Comments from Health Benefits Exchange Shareholders

1. Heartland Alliance for Human Needs & Human Rights

Heartland Alliance is a service-based human rights organization focused on investments in and solutions for the most vulnerable men, women and children in our society. Through a network of dozens of direct service programs located throughout the Chicago-area, Heartland Alliance provides housing, health care, human services and human rights protections to hundreds of thousands of people each year. We are a health care provider to vulnerable populations, operating federally qualified health centers (FQHC), a healthcare for the homeless program, and several health clinics and school based health centers in Chicago as well as community-based treatment and prevention programs. We provide primary health care, oral health care, and a full range of mental health and addictions treatment services and prevention programs to people who are homeless, as well as to refugees and immigrants and other vulnerable populations. Based on this work, our organizational experience is that of a health care provider that bills public as well as private insurance and as an advocate for the vulnerable populations we serve.

With the understanding that the Illinois Health Benefits Exchange will be a critical center point of health care information for the uninsured in Illinois and the main portal of access, it is critical that the unique needs of vulnerable populations are addressed. All aspects of the Exchange design (e.g. governing board, financing, outreach and enrollment) must be flexible and able to take account for these differing needs. As such, we make the following recommendations to the Illinois Legislative Study Committee:

The Exchange Governing Board

A stated goal of the Illinois Health Benefits Exchange is to help individuals shop for, select, and enroll in qualified, affordable private health plans, as well as meet all federal requirements of publically funded programs (e.g. Medicaid) through implementation of the Affordable Care Act. As such, users of the Exchange will consist of individuals and families who will either qualify to receive subsidies through the Exchange or who will be eligible for Medicaid. Since about half of the uninsured in Illinois will qualify for Medicaid in 2014, and will therefore make-up a significant portion of those accessing health care through the Illinois Health Benefits Exchange, Illinois must insure that their interests are represented on the Governing Board. We recommend that the Exchange Governing Board be designed to include the following representatives:
At least one individual who qualifies for Medicaid under current or expanded Medicaid eligibility rules
A community-based provider that mainly serves vulnerable individuals living under 200% of FPL
We are also concerned with the Legislative Study Committee's draft proposal to include legislators as voting members of the Exchange Governing Board. This creates the potential for conflict of interest and raises questions about availability to fully participate in time intensive review as part of the Board, as well as the need for Board members to contribute substantive expertise relevant to its decision making responsibilities. We recommend that legislators not be included as members of the Governing Board for these reasons. If they are to be included in order to connect the Board's work to related policy decisions, we recommend that participating legislators serve in an ex-officio role and not as voting members.

The Navigator Program

How individuals access and navigate through the exchange is a key component of its success in meeting intended purposes. Strategies that make sense for the general public, use of insurance brokers and the like, do not address the unique needs of vulnerable populations, such as the chronically homeless, and those suffering from mental illness and/or substance use disorders who also happen to be high cost users in our current health care system. The Study Committee should provide detailed

language as to who qualifies to be a Navigator and insure that language is inclusive and representative of the diverse populations who will be receiving health care coverage through the Exchange. Keeping the language around Navigator qualifications inclusive of various groups such as those serving vulnerable populations will in turn maximize the number of entities working to do outreach and enroll individuals in the Exchange. We recommend that the Navigator program should ensure that outreach is targeted to hard-to-reach and vulnerable populations, since that group currently represents half the uninsured in Illinois, by including community-based organizations that have experience working with and serving the uninsured and people currently on Medicaid, working with diverse populations, and providing culturally and linguistically competent services. These organizations should receive compensation for the role that they provide, following the successful Application Agent model IHFS implemented with the KidCare program.

Funding of the Exchange

Illinois' ongoing budget crisis reflects the current inadequacy of our state's General Revenue Fund relative to our expenditures for basic programs and services for education, health care, human services and public safety. Relying on GRF for additional areas of spending when other options are both available, more relevant, and more stable, is not in the best interest of the people of Illinois. We recommend that the Legislative Study Committee not rely on GRF funding, but pursue any of the following approaches to fund the Exchange:

Institute a progressive surtax on the insurance industry's revenues (at the end of 2011, these revenues are projected to be $30 billion)

Levy an assessment fee on insurers, both within and outside of the Exchange, in order to avoid creating a disincentive for insurers to participate in the Exchange

Have the state Medicaid program be a part of the Exchange, and therefore some of the administrative Exchange costs would be eligible for Medicaid reimbursement

Thank you for your consideration. Please feel free to contact me if I can provide additional information.

Sincerely,
Nadeen Israel

Heartland Alliance for Human Needs and Human Rights
33 West Grand, Suite 500, Chicago, IL 60654
P (312) 870-4960; C (312) 919-3507
nisrael@heartlandalliance.org | http://www.heartlandalliance.org

October 4, 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. 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 become more affordable. There are many issues related to the creation of the Exchange that were addressed in the Draft Report: Findings of the Illinois Legislative Health Insurance Exchange Commission. 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.

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.

AARP applauds the Commission for limiting the composition of an Exchange Governing Board to the 19 members. We agree that no insurance broker or agent should be appointed to the board. We would also urge that any legislator appointed serve be appointed in a non-voting capacity as modeled by the IL Comprehensive Health Insurance Program board. If appointed as voting members, legislators would be subject to the same conflict of interest provisions as all other members on the board. Furthermore, AARP also would strongly encourage the Exchange Governing board to be set up as a Quasi-Governmental entity, not a Legislative Commission. We believe these two governance issues will be protect consumers and ensure adequate accessibility the IL Health Insurance Exchange. 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.

Illinois should also carefully consider the evolving role of brokers and agents in relation to the Exchange and its Navigator program. 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.

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.

IIA of IL, NAIFA IL, ISAHU – Phil Lackman

On behalf of the Coalition of Insurance Agents and Brokers we have submitted joint comments that will be sent to you from Laura Minzer at the Chamber.

I did want to share with you on behalf of my members only, that we are concerned about the heavy reliance on the consultants reports and the lack of inclusion of all of the Illinois stakeholders who testified. Our Coalition of Insurance Agents & Brokers submitted a "White Paper" which detailed a lot of our suggestions for the Exchange. We produced a White Paper on Navigators in conjunction with the Crossroads Coalition and we testified for over 1 1/2 hours on governance and other Illinois Health Benefit Exchange issues yet there is literally no mention of our or other Illinois stakeholders suggestions, concerns in the report.

United Food and Commercial Workers

Thanks for the opportunity to comment. A few items stand out:

1) Sec. 5-20 (D) states that the committee should study the development of standards for coverage of full-time and part-time employees and their dependents. Where is that discussion in the report? I could not clearly identify it. This was language we included in SB1555. Maybe its in there but under a different heading.

2) I also did not see options for part-time employees. We asked the committee to review options to enroll part-time employees not just full-time. Under the ACA, employers pay no federal monetary assessment for not providing health insurance to part-time employees (under 30 hours per week) who use the Exchange and receive federal tax credits or cost reduction subsidies. We ask that committee review an assessment to employers who do not provide insurance meeting ACA standards to their part-time employees.

3) Several groups gave testimony about the need for participating insurance companies to provide similar plans inside and outside the exchange to avoid adverse selection. Is there any mention of this? I didn't specifically see mention of this.

4) In the discussion about navigators on page 12, it may be worthwhile to mention any safeguards and oversight that should be in place in the event that entities tasked as Navigators are not abusing their role since you are dealing with various public and private entities -- outside of the Exchange organization. Liability around Navigators might be something to look at in the future.

Also, we appreciate the mention of labor representation on the governing board, the discussion around the active exchange, and the discussion of a larger pools achieving greater leverage and efficiency.

ILLINOIS MATERNAL & CHILD HEALTH COALITION

1256 West Chicago Avenue ♦ Chicago, Illinois 60642
Tel: (312) 491-8161 ♦ Fax: (312) 491-8171 ♦ Email: ilmaternal@ilmaternal.org
Website: www.ilmaternal.org

Response to Draft Report by the Health Benefits Exchange Legislative Study Committee
October 6, 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). Thank you also to the staff who contributed towards the draft report and for providing expertise to this process.

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.

Governance

We reiterate our support for a quasi-governmental Exchange and applaud the report recommendation that the board **does not** include insurance industry representative, brokers, or agents. While we agree with the recommended number (19) of board members, we have strong concerns about legislators serving as voting members and recommend that legislators only are allowed on the board as **non-voting members**. While their expertise can be valuable to the work of the Exchange, we have concerns about conflicts of interest and also the amount of time that they would have to devote to fully participate in meetings.

Additionally, we believe that it is important for a community-based provider that has experience with outreach and enrollment for individuals below 200% FPL in public programs AND at least three individuals who represent communities of color to also serve on the Exchange board. These members can provide important perspectives to craft an Exchange that best serve these populations, which have higher rates of being uninsured and other barriers to health care.

IMCHC also believes that the Exchange should be set up as a market developer. This will maximize the opportunities of the Exchange to best serve consumers and small businesses by ensuring that plans compete for business and ensure the quality of products being offered.

Financing

We agree with the report's recommendation to leverage the maximum allowable amount of federal Medicaid dollars to help fund the Exchange. Additionally, given that the Exchange and other health insurance reforms and regulations will encourage and require more people to purchase and enroll in health insurance programs, enrollment in private plans will increase substantially. Therefore, private plans both inside and outside the Exchange should share in the operational costs. Requiring all Illinois insurance health

insurance carriers to help pay for the Exchange will ensure that carriers are not discouraged from participating in the Exchange.

Navigators

We agree entirely with the need for a "boots on the ground" outreach effort to help inform and enroll Illinois residents about the new affordable opportunities for health insurance. The All Kids Application Agent (AKAA) network has proved to be tremendously successful to reach our most vulnerable populations and provide outreach and enrollment services in a culturally and linguistically appropriate manner. We recommend that any Navigator program be **inclusive** of this existing network and that any additional requirements to participate **do not prevent** qualified community-based agencies from acting as Navigators.

Comments on Draft Report of Findings of the Illinois Legislative Health Insurance Exchange Committee

October 4, 2011

On behalf of the thousands of employer, insurer, and agent and broker members our organizations represent, we appreciate the opportunity to participate in the discussion advanced by the Illinois Legislative Health Insurance Exchange Committee and also provide comments and feedback on the first draft of the findings report released by the committee.

As a general comment, we note that P.A. 97-142 (SB 1555) directs the committee to include recommendations concerning prospective action on behalf of the General Assembly as it relates to the establishment of the Exchange in 2011, 2012, 2013, and 2014. To that end, the draft report also notes on page 3 that *"this report also contains specific legislative recommendations for the General Assembly and a timeline for implementation of the Health Benefits Exchange."* The draft report, however, does not currently provide any clear directives in terms of legislative action and recommendations, but does present some of the decision points in such a way as to suggest that the committee supports certain operational and governance decisions with which our organizations would take issue. For example, the draft report fails to acknowledge stakeholder testimony that supported, nearly universally, a quasi-governmental approach to exchange governance.

The draft report also relies very heavily on the findings and recommendations of the HMA/Wakely report overall. While we note that this report was intended to help inform the committee's discussions around key decision points for the exchange, we are disappointed the report did not acknowledge or cite other findings and recommendations brought forward by Illinois-based organizations, both in oral and written testimony.

Furthermore, the draft report fails to acknowledge that the overriding goal of the Affordable Care Act and by extension, the Exchange, is to reduce the number of uninsured and underinsured in Illinois. Finally, we note that the report advances conflicting messages at times, especially with regard to fostering competition, often stressing the need for competition while suggesting the Exchange should be selective in the plans that can be sold; a position we do not support.

This is by no means intended to suggest that we anticipated the committee's findings and recommendations would fully align with the opinions and positions of our organizations. We have, however, noted throughout our comments and feedback areas in which we believe the committee's findings and recommendations do not align with our position.

Our organizations appreciate the transparency and the further dialogue the Commission on Government Forecasting and Accountability and the Legislative Study Committee have furnished throughout this process. We look forward to serving as an ongoing resource and participating in future discussions as Illinois moves forward in its implementation of the Illinois Health Benefits Exchange.

Sincerely,

Illinois Chamber of Commerce
Independent Insurance Agents of Illinois
Illinois State Association of Health Underwriters
Illinois Life Insurance Council
BlueCross BlueShield of Illinois
Aetna
Illinois Insurance Association
Health Alliance
Illinois Manufacturers' Association
National Federation of Independent Business
Illinois Retail Merchants Association
Humana
UnitedHealth Group
National Association of Insurance & Financial Advisors

We have broken down our thoughts and feedback on the report along the Section and Subsection headings used in the draft report.

Introduction:

P.A. 97-142 (SB 1555) establishes the Legislative Study Committee and requires the committee to report on specific findings and recommendations as they relate to the Illinois Health Benefits Exchange. The draft report notes this, but not until the 5th paragraph of the Introduction. Perhaps, for structural purposes and ensuring the goal and intent of this draft report is clearly defined, the introductory paragraph should begin with the purpose of the committee and the statutory requirements included in P.A. 97-142.

The current introductory paragraph also makes a number of statements and assertions that our organizations believe should be updated to reflect a more accurate portrayal of the Health Benefits Exchange and the status of Illinois' implementation of its own health benefits exchange. Specifically:

- The introductory paragraph currently states " *using the definition developed by the Illinois Department of Insurance, a healthcare insurance Exchange is defined as a 'transparent, centralized competitive health care marketplace.'*" While the Department of Insurance has characterized the healthcare insurance Exchange in this way through public and written testimony, the definition only captures the opinion of the Department; this definition is not codified in Illinois law or in any specific regulations to date. Therefore, we recommend updating this statement to provide a more agnostic approach to the definition of the exchange. One way to do this is to reference U.S. Department of Health and Human Services' definition of exchanges that was published in its November 2010 Initial Guidance to States on Exchange, which states: "An Exchange is a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality."

- The introductory paragraph goes on to state that *"an Exchange as authorized by the ACA must provide access (primarily through an internet website) to both public and private health insurance coverage for individual and businesses with fewer than 100 employees."* While this is accurate, the paragraph does not acknowledge the fact that P.A. 97-142 limits eligibility to employers with no more than 50 employees; an option states have under the federal law until 2016 when all states will be required to open eligibility of the exchange to employers with 100 employees or less.

- Finally, the introductory paragraph acknowledges the alternative to a state-operated exchange is a federally-run exchange. While this statement is also accurate, it fails to acknowledge P.A. 97-142 authorization of an Illinois Health Benefits Exchange. Illinois has already statutorily declared its intent to implement a state exchange rather than default to a federally-operated exchange. One of the goals of this legislative study committee and this report is to ensure the state continues to proceed along the implementation timeline outlined by the federal law and additional guidance and regulations so as to ensure the state does not miss crucial benchmarks that could force Illinois to default to a federal exchange.

HMA/Wakely Consulting Group Strategic/Operational Needs Assessment:

On page 5, the draft report summarizes findings presented by HMA/Wakely; however, some of the statements made in this section could be misconstrued as advancing their findings as the recommendations of this particular committee. It is our understanding this Section is intended to summarize, agnostically, the suggestions and opinions of HMA/Wakely and we have provided some suggested language changes that could help to achieve this:

(Paragraph one of this Section)

"The Illinois Department of Insurance also contracted an outside analysis of the needs and possible components of an Illinois Health Insurance Exchange to a collaboration of consulting firms ~~lead~~ led by Health Management Associates ("HMA"). Also included in the contract were the Wakely Consulting Group and, for issues related to the eligibility system, CSG Government Solutions. These consultants have since delivered an analysis that lists many potential goals for an Exchange, including various possible components of an Exchange, ~~important~~ possible functions of an Exchange and budgetary support and other ~~,~~ financial issues regarding the Exchange, and the impact on Medicaid~~, and~~. The report also outlines HMA/Wakely's suggested ~~the~~ next steps for the Illinois Health Benefits Exchange as it attempts to meet federal funding and implementation obligations~~to proceed in line with federal expectations~~."

(Paragraph 6 of this Section)

"The HMA/Wakely report describes the financial implications and potential costs of the Exchange in the startup and ongoing years. The report also provides considerable detail on costs and revenue options. Though this is discussed further in this report, their example revenue-enhancement option for financing the exchange would raise an assessment on participating health carriers and their plans. The HMA/Wakely report also acknowledges, however, other possible funding mechanisms Illinois can use in order to meet the state's financial sustainability obligations required by federal law, beginning in 2015 and beyond.~~This assessment would be between 2.24 percent and 3.39 percent of total premium cost, compared to the similar program in Massachusetts at 3 to 4 percent premium cost for their Exchange ("Health Connector") operation~~."

Governance and Structure of the Exchange:

The discussion of the operations and governance of the exchange outlined in this draft report appears to favor an operating approach that our organizations do not support. While we understand the purpose of this report is to lay out findings and recommendations that are those of the committee and not necessarily those that are supported, in their entirety, by every stakeholder, including organizations such as ours, we do feel it is important that we share our thoughts on the issues presented in this draft report.

Specifically, on page 6 of the draft report, the discussion surrounding the different operating models is not entirely balanced. The draft report correctly points to the two operating exchange models that are often cited as representative of the two different approaches to the marketplace, with Utah's exchange representing the "market organizer" approach and Massachusetts' exchange representing the "market developer" approach. In Paragraph 3 of this Section, however, the report provides a slightly different treatment of the presentation of the "market developer" approach, citing California's yet-to-be-implemented version of the exchange in addition to Massachusetts. The previous paragraph discussing

the "market organizer" approach, however, only cites Utah. If the goal of this Section is to outline the examples in a more agnostic way, we would recommend the following changes:

(Paragraph 3 of this Section)

"On the opposite end of the spectrum is the 'market developer' model, utilized (and envisioned) in Massachusetts (and California, though the Exchange is still in development). This model for an Exchange would more actively pursue coverage ~~in a competitive manner, with the goal of leveraging the Exchange buying power to get its members the best possible deal on the most valuable coverage~~through a more selective and competitive approach. For example, an Exchange in this case might require health plans to submit bids to the Exchange board for participation and only ~~some~~ those that submitted ~~to best~~ bids that meet the criteria outlined by the Exchange would be accepted to sell coverage on the Exchange for that year. ~~A benefit of analyzing this option is the availability of information and experience from Massachusetts, which has had a form of an Exchange since before the ACA mandated it in the other states.~~ In the case of Massachusetts, their Exchange requires that providers must meet state law requirements, provide good consumer value and high quality in their product, among other requirements. ~~In practice, while a more competitive model, Massachusetts has never denied a bid. California's version of an Exchange focuses on specific goals within the authorizing legislation, including that the Exchange must develop criteria for plan selection that 'are in the best interest of qualified individuals and small employers' and that the Exchange must contract with insurers with the goal of providing coverage that optimally combines choice, value, quality, and service. However, California has no clear experience to speak to on their own model at this time.~~"

Comment [LM1]: The ACA already outlines requirements for Qualified Health Plans. States are well within their right to define additional criteria for those plans, whether or not those plans are sold on the exchange by way of a market developer or market organizer approach.

The final paragraph of the first section under "Governance and Structure of the Exchange" on page 8 also makes reference to the comparison shopping option utilized by the exchange as being similar to services such as "name your own price" tools on popular websites. While the goal of the exchange is to provide for the more efficient comparison-based shopping of health insurance options, it is a little misleading to suggest it will be akin to a "name your own price" approach. A more accurate comparison would be to those sites that provide for easily sortable arrangements of options based on price and other criteria identified by the consumer as important, such as well-known travel sites like Travelocity or Expedia.

Considerations and Potential Goals for an Exchange:

The report's discussion of "key points of interest" for the Exchange outlines a series of key points or principles that appear to be in conflict with one another on a number of levels and with which we could not support as stated goals/principles of an Illinois Health Benefits Exchange. Again, we recognize that the goal of this report is not to align with our opinions on these issues, but we still believe it is important for us to note the areas in which we do not agree:

1. **An Exchange should encourage competition among health insurers.**

RESPONSE: Our organizations fully agree that a key to a strong health insurance market, both inside and outside the exchange, is a competitive market. The statements made in the notes below this key point in the report, however, do not accurately reflect the issues that will speak to a competitive market. Exchanges will NOT by the nature bring together competing insurance carriers. How the state decides to set up and operate the exchange, however, will determine the level of competition. The ACA already outlines qualifications for QHP's, including plan levels, which are to be sold on the exchange. The

competitive elements, therefore, will be derived through such factors as network size and access issues, among other things. If the exchange chooses to adopt a more restrictive approach to plan sales on the exchange (as opposed to allowing all plans that meet QHP criteria be sold on the exchange), then competition is not likely to be achieved.

2. **& 3. Seek enhanced value of insurance products and encourage insurers to make their best products available.**

RESPONSE: Both of these key points/principles fail to acknowledge that the ACA already requires insurers to meet specific plan design criteria and benchmark mechanisms for value, such as the second lowest silver plan for premium tax credits. #3 also seems to suggest the Illinois Health Benefits Exchange should take on a more active role in terms of selecting the plans to be sold on the exchange. Market forces, by way of competition, will ultimately dictate what products are and should be available to meet consumer demands. Furthermore, the report fails to acknowledge the fact that additional state coverage mandates that exceed essential health benefits outlined by forthcoming federal regulations must be subsidized by the state.

4. **An Exchange is more attractive to health insurers as it gains more volume.**

RESPONSE: The overriding goal of the exchange is, as it was contemplated by the ACA, is to reduce the uninsured. The goal of the exchange **should not** be to compete for volume from the external market or disrupt employer-sponsored coverage, if the employer desires to keep that coverage intact. This statement, however, appears to support the latter goal – a goal that is not overtly envisioned by the ACA or supported by the business community. A better and more accurate way of stating this key point is to point out that the Exchange should seek to reduce the number of uninsured and underinsured. To that end, the Exchange should hold education and consumer outreach in high regard.

5. **Competition reduces demand for government intervention.**

RESPONSE: This key point/principle is slightly confusing, as are the supporting statements. Our organizations support an exchange governance that is separate and apart from any existing regulatory body. We still believe, however, the exchange should not duplicate existing regulatory functions and this oversight should remain a responsibility of the Department of Insurance. We agree that a competitive exchange is a desirable goal, but are not clear in how competition will reduce the demand for government intervention if the exchange looks towards a more proactive role in selecting plans that will be sold on the exchange.

6. **A better health insurance environment makes Illinois more attractive to employers.**

RESPONSE: While we appreciate this statement, we must point out that it is not entirely accurate. A competitive health insurance environment ***coupled with a high-quality, high-performing health system***, will make for a more attractive environment to employers. Health insurance costs are certainly a factor for employers, but so is ensuring their employees have access to high quality healthcare services to ensure a healthy, productive workforce.

7. **The authorizing legislation to create an Exchange in Illinois "should not require the Exchange to certify all plans meeting federal requirements."**

RESPONSE: Again, our organizations know the purpose and goal of this report is not to align with all of our positions and views of how the exchange should operate in Illinois, but for commentary purposes, we must clearly note that we, under no condition, can support a finding or recommendation such as this. Our position is that the Exchange should certify all plans that meet the federal requirements to

leverage the market forces that encourage competition and innovation. We do not support the active purchaser/market developer approach and while the committee is well within their right to make this assertion, we would strongly oppose this approach. If the goal of the Exchange is to be a competitive market than considering a more restrictive, hands-on approach to which plans are sold would seem to fly in the face of the first key point listed on page 8, as well as key point #5.

Exchange Governance and Accountability Options:

The draft report's treatment of the exchange governance fails to acknowledge that nearly all of the groups that testified before the committee and the Governor's Health Reform Implementation Council believe the Illinois Health Benefits Exchange governance structure should be a quasi-governmental entity. Our organizations suggest this Section be restructured slightly to acknowledge that point and note the other models, including an existing state agency and a non-profit organization, as the other models contemplated by the ACA and proposed regulations. The current treatment of this discussion seems to suggest the committee would favor a state agency governance structure; a point again our organizations would oppose.

Similarly, the draft report, on page 10, cites one possible example of board composition which appears to suggest this is the model the committee would propose. There are many examples of possible board composition and to that end, it may be more appropriate to remove the example and simply limit the discussion to the proposed federal regulations regarding board expertise and conflict of interest. Furthermore (as a point of note), the size of the board suggested in the model (19 members in total) represents a rather unwieldy board size that could pose quorum problems in the future. The CHIP Board, for instance, tends to struggle with quorum issues.

The proposed federal regulations do call for at least 51% (a majority) of the members to be free of any conflict of interest. The draft report, however, states in reference to its board composition example that *"an important issue with the board composition described above is the lack of representation of insurers, agents/brokers, HMOS, PrePaid Service Providers and other individuals with an interest in the Exchange."* The Illinois Chamber, in its response to the proposed regulations on the establishment of the Exchange that asked for comments around board member conflict of interest, noted that conflict of interest, while perhaps more readily apparent with members of the insurance industry, can still apply to a number of non-industry related groups, including unions (those that may operate a Taft-Hartley Plan) and even employers and consumers with ties to associations/entities that offer their own health insurance products. The draft report also fails to acknowledge the testimony around this issue that made very similar points with regards to the extent under which conflict of interest could apply.

Finally, the paragraph on page 10 before the possible board composition example cited also discusses creating a *"legislative committee or commission that is focused and designed to directly oversee operations and policy decisions of the Exchange itself (or to assign these duties to an existing committee or commission.) Such a committee or commission could have a clear mandate and legislative authority to act as a check on the new Exchange in cases where policies or practices may veer from the original intent of the legislation creating the Exchange."*

Our organizations support the idea of continuing the role of the legislative study committee created by P.A. 97-142 in an oversight capacity, but the draft report should be clear in its statement that the role of this committee would be oversight only and a way to offer a check-and-balance on the implementation and eventual operation of the Exchange. The committee CAN NOT act as the governing board itself, as seems to be suggested in the statement "directly oversee operations and policy decisions of the Exchange. . ." The federal law and proposed regulations clearly dictate certain parameters around a governing board that would seem to preclude a purely legislative board. This is not to suggest, however,

that legislative members are precluded altogether from the possibility of serving as voting members on the board.

Public and Governmental Direction in the Exchange – Other States:

The draft report presents two states – Utah and California – as examples of design elements contemplated and in the case of Utah, in place, in state exchanges. The discussion, however, is not necessarily complete and our organizations suggest inclusion of other states to provide other examples and offer a more complete array of other state approaches. For example, Colorado's authorizing exchange language allows for representatives of the insurance industry and the agent/broker community to participate as voting members of their exchange board. The example cited in California prohibits these groups from participating as voting members. Again, we understand the committee is well within its right to propose these types of restrictions on voting board members, but the slant portrayed in this Section, as with the previous Section is that Illinois' Health Benefits Exchange governing board would prohibit insurers and agents/brokers from participating as voting members of the board. The Illinois Chamber, in its testimony to the Legislative Study Committee, supported the presence of these individuals on the board accompanied by conflict of interest provisions and provisions that would allow for recusals when such conflict could arise.

The Navigator Program:

The Navigator program is an important decision point for the state and the Health Benefits Exchange because of its potential revenue cost to the state. We applaud the Legislative Study Committee for taking testimony on the potential role of the Navigators and the agent and broker community. The presentation included in this draft report, however, fails to capture any of the points, including Navigator certification and training requirements, expressed by the Coalition of Insurance Agents and Brokers or the Crossroads Coalition Community, choosing only to include the views and points raised by the HMA/Wakely report.

Our organizations believe the report should include a more well-rounded discussion of the Navigator program to at least touch on those thoughts and ideas presented by the two groups during the September 15 hearing.

Duties of the Exchange:

While this Section notes in the introductory statement that a state-level Health Benefits Exchange is subject to a number of duties "set forth in federal guidelines," the following presentation of these duties does not appear to acknowledge that proposed federal regulations providing further are currently out for comment. Issues such as enrollment periods (referenced in #2) or "essential health benefits" (referenced in #1), as contemplated by federal rules and regulations, are still not yet finalized (in the case of the essential health benefits, proposed regulations have yet to be released). While we do anticipate some level of flexibility in terms of the state's decision points as they relate to enrollment periods and other key operational elements, we believe the report should make note of this still-fluid discussion at the federal regulatory level.

Furthermore, #5 on page 14 fails to acknowledge P.A. 97-142 (SB 1555) codified statement regarding eligibility of employers, limiting access to the exchange to employers with no more than 50 employers (a policy decision also supported by the findings and recommendations of HMA/Wakely's report). The

state, however, is required by federal law to extend exchange eligibility to employers with no more than 100 employees beginning in 2016; a fact that the current law (P.A. 97-142) fails to acknowledge. We suggest that the committee perhaps look to correcting that language in any forthcoming legislation to ensure Illinois is not out of compliance with the federal law beginning in 2016.

Financing the Exchange:

The Section once again appears to rely very heavily on the HMA/Wakely report's presentation of budgetary and financing issues, as they relate to the Exchange. While we understand the report was expected to help inform the committee's findings, the presentation of these findings suggest the committee is in support of the report's conclusions; a point that is well within the committee's right to determine, but again, our organizations would not support. To that end, we have provided specific feedback on issues raised in this Section of the draft report:

- The HMA/Wakely report lists out projected costs (noted in paragraph 2 of this Section) that are based on their assumptions as they relate to operational decisions of the exchange; a fact that goes unnoted in the report.

- The Section, paragraph 5, also outlines HMA/Wakely's perspective on a final funding mechanism in detail, which includes specific assessment ranges for plans that are sold only on the exchange. As noted in the draft report, this approach is only one among a number of approached that could be considered by the General Assembly with respect to financing its exchange. By citing these specific assessment ranges, which are also based on budgetary and operational assumptions specific to HMA/Wakely, the draft report sets out specific expectations that we hope would be the subject of further discussion.

- Paragraph 6 also references an additional financing option of levying an assessment fee on all insurers; a financing model that is, to some degree, currently in place to help subsidized the state's HIPAA-CHIP pool; a point that is not mentioned in the discussion of this particular financing model. Furthermore, the paragraph goes on to note that "*during at least two of the hearings of the Study commission, stakeholders mentioned the viability of a claims transaction fee, such as the one levied in the State of Michigan to fund its Medicaid program.*" While we would not argue this option was discussed during the hearings, we would counter that the discussion was in reference to the Michigan assessment proposal that will take effect on January 1 and not in reference to the "viability" of such a plan.

- Paragraph 8 and 9, both of which discuss leveraging Medicaid funds to help support eligibility screenings and the Exchange as a possible purchasing agent for other state programs like the State Employee Group Insurance Program, respectively, are not necessarily financing options but rather budgetary considerations that may be perhaps better placed in a more distinct discussion of ways to hold down administrative costs of the Exchange and the state. Furthermore, paragraph 7 makes an unstated assumption the state's Exchange is contracting with the Department of Healthcare and Family Services to perform eligibility determinations for the Exchange and Medicaid; an agreement that is fully contemplated by the law and proposed regulations, but should perhaps be stated clearly in the report.

- Paragraph 11, regarding possible licensure fees for Navigators also fails to note that federal law does not allow states to use federal funds for the exchange to fund a Navigator program; these supporting funds must instead come from alternative funding sources, such as licensure fees on navigators. Furthermore, if the state decides to put a Navigator program in place before the fall of 2013 ahead of the initial open enrollment period contemplated by the federal law and proposed regulations, then the state will need to impose these licensure fees or other identified sources of funding separate and apart from any funding mechanism identified to support the exchange in 2015 and beyond.

Concluding Remarks:

While not included in the draft of this report, our organizations would like to suggest the committee expand upon current provisions included in P.A. 97-142 that speak to severability issues. SB 1555 contemplated, in Section 5-25, that the Law be null and void if Congress and the President take action to repeal or replace, or both, Section 1311 of the Affordable Care Act. The legislation, now P.A. 97-142, however, failed to account for any action taken by the courts- specifically, if action be taken by the U.S. Supreme Court to strike down in whole or in part the Affordable Care Act. We would therefore recommend that this committee look to expand upon these provisions to declare this Law (and any forthcoming legislation/laws related to the exchange) null and void if the U.S. Supreme Court strikes down any part of the ACA.

SHRIVER CENTER
Sargent Shriver National Center on Poverty Law

Illinois General Assembly
Health Benefits Exchange Study Committee
October 5, 2011

Comments of the Sargent Shriver National Center on Poverty Law

Thank you for the opportunity to submit comments regarding the Illinois' Legislative Exchange Committee's draft report.

The Patient Protection and Affordable Care Act (ACA) calls for the creation of a competitive health insurance marketplace exchange in every state by 2014. For the Illinois exchange to be fully operational on January 1, 2014, and for Illinois to have the best chance to draw down federal funds to cover ALL of the costs of setting up the marketplace -- over $90 million—we urge the Study Committee to impress upon the full General Assembly the immense importance of enacting legislation setting up the Exchange governance board and identifying a financing source during the fall 2011 veto session. Failure to start the building of the exchange this fall will do big damage to the credibility of Illinois' case to draw down this money (since it will cripple the effort to have the exchange enrolling people in public and private insurance by late 2013 and fully operational on January 1, 2014).

The Sargent Shriver National Center on Poverty Law believes that Illinois' Exchange should promote to the greatest extent competition, transparency, affordability, accountability, quality, and consumer assistance. There needs to be a rigorous and thorough process in place to ensure that Illinois' Exchange operates in compliance with Federal requirements under the ACA, which has as its overall goal to provide consumers with affordable, comprehensive health insurance options. Toward that end, the Committee's recommendations should be subject to the ACA, including its forthcoming final rules and regulations.

Below, we address three areas covered in the draft report---governance, financing, and navigators. We believe the governance and financing areas need to be acted upon in the veto session. We believe the navigator areas could, and probably should, be dealt with at a later date, either by the General Assembly or by the Exchange board itself.

Governance: We are pleased with the Committee's recommendation that the insurance industry, brokers, and agents will not be on the voting Governing board. Exchanges are intended to support consumers, including small businesses, and as such, the majority of the voting members of Illinois' Exchange governing board should be individuals who represent their interests. A voting member of the Exchange governing board should be free from any potential conflicts of interest, which must be clearly and specifically defined.

Representatives of health insurance issuers or agents or brokers, or any other individual licensed to sell health insurance have conflicts of interest. Moreover, the following would also have conflicts of interest and should be prohibited from serving on Exchange boards:

- Individuals affiliated with trade associations or membership organizations comprised chiefly of the above industries; or
- An entity whose primary line of business serves or whose clientele is largely comprised of individuals or organizations identified above as conflicted parties (including major vendors, subcontractors, or other financial partners of conflicted parties).

Conflict of interest prohibitions should also cover immediate family members or spouses of anyone identified as a conflicted party, unless his or her professional qualifications are clearly consumer-oriented. Allowing such interests to hold a governing position on an Exchange would codify their ability to operate the Exchange in their interest, rather than the Exchange's stated purpose of serving consumers. For instance, the inclusion of insurer and broker representatives on the board sets up an obvious conflict between their duties as Board members and as representatives of insurance companies or brokers that do business with the Exchange. Insurers and brokers will have a fiduciary duty to act in the best interests of the Exchange while also having a fiduciary duty to act in the best interests of their respective companies; in fact, they may have a legal or contractual obligation to shareholders or their employer to do so. It will be difficult, if not impossible for these individuals to ensure value and affordability for businesses and individuals, such as seeking to provide the highest quality health plans at the lowest possible premium prices, when insurers and brokers have an inherent financial interest in higher premiums. Additionally, brokers on the Exchange board could seek to ensure that the broker system is selected as navigators as opposed to the many other types of entities that qualify as navigators under the ACA.

While the experience of insurers and brokers could well be an asset to the Exchange, there are ways to take advantage of that experience without creating conflicts of interest. The Illinois' Exchange can establish an advisory board in which insurers and brokers can provide their input. Advisory boards or stakeholder groups are the most appropriate place for such individuals so as to avoid conflicts of interest.

Also, we are concerned about legislators serving as voting members of the Illinois' Exchange Governing Board. We suggest that legislators should serve in an advisory capacity or as non-voting members, as modeled by the Illinois' ICHIP Board (215 ILCS 105/3/b). Legislators' primary allegiance is due to their constituents, so their votes on the Exchange board could, rightly or wrongly, be viewed as favoring the residents and interests of their districts, not the consumers and small businesses of Illinois. Additionally, having legislators serve as voting members of the Exchange board would blur the legislators' roles, particularly when the full General Assembly is considering additional or amendatory legislation regarding the Exchange in future years or the Joint Committee on Administrative Rules is reviewing rulemaking. We also are are concerned that legislators could have a conflict of interest if they accept donations from health insurance issuers or agents or brokers, or trade associations or membership organizations comprised chiefly of the these industries, or from an entity whose primary line of business serves or whose clientele is largely comprised of individuals or organizations identified above as conflicted parties (including major vendors, subcontractors, or other financial partners of conflicted parties). Legislators could have a conflict of interest if they are employed by health insurance issuers or agents or brokers or trade associations or membership organizations comprised chiefly of the these industries, or an entity whose primary line of business serves or

whose clientele is largely comprised of individuals or organizations identified above as conflicted parties (including major vendors, subcontractors, or other financial partners of conflicted parties).

Although legislators' insights would be valuable to the Exchange governing board when offered in an advisory capacity, they might not have the requisite expertise needed for voting members of the Illinois' Exchange Governing board. Exchange governing board voting members should include unbiased experts in relevant fields as well as take into account ethnic and geographic diversity so that the board composition reflects the communities of the state. The types of representatives that should be voting members of the Exchange governing board must guarantee that consumer and small business interests are well-represented while ensuring that the Exchange board as a whole has the necessary technical expertise to ensure successful operation. This necessary expertise includes health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured. And, given that Medicaid enrollment will constitute a large proportion of enrollment via the Exchange, the expertise must also include Medicaid outreach, enrollment, and retention and experience working with uninsured populations.

The Committee's draft report states that the potential board composition include 19 members who are appointed by certain leaders or who fit a specific constituency. What is missing, however, from the requirements is someone with specific knowledge of the uninsured in Illinois. The Deloitte report indicates that most of the uninsured in Illinois are low-income. In addition, the report states that among the largest racial groups in Illinois, Hispanics have the highest uninsured rate (27%), with African Americans second (23%), while white Non-Hispanics have the lowest uninsured rate (13%). As a result, the Exchange Board must have representation from minority communities – who are overrepresented in the uninsured.

In addition, a primary goal of the Affordable Care Act is to provide a route to insurance for people who are low income and people with chronic illnesses/pre-existing conditions. The Exchange Board must have representation of organizations who are familiar with the needs of people with disabilities/chronic illnesses as well as low income populations – many of whom have not had prior experience with the private insurance market.

Financing: Illinois should optimize the flow of federal funds coming into the state. We agree with the HMA/Wakely report that the state should leverage its Medicaid program to finance the Exchange administration to bring in more federal dollars to support the Exchange. We do not believe that levying an assessment on providers is a viable option in Illinois, where Medicaid provider rates are lower than most. Moreover, the ACA explicitly lists assessments and user fees on participating issuers as one potential means for a State to secure operational funding for Exchanges and we recommend that this financing source be strongly considered by the Committee. More specifically, the recommendations should include advising that all plans in the state be assessed—both inside and outside the Exchange. This model will provide a consistent, predictive, and reliable source of funding and will not be subject to the volatility of the state budget by avoiding the use of general revenues. Moreover, this model of assessing plans broadly will help minimize adverse selection. Such fees should be assessed on whatever frequency provides the most consistency, predictability, and reliability for Illinois' Exchange.

We also want to remind the Study Committee that these assessments will pay only for part of the overhead of operating the exchange. Almost all Exchange-related funding will come from the premiums paid by consumers and small businesses and the premium tax credits provided by the federal government. And federal Medicaid funds at very high federal match rate of 90% will pay the exchange operational costs related to enrolling people in public programs. The additional revenues generated by assessments or other fees collected from insurers or other entities would go towards the overhead of operating the Exchange, which represents a small fraction of the overall expenditures. In addition, the ACA allows health plans to include the costs of any such assessments in the monthly premiums (without counting against their administrative and profit portion of the "medical loss ratio"), essentially passing the cost on to consumers and small businesses.

Navigators: We would recommend that the Committee's final report specifically state that navigators could be benefits experts from community based organizations. Navigators must adequately represent a diverse set of organizations and entities throughout a state in order to effectively serve the large number of people who will be eligible for insurance through Illinois' Exchange. In accordance with the law, Navigators specifically must exhibit qualities and expertise that would allow them to serve uninsured and underinsured consumers well. Trusted nonprofit community-based programs can reach and assist low-income and vulnerable individuals and families in a manner appropriate to the community. Illinois already provides a successful model of community-based organizations serving as Navigators. Illinois' Department of Healthcare and Family Services operates an All Kids Application Agent (AKAA) program to help families apply for public health insurance programs, namely, All Kids, FamilyCare and Moms & Babies. AKAAs are community-based organizations, including faith-based organizations, day care centers, local governments, unions, medical providers and licensed insurance agents. In addition to having staff fluent in Chinese, Korean, Japanese, Arabic, Polish, Urdu, and many other languages, these organizations also provide culturally appropriate care and assistance with the application process, particularly for families that may not be accustomed to applying for public benefit programs or have mixed immigration status. Most, but not all, AKAAs receive a $50 Technical Assistance Payment for each complete application that results in new coverage. Illinois' AKAA network is renowned by Medicaid, CHIP and public health insurance experts nationwide, as AKAAs are trusted community partners that have an impressively high first-time application submission approval rate (in the high 80s, low-mid 90s).

Navigators should be required to demonstrate competency in the Exchange, Medicaid, and CHIP, other public programs and the private insurance market in Illinois, the rules for premium tax credits, cost-sharing assistance, as well as the importance of reporting changes in income. Navigators must be trusted by the community to provide appropriate, clear and correct information and effectively connect with low-income, disadvantaged, and hard-to-reach populations. Navigators must be able to provide information to individuals and families in a way that can be understood, in a culturally sensitive manner, for those with low-proficiency English, and people with disabilities who have special communication needs.

Navigators should not be required to be licensed as brokers; any licensing certification or other standards prescribed by the State or the Exchange must be necessary to the Navigator function and not barriers to participation for community based organizations. Navigators need not know about other forms of insurance (e.g. life or disability) or have the level of knowledge required to sell an insurance policy. Existing state licensure requirements for brokers or agents are not the appropriate vehicle to ensure Navigators' competency. Instead, navigators could be trained

and pass competency exams; the state can design training programs appropriate to navigators' duties.

Again, thank you for the opportunity to provide comments. If you have any questions, please feel free to contact me.

Andrea Kovach
Staff attorney
Sargent Shriver National Center on Poverty Law
312.368.1089
andreakovach@povertylaw.org

Sargent Shriver National Center on Poverty Law
50 East Washington
Chicago, IL 60602

ILLINOIS ACADEMY OF FAMILY PHYSICIANS

MEMORANDUM

FROM: **Illinois Academy of Family Physicians (IAFP)**

TO: **IL Health Benefits Exchange Legislative Study Committee**

RE: **Comments to Report: Findings of the Illinois Legislative Health Insurance Exchange Commission as required by SB1555**

DATE: **October 5, 2011**

The Illinois Academy of Family Physicians (IAFP) commends the legislators, consultants, agencies, and staff involved in producing the ***Findings of the Illinois Legislative Health Insurance Exchange Commission as required by SB1555.*** We appreciate recognition of our written testimony, submitted on August 30th, in the report's Addendum.

The comments below are confined to areas of the report of particular importance to family physicians in their efforts to play a critical and **supportive** role in the implementation of a health insurance exchange. Specifically, governance, financing, and one of the outlined goals (#7).

Governance (page 10)
Although we are encouraged by the example of Board composition, we believe that 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, health systems and other stakeholders would be most appropriate. Physicians should not be among the entities that are identified as having a potential conflict of interest. The intent of the conflict of interest standard is to ensure that the membership of the governing board appropriately represents consumer interests. Unless a physician is directly affiliated with or represents a particular health plan, the physician would not pose a conflict of interest and would offer a unique and important perspective to exchange governance.

Financing (pages 15-16)
Budget-strapped states, such as Illinois, will want to optimize the flow of federal funds coming into the state. We agree with the HMA/Wakely report that the state should leverage its Medicaid program to finance the Exchange administration– so by including Medicaid plans and providers, the state would be bringing in more federal dollars to support the Health Benefits Exchange. We do not believe that levying an assessment on providers is a viable option in Illinois; where Medicaid provider rates are lower than most.

Goal #7 (page 9)

As stated: The authorizing legislation to create an Exchange in Illinois "should not require the Exchange to certify all plans meeting federal requirements."

We want the exchange to have the mandate and the power to ensure that consumers get the best possible rates for good insurance. Period. Illinois should have the power to expand the requirements for plans participating in the Exchange beyond the minimum federal requirements. In other words, even if a plan meets federal requirements, the plan must also meet Illinois-specific requirements that account for the unique needs of Illinois consumers.

We appreciate the opportunity to provide these comments and make ourselves available for any questions you might have or clarifications you might need. 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 of External Affairs, at 630-427-8007.

Illinois PIRG
Standing Up
To Powerful Interests

Illinois Public Interest Research Group
328 S. Jefferson, Ste. 620 Chicago, IL 60661
www.IllinoisPIRG.org Brian@IllinoisPirg.org

To: Illinois Health Benefits Exchange Legislative Study Committee
From: Illinois Public Interest Research Group
Re: Comments on Findings Report as required by SB 1555
Date: October 4, 2011

Thank you for the opportunity to respond to the initial findings of the Illinois Health Benefits Legislative Study Commission. Illinois PIRG commends legislators and staff for the Commission's work to date and attention paid to the concerns of stakeholders.

As a non-profit watchdog for consumers, Illinois PIRG's focus is on addressing changes to the private insurance marketplace to increase competition. That means policies that ensure more choices, easier comparison and leveraging the buying power of individual consumers and small businesses.

The effectiveness of the exchange will depend on the policies that govern and operate it. For that reason, it is good to see a focus by the Commission on two of the most important areas; governance – because it must be accountable and free from conflicts of interest – and its finances – since it must be self-supporting and stable.

Governance Structure:
Among the options for governance cited in the Findings report, we support a quasi-governmental board. This will allow the board's structure to be accountable to the consumers and small businesses the Exchange is intended to serve. It will also allow the Exchange to have some degree of independence from the state's government so that it can act quickly and have the authority to effectively operate on behalf of its enrollees. Allowing the Exchange to be governed by a non-profit runs the risk of making it unaccountable to the public. Housing the Exchange in an existing government agency or overburdening it with legislative oversight could deny the needed independence for the Exchange to operate in the best interests of its enrollees.

Additional governance policies not clearly stated in the Finding report that should be part of enabling an Exchange include a clear pro-consumer and small business legislative mission and mandate and a requirement for transparency of budgets and records.

Board Selection:
As recommended in the Findings report, we support appointments of board members by elected representatives (Governor and Legislative leaders). We also strongly support the position that those that could profit from the board's decision not be appointed to the board. An advisory board of industry stakeholders is appropriate to ensure meaningful input in board decisions.

However, to prevent conflict of interest and unduly politicize the Exchange, it is important legislators on the board are there as non-voting members.

Financing:
Among the many financing options highlighted in the report, an assessment on all health plans or insurers is most appropriate. The assessment should be shared by everyone in the market because the Exchange benefits all the health insurance market players. The outreach and engagement generated by the Exchange will increase participation inside and outside the Exchange, increasing the number of customers. The Exchange is likely going to be administering risk adjustment programs that will help keep risk pools stable across the entire market. Federal law requires insurers to charge the same price for a product whether it's offered on the exchange or not, so if the inside-exchange version has a fee attached, but the one outside doesn't, that means the insurer may be charging an unjustifiably high price in the outside market since the exchange isn't getting that extra "fee" revenue. Finally, the Exchange will also expand insurance markets, benefiting all insurers. The more enrollees in the Exchange, the less the assessment will need to be.

The question of general revenue funds is not clearly addressed in the Finding report. There should be a clear provision that bars the use of general revenue funds to pay for the operation of the Exchange. Conversely, no revenue generated should be used for general state government operations. The revenue should only be the operation of the Exchange. Clearly separating the funding will help preserve the program's independence, so that it is self-sustaining and truly operated for the benefit of the customers it is intended to serve.

We appreciate the opportunity to share with the Commission and comment on draft recommendations. For more details on these comments, please review Illinois PIRG's recent white paper titled Health Insurance Exchange Policy Check List. For more information, please contact Brian Imus, Illinois PIRG Director, at 312-544-4433 x210 or brian@illinois.org.

AIDS FOUNDATION OF CHICAGO 25 YEARS
A FORCE FOR CHANGE SINCE 1985

200 West Jackson Blvd.
Suite 2200
Chicago, IL 60606

Tel. (312) 922-2322
Fax (312) 922-2916

Response to Draft Report by the Illinois Health Benefits Exchange Legislative Study Committee

October 6, 2011

The AIDS Foundation of Chicago (AFC) thanks 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. Thank you also to the staff who contributed towards the draft report and for providing expertise to this process.

AFC's statewide membership, health care providers, social service organizations, community residents, and individuals living with HIV/AIDS 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.

Governance

We reiterate our support for a quasi-governmental Exchange. AFC applauds the report recommendation that the board not include insurance industry representative, brokers, or agents. While we agree with the recommended number (19) of board members, we believe legislators should be allowed on the board as non-voting members. While their expertise can be valuable to the work of the Exchange, we have concerns about conflicts of interest from legislators who have received campaign contributions from the insurance industry, the amount of time that they would have to devote to fully participate in meetings, and the perception among employers and consumers that the Exchange is an arm of the political parties.

To ensure that the Exchange meets the care and treatment needs of people living with HIV and AIDS, stakeholder consultation must include HIV/AIDS providers, consumers, and advocates. We recommend at least three individuals who represent communities of color to also serve on the Exchange board. These members can provide important perspectives to craft an Exchange that best serve these populations, which have higher rates of being uninsured and other barriers to health care.

Financing

We agree with the report that the state should leverage its Medicaid program to finance the Exchange administration– so by including Medicaid plans and providers, the state would be bringing in more federal dollars to support the Health Benefits Exchange.

Additionally, given that the Exchange and other health insurance reforms and regulations will encourage and require more people to purchase and enroll in health insurance programs, enrollment in private plans will increase substantially. Therefore, private plans both inside and outside the Exchange should share in the operational costs. Requiring all Illinois insurance health insurance carriers to help pay for the Exchange will ensure that carriers are not discouraged from participating in the Exchange.

Navigators

We support the Navigator Program, insofar as (1) it ensures that outreach is targeted to hard-to-reach and vulnerable populations (including people living with HIV and AIDS currently receiving care through the Ryan White Program); (2) it is conducted by people trained in low-income programs and working with diverse, hard-to-reach populations; (3) it is provided in a culturally and linguistically competent manner; and (4) it allows non-medical providers who are skilled in outreach and benefits coordination to serve as patient Navigators and to directly enroll individuals into the Exchange.

We recommend that the proposed findings/recommendations prohibit a Navigator from receiving compensation from health insurance issuers for enrolling individuals or employers in non-qualified health plans *outside of the Exchange*. Such a prohibition would discourage steering to plans outside the exchange.

In addition, the report should explicit state that Navigators should not be required to be licensed insurance brokers.

Additional Exchange Goal

We recommend the addition of a new Exchange goal that focuses on the needs of the Exchange's ultimate customer, the consumer. While the current seven goals address competition, value, and other factors, consumers—real people who will buy actual health insurance—are barely mentioned. Goal four says, "Health insurers looking to their finances want to market their products to the largest group of consumers possible." The only way to achieve that goal and others is to making the exchange friendly to consumers and make sure they have a good experience using the exchange, so the come back the next year. This goal should be explicit from the start, not an after-thought. Suggested language is below:

8. The Exchange should make it easy for every Illinoisan to choose a plan that meets their needs.
The power of the Exchange to increase competition and lower costs will be realized only if consumers can easily use the Exchange. The Exchange should be friendly to consumers and above all focused on providing good customer service. It should be written in plain English, accessible for people with disabilities, and available in other languages. Plans should have standard benefits so consumers are not presented with an array of hundreds of plans that all look the same.

Thank you for reviewing these recommendations. If you have any questions, please feel free to contact me at 312-334-0928 or at rgardenhire@aidschicago.org.

Sincerely,

Ramon Gardenhire

Ramon Gardenhire
Director Government Affairs

IHA Illinois Hospital Association

October 6, 2011

TO: The Honorable Co-Chairs and Members of the Illinois Health Benefits Exchange Legislative Study Committee

FROM: Kathleen Dunn, Vice President, Government Relations
William R. McAndrew, Senior Director, Finance

SUBJECT: Funding the Illinois Health Benefits Exchange

On behalf of its more than 200 member hospitals and health systems, the Illinois Hospital Association (IHA) appreciated the recent opportunity to testify before your Committee. At this time, we would like to provide additional comments regarding the Illinois hospital community's thoughts on Exchange funding. **In general, we wish to reinforce IHA's prior views that the Exchange not overreach in its early stages to ensure that markets and processes that currently work continue to be supported and that unforeseen consequences be avoided as much as possible by maintaining continuity with existing programs.**

Practice Shows the Most Logical Funding Mechanism for the Exchange is an Assessment on the Health Insurance Industry

While it is still early in the game for most states in their efforts to develop Exchanges, most states seem to be tending toward assessments on insurers as the best way to ensure Exchange self-sufficiency. The following conclusion is excerpted from the Henry J. Kaiser Family Foundation publication: Establishing Health Insurance Exchanges: An Update on State Efforts.

> **Exchange Financing**
> Though the ACA requires all exchanges to be financially self-sufficient by January 1, 2015, few legislatures described the manner in which the exchanges can or should collect money. Nearly all exchanges were authorized to apply for public and/or private grants, though this funding may be most helpful during the planning and implementation stages. A few legislatures specified that the exchanges should collect assessments or fees from health plans, either restricted to plans participating in the exchange or applied broadly to all plans operating in the state. For example, Maryland's exchange is authorized to collect fees from plans within the exchange, but not to the extent that the fees create a competitive disadvantage with plans offered outside the exchange. Connecticut's exchange is authorized to collect charges from all plans capable of offering a qualified plan in the exchange. Oregon's financial provision is the most specific, basing the fee on the number of individuals enrolled in health plans offered through the exchange, excluding enrollees in state programs. The charge is limited such that it does not exceed 5% of premiums for each enrollee through the

IHA HEADQUARTERS
1151 East Warrenville Road
PO Box 3015
Naperville, Illinois 60566
ph 630.276.5400

SPRINGFIELD OFFICE
700 South Second Street
Springfield, Illinois 62704
ph 217.541.1150

WASHINGTON, DC OFFICE
400 North Capitol Street N.W.
Suite #585
Washington, DC 20001
ph 202.624.7880

exchange where the total enrollment is no more than 175,000, 4% of premiums for between 175,000 and 300,000 enrollees, or 3% of premiums for more than 300,000 enrollees. (Information provided by the Kaiser Commission on Medicaid and the Uninsured: Publication Number: 8213, Publish Date: 2011-07-27)

Insurer Assessment Should Be Broad Based

IHA believes that the fairest assessment would be crafted on the model currently used by HIPAA-CHIP to assess health insurers based on direct Illinois premiums, regardless of whether the health insurers participate in the Exchange. Not only will this spread the cost more broadly, but it will also ensure that the Exchange does not create its own barriers to plan participation and help ensure that plans inside the Exchange are not costlier than plans outside of the Exchange resulting from premium surcharges to cover the cost of the assessment. Because an assessment so crafted would be designed to fund the Exchange's administrative costs rather than individual premium shortfall as with HIPAA-CHIP, the legislature or the Exchange board should establish an initial fixed dollar amount as the first-year cost of running the Exchange and have the authority to adjust the assessment going forward as needs arise. The current year's HIPAA-CHIP assessment of approximately $57,000,000 (according to the CHIP 2010 Annual Report) would appear to be a sufficient first year assessment given the Wakely Consulting Group Report. This also would comport with the IHA recommendation that the Exchange take small steps in complying with federal requirements rather than establish overreaching authority which could have the severe negative impact of adversely affecting existing markets.

Avoid Further Disadvantaging Hospital Providers

Hospitals have been the focus of many efforts at the state and local levels to reduce the level of reimbursement for treatment provided to consumers in both the public and private sectors. We urge legislators to understand that an array of unprecedented financial changes and turmoil threaten the stability of Illinois hospitals and the state's health care delivery system. 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. And actions at the federal level threaten to substantially reduce payment for Medicare services.

Illinois already receives less than its fair share of Medicaid funds from the federal government. While providing care to 4.0 percent of the nation's Medicaid population, Illinois receives only 3.3 percent of total Medicaid funding, and the state has one of the lowest federal matching rates, 50.2 percent. Currently, 2.8 million low income Illinoisans rely on the Medicaid program, and this figure is growing.

At the state level, hospital Medicaid funding was already cut by $428 million in the budget approved by the General Assembly and hospitals had previously agreed to a freeze on Medicaid outlier payments in the January lame duck session, saving the state an additional $100 million.

At the federal level, the President has proposed $320 billion in reductions to Medicare and Medicaid as part of a $3 trillion deficit reduction plan he submitted to the Joint Select Committee on Deficit Reduction. The president's plan calls for cutting Medicare by $248 billion and Medicaid by $73 billion over 10 years. If the Congressional "Super Committee" cannot reach an agreement on the $1.5 trillion deficit target, a sequestration cut of up to 2% would automatically be triggered. The cost of this cut is estimated to be $1.2 trillion in total for all programs affected over a 10-year period. Reductions to Medicare are estimated to be $123 billion over that period, including nearly $1.8 billion to hospitals in Illinois.

These challenges come at a time when statewide, one in three Illinois hospitals is losing money and many others have very slim positive margins.

Hospitals Have Already Contributed to Health Care Reform

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 hospitals are already helping finance reform. The Patient Protection and Affordable Care Act contains a number of reforms designed to reduce the rate of increase in Medicare and Medicaid spending. Hospitals are estimated to contribute $155 billion in savings over 10 years through reduced payment updates, decreases in Medicare and Medicaid disproportionate share hospital payments, and financial penalties. For Illinois, these changes will require hospitals to absorb $8 billion in payment reductions by 2020.

Hospitals Create Jobs and Stimulate the Economy

As major employers, hospitals provide more than **425,000 direct and indirect jobs** to Illinoisans and generate an **economic impact of more than $75 billion annually**. Ensuring that hospitals have the resources they need also supports hospitals in their vital role as major economic engines and employers in their communities.

Illinois hospitals are the backbone of a strong and vibrant health sector, one of the few sectors in the economy that is creating jobs and stimulating the local and state economies. **Health care and social assistance employment in Illinois is expected to increase by 22% by 2018, adding 150,000 new jobs – making it the second fastest growing segment of employment in the state.**

Conclusion

IHA understands that establishing a financing mechanism for the Exchange is going to be one of the most difficult decisions the legislature will make in establishing a state Exchange. Our recommendation is not based on any desire to be malicious or to punish any particular industry, but rather conforms to the desire of most groups, including IHA, to build an Exchange that builds on existing state structures with as little disruption as possible. We look forward to working with the Illinois Health Benefits Exchange Legislative Study Committee as it works toward greater access and more affordable health insurance for the uninsured in Illinois.

Health & Disability Advocates

205 W. Monroe, Suite 200, Chicago, IL 60606
312-223-9600 | TTY: 866-584-8750 | FAX 312-223-9518

FROM: Health & Disability Advocates

TO: IL Health Benefits Exchange Legislative Study Committee

RE: Comments to Report: Findings of the Illinois Legislative Health Insurance Exchange Commission as required by SB1555

DATE: October 5, 2011

HDA represents thousands of low income Illinoisians each year with special health care needs who are uninsured or insured under public programs. We expect that many of our clients will be accessing health care coverage through the Illinois Health Insurance Exchange in 2014. We appreciate the opportunity to submit these comments for the consideration of the Committee.

Goals (Page 8): Regarding Goals #1-4, we agree that the Exchange should encourage competition among health insurers, seek enhanced value of health insurance products and encourage insurers to make their best products available to as many individuals and small businesses as possible. In short, we believe that the Exchange should have the mandate and the power to ensure that consumers get the best possible rates for quality, affordable insurance.

Regarding Goal #7 (*The authorizing legislation to create an Exchange in Illinois "should not require the Exchange to certify all plans meeting federal requirements"*): Does this point mean that Illinois should have the power to expand the requirements for plans participating in the Exchange beyond the minimum federal requirements? We suggest adding the following clarification: "even if a plan meets federal requirements, the plan must also meet Illinois-specific requirements that account for the unique needs of Illinois consumers."

Board Governance (Page 10): We are pleased with the recommendation that members of the insurance industry, brokers, and agents will not be on the decision-making board. We do not think it is in the best interests of Illinois consumers and small businesses to have legislators serve as voting members of the Exchange Board either. For an Exchange to be truly independent, non-partisan, and non-political, it must not have the interests of Legislators on the governing board. Similar boards in Illinois including those that govern the Illinois Commerce Commission and the Illinois Comprehensive Health Insurance Program either have no legislators appointed or have legislators appointed as *non-voting* members along with those appointed from the Executive Branch including the Governor's Office, the Attorney General and State Agencies.

The report states that the potential board composition includes 19 members who are appointed by certain leaders or who fit a specific constituency. What is missing, however, from the requirements is someone with specific knowledge of the uninsured in Illinois. The

Deloitte report indicates that most of the uninsured in Illinois are low-income. In addition, the report states that among the largest racial groups in Illinois, Hispanics have the highest uninsured rate (27%), with African Americans second (23%), while white Non-Hispanics have the lowest uninsured rate (13%). As a result, **the Exchange Board should have representation from minority communities – who are overrepresented in the uninsured.**

In addition, a primary goal of the Affordable Care Act is to provide a route to insurance for people who are low income and people with chronic illnesses/pre-existing conditions. **The Exchange Board should have representation of organizations who are familiar with the needs of people with disabilities/chronic illnesses as well as low income populations – many of whom have not had prior experience with the private insurance market.**

Navigator Program (Page 12/16): We applaud your recognition of the various ways that a Navigator system can work in Illinois, including "boots on the ground" such as All Kids agents and use of mass marketing. We believe that the report should explicitly state that navigators do not necessarily need to be licensed as insurance brokers in Illinois. We would recommend that the report specifically state that navigators could be benefits experts from community based organizations. The comments on financing the exchange (Page 16) also seem to assume that one of the financing strategies could be to assess a licensing fee on navigators. This financing tool would not be viable for community based organizations that generally serve a low income population with case managers and social workers familiar with the unique needs of low income and special needs populations, and are not licensed as insurance brokers.

Financing (Page 15-16): We agree with the finding that budget-strapped states, such as Illinois, should optimize the flow of federal funds coming into the state. We agree with the HMA/Wakely report (referenced on Pg. 15) that the state should leverage its Medicaid program to finance the Exchange administration– so by including Medicaid plans and providers, the state would be bringing in more federal dollars to support the Health Benefits Exchange. We do not believe that levying an assessment on providers is a fair or viable option in Illinois, where Medicaid provider rates are lower than most. We also do not believe that levying an assessment on consumers is a fair or viable option since a large majority of those who will be purchasing insurance through the exchange will have incomes below 400% of the Federal Poverty Level and be eligible for a subsidy.

HDA would welcome the opportunity to work with the Illinois Health Benefits Exchange Legislative Study Committee in the implementation of the provisions of the Affordable Care Act in Illinois. If you have any questions, please feel free to contact Stephanie Altman saltman@hdadvocates.org or Stephani Becker sbecker@hdadvocates.org. Also, please see www.illinoishealthmatters.org for information on health care reform implementation in Illinois.

Planned Parenthood®
of Illinois

DATE: October 5, 2011

TO: Members of the Illinois Legislative Health Insurance Exchange Commission,

FROM: Pamela A. Sutherland
Vice President of Public Policy

RE: Draft Findings of the Commission

Planned Parenthood of Illinois appreciates the time you have spent considering the issues related to the development of a Health Insurance Exchange in Illinois. I have reviewed the Draft Findings of the Commission and have a few comments and concerns.

- Pages 6-7: The Illinois Exchange must have the authority to act in the best interest of consumers – both individuals and small businesses – who will be purchasing its insurance products. This means that the Exchange must be given the power to bargain for the best rates for the best value. The Exchange must be provided the mandate to set robust standards for the value required of insurance products and to review and negotiate rates for those products. Although having this authority may require increased complexity, in the end, the Exchange will be a more viable marketplace because it will have greater appeal to consumers.

- Page 7: Another very important issue regarding the structure of the Exchange is its size. PPIL believes that the Exchange will be stronger and more sustainable if it has a large risk pool that includes both individuals and small businesses. A larger risk pool will help avoid the pitfalls of adverse selection. In addition, we urge the Commission and the General Assembly to provide legislative authority to expand the small business definition to include businesses with up to 100 employees.

- Page 9: We request clarification of Goal # 7, "The authorizing legislation to create an Exchange in Illinois 'should not require the Exchange to certify all plans meeting federal requirements'." We have heard various interpretations of this Goal. Again, we urge the Commission to support an Exchange that has the power to choose which plans meet solid standards rather than accept all plans that meet the minimum requirements set forth in federal law.

- Page 9-10: As we stated in our previously submitted written testimony, PPIL supports a quasi-governmental organization for the Exchange structure. We believe it is very important that the governing board of the Exchange avoid any hint of political influence or conflict of interest. The members of the board should represent those who will be served by the Exchange – the consumers. The members should reflect the geographic, ethnic, and economic diversity of Illinois. Also, there should be members of the board who have particular expertise in the area of insurance and the provision of health care,

Springfield Office
1000 E. Washington Street
Springfield, IL 62703
T: 217.522.6776
F: 217.522.7055
www.ppil.org

particularly for underserved populations. Finally, during the first years of the Exchange, the work of the board is likely to be quite time consuming, and certain decisions cannot be delayed. Therefore, we urge the Commission to support the appointment of board members who have the necessary knowledge, background, and diversity.

- Page 10: We applaud the Draft Findings for recognizing the inherent conflicts in having individuals from the insurance industry serve on the governing board. We have a particular concern with any elected officials serving on the governing board as voting members. We do not know of any similar governing board in Illinois that has members who are elected officials with the authority to vote. The CHIP Board does have legislators who serve on it, but they do not vote. While we recognize the interest the General Assembly has in ensuring that the Exchange is run effectively, if elected officials serve as voting members, there is a heightened risk for conflict of interest if they accept contributions from any entities related to the insurance industry or even small businesses that purchase from the Exchange. In addition, the legislators may not have the time or expertise necessary to bring to the roll of voting board members.

- Page 12: We urge the Commission to support a Navigator Program that addresses the needs of Illinoisans who have been medically underserved, chronically uninsured, historically hard to reach, and uneducated about the insurance marketplace. The Navigator Program must include community organizations and medical providers who have experience working with low income populations with cultural and linguistic competence. To avoid the risk of adverse selection, the Navigator Program must ensure that there are no incentives or disincentives built in which would encourage navigators to steer consumers away from the products sold within the Exchange.

- Pages 13-14: PPIL believes that the Illinois Exchange should be more than just an "Expedia" for insurance coverage. As stated above, the products sold within the Exchange should do more than simply meet the minimum standards set forth by federal law. The Exchange must require quality and value from the insurance products sold under its auspices. In addition, there should be a variety of products to allow for adequate choice and competition. Therefore, we ask the Commission to support an Exchange that has strong standards for certifying "Qualified Health Plans".

- Page 13: Because PPIL primarily provides medical services to low-income women, we believe that the Illinois Exchange should provide some flexibility in enrollment periods for pregnant women so that they do not go without necessary prenatal and childbirth services.

- Page 14: PPIL truly appreciates the opportunities to provide input that have been afforded to us. We believe that the Illinois Exchange should continue to seek input and feedback from a variety of stakeholders. The Exchange should have advisory committees that represent each of them – consumers, medical providers, businesses, insurance companies, and community organizations serving at risk and underserved populations.

- Pages 14-16: When it comes to financing the Exchange, PPIL believes the best option is to apply an assessment on insurance company revenue. We believe this is logical and fair since insurance companies will benefit financially from the creation of this new marketplace. Some fees could be collected from the Medicaid Program for the administrative work around determining eligibility. However, we do not believe that these fees alone can sustain the Exchange. We oppose fees or assessments on medical providers, navigators, or consumers. In addition, we oppose the use of General Revenue Funds.

Please contact me if you have any questions or need additional information.

March of Dimes Foundation

Illinois Chapter
Greater Chicago Division
111 W. Jackson Blvd., Suite 2200
Chicago, IL 60604
Telephone (312) 435-4007
Fax (312) 435-0988
nskertich@marchofdimes.com

marchofdimes.com

Lisa Cheers
State Director

October 5, 2011

Illinois Health Exchange Commission

On behalf of the thousands of volunteers of the March of Dimes Illinois Chapter, I am writing to provide comments to the Illinois Health Benefits Exchange Legislative Study Commission in regards to the development of the state's Health Insurance Exchange.

The March of Dimes is a national voluntary health agency founded in 1938 by President Franklin D. Roosevelt to support research and services related to polio. Today, the Foundation works to improve the health of women, infants and children by preventing birth defects, premature birth and infant mortality through research, community services, education and advocacy. The March of Dimes is a unique partnership of scientists, clinicians, parents, members of the business community and other volunteers affiliated with 51 chapters and 213 divisions in every state, the District of Columbia and Puerto Rico. The March of Dimes appreciates the work of the Health Insurance Exchange Commission and the opportunity to provide recommendations to further strengthen the Exchange to ensure comprehensive, affordable, health insurance for women and children.

It has been a long-standing March of Dimes position that every woman of childbearing age, infant and child should have access to comprehensive affordable health insurance. According to the Institute of Medicine (IOM), health insurance status is the most important factor in determining whether a child receives health services when they are needed. In addition, the IOM has also found that health insurance plays a key role in access to maternity care for pregnant women. A Health Insurance Exchange is one important tool that can help address the health insurance needs of women of child bearing age, infants and children.

As Illinois moves forward to implement Senate Bill 1555/Public Act 97--142, the March of Dimes urges state officials to make certain the Exchange provides women and children with access to quality and affordable health care coverage. As such, the March of Dimes requests that the issues listed below be addressed as the Exchange is being established.

Governance Structure

The Exchange board and stakeholder groups should include individuals who represent the interests of pregnant women, children, and infants. The governing board should include members who represent consumer interests and have relevant healthcare experience. To fulfill the obligation, the Exchange should be required to include individuals with maternal and child health expertise on the board. Furthermore, every effort should be made to include maternal and child health organizations in the list of consulted stakeholder organizations. Given the unique and often complex insurance needs of pregnant women, infants, and children—especially those with chronic medical conditions—presence both on the Board as well as in the stakeholder community will ensure their perspectives are being represented.

Plan benefits and network adequacy
All health benefit plans within the Exchange should include maternity and newborn care, preventive and wellness services, and pediatric services, including care for children with special health care needs such as birth defects and premature birth. Materials regarding health plan options should clearly identify items pertinent to women of child bearing age, infants, and children (e.g. family planning, maternity care, pediatric benefits, and dependent coverage), to be included on the Exchange.

Provider networks must include sufficient access to women's health providers and pediatric providers. All plans should specifically be required to maintain an adequate supply of available obstetric and gynecological providers, as well as pediatric providers who care for children with special health care needs. In the absence of available in-network providers, patients should be permitted to obtain covered benefits from out-of-network providers at no additional cost.

Streamlined application process
The Exchange should include a streamlined application process to facilitate maximal and timely coverage for pregnant women, infants, and children. We recommend a short and simple application that determines eligibility to ease the paperwork burden and confusion for families. We also recommend families have a variety of enrollment options available to them, including online, by mail, by telephone, in person at Exchange offices, and in locations already relied upon by intended audiences. For example, in seeking to reach pregnant women and new mothers, the Exchange should partner with and utilize schools and the local offices of WIC, obstetrician-gynecologists, and pediatricians.

Special enrollment periods and eligibility
Pregnancy should trigger a special enrollment period to permit women enrolled in catastrophic plans to switch to more comprehensive coverage that includes maternity care. The March of Dimes strongly urges that pregnancy be added as a 'qualifying life event' that triggers the option for enrollees to change their insurance coverage outside the open enrollment period without any barriers such as waiting periods, affiliation periods, or any other obstacle. Given that 50 percent of pregnancies are unplanned,[1] this policy is a critical safeguard for many women. Comprehensive and timely prenatal care helps ensure women have access to essential screening and diagnostic tests; services to manage developing and existing problems; and education, counseling, and referral to reduce risky behaviors. Such care may thus improve the health of both mothers and infants. Singleton infants born to mothers who received late or no prenatal care in 2004 were nearly twice as likely to be low birthweight. Low birthweight accounts for 10 percent of all healthcare costs for children.[2] Postpartum care has been shown to help women appropriately space pregnancies, reducing the risk of preterm birth which, according to the Institute of Medicine, accounted for more than $26 billion dollars in medical, educational, and lost productivity costs in 2005 alone.[3]

Catastrophic plans are not required to cover any essential benefits, including maternity care, until the covered individual or family satisfies a high deductible ($5,950 a year for an individual; $11,900 a year for a family). In order to encourage early prenatal care and prevent prematurity, low-weight births, and other adverse birth

[1] Statistics on unplanned pregnancies comes from National Survey of Family Growth (NSFG), a periodic survey of women aged 15-44 conducted by the National Center for Health Statistics.
[2] EM Lewitt, LS Baker, H Corman and PH Shiono, "The Direct Cost of Low Birth Weight, " *Future Child,* 1995, (5) 1:35-56.
[3] Institute of Medicine, *Preterm Birth: Causes, Consequences, and Prevention,* National Academies Press: Washington, DC, 2006.

outcomes, designating pregnancy as an "exceptional circumstance," would allow pregnant women in catastrophic plans to elect a plan that offers maternity care.

Coordination with Medicaid and CHIP

The Exchange should coordinate closely with Medicaid and CHIP. For families with income fluctuations, the type of health insurance coverage they qualify for could change within a given year. A sudden increase in income, for instance, could cause women or their children to lose eligibility for Medicaid while becoming eligible for premium subsidies through the Exchanges. Coordination between the Exchanges and Medicaid/CHIP is crucial to ensure a seamless transition without loss of coverage or access to services. Similarly, many families have mixed eligibility status, in which a parent qualifies for subsidies, an infant is eligible for Medicaid, and an older child qualifies for CHIP. Eligibility workers must be familiar with all coverage options to assist families, and additional information and assistance should be easily accessible for families with mixed eligibility status.

Additionally, the March of Dimes recommends that private plans offering coverage in Medicaid and CHIP be permitted to also supply commercial coverage through the Exchange. Such provisions would allow women and children whose eligibility status may change from Medicaid to Exchange coverage (or vice versa) through the course of a year to stay with the same plan and provider network. Maintaining care with the same provider minimizes gaps in access to needed services and provides the continuity of care important for a child's healthy development.

On behalf of the Illinois Chapter of the March of Dimes, we appreciate the opportunity to provide comments, and thank you for your efforts to develop an Exchange that includes meaningful improvements in health coverage and care for women of childbearing age, infants and children.

Sincerely,

Susan Knight
State Director
Program Services and Public Affairs

Shelly Musser
Associate Director
Program Services and Public Affairs

Campaign for Better Health Care

The Voice of Illinois Consumers

Central/Statewide
44 East Main St., Suite 414
Champaign, IL 61820-3642
(v) 217/352-5600
(f) 217/352-5688
e-mail: cbhc-cu@cbhconline.org

Chicago
1325 S. Wabash , Suite 305
Chicago, IL 60605-2504
(v) 312/913-9449
(f) 312/913-9559
e-mail: cbhc-chi@cbhconline.org

Helplines
1-888-511-0290
(Children's Health)
1-888-544-8271
(Medicare & Uninsured)
Website: www.cbhconline.org

TO: Members of the Legislative Committee
FR: Campaign for Better Health Care
RE: Our assessment of the initial findings

A) Governing Board:
- Agree that the insurance industry, brokers, and agents will not directly be on the decision-making board.
- We believe that legislators should not be appointed to this board. If they are appointed that must be non-voting members.
- Agree that the four ex officio members (Department of Insurance, Healthcare and Family Service, Human Services, and Public Health) are non-voting members.
- Agree that the Attorney General's appointees are voting members.
- The five appointees by the Governor are inadequate and not geographic and culturally diverse. This new Marketplace is designed to help small businesses and individuals. This board must be represented by a variety of consumers, small businesses and other stakeholders, such as:

13 voting members:
- 2 small businesses (one Chicagoland and one downstate)
- 3 organizations representing communities of color
- 1 representing disability community
- 1 organized labor
- 1 women's organization
- 2 consumer reps (Chicagoland and downstate)
- 1 health actuary
- 1 health economist
- 1 rural based organization

- Total voting members of the board would be 15.

B) Market developer NOT a market organizer:
- The Marketplace (exchange) should be able to leverage the power of over one million individuals who will be in the exchange by negotiating rates with the insurance industry. This leverage will stabilize costs for small businesses and individuals, increase efficiencies, and produce greater quality accountability.

C) Financing /Sustainability:
- We oppose any fees being levied on consumers within the exchange or a user fee on all

Illinoisans. Estimated yearly costs are between $57 and $89 million.
- There should be a progressive surtax on the insurance industry's revenues. The higher the percent of reserves that insurance companies have, the higher the surtax. Leading health insurers have accumulated a combined 2010 surplus of **$28,353,715,566**, even while individuals and families in Illinois have paid a cumulative average rate increase of **181.8%** since 2005. Due to the current economic situation, hundreds of thousands of Illinoisans have lost their health insurance and those with insurance are facing double-digit rate increases. While, at the same time the insurance industry's reserves increased by more than $2 billion in just 2010 over 2009 figures.

D) Where to location the new Marketplace:
- Quasi-Governmental entity and no other entity usurping their authority.

E). Number of Pools:
- There should be one pool to be able to maximize the overall efficiency, have larger bargaining abilities, and thus lower costs to small businesses and individuals

F) Overturn specific language in SB 1555
- Section 5.5: This section prohibits small businesses with employees from 50 to 99 from joining the new marketplace. The ACA allows states that have small businesses with 50 to 99 to join the marketplace. This needs to be repealed by allowing all small businesses with less then 100 employees to be part of this new marketplace.

Summary of Notable Points from Stakeholder Comments

1. Almost all groups submitting comments have spoken out against legislators either being members of an Exchange governing board or having voting power. It has been suggested by some groups that any legislators who are appointed to the governing board be ex-officio members. This would be similar to CHIP.

2. Most groups have also expressed concern about the role of Navigators in the Exchange and mentioning them in the report. As the federal regulations are still coming out and being reviewed before final distribution, the role of navigators and their qualifications are still somewhat unclear.

3. Most groups have expressed their preference that the Exchange should be a Quasi-Governmental entity.

4. Heartland Alliance for Human Needs & Human Rights
   - The Governing Board should include at least one person who qualifies for Medicaid under current/expanded Medicaid Eligibility rules and one person from a community-based provider that serves individuals living under 200% of FPL
   - The study committee should provide details as to who qualifies to be a Navigator and ensure that it is inclusive of a diverse population.
   - The navigator program should target hard-to-reach/vulnerable people and the navigators should be compensated following the Application Agent model IHFS used for KidCare.
   - The Exchange should not be funded from GRF, but instead from either: a surtax on insurance industry revenues, an assessment on insurers in/out of Exchange to avoid participation disincentive(Illinois Maternal & Child Health Coalition suggest same thing), and eliminate costs by including the state Medicaid program as part of the Exchange.

5. Phil Lackman/IIA of IL/NAIFA IL/ISAHU
   - Wants more mention of other stakeholders' suggestions (Already incorporated into report)

6. United Food and Commercial Workers
   - Want to see discussion of enrollment options for part-time employees (the federal regulations are still be worked out and finalized).
   - They ask that the report review an assessment on employers who do not provide insurance meeting ACA standards for part-time employees.
   - They also mention the ability to reduce adverse selection by having insurance companies provide similar plans in/out of the Exchange.
   - Need safeguards/liability rules over role of Navigators (general concern) (topic for future hearings?)

7. Illinois Maternal & Child Health Coalition
   - Want community-based provide with outreach experience with people living below 200% of FPL and at least three community of color individuals to serve on the Exchange board
   - The Exchange should be a market developer.
   - Private plans in/outside the Exchange should share in Exchange operational costs.
   - Navigator program should include All Kids Application Agent network.

8. AARP –
   - Concentrate decisions on what is best for consumers and have consumer representation on board.

- Develop rules to ensure no inappropriate incentives for brokers/agents to steer people from the Exchange, and to deal with conflicts of interest, etc.
- Need to develop rules for Navigator oversight, licensure, monitoring and rule enforcement.

9. Shriver Center
   - Want Exchange enacting legislation during 2011 veto session.
   - Governing board members should be free from conflicts of interest, which must be clearly defined.
   - Anyone with any role in or relation to insurance industry is conflicted.
   - Governing board representatives should be at least partly composed of consumer/small business interests, while board as a whole must have technical expertise (including health benefits administration, health care finance, etc.)
   - Would like the board to have representatives from minority/uninsured communities.
   - Prefers assessments/user fees on issuers to fund Exchange operations.
   - They would also like the report to discuss the possibilities of navigators being benefits experts from community based organizations. Also, navigators should have competency in the Exchange, Medicaid, CHIP, etc. and should not be required to be licensed as brokers

10. Illinois Academy of Family Physicians
    - Would prefer representation on the board from primary care physicians and consumers.
    - Should not assess providers for financing the Exchange.
    - Any plan that meets Federal minimum requirements to be in the Exchange should also have to meet Illinois-specific requirements.

11. Illinois Chamber of Commerce, et al.
    - Want report to list clear timeline/legislative action suggestions.
    - They also want citation from all groups supporting points suggested in report (difficult to do with so many groups without clogging up report).
    - Suggest that the report acknowledge the goal of the ACA in reducing the number of uninsured/underinsured in Illinois.
    - Suggest that the section in the introduction on SB1555 be moved up to top of report to list committee/statutory requirements.
    - The report should define a health benefits Exchange as defined by the HHS 2010 definition: "An Exchange is a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality."
    - Would like notation that the Exchange under SB 1555 is limited to employers with no more than 50 employees and that the 100 employee benchmark does not start until 2016.
    - Suggest changes in wording for the sections of the Wakely report to make it more "agnostic" and less suggestive of their points as the committee's preferred ideas (and would like Wakely's section about projected costs to note that the costs are based off of their assumptions about operational decisions).
    - In addition to these concerns, they also have an issue with the wording and inclusion of the market developer model, and would seek a more "agnostic" treatment of the discussion of the differences between Utah and Massachusetts.
    - Would like some changes to the Governance and Structure section to eliminate possible confusion with consumers being able to name their own price for insurance. This would be replaced by language comparing the online Exchange to travel sites such as Expedia.

- They have numerous concerns with the "key points of interest" section, including how competitiveness is to be derived, how products are made available and value is determined, wording of certain points, etc. (may be changed based on Dept. of Insurance concerns)
- Also have issues with the inclusion of the possible board composition and suggest eliminating this section. Also noted is the potential conflict of interest for union and other non-industry related groups who may have significant issues with certain Exchange actions.
- Suggest including Colorado and other state approaches to include members of insurance community on governance boards.
- Want to see more information from other sources in the Navigator section, specifically concerning certification and training requirements.
- Would like to see the "Duties of the Exchange" section note that enrollment periods/essential health benefits/etc. have not yet been finalized by the federal government.
- Want to see mention of lack of Illinois legislation accounting for shift in eligibility from 50 to 100 employee businesses by 2016 (future role of committee/legislation?).
- They also note that the possibility of an insurer assessment fee is already used to help subsidize the state HIPAA-CHIP pool and is not mentioned in the report and would like more clear language when discussing claims transaction fees.
- Would like report to mention the inability of the state to use federal funds for the Navigator program. ___/___
- They want a section about the severability of Exchange in the face of federal lawsuits.(At end?)

12. Health and Disability Advocates
    - The exchange should have mandate to ensure best possible rates for consumers
    - All plans in exchange should meet Illinois-specific requirements in addition to Federal ones.
    - Representatives for uninsured should be on governing board.
    - Navigators should not have to be licensed insurance brokers or pay a licensing fee.
    - Exchange should not have a provider fee.

13. Illinois Public Interest Research Group
    - The Exchange should have a pro-consumer/small business mission and show transparency in budgets and records.
    - Prefer an assessment on all health plans for financing the Exchange and no GRF used.

14. Planned Parenthood
    - The Exchange should have power to bargain/review insurance rates.
    - The legislature needs to expand the small business definition to 100 employees.
    - Exchange should certify plans that meet "solid standards" instead of plans that make only Federal minimum requirements.
    - A navigator program must ensure that no incentives exist to steer people away from Exchange products.
    - The Exchange should have strong standards for Qualified Health Plans and advisory committees from a variety of stakeholders.
    - The Exchange should be financed on an assessment of insurance company revenue.

15. AIDS Foundation of Chicago
    - Stakeholders should include HIV/AIDS providers, etc. At least three people from communities of color should be on the governing board.
    - Insurance carriers should pay for the Exchange through plans in/outside the Exchange.
    - Navigators must be trained to reach hard-to-reach people in a culturally/language competent manner and receive no compensation for enrolling people in plans outside the Exchange.
    - The Exchange should have a specific goal to be consumer friendly and easy to understand.

16. March of Dimes
    - Governing board should include representatives of pregnant women/children/infants, people with consumer interest experience and healthcare experience, individuals with maternal/child health expertise
    - All benefit plans in the Exchange should include maternity/newborn care, etc., and provider networks must have sufficient access to women's health providers, etc. (already in report, but we can expand)
    - The Exchange should have a streamlined application process for pregnant women/infants/children.
    - Enrollment should be available by mail, phone, online, in person and at events.
    - Pregnancy should trigger a special enrollment period for women in catastrophic plans to switch to more comprehensive plans (as a qualifying life event).
    - Exchange should coordinate with Medicaid and CHIP
    - Private plans offering coverage in Medicaid and CHIP should be allowed to supply commercial coverage through the Exchange to foster continuity of care.

_____ - points to add to report _____ - unable to add to report _____ - future report topic

All of these groups have other suggestions that have either been accounted for already, are not applicable (due to limited federal guidelines available at this point), or are suggestive of board membership/etc. that directly represents their interest group.