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December 3, 2010

Michael Gelder
Chairman
Illinois Health Care Reform Implementation Council
100 W. Randolph, Suite 16-100
Chicago, IL 60601

RE: The Affordable Care Act: Key Issues for Public Comment

Dear Chairman Gelder:

On behalf of our 200 member hospitals and health systems across the state of Illinois, the Illinois Hospital Association (IHA) appreciates the opportunity to respond to the Illinois Health Care Reform Implementation Council (Council) request for comment on Health Insurance Reform and the Option of Establishing an Insurance Exchange in Illinois as provided by the *Patient Protection and Affordable Care Act (ACA)*.

IHA supports the creation of health insurance exchanges (Exchanges) as marketplaces to not only expand consumers' access to health insurance coverage, but also allow consumers the opportunity to choose health plans that fit their needs. With the proper framework and guidance, the Exchanges will ensure the efficient operation of a marketplace for private health insurance. IHA will be addressing all aspects of the ACA that affect Illinois hospitals, including the formation of an Exchange, in a formal document to be delivered to the Council in the near future. We did, however, want to take this opportunity to specifically address the questions presented in the request for comment issued November 16, 2010.

I. Functions of a Health Benefit Exchange

Questions to Consider:

1. What advantages will Illinois see in operating its own exchange versus permitting the U.S. Department of Health and Human Services (HHS) to run an Exchange for the State?

IHA believes that it is incumbent on the state to both elect to establish an Exchange and to ensure appropriate steps have been taken to ensure the Exchange will be operational by January 1, 2014. Allowing the establishment of an Exchange to default to the federal government would not be in the interest of Illinois citizens. Such action would make it difficult for the Exchange to recognize the nuances of state-specific markets, reduce the likelihood of meaningful stakeholder involvement

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in Exchange decisions, and lead to possible conflicts with existing state programs and regulations relating to the regulation of insurance plans and the administration of the state's Medicaid program.

2. What are the most desirable outcomes from an insurance market perspective? What features should the Exchange contain in order to reach those outcomes?

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.

3. What, if any, Exchange functions beyond the minimum clearinghouse functions required in the ACA would benefit Illinois and why?

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.

4. What advantages are presented to Illinois if the Exchange were to limit the number of plans offered; for example, plans could be required to compete on attributes such as price or quality rating? Is the Exchange a stronger marketplace if it permits "any willing provider" to sell coverage?

Given the state's limited assets, IHA believes that the Exchange should allow the market and a plan's self-assessment to determine whether a plan participates in the Exchange. While it might be possible to establish 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, given the lack of familiarity with acting as a purchaser of insurance, the Exchange should limit its role in this respect.

II. Structure and Governance

Questions to Consider:

1. If Illinois chooses to establish its own Exchange, which governance structure would best accomplish the goal of more affordable, accessible health insurance coverage? Why?

While IHA has not dismissed the idea of housing the Exchange in an existing department and would actively work to ensure its efficient operation within a departmental structure, 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. Not only would such governance maintain stability and neutrality during political change, it would also allow other key agencies, such as the Department of Healthcare & Family Services (DHFS), the Department of Insurance (DOI), and the Department of Public Health (DPH), to continue to focus on their existing duties and responsibilities.

2. If the Exchange is run by an executive director and/or a governing board, what should be the expertise of those appointed? How long should the terms be? Are there existing models to which the State should look?

IHA recommends that the governing board of the Exchange should be broadly defined with a sufficient number of board members to encompass a diverse variety of stakeholders including health care advocates and providers. Within such a construct, the directors of affected state agencies should serve as ex officio members on the board. Conceptually the Exchange could function in a similar manner to the Illinois Comprehensive Health Insurance Plan (ICHIP), but the director and board would need to be more independent of stakeholder interests than the current CHIP board.

III. The External Market and Addressing Adverse Selection

Questions to Consider:

1. Should Illinois establish a dual market for health insurance coverage or should it eliminate the external individual market and require that all individual insurance be sold through the Exchange? What would be the effects of doing so?

Because the only way to access the federal subsidy would be through the Exchange, it is possible that the Exchange will be the de facto market for the uninsured. Therefore, in order to ensure as little market disruption as possible, it may be advisable to allow the continued existence of an individual market external to the Exchange as an alternative for persons who may not be seeking or needing subsidies. Market and Exchange enrollment experience could guide future decisions to combine the Exchange and external markets. To make the decision to combine the two markets at the outset has the potential for creating even greater volatility in the market.

2. What other mechanisms to mitigate “adverse selection” (*i.e.* requiring the same rules for plans sold inside and outside of the Exchange) should the state consider implementing as part of an Exchange?

In order to avoid adverse selection, Illinois should ensure that plans sold outside the Exchange not act to undermine Exchange enrollment by offering plan types that would attract potential Exchange applicants through significantly skewed pricing or benefit structures.

3. Are there hybrid models for the Exchange the State should consider? What characteristics do they offer that would benefit Illinoisans?

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. While as of yet untested, this type of system would most closely mirror the Utah model.

4. If the Exchange and the external market operate in parallel, what strategies and public policies should Illinois pursue to ensure the healthy operation of each? Should the same rules apply to plans sold inside and outside an Exchange? Should the same plans be sold inside and outside the Exchange without exception?

In order to avoid adverse selection, Illinois should ensure that plans sold outside the Exchange not act to undermine Exchange enrollment by offering plan types that would attract potential Exchange applicants through significantly skewed pricing or benefit structures.

5. What rules (if any) should the State consider as part of establishing the open enrollment period?

IHA recommends the Exchange should limit enrollment periods to minimize the potential for adverse selection. The initial enrollment period should be open for at least six months to take full advantage of providing coverage of uninsured individuals. To balance the concerns of adverse selection with the need to decrease the number of uninsured, yearly enrollment should be divided into two semiannual open enrollment periods; the first running from mid-May to the end of June with coverage becoming effective July 1. The second would run from mid-November to the end of December with coverage becoming effective January 1. Special enrollment periods should be established that use the requirements established by HIPAA and state continuation requirements for group health plans as a platform, but tailored for persons losing prior individual coverage.

6. The ACA requires states to adopt systems of risk adjustment and reinsurance for the first three years of Exchange operation. How should these tasks be approached in Illinois? What are issues the State should be aware of in establishing these mechanisms?

Efforts should be made to ensure that any adjustments made both ensure a favorable market in order to lure insurers to participate in the Exchange, and are minimally invasive in order to allow market forces to guide the healthy regulation of the open market. It may be that with the proper establishment of the Exchange, the use of such adjustments might be unnecessary except in circumstance of extreme imbalance of risk.

7. Given the new rules associated with the Exchange, and the options available for restructuring the current health insurance marketplace, what should the state consider as it relates to the role of agents and brokers?

While IHA does not take a position on the specifics of this issue, ensuring a commercial market outside of the Exchange should serve to placate concerns of producers.

IV. Structure of the Exchange Marketplace

Questions to consider:

1. Should Illinois operate one exchange or two separate exchanges for the individual and small group markets? Why?

The choice of either of these schemes should not affect how providers interact with consumers or payers. Still, IHA can see where combining these two markets may be necessary to ensure a sufficient population to establish a risk pool.

2. What should the Illinois definition of small employer be for initial Exchange participation in 2014?

IHA believes the likelihood for success of the Exchange will depend on establishing a limited and orderly transition to the ACA requirements. Therefore, while the Exchange will have to accept groups of 100 in 2016, the current definition of small group in Illinois should be maintained until the Exchange is operational and has demonstrated the capacity to take on greater responsibilities.

3. Should Illinois consider setting any conditions for employer participation in the shop Exchange (*e.g.* minimum percent of employees participating, minimum employer contribution)?

IHA believes that the Exchange should not be involved with making such determinations unless market forces show that coverage that otherwise would be available is being denied to employer groups.

4. Should Illinois permit large group employers with more than 100 employees to participate in the Exchange beginning in 2016? Are there any special considerations for including this group of which the State should be aware?

It is best to leave this decision to a future date in order to assess the market effects of the Exchange. The Exchange should not commit up front to making decisions that could either affect the smooth running of either the Exchange market or the external large group market.

5. Should Illinois consider creation of separate, regional exchanges for different parts of the State? Should Illinois consider a multi-state Exchange?

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. Multi-state Exchanges should be considered only after the establishment of the state Exchange and with enough risk experience to guide the decision to expand the Exchange.

V. Self-Sustaining Financing for the Exchange

Questions to consider:

1. How should the Exchange's operations be financed, after federal financial support ends on December 31, 2014?

Assessing insurers is the most obvious option for funding, but how far afield to cast the net for such an assessment will need to be determined based on actual experience.

2. What are the ramifications of different financing options, specifically as they relate to the unique characteristics of Illinois' existing economy and health insurance marketplace?

Whatever the source of funding, it is imperative that any state fund for the administration of the Exchange should be statutorily protected from use for other state funding purposes.

3. Should the State consider a separate funding source for maintaining state benefit mandates? If so, what are some options?

Given current state budget constraints, it will be difficult to justify diverting funds from existing uses to independently fund existing state mandates. IHA has submitted comments to the Secretary recommending that the definition of essential benefits be broad enough or flexible enough to encompass existing state mandates.

VI. Eligibility Determination

Questions to Consider:

1. How should the Exchange coordinate operations and create a seamless system for eligibility, verification and enrollment in the Exchange, Medicaid, the Children's Health Insurance Plan (CHIP), and perhaps other public benefits (food stamps, TANF, etc.)?

For health reform to achieve its potential, it is critical that the enrollment process be simple and easy for consumers. The state should ensure the electronic enrollment platforms for enrollment in Medicaid and CHIP are developed in such a way to minimize disruption in 2014. Consideration should also be given to ensure that persons who are used 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.

To assist enrollees, the ACA requires an Exchange to establish a program under which it awards grants to qualified entities to carry out defined education of individuals and facilitate enrollment in qualified plans. IHA recommends that hospitals wishing to act as navigators should be awarded such status based on the fact that they are often the first contact point for uninsured persons seeking medical care.

2. When enrollees move between public and private coverage, how should Illinois maintain continuity of health care -- in plan coverage and in availability of providers, e.g. primary care physician?

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.

In addition, current Illinois law already has protections for persons covered by an HMO who lose access to their provider due to the provider leaving the HMO's network. Section 25 of the Managed Care Reform and Patient Rights Act (215 ILCS 134/25) establishes time frames for continuing to see a provider under these circumstances given the provider's acceptance of various terms, including accepting the plan's established applicable reimbursement rates. We believe that such transition language could be used as a starting point for drafting language that would help ensure continuity of providers when persons transitioning out of Medicaid into a commercial plan when the Medicaid provider is not part of the plan's network.

3. What will maximize coordination between Medicaid as a public payer and insurance companies as private payers offering health insurance on the Exchange in their provider networks, primary care physicians ("medical homes"), quality standards and other items?

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.


In addition to the concepts of a "medical home" (where each patient receives primary care and management of overall care to address chronic conditions and promote wellness), and bundling (where the payment for an "episode of care" is to be distributed among various providers in different settings, such as the physician's office, the hospital, and the nursing home, in an effort to increase patient care coordination among providers), another health reform model that is being promoted is the Accountable Care Organization (ACO). Entering into ACO agreements would enable groups of health care providers to become jointly responsible for a population of assigned Medicare patients, and to share in savings realized from higher quality and lower cost patient care. In theory, this model can also work outside the Medicare arena as well to assist in coordinating payments across commercial and public coverage. IHA supports the ACO concept as a key framework upon which to build collaboration and efficiencies and will work with its members, the state and other interested parties to implement ACOs.

4. Should Illinois establish a "Basic Health Plan"? If so, what should be included in such a plan? Specifically, what does a "basic health plan" offer as a tool to facilitate continuity of coverage and care?

Assessing the need to establish a Basic Health Plan should be predicated on whether the minimal requirements of the Exchange are not fully capturing the needs of the uninsured population. With experience, it may very well be that the increased coverage options currently anticipated by the ACA will create adequate avenues for coverage.

IHA looks forward to working with you and the Council to meet the challenge of establishing a viable Exchange 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 or (217) 541-1179.

Sincerely,



Howard A. Peters III
Executive Vice President