

October 6, 2011

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

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

SUBJECT: Funding the Illinois Health Benefits Exchange

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

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

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

Exchange Financing

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

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

Insurer Assessment Should Be Broad Based

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

Avoid Further Disadvantaging Hospital Providers

Hospitals have been the focus of many efforts at the state and local levels to reduce the level of reimbursement for treatment provided to consumers in both the public and private sectors. We urge legislators to understand that an array of unprecedented financial changes and turmoil threaten the stability of Illinois hospitals and the state's health care delivery system. The state has substantially reduced Medicaid and Workers' Compensation funding for hospitals by many hundreds of millions of dollars this year. The recession has swollen the Medicaid rolls and the ranks of the uninsured – putting further stress on hospitals. And actions at the federal level threaten to substantially reduce payment for Medicare services.

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

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

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

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

Hospitals Have Already Contributed to Health Care Reform

While Illinois hospitals support health care reform and its promise of coverage for a majority of the state's 1.9 million uninsured, it is important to understand that hospitals are already helping finance reform. The Patient Protection and Affordable Care Act contains a number of reforms designed to reduce the rate of increase in Medicare and Medicaid spending. Hospitals are estimated to contribute \$155 billion in savings over 10 years through reduced payment updates, decreases in Medicare and Medicaid disproportionate share hospital payments, and financial penalties. For Illinois, these changes will require hospitals to absorb \$8 billion in payment reductions by 2020.

Hospitals Create Jobs and Stimulate the Economy

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

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

Conclusion

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