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

**HEALTH INSURANCE REFORMS AND THE ESTABLISHMENT OF AN  
EXCHANGE**

**INTRODUCTION**

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

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

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

It is critical that the State establish a Health Benefits Exchange in ways that do not disrupt the existing marketplace and undermine hospitals and other providers that are critical to the

health care delivery system. Specifically, we have several key concerns that we believe the state will have to address as it creates an Exchange.

**First, the state shouldn't bite off more than it can chew.** We encourage the Committee to build on existing strengths as you deliberate on how any Exchange will be established. For efficiency purposes, the state should work through a single Exchange that recognizes the limitations on payers' service areas and provider networks just as the commercial market works today.

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

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

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

**Second, the Exchange should ensure an open and simple enrollment process.** Key to a successful Exchange is consumer participation and avoidance of adverse selection. Thus, ease of enrollment for consumers, ease of insurer administration, and clarity of oversight of plans are necessary for the establishment of a successful Exchange. To ensure a smooth transition to an Exchange format, IHA would recommend establishing minimum requirements as required by the ACA to allow the Exchange to facilitate consumer choice and enrollment and not act as a purchaser of commercial health insurance plans. Consideration should also be given to ensure that persons who are accustomed to the

traditional venues for enrolling in Medicaid and other federal and state assistance programs are not forced into an unfamiliar arena to enroll in these programs. The state should ensure the electronic enrollment platforms for enrollment in Medicaid and the state's Children's Health Insurance Program (SCHIP) are developed in such a way to minimize disruption in 2014 when enrollment in these programs will also be incorporated into the Exchange enrollment process. Finally, to assist enrollees, the ACA requires an Exchange to establish a navigator program under which it awards grants to qualified entities to carry out defined education of individuals and facilitate enrollment in qualified plans. Hospitals are often the first contact point for uninsured persons seeking medical care. As such, IHA recommends that hospitals wishing to act as navigators should be awarded navigator status.

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

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

Because hospitals are key economic engines for Illinois communities, generating not only hundreds of thousands of jobs but also billions of dollars for the state's economy, it is critical during this transition, that hospitals have flexibility to sustain current operations, while simultaneously taking steps to re-align, integrate with other providers, and better

coordinate care, in accordance with an expected plethora of new federal rules. The State must resist establishing rigid requirements that impair these efforts. The State should also provide for periodic evaluations of new arrangements and requirements, to allow for mid-course corrections that reflect what is learned by early adopters of new delivery and payment systems.

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