AUTOMATED HEALTH SYSTEMS

Written Testimony for the Illinois General Assembly Health Benefits Exchange Legislative Study Committee
September 21, 2011

Automated Health Systems (AHS) administers Illinois Health Connect, the Primary Care Case Management Program for the Department of Healthcare and Family Services. Additionally, AHS operates Enrollment Broker Programs in multiple states including West Virginia, Ohio, Illinois, Wisconsin, and Florida by offering unbiased information about managed care options for approximately 7.1 million eligible Medicaid clients before, during, and after program enrollment. AHS maintains a consumer-focused approach to coordinating and administering healthcare, with our sole devotion to health programs for low-income families receiving Medicaid services. It is from this consumer lens that AHS provides testimony to the Health Benefits Exchange Legislative Study Committee.

AHS understands the primary focus of the Committee is to make decisions pertaining to governance and financing. Paramount in the governance should be the consumer voice and experience to ensure access to services and products that are explained in an understandable, fair manner, leading to informed decision-making on the part of the consumer. While the Committee is making decisions on a broader scale, it is important to consider the following components in every aspect of Exchange implementation:

1. Consumers will fluctuate between the private plan and Medicaid sides of the Exchange. AHS sees this specifically with administering the Illinois Health Connect program with many consumers moving in and out of Third Party Liability, more so over the last two years as the economy has declined. There is a need to optimize participation in both sides for both plans and providers to avoid interruption of patient/provider relationships and maintain coordinated care. In Minnesota, for example, commercial managed care plans are required to participate in Medicaid.
2. Emphasis on primary care is critical. The medical home model represents the premier embodiment of primary care and should be a requirement of all plans and options through the Exchange.
3. Exchange operators will need extensive outreach strategies, including both the ability to accept incoming calls to render navigation advice and outreach strategies to reach clients not previously eligible. AHS' experience working with consumers is that they often need/prefer to discuss options and ideas with informed staff (navigators) who can talk through options and outcomes. Illinois Health Connect Providers also report patients benefit from additional explanation of how to access services to avoid interruptions in care – which navigators can supply in a culturally and linguistically appropriate manner to suit the consumers' needs. A navigator workforce with experience in Medicaid and social services is particularly valuable to respond to the complex needs of consumers.

AHS acknowledges that the decisions of the Committee pertaining to governance and financing will later affect the operational decision-making that will be required to successfully execute the Exchange. AHS has engaged consumer and community stakeholders through advisory committees and focus groups in multiple states, including Illinois, to implement sound programming to benefit consumers. We can be a committed working partner in developing solutions that will meet the needs of providers, consumers and the State.

Thank you for the opportunity to comment your consideration of this testimony. For more information, contact Christine Cazeau, Enrollee Services Manager by phone (847)610-8422 ext 2217 or by email ccazeau@automated-health.com.

Testimony for Public Hearing on Establishment of a Health Benefits Exchange
For the Legislative Study Committee
September 21, 2011 Chicago, Il

From: League of Women Voters of Illinois
Jan Dorner, President
Laura Kratz, Vice President Issues
Janet S. Craft, Health Care Issue Specialist

The League of Women Voters of Illinois (LWVIL) has a long-standing position for universal access to a basic level of quality health care. League advocated for passage of the federal Affordable Care Act (ACA), and supported an earlier effort to implement the Health Care Justice Act in Illinois. Access is not getting better: last year the number of Americans with health insurance dropped again, the second annual decline since the U. S. Census Bureau began collecting this data in 1987.

League is pleased that Illinois is forming a Health Benefits Exchange in advance of the federal 2014 target date for full implementation. The new law entrusts the General Assembly with the vital task of creating an Exchange for Illinois citizens, especially the 1.7 million without insurance coverage, and small businesses.

LWVIL supports a Competitive Health Insurance Marketplace designed with a consumer focus, independent governance, strong conflict of interest and transparency provisions. The board of the governing entity should have the power to negotiate the services, quality and prices of health care. The integrity and ultimately the success of the Exchange in opening access to affordable health care will rest on the foundation of a governing body free to act in the public interest.

Thank you for this opportunity for public comment.

The Illinois Health Care Exchange
Testimony of the Illinois Main Street Alliance
David Borris: Owner of Hel's Kitchen Catering
September, 2011

Overview

Illinois is in the process of expanding access to quality and affordable health care by creating a health care Exchange. The Illinois Health Care Exchange increases access by creating a one-stop shopping site for the purchase of health insurance.

Why do we need an Exchange? The health insurance industry in Illinois is highly concentrated and lacks the regulations or competition necessary to put downward pressure on premium costs and increase quality. Remember, we are compelled to create an Exchange because of the past failings of the insurance industy.

- Over the last 10 years, the insurance industry raised rates by 73% in Illinois, even though revenue increased by 50% more than payouts.
- Over the last 10 years, we've seen CEO salaries increase from $85 million to $228 million, a 167% increase.
- And every year, most of the small businesses in IMSA have to shop for insurance because the insurance company dropped one of my employees or jacked up rates out of the blue.

I am here today representing hundreds of small businesses in Illinois that are desperate to get a hold of their health insurance costs. If you do this right, small businesses will:

- Be able to access the same type of insurance self-insured big business gets.
- Compete for quality employees and keep them on staff.
- Eliminate the need to shop endlessly for insurance each year.
- **Most importantly, I can hire based on their skills instead of their health risks.**

Doing it Right
Tensions

The idea of enhancing Illinoisans ability to buy health insurance is a universally accepted idea. The tension rises around the reach of the Exchange, the cost of the Exchange, and the impact pending Federal lawsuits and budget fights will have on the Exchange. Right now, 26 states are wrestling with the same issues.

Reach of the Exchange:

The first step in this process is the establishment of a Governance Board. IMSA needs this Board to spend the next year creating a strong Exchange that serves small business, not large insurance companies.

Governance:

There must be a strong conflict of interest provisions that prevent the insurers from (literally) running the exchange (by controlling the board). With 149,000 small businesses coming into the Exchange, we have a real opportunity to remove a significant burden on the backs of each business. We are concerned that the heavy hand of the insurance industry will limit the success of the Exchange.

The golden rule is to eliminate anyone that can benefit directly from the Exchange from voting on its structure. In a number of states, the industry is represented by a retired insurance representative (former VP of Aetna in CN, for example). Otherwise, it is left to the discretion of the legislative leadership. Minimally, the insurance industry should not vote and should not represent a power voting block on the Board.

Reach of the Exchange:

The first question for Illinois is whether or not the Exchange will actively shop for insurance **(Active Purchaser)** or simply set up a website (like Orbitz) that simply makes comparing and buying insurance easier.

Active Purchaser v Passive Exchange: The insurance industry wants the Exchange to simply be a place to buy insurance, like Orbitz. We want the Exchange staff to bargain with insurance companies, the same way Government employees and large corporations do.

Adverse Selection: The insurance industry wants to keep healthy clients outside the Exchange, while sending "riskier" clients to the Exchange. In order to keep brokers from "steering" customers, insurance companies must offer the same products inside and outside the Exchange. We want them to offer the same quality insurance that complies with the same rules and standards inside and outside the Exchange

One or Two Pools: The insurance industry wants the Exchange to have no bargaining power, so they want one pool for small business and one pool for individuals. We want one pool for small businesses and individuals, so we can get the best price and the highest quality plans. Like most Government employee models, the large pool of potential customers will force insurance companies to offer a better product at a competitive cost.

Long-term Funding: States that reach certain thresholds for developing the Exchange will receive grants from the Federal government to "seed" the development of the Exchange. By January of 2015, it will have to be self-sustaining.

Some want the Exchange to be funded out of the General Fund. We want the Exchange to be self-funded by charging a fee on all insurance companies. This small fee is easily offset by the huge increase in new customers. Just last year, 500,000 healthy youth bought insurance thanks to the ACA law allowing youth under 26 to stay on their parent's insurance. As more and more people join the Exchange, the cost per member will decrease. If the whole industry pays a fee, the cost to business will be minimal.

Thank you for taking the time over the last year to listen to the users of health insurance. I am sure you will create an Exchange that will maximize savings, quality, while minimizing the impact on the insurance industry. Thank you for your time.

End of Testimony.

BACKGROUND FOR QUESTIONS FROM PANEL

Medicaid: With the Federal government picking up the tab for newly eligible Medicaid recipients, most of the new client costs will not impact states. There are concerns that currently eligible Medicaid patients will now apply for insurance. Some have put this number at $700 million, ***WHICH NEEDS TO BE ANALIZED!!!!!!***

Federal Issues:

There are 2 issues at the Federal level; the **individual mandate** court cases and the **approval of line item appropriations**.

In regards to appropriations, provisions like Medicaid expansion and premium tax credits, which the law has going into effect only in 2014, are effectively mandatory spending. Unless the law is changed, the money will be available. It doesn't need to be appropriated on an annual basis. For elements of the bill like community health centers, the money has been both authorized and appropriated. In other words, the dollars are out the door.

In cases where the money was authorized but not appropriated, like the wellness initiatives and training for primary care physicians, will have to be set aside in future budgets. There is the money needed for funding the agencies themselves, which is part of the annual appropriations process. This is the area that could cause trouble (imagine Congress saying HHS can't spend any money on changes to Medicaid).

In regard to court cases, it is very likely the individual mandate provision will go to the Supreme Court. It is not likely the individual mandate would impact the constitutionality of the overall law.

Decisions: Virginia (dismissed case), Florida (unconstitutional), Thomas More Law Center (constitutional), Florida multi-state (unconstitutional, leaves rest of law intact), 11th Circuit (unconstitutional), 4th Circuit (dismissed case), 6th Circuit (constitutional).

Impact of ACA on Illinois:

- Illinois pays over $2.2 Billion in uncompensated care each year; $500 million in the Cook County Health Care system alone.
- 194,000 small businesses have access to the small business tax credit.
  - Today: 25 FTE making less than $50,000 get 35% tax break on employer contribution.
  - 2014: 50 FTE making less than $50,000 get 50% tax break on employer contribtuon.
  - If you have 50-100 FTE, you do not receive tax break or incur penalty.
  - If you have over 100 employees, you do not receive tax break and you pay penalty if you do not cover your employees.
- 151,000 Medicare beneficiaries will get help covering donut hole.
- 174,000 early retirees will be able to re-insure if their old employer drops them.
- 47,200 youth qualify to stay on their parent's insurance.
- 570 existing community health centers can access new dollars, and new centers can open.
- $196 million in federal dollars to cover high risk citizens until the Exchange opens in 2014.
- $1.5 Billion available over next 5 years to get doctors into under-served parts of the state, helping 17% of Illinois residents (National Health Services Corp).

Which small businesses are eligible for tax credit?

• Businesses with fewer than 25 full-time equivalent employees
• Employees have average annual wages of less than $50,000
• Employer contributes 50% of the health insurance premium

Details of the credit

• Nonprofit organizations will qualify for tax credits of up to 25% of the employer contribution from 2010-2013. Also, any state tax credit a small business owner receives for providing coverage will not reduce the amount of the federal tax credit.
• In 2014, eligible small businesses purchasing coverage via an exchange will receive tax credits of up to 50% of the employer contribution. Nonprofits will qualify for credits of up to 35%.
• Seasonal employees will not be counted when determining eligibility. A business can claim the credit for any two years in the future. The law explicitly excludes sole proprietorships and family members from the small business tax credits (but they can apply for individual tax credits).
• Nonprofits cannot take a health insurance credit that is larger than their payroll taxes; nonprofits are taking the credit against their payroll taxes.
• Small businesses that take the credit still maintain full deductibility of the cost of health insurance.

Associated Health Plans

Associated health plans are a big problem for small business. Despite claims from industry that this will create an alternative for small businesses is dead wrong.

- Make it easier for insurance companies to cherry pick health workers. By targeting small businesses with young and healthy employees, businesses that are not part of an AHP will face increases in premium rates, increases in dropped coverage for sick employees.
- Uninsured will increase by 1 million: dropped coverage will increase causing a death spiral.
- Non AHP businesses will see a 23% increase in premium rates, while only 20% of businesses will see lower premiums.
- According to studies, AHPs will only impact 1% of uninsured.
- If the AHPs are national or regional, then Illinois consumer protections will disappear.

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Private Attorney Involvement
Pro Se Divorce Clinic
(312) 431-2101
Public Benefits Hotline
(888) 893-5327
Veterans' Law Project

September 22, 2011

Rep. Frank Mautino
Rep. Monique Davis
Rep. Greg Harris
Rep. JoAnn Osmond
Rep. Jim Sacia
Rep. Darlene Senger
Sen. William Haine
Sen. Michael Noland
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

Dear Committee Members:

The Legal Assistance Foundation of Metropolitan Chicago (LAF) is the largest provider of civil legal services to the low-income population in Chicago and Cook County, Illinois. Many of our clients are either current Medicaid beneficiaries, or are uninsured and without the financial means to purchase health insurance.

In representing these individuals, we have seen first-hand the destabilizing financial and psychological effects of being uninsured or underinsured, and the practical problems people encounter when dealing with the Medicaid application process and bureaucracy. Under the Patient Protection and Affordable Care Act, Illinois has an unprecedented opportunity to create a well-planned and easily navigable health insurance system that will remedy many of our clients' current health access and health insurance concerns. Illinois must not waste this opportunity to create a Health Benefits Exchange that will bring high performing health insurance options to our most needy and vulnerable citizens.

To achieve this goal, the Committee should evaluate every aspect of Exchange formation in the context of four overarching concepts: accessibility, quality, transparency, and accountability. The efficacy and efficiency of Illinois' Exchange can best be ensured when these ideas are the starting point for assessing the myriad practical and specific choices that will go into Exchange development.

I. Accessibility

The Exchange's enrollment processes must focus on accessibility and ease of use. To facilitate this goal, the Exchange should:

- Use a single streamlined application for all plans in the Exchange and for Medicaid/SCHIP applicants.
- Provide the maximum possible support for individuals and families filing applications through the Exchange – including those with disabilities, those with Limited English Proficiency, and other hard-to-reach populations – to ensure that they have fully effective and timely access to the application process.
- Operate in places accessible and familiar to current Medicaid recipients in addition to providing a web portal.
- Assess eligibility, wherever possible, using information already gathered on applicants rather than requiring duplicative document submission.
- Design a system that moves people seamlessly between public coverage and private coverage within the Exchange as their income fluctuates.
- Coordinate outreach with existing public programs to ensure such seamless coverage.

II. Quality

The substantial expansion in the number of Illinoisans who will have health insurance, and who will be accessing healthcare, demands that the Exchange must include measures to ensure quality both in clinical care and insurance plans.
Toward this end:

- The Exchange should mandate that insurers publish nationally approved clinical quality measures on enrolled providers.
- The Exchange should publish health insurance plan ratings data.
- The Exchange should set quality requirements for insurers wishing to participate, and implement a subsequent review process to guarantee that poor performing plans either reform or cease to be part of the Exchange.
- The Exchange's quality measures for plans should include network adequacy, reasonable premiums, prohibitions on gender rating, and adequacy of notices and the appeals process.

III. Transparency

The market aspects of an Exchange cannot function if consumers have no information, or inadequate information, upon which to base their health insurance purchasing choices.

- Information about basic insurance concepts, quality standards, the make- up and adequacy of provider networks, appeals processes, and accessibility of specialty care – as well as many other topics – will need to be fully available to consumers of varying educational backgrounds, experience levels and languages.
- This information must be accessible not just electronically but also in more traditional media.

- Plan options should be standardized to enable individuals to better understand the dollar value of their plan choices.

IV. Accountability

The governance structure of the Exchange must make it fully accountable to all stakeholders. A large percentage of individuals and families using the Exchange will be Medicaid applicants and recipients, and estimates are that as many as 700,000 individuals will be participating in Medicaid for the first time in 2014. To ensure that their interests are effectively represented in the governing structure:

- Any governance structure should include Medicaid recipients, other consumers, and small business interests, and these members must have voting positions.
- All governance meetings should comply with the Illinois Open Meetings Act and any other applicable "sunshine" laws, and the Exchange should be required to provide information under state and federal Freedom of Information laws.
- The strongest possible conflict of interest rules, ethical requirements, and recusal provisions for the Exchange governance structure are vital to the protection of every partner in this process, and – just as importantly – to the protection of the public trust. Strong conflict of interest rules will still permit the inclusion of those with expertise and experience in Exchange governance, and will also ensure more rational decision-making and protect the Exchange from allegations of bias, or actual bias.

This committee has an historic opportunity to create an Exchange that meets these four goals and dramatically improves healthcare and health insurance access for the citizens in Illinois. Thank you for this opportunity to participate in the work of the Illinois Health Benefits Exchange Legislative Study Committee.

Sincerely,

Carrie Chapman
Staff Attorney
Public Benefits Practice Group

Nelson A. Soltman
Supervisory Attorney
Health Law Project

Illinois Optometric Association
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September 14, 2011

Dan Long
Committee on Governmental Forecasting and Accountability
703 Stratton Office Building
Springfield, Illinois 62706

Dear Mr. Long,

The Illinois Optometric Association was in attendance at the last hearing of the Illinois Health Benefits Legislative Study Committee and greatly appreciated the committee's diligence in dealing with this complex issue. As a follow up to the meeting, we would like to submit a few comments on optometry's role as it relates to the exchanges and the health care system as a whole.

We represent the over 2100 optometrists in the state of Illinois. The IOA's mission is to assist our members in providing exemplary care to the citizens of Illinois. The IOA has worked to maintain an excellent relationship with the Department of Healthcare and Human Services and has worked together with the department in encouraging optometrists to participate in the Medicaid program. Currently, optometrist's provide over 90% of the non-surgical eye care including medical eye care to the Medicaid population.

Optometrists are primary eye care physicians that treat, diagnose, and manage conditions of the eye and adnexa. In Illinois, all optometrists are licensed to prescribe medications for the treatment of eye diseases including glaucoma and conjunctivitis (pink eye). They may also remove foreign bodies from the eye. Optometrists in Illinois receive intensive, continuous training on medical conditions that impact ocular health, such as hypertension, diabetes, and neurological conditions. Optometrists play an important role in the integrated care model not only in the management of systemic conditions but in reducing the overall cost of healthcare. Indeed, many times the optometrist is the first doctor to notice signs of systemic disease. Conditions such as hypertension and diabetes may be "silent" initially, not significantly affecting the patient's daily activities and therefore go unnoticed. Vision problems are less frequently ignored, and a comprehensive eye examination frequently detects these conditions early, and prompts a referral to the primary care physician.

Optometry constantly faces a dilemma that we serve patients with multiple funding sources for multiple purposes. Some patients are covered by medical insurance plans that pay for both medical and vision care. Others have plans that cover only medical eye care but the patient may or may not have separate vision care coverage. Medicare covers medical eye care but does provide vision care or glasses. Medicaid provides both medical and vision care but the glasses are provided through the Department of Corrections. As you can see designing a program under the exchange that best serves the patient's eye care needs while allowing transition between Public and private insurance is going to be a challenge. We would therefore like to recommend that the governing board of the exchange include at least one representative from optometry. With the inclusion of an eye care benefit requirement in the Health Care Reform Bill and given that optometry provides the large majority of primary eye care in the state this would seem to be the best way to ensure that the public eye care needs are met.

Finally, we would recommend that the Health Benefits Exchange Governance Board be a quasi-governmental agency made up of a mixture of representatives from all of the stakeholders in the healthcare arena. Similar to the CHIP Board, this would include representatives of Government, Insurance, Business, Provider, Public Interest Groups and the general public. Appointments to the Exchange Board should come from a variety of sources including the Governor, the Legislature and other groups such as optometry which should be specified in the law.

We appreciate this opportunity to comment on the Health Benefits Exchange and would be happy to provide additional information as needed. Thank you again for all of your efforts.

Sincerely,

Michael G Horstman
Executive Director

cc. Senator Haine
Senator Brady
Representative Mautino
Representative Osmond