ILLINOIS HEALTH BENEFITS EXCHANGE

LEGISLATIVE STUDY COMMITTEE

TESTIMONY FOR THE AUGUST 30, 2011 MEETING

Updated as of August 31, 2011

TESTIMONY

OF THE

ILLINOIS STATE MEDICAL SOCIETY

BEFORE THE

ILLINOIS HEALTH BENEFITS EXCHANGE LEGISLATIVE STUDY COMMITTEE

AUGUST 30, 2011

Presented by:

James E. Tierney

Vice President

State Legislative Affairs

The Illinois State Medical Society would like to take this opportunity to comment on the State of Illinois current activity with respect to the establishment of a Illinois Health Benefits Exchange consistent with the federal Patient Protection and Affordable Care Act (ACA).

A health benefits exchange has the potential to be a valuable method for obtaining health insurance for a large number of Illinois citizens. Given the importance of the exchange, the overriding goal of the exchange should be to foster fair competition among health plans so that individuals have a wide range of options that fit their individual preferences based on consistent information that allows plan comparison.

Governance

ISMS prefers either establishing the exchange within an existing state agency or as a public-private board as opposed to a wholly independent entity. A public private entity would give the exchange flexibility while allowing the state to retain oversight. Regardless of the specific governance structure, it is imperative that practicing physicians be explicitly included in governance structure and governing board along with broad representation of other key stakeholders.

Scope of the Exchange

ISMS believes that the exchange should be open to all qualified plans that meet the ACA criteria as well as the additional exchange transparency requirements discussed below. The exchange should focus on developing the tools to allow consumers to make informed choices rather than directly negotiating prices with health plans. If the exchange is negotiating prices and other issues, patient choice may suffer as certain plans would not be offered on the exchange. An open exchange might encourage new entrants in the concentrated Illinois market, and having the exchange attempt to become a purchaser would only impede such a development.

Qualified Health Plans

The exchange's primary objective should be to maximize health plan choice and provide meaningful information on health plan options so individuals and families can make an informed decision. ISMS believes that patients should have access to a health benefit plan that includes catastrophic coverage as well as preventive services, appropriate screening, primary care, immunizations, and prescription drug coverage. It is our position that individuals should determine what coverage best suits one's individual needs and, therefore, the coverage parameters such as first dollar coverage, deductibles, and the preferred setting for services, etc., could vary according to individual needs and preferences. As a result, the exchange should not restrict the plans offered through the exchange and instead should promote a diverse offering.

We are hopeful that the federal government will allow sufficient flexibility for its criteria for what constitutes a qualified health plan and it will allow the exchange to offer a wide range of plans, including policies that make consumers more cost conscious. Currently many patients pay little or nothing for the health care services they receive and do not know – let alone care – about the costs of their treatment or the various settings in which such care can be rendered. Policies

should be structured to include transparent payment schedules and a combination of deductible, coinsurance, and copayments in order to make patients conscious of the costs of the health care services they are seeking.

Allowing individuals to choose from a variety of plans will have other benefits a well. The exchange has the potential to provide greater choice and transparency than what many individuals currently experience. For individuals receiving employer sponsored insurance, they are limited to the plan selected by their employer. Therefore when physicians and their patients have difficulty receiving approval for treatment the patient has little influence with the health plan because the employer is the customer, not the patient. While the exchange will initially apply only to individuals and small employers, it may serve as a model to empower individual patients to hold plans responsible for their service to patients as opposed to meeting the needs of employers. We see this unresponsiveness especially with plans that choose not to contract with some hospital based physicians. The plan will cite a hospital as in-network and patients only find out when they receive hospital based care that the network is a charade with groups of specialist physicians are not a part of the network. Transparency and competition will allow patients to review health plan practices and to make informed choices regarding which plans best meet their needs.

Exchange Financing

When the exchange becomes self supporting in 2015, ISMS believes that the current Illinois Comprehensive Health Insurance Plan (ICHIP) assessment process should serve as a financing model for the exchange. An assessment on the health plans would be appropriate as the health plans would in effect be paying for a service to market and sell their plans via an online marketplace. The health plans would pay a fee for each plan sold through the exchange just like they currently pay brokers.

ISMS opposes any physician assessment to finance the exchange. Proponents of physician taxes have argued that since more of their patients will have health insurance coverage due to health care reform, physicians will experience a "windfall" of revenue. Such thinking is misguided because there is no assurance that physicians will experience higher net income, and this is especially true when patients obtain Medicaid coverage that sometimes does not even cover the costs of providing care. It is more likely that the health plans will see increased business and benefit in other ways such as by having the exchange perform some of the functions currently performed by health plans such as collecting premiums and distributing information about their plans. Therefore, physicians should not be the funding source for an exchange.

Physician Participation

The vast majority of Illinois physicians contract with several health care plans, but all too often physicians face take it or leave it contracts where health plans refuse to negotiate. Because of the negotiating imbalance between health plans and physicians, often times the only recourse a physician has is to not sign the contract. Therefore, we believe that it will be imperative that physicians maintain their freedom to contract with health plans. Physicians should not have their participation in a health plan offered via the exchange tied to participation in the other plans

offered via the exchange. The ISMS would strongly oppose any requirements for participation in all qualified health plans or Medicaid as unduly restricting a physician's freedom to practice as it would totally eliminate what little ability physicians currently have to negotiate fair contracts with health plans.

Quality of Care Standards

Some exchange proponents see the exchange as an opportunity to impose quality guidelines, best practices, comparative effectiveness research, and other mechanisms on physicians all in the name of quality improvement. The ISMS cautions against the exchange becoming involved in such programs. While the exchange can provide the opportunity to improve the health care provided to patients, ISMS is concerned that "quality measures" often can be used as nothing more than cost containment mechanisms. If the exchange does become involved in regulating quality it will be imperative that health insurer performance standards should also be developed. ISMS believes that the following non inclusive criteria developed by the AMA should be considered in evaluating the quality of a health plan:

- Practicing physicians, physician organizations, and consumers are involved in the development, evaluation and refinement of the program measures (e.g. AMA Physician Consortium for Quality Improvement (PCPI) physician measures).[1]
- The measures shall be representative of the full range of services typically provided by health insurance issuers, including preventive services.
- The capabilities and limitations of the methodologies and reporting systems applied to the data to profile and rank physicians are publicly revealed in understandable terms to consumers.
- An analysis of health insurance issuer performance data collection and analysis methodologies, including establishment of statistically significant sample sizes for areas being measured, shall be developed.
- Performance data used to compare performance among health insurance issuers shall be adjusted for severity of illness, differences in case-mix, and other variables such as age, sex, and occupation and socioeconomic status.
- Health insurance issuer performance data that are self-reported by health insurance issuers shall be verified through external audits.
- The methods and measures used to evaluate health insurance issuer performance shall be disclosed to health insurance issuers, physicians and other health care providers, and the public.

[1] The PCPI is a national, physician-led initiative dedicated to improving patient health and safety by: (1) identifying and developing evidence-based clinical performance measures and measurement resources that enhance quality of patient care and foster accountability; (2) promoting the implementation of effective and relevant clinical performance improvement activities; and (3) advancing the science of clinical performance measurement and improvement. The PCPI develops, tests, implements and disseminates evidence-based measures that reflect the best practices and best interest of medicine.

- Health insurance issuers being evaluated shall be provided with an adequate opportunity to review and respond to proposed health insurance issuer performance data interpretations and disclosures prior to their publication or release.
- Effective safeguards to protect against the unauthorized use or disclosure of health insurance issuer performance data shall be developed.
- The validity and reliability of health insurance issuer performance measures shall be evaluated regularly.
- Health insurance issuers do not have requirements that permit third party interference in the patient-physician relationship.
- Health insurance issuers do not sponsor tiered and narrow physician networks that deny patient access to, or attempt to steer patients towards, certain physicians primarily based on cost of care factors.
- Health insurance issuers provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features.
- Health insurance issuer benefits are designed with input from patients and actively practicing physicians.
- Treatment decisions are driven by the patient and physician.

In addition, to ensure the quality of care, ISMS supports the AMA's health insurer code of conduct principles. These principles outline how to prevent some of the worst health plan abuses. These principles focus on important issues such as access to care, fair contracting and patient confidentiality, medical necessity, benefit management, administrative simplification, physician profiling, corporate integrity, and claims processing. The Health Insurer Code of Conduct Principles are attached.

Transparency of Information

The exchange will need to provide consumers with a great deal of information to assist them in making an informed choice. Information such as the composition of the provider network including accurate provider listings, and services that are included and excluded will be essential. We understand that the exchange will serve a wide range of individuals with varying levels of understanding. The exchange will not only have to present information in easy to understand language for those who may not be familiar with health insurance, but at the same time allow interested consumers to have access to more detailed information.

One of the key pieces of information that consumers will want to obtain from the exchange is details on the adequacy of the physician network. Specifically, they will want to know if a particular physician or local hospital is part of the network. It will be incumbent upon the exchange to explain what it means to be in-network and the relationship between an in-network hospital and the physicians that provide health care at the hospital. All too frequently we see health plans contract with the hospital but not contract with certain hospital based specialties.

Patients may not choose a particular physician from the hospital based specialties of radiology, pathology, emergency medicine or anesthesia but patients should know to what extent a particular health plan has contracted with physicians from these specialties at individual hospitals. Simply listing a hospital as in-network is not sufficient. Specific information on

which physicians provide care at a hospital would help individuals to determine if the health plan has sufficient physicians in the health plan's network. Providing this information would be consistent with the ACA requirement that plans report information on out-of-network policies as well as the requirements of providing adequate provider networks.

In addition to information about the network of providers, the exchange will need to develop a standardized comparison tool with a variety of health plan information. A template developed by the Texas Medical Association can serve as model. The template would require the reporting of:

- Monthly premium;
- Percent of expense paid by plan in-network;
- Percent of expense paid by plan out-of-network;
- Annual out-of-pocket cost:
- Patient total annual cost;
- Justified complaints;
- Premium to direct patient care ratio; and
- Benefit levels, including:
    - Annual deductible;
    - Annual family deductible;
    - Annual in-network deductible;
    - Annual out-of-network deductible;
    - Annual out-of-pocket maximum;
    - Office visit copayment (primary/specialist);
    - RX co-payment;
    - Emergency room visit copayment;
    - Mental health;
    - Outpatient surgery copayment; and
    - Inpatient cost sharing.

Additional information that plans should be required to disclose to patients include utilization data such as:

- Number of hospital admissions per thousand enrollees in the last year for outpatient, manageable, preventable conditions, including but not limited to community acquired bacterial pneumonia, asthma, and diabetes;
- Number of emergency department visits per thousand enrollees in the last year;
- Number of preventive services, such as immunizations, which reduce the need for later, costlier interventions;
- Percent of out-of-pocket costs incurred by enrollees for emergency department visits as a percentage of total enrollee out-of-pocket costs;
- Number of visits to out-of-network providers per thousand enrollees in the last year;
- Percent of services received from in-network providers as a percentage of total services received by enrollees; and
- Percentage of total costs for in-network and out-of-network services received by enrollees which were paid for by the health insurance issuer.

Health Disparities

The elimination of racial and ethnic disparities in health care is an issue of highest priority for the ISMS. The ISMS supports the importance of culturally effective health care in eliminating disparities and exploring ways to provide physicians with tools for improving the cultural effectiveness of their practices. The cost and coverage of interpretive services is one hurdle that has hindered physicians' ability to care for the hearing impaired and non-English speaking patients. Adequate coverage and payment for interpretive services is a solution to one health care disparity problem. Also, the streamlined enrollment process for Medicaid, CHIP, and exchange plans will help to address health care disparities by enrolling more patients and by promoting continuity of care for these patients.

In summary, ISMS requests the General Assembly to consider establishing an exchange that provides patients with meaningful information that allows them to make an informed choice. By providing patients with meaningful health plan data that will allow plan comparisons, competition will increase as will health plan accountability and service.

We look forward to working with you and other interested parties toward establishing an Illinois Health Benefits Exchange that will improve access to care for all Illinois citizens.

AMA
AMERICAN
MEDICAL
ASSOCIATION

American Medical Association's Health Insurer Code of Conduct Principles

Standards for health insurers' administrative and clinical processes

The Code of Conduct is not intended to, and does not convey legal advice. Users of the Code of Conduct should always consult their own legal counsel when considering a legal arrangement.

1. Health Insurance Cancellation and Rescission

- Health insurer decisions to cancel a person's coverage must be subject to independent, outside review.
- Rescission of coverage should not be permitted for innocent mistakes on applications, nor after significant delay.
- Health insurers must not cancel policies of patients who become injured or severely ill after the policy is issued.
- Paying employees or contractors bonuses or rewards for rescinding the policies of sick consumers, our patients, must be prohibited.

2. Health Insurance Premiums and Spending on Medical Services

- Health insurers must calculate health insurance premiums fairly, and different products must be priced proportionate to their actuarial value.
- Health insurers must spend the substantial bulk of the premium dollar on direct medical care.
- Health insurer expenditures on profit and on administrative, non-medical costs (salaries and bonuses, advertising, utilization review, etc.) must be transparent to the public, based on a single standard definition and reporting mechanism.
- Clear information on covered benefits, including co-payments, co-insurance and other information affecting patient financial responsibility must be readily available to patients and their physicians.
- Consumers must receive written justification for premium quotes or renewal increases, and be provided with a fair opportunity and forum to seek redress.

3. Access to Medical Care

- Health insurance benefits, including all medically necessary and emergency care, must be available to all enrollees on a timely and geographically accessible basis at the preferred, in-network rate.
- Provider directories must be easily accessible in paper and electronic formats and clearly and accurately provide consumers with all information relevant to fulfilling the medical needs of themselves and their families. This includes which physicians (including hospital-based physicians), hospitals, and other health care providers are in-network and accepting new patients.
- Directories which include listings for providers who are not freely accessible, such as providers who are in a restricted "tier" or "out of network," must clearly and conspicuously disclose the specific terms of any financial or other access limitations which may apply, such as increased co-payment, co-insurance or other patient financial responsibility.

4. Respectful Relations

- Health insurers must treat all enrollees, physicians and other trading partners respectfully.
- Health insurers must protect the confidentiality of each enrollee's medical information, and must give appropriate deference to the treating physician's skill and professional judgment.
- Patients must be confident that the physicians and other health care professionals in the network may talk freely, without fear of retaliation.
- Health insurers must cease such unfair practices with physicians as demanding unreasonable contract terms, improperly applying contractual discounts, unilaterally amending contracts or refusing to acknowledge contract terminations.

5. Medical Necessity

- Medical care is "necessary" when a prudent physician would provide it to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.
- All emergency screening and treatment services (as defined by the prudent layperson standard) provided by physicians and hospitals to patients must be covered without regard to prior authorization or the treating physician's or other health care provider's contractual relationship with the payer.
- Health insurers must not use financial incentives that discourage the rendering, recommending, prescribing of, or referral for medically necessary care.

5. Medical Necessity *continued*

- No care may be denied on the grounds it is not "medically necessary" except by a physician qualified by education, training and expertise to evaluate the specific clinical issues.
- Patients and their physicians must have the right to a transparent appeal process and obtain a free, timely, external review of any adverse benefit decision based on "medical necessity" or a claim the service is "investigational" or "experimental."

6. Benefit Management

- Clear information on benefit restrictions must be readily available to patients and physicians.
- Decisions based on formularies or other benefit management tools must be consistent with clinically appropriate medical guidelines, and physicians must have a simple, fast way to get exceptions when warranted by their patients' medical needs.
- Adverse changes to formularies or other benefits must not be made during the plan coverage year, and physicians who have stabilized a patient on a particular medication or other treatment regime must not be forced to change those medications or other treatments, nor should these patients be required to incur additional costs based upon such changes.
- Financial incentives must not corrupt benefit decisions, and all financial incentives potentially impacting benefit decisions must be fully disclosed.

7. Administrative Simplification

- Health insurers must eliminate complexity and confusion from their processes and communications.
- Health insurers must comply with all laws governing the use of electronic transactions, and should participate in efforts to improve these transactions.
- Health insurers must provide clear, timely, and accurate eligibility and benefit information on request.
- Requirements imposed on patients, physicians and other health care providers to obtain approvals and respond to information requests must be minimized and streamlined, and health insurers must maintain sufficient staff and infrastructure to respond promptly.

8. Physician Profiling

- Physician profiling systems must be focused primarily on improving the provision of quality care—not on reducing the cost of care.
- Profiling systems must use good and relevant data and produce accurate, statistically valid results reflecting matters within the physician's control.
- Profiling systems must be appropriately risk-adjusted to account for patient variation for co-morbidities, severity of illness, racial/ethnic factors, compliance and other mitigating factors.
- Physicians must be given a meaningful opportunity to review their data, challenge the insurers' profiles and be afforded due process to remedy incorrect profiles prior to their publication or use in determining incentives or network placement.

9. Corporate Integrity

- Health insurers must conduct their business in compliance with the highest levels of corporate citizenship, consistent with their fiduciary obligations to their enrollees.
- Health insurers must comply with the letter and spirit of all laws that protect the clinical and business integrity of their dealings with their enrollees and their dealings with physicians and other health care providers.
- Policies prohibiting conflicts of interest, retaliation against whistleblowers and sharp business practices must be established and aggressively enforced.
- The corporate compliance officer must be adequately funded and staffed, and be given direct and open access to the health insurer's Board of Directors.

10. Claims Processing

- Health insurers must pay claims accurately and timely, and provide clear and comprehensive explanations of how each claim was handled, including the specific reason for any denial of, or reduction in payment.
- All fee schedules, claim edits and payment policies which may affect payment for a service or a patient's financial responsibility must be disclosed in a reasonably understandable, downloadable format.
- Requests for refunds after payment must occur rarely, and then only within a reasonable time after making the initial payment.
- Patients and their physicians must have a fair, fast and cost-effective right to appeal any contested claim.

Pledge your organization's commitment to abide by or support the American Medical Association's Health Insurer Code of Conduct. Visit www.ama-assn.org/go/codeofconduct to pledge and access supplemental resources.

Statement of the Illinois Hospital Association

August 30, 2011

Bill McAndrew
Senior Director, Finance
Illinois Hospital Association

ILLINOIS HEALTH BENEFITS EXCHANGE
LEGISLATIVE STUDY COMMITTEE

Room 114 Capitol, 1:00 p.m.

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ILLINOIS HEALTH BENEFITS EXCHANGE LEGISLATIVE STUDY COMMITTEE
TUESDAY, AUGUST 30, 2011

HEALTH INSURANCE REFORMS AND THE ESTABLISHMENT OF AN EXCHANGE

INTRODUCTION

Good afternoon Distinguished Co-Chairs and members of the Legislative Study Committee, the Illinois Hospital Association (IHA) and hospital community thank you for the opportunity to speak about the formation of a state level health insurance exchange as provided by the federal Patient Protection and Affordable Care Act (ACA). I am here on behalf of our 200 member hospitals and health systems across the state of Illinois. We believe that the ability for the changes contained in the ACA to move Illinois forward will depend on the informed input from all of the stakeholders that will be affected in order to ensure consumers have access to affordable, quality health care. I am here to express the commitment of the Illinois' hospital community to be a fully participating partner in that process.

IHA and the hospital community have been active and supportive participants in prior meetings of the Governor's Health Care Reform Implementation Council and meetings convened by the Department of Insurance. We have provided you with our prepared statements from those meetings.

As a cautionary note, we urge legislators to understand that an array of unprecedented financial changes and turmoil threaten the stability of Illinois hospitals and the health care delivery system. Statewide, one in three hospitals are losing money and many others have very slim positive margins. While Illinois hospitals support health care reform and its promise of coverage for a majority of the state's 1.9 million uninsured, it is important to understand that they are helping finance that reform by absorbing $8 billion in Medicare payment reductions by 2020. In addition, the state has substantially reduced Medicaid and Workers' Compensation funding for hospitals by many hundreds of millions of dollars this year. The recession has swollen the Medicaid rolls and the ranks of the uninsured – putting further stress on hospitals.

It is critical that the State establish a Health Benefits Exchange in ways that do not disrupt the existing marketplace and undermine hospitals and other providers that are critical to the health care delivery system. Specifically, we have several key concerns that we believe the state will have to address as it creates an Exchange.

First, the state shouldn't bite off more than it can chew. We encourage the Committee to build on existing strengths as you deliberate on how any Exchange will be established. For efficiency purposes, the state should work through a single Exchange that recognizes the

limitations on payers' service areas and provider networks just as the commercial market works today.

For many years, Illinois has developed a reasonably competitive commercial insurance marketplace through a system of open competition. In developing a workable, flexible system of health care coverage through an Exchange, IHA recommends that the state start small by focusing first on the mechanics of providing an efficient private health insurance marketplace for consumers both inside and outside of the Exchange. To limit commercial insurance markets to only those plans provided from within the Exchange, either in the individual or small group markets, would create greater volatility in the market. However, Illinois should avoid possible adverse selection by ensuring that plans sold outside the Exchange do not act to undermine Exchange enrollment by offering plan types that would attract potential Exchange applicants through significantly skewed pricing or benefit structures.

Similarly, creating an Exchange that acts as an active purchaser would introduce regulatory controls in a free market system with unknown consequences. While establishing an Exchange that could perform all of the required and optional functions that would be necessary for the Exchange to act as a purchaser of services such as the Massachusetts and California models might be possible, given the lack of familiarity with acting as a purchaser of insurance, the Exchange should limit its role in this respect.

There are numerous other examples that creating an overreaching authority in an Exchange could lead to greater market volatility and could hamper the provision of health care services to consumers. Addressing possible Exchange shortcomings through incremental changes going forward would provide greater health-care and market stability than overextending from the outset and having to reverse course in an atmosphere where such retrenchment would be difficult. It is advisable that the Exchange learn to crawl before it can run.

Second, the Exchange should ensure an open and simple enrollment process. Key to a successful Exchange is consumer participation and avoidance of adverse selection. Thus, ease of enrollment for consumers, ease of insurer administration, and clarity of oversight of plans are necessary for the establishment of a successful Exchange. To ensure a smooth transition to an Exchange format, IHA would recommend establishing minimum requirements as required by the ACA to allow the Exchange to facilitate consumer choice and enrollment and not act as a purchaser of commercial health insurance plans. Consideration should also be given to ensure that persons who are accustomed to the traditional venues for enrolling in Medicaid and other federal and state assistance programs are not forced into an unfamiliar arena to enroll in these programs. The state should ensure the electronic enrollment platforms for enrollment in Medicaid and the state's Children's Health Insurance Program (SCHIP) are developed in such a way to minimize disruption in 2014 when enrollment in these programs will also be incorporated into the Exchange enrollment process. Finally, to assist enrollees, the ACA requires an Exchange to establish a navigator program under which it awards grants to qualified entities to carry out defined education of individuals and facilitate enrollment in qualified plans. Hospitals are often the first contact point for uninsured persons seeking medical care. As such, IHA recommends that hospitals wishing to act as navigators should be awarded navigator status.

Third, IHA urges the Committee to ensure stakeholder involvement in all aspects of Exchange governance. Regardless of the form and structure the Exchange eventually takes, the governance structure should provide adequate access to affected stakeholders, including hospitals, to provide ongoing input and advice in order to ensure consumer protection and plan oversight. To accomplish this, IHA supports the establishment of an Exchange as an autonomous state agency with a specifically defined board representing key stakeholders and a director with a set term of service. We also urge the establishment of an advisory board specifically tasked with providing recommendations to the board based on the ability of the Exchange to ensure the appropriate provision of health care to enrollees.

Fourth, the authority of the Exchange and accompanying provisions relating to the Department of Insurance and other agencies should avoid rate and reimbursement setting. While "bending the cost curve" is an important consideration in health care reform, the Exchange should not engage in any form of rate setting as a cost containment tool. Establishing artificial rates could have significant and unanticipated effects. In particular, government rate setting often results in problems with consumers being able to obtain adequate access to care. Uninsured individuals needing health services, whether through Medicaid or an Exchange health plan, should have similar coverage and similar access to providers. To achieve this goal, the Medicaid provider rates will need to be comparable to the provider rates negotiated by the private plans offered on the Exchange. However, given the importance of having an adequate network of providers, the state should be careful not to use Medicaid reimbursement rates, which are already low, as the floor for the rates in the Exchange. Also, as witnessed in the Massachusetts experiment, the desire for cost controls could lead to a drive to artificially set provider reimbursement rates. Not only could such policies reduce enrollees access to health care, they could also have a deleterious effect on recruiting providers in the state at a time when Illinois is having difficulty attracting primary care physicians.

Because hospitals are key economic engines for Illinois communities, generating not only hundreds of thousands of jobs but also billions of dollars for the state's economy, it is critical during this transition, that hospitals have flexibility to sustain current operations, while simultaneously taking steps to re-align, integrate with other providers, and better coordinate care, in accordance with an expected plethora of new federal rules. The State must resist establishing rigid requirements that impair these efforts. The State should also provide for periodic evaluations of new arrangements and requirements, to allow for mid-course corrections that reflect what is learned by early adopters of new delivery and payment systems.

IHA looks forward to working with this Committee a meaningful and engaged manner to meet the challenge of establishing the best possible health benefit Exchange designed to meet the needs of the citizens of Illinois and to ensure the successful enactment of the ACA in Illinois. If you have any questions about our comments, please contact Bill McAndrew, Senior Director, Finance, at bmcandrew@ihastaff.org or (217) 541-1179.

December 3, 2010

Michael Gelder
Chairman
Illinois Health Care Reform Implementation Council
100 W. Randolph, Suite 16-100
Chicago, IL 60601

RE: The Affordable Care Act: Key Issues for Public Comment

Dear Chairman Gelder:

On behalf of our 200 member hospitals and health systems across the state of Illinois, the Illinois Hospital Association (IHA) appreciates the opportunity to respond to the Illinois Health Care Reform Implementation Council (Council) request for comment on Health Insurance Reform and the Option of Establishing an Insurance Exchange in Illinois as provided by the *Patient Protection and Affordable Care Act* (ACA).

IHA supports the creation of health insurance exchanges (Exchanges) as marketplaces to not only expand consumers' access to health insurance coverage, but also allow consumers the opportunity to choose health plans that fit their needs. With the proper framework and guidance, the Exchanges will ensure the efficient operation of a marketplace for private health insurance. IHA will be addressing all aspects of the ACA that affect Illinois hospitals, including the formation of an Exchange, in a formal document to be delivered to the Council in the near future. We did, however, want to take this opportunity to specifically address the questions presented in the request for comment issued November 16, 2010.

I. Functions of a Health Benefit Exchange

Questions to Consider:
1. What advantages will Illinois see in operating its own exchange versus permitting the U.S. Department of Health and Human Services (HHS) to run an Exchange for the State?

IHA believes that it is incumbent on the state to both elect to establish an Exchange and to ensure appropriate steps have been taken to ensure the Exchange will be operational by January 1, 2014. Allowing the establishment of an Exchange to default to the federal government would not be in the interest of Illinois citizens. Such action would make it difficult for the Exchange to recognize the nuances of state-specific markets, reduce the likelihood of meaningful stakeholder involvement

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in Exchange decisions, and lead to possible conflicts with existing state programs and regulations relating to the regulation of insurance plans and the administration of the state's Medicaid program.

2. What are the most desirable outcomes from an insurance market perspective? What features should the Exchange contain in order to reach those outcomes?

Key to a successful Exchange is consumer participation and avoidance of adverse selection. Thus, ease of enrollment for consumers, ease of insurer administration, and clarity of oversight of plans are necessary for the establishment of a successful Exchange.

3. What, if any, Exchange functions beyond the minimum clearinghouse functions required in the ACA would benefit Illinois and why?

In developing a workable, flexible system of health care coverage through an Exchange, IHA recommends that the state start small by focusing first on the mechanics of providing an efficient private health insurance marketplace for consumers.

4. What advantages are presented to Illinois if the Exchange were to limit the number of plans offered; for example, plans could be required to compete on attributes such as price or quality rating? Is the Exchange a stronger marketplace if it permits "any willing provider" to sell coverage?

Given the state's limited assets, IHA believes that the Exchange should allow the market and a plan's self-assessment to determine whether a plan participates in the Exchange. While it might be possible to establish an Exchange that could perform all of the required and optional functions that would be necessary for the Exchange to act as a purchaser of services, such as the Massachusetts and California models, given the lack of familiarity with acting as a purchaser of insurance, the Exchange should limit its role in this respect.

II. Structure and Governance

Questions to Consider:
1. If Illinois chooses to establish its own Exchange, which governance structure would best accomplish the goal of more affordable, accessible health insurance coverage? Why?

While IHA has not dismissed the idea of housing the Exchange in an existing department and would actively work to ensure its efficient operation within a departmental structure, IHA supports the establishment of an Exchange as an autonomous state agency with a specifically defined board representing key stakeholders and a director with a set term of service. Not only would such governance maintain stability and neutrality during political change, it would also allow other key agencies, such as the Department of Healthcare & Family Services (DHFS), the Department of Insurance (DOI), and the Department of Public Health (DPH), to continue to focus on their existing duties and responsibilities.

2. If the Exchange is run by an executive director and/or a governing board, what should be the expertise of those appointed? How long should the terms be? Are there existing models to which the State should look?

IHA recommends that the governing board of the Exchange should be broadly defined with a sufficient number of board members to encompass a diverse variety of stakeholders including health care advocates and providers. Within such a construct, the directors of affected state agencies should serve as ex officio members on the board. Conceptually the Exchange could function in a similar manner to the Illinois Comprehensive Health Insurance Plan (ICHIP), but the director and board would need to be more independent of stakeholder interests than the current CHIP board.

III. The External Market and Addressing Adverse Selection

Questions to Consider:
1. Should Illinois establish a dual market for health insurance coverage or should it eliminate the external individual market and require that all individual insurance be sold through the Exchange? What would be the effects of doing so?

Because the only way to access the federal subsidy would be through the Exchange, it is possible that the Exchange will be the de facto market for the uninsured. Therefore, in order to ensure as little market disruption as possible, it may be advisable to allow the continued existence of an individual market external to the Exchange as an alternative for persons who may not be seeking or needing subsidies. Market and Exchange enrollment experience could guide future decisions to combine the Exchange and external markets. To make the decision to combine the two markets at the outset has the potential for creating even greater volatility in the market.

2. What other mechanisms to mitigate "adverse selection" (*i.e.* requiring the same rules for plans sold inside and outside of the Exchange) should the state consider implementing as part of an Exchange?

In order to avoid adverse selection, Illinois should ensure that plans sold outside the Exchange not act to undermine Exchange enrollment by offering plan types that would attract potential Exchange applicants through significantly skewed pricing or benefit structures.

3. Are there hybrid models for the Exchange the State should consider? What characteristics do they offer that would benefit Illinoisans?

To ensure a smooth transition to an Exchange format, IHA would recommend establishing minimum requirements as required by the ACA to allow the Exchange to facilitate consumer choice and enrollment and not act as a purchaser of commercial health insurance plans. While as of yet untested, this type of system would most closely mirror the Utah model.

4. If the Exchange and the external market operate in parallel, what strategies and public policies should Illinois pursue to ensure the healthy operation of each? Should the same rules apply to plans sold inside and outside an Exchange? Should the same plans be sold inside and outside the Exchange without exception?

In order to avoid adverse selection, Illinois should ensure that plans sold outside the Exchange not act to undermine Exchange enrollment by offering plan types that would attract potential Exchange applicants through significantly skewed pricing or benefit structures.

5. What rules (if any) should the State consider as part of establishing the open enrollment period?

IHA recommends the Exchange should limit enrollment periods to minimize the potential for adverse selection. The initial enrollment period should be open for at least six months to take full advantage of providing coverage of uninsured individuals. To balance the concerns of adverse selection with the need to decrease the number of uninsured, yearly enrollment should be divided into two semiannual open enrollment periods; the first running from mid-May to the end of June with coverage becoming effective July 1. The second would run from mid-November to the end of December with coverage becoming effective January 1. Special enrollment periods should be established that use the requirements established by HIPAA and state continuation requirements for group health plans as a platform, but tailored for persons losing prior individual coverage.

6. The ACA requires states to adopt systems of risk adjustment and reinsurance for the first three years of Exchange operation. How should these tasks be approached in Illinois? What are issues the State should be aware of in establishing these mechanisms?

Efforts should be made to ensure that any adjustments made both ensure a favorable market in order to lure insurers to participate in the Exchange, and are minimally invasive in order to allow market forces to guide the healthy regulation of the open market. It may be that with the proper establishment of the Exchange, the use of such adjustments might be unnecessary except in circumstance of extreme imbalance of risk.

7. Given the new rules associated with the Exchange, and the options available for restructuring the current health insurance marketplace, what should the state consider as it relates to the role of agents and brokers?

While IHA does not take a position on the specifics of this issue, ensuring a commercial market outside of the Exchange should serve to placate concerns of producers.

IV. Structure of the Exchange Marketplace

Questions to consider:
1. Should Illinois operate one exchange or two separate exchanges for the individual and small group markets? Why?

The choice of either of these schemes should not affect how providers interact with consumers or payers. Still, IHA can see where combining these two markets may be necessary to ensure a sufficient population to establish a risk pool.

2. What should the Illinois definition of small employer be for initial Exchange participation in 2014?

IHA believes the likelihood for success of the Exchange will depend on establishing a limited and orderly transition to the ACA requirements. Therefore, while the Exchange will have to accept groups of 100 in 2016, the current definition of small group in Illinois should be maintained until the Exchange is operational and has demonstrated the capacity to take on greater responsibilities.

3. Should Illinois consider setting any conditions for employer participation in the shop Exchange (*e.g.* minimum percent of employees participating, minimum employer contribution)?

IHA believes that the Exchange should not be involved with making such determinations unless market forces show that coverage that otherwise would be available is being denied to employer groups.

4. Should Illinois permit large group employers with more than 100 employees to participate in the Exchange beginning in 2016? Are there any special considerations for including this group of which the State should be aware?

It is best to leave this decision to a future date in order to assess the market effects of the Exchange. The Exchange should not commit up front to making decisions that could either affect the smooth running of either the Exchange market or the external large group market.

5. Should Illinois consider creation of separate, regional exchanges for different parts of the State? Should Illinois consider a multi-state Exchange?

For efficiency purposes, the state should work through a single Exchange that recognizes the limitations on payers' service areas and provider networks just as the commercial market works today. Multi-state Exchanges should be considered only after the establishment of the state Exchange and with enough risk experience to guide the decision to expand the Exchange.

V. Self-Sustaining Financing for the Exchange

Questions to consider:
1. How should the Exchange's operations be financed, after federal financial support ends on December 31, 2014?

Assessing insurers is the most obvious option for funding, but how far afield to cast the net for such an assessment will need to determined based on actual experience.

2. What are the ramifications of different financing options, specifically as they relate to the unique characteristics of Illinois' existing economy and health insurance marketplace?

Whatever the source of funding, it is imperative that any state fund for the administration of the Exchange should be statutorily protected from use for other state funding purposes.

3. Should the State consider a separate funding source for maintaining state benefit mandates? If so, what are some options?

Given current state budget constraints, it will be difficult to justify diverting funds from existing uses to independently fund existing state mandates. IHA has submitted comments to the Secretary recommending that the definition of essential benefits be broad enough or flexible enough to encompass existing state mandates.

VI. Eligibility Determination

Questions to Consider:
1. How should the Exchange coordinate operations and create a seamless system for eligibility, verification and enrollment in the Exchange, Medicaid, the Children's Health Insurance Plan (CHIP), and perhaps other public benefits (food stamps, TANF, etc.)?

For health reform to achieve its potential, it is critical that the enrollment process be simple and easy for consumers. The state should ensure the electronic enrollment platforms for enrollment in Medicaid and CHIP are developed in such a way to minimize disruption in 2014. Consideration should also be given to ensure that persons who are used to the traditional venues for enrolling in Medicaid and other federal and state assistance programs are not forced into an unfamiliar arena to enroll in these programs.

To assist enrollees, the ACA requires an Exchange to establish a program under which it awards grants to qualified entities to carry out defined education of individuals and facilitate enrollment in qualified plans. IHA recommends that hospitals wishing to act as navigators should be awarded such status based on the fact that they are often the first contact point for uninsured persons seeking medical care.

2. When enrollees move between public and private coverage, how should Illinois maintain continuity of health care -- in plan coverage and in availability of providers, e.g. primary care physician?

Uninsured individuals needing health services, whether through Medicaid or an Exchange health plan, should have similar coverage and similar access to providers. To achieve this goal, the Medicaid provider rates will need to be comparable to the provider rates negotiated by the private plans offered on the Exchange. However, given the importance of having an adequate network of providers, the state should be careful not to use Medicaid reimbursement rates, which are already low, as the floor for the rates in the Exchange.

In addition, current Illinois law already has protections for persons covered by an HMO who lose access to their provider due to the provider leaving the HMO's network. Section 25 of the Managed Care Reform and Patient Rights Act (215 ILCS 134/25) establishes time frames for continuing to see a provider under these circumstances given the provider's acceptance of various terms, including accepting the plan's established applicable reimbursement rates. We believe that such transition language could be used as a starting point for drafting language that would help ensure continuity of providers when persons transitioning out of Medicaid into a commercial plan when the Medicaid provider is not part of the plan's network.

3. What will maximize coordination between Medicaid as a public payer and insurance companies as private payers offering health insurance on the Exchange in their provider networks, primary care physicians ("medical homes"), quality standards and other items?

Because hospitals are key economic engines for Illinois communities, generating not only hundreds of thousands of jobs but also billions of dollars for the state's economy, it is critical during this transition, that hospitals have flexibility to sustain current operations, while simultaneously taking steps to re-align, integrate with other providers, and better coordinate care, in accordance with an expected plethora of new federal rules. The State must resist establishing rigid requirements that impair these efforts. The State should also provide for periodic evaluations of new arrangements and requirements, to allow for mid-course corrections that reflect what is learned by early adopters of new delivery and payment systems.

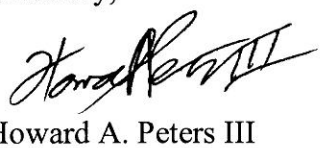
In addition to the concepts of a "medical home" (where each patient receives primary care and management of overall care to address chronic conditions and promote wellness), and bundling (where the payment for an "episode of care" is to be distributed among various providers in different settings, such as the physician's office, the hospital, and the nursing home, in an effort to increase patient care coordination among providers), another health reform model that is being promoted is the Accountable Care Organization (ACO). Entering into ACO agreements would enable groups of health care providers to become jointly responsible for a population of assigned Medicare patients, and to share in savings realized from higher quality and lower cost patient care. In theory, this model can also work outside the Medicare arena as well to assist in coordinating payments across commercial and public coverage. IHA supports the ACO concept as a key framework upon which to build collaboration and efficiencies and will work with its members, the state and other interested parties to implement ACOs.

4. Should Illinois establish a "Basic Health Plan"? If so, what should be included in such a plan? Specifically, what does a "basic health plan" offer as a tool to facilitate continuity of coverage and care?

Assessing the need to establish a Basic Health Plan should be predicated on whether the minimal requirements of the Exchange are not fully capturing the needs of the uninsured population. With experience, it may very well be that the increased coverage options currently anticipated by the ACA will create adequate avenues for coverage.

IHA looks forward to working with you and the Council to meet the challenge of establishing a viable Exchange and to ensure the successful enactment of the ACA in Illinois. If you have any questions about our comments, please contact Bill McAndrew, Senior Director, Finance, at bmcandrew@ihastaff.org or (217) 541-1179.

Sincerely,



Howard A. Peters III
Executive Vice President

Illinois Hospital Association

TESTIMONY BY JOHN BOMHER
SENIOR VICE PRESIDENT
ILLINOIS HOSPITAL ASSOCIATION

ILLINOIS HEALTH CARE REFORM IMPLEMENTATION COUNCIL
WEDNESDAY, SEPTEMBER 22, 2010

HEALTH INSURANCE REFORMS AND THE ESTABLISHMENT OF AN EXCHANGE

INTRODUCTION

Mister Chairman and members of the Illinois Health Reform Implementation Council, the Illinois Hospital Association and hospital community thank you for the opportunity to speak about the formation of a state level health insurance exchange as provided by the federal Patient Protection and Affordable Care Act. I am here on behalf of our 200 member hospitals and health systems across the state of Illinois.

The Illinois Hospital Association and the hospital community recognize that the state faces enormous challenges in forming a state exchange that will assist in improving the health of Illinois' residents by increasing access to health care, reducing disparities, controlling costs, and improving the affordability, quality and effectiveness of health care. As part of our mission to care for our patients and communities, Illinois hospitals are key anchors of the state's health care delivery system – providing quality, accessible care to all who need it – and are vital economic engines for their communities and the state – providing hundreds of thousands of jobs to strengthen local and state economies.

We greatly appreciate the Governor's formation of this Council and the goal of health care reform in Illinois and across the nation. We fully support the creation of health insurance exchanges as a mechanism for consumers to choose health plans that fit their needs. That being said, hospitals are also concerned, as employers throughout the state, that the significant changes required by the federal law do not adversely impact the benefits inherent in the existing health care delivery system. A key factor in that system has been the presence of a competitive market for commercial health insurance.

So, Illinois hospitals examine this issue not only as health care providers, but also as major employers. According to a new report by the Illinois Hospital Association (IHA), the state's 200 hospitals and health systems employ more than a quarter of a million people, resulting in 426,700 direct and indirect jobs, and generate a total annual impact of $75.1 billion on the state's economy. Among the report's other findings:

- Health care and social assistance will be the second fastest growing sector in the Illinois economy in the next eight years;
- Health care and social assistance are projected to create the greatest number of jobs of any sector – nearly 150,000 jobs by 2018; and
- The vast economic activity generated by the health care sector makes it the sixth highest contributor to the state's Gross Domestic Product, accounting for 6.8% of Illinois' economic activity.

With these facts in mind, we all understand that the new law will require dramatic changes in the way people access health care and how such access is funded, but we encourage the Council to build on existing strengths as you deliberate on how any Exchange will be established. We believe that the ability for such changes to move Illinois forward will depend on the informed input from all of the stakeholders that will be affected in order to ensure consumers have access to affordable, quality health care. I am here to express the commitment of the Illinois' hospital community to be a fully participating partner in that process.

It is our intent in the near future to provide this Council with our vision of a blueprint to accomplish the formation of an exchange that will meet the needs stated above, but we would like to initiate our involvement by highlighting several key areas of concern that we would ask the Council to consider as it prepares its recommendations to the Governor.

ISSUES

Governance

Regardless of the form and structure the Exchange eventually takes, the governance structure should provide adequate access to affected stakeholders, including hospitals, to provide ongoing input and advice in order to ensure consumer protection and plan oversight.

Cost Containment

While "bending the cost curve" is an important consideration, the Exchange should not engage in any form of rate setting as a cost containment tool. Establishing artificial rates could have significant and unanticipated effects. In particular, government rate setting often results in problems with consumers being able to obtain adequate access to care. In addition, it is imperative that the quality criteria established to ensure the efficiencies in the system are based on nationally recognized quality measures and that there be consistency and uniformity in how such measures are applied.

Enrollment

For health reform to achieve its potential, it is critical that the enrollment process be simple and easy for consumers. Additionally, the state should ensure that the Exchange set the enrollment periods to minimize adverse selection. The state should ensure the electronic enrollment platforms for enrollment in Medicaid and CHIP are developed in such a way to minimize disruption in 2014. Consideration should also be given to ensure that persons who are accustomed to the traditional venues for enrolling in Medicaid and other federal and state assistance programs are not forced into an unfamiliar arena to enroll in these programs.

Qualified Health Plans
In establishing which qualified health plans will participate in the Exchange, a wide range of plans, from locally based to statewide integrated health systems, including hospital and physician-based systems, should be considered.

Network Adequacy
The Exchange should have the ability to ensure that any qualified health plan meets network adequacy criteria and that network adequacy is measured and evaluated on an ongoing basis.

CONCLUSION
It is critical that the Council, the Governor's Office, the General Assembly and all the stakeholders involved in the delivery of health care to Illinois consumers, come together to establish an Exchange that will meet the requirements of the federal law in a manner that recognizes the challenges faced by the health care delivery system in this State.

We look forward to working with you in a meaningful and engaged manner to ensure we develop the best possible health benefit exchange designed to meet the needs of the citizens of Illinois.

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MEMORANDUM

Date: August 30, 2011

To: Illinois Health Benefits Exchange Legislative Study Committee

From: Mr. Dave Marsh
Director of Governmental Affairs, Illinois State Dental Society
Mrs. Dionne Haney
Director of Professional Services, Illinois State Dental Society

Re: Testimony

Thank you for allowing us the opportunity to provide testimony concerning the Illinois Health Insurance Exchange plan as required by the Affordable Care Act. We have outlined below the Illinois State Dental Society's concerns and major areas of distinction that we feel are important to consider as you develop the framework for the Illinois Health Insurance Exchange.

The Insurance Exchange will affect dentistry in *three* ways:

1. Healthcare Provider
    - Mandated pediatric care benefit.
    - Provider of dental services in any dental plans offered by exchange.
2. Insureds
    - 75% of dentists practice in a solo private practice office or with one associate dentist and small staff.
    - Currently many dentists cannot afford the high cost of their individual coverage.
3. Small Business Owners
    - Costs of small group plans are increasingly expensive, no longer affordable.

Dentistry is different from other healthcare models.

- Many medical plans offer a network of physicians, hospitals and pharmacy benefits. The dental coverage/plan is either a distinct plan offer by the same medical insurance company or the dental plan is purchased from a separate stand-a-lone dental insurer.
- In medicine, ICD-9 codes are used for diagnostic codes, dentistry has no diagnostic codes.
- In medicine, CPT codes are used while dentistry uses CDT for procedure and billing.
- Dentists enroll and are part of a different and distinct network of PPO and HMO providers.
- While a patient's dental health is part of their overall health, the delivery systems traditionally have not mixed well.

As the framework for Illinois' Insurance Exchange develops, ISDS supports:

- Encouraging prevention and routine wellness visits; with an establishment of a dental home by age one for every covered child;
- Maintaining as many dental choices for patients as possible, including allowing stand-a-lone plans. Fee-for-service plans should also be included, as their plan

design requires patients to pay a large portion of the more expensive services provided;

- Dental plans should not simply be an add-on to a medical plan or a sub-contractor;
- Dental plans offering dental benefits should not contain deductibles or patient co-payments for preventive, diagnostic and emergency services because they discourage patients from seeking care. (i.e. Prevention services be covered 100% with no deductible and co-payments.)

The Illinois State Dental Society remains committed to assisting the committee in identifying any administrative or benefit design issues so that they fit into a workable dental delivery model which in most cases is not compatible with existing medical models.

Campaign for Better Health Care

The Voice of Illinois Consumers

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Illinois Health Benefits Exchange Legislative Study Committee
Testimony – August 30, 2011 – Springfield State Capitol
Jim Duffett – Executive Director - Campaign for Better Health Care

Good Afternoon. My name is Jim Duffett and I am the Executive Director of the Campaign for Better Health Care (CBHC). CBHC is a coalition of nearly 350 diverse organizations ranging from small businesses, providers, unions, communities of faith, communities of color, disability and many others.

Thank you for allowing CBHC to testify and we are ready to provide background resources and support to this Committee as it prepares its recommendations.

The Competitive Health Care Marketplace (formerly called the insurance exchange and the focal point of this Committee) is based upon a health care law pasted and enacted in Massachusetts that was signed into law by former Republican Governor Romney, and supported by both Republican and Democratic members of the Massachusetts General Assembly. No matter what your political view is regarding the new federal health care law, it is the law and it is a floor that gives Illinois the ability to craft what we believe should be best for Illinois small businesses and individuals.

If done well, the Competitive Health Care Marketplace would make it easier for small businesses and individuals to buy health insurance and lead to lower prices because of

increased competition. But, if designed poorly or if this process is controlled by the insurance industry, small businesses and healthy people will avoid the exchange, leaving it to sicker people with rising premiums. This Committee will have failed the people of Illinois.

As of August 17, 2011, 38 states and the District of Columbia have introduced some form of legislation promoting the marketplace implementation: ten states have already enacted such bills into law, nine states have passed similar legislation like the one that has established this Committee to move forward, and only nine states did not introduce legislation this year, thus increasing the prospects that their state will be part of the new national Marketplace.

The competitive health care marketplace gives consumer more control, quality choices, and better protections when buying insurance. This new marketplace should be as easy as using the website, similar to Travelocity or Consumer Reports. It must be easy to understand information that allows us to make real comparisons between plans so that we can find the one that best meets our needs and budget. This site should be closely monitored to prevent fraud and protect consumers.

To make sure that the criticism that is so often lodged on the Illinois General Assembly that legislation that is passed is based on "politics as usual" does not contaminate this process -- we are urging that the Illinois General Assembly legislate the same requirement as their Republican and Democratic members of Congress did. That on January 1, 2014 all elected officials of the Illinois General Assembly and the Administration, in order to receive their taxpayer subsidized health care will be required to get their insurance through the Illinois Marketplace, that will also include over one million hard working Illinoisans.

This marketplace will finally give consumers greater control, more choice, improve quality, increase transparency, and create much needed competition in the insurance marketplace.

There are several major issues that the Illinois General Assembly will need to decide on in the coming month. We urge this Committee, at this time, to only focus on two of them that I will briefly discuss. We believe to try to address all the other issues, some that I will comment on later, is impossible to do in just 5-6 weeks.

I. ➢ Who should oversee the decision-making process (Governance) and make the rules of this new Marketplace?

- This new Marketplace should be located at a *new quasi-governmental entity* and maintain its independence from all state agencies.

- This Marketplace should be operated for the *benefit of patients, small businesses and their employees*, not insurance companies.

- Rules should include a *strong conflict of interest* provision that generally bars anyone who will profit from this Marketplace, such as insurers, agents or brokers, health care facilities and health care providers from having a seat on the Marketplace Governing Board. However, a separate advisory board could represent insurer, producers, and provider interests. Marketplace board members should be free from conflicts of interest and instead should represent policyholders of this Marketplace as primary stakeholders. Conflicts of interest should also be avoided by enacting legislation or incorporating by reference existing state legislative provisions that would prohibit Marketplace managers or board members from moving directly to or from the insurance industry.

- The Marketplace *decision-makers* (governance board) *should comprise* of multiple consumers, small businesses, or employee representatives who encompass a variety of demographic variables. Representation should also include: health economists, actuary, lower-income and minority communities (particularly those with limited English competency), rural, and individuals with chronic diseases and disabilities who have a special stake in this Marketplace should be represented.

- *Transparency:* This Marketplace should require all board meetings to comply with open meeting laws and to allow groups to gather information and hear about the decisions made by the decision-making board.

- This Marketplace should be staffed with or have immediate access to *experienced experts* who could resolve marketplace issues quickly and make recommendations to the Marketplace board.

II. ➢ How should this Marketplace be financed and self-sustaining to pay for its many functions?

• *Multiply sources of revenue:* Illinois' Insurance Marketplace should develop a variety of revenue sources to fund the Exchange. The state should carefully consider all options and choose the option that encourages or at least does not discourage participation in the Marketplace, and that promotes transparency and cost-effectiveness to consumers. The funding option must not shrink, but should grow and be an ongoing stable source of revenue.

• *Main revenue source*: Most of the operational funding for the Marketplace should come from an assessment on all insurers in the health insurance market, including administrators of self-funded plans. This assessment would be justified by the fact that the current shifting of the cost of covering the uninsured from providers to insurers would be reduced by the presence of the Marketplace, as the Marketplace will cover many of the uninsured. The Marketplace will also expand insurance markets, benefiting all insurers. The more enrollees in the Marketplace, the less the assessment will need to be. Currently, Illinois insurers have nearly $30 billion in reserves, one of the largest reserves in the nation.

• *Protection of Consumers*: The state should consider whichever financing option has the least likelihood of adding to consumers' cost for coverage.

• The Marketplace should be *the entity that collects premium payments* and premium credits from the federal subsidies and contributions from employers. Premium/payment collection should not be the responsibility of health plans within the Marketplace. The Marketplace should process applications for coverage and subsidies, bill enrollees, develop and maintain the website, perform marketing and outreach, and train navigators and enrollment workers. This will cut administrative costs, and improve plan ratio of spending on medical coverage vs. non-medical expenses.

III. Lastly some other provisions:

➢ Who should be eligible to purchase health insurance in this Marketplace?

• ~~*Uninsured individuals and small businesses as* detailed in this new law;~~

• There *should NOT be a prohibition of small businesses or groups of more than 50 individuals* from joining the Marketplace. Further assessment on this issue should be done, however, it would be "politics as usual" if such a provision were to become law at this time, which would have a negative affect on businesses and hundreds of thousands of Illinoisans throughout the state.

• There should be *one overall insurance pool* versus two to maximize efficiency and spread the overall risk.

• This Marketplace should *minimize adverse selection* to ensure stability both within and outside of the Marketplace. Health plans should meet minimum standards for

participation in the Marketplace and the Marketplace should have the authority to levy sanctions on plans not compliant with the Marketplace's rules of operation. *The same rules governing insurance plans inside the Exchange should be the same as outside of the Exchange.*

• The Marketplace should ensure *adequate choices of health plans,* providers, and coverage options for all populations and for various geographic regions of the state. The Marketplace should ensure that health plans offered thru it are accessible and available to individuals from diverse cultural origins and financial backgrounds, and those with low-literacy, disabilities and limited English proficiency.

• The Marketplace should *coordinate outreach with existing public programs* to ensure that Exchange enrollees eligible for federal tax credits and cost-sharing reductions enroll and maintain their coverage, and also to ensure seamless coverage and continuity of care as people move between public programs and Exchange coverage.

• The Exchange should be an *active purchaser of health care,* using its leverage to limit administrative costs, improve health care outcomes, maximize enrollment, and cost transparency.

I want to thank you for your time and commitment to make this new Marketplace serve the interest of Illinois small businesses and consumers, and not just the insurance industry. I also hope that this committee will allow several small businesses networks that were unable to make it to Springfield today to testify at a future hearing.

Thank You.

For More Information:
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champaign county HEALTH CARE CONSUMERS

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Grassroots organizing for health care justice and access since 1977.

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Sen. Heather Steans
Sen. Bill Brady
Sen. John Jones
Sen. Dave Syverson
Illinois Health Benefits Exchange Legislative Study Committee
C/O Commission on Government Forecasting and Accountability
703 Stratton Office Building
Springfield, IL 62706

August 24, 2011

Dear members of the Illinois Health Benefits Exchange Legislative Study Committee,

Champaign County Health Care Consumers (CCHCC) is a non-profit, grassroots, health care advocacy organization located in Champaign, Illinois. We work to give consumers a voice in the health care system and to make sure that the health care system, laws, and rules are designed to put consumers first.

CCHCC supported the passage of national health reform – the Patient Protection and Affordable Care Act – as it addresses many of health insurance issues facing Americans. One key element of national health reform is the establishment of a health insurance exchange in each state. The health reform law gives states great flexibility in designing an exchange that works best for each state. *As the committee of legislators working to develop the proposal on the Exchange, you have a great responsibility to ensure that the Health Benefits Exchange in Illinois will be successful—specifically in addressing the needs of the residents and health insurance consumers of Illinois—to make the Exchange as affordable, accessible, transparent, and consumer-friendly as possible.*

Below is a list containing fifteen recommendations that we strongly believe need to be part of establishing the Health Benefits Exchange in Illinois.

1. Health Benefits Exchange planning, implementation, and governance must be transparent and receptive to public input.

2. The governing body of the Exchange needs to include consumer representatives as official members. The governing body should not include members who may have conflicts of interest due to affiliations with health care or insurance industries.

3. The Exchange operating entity should be subject to state laws regarding transparency, open meetings, and public input for decision-making bodies, along with other measures that seek to ensure the accountability and integrity of the entity.

4. As required by the Affordable Care Act, consumers need to be able to go to a single website, use one application to find out whether they and their family members are eligible for premium credits, Medicaid, or the Children's Health Insurance Program, and then be able to easily enroll in coverage. Since internet access and use is not possible for everyone, residents have to be able to apply for coverage—and to be assisted in doing so when needed—at community locations, such as social service agencies, health centers, community centers, and other public places. Under the Affordable Care Act, Illinois needs to use existing federal and state financial documents and other information, rather than requiring people to submit all new documentation, when they apply for coverage.

5. The Exchange should be designed to meet the particular needs of individuals who, due to income fluctuations, "transition" between public coverage programs like Medicaid and private coverage through the exchange. To help minimize changes in coverage, we recommend that residents be eligible for Medicaid and CHIP for twelve months at a time.

6. "Navigators"—created by the Affordable Care Act to help consumers and employers—must be selected based on their ability to put consumer and employer interests first, without conflicts of interest, and specifically, should exhibit qualities and expertise that would allow them to serve uninsured and underinsured consumers.

7. Illinois should take an active role in making sure that only health plans that provide good value to consumers are permitted to sell coverage through the Exchange. Factors designating "good value" should include scoring well on quality indicators, having provider networks that meet enrollees' needs, and charging reasonable premiums. Plans need to be prohibited from charging unjustified double-digit annual premium rate increases and practicing gender rating, where insurance companies charge disproportionately higher prices for women than men.

8. Illinois should take an active role in ensuring that the range of health plans offered in the Exchange promotes good decision-making among residents about which plans will best meet their needs. This can be accomplished by making plans easy to compare and further standardizing plan options beyond the tiers required in the Affordable Care Act, for example, limiting the number of different deductible and cost-sharing combinations sold at each tier.

9. Illinois must ensure that coverage for needed services currently required under state benefit mandates is provided in exchange plans.

10. Illinois should enact policies to prevent adverse selection and to ensure the stability of the exchange. The state should require insurance plans sold outside of the Exchange to comply with the same consumer protection requirements as those in the Exchange. For example, like insurers inside the exchange, insurers operating outside should be required to sell at least one silver level plan and one gold level plan. The state should require that brokers do not have financial incentives to steer residents into coverage outside of the Exchange.

11. The Affordable Care Act leaves several decisions up to each state regarding the group insurance market. These decisions should be made based on analyses determining which options would provide the most accessible and affordable health coverage options for consumers.

12. Exchange features should be tested with a diverse range of consumers before their implementation. After exchange implementation, a formal feedback loop should be available to consumers so that any problems with exchange functioning can be reported and addressed.

13. The exchange should provide appropriate language services to meet the needs of individuals who do not speak English or who have limited-English proficiency.

14. Due to provisions of the Affordable Care Act, Illinois currently funds health coverage and other programs that it will no longer need. The money saved from the elimination of such programs should be invested to assist lower income families, like providing further premium or cost-sharing assistance to low-income residents.

15. Any consideration of participation in a regional or interstate exchange must take into account the effects on the state's existing consumer protections. In addition, coordination with Medicaid, CHIP, and other state coverage programs should be carefully examined to ensure that consumer safeguards and access to coverage would not be diminished in a regional or interstate exchange.

Lastly, for the record, we would also like to state that we believe that the citizens and the small businesses of the state of Illinois would be better served if there were only one health insurance exchange, instead of having two separate markets established. Further, Illinois should alter the small group market definition to include employers with up to one hundred employees instead of limiting it at fifty employees. Having one market (exchange) that includes individuals and small businesses would create a bigger risk pool, which would, in turn, help keep the cost of premiums to a minimum. This would clearly be an advantage for individuals and small businesses purchasing health insurance.

Thank you for your time and consideration. We hope that you use these recommendations to help develop a proposal for what we, as consumers, need in our state's Health Benefits Exchange.

Sincerely,

Champaign County Health Care Consumers (CCHCC)
And the Undersigned Illinois Residents

(See attached signatures)

Jen Tayabji, *(217) 840-8248*
Champaign Co. Health Care Consumers

Good afternoon. I would like to thank the Illinois Health Benefits Exchange Legislative Study Committee for holding today's meeting to gather testimony from interested parties, especially consumers, in the proposal being developed for the Exchange.

My name is Jen Tayabji and I am a Community Organizer with Champaign County Health Care Consumers. We are a non-profit, grassroots, health care advocacy organization. We work to give consumers a voice in the health care system and to make sure that the health care system, laws, and rules are designed to put consumers first. I am here to present the Study Committee with a letter containing fifteen recommendations that we strongly believe need to be part of the Health Benefits Exchange in Illinois, which has also been signed by local residents at a Community Meeting held last Wednesday on the Exchange. Today, I will be highlighting several of the recommendations.

First, the Health Benefits Exchange planning, implementation, and governance must be transparent and receptive to public input.

Second, the governing body of the Exchange needs to include consumer representatives as official members. The governing body should not include members who may have conflicts of interest due to affiliations with health care or insurance industries.

Next, as required by the Affordable Care Act, consumers need to be able to go to a single website, use one application to determine eligibility, and then be able to easily enroll in coverage. The goal here is to make using the Exchange as accessible as possible, to as many residents as possible. This can be accomplished through the following methods:

- Residents have to be able to apply for coverage—and receive assistance when needed—at community locations.
- Illinois needs to use existing federal and state financial documents and other information, rather than requiring people to submit all new documentation.

- "Navigators" must be selected based on their ability to put consumer and employer interests first, without conflicts of interest, and have the expertise to serve uninsured and underinsured consumers.
- Illinois should ensure that the range of health plans offered in the Exchange allows for good decision-making by residents about which plans will best meet their needs by making plans easy to compare and further regulating plan options.
- Exchange features should be tested with consumers before their implementation. Once the Exchange is running, there must be a way for consumers to easily submit feedback so that any problems with the Exchange can be reported and addressed.
- The Exchange should provide appropriate language services to meet the needs of individuals who have limited English proficiency.

Next, the Exchange should be designed to meet the particular needs of individuals whose income fluctuates, resulting in "transitioning" between public coverage programs like Medicaid and private coverage through the Exchange. To help minimize changes we recommend that residents be eligible for Medicaid and CHIP for twelve months at a time.

Also, Illinois should make sure that only health plans that provide good value to consumers are permitted to sell coverage through the Exchange. Factors designating "good value" should include scoring well on quality indicators, having provider networks that meet enrollees' needs, and charging reasonable premiums. Plans need to be prohibited from charging unjustified double-digit annual premium rate increases and from practicing gender rating, where insurance companies charge disproportionately higher prices for women than men.

Also, Illinois should enact policies to prevent adverse selection to ensure the stability of the exchange. The state should require insurance plans sold outside of the Exchange to comply with the same consumer protections as those in the Exchange.

Next, the Affordable Care Act left several decisions up to each state regarding the group insurance market. We believe that the citizens and small businesses of the state of Illinois would be better served if there were only one health insurance exchange, instead of having two separate markets established. Further, Illinois should alter the small group

market definition to include employers with up to one hundred employees instead of limiting it to fifty employees. Having one market that includes individuals and small businesses would create a bigger risk pool, which would in turn, help keep the cost of premiums to a minimum. This would clearly be an advantage for individuals and small businesses purchasing health insurance.

Lastly, due to provisions of the Affordable Care Act, Illinois currently funds health coverage and other programs that it will no longer need. The money saved from the elimination of such programs should be invested to assist lower income families by providing further premium or cost-sharing assistance.

At this time, I would like to submit my testimony and this signed letter from consumers and consumer advocates into written evidence for the Illinois Health Benefits Exchange Legislative Study Committee to use in developing the proposal for Illinois' Health Benefits Exchange.

Thank you for the opportunity to testify on behalf of residents and consumers on what we need in our state's Health Benefits Exchange.

Illinois Health Benefits Exchange Legislative Study Committee

Springfield, Illinois August 30, 2011 1 PM Room 114 Capitol Building

TESTIMONY

Patricia Canessa, PhD

Salud Latina/Latino Health

My name is Patricia Canessa, and I am the Executive Director of *Salud Latina/Latino Health* a small size community-based organization located in Chicago, Illinois; a Minority Health Advisor of the Illinois Public Health Association, a Governor's appointed member of the State Health Improvement Plan Implementation Council and a member of the Campaign for Better Health Care Latino Health Reform Committee. As a program administrator I have managed and hired staff through the previous 24 years in medium size and large organizations with over 2000 employees. Through that period I benefit from the protection of the traditional health insurance business model but also, I learned about the punitive inequity of corporate health insurance systems that exclude at their discretion individuals with chronic conditions, and women that due to their reproductive history are often left with a label of pre-existing conditions. But also, as a social service provider I have dealt in numerous opportunities with the fact that medically complicated uninsured individuals are not welcomed by any medical provider, including those funded by state and charitable funds, too often resulting in the economic stress of out of pocket expenses and the alternative of progressive deterioration of their health. There is substantiated research and information that supports the fact that the failure of the health care system to build equity and reasonable cost sharing has resulted in the road to poverty for women and many vulnerable groups that often suffer from relatively low cost chronic conditions.

As the non-profit world suffers from a disproportionate attrition due to escalating state and federal budget deficits leaving our communities with a frail safety net, our organization also has felt the effects of this critical reduction throwing employees into the inhuman market of the short term health insurance industry. I have a mild liver condition that was diagnosed two years ago, and that at the time of the intervention by the treating physician own judgment, and to the benefit of the patient, decided to partially treat resulting in an immediate lifetime exclusion from insurance medical coverage. What are my options to maintain the necessary follow-up care or to seek prevention of a second emergency intervention? None, with the exception of out of pocket expenses.

This experience led me to become educated about the multiple flaws and need to have health care customers involved in the process of health care cost regulation, design of health care insurance policies, informed selection of medical interventions and long term consequences of these selections, intra hospital and ambulatory care advocacy on behalf of cost effective clinical practices, and affordable follow-up services that prevent deterioration and subsequent hospitalizations. All these would be fundamental elements to support the improvement of failing morbidity and mortality rates in a state where despite ailing budgets there is obvious positive standards of living.

Where should we start re-framing the health care principles?

- By changing the equation of cost and power control where the insurance and hospital industry are major players designing a model that educates the consumer on insurance options;
- Creating new cost efficient economic concepts such as cooperative models and re defining the concept of consumer pools;
- Educating doctors about true patient centered care models;
- Engaging patients in understanding a multi-level progressive utilization of health care;
- Develop a transparent mechanism to address cost of services and expert panels to review cost adjustments;
- Include prevention as the most fundamental intervention to avert the course of chronic disease and unexpected acute care, include emerging community-education models (such as health advocates) and reimburse for these services;
- Establish a mechanism to support quality of care and data collection on population and eligibility- based health indicators;
- Set an accountability system to track the implementation of affordable health care policies into wide spread practices;
- And finally, work in establishing models that are inclusive of a myriad of social determinants (such as mental health/ drug abuse treatment, housing, employment, poor environmental conditions, violence among others) that critically impact public and primary health care outcomes in Illinois.

Thank you.

GENE MECHANIC
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August 30, 2011

The Honorable Co-Chairs Senator Bill Brady,
Senator William Haine, Rep. JoAnn Osmond,
and Rep. Frank Mautino and Members
Illinois Health Benefits Exchange Legislative Study Committee
703 Stratton Office Building
Springfield, Il 62706

Re: Testimony of Gene Mechanic on Behalf of United Food and Commercial Workers International Union and UFCW, Local 881 re SB 1555

Dear Co-Chairs and Members:

On behalf of the United Food and Commercial Workers Union ("UFCW") and UFCW Local 881, I submit the following as testimony regarding SB 1555.

By way of background, I am an attorney who has practiced labor, employment, and employee benefits law for more than 30 years. During the past year, I have spent considerable time analyzing the federal Patient Protection and Affordable Care Act ("ACA") and advising union and other clients on its potential impact on consumers, including employees and their families.

Initially, it is important to recognize that UFCW Local 881 has a substantial stake in the Illinois Health Benefits Exchange. Its members are low and middle income employees employed throughout Illinois and Northwest Indiana by supermarket chains, independent grocery stores, bakery shops, drug stores, paint and hardware stores, financial institutions, healthcare facilities and nursing homes, barbers and cosmeticians, eye care centers, auto part stores, flower and meat stores, and a wide variety of other retail, service and professional enterprises. Local 881 is about workers seeking to improve working and living standards through better wages, benefits and working conditions. Accordingly, the UFCW International and Local 881 supported passage of the ACA last year and encourage the State of Illinois to implement a strong health benefits exchange which provides affordable, quality healthcare insurance to as many Illinoisans as possible.

1. Goals of SB1555.

SB 1555 has declared that Illinois, beginning October 1, 2003, in accordance with the ACA, shall establish the Illinois Health Benefits Exchange. It also established this Committee to report its findings concerning the implementation and establishment of the Exchange to the executive and legislative branches, including but not limited to (1) the governance and structure of the Exchange, (2) financial sustainability of the Exchange, and (3) stakeholder engagement. The Committee shall report its findings with regard to (A) the operating model of the Exchange, (B) the size of the employers to be offered coverage through the Exchange, (C) coverage pools for individuals and businesses within the Exchange, and (D) the development of standards for the coverage of full-time and part-time employees and their dependents.

The Committee's assignment is very important to the welfare of all Illinoisans. The cost of health care insurance is driving down the standard of living of all Americans. Through the Exchange, we now have an opportunity to reduce the unacceptable financial burdens of health care insurance placed on the vast majority of Illinoisans. With this in mind, I will address several of the subjects to be considered by this Committee.

2. Governance-The Exchange Board should consist of persons who represent the interest of consumers and contain at least one representative of Organized Labor.

Establishing an independent public corporation to run the Exchange provides the best assurance that the Exchange will be independent of undue political influence and act for the interests of consumers. As required by the ACA, the majority of the corporation's board of directors must represent the consumers' interests. Moreover, a strong conflicts of interest policy is an essential component of a successful Exchange.

Accordingly, legislation should state the following:

> "Whenever a member of the board has an actual or potential conflict of interest on an issue that is before the board, the member shall declare to the board the nature of the conflict and the declaration shall be recorded in the official records of the board. With respect to an actual or potential conflict of interest, the member shall not participate in any discussion on the issue and shall not vote on the issue.

> 'Actual conflict of interest' means that by taking any action or making any decision or recommendation on an issue, the member, the member's relative, or any business with which the member or the member's relative is associated, would receive a pecuniary benefit, unless the pecuniary benefit would affect to the same degree a class consisting of all consumers of or payers for health care in this state." 'Potential conflict of interest' means that such persons or businesses could receive such pecuniary benefit."

In addition, the Exchange Board should include at least one member who represents labor organizations. Such Board member would bring to the table skill, knowledge and experience in negotiating and advocating for the health benefits of low and middle income families, the very people who the Exchange is primarily designed to cover. The labor representative could have experience in the well-established system of non-profit tax exempt organizations currently providing affordable health care to many Americans, known as federal Taft-Hartley Act plans. These are multi-employer health and welfare plans formed through collective bargaining agreements between employers and labor organizations, which are jointly administered by an equal number of labor and management trustees. Under Section 501(c) (9) of the Internal Revenue Code, they are designated as Voluntary-Employees Beneficiary Associations ("VEBAs"). VEBAs are an excellent model for those non-profit health carriers which seek status as Qualified Health Plans ("QHPs") in the Exchange.

Labor organizations have negotiated the provision of health insurance through the VEBA model for over 50 years to provide innovative, effective, high quality, consumer-oriented and affordable health plans for their member employees and their families.

Therefore, future legislation should state that:

> "At least one of the members of the Exchange's Board of Directors shall be a person who is employed by, a consultant to, or otherwise represents one or more labor organizations."

Moreover, the Exchange should establish technical and consumer advisory groups.

3. Taft-Hartley Health Plans should be able to participate on the Exchanges for their participants and beneficiaries.

Taft-Hartley Health Plans have existed for decades and have provided high quality benefits for decades to working Americans who might otherwise have been uninsured. This is particularly true in the retail sector where a large number of individuals are part-time workers. In that regard, UFCW Local 881's plans provide coverage for part-timers. It is important that in any legislation Taft-Hartley Plans be allowed to participate in the Exchanges to the extent permitted in federal rulemaking. These Plans also have been at the cutting edge of developing innovative health care strategies for their participants and beneficiaries. In order to effectively continue, Taft-Hartley Plans must be allowed access to the Exchanges as individual market coverage. In fact, the federal Department of Health and Human Services ("HHS") has acknowledged the importance of ensuring Taft-Hartley Plans a continued role in providing health care coverage to the millions of individuals already covered by such plans by specifically requesting comment in proposed regulations on how Taft-Hartley Plans might access the Exchanges.

4. The Exchange should use its authority to assess fees to QHPs, as well as employers whose employees are not covered by health insurance or have unaffordable coverage.

HHS has issued proposed regulations which grant the states flexibility on how they raise funding for the exchanges to enable them to become self-sustaining. Careful study should be given to all the potential options for the Illinois Health Benefits Exchange to accomplish this goal.

QHPs may be assessed fees to cover the Exchange's administrative costs. However, some distinctions in fees are warranted. For example, QHPs which are non-profit, such as plans developed under the Consumer Operated and Oriented Plan (CO-OP) Program and Taft-Hartley health plans that may be allowed access to the Exchanges as indicated in proposed regulations issued by HHS, should receive reduced assessments. In particular, since Taft-Hartley plans will not be marketing coverage to the general public but rather continuing coverage to a defined group already covered by these plans, certification fees need to be capitated based on total numbers of covered participants residing in the State of Illinois.

Moreover, as discussed in more detail below, employers who fail to cover their part-time employees who use the exchange should incur a state assessment so that taxpayers are not financially burdened.

5. The Exchange should provide that large employers may purchase insurance in the Exchange in 2017 or earlier if allowed under federal law or waiver. Taft-Hartley Health Plans should be within the definition of "Employer."

The ACA provides that states may allow qualified large employers to enroll their employees in qualified health plans under the exchange beginning in 2017. ACA, Section 1312 (f) (2) (B). However, through federal administrative or Congressional action, or requests for waivers from states, it is possible that large employers may be allowed to participate earlier.

Importantly, in accord with the ACA, SB 1555 states that this Committee should study the size of employers to be offered coverage through the Exchange, not just the size of small employers. Allowing for large employer participation would enable the mass market to strengthen the Exchange's solvency, foundation and bargaining leverage to provide affordable, quality health care insurance.

Moreover, the legislation should make clear that a "large employer" includes collectively bargained multiemployer health and welfare plans. Such plans are vehicles under which both small and large employers currently provide health coverage to working families.

With the above in mind, future legislation should state the following:

> Employers with more than 100 employees may purchase qualified health plans through the exchange commencing on January 1, 2017 or earlier if allowed by federal law or waiver.

Further, a subpart should be added to state:

> The term "Employers" in this section shall include but not limited to collectively-bargained multi-employer health and welfare plans.

6. The legislation should protect part-time employees and taxpayers from employers which seek to avoid any health care insurance costs for their employees.

SB 1555 directs the Committee to study the standards for the coverage of both full-time and part-time employees. The ACA's new definition of part-time work as an average of 30 hours per week could lead to additional hardship for workers in the retail industry and the many other industries which substantially rely on a part-time workforce. Indeed, a large percentage of today's workforce works less than 30 hours per week for a given employer. Yet, under the ACA, employers pay no federal monetary assessment for not providing health insurance to part-time employees who use the Exchange and receive federal tax credits or cost-reduction subsidies. This places an undue burden on taxpayers to foot the health insurance bill for an employer's workers.

Accordingly, the State should establish an Exchange structure which discourages employers from receiving the benefit of purchasing insurance in the Exchange without covering their part-time employees. Employers should not be allowed to dump part-time employees onto the exchange at the taxpayers' expense. Rather, the State should establish state assessments or other disincentives for them to do so.

Future legislation should provide the following:

> "The Exchange may implement regulations and seek federal waivers, if necessary, to require qualified employers which seek to purchase qualified health plans through the Exchange to enroll their part-time employees in Qualified Health Plans through the Exchange. In addition, the Exchange shall issue an assessment to employers who do not provide insurance meeting ACA standards to their part-time employees who receive a tax credit or cost-reduction subsidy in the exchange. Such assessment may reflect the average number of hours worked by such employees."

7. The legislation should provide for an "Active Exchange" whereby the number of Qualified Health Plans certified to sell insurance is limited.

A strong Exchange should promote the participation of affordable, quality and consumer oriented insurance plans. To accomplish this, the Exchange should not be open to every issuer which meets the ACA's basic definition for a QHP. For

example, minimum financial ratings should be established for issuers of QHPs on an Exchange. Moreover, premiums and the development of networks by issuers should be based upon reasonable actuarial principles and minimum medical loss ratios. Further, the Exchange should actively review the performance and premiums of those insurers which seek QHP status and negotiate with such insurers for the best deal and plan possible for consumers.

To reiterate, although Taft-Hartley Plans may qualify as QHPs by HHS, they would not be marketing coverage to the general public and would not be health insurance issuers as that term is defined by the ACA. Therefore, the "Active Exchange" concept and state licensing fees charged to issuers should not apply to Taft-Hartley Plans.

8. The legislation should contain language to prevent insurers from having plans outside the Exchange which foster adverse selection.

There is great danger of adverse selection between the exchange and non-exchange markets – which would lead to a classic death spiral of plans in the Exchange and perpetuation of the current unaffordable health insurance system. Adverse selection may be prevented through several key avenues which legislation could recognize. To accomplish this, future legislation should provide that the Exchange shall ensure the following:

a. Uniformity of rules and requirements inside and outside the exchanges.
b. Identical regulation of the individual and group markets inside and outside the exchange.
c. Uniformity of marketing rules and standards inside and outside the exchange.
d. That an insurer offers the same plans inside and outside the exchange.
e. That an insurer charges the same premiums for plans sold through the exchange as for identical plans sold outside the exchange.
f. A standard risk adjustment mechanism for insurers operating inside and outside the exchange.
g. Uniformity of networks offered by plans inside and outside the exchange.

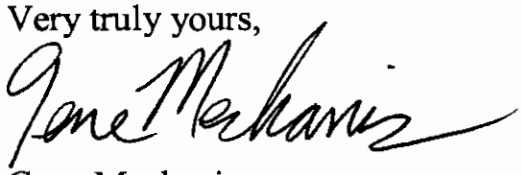
9. Preservation of jobs in Illinois.

One of the by-products of the ACA is the anticipated increase in the number of individuals purchasing insurance from for-profit issuers on the Exchanges. In fact,

because of the power of the premium assistance tax credits offered to individuals purchasing insurance on the individual market, we would anticipate a potential decline in self-funded plans administered by individuals working in the State of Illinois in favor of insured products regulated on the Exchanges. To the extent that occurs, issuers participating on the Exchanges should be required to demonstrate that any additional staffing will not be outsourced overseas but rather will be accomplished through the hiring of workers in the State of Illinois. This is most important in the volatile economic climate that exists today. If the legislation can put people back to work in this State that would be a laudable achievement.

Thank you for this opportunity to discuss the above issues.

Very truly yours,



Gene Mechanic

August 30, 2011

On behalf of AARP Illinois 1.7 million members, we greatly appreciate the opportunity to provide comments to the IL Health Benefits Exchange Legislative Study Commission on establishing an insurance Exchange in Illinois. Extending health coverage to populations who are uninsured today, while facilitating and improving coverage access and affordability for those already in the individual and small group markets is vital to Illinoisans, including many AARP members. The Exchange will provide a new avenue for Illinoisans to learn about and enroll in private and public coverage options. In addition, it will be the way that individuals can access new subsidies to help make private coverage more affordable.

There are many issues related to the creation of the Exchange that will need to be addressed between now and when the Exchange becomes operational on January 1, 2014. We urge, as the issues are discussed, that they be considered through the lens of the consumer and that decisions are made based upon what is in the best interests of the consumer. On December 2, 2010 we submitted public comments to the Illinois Health Care Reform Implementation Council which focuses on a number of key issues and provides more detail on issues which are not addressed within these comments. We are attaching a copy of those comments for your information.

Functions of a Health Benefit Exchange

The mission of the Exchange is to create a well-functioning health insurance marketplace that provides an array of affordable, high-quality health insurance plans to individuals and small businesses while also providing access to Medicaid and federal subsidies. By choosing to run its own Exchange, Illinois can tailor it to meet the unique needs of Illinoisans. Crafted correctly, a state-operated Exchange can be flexible and responsive to the particular needs of the Illinois marketplace and its consumers.

Desirable outcomes of a state-operated Exchange include increased efficiency and effectiveness, with firms competing on the basis of price and quality. Consumers will be best served by the creation of an Exchange large enough to alter the health insurance marketplace and strong enough to foster active negotiation with the plans that wish to be included in the Exchange. This is the same approach large employers use to obtain maximum benefits at affordable rates.

To make the market more accessible to individuals buying coverage in the Exchange, there must be ongoing education and outreach based on a foundation of accurate, understandable consumer information about coverage options, plan benefits and costs. Individuals need to be made aware of the Exchange and its offerings. This will require a major communications and marketing campaign. Navigator programs are a critical part of this outreach effort, and they will play an important role in reaching out to diverse groups that may be harder to reach due to language and cultural differences or lack of familiarity with health insurance.

Including the following functions beyond those required by the ACA would be in the best interests of Illinoisans and will foster a robust marketplace that is adept at meeting the diverse

needs of Illinoisans:

- Permitting only high-quality plans to be available through the Exchange and negotiating with insurers over characteristics such as benefits, premiums, and provider networks;
- Rewarding quality through innovative payment and incentive programs;
- Including information on health plan quality based on nationally endorsed measures, particularly HEDIS and plan member experience of care based on CAHPs and information conveyed about plan performance;
- Featuring plan quality and patient experience of care as prominently as other aspects of plan information such as costs;
- Ensuring that plan quality information can be interpreted at a glance with the option for users to dig deeper in areas of interest, if desired;
- Modifying or adapting state purchasing decisions based upon consumer input and satisfaction reports; and
- Ensuring the availability of a variety of health delivery models under the Exchange, including patient-centered medical homes, community-centered medical homes, or transitional chronic care models.

Structure and Governance

AARP believes that the governance structure of the Exchange must provide for a strong role for the consumers of its services – individuals, small employers and their employees. There should be robust representation of real consumers to ensure that their voices are heard. Moreover, the governing body's deliberations and decisions must be transparent and provide ample opportunity for the consideration and implementation of input from the public.

It will be important for the Exchange to have the authority necessary to ensure full collaboration of all players. It will need the authority to ensure the unprecedented level of state and federal collaboration and the active cooperation of the state agencies (Medicaid, Public Health, Insurance, etc.) that will be required for the successful implementation of the ACA. The Exchange must connect with other State and national entities to provide a "one stop" and seamless process for determining eligibility and effectuating enrollment for federal subsidies, Medicaid or CHIP and other public health programs.

The governing body should also provide the opportunity for additional issue-specific working or advisory groups to be created to give ongoing input into the process. To avoid conflicts of interest, the governing board should not include insurers that would be subject to regulation and oversight by the Exchange.

The External Market and Addressing Adverse Selection

For purchasing pools to be sustainable, they need to be operating on a level playing field with the market outside the pools. Otherwise adverse selection will occur. Thus, it is essential that policymakers create a uniform regulatory framework governing both the Exchange and the broader markets. Successfully establishing and implementing the Exchange by January 2014 will be a major challenge for all involved. A commitment to ongoing problem solving, evaluation, and quality improvement is needed. This will require ongoing partnerships among the state, the Exchange, federal agencies, and private organizations.

It will also be vitally important that Illinois be prepared to mitigate any potential risk to the Exchange's sustainability. The requirements for risk adjustment, and the temporary reinsurance and risk corridor programs, as well as the requirement that plans pool risk inside and outside the Exchange, are critical tools to limit adverse selection and encourage plans to participate in the Exchange. However, these tools will not be sufficient if Illinois does not apply the same rules to plans inside and outside the Exchange. The goal should be for plans in the Exchange to have the incentive to cover and improve care for those individuals with high needs. A robust set of risk adjustment and reinsurance measures will help make that possible.

Illinois should also carefully consider the evolving role of brokers and agents in relation to the Exchange and its Navigator program. The current proposed regulations from HHS permit licensed agents and brokers to carry out the Navigator function. However, they are not the only authorized individuals who may function as Navigators and the state may not prohibit or prevent other qualified individuals or entities from serving in that role. Illinois will need to ensure that there are no inappropriate incentives by brokers or agents to steer people outside the Exchange. In addition, the state will need to develop protocols related to conflicts of interest, training and continuing education. There will also need to be rules developed relating to Navigator oversight, consideration of the need for licensure, and the establishment of a system to monitor Navigators and enforce all proposed protocols and rules.

Eligibility Determination and Coordinated Services

We strongly encourage Illinois to develop and maintain a streamlined application process that takes advantage of the various online capabilities to determine eligibility and coordinate services in order to prevent duplication and ensure compliance with all state and federal regulations. Establishing a consistent point-of-entry for health care via the Exchange will help establish accuracy and provide the level of coordination that the state and consumers strongly desire.

Consumers need smooth integration of these functions behind the scenes so that correct and timely determinations of eligibility for programs and subsidies are made and they are enrolled in their choice of plan without gaps in coverage or other glitches. The Exchange should develop systems and practices that focus on the consumer experience so that this will be a positive one, and that consumers will find it easy to explore and choose the best options for them. Most importantly, the Exchange should be committed to quality consumer service.

Conclusion

AARP appreciates this opportunity to comment on this important issue, and will be pleased to work with the IL Health Benefits Exchange Legislative Study Commission and others in implementing this key feature of reform. If you have any questions, please feel free to contact Jennifer Creasey at 217-747-8883, jcreasey@aarp.org.

December 2, 2010

Director Julie Hamos Department of Healthcare and Family Services
Director Michael McRaith, Department of Insurance
Governor's Health Care Reform Implementation Council
100 W. Randolph, Suite 16-100
Chicago, Illinois 60616

RE: Public Comments submitted by AARP Illinois to the Illinois Health Care Reform Implementation Council

AARP greatly appreciates the opportunity to provide comments to the Health Care Reform Implementation Council on the option of establishing an insurance Exchange in Illinois. We are keenly interested in the establishment and implementation of the Exchange, as this is vital to the effort to both extend health coverage to populations who are uninsured today, and facilitate and improve coverage access and affordability for those already in the individual and small group markets. The Exchange will provide a new avenue for Illinoisans to learn about and enroll in private and public coverage options. In addition, it will be the way that individuals can access new subsidies to help make private coverage more affordable.

There are a host of issues, many of which are identified in the request for comments, related to the creation of the Exchange that will need to be addressed between now and when the Exchange becomes operational – no later than January 1, 2014. What we urge is, as the issues are discussed, they are considered through the lens of the consumer and as decisions are made, they are made in the best interests of consumers.

On October 4, 2010, AARP responded to the U.S. Department of Health and Human Service's Office of Consumer Information and Insurance Oversight (OCIIO) Request for Comment on the planning and establishment of the Exchanges. Because many of the issues we addressed therein are similar, we are attaching this letter for your information.

I. Functions of a Health Benefit Exchange

The mission of the Exchange is to create a well-functioning health insurance marketplace providing an array of affordable, high-quality health insurance plans to individuals and small businesses and to provide access to Medicaid and federal subsidies. Should Illinois choose to run its own Exchange, the obvious benefit is that it could be tailored to meet the unique needs of Illinoisans. Crafted correctly, a state-operated Exchange is also likely to be more flexible and more responsive to the needs of the marketplace and to Illinois consumers.

Desirable outcomes of a state-operated Exchange include increased efficiency and effectiveness, with firms competing on the basis of price and quality rather than on risk selection. Consumers will be best served by creation of an Exchange large enough to alter the health insurance marketplace and strong enough to foster active negotiation with the plans that wish to be included in the Exchange to drive high value. This is the same approach large employers use to obtain maximum benefits at affordable rates.

To make the market more accessible to individuals buying coverage in the Exchange, key initiatives must build ongoing education and outreach on a base of accurate, understandable consumer information about coverage options, plan benefits and costs. Individuals need to be made aware of the Exchange and what it is offering, and this will require a major communications and marketing campaign. Based on experience in states that have undertaken reform efforts, devoting resources to marketing the Exchange and its products and outreach initiatives must be a part of the planning, not an afterthought. Navigator programs are a part of this, and will be important for reaching out to diverse groups that may be harder to reach due to language and cultural differences or lack of familiarity with health insurance. AARP will do our part to educate our members, as we did when the Medicare drug benefit began.

Including some or all of the following functions beyond those required by the ACA would be in the best interest of Illinoisans and foster a robust marketplace that is adept at meeting the diverse needs of Illinoisans:

- As mentioned above, the authority to permit only high-quality plans to be available through the Exchange and to negotiate with insurers over characteristics such as benefits, premiums, and provider networks;
- The ability to reward quality through innovative payment and incentive programs;
- The authority to require compliance with uniform quality reporting measures that are consumer friendly and allow members of the public to compare plan performance -- particularly in prevention and management of the most common chronic disease categories. Uniform care quality reporting among all plans and delivery options in the Exchange will incent insurer competition on the basis of price and outcome-improving delivery innovations. Competition will enhance consumer choice among different care delivery options offered by the plans and among similar delivery options offered by different insurers on the basis of price, value, and quality. From the perspective of moderating insurance premium growth and promoting care quality, this is an optimal market outcome;
- The ability to modify or adapt state purchasing decisions based upon consumer input and satisfaction reports; and
- The ability to ensure the availability of a variety of health delivery models under the Exchange. This could include models such as patient-centered medical homes, community-centered medical homes, or transitional chronic care models.

Exchanges should be able to limit the number of plans available. Limiting the number of plans participating in the Exchange can help reinforce several policy imperatives. It allows the setting of high standards, rather than a "least common denominator" approach that all can meet; it provides a strong basis for negotiation; it rewards with greater market share those plans that meet the highest standards; and it provides real choice for consumers rather than a confusing array of options for which “apples-to-apples” comparisons are difficult, if not impossible, to make. The Massachusetts Connector has completed focus groups on this issue and found a strong consumer preference for a small "manageable" number of plans . Information on the focus group findings can be found on page 21 of the full report which can be accessed at:

https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Executive%2520Director%2520Message/Connector%2520Annual%2520Report%25202009.pdf

An Exchange that allows any willing provider to sell coverage does not support a stronger insurance marketplace. As Massachusetts has learned through its focus groups, the multitude of choices will likely overwhelm many consumers, making choices more difficult and less meaningful.

To the extent possible, the process of determining whether a health plan may participate in the Exchange should involve robust competition. Exchanges should use competitive bidding and negotiation with plans seeking to become Qualified Health Plans. The Exchange's selection standards should include several factors: affordability; the quality and adequacy of the provider network, including collection of data on race and ethnicity to determine disparities and systems to reduce these disparities; quality improvement systems; data collection and reporting requirements to assess quality and efficiency; access to emergency care; and marketing practices. California has included language on selection criteria in its statute at http://www.leginfo.ca.gov/pub/09-10/bill/sen/sb_0851-0900/sb_900_bill_20100930_chaptered.html, which includes assigning a rating to each qualified health plan in accordance with the criteria developed by the United States Secretary of Health and Human Services.

Structure and Governance

Whatever governance structure is ultimately adopted by Illinois, AARP believes that it must include the consumers of its services – individuals, small employers and their employees. Consumers need to have "a seat at the table" and they need to have equal voting rights with other stakeholders. There should be sufficient representation of consumers to ensure that their voices are heard. While other stakeholders have a role, the governing structure should assure that the consumer voice is equal to others. The governing body's deliberations and decisions should be transparent, and should provide ample opportunity for public input.

In addition, the Exchange must have adequate authority to fulfill its responsibilities. The Exchange is charged with functions that are critical to the successful expansion of coverage. Thus, it needs authority to enable it to succeed in bringing consumers the best plans and services possible at affordable prices. As discussed above, the Exchange should have authority to negotiate with and select plans if that is what it determines is needed in order to maximize the value of coverage offered and simplify choices for buyers. Without the ability to negotiate for the best offerings for consumers or to limit offerings, the opportunity for an Exchange to foster improvements in benefits, quality and cost for those in the individual and small group markets may be foreclosed.

Whatever governance structure is ultimately selected, it will be important to ensure that the Exchange has the appropriate authority to ensure full collaboration of all players and appropriate oversight and enforcement authority. AARP urges Illinois to establish an entity that has the authority needed to ensure the unprecedented level of state and federal collaboration and the active cooperation of the state agencies (Medicaid, Public Health, Insurance, etc.) that will be required for the successful implementation of the ACA. The Exchange must connect with other State and national entities to provide a "one stop" and seamless process for determining eligibility and effectuating enrollment for federal subsidies, Medicaid or CHIP and other public health programs. (This may necessitate re-engineering current Medicaid eligibility and enrollment processes.) The key is to provide a "single point of entry" for consumers.

Governing bodies should include strong consumer representation and also provide the opportunity for additional issue-specific working or advisory groups to be created and to give ongoing input into the process. To avoid conflicts of interest, the governing board should not

include insurers that would be subject to regulation and oversight by the Exchange. The governing body's deliberations and decisions should be transparent, and should provide opportunity for public input. It would be worthwhile for Illinois to examine the models developed by California and Massachusetts. California's Exchange was designed as a public entity with no affiliation to a state agency or department. It will be governed by an executive board of five individuals, who are appointed by the Governor, Senate Committee on Rules, Speaker of the Assembly, and the California Secretary of Health and Human Services or a designee. In Massachusetts, the Commonwealth Health Insurance Connector Authority is an independent, public entity. It is governed by a board of ten members: the secretary for administration and finance, ex officio, who shall serve as chairperson; the director of Medicaid, ex officio; the commissioner of insurance, ex officio; the executive director of the group insurance commission; three members appointed by the governor, one of whom shall be a member in good standing of the American Academy of Actuaries, one of whom shall be a health economist, and one of whom shall represent the interests of small businesses; and three members appointed by the attorney general, one of whom shall be an employee health benefits plan specialist, one of whom shall be a representative of a health consumer organization, and one of whom shall be a representative of organized labor.

II. The External Market and Addressing Adverse Selection

For purchasing pools to be sustainable, they need to be operating on a level playing field with the market outside the pools. Otherwise adverse selection will occur. This means that in considering the creation and development of reforms, it is essential that policymakers create a uniform regulatory framework governing both the Exchanges and the broader markets. Absent a uniform regulatory scheme, some will capitalize on differences to ill effect. Those seeking to take advantage of the differences may gain, but at the expense of those served by the Exchange. If selection undermines the Exchange and raises its costs, it will harm those buying in the Exchange and indirectly all of us who help underwrite the cost of coverage for those in the Exchange through our tax dollars.

Clearly, getting the Exchange up and running in the time called for will be a major challenge for all involved. Lessons will be learned along the way, and improvements and refinements will be necessary. A commitment to ongoing problem solving, evaluation, and improvement is needed. This will require ongoing partnership among the state, the Exchanges, and private organizations. AARP is committed to contributing to that effort.

It will be vitally important that Illinois be prepared to mitigate any potential risk to the Exchange's sustainability. The requirements for risk adjustment, and the temporary reinsurance and risk corridor programs, as well as the requirement that plans pool risk inside and outside the Exchange, are critical tools to limit adverse selection and encourage plans to participate in the Exchange. However, these tools will not be sufficient if Illinois does not apply the same rules to plans inside and outside the Exchange.

An Exchange needs to provide defined regular opportunities for people to enroll in health coverage offered through the Exchange. There will need to be an initial enrollment period when the Exchange first becomes operational, as well as annual enrollment opportunities, and special enrollment periods for those who are experiencing coverage transitions. Based on the implementation of Medicare Part D, the initial enrollment period should be an extended one, perhaps a period of several months leading up to the initial coverage date and maybe beyond, and should be coordinated with extensive outreach, marketing, and enrollment efforts. People who have not been outside the health insurance market need to be reached and helped through the process of identifying their coverage choices and selecting and enrolling in one. Not

everyone who may be eligible to enroll in coverage through the Exchange may be reached in this initial enrollment period. In subsequent years, the annual open enrollment periods should be long enough to give consumers already in plans time to examine whether they may want to switch to another plan, and to allow new enrollment. In Medicare, the annual open enrollment period runs for 6 weeks. Massachusetts initially had continuous open enrollment, but has just limited open enrollment to close the opportunity for people to jump in and out of the insurance system. It may be worth considering giving the Exchange authority to require special enrollment in unusual circumstances. The Secretary of HHS has such authority for Medigap enrollment, which has been used in special situations.

AARP's overriding concern with the permanent risk adjustment program as well as the temporary reinsurance and risk corridor programs is to assure that they are adequately address the risk associated with consumers with high health care needs. The goal should be for plans in the Exchange to actually have the incentive to cover and improve care for those individuals with high needs, rather than avoid covering them in the first place. Only a robust set of risk adjustment and reinsurance measures will make that possible; this and a focus on improving the value of care for those individuals is the key to sustainable cost growth.

Illinois should carefully consider the evolving role of brokers and agents in relation to the Exchange and its Navigator program. The law allows for licensed agents and brokers to carry out the Navigator function. The State will also need to ensure that there are no inappropriate incentives by brokers or agents to steer people outside the Exchange. In addition, the state will need to develop protocols related to conflicts of interest, training and continuing education, and oversight and licensure and monitor and enforce them.

IV. Structure of the Exchange Marketplace

In determining whether to operate one Exchange or two separate Exchanges for the individual and small group markets, Illinois should consider the following:

- Whether combining markets will result in higher costs for either the small group or individual market?
- Which of the options will be most beneficial to consumers overall in terms of cost and quality?
- How will the state define “small business”?

Regardless of whether Illinois operates a single Exchange or separate Exchanges for the individual and small group markets, it should establish the same rules for insurance offered inside and outside the Exchange to prevent unfair competition and discourage cherry picking.

We would not recommend consideration of separate intrastate exchanges, as these have the potential to increase administrative complexities with little evidence of benefit to consumers. Consumers generally will be better served by the establishment of pools large enough to foster robust competition. Maintaining a statewide pool would also prevent redlining of high cost populations. Intrastate regional Exchanges could potentially be justified, but only if there were significant differences in health care costs and utilization.

A multistate exchange may be worth consideration in the longer term, but we believe it is important that Illinois move forward on its own and develop an Exchange that will meet the needs of its consumers and provide an appropriate and adequate system within the timeframe that the ACA has set forth.

V. Self-Sustaining Financing for the Exchange

The ACA provides the initial funding necessary for Illinois to build and maintain the Exchange through the end of 2014. Thereafter, the Exchange must be financially self-sustaining. While the long-term financing of each state's Exchange must respond to the unique characteristics of that state, Illinois may wish to examine how California and Massachusetts have addressed the issue of long-term funding and costs.

Regardless of the funding options chosen, we understand that there will have to be tough tradeoffs in terms of financing, especially as the state continues to face severe budget challenges. What is critical is that the cost of the Exchange must be shared broadly; if only those who participate in the Exchange are required to shoulder the burden, participation in the Exchange may be curtailed and individual costs will increase. As the state has already recognized, in developing the state's strategy for financing, it is important to consider how any funding option:

- Encourages or discourages participation in the Exchange by individuals, small businesses, and insurers;
- Affects the reputation of the Exchange;
- Affects accountability, transparency, and cost-effectiveness; and
- Is sustainable over time.

Establishing a reliable, sustainable way to finance the Exchange is vital to its ability to reach its goals. Throughout the process, it is important to keep in mind the potential effects on enrollment as well as the economic, social, and political implications of each financing option.

VI. Eligibility Determination

Many individuals and households with incomes under 400% of federal poverty level will have incomes that fluctuate significantly over relatively short periods of weeks or months. It is vitally important that the Exchange be structured so that transitions between Medicaid, state health care programs, federally subsidized coverage and fully private pay are centralized, prompt, seamless, and ensure continuity of care. It should be possible, for example, for an individual who has purchased unsubsidized coverage through the Exchange while self-employed in a seasonal business to report and document a decrease in income and be swiftly transitioned into tax-subsidized coverage or Medicaid without having to change medical providers.

The ACA requires the simplification of the Medicaid eligibility and enrollment process and implementation of these requirements should be coupled with the design and operation of the Exchange. Under the ACA, the state has the flexibility to delegate to the Exchange the authority to determine Medicaid eligibility or to establish a system of data transfer between the Exchange and a Medicaid agency that would make that eligibility determination. There should be uniformity, however, from the consumer's view, with the individual able to report a change in income to the Exchange and to be granted Medicaid coverage promptly and without having to interact with multiple agencies.

Providing coverage for those who are Medicaid eligible through the Exchange could be a portal to Medicaid elsewhere and may have some advantages, such as allowing those with fluctuating incomes to move between Medicaid, federal subsidies and private pay without changing provider networks and with no disruption in health care, but this issue could be addressed by

inclusion in the Exchange of plans that also serve the Medicaid population independent of the Exchange.

There seems to be an ideal opportunity to incorporate Health Information Technology within the Exchange, especially as we seek to streamline and minimize disruption as individuals and families move through the Exchange and any state-supported system. The continuing emphasis on interoperable Health IT systems, as well as the available funding and grant opportunities, seem to indicate an opportunity for the state to serve both the small business and individual markets, as well as those who participate in Medicaid and other state health programs.

We strongly encourage Illinois to develop and maintain a streamlined application process that takes advantage of the various online capabilities to determine eligibility and coordinate services in order to prevent duplication and ensure compliance with all state and federal regulations. Establishing a consistent point-of-entry for health care, via the Exchange, will help establish accuracy and provide the level of coordination that the state, and consumers strongly desire.

At the end of the day, what matters is that the process of applying for and enrolling in coverage, whether public or private, should be one that is as simple as possible for the consumer. Consumers should be unaware of the complexities that surround the system architecture "behind the curtain". They need smooth integration of these functions behind the scenes so that correct and timely determinations of eligibility for programs and subsidies are made and they are enrolled in their choice of plan without gaps in coverage or other glitches. If the system is complex, cumbersome, inefficient, and frustrating, it will discourage consumers from applying. That is why Exchanges need to develop systems and practices that focus on the consumer experience so that it will be positive, and it will be easy to explore options and apply. The subsidies for private coverage target some who are familiar with Medicaid and navigating welfare programs, but it extends beyond those target groups. So it will be important that the experience of applying for subsidies through the Exchange not follow the model of applying for welfare programs. Finally, the Exchange should be committed to quality consumer service.

Conclusion

AARP appreciates this opportunity to comment on this important issue, and will be pleased to work with the Health Care Reform Implementation Council and others in implementing this key feature of reform. If you have any questions, please feel free to contact Jennifer Creasey at 217-747-8883, jcreasey@aarp.org

American Cancer Society®

Illinois Advocacy

HEALTH BENEFIT EXCHANGE RECOMMENDATIONS

Development of the health benefits exchange is an opportunity for our state to improve access to quality affordable health care coverage for all individuals in Illinois. As we move forward in determining how best to create and implement an exchange, we ask that you prioritize the following areas:

- **Exchange Governance:** The exchange governance board will make the critical management and policy decisions that determine the direction and success of the exchange. It is important that the members have appropriate management to successfully make the many critical administrative decisions that must be made by 2014. And, it is imperative that board members not have a conflict with their business or professional interests. Other stakeholders, like the American Cancer Society, should also be involved through advisory boards. Finally, the governance board must be held publicly accountable through open meeting laws and solicitation of public comments.
- **Parity of the insurance market both inside and outside the exchange:** It is essential that the insurance rules are comparable for plans inside and outside the exchanges, thus promoting a level playing field. If plans outside the exchanges can sell products under more favorable terms, those plans can cherry pick the healthiest consumers, with the exchanges ultimately becoming an insurance pool of primarily high-risk individuals. This would result in high and potentially unaffordable insurance premiums for those consumers who need care the most.
- **Integration of Medicaid:** It will be critical that the exchange is well integrated with the Illinois' Medicaid program to ensure seamless enrollment. And because many individuals will move between Medicaid and the exchange over time due to fluctuation in income, it is crucial that exchange rules allow for coordination of plans, benefits, and physician networks to ensure continuous coverage.
- **Administrative Simplicity for Consumers:** A major goal of the ACA is to make information about insurance more accessible. Consumers must be able to easily access not only information such as premium rates and enrollment forms, but also critical additional information, such as each plan's benefits, provider networks, appeals processes and consumer satisfaction measures. This information should be available in multiple languages and literacy levels.
- **Stable Funding Source:** To facilitate good management and planning, it is important that the exchanges have a predictable and steady source of funding. Otherwise, there is a risk that funding will become vulnerable to the often unpredictable legislative appropriations process. One option is to establish fees on insurers, which should be assessed on plans inside and outside the exchange, so carriers outside the exchange are not afforded an unfair financial advantage that could lead to adverse selection.

- **Adequate authority within the Exchange:** To best promote high quality care, innovative delivery system reforms, and for slowing the rate of growth of health care costs, exchanges should have the authority to be "active purchasers" when selecting participating health plans, as opposed to being required to allow every health plan that can meet the minimum requirements to participate. With this authority, exchanges could use their considerable market power and certification authority to limit exchange participation only to plans with a high level of quality and/or value when market conditions permit.

To be sure, development of the Exchange is no easy task, but it is an important step in ensuring access to quality health care in Illinois. The American Cancer Society, Illinois Division strongly encourages the Illinois Health Benefits Exchange Legislative Study Committee to consider these issues as essential to any exchange legislation.

Testimony of DeLane Adams – Legislative Director Citizen Action/Illinois before the Health Benefits Exchange Legislative Study Committee – August 30, 2011.

Good Afternoon, my name is Delane Adams and I am the Legislative Director of Citizen Action/Illinois. Citizen Action is statewide public interest group that has a long history of working for quality affordable healthcare for all.

We thank the members of this committee for their work and dedication to sorting through the complex issues that our state faces as we work together toward expanding the opportunity to have quality affordable health insurance for a majority of people in Illinois. This is not an insignificant charge and it has the potential to be a win-win situation for both business and consumers in our state.

To begin, we believe it is important to remember that Affordable Care Act has already made several significant improvements in providing access to health insurance, reducing costs for consumers, and improving people's lives.

Since September 2010 –

-All insurance plans can no longer deny care to children because of pre-existing conditions.

-Insurance companies are no longer able to cancel your plan because you get sick or put a lifetime benefit limit on your coverage.

-Small businesses with 25 or fewer employees have been able to deduct up to 35% of their health care premium costs from their taxes, making the cost of coverage cheaper.

-Insurance companies now have to offer you "first-dollar" coverage of preventative care, which means they have to pay for it even if you haven't paid your full deductible.

Also in 2010 senior citizens received $250 toward their prescription drug expenses when they reached the "donut hole" coverage gap.

In 2011 funding is being provided to expand current community health centers and create new ones, giving you access to new places for free or low-cost care. For example just this month the Macoupin County Public Health Department received a grant of $566,000 through the ACA.

Beginning January 2011, all insurance plans now have to report how much of your premiums they spend on care and provide you rebates if they spend too much on profits.

All Medicare Part D enrollees who enter the "donut hole" get 50% off in 2011, with the amount increasing every year to completely phase out the donut hole by 2020.

Starting in 2011, Medicare enrollees also now get a free annual wellness visit, personalized prevention services, and eliminated cost-sharing for preventative care.

With establishment of a marketplace for purchasing healthcare through an Exchange we will begin the next phase of work that needs to be accomplished to modernize our healthcare

system in a way that is fair and equitable to all who participate - from the providers, to the insurers - to the patients.

As this committee enters into this challenge Citizen Action encourages you to focus on three key elements that we believe are crucial for the success of a vibrant and affordable Health Exchange marketplace.

1. Affordability

Use Negotiating Power to Make Quality Insurance Options Available at a Reasonable Price

As an active purchaser, an exchange should use its negotiating power to demand quality, responsiveness to consumer concerns, reasonable rates, affordable plan designs, and good benefits. It should establish plan designs and negotiate for good coverage on behalf of small businesses much like large employers do now. Without an active purchaser there are no good mechanisms to help hold down costs.

2. Accountability

Make the Exchange Accountable to Consumers and Guard Against Financial Conflicts of Interest

The exchange should be a public agency – subject to open meetings and public disclosure laws, and operated by public servants to promote accountability and good service. Small businesses should be actively represented in the process of setting up and operating the exchange. To avoid conflicts of interest, individuals and entities that stand to make money through the exchange (eg, insurers) should be precluded from serving on the exchange governing board.

3. Sustainability

The Illinois Insurance Exchange should be funded mainly from an assessment on all in insurers in the health insurance market. This assessment should be justified by the fact that the current shifting of the cost of covering the uninsured from providers to insurers would be reduced by the presence of the exchange, as the exchange will cover many of the uninsured. The Exchange will also expand insurance markets, benefiting all insurers. The more enrollees in the marketplace of the Exchange, the less the assessment will need to be.

Citizen Action is ready to work with this committee to achieve a balanced approach to creating the Board and developing the financial sustainability for the Health Exchange.

Thank you for your time and service.

ILLINOIS CHAMBER
OF COMMERCE

Illinois Chamber of Commerce Testimony – Exchange Legislative Study Committee

August 30, 2011

Introduction

On behalf of the Illinois Chamber of Commerce and our members, I would like to thank the committee members for the opportunity to provide the employer community's perspective on this important issue. Employers have a tremendous stake in the design and implementation of the exchange, as we hope that it will offer employers- particularly small employers – the opportunity to access coverage options more efficiently and effectively, and we hope, more affordably.

Most of you are aware of the struggles many employers face with regard to providing health benefits and maintaining those health benefits. It is becoming increasingly more difficult for smaller employers to balance operations with the costs of providing benefits for their employees. The situation is only becoming more untenable and employers are often forced to drop coverage altogether; a choice that is neither in the best interest of the employee and their family or the employer. Health benefits are a way for employers to invest in their employees – to attract and retain a high quality and productive workforce. However, the costs of making these investments must be tempered with the basic realities of keeping one's doors open and jobs on the table.

Veto Session/Governance & Financing

Our support for SB 1555 and this Legislative Study Committee was borne out of the recognition that Illinois is in the best position to implement its own exchange. Creating an effective and sustainable health insurance exchange at the state level is in every stakeholder's interest. With that being said, we believe that "slow and steady wins the race" in this case. There are too many complexities, intricacies and unknowns for us to charge forward with implementing

something that has tremendous implications for virtually every individual and entity in this state.

The Administration makes a very compelling argument as to why robust Exchange legislation is needed in the fall veto session and we look forward to being their partners as the state proceeds down the path of implementation. We do not, however, believe the fall veto session is the most appropriate venue for additional legislative action. We believe a more robust bill can be taken up in the spring legislative session that can address exchange governance, operations, and financing- and other areas considered necessary to qualify the state for Level 2 funding and eventual certification by HHS on January 1, 2013.

The Administration cites two areas that must be addressed in the fall veto session, the first of which is governance. We agree that a quasi-governmental approach to Exchange governance is the best option, but we had concerns with the Department of Insurance's proposal (Senate Amendment #1 to SB 1729) in terms of the appointment process used to select voting members of the board in that a majority of the members were to be appointed by the governor. While we do not argue with the fact that the governor should not be excluded from the appointment process, the exchange should not be a creature of politics and the board appointment process should be set out in a way that allows for bipartisan input in the selection of the voting members.

There are currently several examples out there, including examples from other states, in how this can be achieved. Colorado's Exchange law, for example, gives appointment authority to each of the four caucus leaders. In Texas, proposed exchange legislation directed the four caucus leaders to submit names to the governor and from that list, the governor was required to select 2. In Illinois, P.A. 96-857 (sponsored by Senator Steans and Representative Harris), set forth an appointment process for a committee charged with developing the state's uniform health status questionnaire that directed a number of stakeholder groups, including the Chamber and other business, industry, and consumer groups to recommend members for appointment by the governor.

The makeup of the board is also essential, with proposed federal regulations setting forth guidelines that dictate a majority of those members must not have a conflict of interest. We believe employer representation on that board is vital and the proposed regulations contemplate that. We also believe it is important for the board to have a member of the

industry and agent and broker community represented, with strong conflict of interest provisions present and guidelines for recusal in situations in which a conflict of interest may be present. Knowledge of the market and benefits is key on all fronts and also contemplated in the proposed regulations.

The second area the Administration highlighted for fall veto action is financing. While the Chamber has not yet arrived at a position on how the exchange should be financed in 2015 and beyond, we do note that this is a very sensitive issue for everyone. Employers not only have a stake in the exchange from a user's standpoint, they also have a stake in the exchange from a payer's standpoint. We understand that no matter how financing is achieved, employers and consumers will ultimately foot the bill in some way. It is important therefore, to ensure that the exchange represents a good return on investment for everyone – employer, consumer, provider, insurer, agent/broker, etc.

We also believe that it is difficult to talk financing before we know what the price point is, and we only arrive at an actionable cost figure when we know what it is the exchange will be doing. We look forward to the forthcoming release of Department of Insurance-commissioned studies that will detail those costs. We believe, therefore, that exchange operations have to be addressed in some way in authorizing legislation before we move down the path of financing. The abbreviated fall veto session simply does not afford ample time to address all of these issues adequately.

Conclusion

In comments submitted to the Department of Health and Human Services in October 2010, the Illinois Departments of Insurance and Healthcare and Family Services noted that "small employers are the keys to innovation and economic growth. Affordable, meaningful health insurance for small employers allows those employers to retain the employees who will ignite revenue and employment expansion."

We could not agree more. The bottom line for employers is affordability. If the exchange fails to present lower costs options for them, their employees, and their families - if it fails to change the status quo- then it will not be an attractive option for employers. How we achieve this goal is key and one not easily answered. We believe, however, that a market-based approach to exchange design and implementation- one that focuses on competition and choice- is a key element to the success of the exchange for employers.

The policy goals espoused by the Massachusetts' Connector were rooted in those very ideals; however, those goals were ultimately lost in translation. Implementation of the Connector has not been a resounding success for employers in terms of making coverage more affordable, and the small business community there has been left behind in many regards. For example, the Business Express (BE) program that was designed specifically for small employers within the Connector recently reduced the number of plan options from 25 to 7; a move that went directly against employer wishes for greater information and diversity available on the exchange.[1] The state has also turned to regulatory cost control measures, including the rejection of premium increases with strong actuarial backing, that ultimately prompted four major carriers representing approximately 90% of the market to boycott the BE program. In fact, analysts from RAND have argued that ignoring market forces and instead relying on artificial limitations on premium growth will likely result in nominal savings and ultimately erode the quality and availability of insurance products available; a prospect that is not desirable or attractive to employers.[2]

The key to success of the exchange in the eyes of the employers is cost. Bending the cost curve, however, is not a sprint, but rather a marathon and that is why it behooves the state to move very carefully in its implementation of the exchange. There are very definite lessons to be learned from Massachusetts and one of those is not to forget your audience. Policy and intent do not always match end results.

In closing, I would also like to make a few comments about the external forces at work because as all of you well know, nothing occurs within a vacuum. Healthcare costs are indeed high, but the overall economic uncertainty also creates challenges in and of itself. Employers are extremely wary of the mixed messages coming out of Washington on this particular topic. We are very concerned about the impact the employer mandate and subsequent penalties that will occur in 2014 alongside initiation of the exchange. HHS and the IRS are currently not on the same page in terms of defining employer size and application of the penalty vs. eligibility on the exchange. While that is not something this body can address directly, it is something all of you should be aware of. Furthermore, we have heard from employers that such penalties create certain hesitations towards growth and investment; an area that is very concerning given the currently unemployment situation.

[1] Suzanne Curry, "A New Chapter for the Connector: 6/10/10 Board Report," Health Care for All, June 11, 2010 at http://blog.hcfama.org/2010/06/11/a-new-chapter-for-the-connector-61010-board-report/

[2] Christine E. Eibner, Peter S. Hussey, M. Susan Ridgely, and Elizabeth A. McGlynn, "Controlling Health Care Spending in Massachusetts: An Analysis of Options, August 2009, at http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/control_health_care_spending_rand_08-07-09.pdf

I note this only to suggest that we have our work cut out for us. The Illinois Chamber is sensitive to the pressures at hand and political perceptions that play into this entire debate, but the exchange is too important to employers, their employees, their families, and other stakeholders to fail.

We anxiously await the release of the state's Exchange Background Research and Needs Assessment Reports and We look forward to working with all of you in the coming months and in 2012 and beyond to truly make Illinois a model exchange state when it comes to serving the interests of our small employers and our consumers.

ILLINOIS ACADEMY OF FAMILY PHYSICIANS

Written Statement/Testimony

TO: Legislative Study Committee

FROM: Illinois Academy of Family Physicians

RE: Health Benefits Exchange

DATE: August 30, 2011

IAFP is limiting its comments primarily to issues that are of particular importance to family physicians in their efforts to play a critical and **supportive** role in the implementation of health care coverage expansion and reform as provided in the Patient Protection and Affordable Care Act (ACA). The following review and principles best explain and support our focus on certain Exchange implementation and enforcement policies:

In weighing options to form an exchange, Illinois should adopt policies to:

- protect consumers
- improve quality of care provided
- decrease costs across the health care system.

A critical element to achieving such goals is primary care. Studies repeatedly demonstrate that a primary care-based system restrains cost increases, improves quality and increases patient satisfaction. Family physicians in Illinois believe an ideal insurance plan would offer benefits to patients and offer incentives for high value primary care. Primary care is proven to be the foundation of high-performing health systems, including WellMed (San Antonio, TX) Geisinger Health System (Danville, PA), and Group Health Cooperative (Seattle, WA)

To ensure exchanges utilize all primary care has to offer, family physicians encourage members of the Legislative Study Committee to consider the following principles in developing exchanges:

1. Fair Representation of Stakeholders
2. Payment for PCMH & Enhanced Access
3. Standardized Contracting
4. Set Primary Care Targets
5. Require Robust Primary Care-Based Essential Benefits
6. Presume Eligibility
7. Reward Quality
8. Protect Consumers & Physicians

1) FAIR REPRESENTATION OF STAKEHOLDERS: Health care touches everyone's lives – to that end, fair representation of stakeholders ensures that all voices are heard. Representation must be broad-based and include representatives of certain essential segments. The governing body of an exchange should include, by statute, at least one seat for consumers and at least one for primary care physicians, in at least equal proportion

to the total number of seats allotted to insurers, specialty medicine, health systems and other stakeholders. A board of directors should be appointed based on relevant expertise, representing a broad spectrum of interests.

2) PAYMENT FOR THE PATIENT-CENTERED MEDICAL HOME (PCMH) & ENHANCED ACCESS: Benefit design should incentivize primary care. Enhanced payment for PCMHs, care coordination, and enhanced access through e-visits, open scheduling and expanded hours should be considered as part of "qualified coverage" for plans wishing to participate. With new medical-loss ratio requirements and the likelihood of increased competition, insurers participating in the exchange will need to limit costs and encourage savings. Under section 1301, ACA allows qualified health plans to offer coverage through a primary care medical home, also known as a patient-centered medical home, a delivery model that is proven to reduce the frequency and length of emergency room visits and hospitalizations, restrain cost increases, and enhance the quality of care provided, particularly for those with chronic conditions. Our current payment system rewards providers for performing more services, not delivering better care. PCMH is proven to restrain costs and provide better care. Patients want enhanced access; primary care practices should be paid appropriately for providing these important services.

3) STANDARDIZED CONTRACTING: Physician contracting should be standardized across all plans in any exchange, just as enrollee applications are standardized. "All products clauses" must be prohibited. Clear and understandable contracts will help plans meet their requirement to have adequate networks of participating providers. Standardized contracting will help the market determine which plans attract the best physicians.

4) SET PRIMARY CARE TARGETS: Illinois' Exchange should set targets for primary care spending by participating plans. Primary care is undervalued in the current health care payment system. Setting targets for the amount medical spending plans dedicate to primary care will help begin the rebalancing. Rhode Island successfully implemented this strategy to temper the increase of premiums and other costs in the private market, while promoting a more efficient, PCMH- and primary care-oriented delivery system.

5) REQUIRE ROBUST PRIMARY CARE-BASED ESSENTIAL BENEFITS: Illinois should require health plans to offer primary care services beyond those required by the federal essential benefits regulation. An essential benefits package should include important front-end investments in patient health, including, but not limited to, no co-pay for out-of-network primary care services, low or no cost medications for patients with certain chronic diseases (asthma, for example) and incentives for patient engagement. Preventive care works. Primary care works.

6) PRESUME ELIGIBILITY: Enrollees should receive presumptive eligibility—or provisional enrollment—to allow for delivery of essential preventive and primary care services upon submission of an application. 16 states adopted this policy for Medicaid and/or CHIP applicants. Not only do disruptions in insurance coverage have adverse effects on access to care and administrative costs, problems can arise simply from changes in health plans, even without gaps in coverage. Combining presumptive eligibility for all plans, public and private, with the new first-dollar coverage for preventive services delivered by primary care physicians will help keep patients out of emergency rooms while controlling costs.

7) REWARD QUALITY: Providers should be rewarded for providing quality care. Quality measures should be aligned across plans in the exchange(s) and with the state's Medicaid, CHIP and state and local employee health benefits plans. Such measures also should coordinate with Medicare, when possible. Reporting to multiple payers on different measures creates an undue administrative burden on physician practices. If the exchange requires physicians and plans to spend significant resources on initiatives not required of non-exchange plans, exchange plans could seem less competitive and increase the already substantial reporting burden on physicians.

8) PROTECT CONSUMERS & PHYSICIANS: While commonly referred to as the ACA, the first two letters commonly dropped off are "PP" – "Patient Protection" The law provides many new protections for patients and means of seeking redress and assistance. Family physicians, who frequently act as advocates for their patients, should have equal access to the services of programs designed to assist health care consumers. Exchange navigators and consumer assistance offices will provide fair and impartial, culturally- and linguistically-appropriate information concerning enrollment in qualified health plans and available subsidies through the exchange, facilitate enrollment in qualified health plans, and provide referrals for complaints.

CONCLUSION:

The Illinois Academy of Family Physicians welcomes the opportunity to provide additional comments. We urge the Legislative Study Committee to consider these principles and policies as the establishment of an Illinois exchange is deliberated. Furthermore, we ask that the Legislative Study Committee reference these materials and resources as it conducts the study and reports its findings. Thank you.

For more information on the value of primary care, please visit our website www.iafp.com or contact: Gordana Krkic, CAE, Deputy Executive Vice President, at 630-427-8007.

Additional Sources:

Designing an Exchange: A Toolkit for State Policymakers, National Academy of Social Insurance (NASI)

Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues, The Commonwealth Fund

Insurance Exchanges under Health Reform: Six Design Issues for the States, Health Affairs

Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues, The Commonwealth Fund

The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned, Georgetown University Health Policy Institute Center for Children and Families (CCF)

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Written Testimony to Health Benefits Exchange Legislative Study Committee
August 30, 2011

On behalf of the Illinois Maternal and Child Health Coalition (IMCHC), thank you to members of this legislative study committee for undertaking the important task of reviewing and providing recommendations on how Illinois can best implement a Health Benefits Exchange (Exchange). Given the limited amount of time that this study committee has to provide recommendations, IMCHC has focused our testimony on governance, financing, and stakeholder engagement.

Since 1988, IMCHC has been fighting to improve the health of all women, babies, young people and families in Illinois. As an organization, we bridge the gap between policy makers and those affected by their decisions. Through education, we empower people to make healthy choices that strengthen families and communities.

IMCHC's statewide membership includes health care providers, social service organizations, and community residents, primary women and children under 200% of the Federal Poverty Level, who will be directly impacted by the decisions of this study committee and by the enacting legislation to be considered by the General Assembly during the Fall 2011 veto session. Our written comments reflect the concerns of our constituents; if you have any questions, please feel free to contact Kathy Chan, Director of Policy and Advocacy at 312-491-8161x24 or at kchan@ilmaternal.org.

The intent of the Exchange is to create a competitive health insurance marketplace that provides information to consumers and small businesses, so they can make informed decisions about choosing a health insurance plan that is affordable and meets their specific needs. Given that individuals and small businesses are at the greatest disadvantage when it comes to accessing affordable health insurance, they have the most to gain from an Exchange AND their needs **must** be prioritized when designing an Illinois Exchange.

The Exchange will also help facilitate enrollment into Medicaid for those who are eligible and streamline the process for those whose income causes them to move between public and private coverage throughout the year. Early estimates of those who will be newly eligible for Medicaid in 2014 have been as high as 700,000 Illinois residents, so establishing an Exchange that is responsive to the needs of this vulnerable population is critical.

Determining the governance structure of the Exchange is the legislative study committee's *most important task*. In addition to meeting requirements to draw down the second round of Exchange planning grants from HHS, establishing a governance structure that responds first and foremost to individuals and small businesses will help ensure the success of the Exchange. IMCHC considers transparency, strong conflict-of-interest provisions, and representation by individuals and small businesses on the Exchange governing board as high priorities.

In order to assure Illinois taxpayers that the Exchange operates in a process free from patronage or political favoritism, IMCHC recommends that the Exchange operate as a quasi-state agency, but still be subject to FOIA and open meeting rules. The Exchange should be not be required to follow state procurement rules, which can be cumbersome and time-consuming, but instead issue contracts and other business via a competitive request for proposals (RFP) process that is part of an annual independent audit process.

Exchange governing board members should be unpaid and required to adhere to strong conflict-of-interest provisions. Board members should represent those who will benefit from the Exchange, namely individuals and small businesses, and not represent the interests of anyone who would directly profit from the Exchange, such as insurance companies or brokers. Additionally, it will be necessary to implement strong revolving door policies to prevent members from moving directly into or from the insurance industry for at least one year.

Governing board members should serve staggered terms and represent a wide range of experiences. IMCHC recommends that board members have one or more areas of expertise as suggested by the National Academy of Social Insurance[1], which speaks to specialties such as health benefits plan administration, purchasing health plan coverage, or individual or small group health insurance markets. In addition to these areas, there should be at least one board member who has direct experience with Medicaid and/or providing health care to the uninsured. Exchange staff should also be able to provide support in the form of research and timely responses to board members on these and related issues.

In an effort to encourage greater public participation, as well as allow for other stakeholders to provide guidance and input to the Exchange while avoiding conflicts of interest, IMCHC recommends the establishment of advisory boards that could include insurers, brokers, and providers.

Governing board and advisory board meetings should take place in rotating locations throughout Illinois to allow for maximum participation by Illinois residents. Meetings should be posted at least 60 days in advance.

Regarding financing of the Exchange, IMCHC supports an option that would be unlikely to add to consumers' cost for coverage, such as levying assessments or user fees to health insurance companies operating within the entire Illinois market. Illinois should also consider drawing down Medicaid administrative match at the 90/10 rate to help support Medicaid enrollment and coordination with those who may move between public and private coverage throughout the year.

Thank you for considering our comments. IMCHC intends to submit more comprehensive comments on additional issues concerning the Exchange in the next several weeks.

[1] http://www.nasi.org/research/2011/designing-exchange-toolkit-state-policymakers

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August 30, 2011

Legislative Study Committee on the Illinois Health Insurance Exchange
207 Statehouse- Room 114
Springfield, IL 62706

Dear Legislative Study Committee Members,

SEIU Health Care Illinois Indiana represents 85,000 home care, child care, hospital, and nursing home workers. Some of our members receive health insurance through union-administered funds, others have benefits through their employers' fully-insured or self-insured plans, some participate in a spouse's family plan, and there remain members who qualify for Medicaid, and some who are uninsured. We are proud of the efforts we have made, in partnership with the State, to make affordable health insurance available to low-income workers in home care and child care. We recognize, however, that many members are inadequately served by the current health insurance market in Illinois—some members work too few hours to qualify for the home care/child care plan, other employer-sponsored plans may be ill-suited to the new insurance landscape or are unaffordable for some members, and we have members who work for small employers who are unable to offer affordable coverage. A well-functioning, consumer-friendly state health insurance exchange that expands coverage and improves the quality of insurance available to low-income workers and their families is in the interest of SEIU HCII's members.

By creating a simple, regulated portal for individuals and small business employees to access insurance, a State Health Insurance Exchange offers opportunities for convenience and efficiency for consumers, providers, and payers. But most of all it offers a chance for the state, with stakeholder input, to use the leverage created by the major purchasing role of the exchange to shape the health insurance market, and even health care delivery, in a way that reflects both the need for a more rational organization of health care resources and a principled vision of a more just health care system.

This is a remarkable opportunity for us to ensure that healthcare is not considered a luxury but a necessity that all citizens can attain. It is imperative that there are plans offered on the exchange that are reasonably afforded by those with low incomes. This is a welcome opportunity to advance the wellbeing of workers and their families. Although the process with undoubtedly be arduous, we must seize this chance to make sure the citizens of Illinois benefit from the exchange by gaining access adequate that they can afford.

The bullet points below articulate our general views of how to create and implement an exchange that best serves the members and the State:

Functions of a Health Benefit Exchange

- Creating a state-run exchange will allow Illinois to maintain the benefit requirements that we have decided as a state are suitable and fair, but which may not be included in the federal minimum benefits package. In general, a state-run exchange will permit Illinois to tailor the design and structure to our specific needs and values. Consumers and providers, especially safety net providers, will have stronger protections in a distinct Illinois exchange than in a federal exchange.

- The exchange should aim to create a broad, diverse risk pool that will lower costs for consumers in general and allow sick and disabled consumers better access to quality insurance, but avoids adverse selection. It should be a source for simple, impartial information that allows consumers to make informed choices without devoting enormous amounts of time to sorting out the jargon and code words from the basic facts about cost and coverage. Communication to consumers should be sensitive to the needs of consumers with low health literacy, limited English proficiency, and people with disabilities. The impact on low-income individuals and families' access to truly affordable, quality insurance should be a priority concern when designing the exchange.

  Some features that will support those outcomes include, but are not limited to: (1) requiring insurers selling outside the exchange to meet the same requirements that apply inside the exchange to prevent insurers from luring healthier consumers away from the exchange with cheaper, less comprehensive plans, (2) including marketing standards to protect consumers from deceptive practices, (3) designing the exchange as an active purchaser, including restricting the exchange to high quality plans that compete based on quality and price, (5) providing basic health insurance education designed for people with low health literacy and low literacy, perhaps in multi-media format, so that potential enrollees are able to understand the health insurance plans they are comparing, (6) ensuring that exchange staff are walking enrollees through the enrollment process, including helping enrollees understand the differences between plans so they can make informed decisions, (7) ensuring that exchange staff explain the tax implications of a change in income or family status so enrollees understand that if they lose the subsidy mid-year, or if the information they file on their taxes at the end of the year is different than what they provided, that they can owe all or part of the subsidy back, (8) facilitating easy ways for enrollees to update income or family size information and actively making sure enrollees receiving subsidies are aware of the importance of contacting the exchange with an update, (9) creating avenues for meaningful consumer input during the design, implementation, and operation of the exchange.

- Illinois should keep in mind that the primary role of the exchange is to link consumers to the best insurance option—the most appropriate and affordable plan for each consumer. The primary role of an insurance company, on the other hand, is to sell its plan to as many consumers as possible, regardless of its appropriateness for each consumer. It may be constantly trying to attempt to improve its quality and reduce cost relative to competitors to attract those consumers, but its interests are still different from an exchange. Because health insurance is a service that is vital to the lives and well-being of every Illinois resident and because of those diverging interests, the state exchange must play a mediating role between consumers and insurers, and this includes limiting the number of plans by setting high quality standards for plans offered on the exchange. The exchange should standardize health plan offerings beyond the bronze-silver-gold-platinum tiers based on actuarial value set up in the ACA—this framework still allows for variations that can confuse consumers and allow insurers to select risk. Two important network adequacy requirements that Illinois should include are (1) that all plans provide an adequate network with real access to care, with particular attention to the needs of populations affected by provider shortages, such as rural areas with fewer providers and in situations when most providers in the network are not accepting new patients, and (2) that all plans include essential community providers that currently serve the uninsured in their networks to ensure continuity of care.

Structure and Governance

- Illinois should choose the governance structure that allows governmental functions that are properly the domain of public decision-making to be housed in a public entity. Although eligibility determination and customer service should be never be performed by private contractors, if there are exchange functions that can be responsibly contracted out, the exchange should adopt the highest standards of accountability, so that public interest does not become subsidiary to private companies'. Contracts should use competitive, open bidding, require strong employment standards for contractors, and forbid the use of public dollars for anti-union campaigns. There should be a mechanism for front-line employees to bring concerns about contracted work to the Exchange's governing body.
  This basic framework implies that the exchange should be a state entity, not a non-profit created for the purpose of operating the exchange, as is also permitted in the ACA. Illinois should exercise caution in deciding whether to exempt the exchange from various administrative rules that apply to state entities, especially concerning employment and public access to meetings and records, and consider whether the benefits in flexibility override the costs of making exceptions to rules designed to maintain standards of transparency and integrity in government.

- If there is an appointed governing board, the state must balance the need for expertise with the imperative to avoid conflicts of interest. Many candidates will have gained their expertise while working in industries that have a financial stake in the work of the exchange. Illinois should include in the enacting legislation a prohibition on representatives from insurers, brokers, and health care providers or facilities on the exchange board. Health economists and other health policy experts, and actuaries can provide expertise with less potential bias. To prevent a 'revolving door' between the exchange and insurers, Illinois should prohibit exchange board members from moving directly into the insurance industry when their terms on the board expire.

The External Market and Addressing Adverse Selection

- Eliminating the external market would avoid adverse selection, reduce fragmentation in the insurance market' which would simplify regulation and administration. However, there are two concerns with doing so: one is that it would deprive undocumented immigrants in the individual or small group market of any source of health insurance. Apart from the fact that this further immiserates the lives of immigrant workers and their families, it is also bad policy because it will restrict the resources available to undocumented immigrants, who will be forced to use emergency departments—a costly and inefficient way to provide care—and could contribute to public health threats if infectious diseases go untreated in their early stages or at all. An external market that could sell insurance to undocumented workers would provide a way for them to pay for their own benefits, improve access, and reduce uncompensated care costs for providers. The other problem with eliminating the external market is that it may restrict the state's ability to selectively contract with insurers to participate in the exchange, which would deprive the state of a vital means of protecting consumers in the exchange.

- Illinois should work toward a goal of having the same rules for inside and outside the exchange to prevent insurers from marketing lower cost, lower quality plans to healthier consumers outside. All ACA requirements that apply only to exchange plans and any additional requirements that Illinois chooses to develop should apply to plans sold outside of the exchange as well, including requirements to offer 'gold' and 'silver' tiered plans in addition to 'bronze' level and catastrophic plans. Illinois should also consider ways to address adverse selection from grandfathered plans, whose higher risk enrollees may be encouraged to seek better coverage on the exchange, while the lower risk ones stay in the grandfathered plan. However, it is important to do this without undue disruption of existing coverage, so simply extending the ACA's requirements for non-grandfathered plans to the grandfathered plans may not be the solution. Any exchange design features that help the exchange function (by broadening the risk pool and reducing adverse selection) that may raise

costs should be balanced by efforts to make exchange plans affordable for low-income individuals and families.
Adverse selection within the exchange will also be a problem, as higher-risk enrollees may drive up premiums for all members, given the prohibition on setting premiums based on health status and the requirement for plans to treat all enrollees as part of a single risk pool. A sophisticated risk adjustment system that can respond to signs of adverse selection within the exchange can address this problem.

- Illinois should consider a hybrid model that requires all coverage to be sold on the exchange with some limited exceptions for wraparound coverage (including coverage for undocumented immigrants), if and only if doing so would not interfere with the state's ability to restrict the plans participating in the exchange based on quality and cost standards.

- There should be at least one open enrollment period per year. The initial open enrollment period should be longer than the regular period to give consumers the opportunity to learn about the exchange and research options. Special enrollment should at a minimum follow HIPAA special enrollment guidance as well as allowing enrollment or changes if eligibility for a subsidy changes.

- A goal for the exchange is to make sure plans compete based on quality and cost—and cost should vary based on how comprehensive the coverage is, not on the risk profile of the plans' enrollees. A key challenge for risk adjustment programs will be data collection so that they can consider the health status of enrollees in its calculation and correct for differing risk profiles. The three-year state risk adjustment and re-insurance program can set the stage for an effective permanent program if it identifies effective ways to collect relevant data, while protecting consumer privacy.

- Enrollment in a plan through the exchange should not require a broker or an agent, and the State should keep in mind the distinct role of navigators in helping people learn of and access the exchange.

Structure of the Exchange Marketplace

- Combining the individual and SHOP exchanges would create a larger risk pool and avoid duplication of administrative functions, which are important goals. However, more study is needed to understand the potential impacts on premiums in a combined exchange. The exchange needs to be an affordable source of insurance to small employers, and the SHOP exchange's premiums could be pushed higher in a combined exchange then they would be in a separate one, especially if many healthy individuals do not participate in the exchange—either due to adverse selection or because they choose to pay the penalty for remaining uninsured rather than purchase

insurance on the exchange. If these challenges can be addressed, Illinois should regard a combined exchange as an eventual goal,, even if it is not immediately practical.

- To include as many consumers in the exchange as possible, we accept the ACA's definition of small employers (100 or less employees). However, larger employers—even those with 100 rather than 50 employers—are more likely to be self-insured. Self-insured plans are subject to far fewer of the new regulations in the ACA than other plans, so there is a huge risk for adverse selection. Employers could maintain less-regulated self-insured plans to contain costs, and only switch to purchasing on the exchange when the risk profile of their employees worsens.
  Balancing the advantages and disadvantages of including employers with between 50 and 100 employees requires more study and will be impacted by possible federal action on defining 'self-insured' plans.

- Just as Illinois should exercise its ability to shape the insurance market to better meet the needs of consumers, it should also seek to use access to the exchange to encourage fair employer practices. To succeed the exchange will need to attract employers, but it can do that best by performing functions like collecting and allocating premiums and other benefit management services. If the exchange provides these services and is an effective means for employers to provide coverage to their workers, Illinois can add requirements, such as a minimum employer contribution to premiums, that will ensure that the exchange helps maintain and improve worker benefit standards rather than allowing them to deteriorate.

- The exchange should have processes in place to address the specific needs of rural communities, low income, limited-English, and hard-to-reach groups, as well as consumers who live on or near borders with neighboring states and who may work in across the border. If plans are required to contract with traditional community providers that serve these areas and populations, a single state-wide exchange will function well in all regions while benefiting from a larger risk pool and economies of scale for administrative functions. For border areas, a multi-state exchange could have advantages, but would sacrifice the ability of Illinois to design an exchange that reflects our priorities, and inject an added degree of complexity that could undermine the project. Illinois should work with neighboring states to evaluate the needs of populations living, working, and buying insurance, in those border regions.

Eligibility Determination

- The Exchange can contract with HFS to perform eligibility, verification, and enrollment services so the same people currently doing this work continue to do it. The committee should evaluate what necessary IT improvements HFS would need to

meet the expectations for a seamless, coordinated eligibility system for Medicaid, SCHIP , and Exchange subsidies that is described in proposed federal regulations. Agencies that administer other social service programs should assist people in enrolling in the Exchange whenever they enroll in another program, either by assisting them in person if it is in an office or transferring them to assistance if by phone. The Exchange should also reach out to current social service program enrollees about the Exchange as those individuals and families are likely eligible for subsidies.

- Essential community providers that care for a large number of uninsured and Medicaid consumers must be in the networks of plans offered in the exchange. There should be plans that have similar networks to SCHIP so that parents can use the same providers as their children, if the children are enrolled in SCHIP. Exchange should consider encouraging the creation of plans designed specifically for lower income individuals that would be built around a network of essential community providers and designed in a way that there can be a lower deductible, or no deductible on doctor visits and other services, as well as lower co-pays, in order to make access to regular care affordable.

- The Exchange and the State should consider encouraging coordinated care models, such as those promoted in the ACA, be created with multi-payer models. For example, accountable care organizations, medical homes, and care transition programs can be created with providers who participate in a plan offered through the exchange, in Medicaid and in Medicare. When designing these models for coordinated care, Illinois should be careful to include essential community providers.

Thank you for the opportunity to submit testimony on this issue.

For any questions please contact Nora Gaines at nora.gaines@seiuhcil.org or (312)-596-9377.

IPHCA
Illinois Primary Health Care Association

August 30, 2011

Illinois Health Benefits Exchange Legislative Committee
703 Stratton Office Building
Springfield, IL 62706

The Illinois Primary Health Care Association (IPHCA) is pleased to respond to the request for comments from the Illinois Health Benefits Exchange Legislative Committee. IPHCA is the membership organization for Federally Qualified Health Centers (hereinafter interchangeably referred to as "health centers" or "FQHCs") throughout the state, and is a 501(c)(3) organization.

Background

IPHCA is limiting its comments primarily to issues of particular importance to health centers in their efforts to play a critical and supportive role in the implementation of health care coverage expansion and reform as provided in the Patient Protection and Affordable Care Act (ACA), Pub. L No. 111-148, enacted on March 23, 2010. To best explain and support our focus on certain Exchange implementation and enforcement policies, we believe the following background review is appropriate.

In Illinois, there are 42 FQHCs with more than 440 sites serving over 1.2 million patients statewide. Most of these FQHCs receive federal grants under Section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b) from the Bureau of Primary Health Care (BPHC), within the Health Resources and Services Administration (HRSA) of the United States Department of Health and Human Services (HHS). Under this authority, health centers fall into four general categories: (1) those centers serving medically underserved areas; (2) those serving homeless populations within a particular community or geographic area; (3) those serving migrant or seasonal farmworker populations within similar community or geographic areas; and, (4) those serving residents of public housing.

To qualify as a Section 330 grantee, a health center must be located in a designated medically underserved area or serve a medically underserved population. In addition, a health center's board of directors must be made up of at least 51 percent users of the health center, and the health center must offer services to all persons in its area, regardless of one's ability to pay. BPHC's grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of providing comprehensive preventive and primary care and enabling services (such as translation, transportation, smoking cessation classes, etc.) to uninsured and underinsured indigent patients, as well as to maintain the health center's infrastructure. Patients from eligible communities, who are not indigent and are able to pay or who have insurance, whether public or private, are expected to pay for the services rendered.

Approximately 50 percent of Illinois health center patients are Medicaid recipients and approximately 30 percent are currently uninsured. Ninety-five percent of Illinois health center patients have family incomes at or below 200 percent of the poverty level, meaning most will either qualify for the expanded Medicaid program or for coverage within the Health Benefits Exchange beginning in 2014.

Exchange Requirements Should Mandate Inclusion of FQHCs

For the reasons provided above, IPHCA believes that state regulations must make clear that Exchanges can only certify plans as Qualified Health Plans (QHP) if those plans are contracting with FQHCs and reimbursing them no less than they would be reimbursed under Medicaid. Equally important, IPHCA believes that the above provisions as well as other provisions of the ACA**,** require: plans seeking QHP certification contract with all FQHCs that offer to contract with the QHP; that QHPs assure in their marketing practices that individuals eligible for QHP enrollment are made fully aware of, and are fully informed of, the choice of an FQHC and the names of those specific clinical providers working at each FQHC; and, that FQHCs be allowed and supported to play an active role in facilitating the enrollment and determination of the eligibility of applicants for Exchange as well as Medicaid participation.

Specifically, the ACA provides that additional responsibilities of Exchanges include, among other things:

1. Ensuring that consumers are able to make informed health care coverage choices and that families and individuals are able to comparatively shop for their coverage through the use of web portals, other pathways, and through grant funded navigator programs; and,

2. Creating seamless eligibility and enrollment linkages with Medicaid, including use of a single streamline application form, a "no wrong door" system for applicants, enrolling applicants in the appropriate programs without additional burdensome steps to determine program eligibility, and the use of web portals through which families can obtain information on their eligibility for different programs.

Clearly, health centers are a perfect venue for Exchanges to ensure their compliance with these two ACA requirements. There are more than 400 health center sites located in medically underserved communities in Illinois serving more than 1 million poor and low-income patients, 80 percent of whom are currently uninsured or Medicaid recipients. Health centers continue to treat these individuals even when they lose their Medicaid eligibility or other coverage and become uninsured. Health centers, therefore, are perfectly suited, to serve and operate as eligibility and enrollment sites for individuals who are applying for Medicaid or Exchange participation and who may move from program to program as their incomes fluctuate.

Further incentive for Exchanges to require QHPs to contract with health centers is the fact that health centers already engage in substantial ongoing interaction with the Illinois Department of Healthcare and Family Services (HFS) programs; and in a number of cases, health centers actually assist in Medicaid and Comprehensive Health Insurance Plan (CHIP) enrollment at their sites. Since a majority of the health center's Board of Directors must be active registered patients of the center, and because of other FQHC grant requirements, health centers are invariably culturally sensitive to the communities they serve and often provide translation services. Consequently, they are able to assure that Exchange applicants and enrollees are able to comprehend and act on the QHP and service choices available to them.

Other Recommendations in Response to the Committee's Request for Comments

The following recommendations are not necessarily health center specific in nature, but IPHCA believes they are critical to successful implementation of the ACA's mandated provisions for expansion of access to health insurance through the establishment of a Health Benefit Exchange:

1. Illinois should require that the governing board of the Exchange (regardless of whether the Exchange is a governmental agency or a non-profit entity) be composed of a broad range of

stakeholders including consumers and safety net providers. In addition, the establishment of the Exchange and decisions as to its regulatory authority and responsibilities should be determined through a transparent process, with open meetings and opportunity for participation by all those affected, including insurance companies, plans, providers, consumers, employers, labor organizations, etc. Additionally, the Directors of HFS and Insurance should, at a minimum, hold Ex-officio positions on the governing board to further the goals of a seamless system.

2. Illinois must implement and promote rules and policies that will minimize adverse selection among or between QHPs. To some degree, this can be achieved if Illinois applies the statutory protections against adverse selection that are provided in the ACA, as examples: assuring that the insurance reforms imposed by the ACA (such as banning lifetime and annual dollar limits on coverage) are applied both within and outside the Exchange; requiring individual and small-group plans—both within and outside the Exchange—to cover "essential health benefits" as defined in the ACA; and, firmly implementing several risk adjustment programs provided in the ACA, such as the state assessing plans and insurers with low-risk enrollees, and making payments to plans (such as Safety Net Health Plans) and insurers with high-risk enrollees.

3. In general, IPHCA believes an Illinois Exchange should operate as an assertive regulatory body. As examples:

- **The Exchange should establish a framework that will assure seamless interaction with Medicaid, All Kids, Family Care and all other Illinois medical assistance programs.** This provision is of particular importance to FQHCs given the fact that their patients will be fluctuating between the Exchange and those programs.

- The Exchange must be fully empowered to actively certify and de-certify QHPs in accordance with the functional requirements of the law. Specifically, the Exchange should actively ensure that any health plan seeking certification comply with all requirements of the law, including a clear demonstration that it possesses the ability to make payments to providers within its network for covered benefits furnished to enrolled individuals, and that such payments will be made on a timely basis.

- The Exchange must also ensure that, in order to be certified, a health plan must include within its network a sufficient number of essential providers, who are actually accepting new patients, to ensure ready access to covered benefits and in particular, primary and preventive health care services. Demonstration of sufficient access should include sufficient provider locations within the areas where enrolled individuals live and work, hours of service that are available to enrollees, specific minimum waiting time for an enrollee's first appointment and, particularly important, the availability of appropriate linguistic and culturally-appropriate care. As such, it will be vital that Exchanges secure from QHPs, and make readily available to consumers, all pertinent information about plan operations, network configuration, financial viability, enrollee responsiveness, and provider satisfaction.

- Since the Exchange is responsible for certifying insurers as QHPs, it should adopt and apply certification requirements that will allow for a sufficient number of competing plans but that also assure that these plans provide good value and consumer protections.

- The Exchanges should establish criteria for QHP certification that are oriented to assuring that plans have sufficient numbers of primary care providers who are available and accessible to those who are to be enrolled in QHP coverage.

- Illinois must assure that plans within and outside the Exchange provide consumers with clear and understandable descriptions of the important features of the plan, such as services provided, price and cost-sharing requirements, important exclusions and exceptions to the coverage being offered, and the geographic locations and hours of operation of network providers.

Conclusion

IPHCA appreciates the Committee affording us, and so many other interested parties, the opportunity to provide initial comments regarding establishing a Health Benefits Exchange in Illinois. IPHCA is available to provide whatever assistance or support the Committee might request as it endeavors to report its findings to the Illinois General Assembly.

If the Committee has any questions or wishes to follow-up with further communication on these comments, please contact me at (217) 541-7307 or oidowu@iphca.org.

Respectfully Submitted,

Ollie Idowu
Director of State Governmental Affairs

Planned Parenthood®
of Illinois

Illinois Health Benefits Exchange Legislative Study Committee
August 30, 2011

TESTIMONY
Pamela A. Sutherland, Vice President of Public Policy
Planned Parenthood of Illinois

INTRODUCTION

PPIL is a statewide health care organization which operates 17 health centers in Illinois. In FY 2011, PPIL provided 150,936 patient visits. We performed 11,755 Pap smears, 50,792 tests for sexually transmitted infections (STIs), 7,355 HIV tests, and 19,861 pregnancy tests. We dispensed 199,332 birth control prescriptions and 561,387 condoms. Over 57% of PPIL patients live at or below the federal poverty level. About 50% of PPIL patients are eligible for the support of a government health program such as Title X Family Planning, Medicaid, or Illinois Healthy Women. Only 14.5% of our patients are covered by a health insurance plan.

PPIL is excited for the opportunities health care reform will bring for our patients in 2014. We realize that we will likely be serving not only an influx of newly eligible Medicaid patients, but that we will also see a dramatic increase in the number of our patients who will be covered by an insurance plan because of the establishment of the Health Insurance Exchange. Therefore, it is critical that the Exchange be a strong entity that protects the interests of women and men in need of reproductive health care services.

One of the greatest concerns that the public had when the Affordable Care Act was debated was the fear of the loss of access to health care that people already had in their current health plans. The development of an Illinois Exchange is an opportunity to fulfill the promise that people will not lose the health care they already have. This means that the Exchange must protect the progress that has already been made in access to reproductive health care, including access to contraception and abortion care, in Illinois and build upon it.

FUNCTIONS OF A HEALTH BENEFIT EXCHANGE

An Illinois Exchange can be tailored to the specific needs of the Illinois Health Care Marketplace and the needs of Illinois residents. **Illinois should design a strong Exchange that will promote competition, avoid adverse selection, encourage participation, provide disclosure, ensure efficiency, and exercise regulatory authority over participating plans.**

Illinois should not settle for the minimum requirements set forth in the federal Affordable Care Act. Instead, **it should take aggressive steps to avoid adverse selection, provide adequate choices of health plans, and coordinate outreach with existing public programs. Moreover, the Exchange should be an active purchaser of health care.**

The Illinois Exchange must be more than simply an Internet portal used to shop for insurance coverage. The Exchange is an opportunity to improve the insurance market in Illinois for individual consumers and employers. The Illinois Exchange should be a place where those seeking coverage, both individuals and businesses, can find more choices, easy to understand information, and cost savings.

In order to accomplish these goals, the Exchange must be a strong entity that is designed to improve the insurance market in Illinois, not just settle for the status quo. The development of the Exchange should be forward thinking with tough provisions to protect consumers through transparency and disclosure on the part of insurance companies. It should consider structures to assist employers and ease their financial and bureaucratic burdens. And, it should make sure that there are a variety of insurance companies offering a variety of quality plans to Illinois consumers.

The Illinois Exchange should take on certain regulatory functions to ensure quality, accessibility, and affordability within the Illinois insurance market. First, only the highest quality plans should be allowed within the Exchange. These plans should provide coverage for a wide range of health care, including reproductive health care and both preventive and early detection services. By providing high quality coverage, these plans will have healthier enrollees and will save money in the long term. Second, the competition to be a plan included in the Exchange should be value-driven not profit oriented. The Exchange should take an active role in negotiating benefit packages and premiums to ensure that reproductive health services are not only covered but also affordable. Third, the plans should be required to provide consumers with clearly understandable information in order to give consumers the tools they need to purchase a plan that best meets their needs.

An Exchange is not stronger if it permits any willing provider to participate. As stated above, only those providers of quality health insurance plans should be allowed into the Illinois Exchange. If the Exchange controls the quality of the plans it offers, it can drive up value overall and set the standard for the market in Illinois. The goal is not to become simply an ideal marketplace for insurance companies, but to be a marketplace that provides protection and benefits to consumers. Therefore, Illinois should use its authority to set specific standards, including those for reproductive health care coverage, and then allow all insurance companies the opportunity to bid to offer plans within the Exchange.

In addition, when selecting the insurers who will be allowed to participate in the Exchange, safety-net providers must be a strong part of the provider networks. The Affordable Care Act contains provisions to ensure that insured individuals have access to essential community providers. Several studies have shown that a large number of the uninsured who currently rely on essential community providers will continue to prefer those providers once they have insurance coverage through the Exchange. Therefore, **provider networks must include essential community providers in order to adequately serve those they insure.**

ADVERSE SELECTION

As mentioned above, steps must me taken to protect the Illinois Exchange from adverse selection. The strongest method of eliminating adverse selection would be to eliminate the outside market and have the entire Illinois insurance market contained within the Exchange. However, PPIL is keenly aware that not all Illinois residents will be allowed to purchase insurance coverage within the Exchange. We must ensure that there is a safety net for those undocumented individuals who need access to quality health care. If the outside market cannot be eliminated, **it is essential that a fair and even playing field be created for plans inside and outside the Exchange.**

For example, the Affordable Care Act (ACA) requires that there must be a sufficient number of in-network providers which is extremely important for access to gynecological and obstetric care. ACA also requires the inclusion of essential community providers, such as PPIL, that serve low-income, medically underserved individuals. These rules must be applied to plans both inside and outside the Exchange. Only with an even playing field can the State avoid adverse risk selection and ensure stable risk pools. In the case of reproductive health care, if the rules are not across the board, there is a risk of a two tiered insurance marketplace for women's health care coverage. A two tiered system can result in plans within the Exchange offering high quality women's health coverage while plans outside the Exchange offer low cost plans with very limited women's health coverage. We cannot allow for such a large segment of the population to be treated this way.

Adverse selection can also be addressed by opening the Exchange to groups larger than the small employers (50 or fewer) that was enacted in this spring's legislation. If the Exchange were open to larger groups, grandfathered and eventually traditional ERISA plans could have the option of participating. This would extend risk to a wider pool and also provide high quality standards to those covered in these larger groups. The ability to extend a richer benefit package to employees while reaping the cost benefits associated with the Exchange would appeal to large employers.

When including larger employers, adverse selection is a risk if only those large employers who have poor track records join the Exchange. While we recognize that inclusion in the Exchange is beneficial to employees, we cannot put the entire pool at risk. Therefore, the State must consider extending all regulations applied to the Exchange to any employer whose group is eligible to participate in the Exchange. This would mean that employees would reap benefits, but employers would not be given the incentive to "dump" a high risk pool into the Exchange.

STRUCTURE AND GOVERNANCE

When creating the Illinois Exchange, the health and well being of the individuals should be the foremost concern above all other interests. In order to avoid undue influence by any one interest - whether political, consumer, employer, or insurance industry – **the Illinois Exchange must be created as a separate, independent, quasi-governmental entity**. Governance of this entity can include certain stakeholders such as business and consumers, but should not include entities that have conflicts such as those selling insurance within the Exchange or competing with the Exchange in the larger insurance market. **The members of the governing board should be**

subject to strong conflict of interest requirements. In addition, those governing the Exchange should have relevant expertise in health care, insurance, and management.

To further avoid control by any particular interest, any governing board should have certain "slots" assigned to represent the interests of those impacted by the Exchange. For example, there should be an individual consumer representative, a business representative, etc. It is advisable to have multiple slots for each interest so that a variety of ideas and expert backgrounds can contribute. Moreover, consideration of the diversity of the State of Illinois should be should be given a high priority, Thus, the governing board should represent the various ethnic, racial, gender, and geographic communities in our state. Again, insurers within the Exchange should not have governance authority. However, their expertise is valuable, and there should be a mechanism in place to allow them to provide information and advice to the governing board. **The members of a governing board should have staggered terms to ensure continuity and prevent sudden and drastic shifts in governance. There also should be a revolving door policy so that those serving on the governing board cannot move directly back and forth between the board and the insurance industry.**

The business and governance of the Exchange must be subject to high standards of transparency. Board meetings should comply with the laws on open meetings.

SELF-SUSTAINING FINANCING

The Illinois Exchange should develop a variety of revenue sources to fund the Exchange. The revenue sources ideally should provide incentive for participation in the Exchange rather than discouraging participation. The funding should be designed to grow over time to provide ongoing and stable revenue.

PPIL supports an assessment on all insurers in the entire insurance market, including those administering self-funded plans. We anticipate that the new Illinois Exchange will provide cost savings and, therefore, enable insurers to shift the saving to an assessment. Health Care Reform creates an enormous opportunity for insurers to reap additional profits from all of the new individuals and businesses that will be purchasing insurance through the Exchange. If insurers are going to financially benefit from the creation of the Exchange, then they should help pay for its costs.

Because many individuals who will be covered through the Exchange will either have subsidies or move back and forth between the Exchange and Medicaid, it makes sense for the Exchange to be the entity that collects premium payments from those who are insured through the Exchange. The Exchange should process all applications so that it can be the central gateway for individuals to determine if they are eligible for subsidies or Medicaid. **By consolidating the administration of eligibility, applications, and premium payments, the Exchange can cut administrative costs which will benefit consumers, employers, and insurers.** It must be noted that the funding of benefits should be separated from the funding of the administration of the Exchange.

Finally, when considering funding sources for the Exchange, the options that have the lowest likelihood of adding to consumer costs should be given the highest priority.

COORDINATION WITH PUBLIC PROGRAMS

Most PPIL patients are eligible for government health programs and many of them regularly fall in and out of employment. Therefore, **we encourage the State to set up a coordinated system between Medicaid, any other program that provides reproductive health care services, and the Exchange.** This system should allow for one simple initial application that can be used no matter which program the individual is eligible. Rules and verification requirements for government programs and Exchange participation should be compatible. And, when a person's circumstances change, a seamless transfer of coverage should be implemented. If a consumer applies for a government program but is not eligible, eligibility for other programs and for Exchange participation should be automatically determined, and she should be immediately connected to the appropriate coverage mechanism. In turn, if the Exchange discovers a person is eligible for a government program; she should be easily connected and enrolled. The electronic sharing of pertinent information should be facilitated between the Exchange and State programs to ease this process.

We anticipate that a large number of our patients who are already enrolled in programs such as Illinois Healthy Women and Title X Family Planning will be eligible for Exchange participation with the assistance of subsidies. An outreach and education initiative should be undertaken to locate these individuals and provide them with the tools they need to take advantage of the opportunity for full health coverage. Many of our patients have no other health care provider because of lack of insurance. They rely on us because they can obtain subsidized services under certain programs. But, when we diagnose a problem that is outside of the scope of the program, they have nowhere to go for health care. Eligibility for the Exchange will improve the overall health and well being of these patients.

As stated previously, the State should examine and revise government program rules and systems to seamlessly interact with the Exchange. The State should provide support for providers serving the medically underserved. Many of these providers, like PPIL, are non-profit entities with limited resources. Streamlining bureaucracy and providing assistance with adopting health information technology will ensure these providers remain stable and encourage them to expand services to more patients and communities.

THE EXCHANGE & REPRODUCTIVE HEALTH CARE

The new Illinois Health Care Marketplace will provide many women with their first opportunity to have health insurance coverage. For those who already have coverage, they will have coverage that is fairer and provides them with more of what they need. And, for some who have lost insurance, this will be their opportunity to have reliable health care coverage again. Women make the majority of health care decisions in most families, such as choosing a provider and serving as the primary caregiver for children and older adults. Provisions in federal reform will require insurance companies to provide information about coverage in a more uniform and transparent manner. Women are more likely than men to work for small businesses that don't offer health insurance and will therefore benefit from the new tax credits to help small businesses

provide coverage. Young women, who tend to become uninsured once they become adults or graduate from school, will have the option to stay on that coverage up to age 26.

PPIL is strongly supportive of the general insurance reforms included in the Affordable Care Act. In particular, we applaud those that will improve access to reproductive health care:

- Inclusion of prescription drug coverage (including contraception), preventive and wellness services, maternity care, and newborn coverage in basic coverage for insurance plans
- Elimination of cost-sharing for women's preventive health services
- Direct access OB/GYN services without a referral
- Elimination of pre-existing condition exclusions for children and adults
- Ban on gender rating

In order to ensure that value is the highest priority, PPIL supports the Illinois Exchange being an active purchaser of health care. As such, the Exchange can ensure that all of those covered will have quality plans that include coverage for essential health care services. Setting a high standard for a Basic Health Plan is important for people who move back and forth between Medicaid and the Exchange. **For it to be beneficial to PPIL's patients, the Basic Health Plan must include access to a wide range of reproductive health care services.**

Reproductive health care, and in particular women's health care, has historically been marginalized by the insurance industry. Illinois has responded to this with a very positive and forward thinking record of ensuring reproductive health care access in private health insurance through the Insurance Code. The reproductive health care provisions in the Illinois Insurance Code were enacted because real need has been shown after years of denials by insurance companies. An Illinois Exchange can ensure that these protections will continue.

It is essential that with the implementation of health care reform, we do not create a two-tiered insurance system in which there are different rules for plans sold within the Exchange than for those sold outside of the Exchange. As stated above, the Illinois Insurance Code already contains numerous provisions related to women's health care coverage. In many cases Illinois holds reproductive health care to a higher standard. For example, the Illinois Insurance Code outlines specific requirements for minimum hospital stay after childbirth and mastectomy. Women purchasing insurance within the Exchange should have a guarantee that they will have those protections in their plans. **Whether or not a woman is covered by a plan within the Exchange or outside of it, her plan must be held to the highest standard for coverage of her health care needs as a woman.** (I have attached a list of all women's health requirements that are currently part of the Illinois Insurance Code as well as the preventive women's health services required by the U.S. Department of Health and Human Services.)

Finally, we must make a special comment regarding abortion care. There must be a Basic Health Plan that offers coverage for abortion care. If the Illinois Exchange ends up driving the Illinois insurance market and discourages or limits access to abortion care coverage, this will harm women.

Often women do not anticipate a need for abortion coverage, but expect such coverage when they need it. **Currently the majority of private health insurance plans cover abortion care in a similar fashion to coverage for surgical procedures, office visits, and prescription drugs.** If insurance plans generally cover abortion care, the Exchange should have the same choices in coverage. Moreover, women covered by Medicaid have access to abortion care that includes coverage for the exceptions of rape, incest, life and health. Just as with other forms of reproductive health care, we cannot allow abortion care to be marginalized within the Exchange when it is currently part of the standard of coverage for women who are covered outside of the Exchange.

The Affordable Care Act does include restrictions on abortion access via the Nelson Amendment. While the State of Illinois is bound by the federal restrictions, we urge the State to implement the Exchange in a way that ensures women will have access to abortion care.

- **Insurance plans that cover abortion care must be included in the new Illinois Exchange.**
- **Insurance coverage of abortion care should not be limited to only rape, incest, or to save the life of a woman.** Currently, most insurance plans in the U. S. do not include these restrictions. Instead, they treat abortion care as they would any other medical care and allow this to be a decision made by a woman and her physician. Even the Illinois Medicaid program covers abortion care when necessary to protect a woman's health.
- **Insurance plans offered in the Exchange must disclose whether or not they cover abortion care.**
- The Nelson Amendment requires accounting systems to ensure that the appropriate segregation of payments received for coverage of non-excepted abortion services from those received for coverage of all other services. **The Exchange should provide assistance to insurance companies and their enrollees so that federal law is followed while still providing optimum and affordable coverage and for their enrollees without cumbersome payment systems.**

Apart from the requirements of a Basic Health Plan, there is another issue that is important in relation to reproductive health care. **In the area of administering enrollment, we request a system that makes it as easy and timely as possible.** While most consumers will appreciate reduction in time consuming bureaucracy, this is critical to those who are in need of reproductive health care.

We agree that enrollment periods may be specified, but changes in circumstances, such as birth or adoption of a child, should allow for special enrollment. In cases where documentation of citizenship is required, we encourage the State to allow for a reasonable enrollment period prior to the actual provision of documentation to allow individuals time to collect necessary paperwork. Delays in enrollment will adversely impact those in need of time sensitive health services such as family planning and prenatal care. Women who are denied reproductive health care services because of a lack of paperwork will be put at risk of unintended pregnancy or fetal/birth complications.

CONCLUSION

Planned Parenthood of Illinois hopes for positive changes that can come with the establishment of an Illinois Exchange. Although we know that there will be many challenges in the coming years, we believe that if the Exchange is developed with the good health and well-being of Illinois residents as a top priority, it will benefit our patients who need access to reproductive health care. Therefore, we look forward to working with this committee, the Governor, and the General Assembly in creating a strong Exchange for Illinois.

Again, I thank you for allowing me to share with you Planned Parenthood's concerns regarding the establishment of the Illinois Exchange. If you have any questions or need additional information, please contact our Director of Legislative Affairs, Brigid Leahy at 217-522-6776 ext. 6002 or brigidl@ppil.org.

Thank you.

HealthCare.gov

Newsroom

Affordable Care Act Rules on Expanding Access to Preventive Services for Women

Before health reform, too many Americans didn't get the preventive health care they need to stay healthy, avoid or delay the onset of disease, lead productive lives, and reduce health care costs. Often because of cost, Americans used preventive services at about half the recommended rate.

Yet chronic diseases – which are responsible for 7 of 10 deaths among Americans each year and account for 75% of the nation's health spending – often are preventable. Cost sharing (including copayments, co-insurance, and deductibles) reduces the likelihood that preventive services will be used. Especially concerning for women are studies showing that even moderate copays for preventive services such as mammograms or pap smears deter patients from receiving services.

The Affordable Care Act – the health insurance reform legislation passed by Congress and signed into law by President Obama on March 23, 2010 – helps make prevention affordable and accessible for all Americans by requiring health plans to cover recommended preventive services without cost sharing.

Under the Affordable Care Act, women's preventive health care services – such as mammograms, screenings for cervical cancer, and other services – are already covered with no cost sharing for new health plans. The Affordable Care Act also made recommended preventive services free for people on Medicare. However, the law recognizes and HHS understands the need to take into account the unique health needs of women throughout their lifespan.

On August 1, 2011, the Department of Health and Human Services (HHS) adopted additional Guidelines for Women's Preventive Services – including well-woman visits, support for breastfeeding equipment, contraception, and domestic violence screening – that will be covered without cost sharing in new health plans starting in August 2012. The guidelines were recommended by the independent Institute of Medicine (IOM) and based on scientific evidence.

Under the law, many private plans also must cover regular well-baby and well-child visits without cost sharing. With the addition of these new benefits, the Affordable Care Act continues to make wellness and prevention services affordable and accessible for more and more Americans.

Women and Preventive Health

When it comes to health, women are often the primary decision maker for their families and the trusted source in circles of friends. They are also key consumers of health care. Women have unique needs and have high rates of chronic disease, including diabetes, heart disease, and stroke.

While women are more likely to need preventive health care services, they often have less ability to pay. On average they have lower incomes than men and a greater share of their income is consumed by out-of-pocket health costs. A report by the Commonwealth Fund found that in 2009 more than half of

women delayed or avoided preventive care because of its cost, as compared to one-quarter of women in 2007. Removing cost sharing requirements improves women's access to important preventive services. In fact, one study found that the rate of women getting a mammogram went up as much as 9% when cost sharing was removed.

New Comprehensive Coverage for Women's Preventive Care

The Affordable Care Act helps make prevention affordable and accessible for all Americans by requiring new health plans to cover and eliminate cost sharing for preventive services recommended by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices, and the Bright Futures Guidelines recommended by the Academy of Pediatrics.

The law also requires insurance companies to cover additional preventive health benefits for women. For the first time, HHS is adopting new guidelines for women's preventive services to fill the gaps in current preventive services guidelines for women's health, ensuring a comprehensive set of preventive services for women.

Previously, preventive services for women had been recommended one-by-one or as part of guidelines targeted at men as well. The Department of Health and Human Services directed the Institute of Medicine (IOM), for the first time ever, to conduct a scientific review and provide recommendations on specific preventive measures that meet women's unique health needs and help keep them healthy. HHS used the IOM report issued July 19, 2011 when developing the guidelines being issued today.

Additional women's preventive services that will be covered without cost sharing requirements include:

- **Well-woman visits:** This would include an annual well-woman preventive care visit for adult women to obtain the recommended preventive services, and additional visits if women and their providers determine they are necessary. These visits will help women and their doctors determine what preventive services are appropriate, and set up a plan to help women get the care they need to be healthy.
- **Gestational diabetes screening:** This screening is for women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes. It will help improve the health of mothers and babies because women who have gestational diabetes have an increased risk of developing type 2 diabetes in the future. In addition, the children of women with gestational diabetes are at significantly increased risk of being overweight and insulin-resistant throughout childhood.
- **HPV DNA testing:** Women who are 30 or older will have access to high-risk human papillomavirus (HPV) DNA testing every three years, regardless of pap smear results. Early screening, detection, and treatment have been shown to help reduce the prevalence of cervical cancer.
- **STI counseling, and HIV screening and counseling:** Sexually-active women will have access to annual counseling on HIV and sexually transmitted infections (STIs). These sessions have been shown to reduce risky behavior in patients, yet only 28% of women aged 18 to 44 years reported that they had discussed STIs with a doctor or nurse. In addition, women are at increased risk of contracting HIV/AIDS. From 1999 to 2003, the CDC reported a 15% increase in AIDS cases among women, and a 1% increase among men.
- **Contraception and contraceptive counseling:** Women will have access to all Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling. These recommendations do not include abortifacient drugs. Most workers in employer-sponsored plans are currently covered for contraceptives. Family planning services are an essential preventive service for women and critical to appropriately spacing and ensuring intended pregnancies, which results in improved maternal health and better birth outcomes.

- **Breastfeeding support, supplies, and counseling:** Pregnant and postpartum women will have access to comprehensive lactation support and counseling from trained providers, as well as breastfeeding equipment. Breastfeeding is one of the most effective preventive measures mothers can take to protect their children's and their own health. One of the barriers for breastfeeding is the cost of purchasing or renting breast pumps and nursing related supplies.
- **Domestic violence screening:** Screening and counseling for interpersonal and domestic violence should be provided for all women. An estimated 25% of women in the U.S. report being targets of intimate partner violence during their lifetimes. Screening is effective in the early detection and effectiveness of interventions to increase the safety of abused women.

The coverage of these preventive services gives Americans access to many of the services already offered to Members of Congress. In addition, not only are these services similar to a list of preventive services recommended by the National Business Group on Health, but many private employers already cover these services.

New private health plans must cover the guidelines on women's preventive services with no cost sharing in plan years starting on or after August 1, 2012.

An interim final rule was released alongside the women's prevention guidelines to give religious organizations the choice of buying or sponsoring group health insurance that does not cover contraception if that is inconsistent with their tenets. This proposal is modeled on the most common exemption available in the 28 states that already require insurance companies to cover contraception. We invite the public to comment on this proposal as we work to strike the balance between providing access to proven prevention and respecting religious beliefs. In the event that this exemption is modified, it would remain effective on August 1, 2012.

In addition, the rules governing coverage of preventive services which allow plans to use reasonable medical management to help define the nature of the covered service apply to women's preventive services. Plans will retain the flexibility to control costs and promote efficient delivery of care by, for example, continuing to charge cost sharing for branded drugs if a generic version is available and just as effective and safe.

These Guidelines Mean Fewer Health Disparities

Not all Americans have equal access to health care. Low-income and racial and ethnic minorities often have higher rates of disease, fewer treatment options, and reduced access to care. By eliminating cost sharing requirements, these guidelines help improve access to comprehensive quality health care for all women.

You can read the Guidelines for Women's Preventive Services at: **www.hrsa.gov/womensguidelines/**

Read the interim final rule at **http://www.ofr.gov/OFRUpload/OFRData/2011-19684_PI.pdf**.

Posted on: August 1, 2011

Illinois Insurance Facts

Illinois Department of Financial and Professional Regulation
Division of Insurance

Women's Health Care Issues

Revised
December 2009

Note: This information was developed to provide consumers with general information and guidance about insurance coverages and laws. It is not intended to provide a formal, definitive description or interpretation of Department policy. For specific Department policy on any issue, regulated entities (insurance industry) and interested parties should contact the Department.

Women have special health care needs. The State of Illinois has passed the following laws related specifically to female health care issues and insurance requirements.

The following state laws do not apply to self-insured employers or to trusts or insurance policies written outside Illinois. However, for HMOs, the laws do apply in certain situations to contracts written outside of Illinois if the HMO member is a resident of Illinois and the HMO has established a provider network in Illinois. To determine if your HMO provides the benefits required by the following laws, you should contact the HMO directly or check your certificate of coverage.

Some of the laws apply to the Limited Health Services Act, the Voluntary Health Services Plan Act, the State Employees Act, the Counties Code, the Illinois Municipal Code and the School Code. Each law has been noted with the applicable code citations.

Birth Control

Effective January 1, 2004 all individual and group health insurance and HMO policies that provide coverage for outpatient services and outpatient prescription drugs or devices, must also provide coverage for all outpatient contraceptive services and all outpatient contraceptive drugs and devices approved by the Food and Drug Administration. Deductibles, coinsurance, waiting periods are the same as those imposed for any other outpatient prescription drug or device under the policy.

215 ILCS 5/356z.4 Insurance Code
215 ILCS 125/5-3 HMO Act
215 ILCS 165/10 Voluntary Health Services Plan Act
5/ILCS 375/6.11 State Employees Act

Breast Exams, Mammograms, Screenings

Clinical Breast Exams – All individual and group health insurance and HMO policies must provide coverage for a complete and thorough **clinical examination of the breast** at least once every three years for women age 20 to 39 and annually for women age 40 and older.

215 ILCS 5/356g.5 Insurance Code
215 ILCS 125/4-6.5 HMO Act
215 ILCS 165/10 – Voluntary Health Services Plan Act
5/ILCS 375/6.11 State Employees Act
55 ILCS 5/5-1069.3 – Counties Code
65 ILCS 5/10-4-2.3 – Illinois Municipal Code
105 ILCS 5/10-22.3f – School Code

Mammograms – All individual and group health insurance and HMO policies must cover **routine mammograms** for all women age 35 and older. A routine mammogram is an x-ray or digital examination of the breast for the presence of breast cancer, even if no symptoms are present. The insurance company or HMO must provide for routine mammograms according to the following schedule:

- Women age 35 to 39 – one baseline mammogram;
- Women age 40 or older – one mammogram annually.

For women under age 40 who have a family history of breast cancer or other risk factors, coverage must include a mammogram at the age and intervals considered medically necessary by the woman's health care provider.

Mammograms - Cost to Consumer (Public Act 95-1045)
Beginning March 27, 2009, the required coverage for mammograms and ultrasound screenings as described above must be provided **at no cost to the insured** (*i.e.*, co-pays or deductibles may not be applied). The cost of the mammogram or screening must not count against any annual or lifetime benefit limits contained in the insurance policy or HMO contract. [215 ILCS 5/356g(a-5) and 215 ILCS 125/4-6.1]

NOTE: For policies issued prior to March 27, 2009, this cost-sharing prohibition will apply to your policy as soon as your policy is amended or renewed – check with your insurance agent, employer, or insurance company for the date this law will become effective for your policy.

- Until this law applies to your policy, the insurance company or HMO must provide coverage for mammograms and screenings that is at least as favorable as coverage for other radiological examinations (*e.g.*, subject to the same dollar limits, deductibles and co-pay requirements).
- If the mammogram or screening is provided by an out-of-network provider, the cost-sharing prohibition does not apply. However, the insurance company or HMO must provide coverage that is at least as favorable as out-of-network coverage for other radiological examinations.

Ultrasound Screening - If a routine mammogram reveals heterogeneous or dense breast tissue, coverage must provided for a **comprehensive ultrasound screening** of an entire breast or breasts, when determined to be medically necessary by a physician.

215 ILCS 5/356g(a) Insurance Code
215 ILCS 125/4-6.1(a) HMO Act
215 ILCS 165/10 Voluntary Health Services Plans Act
5/ILCS 375/6.11 State Employees Act
55 ILCS 5/5-1069(d) Counties Code
65 ILCS 5/10-4-2(d) Illinois Municipal Code
105 ILCS 5/10-22.3f School Code

Breast Fibrocystic Condition

At least 50% of women of reproduction age have **fibrocystic condition**, the presence of lumps in the breast that may be painful and tender. An insurer or HMO may not refuse to cover an individual nor attach an exclusionary rider to a policy, *solely* because the individual has been diagnosed with fibrocystic condition, *unless* a breast biopsy indicates the individual is likely to incur breast cancer or the medical history shows the condition to be chronic.

215 ILCS 5/356n Insurance Code
215 ILCS 125/4-16 HMO Act

Breast Surgery

Mastectomy – Breast Reconstruction – All group and individual health insurance and HMO policies that provide coverage for mastectomies must also cover **prosthetic devices or reconstructive surgery** related to the mastectomy. Prosthetic devices include breast prosthesis and bras. Reconstructive surgery includes reconstruction of the breast on which the mastectomy has been performed, as well as surgery and reconstruction of the other breast to produce symmetrical appearance. Coverage is also required for prosthetic devices and treatment for physical complications at all stages of mastectomy, including lymph edemas. The coverage may be subject to annual deductibles and coinsurance provisions as deemed appropriate and consistent with other benefits covered under the insurance.

215 ILCS 5/356g(b) Insurance Code
215 ILCS 125/4-6.1(b) HMO Act
215 ILCS 165/10 Voluntary Health Services Plans Act
5 ILCS 375/6.11 State Employees Act
55 ILCS 5/5-1069(d-15) Counties Code
65 ILCS 5/10-4-2(d-15) Illinois Municipal Code
105 ILCS 5/10-22.3f – Schools Code

Post mastectomy hospital stay – All group and individual health insurance and HMO policies must allow the attending physician to determine the length of hospital stay following a **mastectomy**, the removal of a breast. The insurance company or HMO must provide coverage as long as the attending physician determines the length of stay to be medically necessary and in accordance with protocols and guidelines based on sound scientific evidence and an evaluation of the patient.

215 ILCS 5/356t Insurance Code
215 ILCS 125/4-6.5) HMO Act
215 ILCS 165/10 Voluntary Health Services Plan Act
5 ILCS 375/6.11 State Employees Act
55 ILCS 5/5-1069.3 Counties Code
65 ILCS 5/10-4-2.3 Municipalities Act
105 ILCS 5/10-22.3f Schools Code

Breast Implants - In Illinois, no individual or group health insurance or HMO policy may deny coverage for the **removal of breast implants** if:

- the implants were not inserted for purely cosmetic reasons; **and**
- it is medically necessary for the breast implants to be removed.

Implants inserted after a mastectomy due to sickness or injury are not considered purely cosmetic.
215 ILCS 5/356p Insurance Code
215 ILCS 125/4-6.2 HMO Act

Breast Cancer Pain Medication and Therapy

Beginning March 27, 2009, Public Act 95-1045 requires that all group and individual health insurance and HMO policies must provide coverage for all medically necessary **pain medication and pain therapy** related to the treatment of breast cancer. The coverage must be provided on the same terms and conditions that are generally applicable to coverage provided for other conditions.

- "Pain therapy" is therapy that is medically based, includes reasonably defined goals (*e.g.*, stabilizing or reducing pain), and provides for the periodic evaluation of the therapy's effectiveness in meeting those goals.
- **NOTE:** For policies issued prior to March 27, 2009, this coverage requirement will apply to your policy as soon as your policy is amended or renewed – check with your insurance agent, employer, or insurance company for the date this requirement will become effective for your policy.
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215 ILCS 5/356g.5-1 Insurance Code
215 ILCS 125/5-3HMO Act
215 ILCS 165/10 Voluntary Health Services Plans Act
5 ILCS 375/6.11 State Employees Act
55 ILCS 5/5-1069.3 Counties Code
65 ILCS 5/10-4-2.3 Municipality Code

Domestic Abuse

After January 1, 1998, no life, health or disability income insurance company may deny, refuse to issue or reissue, cancel, or restrict coverage **solely** because the individual:

- is the subject of abuse;
- has sought treatment for abuse; or
- has sought protection or shelter from abuse.

The insurance company may not charge higher premiums, deny a claim, or ask for information relating to the abuse. If the company obtains information regarding the abuse, the fact that the condition or treatment is abuse-related must be kept confidential.

An insurance company may restrict coverage or charge higher premiums for coverage based on an individual's physical or mental condition, no matter what the cause. For example, a company may decline to cover an individual who has a permanent disability as a result of abuse. In this case, the denial of coverage would be due to the permanent disability condition itself, not because the condition is abuse-related. (215 ILCS 5/155.22a)

Genetic Testing

Effective June 23, 1997, a health insurer or HMO may not seek or use genetic testing information to deny health coverage. The company or HMO may only use genetic test information if it is provided voluntarily and if the test results are favorable. The company or HMO may not give the information to another party without permission.
215 ILCS 5/356v Insurance Code
215 ILCS 125/5-3 HMO Act
215 ILCS 130/4003 Limited Health Services Act
215 ILCS 165/10 Voluntary Health Services Plans Act
410 ILCS 513/20 Genetic Information Privacy Act

These restrictions on genetic testing information do **not** apply to life insurance policies.

HPV Vaccine

Effective August 24, 2007, all individual and group health and HMO policies must provide coverage for the human papillomavirus vaccine. The law does not specify a benefit level.

215 ILCS 5/356z.9 Insurance Code
215 ILCS 125/5-3 HMO Act
215 ILCS 165/10 Voluntary Health Services Plans Act
5 ILCS 375/6.11 State Employees Act
55 ILCS 5/51069.3 Counties Code
65 ILCS 5/10-4-2.3 Municipality Code
105 ILCS 5/10-22.3f Schools Code

Infertility

Group health insurance and HMO policies that cover more than 25 full-time employees, must provide coverage for the diagnosis and treatment of infertility. For more specific information regarding this mandate, please see the fact sheet entitled, *Insurance Coverage for Infertility Treatment.*

215 ILCS 5/356m Insurance Code
215 ILCS 125/5-3 HMO Act
5 ILCS 375/6.11 State Employees Act

Maternity

Maternity Coverage - HMOs must cover maternity care, including prenatal and post-natal care and care for complications of pregnancy and care with respect to a newborn. (50 IAC 5421.130e)

Other health insurance policies, including PPO policies, must provide coverage for complications of pregnancy. [50 IAC 2603.30(11)]

Federal law (Pregnancy Discrimination Act of 1978, which amended Title VII of the Civil Rights Act) requires employers with 15 or more employees to cover maternity. Note that employers may choose to self-insure this portion of the benefit or they may provide the coverage through the insurance policy.

Maternity – Prenatal HIV Testing - All group and individual health and HMO are required to cover prenatal HIV testing ordered by an attending physician, physician assistant or advanced practice registered nurse.

215 ILCS 5/356z.1 Insurance Code
215 ILCS 125/4-6.5 HMO Act
215 ILCS 165/10 Voluntary Health Services Plan Act

Maternity – Post Parturition Care - All group and individual health insurance and HMO policies must cover a minimum of 48 hours inpatient hospital stay following a vaginal delivery and 96 hours following a caesarian section for both mother and newborn. A shorter length of stay may be provided under certain conditions and if a post-discharge office visit or in-home nurse visit is provided and covered.

215 ILCS 5/356s Insurance Code
215 ILCS 125/4-6.4 HMO Act
5 ILCS 375/6.8 State Employees Act
55 ILCS 5/5-1069.2 Counties Code
65 ILCS 5/10-4-2.2 Municipal Code
105 ILCS 5/10-22.3e Schools Code

Osteoporosis

Effective January 1, 2005, group and individual health insurance and HMO policies must provide coverage for medically necessary bone mass measurement and for the diagnosis and treatment of osteoporosis. Coverage must be provided on the same terms and conditions that are applied to other medical conditions under the policy.

215 ILCS 5/356z.6 Insurance Code
215 ILCS 125/5-3 HMO Act
215 ILCS 165/10 Voluntary Health Services Plans Act
5 ILCS 375/6.11 State Employees Act
55 ILCS 5/5-1069.3 Counties Code
65 ILCS 5/10-4-2.3 Municipal Code
105 ILCS 5/10-22.3f Schools Code

Ovarian Cancer Screening

Effective January 1, 2006 group health insurance and HMO policies must pay for surveillance tests for ovarian cancer for female insureds who are at risk for ovarian cancer. Under the law, an individual is considered at risk for ovarian cancer if she has:

- a family history with one or more first-degree relatives with ovarian cancer,
- a family history of clusters of women relatives with breast cancer,
- a family history of nonpolyposis colorectal cancer, or
- tested positive for BRCA1 or BRCA2 mutations.

Surveillance tests are annual tests using:

- CA-125 serum tumor marker testing,
- Transvaginal ultrasound,
- Pelvic examination.

215 ILCS 5/356u Insurance Code
215 ILCS 125/4-6.5 HMO Act
215 ILCS 165/10 Voluntary Health Services Plans Act
5 ILCS 375/6.11 State Employees Act
55 ILCS 5/5-1069.3 Counties Code
65 ILCS 5/10-4-2.3 Municipal Code
105 ILCS 5/10-22.3f Schools Code

PAP Smears

Group health insurance and HMO policies must pay for an annual cervical smear or **PAP smear test** for female insureds.

215 ILCS 5/356u Insurance Code
215 ILCS 125/4-6.5 HMO Act
215 ILCS 165/10 Voluntary Health Services Plans Act
5 ILCS 375/6.11 State Employees Act
55 ILCS 5/5-1069.3 Counties Code
65 ILCS 5/10-4-2.3 Municipal Code
105 ILCS 5/10-22.3f Schools Code

Sexual Assault or Abuse

Insurance companies and HMOs in Illinois must waive all deductibles and copayments for covered members who are victims of **sexual assault or abuse**. Insurers and HMOs must cover examination and testing of the victim to establish that sexual contact did or did not occur, to establish the presence or absence of sexually transmitted disease or infection, and to treat the injuries and trauma sustained by the victim of the offense.
215 ILCS 5/356e Insurance Code
215 ILCS 125/4-4 HMO Act

Woman's Principal Health Care Provider

HMOs and some Preferred Provider Organizations ("gated" PPOs) require their members to select a Primary Care Physician (PCP) to manage all care. In addition, female enrollees may also designate an obstetrician or gynecologist, or a physician specializing in family practice as their **Woman's Principal Health Care Provider** (WPHCP). The WPHCP can provide services without a referral from the PCP, but the HMO or PPO can require that your primary care physician and your woman's principle health care provider have a referral arrangement with one another.

Both the PCP and WPHCP must be selected from a list of physicians who have contracted with the HMO or PPO to provide health care.

215 ILCS 5/356r Insurance Code
215 ILCS 125/5-3.1 HMO Act
215 ILCS 165/10 Voluntary Health Services Plans Act
5 ILCS 3756.7 State Employees Act
55 ILCS 5/5-1069.5 Counties Code
65 ILCS 5/10-4-2.5 Municipal Code
105 ILCS 5/10-22.3d Schools Code

For More Information

Call our Consumer Services Section at (312) 814-2427 or
our Office of Consumer Health Insurance toll free at (877) 527-9431
or visit us on our website at http://www.insurance.illinois.gov/

Related Topics:

Maternity Benefits in Illinois
Insurance Coverage for Infertility Treatment
Mandated Benefits, Offers, and Coverages for Accident & Health Insurance And HMOs

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Statement regarding the Illinois Health Insurance Exchange

Illinois Exchange Study Committee
Hearing on Consumers' Concerns

August 30, 2011

Members of the Committee,

Thank you for the opportunity to submit written testimony in regard to the creation of state level insurance exchanges. Furthermore, thank you for your dedication to health insurance accessibility for all Illinois residents.

Immigrants make up 13.5 percent of Illinois population, a sizeable group who will be key to a successful state level implementation of insurance exchanges. Immigrants are also more likely to be uninsured leaving them more susceptible to health disparities and their lack of access to insurance more dire. The barriers to immigrant participation in the exchange are significant and should be taken into consideration when establishing the governance and procedures of the exchange.

Regarding numerous technical issues, we would like to highlight the comments of the Healthcare Justice Campaign, particularly related to the points on consumer involvement, who the exchange should most directly benefit, transparency, and the access to immediate experts.

In addition Healthcare Justice Campaign's comments, ICIRR adds the following:

The Exchange Governing Body should represent consumers in Illinois, including immigrants and limited English proficient individuals, as the exchanges will present many of them a viable opportunity to purchase insurance for the first time. The governing body and its experts should be well versed in the consumer demographics, including the level of English language ability and the diversity of immigrants in Illinois in order the make the Exchange as usable as possible. The exchange governing body should be well versed in typical barriers that keep immigrants from participating in government or quasi-government programs in order to effectively overcome these barriers and promote exchange use for those mandated to purchase insurance.

The Exchange should reduce barriers for those mandated to purchase insurance. One of the most significant but manageable barriers is language. According to 2009 American Community Survey (ACS) data, fifty-five percent of Illinois' immigrants speak English less than very well, and will therefore require information as important as health insurance in their native language. While nearly half of Illinois' immigrants are Latino Spanish-speakers, the other half speak a variety of languages and also deserve access to exchange information. According to 2009 ACS data; 25.8 percent

of Illinois immigrants are from Asia, mainly India, China, Korea, Vietnam, and the Middle East; 22.7 percent are from Europe with the largest county being Poland, and 2.6 percent are from Africa. Given the diversity of immigrants, ICIRR supports provisions that promote language accessibility beyond just the largest populations but instead reaches all language groups in Illinois. Linguistic accessibility includes professional interpretation and translation of exchange materials and culturally competent policies and procedures.

Additional barriers to immigrant participation include cultural barriers where the activities of a mainstream institution or of an immigrant consumer are misinterpreted; unfamiliarity with how government-related systems work such as a separation between government agencies or between levels of government; and fear that participating in a government or quasi-government system will have ramifications on applying for US Citizenship, on petitioning other family members to immigrate, and on the immigration status of other family members. It is imperative that the Exchange address and overcome these barriers to ensure full participation of eligible immigrants.

The Exchange should work closely with the types of institutions trusted by immigrants and other hard to reach populations. In order to successfully enroll individuals who are harder to reach, like limited English proficient individuals, the Exchange should have mechanisms to work closely with community based organizations trusted by those vulnerable populations. Formal partnerships with community organizations are an ideal way to reach limited English proficient consumers, educate them on the Exchange, and assist them in navigating it. ICIRR proudly points to our Immigrant Family Resource Program, a partnership with the Illinois Department of Human Services, ICIRR, and ethnic community-based organizations as a ideal model.

Finally, ICIRR maintains that **the verification or authorization mechanisms for the two exchanges, the individual health insurance exchange and the small business exchange, should be operated separately** to ensure the least burden on small businesses, particularly immigrant-owned businesses. ICIRR supports pooling the two exchanges to maximize efficiency and cost savings, but not at the expense of small business owners and their employees' health. Therefore, the two types of exchanges, if combined, should maintain separate enrollment and verification processes. To make it easy for small businesses to participate and insure as many employees, as possible, small business exchange enrollment and verification should be kept to the minimum federal standards.

Thank you for your thoughtful consideration of our recommendations.

Sincerely,

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