

Office of Consumer Information and Insurance Oversight

**State Planning and Establishment Grants for the
Affordable Care Act's Exchanges**

State of Illinois – Quarter 2 Report

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State: Illinois

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Project Summary

In the Second Quarter, the State made substantial progress toward evaluating the establishment of an “American Health Benefits Exchange” (“Exchange”) in Illinois, as envisioned in the Affordable Care Act (ACA). In a report issued to Governor Quinn on February 1, 2011, the Illinois Health Reform Implementation Council recommended that Illinois establish an Exchange. The State executed two separate requests for proposals (RFPs) to obtain consulting services in order to acquire the necessary information to evaluate options for the establishment of an Illinois Exchange. The first RFP, awarded to Deloitte LLP, seeks background information about the current state of health coverage in Illinois. The second, awarded to Health Management Associates (HMA) in partnership with Wakely Consulting Group and CSG Government Solutions, will determine the costs, staffing implications, and infrastructure needs associated with an Exchange and assess options for the State to transition its existing public health program eligibility, verification, and enrollment systems to the level of functionality required under the ACA.

The Illinois Department of Insurance (“Department”), in coordination with the Department of Healthcare and Family Services (HFS) and other key departments and agencies, has continued its active engagement of stakeholder groups throughout the process of drafting Exchange legislation. This includes hosting regular meetings with consumer groups, providers, employers, carriers, and producers, and conducting educational webinars on the Exchange and other ACA-related topics. Based on the recommendations received during these discussions and informed by the Governor’s Council Report, the Department developed legislation (Senate Amendment 001 to SB 1729—see *Appendix A*) to establish an Exchange meeting all ACA requirements. SB 1729 and other Exchange legislation are still in the process of consideration during the ongoing spring legislative session. In the coming months, the State will continue to work closely with stakeholder groups to ensure that the State obtains the necessary authority to create an Exchange.

Core Areas

- *Background Research*

On December 9, 2010, the State issued a Request for Proposals (RFP) entitled *Background Research in Support of a Health Benefits Exchange in Illinois* (RFP# 11-57312). In this RFP, the State sought assistance with the research and development of a comprehensive report detailing the current state of health insurance coverage in Illinois and the existing health insurance marketplace. The research and subsequent report will include an analysis of Illinois’s uninsured, underinsured and insured populations, an assessment of the affordability of coverage statewide and an overview of the State’s private health insurance marketplace. Bids for this RFP were due to the State by January 25, 2011. On March 10, 2011, the State selected Deloitte LLP as its vendor to conduct the research and provide a comprehensive report. The State is currently in the process of negotiating a final contract with Deloitte, and intends to launch work on the project shortly after an agreement is reached.

The State has also worked to compile existing data sources for Deloitte to access when a final contract is executed. This compilation includes data related to Medicaid, the State Children’s Health Insurance Program, the existing State high-risk pool (Illinois Comprehensive Health Insurance Program, I-CHIP), and insurance market information. Specifically, Deloitte has requested information as part of their

proposal on the number of carriers and historical rate of carrier entry, as well as information about number of producers operating in the state and their compensation structures. Obviously, HMA is also in need of this information to help inform their calculations of the impact of an Exchange in Illinois' existing marketplace. Given the limited reporting requirements for health insurance carriers prior to the enactment of the ACA, the Department is drafting a data call (or series of data calls) to carriers for additional information not available or easily accessible. The Department intends to finalize the details of a potential data call or survey the last week in April, and continue to work with Deloitte and HMA to ensure it meets their needs.

Once the Background Research project is launched, the State will establish a structure for appropriately delivering necessary information from this project to HMA to ensure that all associated vendors can provide interim estimates on the impact of the Exchange to the State on a timely basis.

- *Stakeholder Involvement*

The State continues to conduct a diverse array of activities to engage all stakeholders throughout Illinois on the issue of health reform, the impact of the ACA, and the development of a state-level Exchange.

To ensure effective implementation of the ACA in Illinois, the Governor established the Health Care Reform Implementation Council (“Council”), a panel consisting of top-level representatives from eight separate government agencies and the Governor’s Office. After conducting a series of public meetings throughout the state during the First Quarter—including one convened exclusively to discuss the establishment of an Exchange—and soliciting public comments through its website—<http://healthreform.illinois.gov>—the Council issued its final report to the Governor on February 1, 2011 (Health Care Reform Implementation Council: Initial Recommendations—see *Appendix B*). Among other things, the report made several recommendations on the establishment of an Exchange, including general recommendations about governance structure, operational structure, risk pooling, financing, and the general approach the State should take to adopting an integrated eligibility verification and enrollment system for individuals eligible for public health care coverage and premium and cost-sharing assistance. On February 7, 2011, the Council held a public meeting to discuss its findings and solicit comments from stakeholders and interested Illinoisans.

Throughout the Second Quarter, the Department met with representatives from five different stakeholder groups—consumer and patient advocates, providers, employers, carriers, and producers—in order to draw upon their expertise and solicit their opinions as the Department developed legislation to establish an Exchange in Illinois. The working groups met separately five times throughout the quarter to discuss and highlight points of consensus and points on contention on the following issues: Exchange governance, financial sustainability, Exchange operating model, and draft legislation. On March 8, 2011, the Department held a final meeting to make adjustments to draft legislative language, to which representatives from all stakeholder groups were invited. Input from these groups was helpful and influential in the development of the legislation submitted to the General Assembly (Senate Amendment 001 to SB 1729—see *Appendix A*).

In addition, the State has continued its series of educational webinars on topics related to health care reform, including the establishment of an Exchange. Director Michael McRaith conducted two Exchange-related webinars during the Second Quarter. The first, entitled *Exchange Governance and*

Long-Term Sustainability (PowerPoint attached – see *Appendix C*), occurred on January 24 and included 88 live participants. The next webinar, entitled *Exchange Operating Model* (PowerPoint attached – see *Appendix D*), was presented on February 17, 2011, and focused on issues such as the “active purchaser” vs. “market organizer” debate. 60 participants viewed the live webinar. Since the series began, the webinar page has attracted 6,806 views from 2,295 unique viewers. The Department has also hosted webinars related to premium rate increases in Illinois as well as medical loss ratio provisions contained in the ACA, and intends to offer additional presentations in the future regarding other ACA-related topics.

- *Program Integration*

Since the beginning of the Second Quarter, officials from across State government have continued to work in close cooperation to successfully integrate the different public health care programs, as mandated by the ACA. As noted in the State’s First Quarterly Report, lead staff on the Exchange from the Department and HFS, which houses the Medicaid and CHIP programs, jointly convened an intergovernmental working group to address Eligibility, Verification and Enrollment (EVE) determinations and processes across all relevant State departments and agencies as it relates specifically to an Exchange in Illinois. This group includes representatives from the Governor’s office and the Department of Human Services (DHS). Subject matter experts on various aspects of Insurance, Medicaid, CHIP and other public health programs—including policy, operations and information technology—are part of this group, as is the lead staff for the Frameworks project -- an ongoing State effort to integrate and update information systems for all health care and human service programs across seven State agencies. One of several EVE-related recommendations included in the Governor’s Council report was to maintain this working group going forward, and continue to pursue an EVE option that maintains as much of the States’ existing goals for integrated and coordinated public programs as possible.

The ACA EVE group met five times throughout the Second Quarter. After jointly crafting the EVE section of the Needs Assessment RFP, the group nominated several representatives to participate in the team that evaluated submitted proposals. On March 9, 2011, following careful and extensive consideration, the State posted notice of award for the Needs Assessment proposal submitted by a Health Management Associates (HMA), which includes contractual partnerships with Wakely Consulting Group and CSG Government Solutions. On April 4, 2011, representatives from the Department and HFS met with managers from the three vendors to launch the Needs Assessment project in Chicago. Staff leads at the respective Departments met with the vendors for the first several hours to discuss project launch goals, process, and the timeline for deliverables. At the conclusion of those meetings, a second meeting was conducted to introduce the project and consultant leads to the Governor’s health and IT senior staff, as well as the Department and Agency heads from the Departments of Insurance, Healthcare and Family Services, Public Health, Human Services and Office of Health Information Technology. In the coming months, State officials will continue to work with the consulting team in order to ensure the Needs Assessment, scheduled to conclude at the end of July, produces actionable recommendations for a strategic plan for Exchange establishment and public health program integration with the Exchange.

Finally, the Office of the Governor, the Department of Insurance, and the Department of Healthcare and Family Services executed an intergovernmental agreement on February 22, 2011. This agreement

permits the Department to work collaboratively and provide Exchange grant funding to the Office of the Governor and HFS as needed for the purposes of planning for the establishment of an Exchange in Illinois.

- *Resources & Capabilities*

As mentioned under the “*Background Research*” section, on March 10, 2011, the State selected Deloitte to provide the State with the consulting services necessary to craft a comprehensive background research report detailing the current state of health insurance coverage in Illinois. The State has experienced some delays in launching this project, due to delays associated with the procurement process and contract negotiations. The State is currently in the process of negotiating a final contract with Deloitte, and intends to launch work on the project shortly after an agreement is reached.

Per above, the State selected HMA, Wakely Consulting Group, and CSG Government Solutions to provide consulting assistance in planning the implementation of an Exchange. The contract divides the task of evaluating the State’s options for developing one or several Exchanges into two major components.

- *Exchange Organizational and Impact Assessment.* HMA and Wakely will help the State evaluate design options for the Illinois implementation of one or several Exchanges, taking into account the business operations, statutory requirements, and costs associated with various options and the accompanying consumer protections.
- *EVE System.* HMA and CSG will help the State develop an eligibility, verification and enrollment system (EVE) that will comply with the requirements of the ACA to appropriately enroll people in either the Exchange or Medicaid in a connected and transparent manner, while requesting the smallest amount of necessary information.

One of the primary goals of this contract is to assist the State in identifying the necessary resources and capabilities required to establish and maintain an Exchange. This includes an analysis of the cost and staffing implications of these responsibilities, both directly associated with the Exchange as well as any Exchange-related effect on existing State departments or agencies (such as Medicaid and the Department of Insurance). State officials met with the consultants to launch the project on April 4, 2011, and throughout the contract period will be participating in twice-weekly calls and working to provide any information necessary for its execution. A mid-term project report is due at the end of May, with final recommendations scheduled to be delivered in late July.

The State also identified and extended offers to two additional staff to fill the research assistant positions under the Exchange grant during the Second Quarter. These individuals are Max Fletcher for the Department and Megan Moore for HFS (Resumes attached – *See Appendix E*). These individuals began work in a contract capacity in the first half of February.

- *Governance*

As noted under the “*Stakeholder Engagement*” section, the State has solicited and received extensive feedback from diverse groups of stakeholders on an appropriate governance structure for an Exchange in

Illinois, and it will continue to do so throughout the process. The Governor's Council report was the first public document to include key recommendations for the governance structure of the Exchange in Illinois. The Department used these recommendations as a starting point for more detailed discussions. The open stakeholder working group meetings convened by the Department of Insurance sought specific feedback on targeted aspects of Exchange governance, including governance structure, a governing board, the number of members, the make-up and balance of the board, and conflict of interest rules associated with Exchange staff and board members. Based on stakeholder feedback, as well as the recommendations included in the Illinois Health Reform Implementation Council's report to the Governor, the State has drafted legislation to authorize the establishment of an Exchange (Amendment 001 to SB 1729).

This draft legislation establishes the Exchange as a quasi-governmental entity with a governing board. The governing and administrative powers are vested in a nine-member Exchange Board (the Board), with seven members appointed by the Governor and two members appointed by the Attorney General, with the advice and consent of the State Senate. The Gubernatorial appointees represented on the Board are required to include the following as members: a consumer of health insurance from the state's individual marketplace; an individual with experience operating a small business in the state; an employee of a small business; a licensed Illinois insurance producer; a certified health actuary; a state-licensed health care provider with experience serving underserved populations in both the community-based health care setting and a hospital-based setting in Illinois. Of the two Board members appointed by the Attorney General, one must be a health lawyer with experience in public programs or private health insurance coverage and the other a health lawyer with experience working in collaboration with the Attorney General's Health Care Bureau. In addition, the Director of the Illinois Department of Insurance, the Director of the Illinois Department of Healthcare and Family Services, the Director of the Illinois Department of Public Health, and four Members of the Illinois General Assembly will serve as non-voting, *ex-officio* members of the Board. The Board is to elect a Chair from its membership and is required to appoint an Executive Director to act as chief executive officer of the Exchange. The Department's legislation was introduced by Senator David Koehler (D-46th District) as an amendment to a shell bill on March 17 and currently has 18 co-sponsors in the Senate.

Alternative Exchange legislation was also introduced by Representative Frank Mautino (HB 1577) and Senator William Haine (SB 1549). These bills do not establish a formal governance structure, but rather appoint a Legislative Study Committee to recommend a governance structure to the legislative and executive branches by December 31, 2011. HB 1577 passed in the House and is currently pending in the Illinois Senate.

- *Finance*

During the stakeholder engagement process led by the Department, and in subsequent conversations with members of the Illinois General Assembly, all relevant stakeholders were hesitant to agree on a single definitive self-sustaining financing mechanism for the Illinois Exchange until they understood more clearly exactly what would be the start-up and annual costs of such an entity. As noted in the "*Resources & Capabilities*" section, the work being undertaken by HMA, Wakely, and CSG will help the State define the costs of establishing and maintaining an Exchange as well as provide an analysis of financing options for the State. This work will incorporate a description of the requirements of the federal law as it relates to finance, such as identifying appropriate accounting and auditing standards and

mechanisms for transparency that must be incorporated into the Exchange technical planning process. HMA and Wakely will be taking the lead on the aspects of the report related to financing, and a final product is expected by late July. As the State is currently awaiting recommendations from the Needs Assessment, no specific funding mechanism was included in SB 1729. However, the legislation does require the Exchange to be financed independent of general revenue funds.

- *Technical Infrastructure*

As noted in the “*Program Integration*” section, the State has focused much of its planning on the technical aspects of incorporating the eligibility, verification, and enrollment (EVE) systems for public health care programs necessary to meet the minimum requirements of the ACA. In response to new HHS guidance for states incorporated into the January 21, 2011, funding opportunity announcement, the State is preparing a comprehensive IT Gap Analysis. Assistance from the consultants working on the Needs Assessment will directly inform the IT Gap Analysis in enough time for the State to submit an application to HHS for additional Level I Exchange funding in June. Once completed, the Needs Assessment will provide a significant amount of information to the State about the costs associated with the technical requirements of an Exchange, options for transitioning the existing infrastructure to a system that meets the requirements, and will assist the State in choosing a final option for EVE and moving forward with the technical planning and development.

In addition to the EVE components of the Exchange, the State will also use the Needs Assessment findings to launch the design and development phase for the consumer-facing aspects of the Exchange website, improve private health plan reporting and regulation, and establish the necessary interconnections with federal agencies to enable the Exchange to make eligibility determinations for premium and cost-sharing subsidies.

- *Business Operations*

The State expects the Needs Assessment will provide an in-depth analysis of the required set of business operations and mandatory Exchange functions required under the ACA. HMA and Wakely are responsible for this section of the report. Based on this information, the State will ensure that all requirements are incorporated into the technical planning process. Each ACA requirement that necessitates State action – such as charging an entity with certification, recertification, and decertification of health plans – will be included as a milestone in its evolving planning document.

- *Regulatory or Policy Actions*

After careful study of the issue, including extensive consultation with stakeholder groups noted above, the Department produced draft legislation (Amendment 001 to SB 1729) that was introduced in the Illinois General Assembly on March 17, 2011. As noted under “*Governance*”, the legislation establishes the state’s Exchange as a quasi-governmental entity financed in a manner independent of general revenue funds and provides for the inclusion of a SHOP Exchange under its broader umbrella. It also establishes and defines the duties of an Illinois Health Benefits Exchange Board (the Board), a Technical Advisory Committee, and an Executive Director position and authorizes the appointment of additional staff at the Board’s discretion. The legislation also authorizes the Exchange to carry out all the minimum functions necessary to meet compliance with the standards outlined in the ACA. The only minimum necessary

issue not addressed in this legislation is mechanism for financial sustainability beginning in 2015. As noted in the “*Finance*” section, this is one element of the Exchange planning that stakeholders feel they cannot make a determination on until the final Needs Assessment products provide a better understanding of how much an Exchange will cost to sustain over the long-term.

Barriers, Lessons Learned, and Recommendations to the Program

The State has encountered a few barriers to progress during the second quarter. The issues mentioned in the previous quarterly report associated with the state mandated procurement processes have resulted in some residual delays in our original timeline. Illinois procurement code requires a process that is thorough and extensive, and in being so diligent, has delayed the execution of the Background research contract by a few months. Negotiations with the winning vendor on contract terms and conditions also resulted in some delays, though the State has been able to successfully resolve those issues. Deloitte and the State are in the final stages of negotiating the contract for this work. Lead staff for the Exchange grant learned valuable lessons about reasonable time periods for the full length of the procurement process, even if moved at a faster than average pace. This will greatly inform future planning for procuring services for the Exchange planning and implementation.

Technical Assistance

While HHS has launched some very helpful workshops on IT technical assistance, more opportunities for learning about the expectations of the federal government as it relates to the IT Gap Analysis would be helpful. Posting previous webinars online, including the audio file, in a timelier manner would be incredibly helpful. Additionally, the State would benefit from some additional best practices associated with grants management and future expectations of the federal government for this aspect of the Exchange funding opportunities. Illinois has just launched grants management using Microsoft Project. However, given the breadth of functionality built into this program, it would be helpful to get additional technical assistance on grants management and best practices so Exchange planning staff can hone their skills on what is necessary and most effective.

Draft Exchange Budget

Similar to the first quarterly report, the State is still in the very early stages of planning for an Illinois Exchange. As such, the State is able to provide only limited information regarding its anticipated budget for the next several years. More informed preliminary information regarding the costs associated with the Exchange will be available as part of the preliminary assessment due to the State in May from the consultants procured under the Needs Assessment RFP, and a comprehensive analysis will be due to the State in July. All findings will be incorporated into the final report provided at the conclusion of this grant, in addition to future grant funding requests.

In addition to this narrative, please reference the attached budget spreadsheet (*See Appendix F*) for all four Federal Fiscal Years through FFY 2014.

Background Research: *This category includes research that allows the State to better understand the demographic and market conditions that will shape the Exchange in Illinois.* The State has identified

some very limited needs for additional funding to complete its existing procurement for Background Research. Additional analysis has also been identified as a need in the next federal fiscal year (FFY); including assistance in considering the options for establishing a Basic Health Plan in Illinois, and conducting an employer survey to better understand the desired structure of a SHOP Exchange in the State. Some funding will be required to assist staff in travelling to and from Springfield, Illinois (the State Capitol), in an effort to coordinate these projects. The State does not anticipate any additional background research needs beyond the second quarter of FFY2012.

Stakeholder Involvement: *This category considers the process of working with stakeholders as the State moves forward in the development of the Exchange.* The State is likely to incur additional costs in its efforts to convene stakeholder groups, test concepts (e.g. focus groups to test processes and products), and analyze responses for incorporation into legislation, Exchange planning documents and guidance, and other related action items. These expenses will be primarily a combination of consultants to assist with focus group planning and execution, travel, and other items related to conducting these stakeholder engagement exercises, such as printed materials and advertising. The State is anticipating that at least one additional employee will be necessary at least in following two to three years for coordinating all outreach activities with other insurance and consumer-related activities. Beginning FFY2013, the State assumes the staffing costs are consumed under “Business Operations.”

Program Integration: *This category includes planning and other activities to ensure that as the Exchange develops, it is able to fulfill its obligations to integrate Exchange programs into other programs, such as Medicaid.* In this category, the State is estimating only policy planning and conceptual costs and does not include some of the larger business integration items. The State anticipates the need for additional consulting assistance to examine eligibility, verification, and enrollment issues as well as potential adverse selection issues, and a modest increase in staffing; however, the bulk of these expenses will be incurred in federal support for other projects, and allocated appropriately as such.

Resources and Capabilities: *This category estimates costs related to detailing the resources and needs that will be required to stand up the Exchange, including the expenses associated with existing Exchange planning staff.* (The actual deployment of these resources and capabilities is included in other categories.) The State anticipates additional work will be necessary to move from high and intermediate level needs analysis, and further to more granular level specific needs. (e.g. Moving from staffing needs to specific job descriptions.) The State estimates the bulk of these expenses will be contractual and will be front loaded (FFY11 and FFY12). The State also anticipates the additional internal staff in this category (1.5 FTE research assistants) could migrate to other functions associated with the Exchange at a later date.

Governance: *This category estimates costs of Exchange governance through FFY14.* It is hard to differentiate expenses in this category from other categories, particularly Finance and Business Operations. The State has assumed that the process of hiring and reimbursing expenses for executive level staff for the Exchange will be included in this category. While the State is unclear at this point what exact Governance model will be adopted by the Illinois General Assembly, the State has estimated costs for the maintenance of a volunteer Board, as well as occupancy costs.

Finance: *This category includes estimates for the functional administrative costs of the Exchange, as opposed to programmatic costs. These include development of plans for sustainability, internal accounting and controller functions, federal reporting, and defining mechanisms for transparency, human resource functions, and occupancy direction. The State assumes most of these costs will be incurred in hiring staff for these positions, although there will be some consulting costs associated with developing business plans—possibly including actuarial work about the impact of various financing strategies on market performance. The State also anticipates that some portion of these functions will be contracted out.*

Technical Infrastructure: *This category includes costs related to both the development and the operation of the entire technical infrastructure necessary for the Exchange to function. Given the current definitions of each core function, the State considered allocating these costs into the other functions (e.g. Business Operations and Financing), however for the purposes of planning this quarter, the State did not. The State's estimates take into account the budgets proposed by the Early Innovator grant applications and assume a roughly even split in costs with Medicaid and other human service agencies. The State is hopeful that the work of the Early Innovator states will reduce development costs for Illinois associated with the technical infrastructure for the Exchange. However, whereas both Oregon and Wisconsin are starting from much more advanced platforms than Illinois, establishing some infrastructure from scratch is almost certain to result in additional costs. Also, at this point, the State is not convinced that Early Innovators are based on the types of advanced, open-source technologies that we would ideally pursue. The cost of other alternatives is unclear at this point.*

Business Operations: *This category includes all the business functions that are necessary to stand-up the Exchange. This includes, initially, development and execution of communication strategy, negotiations with insurance companies, work with small business owners, operation of a call center, maintenance of mechanisms for enrolling clients, development of quality assessment of plans, and consumer navigation. It includes financial functions that are explicitly programmatic—specifically oversight of premium payments and dealing with tax credit issues. This category also includes the costs of maintaining a robust complaint resolution function, beyond that outlined in the States Consumer Assistance Program grant. Prior to the completion of the needs assessment, it is impossible to know to what extent the Exchange will contract out these functions. The State has estimated expenses as if many of these activities are done in-house. However, there is a reasonable likelihood of contracting out all, or a large portion, of the business operation. At this point, the only functions the State assumes will be contracted out include the call center, the primary navigation functions, and complaint resolution and appeals system (to the Department of Insurance).*

Regulatory or Policy Actions: *This category includes the legal and compliance functions inherent in implementing and maintaining an Exchange. It includes development of rules, handling policy litigation, program integrity monitoring and development of required reports and evaluations. It also includes the costs of developing and maintaining risk adjustment mechanisms. These estimates do not assume substantial new regulatory responsibilities that must be undertaken by the Department of Insurance. As such, these costs are assumed to be a blend of in-house staff and consulting/contractual assistance, particularly actuarial assistance.*

Work Plan

We ask that you begin working on a draft work plan for your Exchanges that will carry your planning and implementation efforts through January 1, 2014. On a quarterly basis, we would like to see your progress in developing this plan. We would like you to provide key objectives for implementing your exchange and corresponding milestones under each of these objectives. For your first quarterly report, please provide two milestones under each core area. In your second report, please provide four milestones. For your third report and the final report, we expect your work plan to be as comprehensive as possible.

Background Research

- **Name of milestone:** Comprehensive Report on the State of Health Coverage in Illinois
- **Timing:** May 31, 2011
- **Description:** Based on the information provided as part of the Background Research, and any additional information that may be identified and compiled in the interim, the State will have prepared a comprehensive report detailing the current state of health insurance coverage in Illinois, including an analysis of the insured and uninsured population, the affordability of coverage, and the current marketplace for health coverage. This report will not only inform the work of the State going forward as it relates to the Exchange, but may become a template for future annual or bi-annual reports to analyze and understand the state of insurance coverage and the marketplace in Illinois, and could inform future policy.

- **Name of milestone:** Gap Analysis for Future modelling or Survey Information
- **Timing:** May 31, 2011
- **Description:** During the course of and, potentially, at the conclusion of both the Background Research and Needs Assessment RFPs, the State should have identified additional micro-simulation modelling of the initial and ongoing capacity and financial needs of the Exchange.

- **Name of milestone:** Employer Survey
- **Timing:** November 1, 2011
- **Description:** The State will need to inform future development of the operational aspects of a SHOP Exchange based on the needs of businesses in the State – particularly small businesses. The State will coordinate with significant State business associations to conduct a comprehensive survey.

- **Name of milestone:** Analysis of Options for Basic Health Plan
- **Timing:** November 1, 2011
- **Description:** The State expects to conduct some analysis through consulting services on the option of establishing a Basic Health Plan in Illinois and making a recommendation to the Executive and Legislative branches about the viability of this option to help address “churning” between public and private health coverage.

Stakeholder Involvement

- **Name of milestone:** Stakeholder Consensus on Exchange Legislation
- **Timing:** Spring 2011
- **Description:** As the State continues its efforts to educate and engage stakeholders, the State hopes to garner consensus among all stakeholder groups on enabling legislation for the Exchange.

- **Name of milestone:** Stakeholder Involvement in EVE Planning
- **Timing:** Spring 2011 and onward
- **Description:** The Department of Healthcare and Family Services will conduct ongoing public sessions to update broader stakeholders on the EVE evaluation process, and elicit their feedback. This includes activities such as the public Medicaid Advisory Committee meetings.

- **Name of milestone:** Formal Website for Public Reporting
- **Timing:** Fall 2011
- **Description:** Although the State will be able to post the mandatory public reporting documents on the Exchange grant, as required under the federal guidelines, the State will also create a more formal, and user-friendly portion of the Governor's Health Reform Implementation website to share information about the progress of the State in planning for and establishing an Exchange and continue to enable two-way communication with all stakeholders.

- **Name of milestone:** Regular Stakeholder Engagement Planning Meetings
- **Timing:** Fall 2011
- **Description:** The State will solidify a process of stakeholder engagement over the course of the next three years of planning. This should include an outreach list, a timeline and agendas for meetings, with everything posted online and in accordance with the State's Open Meetings Act.

- **Name of milestone:** Process for Documenting Stakeholder Input
- **Timing:** Fall 2011
- **Description:** By the time stakeholder outreach meetings are announced publicly, the State will have in place a consistent process for recording stakeholder feedback as part of the targeted stakeholder engagement meetings. The summary of feedback will be made publically available as part of the aforementioned public reporting process.

Program Integration

- **Name of milestone:** Execute Appropriate Interagency Agreements
- **Timing:** January/February 2011 (and ongoing)
- **Description:** At minimum, the Office of the Governor, the Department of Insurance, and the Department of Healthcare and Family Services will execute an interagency agreement to ensure appropriate planning can occur and ensure exchange grant dollars can fund efforts across those three entities. It is likely the State will initiate additional interagency agreements as they relate to EVE planning and implementation, and other activities.

- **Name of milestone:** Consensus on an Eligibility-Verification-Enrollment (EVE) Solution
- **Timing:** May/June 2011
- **Description:** The State expects to achieve consensus among and a commitment by the interagency/departmental working group on a long-term solution for EVE as it relates directly to the Exchange. (A report is required to the State decision-makers by July 2011.)

- **Name of milestone:** Integration with Department of Insurance Duties
- **Timing:** May-July 2011

- **Description:** The State plans to consider and develop a high-level plan for coordination of the duties of the Department of Insurance, as they relate to regulation and oversight of health insurers interested in or already participating in the Exchange. This includes a review of state licensure and solvency requirements, certification of health plans, premium rate review processes, and market conduct examinations and procedures.

- **Name of milestone:** Integration with Office of Health Information Technology
- **Timing:** July/August 2011
- **Description:** The State plans to consider and develop a high-level plan for coordination of the duties of the Office of Health Information Technology, including the key points of mandatory and desired integration with the functionality built or planned to be built as part of the Illinois Health Information Exchange.

- **Name of milestone:** Integration with the Department of Public Health and Population Health goals
- **Timing:** July/August 2011
- **Description:** The State plans to consider and develop a high-level plan for coordination with the Department of Public Health to determine how the Exchange can function in such a way to assist the Department of Public Health achieve its population health goals.

Resources and Capabilities

- **Name of milestone:** Successful Project Launch for Needs Assessment
- **Timing:** February/March 2011
- **Description:** A contract was formally executed in April and vendors launched work immediately on the Needs Assessment. As part of this, the State developed a defined management structure to ensure appropriate accountability that progress is being made and roadblocks to success are constructively addressed.

- **Name of milestone:** Final Analysis on Resources and Capabilities
- **Timing:** May/June 2011
- **Description:** Incorporating all information provided by the final outputs of the Needs Assessment, the State expects to complete a comprehensive report on all estimated staffing, State IT-infrastructure, Exchange entity start-up and maintenance needs, and other associated costs, such as staffing increases in existing State departments and agencies.

- **Name of milestone:** Apply for a First Round of Level I Establishment grant funding
- **Timing:** June 2011
- **Description:** The State intends to prepare an application for Level I establishment grant funding from HHS to, at a minimum, complete the necessary background research, bring on additional planning staff and maintain existing staff, and any other additional consulting services that might be necessary.

- **Name of milestone:** Initial 6-Year Strategic Plan
- **Timing:** July 2011
- **Description:** By this time, the State should have sufficient information to develop an initial 6-year strategic plan to develop, launch, and maintain an Exchange. This plan will include, to the greatest extent possible, details about staffing, funding, contracting, IT infrastructure, the EVE solution

adopted by the State, business operations, oversight and coordination with existing state agencies (such as Medicaid, and the Department of Insurance), a high-level plan for education and outreach to consumers, program integrity, financial management, and a plan for either issuing or identifying necessary future legislation or regulatory action on the part of the State.

Governance

- **Name of milestone:** Introduce Exchange Legislation
- **Timing:** March/April 2011
- **Description:** Once the State has completed efforts to achieve consensus among stakeholders regarding the structure of an Exchange in Illinois, detailed legislation will be introduced in the State legislature to authorize the establishment of an Exchange.

- **Name of milestone:** Passage of Exchange Legislation
- **Timing:** May 2011
- **Description:** After hearings, debate, and negotiation, the legislature will pass enabling legislation for the Exchange, which the Governor would then sign into law.

- **Name of milestone:** Hire Essential Executive Staff for the Exchange
- **Timing:** Winter 2011/2012
- **Description:** Once an Exchange entity is authorized, the State will begin assisting the entity in hiring appropriate executive staff immediately, including an executive director, general counsel, and chief financial officer.

- **Name of milestone:** Launch the Process of Nominating Governing Board
- **Timing:** Winter 2011/2012
- **Description:** Once an Exchange entity is authorized, the State will begin work on the process of nominating, selecting, and seating the Exchange governing board.

Finance

- **Name of milestone:** Interim Plan for Financial Management of Exchange Grants
- **Timing:** March 2011
- **Description:** The State will finalize a plan for financial management of all Exchange-related grant funds, including finalizing all intergovernmental agreements necessary to be in compliance with all state procurement and ethics laws.

- **Name of milestone:** Consensus on a plan for Long-Term Sustainability
- **Timing:** Fall 2011
- **Description:** The State will find resolution among key stakeholders regarding a long-term financial sustainability function for the Exchange that will be incorporated into legislation.

- **Name of milestone:** Mid-term Plan for Financial Grants Management, including New Hires
- **Timing:** Fall/Winter 2011
- **Description:** While the State will already have a firm management plan in place for the federal grants, the State will develop a job description and initiate hiring of a formal financial manager to supervise

the financial aspects of the Federal Exchange grants over the mid to long-term. This position would transition to the formal Exchange entity once established.

- **Name of milestone:** Fraud, Waste, And Abuse
- **Timing:** Winter 2012
- **Description:** Once hired, the grants financial manager will work with State legal staff to review existing protocols for fraud, waste and abuse, and establish more formalized protections against fraud, waste, and abuse related to the expenditure of Exchange grant funds, as necessary or required by federal grant requirements.

Technical Infrastructure

- **Name of milestone:** Complete an IT Gap Analysis
- **Timing:** June 2011
- **Description:** The State plans to conduct a comprehensive IT Gap Analysis, as described in the requirements of the Funding Opportunity Announcement, *Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges*. The IT Gap Analysis for Illinois MMIS will be useful for parts of this process.

- **Name of milestone:** Develop a Plan for Consumer Information and Assistance
- **Timing:** Summer 2011
- **Description:** As part of preparing for the State's 6-year strategic plan, the State will develop an integrated plan for providing consumer assistance on the Exchange. This plan will take into account the role of the online web portal, a toll-free call center, the Navigator role, and an in-person option that coordinates appropriately with existing State programs and offices as well as community partnerships.

- **Name of milestone:** Preliminary Detailed Design and System Requirements
- **Timing:** Fall/Winter 2011
- **Description:** The State will develop its preliminary detailed design and system requirements for the Exchange. This will build off the initial information obtained through the Needs Assessment, and may require some additional consulting services for necessary technical guidance and feedback.

- **Name of milestone:** Define the technical nexus between health information technology and the Exchange
- **Timing:** Fall/Winter 2011
- **Description:** The State will begin to define the technical nexus between the health information exchange being developed by the State and the health insurance exchange, based on the broader planning mentioned under "Program Integration." This technical infrastructure should be incorporated into any planning document which the State drafts for public consumption, or as part of IT infrastructure planning for the Exchange.

Business Operations

- **Name of milestone:** Draft RFP for Design and Implementation of the EVE Functionality
- **Timing:** July/August 2011

- **Description:** Following the development of Needs Assessment, the State will begin the next phase of EVE implementation. It is not yet clear how this will integrate the opportunities from the Early Innovator grants or other re-use opportunities. Additional Federal guidance will be needed—and will be sought as the RFP is being developed. It is very difficult to see how Illinois can have separate planning and implementation vendors in the time frame necessary to establish the Exchange—including, of course, integration between Medicaid and the Exchange. Hopefully, the Early Innovators and other Federal opportunities will make it possible to proceed under a single contract for detailed planning and implementation.

- **Name of milestone:** Health Plan Evaluation and Qualification
- **Timing:** Fall 2011
- **Description:** Whether the Exchange will certify health plans for participation itself, or whether the Department of Insurance has this responsibility, the State must develop a plan for the actual process of certification. If the process requires electronic filing or other IT infrastructure, these requirements must be incorporated into future planning.

- **Name of milestone:** Initial Planning for the Navigator Program
- **Timing:** Fall/Winter 2011-2012
- **Description:** The State will launch a series of meetings to develop a comprehensive plan for the Navigator program, eligibility for participation, and necessary educational requirements for certification of a Navigator.

- **Name of milestone:** Exchange Website and Calculator Requirements
- **Timing:** Winter 2011-2012
- **Description:** The State will begin to work with stakeholders to outline desired Exchange website functionality, including the health plan search capabilities, the different types of plan comparison tools, and process for requesting assistance. This will supplement the design for other mandatory functions of the web portal and other access points to shop for and enroll in coverage through the Exchange.

Regulatory or Policy Actions

- **Name of milestone:** Appropriation for EVE Solution
- **Timing:** May/June 2011
- **Description:** Moving ahead on the EVE solution requires a legislative appropriation in the spring session of the General Assembly, even though the exact nature of the solution will not be determined at that time. Amount is included in current budget proposals and initial legislative readings are favorable (in large part because of the favorable Federal match rate).

- **Name of milestone:** Determine Responsibility for Certification of Exchange Health Plans
- **Timing:** Spring 2011
- **Description:** The State will determine if the Exchange or another existing State entity, such as the Department of Insurance, will bear responsibility for certifying, recertifying, and decertifying health plans for participation in the Exchange. This may need to be incorporated into legislation or regulation.

- **Name of milestone:** Finalize the Necessary Establishment Documents for Exchange
- **Timing:** Winter 2011/2012
- **Description:** The State anticipates the Exchange will have to establish a charter, a formal public staff organizational chart, and other mechanisms of establishment and public disclosure. These will all need to be provided on an interim Illinois Exchange website.

- **Name of milestone:** Regulations for Establishment of the Exchange
- **Timing:** Winter/Spring 2012 and onward
- **Description:** The State anticipates the Exchange will have to issue some amount of regulations once key policy decisions are made about its authority, and the responsibilities of other affiliated entities, such as the Department of Insurance, the Department of Healthcare and Family Services, and other entities.

Collaborations/Partnerships:

None at this time.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1101. The time required to complete this information collection is estimated to average (433 hours) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

STATE OF ILLINOIS – QUARTER 2 REPORTING
STATE PLANNING AND ESTABLISHMENT GRANTS FOR THE AFFORDABLE CARE
ACT'S EXCHANGES

Appendix A: Senate Amendment 001 to SB 1729



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AMENDMENT TO SENATE BILL 1729

AMENDMENT NO. 1. Amend Senate Bill 1729 by replacing everything after the enacting clause with the following:

"Section 1. Short title. This Act may be cited as the Illinois Health Coverage Exchange Establishment Act of 2011.

Section 5. Purpose and intent; application.

(a) The General Assembly hereby declares as follows:

(1) The purpose of this Act is to provide for the establishment of an Illinois Health Coverage Exchange to facilitate the purchase and sale of qualified health plans in the individual market in this State, to provide for the establishment of the Small Business Health Options Program to assist qualified small employers in this State in facilitating the enrollment of employees and their family members in qualified health plans, and to provide an efficient, cost-effective process to test eligibility and

1 enroll eligible individuals in public health care coverage
2 such as Medicaid or the Children's Health Insurance
3 Program.

4 (2) The intent of the Exchange is to offer private
5 health plans that provide financial security and
6 appropriate access to health care for individuals,
7 families, and employers in this State and in a manner that
8 is in the best interest of such individuals, reduce the
9 number of uninsured, provide a transparent marketplace and
10 consumer education, assist eligible individuals with
11 enrollment in public health care programs such as Medicaid
12 or the Children's Health Insurance Program, premium
13 assistance tax credits, cost-sharing reductions, and to
14 promote an innovative delivery system and payment reforms
15 referring to lower cost and improve quality.

16 (3) The federal Patient Protection and Affordable Care
17 Act (ACA) requires states to establish an operational
18 Exchange on or before January 1, 2014. In the event a state
19 does not demonstrate significant progress in the
20 implementation of an Exchange by January 1, 2013, then the
21 federal government will establish an Exchange for the
22 non-compliant state. Pursuant to the ACA, an Exchange will
23 determine eligibility and facilitate enrollment in public
24 health programs, including Medicaid and the Children's
25 Health Insurance Program. The Exchange will also provide a
26 marketplace for individuals, families, and employers to

1 shop for and purchase private health plans. The State of
2 Illinois finds that it is in the State's best interest to
3 establish an Exchange rather than defer to the federal
4 government.

5 (b) This Act shall be null and void if Congress and the
6 President take action to repeal or replace, or both, Section
7 1311 of the Affordable Care Act.

8 Section 10. Definitions. As used in this Act:

9 "Board" means the Illinois Health Benefits Exchange Board
10 established pursuant to this Act.

11 "Director" means the Director of Insurance.

12 "Educated health care consumer" means an individual who is
13 knowledgeable about the health care system and has background
14 or experience in making informed decisions regarding health,
15 medical, and scientific matters.

16 "Employee" has the meaning given that term in the Illinois
17 Health Insurance Portability and Accountability Act.

18 "Exchange" means the Illinois Health Benefits Exchange
19 established pursuant to this Act.

20 "Federal Act" means the federal Patient Protection and
21 Affordable Care Act (Public Law 111-148), as amended by the
22 federal Health Care and Education Reconciliation Act of 2010
23 (Public Law 111-152), and any amendments thereto or regulations
24 or guidance issued under those Acts.

25 "Health benefit plan" means a policy, contract,

1 certificate, or agreement offered or issued by a health carrier
2 to provide, deliver, arrange for, pay for, or reimburse any of
3 the costs of health care services. "Health benefit plan" does
4 not include:

5 (1) coverage only for accident or disability income
6 insurance or any combination thereof;

7 (2) coverage issued as a supplement to liability
8 insurance;

9 (3) liability insurance, including general liability
10 insurance and automobile liability insurance;

11 (4) workers' compensation or similar insurance;

12 (5) automobile medical payment insurance;

13 (6) credit-only insurance;

14 (7) coverage for only on-site medical clinics; or

15 (8) other similar insurance coverage specified in
16 federal regulations issued pursuant to Pub. L. No. 104-191,
17 under which benefits for health care services are secondary
18 or incidental to other insurance benefits.

19 "Health benefit plan" does not include the following benefits
20 if they are provided under a separate policy, certificate, or
21 contract of insurance or are otherwise not an integral part of
22 the plan:

23 (a) limited scope dental or vision benefits;

24 (b) benefits for long-term care, nursing home care,
25 home health care, community-based care, or any combination
26 thereof; or

1 (c) other similar, limited benefits specified in
2 federal regulations issued pursuant to Pub. L. No. 104-191.
3 "Health benefit plan" does not include the following benefits
4 if the benefits are provided under a separate policy,
5 certificate, or contract of insurance, there is no coordination
6 between the provision of the benefits and any exclusion of
7 benefits under any group health plan maintained by the same
8 plan sponsor, and the benefits are paid with respect to an
9 event without regard to whether benefits are provided with
10 respect to such an event under any group health plan maintained
11 by the same plan sponsor:

- 12 (i) coverage only for a specified disease or illness;
13 or
14 (ii) hospital indemnity or other fixed indemnity
15 insurance.

16 "Health benefit plan" does not include the following if offered
17 as a separate policy, certificate, or contract of insurance:

18 (A) medicare supplemental health insurance as defined
19 under Section 1882(g) (1) of the Social Security Act;

20 (B) coverage supplemental to the coverage provided
21 under Chapter 55 of Title 10, United States Code (Civilian
22 Health and Medical Program of the Uniformed Services
23 (CHAMPUS)); or

24 (C) similar supplemental coverage provided as coverage
25 under a group health plan.

26 "Health carrier" or "carrier" means an entity subject to

1 the insurance laws and regulations of this State, or subject to
2 the jurisdiction of the Director, that contracts or offers to
3 contract to provide, deliver, arrange for, pay for, or
4 reimburse any of the costs of health care services, including a
5 sickness and accident insurance company, a health maintenance
6 organization, or any other entity providing a plan of health
7 insurance, health benefits, or health services.

8 "Qualified dental plan" means a limited scope dental plan
9 that has been certified in accordance with this Act.

10 "Qualified employer" means a small employer that elects to
11 make its full-time employees eligible for one or more qualified
12 health plans offered through the SHOP Exchange, and at the
13 option of the employer, some or all of its part-time employees,
14 provided that the employer:

15 (1) has its principal place of business in this State
16 and elects to provide coverage through the SHOP Exchange to
17 all of its eligible employees, wherever employed; or

18 (2) elects to provide coverage through the SHOP
19 Exchange to all of its eligible employees who are
20 principally employed in this State.

21 "Qualified health plan" means a health benefit plan that
22 has in effect a certification that the plan meets the criteria
23 for certification described in Section 1311(c) of the Federal
24 Act and this Act.

25 "Qualified individual" means an individual, including a
26 minor, who:

1 (1) is seeking to enroll in a qualified health plan
2 offered to individuals through the Exchange;

3 (2) resides in this State;

4 (3) At the time of enrollment, is not incarcerated,
5 other than incarceration pending the disposition of
6 charges; and

7 (4) is and is reasonably expected to be for the entire
8 period for which enrollment is sought a citizen or national
9 of the United States or an alien lawfully present in the
10 United States.

11 "Secretary" means the Secretary of the federal Department
12 of Health and Human Services.

13 "SHOP Exchange" means the Small Business Health Options
14 Program established under Section 30 of this Act.

15 "Small employer" has the meaning given that term in the
16 Illinois Health Insurance Portability and Accountability Act.
17 An employer that makes enrollment in qualified health plans
18 available to its employees through the SHOP Exchange and would
19 cease to be a small employer by reason of an increase in the
20 number of its employees shall continue to be treated as a small
21 employer for purposes of this Act as long as it continuously
22 makes enrollment through the SHOP Exchange available to its
23 employees.

24 Section 15. Creation of the Exchange.

25 (a) There is hereby created a political subdivision, body

1 politic, and corporate, that is not a State entity, named the
2 Illinois Health Benefits Exchange. The governing and
3 administrative powers of the Exchange shall be vested in a body
4 known as the Illinois Health Benefits Exchange Board. The Board
5 shall consist of 9 voting members, 7 of whom shall be appointed
6 by the Governor with the advice and consent of the Senate and 2
7 of whom shall be appointed by the Attorney General with the
8 advice and consent of the Senate. The members appointed by the
9 Governor shall include:

10 (1) one consumer representative who is or has in the
11 preceding 2 years been insured in the individual health
12 insurance market in this State;

13 (2) one small employer representative with experience
14 operating a small business in this State;

15 (3) one employee representative of a small employer in
16 this State;

17 (4) one Illinois-licensed insurance producer with
18 experience facilitating the purchase of health insurance
19 coverage in the individual or small group market in this
20 State;

21 (5) one certified health actuary; and

22 (6) one Illinois-licensed health care provider or
23 other qualified representative with experience serving
24 underserved populations, including but not limited to the
25 uninsured and those receiving coverage through public
26 health care programs such as Medicaid or the Children's

1 Health Insurance Program, in both the community-based
2 health care setting and a hospital-based setting in this
3 State; and

4 (7) one representative of the organized labor
5 community in this State.

6 The members appointed by the Attorney General shall include:

7 (i) one health lawyer with experience in public
8 programs, such as Medicaid or the Children's Health
9 Insurance Program, and private health insurance coverage;
10 and

11 (ii) One health lawyer with experience working in
12 collaboration with the Attorney General's Health Care
13 Bureau.

14 (b) The Director of Insurance, the Director of the
15 Healthcare and Family Services, the Director of Human Services,
16 and the Director of Public Health shall serve as ex officio,
17 non-voting members of the Board.

18 (c) Four members of the General Assembly, one each
19 appointed by the President of the Senate, the Minority Leader
20 of the Senate, the Speaker of the House of Representatives, and
21 the Minority Leader of the House of Representatives, shall
22 serve as ex officio, nonvoting members of the Board.

23 (d) In making appointments to the Board, the appointing
24 authorities shall take into consideration the cultural,
25 ethnic, and geographic diversity of the State so that the
26 Board's composition reflects the communities of this State.

1 (e) The Board shall appoint one of its members as
2 chairperson of the Board. Members of the Board shall receive no
3 compensation, but shall be reimbursed for reasonable expenses
4 incurred in the necessary performance of their duties,
5 including travel.

6 (f) The Exchange shall procure necessary services and terms
7 using a process with integrity and transparency and that is
8 free of conflicts of interest and serves the best interest of
9 individuals, families, and employers purchasing coverage
10 through the Exchange.

11 (g) The meetings of the Board shall be subject to the Open
12 Meetings Act, except that the Board may hold closed sessions
13 when considering matters related to litigation, personnel,
14 contracting, and rates.

15 (h) Notwithstanding subsections (8) and (12) of Section
16 10-15 of the State Officials and Employees Ethics Act, no
17 member of the Board or its employees shall accept food or
18 refreshments or any item or items from any prohibited source.

19 (i) Board members shall have the responsibility and duty to
20 meet the requirements of this Act and all applicable State and
21 federal laws and regulations, to serve the public interest of
22 the individuals and small businesses seeking health insurance
23 coverage through the Exchange, and to ensure the operational
24 well-being and fiscal solvency of the Exchange.

25 (j) No member of the Board nor employees of the Board may
26 be an employee of any licensed carrier authorized to do

1 business in this State.

2 (k) No member of the Board nor employees of the Board shall
3 make, participate in making, or in any way attempt to use his
4 or her official position to influence the making of any
5 decision that he or she knows or has any reason to know will
6 have a reasonably foreseeable material financial effect,
7 distinguishable from its effect on the public generally, on him
8 or her or a member of his or her family or on either of the
9 following:

10 (1) any source of income provided to, received by, or
11 promised to a member within 12 months prior to the time
12 when a decision is made; or

13 (2) any business entity in which the member is a
14 director, officer, partner, trustee, employee, or holds
15 any position of management.

16 (1) The Director, or any person he or she may appoint, may,
17 in the same manner as authorized for examination of domestic,
18 foreign, or alien insurance companies, investigate the affairs
19 of the Exchange and examine the properties and records of the
20 Exchange and shall, at least annually, require the Exchange to
21 provide periodic reporting to the Governor and the General
22 Assembly in relation to the activities undertaken by the
23 Exchange under this Act.

24 (m) The Office of the Executive Inspector General shall
25 have jurisdiction over the Exchange and all individuals
26 supervising, directing, contracting, or working for the

1 Exchange.

2 Section 20. Terms of appointments. Within 60 days after the
3 effective date of this Act, the Governor shall appoint 3 voting
4 members of the Board for initial terms expiring June 30, 2015;
5 the Governor shall appoint 2 public members and the Attorney
6 General shall appoint one voting member of the Board for
7 initial terms expiring June 30, 2014; and the Governor shall
8 appoint 2 voting members and the Attorney General shall appoint
9 one voting member of the Board for initial terms expiring June
10 30, 2013. All successors shall hold office for a term of 3
11 years from the first day of July in the year of appointment and
12 running through June 30 of the third year, except in case of an
13 appointment to fill a vacancy. A Board member shall hold office
14 until the expiration of that member's term and until that
15 member's successor is appointed and qualified. Board members
16 may be appointed to subsequent terms. Vacancies shall be filled
17 in the same manner as original appointments for the balance of
18 the unexpired term. In case of vacancy when the Senate is not
19 in session, the Governor may make a temporary appointment until
20 the next meeting of the Senate, when the Governor or Attorney
21 General shall nominate such person to fill the open Board
22 position and any person so nominated who is confirmed by the
23 Senate shall hold his or her office during the remainder of the
24 term and until his or her successor is appointed and qualified.

1 Section 25. Executive Director. The Board shall appoint an
2 Executive Director who shall be the chief executive officer of
3 the Exchange. The Executive Director shall have at least 5
4 years of experience in health care policy, management, service,
5 delivery, or coverage. In addition to any other duties set
6 forth in this Act, the Executive Director shall:

7 (1) employ such staff as may be necessary to carry out
8 the provisions of this Act;

9 (2) direct and supervise the administrative affairs
10 and activities of the Exchange in accordance with its
11 rules, regulations, and policies;

12 (3) attend meetings of the Board;

13 (4) keep minutes of all proceedings of the Board;

14 (5) approve all accounts for salaries, per diem
15 payments, and allowable expenses of the Exchange and its
16 employees and consultants and approve all expenses
17 incidental to the operation of the Exchange; and

18 (6) perform any other duty that the Board requires for
19 carrying out the provisions of this Act.

20 Section 30. Quorum; voting; meetings.

21 (a) Five members of the Board constitute a quorum for the
22 purpose of conducting business.

23 (b) Actions of the Board must receive the affirmative vote
24 of at least 5 members of the Board.

25 (c) The Board shall meet at least quarterly or more often

1 if necessary.

2 Section 35. Powers and authority of the Board.

3 (a) In addition to powers set forth elsewhere in this Act,
4 the Board may do the following:

5 (1) Adopt bylaws, rules, and regulations to carry out
6 the provisions of this Act.

7 (2) Authorize the Exchange to enter into contracts as
8 are necessary or proper to carry out the provisions and
9 purposes or perform any of the functions described in this
10 Act.

11 (3) Take or defend any legal actions necessary to
12 effectuate the purposes of this Act.

13 (4) Appoint appropriate legal, actuarial, and other
14 committees as necessary to provide technical assistance in
15 the operation of the Exchange, contract design, and any
16 other function described in this Act.

17 (5) Authorize commercial, banking, and financial
18 arrangements as needed to manage the day-to-day operations
19 of the Exchange.

20 (6) Appoint and fix the compensation of an Executive
21 Director.

22 (7) Enter into intergovernmental cooperation
23 agreements with governmental entities for the purpose of
24 sharing the cost of providing access to health care
25 coverage that are otherwise authorized by this Act or to

1 carry out other responsibilities under this Act provided
2 such agreements adequately protect the confidentiality of
3 information to be shared and comply with applicable State
4 and federal laws and regulations.

5 (8) Establish conditions and procedures under which
6 the exchange may, if charitable or other funds are
7 provided, discount or subsidize premium rates and
8 cost-sharing or prescription drug costs that are paid
9 directly by other public or private entities, as defined by
10 the Board.

11 (9) Apply for, accept, and spend as appropriate any
12 federal or State grant money made available through or
13 pursuant to the Affordable Care Act or any other federal or
14 State-related opportunity in order to assist the Board as
15 it implements the provisions of this Act.

16 (10) Create an administration fund under direction of
17 the Board and management by the Executive Director to:

18 (A) fund administrative and any other expenses of
19 the Exchange; and

20 (B) receive and deposit into the administration
21 fund any money collected or received by the Board
22 pursuant to this Act.

23 (b) The Board shall create an Exchange that shall:

24 (1) facilitate the purchase and sale of qualified
25 health plans;

26 (2) assist qualified small employers in this State in

1 facilitating the enrollment of employees in qualified
2 health plans;

3 (3) develop a process to certify plans eligible to
4 participate in the Exchange; and

5 (4) facilitate enrollment in Medicaid or the
6 Children's Health Insurance Program for eligible
7 individuals;

8 (5) inform individuals of the potential for
9 overpayments of advance premium tax credits and of
10 procedures by which individuals can report a change of
11 income that may affect the subsequent level of premium tax
12 credits, including the availability of any safe harbor from
13 recoupment of any overpayment, to the extent permissible
14 under the Federal Act or any federal regulations
15 promulgated thereunder; and

16 (6) meet the requirements of this Act and any
17 regulations implemented under this Act.

18 (c) In addition to powers set forth elsewhere in this Act,
19 the Board shall do all of the following:

20 (1) Make qualified health plans available to qualified
21 individuals and qualified employers beginning with
22 effective dates on or before January 1, 2014.

23 (2) Not make available any health benefit plan that is
24 not a qualified health plan.

25 (3) Allow a health carrier to offer a plan that
26 provides limited scope dental benefits meeting the

1 requirements of Section 9832(c)(2)(A) of the Internal
2 Revenue Code of 1986 through the Exchange, either
3 separately or in conjunction with a qualified health plan,
4 if the plan provides pediatric dental benefits meeting the
5 requirements of Section 1302(b)(1)(J) of the Federal Act.

6 (4) Not charge, or allow a health carrier offering
7 health benefit plans through the Exchange to charge, an
8 individual a fee or penalty for termination of coverage if
9 the individual enrolls in another type of minimum essential
10 coverage because the individual has become newly eligible
11 for that coverage or because the individual's
12 employer-sponsored coverage has become affordable under
13 the standards of Section 36B(c)(2)(C) of the Internal
14 Revenue Code of 1986.

15 (5) Implement procedures for the certification,
16 recertification, and decertification, consistent with
17 guidelines developed by the Secretary under Section
18 1311(c) of the Federal Act and Section 35 of this Act, of
19 health benefit plans as qualified health plans.

20 (6) Provide for the operation of a toll-free telephone
21 hotline to respond to requests for assistance.

22 (7) Provide for enrollment periods as provided under
23 Section 1311(c)(6) of the Federal Act.

24 (8) Maintain an Internet website through which
25 enrollees and prospective enrollees of qualified health
26 plans may obtain standardized comparative information on

1 such plans.

2 (9) Assign a rating to each qualified health plan
3 offered through the Exchange in accordance with the
4 criteria developed by the Secretary under Section
5 1311(c)(3) of the Federal Act, and determine each qualified
6 health plan's level of coverage in accordance with
7 regulations issued by the Secretary under Section
8 1302(d)(2)(A) of the Federal Act. The Exchange shall make
9 this information public in a manner consistent with
10 subparagraph (B) of paragraph (18) of subsection (c) of
11 this Section and paragraph (3) of subsection (c) of Section
12 50 of this Act.

13 (10) Use a standardized format for presenting health
14 benefit options in the Exchange, including the use of the
15 uniform outline of coverage established under Section 2715
16 of the Public Health Service Act.

17 (11) In accordance with Section 1413 of the Federal
18 Act, inform individuals of eligibility requirements for
19 the Medicaid program under title XIX of the Social Security
20 Act, the Children's Health Insurance Program under title
21 XXI of the Social Security Act or any applicable State or
22 local public program and if through screening of the
23 application by the Exchange the Exchange determines that
24 any individual is eligible for any such program, then
25 enroll that individual in that program.

26 (12) Establish and make available by electronic means a

1 calculator to determine the actual cost of coverage after
2 application of any premium tax credit under Section 36B of
3 the Internal Revenue Code of 1986 and any cost-sharing
4 reduction under Section 1402 of the Federal Act.

5 (13) Establish a SHOP Exchange, separate from the
6 activities related to the individual market, through which
7 qualified employers may access coverage for their
8 employees. The SHOP Exchange shall enable any qualified
9 employer to specify a level of coverage so that any of its
10 employees may enroll in any qualified health plan offered
11 through the SHOP Exchange at the specified level of
12 coverage.

13 (14) Subject to Section 1411 of the Federal Act, grant
14 a certification attesting that, for purposes of the
15 individual responsibility penalty under Section 5000A of
16 the Internal Revenue Code of 1986, an individual is exempt
17 from the individual responsibility requirement or from the
18 penalty imposed by that Section because:

19 (A) there is no affordable qualified health plan
20 available through the Exchange or the individual's
21 employer covering the individual; or

22 (B) the individual meets the requirements for any
23 other such exemption from the individual
24 responsibility requirement or penalty;

25 (15) Transfer to the federal Secretary of the Treasury
26 the following:

1 (A) a list of the individuals who are issued a
2 certification under paragraph (14) of this subsection
3 (c), including the name and taxpayer identification
4 number of each individual;

5 (B) the name and taxpayer identification number of
6 each individual who was an employee of an employer but
7 who was determined to be eligible for the premium tax
8 credit under Section 36B of the Internal Revenue Code
9 of 1986 because:

10 (i) the employer did not provide minimum
11 essential coverage; or

12 (ii) the employer provided the minimum
13 essential coverage, but it was determined under
14 Section 36B(c)(2)(C) of the Internal Revenue Code
15 to either be unaffordable to the employee or not
16 provide the required minimum actuarial value; and

17 (C) the name and taxpayer identification number
18 of:

19 (i) each individual who notifies the Exchange
20 under Section 1411(b)(4) of the Federal Act that he
21 or she has changed employers; and

22 (ii) each individual who ceases coverage under
23 a qualified health plan during a plan year and the
24 effective date of that cessation.

25 (16) Provide to each employer the name of each employee
26 of the employer described in item (ii) of subparagraph (C)

1 of paragraph (15) of this subsection (c) who ceases
2 coverage under a qualified health plan during a plan year
3 and the effective date of the cessation.

4 (17) Perform duties required of the Exchange by the
5 Secretary or the Secretary of the Treasury related to
6 determining eligibility for premium tax credits, reduced
7 cost-sharing or individual responsibility requirement
8 exemptions.

9 (18) Select entities qualified to serve as Navigators
10 in accordance with Section 1311(i) of the Federal Act, and
11 standards developed by the Secretary, and award grants to
12 enable Navigators to:

13 (A) conduct public education activities to raise
14 awareness of the availability of qualified health
15 plans, premium assistance tax credits, cost sharing
16 reductions, Medicaid and Children's Health Insurance
17 Program eligibility, and related consumer protections;

18 (B) distribute fair and impartial information
19 concerning enrollment in qualified health plans and
20 the availability of premium tax credits under Section
21 36B of the Internal Revenue Code of 1986 and
22 cost-sharing reductions under Section 1402 of the
23 Federal Act;

24 (C) facilitate enrollment in qualified health
25 plans and public health care programs, such as Medicaid
26 and the Children Health Insurance Program, where

1 permitted by State and federal law;

2 (D) provide referrals to the Office of Consumer
3 Health Insurance in the Department for any enrollee
4 with a grievance, complaint, or question regarding
5 their health benefit plan, coverage, or a
6 determination under that plan or coverage; and

7 (E) provide information in a manner that is
8 culturally and linguistically appropriate to the needs
9 of the population being served by the Exchange.

10 (19) Within 30 days after issuance of federal guidance
11 regarding the Navigator function in the Exchange, the
12 Board, in collaboration with the advisory committees,
13 shall establish an open process to explore the design and
14 operation of the Exchange's Navigator Program and any other
15 appropriate consumer assistance mechanisms. Within 6
16 months after the effective date of this Act or by February
17 1, 2012, whichever occurs first, the Board shall provide
18 recommendations related to the functions of the Exchange or
19 the role of navigators to the Governor and the General
20 Assembly for their consideration, including:

21 (A) the infrastructure of the existing private
22 sector health insurance distribution system in this
23 State to determine whether private sector resources
24 may be available and suitable for use by the Exchange;

25 (B) the effect the Exchange may have on private
26 sector employment in the health insurance distribution

1 system in this State;

2 (C) what functions, in addition to those required
3 by the Patient Protection and Affordable Care Act,
4 should be performed by Navigators;

5 (D) what training and expertise should be required
6 of Navigators, and whether different markets and
7 populations require Navigators with different
8 qualifications;

9 (E) how Navigators should be retained and
10 compensated, and how disparities between Navigator
11 compensation and the compensation of insurance
12 producers outside the Exchange can be minimized or
13 avoided;

14 (F) how to ensure that Navigators provide
15 information in a manner culturally, linguistically,
16 and otherwise appropriate to the needs of the diverse
17 populations served by the Exchange, and that
18 Navigators have the capacity to meet these needs; and

19 (G) what other means of consumer assistance may be
20 appropriate and feasible, and how they should be
21 designed and implemented.

22 (20) Review the rate of premium growth within the
23 Exchange and outside the Exchange and consider the
24 information in developing recommendations to the Board
25 about whether to continue limiting qualified employer
26 status to small employers.

1 (21) Credit the amount of any free choice voucher to
2 the monthly premium of the plan in which a qualified
3 employee is enrolled, in accordance with Section 10108 of
4 the Federal Act, and collect the amount credited from the
5 offering employer.

6 (22) Consult with stakeholders relevant to carrying
7 out the activities required under this Act, including, but
8 not limited to:

9 (A) health care consumers who are enrollees in
10 qualified health plans;

11 (B) individuals and entities with experience in
12 facilitating enrollment in qualified health plans and
13 public health care programs, such as Medicaid or the
14 Children's Health Insurance Program;

15 (C) representatives of the employer community,
16 including small businesses, self-employed individuals,
17 and large self-insured plans;

18 (D) providers, including physicians, nurses,
19 behavioral health professionals, other allied health
20 professionals, and hospitals;

21 (E) representatives of union-administered health
22 benefit plans;

23 (F) entities or individuals with experience in
24 designing, managing, and purchasing health benefit
25 plans;

26 (G) the Department of Healthcare and Family

1 Services;

2 (H) the President of the Senate, the Minority
3 Leader of the Senate, the Speaker of the House of
4 Representatives, and the Minority Leader of the House
5 of Representatives;

6 (I) the Department of Human Services;

7 (J) the Department of Public Health; and

8 (K) advocates for enrolling hard to reach
9 populations.

10 (23) The Board, in collaboration with the advisory
11 committees, shall establish an open process to explore
12 several aspects of Exchange policy and provide
13 recommendations to the General Assembly about future
14 legislative action regarding:

15 (A) expanding the definition of small employer to
16 include employers with up to 100 employees, including
17 an analysis of the impact of such a policy on premiums
18 and access to health insurance coverage for
19 individuals and small businesses in this State;

20 (B) permitting employers with more than 100
21 employees to purchase coverage through the Exchange
22 beginning in 2017, including an analysis of the impact
23 of such a policy on premiums and access to health
24 insurance coverage for individuals and small
25 businesses in this State; and

26 (C) additional mechanisms to minimize the risk of

1 adverse selection in the Exchange.

2 In close cooperation with the Department of Healthcare
3 and Family Services and other impacted agencies and stake
4 holders, the Board shall make a recommendation as to
5 whether Illinois should adopt a Basic Health Plan as
6 allowed under Section 1331 of the ACA. Such a
7 recommendation should take into account, among other
8 things the potential impact on individuals who would be
9 covered under the Basic Health Plan, the potential cost to
10 the State, and the overall impact on the Exchange. Such a
11 recommendation must be made within 6 months after the final
12 rules for states by the Secretary regarding the
13 establishment of Basic Health Plans.

14 (25) Meet the following financial integrity
15 requirements:

16 (A) keep an accurate accounting of all activities,
17 receipts, and expenditures and annually submit to the
18 Secretary, the Governor, the Director, and the General
19 Assembly a report concerning such accountings;

20 (B) fully cooperate with any investigation
21 conducted by the Secretary pursuant to the Secretary's
22 authority under the Federal Act and allow the
23 Secretary, in coordination with the Inspector General
24 of the U.S. Department of Health and Human Services, to
25 do the following:

26 (i) investigate the affairs of the Exchange;

1 (ii) examine the properties and records of the
2 Exchange; and

3 (iii) require periodic reports in relation to
4 the activities undertaken by the Exchange; and

5 (C) in carrying out its activities under this Act,
6 not use any funds intended for the administrative and
7 operational expenses of the Exchange for staff
8 retreats, promotional giveaways, excessive executive
9 compensation, or promotion of federal or State
10 legislative and regulatory modifications.

11 (d) Unless authorized by law, the Board and any Exchange
12 employee or representative are not authorized to act in any
13 manner that implies or asserts that the Board or the Exchange
14 in and of itself can add to or impose any fiscal liability on
15 the State.

16 (e) The Board shall recognize waivers approved by the
17 Secretary pursuant to the Federal Act, recognizing that these
18 waivers may change over time and be of limited scope or
19 duration.

20 Section 40. Advisory committees.

21 (a) Within 60 days after the effective date of this Act,
22 the Board shall appoint a Technical Advisory Committee composed
23 of no more than 20 individuals responsible for developing the
24 standards and criteria for selecting qualified health plans to
25 be offered through the Exchange. Such standards and criteria

1 shall be developed based upon the tenets of value, quality, and
2 service and in a manner that serves the best interests of
3 qualified individuals and qualified small employers. The
4 Committee shall meet no less than once every 3 months and shall
5 provide recommendations to the Board regarding standards and
6 criteria for qualified health plans no later than 6 months
7 after its establishment. The Technical Advisory Committee
8 shall consult with the Stakeholder Advisory Committee
9 described in this Section regarding its draft recommendations
10 and provide time for substantive comment no less than once
11 prior to issuing any final recommendations for review by the
12 Board.

13 (b) Each person appointed to the Committee shall serve a
14 2-year term, and have demonstrated and acknowledged expertise
15 in at least 2 of the following areas:

16 (1) Individual health care coverage.

17 (2) Employer health care coverage.

18 (3) Health benefits plan administration, including
19 revenue cycle billing and collections.

20 (4) The health coverage needs of populations with
21 low-income limited health literacy and limited English
22 language proficiency.

23 (5) Health care finance.

24 (6) Administering a public or private health care
25 delivery system.

26 (7) Purchasing health plan coverage.

1 (8) Education and outreach.

2 The Board shall consider the expertise of the other members
3 of the Committee and attempt to make appointments so that the
4 Committee's composition reflects a diversity of expertise.

5 (c) Within 30 days after the Board's establishment, it
6 shall appoint a Stakeholder Advisory Committee composed of no
7 fewer than 5 Illinois health care consumers, 5 Illinois small
8 business owners, 5 Illinois-licensed health care providers
9 from a variety of provider types, including, but not limited
10 to, hospitals, private practice medical groups, community
11 health centers, and safety net providers that have experience
12 providing medical care to underserved populations, and 5 health
13 plans that rank among the 10 largest in this State for premium
14 volume. Committee members shall serve one-year terms.

15 (d) The Board may establish additional advisory committees
16 to assist in carrying out its duties under the Act.

17 (e) Members of committees shall receive no compensation,
18 but shall be reimbursed for reasonable expenses incurred in the
19 necessary performance of their duties, including travel.

20 (f) The meetings of all advisory committees shall be
21 subject to the Open Meetings Act.

22 Section 45. Annual report. The Board shall report in
23 writing to the Governor, the Clerk of the House of
24 Representatives, and the Clerk of the Senate by the 30th day of
25 June, annually, the details and results of its administration

1 of this Act. The Board's report shall include an audited
2 financial report, and may include any recommendation intended
3 to improve the value of health coverage sold through the
4 Exchange to patients, families, and employers. The Board shall
5 make such report publicly available on the Exchange website.

6 Section 50. Health benefit plan certification.

7 (a) The Exchange may certify a health benefit plan as a
8 qualified health plan if:

9 (1) the plan provides the essential health benefits
10 package described in Section 1302(a) of the Federal Act,
11 except that the plan is not required to provide essential
12 benefits that duplicate the minimum benefits of qualified
13 dental plans, as provided in subsection (e) of this
14 Section, if:

15 (A) the Exchange has determined that at least one
16 qualified dental plan is available to supplement the
17 plan's coverage; and

18 (B) the carrier makes prominent disclosure at the
19 time it offers the plan, in a form approved by the
20 Exchange, that the plan does not provide the full range
21 of essential pediatric benefits, and that qualified
22 dental plans providing those benefits and other dental
23 benefits not covered by the plan are offered through
24 the Exchange;

25 (2) the premium rates and contract language have been

1 approved by the Director;

2 (3) the plan provides at least a bronze level of
3 coverage, as determined pursuant to paragraph (9) of
4 subsection (c) of Section 35 of this Act, unless the plan
5 is certified as a qualified catastrophic plan, meets the
6 requirements of the Federal Act for catastrophic plans, and
7 will only be offered to individuals eligible for
8 catastrophic coverage;

9 (4) the plan's cost-sharing requirements do not exceed
10 the limits established under Section 1302(c)(1) of the
11 Federal Act and if the plan is offered through the SHOP
12 Exchange, then the plan's deductible does not exceed the
13 limits established under Section 1302(c)(2) of the Federal
14 Act;

15 (5) the health carrier offering the plan:

16 (A) is licensed and in good standing to offer
17 health insurance coverage in this State;

18 (B) offers at least one qualified health plan in
19 the silver level and at least one plan in the gold
20 level through each component of the Exchange in which
21 the carrier participates, where "component" refers to
22 the SHOP Exchange and the Exchange for individual
23 coverage;

24 (C) charges the same premium rate for each
25 qualified health plan without regard to whether the
26 plan is offered through the Exchange and without regard

1 to whether the plan is offered directly from the
2 carrier or through an insurance producer;

3 (D) does not charge any cancellation fees or
4 penalties in violation of paragraph (4) of subsection
5 (c) of Section 35 of this Act; and

6 (E) complies with the regulations developed by the
7 Secretary under Section 1311(d) of the Federal Act and
8 such other requirements as the Exchange may establish.

9 Should the qualified health plan offer the benefits of
10 qualified dental plans, the health and dental benefits
11 shall be placed separately.

12 (6) the plan meets the requirements of certification as
13 set forth by the Board, in collaboration with the Technical
14 Advisory Committee, and by the Secretary under Section
15 1311(c) of the Federal Act, which include, but are not
16 limited to, minimum standards in the areas of marketing
17 practices, network adequacy, essential community providers
18 in underserved areas, accreditation, quality improvement,
19 uniform enrollment forms, and descriptions of coverage and
20 information on quality measures for health benefit plan
21 performance; and

22 (7) the Exchange determines that making the plan
23 available through the Exchange is in the interest of
24 qualified individuals and qualified employers in this
25 State.

26 (b) The Exchange shall not exclude a health benefit plan:

1 (1) on the basis that the plan is a fee-for-service
2 plan;

3 (2) through the imposition of premium price controls by
4 the Exchange; or

5 (3) on the basis that the health benefit plan provides
6 treatments necessary to prevent patients' deaths in
7 circumstances the Exchange determines are inappropriate or
8 too costly.

9 (c) The Exchange shall require each health carrier seeking
10 certification of a plan as a qualified health plan to:

11 (1) submit a justification for any premium increase
12 before implementation of that increase; the carrier shall
13 prominently post the information on its Internet website;
14 the Exchange shall take this information, along with the
15 information and the recommendations provided to the
16 Exchange by the Director under Section 2794(b) of the
17 Public Health Service Act, into consideration when
18 determining whether to allow the carrier to make plans
19 available through the Exchange;

20 (2) make available to the public, in the format
21 described in paragraph (3) of subsection (c) of this
22 Section, and submit to the Exchange, the Secretary, and the
23 Director, accurate and timely disclosure of current data
24 relating to the following:

25 (A) claims payment policies and practices;

26 (B) periodic financial disclosures;

- 1 (C) data on enrollment;
- 2 (D) data on disenrollment;
- 3 (E) data on the number of claims that are denied,
4 including pre-certification denials and limitations on
5 requested services;
- 6 (F) data on rating practices;
- 7 (G) information on cost-sharing and payments with
8 respect to any out-of-network coverage;
- 9 (H) information on enrollee and participant rights
10 under title I of the Federal Act;
- 11 (I) data on how the plan's quality scores, consumer
12 satisfaction levels, and performance levels compare to
13 national metrics and others in the Exchange; and
- 14 (J) other information as determined appropriate by
15 the Secretary; and
- 16 (3) enable individuals to learn, in a timely manner
17 upon the request of the individual, the amount of
18 cost-sharing, including deductibles, copayments, and
19 coinsurance, under the individual's plan or coverage that
20 the individual would be responsible for paying with respect
21 to the furnishing of a specific item or service by a
22 participating provider; at a minimum, this information
23 shall be made available to the individual through an
24 Internet website and through other means for individuals
25 without access to the Internet, and in a manner consistent
26 with subparagraph (E) of paragraph (18) of subsection (c)

1 of Section 35 of this Act and this paragraph (3).

2 The information required in paragraph (2) of this
3 subsection (c) shall be provided in plain language, as that
4 term is defined in Section 1311(e)(3)(B) of the Federal Act.

5 (d) The Exchange shall not exempt any health carrier
6 seeking certification of a qualified health plan, regardless of
7 the type or size of the carrier, from State licensure or
8 solvency requirements and shall apply the criteria of this
9 Section in a manner that assures a level playing field between
10 or among health carriers participating in the Exchange.

11 (e) Application to dental plans shall comport with all of
12 the following provisions:

13 (1) The provisions of this Act that are applicable to
14 qualified health plans shall also apply to the extent
15 relevant to qualified dental plans except as modified in
16 accordance with the provisions of paragraphs (2), (3), and
17 (4) of this subsection (e) or by regulations adopted by the
18 Exchange.

19 (2) The carrier shall be licensed to offer dental
20 coverage, but need not be licensed to offer other health
21 benefits.

22 (3) The plan shall be limited to dental and oral health
23 benefits, without substantially duplicating the benefits
24 typically offered by health benefit plans without dental
25 coverage and shall include, at a minimum, the essential
26 pediatric dental benefits prescribed by the Secretary

1 pursuant to Section 1302(b)(1)(J) of the Federal Act, and
2 such other dental benefits as the Exchange or the Secretary
3 may specify by regulation.

4 (4) Carriers may jointly offer a comprehensive plan
5 through the Exchange in which the dental benefits are
6 provided by a carrier through a qualified dental plan and
7 the other benefits are provided by a carrier through a
8 qualified health plan, provided that the plans are priced
9 separately and are also made available for purchase
10 separately at the same price.

11 Section 55. Funding; publication of costs.

12 (a) The Exchange shall be financed in a manner independent
13 of general revenue funds, but that shall preclude any
14 allocations of identifiable costs to State entities for
15 specific services.

16 (b) The Exchange shall publish the average costs of
17 licensing, regulatory fees and any other payments required by
18 the Exchange and the administrative costs of the Exchange, on
19 an Internet website to educate consumers on such costs. This
20 information shall include information on money lost to waste,
21 fraud, and abuse.

22 Section 60. Relation to other laws. Nothing in this Act and
23 no action taken by the Exchange pursuant to this Act shall be
24 construed to preempt or supersede the authority of the Director

1 to regulate the business of insurance. Except as expressly
2 provided to the contrary in this Act, all health carriers
3 offering qualified health plans in this State shall comply
4 fully with all applicable health insurance laws of this State
5 and regulations adopted and orders issued by the Director.

6 Section 65. Health insurance coverage survey. The
7 Department of Insurance shall conduct an annual household and
8 employer survey regarding health insurance coverage in this
9 State, the cost of which shall be incorporated into the
10 operation costs of the Exchange. This purpose of this report is
11 to measure the current state of health insurance coverage in
12 this State, and such information shall inform the Exchange in
13 its pursuit to achieve the goals put forth in this Act. The
14 Department of Revenue and other relevant State departments and
15 agencies shall provide the Department with any and all relevant
16 information for the purposes of successfully completing this
17 survey. The Department shall deliver this report to the Board,
18 the Governor, the Clerk of the House of Representatives, and
19 the Clerk of the Senate by November 1, 2012, and the first day
20 of July annually thereafter. The Department of Insurance shall
21 make such report publicly available on its website. At a
22 minimum, the report shall include:

- 23 (1) primary and secondary sources of health insurance
24 coverage for individuals and families in this State;
25 (2) demographic characteristics of insured and

1 uninsured individuals in this State, including, but not
2 limited to:

3 (A) household income and size;

4 (B) age;

5 (C) gender;

6 (D) race;

7 (E) sexual orientation;

8 (F) geographic location;

9 (G) employment status; and

10 (H) disability status;

11 (3) barriers to health insurance coverage including,
12 but not limited to:

13 (A) financial;

14 (B) physical;

15 (C) religious or other personal restrictions;

16 (D) administrative barriers, including barriers
17 resulting from the operation of the Exchange; and

18 (E) language barriers; and

19 (4) survey of Employer-based coverage in this State,
20 including, but not limited to:

21 (A) health benefits offer rates;

22 (B) health benefits take-up rates among employees;

23 (C) scope of benefits provided (including, but not
24 limited to, comprehensive, scheduled, high-deductible,
25 catastrophic, or hospital-only coverage), including
26 the types of health plans;

- 1 (D) exclusions, restrictions, and waiting periods;
- 2 (E) worker and employer premium contributions in
- 3 accordance with the following provisions;
- 4 (i) employer size (under 20; 20-99; 100-499;
- 5 and over 500);
- 6 (ii) part-time, full-time, and seasonal
- 7 employee;
- 8 (iii) salaried, hourly employees, or exempt
- 9 and non-exempt employees; and
- 10 (iv) employee and dependent coverage available
- 11 and take-up rate;
- 12 (F) organizational characteristics of the
- 13 employer, including, but not limited to:
- 14 (i) employer size (under 20; 20-99; 100-499;
- 15 and over 500);
- 16 (ii) part-time, full-time, and seasonal
- 17 employee;
- 18 (iii) salaried, hourly employees, or exempt
- 19 and non-exempt employees; and
- 20 (iv) employee and dependent coverage available
- 21 and take-up rate; and
- 22 (G) for employers not offering coverage, reasons
- 23 for not offering.

24 Section 70. Illinois Administrative Procedures Act. The
25 provisions of the Illinois Administrative Procedures Act as now

1 or hereafter amended are hereby expressly adopted and
2 incorporated herein as though a part of this Act and shall
3 apply to all administrative rules and procedures of the
4 Exchange under this Act.

5 Section 900. The Personnel Code is amended by changing
6 Section 4c as follows:

7 (20 ILCS 415/4c) (from Ch. 127, par. 63b104c)

8 Sec. 4c. General exemptions. The following positions in
9 State service shall be exempt from jurisdictions A, B, and C,
10 unless the jurisdictions shall be extended as provided in this
11 Act:

12 (1) All officers elected by the people.

13 (2) All positions under the Lieutenant Governor,
14 Secretary of State, State Treasurer, State Comptroller,
15 State Board of Education, Clerk of the Supreme Court,
16 Attorney General, and State Board of Elections.

17 (3) Judges, and officers and employees of the courts,
18 and notaries public.

19 (4) All officers and employees of the Illinois General
20 Assembly, all employees of legislative commissions, all
21 officers and employees of the Illinois Legislative
22 Reference Bureau, the Legislative Research Unit, and the
23 Legislative Printing Unit.

24 (5) All positions in the Illinois National Guard and

1 Illinois State Guard, paid from federal funds or positions
2 in the State Military Service filled by enlistment and paid
3 from State funds.

4 (6) All employees of the Governor at the executive
5 mansion and on his immediate personal staff.

6 (7) Directors of Departments, the Adjutant General,
7 the Assistant Adjutant General, the Director of the
8 Illinois Emergency Management Agency, members of boards
9 and commissions, and all other positions appointed by the
10 Governor by and with the consent of the Senate.

11 (8) The presidents, other principal administrative
12 officers, and teaching, research and extension faculties
13 of Chicago State University, Eastern Illinois University,
14 Governors State University, Illinois State University,
15 Northeastern Illinois University, Northern Illinois
16 University, Western Illinois University, the Illinois
17 Community College Board, Southern Illinois University,
18 Illinois Board of Higher Education, University of
19 Illinois, State Universities Civil Service System,
20 University Retirement System of Illinois, and the
21 administrative officers and scientific and technical staff
22 of the Illinois State Museum.

23 (9) All other employees except the presidents, other
24 principal administrative officers, and teaching, research
25 and extension faculties of the universities under the
26 jurisdiction of the Board of Regents and the colleges and

1 universities under the jurisdiction of the Board of
2 Governors of State Colleges and Universities, Illinois
3 Community College Board, Southern Illinois University,
4 Illinois Board of Higher Education, Board of Governors of
5 State Colleges and Universities, the Board of Regents,
6 University of Illinois, State Universities Civil Service
7 System, University Retirement System of Illinois, so long
8 as these are subject to the provisions of the State
9 Universities Civil Service Act.

10 (10) The State Police so long as they are subject to
11 the merit provisions of the State Police Act.

12 (11) (Blank).

13 (12) The technical and engineering staffs of the
14 Department of Transportation, the Department of Nuclear
15 Safety, the Pollution Control Board, and the Illinois
16 Commerce Commission, and the technical and engineering
17 staff providing architectural and engineering services in
18 the Department of Central Management Services.

19 (13) All employees of the Illinois State Toll Highway
20 Authority.

21 (14) The Secretary of the Illinois Workers'
22 Compensation Commission.

23 (15) All persons who are appointed or employed by the
24 Director of Insurance under authority of Section 202 of the
25 Illinois Insurance Code to assist the Director of Insurance
26 in discharging his responsibilities relating to the

1 rehabilitation, liquidation, conservation, and dissolution
2 of companies that are subject to the jurisdiction of the
3 Illinois Insurance Code.

4 (16) All employees of the St. Louis Metropolitan Area
5 Airport Authority.

6 (17) All investment officers employed by the Illinois
7 State Board of Investment.

8 (18) Employees of the Illinois Young Adult
9 Conservation Corps program, administered by the Illinois
10 Department of Natural Resources, authorized grantee under
11 Title VIII of the Comprehensive Employment and Training Act
12 of 1973, 29 USC 993.

13 (19) Seasonal employees of the Department of
14 Agriculture for the operation of the Illinois State Fair
15 and the DuQuoin State Fair, no one person receiving more
16 than 29 days of such employment in any calendar year.

17 (20) All "temporary" employees hired under the
18 Department of Natural Resources' Illinois Conservation
19 Service, a youth employment program that hires young people
20 to work in State parks for a period of one year or less.

21 (21) All hearing officers of the Human Rights
22 Commission.

23 (22) All employees of the Illinois Mathematics and
24 Science Academy.

25 (23) All employees of the Kankakee River Valley Area
26 Airport Authority.

1 (24) The commissioners and employees of the Executive
2 Ethics Commission.

3 (25) The Executive Inspectors General, including
4 special Executive Inspectors General, and employees of
5 each Office of an Executive Inspector General.

6 (26) The commissioners and employees of the
7 Legislative Ethics Commission.

8 (27) The Legislative Inspector General, including
9 special Legislative Inspectors General, and employees of
10 the Office of the Legislative Inspector General.

11 (28) The Auditor General's Inspector General and
12 employees of the Office of the Auditor General's Inspector
13 General.

14 (29) The Board members and employees of the Illinois
15 Health Benefits Exchange.

16 (Source: P.A. 95-728, eff. 7-1-08 - See Sec. 999.)

17 Section 999. Effective date. This Act takes effect upon
18 becoming law.".

STATE OF ILLINOIS – QUARTER 2 REPORTING
STATE PLANNING AND ESTABLISHMENT GRANTS FOR THE AFFORDABLE CARE
ACT'S EXCHANGES

Appendix B: Initial Recommendations, Illinois Health Care Reform Implementation Council

HEALTH CARE REFORM IMPLEMENTATION
COUNCIL



INITIAL RECOMMENDATIONS
GOVERNOR PAT QUINN
JANUARY 31, 2011

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EXECUTIVE SUMMARY

INTRODUCTION

The federal Affordable Care Act (ACA) was signed into law on March 23, 2010. Several of the law's provisions started immediately, others took effect six months later, and more will start in 2014. Already, more than 1,000 people who were denied coverage by health insurance companies because of pre-existing conditions are now insured through Illinois' federally-funded high risk pool. Children in Illinois can no longer be denied health coverage because of a pre-existing condition. More than 120,000 Illinois seniors and people with disabilities received a \$250 rebate check last year to help cover the costs of prescription drugs. Health insurance companies must now cover immunizations, mammograms and other important procedures without charging the high deductibles and co-payments that once deterred consumers from important preventive measures. And, thanks to the ACA, more young adults can remain covered under their parents' health insurance policies.

When fully in effect in 2014, the ACA will provide many more benefits to Illinoisans, including the ability for more than one million to obtain health insurance, many for the first time. The ACA is designed for states to implement key provisions within federal guidelines. Indeed, adding more than a million residents to public and private insurance rolls compels the state to carefully examine the adequacy, quality, efficiency and effectiveness of healthcare delivery resources, insurance oversight, and funding incentives.

In response to this challenge, on July 29, 2010, Gov. Pat Quinn issued Executive Order 2010-12 establishing the Healthcare Reform Implementation Council. The purpose of the council is to recommend steps needed to improve the health of Illinois residents, by protecting consumers, increasing access to care, reducing disparities, controlling costs and improving the affordability, quality and effectiveness of healthcare. The Governor charged the council, comprised of directors of state departments responsible for elements of ACA implementation, to hear from legislators, providers, individuals and organizations throughout the state on how best to implement the ACA.

The council conducted four public meetings in Chicago, Peoria, Carbondale, and Springfield focused on the following issues: 1) establishing a health insurance exchange and related consumer protection reforms; 2) reforming Medicaid service structures and enrollment systems; 3) developing an adequate workforce; 4) incentivizing delivery systems to achieve high-quality health care; 5) identifying federal grants, pilot programs, and other non-state funding to assist with implementation of the ACA; and 6) fostering the widespread adoption of electronic medical records and participation in the Illinois Health Information Exchange. In addition, the council

solicited written comments specifically in response to a series of questions concerning implementation of the insurance exchange in Illinois. More than 150 individuals and organizational stakeholders shared their suggestions with the council.

The council's recommendations fall into two categories: issues that the state must address immediately, and decisions that will be made after the council gathers more information from stakeholders and the federal government provides additional guidance.

This document summarizes the council's initial recommendations. After another public meeting, scheduled for February 7, the council will submit the full report to the governor and begin implementation. The council will continue to advise the governor and oversee state efforts to improve protect consumers and improve access, quality and effectiveness of health care for Illinois residents.

PART ONE: RECOMMENDATIONS-IMMEDIATE ISSUES

A. Establishment of an American Health Benefits Exchange

ACA provides states with funding to plan and establish a centralized marketplace that provides individuals and small businesses with access to more affordable, comprehensive health insurance coverage options. Any state that establishes an Exchange also must establish a Small Business Health Options Program (SHOP Exchange) to assist qualified small employers in enrolling employees in qualified health plans.

By Jan. 1, 2013, states must demonstrate progress toward implementing an Exchange, or the U.S. Secretary of Health and Human Services will implement an Exchange in that state. It must be fully operational by Jan. 1, 2014.

It is in the best interest of employees and families in Illinois for the state to retain control of such an entity. State control will ensure that the Exchange reflects and meets the unique needs of Illinois. By ceding responsibility for the Exchange to the federal government, the state would lose significant oversight and consumer protection authority. The only authority that would remain with the state would involve health plans outside the Exchange. Such disparate oversight could result in adverse selection (attracting individuals with more medical needs), reduce insurance competition, and negatively affect insurance producers and clients. Illinois also would be ceding significant economic and employment opportunities for individuals and firms in Illinois to an entity in Washington, D.C.

B. Establishment of the Exchange as a quasi-governmental entity

The ACA gives states the option to establish an Exchange as a governmental agency or a nonprofit entity. This lends itself to three alternatives for the organizational structure: establish the Exchange within an existing state agency; develop an independent nonprofit entity; or create a quasi-governmental entity led by an appointed board of directors.

The third option structure is more independent from political influence than an Exchange established within an existing state government entity, and can be far more nimble in staffing, procurement and operations. By offering more competitive compensation, a quasi-governmental entity would be able to attract individuals with extensive experience both in the public and private sector, ensuring business savvy. Even with such independence, a quasi-governmental entity maintains a significant tie to the state, making it more accountable to the people and policymakers of Illinois than an independent nonprofit would be. This mechanism is not new to Illinois. Several quasi-governmental entities operate successfully, including the Illinois Health Information Exchange Authority and the Illinois Comprehensive Health Insurance Program (ICHIP).

Should the state decide to proceed with an Illinois Exchange, as the council recommends, the organizational form of the entity should be incorporated into enabling legislation to officially establish the Exchange.

B1: Operating Model

The council recommends initially organizing the Exchange as an “active purchaser” and later transitioning to a “market organizer” model once premium volume and a sufficient number of covered lives are achieved within the Exchange marketplace. This will ensure that the Exchange offers insurers strong incentives to compete, and allows individuals and small employers to benefit from Exchange-based coverage. This approach should be incorporated into the Exchange enabling legislation.

The ACA does not prescribe how the Exchange should operate within a state’s existing marketplace. In determining an operating model, the state can choose to allow all health insurers that meet minimum federal requirements to belong to the Exchange (“market organizer” model), or set more stringent criteria to ensure quality and facilitate competition (“active purchaser” model). In the active purchaser model, the Exchange negotiates with insurers and requires them to compete on price and quality to gain access to the Exchange marketplace.

The market organizer model may offer too many choices for consumers, who could find the process overwhelming. The active purchaser model could increase competition, thus reducing the price of premiums or increasing the quality of service or benefits for consumers. On the other hand, if the requirements to enter the Exchange are too strict, it could fail to offer consumers sufficient options, resulting in a marketplace that is neither competitive nor appealing to individuals or businesses. The challenge is to balance the benefits of a competitive marketplace with one that is consumer-friendly.

B2. Single Exchange or Separate Individual Market and SHOP Exchanges

The council recommends that Illinois initially establish a single Exchange entity that sells products to both individuals and small employers. The council also recommends that the state revisit merging the individual and small group risk pools after it receives additional information and analyses of the marketplace and the potential impact of this option. At that point, the state might consider adopting stricter rating rules or other market reforms to ensure a stable health insurance marketplace.

Illinois can choose to establish a single Exchange, combining the individual and SHOP (Small Business Health Options Program) Exchange, or create two separate entities. Establishing a single Exchange can benefit consumers by eliminating the possibility of confusion between the two entities. However, an individual or family may have different health plan needs than an employer or employee. Depending on the model(s) of health coverage they purchase on the SHOP Exchange, employers would benefit if the Exchange handles the transactions associated

with covering multiple employees. A single Exchange could both reduce confusion and meet the needs of small employers in simplifying health plan administration.

The state also could merge the risk pools of the individual and SHOP exchanges or maintain separate risk pools. While pooling risk could result in lower or more stable premium costs, it is unclear what the impact would be on premiums in either the individual or the small group market. The state intends to assess current market conditions in the individual and small group markets to help identify a solution that would make premiums more affordable or more stable without severely disrupting either marketplace.

B3. Regional or Subsidiary Exchanges

The council recommends that the state further examine the potential benefits of a regional Exchange, which may be necessary to accommodate the healthcare needs of Illinoisans who obtain medical care in other states.

The ACA permits states to establish regional or other interstate Exchanges, or one or more subsidiary Exchanges within a state. States are only permitted to establish subsidiary Exchanges only if each Exchange serves a geographically distinct area.

B4. Financial Sustainability

The council recommends further study to identify a long-term funding mechanism from carriers, other healthcare stakeholders, or both. Funding should be independent of state general revenue funds.

The ACA provides an uncapped amount of federal funding for states to establish an Exchange. However, it requires states to “ensure that such Exchange is self-sustaining beginning Jan. 1, 2015.” states can impose an assessment or user fee on carriers that participate in the Exchange. Illinois will have to decide whether to apply this fee only to plans that participate in the Exchange, or to apply the fee more broadly.

State funding through general revenues is an option states can consider but is highly unlikely in Illinois. Some share of Medicaid or SCHIP funding could be used to support enrollment through an Exchange. An additional option would be to assess all healthcare stakeholders that benefit from broader health insurance coverage offered through the Exchange, including not only carriers, but also providers, pharmaceutical companies, medical supply companies, and even self-insured plans.

C. Additional Health Insurance Consumer Protections

The council recommends that the state incorporate ACA reforms into state law to ensure clear, consistent, and fair implementation.

The ACA establishes important new consumer protections enabling individuals, families, and small employers to secure meaningful and affordable health insurance coverage. Some of the reforms build upon existing protections found within the Illinois Insurance Code, other state laws, or related regulations. However, most introduce new protections. For example, the ACA prohibits pre-existing condition exclusions for children under age 19 and eliminates lifetime dollar limits on “essential health benefits.” Illinois families and businesses must receive the full benefits and protections established by the ACA. The Illinois Health Insurance Portability and Accountability Act, passed by the Illinois General Assembly after enactment of the federal HIPAA law, can serve as one model for incorporating federal reforms into state law.

C1. Internal Appeals and External Review

The council recommends enacting legislation that brings Illinois law into compliance with ACA standards governing internal appeals and external review processes, to avoid federal preemption of state law.

The ACA establishes new protections to ensure that all individuals have the right to appeal an insurance company’s decision to deny needed medical care. Effective July 1, 2010, Illinois residents covered by an individual or group health insurance policy have the right to an internal appeal and an independent, external review of denied health insurance claims. The ACA reforms expand upon the appeal rights currently available to Illinois residents.

C2. Minimum Medical Loss Ratio Requirements

The council recommends enacting legislation to adopt and incorporate the ACA minimum medical loss ratio requirements into state law, given the importance of these provisions to Illinois families and businesses seeking enhanced value from the purchase of health insurance.

The ACA requires insurance companies to spend a minimum percentage of premium dollars on providing health care to policyholders (known as a “medical loss ratio”). The ACA requires minimum medical loss ratios of 85 percent in the large group market and 80 percent in the individual and small group (50 employees or fewer) markets. Insurers that do not meet the applicable minimum medical loss ratio within a given plan year will be required to issue rebates to policyholders. They also will be required to report detailed loss ratio data to regulators and make the information publicly available.

C3. Premium Rate Review

The council recommends enacting legislation giving the Department of Insurance the authority to approve or deny proposed health insurance rate increases.

The ACA includes provisions to provide consumers and regulators with more information about health insurance premium increases. However, it does not provide any new authority for state or federal regulators to prevent insurance companies from imposing unreasonable premium increases. The Department of Insurance's rate authority is limited to assuring that the rates charged by the health insurer are not so low as to jeopardize their solvency. As a result, health insurance premiums in the individual market in Illinois have increased significantly, imposing a severe burden on Illinois businesses and families.

The ACA establishes a process for the review of unreasonable premium increases by state and federal regulators. Insurers are required to submit the justification for a premium increase prior to implementing it, and to post this information on company websites.

Illinois already has taken steps to increase oversight of health insurance rate increases. The Department of Insurance was awarded a \$1 million federal grant to enhance its rate review capacity. This grant will fund upgrades to technical infrastructure and enhanced information for consumers and policymakers. Without action by the state legislature, however, Illinois families and businesses will still be vulnerable to unreasonable premium increases.

C4. Health Care Cooperative Program (CO-OPs)

The council recommends that Illinois law be amended as necessary to remove barriers and facilitate formation of nonprofit member corporations eligible for federal funding under the ACA.

The ACA appropriated \$6 billion in federal funding to facilitate creating nonprofit, member-run health insurance companies. The program, intended to provide additional coverage options for individuals and small employers, is known as the Consumer Operated and Oriented Plans (CO-OP) Program. To qualify for federal funding, an entity must be organized under state law as a nonprofit, member corporation and must meet other criteria established by the ACA. Given the highly concentrated nature of Illinois' health insurance market, the council believes Illinois businesses, in particular, would benefit from new market participants, especially the nonprofit, member-owned corporations envisioned by the ACA.

C5. Mental Health Parity

The council recommends enacting state legislation to bring Illinois law into compliance with the Mental Health Parity and Addiction Equity Act (MPHAEA) and the Mental

Health Parity Act (MHPA), which will enable the Department of Insurance to assure consistency with these federal laws.

In 2008, President George W. Bush signed into law the Wellstone-Domenici MHPAEA, which provides equivalent coverage for mental health or substance use disorders and other medical or surgical conditions.

The MHPAEA applies to group health insurance policies and HMO plans covering 51 or more employees. It builds upon the Mental Health Parity Act of 1996, which prohibited annual or lifetime limits for the treatment of mental health or substance use disorders that are less favorable than those applied to medical and surgical benefits.

Health insurance policies issued in Illinois are also required to cover treatment of certain mental health disorders pursuant to several state laws. Some provisions of these state laws conflict with, and are preempted by, the requirements of the MHPAEA or the MHPA. This recommendation will assure that plans sold outside the Exchange contain the same protections as plans sold on the Exchange.

D. Eligibility Verification and Enrollment (EVE) in Coverage

The council recommends that the state:

- **Establish an interagency project management team to ensure that state departments meet key deadlines;**
- **Allocate sufficient resources to departments engaged in ACA implementation to meet the Oct. 1, 2013, deadline to begin enrollment in the Exchange;**
- **Ensure that development of the EVE system is consistent with state efforts to coordinate enrollment across government programs;**
- **Capture as much federal funding as possible and budget sufficient state funds to acquire the necessary technology.**

The state will face a major challenge enrolling people into the various programs anticipated as part of the ACA. The best current estimate of the number of uninsured in Illinois is about 1.5 million. Of these, the council estimates:

- Between 500,000 and 800,000 people will be added to Medicaid;
- Between 200,000 and 300,000 people will purchase subsidized coverage through the Exchange;
- Between 300,000 and 600,000 people will remain uninsured.

Additionally, the council anticipates that another one million Illinoisans who are currently insured will get private insurance through the Exchange, much of it with some subsidy. The ACA requires people to be able to access Medicaid, Children's Health Insurance Program (in Illinois, All Kids) and private insurance through the Exchange.

Recent legislation in Illinois requires HFS and sister human service departments to prepare an IT plan that anticipates how the EVE system for Medicaid will be upgraded, including preparing for the additional volume and other requirements associated with ACA.

The existing Medicaid enrollment system uses an IT infrastructure that is more than 30 years old. The system is not suitable for effectively serving the current population, let alone handling a significant increase. Moreover, the reduction in caseworker numbers has led to decreased service levels and delays in processing applications. The federal government has acknowledged the policy and technical issues and has agreed to make significant resources available.

PART 2: RECOMMENDATIONS- OTHER CRITICAL ISSUES AND NEXT STEPS

A. Additional Adjustments to the Health Insurance Marketplace

A1. Participation in Exchange

The council recommends further study whether the definition of “small employer” should be increased from 50 to 100 employees and whether larger employers should be allowed to participate in the Exchange.

The ACA requires that states establish SHOP Exchanges through which “qualified employers” can offer health insurance to their employees. While the ACA defines “qualified employers” as those with up to 100 employees, it allows a state to limit Exchange participation prior to 2016 to employers with 50 or fewer employees, to accommodate states such as Illinois that currently define small employers as those with 50 or fewer employees. In 2016, all states must allow employers with up to 100 employees to participate in the Exchange; and beginning in 2017, states can choose to include employer groups of 100 or more.

Experts generally advise that Exchanges should enroll as many participants as possible since insufficient enrollment has been the primary obstacle for earlier state-based Exchanges. While expanding the number of employers who are eligible to participate in the Exchange may seem to be an obvious strategy for increasing participation, rapid expansion could make the Exchange vulnerable to adverse selection, which leads to higher premiums. This threat is particularly acute when participation is expanded to large employers, since they are not required to provide the minimum benefits mandated for plans in the Exchange. Employers with more sick or at-risk workers may choose to purchase through the Exchange, while others with healthier populations may not.

A2. Dual Market and Regulatory Parity

The council recommends that Illinois initially establish a “dual market” system and pursue legislation to foster regulatory parity between the Exchange and non-Exchange markets.

The ACA gives broad discretion to states to set rules about the Exchange’s role in state insurance markets. States can choose to require that all individual health insurance coverage be sold solely on the Exchange, folding the external market into the Exchange; or both markets could continue to exist (“dual market”) under rules that prohibit insurers from discouraging participation in the Exchange. States may also employ a hybrid of these options, such as permitting supplemental or secondary coverage to be sold in an external market but requiring that all major medical coverage be sold only in the Exchange.

The advantage of operating the Exchange as the sole market for individual and small group insurance is that the Exchange would be able to exert more influence on the cost and quality of

health care. However, there are drawbacks. An insurance carrier that did not meet the Exchange's standards for participation would effectively be kept out of the state's entire health insurance market. This could cause disruption for individuals and businesses that are happy with their current coverage.

A3. Risk adjustment, reinsurance, and risk corridors

The council recommends obtaining the statutory authority to implement federal risk adjustment measures.

The ACA provides for three risk spreading or risk mitigation programs to begin in 2014. The states will administer the risk adjustment and reinsurance programs, while HHS will establish and operate the risk corridor program. The state risk adjustment program will provide a mechanism for assessing a charge on plans that incur lower-than-average risk and providing payments to those with higher-than-average risk. According to HHS, federal rules in 2011 will outline risk adjustment methods. HHS will provide further guidance in subsequent regulations. The federal rules will apply risk adjustment consistently to all plans in the individual and small group markets, both inside and outside of Exchanges.

The transitional reinsurance program is intended to stabilize premiums in the individual market during the first three years of operation of an Exchange, when the risk of adverse selection is greatest. Although administered at the state level, the program will be federally funded and based on federal standards.

The risk corridor program established by the ACA is meant to spread risk more evenly among health plans by projecting target health claims for each plan, and then providing payments to those that exceed these health claims by more than 103 percent. The program will apply to individual and small-group products offered through the Exchange, and is based on the risk corridors used in Medicare Part D. Like the reinsurance program, the risk corridor program will be in effect during the three years beginning Jan. 1, 2014.

A4. Benefit mandates

The council recommends waiting for further guidance from HHS before deciding whether to require benefits beyond the "essential benefits" defined by HHS.

Exchanges will offer a choice of qualified health plans that vary in coverage levels but provide a package of "essential health benefits," which HHS will define based on the scope of benefits offered by a typical employer plan. Essential health benefits must include ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Some of Illinois' existing benefit mandates may not be included in the definition of "essential health benefits." The ACA allows states to require qualified health plans offered in the Exchange to provide benefits in addition to the "essential health benefits." However, states must pay for any portion of subsidized coverage that is attributed to the cost of those additional benefits. The state could consider funding these mandates separate from the Exchange.

A5. Basic Health Plan

The council recommends waiting for further guidance from HHS before deciding whether to establish a Basic Health Plan and what it should include.

The ACA allows states to contract for a coverage program for individuals and families with incomes between 133 percent and 200 percent of the poverty line. The state would receive federal funds to operate this Basic Health Plan equal to 95 percent of the cost of the premium, plus cost-sharing subsidies that would have gone to providing coverage for this group in the Exchange.

Because the Basic Health Plan would be operated under the same rules as Medicaid, the state would be able to maintain continuity of care across Medicaid and non-Medicaid programs. If properly designed, a Basic Health Plan could provide more affordable and comprehensive coverage than the Exchange. In addition, a state could provide Medicaid, CHIP, and Basic Health Plan coverage for working families, allowing them to keep the same medical providers if their income changes.

B. Consumer Issues and the Exchange

B1. Consumer Outreach

The council recommends that the state continue to engage employers, consumers, and insurers to develop an aggressive and culturally sensitive outreach plan that reflects Illinois' demographic and geographic diversity and the myriad health care needs of Illinois families and employers.

The ACA requires that the Exchange operate a toll-free customer assistance hotline; maintain a website that allows customers to compare qualified health plans; and establish a network of "Navigators" to raise awareness of the Exchange, provide information, and assist individuals and small employers in choosing and enrolling in qualified health plans.

Although individual premium subsidies and small business tax credits will be available only for plans purchased through the Exchange, participation is voluntary. Successful implementation of the Exchange will necessitate a strong outreach and education component to attract sufficient participants to ensure its stability.

B2. Role of Navigators and Producers (Agents and Brokers)

The council recommends that the state further study this issue to identify innovative solutions that maintain the vital role of insurance producers while keeping costs affordable. Navigators and producers should receive similar or identical compensation for sales both inside and outside the Exchange.

The ACA expressly lists brokers and agents as potential Navigators, but provides that Navigators cannot receive compensation directly or indirectly from insurers. However, the ACA allows states to decide how best to use insurance agents and brokers in the Exchange. Current agents and brokers are generally knowledgeable about a range of insurance products and could be helpful for individuals and groups seeking to buy insurance through the Exchange.

The state also must also ensure that people who purchase insurance outside of the Exchange have access to assistance – a role that has been, and could continue to be filled by agents and brokers.

C. Healthcare and Public Health Workforce

The council recommends convening a Healthcare Workforce work group to develop an aggressive, comprehensive plan to professional and paraprofessional healthcare and public health worker shortages statewide, now and in the future.

The plan should address:

- Workforce shortages statewide;
- Education and training for health professionals and support personnel;
- Racial, ethnic, geographic and cultural diversity of state residents;
- Public health workforce development;
- Collaboration with the Illinois Workforce Development System, including the Illinois and local Workforce Investment Boards;
- Scope of practice laws associated with healthcare, including the medical practice act, nurse practice act, pharmacist practice act, as well as new workforce categories that may be needed to assure that providers can work to the full extent of their training and education;
- Coordinating efforts of community colleges, universities, and academic medical centers to initiate and expand workforce development programs and capture funding under the new ACA Prevention and Public Health Fund and other federal education and training funding opportunities;
- Other human resources needed to prevent disease, detect it early, and manage conditions before they become severe.

The Affordable Care Act includes a comprehensive strategy with \$250 million in funding to achieve these goals by investing in new caregivers through training, new incentives to physicians

for providing primary care to patients, and support for caregivers who choose to enter primary care in underserved areas.

The Association of American Medical Colleges estimates that the nation will have a shortage of approximately 21,000 primary care physicians in 2015. Without action, experts project a continued primary care shortfall due to the needs of an aging population, decline in the number of medical students choosing primary care, and impending retirement of the Baby Boomer generation of providers. This structural shortfall occurs at a time when the ACA will significantly increase access to healthcare to more than one million Illinoisans.

It is critical that a highly qualified workforce exists to meet this heightened demand.

D. Health Information Technology

The council recommends aggressive implementation of the Illinois Health Information Exchange (HIE) Strategic and Operational Plan.

Implementing the ACA offers a historic opportunity to achieve and sustain measurable improvement in the structures, processes, and outcomes of Illinois' healthcare system.

The Illinois HIE plan, which aims to protect the privacy and security of identifiable health information, was approved by the federal government in December 2010. Stakeholders across the state are collaboratively developing the HIE.

The HIE focuses on:

- Promoting the adoption and meaningful use of electronic health records;
- Developing a statewide HIE to ensure that all Illinois providers can exchange data and participate in the federal payment incentive programs;
- Ensuring that providers who wish to begin exchanging health information electronically in 2011 can do so;
- Incorporating state information systems to ensure that providers can fulfill public health and other reporting requirements directly from their electronic health records (EHRs), as well as access vital information, such as immunization data, directly through EHRs;
- Encouraging evidence-based care delivery;
- Prioritizing standards-based public health reporting data functions (information exchange, management, and analytics) consistent with the Quality Data Set (QDS);
- Integrating state information systems (e. g., immunization data, vital records, registries) into the HIE using federally accepted guidelines.
- Developing information systems and data sources, such as an all payer claims database, that will support Illinois' quality initiatives, delivery system innovations and payment reforms

The use of electronic health records can give providers access to critical information that helps them deliver better care and provide patients access to their own health information so they can make better-informed choices about their health care. Standardized data also allows for accurate measurement of clinical quality and health outcomes. The Illinois HIE plan is available at www.hie.illinois.gov.

E. Incentives for High-Quality Care

The council recommends establishing an Interagency work group to develop a coordinated strategy among appropriate state agencies to improve healthcare quality.

The Interagency work group would ensure that Illinois plans are consistent with related federal healthcare quality strategies and federal funding opportunities intended to incentivize value-based purchasing, improve the patient's healthcare experience, promote transparency, and increase care coordination among multiple healthcare settings to improve health outcomes.

Multiple opportunities exist to engage consumers, providers, payers, and purchasers in coordinating and integrating quality improvement efforts across all aspects of healthcare reform. The work group should explore establishing a statewide all payer claims database, which other states are using successfully to monitor and improve quality.

There are numerous provisions within ACA (e.g., National Strategy to Improve Health Care Quality, Medicaid Quality Measurement Program) that address the five components identified by the National Academy for State Health Policy for improving health system quality and efficiency:

- Data collection, aggregation, and standardization, for performance measurement;
- Public reporting and transparency of data, to drive accountability;
- Payment reform and alignment of financial incentives, to encourage value-based purchasing;
- Consumer engagement, to drive policy change and encourage care self-management;
- Provider engagement, to drive policy change and to transform care delivery.

Aligning quality initiatives and incentives across healthcare payers and among multiple state agencies will reduce the administrative burden on providers, which in turn will encourage them to improve quality.

F. Reforms to Medicaid Service Structures and Incentives

The council recommends the state establish a System Design work group to identify options, establish priorities, and take advantage of appropriate funding opportunities under ACA to implement Medicaid program reforms and mandates.

As a result of ACA, Illinois estimates that an additional 500,000-800,000 residents will be eligible for healthcare coverage under the state's Medicaid program. The federal government will pay 100 percent of state costs for the newly eligible Medicaid recipients for the first four years and then reduce its contribution over time to 90 percent.

Since 1965, Medicaid has covered the state's poorest and most medically needy residents. Medicaid coverage is associated with better health compared to those with similar incomes but no health insurance. Unfortunately, decades of significant annual cost increases from higher enrollment, and increased medical and pharmaceutical costs under the state's fee-for-service reimbursement system have left the program financially unsustainable.

The numerous Medicaid challenges — from low reimbursement, to separate delivery systems for people with private insurance and those covered by Medicaid, to a lack of focus on prevention and quality — must be addressed before the influx of new covered individuals begins. Otherwise, whatever doesn't work now, still will not work — only on a bigger scale.

Perhaps more importantly, the ACA creates a real sense of opportunity because of its recognition that new models are needed, along with financial incentives for states to try them. One example is the Center for Medicare and Medicaid Innovation created by HHS to coordinate with states to meet the needs of the most expensive Medicaid beneficiaries.

The ACA is insistent about the need for greater integration in delivery of care. Integration promises reduced costs and higher quality by addressing patients' needs at the earliest possible stage in the illness or disability, while reducing the chances that services are duplicated. The integration model for Medicaid's future involves teams of health professionals in different settings connected through electronic health records, who create and implement treatment plans that meet the comprehensive needs of Medicaid clients. The requirement in the Illinois Medicaid reform legislation to serve at least half of full-time Medicaid beneficiaries in coordinated care systems reflects this priority.

New payment mechanisms also will be necessary to create adequate incentives for providers to work in teams, focus on prevention and wellness, and assure the best possible health outcomes for their patients.

The current hospital rate structure was not designed with the expectation that at least a majority of clients would be served in risk-based coordinated care systems as encouraged in the ACA and mandated in recent reform legislation. The system must be revised to facilitate enrollment of Medicaid clients in coordinated care systems while building on the strength of Illinois' hospitals and medical centers throughout the state.

G. Early Medicaid expansion

The council recommends that Illinois not apply for a federal waiver to expand Medicaid prior to 2014 unless the General Assembly lifts the recent moratorium on eligibility expansion.

The ACA allows states to apply for waivers to expand Medicaid prior to the 2014 official implementation date. However, recent Illinois legislation imposed a moratorium on Medicaid eligibility expansion. In addition, early expansion would be reimbursed only at the state's current federal Medical Assistance Percentage (50 percent, after the stimulus increment expires in 2011) and state resources to expand are not available.

However, there may be other governmental entities within Illinois for which early coverage of low-income adults would be financially beneficial. For example, when the cost of care is funded entirely through intergovernmental transfers it could be worthwhile to collect 50 percent federal matching funds on behalf of residents for whom no federal share is now available.

STATE OF ILLINOIS – QUARTER 2 REPORTING
STATE PLANNING AND ESTABLISHMENT GRANTS FOR THE AFFORDABLE CARE
ACT'S EXCHANGES

Appendix C: Department of Insurance Webinar: Exchange Governance and Long-Term Fiscal
Sustainability



America's Health Benefits Exchanges



Exchange Governance and Long-Term Fiscal Sustainability

IL DEPARTMENT OF INSURANCE
JANUARY 24, 2011

Governance

2

- **Governance Questions to be Considered:**
 - Where should the Exchange be located?
 - Should the Exchange be run by a Governing Board?
 - ✦ What should the composition of the Board be?
 - ✦ How should Board members be selected or appointed?
 - ✦ Conflict of interest provisions?
 - Should the Exchange be subject to State laws governing hiring and procurement?
 - What level of transparency and public accountability is desired?

ACA Requirements and Federal Guidance

3

- Section 1311(d)(1) of the ACA requires an Exchange to be “a governmental agency or a nonprofit entity that is established by a State.”
 - Three basic alternatives: (1) New or existing state agency; (2) Nonprofit entity established by State; or (3) Quasi-governmental entity.
- Section 1311(d)(6) requires an Exchange to “consult with [relevant] stakeholders,” including enrollees, representatives of small businesses, Medicaid offices, and advocates for enrolling hard to reach populations.

ACA Requirements and Federal Guidance (ct'd)

4

- Initial guidance from HHS:
 - Regardless of organizational form (state agency, quasi-governmental, or nonprofit entity), an Exchange must:
 - ✦ Be “publicly accountable”
 - ✦ Be “transparent”
 - ✦ Have “technically competent leadership, with the capacity and authority to take all actions necessary to meet federal standards, including:
 - Discretion to determine whether health plans offered through the Exchange are ‘in the interests of qualified individuals and qualified employers’ as Section 1311(e)(1) requires.”

Governance Options - Location

5

| | State Agency | Quasi-governmental | Nonprofit Entity |
|------|--|--|--|
| Pros | <ul style="list-style-type: none"> • Public accountability, transparency • Coordination among State agencies | <ul style="list-style-type: none"> • More independent • Possible exemption from State procurement and personnel laws | <ul style="list-style-type: none"> • Flexibility in decision-making • Less chance for decisions to be politicized |
| Cons | <ul style="list-style-type: none"> • Possible politicization • Instability and lack of independence | <ul style="list-style-type: none"> • More planning necessary to coordinate among State agencies, including Medicaid office and Insurance Department | <ul style="list-style-type: none"> • Isolation from State agencies • Potential for decreased accountability and transparency |

Models from Other States

6

- Existing Insurance Exchanges:
 - Massachusetts “Connector”
 - ✦ <https://www.mahealthconnector.org/portal/site/connector/>
 - Utah Health Exchange
 - ✦ <http://www.exchange.utah.gov/>
- Legislation Establishing Insurance Exchanges:
 - California (passed), Wisconsin, Pennsylvania, Montana, and others --
<http://www.insurance.illinois.gov/hiric/topical.asp#HIE>
- Other State Entities
 - *e.g.*, Illinois Comprehensive Health Insurance Plan, Office of Health Information Technology

Comparison of Selected State Models

7

| | Massachusetts | Utah | California |
|--------------------------------|--|--|---|
| Location | Quasi-governmental | State agency, with <i>Advisory Board</i> | Quasi-governmental |
| Number of Voting Board Members | 10 | 8 | 5 |
| Length of Term | 3 years | N/A | 4 years |
| Selection of Board Members | <ul style="list-style-type: none"> • 4 <i>ex officio</i> members (e.g., Insurance Commissioner) • 3 Governor appointees • 3 AG appointees | <ul style="list-style-type: none"> • Selected by Director of Office Of Economic Development | <ul style="list-style-type: none"> • 1 <i>ex officio</i> member • 2 Governor appointees • 2 legislative appointees |

Comparison of Selected State Models (ct'd)

| | Massachusetts | Utah | California |
|------------------------------------|--|---|--|
| Board Composition / Representation | <p><u>State agencies</u></p> <ul style="list-style-type: none"> • Medicaid, Insurance, Group Insurance Commission, Administration and Finance <p><u>Interest Groups</u></p> <ul style="list-style-type: none"> • Consumers (1), small businesses (1), organized labor (1) <p><u>Skills/Expertise</u></p> <ul style="list-style-type: none"> • Actuary (1), health economist (1), employee health benefits plan specialist (1) | <p><u>State agencies</u></p> <ul style="list-style-type: none"> • Insurance, Department of Health <p><u>Interest Groups</u></p> <ul style="list-style-type: none"> • Producers (2), consumers (2), “large insurer” (1), “small insurer” (1) | <p>Each board member must have expertise in at least 2 of the following areas:</p> <ul style="list-style-type: none"> • Individual coverage • Small employer coverage • Health plan administration • Health care finance • Administering health care delivery system • Purchasing coverage |

Long-Term Fiscal Sustainability

- The ACA provides federal funding for states to establish an Exchange.
- Section 1311(d)(5) of the ACA requires states to “ensure that such Exchange is self-sustaining beginning January 1, 2015.”
- ACA does not simply allocate funding, but actually appropriates funding.

Long-Term Fiscal Sustainability

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- The ACA does not prescribe how a State Exchange must be self-sustaining, and provides only:

“allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.”

Long-Term Fiscal Sustainability

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Costs Associated with Illinois Exchange

- Unknown: Illinois is requesting analysis of estimated operational costs.

Other States' Experience

- Wide variation: \$600,000/yr (Utah experience) - \$48-49 million/yr (Oregon estimate).
- Basis for Cost Difference: Wide variation in the responsibilities delegated to the Exchange.

Funding Options

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1. Assessment or User fee on insurers
2. State funding, through a commitment of general revenues
3. Assessment or User fee on consumers
4. Licensure fee on “Navigators”
5. Assessment on all health care stakeholders
6. Others?

Funding Options

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1. Assessment or User Fee on Insurers

- Example: Massachusetts
- Considerations:
 - All insurers or only those selling on the Exchange?
 - What is the effect of limiting the applicability of a fee to only some insurers on the cost of coverage in the Exchange?

2. State Funding (General Revenues)

- Example: Utah
- Considerations:
 - Dependence on general revenue fund may be detrimental to stability.
 - Changes in State leadership may lead to instability and defeat the value of the Exchange as a market.

Funding Options

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3. Assessment or User fee on Consumers

- No state currently employs this option
- Considerations:
 - Income sensitivity
 - Protections against multiple assessments

4. Licensure fee on Navigators

- No state currently employs this option
- Consideration:
 - Insufficient to fund Exchange operations

Funding Options

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5. Assessment on all health care stakeholders

- Includes carriers, providers, pharmaceutical companies, medical supply companies, self-insured plans, etc.
- No state currently employs this option, but some (Maryland) are considering it as an option.
- Considerations
 - How broadly to spread the cost?
 - What is the impact on cost of needed medical care and services?

**QUESTIONS
or
COMMENTS?**

ADDITIONAL FEEDBACK

The Department of Insurance welcomes comments at any time. Feedback can be sent to doi.healthreform@illinois.gov .

STATE OF ILLINOIS – QUARTER 2 REPORTING
STATE PLANNING AND ESTABLISHMENT GRANTS FOR THE AFFORDABLE CARE
ACT'S EXCHANGES

Appendix D: Department of Insurance Webinar: Exchange Operating Model: Considerations for
Illinois



America's Health Benefits Exchanges



EXCHANGE OPERATIONS MODEL: CONSIDERATIONS FOR ILLINOIS

ILLINOIS DEPARTMENT OF INSURANCE
FEBRUARY 17, 2011

Previous DOI Webinars

2

- **Exchange Basics (12/14/10)**
 - What is an American Health Benefits Exchange?
 - What are the elements of a successful Exchange?
 - What are the key decision points for Illinois, and what actions has the State taken to date?
- **Exchange Governance and Fiscal Sustainability (01/24/11)**
 - What are the pros and cons of the various governance models for a State Exchange?
 - What are possible funding sources for an Exchange?
- **Health Insurance Premium Increases in Illinois (02/01/11)**
 - What is the rate review process established by the ACA?
 - What authority do insurance regulators in Illinois and other states have to prevent unreasonable premium increases?
 - What factors affect the premiums paid by Illinois families and employers?

Overview of Presentation

3

- Certification of Exchange plans: ACA requirements and federal guidance
- “Market Developer” and “Market Organizer” models
- Examples from other states
- Illinois considerations

ACA Requirements and Federal Guidance

- Only “qualified health plans” can be sold through an Exchange.
- A qualified health plan must (Sec. 1301(a)):
 - Provide the “essential health benefits” package;
 - Be offered by an insurer that:
 - ✦ is licensed and in good standing in the State;
 - ✦ agrees to offer at least one “silver” and one “gold” plan;
 - ✦ agrees to charge the same premium outside the Exchange for each plan offered through the Exchange; and
 - ✦ complies with requirements established by U.S. Department of Health and Human Services (HHS) and **any additional requirements established by the Exchange**; and
 - Have a current certification from the Exchange.

ACA Requirements and Federal Guidance

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- A plan cannot be certified as a “qualified health plan” unless:
 - The plan meets the minimum requirements to be developed by HHS (including requirements respecting marketing, network adequacy, and quality improvement practices); and
 - The **“Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State.”** (Sec. 1311(e))

ACA Requirements and Federal Guidance

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- In other words, the ACA vests Exchanges with broad discretion to determine which (and how many) insurers participate in a given Exchange, and the number and range of plan variations that are made available to consumers.

- Continuum of operating models:

“Market organizer”

“Market developer”

e.g., Utah

e.g., Massachusetts

Market Organizer vs. Market Developer

7

- *HHS Initial Guidance to States on Exchanges:*
 - Under the “market organizer” model, the Exchange “operates as a clearinghouse that is open to all qualified insurers and relies on market forces to generate product offerings.”
 - A “market developer” (or “active purchaser”) Exchange “operates as large employers often do in using market leverage and the tools of managed competition to negotiate product offerings with insurers.”
 - “In both cases...States should provide comparison shopping tools that promote choice based on price and quality and enable consumers to narrow plan options based on their preferences.”

Market Developer Model: Examples from Other States

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- California legislation (AB1602, Sec. 7(c)):
 - The Exchange must develop criteria—in addition to the minimum requirements to be established under the ACA—for selecting plans that “are in the **best interests of qualified individuals and qualified small employers.**”
 - The Exchange must selectively contract with insurers with the goal of providing “health care coverage choices that offer the **optimal combination of choice, value, quality, and service.**”

Market Developer Model: Examples from Other States

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- Massachusetts Health Connector
 - Commonwealth Choice “seal of approval” only given to plans that:
 - ✦ “Meet all requirements of [state law];
 - ✦ provide **good value** to consumers;
 - ✦ offer **high quality**;
 - ✦ are offered through the Connector.”

(Mass. Gen. Laws 176Q, Sec. 10)

Exchange Operations Model: Questions for Policymakers

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- The operating model that is most appropriate for a given state will depend on many factors, including:
 - The organizational structure, governance model, and principles guiding the Exchange's operation;
 - The size of the Exchange:
 - ✦ Exchanges with fewer current or prospective covered lives will be less attractive to insurers and will thus lack bargaining power; and
 - Competition in existing health insurance market
 - ✦ Exchanges in markets dominated by three or fewer insurers may have difficulty bargaining;
 - ✦ However, the Exchange will only be attractive to insurers if there is a sufficient number of covered lives.

Illinois Market Concentration

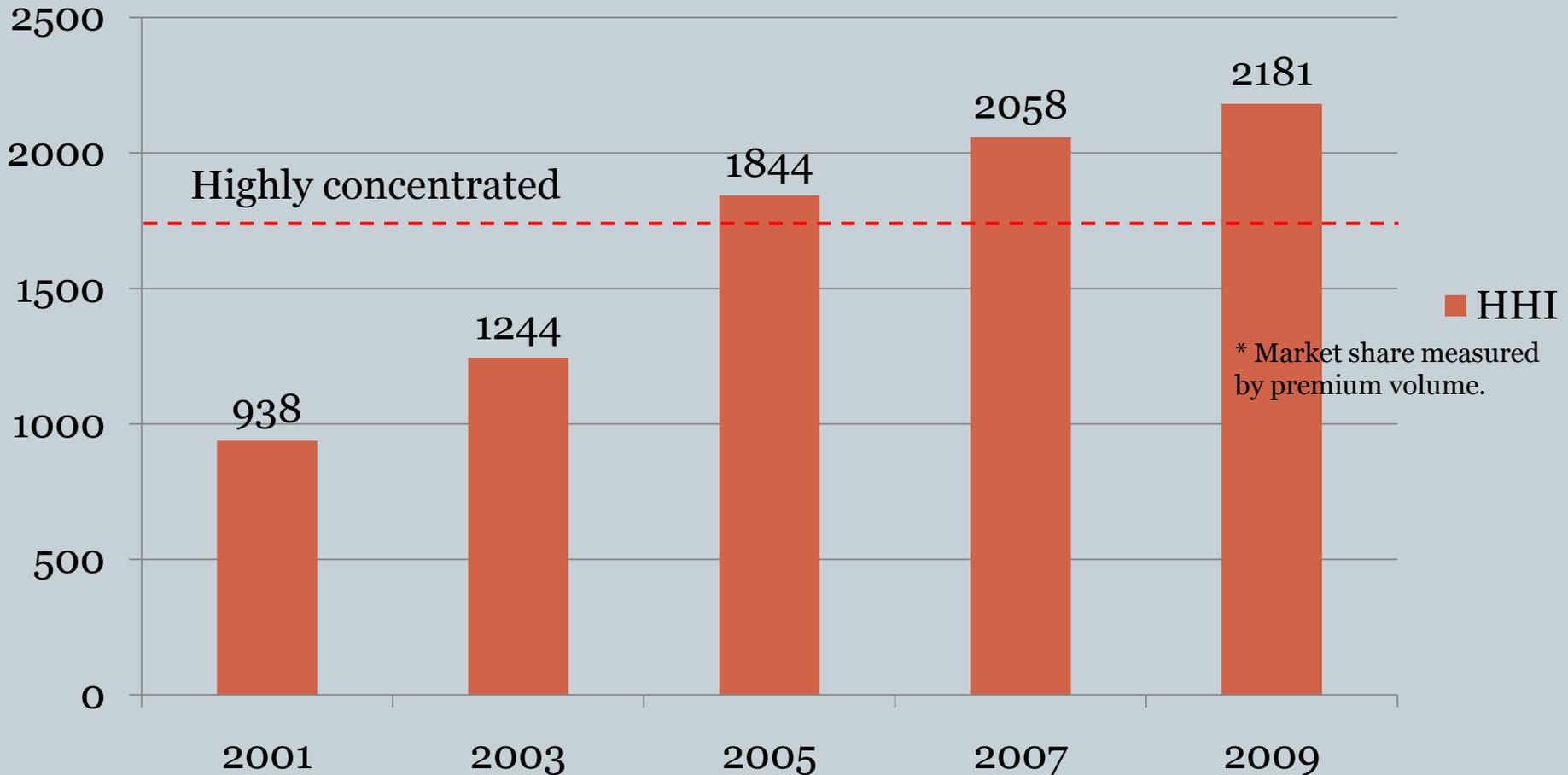
11

- The Herfindahl-Hirschman Index (HHI) is a standard measure of market concentration, taking into account both the number of firms, and the market share that each commands. The lower the HHI index, the more competition in the market.
 - An HHI index of over 1000 indicates a “moderately concentrated” market and an HHI above 1800 indicates a “highly concentrated” market.
 - Generally, more competition means lower prices.
 - Illinois should have a competitive health insurance market that provides meaningful choice for families, individuals and employers.

Illinois Market Concentration

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Herfindahl-Hirschmann Index



Exchange Operating Model: Illinois Recommendation

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- **Primary goals:**
 - Increased competition among health insurers => increased choices for families and small employers;
 - Enhanced value of health insurance products;
 - Better quality of health care;

Exchange Operating Model: Illinois Recommendation

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- Primary Goals (cont.):
 - Health insurer competition benefits patients, families, employers, and providers.
 - ✦ More volume makes Exchange more attractive to health insurers;
 - ✦ Competition between insurers allows consumer choice based on cost and/or quality;
 - ✦ Competition allows providers to better leverage performance and quality of service when negotiating with insurers;
 - ✦ Business owners express concern that the cost of health insurance is a priority -- competition among health insurers makes Illinois a more attractive destination for employers; and
 - ✦ Competition among health insurers reduces demand for regulatory intervention, and allows market forces to hold insurers accountable.

Exchange Operating Model: Illinois Recommendation

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- Competition = Choice;
- Choice = Market Efficiency;
- Market Efficiency = better cost and quality of Illinois Exchange.

Exchange Operating Model: Illinois Recommendation

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- Legislation authorizing an Exchange in Illinois **should not require** the Exchange to certify all plans meeting minimum federal requirements, but may give the Exchange the **option of being a market developer**.
 - Exchange may make choice.
 - The Exchange would then exercise its authority based on early market share of the Exchange (number of covered lives or premium volume) and external market conditions.
 - Depending on experience after first several years, Exchange supervisors may transition from market developer to market organizer model, or vice versa.
- **Feedback welcome!**

QUESTIONS or COMMENTS?

doi.webinars@illinois.gov

ADDITIONAL FEEDBACK

The Department of Insurance welcomes comments at any time. Feedback can be sent to doi.healthreform@illinois.gov .

STATE OF ILLINOIS – QUARTER 2 REPORTING
STATE PLANNING AND ESTABLISHMENT GRANTS FOR THE AFFORDABLE CARE
ACT'S EXCHANGES

Appendix E: Research Assistant Resumes

Megan R. Moore

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meganrmoore@uchicago.edu

5645 S. Blackstone Ave., Apt. 2W
Chicago, IL 60637

EDUCATION

UNIVERSITY OF CHICAGO, Chicago, IL

Master of Public Policy Candidate, 2011

- Recipient of the Dean's Scholarship and the Ray E. Brown Recruitment Fellowship

UNIVERSITY OF MARYLAND, College Park, MD

Bachelor of Arts, Economics (*Magna cum laude*), 2006

- University Honors Program

WORK EXPERIENCE

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Washington, DC

Intern, Office of the Secretary, Summer 2010.

- Analyzed and summarized healthcare reform legislation and related regulations to identify policy concerns for the Assistant Secretary for Financial Resources.
- Drafted and reviewed Medicare legislative proposals and prepared presentation materials for policy officials.
- Worked with the Center for Medicare and Medicaid Services to produce well-justified budget requests that aligned with the President's policy priorities.

MILLS PENINSULA MEDICAL GROUP (MPMG), Burlingame, CA

Special Projects Lead, June 2008 – July 2009.

- Designed and implemented a system to manage high-risk patients across the continuum of care.
- Increased enrollment in MPMG's outpatient heart failure program by improving the inpatient referral and orientation processes.
- Managed the collection of patient satisfaction survey data, generated feedback reports for individual physicians, presented findings, and modeled potential changes to survey methodology.
- Analyzed resource use and health outcomes for patients enrolled in disease management programs.

MEDICARE PAYMENT ADVISORY COMMISSION (MedPAC), Washington, DC

MedPAC is an independent federal agency charged with advising Congress on Medicare issues. A staff of analysts supports a seventeen-member commission of health care experts.

Research Assistant, August 2006 – May 2008.

- Evaluated payment policy, access to care, quality of care, and proposals addressing the sustainability of the Medicare Program.
- Analyzed survey data from beneficiaries and providers to identify trends in access to care.
- Presented analysis at public meetings and wrote text for Congressional reports.
- Interviewed stakeholders, conducted literature reviews, and coordinated expert panels.
- Performed analysis of Medicare claims data using statistical software packages, mapped data, and managed contracts with research organizations.

PUBLIC PRESENTATIONS

- "Findings on physician resource-use: Site visits." Presentation to the Medicare Payment Advisory Commission, Washington, DC, September 6, 2007. Copresenter with Jennifer Podulka.
- "Update on episode grouper work: Stability of year-to-year physician resource-use measurement." Presentation to the Medicare Payment Advisory Commission, Washington, DC, January 11, 2008. Copresenter with Jennifer Podulka.

SKILLS AND TRAINING

- Proficient in SAS, STATA, MapInfo, Microsoft Office
- Management & Clinical Excellence Training on implementing and evaluating quality improvement initiatives, Sutter Health

MAX FLETCHER

EXPERIENCE

Staff Assistant, District Office of U.S. Representative Melissa L. Bean (Schaumburg, IL) July 2009-Present

- Summarized all legislative correspondence received in office for response by Congresswoman and Washington staff
- Assisted constituents with federal agency casework
- Drafted correspondence on behalf of the Congresswoman
- Compiled and distributed morning press summaries for Congresswoman and staff
- Updated and maintained sections of the Congresswoman's website
- Represented and staffed the Congresswoman at community events
- Provided information about legislation to constituents who contacted the office by phone

Volunteer Field Staffer, Melissa Bean for Congress (Palatine, IL and Grayslake, IL) September 2010-November 2010

- Directed all training of volunteer canvassers at an Illinois Democratic Coordinated Campaign staging location
- Compiled data from canvasses and reported to supervisors
- Recruited additional campaign volunteers
- Monitored polling sites on Election Day and conferred with election staff to determine turnout
- Participated in phone banking and canvassing

Co-Chairperson, Northwestern Community Development Corps (NCDC) (Evanston, IL) March 2008-April 2009

- Oversaw all activities of a community service and social activism organization with over 400 active student members and 25 volunteer sites across the Chicago region
- Obtained and managed a budget of over \$25,000 as Financial President of the organization
- Developed partnerships with other campus organizations to educate members about social issues relating to their interests
- Awarded Northwestern University's Most Outstanding Student Organization, 2008 and 2009

Intern, Washington Office of U.S. Representative Timothy Walz (Washington, DC) June 2008-August 2008

- Researched implications of new legislation
- Attended committee hearings and legislative briefings and compiled summaries for members of the Congressman's staff
- Drafted responses to letters from constituents on behalf of the Congressman
- Provided information to constituents who contacted the office by phone

Co-Chairperson, Undergraduate Lecture Series on Race, Poverty, and Inequality (Evanston, IL) April 2007-April 2008

- Researched public policy surrounding issues of social justice and organized lecture events with leading scholars, policy makers, and community activists
- Promoted events to student body and surrounding community
- Raised and managed funds and negotiated compensation agreements with speakers
- Doubled previous year's attendance at events

Iowa Field Intern, Obama for America (Charles City, IA) June 2007-August 2007, January 2008

- Assisted in the coordination of campaign events, including candidate and other VIP visits
- Trained and directed volunteers in phone banking and canvassing operations
- Canvassed voters and participated in final get-out-the-caucus campaign
- Provided information to voters regarding then-Senator Obama's positions on campaign issues

OTHER EXPERIENCE AND SELECTED AWARDS

2007-2009: Security Attendant, Northwestern University Library
2006-2008: Counselor, Northwestern University Freshman Urban Program
2007: National Call Center Volunteer, Obama for America
2006-2007: Volunteer Site Leader, Mather Pavilion Nursing Home
2005-2006: Volunteer Tutor, Family Focus after-school program
2005: National Merit Scholarship winner
2005: Eagle Scout Award, Boy Scouts of America

EDUCATION

Northwestern University, Evanston, IL

B.S., Social Policy, June 2009

GPA: 3.61/4.00

Dean's List, DERU Senior Honorary Society

STATE OF ILLINOIS – QUARTER 2 REPORTING
STATE PLANNING AND ESTABLISHMENT GRANTS FOR THE AFFORDABLE CARE
ACT'S EXCHANGES

Appendix F: Estimated Exchange Budget: FFY 2011-FFY 2014

| FUNCTION | FFY 2011 | FFY 2012 | FFY 2013 | FFY 2014 |
|--------------------------------|---------------------|---------------------|---------------|---------------|
| Background Research | | | | |
| Salaries and Wages | --- | --- | --- | --- |
| FTEs | --- | --- | --- | --- |
| Fringe Benefits | --- | --- | --- | --- |
| Consultant Costs | \$948,704.70 | \$130,000.00 | --- | --- |
| Equipment | --- | --- | --- | --- |
| Supplies | --- | \$500.00 | --- | --- |
| Travel | --- | \$2,000.00 | --- | --- |
| Other | --- | --- | --- | --- |
| Contractual Costs | --- | --- | --- | --- |
| Subtotal | \$948,704.70 | \$132,500.00 | \$0.00 | \$0.00 |
| | | | | |
| Stakeholder Involvement | | | | |
| Salaries and Wages | --- | \$57,600.00 | --- | --- |
| FTEs | --- | 0.50 | --- | --- |
| Fringe Benefits | --- | \$13,500.00 | --- | --- |
| Consultant Costs | --- | \$250,000.00 | --- | --- |
| Equipment | --- | --- | --- | --- |
| Supplies | --- | \$500.00 | --- | --- |
| Travel | --- | \$10,000.00 | --- | --- |
| Other | \$3,000.00 | \$3,000.00 | --- | --- |
| Contractual Costs | --- | --- | --- | --- |
| Subtotal | \$3,000.00 | \$334,600.00 | \$0.00 | \$0.00 |
| | | | | |
| Program Integration | | | | |
| Salaries and Wages | --- | \$42,600.00 | \$60,000.00 | \$60,000.00 |
| FTEs | --- | 0.50 | 1.00 | 1.00 |
| Fringe Benefits | --- | \$9,000.00 | \$18,000.00 | \$18,000.00 |
| Consultant Costs | --- | --- | --- | --- |

State of Illinois -- Quarter 2 Report

State Planning and Establishment Grants for the Affordable Care Act's Exchanges

| | | | | |
|-----------------------------------|--------------------|---------------------|---------------------|---------------------|
| Equipment | --- | --- | --- | --- |
| Supplies | --- | \$750.00 | \$1,000.00 | \$1,000.00 |
| Travel | --- | \$3,000.00 | \$3,000.00 | \$3,000.00 |
| Other | --- | --- | --- | --- |
| Contractual Costs | --- | --- | --- | --- |
| Subtotal | \$0.00 | \$55,350.00 | \$82,000.00 | \$82,000.00 |
| Resources and Capabilities | | | | |
| Salaries and Wages | \$37,707.60 | \$75,415.20 | \$75,415.20 | \$75,415.20 |
| FTEs | 1.50 | 1.50 | 1.50 | 1.50 |
| Fringe Benefits | \$2,884.50 | \$16,500.00 | \$16,500.00 | \$16,500.00 |
| Consultant Costs | --- | --- | --- | --- |
| Equipment | --- | --- | --- | --- |
| Supplies | --- | --- | --- | --- |
| Travel | \$7,703.20 | \$10,000.00 | \$10,000.00 | \$10,000.00 |
| Other | --- | --- | --- | --- |
| Contractual Costs | --- | --- | --- | --- |
| Subtotal | \$48,295.30 | \$101,915.20 | \$101,915.20 | \$101,915.20 |
| Governance | | | | |
| Salaries and Wages | --- | \$87,500.00 | \$320,000.00 | \$320,000.00 |
| FTEs | --- | 0.75 | 3.00 | 3.00 |
| Fringe Benefits | --- | \$26,250.00 | \$96,000.00 | \$96,000.00 |
| Consultant Costs | --- | --- | --- | --- |
| Equipment | --- | \$3,000.00 | \$2,200.00 | --- |
| Supplies | --- | \$500.00 | \$3,000.00 | \$600.00 |
| Travel | --- | \$39,000.00 | \$70,000.00 | \$70,000.00 |
| Other | --- | \$15,000.00 | \$42,000.00 | \$37,000.00 |
| Contractual Costs | --- | --- | --- | --- |
| Subtotal | \$0.00 | \$171,250.00 | \$533,200.00 | \$523,600.00 |

| | | | | |
|---------------------------------|---------------|------------------------|------------------------|-----------------------|
| Finance | | | | |
| Salaries and Wages | --- | \$30,000.00 | \$310,000.00 | \$430,000.00 |
| FTEs | --- | 0.25 | 4.00 | 6.00 |
| Fringe Benefits | --- | \$9,000.00 | \$93,000.00 | \$129,000.00 |
| Consultant Costs | --- | --- | \$100,000.00 | \$30,000.00 |
| Equipment | --- | --- | \$6,000.00 | \$4,400.00 |
| Supplies | --- | --- | \$800.00 | \$1,200.00 |
| Travel | --- | --- | \$5,000.00 | \$5,000.00 |
| Other | --- | --- | \$61,000.00 | \$59,000.00 |
| Contractual Costs | --- | --- | --- | --- |
| Subtotal | \$0.00 | \$39,000.00 | \$575,800.00 | \$658,600.00 |
| | | | | |
| Technical Infrastructure | | | | |
| Salaries and Wages | --- | \$1,200,000.00 | \$1,200,000.00 | \$800,000.00 |
| FTEs | --- | 15.00 | 15.00 | 10.00 |
| Fringe Benefits | --- | \$360,000.00 | \$360,000.00 | \$240,000.00 |
| Consultant Costs | --- | \$8,000,000.00 | \$10,000,000.00 | \$2,000,000.00 |
| Equipment | --- | \$22,500.00 | \$5,250.00 | \$3,500.00 |
| Supplies | --- | \$3,000.00 | \$3,000.00 | \$2,000.00 |
| Travel | --- | \$5,000.00 | \$5,000.00 | \$5,000.00 |
| Other | --- | --- | --- | \$90,000.00 |
| Contractual Costs | --- | \$625,000.00 | \$2,500,000.00 | \$2,500,000.00 |
| Subtotal | \$0.00 | \$10,215,500.00 | \$14,073,250.00 | \$5,640,500.00 |
| | | | | |
| Business Operations | | | | |
| Salaries and Wages | --- | --- | \$600,000.00 | \$1,800,000.00 |
| FTEs | --- | --- | 10.00 | 30.00 |
| Fringe Benefits | --- | --- | \$180,000.00 | \$540,000.00 |
| Consultant Costs | --- | --- | \$75,000.00 | \$25,000.00 |
| Equipment | --- | --- | \$15,000.00 | \$10,500.00 |
| Supplies | --- | --- | \$2,000.00 | \$6,000.00 |

State of Illinois -- Quarter 2 Report

State Planning and Establishment Grants for the Affordable Care Act's Exchanges

| | | | | |
|-------------------------------------|-----------------------|------------------------|------------------------|------------------------|
| Travel | --- | --- | \$5,000.00 | \$5,000.00 |
| Other | --- | --- | \$90,000.00 | \$270,000.00 |
| Contractual Costs | --- | --- | \$550,000.00 | \$17,775,000.00 |
| Subtotal | \$0.00 | \$0.00 | \$1,517,000.00 | \$20,431,500.00 |
| | | | | |
| Regulatory or Policy Actions | | | | |
| Salaries and Wages | --- | --- | \$350,000.00 | \$1,090,000.00 |
| FTEs | --- | --- | 4.00 | 15.00 |
| Fringe Benefits | --- | --- | \$105,000.00 | \$327,000.00 |
| Consultant Costs | --- | --- | \$100,000.00 | \$100,000.00 |
| Equipment | --- | --- | \$6,000.00 | \$17,900.00 |
| Supplies | --- | --- | \$800.00 | \$3,000.00 |
| Travel | --- | --- | \$10,000.00 | \$10,000.00 |
| Other | --- | --- | \$5,000.00 | \$5,000.00 |
| Contractual Costs | --- | --- | --- | --- |
| Subtotal | \$0.00 | \$0.00 | \$576,800.00 | \$1,552,900.00 |
| TOTAL | \$1,000,000.00 | \$11,050,115.20 | \$17,459,965.20 | \$28,991,015.20 |

State of Illinois -- Quarter 2 Report
 State Planning and Establishment Grants for the Affordable Care Act's Exchanges

| <i>TOTAL</i> | FFY 2011 | FFY 2012 | FFY 2013 | FFY 2014 |
|---------------------|-----------------|-----------------|----------------------|------------------------|
| Salaries and Wages | \$37,707.60 | \$1,493,115.20 | \$2,915,415.20 | \$4,575,415.20 |
| FTEs | 1.5 | 18.50 | 38.5 | 66.5 |
| Fringe Benefits | \$2,884.50 | \$434,250.00 | \$868,500.00 | \$1,366,500.00 |
| Consultant Costs | \$948,704.70 | \$8,380,000.00 | \$10,275,000.00 | \$2,155,000.00 |
| Equipment | \$0.00 | \$25,500.00 | \$34,450.00 | \$36,300.00 |
| Supplies | \$0.00 | \$5,250.00 | \$10,600.00 | \$13,800.00 |
| Travel | \$7,703.20 | \$69,000.00 | \$108,000.00 | \$108,000.00 |
| Other | \$3,000.00 | \$18,000.00 | \$198,000.00 | \$461,000.00 |
| Contractual Costs | \$0.00 | \$625,000.00 | \$3,050,000.00 | \$20,275,000.00 |
| Subtotal | \$1,000,000.00 | \$11,050,115.20 | \$17,459,965.20 | \$28,991,015.20 |
| | | | PROJECT TOTAL | \$58,501,095.60 |