standardizing the cost-sharing provisions). If the state did further standardize benefits it could limit the myriad possibilities within the constraints of ACA actuarial value categories and essential benefits and make it more difficult for carriers to target healthier risks. In addition, these standardized packages could be required to be offered inside and outside the Exchange by any licensed plans participating in each or both of these markets. A state may decide to allow plans to offer only the four specific plans – both inside and outside the Exchange – without an option to offer additional plans. This would mitigate adverse selection the most. Alternatively, a state may require plans to offer the four specific plans and leave open the possibility for plans to offer additional designs (all with at least 60% actuarial value). Adverse selection would

greatly be mitigated with this approach as well, but not as much as if fewer plans – all uniform in design – were offered. The state will need to weigh concepts of minimizing adverse selection with allowing more consumer choice.

**Regulations should be the same inside and outside the Exchange.** Illinois currently has fairly liberal rating and underwriting regulations that allow insurers significant leeway in determining rates and in underwriting groups. The more restrictive rules of the ACA apply equally to the Exchange and to the remaining market (if any) outside the Exchange. Any additional protections or health plan requirements that apply to the Exchange should also be applied to the market outside the Exchange, and can be done at state discretion.

**Require meaningful retention of risk by employers in order for those employers to be self-funded.** Prohibit insurers from selling stop-loss coverage to firms below a certain size. (ERISA prohibits states from regulating employer benefits, and thus Illinois cannot require employers to be fully insured. But states can regulate insurers and the coverage they can or cannot sell.)

**In the SHOP Exchange, allow employees to have choices of carriers.** However, do not employ a defined contribution approach with complete choice for employees. Require the employer to define the product level (bronze, silver, gold, or platinum) and then require employees to select a plan at that level. The reason defining a product level mitigates adverse selection is that if given a prescribed contribution, healthier employees will tend to choose the lowest-level plans, and employees with more health care needs will tend to select higher level plans. As a result, the cost of higher level plans in the SHOP will, over time, become increasingly more expensive and eventually become potentially unaffordable or not in the best interest of the carriers to offer.

**Employ income as risk adjustment variable.** Studies have shown that a person’s income can be a predictive indicator of health care claim costs. For risk adjustment to work optimally by maximizing the predictive nature of a population, a state should consider a person’s income as a risk adjustment indicator when determining if a plan has greater or less risk than an average plan.

**Require QHPs to “fairly and affirmatively” market plans offered on the Exchange.** As discussed previously, it is important that there is consistency between plans offered in and out of the Exchange. In addition, all plans must be actively marketed or else the Exchange will face the same adverse selection as if the plans weren’t offered at all.

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#### 4.4.2 Expanding Small Group Definition of 50 to 100

*This section analyzes the impact of expanding the small group-market in Illinois to include groups of up to 100 employees. The current definition in Illinois includes employers with up to 50 employees.*

Effective 2016, the ACA requires the small-group definition to be inclusive of all groups with up to 100 employees. However it allows the restriction of the small-group definition to 50 employees through 2015.

The majority of the documentation published to date regarding this decision recommends that States continue to restrict the definition to 50 lives until 2016. The rationale for this is risk mitigation. Businesses with 51 to 100 workers are more likely to have alternative coverage arrangements marketed to them, including “self-insured” plan arrangements, generally including some sort of stop-loss reinsurance provisions. Allowing the businesses with 51-100 into the SHOP immediately could raise premiums because of adverse selection. Businesses with healthy workforces would choose to self-insure, while businesses with less healthy workforces would choose to take advantage of the non-health-rated coverage available through the SHOP.

In addition to the adverse selection concern outlined above, some of the other considerations that will impact this decision include:

- All employer groups over size 50 will have a penalty if not offering group insurance starting in 2014.
- The loss ratios, benefit designs, and administrative charges of the large-group market compared to the small-group market. The more different these aspects are between the two markets, the greater the potential impact of expanding the definition of small groups to 100 lives.
- Relative size of the 51-100 market compared to the current small-group market under 50, as measured by the number of people covered in both markets.

All groups between 50 and 100 will have an incentive to obtain coverage starting in 2014. This will cause groups that currently do not have coverage to seek coverage. Because they will be just entering the insurance market and likely do not have a current relationship with a producer, we believe it is that they will enter the Exchange rather than using a self-insured or alternative arrangement. This fresh pool of members could have a different risk profile than the average membership for the SHOP.

The loss ratios for the large-group market are greater, causing lower premiums for larger groups compared to the small-group market. This difference in administrative cost must be considered when combining the markets.

Lastly, the size of the 51-100 group market relative to the current small-group market in Illinois is surprisingly small. Without econometric models, it is difficult to tell, but our best information based on combining state information about group sizes from the Health Research Educational Trust/Kaiser Family Foundation study as well as the average small-group sizes from the small group employer data indicate that the 51-100 group market is likely only between 25% and 50% of the under-50 small-group market (so at most it will comprise one-third of the market). Thus, any adverse selection effect that might occur as a result of including small groups with 50 to 100 employees will be limited.

Similar to the analysis done in merging the small-group and individual markets, we have examined potential outcomes of merging the group sizes fewer than 50 and between 51 and 100 employees. Where data was not available specifically for the market between 51 and 100, we assumed that the employers in this market behave similarly to the general large-group market employers.

Based on the analysis described below, the average risk of the small-group market would not be significantly affected by the addition of the group sizes 50-100. Over 30% of the 50-100 employee size firms would need to self-insure before the SHOP would be faced with the need to increase premiums.

**Step 1** – Establish that the overall morbidity of the 50-100 population is similar to the under-50 population. This intuitively seems likely, and our analysis confirms that the morbidity is similar between the markets.

**Table 14: Result of Expanding Small Group Definition**

Step	Description	Groups size 50-100	Group size under 50
<b>A</b>	2010 Premium PMPM - adjusted	\$371	\$384
<b>B</b>	Morbidity Change (guarantee issue)	1.00	1.00
<b>C</b>	Admin and Profit	15%	20%
<b>D</b>	Average Actuarial Value	81%	78%
<b>E = A*B*C/D</b>	2010 Allowable Claims PMPM	\$387	\$394
<b>F</b>	Ave Geo	0.8678	0.8715
<b>G</b>	Ave Age/Gender	1.00	1.00
<b>H</b>	Ave Tobacco	1.00	1.00
<b>J = E/F/G/H/I</b>	Normalized claim cost	\$446	\$453
	Morbidity difference		1.01

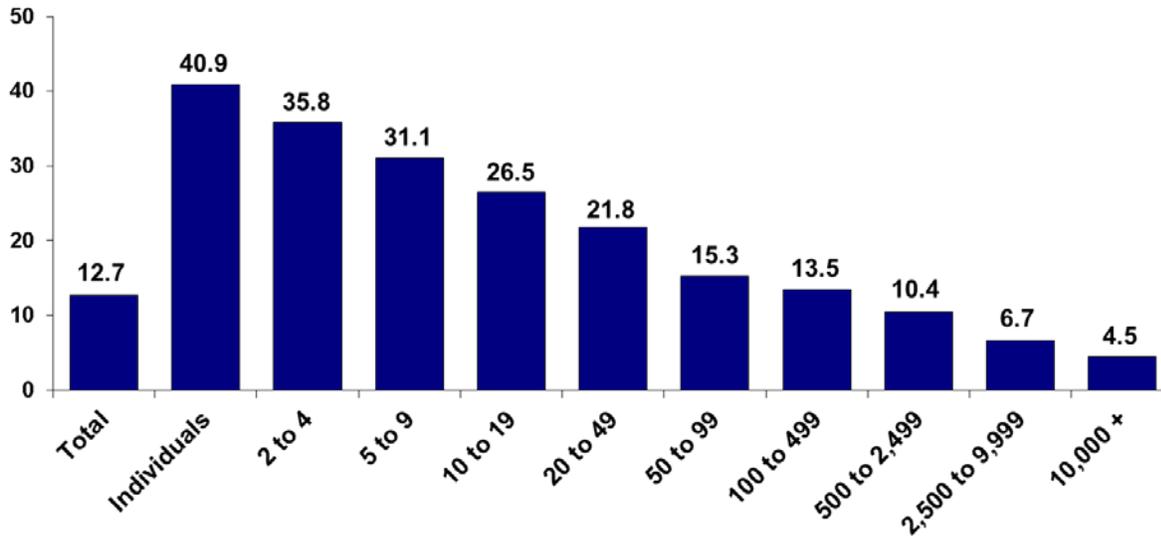
**Step 2** – Compare the average premiums for the markets based on average administrative cost differences.

**Table 15: Premium Difference, Expanding Small Group Definition**

Step	Description	Groups size 50-100	Group size under 50
<b>A</b>	Normalized claim cost	\$446	\$453
<b>B</b>	Admin cost	\$56	\$77
<b>C = A + B</b>	Premium	\$502	\$529
	Premium Difference		1.05

Based on a study of the Lewin Group, administration costs vary significantly based on the size of the group. The figure below indicates the results of this study. For administrative cost differences, we assumed that the 50-100 group market would have 5% lower administrative fees (as a percent of premium).

**Figure 4: Administrative Costs as a Percent of Premium by Employer Group Size**



Source: Estimates by the Lewin group for The Commonwealth Fund Source: Commonwealth Fund Commission on a High Performance Health System

If we stop here, it would indicate that the addition of the 50-100 life groups to the market would actually reduce the premiums in the small group market. However, it is the exodus of the healthiest groups to self-funded options that remains a concern. This item is addressed in Step 3.

**Step 3** – Adjust the risk level of the 50-100 life groups by removing the healthiest groups

Our approach to examine this is similar to reviewing the resulting risk of small-group leaving the market. We make two assumptions:

1. The assumed cost ratio of the highest-cost groups to the lowest-cost groups in this range is 3.2:1, which is a compression of rate range by approximately a factor of .75 relative to the small group market, and
2. The majority of the groups are at the low end of the range (similar to small groups).

Based on these assumptions, almost 30% of the groups (the healthiest groups) in the 51-100 market would need to self-insure before the increase of morbidity in the 51-100 employee groups would reach 4%. This assumption loosely ties to an HRET study that indicates that employees in self-funded groups have on average 5% less costly premiums.<sup>6</sup>

<sup>6</sup> <http://ehbs.kff.org/pdf/2010/8085.pdf>

**Table 16: Increase in Morbidity**

Percent of Members	Average Risk Factor of Small Group 2-50	Assumed Average Risk Factor of 50-100 groups [1]	Membership Leaving to Self-Insured Market	Remaining Distribution	Average Risk Score
12%	1.28	1.21	0%	17.5%	1.21
10%	1.17	1.13	0%	13.6%	1.13
18%	1.05	1.04	0%	25.6%	1.04
29%	0.94	0.96	0%	41.1%	0.96
31%	0.85	0.89	-29%	2.1%	0.89
1	1.00	1.00		100.0%	1.04
<b>Increase in Morbidity</b>					4%

[1] Multiplied by a compression factor of .75.

The increased morbidity with 30% of the market leaving would cause the overall premium levels in the pool to break-even, given the economics of the lower administration in the higher group sizes. Given the analysis presented above, the State should carefully consider options to prevent large groups between 50 and 100 from exiting the fully-insured marketplace (by either dropping coverage or self-insuring) to ensure that the state benefits from an early expansion of the Small Group Market. Such policy considerations are, as noted in previous sections, key for the State consider in any event, given that the market must expand beginning in 2016.

#### 4.4.3 Illinois Health Insurance Exchange Merger Analysis

*This section analyzes the ACA option that allows states to combine (or merge) the small-group and individual markets.*

One of the options available to states under the Affordable Care Act (ACA) is to combine the small-group and individual (non-group) risk pools. Several states have merged the risk pools prior to the ACA laws allowing them to do so. The driving force behind merging the markets is a desire to protect and lower costs for individual policyholders who may have less negotiating power and sophistication and face higher administrative costs. From a very simple perspective, merging the markets will equalize premiums. Therefore, if premiums are lower in the small-group market prior to the merger, then small-group premiums will increase and individual premiums will decrease (and vice versa). The amount of the change in each market depends on the relative size of the markets prior to the merger. If the total market is dominated by small groups, the change to individual premiums could be substantial.

Complicating this analysis is the fact that the decision states need to make is after implementation of all of the ACA changes. These regulatory changes affect the two markets differently. In addition, the shifts

in the market due to provisions such as the individual mandate, premium and cost sharing subsidies, and others will likely be substantial.

In order to analyze the impact of merging the individual and small-group risk pools, what that means first needs to be defined. It is clear that the portion of the premium reflecting medical claims costs must be the same for everyone buying identical products in the newly merged market, but it is not clear from the ACA law or proposed rules whether rates can vary for other differences in costs between the two groups now in the merged market. Specific outstanding questions include:

1. Can rates vary to reflect differences in administrative expenses between the two markets? The costs of administering health insurance vary between the two markets for reasons such as commissions, administrative functions like enrollment and outreach, among others.
2. Can / should rates vary due to the presence of reinsurance required by the ACA in the individual market? Reinsurance effectively transfers funds from the fully insured and self-insured employer markets to the individual market.

For purposes of our analysis, we have assumed that the risk pools need to be identical but that rates can vary between the two markets for the reasons noted above.

**We estimate that rates in the individual market would likely increase significantly, and rates in the small-group market would likely decrease minimally if the markets were merged.** These changes are based on actual historical data provided by Illinois carriers in the individual and small-group markets (as described in the next section of this report) after adjusting that historical information for the impact of ACA reforms (guaranteed issue, adjusted community rating, etc.). Since premium rates inside and outside the Exchange need to be the same, after accounting for allowable rating characteristics, our results do not depend on the size of the health insurance Exchange or whether or not there is a market outside the Exchange. Other considerations in deciding whether to merge the markets including size and stability of the market over time, disruption to policyholders and health plans, continuity of coverage, and others.

***The finding presented here with regard to the market merger is in isolation of other possible findings related to the ACA and should be viewed strictly in relation to a scenario in which the markets were not merged.***

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## THE IMPACT OF RISK ADJUSTMENT IN A MERGED MARKET

While risk adjustment will be budget neutral across the newly merged market, it is important for carriers to understand how it will function and potential limitations in its ability to fully recognize morbidity levels across carriers. If risk adjustment does not fully capture morbidity differences, then the risk-adjustment mechanism will not fully offset the advantages or disadvantages that carriers face because they do not enroll an average-risk population. This issue is pervasive in any discussion of the limitations of risk adjustment, as similar issues exist with regard to risk differences that result from carrier-to-carrier variation in income levels of enrollees, geographic service area, network composition, and other factors.

Another important issue with respect to risk adjustment is the overlap with the reinsurance provisions of the ACA. Reinsurance will effectively limit risk for a particular person in the individual market and therefore will limit the risk of many high-cost conditions. However, that same limitation does not apply in the small-group market, which will bear the full cost of those conditions. Therefore, the calibration of risk weights for the merged market will not be entirely in sync with the application of the risk-adjustment model.

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## DATA RECEIVED

The analysis was based on data provided by the insurers as well as information provided by the state. This information includes but is not limited to:

- Detailed benefit plan information for plans representing at least 80% of the insurers' individual and small group books of business. The detailed information included:
  - 2010 premiums, allowed and paid claims, member months and producer commissions by benefit plan. The same data elements were also provided in aggregate for the balance of the remaining plans in the insurers' individual and small-group books of business.
  - High-level cost sharing and covered services information for each benefit plan
- Underwriting Experience, including
  - Durational factors with persistency by duration (individual)
  - 2010 application experience, including but not limited to the number of applications, number accepted (split by number of standard and nonstandard issues), denied, and number of policies with pre-existing condition exclusions (individual)
  - The average underwriting factor applied, where applicable, for policies issued to enrollees with substandard health status (individual)
  - Average underwriting factor by group size (small group)
  - Distribution of underwriting factors by group size and underwriting factor band (small group)
- Recent rate filings, where available. When rate filing information was not available, assumptions as to the insurers' rating factors were necessary.
- High risk pool experience including number of policies and historical experience
- Additional benefit design information regarding product specifications available online at carrier websites
- Earned premium and member months by member and group zip code, separated by individual, small group and large group lines of business
- Summary earned premium and incurred claims information by insurer for individual, small group and large group lines of business

The following seven insurers provided information for the analysis:

- Aetna

- Blue Cross Blue Shield of Illinois
- Coventry Health and Life
- HealthAlliance
- Humana
- PersonalCare
- United Healthcare (summary of all companies)

The inclusion of information into the analysis was based on quality of data, availability of information and significance in the Illinois market. Note that the majority of benefit plans not included in the detail, and thus not in the analysis, were closed plans.

#### 4.4.4 Early Implementation of Consumer Protections

*This section addresses the possibility of implementing the insurance-related consumer protection reforms in the ACA in Illinois before 2014, when the reforms are required.*

The ACA institutes a wide range of insurance market reforms. This section addresses the advisability and potential cost of early implementation of those reforms. While certain insurance reforms in the ACA are effective before 2014, the substantial consumer protection reforms that affect the individual and small group markets take effect in 2014. These include:

- Prohibition of pre-existing condition exclusions.
- Guaranteed issue and renewal.
- Limits on waiting periods to no more than 90 days.
- Required coverage of certain qualified clinical trials.

These reforms, which concern benefits that must be available to insurance consumers, work alongside a set of rating reforms, including the institution of adjusted community rating standards and a limitation on the use of rating factors.

All of these reforms are to be implemented in 2014 alongside the requirement that individuals purchase insurance, known as the individual mandate, and the associated requirement that carriers offer plans that contain essential benefits to be defined by the Secretary of HHS. In fact, the individual mandate is essential to the operation of these reforms, since without that requirement, a relatively sicker group of purchasers would be in the insurance pool, which would cause the premium impact of the reforms to be significantly higher. We do not recommend wholesale adoption of the ACA insurance market reforms in the absence of an individual mandate. The market impact of early implementation of the insurance reforms in the ACA without early adoption of an individual mandate is likely to cause negative disruption in the market, by increasing premiums. On a purely operational level, the enforcement of an individual mandate is a significant undertaking, with very high visibility that affects every taxpayer. It would be a very difficult and costly undertaking for any state to implement that level of enforcement when taxpayers and plans will be subjected to an entirely different federal enforcement process in 2014.

It is important to note that some states may consider potential partial steps to smooth the path to the 2014 insurance reforms. Most notably, the ACA required that rate bands be limited to 3 to 1 in the individual and small-group markets. Illinois could consider slowly constricting, between now and 2014, rate bands in the small-group market or introducing rate bands in the individual market (where there are none today).

However, the impact of any such step would affect premiums for currently insured individuals and for small employers. In general, in the individual market, premium rates for sicker, older individuals would decrease and premium rates for healthier, younger individuals would increase (as will happen when the new ACA rates bands go into effect in 2014). The HMA team has not analyzed in depth the practical effect of such a step in Illinois, but there is every reason to believe that the effect of doing so on the premiums charged to currently insured individuals would be substantial, and some lower-risk people would likely drop coverage as a result.

Moreover, before 2014, the individual and small-group markets will not have implemented the risk-adjustment processes that are created in the ACA specifically to address the expected outcomes of these reforms. Those risk-adjustment processes, which will be more clearly defined in federal regulations and by states, are designed to protect insurers that enroll a disproportionate share of high-risk individuals from financial losses. We do not recommend implementing state-specific risk-adjustment or risk-sharing mechanisms before 2014, when they will be implemented by Illinois under federal rules. Certainly, preparation for implementation of the ACA's risk-sharing mechanisms will be a high-priority, high-profile, and resource-intensive activity for the state to implement even by 2014.

In sum, while the impetus for early implementation of consumer protections in Illinois is understandable, a review of the practical impact of such a policy argues strongly for waiting until 2014 and instead focusing resources on careful planning to deal with the implementation challenges and market impacts of the ACA.

#### 4.5 Medicaid and the Exchange

*This section addresses some of the dimensions of how an Exchange will relate to existing state programs. Section 4.5.1 analyzes the impact of the ACA's Medicaid expansion in Illinois. Section 4.5.2 addresses one of the often-discussed dynamics set in motion by the ACA—movement between the Exchange and Medicaid for low-income individuals, commonly referred to as the phenomenon of “churn.” Section 4.5.3 analyzes the option of a Basic Health Program in Illinois. Finally, sections 4.5.4 deals with state options for early implementation of the Medicaid expansion that is required to be implemented in 2014.*

Based on our team's experience and our assessment of the challenges presented by the ACA, we believe efficiently integrating an Exchange with existing Illinois state programs will be an essential element of

success for the state. While the Exchange is a new marketplace and a component of the broader commercial health insurance market, it is also deeply connected to, and will have important impacts on, the Illinois Medicaid program and on state programs generally. There are both policy and operational dimensions to the integration of an Exchange with existing state programs, and our strong advice is to pay close attention at all turns to how Exchange decisions and actions will affect other state programs.

This section concerns the ways that the implementation of the ACA and an Illinois Exchange will affect the Illinois Medicaid program. Most obviously, the ACA expands Medicaid eligibility, reforms its eligibility rules to conform to new federally set standards, and requires a streamlined eligibility determination process that must be integrated with the Exchange. In planning for Exchange implementation, current agencies in Illinois (both HFS and DHS) have to confront both the independent challenges of the Medicaid expansion and the need to forge a working relationship with a new entity. Exchanges and Medicaid are deeply integrated, both in terms of operational functions and in the sense that the law is intended to integrate public and private health insurance coverage.

This report, and the separate report concerning development of an Integrated Eligibility System (IES) to comply with the integrated eligibility requirements of the ACA, is intended to support overall Exchange planning in Illinois. In our view, one of the most important elements of that planning effort is to identify and understand the ways that Exchange implementation will affect the state Medicaid program. This introduction discusses certain areas in which resources for HFS or DHS are necessary. It is intended both to provide advice to support implementation and to illuminate the way that the Medicaid program will need to adapt to a post-reform world in which policy and operational decisions it makes affect the Exchange, and vice versa.

- Eligibility Operations Staffing Resources

A strong recommendation of the HMA Team in the context of the IES planning project is to design a Business Process Reengineering (BPR) process to identify specific options for improving business processes associated with eligibility and enrollment functions. That process should inform and complement the implementation of the IES and should also focus on staffing needs of DHS after the IES is implemented.

DHS local offices have caseworkers with large case loads and have had reductions in staff in the last few years. Earlier this year, DHS estimated that a substantial increase in the number of caseworkers would be needed to address the needs of the annual redeterminations due to the Illinois Medicaid Reform initiative. The request for additional funding for staff was not included in the FY2012 budget. In the analysis of the Medicaid expansion in this section, we project that the Medicaid program will serve over 3.1 million members after the ACA is implemented, an increase over the 2.7 million it serves today.

The increased caseload attributable to the ACA, in combination with the need for enhanced program integrity measures from the 2012 reform law, cannot be handled with existing staffing levels given existing business processes. Given the difficulty of hiring caseworkers, improvements are critical in the way the work is handled and the workload is distributed. Specific options for improving processes as the IES is designed and implemented are identified in the IES report. As the state embarks on that project,

improvements that lessen stress on staff and workloads will be a high priority. But it is an unavoidable fact that more people will apply for and become eligible for Medicaid as a result of the ACA. The state should carefully monitor current caseloads, continue to refine the initial projections provided in this report, and throughout implementation pay close attention to the needs of local offices.

This is especially true in the first years of implementation. The IES report proposes a two-stage set of changes, with a full replacement of the current system unlikely until the end of 2015 – a full two years after the ACA is implemented. The case worker demands in those two years while adding a large number of new members and maintaining two systems will surely be severe; it would be unrealistic to not expect additional administrative costs in the short-term.

- Policy and IT Resources for IES Planning

As discussed more fully in the IES report, a comprehensive overhaul of eligibility IT systems will require dedicated staff in IT units at DHS and HFS and agency staff with subject matter and policy expertise to guide development decisions. It is always challenging to devote existing resources with operational and policy responsibilities to a development project, but a lack of business and policymaking input into IES risks failure to meet the project's objectives, which are central to Exchange and ACA implementation effort. As the project is organized, HFS and DHS need to identify resources for the project and agency functions that could suffer from those resources being directed away from ongoing responsibilities. It is unlikely that federal funding will support hiring full-time permanent staff replacements for non-Exchange agencies, but Illinois should explore options for using federal Exchange grants for short-term resources that can support the ongoing operations of its agencies while the IES work is prioritized.

- Ongoing Policy and Decision-making Supports for Program Integration

For both planning and ongoing operations, HFS and DHS will have a need for resources devoted to integration with the Exchange. We also strongly recommend a formalized structure for regular communication, with the involvement of senior staff involved in both operational management and agency policy-setting. As implementation unfolds, the state, and later, the Exchange, will be contracting with vendors to provide call center services, designing a website through which individuals can apply for Medicaid or Exchange coverage, and developing approaches to the many other Exchange functions covered in this report. It will be rare that those functions will not need to be integrated with an aspect of the operational processes or technology systems managed by HFS or DHS. Early planning and engagement together will avoid inefficiencies and re-work but will be particularly challenging given the timeframes required by the ACA and the fact that the Exchange will be a new and fast-growing organization.

In addition to operational cooperation at all levels, the state needs to devote resources to identifying policy issues that are being addressed by both the Exchange and Medicaid. As discussed in this report, the Exchange will be monitoring quality of plans and assessing their provider networks for adequacy – both issues that Illinois Medicaid needs to address in its different context. If the Exchange in Illinois prioritizes outreach to low-income populations, it is important for HFS to understand the outreach strategy, possibly to enhance it and possibly to understand the operational implications.

It is also important to realize that the integration is not simply about monitoring Exchange activities. Medicaid decisions may just as easily affect the Exchange in unforeseen ways. For example, as Illinois sets its priorities for coordinated care and begins the process of contracting with risk-based organizations, the Exchange will need to assess the implications of new policies for the potential plans interested in offering coverage on the Exchange. Finally, there are financial implications to strategic decisions made by the Exchange. For example, pressure on Exchange-qualified plans to reduce premiums will translate swiftly into reduced provider reimbursements from those plans, with the predictable result that providers will resist Medicaid reductions even more aggressively (and with some justification). The important point is not that every dimension of interaction should be identified and dealt with, but rather than the state needs to recognize the deeply connected nature of the Exchange and the Medicaid program and plan ahead to address it by ensuring coordinated planning and communications structures. We recommend senior staff assigned to play this role at both the Exchange and at HFS. As noted repeatedly in this report, current planning is led by engaged and well-coordinated staff at Medicaid and DOI, so Illinois has a strong foundation on which to build this kind of formalized structure.

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#### 4.5.1 Medicaid Expansion

*This section analyzes the impact of the ACA's Medicaid expansion in Illinois.*

In January 2014, the ACA expands Medicaid to cover individuals and families below 133% FPL.<sup>7</sup> The expansion eliminates, for individuals under 65, the historical categorical eligibility standards that have made Medicaid eligibility a complex patchwork with different categories of individuals (children, individuals with disabilities, pregnant women, etc.) eligible at different income levels. In Illinois, the Medicaid expansion will affect primarily two groups:

- Individuals with income at or below 133% FPL who do not meet categorical eligibility criteria
- Individuals with disabilities and income at or below 133% FPL and above the current Medicaid threshold of 100% FPL

In this section we estimate the impact of the Medicaid expansion in Illinois.<sup>8</sup>

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<sup>777</sup> The ACA establishes 133% FPL as the eligibility standard for Medicaid and also requires states to disregard 5% of income in determining eligibility. As a result the effective income standard for Medicaid is 138% FPL, but throughout this report we refer to the legal eligibility standard for the sake of simplicity and clarity.

<sup>8</sup> The analysis necessarily relates to the Medicaid program (42 U.S.C. Title XIX) and the Children's Health Insurance Program (Title XXI). Because Illinois operates a combined Title XIX and XXI program, and to avoid confusion with the separate Illinois Comprehensive Health Insurance Plan, we use the term Medicaid to refer to both Title XIX Medicaid and Title XXI Children's Health Insurance Program. Where necessary to differentiate between the two separate federal programs, we refer to "Title XXI", commonly known nationally as the CHIP program.

For the analysis, we used American Community Survey (ACS) census and HFS administrative data to estimate two populations for December 2013 – those enrolled in state health programs (Medicaid, Title XXI and state programs) and those who are uninsured. First, we estimate projected enrollment in state programs and Medicaid at the end of 2013 based on state enrollment data. Second, we estimate the uninsured at the end of 2013 in Illinois. Third, we allocate December 31, 2013 estimates based on new eligibility rules in 2014 to project the number of individuals who would be eligible in 2014 for state health programs, the Exchange with subsidies and the Exchange without subsidies. Finally, after assuming certain take-up rates for various 2014 populations, assumptions that we think are responsible, we estimate costs to the state of the Medicaid expansion.

This analysis is not derived from the more comprehensive modeling performed by the separate background research vendor but instead is an alternative approach to projecting Medicaid impacts. The significant difference between our analysis and that modeling is in our methodology to estimate potential growth in the Medicaid program and uninsured population between now and the end of 2013. While the Deloitte model makes assumptions about economic factors and behavioral factors that influence projected growth before ACA implementation, HMA conducted a more focused analysis derived, as described in greater detail below, from historical state enrollment and administrative data.

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#### ESTIMATING PROGRAM PARTICIPATION FOR DECEMBER 31, 2013

To estimate the projected number of state program participants for December 31, 2013, we use April 2011 program enrollment figures from HFS as the baseline. HFS provided state program enrollment data for a 21 month period ending April, 2011. These data were detailed by more than 80 Medicaid, Title XXI and State Program comprehensive benefit eligibility categories based on age, parental status, disability status, poverty level, Medicare eligibility, etc. (See the list of eligibility categories in Appendix B.) Enrollment changes over the 21 month period varied significantly by eligibility category. As a result we used 21 month enrollment change figures for each comprehensive benefit eligibility category to estimate enrollment by category for December 2013. We then adjusted these projections to account for known policy changes. Specifically, to adjust for the impact of state Medicaid reform changes to HFS eligibility policies<sup>9</sup>, we:

- Removed enrollment in eligibility categories for children with income over 300% FPL,
- Assumed a modest 1% reduction in growth of All Kids enrollment, which saw notably high growth during the 21 month baseline period.
- Reduced projected growth in several eligibility categories where baseline data showed significant anomalous growth during the 21 month period that appeared unsustainable going forward.

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<sup>9</sup> Despite federal disapproval of two eligibility documentation changes, state Medicaid reform includes other changes that can be expected to reduce enrollment growth rates i.e. reducing All Kids upper income limit to 300% FPL, ending passive redeterminations, mandating a 60 day window for responding to requests for additional information, requiring data matches for verification purposes, etc.

As a result of this process, we estimate that 2.9 million individuals will be enrolled in comprehensive coverage through Medicaid and state programs as of December 31, 2013. As the following table shows, this is equivalent to a 3.1% annual increase over our base April 2011 enrollment numbers.

**Table 17: Medicaid and State Program Enrollment (Comprehensive Benefits Only)  
August 2009 and April 2011 Actual with December 2013 Projected**

	Actual Aug-09	Actual Apr-11	Annual Growth	Estimate Dec-13	Annual Growth
<b>Total</b>	<b>2,548,141</b>	<b>2,702,776</b>	<b>3.6%</b>	<b>2,928,971</b>	<b>3.1%</b>
Children 0-18	1,574,184	1,662,066	3.3%	1,782,433	2.7%
Adults 19-64	820,085	876,368	4.1%	966,986	3.9%
<b>Non-Elderly</b>	<b>2,394,269</b>	<b>2,538,434</b>	<b>3.6%</b>	<b>2,749,419</b>	<b>3.1%</b>
Adults 65+	153,872	164,342	4.1%	179,552	3.5%

#### ESTIMATING STATE UNINSURED POPULATION AS OF DECEMBER 31, 2013

To estimate the number of uninsured Illinoisans in 2013, we started with the 2009 ACS estimates of the proportion of uninsured Illinoisans in each of three age categories (0-18 years, 19-64 years, and over 65). We then applied these proportions to the 2013 projected population estimates, which are derived from the Illinois Department of Commerce and Economic Opportunity's population projections with adjustments based on the 2010 census counts to produce the following results. These estimates exclude uninsured undocumented immigrants who are ineligible for medical assistance through ACA. This population was excluded based on a Metropolitan Chicago Information Center analysis that incorporated data from the U.S. Department of Homeland Security.

**Table 18: Projected Uninsured Population in Illinois, December 2013  
(Excludes undocumented immigrants)**

<b>Total</b>	1,491,662
<b>Children 0-18</b>	150,769
<b>Adults 19-64</b>	1,326,067
<b>Non-Elderly</b>	<b>1,476,836</b>
<b>12/31/13 Uninsured 65+ Pop.</b>	14,826

#### PROGRAM ELIGIBILITY IN 2014

Based on new eligibility standards under the ACA, we split our estimate of 2013 enrollment by eligibility category into three categories for 2014: Medicaid, Exchange with subsidy and Exchange without subsidy. These assumptions are summarized in Appendix B.<sup>10</sup>

ACA implementation will make two groups of adults 19-64 newly eligible for Medicaid in 2014.

<sup>10</sup> Individuals over 65 years of age and Medicare enrolled individuals of any age were not considered Exchange eligible consistent with ACA provisions. In instances where HFS enrollment data did not indicate enrollee income, approximate income distribution proportions from the current population of Illinois uninsured, based on 2009 American Community Survey data, were applied to projected 2013 enrollment numbers.

- Individuals with income between 0% and 133% FPL who are not eligible for programs that cover parents and the disabled.
- Disabled persons with income above the current Medicaid threshold of 100% FPL and at or below 133% FPL.

Most enrollees in current state insurance coverage programs will remain eligible for Medicaid after 2014. However, ACA coverage and financing rules make it likely that (assuming the state decides to eliminate coverage) certain individuals enrolled in state programs will move to the Exchange. We assume that the State will choose to:

- End 100% state funding for children with income over 200% FPL and at or below 300% FPL (23,000 estimate for December 2013) and encourage them to enroll in the federally-funded Exchange in 2014.
- Reduce FamilyCare Medicaid coverage for parents from 185% FPL to 133% FPL in 2014 and encourage these individuals (36,979 estimate for December 2013) to enroll in the federally subsidized Exchange in 2014.
- Move to the Exchange a small portion of the Breast and Cervical Cancer program enrollees, those under 65 with income over 133% FPL who are not dually eligible for Medicare (1,260 estimate for December 2013).
- End the Illinois Healthy Women (IHW) program. Women in IHW receive partial benefits and are considered uninsured in ACS numbers. IHW enrollees who are under 65 and not dually eligible for Medicare (65,000 estimate for December 2013) could become eligible for comprehensive benefits through Medicaid or the Exchange in 2014.

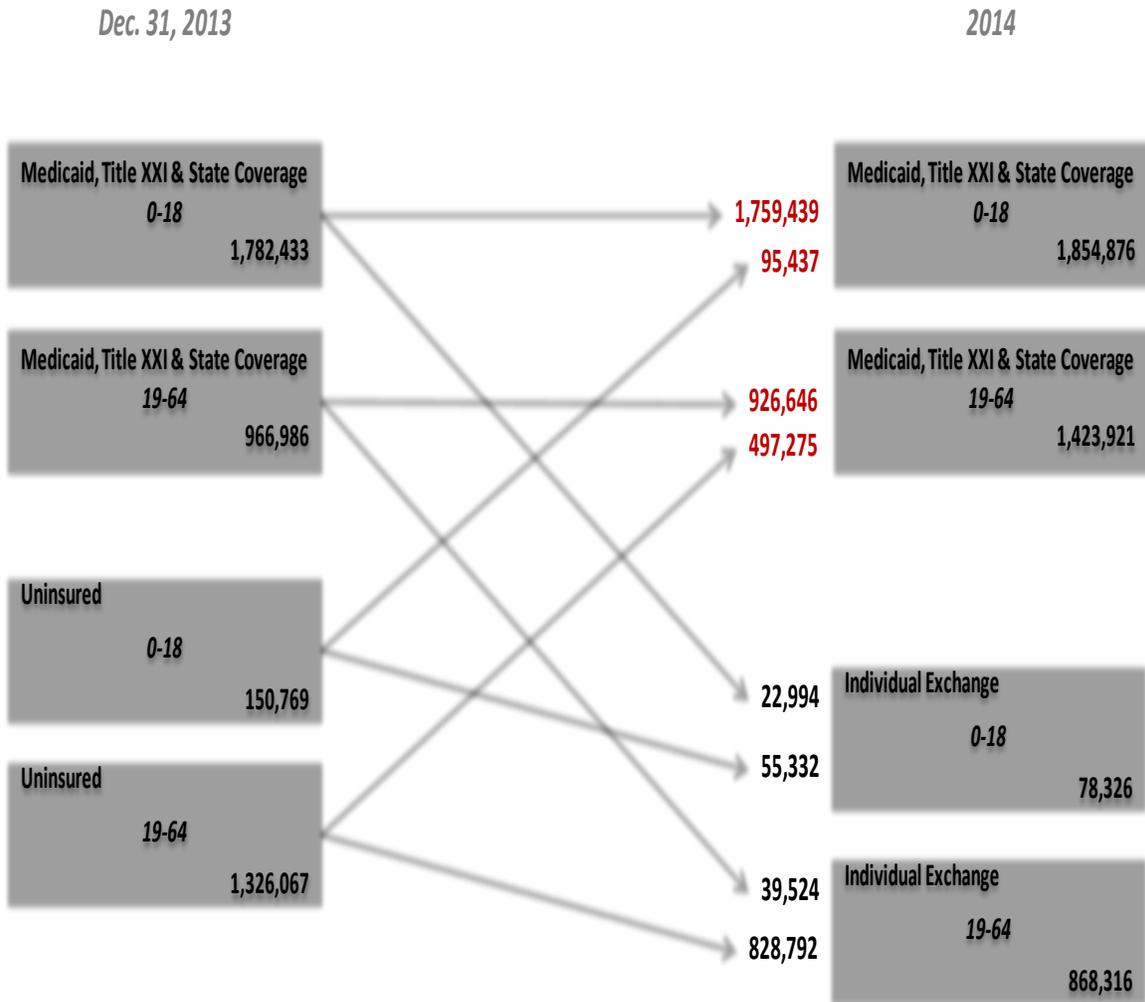
Along with currently enrolled individuals who will become Exchange eligible, a large group of currently uninsured individuals will also become eligible for the Exchange. It is estimated that 55,000 currently uninsured children with income over 200% FPL and 829,000 uninsured non-elderly adults with income over 133% FPL will be Exchange eligible in 2014.

Table 19 shows program eligibility in 2014 for those individuals who are projected to be in state programs or uninsured as of December 2013. The purpose of the table, and the following graphic, is to represent the programs that will become available to individuals who are now either served by state programs or uninsured. The rate at which these individuals actually enroll in programs available to them is addressed in a subsequent step of this analysis. In addition, this analysis is limited to the changes for the uninsured and state program enrollees. Addressed in greater detail in the separate Background Research report is the fact that currently insured individuals will also access coverage through the individual Exchange, and that employers will access coverage through the SHOP Exchange.

**Table 19: 2014 Program Eligibility for State Program Enrollees and the Uninsured  
(Comprehensive Benefits Only)**

Projected Eligibles	Projected 12/31/2013	2014 Medicaid	2014 To Exchange w/Subsidy	2014 To Exchange no Subsidy	2014 To Exchange Total	2014 Uninsured 65+
<b><u>2013 State Program Enrollees</u></b>						
	2,928,971	2,865,637	62,087	431	62,518	-
Children 0-18	1,782,433	1,759,439	22,994	-	22,994	-
Adults 19-64	966,986	926,646	39,093	431	39,524	-
Adults 65+	179,552	179,552	-	-	-	-
<b><u>2013 Uninsured</u></b>						
	1,491,662	592,712	659,950	224,174	884,124	14,826
Children 0-18	150,769	95,437	39,351	15,982	55,332	
Adults 19-64	1,326,067	497,275	620,599	208,193	828,792	
Adults 65+	14,826				-	14,826

**Figure 5: State Program Enrollees and Uninsured Lives; Program Eligibility in 2014 (excludes undocumented immigrants)**



## ESTIMATED 2014 MEDICAID ENROLLMENT UNDER THE ACA

While all the individuals represented in Table 20 are expected to be eligible for Medicaid and the Exchange in 2014, all will not enroll in coverage during the year. As with all coverage programs, 100% enrollment is unlikely to occur at any time but especially unlikely during the first year. While the individual mandate combined with multiple outreach and enrollment simplification strategies can be expected to result in higher take-up rates than traditionally seen with health benefits programs, a portion of the eligible population can be expected to enroll but not maintain coverage while others are expected not to apply for coverage at all.

For the purposes of this analysis, which is to estimate the cost of the Medicaid expansion to the state of Illinois, we assume that:

- 100% of the individuals enrolled in Medicaid or state-funded programs in 2013 will be directly enrolled in Medicaid in 2014, and
- 50% of 2013 uninsured individuals who are eligible for Medicaid in 2014 will enroll in 2014.

**Table 20: Estimated 2014 Medicaid Enrollment Estimates (Comprehensive Benefits Only)**

	2014 Eligible Individuals	2014 Enrollees
<b>Total Estimated Medicaid 2014</b>	<b>3,458,349</b>	<b>3,161,993</b>
<b>2013 State Program Enrollees</b>	<b>2,865,637</b>	<b>2,865,637</b>
Children 0-18 (100% take up)	1,759,439	1,759,439
Adults 19-64 (100% take up)	926,646	926,646
Adults 65+	179,552	179,552
<b>2013 Uninsured</b>	<b>592,712</b>	<b>296,356</b>
Children 0-18 (50% take up)	95,437	47,718
Adults 19-64 (50% take up)	497,275	248,638

## MEDICAID COSTS IN 2014

Total medical spending per enrollee is the other key element in projecting 2014 costs. In order to project the cost of these new enrollees, benefit costs on a per-member per-month (PMPM) basis were projected for 2014, based on 2007-2010 actual PMPMs. The following table shows actual 2007 through 2010 PMPMs as HFS reports costs - for children, non-elderly adults with disabilities and other non-elderly adults. The three-year average percentage change in PMPMs for adults was used to project annual benefit cost changes for 2011 through 2014. For children, since 2008 saw a rare 6% reduction in the average PMPM, the two-year average percentage change for 2009 and 2010 was used. This rate of increase results in projected 2014 PMPMs of \$192 for children, \$1,248 for adults with disabilities and \$399 for other adults. Since the 2014 new Medicaid enrollee projections are not detailed by health status, the two adult rates were blended by assuming 20% of new adult enrollees would have health needs comparable to disabled persons. This results in an average adult rate of \$569 PMPM.

**Table 21: Actual and Projected Per-Member Per-Month Benefit Costs 2007-2014**

Actual PMPMs	2007	2008	2009	2010
<b>XIX/XXI/St Program PMPM Benefit Costs</b>				
Children 0-18	\$173	\$163	\$168	\$172
Adults with Disabilities 19-64	\$968	\$1,017	\$1,065	\$1,079
Other Adults 19-64	\$335	\$349	\$356	\$361
<b>Percent Change From Prior Year</b>				
Children 0-18		-5.8%	3.1%	2.4%
Adults with Disabilities 19-64		5.1%	4.7%	1.3%
Other Adults 19-64		4.2%	2.0%	1.4%

Note: from Illinois HFS Transparency Report extracted 4-27-11; excludes Cook, UIC, administration payments, and other agencies; for full benefit enrollees only; LTC costs excluded

Projected PMPMs	2011	2012	2013	2014
<b>Change From Prior Year</b>				
Children 0-18	2.7%	2.7%	2.7%	2.7%
Adults with Disabilities 19-64	3.7%	3.7%	3.7%	3.7%
Other Adults 19-64	2.5%	2.5%	2.5%	2.5%
<b>XIX/XXI/St Program PMPM Benefit Costs</b>				
Children 0-18	\$177	\$181	\$186	\$192
Adults with Disabilities 19-64	\$1,119	\$1,160	\$1,203	\$1,248
Other Adults 19-64	\$370	\$379	\$389	\$399
Adults 19-64 20% w/Disabilities	\$520	\$536	\$552	\$569

Federal match rates are different for individuals eligible for Medicaid under Illinois’ current rules and those made newly eligible under the ACA. We assume that 80% of the new adult enrollees will be “newly eligible” and that 20% will be individuals who would be eligible under today’s Medicaid rules. Given the differential matching rates for these different categories, this is an area that deserves close scrutiny and monitoring. The state’s liability could be greater if the number of “previously eligible” individuals is higher than this projection, and less if the number of newly eligible” individuals is higher.

Federal support for Title XXI will increase in 2016, but that new matching rate is not relevant to the 2014 costs projected here. We use the most conservative FFP rate for children because the HMA Team has not had access to data necessary to estimate differential or blended matching rates for the combined Medicaid-Title XIX population. Thus, the 50% FFP rate for children in 2014 is understated because it does not factor in new Title XIX children for whom FFP is 65%.

As shown in Table 22, the benefit costs of the new 296,356 2014 Medicaid enrollees in our scenario were calculated using the projected 2014 PMPMs. We project 2014 benefit costs for new enrollees in comprehensive Medicaid, on an annualized basis, would total \$1.8 billion. Net of federal financial participation (FFP) new state costs for Medicaid enrollment would be \$224 million.

**Table 22: Projected 2014 Benefit Costs for New Medicaid Enrollees  
(Comprehensive Benefits Only)**

	2014 New Enrollees Previously Eligible	2014 New Enrollees Newly Eligible in 2014	Projected 2014 PMPM Costs	Annualized Costs	FFP Rate	Net State Annualized Costs
<b>Total</b>	<b>296,356</b>			\$ 1,806,459,977		\$224,513,897
<b>Children 0-18</b>	47,718		\$ 191.52	\$ 109,669,748	50%	\$ 54,834,874
<b>Adults 19-64 (20% of new enrollees)</b>	49,728		\$ 568.69	\$339,358,046	50%	\$169,679,023
<b>Adults 19-64 (80% of new enrollees)</b>		198,910	\$ 568.69	\$1,357,432,183	100%	--

#### OFFSETTING COSTS FROM PROGRAM ELIMINATIONS

If Illinois eliminates FamilyCare Medicaid coverage in 2014 for parents above 133% FPL, these individuals would move from a 50% federal match program to a 100% federally funded program. This would eliminate the state's share of costs for an estimated 36,979 persons in 2014. Assuming \$399 PMPM average costs in 2014 for these parents, this would reduce state costs by \$88 million in 2014.

In addition, we anticipate that an estimated 22,994 All Kids enrollees as of December 31, 2013 who have income between 200 and 300% FPL will move to the Exchange in 2014. Coverage for this population, for which the state would be receiving federal match in 2014, could be eliminated because it is not subject to maintenance of effort requirements. Assuming average benefit costs of \$191.52 PMPM, state spending would be reduced annually by \$26.4 million.

Factoring in all of these cost changes, Illinois Medicaid and state program spending is estimated to increase by \$109.4 million, net of federal match.

<b>2014 net cost of newly eligible Medicaid and Title XIX enrollees</b>	<b>\$224.5 million</b>
2014 savings from reducing FamilyCare eligibility from 185% to 133%	(\$88.7 million)
2014 savings of reducing All Kids eligibility from 300% to 200%	(\$26.4 million)
<b>Total 2014 Spending</b>	<b>\$109.4 million</b>

State costs are likely to increase in subsequent years, as enrollment (from both currently and newly eligible populations) ramps up over time. It is important to emphasize that there are potential other savings associated with ACA implementation that are not analyzed here. We have not quantified potential reductions in state spending for uncompensated care that would reduce overall state costs. Using state-specific enrollment and cost data, the state should analyze potential cost savings as it makes decisions about ACA-driven changes to eligibility standards and uncompensated care arrangements to understand the overall impact of the ACA on the state’s budget. Finally, this analysis does not include administrative costs associated with the Medicaid expansion.

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#### 4.5.2 Options to Mitigate Churn Between Programs

*This section addresses one of the often-discussed dynamics set in motion by the ACA—movement between the Exchange and Medicaid for low-income individuals, commonly referred to as the phenomenon of “churn.”*

While the ACA is intended to, and will, expand health insurance coverage and streamline eligibility and enrollment processes for low-income individuals, there are risks inherent in the structural design of the law that creates Exchange-based subsidies administered separately from the Medicaid program. Specifically, maintaining continuity of coverage for individuals whose income fluctuates above and below 133% FPL (the cutoff between Medicaid and Exchanges) will be challenging.

This section focuses on ways to minimize program turnover and particularly administrative “churn.” The term “churn” refers generally to movement in and out of income-based programs. That movement may be caused by changes in income and access to employer-sponsored insurance. It may also be a result of paperwork and administrative requirements of the public program, for example, the need to complete paperwork for a regular redetermination of eligibility.

Maintaining continuity of coverage has been a longstanding issue in the Medicaid and CHIP programs, because of enrollees’ ongoing changes in eligibility status. Continuity of coverage is important for managing care and improving population health; there are numerous studies that show the relationship between loss of access to health insurance and people delaying or forgoing necessary health care.

But current research indicates that the challenge could be even greater under the ACA, because income fluctuations are much more likely in families at or near the breakpoint between Medicaid and Exchange-based subsidies (133% FPL).<sup>11</sup>

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<sup>11</sup> See “Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges,” Benjamin D. Sommers and Sara Rosenbaum, *Health Affairs*, February, 2011 (finding that 50% of all adults with family incomes below 200% of FPL will have a change in income within one year that will move them from Medicaid to a health insurance Exchange subsidy or the reverse), and “Churn, Churn, Churn: How Instability of Health Insurance Shapes America’s Uninsured Problem,” Pamela Farley Short, Deborah R. Graefe, and

With that context, we discuss here several possible ways that Illinois could mitigate the churn issue when implementing health reform. Although some of these approaches are derived from historical approaches to preventing turnover in Medicaid and CHIP, we focus on opportunities presented by, and relevant to, the implementation of the ACA. We also note that some of the historical approaches, particularly those involving managed care organizations, may not be relevant to Illinois today, but we provide them knowing that the state is designing an initiative to implement coordinated care in certain parts of the state.

### 1. The Basic Health Plan

The Basic Health Plan (BHP) is an important potential option because it is focused on the low-income individuals who are most likely to experience income changes. In addition, the BHP may provide those individuals with a closer-to-Medicaid health insurance alternative to the Exchange that could be more affordable and reduce otherwise-likely barriers to individuals moving from Medicaid to the Exchange. States may design a BHP to reduce the cost sharing requirements for people below 200% of FPL (a population that may struggle with the affordability of the Exchange plans, even with subsidies). A recent Commonwealth Fund study suggests that most low-income people will be able to afford Exchange plans with the subsidies but will be challenged if they face high out-of-pocket costs. The potential design and funding of the BHP could reduce the “cost-sharing cliff” between Medicaid and the Exchange. Another potential advantage of the BHP in terms of reducing churn is that it could be served by the same Medicaid managed care organizations (MCOs) that serve the Medicaid program (see discussion of the role of MCOs below).

There are other potential advantages to implementing a BHP as well as potential disadvantages. These are more fully discussed in section 4.4.5.

### 2. Administrative Approaches to Managing Eligibility

There are a number of approaches Illinois could take to improve its eligibility policies and processes in ways that will minimize unnecessary program churn. A comprehensive Medicaid reform law signed by Governor Quinn in January of this year creates a range of obligations associated with redeterminations and program integrity in Medicaid, which we recognize and do not mean to pass judgment on. However, connected to the implementation of the ACA will be federal regulations that set standards for a streamlined Medicaid eligibility process and which may affect state options on the scale and timing of redeterminations. Given those two factors, we mention two traditional approaches to minimizing churn that the state may consider as it implements the state law and monitors developments on the federal level.

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Cathy Schoen, The Commonwealth Fund, November 2003 (finding that 68% of people with incomes under 200% of FPL became uninsured over a four year period, whereas only 15% of people with incomes above 400% of FPL did).

a. Annual eligibility redeterminations

Illinois could allow for continuous eligibility of Medicaid or Exchange subsidy coverage for 12 months. A presumption of coverage is what the ACA envisions, but detailed federal guidance on eligibility rules has not yet been issued. Continuous eligibility is obviously a challenging prospect in a tight fiscal environment. On the other hand, as noted, there is research that demonstrates real administrative and programmatic costs to excessive churn, including higher administrative processing costs and potentially longer-term health costs due to delays in or forgoing needed care—even temporary lapses in coverage can cause delays in needed care.

b. Streamline eligibility processes

The ACA calls for streamlined and simplified eligibility processes, for both the initial application and in transitions or redeterminations of eligibility. Requirements of the ACA include:

- A “no wrong door” approach to the intake of applications for eligibility.
- A simplified process that is the same for all subsidized health programs.
- The use of federal databases for income and other verifications, rather than requiring additional paperwork.

The implementation of these requirements in Illinois, discussed in detail in the separate report on eligibility and enrollment systems, is among the more complex endeavors for state Exchange planners. For the purposes of this section, the point is simply that the improvements that Illinois will be making, in compliance with federal rules, could be monitored in actual application and operation to assess how successfully the changes are avoiding unnecessary eligibility changes.

Finally, an administrative approach that relates to the specific interaction between Medicaid and the Exchange after 2014 is worth mentioning.

c. Allow for Medicaid coverage to extend until Exchange coverage starts

The Exchange is likely to have enrollment policies that are more similar to the commercial market than Medicaid. Medicaid enrollees who lose their eligibility for Medicaid may have to wait until the first of the next month to enroll in Exchange coverage. (At least some Medicaid enrollees are accustomed to retroactive eligibility, which will not be available through the Exchange.) Illinois could consider allowing people to remain on Medicaid until their Exchange coverage begins.

3. Requirements for Health Plans

There is a fair amount of evidence that Managed Care Organizations (MCOs) can be effective partners with states to help mitigate administrative churn. MCOs can be engaged to help members with renewing eligibility in a timely way, through the use of such techniques as outreach, phone calls, and partnering with health care providers to inform patients. Assisting with certain mechanics of the program, such as obtaining updated addresses from enrollees and providing their renewal dates well in advance, are other ways in which the state can partner with its managed care partners to minimize

churn. As Illinois embarks on its coordinated care initiative, it may wish to consider how to include as a part of that initiative obligations and expectations that will support a goal to reduce administrative dislocations caused by churn.

Depending on that initiative and how it forms, it is worth noting as well that there are approaches the Exchange could take that would make it more likely that individuals moving between Medicaid and the Exchange could remain in their own plan. Without knowing the character of and standards for coordinated care plans, we do not suggest particular options for consideration. However, conceptually a state interested in smoothing a transition between Medicaid and the Exchange could require or incentivize Medicaid insurance plans to participate on the Exchange, in order to make it more likely that individuals will be able to retain health plan and clinical relationships as they move between the programs.

#### 4. Consumer Assistance

Finally, there are numerous ways that Illinois can offer consumers assistance in navigating the post-health reform world of subsidized health insurance coverage. Through a vigorous outreach and education campaign, Illinois can let consumers know what their options are and where they can go for help. This campaign should include the use of advocacy organizations and other community-based groups. A robust call center with a well-trained staff, combined with an easy-to-use website, can help consumers. And finally, the Exchange can seek funding for Navigators and target their work to focus on populations at high risk for churning.

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### 4.5.3 Impacts of Developing a Basic Health Program

*This section analyzes the option of a Basic Health Program in Illinois.*

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#### BACKGROUND

Section 1331 of the ACA gives states the option of establishing a Basic Health Program (BHP) in lieu of Exchange coverage for people ineligible for Medicaid who have income at or below 200% FPL. The eligible population includes legal immigrants who, because they have less than five years of U.S. residency, are ineligible for Medicaid. This section describes the BHP and the potential differences between it and the Exchange, suggests--on the basis of Wakely analysis--an approach to evaluating the feasibility of a BHP in Illinois, and discusses considerations and potential next steps for Illinois as it considers whether to develop a BHP.

#### ELEMENTS OF THE BHP

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The BHP allows states to set different premiums and cost-sharing and provide different benefits to low-income enrollees than the enrollee would pay for Exchange-based subsidized coverage. The state can also offer additional benefits, within federal guidelines.

The ACA allows states to set premiums at levels lower (but not higher) than what a BHP enrollee would have paid on the Exchange. Similarly, other cost-sharing under the BHP may not exceed cost sharing under an Exchange platinum plan for persons with income at or below 150% FPL and under a gold plan for those with income above 150% FPL. In Illinois, Medicaid and FamilyCare premium and cost sharing amounts are significantly lower than Exchange amounts enrollees will pay, even with Exchange premium and cost-sharing subsidies.

BHP plans must cover at least all “essential health benefits” to be defined by the Secretary of HHS later this year. A state can provide additional benefits. Illinois Medicaid includes services that the essential benefit package will likely not include, such as: other practitioners care (podiatrists, chiropractors, audiologists, optometrists, etc.), long term care and community-based long term care, hospice care, transportation, home health, and early intervention services. While, as discussed elsewhere in this document, it is possible to make plausible surmises about the general nature of "essential health benefits", until these are finally determined, it will be very difficult to fully understand the implications of implementing a BHP.

States must use a competitive process to select and negotiate with one or more BHP health plans. Health plans can be licensed HMOs, licensed health insurers, or networks of health care providers that offer managed care systems or attributes of managed care. Health benefit plans that contract with states to provide BHP coverage must maintain a medical loss ratio of at least 85%.

Generally speaking, observers see the flexibility available in the BHP as an opportunity to design a plan that is intended to address the needs of the low-income population. First, benefit design flexibility allows the BHP to be more affordable to the consumer and provide benefits not available on the commercial Exchange market. Second, in a state that utilizes Medicaid delivery systems or health plans, the BHP could improve continuity of care across transitions in coverage due to income changes and within families who would otherwise be “split” between the Exchange and Medicaid.

This flexibility for states comes with trade-offs and risks. Most importantly, the financial structure of the BHP creates significant risk and uncertainty for Illinois. The basic arrangement, analyzed in detail below, is that states will receive 95% of what BHP enrollees would have received in subsidies on the Exchange. The state is at risk for any spending above that amount. The 95% -- really a form of block grant to the state -- is based on the second-lowest cost Silver level plan on the Exchange. This construct creates an immediately apparent conundrum: the lower the premiums are on the Exchange, the less money the state receives for its BHP. A state that wants to prioritize achieving lower cost premium options on the Exchange, through contracting strategies or by incentivizing limited-network plans, is simultaneously lowering its BHP allotment. Moreover, even if Illinois did not care to actively lower prices on the Exchange, the actual price of the second-lowest cost Silver plan, essential to planning for a BHP, is the subject of uncertainty and potential volatility. Finally, it is not clear how the federal government will estimate what it would otherwise have spent on the BHP population, including whether and how it will take into account year-end reconciliation amounts for individuals whose income goes up over the course of the year. More details on BHP administration are expected later this year.

Table 23 summarizes some of the opportunities and challenges presented by the BHP. As noted below, we strongly recommend this as an area for further inquiry, and close monitoring of federal developments.

**Table 233: Basic Health Plan Opportunities and Challenges**

BHP Opportunities	BHP Challenges
<ul style="list-style-type: none"> <li>• Could simplify coverage for families by keeping parents and children on similar, coordinated programs</li> <li>• Could mitigate problems from movement between Medicaid and the Exchange at 133% FPL</li> <li>• Could build on Illinois’ history of covering similar populations</li> <li>• Could reduce out-of-pocket costs from Exchange levels</li> <li>• Could present an affordable alternative for very low-income legal immigrants who have been in the U.S. for less than five years</li> </ul>	<ul style="list-style-type: none"> <li>• Uncertainty of Exchange premium amounts makes financial modeling difficult</li> <li>• Movement between in and out of Medicaid/BHP would still occur at 200% FPL</li> <li>• Potential for drawing individuals from the Exchange which could change remaining risk pool in Exchange and modify Exchange costs and revenues</li> <li>• State capacity and infrastructure needed to administer a BHP may be constrained</li> <li>• Medicaid plans, provider networks and provider rates may not be sufficient to assure adequate access</li> <li>• Health status of BHP population is uncertain which makes financial viability of BHP uncertain</li> </ul>

**PRELIMINARY FINANCIAL RESULTS**

This section outlines an approach to analyzing and evaluating a BHP option that could be implemented in Illinois beginning in 2014. It is important to note that the results presented are only illustrative because there are so many uncertainties regarding final regulations and how private insurers and consumers will react to numerous components of healthcare reform that become effective in 2014. The purpose of the analysis is to provide a framework for modeling cash flows under a BHP and to begin the process of estimating the key components that drive those cash flows.

The basic financial structure cash flows of the program break down as follows:

Revenue

- 95% of any premium subsidies the federal government would have paid for BHP enrollees had they been enrolled in the State Exchange. The premium subsidy in the Exchange is based on the second lowest Silver plan rate.
- 100% of enrollee cost sharing subsidies the federal government would have paid had they been enrolled in the State Exchange

Costs

- Medical costs for minimum essential benefits

- Offsets for member cost sharing up to a maximum actuarial value of 10% for 133% to 150% of FL, and 20% for 151%-200% of FPL.
- Offsets for member premiums up to a maximum percent of income (varying by income level)
- Administrative costs incurred by the State, or inherent in private carrier's capitation rates

Any surplus must be held in a State trust fund and be used for future benefits, cost sharing reductions, or premium reductions.

#### PROJECTED CASH FLOWS FOR AN ILLINOIS BHP

Using publicly available demographic data in Illinois, medical cost information from other state programs, and information provided by the State of Illinois, we projected potential CY2014 BHP cash flows under several different scenarios. Descriptions of our process and key assumptions are in the Method and Assumptions section, below.

One of the most important assumptions in our modeling is the estimate of the premium for the second lowest cost Silver Exchange premium, which drives all of the revenues. In the model, in order to capture a range of scenarios, we utilize a range of potential premiums ranging from \$261 to \$392 PMPM.

We estimate that the BHP will result in a range of about (\$493) million to \$482 million in net cash flows in CY2014. Table 24 below shows the revenue and expenses associated with these estimates.

**Table 244: Illinois BHP Cash Flows by Component and Scenario  
CY2014, Amounts in Millions**

Component	Very Favorable	Favorable	Neutral	Unfavorable	Very Unfavorable
<b>Enrollment</b>	286,000	286,000	286,000	249,000	212,000
<b>Revenue</b>					
Exchange Premium Credits	\$830	\$728	\$627	\$455	\$312
Exchange Cost Sharing Subsidy	\$288	\$264	\$240	\$188	\$142
<b>Total</b>	<b>\$1,119</b>	<b>\$992</b>	<b>\$867</b>	<b>\$642</b>	<b>\$454</b>
<b>Basic Health Program Costs</b>					
Allowed Cost	\$1,010	\$1,136	\$1,262	\$1,251	\$1,214
Member Cost Sharing	\$0	\$0	\$0	\$0	\$0
Member Premium	(\$485)	(\$485)	(\$485)	(\$421)	(\$358)
Administrative Costs	\$112	\$124	\$130	\$112	\$91
<b>Total</b>	<b>\$637</b>	<b>\$776</b>	<b>\$908</b>	<b>\$942</b>	<b>\$947</b>
<b>Surplus (Deficit)</b>	<b>\$482</b>	<b>\$217</b>	<b>(\$41)</b>	<b>(\$300)</b>	<b>(\$493)</b>

Many other scenarios are possible, including ones that produce a surplus or (deficit) outside the range shown in Table 24. Each of the scenarios shown in the table (other than "Neutral") are based on

combinations of all favorable or all unfavorable results for certain key variables for purposes of capturing a range of scenarios. We believe it is more likely that only some variables will be more favorable while others will be less favorable than our Neutral scenario.<sup>12</sup>

The assumptions by key variable in Table 24 are summarized below in Table 25.

**Table 255: Illinois BHP Assumptions by Scenario**

Scenario	2nd Silver PMPM	BHP Med Costs PMPM	Administrative Expense %	Employer-Sponsored Take-Up Rate
<b>Very Favorable</b>	\$392	\$272	10.0%	25%
<b>Favorable</b>	\$359	\$306	12.5%	25%
<b>Neutral</b>	\$327	\$341	15.0%	25%
<b>Unfavorable</b>	\$294	\$375	17.5%	13%
<b>Very Unfavorable</b>	\$261	\$409	20.0%	0%

Please note that these assumptions are not a comprehensive set of all possibilities. Rather, these were the assumptions we believe will have the biggest impact on results.

This model is intended to demonstrate how the state can assess the BHP financial arrangement analytically. As the programmatic characteristics of a BHP are more clearly defined, we recommend ongoing analysis of the potential BHP population, its risk profile, and potential revenues to the BHP.

#### NEXT STEPS

As noted at the beginning of this Section, there are many unknowns in the BHP model we have presented. We believe it will be important to continue to refine and improve the assumptions that drive the projected financial results of the BHP and the overall decision to implement a BHP or not. The reader should carefully review the "Methods and Assumptions" section, in Appendix C. In particular, the development of expected medical costs involves several steps with assumptions that should be thoroughly understood before making decisions based on this analysis.

We suggest a number of important considerations that should be closely reviewed as the state evaluates the results presented here and considers the issues surrounding the BHP as it continues with Exchange implementation planning.

<sup>12</sup> The BHP model requires detailed background on the previous source of coverage of BHP-eligible individuals. In other words, cost assumptions in the model are directly related to the source of coverage (i.e., Medicaid, small group, individual market coverage) a BHP enrollee had prior to 2014. During development of our model, we did not have access to that degree of supporting documentation from Deloitte. More importantly, the existence of a BHP would change a range of assumptions and behaviors that would affect actual enrollment in the BHP population, as compared to enrollment in Exchange coverage. Therefore, enrollment assumptions made concerning BHP enrollment are not derived directly from the Deloitte report. Our method for estimating enrollment, and for other components of the analysis, is described in detail in Appendix C.

- We have not modeled or addressed how the Illinois Health Insurance Exchange will be impacted by the BHP. In general we believe that the subset of individuals between 133% and 200% FPL who do not enroll in the BHP will be slightly healthier than those in the BHP. The BHP and Exchange populations are unquestionably linked and we recommend further analysis of the interaction between these two programs, and how a BHP could affect the risk pool in the Exchange.
- There is considerable uncertainty in what the second-lowest Silver premium will be in the Illinois Exchange, and this is a very sensitive variable in determining the overall outcome. We have shown scenarios up to a +/- 20% change in our mid-point estimate; however the rate depends on many factors and could vary beyond this range.
- The relationship of Illinois Medicaid to the BHP in terms of management and operations is an important factor to explore. And the absence of a robust Medicaid managed care program in Illinois raises issues: under what circumstances would the federal government approve the current Medicaid provider network as an adequate BHP delivery system? Is the current network sufficient to ensure access to care for current enrollees, the Medicaid expansion population, and the BHP?

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#### 4.5.4 Early Medicaid Expansion

*This section deals with the option of early implementation of the Medicaid expansion that is required to be implemented in 2014*

Section 2001 of the ACA expands Medicaid eligibility, effective January 1, 2014, to individuals with incomes below 133% of FPL and sets enhanced federal matching rates (starting at 100% from 2014-2016, declining to 90% by 2020) for the costs of the expansion. The same section also authorizes states to implement the expansion earlier than January 1, 2014. An early expansion may be approved by means of a state plan amendment—for Medicaid, a relatively simple process—but the state is required to bear the cost of the early expansion at its prevailing federal medical assistance percentage rate, not the enhanced rates that begin in 2014.

The State of Illinois, like many states, has experienced a precipitous drop in revenue since the recession in 2009. The state's budget situation, while resolved with a final budget for FY2012, remains very challenging. Moreover, the Medicaid program is implementing the Medicaid reform bill that passed earlier this year (H.B. 5420) during FY12. In the context of necessary preparations that HFS and DHS need to make to prepare for health reform implementation and the 2014 expansion, the law will undoubtedly present a challenge to HFS infrastructure and resources. Given these circumstances we have not spent significant time analyzing the cost impact of a choice to implement the ACA early Medicaid expansion.

It deserves mention, however, that waiting until the January 1, 2014 implementation date also creates operational challenges. There are a significant number of individuals who are currently receiving state benefits and will qualify for Medicaid on January 1, 2014. The state may wish to consider approaches that could ease the administrative difficulties (a flood of applications, calls, and enrollments) that could result from a “big bang” implementation.

One consideration is that draft federal regulations set an initial enrollment period beginning October 1, 2013. Without question, the state will necessarily need to have its enrollment systems set up and operable by the time open enrollment begins. While it is difficult at this stage of planning to suggest a particular action or even to propose a set of options, the point is that the state may consider approaches that allow it to receive applications and process them in advance of the January 2014 coverage date so that eligibility begins right away on January 1. Once the potential operational mechanics of such an approach are more clearly defined, the state certainly will need to analyze what we expect will be a trade-off between complicating an already-complex implementation plan before 2014, on one hand, and relative administrative ease on and after January 1, on the other. Notably, there is not a state programmatic cost element to be factored into this equation, since the Medicaid expansion in 2014 will be fully funded by the federal government.

#### 4.6 Other State Programs and the Exchange

*This section addresses how full ACA implementation in 2014 and the reduced uninsurance rates that will follow will impact state programs beyond those administered by HFS.*

Programs other than Medicaid that serve primarily uninsured persons will see a reduction in eligible individuals. Other programs may see an increase in applicants and enrollees as the Exchange brings more Illinoisans into contact with state programs. Some of the programs likely to be impacted by the Exchange are discussed in the following sections.

##### AIDS DRUG ASSISTANCE PROGRAM (ADAP)

Just over 4,000 uninsured individuals with AIDS or HIV and incomes at or below 500% of FPL<sup>13</sup> receive HIV/AIDS prescription benefits of up to \$2,000 a month (with some exceptions) through the AIDS Drug Assistance Program. Data from the May 2011 National ADAP Monitoring Project Annual Report<sup>14</sup> by the National Alliance of State and Territorial AIDS Directors provides Illinois ADAP enrollment statistics for June 2010.

<sup>13</sup> As of July 1, 2011, the Illinois ADAP program will be limited to qualifying individuals with income below 300% FPL.

<sup>14</sup> [http://www.nastad.org/Files/020035\\_2011%20NASTAD%20National%20ADAP%20Monitoring%20Project%20Annual%20Report.pdf](http://www.nastad.org/Files/020035_2011%20NASTAD%20National%20ADAP%20Monitoring%20Project%20Annual%20Report.pdf)

- There were a total of 5,919 ADAP enrollees.
- Enrollees were almost entirely adults, with 95% over 25 and 5% between 13 and 24.
- Most enrollees were low-income individuals. 85% have income at or below 133% of FPL, 8% between 133% and 200% of FPL, 6% between 200% and 400% of FPL, and 1% over 400% of FPL.
- Annual program spending of \$55 million is supported by federal funds, drug manufacturer rebates, and \$20 million of state funds.

As a requirement of ADAP eligibility, enrollees are not eligible for Medicaid. Many low-income ADAP enrollees are likely to be ineligible for Medicaid as a result of not being disabled and not being a parent, categorical qualifications for Medicaid that will be eliminated for individuals below 133% FPL in 2014. As highlighted above, the vast majority of enrollees are in the Medicaid income range. Others are likely ineligible for Medicaid because of citizenship or immigration status. It is not clear how many enrollees are non-citizens ineligible for Medicaid, so it is difficult to estimate the fiscal impact of the ACA on the Illinois ADAP program. Assuming conservatively that 25% of the ADAP population, or 1,480 enrollees, were ineligible non-citizens, 3,773 enrollees would be eligible for Medicaid in 2014. Another 621 individuals would be eligible for subsidized Exchange coverage.

A 75% reduction in state ADAP funds would save the state \$15 million.

Separately from the Medicaid expansion providing full Medicaid coverage for current ADAP enrollees, the ACA presents a variety of opportunities for states to address the needs of individuals living with HIV. These options are outlined in a State Medicaid Director's Letter issued June 6, 2011.

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## ILLINOIS COMPREHENSIVE HEALTH INSURANCE PLAN

The Illinois Comprehensive Health Insurance Plan (ICHIP) has two parts—a high-risk pool for those considered to be “uninsurable,” those who cannot purchase private insurance because of their health status, and the HIPAA (including Trade Adjustment Act) pool. According to the FY2012 Illinois State Budget Book, FY10 ICHIP enrollment totaled 16,904, with 4,568 in the traditional high-risk pool and 12,336 in the HIPAA-CHIP pool. In FY12 ICHIP is supported by \$54.5 million in carrier assessment and \$24.6 million in state general fund dollars. As with the federally funded Illinois Pre-Existing Condition Insurance Plan (IPXP) in the Department of Insurance, the need for the ICHIP pools will end with full implementation of ACA provisions such as guaranteed issue and the individual mandate on January 1, 2014, with enrollees moving from ICHIP to Medicaid or the Exchange.

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## GROUP INSURANCE

Illinois Group Insurance is the state's self-insurance program that provides health insurance and other benefits to state and university employees, retirees, annuitants, and their dependents. There are four Group Insurance programs—the State Employee Insurance and Benefits Program, the College Insurance

Program, Teachers Retirement Insurance Program, and the Local Government Health Plan. According to a report by the Illinois Commission on Government Forecasting and Accountability,<sup>15</sup> the State Employee Insurance and Benefits Program had 351,566 participants in March 2011. Of these, 118,856 are in the Quality Care Health Plan, an indemnity plan, and 232,710 are in managed care plans. FY11 estimated premium costs per participant (employee contributions and state funds) are \$6,339 for enrollees on the state's indemnity plan and \$5,567 for managed care enrollees. Of these amounts, \$5,596 and \$4,913 respectively are paid for by state funds; the remainder is covered by employee contributions.

As the state receives more information on the potential costs of coverage on the Exchange in our Final Report and on the essential health benefits that will be required to be offered under the ACA, the state will be able to more fully compare existing state insurance programs for employees to the coverage available on the Exchange.

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## NON-HEALTH PROGRAMS

TANF, SNAP, job training, and other state programs providing assistance to individuals may experience increased enrollment as a result of the ACA implementation. First, individuals who have always been eligible for state programs but have not applied may be compelled to apply by the individual mandate and may find that they have eligibility for additional programs beyond Medicaid or the Exchange. It is difficult to estimate the extent to which this will occur and the related cost impact. Second, the development of a new and improved IES system in Illinois may similarly influence take-up rates in the state's non-health programs.

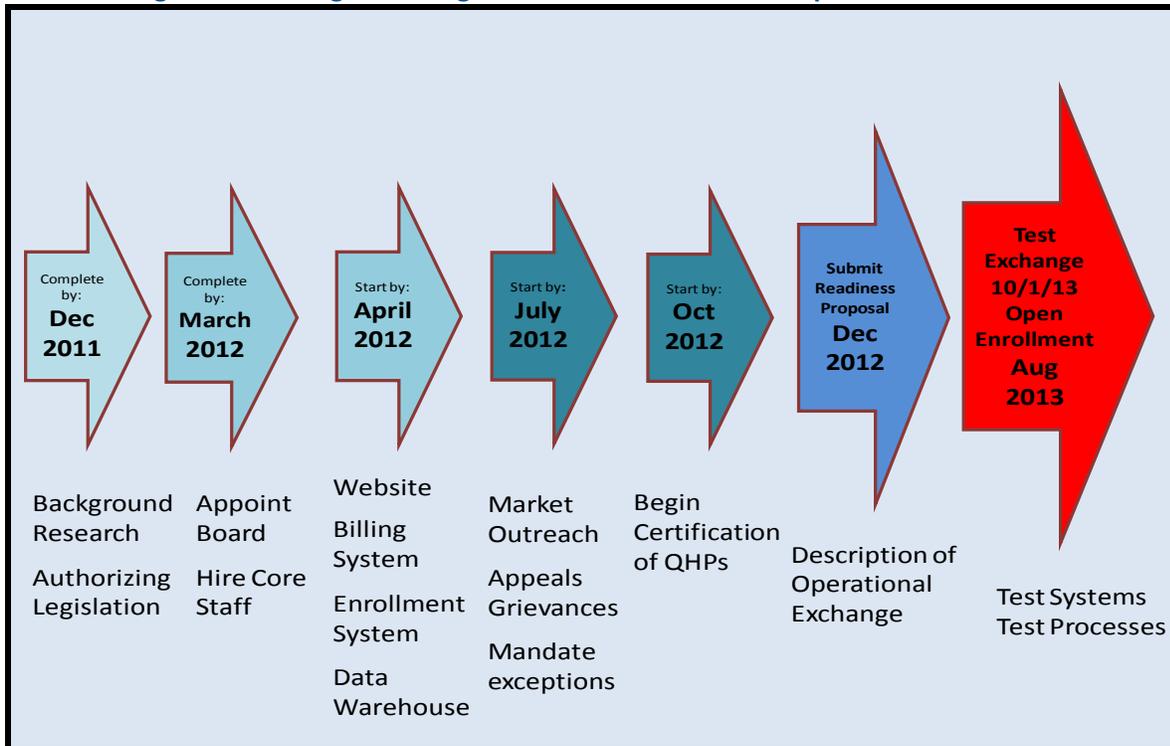
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<sup>15</sup> March 2011 Fiscal Year 2012 Liabilities of the State Employees' Group Health Insurance Program report.

## 5. Next Steps

The work of the HMA Team over the course of this engagement has covered a wide range of issues, and this public report contains an enormous amount of material. As has been noted repeatedly throughout this report, the primary challenge facing Illinois is meeting the very demanding timelines confronting every state planning for health reform implementation. The figure below graphically represents aspects of Exchange planning along a timeline.

**Figure 6: Exchange Planning Activities across the ACA Implementation Timeframe**



The activities organized by date in the figure above refer to areas discussed in varied detail in this report. The graphic is not meant to substitute for a sophisticated project planning effort. It is included to emphasize an immediate and critical point: the most essential step in planning now is to form, through legislative action, an Exchange with appropriate authority over and responsibility for providing direction to the implementation effort.

The federal government, in the context of Exchange establishment funding expectations, has indicated that mid-2012 is a critical milestone for enabling legislation. We think that passage of legislation establishing an Exchange entity, governance structure, and a self-sustaining financing mechanism in 2011 is vastly more preferable and more likely to lead to success. Illinois can coordinate significant planning efforts (and in fact is doing so now). But true progress and concrete steps like hiring and contracting can occur only after an Exchange is established, along with a Board structure and full-time staff with ultimate accountability for success.

Many of the policy and operational decisions faced by the state of Illinois are addressed in detail in this report. We have recommended where appropriate throughout this report areas that warrant additional background research, data collection, or ongoing monitoring of federal regulations. We also recommend that the state set up formalized planning structures that will be capable of supporting an implementation effort of the scale described in this report. Finally, we recommend close collaboration with legislative leadership and with the many stakeholders that will be affected by Exchange establishment in Illinois.

## 6. Appendices

- A. Sample Job Description Outlines
- B. Program participation assumptions for 2014 by age and coverage program
- C. Basic Health Plan Method and Assumptions